Agenda item 5

Health and Well Being Board
9 December 2013

Walsall Council

NHS
Walsall Clinical Commissioning Group

Integration of Health and Social Care – Implementing the Integration Transformation Fund

PURPOSE

To describe government requirements for integration of local health and social care systems and for implementation of the Integration Transformation Fund.

RECOMMENDATION

That the Health and Well Being Board notes the requirements and receives a further detailed report in time to meet a deadline of signing off a plan for integration to be submitted to NHS England by 15 February 2014.

BACKGROUND

Joint letters (attached) from NHS England and the Local Government Association (LGA) were issued on the 17 October and 4 November that set out the Government intentions for the implementation of the Integration Transformation Fund (ITF) and the requirements on local health and social care systems to plan for a higher level of integration as part of a five year strategy.

The main elements of the requirements set out in these letters are as follows:

- Plans to be jointly agreed
- Protection of social care services (not spending)
- 7 day working
- Better data sharing based on the NHS number
- Joint approach to assessment and care planning
- Agreement on the consequential impact on the acute hospital sector

The plan for 2015/16 needs to be started in 2014 and form part of a five year strategy for health and care. The NHS planning framework will invite Clinical Commissioning Groups to agree five year strategies, including a two year operational plan that covers the ITF, through their Health and Wellbeing Board.

Health and Well Being Boards are required to sign off the plan and return the completed planning template (see attached) by 15 February 2014. Key

timelines for development and submission of the 5 year plans are set out as Appendix 4 to the letter dated 4 November.

INTEGRATION TRANSFORMATION FUND

By 2015/16, the Integration Transformation Fund (ITF) will be £3.8 billion to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users.

It is worth noting that the majority of the funding that makes up the Integration Transformation Fund (ITF) will be made up of funding that is already in the system and so is not new or additional funding. The make up of the ITF in Walsall will be as follows:

2013/14

The sum of £900 million available at national level during this financial year translates to a sum locally of £5.124 million. The Vulnerable Adults Executive Board has agreed the commitment of this as recurring funding from this financial year 2013/14 as shown in Appendix 1 to this report.

2014/15

The additional sum of £200 million added nationally in 2014/15 translates to a sum locally of £1.140 million. This sum has been included as part of the SC&I Directorate budget in the Council plans to meet its revenue savings target in 2014/15.

2015/16

By 2015/16 the following sums will also be incorporated in to the ITF:

Carers Break Funding (£130 million)	Walsall's share of this equates to £740,000 and includes £450,000 per annum that is transferred from the CCG to Walsall Council for Short Breaks for children and families. SC&I Directorate carers budget in 2014/15 will be circa £600,000.
CCG Reablement Funding (£300 million)	Walsall's share of this equates to £1.710 million per annum and this is currently allocated to fund the SWIFT Discharge Unit at the Manor Hospital.
DH Capital Grant funding (£354 million including £220 million for Disabled Facility Grant (DFG))	Walsall's share of this equates to £2 million per annum. This is currently made up of the Capital Grant allocation to the SC&I Directorate from the Department of Health, and just over a £1 million allocation to Walsall Council for DFG's.

	The funding to help local housing authorities meet the cost of providing Disabled Facilities Grants (DFG) for disabled people is currently paid by Dept for Communities and Local Government (DCLG) as a capital grant. All of this funding will form part of the ITF.
£1.9 billion NHS Funding	Walsall's share of this equates to £10.830 million per annum and it will be made up of funding that is currently within the CCG budget. Some preparatory work to identify current expenditure against this funding is underway as reported to a special meeting of the VAEB in November 2013.

Further work is needed to more precisely identify the planned expenditure for the ITF in Walsall from 2015/16 onwards.

5 YEAR STRATEGY FOR INTEGRATION

Work to complete a 5 year strategic plan for integration is being overseen by the Integration Board which comprises the Accountable Officer for the CCG, Chief Executive of WHT, Chief Executive of DWMHT and Interim Executive Director for SC&I in Walsall Council. The Integration Board will report to the Health and Well Being Board, and terms of reference are being agreed.

The VAEB will retain its current terms of reference as set out in the S75 agreement between Walsall Council and Walsall CCG, and it will report to the Integration Board.

Two main priorities for increased integration were originally identified in the joint bid for pioneer status as an integrated health and social care economy in the submission dated 28 June 2013 as follows:

The two objectives of our vision are: ▪ Keep people at home as long as possible ▪ Swift return home following episode of bedded care To deliver our first objective, there are three components of our new model of service: ▪ a Single Point of Access for health and social care ▪ co-ordinated locality teams

- pragmatic use of risk stratification to identify those people with the highest take up of service across the system

The second component of the new model of service, that of swiftly and safely transferring people back to their own homes following an acute episode of care, requires a coherent and efficient team, comprising skills of hospital discharge and social care, linking with the wider, co-ordinated locality teams, to agree with people the packages of care they most need at home. Through the Single Point of Access, there will be a menu of services ranging from at the most intense, hospital based intermediate care beds through to at the least intense, 'reablement ' which is available within 24 hours of request and provided for a specified duration of days e.g. four days.

The Integration Board will explore the best ways of ensuring that the range of health and social care workers who work in the community alongside GPs in Walsall can be better integrated and ensure a single care pathway for older people. The co-location of staff; the development of a single point of access; the development of "virtual wards" (linked to risk stratification"); linked-workers attached to GP practices; shared service models e.g. Intermediate Care (under a single manager); the creation of care coordinator posts; and other options will all be explored to ensure that we produce the best outcomes for older people in Walsall.

The submission for pioneer status was not successful, but the work is progressing under the supervision of the Integration Board. Proposals for implementation of the two objectives are to be reported back to the Integration Board early in the New Year.

An additional piece of work on data sharing and analysis has been agreed with the Commissioning Support Unit. This will cross reference case records in social care with NHS patient data in Walsall Healthcare Trust, DWMHT, and primary care to identify those individuals with the highest level of take up of service a cross the whole system. This will subsequently further inform the process of risk stratification.

CONCLUSION

Preparations for the development of a 5 year strategic plan for integration as part of the CCG 5 year strategy and for an outline 2 year plan to cover the use of the ITF during 2014/15 and 2015/16 by 15 February 2014 are underway. The Integration Board will bring a further report back to the Health and Well Being Board early in the New Year.

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Appendix 1

Table 1: S256 Funding 2013/14 Summary

Funding Available	2013/14 Allocation (£)
Total Funding	**5,124,740**

Expenditure	2013/14 Spend £
Services required in the reablemement pathway for people with dementia and frail elderly - Home from hospital & community reablement - Seva Care (2yr contract from 05/03/12)	80,000
Services required in the reablemement pathway for people with dementia and frail elderly - Dementia support workers (based in Manor Hospital), Dementia advisors (Information & Advice), 6 dementia cafes - Accord Carers Support (2yr contract from 23/04/12)	150,000
Continuation and increased capacity for sitting service. In place from mid 2012 with funding for 2 years.	70,000
Integrated Community Equipment Service	877,538
Short term assessment, reablement and response service	1,873,957
Development of Intermediate Care service	500,000
OT posts to support Intermediate Care Service	250,000
Bed Based Reablement (Hollybank)	774,919
Integrated Discharge Team	526,486
Co-ordination of Personal Health Budgets pilot scheme	21,840
Total Spend	**5,124,740**

Local Government Association

NHS England

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 polled 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

NHS England Publications Gateway Ref. No.00535

Annex

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:
• £130m Carers' Breaks funding
• £300m CCG reablement funding
• £354m capital funding (including c.£220m of Disabled Facilities Grant)
• £1.1bn existing transfer from health to social care

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[1] 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*

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[1] 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	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. 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.
Protection for social care services (not spending)	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 paragraph 2, above.

National Condition	Definition
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	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. 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.
Better data sharing between health and social care, based on the NHS number	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. Local areas will be asked to: • 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; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • 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. 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).

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.

Publications Gateway Reference No: 00658

To: CCG Clinical Leads
CCG Accountable Officers
Chief Executives of NHS Trusts
Chief Executives of NHS Foundation Trusts
Chief Executives of Local Authorities
Directors of Adult Social Services
CSU Managing Directors

cc: NHS England Regional and Area Directors
Monitor Regional Directors
NHS TDA Directors of Delivery and Development

4 November 2013

Dear Colleagues

Strategic and operational planning in the NHS

The NHS faces an unprecedented level of future pressure. This is the definitive conclusion of the recent 'Call to Action' and 'Closing the Gap' reports issued by NHS England and Monitor respectively, which warns of substantial impending challenges driven by an ageing population; increase in long-term conditions; and rising costs and public expectations within a challenging financial environment.

In order to respond to these significant challenges the NHS is likely to have to change; all parties - CCGs, foundation and non-foundation trusts - need to play a leading role. They must develop and implement bold and transformative long-term strategies and plans for their services, otherwise many will become financially unsustainable and the safety and quality of patient care will decline.

This long-term transformation will only be achieved through our commitment to create a fully integrated service between the NHS and local government. NHS England and the Local Government Association have recently written to outline the next steps for implementing the £3.8bn Integration Transformation Fund for 2015/16, which will have significant implications for commissioners and providers alike. But 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. This is why Health and Wellbeing Boards must also play a leading role in developing local strategic plans and why the LGA is a co-signatory of this letter.

All four bodies, NHS England, NHS Trust Development Authority, Monitor and LGA consider robust planning to be of paramount importance to both providers and commissioners. Robust plans should be coherent long term strategic plans,

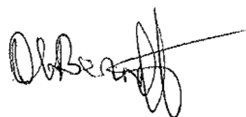
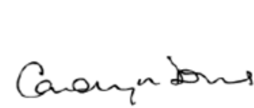
underpinned by medium-term detailed operational plans that are consistent in their intentions across local health economies and are developed applying consistent ground rules as articulated in national policy e.g. standard national contract and Payment by Results. Given the scale of the challenges we are facing, we are moving away from incremental one year planning and instead asking bodies to develop bold and ambitious plans which cover the next five years, with the first two years mapped out in the form of detailed operating plans. This is crucial to enabling us to take a longer term, strategic perspective of the direction of travel across the health and social care landscape.

We recognise it is our role and responsibility to provide the right framework for this to happen. We have recently engaged with a range of stakeholders to understand the needs of the sector. We have heard the importance of making the planning process as rigorous and consistent as possible, to ensure alignment and agreement to the key dates across all parties and to release information and guidance as early as possible.

We have taken this feedback on board and we have taken, or will take, the following actions:

- provide draft guidance now as to the process and expectations (as set out in Appendix 1) and full guidance in December, including a joint set of assumptions agreed by all parties;
- align our respective timelines in regards to the planning process. The detail of this joint timetable is set out in Appendix 2;
- each body is revisiting their own process to consider how these can be adapted to better facilitate operational and strategic planning; and
- further support will be provided and this will be communicated separately by each body as appropriate.

The initial guidance gives some of detail of the planning process so that commissioners, providers and local authorities know the expectations of them and can start working together over the coming months before final guidance is issued in December.

			
Sir David Nicholson Chief Executive NHS England	**David Bennett** Chair and Chief Executive Monitor	**David Flory CBE** Chief Executive NHS Trust Development Authority	**Carolyn Downs** Chief Executive Local Government Association

Appendix 1: Initial guidance – key objectives of planning process and changes made

1. **Improving outcomes –** improved outcomes must be at the heart of the strategic and operational planning process. All bodies should prioritise an approach to planning which combines transparency with detailed patient and public participation***.***

   We need to construct, from the bottom up, quantifiable and deliverable ambitions for each domain of the NHS Outcomes Framework. We will, therefore, be asking providers and commissioners to work together to determine local levels of ambition, based on evidence of local patient and public benefit, against a common set of indicators.

   Setting levels of ambition against the NHS Outcomes Framework is intended to galvanise the whole commissioning system around a clear and common purpose, aligning the development of our long term strategy and the *Call to Action* with the development of our 5 year strategic and 2 year operating plans and allowing us to articulate the improvements we are collectively aiming to deliver for patients across the seven ambitions.

2. **Quality, Expectations and Sustainability –** while we want the five year plans to reflect local need and be ambitious we are keen to ensure that actions are taken as early as possible in order to deliver the maximum benefit over the period. With that in mind we shall expect more granular detail covering the first two years that set out the measures that will be used to demonstrate progress against improving outcomes while delivering patients' rights and pledges under the NHS Constitution and operating with robust financial control.

3. **Joint assumptions –** a number of planning assumptions are included under the relevant headings in this document, and further joint planning assumptions will be published in December. NHS England, Monitor and the NHS TDA also have planning expectations that relate to the organisations which each of us oversee and these are set out in Appendix 3.

4. **Tariff –** Monitor and NHS England plan to publish the 2014/15 tariff in December.

   The 2014/15 tariff guidance has been strengthened to confirm that where a Trust is being reimbursed at less than 100% of the national tariff, both the provider and commissioner will be jointly engaged in the reinvestment decision. The scope of this improved arrangement includes the non-payment for emergency readmissions and the marginal rate emergency tariff and we would expect to see plans that demonstrate how this funding has been transparently re-invested in appropriate demand management and improved discharge schemes.

5. **Allocations –** we will be able to notify CCGs of their financial allocations for both 14/15 and 15/16 in the week commencing 16 December and will also provide broad assumptions regarding allocations for years 3 – 5 to the same timescale.

6. **Efficiencies**

	2014/15	2015/16 – 2019/20
Efficiencies -	4.0%*	Published in December

* Subject to consultation

7. **Cost Inflation**

	2014/15	2015/16 – 2019/20
Weighted average cost inflation	2.1%*	Published in December

* Subject to consultation

8. **Price deflation – tariff**

	2014/15	2015/16 – 2019/20
Average tariff deflation	1.9%*	Published in December

* Subject to consultation. The 1.9% excludes the impact of CNST on specific HRG groups.

Any further forward guidance provided in December will be indicative only and will not represent a commitment to future tariff pricing beyond 2014/15, which will be subject to consultation in future years.

9. **CQUIN –** NHS England is refreshing the CQUIN scheme and associated guidance for 2014/2015. It is proposed that the final CQUIN scheme will be agreed and published in December 2013.

10. **Integration Transformation Fund –** the Local Government Association and NHS England published further guidance on 17 October 2013 on how CCGs and councils should work together to develop their plans for the pooling of £3.8 billion of funding, announced by the Government in the June spending round, to ensure a transformation in integrated health and social care.

    The 'Integration Transformation Fund' is a single pooled budget to support health and social care services to work more closely together in local areas. The publication provides further advice, ahead of the formal planning guidance in December, on how the Fund will operate. The publication also includes a draft plan submission template.

    Whilst the fund itself does not address the financial pressures faced by local authorities and CCGs, it can act as a catalyst for developing a new shared approach to delivering services and setting priorities.

    It is essential, therefore, that CCGs and Local Authorities engage from the outset with all providers likely to be affected by the use of the Integration Transformation

Fund so that plans are developed in a way that achieves the best outcomes for local people. Commissioner and provider plans should have 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.

This new shared approach to delivering services needs to be reflected in the planning units chosen for the development of 5 year strategic plans.

11. **Joint working –** it will be essential for all health (commissioners and providers) and social care practitioners to work together with other partners to develop locally owned and agreed plans. We expect the shape of size of planning units to depend on local arrangements, but all relevant parties should be included and national coverage is required.

    To support mutual working between commissioners and providers, we expect local organisations to share their own assumptions with each other. For commissioners, this will mean ensuring plans reflect the local Health and Wellbeing Strategy and have been discussed with providers. Providers will need to be satisfied that their plans reflect the commissioning intentions of CCGs and NHS England's Area Teams.

12. **Unit of planning –** as CCG sizes and local configurations differ, a larger unit of planning is required for the development of consistent and integrated long-term strategic plans**.** Each statutory body (CCG, Trust, FT) must produce its own operational plan that reflects the wider strategic plan. For the five year strategic plans CCGs will work with Trusts and local government to identify and communicate the larger footprint within which they will sit. The guidance is that each CCG should only sit in one larger footprint. This unit of planning will consist of at least one CCG and CCGs will contribute to a larger footprint where one CCG is too small. CCGs will be required to nominate their choice of planning unit to NHS England by 12 November 2013 through Area Team Directors of Operations and Delivery.

    Table 1 – unit of planning guidance

Each commissioner is asked to cast its strategic plan in a wider footprint that meets the following characteristics:
• each CCG to belong to one unit only; • the unit has been locally agreed and has clear clinical ownership and leadership; • it is based on existing health economies that reflect patient flows across Health & Wellbeing Board(s) and local provider footprints with no CCG to be split across boundaries; • it includes significant local trusts (e.g. where CCG spend is > 25%) and some trusts may participate in more than 1 unit of planning;

- it has sufficient scale to deliver geography wide clinical improvements;
- it enables the pooling of resources to reduce risk associated with large investments;
- it does not cut across existing locally agreed collaboration agreements; and
- engagement has been secured from Local Authorities.

The Integration Transformation Fund will need to be identified within each plan so that the CCG can identify its contribution to the amount and approach to be agreed by its Health & Wellbeing Board(s).

13. **Support –** we recognise that producing fully integrated and assured strategic plans is a challenging task and to support this programme NHS England, NHS TDA, Monitor and LGA are exploring the possibility of a joint approach to support packages.

14. **Proposed assurance / challenge process –** the assurance processes used in the 2013/14 planning will be enhanced. For 2014/15 planning we are including an additional step to ensure that commissioner and provider plans are aligned by reconciling activity and revenue figures between CCGs, foundation and non-foundation trusts. The assurance on alignment will be conducted jointly between NHS England, Monitor, NHS TDA and LGA. Please note that every step will be taken not to prejudice the position of any provider or commissioner, no information will be shared without first contacting the appropriate party. This exercise is to highlight risk where parties within the local health economy are planning on a directional inconsistent basis.

15. **Further guidance –** further detailed guidance will be issued in December 2013 and will be tailored to providers and commissioners respectively.

Appendix 2: Key dates

Key dates – NHS England

Planning Units received from CCGs	12 November 2013
Final guidance, templates and tools issued	w/c 16 December 2013
Allocations issued	w/c 16 December 2013
1st Submission	14 February 2014
Contracts signed	28 February 2014
Refresh of plan post contract sign off	5 March 2014
Dispute resolution for 2014/15 with NHS TDA	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year plans and draft 5 year	4 April 2014
Submission of final 5 year plans • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Key dates – Monitor

Final guidance, templates and tools issued	w/c 16 December 2013
Planned publication date of the 2014/15 National tariff Payment System (subject to the outcome of a statutory consultation process)	December 2013
Contracts signed	28 February 2014
Submission of final 2 year plans	4 April 2014
Submission of final 5 year plans • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	June 2014

Key dates – NHS TDA

Final Guidance, templates and tools issued	w/c 16 December 2013
Initial, high level plans	13 January 2014
Contracts signed	28 February 2014
Full plan collection	5 March 2014
Dispute resolution for 2014/15 with NHSE	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year plans	4 April 2014
Submission of 5 year LTFMs and IBPs • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Key dates – LGA

HWBs to return completed template on the ITF	15 February 2014

Appendix 3: Assumptions

Further guidance to commissioners on the feasibility of bringing forward an element of the 15/16 saving requirement into 14/15 to avoid a financial 'cliff edge' in 15/16, in order to fund strategic change, will be given by December.

Table 2 – NHS England specific assumptions

CCGs	
Demographic growth	Local determination using ONS age profiled weighted population projections
Non-demographic growth	Local determination based on historic analysis and evidence.
Price inflation - prescribing	Local determination - would expect this to be in a range of 4% to 7% per annum increase
Price inflation – continuing health care	Local determination - would expect this to be in a range of 2% to 5% per annum increase
Business rules	• Minimum 0.5% contingency fund held • 1% surplus carry forward • 2% underlying surplus • 2% non-recurrent spend • Local determination of impact of ITF on plans
Primary care	
Demographic growth	Local determination based on resident population in line with crude population projections
Price increase	1.3% per annum increase
Business rules	• Minimum 0.5% contingency fund held • 1% surplus carry forward • 2% underlying surplus • 2% non-recurrent spend
Direct commissioning (excluding Primary Care and Public Health)	
Demographic growth	Local determination using ONS age profiled weighted population projections for population covered by Area Teams
Non-demographic growth	Local determination based on historic analysis and evidence
Business rules	• Minimum 0.5% contingency fund held • 1% surplus carry forward • 2% underlying surplus

	• 2% non-recurrent spend
Public health	
Demographic growth	Local determination using ONS age profiled weighted population projections for population covered by Area Teams
Price increase	0% per annum increase
Business rules	• Minimum 0.5% contingency fund held • 0% surplus carry forward • 0% underlying surplus • 0% non-recurrent spend

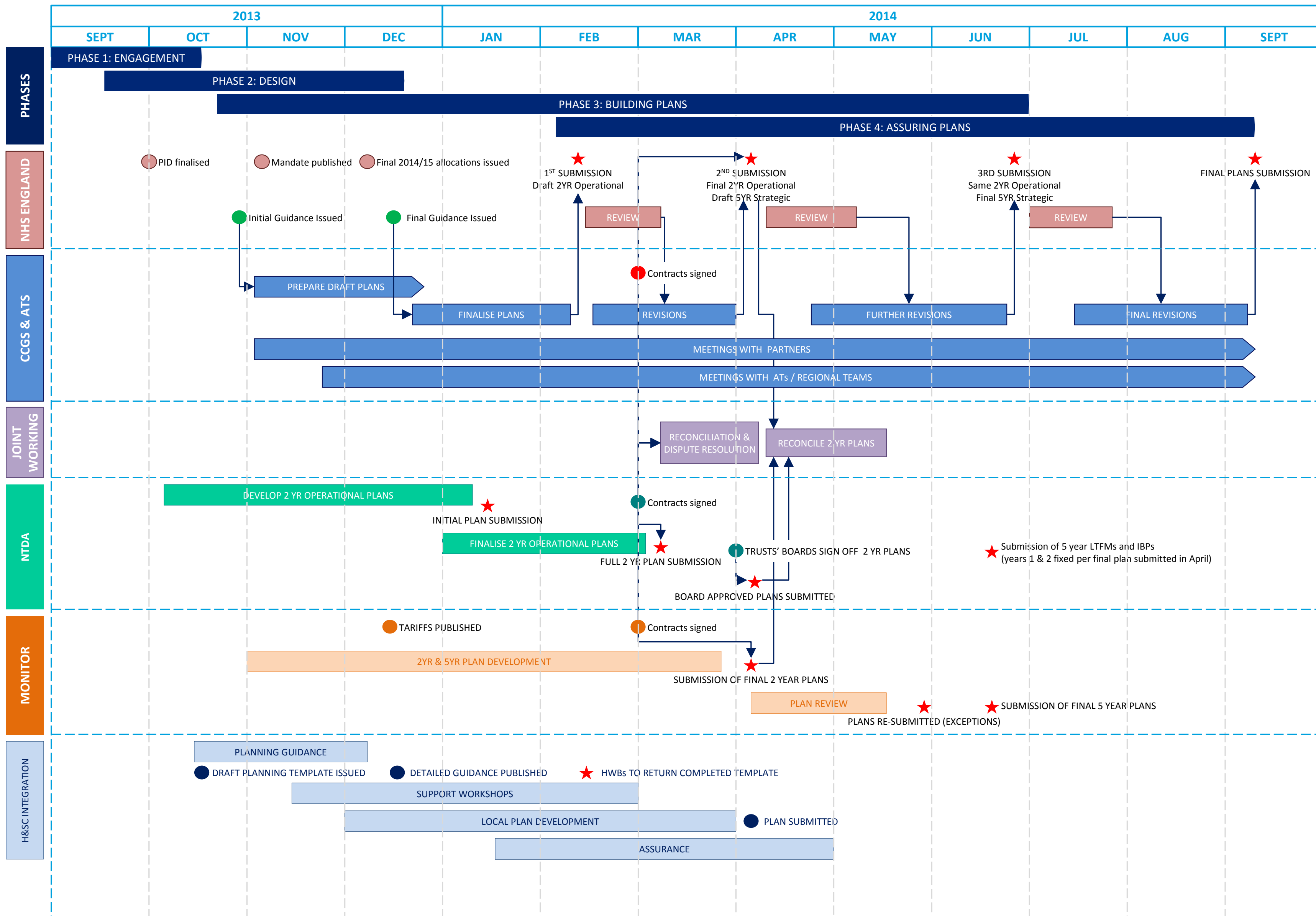
Table 3 – NHS TDA specific assumptions

Business Rules	• Minimum 0.5% contingency fund held • 1% surplus requirement or for those NHS Trusts in formal recovery the planned outturn should be consistent with the recovery plan signed off by the NHS TDA

Table 4 – Monitor specific assumptions

Business rules	Monitor does not require foundation trusts to deliver a surplus. The provider licence requires foundation trusts to have regard to the desirability of maintaining an acceptable continuity of service risk rating. In practice, a lower risk rating will prompt Monitor to ask whether there is a risk to the continuity of services. Where foundation trusts plan for a lower risk rating, they should explain their rationale to Monitor.

Appendix 4 - Joint Timeline



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>
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**

Minimum required value of ITF pooled budget: 2014/15	£0.00
2015/16	£0.00

Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£0.00

Authorisation and Sign Off

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

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

<Insert extra rows for additional CCGs as required>

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

date	<date>

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

Vision for Health and Care Services

Integration Aims & Objectives

Description of Planned Changes

Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

National Conditions

Protecting social care services

Please outline your agreed local definition of protecting social care services.

Please explain how local social care services will be protected within your plans.

7-day services to support discharge

Data-sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are commited to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Joint-assessments and accountable lead professional

Outcomes and metrics

Please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Outcome measures- Examples only	Current Baseline (as at....)	14/15 Projected delivery (full year?)	15/16 Projected delivery (full year?)
Delayed transfers of care			
Emergency admissions			
Effectiveness of reablement			
Admissions to residential and nursing care			
Patient and service-user experience			
<Local measure>			
<Local measure>			
<Local measure>			

NB: National metrics remain subject to confirmation

Finance

Please summarize the total health and care spend for each commissioner in your area. Please include sub-totals for each organisation where there is more than one type of organistion involved

Organisation	**2013/14 spend**	**2013/14 benefits**	**2014/15 spend**	**2014/15 benefits**	**2015/16 spend**
Local Authority Social Services					
CCG					
Primary Care					
Specialised commissioning					
Local Authority Public Health					
Total					

Please summarize where your pooled budget will be spent. NB the total must be equal to or more than your total ITF allocation

ITF Investment	**2014/15 spend**	**2014/15 benefits**	**2015/16 spend**	**2015/16 benefits**
Scheme 1				
Scheme 2				
Scheme 3				
Scheme 4				
Scheme 5				
Total				

Approximately 25% of the ITF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Key Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	**Risk Rating**	**Mitigating Actions**
Risk 1		
Risk 2		
Risk 3		
Risk4		