	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**4th July 2017**
TITLE:	**Improving the Independence of Adults**
Organisation	**Birmingham City Council/Birmingham Cross City CCG**
Presenting Officer	**Adrian Phillips**

Report Type:	**Decision**

1. Purpose:
To inform the Board of a successful application to NHS England, which will support a strategic objective of Improving the Independence of Adults

2. Implications:		
BHWB Strategy Priorities	Child Health	
	Vulnerable People	Y
	Systems Resilience	Y
Joint Strategic Needs Assessment		Y
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		
Financial		Y
Patient and Public Involvement		Y
Early Intervention		
Prevention		

3. Recommendation
It is recommended that the targets in the Integrated Personal Commissioning adopter programme are adopted by the Health and Wellbeing Board for its strategic objective of improving independence of adults

4.	Background
	Improving the Independence of Adults is an agreed strategic objective of the Board. The accompanying paper describes how a joint initiative between the NHS and Council would help take this forward.

5.	Compliance Issues
5.1	***Strategy Implications***
	It supports the refreshed strategy of the Board
5.2	***Governance & Delivery***
	Through the IPC Board
5.3	***Management Responsibility***
	Accountable Board Member to be agreed

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
That the culture of professionals and organisations will not change	Medium	High	Staff involvement in the process. Development of champions
New financial systems may lead to inappropriate use of public funds	Medium	Medium	Learn from other successful sites in appropriate financial governance

Appendices

Signatures	
Chair of Health & Wellbeing Board (Councillor Hamilton)	
Date:	

The following people have been involved in the preparation of this board paper:

Anita Hallbrook – Birmingham Cross City CCG
Adrian Phillips – Birmingham City Council

Detail

NHS England announced the launch of the Integrated Personal Commissioning (IPC) Programme in July 2014. It was described as "radical new option in which individuals could control their own combined health and social care support".

It fits into the Health and Wellbeing Boards' strategic approach to independence for adults as well as promoting more choice. It incorporates Direct Payments, Personal Health Budgets as well as Personal Budgets. However it does not have to involve financial transfer but at its heart is personal choice and control.

The prospectus for the programme, published in September 2014 with LGA, ADASS and Think Local Act Personal, set out the vision and requirements in more detail:#

- People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and circumstances

- Prevention of crises in people's lives that lead to unplanned hospital and institutional care by keeping them well and supporting self-management as measured by tools such as 'patient activation' – so ensuring better value for money

- Better integration and quality of care, including better user and family experience of care.

It is an ambitious programme that seeks to systematically harness the potential of people needing support and their families to be active co-producers of that support, and of their communities to help keep them independent and well. It works across health, local government and the voluntary sector to pull together the resources available to people, and to work with people to understand and plan how best to use these.

It is particularly suited to individuals who are "complex", where our current system can't easily accommodate their needs. It is also very useful in instances where promoting independence actually helps an individual. Earlier work showed particular improvements in patients with severe mental health problems and those approaching End of Life. The studies also demonstrated much greater efficiency.

The Integrated Personal Commissioning Model

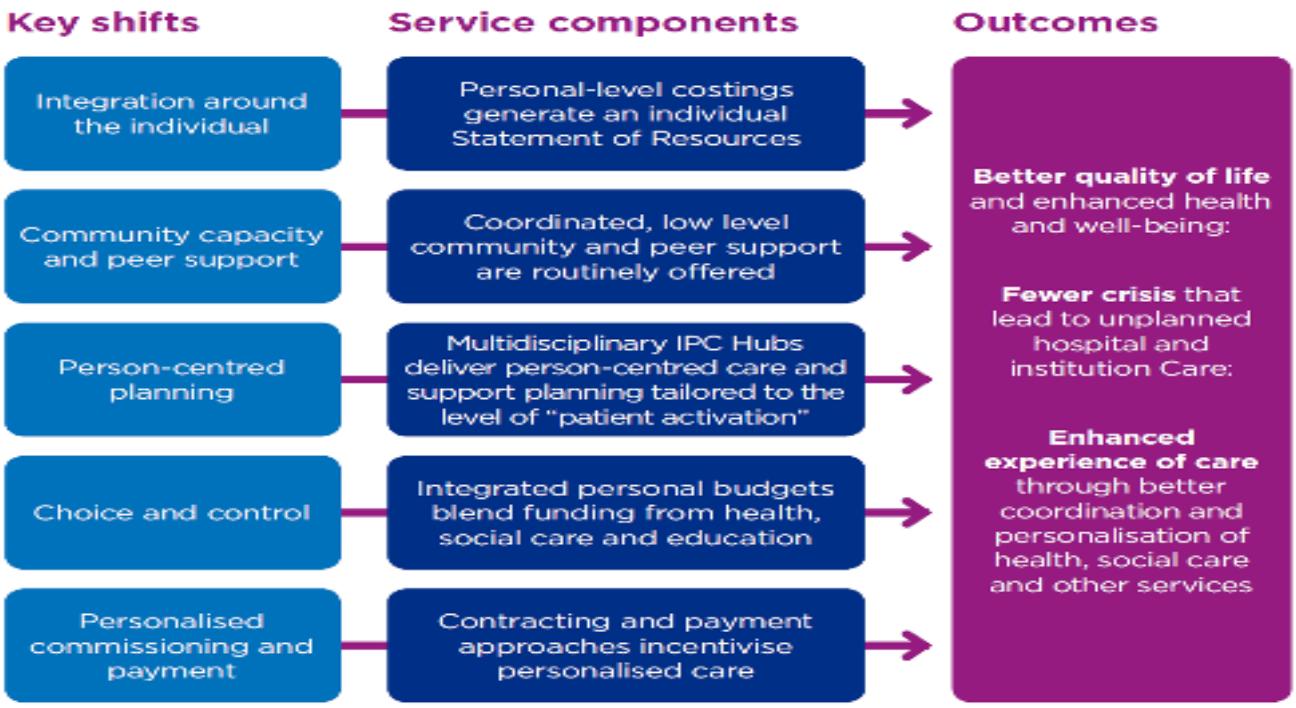
The specific responsibility of all Integrated Personal Commissioning sites is to introduce Integrated Personal Commissioning as the main model of care for 5% of a local system's population, including people with multiple long-term conditions, people with severe and enduring mental health problems, and children and adults with complex learning disabilities and autism. This includes putting in place the Integrated Personal Commissioning Framework to include:

- **Proactive coordination of care:** People proactively or reactively identified and offered information about IPC

- **Community capacity, co-production and peer support:** Making the most of what's available to you through Local Area Coordination and systematic access to peer support
- **Personalised care and support planning:** Having a different or better conversation to identify what matters to you, and capture this in one place.
- **Personal budgets:** A personal budget blends resources to achieve health, wellbeing and learning outcomes
- **Personalised commissioning and payment:** Accessing a wider range of care and support options tailored to individual needs and preferences, through personalised contracting and payment.

The following figure is taken from the reference document and describes the key "shifts" which the approach aims to deliver:

Figure 1: The emerging IPC Framework



Source: Integrated Personal Commissioning Emerging Framework - NHS England (May 2016). https://www.england.nhs.uk/healthbudgets/wp-content/uploads/sites/26/2016/05/ipc-emerging-framework.pdf

Local Relevance

Work was undertaken in 2016 across the NHS and Councils in Birmingham and Solihull (BSOL) to submit an application to be a "demonstrator" site. Approval to submit the application was sought and endorsed through the Local STP governance structures. A partnership approach was undertaken and has achieved programme has sign up from the following organisations:

- Birmingham City Council
- Solihull Metropolitan Borough Council
- NHS Birmingham Cross City CCG
- NHS Birmingham South Central CCG
- NHS Solihull CCG

- Birmingham and Solihull Mental Health Foundation NHS Trust
- MERIT Vanguard

In November 2016, NHS England advised that following an application process, Birmingham and Solihull would become one of seven second wave sites for the early adoption of the IPC Operating Model. Participation in this national programme commenced in December 2016 and will continue until March 2018.

Work undertaken with the existing Demonstrator sites in 2016/17 has helped identify the priority activity to deliver on these shifts, produced the IPC Operating Model and associated guidance and products. Integrated Personal Commissioning Early Adopter sites will need to plan to implement these over the course of the programme and test and further refine the guidance for future areas to implement.

Following the notification by NHS England, we were invited to consider a similar but much smaller process for Looked After Children (LAC) with poor mental wellbeing. We have been successful in becoming an adopter site in this area although it is less well established due to time scales.

The following are projections of people that BSOL expect to take part in the main IPC programme by March 2018.

Site: Birmingham and Solihull Date submitted: March 2017	**Definition**	**Number of people**	**Proportion of population**
Population	Based on CCG populations.	1,300,000	100%
People in the IPC cohort	People within your IPC cohorts and who are in the linked dataset – data to include health, social care and education activity and spend	26,000	2%
People with a care plan/EHC plan	People within your IPC cohorts who have a completed care plan/EHC plan	13,000	1%
People with a personal budget (includes NHS-funding)	People within your IPC cohort who have a completed care plan/EHC plan and personal budget in place. Must include NHS funding.	1,040*	1 in 1,000

*** Based on the total of the individual trajectories of each CCG as supplied by NHS England and will include PHBs both within and outside the chosen IPC cohorts of mental health and learning disabilities.**

Progress to Date

Learning Disability and Mental Health

These thematic projects are focussed on adopting a recovery focused approach to providing services. The aim is to move beyond symptom and risk management to support people to re-establish a meaningful life for themselves. The project focus recognises that recovery requires services to look beyond treatment to consider wider issues such as housing, employment and family relationships. Further, that implementation of Personalisation is seen as a tool that will allow individuals to define their own outcomes and design their own packages of care and support.

Future work is planned in relation to those individuals requiring S117 arrangements or requiring community step-down.

Wheelchairs

This project aims to see 185 individuals access wheelchair provision using their allocated PHB.

Complex and Continuing Health Care

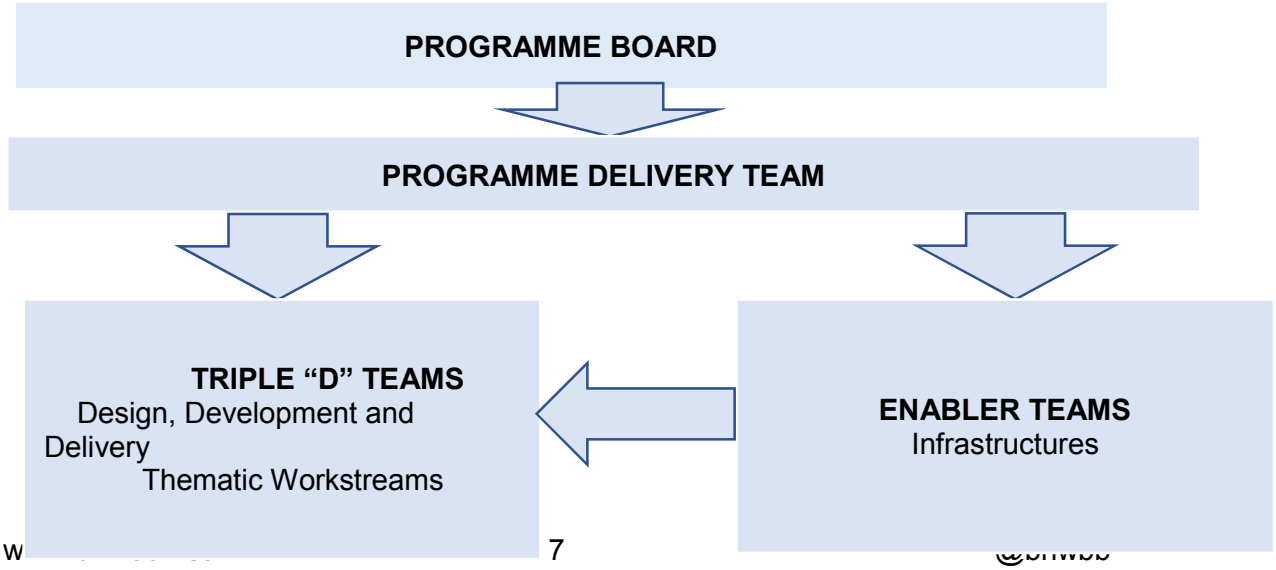
There are currently 87 individuals in receipt of a PHB with a target to stretch this number to 265 during the lifetime of the Programme.
The IPC Programme will be further developed to explore the following areas:

- Long Term Conditions
- Frailty
- End of Life
- SEND

Governance and Programme Team

There is a newly established IPC Programme Board with membership reflective of both the partnership and those organisations responsible for delivery of targets. The Board is supported by a small dedicated Programme Team consisting of a Programme Manager. Personal Health Budget Manager and Evaluation Officer.

Governance Structure



Challenges

The IPC Programme is ambitious and as faces a number of challenges. There is an expectation that Early Adopter sites will work towards achieving a necessary cultural shift, adjustments to existing systems and processes, whilst achieving volume in the uptake of Personal Health Budgets.

Some areas of particular challenge relate to the following:

- The necessity to understand the needs and preferences of individuals and then to ensure that there are a range of providers available to meet those needs. Existing providers express a concern around de-stabilisation but the numbers are so low as to make this theoretical not actual.
- If volume of individuals targeted for PHB's remains low there will be difficulty in de-commissioning elements of existing services, not chosen by individuals, particularly where block contracts are in place.
- Systems are required to manage budget setting, assurance, monitoring, financial and clinical sign off. There are complex health and social care systems that do not "talk to each other" not least lack alignment. It means that the "system" has to change do facilitate this, not just bolted-on.
- The basis for measuring patient-led outcomes and their influence on commissioning not just outputs. Systems currently measure activity as opposed to outcomes.
- Misaligned timescales in particular for the local IPC Programme. Contracts are already agreed and in place with no additional money available or funds to release.
- There is a risk of creating inequality in accessing PHBs as each local area will determine, cost, numbers with differing levels of commitment. This is mitigated to an extent by a learning network instigated by NHS England.
- Cultural attitudes to providing care is challenged by allowing individuals to take control of their care programme and exercise choice in their care options which are likely to be less traditional. A change in thinking and attitude is as critical as systems and processes, there will be a requirement for organisations to become more risk averse. This is probably the biggest barrier.
- The investment and skills required to develop and use technology as a platform to enhancing personalised care.

Opportunities

Personalisation has a place in nearly all aspects of care where care is complicated, long term or independence promotes recovery (and often all three are present such as mental ill-health). It is not the "answer" but another type of commissioning and thus offers more choice. So it offers another option to "system transformation".

The existing demonstrator sites and previous work have shown it can be applied to a vast range of circumstances with good effect. There is a real opportunity to use this approach in other areas locally, such as children's disability, End of Life care, Joint Care Plans for children (EHC) and also scale up existing areas. An obvious area is the BCF, especially frailty (where there is an existing demonstrator site) and EOL. As it is a key issue in the NHS five year plan, it could usefully form a principle for the STP.

Conclusion

The IPC programme is a key part of the NHS “five-year forward view” and a policy supported by the LGA. At its heart is the philosophy of independence, not dependence. This is seen practically as people control their care and having choice on delivery linked to clear outcomes set by them.

It is proposed that the targets in the IPC adopter programme are adopted by the Health and Wellbeing Board with future modifications based upon the LAC work and other possible planned activity.