Triborough Integration Transformation Fund First Draft Submission

Appendix 1

Context

This document is a first draft, developed by the 3 London local authorities of the Triborough (the City of Westminster, the London Borough of Hammersmith & Fulham, and the Royal Borough of Kensington & Chelsea) in partnership with the corresponding 3 Clinical Commissioning Groups (NHS Central London CCG, NHS Hammersmith & Fulham CCG, and NHS West London CCG); with assistance provided by the Integrating Care team at PPL and the LGA.

It represents an initial response to the opportunities and challenges presented by the Integration Transformation Fund. It is explicitly work-in-progress, subject to further consultation with key stakeholders across the 3 localities including our citizens, voluntary and community sector, primary, acute and community health providers, and our social service teams. Any numbers included at this stage are simply best current estimates, based on work-to-date; and these together with our overall proposals will invariably evolve and change through the consultation process and as our knowledge and understanding grows.

The final section describes the next steps around this journey, and this document should be read in the context of the appendices as a whole.

The intention is to share this work at this early stage, to elicit feedback, to support further development work, and to ensure maximisation of the opportunity that the ITF represents – both within North West London and across the country as a whole, in addressing the common challenges and the potential for shared improvements over the next 5 years.

NHS West London Clinical Commissioning Group

NHS Central London Clinical Commissioning Group

NHS Hammersmith and Fulham Clinical Commissioning Group

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

h&f hammersmith & fulham

Triborough
Integration Transformation Fund
First Draft Submission

Contents

Introduction

The Triborough consists of the 3 Local Authorities and 3 Clinical Commissioning Groups serving a diverse population of over 550,000 people in Westminster, Hammersmith & Fulham and Kensington & Chelsea.

From its inception, the Triborough has been about combining services across geographies to improve lives and make public funds go further for the people we serve. In common with the rest of England, we are experiencing an unprecedented period of growing demands on current services, with limited resources to meet these demands.

Despite progress in recent years, the resulting pressures are being reflected daily across our hospitals, our GP surgeries, our community healthcare teams and our social services. As our populations grow and people live longer, so the challenge of balancing available resources and local needs will continue to grow. Our starting point in responding to the challenge is that this is not simply a financial issue, nor can pressures in one part of our public services be solved in isolation from the others. Our vision for the next 5 years is therefore nothing less than a fundamental transformation of the quality and experience of care, across all elements of commissioning and provision, and on behalf of our communities as a whole.

Building on our experience of the Community Budget and Integrated Care Pilots, the work of National Voices, and on best-practice from across the UK and internationally, the Triborough is now a central part of the drive to develop person-centred, co-ordinated care.

We recognise that change on this scale will mean consistently providing people with the right care, in the right place, and at the right time; care that is planned and tailored to individual capabilities and needs; care that is delivered in partnership, to the highest possible standards. This will involve putting individuals at the heart of everything we do, not simply because it is what people tell us they want, because it is morally the right thing to do, or even because it is the most efficient way of doing things (although our experience demonstrates all of these statements are true); but because this is the only way we will ensure a sustainable, healthy future for the communities we serve.

Our vision is being realised through the North West London's *Whole System Integrated Care Programme*, as a part of the successful *Living Longer and Living Well* Pioneer application, through *Shaping a Healthier Future* and our supporting *Out of Hospital Strategies*.

This document brings together the strategic intent and operational planning that sits behind these, together with the *Triborough Market Position Statement* in which are set out the strategic priorities for adult social care, including:

- integrating reablement and intermediate care;
- building capacity in the community via the voluntary sector;
- shifting from a model of dependency and direct provision to supported self-management and care;

- linking formal and informal networks of support around individuals and within communities such that these better support and reinforce each other;
- improving understanding and use of resources across our populations and all those individuals and organisations providing support to those in need.

Together these documents capture not just our vision and commitment, but the practical steps we are taking in order to

- transform the quality of care for individuals, carers and families;
- empower and support people to maintain their independence;
- lead full lives as active participants in their community;
- shift resources to where they will make the biggest positive difference.

We believe that the Integration Transformation Fund (ITF) is a fundamental part of this journey.

We understand that this scale of change will not happen without significant and joined-up investment. Our ITF plans explicitly build upon progress to-date. Together, we have already agreed to pool our resources across many areas joining together. a significant amount of health funding on joint schemes with local social services. By working together across traditional public sector boundaries, keeping people well, and supporting their recovery after periods of illness, we know we can improve individual quality of life whilst also reducing demands upon local services.

However, we also recognise we need to go beyond what we are doing now. This is why we are proposing to pool a large proportion of our future health and social care funding, in excess of the minimum mandated by the ITF, in order to create new forms of joined-up support and care within our communities, in and around people's homes, covering both urgent and planned care, that will transform outcomes and transform lives.

The success of these changes will, from 2015/16 onwards, help drive reductions in emergency admissions to hospital, and the demand for nursing and residential home care, with benefits for individuals, the local authorities and the CCGs alike. This is about working together and working better, to put our health and social care systems on a steady footing, translating improved outcomes for individuals into long-term, sustainable support for our communities as a whole.

This is why we are investing now and in 2014/15 in working with individuals, communities and providers of health and care services. Such investments will develop our understanding, our organisations, our shared infrastructure, and the way in which our services operate to ensure real progress towards our vision for health and care services in 2018/19, with associated improvements in the quality and experience of care today.

Last but not least, this is why we are keen to share our proposals at this early stage.

We recognise that there is much more work to do, and that a number of uncertainties that still exist in relation to proposed investments and outcomes. This document is being shared as a first draft, and work in progress. The figures we are sharing are our best estimates based on work-to-date, and these will invariably evolve and change as our knowledge and understanding grows.

However, we believe we have an opportunity to contribute to the broader debate, and in turn benefit from feedback and experience across country as a whole. This is our opportunity to work together, to overcome barriers that have constrained us in the past, and to shape a better future for health and care services, and all of those we serve.

Dr Fiona Butler
Chair,
West London CCG

Councillor Mary Weale
Cabinet Member for Adult Social Care &
Public Health, RB Kensington & Chelsea

Dr Ruth O'Hare
Chair of Central London CCG

Councillor Rachael Robathan
Cabinet Member for Adults &
Public Health, Westminster City Council

Dr Tim Spicer
Chair of Hammersmith & Fulham CCG

Councillor Marcus Ginn
Cabinet Member for Community Care
LB Hammersmith & Fulham

Purpose

The submission combines commissioning intentions, local operating and service planning with our shared 5 year vision for the Triborough, as a part of North West London, including the NW London Integrated Care vision “Living Longer, Living Well” and “Shaping a Healthier Future” our hospital reconfiguration and out of hospital invest strategy.

Underpinning all of our plans is a focus on systems that support and remove barriers to integrated care through:

- Prevention and proactive support through care planning and co-ordination
- Caring for people in the most appropriate setting, starting at home
- Supporting independence through understanding individual capabilities and needs
- Tackling social isolation, with a “whole-person” approaches to wellbeing
- Using technology to develop networked, personalised health and care services
- Eliminating gaps, duplication and disconnects between our health and care services

Our vision for the future will require whole system change; how we commission work from providers, how providers interact with patients and with each other. Working together as the Triborough we are committed to effecting behavioural and attitudinal change in partnership all areas of the health & social care system, with a central role for the voluntary, community sectors, and not least our citizens themselves.

This document sets out our joint commissioning intentions and areas for development. It explains how our local authorities and clinical commissioning groups, working with individuals and communities, will mobilise resources to target areas of need and deliver improved outcomes, in 2015/16 and beyond. It captures why we need to do this, what the expected outcomes are on both an individual and locality-wide basis, and our best estimates currently of the specific investments required to make this happen.

Our Vision - What this will mean for the people we serve

Our aim is to provide care and support to the people of Westminster, Hammersmith & Fulham and Kensington & Chelsea, in their homes and in their communities, with services that:

- **co-ordinate around individuals**, targeted to their specific needs;
- **improve outcomes**, reducing premature mortality and reducing morbidity;
- **improve the experience of care**, with the right services available in the right place at the right time;
- **maximise independence** by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing;
- **through proactive and joined up case management**, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

To do this, our starting point is our patients and service users themselves.

The following 3 “personas” are examples of those which have been developed to capture the experience of typical service users. They bring together feedback from real people and from the frontline professionals who are working to help them today. They allow us to focus our interventions on meeting the needs of individuals, working with them on the things which are most important to them.

Example Personas

Asmita

- *Asmita is 66 and lives in Westminster. She has a low income and lives alone in a rented basement flat. She is recently widowed. Her husband, who was her carer and organised her medicines also used to translate for her as English is not her first language*
- *She often feels lonely as her family lives abroad and she cannot communicate easily with her neighbours.*
- *Asmita has multiple long term conditions including diabetes, arthritis, chronic heart failure and early onset dementia. However, she does have some capacity at the moment.*
- *She receives a number of different services which include meals on wheels, two homecare visits a day to help her dress. Since her husband died, she makes frequent 999 calls and associated A&E visits. Her medicines are delivered by the pharmacy but she often misses her regular doses.*

April

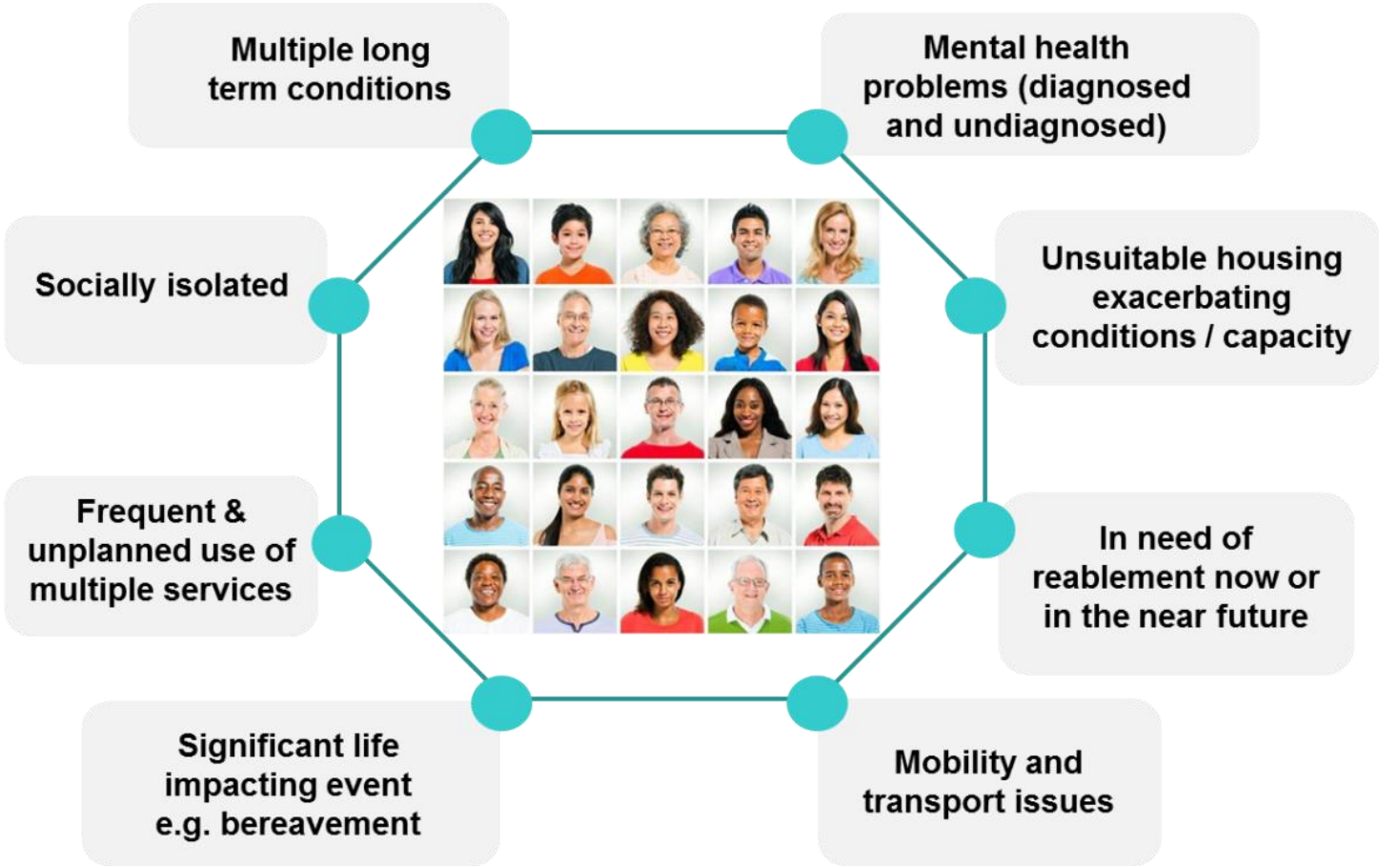
- *April is 82. She lives in a second floor, privately-rented flat near Holland Park. There is no lift and a stone staircase, so she is at high-risk of falling. She has had 2 hip replacements and is currently warfarinised following general anaesthetic for her second operation.*
- *She regularly visits her GP for blood pressure checks and has high levels of anxiety, leading to panic attacks. She has an informal support network in her block of flats, but her daughters live abroad and will not be returning to the UK.*
- *She has physio services for her hips and accesses transport services for hospital appointments. April has capacity at the present time, but is at high risk of losing her independence. She would benefit from help in the home to keep her in her current accommodation for as long as possible. She would benefit from some computer literacy, for example, to help with shopping, general contact etc.*

Les

- *Les lives in Hammersmith. He has two children. He lives on his own in social housing and is currently unemployed.*
- *Les feels isolated. He receives services in a reactive way, although he is on the brink of receiving more proactive services. He does not have a care manager.*
- *Les has multiple long term conditions including diabetes (which may not have been diagnosed). He is a smoker who has alcohol issues and heart problems. He also has mental health problems (a combination of depression and dementia).*
- *He frequently uses Charing Cross Hospital A&E (visits are often alcohol related). He has lots of disconnected referrals to care managers, social workers and district nurses. With the right advice and support Les could potentially care for himself.*

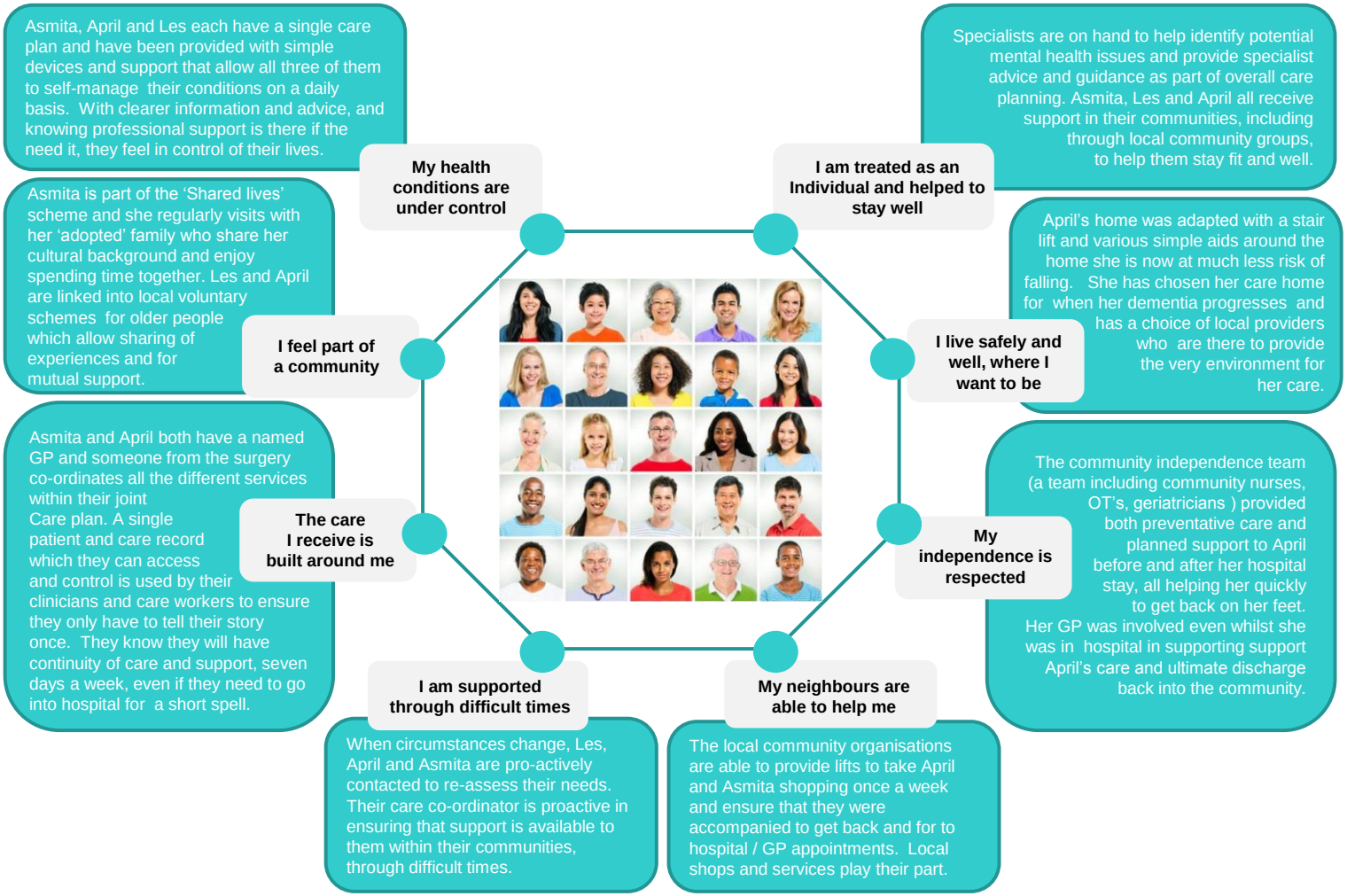
Transforming outcomes, transforming lives

As our work and engagement in this area has evolved, so increasing we have been able to identify a number of common challenges for those in greatest need, which if addressed, would genuinely transform the quality of life and wellbeing.



Our vision for those we serve

Our vision for 2018/19 is built around tackling these issues, empowering and supporting individuals to live longer and live well. This is about creating services that enable frontline professionals to work with individuals, their carers and families to maximise health and wellbeing and address specific individual needs.

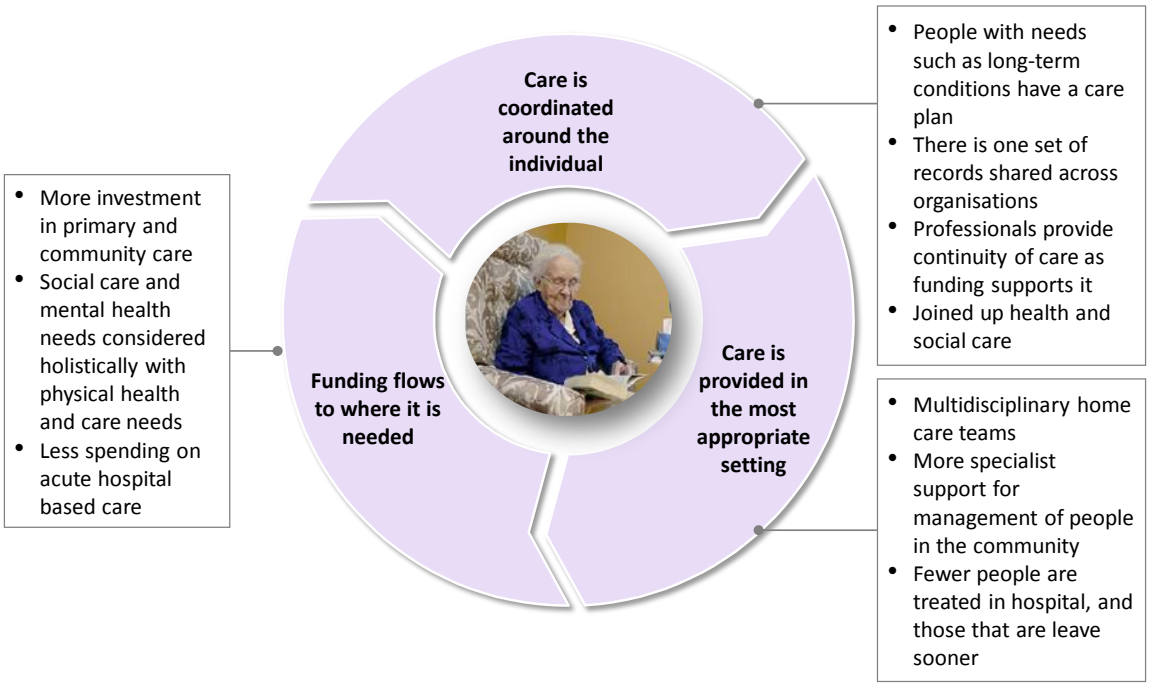


Our Vision - What this will mean for our health and social care services

Our vision for whole system integrated care is based on what people have told us is most important to them. Through patient and service user workshops, interviews and surveys across North West London (NWL), we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations who show dignity, compassion and respect at all times.

We recognise that realising this vision will mean significant change across the whole of our current health and care provider landscape. Whilst our GPs will play a pivotal role within this, all providers of health and care services will need to change how they work, and particularly how they interact with patients and each other. The CCGs and local authority commissioners who make up the Triborough are committed to working together to create a marketplace, and to effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

Integrated care means care that is coordinated around the individual, provided in the most appropriate place, and funding flows to where it is needed



In ***Living Longer and Living Well***, our application for Pioneer status, we set out our strategy for developing person-centred, co-ordinated care in North West London.

This strategy is based on **3 core principles**:

1. **People will be empowered** to direct their care and support, and to receive the care they need in their homes or local community.

2. **GPs will be at the centre** of organising and coordinating people's care.

3. **Our systems will enable and not hinder** the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system

To achieve this we are engaging with local health and care providers, and associated public, private and voluntary and community sector groups, to "co-design" models of care that will engage with and meet people's aspirations and needs. The following sections provide a summary of what this will mean, in practice, and the specific ITF investment areas for the next 2 years that will deliver on our aims and objectives.

People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

Over the next 5 years community healthcare and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home.

Our teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well. We will invest in empowering local people through effective care navigation, peer support, mentoring, self-management and time-banking programmes to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

We will invest in integrated Community Independence teams that will provide a rapid response to support individuals in crisis and help them to remain at home. Community Independence will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication. The service will introduce individuals to the potential of assistive technologies and, where these are to be employed, will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the ITF will enable us to start to release health funding to extend the quality and duration of our reablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:

- Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention;

- Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals"

In doing so our plan is to go far beyond using ITF funding to back-fill existing social care budgets, instead working jointly to reduce long-term dependency across the health and care systems, promote independence and drive improvement in overall health and wellbeing.

Shaping a Healthier Future is the strategy which describes what success will require of and mean for our hospitals, with services adapting to ensure the highest quality of care is delivered in the most appropriate setting.

The volume of emergency activity in hospitals will be reduced and the planned care activity in hospitals will also reduce through alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the Community Independence Service, will mean we will minimise delays in transfers of care, reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

We recognise that there is no such thing as integrated care without mental health. Our plans are, therefore, designed to ensure that the work of community mental health teams is integrated with community health services and social care teams; organised around groups of practices; and enables mental health specialists to support GPs and their patients in a similar way to physical health specialists.

By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care.

We will use the ITF to:

- **Help people self-manage and provide peer support** working in partnership with voluntary, community and long-term conditions groups.

- **Invest in developing personalised health and care budgets** working with patients and service users and frontline professionals to empower people to make informed decisions around their care.

- **Implement routine patient satisfaction surveying** from GP Practices to enable the capture and tracking of the experience of care.

- **Invest in reablement** through a new joint Triborough Community Independence Services, reducing hospital admissions and nursing and residential care costs.

- **Reduce Delayed Discharges,** through investment in Neuro-Rehabilitation services and strengthen 7 day social care provision in hospitals.

- **Integrate NHS and social care systems** around the NHS Number to ensure that frontline professionals, and ultimately all patients and service users, have access to all of the records and information they need.

- **Undertake a full review of the use of technology** to support primary and secondary prevention, enable self-management, improve customer experience and access, and free up professional resources to focus on individuals in greatest need.

GPs will be at the centre of organising and coordinating people's care.

Through investing in primary care, we will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over, practices taking responsibility for out-of-hours services and individuals being able to register with a GP away from their home. Flexible provision over 7 days will be accompanied by greater integration with mental health services, and a closer relationship with pharmacy services. Our GP practices will collaborate in networks focused on populations over at least 20,000 within given geographies, with community, social care services and specialist provision organised to work effectively with these networks. A core focus will be on providing joined-up support for those individuals with long-term conditions and complex health needs.

As a result of all of these changes, some GPs may have smaller list sizes, with more complex patients, and with elements of basic care delivered by nurse practitioners. In the acute sector, our specialist clinicians will work increasingly flexibly, within and outside of the hospital boundaries, supporting GPs to manage complex needs in a “whole person” way.

We will use the ITF to:

- **Roll out the Whole Systems Integrated Care model** building on existing care planning, care co-ordination, risk stratification and multi-disciplinary teams.

- **Invest in 7 day GP access** in each locality and deliver on the new provision of the GMS.

Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

Our CCG and Social Care commissioners will be commissioning jointly, focussed on improving outcomes for individuals within our communities.

In partnership with NHS England, we are identifying which populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care; and the performance management and governance arrangements to ensure effective delivery of this care.

In order that our systems will enable and not hinder the provision of integrated care, we will introduce payment systems that improve co-ordination of care, by incentivising providers to coordinate with one another. This means ensuring that there is accountability for the outcomes achieved for individuals, rather than just payment for specific activities. It also means encouraging the provision of care in the most appropriate setting, by allowing funding to flow to where it is needed, with investment in primary and community care and primary prevention.

This means co-ordinating the full range of public service investments and support, including not just NHS and adult social services but also housing, public health, the voluntary, community and private sectors. As importantly, it means working with individuals, their carers and families to ensure that people are enabled to manage their own health and wellbeing insofar as possible, and in doing so to live healthy and well lives.

In order to track the results, we will leverage investments in data warehousing, including total activity and cost data across health and social care for individuals and whole segments of our local populations. We are developing interoperability between all systems to provide both real time information and managerial analytics. By Autumn 2014, our GP practices will all be using the same IT system, providing the opportunity for our care providers to all use the same patient record; the ITF will help ensure this happens by joining up Health and Social Care data across the Triborough, linked via the NHS number, and guaranteeing that individual information is shared in an appropriate and timely way.

We are ensuring related activity will align, by working in close collaboration with the other boroughs in northwest London (NWL) in co-designing approaches to integrating care. This is designed to ensure shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries. Our plans are aggregated into the NWL Pioneer Whole Systems Plan in order to accelerate learning and joint planning. On a NWL basis the NWL Integration Board provides oversight to this process, as described in the governance section below; with each locality Health & Wellbeing Board taking the lead in approving local joint commissioning plans.

We will use the ITF to:

- **Establish a Joint Integration Team** working across the local authorities and CCGs to support the implementation of integrated commissioning of health and social care.

- **Review all existing services**, including services commissioned under existing section 256 agreement, to ensure they represent VFM and re-procure services where necessary to enable integrated working.

- **Create a joint Nursing and Care Home Commissioning Team** focussed on improving outcomes through transforming the quality, consistency and co-ordination of care across the nursing and care homes of the Triborough.

- **Extend Psychiatric Core 24 services** to cover all acute sites in Tri-borough, providing holistic support for physical and mental health needs.

The financial implications

Our ambition

In developing our plans for jointly funded services from 2014/15 onwards, our starting point has been the scale and scope of our existing transfers from health to local government and the services that they support.

Within the Tri-borough there is a significant history of joint-commissioning, with £113m of Section 75/76 agreements in place for 2013/14 covering learning disabilities, mental health and older people's services; and a further £11m investment in social care to benefit health through the Section 256. Our proposal is to use the establishment of the ITF to build on this tradition, and significantly increase the scope and scale of joint commissioning.

Whilst these existing transfers have delivered benefits for individuals, communities and for our local public service organisations, we recognise that the financial challenges ahead are significant. We will need to build upon the work to-date if we are to provide high-quality services in a sustainable way.

Our estimate of the mandated value of the ITF across the tri-borough is £22.2m in 2014/15, which will grow to £46.9m in 2015/16; however, our ambition is to go much further than this.

The Tri-borough local authorities and the CCGs are exploring the possibility of expanding the shared fund so that there is joint commissioning of all residential and nursing homes, domiciliary care, community healthcare and the emergency patient pathway. If realised, this would see the jointly commissioned ITF grow to £442m, bringing together the commissioning of all these services and allow us to track and jointly manage the shift from acute hospital, nursing and residential home based care into community and domiciliary care settings.

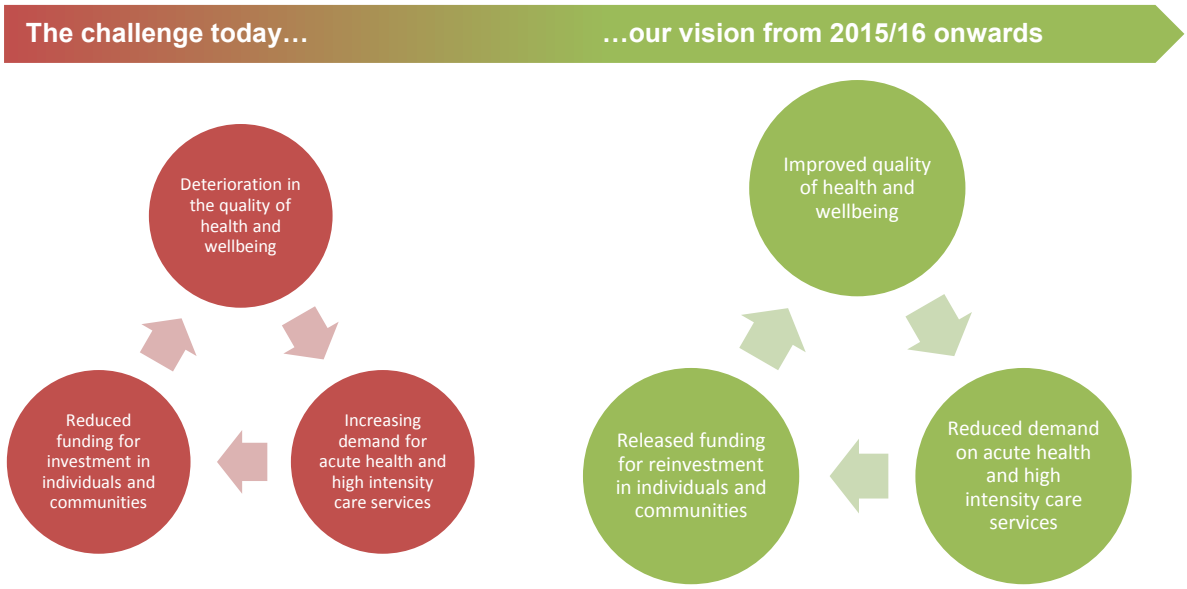
Changing the dynamic of local health and care funding

At a time when we are planning to make significant investments in community-based, person-centred health and care services, pressures and demands on our acute services continue to grow, and local authority social care budgets are facing a prolonged period of real-term reduction, increasing the risk that individual care needs will not be met.

Our ITF plan is about applying targeted investments to convert this potentially negative cycle into a positive one, driven by improved outcomes for individuals, communities and the health and care economy as a whole.

This means:

- Supporting people to live independently and well
- Releasing pressure on our acute and social services
- Investing in high-quality, joined-up care in and around the home



Whilst detailed plans are currently in development, and subject to approval by our Health & Wellbeing Boards, we have identified a range of potential schemes to help make this shift a reality, and for each a likely range of expenditure and returns.

In 2014/15 we will be investing between £1.7m and £3.1m of additional health funding into the ITF. This investment is not about immediate financial returns, but rather creating the capabilities and infrastructure to enable outcomes in 2015/16; whilst ensuring local social services can continue to meet the care needs of our population.

No.	Scheme 2014/15	Description	Investment		
			Recurrent / Non-recurrent	Min £000	Max £000
ITF01	Strengthen 7 day social care provision in hospitals	This scheme will extend current arrangements for increasing social care provision in hospitals during the winter months, to provide full 7-day social care support all year. This will help to deliver the reduction in delayed discharges in ITF10.	**Recurrent**	950	1,650
ITF02	Developing self-management and peer support	Working with individuals and through local voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, ensuring that the patient and service user capacity within the system is maximised	**Recurrent**	150	250

No.	Scheme 2014/15	Description	Investment		
			Recurrent / Non-recurrent	Min £000	Max £000
ITF03	Transforming Nursing & Care Home Commissioning	Project set up costs for creating a single nursing and care home commissioning team and outcomes-based specification, maximising efficiency and ensuring that appropriate and timely provision reduces the requirements on the acute sector	**Non-recurrent**	125	250
ITF04	Supporting Integration	Establishing a Joint Integration Team working across LA and CCGs to lead the implementation of integrated commissioning of health and social care	**Non-recurrent**	250	500
ITF05	IT Integration	Project costs to implement an IT solution to link Triborough Social Care Systems to the GP system and to ensure consistent use of the NHS Number as the primary identifier	**Non-recurrent**	125	250
ITF06	Transforming Patient Satisfaction	Project to set up routine collection of patient satisfaction from GP Practices to enable capture of experience of care for people with Long Term Conditions	**Non-recurrent**	125	250
		Total additional 2014/15		**1,725**	**3,150**

From 2015/16 onwards we will start to realise significant benefits in terms of both the quality and cost of care.

The ITF fund in 2015/16 will be in the range £47.0m to £69.3m (excluding existing Section 75 agreements but including investments in Social Care to Benefit Health).

The estimated value of the mandated ITF is expected to be £46.9m. The table below shows the current proposal for the ITF in 2015/16:

	Ref. to Invest-ment Table	Baseline ITF		New Investment		Total ITF	
		Min	Max	Min	Max	Min	Max
Section 256 Social Care to Benefit Health	ITF07	11,126	11,126	-	-	11,126	11,126
Community Health - Target Operating Model	ITF07	5,678	22,710	-	-	5,678	22,710
Community Independence functions	ITF08	13,000	13,000	5,400	5,400	18,400	18,400
Joint Nursing and Care Home Commissioning	ITF09	900	900	-	-	900	900
Reducing Delayed Discharges	ITF11	-	-	1,800	3,900	1,800	3,900
Psychiatric Liaison	ITF13	2,200	2,200	600	1,100	2,800	3,300
7 Day Social Care/7 Day GP Access	ITF10/ 15	-	-	2,550	4,850	2,550	4,850
Other Investments	ITF02/ 12/16	-	-	750	1,200	750	1,200
Disabled Facilities Grants		1,288	1,288	-	-	1,288	1,288
ASC Capital Grants		1,672	1,672	-	-	1,672	1,672
Total Proposed ITF in 2015/16		**35,864**	**52,896**	**11,100**	**16,450**	**46,964**	**69,346**
Mandated ITF Value 2015/16 (estimated)						*46,852*	

Detailed investment and benefit management plans will be refined throughout 2014/15, but already from our work on *Shaping a Healthier Future*, *Whole System Integration* and with support from *Integrating Care* and the *National Collaborative*, we have been able to identify and quantify a number of reductions in demand and cost that would accrue from better management of long-term health needs across our population.

No.	Scheme 2015/16	Description	Investment			Return	
			Recurrent / Non-recurrent	Min £000	Max £000	Min £000	Max £000
ITF02	Developing Self-Management and Peer Support	Working with individuals and through local voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, ensuring that the patient and service user capacity within the system is maximised	Recurrent	150	250	0	0
ITF07	Review existing service portfolio	Project to review all existing services, including those services commissioned under existing section 256 agreements, to ensure services provide value for money and are aligned with the objective of transforming to integrated working.	Recurrent	0	0	0	4,000
ITF08	Community Independence	Investment in an integrated network of community support and multidisciplinary teams to provide step up and step down care, preventative care and reablement through a community independence approach. National and international evidence shows that this will significantly reduce NEL admissions and nursing and residential care costs. In addition, this service will ensure that the capacity existing within service users and patients is used to maintain independence positively and local analysis suggests significant savings as a result of the change.	Recurrent	5,400	5,400	11,700	25,100
ITF09	Joint Nursing and Care Home Commissioning	Create a single LA and CCG team for commissioning Nursing and Care Homes. This will achieve savings from better contract management and better procurement of nursing and residential care. It will also enable more appropriate use of acute provision, by ensuring that appropriate care is available to service users in their current care setting, where possible. Joint management will also enable strategic market management and development,	Recurrent	0	0		

No.	Scheme 2015/16	Description	Investment			Return	
			Recurrent / Non-recurrent	Min £000	Max £000	Min £000	Max £000
		as well as joint assessment and monitoring of placements, leading to improved quality of care and safeguarding.					
ITF10	Reducing Delayed Discharges	We will increase our investment in additional capacity within the Tri-borough, particularly in relation to Neuro Rehab, and work to simplify and streamline the assessment processes in order to reduce delayed discharges and deliver a better experience for patients. Our aim is to improve the level of delayed discharges to match the top quartile of boroughs across England by 2015/16	Recurrent	1,800	3,900	2,900	7,500
ITF11	Strengthen 7 day social care provision in hospitals	This scheme will extend current arrangements for increasing social care provision in hospitals during the winter months to provide full 7-day social care support all year. This will help to deliver the reduction in delayed discharges in ITF10.	Recurrent	950	1,650	Included in ITF10	
ITF12	Patient Surveys	We will continue on a recurrent basis the routine collection of patient satisfaction from GP Practices to enable capture of experience of care for people with Long Term Conditions	Recurrent	500	750	0	0
ITF13	Psychiatric Liaison	This scheme will develop psychiatric liaison services (LPS) in line with the NWL-wide review, delivering a common specification and contracting of services to ensure equity of access, improved performance and consistent standards assurance reporting to deliver a reduction in inappropriate emergency admission avoidance, medication reviews and length of stay minimisation for mental health patients	Recurrent	600	1,100	0	2,000
ITF14	Ambulatory Care-Sensitive Conditions	Establishing ambulatory emergency care services, offering patients a safe alternative to hospitalisation with improved patient experience and avoiding unnecessary admissions.	Recurrent	TBD	TBD	Included in ITF08	

No.	Scheme 2015/16	Description	Investment			Return	
			Recurrent / Non-recurrent	Min £000	Max £000	Min £000	Max £000
ITF15	GP 7 Day Access	Investing in ensuring that everyone within the Tri-borough has access to GP services 7 days a week.	Recurrent	1,600	3,200	0	1,000
ITF16	Developing personal health and care budgets	Extend our current plans for personal health budgets, working with patients, service users and frontline professionals to empower people to make informed decisions around their care.	Recurrent	100	200	TBD	TBD
ITF17	Whole Systems Integration	Incorporating our current investment in the Whole Systems Programme and Pioneer status within the ITF, to build fully integrated and sustainable care planning, care co-ordination, risk stratification and multi-disciplinary teams across health and social care.	Recurrent	TBD	TBD	TBD	TBD
Total 2015/16				**11,100**	**16,450**	**14,600**	**39,600**

Whilst the above tables capture our current plans, our ambition is to expand the ITF fund to encompass our whole emergency care pathway budget. This would mean all of social care, all of community health and all of A&E and emergency admissions would come into pooled budget arrangements, allowing us to track the total shift from acute hospital and nursing and residential home based care, to community and home based care schemes.

How we will govern and manage these developments

Across the Triborough, we have invested significantly in building strong governance that transcends traditional boundaries. The Health and Wellbeing Board in each of our boroughs has matured well, and this year we have been able to write joint commissioning intentions covering all of our CCGs and local authorities. We have regular meetings between our 3 council cabinet members responsible for health-related services and our 3 CCG chairs, together with routine parallel meetings between the executive teams of our CCGs and local authorities. Our transformational plans and programmes are formally discussed and approved at local borough governance levels within each local authority and CCG.

However, we also recognise the opportunities to deepen these relationships in the context of the scale and ambition of our future joint fund.

A shared approach to leadership and management

To deliver the ambition contained in our ITF, we recognise the need to develop further our strategic and operational governance arrangements. We therefore propose to look at, as part of this process, how we start to bring together management responsibilities and accountability across care and health services, for our residents and patients and as whole. We would see our future management team accountable for the commissioning of integrated care, through the Health and Wellbeing Board, to both the Local Authorities and the CCGs. In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

Our current proposal is to delegate specific functions between Local Authority and CCGs in areas that facilitate delivery of the ITF. The initial areas that we wish to consider are the commissioning of nursing and residential care homes, and the commissioning of care delivered in people's homes.

Our business case for the commissioning of nursing and residential care homes demonstrates that, if this were done as one team across our agencies, we would save money and improve quality. Our local authorities have a strong track record in this area, and we are therefore looking at options for our CCGs to delegate this responsibility to the local authorities. We envisage that these joint arrangements would enable us to deliver the full benefits of reablement and intermediate care services provided in people's homes, and to remove current gaps and duplication in provision.

The first step in doing this will be to pool our funding for these services, and to commission one team who will be responsible for this budget, the health and social care needs (including assessment, brokerage and in-house provision). We envisage that both the local authority teams and the CCG teams would be held to account for the delivery of these services by a strengthened Health and Wellbeing Board. Reviewing the Terms of Reference of our current Health and Wellbeing Boards, and ensuring they are in a position to provide effective governance for the new joint funding, will be a priority for the coming months.

Providing effective oversight and co-ordination

Regular briefings to Cabinet are designed to help to ensure effective debate and engagement at a borough level, and that our plans are directionally aligned with the priorities of local communities. Cabinets are the constitutional forum for key decision making and a core part of the due process for the changes envisaged in this document, which will also include scrutiny and challenge across each locality.

Throughout this process, we will ensure that the local Health and Wellbeing Boards for each borough remain central to the development and oversight of the proposed schemes making up our Integration Transformation Fund, with a principle of pooling as much health and care funding as is sensible to do so, and with a focus on developing our joint commissioning and outcomes frameworks to drive quality and value.

Across North West London, the North West London Whole System Integration Board, combining health and local authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography. The Shaping a Healthier Future Programme Board will continue to oversee the delivery of the acute hospital and Out of Hospital reconfigurations, and we will continue to be accountable to the CCG collaboration board made up of the 8 CCGs in NW London. This will ensure we have a comprehensive view of the impact of changes across North West London on the Triborough, and vice-versa; and that we are able to make the necessary shared investment across our region in overcoming common barriers, and maximising common opportunities.

Next steps

This document is a draft, designed to share current progress and thinking around the development of the ITF in the Triborough. The proposals within this document will be refined, developed and signed-off through the following timeframe:

Date	Governance Process
Dec 2013	First draft to Governing Bodies and key stakeholders (including Housing, Public Health, Health & Care Providers and the Voluntary sector)
Jan 2014	Iterations of comments and feedback and updating of document
8th Jan 2014	Central London CCG Governing Body
14th Jan 2014	H&F CCG Governing Body
28th Jan 2014	West London CCG Governing Body
31st Jan 2014	Final submission to the HWB for sign off
15th Feb 2014	Formal submission to NHSE

These dates are subject to confirmation based on national and local timetables. Throughout this process drafts will continue to be circulated to the Integration Partnership Board, Health and Well-being Boards, CCG Governing Bodies and Cabinet members.

Priority areas we will be exploring through this process include:

- **Our joint governance arrangements** including the terms of reference for our Health and Wellbeing Boards, to ensure these are fit-for-purpose in relation to the enhanced roles we wish these to play.
- **The role of planned medical activity** and the full evidence base for moving activity into the community and driving improved outcomes through better co-ordinated care.
- **A full options appraisal for pooled funding** including developing the detailed governance model, and describing the specific roles, accountabilities and responsibilities of a Joint integration Team
- **A detailed risk analysis**, and further development of mitigation strategies for the major risks identified so far; including in relation to avoiding “double-counting” of benefits, and managing a stable transition to any future provider arrangements.
- **The pathway for aligning and joining up IT strategies** for data warehousing and interoperability, including required investments in health and social care systems to ensure a single accessible care record.
- **The use of technology in supporting home-based care** including potential joint investments and benefits from telehealth and telecare.
- **Developing local, person-centred outcomes** to support outcome-based commissioning of future joint services, and to allow us to assess the results of these investments over the next 5 years.

Appendices

Please see attached files for

Appendix A Triborough ITF Populated Template

Appendix B Triborough ITF Outcomes and Finances

Appendix C "Living Longer and Living Well" North West London Pioneer Application

Appendix D Community Independence Service Outline Business Case

Appendix E Joint Nursing and Care Home Commissioning Outline Business Case

Appendix F "Delivering Seven Day Services": North West London's vision