Warwickshire Health and Wellbeing Board

Agenda

6 July 2016

A meeting of the Warwickshire Health and Wellbeing Board will take place at **Shire Hall, Warwick** on **Wednesday 6 July 2016 at 13:30.**

The agenda will be:-

1. (13.30 – 13.35) General

(1) Apologies for Absence

(2) Appointment of Board Members
To note the following appointments to the Board:

Councillor Barry Longden (Nuneaton and Bedworth BC)
Councillor Leigh Hunt (Rugby BC)
Philip Seccombe (Police and Crime Commissioner)

(3) Members' Disclosures of Pecuniary and Non-Pecuniary Interests.

Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. A member attending a meeting where a matter arises in which s/he has a disclosable pecuniary interest must (unless s/he has a dispensation):

- Declare the interest if s/he has not already registered it;
- Not participate in any discussion or vote;
- Must leave the meeting room until the matter has been dealt with (Standing Order 43); and
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests must still be declared in accordance with the new Code of Conduct. These should be declared at the commencement of the meeting.

(4) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 11 May 2016 and Matters Arising.

Draft minutes of the meeting are attached for approval.

2. (13.35 – 14.00) Multi Agency Safeguarding Hub (MASH)

John Coleman

3. (14.00– 14.30) Coventry & Warwickshire Sustainability and Transformation Plan (STP)

Andy Hardy

4. (14.30 – 14.45) Coventry & Warwickshire Health & Wellbeing Alliance Concordat

Chris Lewington

5. (14.45 – 15.00) LGA Integration Tool

Gereint Stoneman

6. (15.00 – 15.15) North Warwickshire Borough Council Health and Wellbeing Working Party

Jerry Hutchinson

7. (15.15 – 15.45) Warwickshire Health & Wellbeing System Development

Gereint Stoneman

8. (15.45 – 16.00) Meeting Schedule & Work Programme

Gereint Stoneman

9. Any other Business (considered urgent by the Chair)

Further Information, Future Meetings and Events:

- Health and Wellbeing Board Newsletter
  http://hwb.warwickshire.gov.uk/about-hwbb/newsletters/
- Healthwatch Newsletter
  http://www.healthwatchwarwickshire.co.uk/?page_id=237

Health and Wellbeing Board Membership

Chair: Councillor Izzi Seccombe (Warwickshire County Council)

Warwickshire County Councillors: Councillor John Beaumont, Councillor Les Caborn, Councillor Jose Compton.

Warwickshire County Council Officers: John Dixon – Interim Strategic Director, People Group, John Linnane - Director of Public Health

Clinical Commissioning Groups: Deryth Stevens (Warwickshire North), David Spraggett (South Warwickshire), Adrian Canale-Parola (Coventry and Rugby) (Vice Chair)

Provider Representatives
Andy Meehan (University Hospital Coventry & Warwickshire), Russell Hardy (South Warwickshire NHS Foundation Trust), Jagtar Singh (Coventry & Warwickshire Partnership Trust), Stuart Annan (George Eliot Hospital NHS Trust)

Healthwatch Warwickshire: Phil Robson

NHS England: David Williams.

Police and Crime Commissioner: Philip Seccombe

Borough/District Councillors: Councillor Barry Longden (NBBC), Councillor Leigh Hunt (RBC), Councillor Moira-Ann Grainger (WDC), Councillor Margaret Bell (NWBC), Councillor Mike Brain (SDC)

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E-mail: paulspencer@warwickshire.gov.uk
All public papers are available at www.warwickshire.gov.uk/cmis

Minutes of the Meeting of the Warwickshire Health and Wellbeing Board held on 11 May 2016

Present:-

Chair
Councillor Izzi Seccombe

Warwickshire County Councillors
Councillor John Beaumont
Councillor Les Caborn
Councillor Jose Compton

Warwickshire County Council Officers
John Dixon (Interim Director for the People Group)
Dr John Linnane (Director of Public Health)

Clinical Commissioning Groups (CCG)
Dr David Spraggett (South Warwickshire CCG)
Dr Deryth Stevens (Warwickshire North CCG)

Provider Representatives
Stuart Annan (George Eliot Hospital NHS Trust)
Russell Hardy (South Warwickshire NHS Foundation Trust)
Simon Gilby (Coventry & Warwickshire Partnership Trust)

Healthwatch Warwickshire
Phil Robson (Chair)

NHS England
David Williams

Borough/District Councillors
Councillor Margaret Bell (North Warwickshire Borough Council)
Councillor Mike Brain (Stratford District Council)
Marianne Rolfe (Warwick District Council)

1. (1) Apologies for Absence

Dr Adrian Canale-Parola (Vice Chair) (Coventry and Rugby CCG)
Andy Meehan (University Hospitals Coventry & Warwickshire)
Councillor Neil Phillips (Nuneaton and Bedworth Borough Council)
Councillor Derek Poole (Rugby Borough Council)
Councillor Moira-Ann Grainger (Warwick District Council)
Jagtar Singh (Coventry & Warwickshire Partnership Trust)

(2) Appointment of Board Members

The Board approved the appointment Councillor Mike Brain as the representative for Stratford District Council and the Chair welcomed him to the meeting.

(3) Members' Declarations of Pecuniary and Non-Pecuniary Interests

Councillor Margaret Bell declared a non-pecuniary interest, as a member of the County Council's Adult Social Care and Health Overview and Scrutiny Committee.

(4) Minutes of the meeting held on 20 January 2016 and matters arising.

The Minutes were agreed as a true record.

2. Report on the Integration Summit and Concordat

The Chair introduced this item, speaking about the well-attended Integration Summit held on 7-8 April and the decision sought at this meeting regarding the Concordat. A key theme from the two days was the need to work closely with Coventry and she had made contact with the new leader of that Authority.

Chris Lewington, Head of Strategic Commissioning at WCC took members through the circulated report and appended photobook of the Integration Summit. The event had been supported by the Kings Fund. From it emerged three priority areas, being frailty, workforce and communities. The Health and Wellbeing Board (HWBB) needed to retain a focus on children's services also.

A key piece of work was the Alliance Concordat, which set out a vision and principles of how the health and care system, with wider partners, would work together. Discussions were taking place with officers at Coventry City Council, to coordinate a joint HWBB meeting in June, to progress jointly the Sustainability Transformation Plans.

An area for debate on the Concordat concerned its principles and specifically a proposed change to the principle 'we will only take decisions that impact on other parts of the system after consultation' where the word consultation would replace agreement. Approval was sought to the Concordat, so it could be communicated to the workforce of each organisation.

There was praise from Board members about the integration summit and the progress made. Differing views were stated on the wording change proposed, with one Board member feeling this change undermined the good work at the summit. The need for trust amongst organisations was stated. A member referred to the financial saving requirement of £200 million. He was surprised that this had not been reflected in the report before the Board and was concerned that the saving requirement may affect future cooperation. John Dixon, Interim Director for the People Group, WCC responded to the points raised, assuring that the financial aspects had been discussed at length. All partners had savings targets, but would need to work together and take a 'whole system' approach.

Another view was the need to focus on communities, community resilience and integration, rather than just the financial savings. The priorities could be made clearer in the Concordat and minor changes were agreed to list the priorities under the principles.

It was acknowledged that the financial envelope would dictate service provision, but there was also a clinical argument for change, which would come through the Sustainability Transformation Plan. Others echoed the need for working together in different ways and a good example of this was the recent launch of the Multi Agency Safeguarding Hub, which had brought together a number of agencies, to work on safeguarding cases.

The Chair reiterated the importance of working with Coventry and securing their involvement in this process. She reminded of the planned joint HWBB meeting in June.

Chris Lewington pursued the points about partnership working and relationships, building trust and dealing with complex and/or difficult issues. The need for strategic discussions in between the formal Board meetings was suggested. The Chair felt this would be a useful mechanism to build the relationship with Coventry as well.

Resolved

1. That the Health and Wellbeing Board endorses and approves the Coventry & Warwickshire Alliance Concordat, subject to the minor changes agreed above and that a copy of the revised Concordat is circulated to all Board members.

2. That the Health and Wellbeing Board supports the merger of the three priorities; Workforce, Communities and Frailty, from the Integration Summit event with the work streams of the Sustainability and Transformation Plan.

3. That the Health and Wellbeing Boards for Coventry & Warwickshire hold a joint meeting in June to:
    a) approve the Alliance Concordat
    b) to comment and approve on the STP plan before submission and
    c) to agree further opportunities to meet as joint Boards.

3. Better Care Fund 2016/17 Submission

Chris Lewington gave a presentation to the Board on the Better Together submission 2016/17. This reported the elements of the Better Care Fund Policy Guidance and Policy Framework, national conditions and the assurance timetable. It was emphasised that there had been a tight timescale for the completion of the first phase. Headlines of the first submission were reported. A new area for this year was the housing work stream, with Disabled Facility Grants (DFGs) being included for the provision of adaptations to people's homes, to help them to live independently. Key projects for 2016 were reported. Given the complexity of the plans, delegated authority was sought to approve the final submissions. It was suggested that this be through the Board's Senior Responsible Officer, in liaison with the Chair of the Board.

A Board member referred to a case of delayed discharge from hospital and questioned whether DFG funding would help to resolve such cases, where the delay was due to the property not being adapted to meet the resident's needs. The specific case could be discussed outside the meeting, but it was a felt the DFG funding was positive. Agreeing a protocol to streamline processes and ensuring works took place in a timely manner before discharge were further points.

Resolved

That completion of the Better Care Fund submission is delegated to the Board's Senior Responsible Officer, in liaison with the Chair of the Board via a Sub-Committee decision.

4. End of Life Care Review and Improvement Plan

Bernie Lee, Locum Consultant in Public Health, WCC presented this item. She explained that there would be increased pressure on End of Life Care (EoLC) services across Warwickshire as a consequence of predicted demographic changes and the sustained increase in long-term conditions, including dementia.

An EoLC review and improvement plan were submitted for the Board's consideration. The covering report provided a context for these documents, outlined the process undertaken in developing them and summarised the actions required to secure longer-term improvements in EoLC across Warwickshire.

By way of background, it was explained that EoLC was provided for people with an incurable illness who were approaching death, through a range of formal and informal support mechanisms. Currently there were over 5000 deaths in Warwickshire each year, but nationally a 17% per annum increase was projected. Over recent years, there had been numerous national reviews, strategies, guidance and policies aimed at improving EoLC.

The detail of the report focussed on the following areas:

- Evidence in Relation to EoLC Outcomes
- Review: Content and Process
- Overview of Review Findings
- Improvement plan: Content and Process
- Feedback Received Through Public Engagement
- Issues in Finalising the Plan

It was stated that EoLC was not an entity in itself. It required the involvement of a broad spectrum of professionals, not just clinicians, particularly in the final six months of a person's life. Aspects for GPs and hospitals were discussed, particularly that conversations with a patient about their death and also with the patient's family members could be improved. Making better use of digital technology, particularly in rural areas was suggested. This could give more patient choice over their palliative care arrangements. The document and commitment to providing good EoLC was welcomed. It would now be for the HWBB to monitor delivery and was requested that this be moved forward by the Executive Officer Group.

Resolved

That the Health and Wellbeing Board accepts the End of Life Care review findings and endorses the Improvement Plan.

5. Update on the Sustainability Transformation Plans

Gillian Entwistle, Chief Officer for South Warwickshire CCG gave a presentation on the Coventry and Warwickshire System Transformation Plan. Initially, she explained the NHS shared planning guidance and gave an outline of Sustainability Transformation Plans (STPs). These would be delivered by local health and care systems or 'footprints', effectively through organisations working together to deliver transformation and sustainability. Slides explained how the 'footprints', of which there were 44 nationally, were formed. Maps showed the national arrangements and that for the Midlands and East Region, in which the Coventry and Warwickshire STP was included. Further slides showed the partners involved in the STP, the governance arrangements and the purpose of the STP. This was known as the Triple Aim and concerned the health and wellbeing gap, the care and quality gap and the finance and efficiency gap. The presentation concluded with slides on priority setting, the main project areas and timeline for submission of the STP.

Members asked about cross-border arrangements for care. These issues were managed by the clinical commissioning groups. With regard to the slide on main project areas, it was noted that there was no reference to local authority involvement. Gillian Entwistle clarified that Chris Lewington of WCC would be involved in the Out of Hospital project area.

Resolved

That the Health and Wellbeing Board receives the presentation.

6. Report of the Health and Wellbeing Executive Team

John Dixon provided a verbal update on the work of the Health and Wellbeing Executive Team. Its next meeting would take place on 12 May. A workshop had been held on systems leadership, with a focus on End of Life Care. The next meeting would consider the outcomes from the Integration Summit. A further key area was progressing joint work with Coventry on which the future of the Sustainability Transformation Plan was heavily reliant.

Councillor Compton asked the Executive Team to consider an issue raised through the County's Adult Social Care and Health Overview and Scrutiny Committee. This concerned ambulance service response times for Rugby as compared to the rest of Warwickshire. David Williams of NHS England similarly offered to provide data on this.

It was questioned who the Stratford District Council representative on the Executive Team would be, following the retirement of Paul Lankester. This would be researched.

7. Health and Wellbeing Easy Read Publication

Dr John Linnane, Director of Public Health presented this item. He advised that part of the communications plan for the Health and Wellbeing Strategy was to engage with a wide range of groups. Feedback had been received that the full Strategy was not easy to understand. This had led to the production of an easy ready summary on which the Board's approval was sought. It would then be publicised via the Health and Wellbeing newsletter, which had a circulation of over 600 people.

Resolved

That the Health and Wellbeing Board approves the easy read summary for publication.

8. Healthwatch Priorities 2016/17

Phil Robson, Chair of Healthwatch Warwickshire (HWW) presented the organisation's priorities for 2016/17. He explained the process undertaken to formulate the priorities. This comprised a workshop involving volunteers, staff and directors, using a structured discussion and scoring. The HWW priorities for 2016/17 were confirmed as:

- End of Life Care
- Mental Health Services
- Cancer Services
- Domiciliary Care Services
- Care in the Community Assessments

The importance of the public's feedback was recognised to shape all services.

Resolved

That the Health and Wellbeing Board receives the presentation on the 2016/17 priorities of Healthwatch Warwickshire.

9. Forward Plan

The Board reviewed its Forward Plan, which detailed the dates for agenda items and proposed development sessions.

Resolved

That the Board approves its updated Forward Plan.

10. Any Other Business

The Chair reported back on the healthy living pharmacy summit led by Public Health, which she had attended. It had been questioned why the Health and Wellbeing

Board's membership did not include a pharmacy representative. The Chair asked Board members to consider this suggestion and that it be discussed further at a future meeting.

The meeting rose at 3.45pm

……..Chair

Item 2

MASH
Warwickshire
Multi Agency
Safeguarding Hub

People in Warwickshire are safeguarded from harm, receiving the services they need, at the right time, effectively and efficiently.

Report for Health & Wellbeing Board

27th June 2016

Health Economy Contribution to the MASH

Summary:

This paper provides a summary of the current position regarding the health contribution towards the Warwickshire MASH.

Recommendation:

Members of the Health & Wellbeing Board are asked to:

i. Consider the issues raised and request Chief Officer's across CCG's, Public Health and Providers work together to establish an urgent solution to ensure health representation within the MASH.

1. Background

1.1 Warwickshire's Multi-agency Safeguarding Hub (MASH) provides a single front door for the assessment and initial planning of safeguarding services for Warwickshire's residents. The assessment of such a referral requires lateral checking between agencies to ensure a full picture of the person's needs are understood in order to develop the most effective of plans to reduce risk. Many referrals to the MASH for safeguarding will result in the provision of an early help provision as the threshold for safeguarding purposes is not met.

1.2 The Multi-Agency Safeguarding Hub (MASH) has been a multi-agency project in development over the last two years. Health, Police and County Council are the three key partners within the project as each have a statutory responsibility to share the information it holds on children, young people and adults known to the service in order to safeguard them. An initial scoping paper was completed in June 2014 and from April 2015 a multi-agency strategic group

including members from public health and CCG's have met monthly to establish and review progress of the MASH. In addition, seven additional work streams were established and were well represented by safeguarding leads for children and adults from across health providers.

1.3 In May 2015 Lesley Tregear was appointed as MASH Implementation Manager by the Strategic Board who remained in post until March 2016; when John Coleman, MASH Service Manager was appointed. Both have worked with representatives from across the health economy to seek agreement regarding the contribution from health but unfortunately no solution has been reached to date.

1.4 In September 2015, the MASH Strategic Board noted that meetings had been held with Chief Officers in CCG's and Providers by Lesley Tregear and John Linnane to formalise engagement. Shortly afterwards it was noted that Rebecca Bartholomew, Director of Quality, Safety and Personalised Care from North Warwickshire CCG would represent all three CCG's at the Strategic Board. Dr John Linnane was already attending as Director of Public Health.

1.5 Initially in November 2016 the project established that the MASH model required six nurses and one senior nurse. However, in March 2016 it was agreed by John Coleman, Service Manager that one health decision maker for the children's pathway, a health decision maker from mental health services for the adults pathway and one business support officer to support in the gathering of information would be sufficient.

2. Action taken to reach a solution

2.1 In April 2016, the CCG's requested that providers establish a solution in order for there to be MASH representation in the MASH and a further meeting was held in May 2016. However, these have not produced a solution. Providers commissioned by Public Health have offered to provide virtual arrangements to the MASH. These have been established in the interim until there is an agreement across the health community on funding.

2.2 On 5th May 2016. Warwickshire Safeguarding Children's Board raised serious concerns and felt the situation as most unsatisfactory that no solution had been received. In addition John Dixon on the same date had already written on behalf of the MASH Strategic Board to Chief Officers across health requesting a solution is found.

2.3 A number of meetings have been undertaken with representatives from health including commissioners and providers. Within the CCG's several meetings have been held with one another and providers. Presentations have been undertaken and information provided outlining the benefits for health specifically and a draft role and responsibilities for health representation has been produced.

2.4 Recently CCG's have also requested funding from NHS England but this was not successful.

3. Benefits and Risk Analysis

3.1 There are some very clear benefits of the MASH to improve outcomes for children and adults who require safeguarding intervention. These include:

- Professionals and agencies being co-located,
- Sharing information and triangulation of information
- Consistency in threshold
- Co-ordinated and integrated intervention
- Closes the feedback loop
- Prevention of duplication
- Identify emerging problems. Allows early help to be provided before issues escalate.
- Stops failure demand across all organisation (Featherstone et al 2014)
- Develops a wider approach to risk harm and needs. (Wardell 2015)
- Improvement in intelligence leads to a reduction in repeat referrals and a better understanding of histories and patterns of behaviour. (Home Office 2014)
- Address identification of best practice (Munro 2012).

3.2 In addition, for the health economy one of the key factors is the improvement in communicating information. This has been identified as one of the most prominent factors for health professionals from research completed in other multi-agency safeguarding hubs. This is important as there is a relatively small number of referrals made to safeguarding services from some areas of health such as GP's. This is an issue across the UK, not just in Warwickshire. However, the research identifies that health professionals are more likely to share information with other health colleagues, rather than none health professionals. In other multi-agency safeguarding hubs; research has indicated increased referrals from health professionals and more timely information sharing when there is representation from health within the safeguarding hub.

4. Summary and Recommendation

4.1 The vison of the MASH is: 'People in Warwickshire are safeguarded from harm, receiving the services they need, at the right time, effectively and efficiently.' It is vital that the MASH have a contribution from the health economy to fulfil this vision. It is clear that representatives from health are committed to the MASH and want a solution to be obtained but to date a solution has not been achieved. Without a representative in the MASH who is able to contribute information and be involved in the decision making process; its future success and realising the full benefits will always be limited if this is not achieved.

4.2 Members of the Health & Wellbeing Board are asked to consider the issues raised within this report and request Chief Officers across CCG's Public Health and Providers work together to establish an urgent solution to ensure health representation is provided within the MASH.

John Coleman, MASH Service Manager, 27th June 2016

Item 3

Health & Wellbeing Board

6 July 2016

Coventry & Warwickshire Sustainability and Transformation Plan

Recommendation(s)

1. The Health and Wellbeing Board consider the development of the Sustainability and Transformation Plan (STP) for Coventry and Warwickshire.

2. The Health and Wellbeing Board acknowledges the importance of the Warwickshire and Coventry Health and Wellbeing Boards and their full engagement in developing an effective STP for the area.

1.0 Key Issues

1.1 Following issue of NHS guidance in December 2015, every health and care system in England is required to produce a multi-year Sustainability and Transformation Plan (STP).

1.2 The STP will show how services across Coventry and Warwickshire will evolve and become sustainable over the next five years – ultimately delivering the *Five Year Forward View* vision of better health, better patient care and improved NHS efficiency.

1.3 The Health and Wellbeing Board and wider system will have a key role in both developing and delivering the outcomes of the STP.

2.0 Options and Proposal

2.1 On 6 July the Board will consider a presentation from Andy Hardy, Chief Officer, UHCW on the development of the Coventry and Warwickshire STP, covering background, progress, content and timescales.

3.0 Timescales associated with the decision and next steps

N/a

Background papers

None

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The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: None

Item 4

Health and Wellbeing Board

6 July 2016

Coventry and Warwickshire Alliance Concordat

Recommendation(s)

1. The Health and Wellbeing Board note and support the involvement of Coventry Health and Wellbeing Board in developing the Concordat and approve the updated version and next steps.

1.0 Key Issues

1.1 Following the Integration Summit held in April 2016, the Coventry and Warwickshire Alliance Concordat was developed.

1.2 This was endorsed by the Health and Wellbeing Board on 11 May 2016 and a commitment made to pursue alignment with Coventry's Health and Wellbeing Board and the emerging Sustainability and Transformation Plan (STP).

2.0 Options and Proposal

2.1 Following discussion with colleagues, the Coventry Health and Wellbeing Board will formally consider the Concordat at their meeting of 27th June 2016. Minor amendments have been made to this version and the joint version is presented to the Warwickshire Board today.

3.0 Timescales associated with the decision and next steps

3.1 Subject to approval, a formal signing of the Concordat is scheduled for mid-July.

3.2 An Executive Group meeting will follow this and look to explore what is needed to translate the commitment of the Concordat into practical action. This will incorporate consideration of the Sustainability and Transformation Plan (STP).

3.3 The Executive Group meeting will inform a follow up session to the Integration Summit in October 2016 with facilitation from the Kings Fund.

Background papers

None

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The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: None

COVENTRY & WARWICKSHIRE

Appendix

Health & Wellbeing Alliance Concordat

We will do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people and communities at the heart of everything that we do.

We will share responsibility to transform our services whilst making over £500m savings and efficiencies across Coventry and Warwickshire over the next five years.

PRINCIPLES

- ***We will*** be bold, brave and challenging in the service of the people of Coventry and Warwickshire.
- ***We will*** align, share and pool resources, budgets and accountabilities where it improves outcomes for the public.
- ***We will*** focus on benefits to the public as a whole rather than organisational interests.
- ***We will*** only take decisions that impact on other parts of the system after consultation.
- ***We will*** streamline system governance to enable decisions to be taken at scale and pace.
- ***We will*** design a system that is easy for everyone to understand and use.

To achieve this we will work in alliance with each other operating with mutual respect and mutual accountability.

Item 5

Health and Wellbeing Board

6 July 2016

LGA Integration Tool

Recommendation(s)

1. The Health and Wellbeing Board approve the piloting of the LGA integration tool in September 2016, as part of the next steps to the Coventry and Warwickshire Alliance Concordat.

1.0 Key Issues

1.1 Warwickshire has been presented with the opportunity to pilot the LGA's new tool for assessing levels of integration within health and wellbeing systems.

1.2 The tool has been developed to support the recently published 'Stepping up to the place document, which has been collectively produced by the Local Government Association, NHS confederation and Association of Directors of Adult Social Services.

1.3 The report itself is attached in Appendix 'A'. In support of the concordat, the Health and Wellbeing Board are particularly recommended to consider Section 3 and the sections *'What do we need to make integration happen?'* and '*Questions for local and national leaders*'.

1.4 This is a very timely opportunity which builds upon the findings of the LGA Peer review conducted in 2015 and the Integration Summit held in April 2016.

2.0 Options and Proposal

2.1 The self-assessment tool is for Health and Wellbeing Boards and place-based local health and care systems wishing to improve their capability to integrate health and care services. The tool offers an opportunity to self-assess the present state of readiness across the key elements and characteristics needed for success and to identify areas for improvement

2.2 It is felt this will provide the Warwickshire Health and Wellbeing Board with a detailed understanding of the current level of integration and an objective baseline from which system development can then be measured.

3.0 Timescales associated with the decision and next steps

3.1 The tool will be launched at the LGA conference on 6 July and embargoed until this time. Copies will however be shared with Board members at the meeting of the same day.

3.2 Deployment of the self-assessment tool will require a section of interviews and a facilitated workshop session in October 2016.

Background papers

None

	Name	**Contact Information**
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Portfolio Holder	Cll Jose Compton Cllr Les Caborn	cllrcompton@warwickshire.gov.uk cllrcaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: None

Item 6

Health and Wellbeing Board

6 July 2016

North Warwickshire Health and Wellbeing Working Party

Recommendation(s)

1. The Health and Wellbeing Board commend and support the approach being taken to Health and Wellbeing by North Warwickshire Borough Council.

1.0 Key Issues

1.1 The attached Appendix, comprising Terms of Reference and first set of minutes, shows the approach being taken to Health and Wellbeing within North Warwickshire Borough Council through the establishment of a dedicated working party.

2.0 Options and Proposal

N/a

3.0 Timescales associated with the decision and next steps

N/a

Background papers

None

	Name	Contact Information
Report Author	Gereint Stoneman	gereintstoneman@warwickshire.gov.uk Tel. 01926 742814
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Portfolio Holder	Cll Jose Compton Cllr Les Caborn	cllrcompton@warwickshire.gov.uk cllrcaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: None

Health and Wellbeing Working Party
Terms of Reference
(March 2016)

Purpose

The Health and Well-being Working Party is established to identify and structure the corporate contribution to the health and well-being agenda.

The Working Party will bring focus and co-ordination to health improvement activity across North Warwickshire.

Aims

1. To map and monitor health improvement activity across the Borough
2. To influence the development of health and well-being policy and strategy and to ensure equitable access to services for local residents
3. To work with partners, including the Clinical Commissioning Group and Public Health, to identify the key health issues in North Warwickshire and, thereafter, to explore opportunities to secure external funding support for undertakings designed to positively address these issues
4. To scrutinise health-related Borough Council activity
5. To monitor implementation of the North Warwickshire Health Improvement Action Plan, 2016 / 17
6. To develop a Corporate North Warwickshire Health Improvement Action Plan for 2017 to 2020, taking in to account the priorities of the Corporate Plan, the Sustainable Community Strategy, Warwickshire Health and Well-being Strategy, 2014 to 2018, and other relevant plans and documents
7. To respond to relevant health-related consultations on behalf of the Borough Council, to receive reports from, and submit questions to, external organisations to promote understanding of, and improve services that address, the health needs of North Warwickshire residents. These organisations will include, but not be limited to, the County Health and Well-being Board, the County Health Scrutiny Board, Health Portfolio Holder meetings and the Warwickshire North Health and Well-being Partnership
8. To determine how allocated health and well-being monies are spent

Membership

1. The Working Party shall consist of:
    a. Spokesperson and Shadow Spokesperson for Health, Well-being and Leisure
    b. Chairman of the Community and Environment Board
2. Non-members will be invited to the Working Party where expert advice is required

Review

On an annual basis, the Working Party will review the focus and value of its work.

Working Party Meetings

1. Meetings will take place once per Board cycle in advance of the Community and Environment Board. *(*Thursday's 10:00am approximately four weeks in advance of the Board).*
2. Meetings will be will be chaired by the Health, Well-being and Leisure Portfolio Holder and will be organised by the Leisure and Community Development Division
3. Agenda items will be set by the Working Party and / or the Community and Environment Board
4. The notes of each meeting will be reported to the Community and Environment Board

Health and Well-being Working Party
12 April 2016

Minutes

Present	Cllr Bell (Chairman), Cllr Chambers
	Rachel Robinson (WCC), Simon Powell, Jaki Douglas and Becky Evans were also in attendance
Apologies for Absence	Cllr Smith

Item	Notes	Action
3	**Terms of Reference** The Terms of Reference for the Working Party had been agreed by the Community and Environment Board at its meeting held on 14 March 2016. The Working Party agreed to send a letter to the Warwickshire Health and Wellbeing Board, the Adult Social Care and Health Overview Scrutiny Committee and the Warwickshire North Health and Wellbeing Partnership, to inform them of the establishment of the Working Party and its remit.	SNP
5	**Health Funding** The Working Party discussed the various sources of funding that were known to be available to support local health-related activity, as follows: • Borough Council Health and Well-being budget of £8,750 (2016 / 17) • WCC Public Health grant of £17,000 to support delivery of the final year of the joint Health Improvement Action Plan (as approved by the Community and Environment Board) • Public Health had provided a sum of £15,000 in 2015 / 16 to the North Warwickshire Community Partnership for health-related activity. RR agreed to check the sum remaining to be allocated. • A possible further £10,000 from Public Health for activity in 2016 / 17 (budget to be confirmed). • WCC also provided funding through its Transformational Fund (see 14 b), as well as small scale support for green space improvements and funding through its County Councillor Grant Scheme (£5,000 per Councillor) RR to request information on where Public Health funding is currently allocated (including which services and localities receive what). As knowledge of additional funding opportunities became apparent, the information would be circulated to the Working Party.	RR RR JD

Item	Notes	Action
6	**Health Improvement Action Plan** **a - Current Action Plan** The 2016 / 17 Health Improvement Action Plan had been approved by the Community and Environment Board. An update on progress would be provided to the Board in October. The Working Party requested that it be condensed to include only active projects, which could then be better evaluated for its impacts. As well as the evaluation of impacts, the Working Party requested that Officers identify those projects / activities that they felt should be retained within the next, more corporate Health Improvement Action Plan. **b - Future (2017 to 2020) Action Plan** The Working Party agreed to consider the development of the next corporate Health Improvement Action Plan at its meeting to be held in June. A draft could then be considered by the Community and Environment Board in October, subsequent to which the Working Party could discuss the funding of approved actions with potential partners, including Public Health.	BE SNP/ JD/BE/ RR H&W WP / Officers
7	**Leisure and Community Development Services Review** The Commission Brief for the Leisure Services Review, a copy of which was circulated to the Working Party, has been agreed by Members. It was currently anticipated that the external consultants would be appointed in the week beginning 06 June and that the Commission would take at least 12 months to complete. Outputs from the Review would include the production of an overarching Health, Well-being and Leisure Strategy and under-pinning Leisure Facilities, Green Space and Playing Pitch Strategies. The Review would be required to investigate both current and anticipated future need and growth. The Working Party anticipated that it had an important role in helping to direct the work of the consultants and requested that they be invited to attend the next meeting (21 June).	SNP
8	**Internal Health-related Consultation Updates** **a - Arley Sports Centre** Community consultation began on 01 March and will end on 22 May 2016. An update on progress will be presented to the Community and Environment Board on 17 May. The current consultation position was discussed and the Working Party noted its interest in trying to establish how best to improve the health and well-being of the local population. **b - Borough Care** The consultation ended on 04 April 2016, further to which a report is to be presented to the Resources Board on 18 April. The general outcome of the consultation process was discussed. The Working Party was particularly interested in the potential future role of the Clinical Commissioning Group in helping to fund related services. After the Resources Board had met, SNP would arrange for Cllrs. Bell and Chambers to meet with the Assistant Director (Housing) to try and establish a way forward for securing external support for	SNP

Item	Notes	Action
	the Borough Care service.	
9	**Fitter Futures** The Working Party received an update on the current services provided through Fitter Futures, subsequent to which Councillors discussed ways in which to improve the take up of the service in North Warwickshire. The Working Party requested that a report be prepared for the consideration of the Community and Environment Board, which provided options for reducing the price for people referred by an health professional. The options for consideration are: • 50% reduction at any time (preferred option) • 50% reduction for off peak usage and 30% peak • No reduction (current position) The Working Party also emphasised the need for much better promotion of the scheme to health professionals in the Borough.	SNP RR/BE
10	**Food Bank - Policy on the Distribution of Formula Milk** Further to advice from Public Health, the Working Party held the view that the Borough Council should probably follow the UNICEF guidance on the distribution of formula milk, but acknowledged that this was a matter upon which an informed legal opinion was required.	JD/LH
11	**End of Life Care** Cllrs. Bell and Chambers determined to meet with Julia Grant (George Eliot Hospital) to discuss her proposals / suggestions for improving "End of Life Care" for people living in North Warwickshire. The outcome of the discussion would be reported to the next meeting of the Working Party. RR will clarify the outcome of the countywide consultations, including what the next steps are.	Cllr B / Cllr C RR
12	**North Warwickshire GP Provision** It was understood that there was a significant shortage of GPs in North Warwickshire, which was a matter of considerable regret for the Working Party. Cllrs. Bell and Chambers resolved to draft a series of questions on this matter for the consideration of the Clinical Commissioning Group.	Cllr B / Cllr C
13	**Priority Ward(s) – Analysis of Health Data** Subsequent to a discussion on a range of health data for the Borough, the Working Party determined the need for a full "Health Needs Assessment" to be undertaken in a priority Ward, in order to try and better understand what was causing the health of the population to be relatively poor in certain areas. It was agreed to focus this work on Atherstone / Mancetter. RR undertook to lead on this work through her County Council / Public Health colleagues. Initially, a desk top research exercise would be undertaken, the results of which would be presented to the Working Party. The complete Health Needs Assessment could take at least six months to complete. RR informed the Working Party that the "Living in Warwickshire Survey" is to be launched shortly. It was important to encourage as many returns as possible, as this would improve our understanding of the Borough.	RR

Item	Notes	Action
	With regard to their health-related services, Assistant Directors would be asked for their views on any matters of particular significance to either their services or the people living in Atherstone.	SNP/ JD
14	**Correspondence / Consultations to / from External Organisations** **a - CAMHS** Waiting times for access to the service for people living in Northern Warwickshire was a matter of serious concern to the Working Party. The CAMHS Lead was attending the next meeting of the Warwickshire North Health and Well-being Partnership, at which the matter would be raised by Cllr. Bell. **b - Third and Public Sector Partnership Group** JD informed the Working Party about the Group and its purpose to: • Build better relationships between the public and third sectors across the County for the benefit of the people of Warwickshire • Create a voice for the third sector and the communities they support • Ensure that the third sector is an active partner in the strategic development of services that address the changing needs of the community Delivered through its priorities of: • Communication and Engagement • Commissioning and Procurement • Foresight and Strategic Direction Details were also provided of the latest awards made through the County Council's Transformational Fund. **c - NHS Warwickshire North Clinical Commissioning Group (CCG) Draft Business Plan** Cllrs Bell and Chambers undertook to review the draft Business Plan. SNP would clarify the deadline for responses to the associated consultation process. **d - Healthwatch Review** The Working Party was informed about an imminent electronic survey concerning Healthwatch.	Cllr B Cllr B / Cllr C / SNP
15	**Community and Environment Board – Report(s) and Issues to be Raised by the Working Party** Working Party minutes to be reported to the Board. Fitter Futures - Exercise on Referral: A report relating to the level of charges made in North Warwickshire	SNP SNP
16	**Forward Work Programme** Matters requiring the early consideration of the Working Party included: • 2016 / 17 Health Improvement Action Plan	SNP

Item	Notes	Action
	• Development of the corporate 2017 / 20 Health Improvement Action Plan • Meeting the Leisure Services Review Consultants • Presentation by Revenue and Benefits on the health-related services provided through the Division • Health Needs Assessment in Atherstone.	
17	**Future Meeting Dates (all 10.00am in the Board Room)** 21 June 2016 (10.30am) Leisure Review Consultants, Revenues and Benefits 15 September 2016 Draft NW Health Improvement Action Plan (2017 to 2020) 05 December 2016 Atherstone Health Needs Assessment 16 February 2017 20 April 2017	

Item 7

Health and Wellbeing Board

6 July 2016

Board and System Development

Recommendation(s)

1. The Health and Wellbeing Board note the approach being taken to supporting the Board and Executive in developing the Health and Wellbeing system in Warwickshire.

1.0 Key Issues

1.1 In support of the Concordat and commitment to the development of the Health and Wellbeing system in Warwickshire, dedicated support to the Board, Executive and wider system is now in place.

1.2 This work will build upon the findings of the LGA Peer Review conducted in 2015; the associated action plan; and outputs of the partnership Summit delivered in April 2016.

2.0 Options and Proposal

N/a

3.0 Timescales associated with the decision and next steps

3.1 The Board will consider a presentation on the approach being taken to this work and initial findings at the meeting.

Background papers

None

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The report was circulated to the following members prior to publication:

Local Member(s):
Other members:

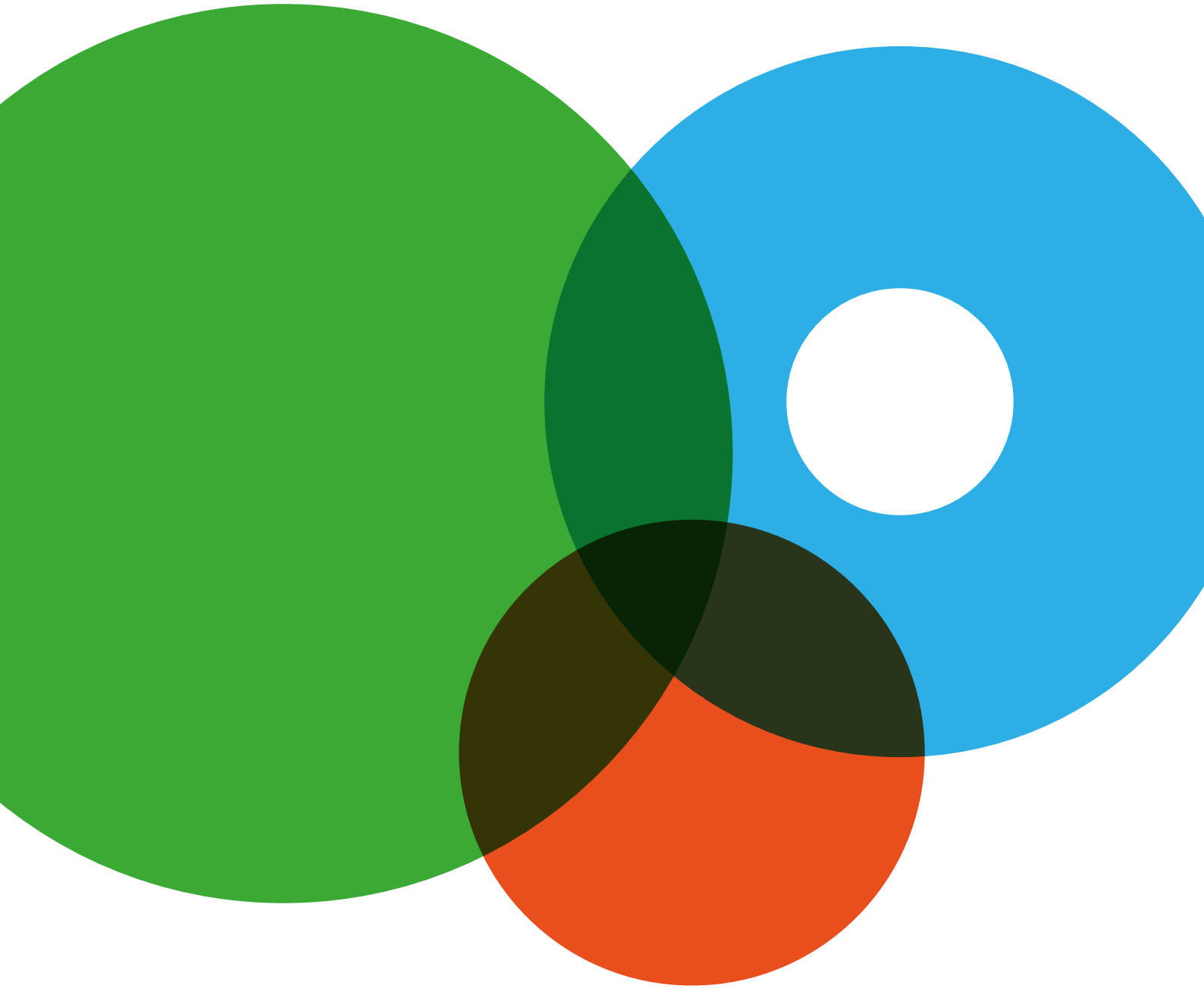
Local Government Association

Item 7 Appendix A

NHS CONFEDERATION

Stepping up to the place

The key to successful health and care integration



directors of adass
adult social services

NHS Clinical Commissioners
The independent collective voice of clinical commissioning groups

Contents

"We are very pleased to have developed and shaped this vision with our partners across the system, who like our member CCGs, recognise that the integration of health and social care is key to delivering truly person-centred care and that we must focus on the concept of place-based commissioning. Fulfilling the vision we've collectively set out here at a local level is also critical if we are to achieve our shared ambitions of transforming care and delivering better outcomes for our populations."

Dr Amanda Doyle and Dr Graham Jackson, Co-chairs, NHS Clinical Commissioners

"Integration is an important step towards transforming services for adult social care so they are sustainable for the future, but cannot be seen as an end in itself. It is a means to improving outcomes and the experience for individuals who receive care and health services. It is clear that the need to transform services has never been greater, given our ageing population and the complex care and health needs of people who we are supporting and of course the unprecedented financial pressures facing local government and adult social care.

"When we need care and support, we need services that are personalised, of good quality, that address our mental, physical and other forms of wellbeing, and are joined-up around our individual needs and those of our carers. Our care and support needs to be well connected to the community in which we live."

Harold Bodmer, President, ADASS

"We've made great strides over the last few years to bring together services to get better services, better health and wellbeing outcomes and better use of our resources, but we need to go further and faster in order to address the demographic and financial challenges facing us. Through our shared vision, we are supporting local political, clinical and community leaders to ensure that integration moves from the sidelines to the mainstream."

Councillor Izzi Seccombe, Chair, LGA Community Wellbeing Board

"This report sends a clear message that to improve the standard of care that we deliver to people we must better integrate our health and care services. The NHS continues to face unprecedented demand and challenging financial circumstances. Against this background, we need to make sure we are utilising all the collective resources of a 'place' to benefit our local communities. There is now a real urgency to deliver on this ambition. Our shared vision, outlined in this report, is matched by the commitment shown by the whole health and care sector to provide integrated services to those that need it most. The report sets out guidelines for local leaders, drawn from what we have learnt so far and offered to support them to step up the pace of transforming care. Our priority now must be to turn rhetoric into action so that we can realise a health and care system that meets the needs of people today and tomorrow."

Stephen Dorrell, Chair, NHS Confederation

1

Our shared vision

Introduction

Bringing together health and social care has been a constant and dominant policy theme for many decades, and many places around the country are already demonstrating the potential to do things differently.

We – the Association of Directors of Adult Social Services, Local Government Association, NHS Clinical Commissioners and NHS Confederation – believe, however, it is time to change gear. The status quo is no longer an option, and everyone must innovate and transform on a scale and at a pace not yet seen.

The imperative to integrate and transform has never been greater – from finding ways to organise services around the demands of a population with more complex and chronic health and social needs, to responding to the extremely challenging financial context for the NHS and local government. Integration is not an answer in itself, or a panacea for the system's financial challenges. Its primary purpose is to shift the focus of health and care services to improving public health and meeting the holistic needs of individuals, of drawing together all services across a 'place' for greatest benefit, and of investing in services which maximise wellbeing throughout life.

We believe it is time to put integrated systems and services to the test, to translate aspirations into action, and to ensure they deliver for our citizens. So we have come together to describe what a fully integrated, transformed system should look like based on what the evidence tells us. This builds on our existing joint work over many years, and takes it to the next level – to call on local and national stakeholders to work together to ensure integration becomes integral to a transformed system. In short, to enable integration to be seen as business as usual.

To make this happen, we call on everyone to join us in testing and developing the principles and practices set out in this vision, to learn and to share, to challenge and to deliver. This will involve pushing ourselves and our partners to deliver the best outcomes for our communities. It will mean understanding the big issues that need to be addressed – at a local and national level – to make integration not only happen but to make sure it improves the health and wellbeing of our populations. This includes acknowledgement and redress from national leaders that the unprecedented pressure on funding remains one of the greatest risks to success.

It will mean being clear why partners stand together, stepping outside institutional siloes and navigating multiple meanings of 'place'. It means redesigning the health and social care landscape together, decommissioning services as well as creating new ones, sharing risks and jointly being responsible for what may be difficult decisions within a complex, challenging and changing system. To really make a difference, it will be a demanding task at times, but is one we must, and can, achieve together.

What are we calling for?

- Local systems to embed integration as 'business as usual'.
- A collective approach to achieving integration by 2020.
- Consensus and action on the barriers to making integration happen.
- Dialogue with national policy makers on ensuring integration is effective.
- Ongoing testing and evaluation to develop the evidence base.
- National partner action to enable the minimum requirements to integrate effectively.

Our vision for integrated care

Services that are organised and delivered to get the best possible health and wellbeing outcomes for citizens of all ages and communities. They will be in the right place – which is in our neighbourhoods, making the most of the strengths and resources in the community as well as meeting their needs. Care, information and advice will be available at the right time, provided proactively to avoid escalating ill health, and with the emphasis on wellness. Services will be designed with citizens and centred on the needs of the individual, with easy and equitable access for all and making best use of community and voluntary sector provision. And they will be provided by the right people – those skilled to work as partners with citizens, and who enable them to be able to look after their own health and wellbeing.

Leaders – local and national – will together do what is best for their citizens and communities ahead of institutional needs. It means directing all of the resources in a place – not just health and care – to improving citizens' wellbeing, and increasing investment on community provision. It also means sharing responsibility for difficult decisions, particularly in securing sustainable and transformed services.

Why integrate?

Integration is not an end in itself. A clear consensus has developed that redesigning services around the needs of individuals in a place provides the best opportunities to improve people's health and wellbeing including closing health inequalities, and helping to bring financial sustainability. Increasingly, as financial and performance pressures continue to increase, the focus is on changing the conversation about the objectives of health and social care.

This consensus has developed from the evidence emerging from the many places implementing integrated approaches – including trailblazers such as integrated care pioneers and vanguards, as well as national programmes including the Better Care Fund. The evidence indicates that integration results in improved clinical outcomes and a better patient experience. There is also evidence that integrated, person-centred services can change the pattern of demand and bring service efficiencies. There is less evidence, however, that integration, on its own, will address the serious financial challenges facing the system. This evidence base is explored in section two of this document: What we have learnt about successful integration.

What are the big issues to address?

Implementing our vision for integration requires system transformation. To succeed, local and national leaders have to address a number of fundamental questions.

Although different places will develop an integrated system tailored to local needs and aspirations, there are common issues to address, and these are explored in section three of this document: What are the big issues for local and national leaders?

What we can achieve through integration

Individuals

- Information, advice and support to improve physical, mental, emotional and economic health and wellbeing throughout life.
- Information, advice and support that helps you take care of your own health and wellbeing.
- More choice and control over the services you receive, such as through a personal budget.
- Support developed jointly with practitioners, built around your needs as a whole person.
- Confidence that local services are safe, effective, high quality and accountable.
- Control of and access to your own information.

Communities

- Stimulating and supporting communities to be active, safe and well, making the most of their own strengths and resources.
- As taxpayers, confidence that the local system is effective and offers value for money.
- Ongoing information and opportunities to hold local leaders to account for progress on health outcomes.
- Health and care that supports better health and wellbeing for all, and a closing of health inequalities.
- Opportunities to shape local services and plans for change.

Local health and wellbeing systems

- Collective leadership, which drives culture change, accepts responsibility for achieving the vision and ensures commissioning for and provision of better outcomes.
- Local revenue-raising powers and greater flexibilities and freedoms to deploy resources according to local need.
- A workforce that meets the needs of citizens, and is equipped to deliver holistic, proactive, integrated care.
- A clear shared vision and action plan based on the needs of the community and designed with them, backed by clear system governance.
- Models of care and support that enable the shared vision and flexibility to meet the varying needs of the population.
- A joint understanding of the resources available locally, and agreement to direct them to the most effective interventions.

Government and national bodies

- A permissive culture and increasing devolution or delegation of resources and decision-making to local clinical, political and professional leadership.
- Driving forward devolution or delegation of regulation and performance management of local services, and a recognition that a sector-led approach to improvement is the most effective way of ensuring continuous improvement in local services.
- A single national outcomes framework for health, public health and social care, with flexibility to enable local leaders to determine their priorities.
- Investment in building the capacity and competency of the workforce to provide integrated care.
- Simplification of the rules to support comprehensive information-sharing at all levels.
- Funding and financial systems which incentivise integrated, preventative, proactive and community-based services.
- Empowering local systems by supporting flexibility to design services around local needs.

What do we need to make integration happen?

We agree a fully-integrated system should have the following essential characteristics:

Shared commitments

1 A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities.

What does this mean?

- Moving away from a focus on episodic care and treating ill health towards an emphasis on independence, wellbeing and holistic care for everyone.
- Understanding the needs and wishes of citizens, including the resources they and those around them can contribute to their own health and wellbeing.
- Bringing together all the assets in a place to stimulate and support individuals, families and communities to be more able to lead happy, safe, independent and fulfilled lives.

2 Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provide services and their communities.

What does this mean?

- Involving individuals and communities in decisions at all levels of the system, from jointly writing a care and support plan with service providers, to groups of community stakeholders playing a central role in designing, implementing and reviewing services.
- Ensuring services treat people with dignity and are personalised to their needs, and are based on a single system-wide assessment of the needs of the whole population.
- Giving citizens greater choice and control of services and support, including encouraging the use of a personal budget for health and social care.

3 Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing.

What does this mean?

- Offering information, education, advice and support to enable everyone to understand how to make changes for a healthier lifestyle and support their care needs.
- Building capacity in the community to be able to support all citizens to make full use of community and social networks and activities.
- All system leaders and practitioners actively ensuring their actions support their shared vision and their contribution to improving health and wellbeing.

4 A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens.

What does this mean?

- Changing the perception of health and care from just treating ill health or substantial care needs to one which keeps people well and safe, leading happy and fulfilled lives.
- Redirecting investment to prioritise public health and community services, as well as wider issues affecting health such as education, housing and jobs for all citizens.
- Having open and trusting relationships with partners, stakeholders and the public from which to make effective, targeted and needs-based decisions about service provision.

Shared leadership and accountability

5 Locally accountable governance arrangements encompassing community, political, clinical and professional leadership which transcend organisational boundaries are collaborative, and where decisions are taken at the most appropriate local level.

What does this mean?

- Leaders stepping beyond their organisation's walls to listen and understand each other, and to lead and make decisions collectively for the benefit of citizens.
- Local leaders being best placed to interpret and respond to community needs drawing in wider services and local resources where appropriate to improve health and wellbeing.
- Leaders being inclusive and collegiate, investing time and energy in relationships, ceding some control, and navigating complexity across multiple accountabilities.

6 Locally appropriate governance arrangements which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning requirements.

What does this mean?

- Navigating across footprints and local identities which exist within any one place, ensuring that the focus remains on what most benefits local populations taking account of whole community need and multiple organisational governance.
- It can mean health and wellbeing boards agreeing to sit within larger arrangements as well as establishing alternative partnerships to carry out business effectively.
- It can mean multiple arrangements for different purposes – the key is ensuring decision-making is with the right people and in the right place.

7 A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens.

What does this mean?

- Working together to align priorities and responsibilities, including overcoming cultural and performance challenges to establish a common language and set of objectives.
- Exploring the many ways to integrate health and care to find the models and approaches which best meet local needs and aspirations.
- Developing a system which works cohesively, with individual services that are high-quality and safe, and is sustainable in terms of services, markets and workforce.

Shared systems

8 Common information and technology – at individual and population level – shared between all relevant agencies and individuals, and use of digital technologies.

What does this mean?

- A common information basis and sharing for planning purposes and shared care records – both for individual care and population-based planning.
- Service arrangements and plans involve enabling and empowering people through technology, and also meaning they tell their story only once.
- Developing a shared risk stratification model to identify individuals most at risk.

9 Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability.

What does this mean?

- Aligning commissioning across all budgets, whether pooled or not, focusing on outcomes and increasing investment in community services that build independence.
- Agreeing how to assess and share risk between partners.
- Shared long-term planning, which charts an achievable course to transform services and improve health, wellbeing and financial sustainability.

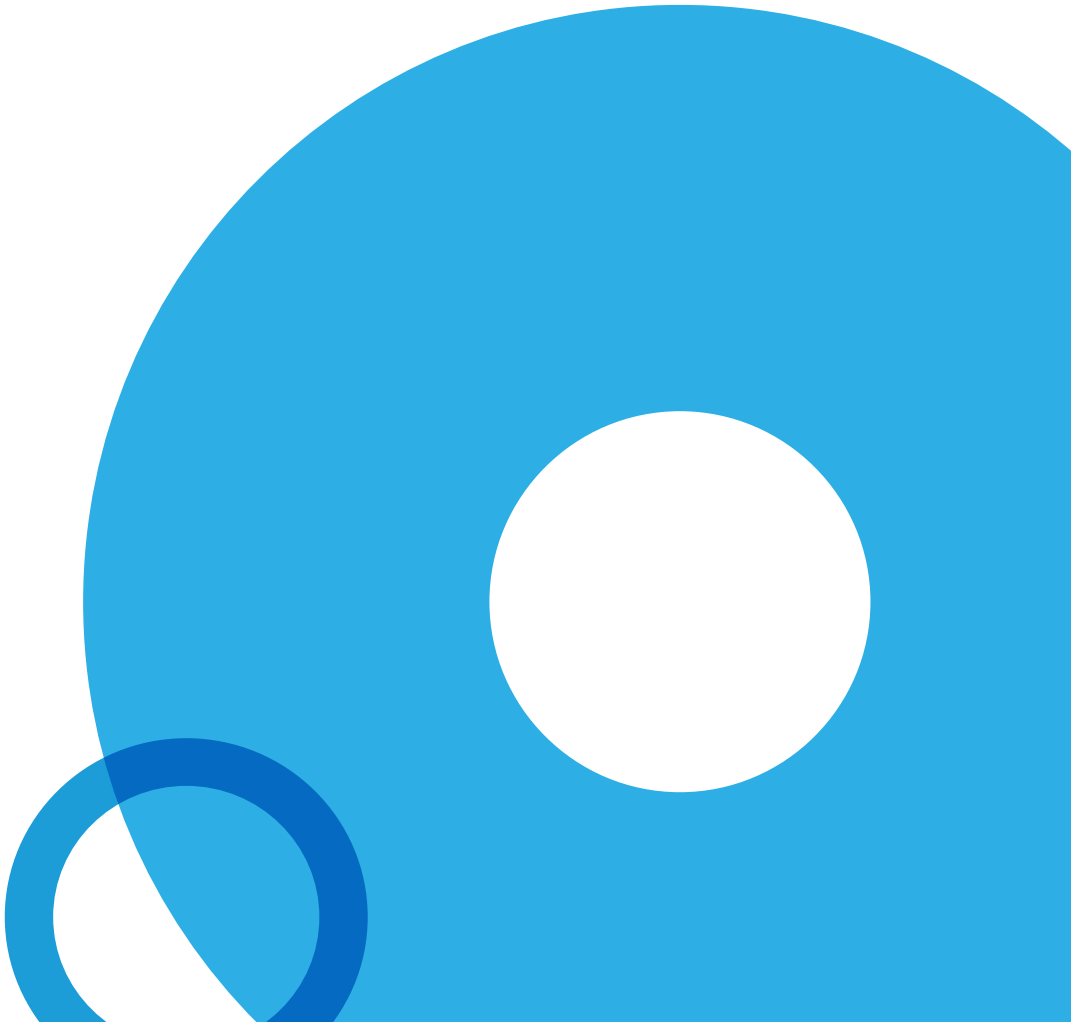
10 Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches.

What does this mean?

- Developing a joint workforce strategy across the health and care system, involving formal and informal workforces, and based on the needs of the population.
- Investing in changing skills and behaviours towards ones which enable person-centred, coordinated care in order to promote people's independence and wellbeing.
- Practitioners across health and care disciplines working seamlessly together to plan and provide care which is proactive and holistic, and supports independence.

2

What we have learnt about successful integration



Introduction

The essential characteristics in our vision for a fully integrated health and care system are based on considerable learning and evidence from across the country, where local leaders are transforming services for the benefit of their users and residents. From vanguards to integrated care pioneers, the Prime Minister's Challenge Fund to Transforming Care, there is a groundswell of good practice from which we can learn.

Though integrated systems can take any shape, depending on local need, the evidence base points towards a number of key elements and characteristics that they must have in order to succeed. These are the basis of our vision, and are explored in more detail in this section.

The impact of integration is hard to measure. It can take years to materialise, and there are currently gaps in the evidence base. All the signs, however, indicate that integrated care can be effective in meeting the needs of an ageing population, particularly one with more complex, chronic health needs. Care that is centred around the person improves the patient experience and clinical outcomes, such as fewer emergency admissions to hospital or better quality of life, and brings service efficiencies.

Transformation, where successful, is iterative and requires trial and error, incremental change, and sustained effort and commitment. Many case studies in this section point to the importance of starting small, where it most makes sense to test and refine thinking, and to build engagement, momentum and learning to deliver lasting change. The evidence points to the need for investment to enable transformation. In the 2015 Challenge, NHS Confederation, NHS Clinical Commissioners, Local Government Authority and Association of Directors of Adult Social Services, among others, have called for a transformation pot to enable this, as have The King's Fund and The Health Foundation in the publication *Making change possible: A transformation fund for the NHS*.[1]

This learning is not new – from the Wanless review of social care[2] to Total Place, from children's trusts to the *Five Year Forward View*,[3] many programmes and initiatives have advocated the principle of partnership working across a locality. More recent initiatives, including the Better Care Fund and new care models continue to develop and test place-based approaches.

This section does not seek to repeat the range of learning and good practice evident across the country, but to point to where local experience is showing the way in improving people's health, wellbeing and care experience. A key resource in developing this section is the recent Local Government Association publication, *The journey to integration – Learning from seven leading localities*.[4]

The Health Foundation provides a comprehensive timeline[5] and resource library charting the history of adult social care and integration. The King's Fund has produced a map of case studies.[6] Further compilations and reports are listed throughout and at the end of this document, with thanks to the organisations from which this document draws evidence.

Shared commitments

1 A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities.

Areas that are at the cutting edge of integration are demonstrating that the most effective approaches to enable a shared focus on communities' health and wellbeing are underpinned by a shared narrative of why integrated care matters, a comprehensive assessment of people's needs and priorities, deep community engagement, and payment and commissioning systems which align financial incentives with improvements in population health and wellbeing. These aspects and characteristics will be explored further in this section.

These areas have designed their system around the needs of their population's health. This approach enables leaders to think differently about the needs and solutions for local communities, bringing in wider factors which affect health, addressing inequalities in health and wellbeing, and considering needs holistically, encompassing multiple morbidities and contributing factors. Increasingly, this involves wrapping the whole system around shared priorities, utilising all the assets and resources across the locality.

To find out more, please see these reports and case studies:

- Local Government Association: *The journey to integration: Learning from seven leading localities*
- The King's Fund: *Population health systems: Going beyond integration care; and Place-based systems of care*

For links to the reports and case studies referred to in this document, please go to: **www.nhsconfed.org/steppingup**

2 Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provide services and their communities.

All the evidence underscores that strong leadership and shared purpose must be underpinned by deep, meaningful and ongoing dialogue with all stakeholders in a system, from leaders, managers and workers to the public, communities and those using services. This dialogue must occur at every stage of designing, developing, delivering and evaluating services, ranging from individual care planning to whole-system reform. This dialogue must seek to understand health and wellbeing in broad, holistic terms, seeing it from the point of view of the individual, not the service or organisation.

At individual service planning levels, this means co-creating personalised care plans. A core tool, initially utilised by the integrated care pioneers, is National Voices' 'I statements', which states as an overarching principle: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."[7] These statements can be used to frame the partnership between professionals and those using health and care services. It also means developing the services that individuals say are important to them.

To find out more, please see these reports and case studies:

- Local Government Association: *Health and Wellbeing Board good practice – Durham: 'Big Tent' events*
- Threshold Pathways to Independence: *Stockport's Targeted Prevention Alliance,* [online]
- Oxleas NHS Foundation Trust: *Case study: Greenwich – Co-ordinated care – a patient's story*

- National Voices: *What is the role of VCSE organisations in care and support planning?; Supporting shared decision-making: A summary of the evidence;* and *Enhancing experience of healthcare: A summary of the evidence*
- NICE: *Community engagement: Improving health and wellbeing and reducing health inequalities*

3 Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing.

Investment in more preventative, proactive and responsive care is a key component of integration. The evidence strongly suggests that asset-based approaches, which focus on communities' skills and capacities rather than their deficits, help people to improve their resilience, independence and wellbeing. They also enable leaders to see their local system differently, working with their communities to share and shift resources to support improved health and wellbeing.

These approaches build the capacity of individuals and the community to take control of their own health and wellbeing. Effective approaches include health education, community coordination roles and peer support to encourage people to share knowledge, experience or practical help with each other. In addition, there are interventions which enable individuals to be responsible for their own care, such as patient activation, expert patient programmes, or health trainers or coaching.

Frequently, these approaches involve increasing use of voluntary and community sector organisations, such as in working with individuals to agree their care plans, expanding volunteer, community or peer roles, or undertaking 'social prescribing' where community and social activities are promoted as routes to better health and wellbeing.

At a system level, taking responsibilities for one's contribution includes leaders and partners being clear of their roles and responsibilities, developing trust in each other's commitment to deliver. This requires clarity of shared vision and priorities across all partners, covering both short- and long-term timeframes, and backed by a strong narrative and roadmap for change, with achievable steps towards the long-term vision. The acid test of this is when individual organisation's actions are evidently coherent within the shared vision, even when they are working within their own organisation. Another lesson is the need to invest levels of resource in programme management commensurate with the scale of challenge and ambition of transformation.

To find out more, please see these reports and case studies:

- Cornwall Pioneer Knowledge Bucket: *JSEC briefing on the approach and findings from the matched cohort evaluation of the Age UK Living Well programme*; and *Living well* infographic
- NHS Clinical Commissioners: 'Social prescribing to improve outcomes in Gloucestershire', *Delivering a healthier future: How CCGs are leading the way on prevention and early diagnosis*, pp30–31
- National Voices: *Peer support: What is it and does it work?;* and *Supporting self-management: A summary of the evidence*
- The Health Foundation: *Heads, hands and hearts: Asset-based approaches in health care*

4 A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens.

The evidence is showing that transformation through integration, through embedding person-centred approaches, requires a transformation in perceptions of healthcare, among leaders, the health and care workforce and the public alike, towards one that keeps people well rather than focusing on treating ill health. This emphasis on more preventative approaches usually involves shifting resources 'upstream' to community or home settings to emphasise wellbeing rather than ill health, and increasingly of utilising the full spectrum of local services to improve community's health and wellbeing. Typically it means investing in community-based services as well as tackling the wider issues that can affect health, ranging from alcohol and diet, to poverty, housing quality or employment.

Given the financial and performance pressures across local systems, changing investment to prioritise community and social support can involve difficult disinvestment decisions. Prevention is no longer an optional add-on, it is an essential lever to improving people's health and experience of care, and the financial sustainability of the system.

To find out more, please see these reports and case studies:

- Bristol Ageing Better: *Bristol – A brilliant place to grow old*, [online]
- NHS Southampton City CCG: *Mental health matters in Southampton*, [online]
- NHS Confederation: *Dorset fire and rescue service – case study*, [online]; *Bradford – case study*, [online]; and *Humberside fire and rescue service – case study*, [online]
- Local Government Association: *Prevention: A shared commitment*
- NHS Clinical Commissioners: *Delivering a healthier future: How CCGs are leading the way on prevention and early diagnosis*
- National Voices: *Promoting prevention: A summary of the evidence*
- Public Health England: *Health and care integration: Making the case from a public health perspective*

Shared leadership and accountability

5 Locally accountable governance arrangements encompassing community, political, clinical and professional leadership which transcend organisational boundaries are collaborative, and where decisions are taken at the most appropriate local level.

Effective system leadership requires collaborative, inclusive governance arrangements across all agencies in a place – it is not enough to be a coalition of the willing, or of like-minded sections of the system. It is vital that every part of the local system is engaged.

Overwhelming evidence indicates that strong relationships are the most important factor in leading successful transformation, ones which enable leaders to overcome organisational boundaries for the benefit of the whole system and the whole population. Where this is working well, it is often because local leaders at all levels – clinicians, health and care workers, managers and communities – are taking bold steps to move away from traditional ways of working individually towards collaborative approaches that benefit all.

This takes time, effort and sometimes a leap of faith to develop these system behaviours. Many innovating localities point to working together on a collective problem to build relationships and trust, such as collaborating on a contract bundle, integrating pathways around a population group, or developing federations or new organisational forms.

There is growing evidence of the value of health and wellbeing boards in joining up strategic commissioning of health and care, of taking a preventative, place-based approach and of bringing together key local players and public services within a very difficult financial climate. It is crucial that they increasingly demonstrate their value in balancing the short-term priorities within a longer-term vision, and of harnessing the energy within their geographical area to underpin a strategic focus on delivery. Devolution is another way of implementing the principle of subsidiarity it built on the premise that decisions taken more locally better serve the population.

To find out more, please see these reports and case studies:

- Local Government Association: 'Leadership', *The journey to integration*: *Learning from seven leading localities* pp51–54
- The King's Fund: *System leadership: Lessons and learning from AQuA's integrated care discovery communities; The practice of system leadership: Being comfortable with chaos*; and *Making integrated care happen at scale and pace*
- The Leadership Centre: *The revolution will be improvised part II: Insights from places on transforming systems*

6 Locally appropriate governance arrangements which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning requirements.

Good governance ensures clear accountability. The strongest lessons from innovating systems are that governance arrangements must allow transformation to take place, and that any changes must ensure form follows function. A lack of clear, shared governance structures is seen by many leaders as a barrier to creating joined-up and integrated plans.

The nature of the governance arrangements is entirely down to local context, though typically they start with a partnership-wide board to oversee developments. There are existing structures, most notably health and wellbeing boards, which have a statutory role in bringing local government and health together to agree what the health and care needs

of the local population are and plan services on this basis. In other places, new forms are developing, such as creating group structures and qualified majority voting, as is emerging in Greater Manchester. New integrated models, such as accountable care organisations, have also begun to go beyond existing governance mechanisms.

In other localities, agencies have come together to create networks or partnerships, backed by a compact that sets out responsibilities as well as dedicated programme management support. Others still have developed infrastructure underneath their health and wellbeing board, such as an executive group or wider stakeholder fora. The key is ensuring that lines of sight, up through the NHS as well as outwards to local communities, are clear and understood.

Another lesson from these localities has been to ensure decisions are taken at the most appropriate level – and that this will vary according to context. This is particularly the case when reconciling multiple planning requirements. Currently, the Better Care Fund, devolution, sustainability and transformation plans, co-commissioning, and health and wellbeing strategies may dominate, but at any time, there are always multiple competing demands on local systems. The key is aligning around the shared vision for the patch, keeping decisions as local as possible. Many also point to creating governance which can adapt and flex to local circumstances, for example developing 'systems within systems' to respond to multiple priorities and visions.

To find out more, please see these reports and case studies:

- Local Government Association: *The journey to integration: Learning from seven leading localities; Body of knowledge on HWBs*, [online]; and DevoHub – *Building the evidence base*, [online]
- Greater Manchester Combined Authority: *Taking charge of our health and social care in Greater Manchester*

7 A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens.

All the evidence points to the need to have a clear, shared vision which is built around the needs of the local community, with clarity about what partners, services and objectives are needed to achieve the vision. This must be backed by a strong narrative, clear long-term goals and a roadmap for change, to bring coherence to what is likely to be a fluid and challenging environment which must respond to a range of short- and long-term pressures and ambitions.

To be successful, committed leaders highlight the need for sustained partnership work to develop a common narrative and case for change, noting that this collective commitment, including clinical, managerial and political leaders, creates significant drive and momentum for change. Furthermore, this approach emphasises that integration is not an end in itself. Key too is ensuring the vision focuses narrowly on the most important system issues, ones which need collective action and which will make the biggest impact on people's health and wellbeing.

Increasingly local health and wellbeing strategies are providing the platform for this collective action, with local partners coalescing around the priorities of their population and finding local solutions to often multi-faceted problems. These strategies are grappling with the 'big' issues using a wide range of intelligence, both quantitative data and qualitative engagement of communities. They are considering both the issues and the solutions in the broadest terms, drawing in other public services including housing, jobs and environment, linking improving health and wellbeing with growth and prosperity.

It is clear there is no single definition of or approach to integration. The evidence points to arrangements and organisational forms building on local circumstances and ambitions – be they joint commissioning, integrated provision or devolved arrangements. It is seen too that any given health and

care economy will likely have a diversity of provider and commissioning models that span organisational and service boundaries, according to different objectives.

Integration does not always involve structural changes to organisations, however. In 2010, the King's Fund concluded that organisational integration alone is unlikely to deliver better outcomes, and that attention should focus on clinical and service integration. Many localities have developed integrated community health and care teams, usually around GPs or neighbourhoods. Similarly many are integrating around pathways, priorities or population groups. There is a growing evidence base, too, for the most effective interventions to underpin new care models – *The journey to integration* explores the most common across the case studies.

To find out more, please see these reports and case studies:

Strong visions

- NHS Providers: *Birmingham Community Healthcare NHS Trust: Healthy villages and the complete care model*
- The King's Fund: *Integrating health and social care in Torbay: Improving care for Mrs Smith*
- Wiltshire Council: *Public health in Wiltshire – Public health intelligence*, [online]
- NHS Clinical Commissioners: 'Addressing preventable early deaths in Brighton and Hove', *Delivering a healthier future: How CCGs are leading the way on prevention and early diagnosis*, p8

Integrating

(see 'Shared systems' on pages 22–25 for further examples)

Around a population group

- NHS Confederation: *Growing old together: Sharing new ways to support older people; Walsall Healthcare NHS Trust – case study*, [online]; *South Warwickshire NHS Foundation Trust – case study*, [online]; and *Liverpool – case study*, [online]

Around older people

- The King's Fund: *Making our health and care systems fit for an ageing population; Providing integrated care for older people with complex needs: Lessons from seven international case studies*; and *Coordinated care for people with complex chronic conditions: Key lessons and markers for success*

Proven interventions

- Local Government Association: 'Impact', *The journey to integration: Learning from seven leading localities*, p17
- The King's Fund: *Transforming our health care system: Ten priorities for our commissioners*; and *Clinical and service integration: The route to improved outcomes*
- The Nuffield Trust: *Evaluating integrated and community-based care: How do we know what works?*
- NHS Providers: *Right time, right place commission into transfers of care: Evidence review*

Shared systems

Integration can take many forms but the evidence points strongly to several underlying enablers. These are explored more fully in the publication *The journey to integration: Learning from seven leading localities*.

8 Common information and technology – at individual and population level – shared between all relevant agencies and individuals, and use of digital technologies.

There is strong evidence that the free flow of information is an essential prerequisite to making change happen – the sharing of information is required not only around an individual's care, but also must underpin population-based approaches such as proactively targeting preventative support to people at greater risk of poor health, as well as system-wide issues such as workforce reform.

The evidence, captured in *The journey to integration*, suggests that it is essential to understand the totality of your population's needs, and segment them into different groups to identify those most likely to be admitted to hospital. More sophisticated systems are broadening their focus to consider all health and care needs. Typically integration programmes have used these tools to identify the top 1–2 per cent at risk of admission, who are the most costly patients, to proactively target with more preventative and personalised support. The early evidence suggests that this narrow focus is not sufficient to have the impact desired on demand, outcomes or cost, and that leaders must extend the scope of transformation programmes to cover larger proportions of the population if they are to achieve their intended impact.

The use of technology to improve outcomes and experience of care is also proving a vital driving force for change. Most commonly this includes the use of telecare and telehealth systems, such as using video conference consultations, or installing monitoring devices in care homes or private homes to enable passive remote patient monitoring. Technology is also increasingly useful in terms of supporting people to look after themselves, such as self-care apps.

To find out more, please see these reports and case studies:

- Local Government Association: 'The flow of information', *The journey to integration: Learning from seven leading localities*, pp36–39
- NHS Islington Clinical Commissioning Group: *Integrated digital care record and person held record full business case*
- NHS: 'Nottingham City: Treating people through technology' and 'Leeds: Tele X marks the support', *People helping people: Year two of the pioneer programme*, pp60–61 and pp62–64
- NHS Providers: *Telemedicine at Airedale NHS Foundation Trust: Better care in the community for elderly patients*
- The King's Fund: *The digital revolution: Eight technologies that will change health and care*, [online]; and *Reading list – Technology in health and social care: telehealth, telecare and telemedicine*

9 Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability.

A clear lesson is that payment reform is needed to fund direct changes in care and change incentives for organisations. Whatever the locally chosen financial model, this must be underpinned by the needs of the population seen as a whole. What matters is aligning commissioning activity and payment mechanisms across organisations and creating strong, shared risk assessment and risk sharing. This can include reframing the commissioner/provider divide, to one of strategically commissioning provision around the needs of the local population, or groups within it. This requires careful understanding of the demand, costs and outcomes of the population, and consequently a very clear understanding of how to share risk equitably across partners. It also requires ongoing communication and engagement across providers, commissioners and the community to develop and embed a shared vision.

Commissioning models can range from pooling budgets, using integrated or joint commissioning, commissioning around outcomes, or developing capitation or personal budgets – how this is configured is for local determination. For example, Salford Royal NHS Foundation Trust working with a local mental health trust and CCG are creating a single health and social care budget by pooling funds. In Northumberland the local authority will be the strategic commissioner across all health and care spend. Meanwhile in Plymouth there is joint commissioning and delivery of adult social care and community health provision.

Integrated provider forms, similarly, are evolving to meet local need. The vanguard programme is testing different forms, including joining acute provision with primary care, as well as bringing all out-of-hospital provision together around GP practices. Some localities are combining the services into one organisation, others are developing federated or partnership models.

To find out more, please see these reports and case studies:

- The Nuffield Trust: *The NHS payment system: Evolving policy and emerging evidence; New models of primary care: Practical lessons from early implementers*; and *Provider chains: Lessons from other sectors*
- North West London: *Finance, analytics and information tools,* [online]; and *Governance and contracting tools,* [online]
- The King's Fund: *Commissioning and contracting for integrated care; Accountable care organisations in the United States and England*; and *Options for integrated commissioning: Beyond Barker*
- Royal College of Physicians/Royal College of General Practitioners: *Patient care: A unified approach*

10 Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches.

It is evident that integration cannot occur without creating new ways of working across organisations and between professional and managerial teams. Overwhelmingly, the evidence shows the importance of planning and training the workforce around the needs of the population, which requires a profound shift in the thinking of workforce planners and of those providing care. In addition, the evidence highlights that the workforce must be seen in the widest possible context, including voluntary and community partners as well as carers and the private and independent providers in the social care market.

The most powerful way to develop the workforce to work in new ways is to engage them in designing and implementing the new approaches. It is critical to help workers to understand the person-centred narrative and case for change, and for them to feel empowered to own and develop it within their own practice. This culture change takes considerable time and effort. Some key learning points include the need to consider the skills and competencies required in the workforce, rather than the professionally defined roles and tasks. In addition, of developing new roles to support integrated working. The most common ones include care coordination or of shifting expertise to new settings, such as moving specialities from acute to community settings.

There are a range of proven benefits of integrated approaches which can support the development of integrated workforces. These include case management and care coordination through multi-disciplinary teams, which typically have lead professionals and employ joint assessment and planning arrangements.

To find out more, please see these reports and case studies:

- Local Government Association: 'Workforce', *The journey to integration: Learning from seven leading localities*, pp44–47
- NHS Confederation: *Cumbria Partnership NHS Foundation Trust – case study*, [online]
- NHS England: *MDT development: Working towards an effective multidisciplinary/multiagency team*
- The King's Fund: *Specialists in out-of-hospital settings: Findings from six case studies*

For links to the reports and case studies referred to in this document, please go to: **www.nhsconfed.org/steppingup**

Further reading

- Local Government Association: *The journey to integration: Learning from seven leading localities; Integrated care pioneer programme annual report 2014; Integrated care pioneer programme annual report 2015; Integrated care value case toolkit*, [online]
- NHS Confederation: *All together now: Making integration happen*
- NHS England: *New care models – vanguard sites*, [online]; *Prime Minister's GP Access Fund*, [online]; *Integrated personal commissioning (IPC) programme*, [online]
- NHS Providers: *Locally driven change: Selected case studies*, [online]
- The King's Fund: *Integrated care reading room*, [online]

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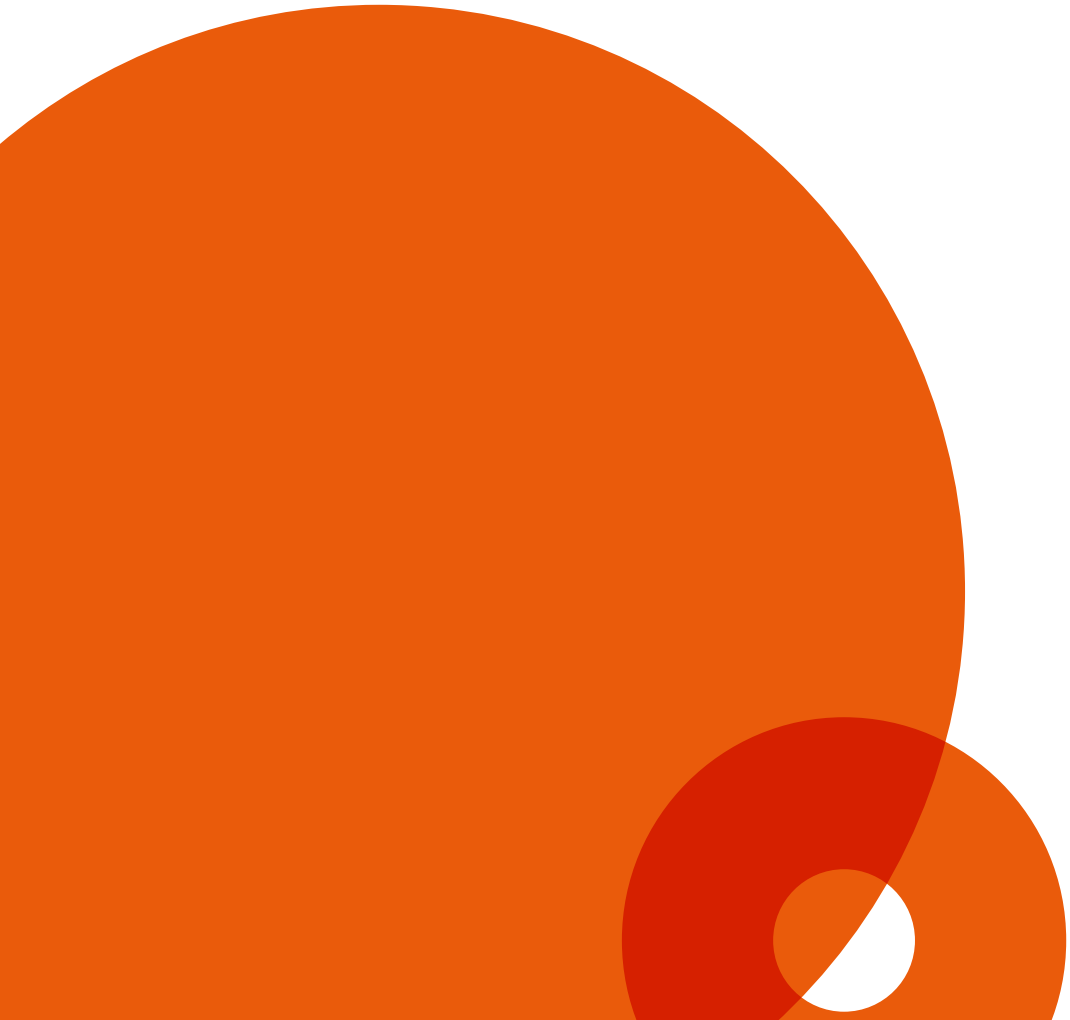
1. The King's Fund and The Health Foundation (2015), *Making change possible: A transformation fund for the NHS*
2. Wanless D (2006), *Securing good care for older people: Taking a long-term view*, The King's Fund
3. NHS (2014), *Five year forward view*
4. Local Government Association (2016), *The journey to integration: Learning from seven leading localities*
5. The Health Foundation, *Adult social care and integration*, [online], accessed May 2016
6. The King's Fund, *Integrated care map: examples of new models of care in practice*, [online], accessed May 2016
7. National Voices (2013), *A narrative for person-centred coordinated care*

3

What are the big issues for local and national leaders?



Introduction

If we – the Association of Directors of Adult Social Services, Local Government Association, NHS Clinical Commissioners and NHS Confederation – are serious about implementing our vision for integration and achieving better health outcomes, this will require wholesale system transformation. System change requires local leaders and national policy makers to address some big questions that arise from integrating two very different systems.

Different areas may come to different conclusions about the shape of services, governance of the system and the underpinning infrastructure required to develop a fully integrated system, but there are fundamental questions which are common to all areas embarking on integration. These are discussed on the following page. The evidence and rationale behind these questions is captured in section two of this document: What we have learnt about successful integration.

We are also developing a self-assessment toolkit for local system leaders to provide a framework with which to assess and challenge their current capacity to lead system transformation and to identify what they need to do. This will be published in July 2016.

Our vision for integrated care

Services that are organised and delivered to get the best possible health and wellbeing outcomes for citizens of all ages and communities. They will be in the right place – which is in our neighbourhoods, making the most of the strengths and resources in the community as well as meeting their needs. Care, information and advice will be available at the right time, provided proactively to avoid escalating ill health, and with the emphasis on wellness. Services will be designed with citizens and centred on the needs of the individual, with easy and equitable access for all and making best use of community and voluntary sector provision. And they will be provided by the right people – those skilled to work as partners with citizens, and who enable them to be able to look after their own health and wellbeing.

Leaders – local and national – will together do what is best for their citizens and communities ahead of institutional needs. It means directing all of the resources in a place – not just health and care – to improving citizens' wellbeing, and increasing investment on community provision. It also means sharing responsibility for difficult decisions, particularly in securing sustainable and transformed services.

Our full vision is available in section one of this document: Our shared vision.

Questions for local and national leaders

Local	National
Shared commitments	
Are local political, clinical, commissioning and community leaders clear on why and how integration will improve their citizens' health and wellbeing, and how these support transformation locally, irrespective of national requirements and imperatives?	
	Does national policy for and action on health and social care empower and support local leaders or act as a barrier?
Is your vision grounded in promoting wellness, supporting citizens and the whole community to be more able to lead happy, safe, independent, fulfilled lives? Does it include appropriate allocation of resources to support them in this way?	
	Do national policies and actions support local action?
Shared leadership and accountability	
Do governance structures have the appropriate accountability and authority to take decisions on integrated planning, commissioning and oversight?	
Do governance structures, including in devolved areas and for NHS footprints, build on or align with existing structures for integrated planning and commissioning? Do strategic governance structures build on and have the support from those on a smaller footprint?	
Do all system leaders work together to ensure that there is meaningful and ongoing engagement with all local stakeholders and citizens? Are all system leaders authentically committed to taking responsibility for decisions about service change to improve health outcomes beyond their own organisational boundaries?	
Shared systems	
	What can national policy makers do to align more closely the funding of health and social care at national level to enable local leaders to provide seamless care? Are national policy makers considering to what extent a fully integrated health and care system is possible while health services are free at the point of delivery and adult social care services are means tested? If means-testing is retained, at what level of need should the threshold be set, in order to avoid displacing demand onto healthcare?
Are local leaders able to ensure that resources are directed to their shared priorities, and are sustainable in the long term? Do legal and reporting requirements allow this freedom and flexibility?	
Do local leaders all work to a common set of performance indicators and outcome measures? Do they have shared information in order to have sufficient oversight of their shared outcomes and performance?	
	How can national policy makers reconcile the different accountabilities, performance and regulatory frameworks across health and care? Should the approach be place-based? And what are the respective responsibilities of local leaders and national policy makers in regulation?
How will system leaders ensure that they have a workforce able to deliver new integrated ways of working?	

Key components of integrating health and social care

Successful transformation is iterative requiring sustained effort and commitment as well as financial investment to make it happen. Evidence shows the importance of starting small, testing and refining, building in engagement and learning. The importance of leadership and shared purpose underpinned by ongoing dialogue with all stakeholders in the community cannot be overstated.

These are the other key components for effective integration, drawn from the evidence we have so far:

Shared commitments

This means:

- A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities.
- Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provide services and their communities.
- Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing.
- A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens.

The evidence is showing that transformation through integration, through embedding person-centred approaches, requires a transformation in perceptions of healthcare, among health and care leaders, and the public alike, towards one that keeps people well rather than focusing on treating ill health.

Shared leadership and accountability

This means:

- Locally accountable governance arrangements encompassing community, political, clinical and professional leadership which transcend organisational boundaries, are collaborative, and where decisions are taken at the most appropriate local level.
- Effective system leadership requires collaborative, inclusive governance arrangements across all agencies in a place – it is not enough to be a coalition of the willing, or of like-minded sections of the system. It is vital that every part of the local system is engaged.
- Locally appropriate governance arrangements which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning requirements.
- Good governance ensures clear accountability. The strongest lessons from innovating systems are that governance arrangements must allow transformation to take place, and that any changes must ensure form follows function.
- A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens.

Shared systems

This means:

- Common information and technology – at individual and population level – shared between all relevant agencies and individuals, and use of digital technologies.
- Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability.
- Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches.

Further information

For more information on the issues covered in this report, please contact:
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Item 8

Health and Wellbeing Board

6 July 2016

Meeting Schedule and Work Programme

Recommendation(s)

1. That the Health and Wellbeing Board approve the proposed meeting schedule for the remainder of 2016/17 and commission the Executive Team to develop a detailed work programme to support this.

1.0 Key Issues

1.1 Currently the Health and Wellbeing Board meet three times a year. A further commitment has been made to participate in an additional three development sessions throughout the year.

1.2 This commitment reflects the need to both fulfil the immediate needs and 'day job' relating to oversight of live activity and shape the future direction of services through the fostering of system leadership.

1.3 The Board is further supported by an Executive Team, comprising Chief Officers form the respective organisations, whose meetings are currently scheduled to fall after the Board.

2.0 Options and Proposal

2.1 It is proposed that from September the dates for the formal Board meeting and development sessions be combined:

- 7th September 2016
- 9th November 2016
- 23rd January 2016
- 22nd March 2016

2.2 Each session would then comprise a formal element plus an opportunity for informal discussion and development sessions following the main meeting.

2.3 This arrangement would be further supported by the rearrangement of the Executive Team meetings so that these are scheduled to inform the Board. These will in turn be informed by reports to the Executive Team from supporting sub-groups.

2.5 To complement these arrangements a detailed Forward Plan for the Board and Executive Team will be produced, reflecting all statutory obligations plus a locally agreed work programme.

2.6 It is envisaged that these small revisions will increase visibility and momentum around the Health and Wellbeing agenda within Warwickshire and facilitate greater opportunity for system development and fostering of key relationships.

3.0 Timescales associated with the decision and next steps

3.1 It is proposed that the above arrangements are agreed in principle by the Board and developed in detail through the Executive Team in July 2016, ahead of becoming operational in September 2016.

3.2 A detailed work programme should be submitted to the Board in September for consideration.

Background papers

None

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The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: None