EXECUTIVE
25th August 2022

Report Title	**Integrated Care Across Northamptonshire (iCan) Case for Change**
Report Author	David Watts - Executive Director of Adults, Communities and Wellbeing (DASS)
Lead Member	Councillor Helen Harrison, Executive Member for Adults, Health and Wellbeing

Key Decision	☒ Yes ☐ No
Is the decision eligible for call-in by Scrutiny?	☒ Yes ☐ No
Are there public sector equality duty implications?	☐ Yes ☒ No
Does the report contain confidential or exempt information (whether in appendices or not)?	☐ Yes ☒ No
Applicable paragraph number/s for exemption from publication under Schedule 12A Local Government Act 1972	

List of Appendices

Appendix A – iCAN Case for Change

1. Purpose of Report

1.1 This report provides an overview of the case for change for the current Integrated Care Across Northamptonshire (iCAN) transformation programme to develop into an iCAN collaborative. This will mean that the collaborative will have delegated commissioning responsibilities, including some elements of the Better Care Fund (BCF) being proposed as of April 2023.

2. Executive Summary

2.1 A summary of iCAN aims progress and next steps was presented to the Integrated Care Board (ICB) on 21st April 2022. The ICB supported the broad direction and progress of iCAN and the plans to deliver specific improvements for winter/surge activity.

2.2 Work has also progressed on shaping the iCAN collaborative and road map for the contractual development of the collaborative to move from a programme approach into a permanent way of working.

2.3 The proposed operating model and initial scope for the iCAN collaborative case for change and next steps are being presented to the ICB in August 2022, with recommendations to:

- agree that iCAN aims and objectives remain valid
- agree the scope of services to form a collaborative arrangement from April 2023
- agree iCAN should proceed to through a collaborative framework - Gateway 4 and develop proposals in relation to delegated budgets (including alignment in part with the BCF), workforce and contractual format
- agree that service user and staff engagement is progressed to inform arrangements for April 2023.

2.4 There is now a need to move from a transformation programme to a permanent way of working by developing a service delivery model that formalises/embeds what has been achieved and creates the conditions for long-term integrated working and better outcomes. This will not interfere with the National reporting requirements of the BCF through the Health and Wellbeing Boards.

2.5 The proposed framework of formal agreements for the iCAN collaborative will utilise all available relationship options including those newly available or utilised within Northamptonshire for the first time in July 2022, namely:

- Collaborative Agreements
- Collaborative Contract Approaches
- Additional delegation options for Integrated Care Boards

3. Recommendations

3.1 It is recommended that the Executive:

a) Support the broad direction of travel set out in the iCAN case for change and the ambitions and intentions to improve the experience of people

b) Agree that the Executive Member for Health Wellbeing and Vulnerable People formulates a written response to the Senior Responsible Officer for the iCAN collaborative and the Chair and Chief Executive of the Integrated Care Board setting-out the Executive's position regarding concerns identified including:

- Member oversight of the collaborative when it does not report in to the health and wellbeing board and no elected members are members of the Integrated Care Board

- Governance around financial decision making and operational boards if

commissioning of services currently funded through the Better Care Fund and earmarked for meeting the needs of North Northamptonshire residents if it were to be included in a countywide pooled budget

- Seeking an opportunity to discuss and address the concerns identified with key members of the Integrated Care Board in order to provide sufficient assurance and resolution to the Council's Executive regarding the concerns it has identified.

3.2 Reasons for Recommendations:

- The broad direction of travel is one that fits with the overarching priorities set out within the corporate plan.

- Whilst socialising the case for change with elected members within the council, there have been some concerns raised regarding adequacy of governance arrangements that it is important are raised with the ICB as part of the Executives feedback on the case for change.

- Member oversight of performance and expenditure for which it is responsible is a fundamental requirement in ensuring that local-authority public money is being spent in accordance with national requirements alongside the priorities set out in the corporate plan.

4. Report Background

4.1 Better Care Fund

4.2 The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. Nationally, it represents a collaboration between:

- The Department of Health and Social Care
- Department for Levelling Up, Housing and Communities
- NHS England and Improvement
- The Local Government Association

4.3 The four partners work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the NHS Long Term Plan. Locally, the programme spans both the NHS and local government to join up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

4.4 Launched in 2015, the programme established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:

- minimum allocation from integrated care systems (ICSs)
- disabled facilities grant – local authority grant
- social care funding (improved BCF) – local authority grant
- winter pressures grant funding £240 million – local authority grant.

4.5. Disabled facilities grant

4.6 The disabled facilities grant (DFG) is a capital grant paid from the Ministry of Housing, Communities and Local Government (MHCLG) to local authorities in England to adapt older and disabled people's homes to help them to live independently and safely. Adaptations can include ramps, stair lifts and suitable heating systems. The DFG, which has run for more than 30 years, became part of the Better Care Fund (BCF) in April 2015.

4.7 The DFG aims to support disabled and older people to be independent, enabling carers to continue their role safely, preventing accidents and helping people to return from hospital. It therefore crosses the boundaries between housing, health and social care and reflects the increasing national focus on the integration of housing with health and social care services.

4.8 Since the DFG became part of the BCF there has been a significant increase in central government resources. In 2014/15 central government provided £220 million through the grant, but by 2017/18 this had almost doubled to £431 million in total and for 2020/21 was £573 million.

4.9. Improved Better Care Fund (iBCF)

4.10 The improved Better Care Fund (iBCF) grant was announced in the 2015 Spending Review and was introduced from 2017/18 onwards. The grant provides local government with new funding for adult social care and must be pooled alongside the clinical commissioning group and DFG funding in the BCF. The original funding was increased by £2 billion in total from 2017/18 to 2019/20 in the 2017 March Budget, rising to an annual allocation of £1.837 billion by 2019/20.

4.11 In 2020/21, the £240 million winter pressures grant was combined with the iBCF. The value of the iBCF in 2020/21 was £2.077 billion.

4.12 The fund is paid directly to local government and must be used to support social care activity.

4.13. Purpose of the iBCF

4.14 The iBCF is passed to local authorities with social care responsibilities as a Section 31 grant, with conditions. The grant determination in 2020/21 requires the money to be used only for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready

- ensuring that the social care provider market is supported.

Conditions were placed that a recipient local authority must:

- pool the grant funding into the local BCF, unless the authority has written ministerial exemption
- work with the relevant CCG and providers to meet National condition 4 (managing transfers of care) in the Integration and BCF policy framework and planning requirements 2017/19
- provide quarterly reports as required by the Secretary of State.

4.15. Winter Pressures Funding

4.16 In 2019/20, the government set a condition that the grant determination for winter pressures funding must be pooled into BCF plans and specified that the grant must be used to support the local health and care system to manage demand pressures on the NHS with particular reference to seasonal winter pressures. This includes interventions that support people to be discharged from hospital, who would otherwise be delayed, with the appropriate social care support in place, and which help promote people's independence.

4.17 In their BCF plans, local systems should set out the agreed approach to use of the winter pressures grant, including how the funding will be utilised to ensure that capacity is available in winter to support safe discharge and admissions avoidance. Details of planned schemes and expenditure should be confirmed in the annual planning template and reporting on the grant should go through the main BCF process. The money is paid directly to local government via a Local Government Act 2003 section 3 grant. The funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

4.18. Integrated Care Systems

4.19 Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

4.20 Following several years of locally led development, recommendations of NHS England and passage of the Health and Care Act (2022), 42 ICSs were established across England on a statutory basis on 1 July 2022.

4.21 What is included in an integrated care system (ICS)?

4.22 Integrated care partnership (ICP)

4.23 A statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

4.24 Integrated care board (ICB)

4.25 A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. The establishment of ICBs resulted in clinical commissioning groups (CCGs) being closed down.

4.26 Local authorities

4.27 Local authorities in the ICS area, which are responsible for social care and public health functions as well as other vital services for local people and businesses.

4.28 Place-based partnerships

4.29 Within each ICS, place-based partnerships will lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships will involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.

4.30 Provider collaboratives

4.31 Provider collaboratives will bring providers together to achieve the benefits of working at scale across multiple places and one or more ICSs, to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers.

4.32 What is the purpose of integrated care systems (ICSs)?

4.33 The purpose of ICSs is to bring partner organisations together to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

4.34 Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

4.35 Integrated Care Across Northamptonshire (iCAN) collaborative

4.36 The iCAN programme is intended to transform and improve care for our frail and elderly population and build on initiatives and in national programmes like Age Well, the Better Care Fund, Urgent Community Response, National Discharge programme and Enhanced Care in Care Homes.

4.37 Despite this progress, there remain significant opportunities to deliver better outcomes and manage demand more effectively to ensure more people stay well at home and avoid admissions to hospital where there is the potential to design and deliver better "out of hospital" services.

4.38 Whilst impacting the quality and continuity of care people receive, it also significantly affects how effectively systemwide resources are best used. Our demographic means that, without action, demand will outgrow our resources and reduce our ability to meet the standard of care we should aspire to deliver. North Northamptonshire experienced a 13.5% growth in population since the last census in 2011 in comparison to the increase seen across the East Midlands (7.7%) or England (6.6%)

4.39 Patient experience for people aged 65+ has also been varied and sometimes unsatisfactory for too long. We know we have more stranded and super stranded patients compared to other areas (with many patients in acute and community beds no longer needing to be there) and we are not maximising the opportunity to return people to independence and their normal place of residence. (a stranded patient is someone that has been in hospital for between 7 and 20 days and super-stranded 21 days +). High acute hospital occupancy is also creating significant pressure in the emergency departments when admissions are needed because of delays in supporting people to leave the hospital in well-planned ways.

4.40 All these issues have been exacerbated by either a reduction, or lack of a proportionate increase in community wellbeing and preventative support services to help people stay well at home and not using our limited resources effectively.

4.41 If we are to make sustained change, we need to formally commit to work within integrated service arrangements, exploring where pooled finances and staff working across a range of services may lead to greater benefits for people and better use of collective resources. This should mean all partners are working together in a person-centred approach, across our community and hospital pathways to improve outcomes. It will also build the foundation of future wider integrated services that shift our focus to prevention and community and enabling people to choose well, live well and stay well.

4.42 Reasons for the collaborative case for change

- The ICAN programme is a five-year transformation plan, it has already achieved some early results in our hospitals and community.

- External support ends December 2022 - we need to secure existing and new ongoing benefits from our work.

- There is now a need to move from a programme to embedding those new ways of working into business-as-usual practice and processes, by developing a service delivery model that formalises/embeds what has been achieved and creates the conditions for long term integrated working and better outcomes.

- As a multi-year programme of work, changes will be made in tranches rather than all together. In the first tranche of work, a range of out of hospital services and partners are brought together as pooled resources to develop and deliver more integrated pathways of care.

4.43 There are already a set of pooled budgets and contracted out of hospital services within the Better Care Fund (BCF) that support much of the activities in ICAN. The BCF is monitored by Health & Wellbeing Boards, subject to section 75 arrangements (pooling of resources) and has a national performance framework that aligns to ICAN.

4.44 BCF funding could be used as a foundation for future arrangements and the pooling of resources, and the current thinking is that there would be a single contract for our ICAN Tranche 1 collaborative services that holds all partners to common outcomes and improved performance to meet system and national objectives.

4.45 Additionally, the national BCF policy for 2022/23 states two objectives:

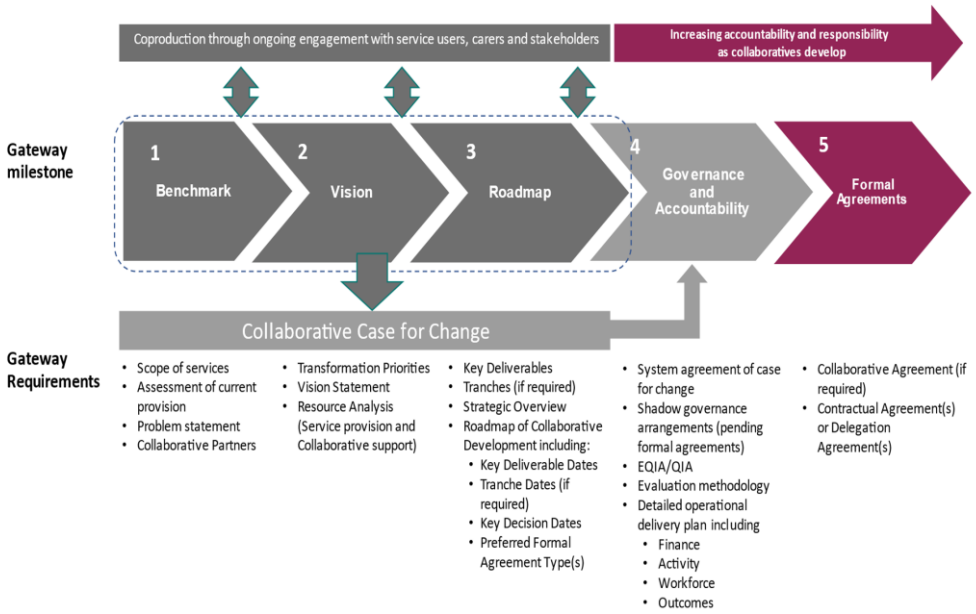
- enable people to stay well, safe, and independent at home for longer
- provide the right care in the right place at the right time

4.46 The alignment of these objectives with iCANs, the mandatory nature of the BCF S75 and the need for a formal agreement between commissioners working together to deliver the iCAN vision all suggest the use of the BCF S75 as a key vehicle for iCAN delivery. However, the current proposals within the iCAN case for change do not clearly set out how Health and Well-being Boards and elected members will maintain oversight and sign-off of the BCF returns if the iCAN Collaborative is reporting into the Integrated Care Board of which no elected councillors are members.

4.47 There is a series of collaborative development gateways for a transformation programme to pass through before they can have a delegated collaborative function as outlined below:

The iCAN collaborative development gateways (proposed)

We are seeking ICB support to move through Gateway 3 and commence work on Gatweays 4 and 5



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4.48 The operating model below provides some context as to how BCF services may align to the proposed future operating model,

iCAN proposed operating model and scope of services

The operating model will build on our ICAN work with tranche 1 including all the services from ICAN and the BCF detailed in sections 1 to 4 in the diagram to:

- create formal structures and shared ownership of pathways
- develop more trusted assessor approaches with shared referral points in hospitals and from the community
- operate integrated Pathway 1 and Pathway 2 models with shared SLAs, less handoffs and shared outcomes
- increase avoided escalations to hospitals with up services to be developed working with GPs
- develop a flexible shared workforces that can respond to surges/Winter using data to inform joint interventions
- expand ICAN pilots and integrate more prevention and wellbeing services that can help avoid escalation for e.g. falls, supporting independence
- work within the Neighbourhoods and interact with the emerging Local Area Partnerships and wider services that effect wider determinants of health

- The model excludes services commissioned through GP contracts we would develop the ICAN collaborative services working with GPs and system partners to ensure we are aligned to the future CAS/Same Day/Urgent Care strategy when agreed

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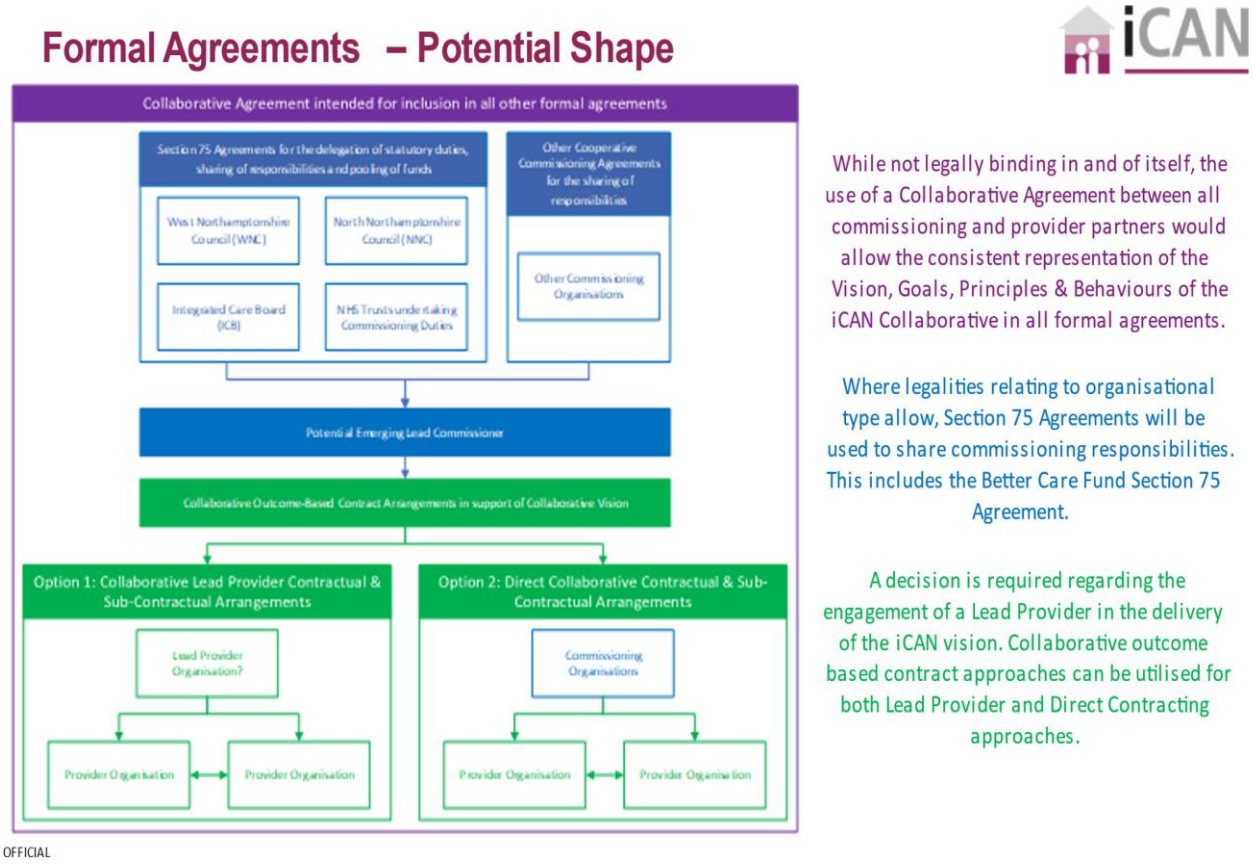
5 Issues and Choices

5.1 A decision may be required through the passage of the governance process regarding the engagement of a Lead Provider in the delivery of the iCAN vision. Collaborative outcome-based contract approaches can be utilised for both Lead Provider and Direct Contracting approaches; however, all organisations will need to be comfortable with governance, decision making and commissioning arrangements.



6. Next Steps

6.1. The timelines below represent current plans for the development of the collaborative and key steps in engagement, agreement on financials and delegated budgets and agreement on the contract construct as well as completion of the final two gateways of ICB approval before the collaborative could go live. They allow for the final scope of services to flex and change.

7. Implications (including financial implications)

7.1 Resources and Financial

7.1.1 Whilst further work is required to explore different contracting and resourcing arrangements it is not possible to fully assess any potential financial implications. However broadly speaking, current proposals are that those

services that are currently delivering on iCAN priorities could be delivered through the iCAN collaborative approach, allowing greater flexibilities in directing resources in more agile ways. This could mean a range of integrated teams or making changes to what those teams do in order to meet anticipated or un-anticipated fluctuations in demand, or potentially directing resources to other organisations to deliver targeted or universal services where appropriate.

7.1.2 Where pooling of budgets is undertaken, the Executive wishes to have sufficient confidence in the governance arrangements to ensure that spend, such as that out in the Better Care, and intended to be used for the benefit of North Northamptonshire residents has an element of protection or ring-fencing to ensure that the council is able to account for and evidence that those funds have been spent for the benefit of North Northamptonshire residents.

7.2 Legal and Governance

7.2.1 The legal context for Integrated Care Systems and the Better Care Fund are set out within various legislation. For example, the Care Act (2014), whereby closer integration and an emphasis on wellbeing and prevention run strongly throughout the legislation and guidance documentation.

7.2.2 The Health and Care Act (2022), led to the dis-establishment of Clinical Commissioning Groups (CCG), and led to the implementation of Integrated Care Systems and Integrated Care Boards from July 2022.

7.3 Risk

7.3.1 There are pressures within the local health and care system that increase risks around the deliverability of plans.

7.3.2 There are concerns that have been raised during discussions with elected members regarding financial decision making (set out in paragraph 7.1.2) and sufficiency of governance arrangement to ensure elected members are suitably sighted on decisions being made that may impact on council budgets and performance or the work of Health and Wellbeing boards.

7.4 Consideration by Executive Advisory Panel

7.4.1 The Case for Change was shared with the Health, Wellbeing and Vulnerable People EAP and comments invited to be returned by EAP members to be fed back to Executive and the Integrated Care Board.

7.5 Consideration by Scrutiny

7.5.1 Updates have been provided to Scrutiny Commission in order to ensure that the commission was sighted on direction of travel and any subsequent changes as they have occurred.

7.6 Equality Implications

7.6.1 There are no direct equality implications as a result of the production of the case for change document, however equality impact assessments will ned to be undertaken at any point that changes are made to services in order to understand the impact on groups of people with protected characteristics.

7.7 Climate and Environment Impact

7.7.1 There are no direct impacts as a result of the case for change, however where changes impact on how buildings, fleet or workforce are deployed there will be opportunities to consider the impact on the climate of those changes.

7.8 Community Impact

7.8.1 The intention of the case for change is to improve the health and wellbeing outcomes of our population. Evaluation of that impact will form a key part of how we monitor the benefits for our communities over the term of the programme.

7.9 Crime and Disorder Impact

7.9.1 None directly as a result of the case for change report

8. Background Papers

8.1 None