Restructured Older People Joint Management Group and pooled budget: a possible approach

Remit

Health and social care for frail older people[1]

Resources

All resources devoted by the Oxfordshire Clinical Commissioning Group (OCCG) and Adult Social Care specifically for the benefit of frail older people. Analysis undertaken for the previous Health and Well Being Board suggests that this is nearly £300m. This comprised: adult social care £100m (already in the pool); continuing health care and rehabilitation £25m (already in the pool); acute care £93m; community care £26m; prescribing £27m.

Objectives

1. To achieve the best possible outcomes for frail older people – maximise their independence, maximise their enjoyment of their remaining years, minimise their need for health and social care.
2. To ensure that health and social care help deliver these outcomes in a seamless way where the individual sees no differences in the support they receive from different organisations.[2]
3. To ensure that the quality of health and social care that is provided is of high quality.
4. To ensure that public resources are used in the most effective and efficient manner.

Outcomes for Older People

This will require further discussion but they should be based on the final national outcomes for older people (see Annex A).

Accountability

To the Adult Health & Social Care Board (and through them to the Health and Wellbeing Partnership Board), the OCCG Board and the County Council's Cabinet.

Financial risks

1. Both OCCG and the County Council will be worried about their possible exposure to financial pressures within the system which are currently managed by only one organisation. Examples within this possible pool are: unanticipated increases in the demand for or cost of adult social care

[1] This is a different focus from the current older people pool because this is targeting activities on those older people who are frail (or may become so in the near future). This makes sense because this is how the money is spent at the moment. It is also consistent with the development of a frail older persons pathway which has already been agreed between adult social care and the PCT.

[2] With the sole exception of charging for social care.

or inadequate budgets (e.g. continuing health care, unplanned health care, equipment).[3]

2. In principle, the solution should be to work on the basis that the pool should define the total resources available to be spent in any one year with no extra resources available. Resources should be moved around to fund the most effective and efficient forms of care. In practice, some contingency resources will be necessary to help cope with the fluctuations in the demand for care during the year.
3. A further dimension is that both Oxfordshire Clinical Commissioning Group and adult social care are keen to see the delegation of a significant element of the budget to localities.[4] One option may be to allocate as much as the budget to localities (however defined) with sums retained centrally to act as the contingency described above.
4. We need to understand the impact of financial and other incentives on different organisations (whether they are commissioning care or responsible for providing care).

Membership of the Joint Management Group

1. This would be on a similar basis to now. Both OCCG and adult social care would have two nominated votes each. In the case of adult social care, this would be the Deputy Director (Joint Commissioning) plus a finance vote. In the case of the unavailability of the Deputy Director, this would pass to the Director. The expectation is that the decision making by OCCG would be at a similarly senior level (they will need to decide whether this is by a GP or by a senior manager).
2. Older people would have 3 representatives selected by the Health and Social Care Panel. They would have the right to attend and speak (on all items) but not vote.
3. We have recently started involving the two major health providers in the JMG discussions (Oxford University Hospitals Trust and Oxford Health). These two providers would continue to have the right to attend and speak on all issues except where this would invalidate the procurement process. We will need to consider further whether we should have some involvement by adult social care providers (who are a much more diverse group).

Method of operation

1. Monthly meetings which focus on the key decisions and monitoring of performance against the key targets.
2. Short papers which concentrate on the key issues.

[3] There are issues in other pools notably the adult social care budget for younger adults with physical disabilities and the adult social budget for residential mental health placements

[4] How these are defined will require further discussion. The GP localities are similar to the local teams within adult social care. Both are larger than the County Council's locality areas although these may be most relevant to individual GP practices.

3. Analysis and consultation should take place before the meeting[5].
4. Frank and open discussion.
5. Information provided to the JMG is likely to appear in public reports following the meeting.
6. Involvement of older people in the meeting and wider engagement with a larger group of older people (through the Health and Social Care panel supported by Age UK Oxfordshire).

Potential timescale if the new arrangements are approved

1. This issue was discussed at the OCCG Transition Board on 1st November 2011.
2. The new arrangements will be subject to a Section 75 agreement which will have to be approved by both the Cabinet and the PCT Cluster Board (OCCG do not have the formal powers to make such an agreement at this point in time).
3. Formal approval is likely to take some time as all parties need to be satisfied not only with the principles that underpin the agreement but also the precise details (such as which budgets should be included and how risks will be managed). This means that it is unrealistic to assume that the new arrangements can be up and running by 1st April 2012. However, I think we should aim to agree the principles by then (and to have done so formally and publicly. This would allow shadow arrangements to be introduced on 1st April (or soon as possible thereafter) for full scale implementation on 1st April 2013.

John Jackson
23rd November 2011

[5] We need to control the supporting arrangements that sit behind the JMG. There has to be the opportunity for regular liaison and discussions but this should not be reflected in a myriad of unstructured and unproductive meetings.