Nottinghamshire County Council

**Report to the Adult Social Care and Health Committee**

**02 February 2015**

**Agenda Item: 4**

# REPORT OF THE DEPUTY DIRECTOR, ADULT SOCIAL CARE HEALTH AND PUBLIC PROTECTION

# BETTER TOGETHER PROGRAMME IN MID-NOTTINGHAMSHIRE

## Purpose of the Report

1. The report provides an update on progress in delivering the Better Together programme (BTP) within Mid Nottinghamshire.

2. This report asks members to consider the implications, risks and issues of the development of a capitated budget model of commissioning on the local authority and social care services.

3. Committee are asked to agree further work to be undertaken to determine the future configuration of services in the context of integrated health and social care commissioning and provision.

## Information and Advice

4. The Better Together Programme (BTP) aims to deliver a sustainable health and social care system with improved outcomes for local people within the districts of Ashfield, Mansfield and Newark and Sherwood. The BTP forms the basis of the Better Care Fund submission for the Mid Nottinghamshire planning area.

5. The programme is a collaboration between the two Clinical Commissioning Groups, the County Council, all NHS health providers and voluntary sector partners, and which focuses on specific areas of health and social care:

   - urgent and proactive care (including care for people with long term conditions like diabetes, asthma, and frail older people),
   - elective care,
   - maternity and paediatric care.

6. The aim of the programme is to connect services together to ensure that people can better support themselves through self care, get the right advice in the right place, first time when they need it, ensure responsive urgent care services outside of hospital wherever possible and responsive treatment for people with serious or life threatening emergency care needs to maximise chances of survival and a good recovery.

**Self Care and Care Planning**

7. A Self Care Hub will be developed which will support patients to learn more about their conditions. Patients will benefit from being able to become more involved in making decisions about and planning their own care.

8. The hub will support the delivery of education programmes for people with Long Term Conditions. The hub will work closely with the teams who provide a community based service using a multi-disciplinary team. This is just like a hospital ward, using the same staffing, systems and daily routines, except that the people being cared for stay in their own homes throughout.

9. **Proactive care.** Proactive care known as PRISM is currently being successfully delivered across Mansfield, Ashfield, Newark and Sherwood. These teams focus primarily on people who are at high risk of future admission to hospital and then work with them to put in place care and support which reduces that risk and avoids the need for an unnecessary admission.

10. **Enhanced Intermediate Care.** Intermediate Care can help support people experiencing a period of ill health or difficulty to remain at home rather than having to go into hospital. It can also help people to regain independence following a hospital stay. The new intermediate care model will focus on increasing the number of people receiving care and support at home rather than in a hospital or care home bed. People receiving the most intense level of care can expect to receive up to four visits per day from a joint health and social care team and if needed, have access to night sitting and tele-health services. The proposal is that **Specialist Intermediate Care Teams** (SICT) will provide health and social care and support to bridge the gap between acute and community services. Linking these services together will help avoid unnecessary admissions, reduce delays in discharge and enable more effective patient flows through the system.

11. **Care Navigator** - Often healthcare professionals do not know which services are available for them to offer help to patients and so a new service called the **Care Navigator** will be developed. This will be used specifically for Health and Social Care professionals to contact services when they need to arrange support for their patients who need help. The Care Navigator service will be available seven days a week and will help identify and arrange alternatives to hospital admission or support a discharge from hospital or care home. This means that patients will be signposted to and supported by the most appropriate service in the most appropriate care setting in a timely and co-ordinated way.

12. **Crisis Response Team** - A community based crisis response service will operate 24/7 and provide intense and focused health and social care support (including personal care) to assist people experiencing difficulties and support them to remain living in their own home and maintain independent living skills rather than having to go into hospital. The crisis response staff will be trained staff who will respond to a request for support within 2 hours and will work closely with community teams who will provide clinical support.

13. **Discharge Function** - The new discharge service will ensure that people do not need to stay in hospital any longer than necessary and that they can be discharged with all of the support they need to the most appropriate care setting. The aim will always be to support

patients to return to their own home The team will start this planning process very early on in the hospital stay and they will work closely with their colleagues in the community to ensure that all of the support needed is in place ready for when the patient is medically fit for discharge.

14. The BTP provides a blueprint for action which includes a range of activities required in order to deliver the anticipated outcomes. These activities include the development of a joint commissioning strategy, an estates strategy, IT infrastructure plans, workforce development plans, and performance management framework.

15. The development of a joint commissioning strategy is now being considered through the development of an **outcome based capitated model** of commissioning led by a single lead provider who will co-ordinate all service delivery across the area.

16. Capitated commissioning aims to deliver better outcomes by removing the incentives for providers to maximise income through episodic care within the current NHS commissioning process. Rather than providers being remunerated for each treatment episode (outputs), they are given a capitated budget to cover the whole population with incentives linked to specific outcomes. This model aims to reward providers for delivery of high quality care rather than by quantity of care.

17. The lead provider model takes this one step further by requiring one co-ordinating provider to lead the delivery system, co-ordinating the activity of all other local providers. In this way commissioners can transfer or delegate accountability for delivery to a single accountable provider (SAP) who becomes responsible for establishing an integrated care pathway, procuring services to deliver care and navigating people through the system.

18. Across the three Districts, the health and social care spend amounts to over £300m per annum, of which Nottinghamshire County Council spends in excess of £80m on social care services. A process is underway to map all the expenditure across health and social care within the mid Nottinghamshire area to develop a profile which can then be used to enable the commissioning of a capitated contract across health and social care. A further report will be presented to members to identify the different areas of expenditure across the County.

19. In entering into an agreement to deliver a single capitated budget across health and social care services within mid Nottinghamshire, there are a number of issues and risks which will need to be understood and addressed by the County Council. These can be summarised as having impact in the following areas:

**Outcomes**

20. The County Council is accountable for the delivery of social care services to the population of Nottinghamshire. The Council may delegate both the commissioning and provision of services to other bodies but retains accountability for the outcomes of any services which individuals receive. The Council is held to account by Government and the regulator and measures delivery through the Adult Social Care Outcomes Framework, sector led improvement processes and other performance management frameworks.

21. Previous experience of integrated provision across health and social care locally has shown that NHS providers have struggled to meet social care outcomes, and national evidence of

integrated provision has largely not demonstrated success in providing value to social care services. It is therefore essential that any future development of integrated commissioning and provision is based upon an agreed outcomes framework which meets the requirements of the Council.

22. Social care is highly personalised, through the provision of personal budgets within which people exercise choice of service delivery. Nottinghamshire County Council is a high performing council with nearly 100% of community based service users having a personal budget and nearly 50% of those having some form of direct payment. Nottinghamshire County Council would wish to see the continued personalisation of social care (and Health) services in line with the duties and requirements of the Care Act 2014.

23. Whilst it is essential that the SAP can procure social care services for the local population, it is as yet unclear how a SAP can deliver personal budgets in line with Council policy without access to the local authority's underpinning systems and processes such as the assessment process, resource allocation system, commissioning processes and direct payments systems.

24. It is not considered feasible or desirable for the SAP to develop its own bespoke processes for the delivery of personal budgets as this would be resource intensive for the provider and could result in differential outcomes for individuals across the county who may be subject to different systems.

25. It is recommended therefore that the County Council maintains a county wide system and process to deliver personal budgets which can be accessed by the SAP on a case by case basis in order to deliver personal social care services to individuals.

26. The allocation and ongoing review of a personal budget is driven by the care management and assessment process which is undertaken by social care staff. In order to deliver an integrated health and social care offer to individuals, the SAP would need to be able to direct both health and social care resources. This will be particularly important where health and social care service interface such as at the point of hospital admission / discharge and where individuals have both health and social care provision for example people with multiple long term conditions.

27. Therefore the SAP will need to be able to both deploy the contracted social care provision and deploy the assessment and care management activity which supports the procurement of services. It is envisaged that should the Council adopt a lead provider model, the SAP will have day to day operational responsibility for the assessment and care management staffing which supports this activity in order to have full control of the overall health and social care resource.

28. The current deployment of assessment and care management services reflects both the point at which people access services and the social care functions of the authority. This entails staff located at hospitals, within locality teams, in integrated teams such as PRISM and IRIS (Information Service for parents and carers of children and young people with disabilities in Nottingham and Nottinghamshire) as well as staff who work in corporate structures such as the Adult Access team and MASH. Whilst it is clear that some of these staff would need to be within the scope of a SAP, others may not, and some of these

functions support wider areas of the Council's social care responsibilities which may remain outside of the SAP contract.

29. One such area of activity which may or may not be a delegated to the SAP is the authority's safeguarding responsibility. The local authority is the lead organisation tasked with safeguarding adults who may be at risk of harm or abuse. These responsibilities are being extended with the introduction of a new legislative framework from April 2015. Currently the Council requires all experienced social work staff to undertake safeguarding assessment duties which involve the investigation of allegations of harm and abuse wherever these occur within the geographical boundary of Nottinghamshire. The Council together with the Safeguarding Adults Board has held the view that individual providers should not investigate allegations (other than in relation to employment issues) concerning their own provision other than in exceptional circumstances. Health services however have developed internal processes for the investigation and governance of safeguarding arrangements within the NHS. Requiring a provider to carry out safeguarding investigations and decision making of itself and others on behalf of the Council raises potential conflicts of interest and would entail a revision of safeguarding policies and procedures which would require the approval of the Safeguarding Adults Board.

30. Members may therefore wish to consider the options of retaining a safeguarding function within the Council or of delegating functions and responsibilities to the SAP. Members may further wish to take advice from the Safeguarding Adults Board in this respect.

31. The promotion of independence, the achievement of value for money and the continued personalisation of services is the agreed strategy for adult social care, which together with the Care Act implementation forms the priority for adult social care commissioning.

32. The Better Together programme also enshrines these principles although it is not yet fully understood how these can be enacted and fulfilled at a system level. It is essential therefore that the County Council is fully engaged in the establishment of an agreed joint outcomes framework which can provide evidence of improvements in social care in line with the local strategy and national policy. A draft joint outcomes framework is being developed and is attached to this report for members' information.

33. One issue which members may wish to consider is the historical difference in how health and social care services approach risk to individuals. Health services have often tended to be more risk averse than social care services. Whilst it is difficult to generalise there are a number of factors which influence appetite for risk such as professional values, ethics, litigation, regulation, choice, individual responsibility, situational responsibility, public expectation, expediency etc. These factors all contribute to the manner in which people receive their care, where and how they receive care and the level of care provided. There are no rights and wrongs in this area it is more a matter of philosophy and ethos, however the degree of difference in approach can be substantial and have consequence on outcomes for individuals. The development of an outcomes framework does not in itself resolve this issue as there may be outcomes which conflict or which may not be mutually supportive, for example keeping people safe versus promoting independence, maximising choice versus being most efficient. Members may therefore wish to specify which outcomes are more of a priority or consider whether a weighting should be applied to ensure approaches to risk reflect the authority's priorities.

34. Advice information and advocacy forms the first requirement for local authorities in their delivery of social care functions. Ensuring people receive the right information at the right time in the right way is intrinsic to the authority's ability to manage demand and therefore manage its resources going forward. Therefore a co-ordinating provider would need to be able to provide relevant information and advice in a timely way to people who are using health and social care services. However the delivery of these functions requires a much broader approach than that envisaged for the SAP and will require the involvement and intervention from many different organisations across the statutory, voluntary and third sector. The Council is currently developing a range of information services which will be available in different formats to the wider population which will be based upon a digital platform to enable the information to be updated as required and accessible to agencies, organisations and individuals.

35. Members may therefore wish to consider the role that the SAP should play in delivering information and advice within the broader framework having thought to the balance to be struck between general advice information and advocacy and that which is required to be given to individuals with specific needs and any potential conflict of interest which could be perceived for a provider who will have a focus on ensuring a value chain of provision and the wider needs of individuals and the population at large.

36. Prevention and early intervention services are key to the delivery of a capitated budget model. The SAP must over time be able to deliver interventions which defer, delay or prevent recourse to further services if the model of a capitated budget is to be able to fulfil the future demand for health and social care. Members may wish to consider whether a distinction could or should be made between areas of primary prevention which may be based at population level, secondary prevention which may be targeted at individuals who are at risk, and tertiary prevention which relates directly to people who are in receipt of health and social care services. As an authority with both social care responsibilities and public health functions, the Council has a duty to arrange prevention services at all levels. However it is within the discretion of the Council to commission these services in whatever manner best meets the needs of the local population. Members may therefore wish to consider which prevention and early intervention services are best placed within the scope of a SAP such as reablement services, intermediate care services and hospital discharge services and those which may be better commissioned at a population level such as advice information, short term prevention and screening services. In addition the Council is also progressing work to develop the capacity of local communities and third sector organisations to help support to people who have additional needs to prevent them from needing to access health and social care services. It is recommended that this work should continue outside the scope of the SAP.

37. The draft outcomes framework is attached as Appendix 1.

**Finance and Procurement**

38. The Council currently spends over £300m gross (over £200m net) on adult social care. The vast majority (over 70%) of this expenditure is on services procured from over 300 different providers.

39. The majority of council managed community based services are contracted through framework agreements to preferred suppliers both at an individual service user level and as a capitated contract giving providers more responsibility for delivery of individual outcomes. Contracts for these services could be either novated to a lead provider, or retained by the authority with permission given to the lead co-ordinating provider to purchase from the contract. In this way the lead provider could develop a supply chain within which the health and social care needs of individuals and the wider community could be met, thereby managing supply and demand. However as the scope of the proposed capitated budget is limited both geographically and in respect to need, members will need to ensure that services are available and accessible to service users from across the whole spectrum of need and across the whole of the county. The contracts which are currently procured to deliver these services are commissioned on that basis and any change to this in the near future may present difficulties in respect to access and equity of provision, contract management, and the achievement of best value.

40. Therefore it is not recommended that the Council should transfer its procurement of independent and third sector providers to the SAP. This does not prevent the Council from allowing a lead provider to call off services from a contracted provider through a delegated arrangement. By doing so the Council would need to ensure itself that services were being procured in line with legislateive requirements, statutory guidance and local social care policy. This could be achieved through the delegation of assessment and care management functions to the SAP. Whilst the Council has wide ranging experience of procuring services from third parties to deliver services, the council has never previously transferred responsibility for the commissioning of services at an individual level (sometimes known as micro commissioning). Allowing a third party, contracted provider to carry out assessment and care management functions on behalf of the authority has potential implications for budgetary and financial management, in that the Council is giving responsibility for the commissioning of personal social care to a different organisation outside of the corporate control of the Council. These budgets are to some degree demand led, highly volatile in spend and can be difficult to forecast, manage and control.

41. The capitated budget model requires the provider to deliver services to meet the health and social care needs of the population (within scope) within a defined (capped) budget. Therefore the Council could determine an overall budget within which the provider must operate and expect that the provider will deliver to this bottom line, whilst at the same time providing sufficient flexibility to allow the provider to procure services. The Council would need to ensure there were effective control mechanisms, monitoring systems and risk sharing agreements in place to alert the Council to; and detail arrangements for any over commitment, overspend, under delivery, or underspend. The delegated budget would also need to reflect the agreed (current and future) savings and efficiency targets which are required to balance the authority budget in the medium term, alongside any demand or cost led budget pressures which the authority may agree to meet.

42. Members will need to consider that a desired outcome in developing a SAP model will be that there would be a shift from acute care to community based care and from health care to social care. Whilst this is beneficial in meeting people's individual outcomes and has an overall financial benefit for the health and social care system, in the longer term it will potentially increase the proportion of expenditure on social care at a time when local authority resources are reducing. Members should therefore seek to assure themselves that the SAP is able to meet current demand within a reducing resource base and that the

authority is protected from any longer term financial consequence of increased social care provision should members agree to the delegation of functions and budget to a SAP.

43. Many of the services procured are arranged at an individual level through individual service contracts for residential/nursing care or through individual Personal Budget and/or Direct Payment agreements. The contracting of services on an individual basis is complex and requires the support of both specific adult care financial services and the general financial services and systems of the authority. The specific adult social care financial services are intrinsic to the delivery of these individually contracted services, not least due to the requirement of the authority to collect client contributions and other income to offset the gross cost of services. The assessment for, determination of, and collection of individual contributions is critical to the financial sustainability of the authority. In addition these services provide invoice and payment processing for providers; payments, monitoring and auditing of direct payment accounts; as well as other related client money functions such as deferred payment systems, appointeeships and deputyship services. It is not recommended that these services are delegated or included within the scope of a SAP, and therefore any agreed financial delegation should be at a net budget level rather than a gross budget.

44. All adult social care services are commissioned through the Frameworki information system which records the level of personal budget, the indicative and actual support plan and the agreed service procured to meet the individual needs of each service user. During 2015 the Frameworki system is to be updated to provide a major system upgrade called MOSAIC which will provide additional functionality and ensure the system is Care Act compliant. Alongside this upgrade the County Council is also in the process of considering the outcome of a systems review of all adult social care information and data management systems with a view to rationalising systems and ensuring that the corporate business management system and the Frameworki (MOSAIC) system are fully aligned. Given these large scale changes to the ICT infrastructure, careful consideration should be given to any further changes or disruption that may be caused as a consequence of integrating health and social care service within the next 12 months.

45. The third area of service provision is through the Council's direct services which accounts for around £30m of expenditure across the County and for which the Council is currently considering alternative delivery models. The development of a lead provider model of service could offer opportunities for some or all of these services to operate as integrated health and social care services. For example services could be seconded to the lead provider whilst the Council retained employer status, or services could be transferred to the lead provider utilising TUPE arrangements.

46. Should this type of arrangement be considered, it is likely that the SAP would only wish to take management responsibility for those services which have a direct influence on their existing core business such as Re-ablement services and possibly some bed based provision, leaving other services such as employment, and catering with the authority.

47. A further option would be for the authority to develop an alternative delivery company such as a Local Authority Trading Company or social enterprise which could then be contracted directly by the SAP to deliver services as part of the overall supply chain of provision. Should this option be considered appropriate then all current direct provision could be included in a new business model which could then offer an integrated service to the SAP.

48. Alternatively the Council may decide to retain the services in house, in which case either of the two options discussed above could be adopted with some changes made to existing management and operational structures. Members may wish to consider these options when coming to a determination about the future direction for direct service provision.

**Employer Responsibilities**

49. There are a range of options open to the authority in respect to the workforce. Employees could be transferred to a partner organisation as part of a service transfer, employees could be formally seconded to a partner organisation or employees could be retained by the authority and aligned to a lead partner who may or may not have day to day management responsibility.

50. The consideration of the Council's on-going employer responsibilities should be determined by the functions under discussion having thought to issues such as future recruitment, retention, staff development, professional support, terms and conditions of employment, and workforce development.

51. A key consideration is learning and development and workforce development in the context of the Care Act implementation with associated changes to policies, procedure, practice and process. The authority needs to be assured that staff are fully conversant with new working systems and methods and able to implement changes to practice and processes at this critical time. Workforce development is not only related to the introduction of new policies and working practices, but is also important in considering the future role of Social Work as a profession and the future delivery, of social care as an intervention to aid people's health and wellbeing. Previous integrated approaches to health and social care have proved less successful over time due in part to an underestimation of the importance of supporting and building and maintaining an ethos and philosophy of social care and the professional development of Social Workers, Occupational Therapists and others. Members should ensure that integrated health and social care arrangements embed a strong focus on the on going workforce and learning and professional development of social care staffing.

52. Leadership is a further area of consideration dependent on the future model of service delivery. Experience has shown that staff that have been seconded or aligned to another organisation can become distant form the Council which continues to be their host employer. This can lead to role ambiguity, loss of organisational and professional accountability and low staff morale. The Council will need to determine how organisational and professional leadership can be delivered to staff who may be working outside the organisation and in different parts of the health and social care system. This could be achieved through ensuring a robust social care based management and leadership function is retained in a structurally integrated care arrangement together with a requirement for the local authority to retain oversight for these areas of practice development. However one of the largest challenges in bringing together staff across health and social care is to bridge the different organisational and professional cultures which exist.

53. It is envisaged that an integrated health and social care system can bring benefit to the local population through the delivery of a holistic care pathway from information advice and self care through to acute medicine and on to long term care. This will require the coming together of various professional disciplines, organisations and agencies each with their own

identities, values, and ways of working; all of which will need to be understood, embedded and cherished if the benefit to users of services is to be achieve.

54. A new operating culture may emerge as new models of practice are developed and new organisational units formed but this is likely to take time and require considerable leadership and workforce development intervention. It is suggested therefore that Members consider a phased approach to integrating services, ensuring professional and organisational leadership is assured and Human Resource capacity is made available to support the alignment and possible future integration of services.

**Governance**

55. The Council governance process is detailed in the County Council constitution and is enacted through elected members and officers within a scheme of delegation.

56. The accountability members hold for assurance together with their decision making responsibilities and those of committees cannot be delegated to a third party. That is not to say that functions and responsibilities of the Council cannot be delegated, but the accountability for any delegated activity will rest with the Council through the elected members

57. Therefore should the council agree to transfer or delegate functions to a third party, members will need to assure themselves that there is a robust and transparent process of governance in place which provides the authority with oversight of activity and quality, scrutiny of outcomes, workforce and financial assurance. Whilst the provision of services may be delegated or contracted to a different organisation, the strategic and policy direction of social care in the county will remain a responsibility of the local authority to determine and enact.

58. There are some statutory responsibilities and functions which members may determine should not be fulfilled through a SAP, or which the Council or provider may determine should remain within the local authority. Such functions will need to continue to have internal oversight by members and members will need to ensure the continuance of a robust management and performance framework for these. Examples may include services where a provider may have a conflict of interest or where an independent assessment/decision is required such as Mental Health Act assessments, Best Interest Assessments and Deprivation of Liberty assessments. It is suggested that work is undertaken to map local authority functions to determine which areas should remain within the authority and those which may/should be delegated.

59. In addition to the matters noted above in respect to finance, members may wish to also consider the development of a pooled budget arrangement and how the governance of any such pooling of resources may be undertaken.

60. There are discussions already underway in respect to pooled budgets for areas such as the Better Care Fund and transforming care in learning disabilities but a pooling of resources for this programme would be for a different purpose and would require specific governance arrangements

61. Pooling could take place at a commissioning level with the CCGs to deliver a joint capitated budget to the SAP, or could take place at the provider level through separate but related contracts between the CCGs and the Local Authority. Members are recommended to consider the former option as being the most suited to deliver the outcomes sought but may wish to consider alignment of resource at provider level as a first step toward this objective.

62. The outcome of decisions made on the functions which may be delegated and the responsibilities which may need to be retained will help members to determine what form the integration of health and social care may take. There are various options from the alignment of current systems, processes and pathways to a formal integration of commissioning and/or provision. The specific governance requirements of each option will be further developed over the course of the next few months.

**Scope**

63. The Better Together Programme is aimed at providing an integrated health and social care provision across the areas of Mansfield, Ashfield and Newark and Sherwood for a designated population of older people and people with long term conditions. Therefore people outside of this catchment area and people with different needs such as younger adults or those with learning disabilities fall outside of the remit of this programme.

64. The Council will need to ensure that access to services and provision of services is equitable across the county. This will be potentially more difficult to achieve as services are developed to meet the requirements of the different planning areas and different partner delivery strategies across the county. Access to services is not merely a matter of where and how people access services but more fundamentally who can access services. Currently the Council has agreed a local threshold at which people become eligible for social care, and once eligible a personal budget is calculated to fund services that will meet the person's assessed eligible need. This process will change somewhat as the Care Act is implemented in April 2015 when the eligibility threshold becomes a national determination and the definition of eligibility changes to include the concept of wellbeing. However the overall social care assessment and individual commissioning process remains and the Council is in the process of developing systems and processes to enact the new responsibilities to ensure equitable access cross the county for all residents regardless of nature of need or geographical location.

65. The development of a capitated budget contracted to a SAP is predicated on the provider being able to develop different care models and new care pathways with the aim to reduce people's need for intensive health and social care services. Inevitably this may lead to the delivery of care to people who may not be eligible for local authority funded care if this is seen to prevent longer term use of health and social care services. Whilst access to such preventative services is to be welcomed, it may be that access to similar services will not be available in other parts of the county where different commissioning and provision arrangements exist; and equally that may not be available in the same area to people whose needs fall outside of the SAP contract. Members will need to consider how this potential inequity of access can be resolved.

66. In addition the way in which people access services will change through the development of integrated provision. The Council has for some years been developing a central point of access for all local authority services through the Customer Service Centre, however the integration of health and social care provision will require multiple points of access which will need to reflect local integrated care arrangements. Developing local access points will help to ensure people have a timely access to a range of provisions through a single point of entry (locally) to health and social care resources and reduce the need for hand offs and duplicate assessments. The development of a digitally based referral and assessment process will help to facilitate more flexible access arrangements but Members should assure themselves that there are robust systems to monitor activity and performance and ensure a parity of service user experience.

**Support to Carers**

67. Alongside the commissioning and provision of services to people who have eligible needs the Council also commissions and provides services to carers. The duties of assessment and provision of services that the Council has toward Carers are due to increase in April 2015 following the implementation of the Care Act. Whilst the capitated budget and SAP contract are designed to cover the totality of needs of the population for secondary health and social care, it does not cover the needs of carers. However, the service which an individual receives is often directly linked to a need identified through a carer assessment, for example respite care. Therefore separation of service user and carer needs is not always possible, and further the assessment of each need is often dependent on the other, for example, in determining a personal budget account will always be taken of the ability of carers to continue to provide care. It is also the case that at present, many carer assessments are carried out by the same Care Management staffing who carry out the service user assessment; indeed the Care Act specifically promotes the use of joint assessments. It is recommended therefore that members consider whether the SAP should also take responsibility for carer assessment and provision or if there needs to be a separately identified and scoped provision to meet the needs of carers outside the scope of the SAP.

**Strategic Commissioning**

68. Members should also note that there will remain a number of areas of strategic commissioning which will by necessity remain the responsibility of the authority and not form part of any contract with a SAP. The Council will continue to be responsible for a number of areas of commissioned services from third sector and independent sector providers alongside responsibilities for market facilitation, market development and ensuring a high quality of market provision. The responsibilities and duties of the authority and those which will be conferred on the authority from April of this year could be delegated to a third party such as a SAP, but it is not recommended that the Council do so. However members may wish to consider how a more joined up approach to these areas could be developed with NHS commissioning partners through an integrated commissioning arrangement.

69. In addition from April the Care Act brings new roles for local authorities in respect to people who fund their own social care. Over the course of the next 12 months the Council will be developing new information systems, new assessment processes and new financial processes such as deferred payments and individual care accounts to provide for people

who will continue to fund their own care. All of these processes will continue to be undertaken outside of the proposed development of a SAP.

**Other Options Considered**

70. The Council could continue to deliver social care services outside of a jointly agreed commissioning process with NHS partners. The Better Together programme would continue to be delivered as a health based programme without social care resources and services, however both health and social care partners may then miss the opportunities which working together may bring in terms of system change, financial gain and improved outcomes. This is a watershed moment for the Council. The decisions made in relation to the BTP will begin to determine the authority's position in respect to integration of health and social care.

**Implications for Service Users**

71. People will receive the right care at the right time in a place closer to home wherever possible. The new model will mean that people will only need to go into hospital when they need specialist help and will be able to remain living in their familiar surroundings at home with the support they need to do so.

72. They will have a named person responsible for co-ordinating their care and all of the people involved in that care will have the information they need about the person and will work closely with each other to ensure that the care being delivered is seamless.

73. People will have more information about their own condition and support to help both themselves and their carers to become more involved in decisions about how their care is planned and delivered.

**Reasons for Recommendations**

74. The BTP has forecasted a future financial gap of £140m across the health and social care system if organisations do nothing to address rising demands and shrinking resources.

75. This is a system wide model of care which requires all organisations to work closely together, develop new ways of working and break down traditional organisational boundaries.

**Statutory and Policy Implications**

76. This report has been compiled after consideration of implications in respect of finance, the public sector equality duty, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

**Financial Implications**

77. Financial implications are set out in the report in paragraphs 38 to 48.

## RECOMMENDATIONS

It is recommended that the Adult Social Care and Health Committee:

1) consider the issues and implications of establishing a capitated budget and Single Accountable Provider across Ashfield, Mansfield and Newark and Sherwood;

2) agree to further work being undertaken to consider the development of the capitated budget and Single Accountable Provider model in Mid Nottinghamshire;

3) receive a further report on progress in April 2015 on the Better Together programme;

4) receive further reports on the integration of health and social care services in South Nottinghamshire and Bassetlaw respectively;

5) convene a workshop event to further discuss the integration of health and social care services.

**JON WILSON**
**Service Director, Personal Care and Support, Younger Adults**

**For any enquiries about this report please contact:**
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**Constitutional Comments (LMc 20/01/15)**

78. The Adult Social Care and Health Committee has delegated authority within the Constitution to approve the recommendations in the report.

**Financial Comments (to follow)**

79.

**Background Papers**
None

**Electoral Division(s) and Member(s) Affected**

All

ASCH