Moving towards integrated care

A study of the feasibility of integrating community health and social care in Hounslow and Richmond

February 2013
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A message from the team which has led this study

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This feasibility study is the product of five months exceptionally hard work across five different organisations, who have come together to try and achieve a single, shared ambition – to make things better for patients and residents who need care and support.

We know that within our current structures across councils and NHS organisations, health and social care could work together more effectively. We know that there are some pockets of good practice, but this needs to be more widespread across all areas.

We know that patients and carers are frustrated by the duplication and lack of clarity in the current system.

We know that those thoughts are shared by professionals working at all levels in health and social care.

Many of these problems could be solved by an Integrated Care Organisation.

The question could be: “Why didn’t you do this years ago?”

The answer would be: “If it was that easy, we would have done.”

Although the national agenda around integration is gathering pace, we will be among the first to take this step towards an Integrated Care Organisation.

We are pleased to say we’ve accepted that challenge.

This document is the first stage in a journey that could end up in the creation of an Integrated Care Organisation across the boroughs of Hounslow and Richmond.

There would still be much work to be done if we agree to go forward with the concepts and models suggested within the study. There would be much to do before we could agree exactly what that model would look like.

However, what is clear is the commitment of the partners in health and social care to create something which is better than the current system. That is because of our shared belief that we would be doing the right thing for our residents, service users, patients and carers.

The direction of travel is defined. This document marks the end of the first stage of the journey, and provides the basis for decisions on how we go forward from here.
Executive summary

Across the country local authorities and the NHS have traditionally commissioned health and social care services separately, often for the same patients/service users at the same time. The problems this creates for patients, service users and carers are long-standing and well-documented. However, while some councils and some health organisations have successfully created some joint teams, with few exceptions little real progress has been made to deliver properly co-ordinated social care and health services to vulnerable residents.

Our engagement with patients, service users and carers across Hounslow and Richmond during this feasibility study has confirmed not only that the problems persist, but they at best cause huge frustration and at times have an adverse impact on the quality of the lives of some of the most vulnerable people. Our engagement with staff and professionals informed us about the problems they face in trying to provide person-centred care across multiple organisations and how difficult it is to keep GPs involved in their patients’ care when it is delivered by different organisations.

The delivery of properly co-ordinated social care and health services makes a huge difference to people’s lives and gives them the best possible chance of staying fit and healthy and of remaining independent. It also gives people the best possible chance of staying out of hospital or residential or nursing care altogether. For people who do need to be admitted to hospital, integrated care would give them the best possible chance of being discharged to continuing independence at home. Integrated care would also give people the best possible chance of dying at home if they wished to.

In response to this compelling case for change five organisations – Hounslow Council, Richmond Council, Hounslow Clinical Commissioning Group, Richmond Clinical Commissioning Group, and Hounslow and Richmond Community Healthcare NHS Trust – are individually and collectively determined to lead a concerted effort to deliver substantial change to the care system in the London boroughs of Hounslow and Richmond.

We believe the care system as set out in this report is what is required to:

- reduce the fragmentation of provision and the problems this creates
- put people at the heart of their own health and care
- embed personalisation as a core tenet of both health and care provision
- invest in prevention and community recovery to reduce long term care needs
- bring about better engagement between social care, community health, GPs and hospitals

The proposed new care system would start with integrated commissioning and with the two Council/CCG pairs working together to jointly commission services for their respective populations in line with their agreed commissioning intentions. While the broad commissioning intentions in both boroughs are already very well-aligned, there are of course some specific differences in the needs of the two populations and these would continue to be met.

Key features of the proposed care system are:

- one initial point of contact, empowered to trigger urgent response packages of support, as well as information sign-posting, and initial response for people with less urgent needs
- a community recovery service combining the best of community health and social care resources working together to help maximise people’s ability to regain their independence and live independently
- long term care teams who will work across health and social care to support our residents who have long term needs.

In this care system, people would be helped to stay independent and healthy, with a greater emphasis on early intervention and prevention. People would be able to access and navigate the system in which staff and professionals across disciplines would work together to provide the best care, with care co-ordinators taking on the responsibility for supporting residents to access the support they need. People would also be active
partners in their own health and care and would be supported to receive their care as an integrated health and care individual budget where appropriate.

Core to the delivery of this new care system is the Integrated Care Organisation proposed in this report. It is the only way to join up fully the fragmented parts of the current system and to enable a focus on health and social care outcomes for patients. As set out in this study, the Integrated Care Organisation would be able to deploy both social care and community health resources in a co-ordinated way to achieve this goal.

We have designed outline structures for the multidisciplinary teams which would deliver the three elements of the new care system. In some cases one centrally-located team would serve both boroughs; in others, single teams will be based in multiple locations across both. The quality of the leadership of the new multidisciplinary teams will be critical to success, as will a significant focus on organisational and workforce development.

In moving to this model of care we expect rapid improvement to residents’ and patients’ care experiences and for their health and care outcomes to improve significantly.

In the shorter term we expect to achieve efficiencies through removing the duplication in the current system – in many cases we carry out separate health and social care assessments on the same people, create separate care plans for them and deploy separate resources to support them.

In addition we expect to realise significant cash savings in the long term through preventing people going into long term care or having unnecessary emergency admissions into hospital. There are likely to be significant savings from achieving this in the longer-term.

The Integrated Care Organisation we have described in this report is innovative and there is no clear track record for us to reference. As we have worked through this feasibility study we have recognised that we cannot move to this model as quickly as we had originally thought might be possible. The timing of the completion of Hounslow and Richmond Community Healthcare Trust’s current application for Foundation Trust status remains uncertain and the information governance and IT requirements of the new care system need much further work. What is more, patients, service users, carers and our own staff have all told us that we must get this important and significant change right. It is a direction of travel which all these groups support, but the very clear message is that we must not rush this. There is much detailed design work still to be done, many aspects of which will need piloting and testing before they are implemented fully.

We are therefore proposing to move to the new care system on a phased basis, starting (subject to the approval of the full business case) in July 2013 and continuing through to September 2014 at the latest. This will allow sufficient time for:

- Hounslow and Richmond Community Healthcare Trust’s application for Foundation Trust to be approved and any regulatory issues to be addressed before we complete implementation
- key aspects of the model to be developed, piloted and tested
- patients, service users, carers and staff to be engaged in making the new model work
- ensuring that we implement this new model in a way that manages risks appropriately

We now propose to develop a full, robust business case for the creation of a new integrated care organisation, which will build on the work done in this feasibility study to identify the estimated costs and benefits and how these will be funded/shared between our five organisations and potentially others, in particular the mental health and acute partners in the two boroughs. It will also establish the upfront and ongoing investment to which partners would need to commit if we create this integrated care organisation.

The eight appendices referred to throughout in this report are in a separate accompanying document.
The case for change

- The current health and social care system is fragmented, resulting in a frustrating customer experience, duplicated activity and less than good outcomes

- Early engagement with patients, service users, carers and professionals has endorsed the need for change and the creation of an integrated care organisation

- Commissioners in Hounslow and Richmond are agreed and committed to changing the current care system together

Shortcomings of the current health and social care systems

The national context

Across the country, local authorities and the NHS have traditionally commissioned health and social care services separately, often for the same patients/service users at the same time. While some councils and health organisations have successfully created joint teams, with few exceptions little real progress has been made to deliver properly co-ordinated health and social care to vulnerable residents.

The Integrated Care Organisation model

Some localities have started to explore the option of forming an Integrated Care Organisation (ICO). An ICO is an organisation set up to provide joined up health and social care services to the population that it serves.

Although there is broad consensus that integrating care is the right thing to do, work in this area is not very advanced in the UK, with only a few examples in place or being set up. This means there are no fixed models for how to develop an ICO, although increasingly more positive evidence is becoming available as to how this might work.

However, the ICO is not a new phenomenon. ICOs are becoming a feature of health and social care systems in other countries such as Canada and Australia. Furthermore, there has been considerable experimentation into different models of integrated care across Europe, e.g. in Germany and the Netherlands.

This journey is now beginning in the UK. Since the 1950s the NHS has been looking for ways to improve care coordination. In 2008 Lord Darzi published a report into the next stage of the NHS which introduced the concept of the ICO. Since then a number of pilots have been launched in the UK to experiment with different ways of developing integrated care and a number of localities have begun designing their own ICOs, e.g. Staffordshire. The box below shows some of the key points that Staffordshire has learned from experience of their integrated care organisation so far.

What we’ve learned from Staffordshire

Integration was a corporate priority and not just a priority for adult social care. It took the ‘whole’ organisation to make the change, including a concerted effort to address the back office, especially since support staff were not aware of the integration agenda

Existing NHS systems made the integration difficult to deliver, which included the unclear authorisation process

Benefit to patients was absolutely key. This included creating locality based teams that are aligned to GP practices to better meet the needs of the local community
The case for change

NHS staff initially found the integration culture harder than social care staff who had understood for some time that they would be moving to another organisation. This was because NHS staff were not moving to another organisation they took longer to recognise that this meant change for them too.

Staff were immediately TUPE transferred and as a result have better ‘ownership’ and are generally happy because they feel like part of the organisation.

Three tiers of governance were set up to drive accountability of service between the Council and the Trust. The tiers are Board level, CEO/Director and Client side meetings with the Director of Operations and Finance.

The Hounslow & Richmond situation

Public and staff view

The problems created for patients, service users and carers by social care and health commissioners and providers in effect supporting the same patients separately, are long-standing and well-documented. During this feasibility study we have engaged with patients, service users and carers as well as with staff and professionals in Hounslow and Richmond. We asked them their views on both the current system and our emerging thoughts on a new care system with an ICO. Their feedback on the strengths and weaknesses of the current system is set out below. They confirm, not only that the problems persist, but that they cause, at best, huge frustration and at times have an adverse impact on the quality of the lives or even survival of some of the most vulnerable people. It is also clear that the problems stem from the historical separation of health and social care commissioning and delivery.

A detailed summary of the comments we received is in Appendix 1 – Findings from our engagement with service users, patients, carers and staff. Key excerpts are on the next page. The main points are:

- Patients and other members of the public find the current system complicated, difficult to access and hard to navigate.
- Communication and information sharing between professionals is currently inconsistent and multiple care assessments and overlapping care plans or gaps between care plans can be frustrating.
- The fact that no single organisation is responsible for delivery of care is seen to lead inexorably to a failure to deliver that care seamlessly.

Although integrating community health and social care services would help, service users, patients and carers are of the view that care often breaks down between the acute/mental health sectors and community services. Therefore the wider care provider context must be considered if the objective of increased independence for our vulnerable residents is to be met. There is also concern about the quality and consistency of GP services across both boroughs, given the role they should/would play in coordinating their patients’ care.

Financial challenge

At present the NHS spends approximately £11bn per annum on emergency hospital admissions, which are rising each year. Benchmarking data suggests that together, Hounslow and Richmond Clinical Commissioning Groups (CCGs) spend approximately £6m per annum more on emergency admissions than the highest performing CCGs nationally. The cost of long term social care is £97m (gross) across both Boroughs, including £55m on residential and nursing care for all service user groups. Of this, approximately £60m relates to long term adult social care services within the scope of this feasibility study. Further information about Hounslow and Richmond’s relative performance in these areas is included at Appendix IV – Long Term savings potential. Demographic pressure, rising expectations and increased demand for services mean that the financial challenge will continue to grow unless we do something different.
The case for change

What patients, service users, staff and professionals have told us

Complexity of services
The overwhelming response from the patients, service users and carers we spoke to when we asked them about the current system was that it is complex and difficult to understand.

People didn’t always know where the current boundaries are between health and social care but they were aware that there are different funding mechanisms.

Accessing the system
The ability to access services quickly and easily was something people felt very strongly about. They feel that they are not currently easy or quick to access. In addition people worried that their GP’s didn’t understand the system either.

Care coordination
In addition some patients and service users found care wasn’t very well coordinated once they were in the system and that care focused on crisis intervention not prevention.

Communication & information sharing
Communication and information sharing between professionals was also highlighted as a problem by patients, as well as inconsistent quality of care.

Professionals too, recognise that the current system operates with multiple different processes, systems and IT that hinder staff especially in relation to information sharing.

Assessments
It is felt that currently there is duplication. People have to go through multiple assessments and tell their story to professionals a number of times.

Discharge and hand-offs
Gaps between hospital care, community care and social care regarding discharge were highlighted, including the differing views on hospital discharge between health and social care.
Why are commissioners seeking to change their approach now?
Currently five key organisations – Hounslow and Richmond Councils, Richmond and Hounslow CCGs and Hounslow & Richmond Community Healthcare NHS Trust (HRCH) – are individually and collectively determined to lead a concerted effort to deliver properly co-ordinated social care and health services to vulnerable residents. They want to give them the best possible chance of staying out of hospital, residential or nursing care altogether, being discharged from hospital to continue to live independently at home rather than in residential care, or, where people wish, of dying at home.

Laying the groundwork for integration
In recent years both Hounslow and Richmond Councils have separately worked with their respective Primary Care Trusts (and continue this work now with their CCGs) to ‘join up’ commissioning of health and social care services, with the aim of putting residents/service users at the heart of all planning and to secure the best possible benefit for them. The extent to which this has developed is demonstrated by the 2013/14 Joint Commissioning Intentions presented to the Health & Wellbeing Boards in both Hounslow and Richmond in late November 2012. They bring together, as never before, the health, social care and public health commissioning intentions of each council/CCG pair. They also demonstrate that there is substantial common ground between the commissioning intentions of Hounslow and Richmond Boroughs, providing the necessary starting point for effective and efficient delivery through a single ICO.

Moving towards an integrated care system
In parallel to this development of joint commissioning intentions, both councils have created good examples of integrated working with the Hounslow & Richmond Community Healthcare Trust. These include Hounslow’s integrated service for adults with learning disabilities and co-located teams for older adults and adults with physical disabilities in Richmond. However, for the most part, the councils and CCGs in both Hounslow and Richmond have, in effect, commissioned services separately, in many instances from the same provider. There is so much more that could be done and the CCGs are leading the way with integrated care pilots in Chiswick and the out of hospital strategy and community ward pilot in Richmond. At the same time, both councils have the clear appetite to step up to their new leadership roles to oversee the health and social care systems in their respective boroughs. This local push is driven in part by the financial pressures faced by both councils and both CCGs. It is also motivated by a greater determination to harness the opportunities offered, by the Health & Social Care Act 2012 and the Care and Support Bill, to put GPs and their patients at the heart of an integrated system, to re-direct resources over time from treatment to prevention and to avoid the pitfalls of any further fragmentation in the new system.

Although the boundaries between different organisations and different professions are seen as one of the reasons for the problems in the current system, very recent engagement with professionals across the five organisations demonstrates an unequivocal willingness, even excitement, to explore new ways of working in order to achieve longer independence for service users, clearer support for carers and the removal of duplication across the current health and social care systems. The discussion we held with our professionals was overwhelmingly about what it would take to deliver integrated care at a practical level rather than whether we should embark on this.

Aligned IT and information sharing systems are considered one of the absolute ‘must haves’ if integration is to work, alongside significant culture change and highly effective leadership.

Proposed future commissioning arrangements
Collaboration in the commissioning of services
It is our intention that the two Council / CCG pairs will work together to jointly commission services for their respective populations against their agreed commissioning intentions.

Although each area will have separate contractual arrangements with the integrated provider, the two council / CCG pairs will collaborate both in the commissioning of services and contract management to ensure maximum effectiveness and efficiency, particularly in the case of the services which are required across both
The case for change

There are of course some specific differences between the boroughs but there is sufficient common ground so that collaborative commissioning will bring result in effectiveness and efficiency.

For the time being at least, this collaborative work will focus on the needs of frail older people and all other adults with physical disabilities across both boroughs. These care groups represent the areas where Hounslow and Richmond Councils are free to work with each other in any such new arrangement. Richmond is currently finalising a partnership for children’s services with Kingston Council and both councils have different partnership arrangements in place for the care of adults with learning disabilities. Other care groups may come into the scope of these integrated arrangements in the future. Hounslow’s service for adults with learning disabilities, already integrated with the Hounslow & Richmond Community Healthcare Trust, would continue to be delivered by the ICO.

Commitment to a local Community Healthcare Trust

Both councils and both CCGs (via the outgoing Primary Care Trusts) commission considerable services from the Hounslow & Richmond Community Healthcare NHS Trust. All four commissioning organisations are committed to the continuing existence of a local Community Healthcare Trust and have supported the Hounslow & Richmond Community Healthcare Trust at all the key stages of its development, including its current pursuance of Foundation Trust status. All four envisage that the ‘one provider in which delivery is fully integrated’ will be an organisation which evolves from the current NHS Trust into a new ICO and is commissioned by the two Councils / CCGs working together for maximum efficiency.
The care system

- The features of the proposed care system will significantly address the frustrations currently experienced by service users and patients and help to improve outcomes
- The focus on early intervention, prevention and the co-ordination of an individual's care will reduce the costs associated with long term care packages and unnecessary emergency hospital admissions

The Hounslow & Richmond care system

‘The case for change’ chapter demonstrates the strong agreement between commissioners in Hounslow and Richmond over the need for a care system which addresses the duplication in the current system and that delivers services with the patient / service user at the heart rather than responding from the perspectives of each organisation. We believe that this can only be delivered by a care system with an Integrated Care Organisation at the centre, as described here.

Our vision and design principles

This is our shared vision of the integrated care system.

A shared vision statement for an integrated care system

- People engaging with the integrated service tell their story only once
- People can live their lives safely and are safeguarded from risk
- There is a single point of access and single assessment process
- We ‘join up’ to give an integrated, person-centred response across agencies and reduce the number of ‘hand offs’ between teams and services enabling a timely, coherent and streamlined access to support
- There is one care plan with access to patient/service user records in one place
- There is easy access to specialist support and planned care when needed
- There are creative and flexible solutions which focus on promoting and maintaining independence

The diagram below shows the integrated care system, the key features of which include:

- **First contact** - a single point of access for all into the integrated health and social care system. Entry might be through self-referral, referral from GPs or referral from hospitals.
- **Urgent response** - immediate and rapid response to a crisis arranging appropriate services, including provision of equipment, telecare and telehealth.
- **Community recovery service** – aiming to supporting people to greater independence, whether those people needing the support come from the community or from a period of medical intervention in hospital. This service will aim to support recovery and provide rehabilitation within a 12 week period.
- **Long term care & support** - continuing health and care support to people with ongoing health and social needs. It will help people manage their care by providing personal budgets and direct payments, and/or through arranging access to commissioned support through domiciliary care, or access to residential and nursing care as appropriate.
- **Risk stratification** - profiling activity to identify and develop packages of integrated care to patients who, without intervention, would be at risk of requiring long term support, or would develop complex or worsening conditions whilst receiving long term care.
Features and benefits

There are a number of benefits to patients / service users which commissioners would like to see this care system deliver. These fall into a number of categories, as described below.

Building on personalisation

We anticipate that our care system will build on the strong track record of local authorities, Richmond in particular, in delivering personalised support and implementation of personal budgets. This care system will take advantage of the new opportunities which health budgets provide to deliver integrated health and social care support.

Benefit – People will have as much choice and control over their care and support as possible.

Access and navigation

People will be provided with a single access point, regardless of whether their needs are for health or social care. It will provide quick and easy access to advice and support and signpost people quickly to the services that they require. It will also provide a direct referral route to any follow on community health and social care services.

Patients with a medium to longer-term requirement for care will be allocated a care coordinator, who will manage their care making the system easier for patients to navigate.

Benefit - The system will be easier to access and navigate.

Improved care management

In the new system health and social care staff will be working closely together. They will be able to talk and share information related to a person’s care.

Benefit – Staff will be able to have a clearer view of the patient / service user’s holistic needs, enabling them to provide a better, more personalised service.
**Joined up care**

Improved care management will have at its core one joint health and social care assessment and one joint care plan for each individual, thus removing duplication of activity and increasing efficiency.

**Benefit** - The result of improved care management will be that the care a person receives will be a single ‘joined up’ health and social care package.

**Hospital discharge pathway**

Community health and social care services will link closely with hospitals to ensure a smooth, consistent and effective discharge process. The service will proactively look to get people out of hospital sooner, where they are medically fit to be discharged, and put them through an early supported discharge or reablement pathway with the aim of getting people to manage independently in their usual place of residence as soon as possible. We will look to increase the number of people who support those discharged early or being reabled.

**Benefit** - The pathway from hospitals to the community will be proactive and coordinated, adopting best practice approaches.

**GPs are closer to a patient's care**

In the new system GPs will have a greater involvement in all aspects of a patient's care. Their involvement is likely to include:

- referring their patients to the single point of contact for health and social care
- being informed of a patient's referral/acceptance into the service and is provided with the information which was used to make the referral decision
- being provided with ongoing information on a patient's support or treatment
- being informed of a patient's progress – any information gathered from monitoring and reviewing a patient is made accessible to a GP
- carrying out risk profiling and stratification work to identify people who require support to prevent them from requiring long-term care / greater long-term care provision.

**Benefit** - GPs will be at the heart of the system, engaged in preventative activity and supporting their patients in the community. GPs will also be updated on their patients’ support needs and progress.

**Maximise independence**

Throughout the service, where possible, there will be a focus on maximising a patient’s / service user’s independence. This will be through providing services with the aim of preventing hospital admission and reducing the size of long term care packages/residential care i.e. allowing people to live in their usual place of residence for longer.

**Benefit** – The care system will focus on maximising a patient's independence with better outcomes for individuals, reducing the cost of long term care and unnecessary emergency hospital admissions.

**Focus on prevention**

Throughout the service the focus will be on preventing a patient needing to go any further through the service:

- Where possible the single point of contact will signpost people to other services if these might prevent the service user from requiring care.
- Combined rehabilitation/ reablement will help prevent the requirement for long term care and support.
- During long-term care and support, care packages provided will aim to support the patient in such a way that they don’t come to require complex care packages and residential care

**Benefit** – Resources will be focused on prevention and recovery wherever possible, reducing long term care needs.
**Improved efficiency**

In the new system efficiency will be improved by reducing the number of times that an activity happens:

- There will be a phone number to access the single point of contact, which will provide one port of call for advice on both health and social care needs.
- When an urgent response is required this will be allocated to the joint urgent response team who will be able to deal with both health and social care needs.
- Patients will receive one assessment, which will cover all of their health and social care needs.
- Patients will receive one care plan to meet both their health and social care needs.
- Teams will aim to address all of a patient’s health and social care needs with a single planned intervention through rehabilitation/reablement.

Further to this, patients will be encouraged, where appropriate, to self-serve through the initial stages of the system which will improve efficiency by reducing the demand on staff.

**Benefit - Self-service is enabled and duplication of activity reduced.**

**Benefits heat map**

The heat map below sets out by benefit category the likely scale of the benefit to be realised across each of the three main service areas in the care system.

![Figure 2: Benefits heat map](image-url)
The Integrated Care Organisation (ICO)

- An ICO is the heart of our care system, bringing together social care and community health resources into co-located, multidisciplinary teams

- It will address the issues which patients, service users, carers and staff identify in the current system, by removing fragmented access and duplicated activities like assessments and care plans, and bringing to the fore the creation of a care coordinator role to support patients and service users

Introduction
Commissioners want a care system that provides better outcomes for our patients and service users. We believe that the only way to deliver this is with an ICO at the heart of the care system. This will address a large number of the issues which patients, service users, carers and staff identify in the current system. It will also provide the means to allocate funds more effectively across health and social care.

Design principles
To guide the development of the ICO, a set of design principles were developed in consultation with stakeholders from the health and social care commissioners, HRCH and GPs. These principles were broken down into the following four areas:

- how we connect with patients and service users
- services we offer and delivery models
- how we are organised
- how we work

The principles under each of these areas can be seen in Appendix II – ICO Target Operating Model design.

Target operating model
The ICO was developed using a Target Operating Model (TOM) framework. The TOM describes, through different layers, how the organisation will need to be organised and behave in order to carry out its functions and deliver its services. We have carried out a predominantly top down design of the ICO which remains at a high level, but with enough detail to be able to describe how the elements make up the TOM. If the decision is to go ahead with the ICO, further work will be required to develop the TOM in a lot more detail.

The TOM Framework (Figure 3) sets out the layers that have been considered in designing the ICO, with each layer described in more detail below, with the exception of governance, which is dealt with in the chapter ‘Governance and regulatory issues’.
IT requirements

Figure 3: The Target Operating Model Framework

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<thead>
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<th>Functions</th>
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<tbody>
<tr>
<td>• What core functions will the ICO deliver?</td>
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<td>• How will these be delivered through a set of services?</td>
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<th>Process and activities</th>
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<td>• What processes and activities make up these services?</td>
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<th>Systems and information</th>
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<td>• What systems and information are needed to support the organisation and the functions it carries out?</td>
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<th>People and Organisation Structure</th>
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<td>• How we would organise and deploy our resources to deliver the outcomes within the resource envelope?</td>
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<th>Accommodation</th>
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<td>• What property arrangements are required to deliver these services?</td>
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<th>Governance</th>
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<tr>
<td>• What governance arrangements need to be in place to effectively deliver the outcomes within the resource envelope?</td>
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**Functions**

Using the design principles and the proposed care system described in the previous chapter, Figure 4 on the next page highlights the functional areas, services and staff resource for the ICO.

The system of care to be delivered by the ICO envisages providing more prevention, intervention and recovery services, with the aim of preventing or reducing the number of people who would unnecessarily receive ongoing long-term support. The model, which has been aligned to the care system, suggests that our integrated service should be broken down into the following four service elements which could make up a customer’s pathway:

- First contact
- Urgent response
- Community recovery service
- Long term care & support

A detailed description of each service area and its functions and services can be found in Appendix II – ICO Target Operating Model design.

**Process and activities**

Fundamental to the delivery of the ICO will be the development of standardised, best practice and where possible, shared processes. We carried out a high level design of a potential end to end process to define what the customer journey could look like and to identify the critical interactions between teams in the ICO and the care system.

The customer journey will be based on the completion of one assessment and one care and support plan for patients and service users, with capability and capacity enhanced through mobile and flexible working and proportionate gathering of information on the service user at all stages of the customer journey. There will be consistent triage and navigation to prevent unnecessary assessments taking place and to facilitate a smooth transfer of care.

Additional features of the processes are described below:

- A proactive way to discharge patients out of hospital through the use of a ‘case finding’ approach and an early discharge co-ordinator.
Figure 4: Functions, Services and Staff Resource for the ICO

**Functions**
- Universal Information
  - First Contact
    - Intelligent signposting
    - Providing advice
    - Gathering information

**Resource and staff**
- Self Serve
- Web content management staff

**Call Handling Core Staff**
- General call handling staff
- Professional and specialist clinical input
- Business support

**Urgent Response**
- Richmond locality
- Hounslow locality
  - Provide immediate & rapid response service for crisis events (e.g. Telecare)
  - Providing referrals for diagnostics
  - Referrals and pulling in specialist advise
  - Connecting with Mental Health Services
  - Carry out health interventions
  - Supporting clinicians

**Specialist Resource**
- CPN
- Specialist community medical professional
- Neurology
- Geriatric
- Nutritionist and dietician
- Dementia and falls
- Diabetes
- Respiratory
- Housing links (e.g. extra care and sheltered)

**Community Recovery Service**
- Richmond locality
- Hounslow locality
  - Reablement services
  - Organised hospital discharge
  - Rehabilitation services
  - Pulling in specialist advise
  - Carrying out holistic response (short assessment and planning)
  - Referrals/signposts to long term support
  - Co-ordinating further support
  - Co-ordinating with community based services
  - Connecting with communities, support networks and families

**Medium Term Core Staff**
- Occupational therapists and physiotherapists
- Nurses and community matrons
- Social workers
- Health and Social care support workers
- Early supported discharge
- Business Support (specialist)

**Long Term Care & Support**
- Richmond locality
- Hounslow locality
  - Continuing healthcare
  - Residential Care
  - Nursing Care
  - Domiciliary Care
  - Palliative Care
  - End of Life Care
  - Managing long term conditions
  - Carrying out holistic response and planning
  - Pulling in specialist advice
  - Self management planning
  - Making decisions for people requiring support
  - Understanding and supporting other needs

**Specialist Resource**
- Qualified social workers
- Community nursing
- Some health support e.g. Nursing
- District nurses and community matrons
- Mental Health Liaisons
- Healthcare Assistants
- Phlebotomy
IT requirements

- Clear routes between the ICO and risk stratification and profiling activity to identify and develop packages of integrated care to patients who, without intervention, would be at risk of requiring long term support, or would develop complex or worsening conditions while receiving long term care.
- A care coordinator role will be adopted within the core multidisciplinary teams to help service users navigate the care system through one named individual.
- Clear points of interaction between the patients, the ICO and GPs, including the triggers for these interactions.

Organisation structure

An emerging organisation structure has been developed to show how the ICO could be organised to deliver the care system in an efficient, effective and integrated way. As much as possible the aim is to ensure integration of management across the two social care and health teams.

Multi disciplinary teams have been proposed which will bring together teams to discuss a person’s support in an integrated way, not just restricted to one discipline. The structure also supports the co-location of teams so that boundaries are removed physically and professionally and there is better alignment with GP practices.

The structure requires three main service areas to deliver the system:

- first contact, urgent response and community recovery service
- long term support and care service
- specialist service

The First Contact team will provide services for the whole of Hounslow and Richmond and will be staffed with multi-disciplinary call handling staff with professional and specialist input for more complex enquiries. The Urgent Response, Community Recovery and Long Term Support teams will be staffed with a range of health and social care professionals. For each service, there will teams to cover the Hounslow and Richmond localities, although these will be the responsibility ultimately of one manager.

A more detailed description of the emerging structure can be found in Appendix I – ICO Target Operating Model design.

Role of the care co-ordinator

Pivotal to improving the journey and experience of service users and patients, a care coordinator role will be developed within the core Multi-Disciplinary Teams (MDTs) to support service users to navigate the care system through one named individual. Typically drawn from the core team, care co-ordinators can also be drawn from the specialist resource if it is deemed beneficial to do so. Care-coordinators will have a good knowledge of health and social care options, networks and relationships to enable them to carry out their role. The care co-ordinators will be allocated to cases using a rota system from those designated to perform that role.

A list of activities carried out by the care co-ordinator in both the hospital and community setting is highlighted below.

<table>
<thead>
<tr>
<th>Community</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Help the user navigate around the care systems, including accessing care and providing the link between accessing ongoing care where required once medium term intervention is complete</td>
<td></td>
</tr>
<tr>
<td>• Liaise with the GP once a decision has been made about the service a person will access</td>
<td></td>
</tr>
<tr>
<td>• Support the proactive discharge of patients out of hospitals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Draw on the relevant support for patient as part of discharge activity – e.g. Could be adaptations, equipments</td>
</tr>
<tr>
<td></td>
<td>• Make sure GP is contacted as soon as discharge plan is made available.</td>
</tr>
<tr>
<td></td>
<td>• GPs will also be proactive in contacting the co-ordinator for such cases</td>
</tr>
</tbody>
</table>
Senior management/executive

It is recognised that the development of the ICO will require a review of the competencies and capacity required of the HRCH Board, and this will have an impact on both executive and non-executive director roles. The HRCH executive structure will include a social care focused executive role which will be made available in the first instance for existing senior social care managers from both boroughs.

Structure process and principles

The creation of the new structures will take place under a jointly agreed change management policy which will be underpinned by principles of openness, transparency and equity. This policy will apply equally to the creation of new posts and assimilation of existing posts into the ICO. Where new posts are created in the integrated structure, opportunities will be made available to all eligible staff from the three organisations. The detailed process for appointing to posts in the new structure will be determined in the next phase in line with each organisation’s change management policies. There are several options for achieving the deployment of staff to the integrated teams from their employing organisation. These will need to be explored further to determine the most appropriate route for the creation of the ICO.

Culture and values

In order to successfully develop an ICO we cannot underestimate the importance of developing and embedding a new culture. We recognise that it will involve three different organisations’ cultures coming together across health and social care. In order to create a new culture of integrated working within the ICO it is important to realise that it is not enough to just set up an ICO and employ integrated managers. We need to embed in all staff a culture that will promote integrated working and:

- builds on existing good practice
- reflects both health and social care perspectives
- puts the person at the centre of all services with the aim of maximising their independence
- asks staff to take on more generic responsibilities across the provision of health and social care
- asks staff to take responsibility for coordinating care

Strong leadership will be important in driving the cultural change. We need to define the leadership qualities and practices that we require early on and get these into place before the ICO is fully implemented. We would expect our leadership to be talking to staff, making sure that they understand the change and motivating staff to change. We would also expect that our staff will help to shape the future culture and values of the new organisation.

Accommodation

The integrated teams will be located in their respective boroughs for preventative, recovery and long term services, apart from first contact services which will be delivered from one location for both boroughs.

London Borough of Richmond proposes to maintain the current four locations, where staff are already working together, to carry out community recovery and long term support work.

For Hounslow, teams carrying out community recovery and long term support will remain in their existing location (Civic Centre) but will also have a home in the five GP hubs.

It is recognised that co-location of teams will be important to foster the cultural change required, but that in itself it is not enough. Richmond has had co-located teams for several years and this has not driven the desired level of integration. A move towards mobile working, along with the systems and hardware needed to support mobile working, will enable teams to not be so closely linked to an office, therefore saving travel time and reducing the time taken to complete assessments.
IT requirements

- We will require IT systems that enable health and social care professionals to co-ordinate an individual’s care, supported by the information they need at the time they need it.

- There are several possible solutions which could meet these needs. Further detailed work is required to develop a better sense of our requirements and to evaluate and cost the options open to us.

The business need for technology

For the ICO to function effectively for both health and social care to work together it will need:

- One view of the patient/service user, for example, demographics, family/carer details, services received, previous contacts, workers involved etc.

- To know the outcomes for people who contact the ICO whose needs are met at the first point of contact: Many calls/emails will be made to the ICO (in Richmond alone there are approximately 500 calls and emails each week) and a system is needed to manage the initial contact and to know the outcomes when needs are met at that stage.

- To record information easily: All staff will need to know how to update information relevant to the service user they are supporting and it must not be an onerous task. There must be no double entry of data and there is a fully electronic record.

- To map and monitor the customer journey through the care system from initial contact to receiving a service.

- To capture information from patients and service users only once.

In addition, in order to deliver the data and reports required by the commissioning councils and CCGs, the ICO will require:

- Performance management systems: A performance framework across all the disciplines in the ICO that sets out the information that the ICO uses to manage their business and to inform commissioners of outcomes. Data across health and social care will need to be produced and analysed throughout the ‘customer journey’. The performance framework is the basis of the specification for the service.

- Back office systems: Back office support systems that support integrated working, including the ability to pay people direct payments or to manage individual budgets across health and social care.

- Information security systems: Data is accessible on a need to know basis and all systems only give access to data on this basis. There is an information sharing protocol in place and information sharing agreements that set out the data that can be shared.

IT options

At this stage we have not scoped the full future IT requirements or determined if or how the current multiple systems could be brought together to deliver what we will need. This work will be done as part of the full business case.

A core part of the change will be providing staff with one view of the customer and enabling the delivery of a joint care plan worked on by multiple professionals. We have started to explore the IT options to enable this and believe we can source a system or systems to meet our needs. Both CRM (customer relationship management) and portal systems could deliver this functionality. A very early estimate of the one-off investment needed for this is in the range of £0.5m - £1m, but this figure may change substantially once we have done further work.
Governance and regulatory issues

- We set out here, at a high level, how governance would work, including new roles for existing bodies (such as the two Health and Wellbeing Boards and Overview & Scrutiny Committees) and roles for the new bodies which we would create specifically to enable Councils and CCGs as commissioners to hold the ICO to account for delivery of agreed outcomes to budget.

Governance

Principles

The principles that will underpin the design of our specific arrangements are as follows:

- decision making will be through a single process
- delegation of decision making will be as close to the service as possible
- responsibilities will be transferred to the right place in order to reduce duplication and confusion
- resources will follow responsibilities
- we will streamline and standardise our processes
- we will reduce double handling

These principles are our starting point for testing out our governance arrangements in terms of delivering robust decision making and clarity of responsibilities and the degree to which they meet those needs for each organisation.

Constraints

In designing a framework, some limiting factors need to be acknowledged and accommodated.

These include the statutory responsibilities of the commissioning bodies and provider organisation and the statutory responsibilities of individuals appointed to specific posts, which cannot be delegated; including for social care and safeguarding.

Delegation of responsibilities

The provisions of the NHS Act 2006 section 75 allow for the functions (statutory powers or duties) of one partner to be delivered by another partner, subject to agreed terms of delegation. Responsibility for undertaking certain functions, activities or decisions can be transferred from one partner to another to achieve the partnership objectives. Although the functions are delegated, partners remain responsible and accountable for ensuring they meet their own duties under the legislation and cannot pass on responsibility for services outside the agreed activity.

Regulatory bodies

The governance framework and each organisation involved must also take into account the requirements of the various regulatory bodies to which the parties are subject. These include the Department of Health, Monitor, CCP, the National Commissioning Board and the Care Quality Commission.

Organisational and operating model constraints

Finally the proposed organisational and operating model may impose some constraints on governance. The principal aim should be to ensure that HRCH has sufficient resources and control over those resources to be held to account for performance against targeted outcomes. To ensure this consideration will need to be given to the extent to which back office and support functions (including IT, HR, finance and administrative support) are retained in the commissioners or transferred to the ICO.
**Decision making roles and architecture**

A diagram of the proposed top-level governance for the performance of integrated care can be seen in Figure 6 below. The proposals are designed to be fit for purpose and robust for the current configuration of community health and social care services. However, they will need to be reviewed if the environment changes.

![Figure 6: Top Level Governance for the Performance Monitoring of the Integrated Care Organisation](image)

**Proposed governance structure**

The proposed governance structure is made up of existing and new bodies with a set of defined roles and responsibilities to enable effective governance. The following proposals have been made for existing bodies:

- **Health and Wellbeing Boards** to develop and align the strategic direction given to commissioners in the co-commissioning of HRCH.
- **Commissioners (Councils and CCGs)** to align their commissioning of community health and social care for their area. Additionally it is expected that the two CCGs will have a Memorandum of Understanding which will promote closer working and alignment of their commissioning intentions for health care.
- **Overview and Scrutiny Committees** to align their work programmes so that issues relating to the provision of community health and social care by HRCH are the subject of joint meetings (agreement of the two Committees will be needed for this).
- **HRCH (ICO) Management Board** - HRCH discharges its current responsibilities through a robust board and committee structure. The key formal committees supporting the Board are Finance and Performance, Integrated Governance (which discharges responsibility for safeguarding), Audit and Nominations and Remuneration. Going forward, in line with the requirements of the ICO, it is acknowledged that there will be a need to enhance capacity and capability in relation to social care provision at both an executive and non-executive level.

The final management structure for the ICO will be designed in collaboration with partners to ensure that is has sufficient capability and capacity to deliver the performance outcomes commissioned from the ICO and that it can provide the Councils with the necessary assurance that the operating system will fully support the delivery of statutory responsibilities.

We have identified that the following new bodies will need to be created under this new structure:
**Joint commissioning groups**

These will allow each Council and CCG pair to integrate and align their local community health and social care commissioning of the ICO and to manage the ICO’s performance against the contract.

Key roles and responsibilities for this body include:

- identifying common priorities and requirements of HRCH in their commissioning intentions and to align their performance management of HRCH as closely as possible within a joint framework
- holding HRCH to account for localised services specific to their population
- having a section 75 agreement with HRCH, to enable the transfer of responsibility for certain functions, including budgets.

Joint commissioning groups will hold monthly contract management meetings to consider performance against key indicators and against budget. The membership of these joint groups will comprise the named officers in the contract with HRCH, lead commissioners if different, as well as finance and performance leads. The relevant operational managers of HRCH will also attend.

Each Council/CCG pair will also be commissioning other providers and there could be opportunities in the future to use the joint commissioning groups to use these arrangements to work with these other providers.

**Operational contract management - Hounslow & Richmond Integrated Care Delivery Monitoring Board**

A new joint strategic board will be created whose purpose is to agree HRCH’s delivery plan and to hold HRCH to account for its performance against agreed outcomes. This will effectively be the high level vehicle for contract management of HRCH.

The Delivery Monitoring Board will meet quarterly to:

- hold the ICO to account for the delivery of high quality services and agreed outcomes within agreed budgets
- review information both collectively across the whole ICO and on a borough/organisation specific basis
- look at trends in performance and consider how the contract is delivering the strategic objectives
- consider how improved performance can be supported.

HRCH will have the freedom to challenge this Board and negotiate changes to its delivery plan with regard to the way it delivers the outcomes required by the commissioning bodies and the way it operates in order to deliver the outcomes.

The sanction the Board will have against HRCH for inadequate performance is the review and possible termination of the section 75 agreement.

**Membership of the Delivery Monitoring Board**

The membership of the Hounslow & Richmond Integrated Care Delivery Monitoring Board will comprise:

- Accountable Officers of the two CCGs
- Lead GPs
- Director of Children’s and Adults Services (LBH)
- Director of Adult and Community Services (LBR)

Other officers will attend the Board to advise them, including finance and quality assurance representatives and lead commissioning officers as required.

HRCH will attend the Board to be held to account, listen, respond and raise issues about delivery and performance.

A more detailed description of the new and existing bodies can be found in Appendix VI – Governance and regulatory issues.
Performance management
In the new model both Hounslow and Richmond Councils will need assurances that the ICO is managing its performance and is taking appropriate actions if performance and budgets are not on track. To do so the Delivery Monitoring Board will work with HRCH to review operational and financial performance on a monthly basis. It is anticipated that the Delivery Monitoring Board will be looking for regular high level visibility of performance as opposed to ‘package by package’ contract management.

We will need to carry out further work to define the exact metrics. We have defined some examples of metrics (Appendix V – Performance management) which cover access and avigation, activity, mix of patients, mix of services, maximising independence, improved efficiency, finance, establishment and safeguarding.

Statutory responsibilities
It is recognised that each organisation has key statutory responsibilities for which it will remain accountable in law. Social service responsibilities are very broad. Not all would pass to the ICO. Some would be retained within each Council as the commissioning authorities. A number of health responsibilities would also remain with CCGs. A key example of where responsibilities need to be clearly defined is safeguarding. Safeguarding statutory responsibilities would remain with the Director of Adult Social Services (DASS) in both Councils. The operational delivery of safeguarding responsibilities will sit within the ICO. Refer to Appendix II – ICO Target Operating Model design for more detail on statutory responsibilities.

Financial governance
Financial governance arrangements for the ICO will be detailed in Section 75 Agreements held between HRCH and the four commissioning organisations. Their main objective of these agreements will be to provide assurance that resources are being managed efficiently and effectively, with clear financial accountability and robust risk management processes.

The financial governance framework will set out the following main elements in detail:

- financial management arrangements, including Scheme of Delegation
- risk and benefits sharing agreement
- benefits realisation plan
- VAT arrangements
- audit arrangements
- anti-fraud and corruption policy.

Key financial controls and how they may be exercised
Controls will be put in place to ensure that staffing resources and budgets within the ICO are deployed on each borough’s population so that the Councils and CCGs can be assured that the funding they have put into the ICO is being spent on their patients and service users. Controls will include:

- commissioners to agree the organisational structure and the change control mechanism
- changes to staff deployment across boroughs to be agreed by the Councils and the Trust in the short term i.e. any changes in the initial model will be by mutual agreement rather than through outcome targets set for the Trust
- budget management controls to ensure spend is within approved budget; these controls would form part of the overall ICO performance monitoring framework
- the use of the performance monitoring framework to ensure the desired outcomes are being delivered for the residents of both boroughs

Financial controls will be put in place for the ICO to maintain sound financial control over the budgets transferred into the ICO, including those for commissioned care services. These controls will ensure that commissioned care services are provided to Hounslow and Richmond residents based on population and local need and that each Council and CCG continues to commission services exclusively for its own residents. The controls will ensure that social care needs assessments undertaken by the ICO will take into account each
Council’s eligibility criteria and means-testing thresholds, as each Council will retain the flexibility to set these according to local needs, priorities and resources.

**Financial systems**

In setting up an ICO, it is recognised that each organisation is at a different starting point in terms of its financial and budget management systems for commissioned care services. The ICO will be developed with the aim of having financial data, held at individual service users/patient level, to allow robust management of care services budgets with flexible reporting by service type or locality team. Each organisation will need to be satisfied that its financial management and budget reporting can be maintained under the ICO without a loss of financial control.

**Procurement obligations**

The Councils and CCGs need to ensure that all parties can show (and continue to show) that moving to the proposed ICO model represents the ‘best value’ option and that HRCH is the best possible ‘provider’. CCGs will also continue to ensure that they support competition in their market. An audit trail will be needed to ensure that these requirements can be demonstrated at all times. The Department of Health, the Co-operation and Competition Panel and Monitor will need to be involved to ensure all three are content with the envisaged arrangements, given that this is such an innovative approach. We are already talking to all three and we are confident that these issues will be resolved.

**Equalities impact assessment**

We have jointly conducted an initial high level Equalities Impact Assessment (EIA). The purpose of the EIA is to demonstrate that we have given due regard to our equalities duties and that the proposals outlined in this report are not in breach of those duties. The aim of an EIA is to support those making decisions to do so in an informed way that allows them to balance the proposal against any likely adverse impact.

At present only a high level equalities screening exercise has been carried out. The next step is the completion of a full EIA.

A summary of the conclusions of the EIA, which also highlights some specific areas where care will need to be taken during the design phase can be found in Appendix VI – Governance and regulatory issues.
Implementation timeline and next steps

- The first step is the completion of more detailed design work and approval of a full business case by June 2013

- Subject to the approval of the business case we will commence a staged implementation in July 2013, running through to September 2014 at the latest

- This phased approach will enable us to manage the current uncertainty around the timing of the completion of HRCH’s application for Foundation Trust status, to seek realisation of benefits as early as possible and to reduce the risk of the transition from the current care systems to the new

Options considered
The proposal to design an integrated model of care is significant and transformational and goes beyond anything that has been previously considered across and within our five organisations. The greatest benefits will come from full integration of all health and social care functions including the full transfer of all staff, their management and budgets (probably including micro-commissioning budgets for individualised placements overseen and managed through the integrated teams) into a single managed service arrangement.

We recognise that certain conditions have to be in place to achieve this aspiration and that the performance and regulatory regime across the health and social care spectrum needs to allow it. Therefore, in the course of this study we considered several interim models which might provide some of the benefits of integration without a full transfer of staff and financial resources which we believe has to wait until Hounslow and Richmond Community Healthcare Trust’s Foundation Trust status is confirmed. We have concluded that we need to approach implementation in a phased way concluding by September 2014.

Moving towards implementation
We recognise that each organisation has a different starting point for the journey towards an ICO and, although the destination is common, the journey each undertakes will be different.

We also recognise that in implementing an ICO we are embarking on a large, complex change programme. This will have elements of IT procurement and implementation, significant change management and organisation development for all those involved. Our aim in developing our implementation plan is to manage risks in a sensible way by taking measured steps towards our goal and to deliver real benefits as early as possible.

Richmond Council has already made major strides on its journey to deliver integrated health and social care. It is therefore already some way towards developing functions and structures similar to those of the proposed new care system.

Hounslow Council is now embarking on a journey to further develop its adult health and social care system. In the first half of 2013 the Council will be putting in place functions and structures which again are similar to those of the proposed new care system.

We have set out, in Appendix VII – Scale of change a fuller sense of the type and scale of change required in each organisation which has helped inform early drafting of the implementation plan.
Implementation timeline

Figure 7 shows the suggested phased implementation plan, highlighting the current uncertainty around the timing of the completion of HRCH’s application for Foundation Trust status which is unlikely before December 2013 and could be as late as April 2014.

Figure 7: Implementation Timeline

<table>
<thead>
<tr>
<th>Design Phase (Feb – May 2013)</th>
<th>Implementation Phase (June 2013 – Sept 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCGs Transition</td>
<td>FT Status Known (April 2014 at latest) and into effect</td>
</tr>
<tr>
<td>Feasibility Decision</td>
<td>ICO up and running</td>
</tr>
</tbody>
</table>

- Design End State ICO
- Design Pilots
- Activity, baseline and Bus. Case
- Engagement & Participation Activities
- Hounslow Restructuring
- Enhanced Engagement and Change Management
- Continued Engagement & Consultation
- TUPE staff

Business case and design phase

This will be a four month phase from March-June 2013 which will develop a full business case. This phase will conclude in June 2013 with decisions in each participating organisation on whether to proceed to implementation. The phase will include:

- design of the proposed ICO
- IT requirements and costs
- description of planned pilots
- completed business case
- detailed implementation plan
- finalised governance arrangements
- continued engagement and consultation with service users, patients, carers and staff

A dedicated project team will need to be set up and different work streams established; further details of these are in Appendix VII – Business case work streams.

Implementation phase

This phase will run from July 2013 to September 2014. During this phase we will pilot and test aspects of the care system and, where possible, deliver early benefits. We will in effect be taking steps towards the new care
system with the ICO, in its fully-functioning form, in place at the end. Strong operational leadership will be needed during this phase to ensure that developmental and piloting activity and the delivery of ‘business as usual’ services are both given the necessary attention.

Pilots and early implementation activities
The piloting and testing period will run from July 2013. The purpose of this activity will be to test out different ways of working and to help to understand the requirements of all elements of the ICO. Individual pilots are likely to run in only one or other of the local authorities or in a limited number of teams. These pilots will be designed in detail during the design phase but may include:

- **Joint care assessments and plans.** We would develop and pilot the use of a single care assessment and planning process, with the objective of ensuring that patients and service users receive appropriate, effective and timely responses to their health and social care needs.
- **Care co-ordinator role.** We would train some staff to take on the role of care-coordinator which would enable them to support patients and service users to navigate the care system effectively.
- **First contact.** Access team staff from one or both Councils could work closely with HRCH to test the proposed First Contact approach and processes.
- **Integrated management of long term care teams.** As and when vacancies arise in long term care teams it may be possible to create an integrated manager post early on to test out integrated working in these teams.
- **Community Recovery Service.** Integrated intermediate care & reablement teams will be in place in Richmond from April 2013. We can use these to test aspects of the proposed Community Recovery Service, including hospital discharge.

Benefits of the implementation timeline
We believe that a phased approach to implementation will help us to start to deliver some of the non-financial and financial benefits of integrated health and social care as soon as possible.
Costs and benefits

- **The value of the services to be commissioned from the ICO and the staffing resources transferred to it will be circa £132m based on current figures (and including the value of the current commissioning)**

- **Longer-term benefits of reduced hospital admissions resulting directly from changes to the health and social care system are estimated at £8m-£13m**

- **The creation of the ICO will realise further efficiencies by removing duplicated activity across health and social care**

- **Organisations will have to be prepared to fund a share of an initial investment required to establish and develop the ICO**

- **Costs and benefits will need to be shared by all the participating organisations**

**Proposed ICO resources**
The financial envelope for the functions that are in scope for the ICO is currently £132m. This comprises:

- community health services commissioned by Hounslow and Richmond CCGs and provided by HRCH
- adult social care services provided by both Councils
- commissioned care services – individual packages of support for service users provided by external care providers
- support/back office services in both Councils which support adult social care teams

The proposed resources are summarised below and a detailed breakdown is included in Appendix III – Current resources for functions within the ICO.

**ICO resources**

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>£8.1m (193FTE) Hounslow Council social care staff</td>
<td></td>
</tr>
<tr>
<td>£5.2m (103 FTE) Richmond Council social care staff</td>
<td></td>
</tr>
<tr>
<td>£46.5m (422 FTE) healthcare staff and services provided by HRCH</td>
<td></td>
</tr>
<tr>
<td>£4m Support/back office services - partly retained by Hounslow and Richmond Councils, partly transferred to the ICO</td>
<td></td>
</tr>
<tr>
<td>£0.5m Management costs</td>
<td></td>
</tr>
<tr>
<td>£68m Commissioning care service budgets; Hounslow (£40m) and Richmond (£28m) Councils</td>
<td></td>
</tr>
</tbody>
</table>

Adult social care represents a significant proportion of the Councils’ overall budgets. Hounslow and Richmond spend 33% and 39% of their respective overall Council budgets on these services. There are some differences in the resources allocated to these services, reflecting local needs, priorities and different approaches to commissioning. Richmond spends more of its overall adult social care budget on services for older people; Hounslow spends slightly more on services for people with learning disabilities.

Hounslow and Richmond CCGs allocate approximately 8% of their overall resources to community health services. Their existing community health services contracts account for 86% of HRCH’s total operating
Cost and benefits

revenue. This feasibility study assumes that HRCH will continue to provide its existing range of services across both boroughs, although not all these services will be fully integrated in the ICO.

Management and staffing arrangements

The management teams and adult social care staff (social workers, occupational therapists and unqualified social care assessors) will transfer to HRCH from both Councils to the ICO, along with the budgets for these staff.

In the initial stages of our phased implementation, while piloting aspects of the new model, it may be necessary to second some Council staff to work with HRCH’s healthcare staff.

Support services

Under the proposed model, the Councils’ support/back office arrangements for adult social care would need to be reviewed to reflect the new ICO arrangements. For some support functions, there may be economies of scale to be gained by retaining them in the Councils as they also support other functions not transferring to the ICO. Arrangement would be made to provide services to the ICO. It may be sensible for other services, for example, human resources, to be integrated into the ICO and therefore an appropriate level of resource would need to transfer from the Councils. The aim would be for a greater proportion of the support services to transfer to the ICO, creating some additional potential efficiency.

The community health services contracts commissioned by Hounslow and Richmond CCGs reflect a share of support services and management costs for these services and therefore there would be no impact on support service functions for the CCGs. The creation of the ICO will provide an opportunity for management costs and support services to be deployed efficiently across the ICO with its expanded remit.

Potential financial benefits

The major potential financial benefits (whether saved or reinvested in services) come from:

- the proposed holistic approach to care – joined up care with better planning and outcomes
- improved management of long term conditions with better co-ordination of care services
- an increased focus on prevention to help manage demand across health and social care

The proposal to create an ICO is driven by a desire to improve outcomes rather than to make savings as such. In the shorter term it is recognised that all the organisations involved will need to invest in setting up this service. However, in the current public sector financial context, Councils and CCGs are required to make efficiency savings to meet increased demand for services and reductions in public sector funding. This financial climate is expected to continue for a number of years. Councils are therefore increasingly looking for innovative ways to deliver services more efficiently to meet increasing service demand and to make services sustainable.

All our organisations are committed to delivering services in the most efficient way possible and have made a firm commitment that integrated care must not be driven by savings at the expense of delivering excellent outcomes for service users and patients. However, we believe there are a number of potential efficiencies including:

- Pre-ICO – savings from more efficient processes and effective integrated service provision, some of which can be delivered prior to the establishment of the fully functioning ICO
- Once the ICO is fully functional – more savings from more efficient processes and effective integrated service provision, including savings from combining the staff and management structures from three organisations into one ICO.
- Longer term – savings from commissioning budgets across the health and social care system through reducing avoidable emergency hospital admissions and reducing the need for long term care packages.
Benefits summary

At a high level, acknowledging the considerable uncertainty about the potential longer-term efficiencies, the range of efficiencies per annum is:

<table>
<thead>
<tr>
<th></th>
<th>Richmond Adult Social Care</th>
<th>Richmond CCG</th>
<th>Hounslow Adult Social Care</th>
<th>Hounslow CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-ICO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>£0.3m to £0.5m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existing QIPP</td>
<td></td>
<td>Approx. £1m</td>
<td></td>
<td>Existing QIPP targets 5-6%</td>
</tr>
<tr>
<td><strong>Fully functioning ICO</strong></td>
<td>Range £120k to £160k¹</td>
<td>Existing QIPP targets 5-6%</td>
<td>Range £120k to £160k²</td>
<td>Existing QIPP targets 5-6%</td>
</tr>
<tr>
<td><strong>Longer term</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Overall it is considered that moving to an integrated care model should enable costs for emergency admissions and long term care to be reduced by around £8m to £13m,</td>
<td></td>
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</tbody>
</table>

Pre-ICO

Both Councils will continue to move their social care functions towards the ICO model and realise benefits from doing so.

Fully functioning ICO

We expect that there will be initial efficiencies by bringing together staff and management structures from three organisations into one ICO. This feasibility study acknowledges that both Councils are starting the integration process from different positions and where new models of care are already in place, there is a lower potential for further efficiencies. It is likely that Hounslow will be making more significant change in advance of placing staff into the ICO and the savings from this will accrue to the Council. Subsequently, efficiencies from the creation of an integrated organisational structure will be realised by the commissioners, mainly the two Councils. In commissioning services from HRCH, the CCGs set annual efficiency targets under the Quality Innovation Productivity and Prevention (QIPP) framework. In setting up the ICO, the CCGs acknowledge that they do not expect any efficiencies in addition to existing QIPP targets. The development of the ICO will assist HRCH in meeting its own target to achieve a small surplus in order to satisfy required financial risk ratings and to maintain its own competitiveness from cost efficiencies.

Longer term

Benchmarking comparisons (detailed in Appendix IV – Long term savings potential) show that spend on emergency hospital admissions could be substantially reduced and there is also scope for efficiency within the large budget for long term social care. The ICO will aim to address these areas of spend to deliver efficiencies in the longer term.

Our target in moving to an integrated care model should be to enable savings of 2-3% on acute commissioning budgets (£350m) and between 2-5% on long-term adult social care budgets relating to the ICO functions (£60m). This presents a long-term goal with a considerable value of £8m - £13m based on current spend. It must also be recognised that it may not be possible to realise savings in full from the acute sector if commissioners do not shift resources from acute commissioning to community services in line with the reduction in activity from avoidable emergency admissions.

Evidence² shows that improving joint working across the boundary between health and social care has the potential to deliver significant efficiencies. The main areas which would provide efficiencies are:

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¹ The savings range quoted here is estimated from bringing together the management structures only from the three organisations. It is likely that further savings could be identified through efficiencies throughout teams at all levels.
² Evidence shows that improving joint working across the boundary between health and social care has the potential to deliver significant efficiencies. The main areas which would provide efficiencies are:
Cost and benefits

- preventing avoidable hospital admissions
- reducing emergency bed days through more effective hospital discharge arrangements
- enabling people to live more independently for longer at home
- enabling more people to choose to receive end of life care at home

In Richmond, analysis of patient data as part of risk stratification work shows that around 5% of patients account for around 40% of the hospital and estimated GP pharmacy spend. The top 1% roughly account for 20% of this spend. This data indicates the possibility of significant savings from integrated care. The proposed model of care will ensure that patients will be supported more effectively by improved patient pathways, resulting in reduced hospital admissions for this group.

Initial set-up costs

There is a significant initial investment required to develop the ICO and providing an accurate estimate of this will be central to the business case development. Set-up costs will include:

- programme management – around £0.5m plus significant existing staff time and back fill for the design phase
- organisational development – around £300k
- IT systems – a very early estimate is in the range of £0.5 -£1m, but this figure may change substantially once we have done further work.

Other costs

There will be some other costs associated with the set up of the ICO. The Councils, as commissioners, will need to establish contract management systems, and retain sufficient capacity for a client management function to provide assurance that the ICO is delivering services to the required specification. Wherever possible, each Council will work with its CCG in a co-ordinated way to manage the ICO contract, making use of existing contract monitoring processes in place for the existing commissioned community health services. It is also envisaged that Hounslow and Richmond commissioners will join together in commissioning services from the ICO and managing the ICO contract where this makes sense, recognising that there will also be some different services commissioned by each locality to meet local needs.

Sharing of benefits and costs

How benefits and costs will be shared will be developed in more detail in the business case, but we have developed some initial principles:

Overarching principles

We have agreed some overarching principles to govern the sharing of costs and benefits arising from the ICO:

- the ICO will improve outcomes and the customer journey within available budgets
- costs and savings will be ring-fenced to each borough
- investment will be made in early intervention and prevention activities with the aim of reducing long term care costs
- any investments made by the Councils which reduce spend in the acute sector, will be co-funded by the CCG, potentially by the transfer of grant funding to Councils under s256 agreements
- benefits realised will be shared fairly and transparently, in proportion to the investments made
- initial costs and efficiencies from staff re-structuring will be shared according to a risk and benefit sharing agreement; any FTE efficiencies post staff-transfer will be mutually agreed with commissioners
- in the longer term, cost savings need to be jointly agreed by commissioners

These principles will be reflected within the financial governance arrangements for the ICO and set out in a benefits realisation plan.

2 Audit Commission Joining Up Health and Social Care: Improving Value for Money Across the Interface 2011
Sharing initial development costs and benefits

In the initial development of the ICO, costs and benefits will be shared as follows:

- programme management costs – shared equitably by Hounslow and Richmond Councils, Hounslow and Richmond CCGs and HRCH
- IT costs – shared equitably by Hounslow and Richmond Councils and HRCH
- senior management posts – shared equitably by Hounslow and Richmond Councils and HRCH Trust
- management structures – to be agreed to ensure fairness and transparency
- ICO functions which cannot be separately attributed to health or social care or to an individual borough – shared in proportion to initial investment in the ICO by Hounslow and Richmond Councils and HRCH
- ICO functions which relate solely to an individual borough – risks/benefits to accrue to each borough separately
- ICO community health services – benefits will contribute towards CCG annual QIPP targets
- commissioned care services – subject to agreements made between each Council and HRCH.

Impact on other council services

The establishment of an ICO will transfer approximately 300 staff from the two Councils to the ICO and this will contribute to the wider transformation taking place in each Council. Consideration has been given to the impact on the remaining organisations and what resources will be retained for residual functions which are not part of the ICO, including those services which are out of scope for the ICO.
Risks and how they will be mitigated

- *The organisations will be among the first in the country to establish an ICO – this, of course, entails taking a degree of risk*

- *Our phased approach to implementation will help to mitigate the risks*

- *This section summarises the key risks which, if not mitigated, would have a major impact on the success of the ICO*

**Risks on the journey to the ICO**

**HRCH Foundation Trust application**

HRCH is currently applying for Foundation Trust status with the aim of achieving this by April 2014 at the latest. This means that HRCH’s Foundation Trust status may not be confirmed until just a few months before Council staff transfer into the ICO, requiring a significant amount of work to be done without absolute certainty that Foundation Trust will be secured. We will therefore need to commit to significant investment in advance of HRCH attaining FT status.

To mitigate this risk, the Councils and HRCH have engaged early with the new NHS Commissioning Board and the regulator Monitor.

**IT systems**

There is a risk that the costs of the IT systems required to support the ICO model are significant and we will have limited options in terms of systems and providers.

We can mitigate this risk by specifying a system based on early testing of elements of the new model of care, such as the care coordinator role and joint assessments. Taking a staged approach to developing the required IT suite will also enable us to take decisions along the way on which elements are really needed to deliver benefits, based on informed input from staff.

**Lack of an established ICO model and the regulatory context**

We will be among the first organisations in the county to establish an ICO. The new NHS Commissioning Board, Monitor and the Care Quality Commission are still considering how they will monitor organisations moving to this model.

To mitigate this risk, the Councils and HRCH have engaged early with the new NHS Commissioning Board and the regulator Monitor and will continue to work closely with these and other key organisations and regulators.

**Risks to the ICO itself**

**Governance**

With five organisations working together to create the ICO there is a risk that each organisation will not be appropriately represented in the new management and governance arrangements.

This risk will be mitigated in further detailed work on the proposed senior management structure of the ICO and the governance arrangements.

**Culture change**

The culture is different across health and social care so a programme of significant culture change will be required to ensure a high performing ICO. Unless this is delivered successfully there is a risk that the benefits from integrating health and social care staff will not be realised. This risk can be mitigated through having
strong leadership, a clear communication plan and carefully considering organisation development issues when designing the ICO.

**Value for money**

There is a risk that the Councils and CCGs may be unable to obtain assurance that each organisation is obtaining value for the money from the ICO.

The feasibility study identifies the high-level financial governance arrangements that the new ICO will need to have in place. The details of the key controls and reports will need further development during the next phase.

There is a further risk that the benefits from integrating health and social care do not accrue fairly to our organisations. To mitigate this risk, detailed proposals for monitoring performance, targeting service improvements and sharing costs and benefits will be developed in the business case.

**Other services**

Hounslow and Richmond Councils have different approaches to providing services to children and adults with mental health issues and learning difficulties. Therefore the ICO will need to take account of different interfaces to these services in Hounslow and Richmond.

This risk could be mitigated by putting in place protocols to ensure that the requirement of both Councils for all service provided by HRCH are met.
We have concluded that we should continue to pursue the creation of a new Integrated Care Organisation that brings together social care and community health resources into multi-disciplinary teams, focused on improving outcomes for patients and residents by helping people to stay independent and healthy.

We seek approval to develop now a full business case for the creation of an ICO and to the allocation of further funds to deliver this.

Summary

- We have set out a case for change in which both Councils and CCGs, as commissioners, recognise that the current health and social care systems cannot deliver the best outcomes for patients/service users or address the future cost pressures caused by demographics and reductions in public sector funding.
- Commissioners agree that they want a care system in which services are centred on patients and service users.
- We believe that a new Integrated Care Organisation (ICO) is crucial to a new care system.
- We will create an ICO by transferring the social staff and associated budgets from both Councils to HRCH, our current community health care provider, in order for Council and HRCH staff to deliver an integrated health and care service from the ICO.
- The journey to completed implementation will be challenging and not without risk. We have concluded that the best way to do this is by staging implementation between July 2013 and September 2014, taking measured steps towards our goal while delivering real benefits as early as possible.
- The next step on that journey is a design phase which results in the development of a full business case and design of the ICO and detailed implementation plan to get there.

The decision requested

We seek approval to develop now a full business case for the creation of an ICO and to have sufficient funds allocated to do this. The business case will build directly on the work done in this feasibility study and will provide the detail required on all aspects of the proposed ICO and its costs and benefits to enable our organisations to take the final decision in June 2013 whether or not to proceed. Further engagement with service users, patients, care and staff will be critically important to the completion of the business case.