Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**Health and Social Care Integration update: development of a target operating model for integration in Barnet**
Report of	Adults and Communities Director, LBB Barnet CCG Chief Officer
Summary of item and decision being sought	This report updates the Health and Well-Being Board on the local plans to develop integrated care and an integrated budget across Barnet CCG and Barnet Council, in response to both the recent government announcements about integrated care funding, and local financial challenges.

Officer Contributors	Karen Ahmed, LBB Later Life Lead Commissioner Claire Mundle, LBB Commissioning and Policy Advisor Tom Fennerty, Consultant, Agilisys Prema Mehta, Project Officer- Health and Social Care Integration
Reason for Report	This report presents a summary of the work taking place locally to develop integrated care and integrated budgets in line with national policy directives, and in response to national and local financial challenges. The Health and Well-Being Board is asked to approve the current plans to develop a target operating model for health and social care integration in Barnet. The Board is also asked to note its responsibilities to review the model at the November 2013 Board meeting, and to sign-off Barnet's integrated locality plan and budget before March 2014.
Partnership flexibility being exercised	The health and social care integration target operating model will direct the commissioning strategy, commissioning intentions, contracting approach with existing providers and development of business cases for integration projects that will benefit partners and these may include use of the partnership flexibilities available under section 75 of the National Health Service Act 2006, and the grant flexibilities under section 256 and section 76 of this Act.
Enclosures	Appendix 1: Briefing paper from London Councils on the Integration Transformation Fund
Wards Affected	All
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1. RECOMMENDATIONS

1.1 That the Health and Well-Being Board approves the work plan to develop a high level Health and Social Care integration target operating model and integrated budget in Barnet.

1.2 That the Health and Well-Being Board receives an update report on progress to develop this model at the November Board meeting.

1.3 That the Health and Well-Being Board agrees to receive and ultimately sign-off jointly agreed locality plans and budgets for 2014-2016 ahead of March 2014.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 In May 2012, the Health and Wellbeing Board endorsed the Health and Social Care Integration Strategic Outline Case, considered the proposed vision for integration; agreed the shared governance structure and integration initiatives, and endorsed the initial commitment of £1m by Barnet Council to fund the delivery of a local health and social care integration work programme.

2.2 On the 27th June 2013, the Health and Well-Being Board approved the Barnet CCG proposals to further develop integrated care, and these were also endorsed by the Health and Well-Being Integration Board on the 19th July.

2.3 On the 8th August, the Health and Well-Being financial planning group (the delegated sub-group of the Health and Well-Being Board responsible for overseeing and aligning the finances across health and social care to further integration) considered a paper on integrated budget proposals presented by the CCG, and made a decision to commission the development of a target operating model for health and social care integration. This decision was preceded by a discussion about changes in national policy, and the need to respond to local financial challenges (as set out in the body of this report).

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 The Health and Well-Being Strategy sets out the aspirations of the Health and Well-Being Board and its member organisations, including its aspirations to deliver integrated health and social care for Barnet's residents. The Health and Well-Being Board is responsible for promoting greater coordination of planning across health, public health and social care, and is accountable to the Barnet Partnership Board for delivery against this goal.

3.2 The plans to develop a target operating model for health and social care integration will support the delivery of the Council's medium term financial strategy and Priorities and Spending Review, both of which seek to secure the economic sustainability of the Council through to 2020. The operating model for integration has an equally important role to play in supporting delivery of Barnet CCG's financial recovery plan, which aims to secure financial balance for the organisation by 2017.

3.3 NHS Barnet CCG as a newly established organisation has developed with LBB input, and based on the Health and Well-Being Strategy, its strategic commissioning plan. The plans to develop a target operating model for health and social care integration will support the delivery of the plan and the associated CCG financial recovery plan.

3.4 Core to this proposal, and to the Health and Social Care vision to provide support to a typical Barnet resident - for these purposes called Mr Colin Dale, is the integration of health and social care support provided in Barnet, including health promotion education and prevention services.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 All identified opportunities for the integration of health and social care services in Barnet will be informed by an analysis of local and national data and evidence of what has been proven to work elsewhere. It will ensure that any subsequent work on integration is informed by the local population needs identified in the Joint Strategic Needs Assessment and the priorities for health improvement and wellbeing set out in the Health and Wellbeing Strategy. The three priorities driven by this needs assessment are set out in the CCG plan.

4.2 The benefits from the proposed programme of integration initiatives should enable partner organisations to identify more effective ways of meeting future demographic challenges that are facing the commissioning and delivery of health and social care services in Barnet, such as the aging population and substantial growth in the numbers of frail older people, and the growth in young families.

4.3 An Equalities Impact Assessment will be conducted for each health and social care integration initiative to determine its potential impact on different groups and communities in Barnet, including people within the protected characteristics of age, disability and gender as defined by the Equality Act 2010, such as older people and carers of older people or disabled people, and the requirement for any reasonable adjustment and or mitigating steps that can be put in train.

5. RISK MANAGEMENT

5.1 The evidence base for health and social care integration continues to grow. There is a need to pull together the various strands of local evidence and data into one place to ensure that there is a comprehensive evidence base from which to make decisions about the use of an integrated care budget. This risk will be mitigated by the development of a target operating model for integration which will consider both the costs and the expected shifts across both health and social care activity ahead of operationalising any further projects in Barnet. This model will consider evidence of best practice and on results from other integration projects, in order to inform its development. The creation of this target operating model will ensure that benefits measurement will be an essential component of integration project development and delivery.

5.2 Barnet CCG is recognised as one of the most financially challenged in the country. The CCG is likely to continue with a small number of conditions and directions in relation to financial plans. The CCG had a five year recovery plan which maintains spending levels in community and mental health services and reduces secondary care costs. The cost reduction is based on detailed analysis of activity and returning specific areas of over activity to expected norms. It is evidence based and has been accepted by NHS England. In addition it is recognised that Barnet and Chase Farm hospitals are not independently financially viable. The CCGs are considering a possible acquisition by the Royal Free Hospitals NHS Foundation Trust which will require commissioner transitional support for up to five years. Against this background the funding to the integration pooled budget, if seen as a transfer of NHS resources to the London Borough of Barnet, would be extremely challenging.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed functions of the NHS and health-related functions of local authorities for the commissioning, planning and provision of staff, goods or services under Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. This legislative framework for partnership working allows for funds to be pooled into a single budget by two or more local authorities and NHS bodies in order to meet local needs and priorities in a more efficient and seamless manner. Funds pooled by the participating bodies into single budget can be utilised flexibly to support the implementation of commissioning strategies and improved service delivery. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions. The Council and CCG now have two overarching section 75 agreements in place.

6.2 The Act now allows for local authorities to provide services which improve the health of the population.

6.3 There is likely to be new guidance on integrated budgets shortly, which the Council and the CCG will need to be responsive to in the development of their plans.

6.4 NHS organisations also have the power to transfer funding to the Council under Section 256 of the National Health Service Act 2006, and the Council similarly has the power to transfer money to the NHS under Section 76 of the NHS Act 2006. These powers enable NHS and Council partners to work collaboratively and to plan and commission integrated services for the benefit of their population. The new integrated budgets arrangements replace the current use of Section 256 money although Section 256 will remain in place.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 This paper outlines the work being undertaken to estimate the health and adult social care savings that integration across these services will bring, which will be completed in October 2013. These savings, once calculated, will be factored into the Quality, Innovation, Productivity and Prevention (QIPP) and CCG Recovery Plan in the NHS, and the Council savings requirements in the Medium-Term Financial Strategy and Priorities and Spending Review.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 A communications working group has been set up by the Health and Social Care Integration programme, consisting of Communication Officers from the eleven organisations that are part of the Health and Social Care Integration programme. The working group will consider communication to residents, service users and staff groups at programme and project level. This strategy will provide key guidance to the Health and Well-Being financial planning group as to how, when and with whom it will be most appropriate to engage on the target operating model once it has been developed.

8.2 Early engagement with Healthwatch for forthcoming Health and Social Care Integration projects is currently being discussed.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Provider organisations represented at the Health and Social Care Integration board have been involved in the development of both the strategic outline business case for the integration programme, and the subsequent integrated commissioning plans. These recognise the important role providers have to play in improving levels of integration an innovation within the local system of care and this is reflected in the prioritisation of a health and social care summit which seeks to engage providers in the transformation of health and social care in Barnet through integration.

10. DETAILS

10.1 Executive Summary

10.1.1 The Council and the CCG already have a vision for integrated care which is aligned with the national aspiration for integration set out by the Government. They are delivering this through the Health and Social Care Integration programme. Further detail about this programme has been provided through the recent documents referred to in section 2.2 above, and is also explained in section 10.6 below.

10.1.2 The announcement in the June 2013 Spending Round of a pooled budget of £3.8 billion nationally for health and social care systems in 2015/16 has significant implications for health and social care integration, and has a bearing on the development of the local programme. The funding will be largely sourced from existing health and social care funding and being moved in to an integrated budget, and will enable local integration to develop at greater scale and pace, and support local areas to develop economic sustainability plans in partnership. The funding has been made available by the Government on the proviso that local authorities and CCGs develop clear plans for delivery over the next two financial years (2014/15 and 2015/16).

10.1.3 In response to this announcement, the Health and Well-Being financial planning group has commissioned a piece of work to develop a target operating model for integrated health and social care that supports the realisation of the vision for integrated care in Barnet, supports efforts to secure the financial sustainability of the Council and the CCG, and identifies the next steps for the existing integration programme.

10.1.4 In Barnet, the decision making over Section 256 monies already takes place through the Health and Well-Being Board and the financial planning group, so local practice is already in line with the new requirements. The Board is asked to approve the approach set out in the paper that will be taken locally to develop a target operating model for integration, and planned use of the pooled budget.

10.2 Update on national policies: Spending round health settlement 2015-16

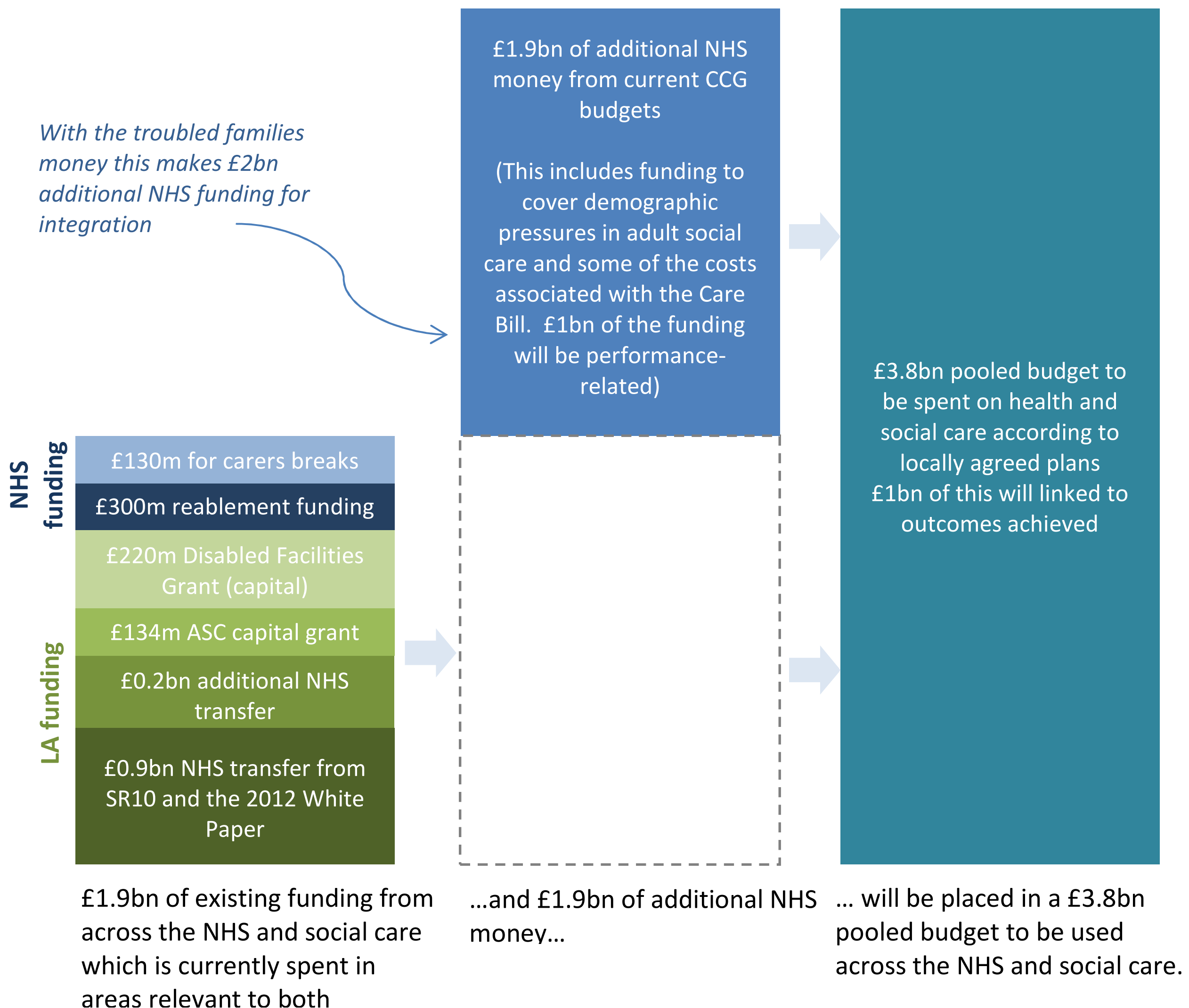
10.2.1 The June 2013 Spending Round announced that the NHS, Department for Communities and Local Government and the Department of Health will pool £3.8bn of funds for investment in the integration of health and social care (the “Integration Transformation Fund”). However, there is very little new money being allocated to support integration; the vast majority of resources will come from existing NHS budgets (the NHS will contribute c£3.4bn towards the Transformation Fund, compared to the £0.9bn the NHS currently transfers to support integration with social care).

10.2.2 The national £3.8bn Integration Transformation Fund will be a pooled fund, funded from:

- The £0.9bn of funding NHS England planned to transfer to fund social care in 2014-15
- An additional £0.2bn of investment in 2014-15 (to be agreed as part of mandate discussions for 2014-15 with DH)
- DH and other Government Department transfers of £0.4bn (capital grants)
- CCG pooled funding of:
    - Reablement funding of £0.3bn; *and*
    - Carers' break funding of £0.1bn
    - Core CCG funding of £1.9bn

The total amount of the fund for Barnet still needs to be confirmed. Barnet CCG has made an estimate that the total potential Barnet CCG contribution to pooled integrated budget could be up to £21.8M before capital grants; however, this figure has not been confirmed by local or national partners.

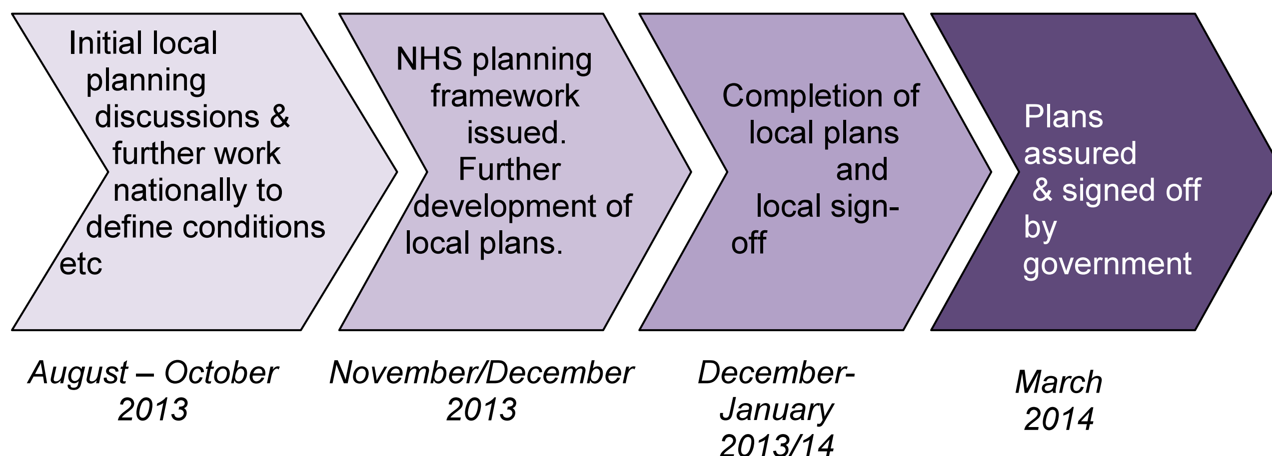
These transfers of money have also been set out in the diagram below, set out in a recent briefing paper from London Councils (also attached as Appendix 1):



10.3.3 CCGs and Councils will need to jointly develop a two-year locality plan that details how the pooled budget will be spent. This plan will need to be assured and signed-off by the

Health and Well-Being Board in early 2014 and by central government by March 2014. Plans must demonstrate how they meet the set of requirements listed in Appendix 1, at which point part of the funding for integration will be released. The second part will only be released once central government is satisfied with local performance achieved from use of the money.

10.3.4 The broad timetable for the plans, as set out in the London Councils briefing paper, is:



10.4 Update on local financial challenges

10.4.1 This national direction has been given at a time when there are significant financial challenges facing the local authority and CCG in Barnet, which will last until at least 2020. Both organisations have already recognised the role that the integration of health and social care will play in driving financial efficiencies and securing economic sustainability, as documented in their core financial savings plans:

- The Council's Medium-Term Financial Strategy makes reference to the savings that can be realised through health and social care integration: the Council needs to reach its c£75m savings target by 2015, before undertaking a further c£70m saving programme (known as the Priorities and Spending Review) between 2016 and 2020.
- The CCG financial recovery plan contains plans for integration in frail elderly; urgent care; and continuing care pathways: Barnet CCG needs to make up to £50m savings over the next 5 years to reach financial balance. Approximately £12.4m will be transferred from the CCG to the local authority from 2015 to fund integrated care. Unless properly managed, this transfer could lead to very significant underfunding of some CCG commissioned community services.

10.4.2 There is a risk that the financial savings plans set out above will not be achieved unless there is a focus on integrated commissioning and delivery, which will, among other areas, involve actively exploring estate rationalisation; the opportunities for sharing back-office functions; and the development of single electronic patient record.

10.5 The local policy response: development of a Health & Social Care Integration Delivery Model for Barnet

10.5.1 Barnet has already spent a substantial period of time developing its integration agenda between health and social care locally, which means there is information data and on-going work already available to support the development of the target operating model. For example, the Health and Social Care Integration Board, which brings together a range of local health and social care partners, has as part of its development work already developed and approved an integrated care concordat that sets out a shared

vision for integrated care in Barnet. A Joint Commissioning Unit has been established and is being operationalized so that it can deliver on the plans approved by the Integration Board. However, whilst the Joint Commissioning Unit will have a key role in implementing the integrated care system, there is now additional requirements for a more detailed articulation of the vision into a structure that can inform allocation of spend based on agreed priorities that achieve the overarching vision within the necessary timescales.

10.5.2 As such, and in response to the national direction and the local financial pressures set out above, Barnet's Health and Well-Being Financial Planning Group has identified the need to develop a headline health and social care integration target operating model for the Borough. This work will join up the Health and Social Care Integration projects into a coherent whole, developing them so that they are fit for the future, and ensure that financial flows across the whole system are reasonable. Barnet already has the core of the Target Operating Model in its Older People's Integrated Care Service project, which bases its model on risk stratification, care navigators and Multi-Disciplinary Team case management. The target operating model will draw on this and other existing work to create a coherent model for integrated care in the Borough.

10.5.3 Karen Ahmed, Later Life Lead Commissioner at LBB, will lead the process locally of developing proposals for use of the pooled budget. The Health and Well-Being Financial Planning Group has agreed to release up to £100k if required to support the Lead Commissioners in this design work (for employing external consultants to support the project if deemed necessary).

10.5.4 This modelling work will outline:

- A shared statement of requirements (from which to design the new model)
- Underpinning activity and spend data across acute, intermediate, primary, community, residential and social care (which will be used to support the modelling work that will inform the future model)
- An analysis of the funding streams that fall within the Integration Transformation Fund and proposals for how this will be managed.
- The evidence base of what works, and what is already working elsewhere, with particular focus on demand management (*stopping people from entering the system unnecessarily*); treatment and intervention (*supporting people in and out of the system safely and efficiently*); rehabilitation and reablement (*supporting people out of the system to maintain independence and reduce future need for service use*) and workforce development.
- A set of proposals to inform the development of a target operating model. These will include the spearhead projects already underway by the Health and Social Care Integration Programme and options identified by the Health and Social Care Integration Board through the recent set of interviews to identity priority pieces of work (see Section 10.6 below).
- The model will also, where appropriate, make reference to the integrated services that already exist in Learning Disabilities and Mental Health, plus the established integrated commissioning of prevention, voluntary sector and equipment services.
- The model will also make suggestions for 'future proofing' the local health and social care integration system, including a coherent set of governance arrangements across the LA and CCG to support the delivery of this work.

10.5.5 The model will be developed by a Reference Group appointed across the NHS and the Council, who will call on external expertise as required. The Group have already identified a number of external contacts who will be able to provide support to the development of the model.

10.5.6 The intention is to submit the initial proposals for the model to the Health and Well-Being Finance Group for consideration on the 17th October. The model will also be presented to the Health & Social Care Integrated Care Board at the end of October 2013. It is proposed that the HWBB receive an update report on the work in November 2013, and receive a final draft of the locality plan in January 2014.

10.6 The supportive function of the Health and Social Care Integration Programme

10.6.1 The target operating will, as mentioned, need to reference the existing projects that are already taking place as part of the Health and Social Care Integration programme. The delivery of both Health and Social Care Integration spearhead projects within the Programme is well underway. The training that has formed part of the Care Homes Pilot is being delivered to care homes and additional support such as the portal has been set up. Recruitment of staff for the Older People Integrated Care Service is in progress and multi-disciplinary meetings between practitioners are now running on a regular basis.

10.6.2 A business case for a shared record is currently being developed and shall be considered by the Integrated Care Programme Board for delivery in October. There is the possibility of NHS monies being available for part funding the project. An “Expression of Interest” has been completed and the decision will be known soon.

10.6.3 Overarching Section 75 agreements for both Adults’ and Children’s health and social care services have also been developed between the Council and the CCG. An overarching agreement contains all the ‘generic’ terms that are required as part of any agreement and the principles by which services will be commissioned and managed. It provides a platform for the Council and the CCG to robustly manage and finance new and existing integrated services. Specific arrangements for each integrated service will be covered in schedules that will be appended to the overarching agreement.

10.6.4 Separate (but near identical) overarching agreements cover children’s services and adults services. This will allow for different approval and sign-off processes that incorporate the differing governance arrangements existing in adults and children’s services. It will accommodate the different policies and strategies that each service area is subject to.

10.6.5 The Agreement will act as an enabler for the robust management of the integrated health and social care services that will be delivered through the development of the overarching model of integrated care.

11 BACKGROUND PAPERS

11.1 None attached to this report.

Legal – LC
CFO – JH

Appendix 1: Briefing paper from London Councils on the Integration Transformation Fund

£3.8BN INTEGRATION TRANSFORMATION FUND 2015/16

LONDON COUNCILS BRIEFING NOTE

The Spending Round 2013 announced a pooled budget of £3.8 billion for local health and care systems in 2015/16. This is now being referred to as the "Integration Transformation Fund".

What is the Integration Transformation Fund for?

The government's stated goal is to get local health and care partners to work more closely, through creating a pooled budget in every area. This follows the publication of the National Vision on health and care integration, which defined integration from the perspective of the individual. The fund is intended to support an increase in the scale and pace of integration. It is clearly also a mechanism for promoting joint planning for the sustainability of local health & care economies.

Where does the money come from?

In reality, little of this is new money. The fund is made up as follows:

With the troubled families money this makes £2bn additional NHS funding for integration

£1.9bn of additional NHS money from current CCG budgets

(This includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. £1bn of the funding will be performance-related)

NHS funding
£130m for carers breaks
£300m reablement funding

LA funding
£220m Disabled Facilities Grant (capital)
£134m ASC capital grant
£0.2bn additional NHS transfer
£0.9bn NHS transfer from SR10 and the 2012 White Paper

£3.8bn pooled budget to be spent on health and social care according to locally agreed plans £1bn of this will linked to outcomes achieved

£1.9bn of existing funding from across the NHS and social care which is currently spent in areas relevant to both

…and £1.9bn of additional NHS money…

… will be placed in a £3.8bn pooled budget to be used across the NHS and social care.

The additional £1.9 billion NHS funding will be drawn from current CCG budgets. Given existing demographic pressures & efficiency requirements, CCGs are likely to have to make cuts in existing services to release this money. Although the basis on which this will be taken from individual CCGs is not yet clear, as an initial rough planning guide CCGs have been advised to start considering how to free up around £10 million each.

In addition to this £3.8bn, DCLG have included in the overall grant settlement for local authorities £188m for pressures from the closure of the Independent Living Fund and £285m for the introduction of deferred payments from April 2015 and the transition to the capped cost funding policies flowing from the Dilnot report that will take effect from April 2016 once the Care Bill has been passed into law. The NHS has also contributed £70m to the Troubled Families programme.

The Spending Round also announced a further £200m transfer from the NHS to social care in 2014/15, in addition to the £900m already committed.

How the funding will come to local areas?

The 2015/16 funding will be a pooled budget between local authorities and CCGs. CCGs will use funds from their normal allocation to create it.

This means that there will be no automatic transfers of any funding to boroughs, as has been the case with the NHS c.£900m annual transfers in recent years (s256 transfers). However, it will be possible for money to be transferred to councils by local agreement, as part of local plans.

The basis for determining local shares of the £3.8bn has not yet been decided. However, it has been suggested that the same broad splits as used for the s256 allocations is a reasonable planning proxy for most of the funding.

DCLG are specifically considering how to handle the Disable Facilities Grant capital element of the fund allocations, in the light of local authorities' statutory responsibilities.

Local partners will be able to put additional funding into the pooled budget from their existing allocations if they want to do so.

Two year plans

Access to the Integration Transformation Fund in 2015/16 will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. The plans will need to be agreed by March 2014.

As well as covering the way in which the Integration Transformation Fund will be used locally in 2015/16, the plans will also need to set out how the £200m additional transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

The plans will need to be jointly agreed between key partners – as well as local authorities and CCGs, this will include local clinicians. Health & Wellbeing Boards will have to sign off the plans.

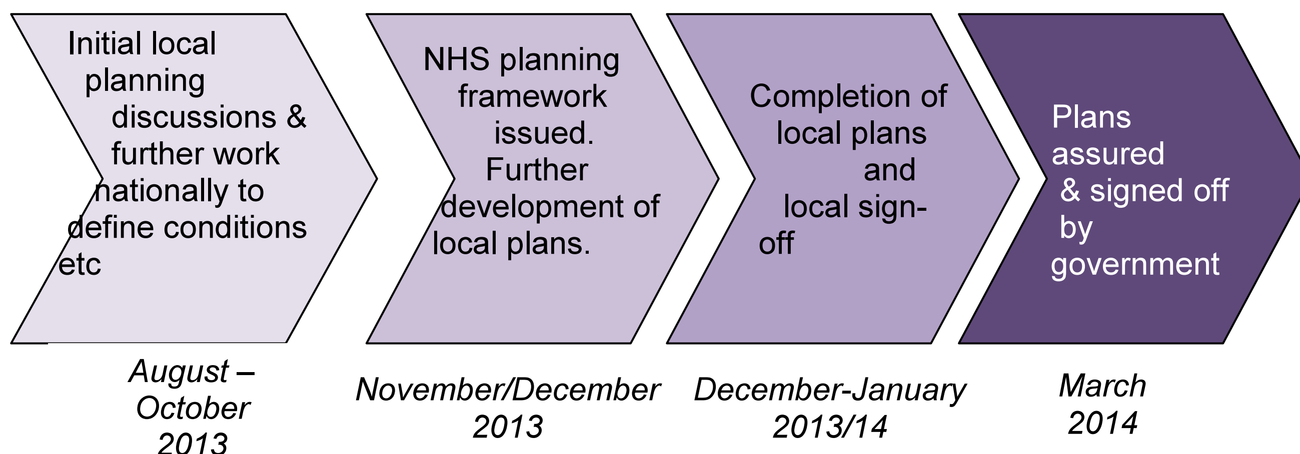
As well as being locally agreed, Ministers have decided that they will oversee and sign off the plans (DH, DCLG and HM Treasury Ministers all have an interest in this). The LGA and NHS England are developing proposals about how this can be done in an efficient and proportionate way. NHS England's role in either local or national agreement has not yet been clarified.

Joint LGA/NHS England guidance has been published clarifying that the plans should be developed in the context of:

- local joint strategic plans;

- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term – currently expected to be 3-5 years – strategic plans as part of the NHS Call to Action);
- the announcement of integration pioneer sites in October, and forthcoming integration roadshows.

The broad timetable for the plans is:



Conditions for the plans

Funding will only be given on the condition that services are commissioned jointly and seamlessly between the CCG and councils, on the basis of their agreed local plan.

The following national conditions will need to be addressed in local plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health);
- ensure a joint approach to assessments and care planning;
- ensuring that, where funding is used for integrated packages of care, there will be an accountable professional (ref. Jeremy Hunt's recent request for views on improving care for the vulnerable elderly, that will culminate in some announcements expected in October)
- risk-sharing principles and contingency plans if targets are not met – including redeployment of funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

How will the £1bn performance-related element work?

As part of their plans, local areas will need to set outcome goals and monitor delivery against these during 2014/15 and 2015/16. £1bn of the total fund will be based on achievement of these goals. This funding is likely to be unlocked in two tranches – half in April 2015 on the basis of performance in 2014/15, and the second half in autumn 2015 on the basis of performance in the first part of the financial year.

The outcome measures will be a mix of national requirements and local choice. The national requirements are yet to be determined, but early discussions include eg. delayed discharges.

Issues that still need to be resolved

There are a range of issues that still need to be clarified on which the government, LGA , NHS England and other national partners are working – and which London Councils will continue to seek to influence. These include:

- allocation of funds;
- national conditions, including definition, metrics and application (including whether the performance-related element of the funding will be based on 'all-or-nothing' achievement of outcomes);
- risk-sharing arrangements;
- assurance arrangements for national sign-off of the plans and subsequent monitoring;
- analytical support, eg shared financial planning tools and benchmarking data packs.

Action that boroughs and their partners can start to take now

Given the timescale for the preparation and agreement of plans on which this will all hang, and the aspirations for the strategic ambition of these plans, the earlier local thinking and discussions start the better.

Some of the issues that boroughs should start considering with their partners are:

- the basis that existing local plans and priorities – joint and individual – provide as a starting point for their Integration Transformation Fund plan, and early identification of further analytical needs and joint strategy development so these can be got underway as soon as possible;

- the implications of the way the fund has been drawn together on current planning and budgeting intentions eg in CCGs the need to free up the additional money to put into the fund and for local authorities the need to recognise that the s256 monies will no longer form an automatic transfer;

- the process for developing the plan and securing local sign-off, including through the Health & Wellbeing Board;

- how to handle engagement with clinicians and acute trusts – particularly given that in most parts of London individual trusts will need to engage in several local area plans;

- what community and patient engagement to include as part of the development of the plan.

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