Public Document Pack

Brent

Brent Clinical Commissioning Group

Health and Wellbeing Board

Wednesday 11 December 2013 at 7.00 pm
Boardroom - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members	representing
Dr Sarah Basham	Brent CCG
Councillor George Crane	Brent Council
Christine Gilbert	Brent Council
Sue Harper	Brent Council
Councillor Krupesh Hirani	Brent Council
Dr Ethie Kong	Brent CCG
Rob Larkman	Brent CCG
Councillor Ruth Moher (Chair)	Brent Council
Ann O'Neill	Brent Health Watch
Jo Ohlson	Brent CCG
Councillor Harshadbhai Patel	Brent Council
Councillor Michael Pavey	Brent Council
Phil Porter	Brent Council
Melanie Smith	Brent Council
Sara Williams	Brent Council

For further information contact: Lisa Weaver, Democratic Services Officer
0208 937 1358

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democracy.brent.gov.uk

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item Page

5 Health and Social Care Integration 1 - 40

Health and social care integration is the focus of the Health and Wellbeing Board's fifth priority: '*Working together to support the most vulnerable adults in the community'* . This paper provides an overview of the:

- Development of the Pioneer (Whole Systems Integrated Care – WSIC) programme in North West London and in Brent
- The national Integration Transformation Fund implementation over the next 2 financial years, and
- The proposed priorities for the delivery of health and social care integration in Brent.

Date of the next meeting: Wednesday 26 February 2014

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

Brent	**Health and Wellbeing Board** 11 December 2013 **Report from the Acting Director of Adult Social Care**
For Action	Wards Affected: ALL

Health and Social care Integration Update

1. Summary

1.1 Health and social care integration is the focus of the Health and Wellbeing Board's fifth priority: '*Working together to support the most vulnerable adults in the community'* . This paper provides an overview of the:

- Development of the Pioneer (Whole Systems Integrated Care – WSIC) programme in North West London and in Brent
- The national Integration Transformation Fund implementation over the next 2 financial years, and
- The proposed priorities for the delivery of health and social care integration in Brent.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

(i). Note and comment on the regional (Pioneer/Whole Systems Integrated Care) and national (Integration Transformation Fund) framework that is developing

(ii). Comment on and approve the approach currently being developed to develop and deliver health and social care integration and the Integration Transformation Plan for Brent

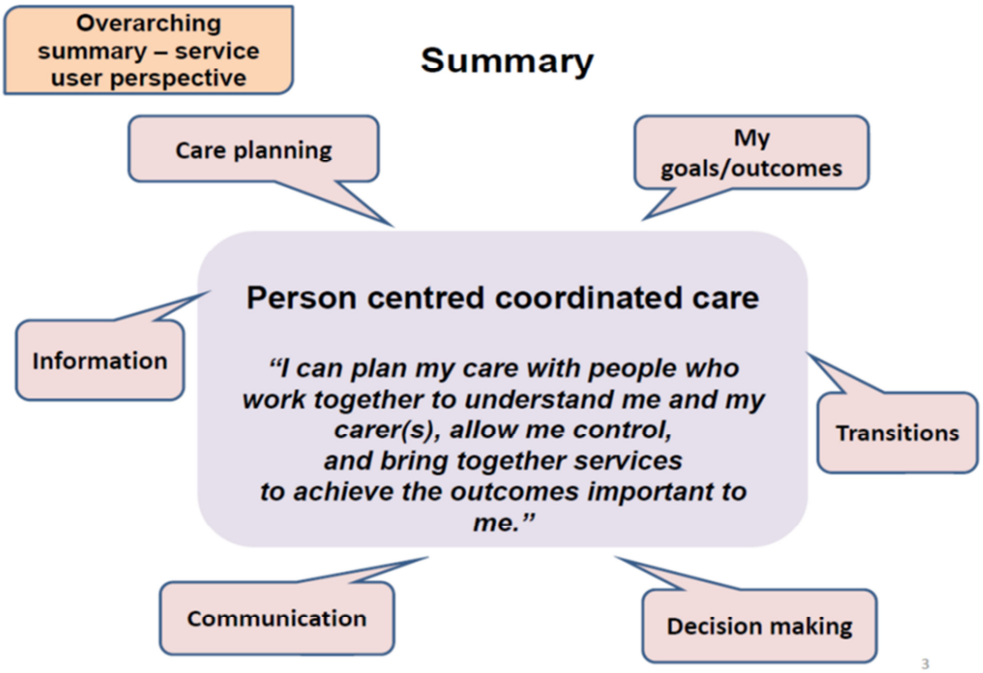
(iii). Agree the Section 256 document (attached at Appendix A) for submission to NHS England as the first step in the Integration Transformation Fund process.

3. North West London – Pioneer / Whole Systems Integrated Care Programme

3.1 In October 2013, North West London was named as a national Pioneer for health and social care integration. The North West London pioneer application set out an ambitious vision to integrate health and social care to bring about better outcomes and experiences for people (service users and carers) using health and social care

services. It set out a clear commitment that people should be supported to live independently for as long as possible and lead full lives as active participants in their community.

3.2 People's current experience of health and care services is often disjointed and fragmented. Each individual providing care may be doing a good job, but taken as a whole the individual and their family often experience care that is poorly coordinated and confusing. That is why the Pioneer application adopted the National Voices definition of person centred care (diagram below), which puts the person, not the profession or organisations at the heart of the system.

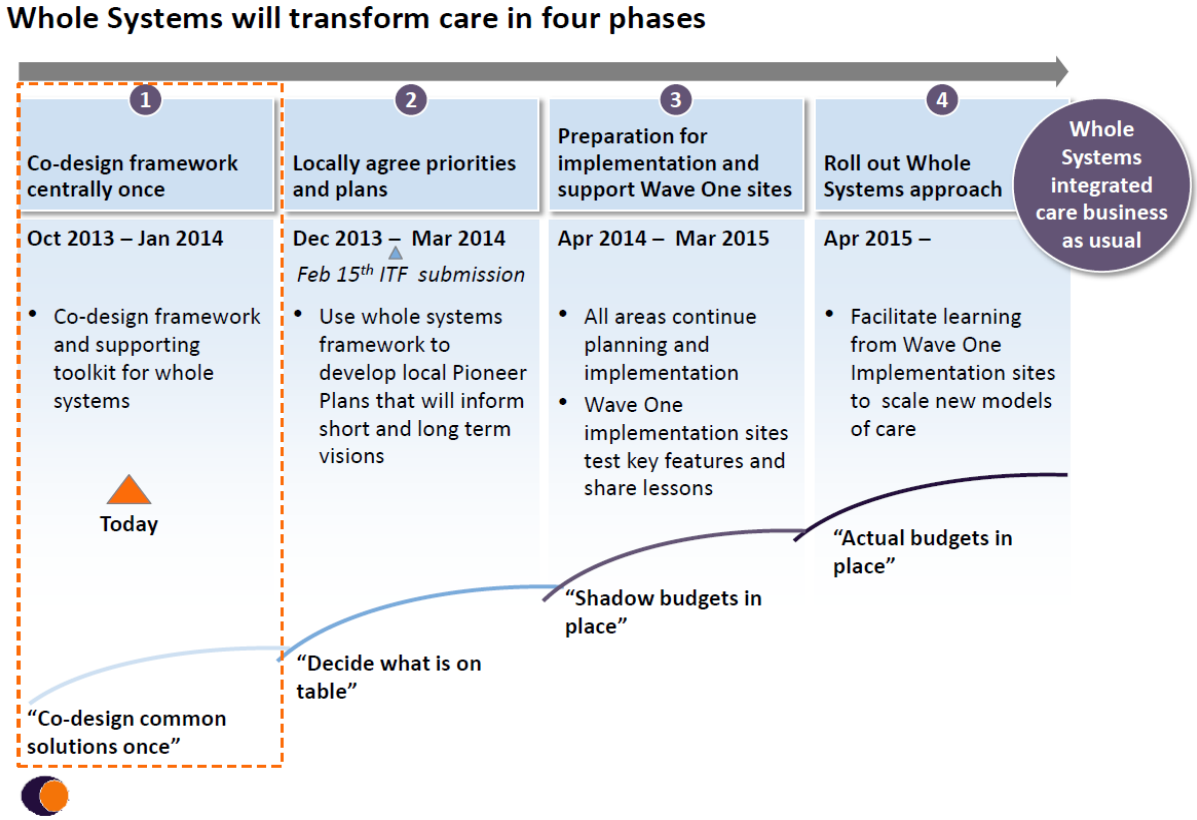


3.3 Although health and social integration must deliver financial efficiencies, we will only be successful if we support more people to be live independently while also delivering against their expectations for care and support. In other words, we must remain focused on what people tell us about their outcomes and experience of care, and we must be able to evidence that they have improved.

3.4 In order to achieve this, the Pioneer application made three commitments:

1. People and their carers and families will be empowered to exercise choice and control and to receive the care they need in their own homes or in their local community
2. GPs will be at the centre of coordinating care, working with others in integrated networks to support people to meet their individual goals
3. Systems will enable not hinder the provision of integrated care, we will focus on people, outcomes and align budgets to them.

3.5 The Pioneer process is now up and running in North West London and called the Whole Systems Integrated Care programme (WSIC)). This a hugely complex programme of change, which is divided up into four phases as set out in the diagram below:



3.6 We are currently in the co-design phase (October to January 2014). In this phase stakeholders (health and social care commissioners, health providers, service users and carers) from across North West London are working together to co-design:

- a technical toolkit, which will include analytical tools to support population segmentation
- payment models and organisational development tools, e.g. template legal contracts for potential provider and GP networks, and
- a map of current integration programmes – what programmes are happening where, how they work and how they involve as well as a summary of immediate plans and proposals for new integration programmes that could impact WSIC implementation.

3.7 The aim of this phase is to provide each of the boroughs with the tools to design a local health and social care integration solution. It is a model which is attempting to harness the best from across North West London to support boroughs to deliver a local solution, which meets the needs of the local population. The six workstreams which will underpin the local models are set out below.

3.8 *Population and Outcomes.* This workstream will define all of the other workstreams. The aim is to challenge historic organisational boundaries and define a new organising logic for services, focusing on patient/service user groups and the outcomes they want rather than organisations. Underpinning this will be new models of care which deliver on a continued commitment to the outcomes that are important to the people themselves.

3.9 *GP Networks*. This workstream will set out a range of options for how GPs must operate if they are to be at the centre of co-ordinating care. It will also benchmark where different CCGs in North West London are currently in order to identify any capabilities gaps that may exist and what organisational assistance is needed to develop networks that deliver for patients.

3.10 *Provider Networks*. This workstream is focused on how providers (primarily health providers at this time) can work together across their historic organisation boundaries. It is exploring a spectrum of integration options from loose collaboration (designed around the needs of patients and service users) to full integration of different health and social care providers in a single organisation.

3.11 *Commissioning, Governance and Finance.* This workstream will identify a preferred list of commissioning governance and financing options for integrated care. The group will also confirm stakeholders budgets for pooling/capitation and the measures that commissioners might take to assure accountability are being discussed in the context of payment and risk and reward mechanisms.

3.12 *Informatics.* The informatics workstream is focused on the integration of all sources of data across health and social care to provide service users and patients with access to their data as well as giving providers and commissioners real time information and managerial analytics.

3.13 *Embedding Partnerships.* This workstream underpins the other 5. It is focused on ensuring that the patient/service user and carer voice is clearly heard in the co-design phase, and modelling co-design best practice to ensure it underpins the work that will continue in the boroughs.

4. National Funding to Drive Integration

4.1 Running alongside the development of the Whole Systems Integrated Care (WSIC) programme is a key change to funding for health and social care: the Integration Transformation Fund (ITF). The ITF is designed to provide a catalyst for integration, or in the case of North West London, a further catalyst for change. This section of the report provides an overview of this funding and how it will change in order to highlight how it should reinforce the transformational work set out in section 3 above.

4.2 Over the last few years the NHS nationally has transferred small but significant amounts of funding to adult social care with the aim of protecting adult social care and promoting health and social care integration. Although clear objectives were set nationally for the funding, there has been flexibility for local areas to determine how this investment is best used. In Brent this has been done bilaterally through a Section 256 agreement between the council and the Primary Care Trust. In Brent, as in most other local authorities, these funds have become part of the base budget as it is very difficult to identify any adult social care service, which does not have an impact on health.

4.3 In 2013/14 the rules for the transfer of this funding have changed. The focus for the funding is still the same, but instead of the funding being agreed by the council and the Primary Care Trust (now the Clinical Commissioning Group (CCG)), there is now a requirement for the Health and Well being Board to approve the approach and recommend sign off to NHS England, who will release the funds. Therefore, the draft Section 256 is attached at Appendix A for the Health and Well being Board to comment on and agree.

4.4 While the Section 256 agreement can be seen in isolation, it is important to see it as the first step (2013/14) towards the implementation of the ITF which goes fully live in 2015/16 (latest national guidance is attached at Appendix B). The catalyst funding targeted at transforming health and social care to deliver genuine integration is increasing over the next 3 years from:

- 2013/14: £900m nationally - £4.8m in Brent
- 2014/15: £1.1bn nationally – local allocations to be issued in December
- 2015/16: £3.8bn

4.5 As the pot grows over the next two years, the rules for the use of the money change. There will be increasing performance requirements. The money will be released in two halves in 2015/16. In April 2015, the first half of the allocation will be released by NHS England based on evidence of progress in 2014/15. In October 2015 the second half of the money will be released by NHS England based on performance over the first 6 months of 2015/16. The aim is to drive a change in culture as the money will only be released if we can prove we are delivering integrated care and that integrated care is delivering better outcomes for people. For example, one of the key objectives for social care over recent years has been to reduce the number of social care related delayed discharges as defined under the Delayed Discharges Act. In the future this will not be good enough. It will not matter if social care delays are going down, it will only matter that all delays are going down – that everyone is getting a safe and timely discharge from hospital. This is our new challenge: to deliver against measures for the system (and ultimately for people), not for individual organisations:

- Reductions in delayed transfers of care
- Reduction in emergency admissions
- Effectiveness of Reablement schemes
- Reduction in admissions to residential and nursing homes
- Measures of patient and user experience.

4.6 It should also be noted that there are seven national conditions which proposals for the funds must demonstrate:

- Plans jointly agreed
- Protection for social care services
- 7 day services in health and social care to support discharge and prevent weekend admissions
- Better data sharing between health and social care based on use of the NHS number

- A joint approach to assessments and care planning with an accountable professional for integrated packages of care
- Agreement on the consequential impact of changes in the acute sector

4.7 However, it is also important to note that none of this is new money. As already described the £900m nationally for 2013/14 (£4.8m in Brent) is part of the adult social care base budget. There is an additional £0.2bn nationally in 2014/15, but is expected that this will relate to current funding. In 2015/16 the £3.8bn nationally will be made up of: a range of existing funds that are added to the integration pot, including:

- £1.1bn which makes up the budget for 2014/15
- £130m carers breaks funds
- £354m capital funding to include £222m Disabled Facilities Grant
- £300m CCG Reablement monies
- £1.9bn nationally, which will be provided through a top slice of 3% of the CCG budget which equates to £15.8m for Brent (MTFS 25/9/13) by 2015/16 without a corresponding reduction in spend.

4.8 The ITF will be a significant pooled budget in Brent, but it will still only be somewhere between 5-10% of the overall spend across the council and the CCG on health and social care. Therefore, the more important challenge is how we use the ITF as a catalyst for the wider, more fundamental, change. This will be the only way we can deliver the national targets and the only way in which we can make a real difference to people's lives. This is where the ITF and the Whole Systems Integrated Care pilot align.

4.9 The four phases of Whole Systems Integrated Care programme (WSIC) are set out in point 3.5 above and these four phases broadly align with the timescales for the ITF:

Time Period	**WSIC Phase**	**ITF timescales**
Oct – Jan 2014	*Phase 1- North West London co-design*	Initial thinking in Boroughs about the two year health and social care integration (ITF) plan
Jan – March 2014	*Phase 2 – locally agree priorities for whole systems*	Drafting (14 February) and finalising (4 April) the two year ITF plan with the Health and Wellbeing Board and NHS England
Apr 14 – March 15	*Phase 3 – wave one sites implementation*	Implementing elements of the ITF plan
April 2015 onwards	*Phase 4 – whole systems roll out*	Delivery of full integration – delivery of national targets to release funding.

5. Health and Social care Integration in Brent: next steps

5.1 As the previous sections highlight, there are strong drivers national drivers for change and significant regional change management capacity aligned to deliver the change. There are clear timescales set out for those national and regional changes, which is why it is so important to build on the clear local support for integration and develop and deliver a clear vision for health and social care integration in Brent. The integration programme is central to Brent CCG's Out of Hospital Delivery Strategy which aims to ensure accessible, pro-active and coordinated care. The Health and Wellbeing Board will need to lead this, but significant work will need to be done to prepare proposals for the Board. Therefore, it is suggested that a *Brent Integration Board* is set up to work to the Health and Wellbeing Board.

5.2 The Board has met once in embryonic form to discuss potential role, function, accountability and membership of such a Board – draft terms of reference are attached at Appendix C**.** The Health and Wellbeing Board is asked to comment on the Terms of Reference and membership of the Integration Board.

5.3 The first Integration Board meeting also had an initial discussion about priorities for integration and the two year plan:

- *Integrated Rehabilitation and Reablement* Service focused on delivering personalised short term support to help people to regain their independence. This would be a 7 day working service and would reduce unnecessary hospital admissions and allow people to continue to live at home
- *Integration Care Pathway (ICP2)* – a case management service to support people with complex health and social care needs to live independently in the community
- *Improved discharges from hospital* – an integrated service across hospitals, social care and community health to deliver a 'pull' model of discharges, so people are 'pulled' back into the community with an integrated discharge plan, rather than pushed back because of the need to free up beds. This will reduce delayed discharges and ensure people can live independently after discharge
- *Alcohol and Homelessness* – focused on early intervention, multi-agency individual solution for people to reduce the incidence and the impact on secondary care services
- *Learning Disabilities* – building on the work of the Winterbourne View Collaborative to re-design health and social care services to reduce health inequalities for people with a Learning Disability and ensure they can live as independently as possible
- *Mental health* – building on the OneCouncil adult social care mental health project and the 'primary care plus' work being done by the CCG to design a cradle to grave mental health service focused firmly on community support and a recovery pathway.
- Additionally, it will be important to ensure that the needs of carers and a commitment to delivering 24/7 care underpin all of these areas.

5.3 The Board is also asked to comment on the priorities to provide a clear steer to the work that will continue until the next Health and Well Being Board.

5.4 Finally, the Board is also asked to note that the timescales for delivering the Brent ITF plan and the local priorities for Whole Systems Integrated Care are relatively tight. Therefore, the Integration Board will take a lead and seek to engage a wide range of stakeholder prior to the draft of the ITF being presented at the next Board.

Contact Officers:

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Template for Submission of the Section 256 Agreements to Area Team

Introduction:

The following has been developed with colleagues from London Directors of Adult Social Services in response to the requests from several London LA for a common template to support their submission of the S256 Agreements.

The template brings together;

• The National Health Service (Conditions Relating to Payments by NHS Bodies to Local Authorities) Directions 2013*.
• The conditions set out in the Funding Transfer from NHS England to social care – 2013/14 letter (Gateway reference: 00186).
• The funding breakdown required to enable a consolidated NHS England position on adult social care expenditure.

It is suggested that this template be appended to your local S256 documentation and submitted (to your NHS England (London) Delivery Team.

Payments will be administered by the NHS England (London) Delivery Teams and the funds will pass over to local authorities once the Section 256 agreement has been signed by both parties.

Funds will be applied in three equal payments in quarters 2, 3 and 4, contingent on the appropriate application of funds and the monitoring against the agreed outcomes in your plan.

Guidance notes:

Please complete all sections of the submission form worksheet with free-text or as prompted in the drop down menus.

An additional worksheet for a more detailed financial breakdown is also provided, if Local Area wish to use this.

Once complete please save a copy and submit to the relevant NHS England (London) Delivery Team. (details of delivery team contacts are provided in the Delivery Team Contacts worksheet.)

* The documents on the National Health Service (Conditions Relating to Payments by NHS Bodies to Local Authorities)Direction 2013 can be found at this link;
https://www.gov.uk/government/publications/conditions-for-payments-between-the-nhs-and-local-authorities

NCEL

Delivery director: paul.bennett8@nhs.net

Barnet CCG	Barking and Dagenham CCG
City and Hackney CCG	Enfield CCG
Havering CCG	Islington CCG
Redbridge CCG	Tower Hamlets CCG

SL

Delivery director: jacqui.harvey2@nhs.net

Bexley CCG	Bromley CCG
Greenwich CCG	Kingston CCG
Lewisham CCG	Merton CCG
Southwark CCG	Sutton CCG

NWL

Delivery director: AlexGordon@nhs.net

Brent CCG	Central London CCG
Ealing CCG	Hammersmith and Fulham CCG
Harrow CCG	Hillingdon CCG
Hounslow CCG	West London CCG

Camden CCG
Haringey CCG
Newham CCG
Waltham Forest CCG

Croydon CCG
Lambeth CCG
Richmond CCG
Wandsworth CCG

Funding Transfer from NHS England to Social Care - 2013/14

Suggested Submission Template

Local Authority	**Brent**
CCG	**Brent**
Scheme Name	**<Scheme name>**
Date agreed at Health and Well-Being Board:	**11-Dec-13**
Date submitted to NHSE (London):	**<dd/mm/yyyy>**
Total value of funding transfer:	**£4,806,952.00**

Rationale:

***As per the National Health Service (Conditions Relating to Payments by NHS Bodies to Local Authorities) Directions 2013**, Please provide information on how the section 256 transfer will secure more health gain and improved patient outcomes than an equivalent expenditure of money on the National Health Service?*

The 2013/14 allocation builds on the monies previously received via the PCT. The money has been invested in developing a responsive Adult Social Care service, which delivers not only on core statutory requirements (managing continuing demographic pressures), but also, jointly with the CCG, the potential additional pressures on health services. There is a clear focus on older people through the Reablement and Hospital Discharge functions, which work closely with the health commissioners and providers to support people to live safely in the community. This is a comprehensive offer which ranges from reablement homecare to equipment (including Telecare) to fast track access to adaptations and work with housing to meet other housing needs. However, work is also ongoing for people with Learning Disabilities, Mental Health needs and excluded groups such as the homeless and people with substance misuse needs, (we work very closely with housing on all of these issues too) to ensure that the services we provide across health and social care meet individual needs and support people to live as independently as possible. There has also been investment in a dedicated Safeguarding Team, which works closely with health and social care commissioners as well as CQC to identify and respond to establishment concerns and drive up quality to promote dignity in care.

Description:

Please provide an overview of the scheme and relationship to the JSNA, CCG commissioning plan and Local Authority's plan for social care

This spend is fundamentally linked to the Heath and Well being Strategy,which was derived from the JSNA process. The fifth priority in Brent's HWB strategy is: Working together to support the most vulnerable adults in the community. This is linked to the Council's five priorities set out in its recently agreed Local Account:

- Maintain a strong focus on prevention
- Provide short term help so that people can regain their independence
- Promote the use of personal budgets to ensure people have as much choice and control as possible
- Ensure there is more support for carers, and
- Focus on dignity in care and ensure there is a 'zero tolerance of abuse' across health and social care.

Outcomes and evidence of benefit:

Please provide details of the expected outcomes and benefits of the scheme and how these will be measured to ensure the purposes described in the rationale and description of the scheme have been secured.

The six target areas which the Health and Well Being Board have decided to use as the measures for the 5th priority (working to support the most vulnerbale adults) are:

1. Reduce A&E attendances
2. Reduce hospital admissions
3. Reduce delayed discharges
4. Improve support in the community to help people remain independent and reduce residential care
5. Customer satisfaction with management and support of long term conditions
6. Zero tolerance of abuse (ensuring everyone knows how to raise an alert, that all alerts are responded to within 24 hours, all referrals are investigated effectively, and outcomes the vulnerable adult seeks is achieved)

Relationship to national outcome frameworks:

Please provide information on how the scheme is expected to contribute to local delivery against the national outcome frameworks selecting which domains are addressed in the tables below

The Adult Social Care Outcomes Framework and the commitment to stable accommodation, employment (where appropriate), reablement and independnece and user satisfaction and quality of life are at the core of what we do. These monies alone will not deliver on those commitments, but they are aligned and will play a strong role particularly in relation to reablement, delayed discharges, user satisfaction and quality of life.

Domains of the Adult and Social Care Outcomes Framework - *please select the domains relevant to your scheme*	
1. Enhancing quality of life for people with care and support needs	☑
2. Delaying and reducing the need for care and support	☑
3. Ensuring that people have a postitive experience of care and support	☑
4. safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm	☑

Domains of the NHS Outcomes Framework - *Please select the domains relevant to your scheme*	
1. Preventing people from dying prematurely	☑
2. Enhancing the quality of life for people with long term conditions	☑
3. Helping people to recovery from periods of illness or following injury	☑
4. Ensuring that people have a positive experience of care; and	☑
5. Treating and caring for people in safe environment; and protecting them from avoidable harm	☑

Governance:

Please provide details of the arrangements are in place for outsight and governance for the progress and outcomes of the scheme

The Health and Well being Board will provide strategic oversight as outlined above. The Health Partnerships Overview Scrutiny Committee will also scrutinise as they scrutinise all significant spend in the health and social care economy. The Brent Integration Board has been set up (and has met twice so far) to deliver on this agenda. This Board is made up of all the key commissioners and providers. It provides the delivery capacity for this priority as well as managing the interface between the day to day management of key services through the Urgent Care Board and the wider strategic development of this agenda through the NWL Whole Systems Integrated Care programme/Pioneer. This group has a clear programme of action in the run up to the delivery of the first ITF proposal and pilot Pioneer projects in April 2014, which are: - Integrated Short Term Assessment, rehabilitation and Reablement Service (STARRS)/Homecare Reablement to delver a fully integrated 7 day a week reablement and rehabilitation service building on the currently aligned services - Integration Care Pathway 2 (ICP2) - focused on case management in the community for those at high risk, frequent users of urgent care - multi-disciplinary approach, single care plan and outcomes - Improving discharge - developing a 'pull' model fo discharges to ensure safer and more effective discharges to reduce delayed transfers of care - Alcohol and Homelessness - tackling the biggest delays in hospital and supporting people who have been excluded to regain their independence and quality of life - Learning Disabilities - building on the work of the Brent Winterbourne Collaborative Group to reduce health inequalities and improve outcomes for people with a learning disability by ensuring they have the support they need to live independently - Mental health - primary care plus, redesigning Mental Health services to focus on early interventions with a clear recovery pathway to reduce institutional care.

Finance:

*Please provide a full breakdown of your expenditure plans categorised into the following services areas - An outline template for this is provided in the "**financial breakdown**" worksheet.*

Service Areas- 'Purchase of social care'	**Subjective code**	**Planned Expenditure**
Community equipment and adaptations	52131015	495000

Telecare	52131016	348000
Integrated crisis and rapid response services	52131017	507000
Maintaining eligibility criteria	52131018	1054952
Re-ablement services	52131019	307000
Bed-based intermediate care services	52131020	
Early supported hospital discharge schemes	52131021	838000
Mental health services	52131022	447000
Other preventative services	52131023	230000
Other social care	52131024	580000
Total Expenditure		**4806952**
Notified Allocation		**£4,806,952.00**
Variation		**£0.00**

Variance against notified allocation.

Expenditure should match notified allocation if not please included any information on variation within the box below.

Related documentation

Please include information/links to any related documents such as the full project plan for the scheme.

Authorisation and Sign Off

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<Scheme name>

Expenditure Plan

Local Authority: Brent
CCG: Brent
Title of Scheme <Scheme name>

Service Areas- 'Purchase of social care'		Subjective code	Planned Expenditure
1. Community equipment and adaptations		52131015	495000
a.	Community Equpment Services		495000
b.			
c.			
2. Telecare		52131016	348000
a.	Telecare		348000
b.			
c.			
3. Integrated crisis and rapid response services		52131017	1345000
a.	EDT		507000
b.	HDT		838000
c.			
4. Maintaining eligibility criteria		52131018	1054952
a.	Pressures		1054952

b.			
c.			
5. Mental health services		52131022	447000
a.	Employment Support & Welfare Team		447000
b.			
c.			
6. Other preventative services		52131023	537000
a.	Carers Service		230000
b.	Reablement Service		307000
c.			
7. Other social care		52131024	580000
a.	Reablement focused day opporuntinties building indepenedence for people with LD		580000
b.			
c.			
Total Planned Expenditure			**4806952**
Total value of funding transfer (notified allocation)			**4806952**
Variation			**0**

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SCHEDULE

Local authority allocation for 2013-14

Barking and Dagenham	£3,267,999
Barnet	£5,180,804
Barnsley	£4,432,443
Bath & North East Somerset	£2,611,907
Bedford	£2,221,990
Bexley	£3,322,808
Birmingham	£20,044,390
Blackburn with Darwen	£2,735,974
Blackpool	£3,234,438
Bolton	£4,975,408
Bournemouth	£3,163,676
Bracknell Forest	£1,295,071
Bradford	£8,222,095
Brent	£4,806,952
Brighton & Hove	£4,397,579
Bristol	£7,259,859
Bromley	£4,260,838
Buckinghamshire	£5,981,927
Bury	£2,923,145
Calderdale	£3,295,041
Cambridgeshire	£8,318,185
Camden	£4,601,957
Central Bedfordshire	£3,099,459
Cheshire East	£5,192,074
Cheshire West and Chester	£5,251,421
City of London	£174,630

Cornwall	£9,997,987
Coventry	£5,551,509
Croydon	£5,015,626
Cumbria	£8,973,765
Darlington	£1,793,778
Derby	£4,110,920
Derbyshire	£12,982,732
Devon	£12,797,426
Doncaster	£5,404,111
Dorset	£6,926,360
Dudley	£5,589,300
Durham	£10,101,753
Ealing	£5,073,714
East Riding of Yorkshire	£5,175,361
East Sussex	£9,254,475
Enfield	£4,648,033
Essex	£21,186,856
Gateshead	£4,056,214
Gloucestershire	£9,055,236
Greenwich	£4,761,282
Hackney	£5,028,740
Halton	£2,287,560
Hammersmith and Fulham	£3,287,039
Hampshire	£17,017,137
Haringey	£4,109,607
Harrow	£3,471,178
Hartlepool	£1,793,604
Havering	£3,599,507

Herefordshire	£3,151,863
Hertfordshire	£14,797,761
Hillingdon	£3,726,297
Hounslow	£3,576,811
Isle of Wight Council	£2,743,128
Isles of Scilly	£45,316
Islington	£4,602,411
Kensington and Chelsea	£3,102,442
Kent	£22,063,537
Kingston upon Hull	£5,200,325
Kingston upon Thames	£2,051,503
Kirklees	£6,656,826
Knowsley	£3,497,046
Lambeth	£5,400,663
Lancashire	£19,750,385
Leeds	£11,849,652
Leicester	£5,632,672
Leicestershire	£8,640,994
Lewisham	£4,895,878
Lincolnshire	£12,054,454
Liverpool	£10,583,981
Luton	£2,820,830
Manchester	£9,542,236
Medway	£3,571,548
Merton	£2,676,894
Middlesbrough	£2,712,784
Milton Keynes	£3,250,162
Newcastle upon Tyne	£5,371,723

Newham	£5,255,695
Norfolk	£14,956,185
North East Lincolnshire	£2,790,712
North Lincolnshire	£2,723,456
North Somerset	£3,306,955
North Tyneside	£3,690,396
North Yorkshire	£8,674,471
Northamptonshire	£9,724,981
Northumberland	£5,445,531
Nottingham	£5,547,807
Nottinghamshire	£12,623,972
Oldham	£4,017,093
Oxfordshire	£8,201,856
Peterborough	£2,840,646
Plymouth	£4,596,024
Poole	£2,281,887
Portsmouth	£3,186,951
Reading	£2,038,343
Redbridge	£3,994,265
Redcar and Cleveland	£2,577,805
Richmond upon Thames	£2,365,264
Rochdale	£3,966,999
Rotherham	£4,815,007
Rutland	£485,765
Salford	£4,716,153
Sandwell	£6,614,042
Sefton	£5,457,818
Sheffield	£9,682,589

Shropshire	£4,988,726
Slough	£1,844,892
Solihull	£3,115,150
Somerset	£8,939,209
South Gloucestershire	£3,346,684
South Tyneside	£3,275,870
Southampton	£3,970,677
Southend-on-Sea	£2,949,235
Southwark	£5,621,610
St Helens	£3,446,221
Staffordshire	£12,677,280
Stockport	£4,592,842
Stockton-on-Tees	£3,025,250
Stoke-on-Trent	£4,767,077
Suffolk	£11,673,091
Sunderland	£5,611,337
Surrey	£14,297,472
Sutton	£2,638,857
Swindon	£2,753,293
Tameside	£4,130,488
Telford and the Wrekin	£2,771,315
Thurrock	£2,341,506
Torbay	£2,965,625
Tower Hamlets	£5,243,352
Trafford	£3,384,835
Wakefield	£5,901,600
Walsall	£5,124,740
Waltham Forest	£3,896,610

Wandsworth	£4,643,811
Warrington	£2,948,293
Warwickshire	£7,997,949
West Berkshire	£1,792,796
West Sussex	£11,823,605
Westminster	£4,735,807
Wigan	£5,698,831
Wiltshire	£6,525,049
Windsor and Maidenhead	£1,705,319
Wirral	£6,443,824
Wokingham	£1,437,354
Wolverhampton	£4,926,642
Worcestershire	£8,534,970
York	£2,619,236
TOTAL	£859,000,000

17 October 2013

To: CCG Clinical Leads
Health and Wellbeing Board Chairs
Chief Executives of upper tier Local Authorities
Directors of Adult Social Services

cc: CCG Accountable Officers
NHS England Regional and Area Directors

Dear Colleagues

Next Steps on implementing the Integration Transformation Fund

We wrote to you on 8 August 2013 setting out the opportunities presented by the integration transformation fund (ITF) announced in the spending review at the end of June. While a number of policy decisions are still being finalised with ministers, we know that you want early advice on the next steps. This letter therefore gives the best information available at this stage as you plan for the next two years.

Why the fund really matters

Residents and patients need Councils and Clinical Commissioning Groups (CCGs) to deliver on the aims and requirements of the ITF. It is a genuine catalyst to improve services and value for money .The alternative would be indefensible reductions in service volume and quality.

There is a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund. We encourage Health and Wellbeing Boards to extend the scope of the plan and pooled budgets.

Changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five year strategy for health and care. Accordingly the NHS planning framework will invite CCGs to agree five year strategies, including a two year operational plan that covers the ITF through their Health and Wellbeing Board.

A fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. There is excellent practice in some areas that needs to be replicated everywhere. The ingredients are the same across England; the recipe for success differs locality by locality.

Integrated Care Pioneers, to be announced shortly, will be valuable in accelerating development of successful approaches. We are collaborating with all the national partners to support accelerated adoption of integrated approaches, and will be launching support programmes and tools later in 2013.

Where does the money come from?

The fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16, which remain very challenging. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. (The requirements of the fund are likely to significantly exceed existing pooled budget arrangements). Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

Working with providers

It will be essential for CCGs and Local Authorities to engage from the outset with all providers, both NHS and social care, likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the fund includes agreement to the service change consequences.

Supporting localities to deliver

We are acutely aware that time is pressing, and that Councils and CCGs need as much certainty as possible about how the detail of the fund will be implemented. Some elements of the ITF are matters of Government policy on which Ministers will make decisions. These will be communicated by Government in the normal way. The Local Government Association and NHS England are working closely together, and collaborating with government officials, to arrive at arrangements that support all localities to make the best possible use of the fund, for the benefit of their residents and patients. In that spirit we have set out in the attached annex our best advice on how the Fund will work and how Councils and CCGs should prepare for it.

The Government has made clear that part of the fund will be linked to performance. We know that there is a lot of interest amongst CCGs and Local Authorities in how this “pay-for-performance” element will work. Ministers have yet to make decisions on this. The types of performance metrics we can use (at least initially) are likely to be largely determined by data that is already available. However, it is important that local discussions are not constrained by what we can measure. The emphasis should be on using the fund as a catalyst for agreeing a joint vision of how integrated

care will improve outcomes for local people and using it to build commitment among local partners for accelerated change.

Joint local decision making and planning will be crucial to the delivery of integrated care for people and a more joined up use of resources locally. The ITF is intended to support and encourage delivery of integrated care at scale and pace whilst respecting the autonomy of locally accountable organisations.

This annex to this letter sets out further information on:

- How the pooled fund will be distributed;
- How councils and CCGs will set goals and be rewarded for achieving them;
- Possible changes in the statutory framework to underpin the fund;
- The format of the plans for integrated care and a template to assist localities with drawing up plans that meet the criteria agreed for the fund;
- Definitions of the national conditions that have to be met in order to draw on the polled fund in any locality; and
- Further information on how local authorities, CCGs, NHS England and government departments will be assured on the effective delivery of integrated care using the pooled fund.

Leads from the NHS and Local Government will be identified to assist us to work with Councils and CCGs to support implementation. More details on this can be found in the annex. We will issue a monthly bulletin to Councils and CCGs with updates on the Integration Transformation Fund.

Yours faithfully

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

NHS England Publications Gateway Ref. No.00535

Annex

Advice on the Integration Transformation Fund

What is included in the ITF and what does it cover?

Details of the ITF Fund

The June 2013 SR set out the following:	
2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the ITF will be created from the following:
£1.9bn NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. Composed of:
• £130m Carers' Breaks funding
• £300m CCG reablement funding
• £354m capital funding (including c.£220m of Disabled Facilities Grant)
• £1.1bn existing transfer from health to social care

1. The Integration Transformation Fund will be £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users. In 2014/15 an additional £200m transfer from the NHS to social care in addition to the £900m transfer already planned will enable localities to prepare for the full ITF in 2015/16.

2. In 2014/15 use of pooled budgets remains consistent with the guidance[1] from the Department of Health to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

3. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

4. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

5. *In line with our responsibilities under the Health and Social Care Act, NHS England is also making it a condition of the transfer that local authorities and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

6. *NHS England is also making it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

7. In 2015/16 The fund will be allocated to local areas, where it will be put into pooled budgets under joint governance between CCGs and local authorities. A condition on accessing the money in the fund is that CCGs and local authorities must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

How will the ITF be distributed?

8. Councils will receive their detailed funding allocation following the Autumn Statement in the normal way. When allocations are made and announced later this year, they will be two-year allocations for 2014/15 and 2015/16 to enable planning.

9. In 2014/15 the existing £900m s.256 transfer to Local Authorities for social care to benefit health, and the additional £200m will be distributed using the same formula as at present.

10. The formula for distribution of the full £3.8bn fund in 2015/16 will be subject to ministerial decisions in the coming weeks.

11. In total each Health and Wellbeing Board area will receive a notification of its share of the pooled fund for 2014/15 and 2015/6 based on the aggregate of these allocation mechanisms to be determined by ministers. The allocation letter will also specify the amount that is included in the pay-for-performance element, and is therefore contingent in part on planning and performance in 2014/5 and in part on achieving specified goals in 2015/6.

How will Councils and CCGs be rewarded for meeting goals?

12. The Spending Review agreed that £1bn of the £3.8bn would be linked to achieving outcomes.

13. In summary 50% of the pay-for-performance element will be paid at the beginning of 2015/16, contingent on the Health and Wellbeing Board adopting a plan that

meets the national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. We are still agreeing the detail of how this will work, including for any locally agreed measures.

14. In practice there is a very limited choice of national measures that can be used in 2015/6 because it must be possible to baseline them in 2014/5 and therefore they need to be collected now with sufficient regularity and rigour. For simplicity we want to keep the number of measures small and, while the exact measures are still to be determined, the areas under consideration include:

    - Delayed transfers of care;
    - Emergency admissions;
    - Effectiveness of re-ablement;
    - Admissions to residential and nursing care;
    - Patient and service user experience.

15. In future we would hope to have better indicators that focus on outcomes for individuals and we are working with Government to develop such measures. These can be introduced after 2016/7 as the approach develops and subject to the usual consultation and testing.

16. When levels of ambition are set it will be clear how much money localities will receive for different levels of performance. In the event that the agreed levels of performance are not achieved, there will be a process of peer review, facilitated by NHS England and the LGA, to avoid large financial penalties which could impact on the quality of service provided to local people. The funding will remain allocated for the benefit of local patients and residents and the arrangements for commissioning services will be reconsidered.

Does the fund require a change in statutory framework?

17. The Department of Health is considering what legislation may be necessary to establish the Integrated Transformation Fund, including arrangements to create the pooled budgets and the payment for performance framework. Government officials are exploring options for laying any required legislation in the Care Bill. Further details will be made available in due course. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the fund?

18. Each upper tier Health and Wellbeing Board will sign off the plan for its constituent local authorities and CCGs. The specific priorities and performance goals are clearly a matter for each locality but it will be valuable to be able to:

    - Aggregate the ambitions set for the fund across all Health and Wellbeing Boards;

- Assure that the national conditions have been achieved; and

- Understand the performance goals and payment regimes have been agreed in each area.

19. To assist Health and Wellbeing Boards we have developed a draft template which we expect everyone to use in developing, agreeing and publishing their integration plan. This is attached as a separate Excel spread sheet.

20. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the ITF. We strongly encourage Councils and CCGs to make immediate use of this template while awaiting further guidance on NHS planning and financial allocations.

21. Local areas will be asked to provide an agreed shared risk register, with agreed risk sharing and mitigation covering, as a minimum, steps that will be taken if activity volumes do not change as planned. For example if emergency admissions increase or nursing home admissions increase.

What are the National Conditions?

22. The Spending Review established six national conditions:

National Condition	Definition
Plans to be jointly agreed	The Integration Plan covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and Local Authorities should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 2 to 6,

National Condition	Definition
	above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The forthcoming national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England will provide guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas will be asked to: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas, and will make this available alongside the planning template. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas will be asked to identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning.
Agreement on the consequential impact of changes in the acute sector	Local areas will be asked to identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient engagement in this planning, as well as plans for political buy-in.

How will preparation and plans be assured?

23. Ministers will wish to be assured that the ITF is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

24. To maximise our collective capacity to achieve these outcomes and deliver sustainable services we will have a shared approach to supporting local areas and assuring plans. This process will be aligned as closely as possible to the existing NHS planning rounds, and CCGs can work with their Area Teams to develop their ITF plans alongside their other planning requirements.

25. We will establish in each region a lead local authority Chief Executive who will work with the Area and Regional Teams, Councils, ADASS branches, DPHs and other interested parties to identify how Health and Wellbeing Boards can support one another and work collaboratively to develop good local plans and delivery arrangements.

26. Where issues are identified, these will be shared locally for resolution and also nationally through the Health Transformation Task Group hosted by LGA, so that the national partners can broker advice, guidance and support to local Health and Well Being Boards, and link the ITF planning to other national programmes including the Health and Care Integration Pioneers and the Health and Well Being Board Peer Challenge programme. We will have a first review of readiness in early November 2013.

27. We will ask Health and Well Being Boards to return the completed planning template (draft attached) by 15 February 2014, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the ITF.

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DRAFT TERMS OF REFERENCE – BRENT INTEGRATION TRANSFORMATION BOARD

1. PURPOSE

The Brent Integration Transformation Board is collectively accountable to the Brent Health and Wellbeing Board. Its main purpose is to provide system wide leadership and accountability for delivery of integration within Brent's health and care economy . The Brent Integration Transformation Board will implement the vision and direction for integrated care as set out in the Health and Wellbeing Board and the Integration Transformation Fund.

It will provide advice and recommendations to the Health and Wellbeing Board and seek its support in achieving rapid and dynamic change. It will be informed by Brent Health and Wellbeing Board, along with national priorities, local priorities, communities, users of services and clinical priorities.

Key success criteria are:

1. Achieving a framework and ability for different models of integration to emerge
2. Ensuring that the whole system benefits from integration, demonstrates efficiencies and that we improve outcomes
3. Ensuring that the system delivers the both national voices definition of integration and translates them into integration of local service delivery

2. AGREED PRIORITIES

2.1 Integrated STARRS, Reablement and Rehab

2.2 Integrated Frequent Attenders MDT / ICP

2.3 Delayed Transfers of Care

2.4 Alcohol and Homeless

2.5 Learning Disabilities

2.6 Mental Health Primary Care Plus

3. RESPONSIBILITIES

3.1 To develop the vision for integration of health and care with clear aspirations and outcomes, maintaining the health, well-being and independence of the citizens of Brent.

3.2 To develop a health and social care system which commissions and provides different models of integration through innovation and transformation to deliver more co-ordinated care in the community to enable people to live longer and live better.

3.3 To oversee the development of a system of care which co–ordinates in hospital and out of hospital services, including 7 day availability, across Brent to achieve better outcomes which will enable people to live longer and live better

3.4 To take an economy wide approach to managing difficult issues and where appropriate to use freedoms and flexibilities available to maximum advantage locally and challenge the system where barriers exist and seek solutions at the necessary level.

3.5 To understand the total NHS and Local Authority resources and directing those resources to support integration as required. This will include advising and informing the Health and Wellbeing Board on the targeting of transferred NHS resources to social care (including the Integration and Transformation Fund) and creating opportunities for supporting integration.

3.6 To support the move to towards a joint health and social care information system and joined up information technologies, maximising the benefits of a single shared record users of services and staff

3.7 To support the Health and Wellbeing Board and develop a two way relationship to inform and support the delivery of integrated health and care.

3.8 To establish relationships for engaging with local communities, the public and users of services and assure itself that any changes to the system reflect the views and experience of local people and users of services.

3.9 To develop a financial model which supports the spectrum of integration, including risk and benefit sharing, proposing changes to existing payment mechanisms and contractual arrangements where necessary.

3.10 To work to the following principles, as reflected in Integration Pioneer:

We will ensure person focused services by...

• Working better together is first and foremost about what is best to add value for the people we care for
• Improving the quality of care and support available
• Looking for improvement through the eyes of the people we care for and the staff providing the care

We will ensure collective ownership by...

• Continuing to create a culture of trust, openness and transparency, including demonstrating a collective stewardship of resources
• Putting the interests of the people we serve ahead those of our individual organisations

We will ensure learning and development by...

• Sharing our learning from working together with one another, and others as well as learning from elsewhere and will share our learning more widely
• Building on existing work that has established strong foundations for integration e.g. NWL WSIC
• Ensuring our clinicians, social care professionals, managers and others will work together to make change happen we will ensure pace and focus by.
• Collectively agreeing our future priorities as a whole system
• Adopting a positive mind-set – 'we can, we will'
• Committing to working at pace, to achieve rapid progress, make decisions and see them through

3.11 Promote learning that could be shared with other programmes and/or applied to different client groups

3.12 To oversee service development and a culture change to deliver integration, innovation and transformation.

4. MEMBERSHIP, FREQUENCY OF MEETINGS AND QUORUM

4.1 The Brent Integration Board will comprise the main partners as core member as follows:

Chair	}	
Deputy Chair	}	To be agreed
Membership	}	

4.2 Frequency – To be agreed

4.3 Quorum – To be agreed

4.4 Administration – To be agreed

5. CONFLICTS OF INTEREST

5.1 As commissioners and providers will be jointly developing new models of integration, careful consideration will need to be given to potential conflicts of interest.

5.2 Members of the Integration Board are expected to conduct themselves in an appropriate manner. They must refrain from actions that are likely to create any real or perceived conflict of interest, save those that are inherent in the institutional interests of the organisations that members represent.

5.3 Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Board. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair.

6. REPORTING

6.1 The Brent Integration Transformation Board is collectively accountable to the Brent Health and Wellbeing Board. It will report to the Brent Health and Wellbeing Board through its Chair and will develop a two way relationship and feedback from the Health and Wellbeing Board.

6.2 The minutes of the Brent Integration Transformation Board will be made available to the Health and Wellbeing Board and to constituent organisations.

6.3 Minutes with clear sets of actions from both will be received at each Brent Integration Transformation Board Meeting.

7. REVIEW

7.1 The Brent Integration Transformation Board Terms of Reference will be formally reviewed in November 2014.