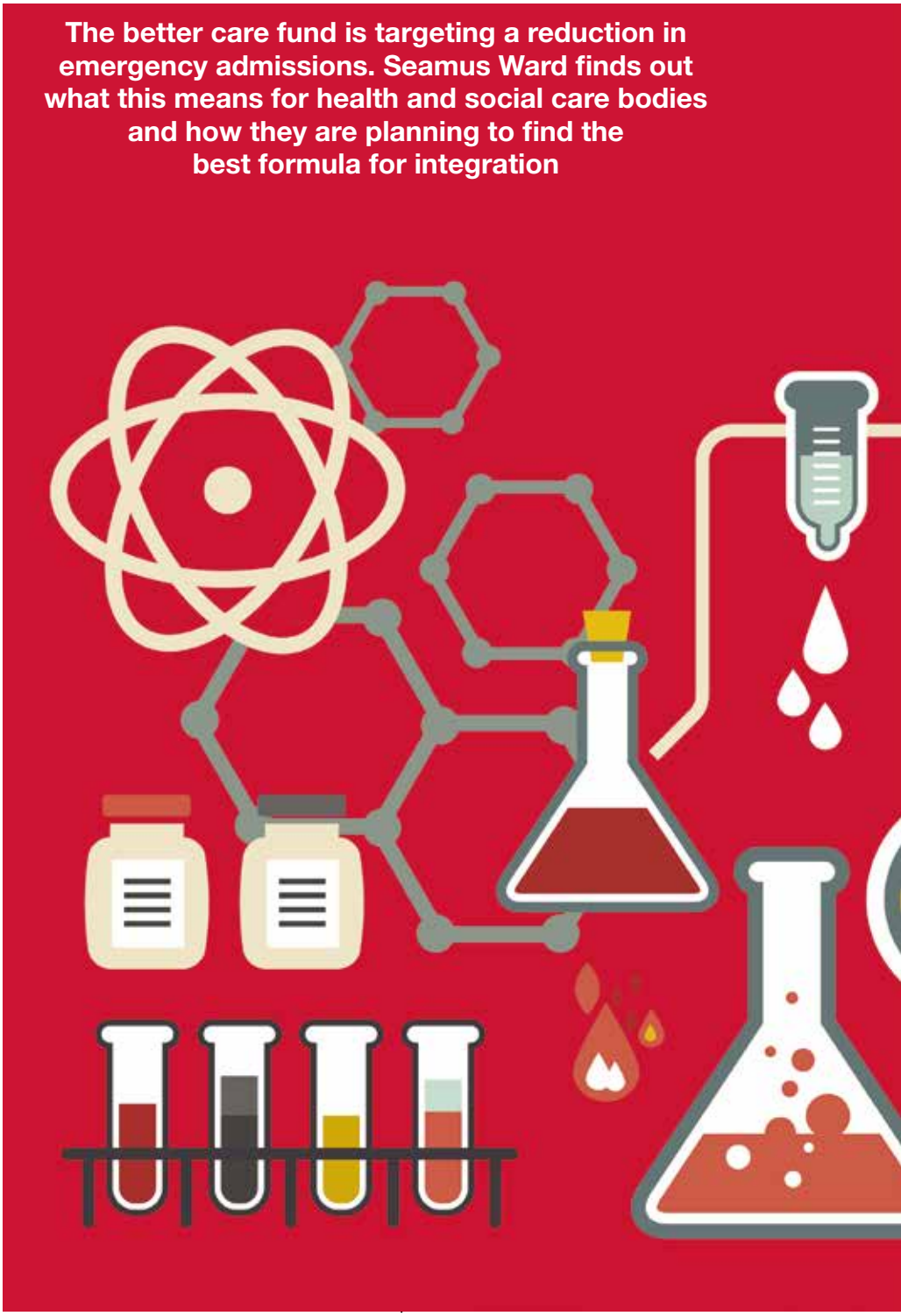
The right chemistry?

The better care fund is targeting a reduction in emergency admissions. Seamus Ward finds out what this means for health and social care bodies and how they are planning to find the best formula for integration



The better care fund (BCF) has always been multi-faceted, taking in integration of health and social care and service transformation, as its name implies, but also personalised care closer to home.

Some commentators have even argued that the fund, worth at least £3.8bn in 2015/16, amounts to a rewriting of the current spending settlement to ease the financial pressure on local authorities.

Following a review of plans submitted at the beginning of the summer, the government has insisted integration, transformation and protection for social care remain central to its plans. But one strand of the initiative – the reduction of emergency admissions – appears to have gained new importance.

Revised guidance from NHS England and the Local Government Association demonstrates this. It says £1bn of the fund will be ring-fenced in 2015/16, with each clinical commissioning group (CCG) holding their share.

The non ring-fenced funding will be allocated and available to spend from April 2015 onwards.

Emergency focus

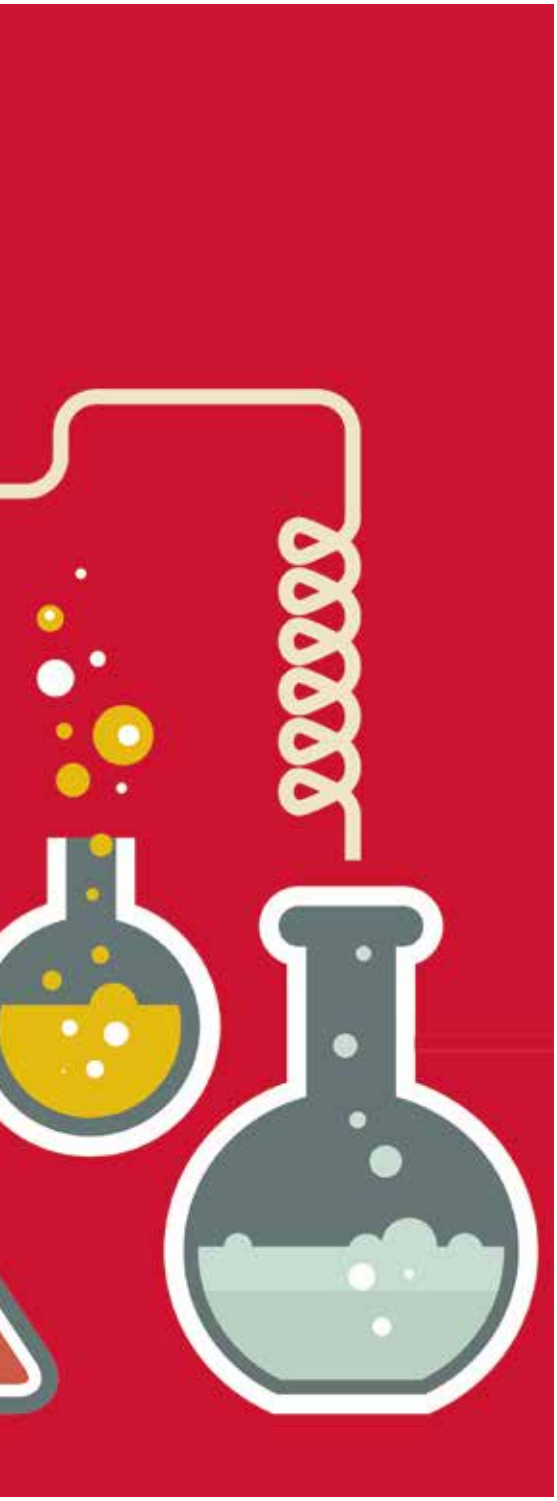
Payments from the ring-fenced sums into pooled BCF allocations will be linked to the reduction in the total number of emergency admissions locally – earlier plans were based on avoidable emergency admissions.

Guidance issued by NHS England in July said the minimum reduction should be 3.5% of total emergency admissions, unless there is a credible case for a lower target. Higher targets can be set locally.

There will be four quarterly payment points, beginning in May 2015 (based on reduction in emergency admissions in the final quarter of 2014/15).

The amounts paid will be in line with the reduction achieved. If the targeted reduction in emergency admissions is met, 100% of the quarterly ring-fenced sum will be released to the pooled budget. If, say, 30% is achieved, 30% of the funding will be released.

The focus on emergency admissions is



largely due to the need to reverse the rising trend in non-elective admissions and their cost. According to a 2013 National Audit Office report, emergency admissions cost the NHS £12.5bn in 2012/13 and admissions had increased 47% over the past 15 years.

The ring-fence in the BCF funding aims to protect both CCGs and their hospital providers. With CCGs contributing £1.9bn to the BCF, there will be less money for hospital-based care.

Providers could become financially unstable, particularly if greater health and care activity in the community is not matched by reduced workload in hospitals.

To mitigate this, the guidance says that any performance-related funding not released due to a failure to meet the admissions target will be available to CCGs. It is assumed these funds will be used to cover the cost of unplanned activity.

Delivery plans

The 3.5% target certainly raised eyebrows, given the historic upward trend, but commissioners and providers feel it is too early to say whether it can be delivered. Plans submitted at the beginning of the summer included targets to reduce avoidable emergency admissions. Some were as low as 1%, while others targeted 10% and above.

CCGs are now examining how these figures relate to total emergency admissions, though many already have plans to reduce overall emergency admissions.

Tim Furness, business planning and partnerships director at Sheffield Clinical Commissioning Group, says the reduction of adult non-elective admissions is a major element of the city BCF plan. Sheffield aims to reduce emergency admissions by 20% over the next five years, he says, comfortably more than the 3.5% national target.

He adds: 'We want to invest in keeping people well at home and get better outcomes from intermediate care, to reduce emergency hospital activity and therefore urgent care spend.'

Dorset Clinical Commissioning Group chief financial officer Paul Vater says the local draft plan aimed for a 10% reduction in avoidable emergency admissions compared with 2013/14.

The CCG and local authorities are now revising their plans in accordance with the new guidance, but this will not delay the work done up to now on developing new models of integrated care.

The CCG and three local authorities have pooled funds for equipment services, with joint arrangements for care packages, particularly in mental health. And, since April, CCGs have been expected to set aside about £5 per head of population to fund GP practices to provide enhanced services that will reduce avoidable admissions among over-75s.

For Dorset, the fund is about £4m and this has helped drive integration, he adds. However, the BCF will take this joint working onto another level.

£5bn target

Nationally, it is predicted the full value of pooled funds under the BCF umbrella could reach more than £5bn in 2015/16, driven by a number of areas with well-developed NHS-local authority links, including Dorset, Sheffield and Sunderland.

Mr Furness says discussions in Sheffield about making best use of resources began well before the BCF. The aim is to make the most of 'the Sheffield pound' and the partners are aiming to have a pooled budget of £280m in 2015/16. The minimum joint BCF contribution in Sheffield is just over £41m.

The city plan focuses on intermediate care, community equipment and long-term care. 'We felt we needed to look at long-term care together, otherwise there was a risk that we would have a savings plan that would benefit one organisation at a cost to the other, moving the problem around rather than solving it,' Mr Furness says.

> **"We have to be careful as we can't lift and shift services straight out of acute and into the community"**
>
> **London acute provider finance director**

Mental health and learning disabilities services have not been included in the 2015/16 plan but it is expected that they will in future years. The priority for 2015/16 has been those service areas where partners felt they could have the greatest impact on demand for health and social care.

Mr Furness adds that measures to keep people well and out of hospital are the most developed. These are based on tools such as risk stratification with GP and community nurse support for those identified as the most vulnerable.

This will be supplemented by other initiatives designed to help people improve their lifestyles. The CCG and council are working with a number of community

organisations that already promote better health through exercise and advice from volunteer health champions – including smoking cessation and healthy eating – to develop partnerships with practices to support people to stay well.

Dorset aspirations

The minimum amount of pooled funds in Dorset has been set at just under £55m, but the local partners believe, in time, they could pool up to £345m.

While this figure remains an aspiration, in 2015/16 the pooled budget could be around £100m. To reach this figure, a number of services may be added, such as learning disabilities and reablement.

'We are confident we can develop a pooled fund in the range of £100m, subject to governing bodies' approval,' Mr Vater says. 'The numbers in Dorset are quite significant. District nursing alone is £25m, so putting together a few services can take you quite a way towards that level. Combining what we are already doing and changing and transforming them is the way forward.'

Mr Vater accepts that the Dorset plan focuses on existing service areas, but he insists streamlining services, removing duplication and shifting care away from the high-cost option – care homes and acute hospitals – will bring rewards.

It hopes to allocate £4m to boost service provision, particularly around seven-day services.

'When we looked at emergency services, we saw the weekend and out of hours were the key ones that needed support. Some of that is about investment to get seven-day working, though we realise it will have a bit of a price tag.'

Mr Vater adds that the budgets for much of the remaining £245m could be aligned – where the budgets are spent jointly, but the NHS commissioner or local authority holds the contracts.

'We are treating this as the first stage in the development of pooled budgets for these services,' he says.

There is a proposal, for example, to integrate services for the frail elderly and people with long-term conditions.

'All the streams of social care and health for these individuals are worth around £185m a year. To bring the budgets together would be transformational – at the moment there are multiple points of access and almost too many service offerings. In the future we may be able to streamline our approach through our 13 localities, which will each have a common assessment and review process.'

"Combining what we are already doing and changing and transforming them is the way forward"

Paul Vater, Dorset CCG

Efficiency boost

While the better care fund is ultimately about providing better services for patients and clients, pooled budgets and joint commissioning can produce more efficient services.

Birmingham, for example, is now in its fifth year of joint commissioning for learning disability and mental health services. Jon Tomlinson, director of Birmingham's joint commissioning team, says joint commissioning arrangements for the two areas were launched in April 2010.

'When we started we had a few issues to resolve, including significant budget pressures – for example, learning disability services were overspending several million year on year. In mental health, we wanted to establish more effective partnership working between the NHS and the local authority,' he says.

Prior to 2010/11, a number of small, pooled funding arrangements – for equipment, for example – had existed. However, the section 75 pooled budget for mental health and learning disabilities was about £340m in the first year, divided almost equally between the two services.

'The current year contribution stands at just under £300m. I like to think that part of that reduction has been the more effective way we commission services. This in turn has led to a more effective use of public funds, increased quality and better outcomes for individuals,' he adds.

The joint commissioning team has found that even small changes to processes can make a big difference. For example, previously clinical staff would carry out an assessment of a patient's needs, but would then become involved in the commissioning of the care package without the involvement of the commissioner or its wide market knowledge.

'By tweaking the process and ensuring proper reference back to the commissioner on placement decision, we found cost differences of up to 40% for services that effectively met assessed need,' Mr Tomlinson says.

Acute concerns

Acute providers are concerned about the impact of the BCF. While accepting the £1bn top slice will help manage the risk of community schemes failing to reduce emergency admissions, one London provider finance director says there is little clarity on how trusts can take out costs and the anticipated impact on individual providers and services.

He has sympathy for CCG colleagues, whom he feels have been passed a difficult agenda at short notice, and he acknowledges they are working hard to provide information on the impact of the BCF.

But at the beginning of quarter two in 2014/15, he says his trust still did not know where to invest

and where to disinvest. 'We are both an acute and community provider and are expecting some disinvestment on the acute side and some investment on the community side.

'The bottom line is that this is potentially good news for us, so we are excited about the potential opportunities. But we have to be careful as we can't lift and shift services straight out of acute and into the community. If we are to reduce A&E activity, we can't take an A&E nurse and put them straight into the community without retraining. Recruitment is a big issue for us, particularly with community and district nurses.'

He is a supporter of more integrated care, but cautions that some double running is inevitable and that change is not going to happen overnight. 'As the community services start to become more effective and gradually begin to increase, there will be a gradual decline in the acute side.

'I don't think you will see a community team being put in place on 1 April and on 2 April we will be twiddling our thumbs in A&E.'

BCF plans are gearing up, with a renewed focus on emergency admissions, but change will be gradual.

The Sunderland way

The Sunderland BCF plan is unusual in that it does not include a target of at least a 3.5% reduction in non-elective admissions in 2015/16. Yet it is one of six high-potential areas named by the Department of Health asked to complete their plans early.

Sunderland Clinical Commissioning Group chief finance officer Chris Macklin says the plan is realistic. In 2015/16 schemes will be put in place to reduce emergency admissions. While they may have an effect next year, the aim is to produce savings from 2016/17 to 2018/19 and reduce emergency admissions by 15% gross over three years – offset to a degree by demographic pressures. Although hard to quantify, he expects its plans to deliver no more than 1% in 2015/16.

'Our plan will not have a 3.5% reduction in 2015/16, but there will be more than 3.5% in 2016/17 to 2018/19,' he says. 'We don't expect savings to materialise until 2016/17. Undoubtedly, some of things we do in 2015/16 will have an impact, but it is difficult to quantify – hence our cautious approach.'

Sunderland has a proud history of collaboration between the NHS and local government, he says – an advantage when putting together BCF plans to cut emergency admissions.

Risk stratification

The area aims to introduce risk stratification to identify the most vulnerable and an intermediate care hub. Clinicians can refer patients to the hub if they are unsure where a patient should go, rather than follow the most common position – an emergency admission.

Mr Macklin says the local major acute provider, City Hospitals Sunderland NHS Foundation Trust, is key to the plans. 'This is not just about the commissioners deciding something and then rushing headlong into it. We have involved the local FT. If our schemes do what we say they will, the foundation can take out infrastructure and its plans reflect that.'

The CCG has financial headroom, with a £17m retained surplus. For four years from April 2015, it intends to use £12m (£3m a year) of the retained surplus to transform services.

'This will give us transitional funding to help with double running or pump priming,' says Mr Macklin. 'If you want to carry out large transformational change, you can't stop something one day and start something new the next. You need some smoothing monies.'

"This is not just about commissioners rushing headlong into it. We have involved the local FT"

Chris Macklin, Sunderland CCG

The GP practice and local community group in Sheffield's Darnall area is one example of the type of partnership being developed to keep people well in the city