Report of the Director of People

Agenda Item No: 9
Meeting: 10 December 2013

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

INTEGRATED WORKING PARTNERSHIP UPDATE

1. **OBJECT AND KEY POINTS IN THIS REPORT**

1.1 To update the Health and Wellbeing Board (HWB) on the work of the Integrated Working Partnership, including the development of the Integration Statement and progress against the priority work streams agreed via the pioneer bid; and

1.2 To request that the Integration Statement is approved.

2. **BACKGROUND INFORMATION**

2.1 The HWB agreed to the submission of the Pioneer Bid at the meeting on the 14th June 2013. The bid set out the principles for integration and the priority integration work steams. Although the Pioneer Bid was not short listed by the Department for Education, the HWB at the meeting on 3rd October 2013 agreed to continue to prioritise local work towards whole system integration.

2.2 The priority work streams identified in the bid are:

- Conception to two (pre birth to 2 years)
- Young People who are vulnerable to risk taking behaviours aged 13 to 19 years
- The frail and elderly

2.3 The North Lincolnshire Health and Social Care Pioneer Bid has been used as the basis for the development of the Integration Statement which sets out the collective ambition to transform services to provide sustainable and integrated care and support where:

- Individuals will be supported to be resilient and safeguarded
- Families and carers will be supported
- Communities will be safer and stronger

2.4 Through the Pioneer bid, the HWB has committed to whole system integration across all life stages: starting well; growing well; living well; retiring well and ageing well and dying well and across levels of need: universal; targeted and specialist and across the workforce sectors. The 'Single Organisational Model' referenced in the pioneer bid, provides the framework for our integration intent to be developed.

2.5 The aim is to achieve the right service, at the right time, in the right place with the right management. This requires new and innovative ways of integrated working within and across agencies to support positive outcomes for children and adults.

2.5 The Integrated Working Partnership has continued to develop the principles for integration and the meeting in November 2013 was focussed on agreeing a common language and understanding in relation to the model of integration and the development of integrated working across levels of need. The outcomes from the workshop have been utilised to inform the development of the Integration Statement. This statement forms the baseline of principles for integration. The Integrated Working Partnership will further define and agree the meaning and shared understanding behind these principles.

3. OPTIONS FOR CONSIDERATION

3.1 Following the work of the IWP it is proposed that the HWB agree to the Integration Statement.

3.2 The Integration Statement has been developed in collaboration with partners whom have an investment in the three priority work streams and sets out North Lincolnshire's strategic intent to work together more collaboratively in order to improve outcomes for the most vulnerable in our society.

3.4 The Integration Statement forms the basis of a shared commitment to improving the lives of the most vulnerable in our society, and sets out the ambitions, principles and **outcomes** that we expect to see:

- Improved health and wellbeing and reduced inequalities
- Care and support are more effectively delivered and co-ordinated at the earliest point
- A co-ordinated solution designed with the person to meet the assessed needs
- Better value for money and reduction in costs
- Our local population are empowered by building on their strengths and resilience
- Supported choice, maintained independence and intervention at the earliest points
- A maximisation of resources
- Children, young people, vulnerable adults, families and carers are safe and supported and have transformed lives

3.5 Core membership for the three priority work streams has been agreed and work is now underway to develop SMART action plans to contribute to improved outcomes. The indicative timelines showing key actions are shown in the Appendices.

4. ANALYSIS OF OPTIONS

4.1 Achieving integration will require established conditions for success and only by adopting this approach we will successfully transform services and ways of working. This will involve a common language, workforce development, sharing data and information, a shared risk management framework, identified lead professionals, shared performance and joint financial governance, joint commissioning and pooled budgets where this is required. The IWP will agree the arrangements for this and develop action plans to implement this work.

4.2 The Single Organisational Model provides the basis for agencies to organise services in a similar way based levels of need: universal/community; targeted and specialist. This will enable alignment and integration of services at all levels, vertically and horizontally. Further work will be undertaken through the IWP to agree a glossary of definitions and meaning behind the statement.

4.3 The ultimate aim is to prevent unnecessary and costly interventions by acting early and decisively and supporting families to build upon their own strengths.

5. RESOURCE IMPLICATIONS (FINANCIAL, STAFFING, PROPERTY, IT)

5.1 The development of the Integration Statement does not create any resource implications in itself; however, as the plans are developed and implemented there may be an impact on the use and distribution of resources both financial and human.

6. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

6.1 Not applicable at this stage, however, future action plans will be subject to Integrated Impact Assessment.

7. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

7.1 The over arching principles for Integration were included in the Pioneer Bid which was agreed by partners and approved by the HWB.

7.2 The creation and content of an Integration Statement was discussed at the November 2013 IWP meeting where all members or representatives were in attendance:

- NLC
- CCG
- Humberside Police
- Healthwatch
- NLaG
- RDash
- Humberside Probation
- Schools
- North Lincs Homes

- Voluntary Sector

7.4 A draft Integration Statement was circulated to members for comment. The Feedback confirms the need for the IWP to develop the definitions and meaning behind the statement and to agree the practical detail behind the conditions for success, such as a risk management framework.

7.5 There are no declared conflicts of interest at this stage.

8. RECOMMENDATIONS

8.1 That the Health and Wellbeing Board receive this report and note the progress and plans in place to implement the priority work streams for integration; and

8.2 That the Health and Wellbeing Board approve the Integration Statement.

DIRECTOR OF PEOPLE

Civic Centre
Ashby Road
Scunthorpe
DN16 1AB
Author: Becky McIntyre
Date: 10 December 2013

Background Papers used in the preparation of this report:
North Lincolnshire Expression of Interest Health and Social Care Pioneer Bid
IWP HWB Report October 2013

Work stream: Frail and Elderly Strategy
Lead: Assistant Director Adult Services North Lincolnshire Council and Director of Strategy and Joint Commissioning Clinical Commissioning Group NL
Work stream Group: Integrated Working Steering Group (IWSG)
Links to: Integration Transformation Fund Working Group (ITFWG)

	Action Outline	Timescale	Lead
1.	Agreed who we mean by the frail elderly. Revisited the integrated locality work. Understood the requirements of the ITF and how this will enable this vision and approach. Begun to work out 7 day working across social care	To Date December 2013	KP/CB
2.	Review the whole system from A & E to the home and agree what aspects we need to further integrate and agree the common language used for integration and person centred approaches. Pilot 7 day working in social care.	January 2014	IWSG
3.	Engagement event with primary care and agree what in social care is protected by the ITF	January 2014	IWSG
4.	Agree the single organisation model service shape based on assessed need across NLaG, LA, RDaSH and primary care	February 2014	IWSG
5.	Agree the sec 75 that underpins the pooled budget arrangements with agreed funding and performance framework.	January/February 2014	KP/CB
6.	Develop an approach for the workforce that embraces changes in practise that embrace person centred co-ordinated care.	February to April 2014	IWSG
7.	Sign off ITF plan at H WBB a one year plan with a five year strategy based on agreed Jointly agreed plans (LA, & CCG) • Protection for social care services • 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends. • Better data sharing between health and social care (NHS number) • Joint approach to assessment and care planning • Accountable professional where integrated packages of care	February 2014	ITFWG with IWSG

	• Risk-sharing principles and contingency plans (including redeployment of the funding if local agreement is not reached • Agreement on the consequential impact of changes in the acute sector.		
9.	Agree the risk and demand management system and lead professional role.	**March 2014**	**IWP**
10.	Redesign the system in line with the agreed plan	**April to May 2014**	**IWSG**
11.	Implement the integrated system with performance measure that show outcomes and VFM	**January 2015**	**HWB**

Work Stream: 13 to 19 Young People who are vulnerable to risk taking behaviours aged 13 to 19 years
Lead: Assistant Director Children's Services North Lincolnshire Council
Work stream group: Early Help Transformation Group

	Action Outline	To be completed by	Lead
1	Collate relevant data and service provision to underpin integration	April 2014	Early Help Transformation Group
2	Roll out and development of the TFI and develop a locality focus within the context of the Locality Pilot.	January 2014	Early Help Transformation Group
3	Implement the Locality pilot model made up of secondees and multi-agency contributions – in reach	April 2014	Early Help Transformation Group
4	Review and adapt the TFI vision and model to underpin a wider criteria and approach to integrated work with 13 to 19 year olds, using the Single Organisational Model.	By September 2014	Early Help Transformation Group
5	Staff reviews to be undertaken and completed	Service Review Completed September 2014 Review Implementation date by September 2015	Early Help Transformation Group
6	Agree single outcome framework for 13-19	March 2014	Early Help Transformation Group

Work stream: Conception to 2 (Pre Birth to 2 year old)
Lead: **Assistant Director Children's Services**
Work Stream Group: Early Help Transformation Group

	Action Outline	Timescale	Lead
1	Systems Review and Redesign to inform commissioning.	April 2014	AD Children's Services
2	Build on the Early Help Safeguarding Strategy service offer and pathways to inform families.	April 2014	Early Help Transformation Group
3	Develop the workforce to embrace a strengths based approach as a preferred approach.	April 2014	Children's Trust Board
4	Implement a single approach to assessment and planning.	April 2014	Early Help Transformation Group
5	Implement systems management and feedback to ensure service outcomes and value for money.	April 2015	Early Help Transformation Group
6	Work with families in their own homes and their communities	April 2015	Early Help Transformation Group
7	Implement an integrated service and delivery within the locality	By September 2015	Early Help Transformation Group

NORTH LINCOLNSHIRE HEALTH AND WELLBEING BOARD

INTEGRATION STATEMENT

WHAT WE MEAN BY INTEGRATION

In its most simplest form, integration can be best described as:

"When more than one organisation works together to achieve a shared outcome".

OUR AMBITION FOR INTEGRATION

'The Right Service, at the Right Time, in the Right Place, with the Right Management'

Our collective ambition is to transform services to provide sustainable integrated care and support that:

- Empowers our local population by building on their strengths and supports them to be more resilient through making sure they have the knowledge and skills they need to be independent and more self-caring
- Unlocks citizen resource that supports existing social networks and builds collective community capacity
- Underpins our key commitments of supporting choice, maintaining independence, intervening at the earliest point, providing access to early advice and interventions to create a more resilient population
- Informs innovative and transformational approaches to commissioning, contracting and financing to enable a social and financial return on investment

We are in agreement that transformation is the process of profound and radical change that will orientate our organisations in a new direction, taking it to a different level of effectiveness. It is with integration as a central component that we will achieve successful transformation.

HOW WE WILL INTEGRATE

Locally we have agreed that the 'Single Organisational Model' (SOM) (Appendix 1) will provide the basis on which services can be organised on levels of need and thus enable integration.

Using this model services will integrate:

- Vertically/horizontally; and/or
- On levels of need; and/or
- Locality based/area wide;

The level of integration will be dependent on the outcome to be achieved and the intensity of the integration required to achieve that outcome.

As Health and Wellbeing Board partners, we have committed to 'Whole System Integration' across:

- life stages (starting well, growing well, living well, retiring and ageing well and dying well),
- the levels of need (universal, targeted and specialist)
- workforce sectors (public, private, independent, voluntary (paid and unpaid)

WHAT WILL BE INTEGRATED

Our priority areas for integration 2013/15 are:

- Children aged -9 months to 2 years
- Vulnerable young people aged 13 to 19
- People who are frail and elderly

PRINCIPLES FOR INTEGRATION

We will work together to ensure:

- that approaches and services are person centred and designed around the needs of the individual or family rather than an organisation
- needs are identified early and support is delivered at the earliest point
- services are targeted to meet assessed need and implemented locally
- we actively collaborate and engage with service users in assessment, decision making and planning
- that individual, child and family plans are outcome focussed
- we recognise and make use of the top 10 insights from Experience Led Commissioning (ELC) (appendix 2)

COMMITMENT TO INTEGRATION

We are committed to promoting, nurturing and creating a culture where:

- the workforce have permissions to do things differently to contribute to better outcomes
- families are enabled and empowered to help themselves and the workforce is enabled and empowered to help them to do that
- risk is managed at the lowest level
- there is a common purpose, common direction, shared goals and outcomes
- we hold each other to account for meeting our obligations
- there is professional accountability
- there is continued democratic engagement
- there is good governance and professional leadership
- there are innovative and transformational approaches to commissioning, contracting and financing to enable a social and financial return on investment
- we work together to deliver on the vision for wellbeing

CONDITIONS FOR SUCCESSFUL INTEGRATION

Successful integration will be achieved through the agreement to and development of:

- a common language
- common knowledge and skill set development
- information and data sharing in line with Caldicott principles (appendix 3)
- a single organisational model based on assessed need, integrated and outcome based assessment, planning and pathways
- a shared risk management framework
- identified lead professionals
- a shared performance framework based on outcomes
- joint financial governance, joint commissioning and pooled budgets where required

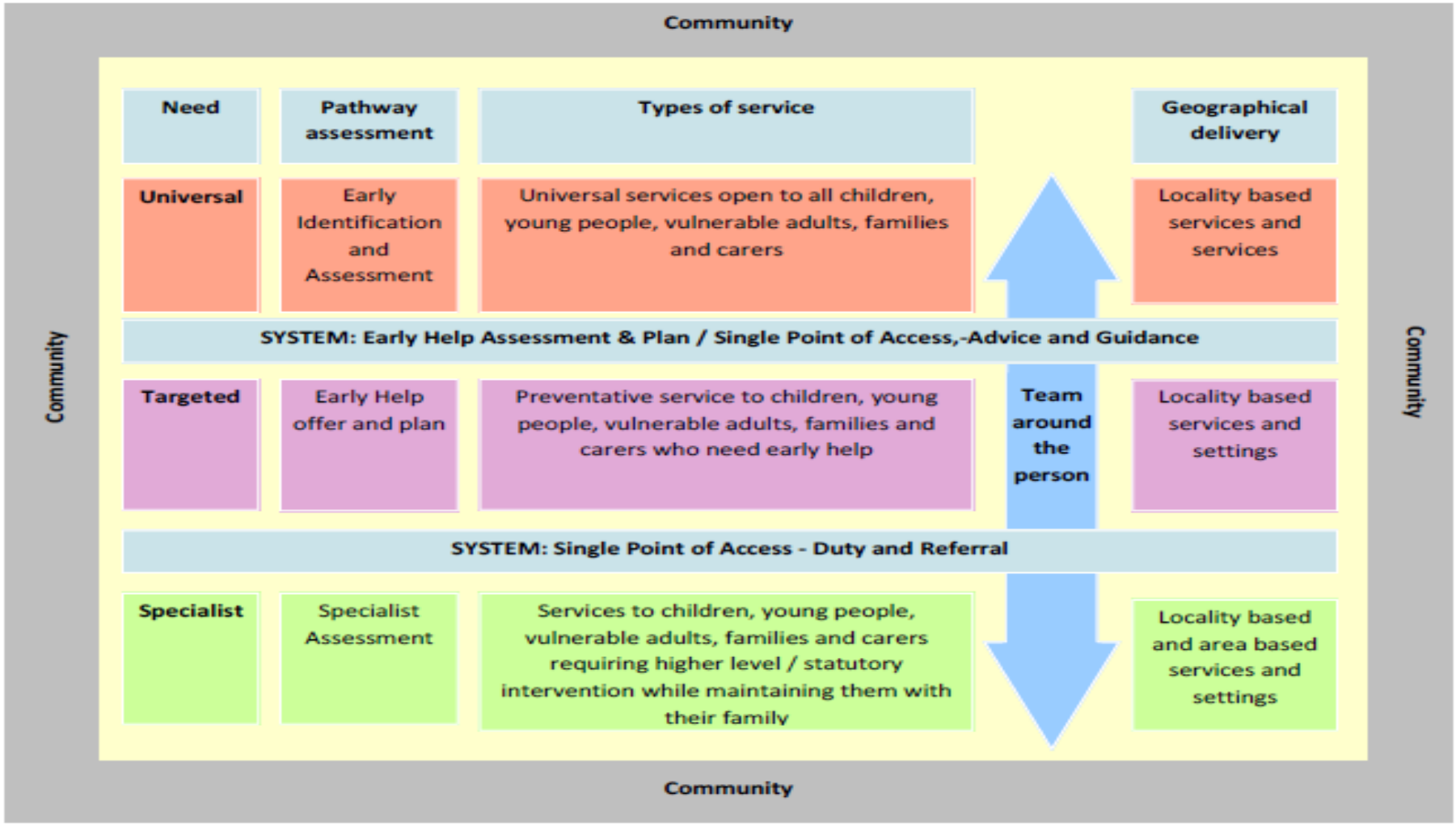
OUTCOMES OF INTEGRATION

The integration outcomes that we expect to see are:

- improved health and wellbeing outcomes and reduced inequalities
- care and support are more effectively delivered and co-ordinated at the earliest point
- co-ordinated solution designed with the person to meet the assessed needs
- better value for money and reduction in costs
- our local population are empowered by building on their strengths and resilience
- supported choice, maintained independence and intervention at the earliest points
- a maximisation of resources
- children, young people, vulnerable adults, families and carers are **safe** and **supported** and have **transformed** lives

APPENDIX 1

Single Organisational Model Diagram



APPENDIX 2

Experience Led Commissioning
Top 10 insights

1. Independence keeps you well. The NHS and social care tend to behave as if keeping people well keeps them independent. This work suggests that it is, in fact, the other way around and that preserving and supporting 'independence' (and as part of that – preserving mobility) is actually keeping people well. In this work, people define 'independence' as: being in control of my life, doing the things that fulfil me, being able to care for myself and my condition and being able to get out and about to see friends and family and do the things that fulfil me.

2. Mobility is a major determinant of independence. Investments in 'mobility preservation' are not just about mobility aids and house adaptations – although these are important. It is also about things like: safe pavements, organised walking clubs, good public transport links and car sharing schemes, disabled badges and access – plus all work to prevent falls. This work suggest that there should be more investment in 'mobility preservation' and that commissioners should ensure there a minimal or zero waiting times for all types of mobility support for maximum commissioning impact on keeping well.

3. People who care for others – both those who work in caring professions (including front line health care professionals) and family carers – have much in common. Both put the health of the person or people they care before their own health and are prone to delaying seeking help with their own symptoms and health issues. This puts both groups at additional risk and means commissioners need to think about directing providers to identify and support them to keep well.

4. Conversely, the fulfilment both groups get from their caring work keeps them well. It is a fine balance. Both paid, professional and unpaid carers and the health professionals who care for them need to watch for signs that they may be approaching the 'tipping point' so that support is provided proactively and in advance to help them keep going and coping.

5. People who work in front line health care provision and caring roles in care homes perceive they have unsupportive relationships with GPs and feel their health concerns are being not taken seriously by their GP.

6. Peer support provided by people who are 'experts through experience' is an essential part of any wellness system. It needs infrastructure to support and embed it and it needs to be commissioned. It is not a free good and needs to be supported. The voluntary sector may be especially good at supporting peer support. Commissioners should commission for outcomes from support – not simply provide funding.

7. People and families do not talk about 'integrated care'. They talk about the relationships with professionals contributing to keeping them well. Relationship based care systems keep people well. Relationships between front line teams and across organisations are part of this. It is relationships between people - not processes - that achieve integrated care. Commissioners should invest in building relationships instead of designing pathways and processes.

8. From the person and family perspective, being listened to, supported and understood by the teams who support them is key. Having one safe, trusted person to go to for reassurance who listens and deeply understands them as a person and their story (life context of their condition) is key. Knowing they are 'there' if needed is often enough.

9. Friends and family are the main source of emotional support for people. That is why it is so important to keep people connected with loved ones when they going through transition and to involve loved ones in planning and conversations about care. It is also the reason why those who have little social support are especially vulnerable to becoming ill and dependent. Peer support from people with shared experience is part of this support circle. It may be more or as helpful to help people deal with emotional wellbeing issues.

10. Everyone needs to have purpose to keep them well. That purpose is often not paid work - although that is important for those who can find work. For most people that purpose comes from caring for others. This desire to care is an asset as there are many people in the community - especially older people - who want to contribute and care. Commissioners can invest in enabling this. It will enhance well-being within both those who do the caring and those who receive the care.

APPENDIX 3

Information: To Share or Not to Share
SEVEN Caldicott Principles

1. **Justify the purpose(s)**

Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing usage regularly reviewed, by an appropriate guardian.

2. **Don't use personal confidential data unless absolutely necessary**

Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. **Use the minimum necessary personal confidential data**

Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

4. **Access to personal confidential data should be on a strict need-to-know basis**

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

5. **Everyone with access to personal confidential data should be aware of their responsibilities**

Action should be taken to ensure that those handling personal confidential data — both clinical and non-clinical staff — are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. **Compliance with the law**

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should have designated responsibility for ensuring that the organisation complies with legal requirements.

7. **The duty to share information can be as important as the duty to protect patient confidentiality**

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.