AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

26 SEPTEMBER 2017

REPORT OF IPC PROGRAMME MANAGER

INTEGRATED PERSONAL COMMISSIONING BRIEFING UPDATE 2017

Summary

1.1 The purpose of this report is to:

- Provide a general overview of the Integrated Personal Commissioning Programme (IPC)
- Provide an outline of the development and progress of the programme to date
- Provide recommendations to receive further updates as the programme progresses.

2 Background

2.1 The joint IPC bid was agreed by Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG), North Tees Hospital Foundation Trust (NTHFT), Stockton on Tees Borough Council (SBC) and Catalyst. It was awarded in late 2014 as a natural continuation of the development of integrated services in the Borough, through excellent and creative partnerships to ensure better health & social outcomes for all, especially those facing greater challenges than others.

2.2 The CCG and its partners have identified people aged over 65 with Long Term Conditions (LTCs) in Stockton on Tees to be the main cohort for the demonstrator programme, with an initial smaller cohort of people with respiratory conditions in particular COPD being targeted at first.

2.3 Stockton on Tees has an estimated population of over 33,000 people aged over 65 and projections from the Joint Strategic Needs Assessment suggest that there will be an additional 5,203 people over 65 in 2021. Research shows that older age is associated with an increased incidence of multiple long term conditions and a growing number of functional and cognitive impairments. It is estimated that 58% of those aged 60 and over report having a LTC with 25% of over 60s having two or more LTCs. Stockton-On-Tees has identified a cohort of approximately 7488 patients with Long Term respiratory conditions. In October 2017 the cohort was expanded to include people aged over 65 with diabetes (both type 1 and type 2) and this equates to an additional 4501 people.

3 The IPC Model

3.1 IPC is based on NHS England's "five key shifts"[1]:

1. A proactive approach to improving an individual's experience of care and preventing crises.
2. An individual will have a different conversation with the people involved in their care and will be focused on what is important to the individual.
3. A shift in control over the resources available to an individual, their carers and family.
4. A community and peer focus to build the individuals knowledge, confidence and connections.
5. A wider range of care and support options tailored to an individual's needs and preferences.

4 Programme Structure

4.1 In March 2015 representatives from the partner organisations came together for a Strategic Planning Workshop facilitated by Think Local, Act Personal (TLAP) and NHS England, to enable the development of a vision for IPC in Stockton and identified and created the governance structure (IPC Steering group). The steering group comprises of senior leaders from the key stakeholders and wider partners:

- CCG
- SBC
- Catalyst
- NTHFT
- Healthwatch
- North East Commissioning Support (NECS)
- Voluntary sector
- GPs
- NHS England Regional IPC Lead.

4.2 A project plan was devised and a programme manager appointed to oversee 5 work streams that have recently been updated in June 2017:

1.Personal Budgets
2. Community Assets
3. Communication
4. Finance.

4.3 National support has been provided from NHS England, Deloitte Touché have provided finance support, Coalition for Collaborative Care have provided a model of care support and community assets support, People Hub have supported co-production, peer network development and brokerage support and Helen Sanderson

[1] https://www.england.nhs.uk/commissioning/ipc/

Associates have provided person centred care and support planning training and support.

5 Personal Budget Work stream (formally Care Model Work stream)

5.1 The proposed model of care is based on the premise that with the right support, individuals with significant health and care needs are often better placed than statutory bodies to design and integrate their own care. The proposed care model will include personalised care and support planning, independent advocacy, peer support and brokerage with a strong emphasis on co-production and developing a personal budget process. People will be able to take as much control as they want including a clear offer of integrated personal budgets for those who will benefit.

5.2 Stockton on Tees's approach has the person at the heart of IPC; we are working to an asset based community development approach, building our care model from the bottom up from within and our initial cohort leading on the co-production.

5.3 We have a well-established co production group that consists of people with lived experience of Long Term Conditions or disability, lived experience of holding a person budget either health or social care and lived experience of caring for someone with one of the above. The group is now working closely with the work streams to test out processes, create new communication material, develop a peer support group and advise on key decisions within the development of IPC and Personal Health Budgets. Two members of the co-production are part of the National Strategic co-production group that oversees the whole of the IPC programme nationally.

5.4 Our programme is built through co-production and has effective leadership from each of the organisations involved. As our Model of Care develops, we will see cultural change both in the workforce, the way people manage their own health and wellbeing and importantly in the market, influencing commissioning processes.

5.5 We are part of the IPC National Collaborative Development Group (CDG) on Person Centred Support Planning.

Key Achievements:

- The creation of a single care plan for individuals has been a prime focus of the project in Stockton and received national recognition. A person centred 'My Voice, My Choice Care Plan' has been developed that will be integrated across both health and social care. It has currently been agreed that it will be used by GP Care Co-ordinators, adult social care, acute respiratory services, CIAT and it will be developed throughout the care pathway. We have also created an online care plan that individuals can access themselves and create their own plan and share with relevant stakeholders. We were successful in receiving £50,000 funding from the LGA/IDeA Local Investment Programme to develop an Open API system to allow the care plan to be shared through each of our IT systems.

- Clinical input has been vital to the care model development and the work stream has a strong clinical presence including primary care GP leads, respiratory physiotherapists and respiratory consultants.
- The GP clinical lead for Stockton is also leading the National Clinical Network for IPC.
- Stockton was successful in bidding for licences for the Patient Activation Measure (PAM) tool and this is now being implemented through the GP Care co-ordinators. Through the Better Care Fund we are aligning both programmes and exploring how we can implement PAM in the MDS and wider services.
- From the 1st September 2017 the Non Continuing Health Care (CHC) personal budgets is being co-ordinated by the Hartlepool and Stockton Health GP Federation (HaSH) as part of their GP care Coordinator programme.
- A co-production group has been established for people with lived experience to have a strong voice throughout the development of IPC.

6 Community Assets Work stream

6.1 An integral part of IPC is the development of community assets and the development of co-production throughout the programme.

6.2 We are part of the IPC National Collaborative Development Group (CDG) on Community Capacity and Co-Production including taking the role of Co-Chair of the group.

Key Achievements;

- A mapping of the VCSE sector has been undertaken to identify gaps in support for the IPC cohort and also to undertake an early market development scoping with the sector.
- Peer support groups for people with respiratory conditions and diabetes have been developed with VCSE organisations and North Tees and Hartlepool Foundation Trust. Funding has been identified to support the implementation of these groups initially with an expectation that this will become self-funded with the use of personal budgets.

7 Communication Work stream

7.1 A communication plan has been developed through the steering group. The initial key focus was to provide key stakeholders and partners with the developments, progress and challenges within IPC. This focus has now widened to also include how we communicate IPC to the wider workforce and public domains.

Key Achievements:

- A stakeholder e-bulletin is issued on a fortnightly basis to keep stakeholders informed of the progress, development and challenges of IPC.
- The communications working group, in collaboration with the co-production group are re-designing the original marketing materials that were created at the start of the programme. The branding ‘My Voice, My Choice’ was created as the name for IPC in Stockton on Tees.

- The co-production group of service users has designed new literature to improve the understanding of IPC and the language used. This will aid understanding of the IPC concept, processes and implementation as IPC evolves and how this is communicated with the wider community, highlighting again the importance of the partnership approach being taken in Stockton on Tees.
- A 'My Voice, My Choice' website has been created with information available for individuals to find out more about IPC and PHBs.
- A video explaining IPC has been created to explain what it is and also depicts the impact on the wider workforce and how this has changed the ways in which frontline staff work to become more person centred. The video shows how IPC gives patients more choice, thus creating better outcomes for people. This video is available to view on the 'My Voice, My Choice' website.
- A video documenting the success of the Nesta 100 Day Challenge has also been created to share with wider partners about the impact of IPC/PHBs on the wider system. The video was recently shared at the NHS Expo in Manchester in September. The Stockton IPC programme manager presented at the Expo in two sessions, one focused on co-production and the success of the group in Stockton and the second session was delivered with James Sanderson – Director of Personalised Care, NHS England on Integration and the impact of the 100 Day Challenge on the wider system in Stockton on Tees.
- The Stockton on Tees IPC programme is held nationally as one of the pioneers in delivering IPC and due to this we are asked to speak nationally about our work in Stockton. In the past year we have delivered sessions at the NHS Expo, Nesta National Healthcare Conference, Regional and National Personal Health Budgets Networking meetings, HFMA (Healthcare Financial Management Association) Conference and national IPC meetings.

8 Finance Work stream

8.1 Current financial models can tend to reward NHS and social care for activity and crisis services. The IPC model builds on existing national and local development work on new financial models, for example the long term conditions year of care early implementer programme, and NHS England and Monitor payment innovation sites. The IPC programme has significantly widened this activity to include local authority services, and substantially accelerate its use. It will also consider the inclusion of all NHS spend including specialised commissioning.

8.2 The IPC financial model attempts to shift incentives towards prevention and coordination of care, by testing an integrated capitated payment approach. The

attraction of a capitated payment is that it can align financial accountability and the outcomes that matter to people.

8.3 The IPC financial model aims to remove existing financial barriers to prevention and integration, by aligning the two personal budget systems (health and social care) and make integrated budgets possible. However, financial risk will continue to be pooled across individuals and populations by commissioners so no individual service user would face an arbitrary cap on the unplanned service they needed. Most importantly the overall IPC approach will focus on what works for individuals, their families and their carers – not what works best for existing systems and institutions.

8.4 As part of the national IPC programme and recognition as an innovative site Stockton on Tees was asked by the national Project Board to work with Deloittes Touché on the development of the national finance model. This work has been completed and the model is being rolled out at national level so that all sites can develop their individual approach to integrating social care and health care spend and creating a linked data set.

8.5 We are part of the IPC National Collaborative Development Group (CDG) on Cohort Identification and Person-level costing.

Key Achievements:

- We have developed information sharing agreements with all partners and they are all in place in order to develop the finance model. We have also developed information sharing agreements for patients who have a care plan in order to 'track' and monitor the financial impact of their care pan and personal budget.
- A linked data set has been created for acute services, continuing health care, community services and mental health and sample data is being used for primary care and social care.
- Nationally we have been recognised for our work in overcoming Information governance and we are the only demonstrator site to locally try to solve some of these issues. We were successful in an application to NHS Digital to link health and social care data using pseudonymisation software that we have tested. We were the first IPC site to achieve this and subsequently have supported several other sites to start this process.
- We are working closely with providers to explore costing pathways and where services can be reformed to respond to demand and adapted to meet the cohort's needs and outcomes.
- We have had preliminary meetings between NHS England, the CCG and North Tees and Hartlepool Foundation Trust to release some funding from the respiratory contract to finance personal health budgets.

9 Measuring the Change

9.1 The National IPC Evaluation team have supported us around measuring the outcomes of IPC and have created three evaluation metrics. We have quarterly structured conversations with the National IPC team where we measure 'enabler' metrics as part of IPC. In addition to this on a monthly basis 'activity' metrics are submitted to NHS

England and most recently ‘outcome’ metrics. The National evaluation team have worked closely with Stockton on Tees to be the first site to pilot the implementation of the ‘outcome’ metrics.

10 NESTA 100 Day Challenge

10.1 The Stockton on Tees demonstrator site was approached by NHS England to be part of a radical transformation programme delivered by NESTA.
The National IPC team requested that two sites work with NESTA on an intense programme of work to look at integrating frontline teams and to challenge how we can deliver IPC at scale. Stockton on Tees was chosen as the only site to take part in this due to our commitment to IPC but also due to us being the site furthest ahead nationally in our model maturity in developing and delivering IPC.

10.2 This challenge has enabled us to again align IPC and BCF together to address integration across the over 65s with a particular focus on LTCs, frailty and the Discharge to Assess Model.

10.3 A Leadership team was established that worked closely with the support team from Nesta and NHS England to set the learning agenda for the challenge.

10.4 The challenge mobilised three teams of frontline staff across community and hospital settings. Teams were challenged to rapidly implement IPC across their areas – based on the key themes of IPC mentioned earlier – with explicit permission from leadership to adopt an experimentation mind-set – rapidly adopting and adapting ways of working to improve outcomes for older people.

10.5 The teams quickly stepped into action, testing a whole range of ideas in people’s homes, in community settings, in primary care and in hospital settings to support people at different points in their journey. The dedication from the teams was exceptional and demonstrated a new way of implementing transformational; change.

10.6 Early Results from the challenge were promising.

From an individual, system and outcomes perspective:

- Developing a system-wide consistent approach to personalised care and support planning
- Almost 300 care plans completed over 100 days
- Over 100 new referrals and connections to community groups and services
- Over 40 new multi-disciplinary team meetings held
- 40 out-of-hours sessions run focused on admission avoidance

- 41% reduction in A&E attendance, and 19% reduction in one day admissions from an urban-based team
- 35% reduction in DTOC across the hospital (combined with other efforts).

10.7 The full Nesta 100 Day Challenge Sustainability review is included in Apppendix A

11 Challenges

11.1 'Scaling up' IPC

Health and social care integration is a key focus both locally and nationally and IPC provides the operating framework to lead on this and deliver quality person centred care. It provides a framework to align integration programmes such as the Better care Fund and new models of care. It is a challenging process that requires strong relationships, investment, resource and flexibility from all partners.

In order for us to 'scale up' to our ambitious targets of achieving over 2000 care plans and 400 budgets (either individual personal health budgets or integrated budgets) we need to prioritise IPC locally and ensure that we continue to make effective progress.

11.2 The National IPC demonstrator programme ends in March 2018 and the National team will be starting to have local conversations to discuss how IPC can be scaled up across Sustainability and Transformation Partnerships (STPs) and Accountable Care Systems (ACSs).

12 Next Steps

12.1 Each of the work streams are reviewing their action plans and the steering group is reviewing the overall action plan in order to develop the programme through the next phase.

12.2 The programme team is working closely with both the regional lead and national team from NHSE in order to progress within IPC and to plan what will happen post March 2018.

13 Recommendation

13.1 The HWBB is asked to receive further updates over the life time of the project.

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