Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Glen Garrod, Director of Adult Social Services, Lincolnshire County Council

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**10 December 2013**
Subject:	**Integrated Transformation Fund and Proposals to Develop a Structure to Support Joint Commissioning**

Summary:

The shadow Health and Wellbeing Board received a report in March 2013 detailing the proposed use of the funding transferred from the Department of Health for Adult Social Care in 2013/14. Since that time a further report has been produced for the formally constituted Health and Wellbeing Board, in September 2013, detailing changes to this funding: now entitled the Integration Transformation Fund or ITF with associated new national guidance.

This paper provides an update to the use of the ITF in 2013/14 and how plans are developing to meet national requirements for the use of the funds in 2014/15 and 2015/16.

In addition a recommended number of 'early implementer' priorities against which ITF funding can be used are included in this paper.

Finally the report proposes joint governance arrangements which should govern how the Council and Lincolnshire Clinical Commissioning Groups work together to improve the health and social care outcomes for Lincolnshire communities.

Actions Required:

1. Members of the Health and Wellbeing Board are asked to note the contents of this Report and Appendices.
2. Note the agreement previously reached in March 2013, on the use of allocated funds in 2013/14 in order that money can be transferred from the Area Team to Lincolnshire (Appendix A, B and C).
3. Note the 'special' Health and Wellbeing Board meeting on 5 February 2014 to formally agree the two year plan to spend the Integration Transformation Fund in

2014/15 and 2015/16.

4. Agree the five 'early implementer' priorities.
5. Agree the outline structure for joint commissioning arrangements (see Appendix D).

1. Background

Members of the Health and Wellbeing Board will be increasingly familiar with the term Integration Transformation Fund (ITF) although it represents a recent and fundamental change to the way in which health partners and the County Council work together and, to what end.

Guidance produced nationally by both the Local Government Association, in this matter representing upper tier Local Authorities, and NHS England was produced at the beginning of October. This guidance detailed the requirements for spending the ITF in 2014/15 and 2015/16. One key facet within the guidance is the need to produce a detailed two year plan to spend the 'pooled' ITF based on a collective agreement between NHS Commissioners and the relevant Local Authority. The plan MUST be agreed by the Health and Wellbeing Board before it can be submitted to the Area Team by the deadline of 14 February 2014. This detailed two year plan must also be accompanied by a more outline five year strategy.

Interestingly the plan must also have the involvement of key providers (NHS and Social Care). Though there is no detail about what this means in practice. However all major providers have been integral to the co-creation of the Lincolnshire Sustainability Services Review Blueprint (the 'Blueprint') which forms the basis of the county's five year strategic plan and are therefore aware of the strategic themes within it.

Failure to achieve this or, failure to deliver a sufficiently robust plan within the timescale jeopardises the allocation of the ITF in future years.

The timescale is incredibly tight and very ambitious but will be a common experience across health and social care communities in England.

It is worthwhile noting that the ITF grows as it begins to incorporate funding for use in satisfying other requirements (such as the costs associated with the advent of the 'Care Bill', Funding Reforms for Adult Care, Disabled Facilities Grants and the Independent Living Fund (now subject to judicial proceedings) which the Table in Appendix E seeks to illustrate. Members should also note that a large portion of the total (£1.9bn of the £3.8bn nationally) is base funding contained within the NHS. As such it is critical that ITF funding is used to redirect 'baseline allocations' in health and social care. Failure to do so will in effect leave both health and social care commissioners with the current financial and service commitments without the resources to pay for them. The Blueprint implementation will provide that opportunity.

The Lincolnshire Sustainability Review (the 'Blueprint')

This subject has, topically, been considered by members of the Health and Wellbeing Board today and so there will be a level of familiarity with the Blueprint and the stage of development that it has reached. The Blueprint is in effect the outline five year plan for Lincolnshire and as such provides a good framework in which to consider the two year plan for the use of ITF. Self-evidently then the ITF is a catalyst that begins to create a momentum for change that reflects the key requirements of the Blueprint. This can ONLY be achieved if the ITF funds begin to draw together much larger baseline funding across health and social care organisations which includes the funds managed by the Area Team for Primary Care Services. Early discussions with Lincolnshire CCGs suggest that there is enthusiasm for such an approach from within the NHS England Local Area Team.

The Task Group

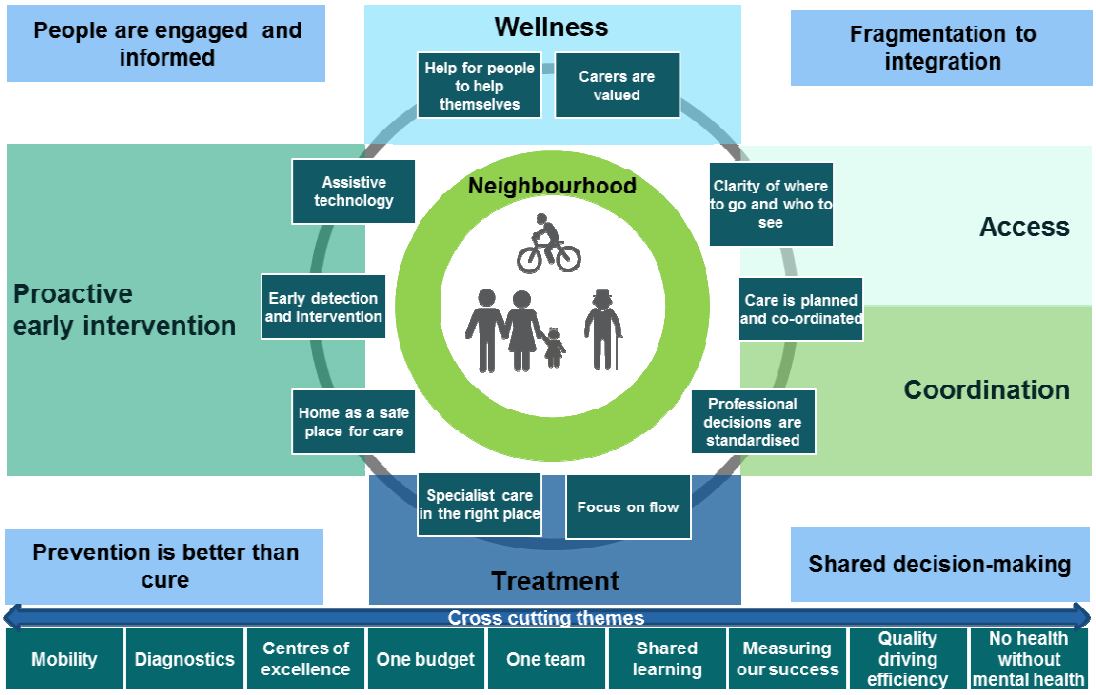
Prior to receipt of the October guidance concerning use of the ITF a small Task Group of officers from the NHS and Adult Care had begun to meet to consider reviewing existing plans for the ITF. The requirement to produce a detailed two year plan has meant the Task Group has been expanded to include senior officers from each of the four CCGs and the Director of Adult Social Services in a co-ordinating role.

The first two meetings of the enlarged Task Group (on 12 and 28 November) has begun the process of reviewing all areas of ITF spend in order to understand what can be 'freed-up' in 2014/15 and 2015/16 to allocate on fewer priorities that will more successfully deliver against the 'early implementer' priorities and the wider ambition of the Blueprint.

The Task Group proposes a number of priorities for investment as 'early implementers' to create urgent momentum for change in support of the future model of care outlined in the Blueprint. These are (in no particular order of priority):

- The development of **'neighbourhood teams**' in a number of sites.
- The Development of a pooled budget and jointly commissioned **Intermediate Care Layer**.
- **Seven-Day Hospital Working** which is a requirement in the guidance on use of the ITF and must be included in the two year plan.
- **Prevention** which will incorporate a number of short term projects funded by the ITF and the developing 'Wellbeing' service. It will also need to include young people – notably regarding the implications of 'Support and Aspiration'.
- **Enablers** notably estates and IMT.

The Blueprint Future Model of Care Principles



Without the ability to define a small number of priorities the two year plan will not be able to exhibit the necessary level of detail to satisfy national requirements (for example., seven-day working) and, meet performance requirements which are prescribed as:

- Emergency admissions
- Effective re-ablement
- Delayed Transfers
- User experience

Of course additional targets may be added that are particular to Lincolnshire should this be seen as desirable. However, the timetable and prescribed conditions for the two year plan would suggest restraint.

As with previous use of the transferred Department of Health (DoH) funds a component of the now ITF fund is used to protect social care from further cuts that would be made that would have deleterious effects on wider health outcomes. The current use of ITF in this way is £4.418m which equates to 37% of the total available. This can be set against the average usage by Adult Social Service Departments nationally of approximately 46% (based on 2012/13 data).

Early analysis of existing spend indicates a substantial proportion is used for short term projects that are expected to be reviewed formally before the end of 2014/15. If these are not considered worthy of longer term funding then the sums available to use against the Blueprint will grow. It is imperative therefore that officers across both health and social care services (adult and children's) acting as project lead are able to clearly illustrate both enhanced performance and/or the deleterious effect of stopping spend. It will be necessary for the Health and Wellbeing Board to consider how best such decisions are to be made.

What is increasingly clear is that there is no pre-existing and formal infrastructure to collectively manage the complex array of changes underway and this must be a matter of priority for the Board.

Governance Arrangements

Lincolnshire Health and Social Care agencies have a long history of successful joint commissioning arrangements.

We currently jointly commission a range of services including but not limited to: learning disability, children with disability, child and adolescent mental health services (CAMHS) and drug and alcohol treatment (DAAT) for example, each with their own governance structures.

There are also a range of aligned commissioning arrangements where both LCC and CCG's are commissioning services from the same provider. For example LCC have a Section 75 agreement with LPFT for Adult Mental Health Services and the CCGs have a contract for services with LPFT for Adult Mental Health Services.

As we seek to achieve further integration and achieve the ambitions of the Sustainable Services Review, our current governance structures need to be strengthened, given more flexibility and become more efficient/effective. This section of the report sets out the proposed joint commissioning arrangements between Lincolnshire County Council, the Local Area Team of NHS England and the four Lincolnshire Clinical Commissioning Groups. The proposals outlined in the paper are intended to stimulate debate and it is recognised that further work is needed to clarify terms of reference etc.

Formal Commissioning Structures

The structure in Appendix D demonstrates proposed commissioning governance structures. It is recognised that current arrangements are condition specific with no overarching strategic commissioning body to monitor the totality of health and special care spend and outcomes. Current arrangements are highly complex, with duplication of governance and therefore in need of being streamlining. The proposed structure provides greater flexibility and has strategic overview of all joint commissioning activities

Using the current work streams in the Sustainable Services Review as the baseline to describe activity alongside other key agency responsibility, it is proposed that the relevant Boards would be responsible for the following areas of activity:

Commissioning Board	**Areas of Responsibility**
Joint Commissioning Board	• Strategic Leadership; • Strategic responsibility for commissioning integrated health and social care to meet the aspirations of the key stakeholders, commissioners and the outcomes of the Health and Well Being Board; • Strategic Risk Management ; • Endorsing Joint Commissioning Strategies to achieve agreed Priorities.

	• Reporting on progress to the Health and Wellbeing Board
Urgent Care (Delivery Board)	• Needs and Resource Assessment, Strategy development and implementation of Reactive Care; • Specification, Procurement, Contract Management, Quality Assurance and Safeguarding of Reactive Care; • Single point of access for crisis co-ordination; • Management of unnecessary admission to acute care from care and nursing care homes; • Discharge arrangements to care and nursing homes; • Commissioning lead for: - Acute Care - Accident and Emergency - Integrated Urgent Care - Secure Accommodation.
Proactive Care (Delivery Board)	• Needs and Resource Assessment, Strategy development (prevention focused) and implementation of Proactive Care; • Specification, Procurement, Contract Management, Quality Assurance and Safeguarding of Proactive Care; • Trigger Response (early identification of needs to prevent problems escalating) ; • Integrated Discharge to assess (co-ordinated community based discharge support); • The declining Patient (single point of access and unified team for care planning and delivery) ; • Commissioning lead for: - Recovery, re-ablement and rehabilitation - Intermediate Care - Remote Monitoring of Tele-health - Integrated Community Equipment - End of life care - Self-care Enhanced Carer support - Falls Prevention - Wellbeing Network. • Assessment and care management for adults with physical disability and older people
Women and Children's (Delivery Board)	• Needs and Resource Assessment, Strategy development (Early Intervention focused) and implementation of Women & Children's Services; • Specification, Procurement, Contract Management, Quality Assurance and Safeguarding of Services for Women & Children; • One Commissioner ethos; • Admission avoidance; • Early Intervention and targeted intervention through neighbourhood teams; • (primary care and targeted interventions across health and

	social care) • Child development centre network (integrated assessment, care planning and care delivery for children) ; • Commissioning lead for: - Consolidation and integration of specialist services including LAC,CAMHS &SEN - Early Years Services - Education Support Services - Readiness for Adult Life
Adults specialist (Delivery Board)	• Needs and Resource Assessment, Strategy Development and delivery of Specialist services; • Specification, Procurement, Contract Management, Quality Assurance and Safeguarding of Services for Adults with Learning Disability, Mental Health problems, Autism; • Commissioning lead for: - Assessment and care management for adults with learning disability need - Assessment and care management for adults with mental ill health - Assessment and care management for adults with autism.

The arrangements described in this report are developing. The foundation of a Joint Commissioning Board is in place and there are plans to evolve the Learning Disability Joint Commissioning Board into the Adults Specialist Delivery Board with a proposal that the Women and Children's Delivery Board should be an early implementer. Other delivery boards would be developed with informed learning from the forerunners.

Terms of Reference

The following outline/ summary Terms of Reference are proposed :

Terms of Reference Joint Commissioning Board	
Purpose of Group	• To provide strategic leadership; • Coordinate the outputs for service area specific commissioning board to achieve agreed Outcomes and other priorities; • Strategic Risk Management; • To discuss and provide areas that may be priorities for future change to Health and Wellbeing Board; • To propose programmes of joint investment to support Joint Health and Wellbeing priorities, • Provide updates to CCGs, LA and Health and Wellbeing Board on performance against specified outcomes
Membership:	• Representatives from the Clinical Commissioning Groups covering Lincolnshire

	• County Council Corporate Management Board
Areas of Responsibility	• To coordinate the delivery of the agreed Joint Commissioning and Health and Wellbeing priorities and monitor delivery of the Sustainable Services Review • To review and as required prepare proposals about Joint Commissioning and Health and Wellbeing priorities between the CCGs and LA • To co-ordinate joint commissioning activity to deliver outcomes for local people in local areas • To ensure that the constituent organisations consider any decisions required to deliver agreed programmes of joint investment.
Frequency of meetings:	• Meetings will take place each month in the first instance; • NB - Quoracy: The group is a coordinating partnership group so quoracy is not an immediate issue as decisions will be taken by individual organisations
Terms of Reference **Joint Commissioning Delivery Boards**	
Purpose of Group:	• To deliver the outcomes and priorities agreed; • To agree a joint strategy for the assessment of need, service re design, procurement and monitor implementation of services related to area of responsibility • To ensure clear communications to the Joint Commissioning Board and own organisation on commissioning related to area of responsibility • Deliver Best Value • Ensure compliance with confirmed policy and standards.
Membership	• Representatives from at least two Lincolnshire Commissioning Groups; • Representatives from Lincolnshire County Council All delivery commissioning boards will have clinical/ technical and management representation. Executive decisions stemming from the Group's work will be made by the constituent organisations as required
Areas of Responsibility	• To steer the delivery of the agreed Joint Commissioning priorities and to report on progress to own organisation and the Joint Commissioning Board - This may include identifying action required to

	deliver the agreed priorities; • Ensure engagement and co-production with service users, carers and other stakeholders; • To ensure actions are being taken forward through functional activity groups as relevant; • To propose and monitor agreed programmes of joint investment, • To prepare proposals about future Joint Commissioning priorities between the Clinical Commissioning Groups and the Council • To co-ordinate joint commissioning activity across Lincolnshire to deliver consistent outcomes for local people • To provide reports for own organisation and the Joint Commissioning Board as required. • To ensure that the constituent organisations consider any decisions required to deliver agreed programmes of joint investment or transfer.
Frequency of meetings	• Meetings will take place each month in the first instance.

2. Conclusion

There is an urgent need for the H&WB Board to agree a range of activity (notably the priorities and the joint commissioning structures) that will begin to underpin the longer term 'Blueprint' and, critically satisfy the requirement of a detailed two year plan in the use of Integration Transformation Funding. The risk of failure to progress is that we fail to produce a satisfactory two year plan and lose nominally allocated sums in 2015/16 as part of the ITF, reputational damage, loss of momentum against the Blueprint and, find the scale of the financial challenge has grown as a result of collective lack of progress.

3. Consultation

The four CCGs and the Corporate Management Team of Lincolnshire County Council have been involved in the production of this paper. It is a condition of the ITF two year plan submission that Providers (health and social care) are engaged and this will be a matter of priority for social care providers given early involvement of the three NHS providers in Lincolnshire.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Integration Transformation Fund Spread sheet for 2013/14
Appendix B	Section 256 Funding Transfer
Appendix C	Section 256 Agreement
Appendix D	Joint Commissioning Structure

Appendix E	Integration Transformation Fund

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Glen Garrod and Debbie Barnes, who can be contacted on 01522-550808 or Glen.Garrod@lincolnshire.gov.uk, and 01522-553200 or Debbie.Barnes@lincolnshire.gov.uk.