From: Roger Gough, Cabinet Member for Education and Health Reform

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To: Kent Health and Wellbeing Board

Subject: The Integration Transformation Fund

Classification: Unrestricted

Summary:

The £3.8bn Integration Transformation Fund (ITF) announced by the Government dramatically accelerates the timescale for achieving the integration of health and social care services. Government expectations are that a fully integrated system should be in place by 2018 based on actions identified to start in 2014-15 and begin significant delivery in 2015-16. The funding consists of a number of existing components as well as new allocations from CCG budgets.

Plans to spend the funding must be agreed by Health and Wellbeing Boards who must assume responsibility for monitoring the achievement of the targets required, agree contingency plans for re-allocating funding if targets are missed, and be satisfied that providers, especially acute hospital trusts, have been effectively engaged in the planning process.

Recommendations:

The Health and Wellbeing Board is asked to:

(i) Acknowledge the timescales involved for the preparations of the Kent plan for the Integration Transformation Fund

(ii) Agree to establish the necessary processes and mechanisms to construct the plan and deliver the required activity across Kent.

1. Introduction

The Integration Transformation Fund was announced in the Comprehensive Spending Review It follows the NHS “Call to action” that identified a £30bn shortfall in NHS funding in 2020 unless action to manage demand is taken. This has also spawned the integrated care “Pioneer Programme”.

The funding is described as “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”

Funding will be awarded to local plans, based on a Health and Wellbeing Board footprint and with Boards as the leaders for implementation. Health and Wellbeing Boards will need to agree plans to spend the money to deliver agreed outcomes.

Plans will also need to take account of the implications for the acute sector of service transformation and set out arrangements for the redeployment of funding within the system if outcomes are not reached.

There will need to be some oversight and ministerial sign off of plans but it is intended that this be “light touch”.

The funding is a pooled budget, not a transfer, and local authorities and the NHS are equal partners. It is not necessarily confined to social care and other LA functions may be relevant. It is expected that the funding will be allocated under s256 arrangements.

A great deal of effort is already being devoted to furthering integration across Kent and there is a sound basis to build upon. The Integration Transformation Fund seriously increases the pace and the scale at which these developments need to deliver. The government expects “that each area moves to a wholly integrated approach to health and care by 2018” (Refreshing the Mandate to NHS England: 2014 – 2015 Consultation)

2. ITF Funding components

Half the ITF funding will come from existing commitments:

- £1.9bn of existing funding continued from 14/15 – this is money already allocated across the NHS and social care to support integration and including:

- £300m of CCG re-ablement funding

- £130m of CCG carers' break funding

- £900m existing transfer from health to social care plus £200m for the joint fund

- c. £350m in capital grants from government departments including £220m of Disabled Facilities Grant

Whilst it is not expected that these components will be diverted into funding other services the implication is that the plan associated with spending the ITF must show how each of these elements will contribute to the overall aim of achieving integrated services by 2018.

There is an additional element of £1.9bn from NHS allocations which includes funding to cover demographic pressures in adult social care and some costs associated with the Care Bill.

Of this £1bn has been designated as "at risk money". This will be paid dependent upon performance with particular reference to taking pressure off the acute sector and improving patient experience. If not paid, the funding will revert to the general NHS budget. The "at risk" funding will be split over the 15/16 financial year:

£0.5bn at start of 15/16 dependent upon performance in 14/15

£0.5bn at end of 15/16 dependent upon performance in 15/16

This £1.9bn contribution from core CCG budgets equates to £10m from an "average" CCG.

3. Conditions of the full ITF

The ITF will be a pooled budget that can be deployed locally on social care and health, subject to the following national conditions which will need to be demonstrated in the plans:

- joint agreement between local authorities and the NHS through the Health and Wellbeing Board.
- protection for social care services (not spending)
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health)
- ensure a joint approach to assessments and care planning
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached
- agreement on the consequential impact of changes in the acute sector.

4. Timetable

Money is for 1 year with no guarantee of repeat funding. There will be a general election and a further Comprehensive Spending Review in 2015. Funding is to establish practice that can be incorporated into allocation of base budgets in following years.

Further guidance and support will be issued in the Autumn to enable consideration within CCG commissioning plans for 14/15 with more events and engagement planned over the Autumn

However guidance states: "we think it is essential that CCGs and local authorities build momentum in 2014/15 using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and 2015/16, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter".

5. Key Messages

- This will only work if services are redesigned to move activity from the acute sector to the community and primary care.

- Successful implementation of plans may lead to significant hospital reconfiguration. Potential impact on providers (acute trusts) needs to be part of the planning process. Changes to service that are not properly planned could potentially destabilise providers. This led to emphasis being placed on involvement of providers with an urgent need to revisit how they engage with the commissioners and the Health and Wellbeing Board.

- This is urgent – get on with it. There are early wins to be had regarding winter pressures and in any event Boards need to start building momentum towards 14/15.

6. Outcome measures

Measures to determine progress and success have not yet been established. The general view is that any outcome measures should be taken from existing outcome frameworks and should not generate extra data collection for new indicators.

Some new measures may be necessary to demonstrate how issues such as better data sharing based on use of the NHS number have progressed

7. Timetable and Alignment with Local Government and NHS Planning Process

Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)
- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows
- The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:
- August to October: Initial local planning discussions and further work nationally to define conditions etc
- November/December NHS Planning Framework issued
- December to January: Completion of Plans
- March: Plans assured

8. National next steps

NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk-sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

9. Other Issues

Analysis from Greater Manchester highlighted the scale of the issue. Their advice is that partners should agree how much money needs to move

across sectors in the system. Their calculation was that Greater Manchester needed to transfer £250m worth of activity from acute to community and primary care which translated into a potential 25% of hospital activity. There was concern whether existing systems such as HR and finance can cope with the required shift of resources and personnel around the system at this scale. Greater Manchester's experience also demonstrated the need for robust financial modelling and the need to "develop investable propositions".

10. Kent Workforce

Locally some discussions have already been held about how workforce planning needs to respond to the challenge posed by the integration agenda, including representatives from social care and KCHT. These discussions have led to the following summary for the Board:

The health and social care economy is reliant on the right staff and multi-professional teams being available at the right time, in the right place to deliver the right care and service. As we face the challenge of ensuring our services are sustainable for the future, meeting the need for improving outcomes and experience of patients whilst making best use of the public pound, a key factor in delivery will be workforce availability. This workforce stretches from carers through volunteers and on to registered health and social care professionals. How will HWBB commissioning partners be assured that the necessary workforce, with the right skills and competencies for future models of health and social care is being developed?

Health Education England (HEE) is the national NHS and social care body responsible for the education and development of the health workforce. The local presence of HEE is HE Kent Surrey Sussex who have a local partnership arrangements in Kent and Medway. The HEE work with their local membership of health providers and education institutes to ensure there are comprehensive workforce strategies and plans in place so that resources are appropriately focused. In order for providers to have detailed and deliverable workforce plans they need to have a clear strategic steer as to the future services to be commissioned. There is clearly a potential role for the HWBB partners to clearly describe the strategy for service change and development into the future in a way that enables HEKSS to respond.

The pioneer bid for integration provides an ideal and clear opportunity to test the new governance, roles and responsibilities with a focus on delivery. The HWBB should consider how it adequately describes the future service strategy in a way that the Local Partnership group, chaired by Marion Dinwoodie can consider how they provide assurance to the HWBB that plans are in place to implement the necessary changes in workforce that this may require. It is recommended that the Local partnership Board be asked to set out how local partners will develop the workforce to meet the requirements of the bid.

11. Issues for the Kent Health and Well Being Board

The Integration Transformation Fund raises a number of issues for the Health and Wellbeing Boards across Kent apart from the pace and scale of the changes required. The level of involvement in the planning process, oversight of effectiveness and responsibility to redeploy resources if plans are unsuccessful brings the Kent Board closer to being a joint-commissioning body and the group that manages risk within the wider system. The need to engage the acute trusts and others emphasises the importance of ongoing discussions about how to involve providers with the business of the Board.

In delivering the requirements of the Integration Transformation Fund it will be important that we bring all relevant resources to bear and there are a number of existing initiatives that can be deployed:

The Pioneer programme derived from the current bid could provide a focus for delivery of the plan

The local Health and Wellbeing Boards with their associated Integrated Commissioning Groups will be an essential element in developing plans.

12. Conclusions

The Board may wish to consider other ways the planning and delivery of the Integration Transformation Fund may be supported in Kent. In particular the Board will need to be assured that it can address the following questions.

What processes and mechanisms do we need to establish to deliver the ITF in Kent ?

Does the Pioneer Programme provide the vehicle for delivery ?

What will be the involvement and responsibility of local Health and Wellbeing Boards ?

How will providers, especially the hospital trusts, be engaged ?

Are local support systems including those for finance and Human Resources robust enough to deal with the scale of change within the system ?

How will the pooled funding be managed ?

Who will write the plan?

Recommendations:

The Health and Wellbeing Board is asked to:

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(ii) Agree to establish the necessary processes and mechanisms to construct the plan and deliver the required activity across Kent.

13. Contact details

Report Author

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