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## **HEALTH AND WELLBEING BOARD**

**12 DECEMBER 2013**

### **SUPPLEMENTARY PAPERS**

**TO: ALL MEMBERS OF THE HEALTH AND WELLBEING BOARD**

The following papers have been added to the agenda for the above meeting.

These were not available for publication with the rest of the agenda.

Alison Sanders  
Director of Corporate Services

	<b>Page No</b>
<b>7. INTEGRATION TRANSFORMATION FUND</b>	
Annex 1 and 2.	1 - 14

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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 pooled 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**

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## 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:	
<ul style="list-style-type: none"> <li>• £130m Carers' Breaks funding</li> <li>• £300m CCG reablement funding</li> <li>• £354m capital funding (including c.£220m of Disabled Facilities Grant)</li> <li>• £1.1bn existing transfer from health to social care</li> </ul>	

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<sup>1</sup> 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*

<sup>1</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf](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	<p>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.</p> <p>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.</p>
Protection for social care services (not spending)	<p>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,</p>

National Condition	Definition
	above.
<p>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</p>	<p>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.</p> <p>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.</p>
<p>Better data sharing between health and social care, based on the NHS number</p>	<p>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.</p> <p>Local areas will be asked to:</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• confirm that they are pursuing open APIs (ie. systems that speak to each other); and</li> <li>• 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.</li> </ul> <p>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).</p>

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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## Integration Transformation Fund

### Draft Plan Submission Template

Local Authority

<Name of Local Authority>
---------------------------

Clinical Commissioning Groups

<CCG Name/s>
<CCG Name/s>
<CCG Name/s>
<CCG Name/s>
<CCG Name/s>

11

Boundary Differences

<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>
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Date agreed at Health and Well-Being Board:

<dd/mm/yyyy>
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Date submitted:

<dd/mm/yyyy>
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Minimum required value of ITF pooled budget: 2014/15  
2015/16

<b>£0.00</b>
<b>£0.00</b>

Total agreed value of pooled budget: 2014/15  
2015/16

<b>£0.00</b>
<b>£0.00</b>

## Authorisation and Sign Off

<b>Signed on behalf of the Clinical Commissioning Group</b>	
<b>By</b>	<Name of ccg>
<b>Position</b>	<Name of Signatory>
<b>date</b>	<Job Title>
	<date>

<b>Signed on behalf of the Clinical Commissioning Group</b>	
<b>By</b>	<Name of Signatory>
<b>Position</b>	<Job Title>
<b>date</b>	<date>

<Insert extra rows for additional CCGs as required>

<b>Signed on behalf of the Local Authority</b>	
<b>By</b>	<Name of Signatory>
<b>Position</b>	<Job Title>
<b>date</b>	<date>

<b>Signed on behalf of the Health &amp; Wellbeing Board</b>	
<b>By Chair of the HWB:</b>	<Name of Signatory>
<b>Position</b>	<Job Title>
<b>date</b>	<date>

## Service provider engagement

*Please describe how health and social care providers have been involved in the development of this pla, and the extent to which they are party to it*

**Patient, service user and public engagement**

*Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it*

**Related documentation**

*Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition*

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