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

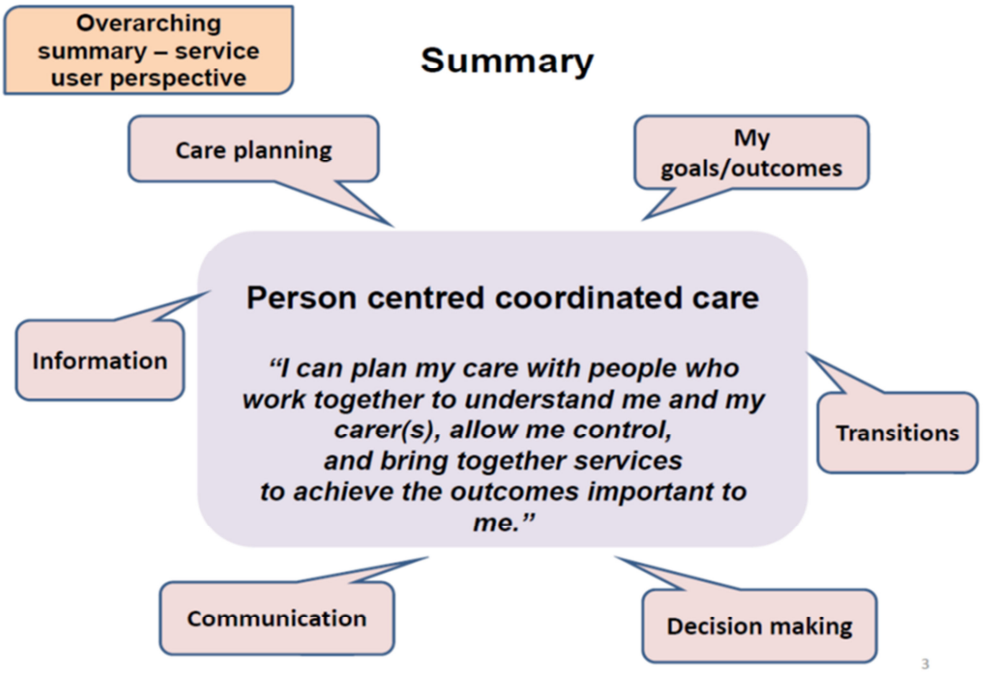
(iii). Agree the Section 256 document (attached at Appendix A) for submission to NHS England as the first step in the Integration Transformation Fund process.

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.

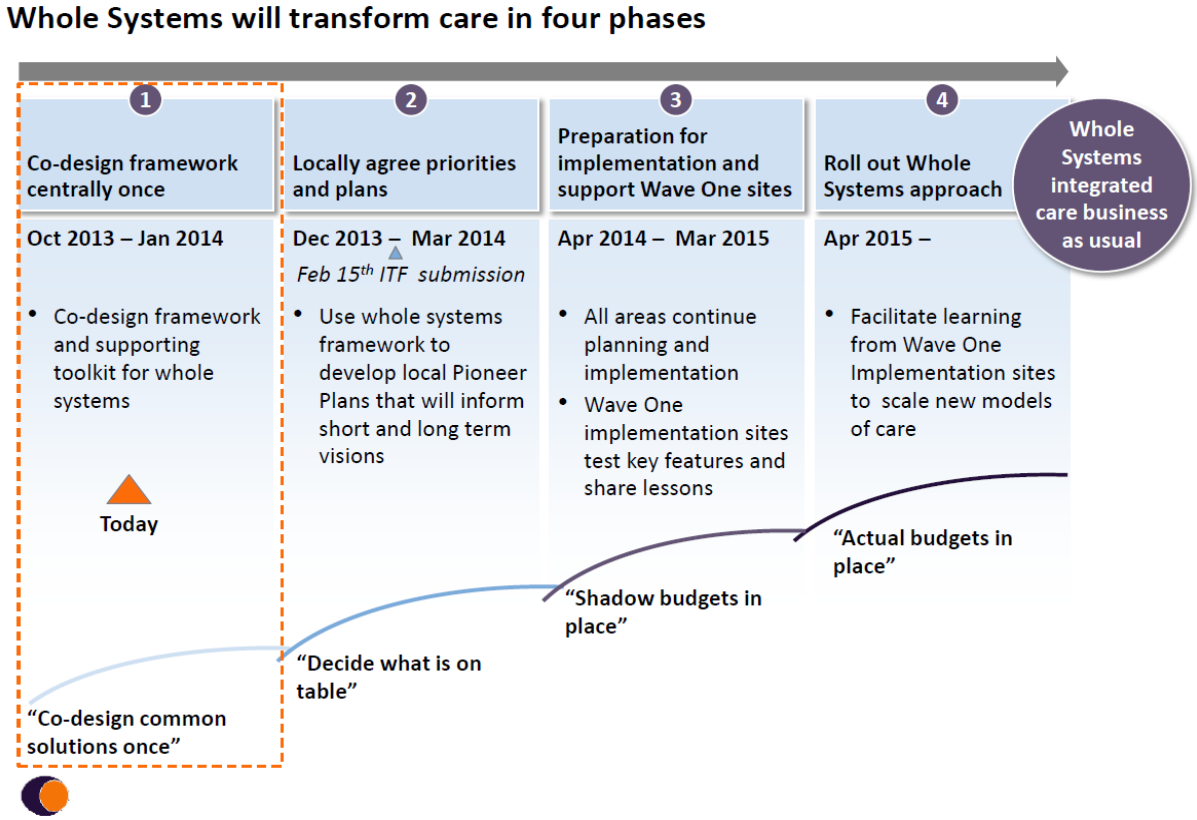


3.3 Although health and social integration must deliver financial efficiencies, we will only be successful if we support more people to be live independently while also delivering against their expectations for care and support. In other words, we must remain focused on what people tell us about their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

Phil Porter
Acting Director of Adult Social Services
Email – phil.porter@brent.gov.uk

Sarah Mansuralli
Deputy Chief Operating Officer
Brent Clinical Commissioning Group
Email - sarah.mansuralli@brent-harrowpcts.nhs.uk