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Meeting	**Business Management Overview and Scrutiny Committee**
Date	29 February 2012
Subject	Health and Social Care Integration Task and Finish Group – Final Report and Recommendations
Report of	Health and Social Care Integration Task and Finish Group
Summary	The report sets out the recommendations of the Health and Social Care Integration Task and Finish Group which include: a vision for the integration; principles to guide integration; a suggested approach to deliver integration projects; and recommendations for the scrutiny and quality assurance of future health and social care integration projects.
Officer Contributors	Dawn Wakeling, Deputy Director, Health and Adult Social Care Ceri Jacob, Associate Director, Joint Commissioning, London Borough of Barnet and NHS North Central London
Status (public or exempt)	Public
Wards Affected	All
Enclosures	Appendix 1 – Health and Social Care Integration Task and Finish Group: Final Report and Recommendations
Key Decision	Not applicable
Contact for Further Information:	Rohan Wardena, Health and Social Care Integration Programme Lead: rohan.wardena@barnet.gov.uk

1. RECOMMENDATIONS

1.1 Members of the Committee consider the findings and recommendations of the Health and Social Care Integration Task and Finish Group, as set out in the report attached at Appendix 1.

1.2 Members of the Committee discuss and agree the findings and recommendations of the Task and Finish Group.

1.3 Members of the Committee consider the recommendation of the Task and Finish Group as set out in paragraph 9.3 and 9.4 below and make recommendations as to how the ongoing work of health and social care integration is to be incorporated into the council's overview and scrutiny framework and work programme.

1.4 The agreed findings and recommendations are forwarded to the Cabinet for their consideration. Subject to the Cabinet's approval, the findings and recommendations be referred to the Health and Well Being Board and health partners as the basis of the Council's position.

2. RELEVANT PREVIOUS DECISIONS

2.1 Business Management Overview and Scrutiny Committee, 17 October 2011, Agenda Item 7, Task and Finish Groups/Scrutiny Panel Update – the Committee agreed to establish a time-limited Task and Finish Group to consider the council's approach to health and social care integration.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 Link to Sustainable Community Strategy

3.1.1 The Task and Finish Group recommendations support the Council's Sustainable Community Strategy 2010-2020 which is committed to achieving its objectives through working *"together to draw out efficiencies, provide seamless customer services; and develop a shared insight into needs and priorities, driving the commissioning of services and making difficult choices about where to prioritise them."* The integration of health and Social care services embodies this approach to partnership working.

3.1.2 Successful integration of health and Social care services should promote the Sustainable Community Strategy priority of *"healthy and independent living".*

3.2 **Link to Health and Wellbeing Strategy**

3.2.1 The draft Joint Health and Wellbeing Strategy sets out the aspirations of the Health and Wellbeing Board and its member organisations. The Health and Wellbeing Board is responsible for promoting greater co-ordination of planning across health, public health and Social care. This is recognised in the draft Joint Health and Wellbeing Strategy and the linked draft Integrated Commissioning Plan. The Task and Finish Group recommendations support the Health and Wellbeing strategic intentions.

3.3 **Link to Commissioning Plan**

3.3.1 A draft Integrated Commissioning Plan is being developed as one of two delivery vehicles for the Joint Health and Wellbeing Strategy. This commissioning plan will form part of the Barnet Clinical Commissioning Group overall commissioning plans. The Task and Finish Group recommendations support the intentions that are set out in the draft Barnet Integrated Commissioning Plan.

3.3.2 The delivery of an integrated frail elderly community based service is included in the draft NHS NCL Commissioning Strategic Plan and associated QIPP (Quality, Innovation, Productivity and Prevention) plan.

4. RISK MANAGEMENT

4.1 The recommendations from the Task and Finish Group will inform the Health and Social Care Strategic Outline Case (SOC) and any subsequent integration projects. The SOC will include an initial risk register for this work.

5 EQUALITIES AND DIVERSITY ISSUES

5.1 The approach recommended by the Task and Finish Group is predicated on the principle that any integration of health and social care services and pathways should only be considered if there is clear evidence that this will substantially benefit Barnet's citizens by improving the experience and outcomes of people who use care. However, it is likely that the areas identified as opportunities for integration may focus on particular groups and communities, for example the care of frail elderly people and their carers and people with complex health and social care needs, as this is where most benefit can be realised for service users.

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5.2 The recommendations from the Task and Finish group will inform the Council's approach to health and social care integration. The

recommendations are informed by an analysis of local and national evidence. Their recommendations draw on this evidence and their own knowledge to guide future integration projects and ensure that any subsequent work on integration is informed by a clear understanding of local need identified in the Joint Strategic Needs Assessment (JSNA), and what has been proven to work elsewhere.

5.3 The recommendations from the Task and Finish group should support the Council and partner organisations to identify effective ways of working together to deliver integration and address the needs of all people who use care.

5.4 The integration of health and social care services could have a differential impact on different groups of citizens and communities within Barnet. This could include people within the protected characteristics of age, disability and sex as defined by the Equality Act 2010, such as older people and carers of older people or disabled people. An Equalities Impact Assessment will be undertaken for all health and social care projects to ensure that the approach and solutions are inclusive and the local authority discharges its duties under the Equality Act 2010.

5.5 The integration of health and social care services could also impact staff involved in the commissioning and delivery of local care services. The impact on staff will be included within the scope of all project Equalities Impact Assessments.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 Financial Implications

6.1.1 Integration has the potential to increase value for money of health and social care and enable public funds to meet increases in health and social care demand by:

- Improving outcomes for patients and users, reducing repeat and crisis demand on services such as emergency departments
- Reducing the costs associated with providing a specific service (through more efficient use of staff and other resources – such as buildings – across organisations)
- Reduction of duplication in assessment and provision
- Preventing demand for typically more expensive services such as acute hospital and residential care provision services, through more

effective and coordinated use of prevention and early intervention services.

6.1.2 The recommendations from the Task and Finish Group will inform the Strategic Outline Case (SOC) and any subsequent integration project. The SOC will provide an illustrative assessment of potential savings for Barnet based on evidence and examples from elsewhere. Benefits potential will form part of the criteria to prioritise and select project opportunities. The detailed financial benefits and realisation schedule will be fully developed as part of the production of each project business case.

6.1.3 The London Borough of Barnet is funding a project manager (3 days a week) and consultancy support work package from its implementation partner (Agilisys / iMPOWER) to complete the SOC and support the Task and Finish Group.

6.1.4 The Strategic Outline Case will specify what costs would be associated with taking any agreed integration initiatives forward.

6.2 **Staffing Implications**

6.2.1 The recommendations from the Task and Finish Group will inform the Strategic Outline Case (SOC) and any subsequent integration project. There are no staffing implications in the development of the Strategic Outline Case.

6.2.2 It is possible that the additional or new integration of health and social care services would impact staff currently working for the Council or for NHS organisations. This would be explored in more detail within the Strategic Outline Case and subsequent project work. See 4.2.2 above.

7. LEGAL ISSUES

7.1 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. The provision of health and social care services takes place within a complex regulatory environment and the potential impact of this on any integration proposals arising from this scoping project will be explored as part of the development of specific proposals. Arrangements made pursuant to S75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions.

7.2 The Health and Social Care Bill 2011 is currently progressing through Parliament and has not yet received Royal Assent. Hence, the final legislative provisions are yet to be confirmed. A key theme of the Bill is

for local authorities to have a much stronger role in shaping health services and taking over responsibility for local health improvement, through the establishment of new Health and Wellbeing Boards, thereby improving democratic accountability.

7.3 Pursuant to Section 2 of the Local Government Act 2000, the Council has the power to do anything that it considers will promote the economic, social or environmental well-being of its area. Pursuant to Section 21 of the Local Government Act 2000, the Council has existing powers to review and scrutinise matters relating to the health service in the local authority's area and to make such reports and recommendations on such matters.

8. CONSTITUTIONAL POWERS

8.1 The scope of the Overview & Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Overview & Scrutiny Committees are set out in the Overview and Scrutiny Procedure Rules (Part 4 of the Constitution).

8.3 The Health and Social Care Act 2001 paved the way for scrutiny by local authorities of other statutory bodies, by establishing Overview and Scrutiny Committees with the remit of scrutinising health service provision.

8.4 Item 8 of Business Management Overview & Scrutiny Committee Terms of Reference states that the role of the Committee is:

"To coordinate and monitor the work of scrutiny panels and task and finish groups, including considering reports and recommendations and referring to the relevant decision-making body."

9. BACKGROUND INFORMATION

9.1 At its meeting on 17 October 2011, the Business Management Overview and Scrutiny Committee established a Health and Social Care Integration Task and Finish Group to explore and review the benefits of health and social care integration for Barnet citizens and the Council. The Group was tasked with helping to develop a vision and principles to inform the local approaches to integration in Health and Social Care with partner organisations and stakeholders.

9.2 The Group held a series of five meetings during December 2011 and January 2012, and heard evidence from a range of expert witnesses on the approach to health and social care integration in various parts of England, in other London boroughs and an example of integrated working across health and social care in Barnet.

9.3 During the evidence gathering it has become clear to the Task and Finish Group members that providing effective oversight and scrutiny to health and social care integration projects requires a high level of knowledge of local care services. The Group therefore concluded that it would be helpful if the Group and its current membership were retained to support the scrutiny and assurance of the expected health and social care integration project opportunities that will be identified in the SOC.

9.4 The Group's findings, recommendations and summary of evidence are set out in the attached report in appendix 1: Health and Social Care Integration Task and Finish Group Final Report and Recommendations.

10. LIST OF BACKGROUND PAPERS

10.1 Most evidence received by the group was from witnesses, but the most important background papers are:

10.1.1 Kings Fund and Nuffield Trust: Integrated care for patients and populations: Improving outcomes by working together

10.1.2 NHS Institute for Innovation and Improvement: Joined-up care delivering seamless care

Legal – MM
CFO – AT

Appendix 1

Health and Social Care Integration Task and Finish Group

Final Report and Recommendations

Introduction from the Chairman

Introduction

In October 2011, the Business Management Overview and Scrutiny agreed to establish a time-limited Task and Finish Group to oversee the One Barnet Health and Social Care Integration project. The Group was convened to develop a vision for health and social care integration in Barnet; it has worked effectively across party lines to achieve this. It has also developed a good level of knowledge of health and social care.

The group was composed of the following members:

- Councillor Braun (Chairman)
- Councillor J Hart
- Councillor Khatri
- Councillor Farrier
- Councillor G Johnson

Substitute Members

- Councillor Rawlings
- Councillor K Salinger

In addition to assisting in developing a vision, the Group has developed principles which will be used to guide the approach to integration projects. The work of the Group will inform and shape the development of the One Barnet Programme and delivery of the Council's strategic priorities. The Group conducted its work through a mixture of meetings, research and receiving evidence from external witnesses.

During the evidence gathering it has become clear that providing effective oversight and scrutiny to health and social care integration projects requires a high level of knowledge of both services. The Group therefore proposes it continues and provides oversight to the subsequent health and social care integration projects.

The Group would supplement the work of the Health and Safeguarding Overview and Scrutiny Committees by creating time for projects to be reviewed in more detail and discussions to be held at greater length. It would not duplicate the role of the Health and Wellbeing Board and the One Barnet Programme Board who will be responsible for leading the projects. If permitted to take on a longer term oversight role, the Group suggests expanding membership to include Barnet LiNK and oversight representatives from health.

Recommendations

1. Cabinet and the Health & Well Being Board are requested to endorse the vision proposed by the Task and Finish Group for the integration of health and social care in Barnet, as set out in section 1.

2. Cabinet and the Health & Well Being Board consider and agree the principles proposed by the Task and Finish Group for the integration of health and social care, as set out in section 2.

3. Cabinet and the Health & Well Being Board consider and agree the recommendations on the approach to health and social care integration proposed by the Task and Finish Group as set out in section 3.

4. The Business Management Overview and Scrutiny Committee consider and agree the proposal that the Task and Finish Group is given a longer term role in providing oversight to health and social care integration projects, as described in the *Introduction*.

1. Vision

Barnet will place people who use care at the heart of integration. It will integrate services from health, social care, the voluntary sector and the private sector in a way that makes them easier to access and better meets the needs of people who use care. It will integrate both the commissioning and delivery of care. Barnet's leadership in health and social care are committed to full integration and recognise that integration is best built and delivered by people who provide care and people who use it.*

**people who use care includes: carers, service users and patients*

The statement above is based on the Task and Finish Group's list of key characteristics for their vision. The Group felt the vision should:

1. Focus on people who use care and emphasise that all changes made should make services easy to access and navigate.
2. Include reference to the role of the voluntary sector and ancillary health professions (to make it clear that the vision does not just apply to doctors, nurses and social workers).
3. Reflect the preference for a 'bottom up' approach built on the needs of people who use care and the knowledge and capabilities of those who provide it.
4. Emphasise the need for on-going consultation with people who use care to help maintain and develop services.
5. Show the commitment to full integration of both commissioning and delivery.

2. Principles

The Task and Finish Group endorsed the following principles to guide integration projects.

1. Integration should be based around people who use care.
2. Social Care and Health should be fully integrated.
3. People who use care should be able to access medical and social support through the same access point.
4. People who use care should have choice about how their needs are met. This should include being able to choose and change the providers they work with at different stages and being able to pay to use private services alongside public provision if they wish (e.g. private provision should be integrated with public provision).

5. Information should be shared between health and social care, the “Tell us once” principle.
6. People who use care and request help should not be told to go elsewhere because they approached the wrong agency, the “No door is the wrong door” principle.
7. People who use care should be treated as individuals and not defined by their needs.
8. Health and Social Care staff should work to understand each other’s services, professions and approaches. This understanding will help them give advice to people who use care and work across professional and organisational boundaries.
9. Health and Social Care staff should develop shared language and new ways of working.

3. Approach

The following points were highlighted by Members as important for successful integration:

Timing

1. Make a commitment to full integration in delivery and commissioning, but take a targeted approach at groups most likely to benefit first.
2. Children’s health & social care should also be integrated where it will benefit children. However, this is likely to be more complex so should not be addressed first.

Engage people during the change

1. Plan each integration carefully involving all partners (health, social care, councillors, private sector, voluntary groups, patient groups) and engaging with the people affected.
2. Engage all partners equally. Integrated services need all the partners involved to engage fully in their creation. Management and leadership structures in the new service should not be dominated by one partner, but reflect all the partners and their professions.
3. Do not attempt too many changes at once or you will overwhelm staff. If you are redesigning an organisation, complete this before redesigning the process. This ensures those running the processes feel responsible for making them work.
4. The creation of integrated teams and services should not undermine professional development. This may mean dual management with a professional lead mentoring and developing staff, but day-to-day management being delivered by a team lead. Professionals need to agree what they can all do and what is reserved to each profession.

5. Cultural change is very important and will take time to develop. Staff in integrated services should work together to agree: principles to govern their work, common language, how they will work together and share skills.

Clear responsibility for the change

1. Leadership is critical. There should be a small group of named leaders responsible for the overall integration and each project needs clear leadership and accountability. All the partners involved need to be committed to the change and this commitment should be reflected at all levels of management.
2. Set targets for delivering benefits from integration, establish who is responsible for them and monitor them.
3. Governance structures should support integration and represent all partners.
4. Ensure there is a mechanism in place to allow members an appropriate level of on-going scrutiny/monitoring of the integration process.

Investment to enable integration

1. Compatible IT systems that enable data sharing and shared workflow are a vital building block of integration. Invest to get the right systems across all partners.
2. Health and social care services should be co-located wherever possible.
3. Integrated services should be based in buildings that meet staff and users' needs. GP practices could act as hubs for health and social care service.
4. Ensure there is expert procurement advice to the integration projects, especially on any IT procurement. Have one procurement organisation supporting the integrated services; do not maintain a separate health and social care team.

4. Evidence

During the course of the review, the Task and Finish Group received evidence from internal and external witnesses. Additionally, they reviewed the recommendations of The King's Fund, the Nuffield Trust , the Department of Health and NHS Future Forum. The Group used their knowledge of Barnet, own experience as carers and people who use health and social care services to bring a personal perspective to the recommendations. The Appendix contains a summary of the evidence received by the Group, below are the key points.

Key evidence

The group identified the points below as the most important ones emerging from the evidence they received and their discussions. This evidence tells us about the context in which the Group made its recommendations.

- There is a successful history of integration in Barnet; in the 1980s Barnet had one of the first integrated mental health services. Barnet also has several very successful current integration projects in the areas of: learning difficulties, mental health, community equipment, frail and elderly, voluntary sector and children.
- Barnet is a large borough with multiple town centres. Its size and multiple centres mean that service will need to have multiple locations to be accessible.
- There is a high level of uncertainty in health. The PCT (Primary Care Trust) will cease to exist next year and the CCGs (Clinical Commissioning Groups) are in their early stages. This means it may be difficult for health to commit to some long term goals because the PCT cannot make strategic agreements for the CCGs and the CCGs may not be ready to commit yet. However, progress cannot be halted to wait for this to be resolved.
- Health has a significant budget deficit and their focus over the next couple of years is likely to be reducing this. This may lead it to focus on vertical integration within health first and horizontal integration with social care may have a lower emphasis.

Appendix

Summary of evidence from case studies and reports

The Group considered evidence from case studies from the Department of Health's Institute for Innovation & Improvement, Herefordshire, Barnet and Islington. It also received a summary of The King's Fund and Nuffield Trust's recommendations to the Department of Health and NHS Future Forum (5 January 2012) for integration and a briefing on the current changes in the NHS.

Joined-up Care: Case Studies – Torbay and Northamptonshire

Northamptonshire's integration focuses on Older People with long term conditions, it is a partnership arrangement initially driven by clinical commissioning and now driven by a shared vision and aims. Torbay's integration is wider and covers all older people; Torbay Council transferred its social work and care staff to NHS (S75). Torbay council retains its commissioning function.

Some of the key lessons drawn from the case studies were:

- Be clear about what you are trying to achieve through integration
- Create and communicate a clear vision that has the customer, patients and carers at the heart of it
- Identify a shared vision that is owned jointly with partners and achieves mutually beneficial outcomes
- Really strong and consistent leadership is crucial to make the vision reality
- Involve front line staff and empower them to own and drive the integration agenda
- Spread the news – be relentless in sharing everything – in every format available
- Engage all partners and gain commitment from the right people to create a culture that encourages innovative, long-term solutions and challenges the historical ways of working
- Strong clinical leadership is essential

Two out of the ten case studies featured the integration of health and social care and a further three case studies indicated they planned to involve social care in later stages of their integration. These case studies reflect that vertical integration (integration within health) by providers of acute, community and primary care services is much more developed than horizontal integration with social care. A consequence of this is that there is more information (especially quantifiable savings estimates) available for health integration. This may be a factor in some health manager's decision making.

Case study - Herefordshire

Carmen Colomina from iMPOWER helped develop the new assessment and review process that underpinned the integrated teams in Herefordshire. Herefordshire County Council transferred its social workers and care providing staff to 2gether the Mental Health Trust and NHS Wye Valley under a Section 75 arrangement (a formal joint working agreement between local authorities and NHS organisations). This created integrated provider organisations. Again, Herefordshire County Council retained its commissioning role.

Carmen facilitated the design of new processes that could be used by all professionals and both provider organisations (2gether the Mental Health Trust and NHS Wye Valley). This work took place at the same time as the Section 75s were being finalised and the new organisation structures drawn up. Some of the key lesson's identified were:

- All organisations must be equally involved & committed.
- Don't try to do too many changes at once.
- Joint and consistent leadership is critical.
- Complete any organisation design before designing new processes.
- Cultural change is key - within team and across organisations.
- Have a clear vision for patient / customer experience.
- Get frontline staff to set the principles they will work to.
- Agree a common language and terminology.
- Agree boundaries between professions.
- IT must be involved at the outset in any process change to avoid potential delays later on.

Case study - Barnet Learning Disability Service

John Binding and Rene Betts of Barnet Learning Disability Service provided a presentation outlining the integrated working arrangements of the Barnet Learning Disability Service. The Learning Disability Service combines health and social care staff including: nurses, therapist and social workers. The presentation focused on a practical example of integrated working arrangements based on a case study of a young woman, Nina, who had come to the attention of the Learning Disability Service.

Nina benefitted from a close working relationship between health and social care staff that helped to identify a misdiagnosis. Nina had been misdiagnosed with severe learning difficulties, the involvement of Speech and Language therapists in Nina's integrated social care and health team helped quickly identify this error.

Integrated working meant both health and social care professionals had access to all the information relating to Nina and could verify and cross reference it. This enabled professionals to make more informed assessments and decisions about the approach they would use and the type of care package required.

The case study highlighted the value and importance of:

- breaking down boundaries and sharing skills,
- teams working together e.g. social workers and nursing teams,
- developing compatible IT systems,
- the value of formal arrangements such as joint management structures as well as more informal arrangements such as sharing buildings/allowing teams to get to know each other – sharing experiences and know-how.

Case study - Islington

Carol Gillen the Director of Operations - Integrated Care and Acute Medicine at Whittington Health, delivered a presentation outlining the process of integration undertaken to create Whittington Health.

Whittington Heath was created through section 75 agreements with staff from Whittington Hospital, Haringey Community Services (adults & children), Islington Integrated Services (Community adult & children services, Adult Social Care & LBI Children with Special Needs). It came into existence on 1 April 2011.

Carol shared the benefits that Whittington Health is trying to deliver for service users / patients and carers.

- Help people navigate complex health and social care systems, thus easing stress and anxiety (older people with complex long term conditions).
- Reduce duplication through coordinated care.
- Offer better access to services and information – are not ‘pushed from pillar to post’.
- Reduce the number of professionals involved.
- Reduce the risk of ‘falling through the net’.

Carol identified some important lessons learned from the Whittington’s experience, many of these echoed those in other case studies but Carol emphasised the following points:

- Integrated management structure at executive, senior and middle levels across acute, community and social care.
- Development of stronger, integrated governance (corporate and clinical) structures to manage risk.
- Ensuring that each group of professionals has a lead that is accountable for the performance of that group (even if day-to-day line management comes from another professional).
- Development of a bespoke IT system that interfaces with Primary Care & Social Care.

Integrated care for patients and populations: Improving outcomes by working together

The King's Fund and Nuffield Trust's recommendations on integration formed part of a report to the Department of Health's Future forum. They have been advising the department on NHS reform. The recommendations were drawn from review of case studies (including Torbay) and engagement with professionals in health and social care. The report made recommendation on how to use integration to improve care standards, the recommendations were directed to central government, but those that are relevant to Barnet's situation are:

- Performance is better where there are clear, ambitious and measurable goal to improve the experience of patients and service users.
- Organisational integration appears to be neither necessary nor sufficient to deliver the benefits of integrated care.
- There is no single 'best practice' model of integrated care. What matters most is clinical and service-level integration that focuses on how care can be better provided around the needs of individuals.
- Integrated care is not needed for all service users or all forms of care but must be targeted at those who stand to benefit most: people with addictions, those with complex needs, those with mental health illnesses, those requiring urgent care where a fast and well-co-ordinated care response can significantly improve care outcomes e.g. strokes and cancers.
- Patients with complex care needs should be guaranteed a care plan, a named case manager responsible for co-ordinating care, and access to telehealth and tableware and a personal health budget where appropriate.

Briefing on changes in the NHS

The key changes in the health system were summarised for the Group and their implications explored. The key changes were identifies as:

- The abolition of Strategic Health Authorities and Primary Care Trust
- The creation of:
    - Clinical Commissioning Groups from local GP practices and clinical practitioners, who will commission most local healthcare.
    - Commissioning Support Organisations will initially be formed from legacy PCT organisations and staff and will support CCGs in their commissioning role.
    - Health and Wellbeing Board (H&WB) with representation from Barnet Council's Cabinet, North Central London Cluster PCT, Clinical Commissioning Groups, social care directorates and Public Health. The Board create strategy and coordinate provision of care across providers.

- Public Health will transfer to the Local Authority with new responsibilities to protect the local population's health and advising CCGs on local health needs and informing local commissioning priorities.
- Health care providers must either become Foundation Trusts or be taken over by one.

The cumulative impact of these changes is instability and uncertainty in the health system until the Health and Social Care Bill 2011 has been passed by Parliament, the structural changes have been implemented and embedded, and policies have been developed and agreed across the health and social care system. This uncertainty substantial reduces the ability and capacity of health organisations to engage meaningfully with social care on integration. The instability will continue until 2014 and possibly into 2015.

What we learnt about Barnet

Health and Wellbeing Strategy

Ceri Jacob's presented working draft of the Health and Wellbeing Framework. This outlined Barnet's response to its JSNA assessment identifying 4 priority areas and a series of recommendations. The framework will be reviewed and endorsed by the Health and Wellbeing Board and used to inform commissioning decisions in social care and health.

Four priority areas

- Preparing for a healthy life – from pre-natal to adulthood
- In the community – looking at the influence of the environment on wellbeing and health
- How we live – lifestyle choices and issues
- Care when needed

Recommendations

Based on JSNA the H&WB Board made a series of recommendations that outline the areas they wish to focus on.

- Support residents to take greater responsibility for their own health.
- Develop more effective campaigns to ensure individuals with mental health problems and those with learning disabilities receive appropriate health checks.
- Tackle the obesity epidemic.
- Reduce the rate of hospitalisation among older people following attendance at A&E.
- Maintain and increase, smoking cessation activity, especially during pregnancy.
- Increase the uptake of all childhood immunisations and seasonal flu immunisation in at-risk groups.

- Improve uptake of breast screening in Barnet to increase identification and reduce mortality.

Integrated Commissioning Plan

The integrated commissioning plan builds from the Health and Wellbeing Framework and outlines a proposed approach and scope for integration and some key areas for integration. Like the Framework it is still in draft form and will be reviewed by the H&WB board when completed.

Principles of integration

The principles that should underpin integration were split into principles based on national and local principles.

National

- A shared understanding of what is meant by integration
- A clear case for integration with tangible benefits to service users and across the system – a means for achieving specified ends.
- Form follows function – governance to support achievement of aims Integration at all levels whether it's about commissioning or service delivery – must make it from the Board room to the front line
- Weave integration into existing set ups as organisations have been set up to be separate with separate governance structures etc.
- Trust and continuity – relationships and behaviour are key at every level and stage.

Local

- Integration should as a minimum maintain quality and safety and ideally improve the quality and safety of services
- Integration should represent value for money for all organisations leading to a more sustainable public sector.

Scope

- Any area where health and social care are interdependent or overlap will be included in the remit of an integrated commissioning function.
- Health and social care will seek to eliminate silo commissioning and move to whole system commissioning.
- New commissioning and contracting models will be actively explored.
- There will be consolidation of commissioning capacity within and across organisations where this makes sense within the emerging commissioning landscape for the NHS and the Council.

Areas of focus

Providers of health and social care in Barnet identified the following areas of overlap where a more integrated approach could help providers and service users / patients:

- Older people, including those in care homes,
- People with complex needs including learning difficulties, mental health and continuing health care,
- People being discharged from hospital,
- People using A&E inappropriately,
- People at the end of their life,
- People who need rehabilitation,
- Better communication and IT that supports joint working,
- Having a lead professional for people with complex needs,
- Having more multi-disciplinary team, integration and one stop shops,
- Better information and sign posting.

Existing integration

- Community equipment (C)
- Mental health (P)
- Voluntary sector (C)
- Learning Disabilities (C&P)
- Frail elderly (C&P)
- Children's (C)

C= commissioning P = provision of services

Integrated Prevention Plan

The integrated prevention strategy draws on the Health and Wellbeing Framework, and fits it recommendations into the priority areas identified. It identifies areas for action that could help Barnet target its priority area but it does not propose initiatives or projects.

3 types of prevention

1. Primary prevention is taking action to stop something happening in the first place e.g. immunisation.

2. Secondary prevention is taking action to manage potentially harmful situations and conditions before they cause irreversible damage e.g. treating high blood pressure.

3. Tertiary prevention is reducing the effects of damage and disability already caused as much as possible and reducing the risk of progression e.g. foot care for diabetics.

Examples of suggested interventions:

- Ensuring that all children have all of the routinely available childhood immunisations at the right time
- Using the planning process, policies on leisure, green spaces and the built environment can – and should – all play a part in enabling prevention of ill-health through the promotion of simple, easy-option, choices that encourage people to take more physical exercise.
- Promoting a healthy lifestyle and enabling people to reduce their alcohol consumption and drink safely, stop or avoid smoking, eat more healthily and exercise regularly.
- Using reablement to reduce long term dependence on care.