MEETING HEALTH & WELL-BEING BOARD
DATE AND TIME THURSDAY 31ST MAY, 2012 AT 9.00 AM
VENUE HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

TO: MEMBERS OF HEALTH & WELL-BEING BOARD (Quorum 3)

Councillor Helena Hart (Chairman)	Cabinet Member for Public Health
Councillor Andrew Harper	Cabinet Member for Education, Children & Families
Councillor Sachin Rajput	Cabinet Member for Adults
Dr Charlotte Benjamin	Clinical Commissioning Group Lead, South Locality Cluster
Dr Andrew Burnett	Joint Director for Public Health, LBB/ NHS NCL
Alison Blair	NHS NCL Borough Director (Barnet)
Gillian Jordan	Barnet LINK representative
Robert McCulloch Graham	Director of Children's Service, LBB
Ceri Jacob	Associate Director, Joint Commissioning, LBB/NCL
Kate Kennally	Director of Adult Social Care and Health, LBB
David Riddle	NHS Barnet, Vice-Chair
Dr Clare Stephens	Clinical Commissioning Group Lead, North Locality Cluster
Dr Sue Sumners	Clinical Commissioning Group Chair and Lead, West Locality Cluster

You are requested to attend the above meeting for which an agenda is attached.

Aysen Giritli – Head of Governance

Governance Services contact: Andrew Nathan Tel: 020 8359 7029

Media Relations contact: Sue Cocker 020 8359 7039

CORPORATE GOVERNANCE DIRECTORATE

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AGENDA ITEM 1

BARNET HEALTH AND WELL BEING BOARD (SHADOW)
Minutes of meeting held on 22 March 2012 at, 9:00am
Committee Room 2, Hendon Town Hall, the Burroughs London NW4 4BG

Present:

Councillor Helena Hart (Chairman)	Cabinet Member for Public Health, LBB
Councillor Andrew Harper	Cabinet Member for Education, Children and Families, LBB
Councillor Sachin Rajput	Cabinet Member for Adults, LBB
Kate Kennally	Director of Adult Social Care & Health, LBB
Ceri Jacob	Associate Director, Joint Commissioning, LBB / NHS NCL
Bernadette Conroy	NHS Barnet, Non-Executive Director (deputising for David Riddle)
Alison Blair	NHS NCL Borough Director (Barnet)
Dr Sue Sumners	Clinical Commissioning Group Chair and Lead, West Locality Cluster
Dr Clare Stephens	Clinical Commissioning Group Lead, North Locality Cluster
Dr Charlotte Benjamin	Clinical Commissioning Group Lead, South Locality Cluster
Gillian Jordan	Chair of Barnet LINK
Dr Laura Fabumni	Assistant Director for Public Health, NHS NCL (deputising for Dr Andrew Burnett)

Also present:

Andrew Nathan	Chief Executive's Service, LBB
John Murphy	Governance Service, LBB

Apologies:

Robert McCulloch Graham	Director of Children's Service LBB

1. MINUTES OF THE LAST MEETING

The minutes of the meeting held on 19th January 2012 were agreed as a correct record.

Matters Arising

Item 5: Draft Health and Well-Being Strategy

Kate Kennally advised the Board that the development of risk register for next year was to be incorporated into the Forward Work Programme.

Item 8: Health Services in North Central London – Quality and Safety

Ceri Jacob and Alison Blair to provide details of a seminar session on investment in the Quality of Care Homes and the usage of primary care funds to the May meeting of the Health and Well-Being Board

2. ABSENCE OF MEMBERS

An apology for absence was received from Robert McCulloch Graham Director of Children's Service LBB.

An apology for absence was received from Dr Andrew Burnett with Dr Laura Fabumni substituting in his place.

An apology for absence was received from David Riddle with Bernadette Conroy substituting in his place.

3. DECLARATION OF MEMBERS PERSONAL AND PREJUDICAL INTERESTS

There were none.

4. HEALTH AND WELL-BEING STRATEGY

The Chairman of the Health and Well-Being Board introduced the item noting the many improvements both in content and presentation made to the Strategy since its first draft.

Kate Kennally, the Director of Adult Social Care and Health, LBB, presented a summary of the Strategy to the Board, noting how it set out a clear programme for delivering the objectives of improving the health and wellbeing of Barnet citizens and patients. She highlighted that the Strategy was based upon a strong evidential base incorporating the Joint Strategic Needs Assessment (JSNA) and the findings of the Marmot Review. It was also noted that the production of the Strategy had involved stakeholder engagement with two engagement exercises having taken place in relation to the integrated commissioning Strategy.

She drew the Board's attention to appendix two, the proposed consultation and engagement plan for the Strategy. The Board was informed of the significance of the consultation process, particularly its relation to understanding public views in relation to meeting of responsibilities and duties of the local authority and residents own responsibilities for their own health and wellbeing.

The Board was informed that the Strategy was based upon four main themes:

- preparing for a healthy life;
- wellbeing in the community
- how we live and;

- care when needed.

This thematic approach would provide a basis for responding to the challenge of the Borough's demographic changes and the resulting health and wellbeing issues that will arise in the coming years.

In relation to questions regarding target setting and monitoring progress the Board was informed that the Strategy would adopt targets that are considered the most relevant to health and wellbeing strategic priorities. Furthermore, targets would be monitored and reported to the Board to assess progress.

The Board was also reassured that the targets would be reviewed annually with results being published in the Annual Report of the Director of Public Health. This annual report will provide a means for the public to hold the Health and Well-Being Board to account and ensure that the Strategy was being delivered.

The Chairman noted the positive response of the Children's Trust Board and the Youth Board and commented on the positive role they can play in helping achieve targets such as reducing the rate of obesity in reception year school children.

Councillor Harper, the Cabinet Member for Education, Children and Families, also noted the importance of engagement with the Childrens Trust Board as well as other groups such as the Role Model Army to help address issues such as health inequalities experienced within the Borough. Councillor Harper also noted the importance of not being complacent in relation to targets, such as the number of NEETs within the Borough, which may be lower than other London Boroughs but nevertheless should be carefully monitored.

In relation to the public consultation process, Bernadette Conroy, Non Exectuive Director, NHS North Central London, drew the Board's attention to the importance of the use of language, for example, talking to young people using language and phrasing that they understood and were familiar with. She also highlighted the possibilities for delivering health messages through everyday channels such as maths and science lessons. These lessons could provide a platform for young people to engage with the rationalising of the health and lifestyle choices they make such as understanding the process and consequences of consuming high levels of calories.

Dr Sumners also noted the importance of presentation in getting the Strategy's message across to the Public particularly in reference to the Public Health story presented through the JSNA. Gillian Jordan, the Barnet LINk representative supported this point commenting on the need to ensure that health and wellbeing messages were delivered in an accessible but non-patronising manner.

In response to these comments Ceri Jacob, Associate Director Joint Commissioning, LBB/NCL stated that the presentation of the Strategy's message would be tailored to suit audiences as appropriate.

Dr Stephens supported the comments made by Ms Conroy in relation to schools but noted the challenge of working with a largely prescriptive school curriculum. However, Kate Kennally also reminded the Board of the work of of the Children's Service with schools in developing means of supporting childrens' health and wellbeing across the Borough.

Councillor Rajput, the Cabinet Member for Adults commented upon the challenges faced in addressing mental health issues and its relationship to unemployment with the Board commenting on the subtleties and complexity of mental health issues.

Mrs Gillian Jordan commented upon the difficulties being reported by individuals seeking assessment for mental health issues. In response, Ceri Jacob advised the Board that the Council was undertaking work to improve the assessment process.

In relation to measures and targets the Board discussed the complexities of deciding on appropriate measures for evaluating the wellbeing of the Borough's residents particularly in relation to breast screening; male prostate and colo-rectal cancer screening (tie-in to national screening).

Kate Kennally commented that the key point was the need to have reliable baseline figures and to ensure that the Strategy captures how they are measured.

Action – Public Health to confirm whether the breast screening uptake target is sufficiently challenging.

Action - Dr Sumners to provide clarification in relation to figures for colo-rectal screening.

Following discussion of the content of Appendix B – the Consultation and Engagement Plan – Members of the Board raised the following points:

- Kate Kennally clarified in response to Dr Stephens' query that the figure of £250 available to Barnet Homes tenants was per group
- Bernadette Conroy highlighted the importance of people's environmental surrounding to their health and welling. In particular she suggested that efforts should made to engage young artists and school children to brighten up hoardings. Councillor Harper noted that many hoardings were situated on private property which could hinder gaining access as property owners must give their consent. The Board agreed that environmental improvements of the type described by Ms Conroy could be included within the public consultation.

- Councillor Harper suggested that residents forums could be utilised for the consultation process with the Barnet Youth Board and Role Model Army also providing a channel for engaging young people in the consultation.
- Dr Sumners noted the importance of gaining insight into all the physical activities that mature residents enjoy in order to consider health promotion beyond activities limited to the gym environment.
- The Chairman suggested that the fourth theme of care when needed was extended to include “and to improve the patient experience.”

Action – Bernadette Conroy to forward to board members a more detailed description of possible opportunities for engaging residents in environmental improvements.

Action – The fourth theme of the Strategy to be extended to include “and to improve the patient experience”.

RESOLVED that –

1) The Health and Well-Being Board approves the Health and Wellbeing Strategy, ‘Keeping Well and Keeping Independent’ for consultation.

2) The Health and Well-Being Board endorses the consultation and engagement plan set out in appendix 2 of the report.

5. FORWARD WORK PROGRAMME

Andrew Nathan, Strategic Policy Adviser, introduced a potential work programme for the Health and Well-Being Board for 2012/13. Board members were invited to note and comment on the proposed work programme with particular reference to the proposal to adapt the structure of future meetings to include both formal board meetings held in public and workshops for Board members to support effective joint working and prioritisation arrangements in this shadow year of operation. This proposal was based on the outcomes from the Board Development Session organised by NHS London in February to which the Board attended.

In relation to the monitoring of targets and measures included within the Director of Public Health’s Annual Report, Board members suggested that the review of at least one of these measures should be included as a standing item on the work programme of the Board.

Action – Andrew Nathan to forward details of arrangements for a workshop session that is due to be arranged with the Marmot Review team.

Action – Board members to forward any comments in relation to proposed work programme to Andrew Nathan.

RESOLVED that –

1) **The Health and Well-Being Board note the draft forward work programme.**

6. PUBLIC HEALTH TRANSITION PLAN

Rohan Wardena, Public Health Transition Programme Lead, presented a report updating the Board on the development of the local transition plans and process to prepare for the transfer of public health responsibilities from NHS North Central London Cluster PCT to Barnet Council.

Mr Wardena asked the Board to endorse a Memorandum of Understanding, which was not a legally binding document, between NHS North Central London Cluster PCT and Barnet Council supporting the development of joint transition plans and the definition and operation of shadow working arrangements during 2012/13.

The Chairman stated that she wished to note formally for the public record her concerns in relation public health funding in Barnet. At a public health spend per head of population of £32, Barnet would receive the fifth lowest allocation in London which was substantially lower than the London average of £40 per head. She felt this level of funding would make it extremely difficult to provide the recommended increase in health checks and obesity reduction services. She confirmed that strong representations had been made to NHS NCL, NHS London and the Department of Health in this regard.

Action – That Board members send their comments in relation to the Memorandum of Understanding to Kate Kennally and Alison Blair to enable the submission of the signed document to NHS London by the 5th of April 2012 .

RESOLVED that-

1) **The Board endorse a Memorandum of Understanding, subject to final comments to be submitted by Board members, between NHS North Central London Cluster PCT and Barnet Council to support the development of joint transition plans and the definition and operation of shadow working arrangements during 2012/13.**

2) **The Board endorse the approach to develop and implement joint local public health transition plans.**

7. MINUTES OF FINANCIAL PLANNING SUBGROUP

The Board considered the minutes of the Financial Planning Subgroup which was a standing item providing updates to the Board on the joint planning of health and social care funding in accordance with the Council's Medium Term Financial Strategy and the NHS Quality Improvement and Productivity Plan (QIPP).

RESOLVED that –

1) **The Board note the minutes of the Financial Planning Subgroup.**

8. OLDER ADULTS PARTNERSHIP BOARD ANNUAL REPORT

Peter Cragg, Co-Chair of the Older Adults Partnership Board, and Caroline Chant, Joint Commissioner Older People and Physical Sensory Impairment, presented the Older Adults Partnership Board Annual Report.

In addition to the points noted in the report Mr Cragg reported he was encouraged by earlier discussions relating to community engagement in relation to the Health and Well-Being Strategy's consultation process.

Mr Cragg drew the Board's attention to an Aging Well pilot that had commenced on the Stonegrove Estate which would include discussions and workshops with local residents aimed at getting their views on what it meant to age well on the estate.

Mr Cragg noted that these workshops could also provide a platform for the Health and Well-Being Strategy Public Consultation process.

Finally, Mr Cragg wished to draw a distinction between the role of the LINk, which he saw as acting as a vehicle for scrutinising the work of the Health and Well-Being Board, and the Older Adults Partnership Board, whose role was aligned to helping build relationships between the Board and the Community.

Caroline Chant presented the Health and Well-Being Board with an overview of the annual report.

RESOLVED that –

1) **The Health and Well-Being Board note the Older Adults Partnership Board Annual Report.**

9. MEETING WITH CHAIRS OF PARTNERSHIP BOARDS

The report provided the Board with feedback from the Partnership Boards allowing for the needs of service users to be factored into the development of strategies and programmes overseen by the Health and Well-Being Board.

The Chairman advised that it had been agreed that the Partnership Board members would hold more joint meetings in the coming year.

RESOLVED that –

1) **The Health and Well-Being Board note the minutes of the meeting between the Chairman and the Partnership Boards held on February 9 2012.**

10. ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 12)

There were none.

The meeting finished at 11:05 A.M.

Meeting	Health and Well-Being Board
Date	31 May 2012
Subject	**Health and Well-Being Board – Governance and Development 2012/13**
Report of	Director of Adult Social Care and Health
Summary of item and decision being sought	This report asks the Health and Well-Being Board to review its Terms of Reference and membership for 2012/13, and that the preferred working styles agreed at its inception are still relevant and being pursued. It also updates the Board on recent development activity, including the Action Plan that was developed at the Health and Well Being seminar at the Oval.

Officer Contributors	Strategic Policy Adviser
Reason for Report	It is a principle of good governance that governance documents such as Terms of Reference be reviewed regularly. Given that the Board is new and still in the early stages of development it is particularly important to create space to review whether it is working effectively as it prepares to take on its statutory responsibilities from 1 April 2013.
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	Andrew Nathan, Strategic Policy Adviser, 020 8359 7029

1. RECOMMENDATION

1.1 That the Terms of Reference attached at ‘Appendix A’ be approved.

1.2 That the Board review whether the ways of working agreed at inception are being implemented and consider if any refinements are necessary

1.3 That the draft Action Plan attached at Appendix ‘B’ be implemented and the Board review progress at future meetings

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well Being Board 26 May 2011- decision item 8

2.2 Health and Well Being Board 19 January 2012- decision item 8

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

3.1 This report relates to the collective ability of the Board to function effectively and therefore lead the development of the strategies the Board is responsible for**.**

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Understanding the health needs of specific communities is one of the aspects of development where the Board will need to develop its expertise.

5. RISK MANAGEMENT

5.1 Explicit Terms of reference and a clear plan to develop the Board into one fit for purpose will mitigate the risk that the Board will fail to understand its remit or operate effectively.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The Health and Social Care Bill received Royal Assent on 27 March 2012. Barnet’s Health and Well-Being Board has been operating in shadow form in readiness for the legislative changes.

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

7.1 £15,000 has been received from the Department of Health to commission development support and any development activities will be supported from those funds.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Each HWBB member has been consulted at every stage on development needs and given the opportunity to complete self-assessments and attend events.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 None

10. DETAILS

10.1 Barnet Health and Well Being Board held its first meeting on 26 May 2011, at which it agreed initial Terms of Reference and membership. These are set out at Appendix 'A' and with the exception of a few minor changes, which are tracked, it is suggested that the Board continue to adopt these.

10.2 Also included in Appendix 'A' is a note on how the Board would operate, which was agreed by the Board at its inaugural workshop on 12 May 2011, independently facilitated by Robin Lorimer. This is a suitable moment for the Board to reflect whether this still represents their desired way of working and to what extent it has been implemented in practice.

10.3 Subsequently the Board has undertaken further development work, including the completion of a self-assessment (the maturity matrix) and collective attendance at one of the seminars organised by the NHS London Joint Improvement Partnership at the Oval in February 2012. At the seminar, the Board drafted an Action Plan and this is attached at Appendix 'B'. The Board are asked to confirm that this Plan should be implemented and a progress update made to a future meeting. In addition the official report of all of the London seminars has been circulated to all Board members.

10.4 The Board has already taken action as a result of this work, agreeing to complement formal meetings with workshops on particularly complex topics where the issues and how different parts of the health and social care system need to work together can be explored in a less formal and more meaningfully productive way. A seminar on health and social care integration was held after the last meeting and a follow up is being arranged. The Marmot Review team are leading a seminar after this Board meeting on health inequalities, specifically around Children's Health (including ante-natal activity) and reducing child poverty, and the impact of regeneration and the economy on health and well being.

10.5 The Strategic Policy Adviser has been attending the dissemination events held by the national network of Health and Well Being Board learning sets. Each of these has developed resources, such as 'top tips,' that can be shared on specific issues ranging from governance and joint strategies to service redesign and improving public engagement. These will be brought into relevant local discussions and are available as required, although it should be acknowledged that Barnet is in at least as advanced a stage of development as most of the participating authorities.

10.6 The King's Fund also recently produced a report on Health and Well Being Boards entitled 'system leaders or talking shops?' The key message of this report is that the biggest challenge facing the new boards is whether they can deliver strong, credible and shared leadership across local organisational boundaries. Unprecedented financial pressures, rising demand, and complex organisational change will severely test their political leadership. Board members need time and resources to develop their skills and

relationships with other stakeholders. The report also highlights uncertainty over to what extent national policy imperatives and NHS Commissioning Board decisions will reduce local autonomy, and the need for a stronger national framework for integrated care with a single outcomes framework to promote joint accountability.

11 BACKGROUND PAPERS

11.1 **Kings Fund- 'System leaders or Talking Shops'- April 2012**
http://www.kingsfund.org.uk/publications/hwbs.html

11.2 **National Learning Network for Health and Well-Being Boards at**
https://knowledgehub.local.gov.uk/group/nationallearningnetworkforhealthandwellbeingboards (registration required)

11.3 London Health and Well Being Challenge Events Report 2012- Cap Gemini Consulting

Legal – HP
CFO – JH

APPENDIX A
TERMS OF REFERENCE (agreed May 2011- with suggested changes highlighted)

1. On behalf of the Barnet Partnership Board, to be the lead partnership body for health and social care matters in the borough as identified in the Sustainable Community Strategy and other Barnet policies and programmes.

2. To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social well-being (i.e. not just an absence of disease or infirmity[1]). Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; and Section 75 partnership agreements between the NHS and the Council.

3. To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.
4. To agree a Health and Well-Being Strategy for Barnet taking into account the findings of the JSNA and performance manage its implementation
5. To consider the Quality, Innovation, Productivity and Prevention (QIPP) plan[2] and ensure its relevance to the Health and Well-Being Strategy and commissioning strategies.
6. To directly address health inequalities through its strategies and have a specific responsibility for regeneration and development as they relate to health and care. To champion the commissioning of services and activities across the range of responsibilities of all partners in order to achieve this.

7. To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health.
8. To support joint commissioning of services and the use of pooled budgets, where appropriate, to enable the more efficient use of resources. As and when they are introduced, to manage and allocate a 'community budget' for health and care.

9. To oversee and give direction to the work of sub groups such as the Financial Planning Group, the Health and Well-Being Implementation Group and client group specific partnership boards and receive reports from them at least annually.

10. To assess its contribution by using outcomes of measures which are published

MEMBERSHIP

The meeting will be chaired by an elected Cabinet member.

- Cabinet Members with responsibility for Public Health; for Education, Children and Families; and for Adults
- NHS North Central London- Barnet Borough Director and non executive Director
- Clinical Commissioning Group reps for each locality (x 3)
- Director of Adult Social Care and Health

[1] Based on the World Health Organisation definition of health
[2] This is a document analogous to a medium-term financial strategy that the local NHS must prepare

- Director of Children's Service
- Joint Director of Public Health
- Barnet Link representative (to become Healthwatch rep when latter in place)

In attendance:
- Associate Director of Joint Commissioning
- Providers as and when issues being discussed

(Exact titles may change during the year as NHS reforms are rolled out).

Methods of Working- as agreed at the HWBB Development Day- 12 May 2011

1. Scope:

a. Scope of the Board would be limited to priorities where it can make an impact through focusing resources
b. It will be guided by the JSNA and through that the production of the ensuing strategic priorities, expressed through a Health and Well Being Strategy for meeting JSNA identified needs
c. Subsequent Health, LBB Social Care and GP Consortia commissioning plans would reflect the strategic priorities agreed and be shared plans.
d. This would accord with the expectations of the reforms and legislative design
e. Where plans were shared, these would be the primary focus of Board members, not an 'add on'. The ultimate goal was integrated commissioning around the shared priorities.

2. Style:

a. The Board would not become involved in wider service related matters
b. It would be driven by the priorities agreed by itself
c. It would not be a performance managing body
d. It would receive a high level, outcome focused performance assurance framework report on a regular basis, to be designed around the key priorities and its own emerging plans for improvement
e. A key role would be in encouraging formal use of partnership arrangements such as S75s where these provided added value to the local system. It was agreed use of these had been too limited to date, and existing joint arrangements needed review
f. The focus would be not only on shared planning, but shared implementation of these plans

3. Priorities

Priorities for commencement in the year ahead would include developing agreements and approaches to:

a. Disease prevention/health improvement
b. Encouraging residents to take responsibility for their own and their families' health and well being.
c. Demand management - including expectations of patients
d. Reducing 'Social Admissions' to hospital and concentrating on 'admission avoidance'
e. Reducing A& E attendance by people over 65yrs
f. Developing 'Care Closer to Home'
g. Increasing 'Care Outside of Hospital' services appropriate to the above

h. Supporting Children Trust priorities (specifically Children's Health) through early intervention and prevention
i. Early intervention to reduce complex needs (example of mental health service users on Incapacity Benefit)
j. Reducing health inequalities particularly for those with Learning Disabilities and Mental Health Problems

4. Resources

a. The resources of the partners covered by the above priorities would within the scope of the Board's discussions at any time
b. The Board would manage the NHS monies for reablement and social care allocations through the NHS (approximately £3.5 mlln in 2011/12) as a strategic fund for leveraging change
c. The Board would have as a key resource, Public Health and the Public Health Budgets to be transferred to LBB pending legislation
d. The Board would also be supported by the Associate Director Joint Commissioning
e. LBB Chief Executive Service would provide business support eg developing work plan, following up action and 'Governance Services' would provide the formal secretariat support
f. Estates would be a potential area for supporting the change in service design necessary especially ways in which common estate utilisation can be agreed to support NHS change in the community

5. High Impact Plans

a. The NHS QIPP and LBB Medium Term Financial Strategy would be crucial as documents to be shared for discussion at the Board.
b. The purpose would be to identify common areas of interest and impact between the partners so that measures might be agreed jointly to support and manage the effects of necessary change.
c. Increasingly such plans would be prepared in consultation together prior to their finalising within the individual organisations.

6. **Effective relationships with General Practice**

a. The role of GPs in having detailed knowledge of the population is a strength to tap into
b. LBB will develop stronger links between the Council and General Practice whilst maintaining close links with the wider NHS Sector.
c. The Board would have a role in commenting on GPs commissioning strategies and ensuring alignment to shared priorities

7. **Essential Behaviours**

The Board will consider how to ensure effective behaviours for working together and with others

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Action plan template

Barnet

	0-3 months	3-6 months	6-9 months	9-12 months
Development needs	• Need to develop sense of how we work together • Need to develop common language • Need a way to deal with complex issues • Need a way to deal with deep disagreements • What are the issues: what do we want to do? • Agreed behaviours & ground roles • Resist invoking our representative roles (eg as a councillor…as a clinician)	• Really get our heads round the money and resources , now – and over the next 2-3 years • Work on our own, Barnet specific equivalents of the scenarios in order to anticipate some of the issues we will have to face • Understand the real-politic of our role and agenda – how we play into local political power and mechanisms		• Evaluate our first year's activity and impact
Key Actions	• Work on a process for indentifying/ filtering what needs to go to HWBB and what doesn't (is what relates to JSNA, HWB strategy and H&C integration) • Review arrangement for public question time and presentations • Forward agenda planning – mix proactive and reactive • Develop the narrative about our added value in ways which make sense to all	• Work out what relationship we have with NHS Commissioning Board • Agree an implementable H&WB strategy • Make sure our grasp of the JSNA – in absolute numbers, not just rates and %s – is projected into the future and linked to plans for provision • CJ – all board to see commissioning forward plan	• Develop a de-commissioning policy and strategy • Review how we are doing • Think about the 'forward plan for 2013' • Begin to model and understand the impact of London-wide changes ion the provider infrastructure and population of Barnet • Think about what our role as stewards of the provider infrastructure means in practice	• Review and refresh health and well being strategy to ensure it fully addresses service improvement and health protection priorities (and any further statutory function when legislation gets through) • Plan transition into 'live' arrangements for new health system in 2013
Actions from others				

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Meeting	Health and Well-Being Board
Date	31 May 2012
Subject	**Annual Report of the Director for Public Health**
Report of	Director for Public Health
Summary of item and decision being sought	This report focuses on prevention in the areas of tobacco control, overweight and obesity, and improving the home learning environment for children living in poverty to reduce health inequalities consequent upon poor educational attainment. Health & Well-Being Board members are asked to decide whether they support the Director for Public Health's recommendations.

Officer Contributors	Dr Andrew Burnett – Director for Public Health
Reason for Report	Directors for public health are expected to produce an annual report concerning the health of the population for which they are responsible. Such reports are often based on a particular theme (which avoids duplication with the JSNA) and make recommendations for action. Director for public health reports reflect advice to the relevant authorities and are not, of themselves, policy statements by those authorities unless they choose to adopt them as such. There is an obligation for annual Director for Public Health reports to be published, for example, on NHS and council websites
Partnership flexibility being exercised	N/A
Wards Affected	All wards

Contact for further information

Dr Andrew Burnett, Director for Public Health andrew.burnett@nclondon.nhs.uk

1. RECOMMENDATION

1.1 That the Health & Well-Being Board note the report.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 This report has been presented to the Board of the Barnet Clinical Commissioning Group and will be sent to the board of NHS North Central London

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

3.1 This report focuses on preventing avoidable ill-health. There is considerable scope for partnership working and it is fully compatible with the draft Health and Well-being Strategy, the draft Integrated Commissioning Strategy, the draft Prevention Strategy and the Joint Strategic Needs Assessment (JSNA).

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 This report is based on assessed needs and implementing its recommendations can reasonably be expected, over time, to significantly contribute to reductions in health inequalities

5. RISK MANAGEMENT

5.1 Failure to address the ‘causes of the causes’ of avoidable ill-health and health inequality will lead to greater levels of ill-health, greater health and social care costs and widening health inequalities

6. LEGAL POWERS AND IMPLICATIONS

6.1 The Health and Social Care Act 2012 provides the relevant statutory framework for the establishment of the Health and Well-Being Board, the JSNA and the Health and Wellbeing Strategy.

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

7.1 Additional resources will be needed to implement the recommendations in this report, but the recommendations have been shown to be cost-effective. Work is required to develop implementation plans and business cases.

7.2 Any resource implications will need to be contained within the Adults and Health Budgets.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 None specifically arising from the report, but action to be taken as a result will engage and assist the community in taking responsibility for their own health.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 None specifically arising from the report.

10. DETAILS

10.1 The health of Barnet people is generally better than average but an argument is put forward in this report that we should not be content with this.

This report focuses on ill-health prevention in three areas where we can have the maximum impact on people's well-being. The first two areas, reducing the prevalence of both smoking and of people who are overweight and obese will have a direct impact on people's well-being. The third area, improving the home learning environment for children who live in poverty, will have an indirect impact on their well-being because this will improve their educational attainment, which is a major determinant of health. Addressing these three topics can also reasonably be expected to reduce health and social care costs and free-up resources for other activities.

Based on evidence of effectiveness and value-for-money, the report recommends that we should:

- substantially reduce the prevalence of smoking amongst Barnet's residents (that is, much more than we have already);
- significantly reduce the number of people in Barnet who are overweight and who are obese; and
- improve the life chances of the above-average proportion of children living in poverty in Barnet by enabling the parents and carers of pre-school children to provide them with a better home learning environment.

The report consists of a three-page summary and a more detailed review of the situation in Barnet with comparisons with elsewhere, the cost effectiveness of interventions, the relevance of action in Barnet, and recommends specific actions to be taken.

11 BACKGROUND PAPERS

11.1 JSNA (available at http://www.barnet.gov.uk/info/930089/plans_performance_and_partnerships/900/plans_performance_and_partnerships

11.2 Draft Barnet Health & Well-being Strategy

Legal – HP
CFO – JH

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Annual Report of the Director for Public Health, Barnet

2012-13

Prevention is better than cure

Dr Andrew Burnett

Director for Public Health, Barnet

April 2012

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SUMMARY

Whilst the health of Barnet people is generally better than average we should not be content with this: we can, and should, do better. In particular, and based on evidence of effectiveness and value-for-money, I consider that we should:

- substantially reduce the prevalence of smoking amongst Barnet's residents (that is, much more than we have already);
- significantly reduce the number of people in Barnet who are overweight and who are obese; and
- improve the life chances of the above-average proportion of children living in poverty in Barnet by enabling the parents and carers of pre-school children to provide them with a better home learning environment.

In my report for 2012-13, I have focussed on ill-health prevention and done so in three areas where I consider that we can have the maximum impact on people's well-being. The first two areas, reducing the prevalence of both smoking and of overweight and obesity will have a direct impact on people's well-being. The third area, improving the home learning environment for children who live in poverty, will have an indirect impact on their well-being because this will improve their educational attainment, which is a major determinant of health. Addressing these three topics can also reasonably be expected to reduce health and social care costs and free-up resources for other activities.

Tobacco control

Over the last few years, Barnet has consistently exceeded its NHS smoking cessation target. I wish to challenge both the NHS and the council in Barnet to deliver a step-change in tobacco control and to seek to reduce the prevalence of smoking in the borough to levels similar to those in California and in Sweden. This will substantially reduce mortality and morbidity amongst the people for whom we are responsible. For example, the substantial decline in smoking prevalence in California has been associated with declines in lung cancer, heart disease and other tobacco-related illnesses. And in Sweden, reducing smoking prevalence has also reduced smoking in pregnancy, has led to a statistically significant reduction in the risk of low birth-weight babies and to a reduction in the prevalence of abdominal aortic aneurysm.

In Barnet, I recommend that we seek to reduce the number of young people taking up smoking each year; encourage and enable smokers to quit; and contribute to protecting families and communities from second-hand smoke. Helping to stop young people from starting smoking is particularly important because the perpetuation of tobacco use through successive generations is one of the major causes of health inequality.

Overweight and obesity

We have taken little action in the past in Barnet to deal with the second-most significant challenge to our population's well-being: overweight and obesity. Obesity, like smoking, is a major cause of health inequality and our work so far on reducing health inequalities will be undone if we do not also address the obesity epidemic as well. It is the complications of obesity that matter, the principle one of which is diabetes and its own principal consequences – heart disease, kidney failure and premature death. The overall risk of dying prematurely for a person with diabetes is at least double that of the risk for someone without this disease. Other complications

of diabetes include blindness and long-term reduced kidney function, both of which have severe consequences for the sufferer and significant cost implications for health and social care services.

Being overweight or obese is due to eating more than the body needs, possibly leading some to consider that overweight and obesity are self-inflicted conditions caused simply by a lack of willpower. However, there is now evidence that, in people who are significantly obese, the internal mechanisms that control the sense of satiety are automatically and permanently re-set, with the body' s normal function being dysregulated such that the obese person becomes 'locked-in' to their new body weight by a powerful physiological mechanism. Such people will literally be unable to lose a significant amount of weight without specialist help, including, for those with more extreme weight problems, surgical intervention. It is important to note that there is good evidence that surgery for obesity results in greater, and more sustained, weight loss than conventional treatments in both moderate and severe obesity, with reductions in conditions such as diabetes and high blood pressure and improvements in quality of life, and a reduction in long-term mortality. It is especially noteworthy that 85% of the people reported in the National Bariatric Surgery Register who had diabetes at the time of surgery for obesity had no indication of this disease at two-year follow-up and that other studies have shown this benefit to persist for many years. Principally because of the persisting benefits of surgery for obesity, it is one of the most cost-effective interventions for it. Indeed, modelling we have undertaken shows that, unequivocally, surgery for obesity in people who have already developed type 2 diabetes saves health service costs (and by implication, social service costs) after some five years. Not funding this treatment would increase health and social care costs after a similar period of time as well as worsen people's wellbeing.

I am particularly concerned that 10-11% of children who start school in Barnet are already obese and, even more worryingly, more than 17% are obese in Year 6. Not only is this likely to presage an increasing proportion of obese adults, it is likely to mean that the complications of obesity are likely to affect people at an increasingly younger age. It is noteworthy that the prevalence of diabetes is already above-average in Barnet.

In Barnet, I recommend that we prioritise the prevention and the management of overweight and obesity. This will require a multi-faceted approach and I have provided more detail of this in this report.

The impact of child poverty on educational achievement and consequent health

Finally, the impact of child poverty on educational achievement and consequent health is an important area for action in Barnet. There is an above-average proportion of children living in poverty in Barnet (23.7% vs 20.9% nationally) and numerically more children in Barnet live in poverty than do in, for example, either Islington or Camden, which are both boroughs with higher proportions of deprivation than Barnet.

There is substantial evidence that people in higher socioeconomic groups generally experience better health and there is strong evidence that the relationship between educational achievement and health shows a similar gradient: people with better educational achievement generally enjoy better health. Children born into families with high socioeconomic status, whether their cognitive scores as babies are, on average, high or low, generally have higher cognitive scores by the age of about ten years. In contrast, those born into lower socioeconomic group families, on average, have lower cognitive scores at the age of 10 years, irrespective of their scores at ten months. Such educational inequalities persist at secondary age: children eligible for

free school meals are half as likely to achieve 5 GCSEs A*-C compared to those not eligible for free school meals. For many, we can expect these educational achievement differences to translate into health inequalities in later life. Importantly, there is a large body of evidence that children cannot take good advantage of their school-based education if their pre-school home learning environment is inadequate, but there is also good evidence that this is remediable.

Various studies have shown that early childhood intervention programmes, such as providing parental support and training, learning activities and structured experiences for children and enhancing the home learning environment lead to statistically significant improvements, including improved developmental and intelligence scores and better cognitive development, creative thinking and concept development. There is also evidence that interventions that supplement the early lives of children of disadvantaged families promote schooling, reduce crime, foster work productivity and reduce teenage pregnancy, and that these interventions are cost-effective.

The most significant of these interventions is for parents and carers to read to and to read *with* their children. Enabling parents and carers to be able to do this has been shown to lead to sustained, statistically significant, improvements in children's reading and writing skills and to better behaviour in school as well as greater academic achievement. Thus, based on a good evidence-base, helping parents of families living in poverty in Barnet to improve both their parenting skills and the home learning environment can reasonably be expected to improve children's success at school and to improve their life chances and thus prospects for future good health.

It is also important to recognise that smoking is a particular issue for families living in poverty because a much higher proportion of disposable income is spent on tobacco in such families. Crucially, there is evidence that low-income households where parents smoke are much more likely to lack adequate basic amenities, such as food, shoes, coats, than non-smoking parents on Income Support. Targeting families living in poverty in non-stigmatising ways to enable smokers to quit will improve their health directly and make more money available for both basic amenities and an improved home learning environment for children.

In Barnet, I recommend that we expand our current work on child poverty to enable a much higher proportion of parents and carers of children living in poverty to be able to provide a much more effective home learning environment for their children.

Taking action to improve people's health in Barnet further

In each of the three main sections of this report (tobacco control, overweight and obesity, and child poverty) there are specific sections looking at the relevance to Barnet and what I recommend we should do. I hope that these, and the underlying evidence-base presented here, will be useful in enabling actions to improve the health of Barnet's people still further.

Dr Andrew Burnett
Director for Public Health, Barnet
April 2012

Annual report of the director for public health, Barnet

Prevention is better than cure

1 Introduction

In my report on health in Barnet for the year 2012/13, I wish to emphasise the importance of all of us taking actions to prevent avoidable illness and disability at every opportunity.

The aphorism "An ounce of prevention is better than a pound of cure" has been attributed to Benjamin Franklin in relation to his organisation of the Philadelphia Union Fire Company in 1736.[1] Few would argue against the desirability of preventing fire rather than waiting for one to occur and then trying to put it out. Franklin's observation is particularly apposite in the context of health services and, to some extent, to social care and some children's services, where it seems that we spend so much time 'fire-fighting' that we probably feel we have little or no time for prevention.

If we amend Franklin's phrase to "A penny of prevention is better than a pound of cure" then we remind ourselves that preventing things that are avoidable not only reduces or eliminates some types of ill-health and disability and associated suffering, but can save money too. The potential for this in terms of NHS costs was writ large in 2004 by Derek Wanless in his exhortation for a shift from a national sickness service to a national *health* service that was 'fully engaged' in prevention. The figures in his report[2] are now out of date, but the principle remains: if we want to make sustainable financial reductions in health and social care costs then we have to do much more to prevent avoidable conditions occurring. Wanless depicted this in relation to the proportion of the country's gross domestic product required for NHS services in three scenarios of 'slow uptake', 'solid progress' and 'full engagement' in prevention. This is shown in Figure 1, which is taken from his report, and shows that only with 'full engagement' of both public services and the public themselves can we expect the amount of funding needed for health services to level-off. I see no reason why this should not also apply to social care and children's services costs and that, with an increasing proportion of elderly people in the population and the present economic situation, Wanless's exhortation for our much greater involvement in preventing avoidable illness and disability is even more important now than it was in 2004.

1.1 Context

Overall, death rates from the main killers, heart disease and stroke, cancer, and respiratory disease, are dropping in Barnet and, as described in the Barnet Joint Strategic Needs Assessment,[3] the health of the people of Barnet is generally good. However, there are significant health inequalities and, as identified in the *Finding the Five Thousand* project,[i] there are a large number of people in Barnet with unrecognised and, crucially, remediable, risk factors for certain diseases. There are also important inequalities in health in the borough, closely correlated with deprivation, and reflected in differences in life expectancy.

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i This is described in the current Barnet Joint Strategic Needs Assessment

For example, the difference in life expectancy for boys born in the most deprived parts of the borough compared with those in the most affluent is seven years (five years for girls) and this difference is statistically significant,[4] as shown in Figure 2.

Figure 1: Wanless's prediction in 2004 of the impact of different levels of engagement in prevention on the proportion of gross domestic product required for the NHS. (The figures are now out of date but the vital message remains: prevention is cheaper than cure and frees resources for other things)

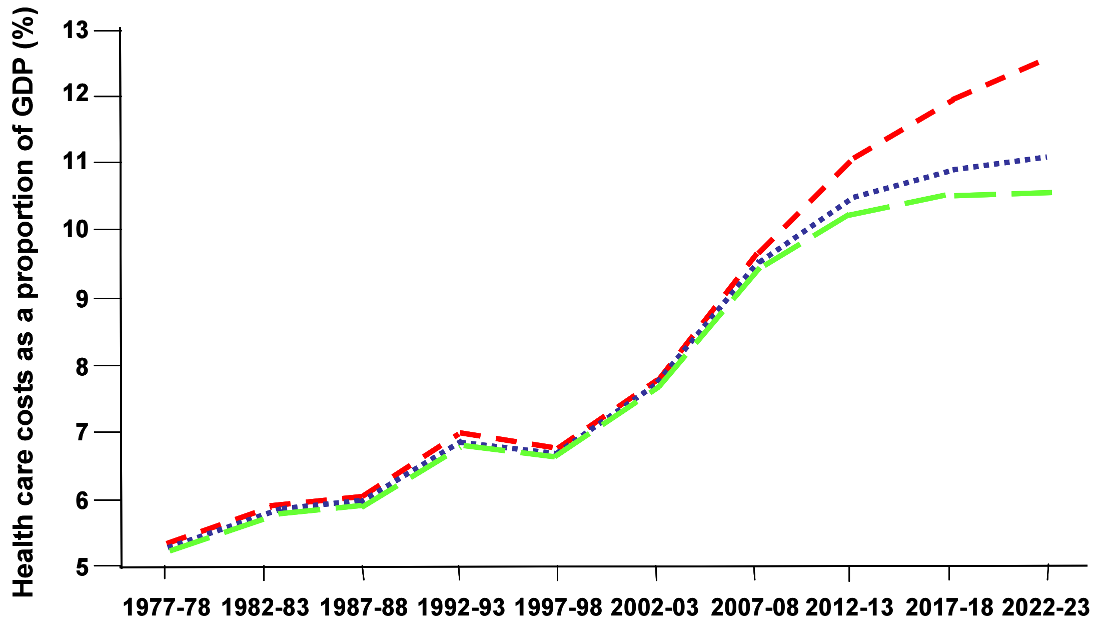

Figure 2: Differences in male and female life expectancy at birth in different parts of Barnet

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2005-2009) for each of the quintiles in this area.

N

0 1 2 Miles

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Life expectancy at birth (years)

95 90 85 80 75 70 65 60

Quintile 1 Quintile 2 Quintile 3 Quintile 4 Quintile 5

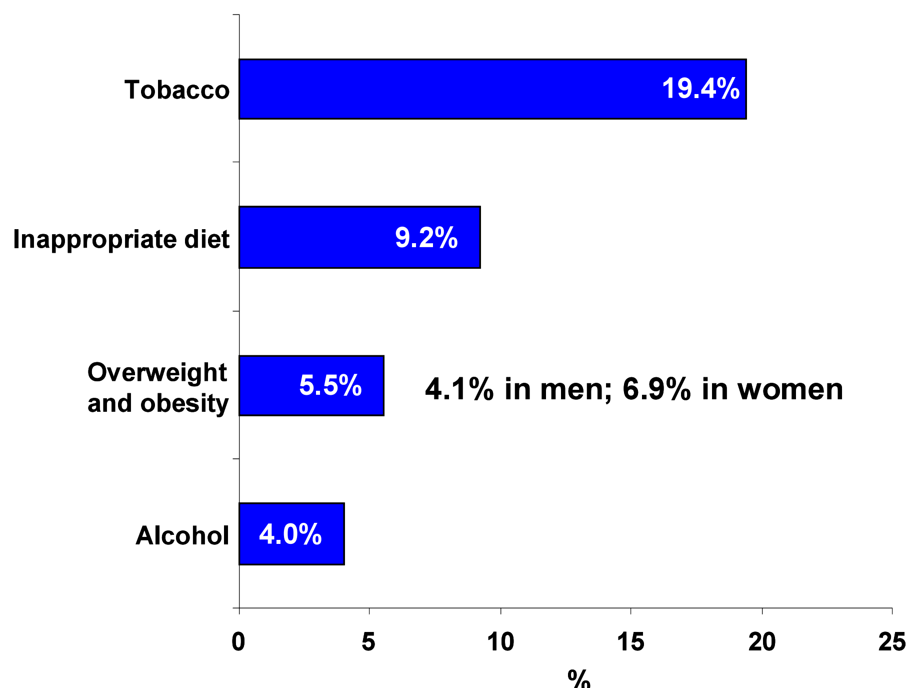
M = Males F = Females

95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile 2 3 4 5 - most deprived quintile

Such differences are not inevitable nor are they immutable. As discussed in section 2.3, health inequalities can be reduced, and, for premature cardiovascular disease mortality, have been in Barnet. The important point is that there is scope in Barnet to reduce avoidable disease further, and to reduce both the associated suffering and the costs. For example, in a recently published review of the epidemiology of a wide range of cancers, it was identified that about one third overall can be attributed to just four lifestyle choices.[5] This is depicted in Figure 3, taken from the report.

Figure 3: The proportion of cancers in the UK attributable to different exposures



Cancer is not the only disease, with cost implications for both health and social care services, that is a consequence of risky lifestyle choices. Heart disease and stroke, aortic aneurysm, peripheral vascular disease, respiratory disease, osteoarthritis, age-related macular degeneration, diabetes, osteoporosis, liver failure and upper gastrointestinal diseases are all more likely to occur in people who smoke, or who are overweight or obese, or who have an inappropriate diet, or who take insufficient exercise, and/or who misuse alcohol.

Most of these conditions occur more frequently in people living in deprived areas. Deprivation, for many, has its origins in child poverty and so does poor health. For example, three-year olds in families with a combined income of less than £10,000/year are two-and-a-half times as likely to develop life-limiting chronic illness as are three-year olds in families with an income of more than £52,000/year.[6] They are also twice as likely to develop asthma and nearly three times as likely to develop a mental disorder.[7]

The key areas of prevention that I wish to draw to the attention of Barnet Council, the Barnet Clinical Commissioning Group, education providers and health and social care providers for the purposes of service development in 2012/13 and beyond are:

- tobacco control – smoking avoidance and smoking cessation;
- overweight and obesity; and
- the pre-school educational aspects of child poverty.

I discuss each of these in the next three sections.

2 Tobacco control

2.1 Background

In a publication in 2004, Doll and Peto, the doctors who first brought attention to the significant harms to health caused by tobacco use, published the findings of a 50-year prospective study of the hazards of cigarette smoking in doctors and the extent of the reduction in risk on stopping smoking at different ages in terms of premature mortality.[8] They found that, in this relatively affluent group (in whom one would therefore not otherwise expect high mortality rates), that:

- men born in 1900-1930 who continued to smoke cigarettes died on average ten years younger than lifelong non-smokers;
- stopping smoking in this group at 60, 50, 40 and 30 years of age gained, respectively, 3, 6, 9 and 10 years of life expectancy;
- the probability of dying between the ages of 35 and 69 years in this group were 42% in smokers and 24% in non-smokers – a two-fold increase in risk of death in smokers.

Put another way, it is unequivocally best not to start smoking, but it's never too late to stop.

2.2 Is smoking cessation cost effective?

Enabling people to stop smoking is one of the most cost-effective interventions to improve health.

Based on prices in 1998, the most expensive NHS smoking intervention (specialist smoking cessation support) cost £873 per life-year saved, whilst a review of more than 310 other medical interventions identified that the median societal cost for these was £17,000 per life year gained.[9] And a review of the cost-effectiveness of implementing the American Agency for Health Care Policy and Research guidelines on smoking cessation found that smoking cessation is 'extremely cost-effective', with a cost per QALY[ii] of $1,108–$4,542 (£705–£2,891) with the more intensive interventions being more cost-effective, suggesting that 'greater spending on interventions yields more net benefit'.[10]

A more recent systematic review of nine randomised controlled trials of smoking cessation in patients with chronic obstructive airways disease, that is, in people with established smoking-related morbidity, found that, compared with usual care, the costs per QALY of minimal counselling, intensive counselling and pharmacotherapy were, respectively, €16,900, €8,200 and €2,400 (£14,000, £6,856, £2,006).[11] The

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ii Quality adjusted life years (QALYs) are a measure of cost per increase in utility that can be used in assessing the value-for-money of a clinical intervention. (A 'utility', from an economics perspective, is a measure of relative satisfaction or benefit, and thus is something that can increase or decrease. Cost-utility in a health care context is an economic evaluation of the degree to which quality of life is improved per pound spent using measures such as QALYs). A QALY is based on the number of years of life that would be added by the intervention. Each year in perfect health is assigned the value of 1.0 down to a value of 0.0 for death. If the extra years would not be lived in full health, for example if the patient would lose a limb, or be blind or have to use a wheelchair, the extra life-years are given a value between 0 and 1 to account for this. In some instances, a negative value is applied, when the health state is considered to be 'worse than death'.

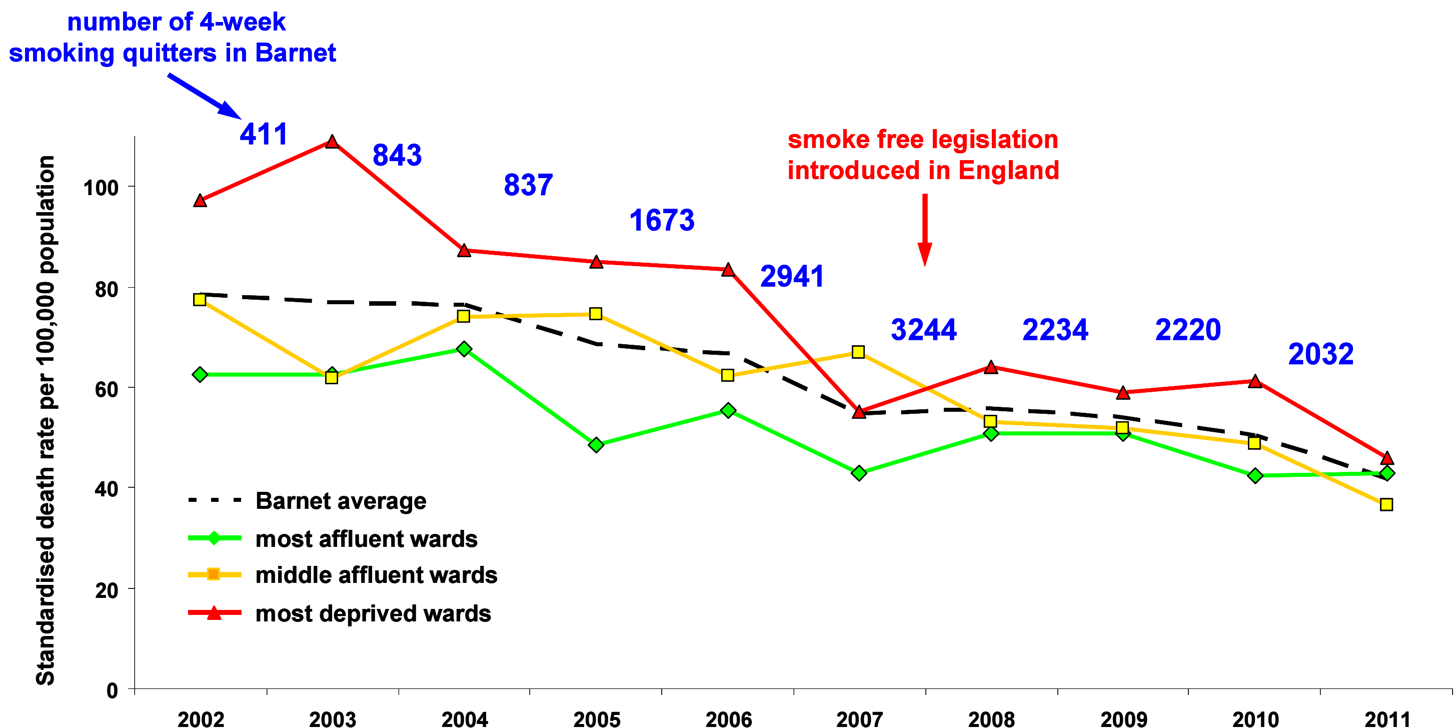
threshold normally used by the National Institute for Health and Clinical Excellence for cost effectiveness is £20,000-30,000 per QALY.

On this basis, spending money on smoking cessation, especially on more intensive (specialist adviser) interventions, will reap benefits in terms of improved wellbeing, reduced health inequalities and more effective use of scarce resources.

2.3 How is this relevant in Barnet?

Currently, some 350 people die each year of smoking-related diseases in Barnet (based on pooled data for the years 2007-09).[4] This is down from 440/year as reported by the London Health Observatory in 2001.[12] This reduction is encouraging, and consistent with other data, for example the greater reduction in deaths from cardiovascular disease (heart attack and stroke) amongst people living in the most deprived parts of the borough in recent years. In Barnet, we have concentrated smoking cessation activity especially in these most deprived areas and it is plausible that the reduction in death rates in these places, which has closed this health inequality gap, is predominantly attributable to this. This is shown in Figure 4.

Figure 4: Death rates from cardiovascular disease in Barnet GP-registered patients aged under 75 years in deprivation tertiles



Prior to 2002, there were 20 electoral wards in Barnet, rather than the current 21, so the data were collected differently then. However, these older data show that there has been a substantial and sustained difference in death rates from cardiovascular disease between people living in the most affluent parts of the borough and the most deprived. These differences have remained unchanged from the early 1990s until quite recently.

It is noteworthy that the association between increasing smoking quit rates and decreasing cardiovascular disease death rates some six to twelve months later has also been found elsewhere. For example, a study in Montana, USA, examined the impact of a local law banning smoking in workplaces and public places and found that, during the six-month period that the law was in effect that there were 16 fewer

hospital admissions for heart attack compared with the same period in the previous year when there were 40 (which is a 40% reduction).[13] This decrease was statistically significant. Further, a review of hospital admissions for acute coronary syndrome[iii] in Scotland following the introduction of smoke-free legislation there found an overall reduction in admissions of 17% in the year following the introduction of legislation compared to the period preceding it, in contrast to a 4% drop in England over the same period when there was no such legislation in place.[14] And in England, following the subsequent introduction of smoke-free legislation, and having adjusted for secular trends and variations in population size, there was a statistically significant 2.4% reduction in admissions to hospital for heart attack attributable solely to the legislation.[15] In Barnet, the impact on costs for emergency hospital admissions for heart attack in the first year following smoke-free legislation has been estimated to be a saving of £61,000 (estimated range £17,000-£104,000).[16] (Note that this estimate only applies to the immediate hospital costs of dealing with a heart attack and not to the other health conditions associated with smoking nor to the social care costs associated with these.)

Smoking tobacco increases the risk of heart attack but this risk falls rapidly in smoking quitters.[17] The effects of tobacco smoke on the lining of blood vessels and on platelets (increasing the risk of the development of blood clots) occurs within 30 minutes of exposure and is nearly as great in people inhaling second-hand smoke ('passive smoking') as it is in smokers.[18,19,20] The effect on death rates shown in Figure 4 is likely to be related to a combination of increasing smoking cessation activity in Barnet in the preceding years and the introduction of smoke-free legislation in 2007, but it is important to note that the greater decreasing trend in cardiovascular deaths in Barnet follows smoking cessation activity for some years prior to this.

But could the closure of this health inequality gap be related to other factors? The most likely ones are changes in the prescribing of drugs for raised cholesterol, for high blood pressure and for diabetes and/or an increase in surgical procedures to manage acute coronary syndrome.

Figure 5, Figure 6 and Figure 7 present data showing trends in these activities in recent years. (There are no data available for years earlier than shown in these graphs.)

Figure 5 shows Barnet GP prescribing of drugs, across the borough, for raised cholesterol (lipids), high blood pressure (hypertension) and heart failure, and for diabetes. All of these conditions increase the risk of death from heart attack and stroke. Whilst there is a trend of more of these drugs being prescribed, their impact generally takes some time to be seen and the rate of increase of prescribing does not correspond to the rate of decrease that we see in deaths in people living in the most deprived areas in Barnet as shown in Figure 4. Indeed, as the prescribing trends shown in Figure 5 apply across the borough, if there were a significant early effect of this prescribing trend we would expect to see a decrease in deaths from cardiovascular disease amongst all people in Barnet. However, Figure 4 shows us that death rates from cardiovascular disease amongst people living in the more affluent parts of the borough were relatively static during the years 2007-2010. I am not suggesting that these drugs do not reduce the risk of death from cardiovascular

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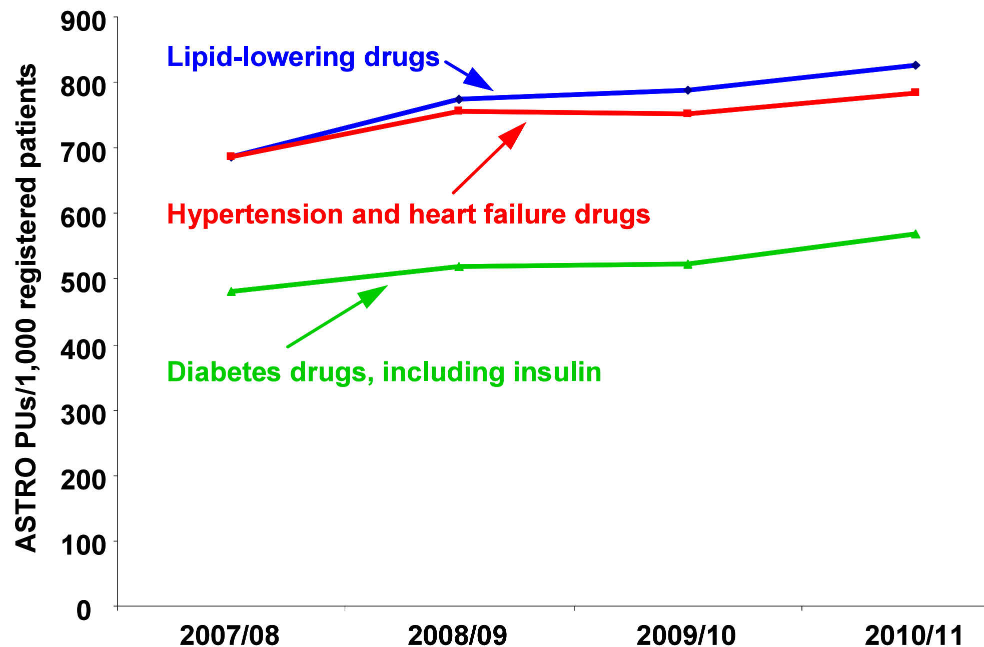
iii Acute coronary syndrome covers a spectrum of unstable coronary artery disease ranging from unstable angina to a complete heart attack. All have the same origin, that is the formation of a blood clot on a narrowed coronary artery. Management is similar, depending on the severity of the condition at the time of presentation

disease. There is good evidence that they do and their use should be encouraged. But their use does not seem to explain the closure of the health inequality gap that is shown in Figure 4.

Figure 5: Barnet GP prescribing of various drugs that can be expected, over time, to have an impact on the incidence of cardiovascular disease



In Figure 6 and Figure 7 we can see what has happened to hospital admissions for heart attack and stroke and for non-drug interventions to treat heart attack in Barnet GP-registered patients in recent years. These data are for people living in all parts of the borough. If the reduction in deaths shown in Figure 4 were due to hospital treatment, including non-drug interventions, then we might expect to see an increase in the number of admissions and, certainly, an increase in the number of procedures being undertaken. But what we see is actually are relatively static hospitalisation and intervention rates from 2005 to 2009, with a large decrease in 2010. We might also expect to see a decrease in deaths amongst people living in the more affluent parts of the borough, but we do not. Again, I am not suggesting that these interventions do not reduce the risk of death from cardiovascular disease. There is good evidence that they do and their use should be encouraged as well. But their use does not seem to explain the closure of the health inequality gap that is shown in Figure 4 either.

Figure 6: Hospital admissions for heart attack and stroke in Barnet GP-registered patients

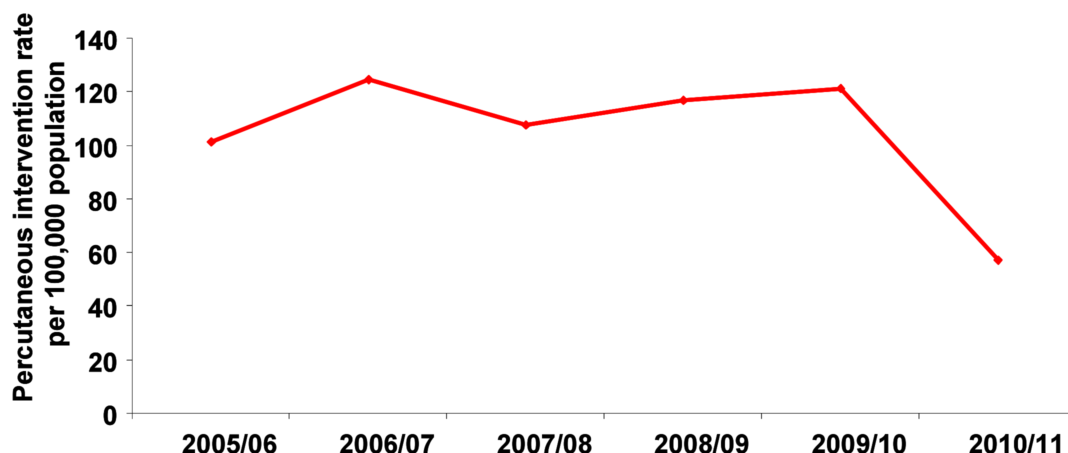
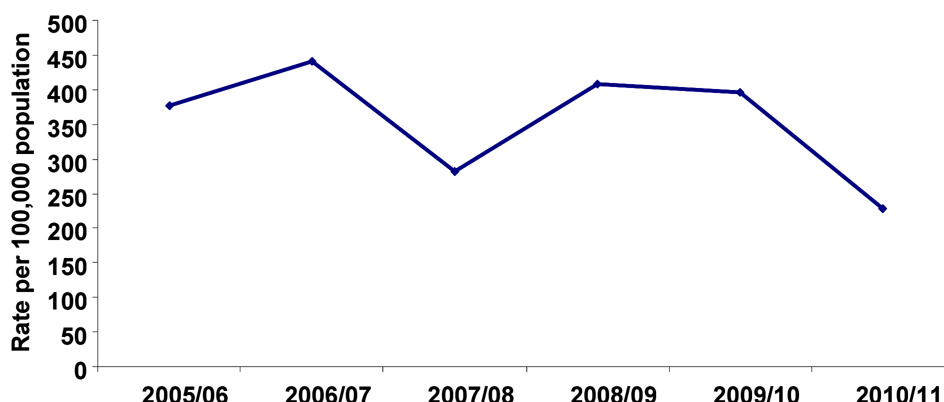


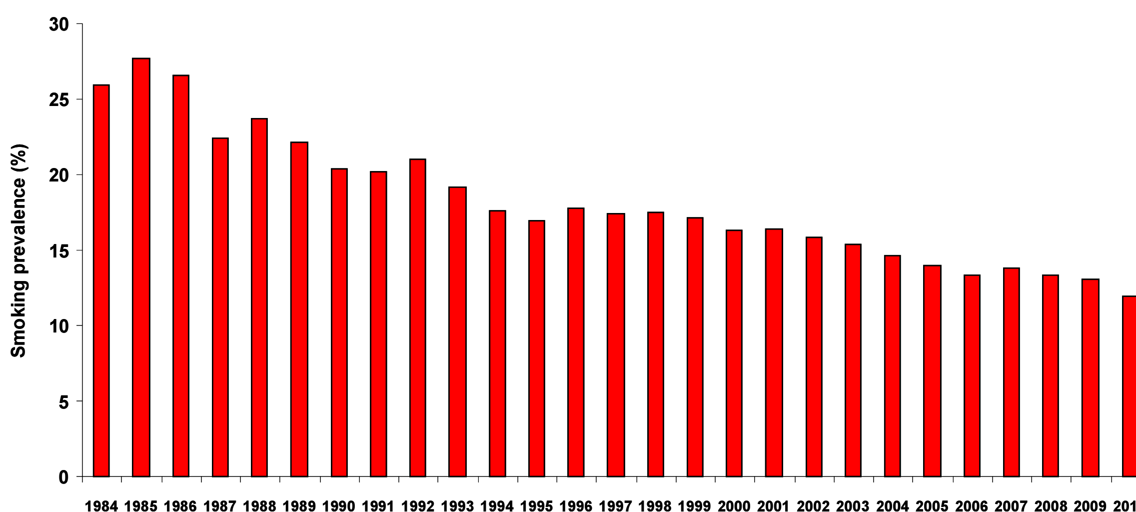
Figure 7: Cardiac interventions in Barnet GP-registered patients



On the basis of the currently available evidence, the most likely explanation of the closure in the health inequality gap for cardiovascular disease in Barnet residents aged under 75 years would seem to be a combination of all of these factors but with the greatest effect being due to people quitting smoking.

Is this plausible? If we look at what has happened elsewhere in the World, notably in California, where smoking prevalence has been reduced very substantially over the years, then I suggest that it is. California has reduced its smoking prevalence substantially, from just under 26% in 1984 to just under 12% in 2010.[21] This is shown in Figure 8. (By contrast, Barnet's smoking prevalence amongst adults was 16.6% in 2009/10.[4]) According to the California Department of Public Health, the substantial decline in smoking prevalence in the state since tobacco education efforts started in 1988 have been associated with declines in lung cancer, heart disease and other tobacco-related illnesses.[22,iv] This is born out in an independent study which found that since the introduction of California's approach to smoking, the prevalence of both smoking and deaths from heart disease have dropped at a statistically significantly greater rate in this state than in the rest of the USA.[23]

Figure 8: Smoking prevalence in California



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iv The State of California supports local health departments and community organisations to help reduce smoking, it supports 'aggressive' media campaigns and provides tobacco-related education and surveillance. Since the introduction of the California Tobacco Control Program in 1988, it is estimated that more than one million lives have been saved and $86bn-worth of savings in health care costs have been made. See http://www.cdph.ca.gov/Pages/NR11-031.aspx (accessed 27 January 2012)

The situation in Sweden is also impressive. Sweden has one of Europe's highest smoking cessation rates and one of the lowest prevalences of smoking in the industrialised world (11% in men, 14% in women).[24] Table 1, taken from a study comparing Sweden with other European Union countries, predicts the impact on smoking-attributable deaths if these other countries were to achieve the Swedish smoking prevalence.[25] (Note that Table 1 only refers to men aged 25 years and over. The paper from which it is taken includes an equivalent table for women. The predicted benefits are similar in women.) This potential benefit is striking: If we achieved a smoking prevalence in the UK equivalent to that of Sweden, we would reduce annual smoking attributable deaths by some 42%, that is a reduction in such deaths by nearly 45,000 amongst men aged 25 years and over each year and 15,500 in women, a 41% reduction. It is also noteworthy that there is evidence that Sweden's work in reducing smoking, which has also reduced smoking in pregnancy, has led to a statistically significant reduction in the risk of low birth-weight babies,[26] and to a statistically significant association between reduction in smoking prevalence and the prevalence of abdominal aortic aneurysm that was sufficient to suggest that the thresholds for screening could be raised and in future confined to smokers.[27]

2.4 What do we need to do in Barnet?

There are clear benefits from smoking cessation. There has been a demonstrable benefit from this in Barnet in recent years, and there is good evidence that increasing our efforts to control tobacco consumption (not just support smoking cessation) will lead to significant improvements in well-being and reduce health and social care costs.

Following Department of Health guidance and declared intentions,[28] in Barnet I consider that we should aim to:

- stop the inflow of young people recruited as smokers;
- motivate and assist every smoker to quit; and
- protect our families and communities from tobacco-related harm.

We cannot do all of this alone, but we can make a significant contribution by:

- enforcement of regulations and law and trading standards concerning tobacco sale and tobacco use;
- working with schools and community groups;
- training and encouraging all front-line NHS and local authority personnel to use all opportunities to encourage people not to start smoking and to encourage and sign-post those who do to smoking cessation services;
- ensure our contracts with providers actively promote reducing the prevalence of smoking; and
- improving smoking cessation performance overall, but especially amongst pregnant women and in families living in poverty.

Undertaking work to stop young people from starting smoking is particularly important because:

- the perpetuation of tobacco use through successive generations is one of the major causes of health inequalities;[28] and
- whilst it might be argued that people have a right to choose to smoke, the majority of smokers start to do so before the age of 18 years[29,30] and –

- nicotine is an addictive drug and tobacco use is its main means of self-administration,[31]
- the pharmacological and behavioural characteristics that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine,[32] and thus it is difficult to argue that it is someone's free choice to be dependent on a substance as addictive as heroin or cocaine that they became addicted to when under the age of 18 years; most adult smokers say they started smoking regularly before they turned 18.[33]

We therefore need to try hard to reduce the prevalence of smoking in children and young people as much as possible if we are to improve health and wellbeing in the people of Barnet.

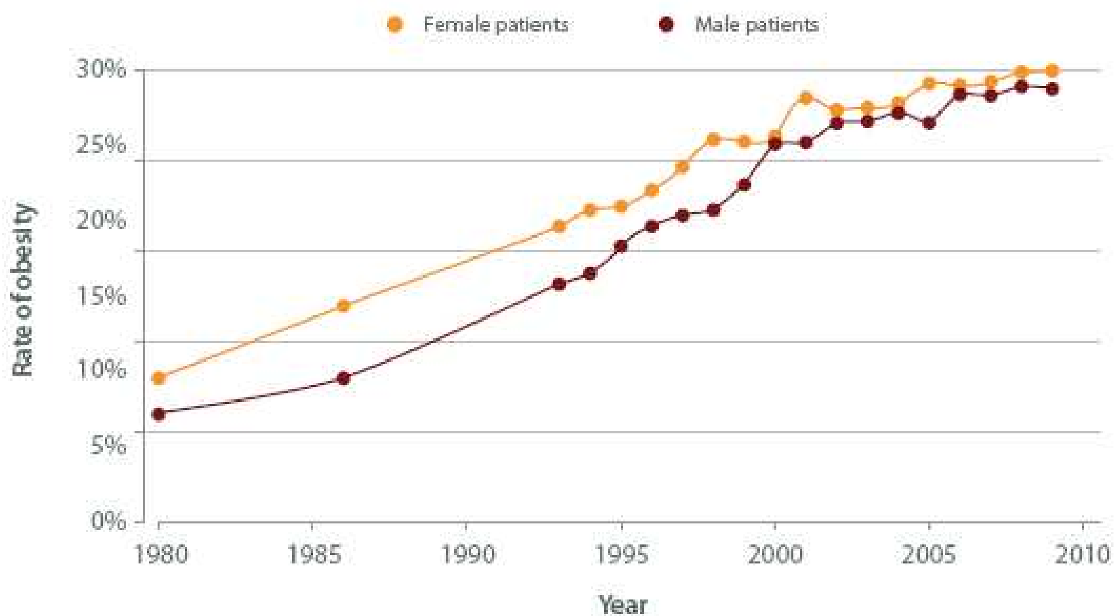
Table 1: Smoking prevalence and smoking-attributable deaths among men aged 25 years and over in the European Union in 1999

			At country-specific smoking prevalence		At Swedish smoking prevalence		
Country	**Population (millions)**	**Smokers (millions)**	**Proportion of smokers in population (%)**	**Smoking-attributable deaths**	**Smokers (millions)**	**Smoking-attributable deaths**	**Reduction in smoking-attributable deaths (%)**
Austria	2.75	1.28	47	10,897	0.54	5,839	46
Belgium	3.45	1.57	45	16,227	0.68	8,014	51
Denmark	1.81	0.63	35	8,236	0.36	4,041	51
Finland	1.70	0.69	41	5,293	0.34	3,723	30
France	19.16	7.72	40	63,153	3.80	43,913	30
Germany	28.77	11.47	40	112,274	5.66	63,362	44
Greece	3.60	2.19	61	22,131	0.71	8,850	60
Ireland	1.10	0.44	40	4,462	0.22	2,293	49
Italy	20.30	7.07	35	76,234	3.99	47,797	37
Luxembourg	0.15	0.06	38	475	0.03	304	36
Netherlands	5.38	1.99	37	17,345	1.07	11,146	36
Portugal	3.16	1.48	47	11,082	0.62	7,204	35
Spain	13.43	6.36	47	53,681	2.65	31,172	42
Sweden	3.01	0.59	19	7,396	0.59	7,396	–
United Kingdom	19.61	6.97	36	76,771	3.88	44,793	42
TOTAL	127.38	50.45	40	485,657	25.14	289,793	40

3 Overweight and obesity

The Health Survey for England report shows that overweight and obesity has increased substantially and we are rapidly approaching a situation where two thirds of the population of England will be will be overweight or obese.[34,v] The trend in obesity in England is shown in Figure 9, which is taken from data from the Health Survey for England. Obesity substantially increases the risk of developing a number of conditions, which themselves create significant health risks. The most significant of these is diabetes; it has been estimated that obesity reduces life expectancy by some nine years and accounts for 30,000 deaths in the UK each year.[35] Obesity therefore has significant implications for both health care services as well as well-being.

Figure 9: Changes in obesity in England over time



It is important to note that whilst the substantial increase in obesity in the UK in the last 20 years can be attributed in large part to reductions in physical activity (as depicted by the pictures of commuters at different times in Figure 10) and to changes in the type of food being eaten (with a major shift from carbohydrates to fat consumption) there is little evidence supporting the efficacy of health education programmes within the general population; behaviour modification is required in addition to education programmes.[38] And for people who are obese, behaviour modification – in whatever guise it may take – probably does not have much impact either. For example, a trial of 76 obese women with a mean age of 42 years and a mean weight of 106kg, randomly allocated to receive either a very low calorie diet alone, behaviour therapy alone, or both in combination, found whilst that statistically significantly more women maintained their full end-of-treatment weight losses in the

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v The body mass index (BMI), which is the most commonly used way of measuring someone's relative weight and height, is calculated by dividing weight (in kilograms) by the square of the height (in metres). Someone with a healthy weight has a BMI in the range 18.5-24.9. A BMI of 25-29.9 is defined as being overweight. 'Class I obesity' is defined as a BMI of 30-34.9, 'Class II obesity as a BMI of 35-39.9, and 'Class III' or 'morbid' obesity a BMI of 40 or greater

By way of example, someone who is 5'9" tall (1.75m) and who weighs 12st 7lb (79.63kg) has a BMI of 26 and is clinically overweight. If this same person weighed 14st 13lb they would have a BMI of 31 and be clinically obese

behaviour group alone and the combined behaviour-very low calorie diet group this outcome was found in only about one third of participants and overall, weight loss reduced at 1-year and at 5-year follow-up.[36] This suggests that calorie restriction alone is insufficient to enable significant weight loss and that whilst behaviour therapy can help, only a modest proportion of people benefit and even then, the weight loss is often not maintained.

Figure 10: Changes in our levels of everyday physical activity, such as how we get to work, have contributed to the increased prevalence of obesity

Why might this be? Whilst being overweight or obese is due to eating more than the body needs,[vi] possibly leading some to consider that overweight and obesity are self-inflicted conditions simply caused by a lack of willpower, there is now evidence that, in people who are significantly obese, the internal mechanisms that control the sense of satiety are automatically and permanently re-set, with the body's normal function being dysregulated such that the obese person becomes 'locked-in' to their new body weight by a powerful physiological mechanism.[37]

There are two important considerations in the context of this re-setting of the internal controls that help us to regulate the amount that we eat. The first is that people with a normal weight and those who are overweight can, with not too much difficulty, vary their weight voluntarily by small amounts. But for an obese person to vary their weight by a proportionately similar amount requires a substantially greater change in weight; this is no simple matter and many people who are significantly obese are most unlikely to respond to non-surgical treatments for their obesity.[37] The second reason is that it is important to encourage and enable people to manage overweight before it develops into obesity.

3.1 Why does obesity matter to the health and social care economy?

Obesity is significant because of the substantially increased risk of diseases that it causes. This has an impact on health inequalities as well as on health and social care costs. The most significant condition associated with obesity diabetes. The first report of the National Bariatric Surgery Register estimates that treating the consequences of obesity costs the health economy in England some £5bn each year

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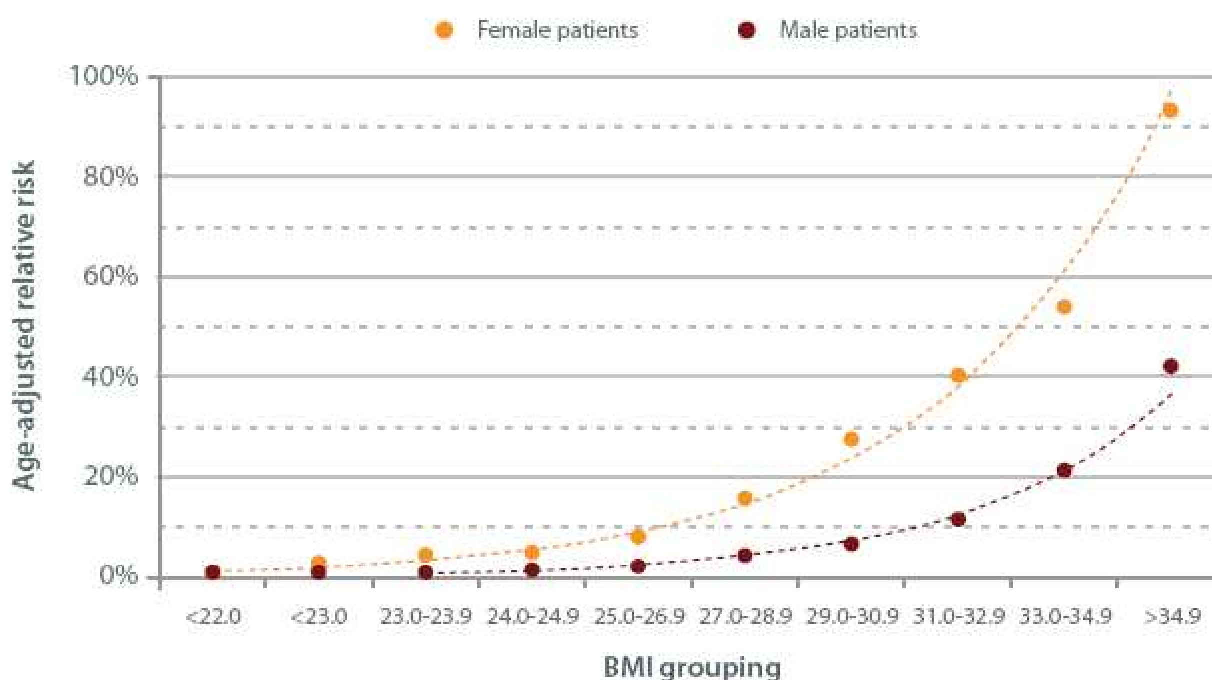
vi We take in energy in what we eat and drink. We use up energy in what we do physically. If we take in more energy than we use up then the body stores it as fat.

and that this is likely to double in real terms by 2050.[37] A major component of this cost is the management of diabetes and its consequences; diabetes is a serious, life-shortening condition. The National Bariatric Surgery Register report shows that there is almost an exponential increase in the incidence relative risk of developing diabetes with increasing weight, as shown in Figure 11**Error! Reference source not found.**, taken from the report. Diabetes increases the risk of premature death, especially from cardiovascular disease, in addition to the development of conditions such as peripheral vascular disease and blindness.

Overall, taking the risks of diabetes and the other life-shortening conditions associated with obesity into account, it has been estimated that obesity reduces life expectancy by some nine years and accounts for 30,000 deaths in the UK each year.[38]

Figure 11: The age-adjusted risk of developing diabetes with increasing body mass index[39,40]



Guh and colleagues undertook a detailed analysis of a large number of published studies of the diseases associated with overweight and obesity in order to estimate the the incidence of a variety of conditions in relation to overweight and to obesity.[41] The results are shown in

Table 2. The key points to note are:

- whilst most findings were statistically significant (denoted in Table 2 with an asterisk), that is, these findings were unlikely to have occurred by chance, those that were not found to be statistically significant may have been so because the number of people involved were small;
- in most instances, even being overweight increases the risk of developing each of the 18 conditions reviewed;
- in many instances, the relative risk of overweight and of obesity in relation to the 18 diseases reviewed was greater for women than for men; and
- the greatest risk of both overweight and of obesity is that of developing Type 2 diabetes.

Table 2: The incidence rate ratios[vii] of various conditions occurring in people who are overweight and obese

Condition	Men		Women	
	Overweight	Obese	Overweight	Obese
Breast cancer	–	–	1.13*	1.30*
Endometrial cancer	–	–	1.15*	1.42*
Ovarian cancer	–	–	0.61	1.35
Colorectal cancer	1.88*	2.93*	1.25*	1.55*
Oesophageal cancer	1.15	1.20	1.13	1.21
Kidney cancer	1.40*	1.82*	1.82*	2.64*
Pancreatic cancer	1.28	2.29*	1.24	1.60*
Prostate cancer	1.14	1.05	–	–
Type 2 diabetes	2.40*	6.74*	3.92*	12.41*
High blood pressure	1.28*	1.84*	1.65*	2.42*
Stroke	1.23*	1.51*	1.15*	1.49*
Coronary heart disease	1.29*	1.80*	1.72*	1.80*
Congestive heart failure	1.31	1.79*	1.27	1.78*
Asthma	1.20*	1.43*	1.25*	1.78*
Chronic back pain	1.59*	2.81*	1.59*	2.81*
Osteoarthritis	2.76*	4.20*	1.80*	1.96*
Pulmonary embolism	1.91*	3.51*	1.91*	3.51*
Gallbladder disease	1.09	1.43*	1.44*	2.32*

* statistically significant increased risk

The authors of this comprehensive estimate of the risks to people who are overweight and people who are obese developing one or more of these 18 conditions concluded that their findings confirmed that overweight and obesity "carry a profound health burden and will have a significant impact on health expenditure".

BMI is not the only factor to consider when assessing the risk of overweight and obesity. Waist circumference also plays a part, as shown in Table 3, taken from NICE guidance on overweight and obesity.[42] Considering waist circumference helps to get over the problem of using BMI alone in some people. A number of athletes, for example, have very lean bodies but high BMIs because of high muscle mass, which

vii The incidence rate ratio is the incidence rate of something occurring in someone exposed to a risk factor divided by the incidence of that same thing occurring in someone who is not so exposed. It provides a relative measure ('relative risk') of the exposure against not being exposed. In the context of overweight and obesity, this measure shows the increased risk of certain diseases in people who are overweight and who are obese in comparison with people who have a healthy weight

may or may not be a risk to their future health. But for people who are not athletically lean BMI is a good proxy of risk when combined with waist circumference.

Table 3: The degree of health risk associated with overweight and obesity with different waist circumferences

BMI	Waist circumference		
	‘Low’	**‘High’**	**‘Very High’**
Overweight	No increased risk	Increased risk	High risk
Obesity class 1	Increased risk	High risk	Very high risk

Waist circumference definitions
Men: ‘Low’ = <94cm (37in); ‘High’ = 94-102cm (37-40in); ‘Very high’ = >102cm (40in)
Women: ‘Low’ = <80cm (31.5in); ‘High’ = 80-88cm (31.5-34.5in); ‘Very high’ = >88cm (34.5in)

3.1.1 What is diabetes and why is it significant to people’s well-being?

The most common form of diabetes (diabetes mellitus; ‘sugar diabetes’),[viii] which is a long-term condition, occurs when the body becomes unable to use insulin effectively. Insulin is the hormone responsible for regulating blood sugar levels by controlling the flow of sugar into the cells of the body. About 10% of people with diabetes mellitus have Type 1 disease. The cause is unknown and it occurs when the pancreas – the gland that produces insulin in the body – fails to do this adequately. Put simply, it is treated with regular insulin injections.

The majority of people with diabetes mellitus have Type 2 disease. This condition was once called ‘maturity onset’ diabetes because it was normally only seen in older people. It is now seen in an increasing proportion of young adults and even children, largely as a consequence of excess body weight and inadequate levels of physical activity.[43] Put simply, it is treated with weight management and, usually, drugs that lower blood sugar levels.

Diabetes mellitus causes severe damage to the lining of blood vessels and this is the main issue with the disease. Every cell in the body is dependent upon having an adequate blood supply to bring it oxygen and nutrients and to take away waste products. The blood also circulates a variety of substances, for example hormones, which control a variety of body functions. If the blood supply to a part of the body is compromised, for example through damage to the lining of the blood vessels (causing them to be narrowed or blocked) then cell damage and, ultimately, cell

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viii Most people are familiar with the word diabetes, but not all may be familiar with the two types of diabetes and why they are so named. Diabetes mellitus (that is, ‘sweet’) is the more familiar condition where the body becomes unable to control glucose levels in the blood. The less well-known diabetes insipidus (that is, ‘bland’) is usually caused by the pituitary gland failing to produce sufficient quantities of antidiuretic hormone (ADH). ADH helps to control the output of the kidneys. With inadequate levels of ADH circulating, the kidneys produce copious quantities of very dilute urine. Untreated patients with both conditions produce large quantities of urine; the word diabetes coming from the Greek word for siphon, because sufferers passed urine ‘like a syphon’. In the days before chemical tests were available to assess the contents of a patient’s urine, the only option was to taste it: people with ‘sugar’ diabetes had urine that tasted sweet, those with diabetes caused by insufficient ADH had urine that tasted insipid. Diagnostically, this early testing method was probably quite accurate, but perhaps not for those of a more fastidious nature

death, is inevitable. The consequences of diabetes, because of the damage to the lining of the body's blood vessels, include:[43]

- heart disease and stroke – 50% of people with diabetes die of cardiovascular disease;
- neuropathy (that is, damage to sensory nerves) of the feet, which, combined with reduced blood supply, leads to ulceration on the feet and dry gangrene, which often necessitates amputation;
- neuropathy affecting other parts of the body, affecting some 50% of people with diabetes, leading to numbness, tingling, pain and weakness especially affecting the feet and hands;
- retinopathy (that is, damage to the light-sensitive lining of the eye) – after having diabetes for 15 years, some 2% of people will become blind and 10% will have severe visual impairment because of it: diabetes is the most common cause of blindness in people of working age; and
- kidney failure – diabetes is the main cause of this and 10-20% of people with diabetes will die of kidney failure.

The overall risk of dying prematurely in people with diabetes is at least double that of the risk in people without this disease. Diabetes is therefore a significant disease in terms of well-being and we should help people to avoid developing it.

The health and social care consequences of supporting people with diabetes and its complications are very substantial, and rising, because the incidence of diabetes is increasing and because the cost of most treatments rise each year.

Last year, the National Institute for Health and Clinical Excellence (NICE) published a review of the cost impact of diabetes.[44] Noting that 'it is not possible to quantify the full costs of diabetes', and taking account of the healthcare costs excluding community care (that is, predominantly hospital treatment) and GP prescribing, NICE estimates that the health care costs of diabetes in England rose from £1.61bn in 2006/7 to £2.08bn in 2009/10. This does not take account of the GP prescribing costs for the potential or actual complications of diabetes[ix] nor for the social care costs of people suffering from the consequences of diabetes.

NICE estimates that the average health care cost of treating diabetes is £27.50 per head of population. With 349,800 people living in Barnet[45] this suggests that we are spending about £9.6m on managing diabetes in the NHS alone. But this is an underestimate: NICE's calculation excludes the cost of treating patients with the complications of diabetes who are managed in non-diabetic services (such as GP prescribing of drugs to lower blood pressure and cholesterol), and it is based on the English average prevalence, yet Barnet's prevalence of diabetes is above-average.

3.2 How can obesity be managed? Can its complications, particularly diabetes, be reduced?

3.2.1 Prevention

Other than babies who are born to women who develop diabetes in pregnancy (such babies are often significantly large), none of us is born overweight or obese. We become overweight, with many subsequently become obese, in childhood or in

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ix For example, drugs to lower blood pressure and to lower cholesterol levels

adulthood. Obviously, the most important thing to do is to enable and encourage people to not become overweight in the first place.

NICE has issued guidance on the prevention of overweight and obesity.[42] Based on this, our priorities should be:

- making the prevention and the management of overweight and obesity a priority at both strategic and operational levels in both health and social care services;
- as employers, we should also promote the prevention and the management of overweight and obesity amongst staff through –
  - on-site catering facilities promoting the consumption of healthy foods and drinks (for example by signs, posters, pricing and positioning of products),
  - policies, information and facilities that promote physical activity (for example with travel plans, by encouraging and enabling active transport, by signposting and using décor that encourages stair use and for reception and other staff to direct visitors to the stairs as a default);
- providing training and support for front-line personnel in health and social care to better enable them to promote healthy diets and exercise to their clients/patients and to help them manage overweight and obesity in their clients/patients;
- ensure that similar approaches are taken by health and social care provider organisations through our contracts;
- to promote interventions through policies on leisure services and facilities and open spaces, planning processes, other policies and the advice given by front-line personnel to their clients/patients that -
  - increase physical activity in ways that fit easily into people's everyday life, and that are tailored to their preferences and circumstances, such as –
    - walking,
    - using stairs,
    - cycling;
  - improve diet and reduce energy intake through –
    - dietary modification
    - targeted advice
    - family involvement
    - goals to encourage beneficial change;
- to work with shops, supermarkets, restaurants, fast food outlets, cafés and relevant voluntary organisations to promote healthy eating choices.

Our approach to enabling people to avoid becoming overweight in the first place, and to reduce established overweight and obesity, needs to be long-term and multi-faceted. It should include promotional and awareness-raising activities as well as developing a less obesogenic environment and providing individual advice to clients/patients at every suitable opportunity.

It is also important to remember that overweight and obesity tend to be family problems rather than individual ones, and, especially in terms of avoiding and reducing overweight and obesity in our children, it is vital to engage whole families. Taking this approach is particularly important for front-line personnel working in children's centres, nurseries, pre-school groups, schools and voluntary organisations working with children.

3.2.1.1 Management of overweight and obesity – non-surgical approaches

Again, based on NICE guidance,[42] managing overweight and obesity needs to:

- have realistic goals, with people usually aiming to lose 5-10% of their weight;
- aim for a maximum weight loss of 0.5-1kg each week;
- focus on long-term lifestyle changes rather than on short-term quick-fixes; and
- be multi-component, that is address both diet and physical activity, offering a variety of approaches –
  - encouraging a balanced, health-eating approach,
  - involving regular physical activity, particularly those that can be part of everyday life, such as brisk walking, using stairs rather than standing on escalators or using lifts
  - including behaviour-change techniques, such as keeping a diary, and providing advice on how to cope with lapses and with 'high risk' situations
  - recommending or providing on-going support and encouragement.

Part of the success that we have had in Barnet with smoking cessation is ensuring that front-line personnel know how to raise the subject of a need for lifestyle modification and for them to be able to signpost patients/clients to appropriate services. It will therefore be necessary to ensure that suitable services are available, and these may include commercial, community and/or self-help weight management programmes. Obviously, people who have co-morbidities, for example, diabetes, hyperlipidaemia, hypertension, will need careful monitoring of such conditions to ensure that weight loss and medical management go hand-in-hand.

3.2.1.2 Management of obesity – surgical approaches

As referred to in section 3, for many people who are obese, behaviour modification alone is often of little benefit, probably because the internal satiety control becomes permanently re-set and the body's normal food intake function is thus deregulated.[37] In such people, there is substantial evidence of the clinical and cost effectiveness of bariatric surgery, particularly in terms of reducing or, to all intents and purposes, eliminating, a number of the more significant problems associated with obesity, most notably diabetes. This has considerable beneficial implications for health and social cares costs.

For example, a systematic review of 26 studies (including three randomised controlled trials and three prospective cohort studies) on surgery for obesity by the Cochrane Collaboration, updating previous Cochrane reviews,[46] found:

- Good evidence that bariatric surgery results in greater, and sustained, weight loss than conventional treatments in both moderate (body mass index [BMI] >30) and severe obesity, with reductions in comorbidities including diabetes and high blood pressure and improvements in quality of life, and, in one publication, a reduction in long-term mortality – in the main, these differences were statistically significant.
- Follow-up in the reviewed studies varied from 12 months to 10 years, with the differences in weight loss, BMI change and measures of quality of life between bariatric surgery and conventional treatment being maintained for at least ten years.
- Remission of diabetes was found in 70-75% of surgical patients at two years vs 8-13% in patients undergoing conventional treatment, and in ten year-follow-up studies this statistically significant difference in the recovery of diabetes was maintained.

- There were similar benefits for reductions in high blood pressure and raised blood cholesterol levels with surgery, and reductions in the incidence of other complications of obesity such as certain types of cancer, gall bladder disease and gout.
- One study showed a statistically significant reduction in overall mortality from both cardiovascular and non-cardiovascular events at 16 years between surgical and conventional treatment of obesity.
- The incidence of complications and adverse events was relatively low in both the surgery and the conventional treatment groups.

A number of other papers published in peer review journals have identified significant benefits of bariatric surgery over conventional treatment. For example:

- In an eight-year follow-up study of 141 patients undergoing bariatric surgery in Switzerland by Kruseman and colleagues, average weight loss eight years after bariatric surgery was -30.7 (+/- 13.8)kg with an excess weight[x] loss of greater than 50% in 59% of patients.[47]
- In contrast, in a randomised controlled trial (RCT) by Toumilehto and colleagues, 522 middle-aged people with a mean BMI of 31 and impaired glucose tolerance were allocated to an intervention group receiving individualised counselling aimed at weight reduction or a control group.[48] The mean weight loss at one year was -4.2 +/- 5.1kg in the intervention (counselling) group and -0.8 +/-3.7kg in the conventional treatment group. This was a statistically significant difference. The proportion of subjects without diabetes during the trial was statistically significantly different, with fewer in the intervention group, in years 2, 3 and 4 of follow up but not at years 5 and 6.
- Picot and colleagues undertook a health technology assessment of bariatric surgery in which they looked both clinical and cost effectiveness.[49] They found statistically significant evidence that bariatric surgery is a more effective intervention for weight loss than conventional, non-surgical, treatments. In two RCTs reporting outcomes at two years, the mean proportional initial weight loss in the surgical groups was 20% and 21.6% whilst it was just 1.4% and 5.5% in the non-surgical groups. Most significant was their finding in relation to diabetes: weight loss reduces the risk of developing diabetes, and bariatric surgery has been found to resolve pre-operative diabetes in more than 75% of cases.
- A systematic review and meta-analysis also found a significant reduction in the incidence of type 2 diabetes following bariatric surgery, with 82% of patients having resolution of their clinical and laboratory manifestations of diabetes in the first two years following surgery and 62% remaining free of diabetes more than two years after surgery.[50]
- Bariatric surgery has been shown to improve outcomes in other obesity-related morbidities. For example, a longitudinal study from 1948 to 1985 of the impact of weight loss on the risk of symptomatic knee osteoarthritis in women found that a decrease in BMI of 2 units or more in the ten years preceding assessment reduced the risk of developing osteoarthritis by over 50%.[51]

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x Excess weight (in kilograms) is defined as ((initial weight – current weight) ÷ (initial weight – (25 x height))) x 100 and is normally expressed as a percentage. Note that 25 is the upper limit of a normal body mass index. Also note that a very heavy person may lose many kilograms of weight but their percentage excess weight loss will be lower than that of a less heavy person who has lost the same amount of weight

- In a publication of particular significance, the Swedish Obese Subjects (SOS) study by Sjostrom and colleagues, a prospective, controlled study of patients undergoing bariatric surgery matched with patients receiving conventional treatment, showed some long-term benefits of bariatric surgery.[52] After two years, whilst weight had increased in the control group it had decreased in the surgery group by 23.4%. At ten years, weight in the control group had increased 1.6% but in the bariatric surgery group it had decreased by 16.1%.

  As shown in Figure 12, copied from Sjostrom's paper, not only was there a substantial difference in weight loss between controls and those undergoing surgery, but statistically significant differences between the two types of bariatric surgery used, with bypass surgery producing better results than banding. Increasingly, patients in this country are having bypass surgery, which is more suitable for binge eaters, as well as being more effective in enabling sustained weight loss.

Figure 12: Weight changes in subjects in the SOS trial over ten years

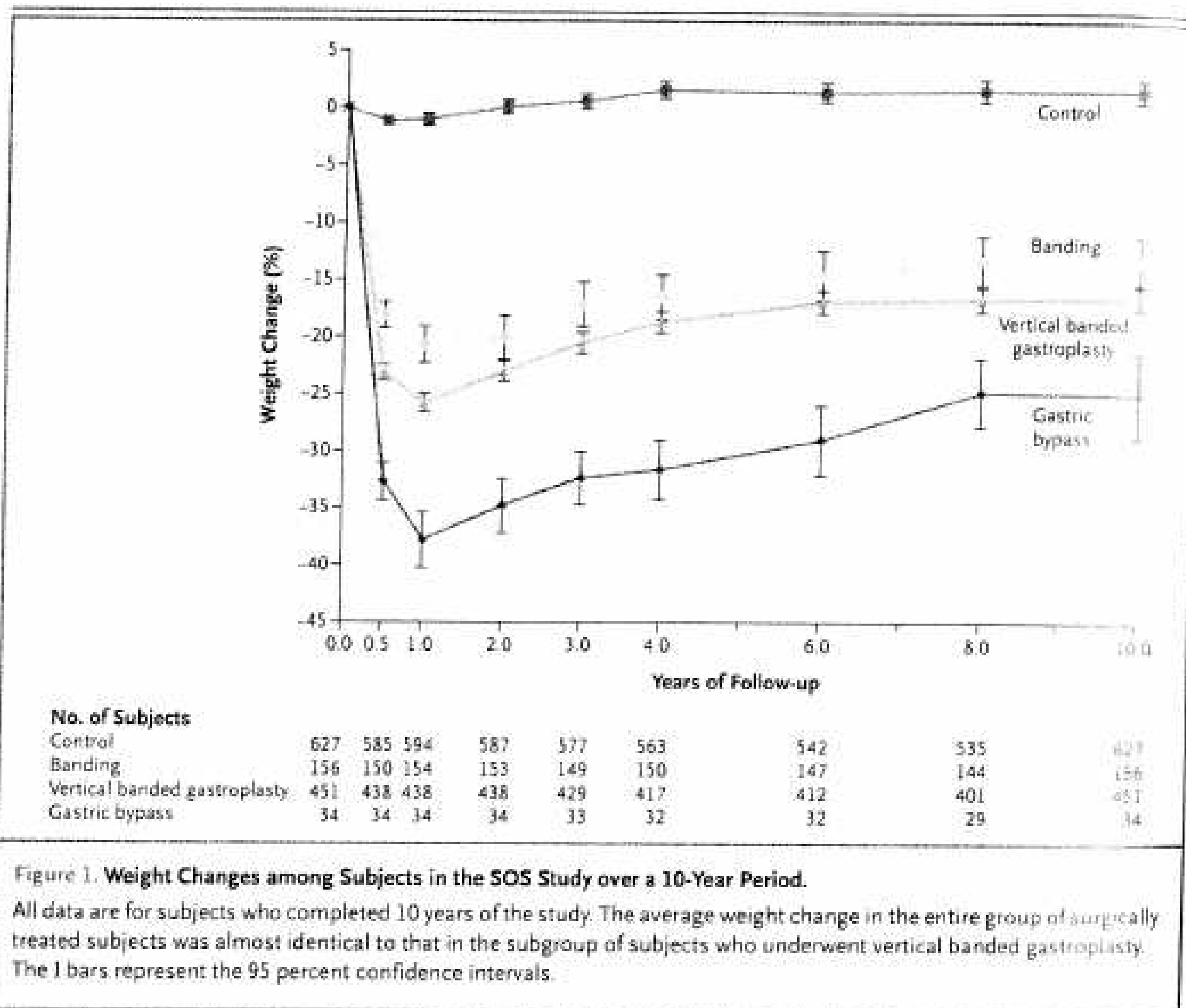

Figure 1. **Weight Changes among Subjects in the SOS Study over a 10-Year Period.**
All data are for subjects who completed 10 years of the study. The average weight change in the entire group of surgically treated subjects was almost identical to that in the subgroup of subjects who underwent vertical banded gastroplasty. The I bars represent the 95 percent confidence intervals.

The SOS Study findings were supported by a literature review and data pooling exercise from 43 reports providing follow-up for up to ten years undertaken by O'Brien and colleagues.[53] As shown in

Figure 13, excess weight loss was substantial and this was maintained over ten years. The authors commented that 'No other therapy for obesity in use today could approach this degree of weight loss over such a period of time'.

Figure 13: Pooled data showing the proportion of excess weight loss (%) and duration of follow-up for all bariatric procedures in O'Brien and colleagues' review

- In a five-year observational 2-cohort study, Christou and colleagues showed that bariatric surgery statistically significantly reduced both the development of new health-related conditions in morbidly obese patients and death.[54]

  They also showed that patients undergoing bariatric surgery made fewer physician visits than controls in the 5-year follow-up period. They estimated that the total health care costs of controls were 45% higher than that of bariatric surgery patients.

The recently-published report of the National Bariatric Surgery Register[37] also provides important information that is consistent with findings reported by studies published in peer review literature. Of the 6,483 people whose details are recorded on this register, 27.5% had type-2 diabetes, 16.5% were receiving treatment for obstructive sleep apnoea,[xi] and 69% had some functional impairment, for example they could not climb three flights of stairs without resting. It is important to recognise that the people on the registry are a select group – they have all had bariatric surgery – and they are therefore not necessarily representative of all people in the country with obesity. However, I consider the following points raised in the registry report to be especially noteworthy:

- Analysis of this registry showed that, of the 1,783 people[xii] who had bariatric surgery and who had diabetes at the time of surgery, at two-year follow-up, 85.5% 'had returned to a state of no indication of diabetes', meaning that they no longer needed medication.

  This will not only save the cost of diabetes medication (quoted by the report as being an average of £3,000/year), but these people will not require the relatively

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xi Obstructive sleep apnoea is a condition that interrupts breathing during sleep causing a drop in blood oxygen levels. The sufferer wakes sufficiently to restore normal breathing but on subsequently falling into a deeper sleep their breathing becomes obstructed again. This cycle of recurrent low levels of blood oxygen (each lasting from a few seconds to several minutes) can occur every few minutes during the night. Untreated, this condition caused daytime fatigue and difficulties in cognition, but, more importantly, increases the risk of heart failure and death. A common cause of obstructive sleep apnoea is overweight and obesity. The most common treatment is the use of continuous positive airways pressure using a mask and respirator

xii That is 27.5% of 6,483 people

intensive follow-up that people with diabetes have, nor be at risk of developing the complications of diabetes, including peripheral vascular disease, neuropathy, blindness, heart attack and death.

- The registry report noted that, one year after surgery, on average, patients had lost 57.8% of their excess weight, and that almost half with a functional impairment before surgery had returned to a state of no such impairment (that is they could climb three flights of stairs without needing to rest), and 60% with obstructive sleep apnoea were able to stop treatment for this condition.

It is also important to note that even modest weight losses are associated with significant improvements in blood cholesterol, and this can be achieved with non-surgical treatments.[55] However, a review of much of the literature on the use of lipid-lowering drugs (such as the group called statins) shows that there is not necessarily a relationship between lowered lipid levels and clinical outcomes such as fewer cardiovascular events, and that there may be a direct impact of some statin drugs on such outcomes and not just the lowered blood lipid levels.[56] It is also noteworthy that both weight loss (using non-surgical interventions) and, separately, dietary sodium restriction, have been associated with reductions in the incidence of high blood pressure at seven years' follow-up.[57] However, I have not found any trials published in peer review journals that show a reduction in the incidence of diabetes following non-surgical treatments of obesity.

3.3 Is managing overweight and obesity cost effective?

The cost-effectiveness of managing overweight and obesity has been reviewed by NICE.[58] The first point to note is that whilst the management of obesity itself is potentially beneficial, obesity management also plays a part in the management of a number of other conditions, including (but not limited to) heart attack;[59] coronary heart disease, stroke and atrial fibrillation;[xiii, 60] stress incontinence, diabetes, raised cholesterol levels, high blood pressure, back pain, arthritis;[61] infertility, and sleep apnoea.[xiv] The management of these conditions, which, with others, are all associated with obesity, is probably part of the reason why, according to NICE, people who have a BMI of >30 have statistically significantly more contacts with their GP, practice nurses and hospital outpatient clinics and receive more NHS prescriptions than those who have a healthy weight.

In its assessment of the cost-effectiveness of managing overweight and obesity, NICE does not directly comment on its associated social care costs, but notes that the National Audit Office has estimated the financial burden to society of obesity is

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xiii Atrial fibrillation, the commonest heart rhythm disorder, affects about 1% of the population. atrial fibrillation its treatment costs are substantial taking up about 1% of the NHS budget in 2004. Left untreated, atrial fibrillation is a significant risk factor for stroke and other conditions, including symptoms such as breathlessness, difficulty in breathing, palpitations, dizziness and fainting, and conditions such as heart failure

xiv Obstructive sleep apnoea is a condition that interrupts breathing during sleep causing a drop in blood oxygen levels. The sufferer wakes sufficiently to restore normal breathing but on subsequently falling into a deeper sleep their breathing becomes obstructed again. This cycle of recurrent low levels of blood oxygen (each lasting from a few seconds to several minutes) can occur every few minutes during the night. Untreated, this condition caused daytime fatigue and difficulties in cognition, but, more importantly, increases the risk of heart failure and death. A common cause of obstructive sleep apnoea is overweight and obesity. The most common treatment is the use of continuous positive airways pressure using a mask and respirator

some £2bn, which is much more than the estimated NHS cost of some £480m because it includes lost productivity as well as direct service costs.

Based on the NICE report, it is difficult to draw robust conclusions about the cost-effectiveness of interventions such as diet, physical activity and behavioural treatment because of the paucity of published research, the poor generalisability of what has been published and the high sensitivity of cost-effectiveness calculations to the duration of benefit. That said, an Australian study has indicated that, at October 2005 exchange rates, the incremental cost[xv] per kilogram of weight lost following of six counselling sessions over 12 months was £4.13 for a doctor and dietician intervention and £3.09 for dietician-alone sessions in comparison with a control group receiving no intervention.[62] It is not clear whether these findings would be applicable in the UK. And a study in the USA of the effectiveness of group and mixed family-based treatment for childhood obesity found a statistically significantly greater weight loss per dollar spent and concluded that this was not cost-effective, but that it might be so for a more obese population.[63] It is not clear whether these findings would be applicable in the UK either. However, a review of the control arm of a study of drug treatment of obesity, which underwent monthly monitoring by a GP for the first year and by a nurse for the second, found a cost per QALY of between £16,000 and £17, 400, [64] which is well within the normal range used by NICE as a threshold for cost-effectiveness for NHS-funded interventions. The NICE paper reporting this noted that, for various reasons, this was likely to be an under-estimate of the cost-effectiveness of the intervention.

NICE found a number of publications reporting relative weight losses at 12 months and costs per kilogram lost attributable to dietary changes. These ranged from 0.4kg–13.4kg lost at 12 months with costs/kilogram lost ranging from £17–£1215.[65,66,67,68,69,70,71] Because of the heterogeneity of the interventions used in these various trials, NICE considered that they were 'suggestive of cost-effectiveness but found that exercise alone was not cost-effective and that there was only 'weak evidence' of the cost-effectiveness of behaviour therapy compared to diet.

Importantly, NICE noted that the longer a weight loss is maintained then the more cost-effective is the intervention that enabled it, and its recommendation is for a multi-faceted approach to non-drug/non-surgical management of overweight and obesity; this makes the differences between different approaches less important. Put another way, the differences between the various published trials makes it difficult to be definitive about one approach to weight management or another, but a simultaneous combination of different approaches is likely to be more beneficial because of a synergistic effect and the longer any weight loss is maintained then the more cost-effective the interventions will be.

NICE considered the evidence for the use of a drug called sibutramine in the management of obesity. However, this drug has since been withdrawn on safety grounds.

NICE reviewed the evidence for the clinical and cost-effectiveness of a drug called Orlistat in the management of obesity and found it to be cost-effective in comparison with non-pharmacological interventions, with an incremental cost effectiveness ratio of £22,099 to £39,308 per QALY, dependent on gender, initial BMI, the natural rate of

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xv The incremental cost is the change in cost associated with an intervention compared with doing nothing. It is usually expressed as the ratio of the costs of two different interventions with each expressed in terms of anticipated benefit, for example, quality-adjusted life years

weight gain and the rate of weight regain after conclusion of treatment when used over 48 months.[72]

NICE also reviewed the evidence for the clinical and cost-effectiveness of bariatric surgery in comparison with non-pharmacological interventions and found this to be cost-effective with an incremental cost-effectiveness ratio per QALY of between £6,300 and £8,500,[73] which is substantially cheaper than pharmacological therapy, probably because of the duration of benefit. The cost-effectiveness of bariatric surgery is discussed in greater detail in the next sections, 3.3.1 and 3.3.1.1.

3.3.1 The cost-effectiveness of bariatric surgery and the impact of the NHS investing and not investing in this

Picot and colleagues' health technology assessment of bariatric surgery also looked at its cost effectiveness.[49] Five original economic evaluations were assessed but were considered not to provide reliable and generalisable estimates of the incremental cost-effectiveness of bariatric surgery of various types in comparison with non-surgical treatment. The authors thus developed their own economic model which was extended to include the impact of cardiovascular disease as well as diabetes. Three different patient groups were considered: those with a BMI>40; those with a BMI of 30-40 who also had diabetes; and those with a BMI <35. Modelling was based on data obtained from various trials of such patients and looked at 'optimistic' and 'pessimistic' outcomes derived from different trials. The results are shown in Table 4, from which it can be seen that bariatric surgery is cost effective in people with a BMI of 30-35 with no complications if the benefits last 20 years or more (for which there is currently no evidence); it is cost effective in people with a BMI of 40 or greater, and cost effective in people with a BMI of 30-35 if they also have type-2 diabetes.

Table 4: Results of cost effectiveness modelling by Picot and colleagues

Condition being treated	Incremental cost effectiveness ratio (£/QALY gained)	Comment
Moderate obesity (BMI 30-35)	60,754 at 2 years 12,763 at 20 years	The second figure assumes benefit lasts for 20 years. There is good evidence that bariatric surgery maintains weight loss at ten years in a majority of patients
Morbid obesity (BMI >40)	1,897 – 4,127	Optimistic/pessimistic calculations assuming 10 years' benefit
BMI 30-35 plus type-2 diabetes	18,930 at 2 years 1,367 at 20 years	The second figure assumes benefit lasts for 20 years. There is good evidence that bariatric surgery maintains weight loss at ten years in a majority of patients

3.3.1.1 Modelling the impact of funding/not funding bariatric surgery

We have modelled the effect of funding and of not funding bariatric surgery across the five boroughs of NHS North Central London (NCL), that is, Barnet, Enfield, Haringey, Camden and Islington.[xvi] Using this larger population base provides more accuracy to the modelling and I consider it reasonable to assume that the findings are generally applicable to people living in Barnet.

The average BMI of NHS NCL patients undergoing bariatric surgery at the Whittington Hospital is 48 and the median is 48.65. This approximates to the figures in the National Bariatric Surgery Register and we can reasonably assume that this proportion applies to patients receiving bariatric surgery in other hospitals.

We do not know the BMIs of patients with diabetes undergoing bariatric surgery and thus have had to make assumptions. We have modelled[xvii] the costs and benefits of bariatric surgery for people with diabetes assuming that those undergoing surgery represent 1%, 5% and 10% of those with diabetes and obesity at BMIs of 30 or greater, 40 or greater and 50 or greater. The number of bariatric procedures undertaken on NHS NCL patients in 2010/11 is equivalent to approximately 0.5% of our estimate of people with diabetes with a BMI of 30 or greater, 3.5% of those with diabetes and a BMI of 40 or greater and 100% of those with diabetes and a BMI of 50 or greater.

Whatever the proportion of people with diabetes undergoing surgery at different BMIs, the outcome of this modelling shows that there is an increasing financial saving over the years. This is shown in Figure 14, Figure 15 and Figure 16.

II consider it especially important to note that if we stopped funding bariatric surgery for people with diabetes, whilst there would be an initial saving (because we would not be paying for the operations) we would quickly incur additional costs because of the need to treat diabetes and its complications. The estimated financial effect of this is shown in Figure 17.

Put another way, this modelling shows that, unequivocally, bariatric surgery in people who have already developed type 2 diabetes saves health service costs (and by implication, social service costs) after about five years, and, continuing to provide this treatment to others after this time leads to more savings than costs. Not funding this treatment would increase health and social care costs as well as worsen people's wellbeing.

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xvi This modelling was led by Ian Newman, Business Analyst Manager, NHS North Central London (Barnet)

xvii The population in NCL with obesity was modelled using Health Survey for England 2009 data [Health Survey for England 2009 trend tables (see http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england--2009-trend-tables [accessed 9 February 2012]). Trends were identified from these data and combined with Greater London Authority population estimates (2008) to estimate the number of people with different body mass indices. The cost of bariatric surgery was taken from the average costs of these procedures for Barnet PCT patients in 2010/11. The proportion of people with diabetes for each level of BMI, the cost of treating people with diabetes and the evidence of benefit was taken from the National Bariatric Surgery Register. It was assumed that bariatric surgery procedures were undertaken at a similar rate for each group of patients throughout the year

Figure 14: Modelled costs/(benefits) of bariatric surgery performed on 1% of people in NCL with obesity and diabetes at different BMI levels

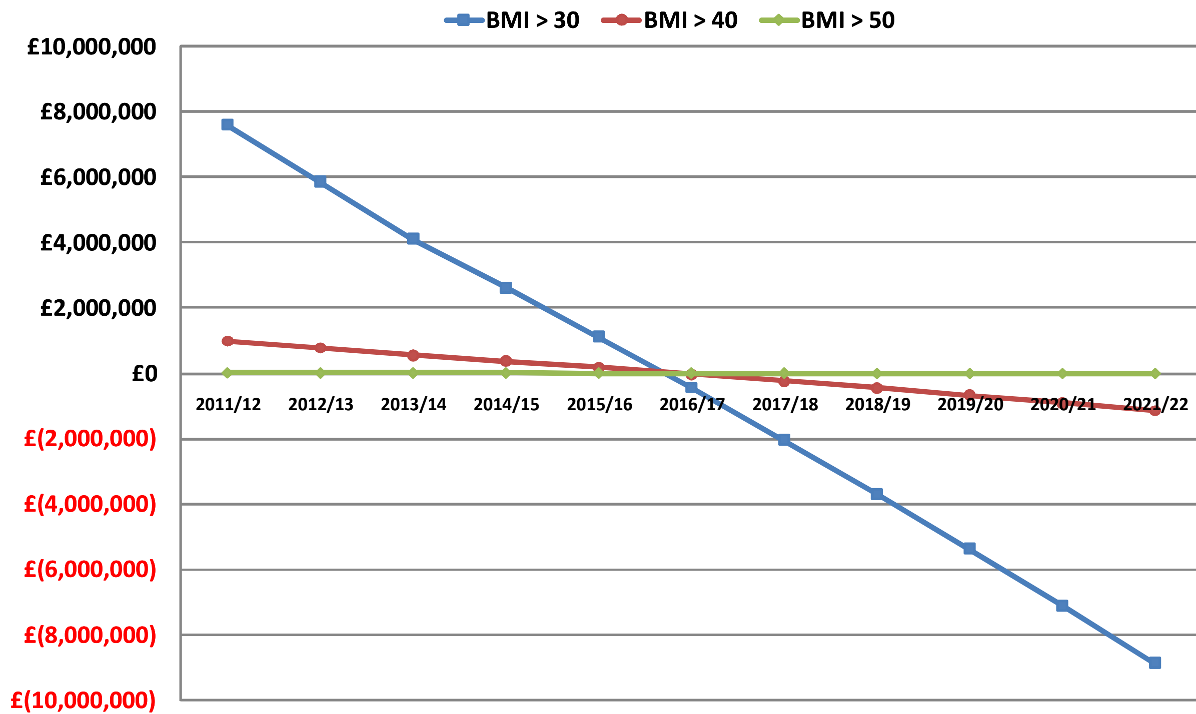


Figure 15: Modelled costs/(benefits) of bariatric surgery performed on 5% of people in NCL with obesity and diabetes at different BMI levels

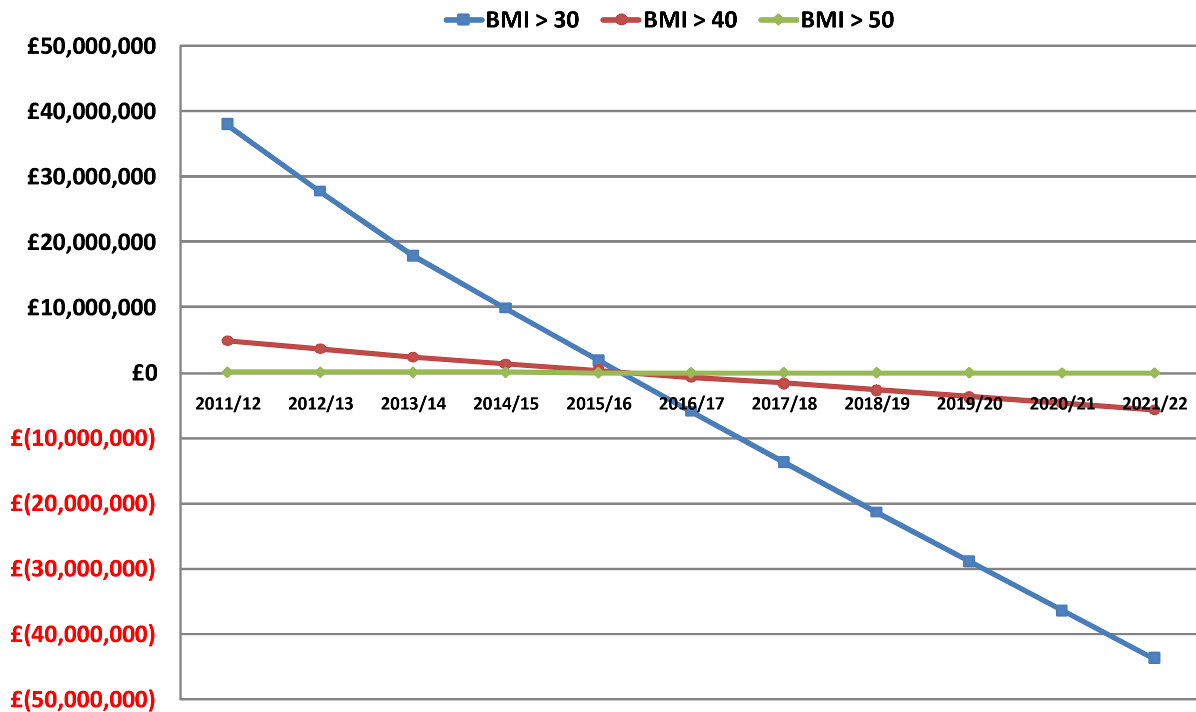


Figure 16: Modelled costs/(benefits) of bariatric surgery performed on 10% of people in NCL with obesity and diabetes at different BMI levels

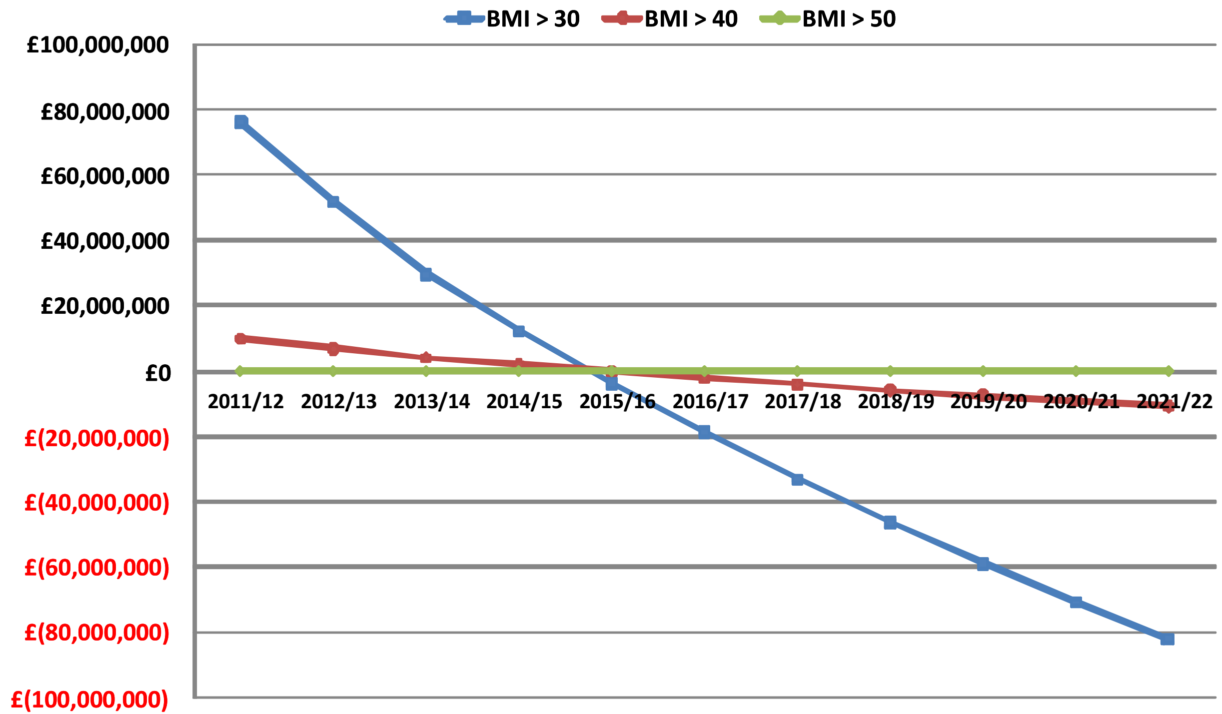
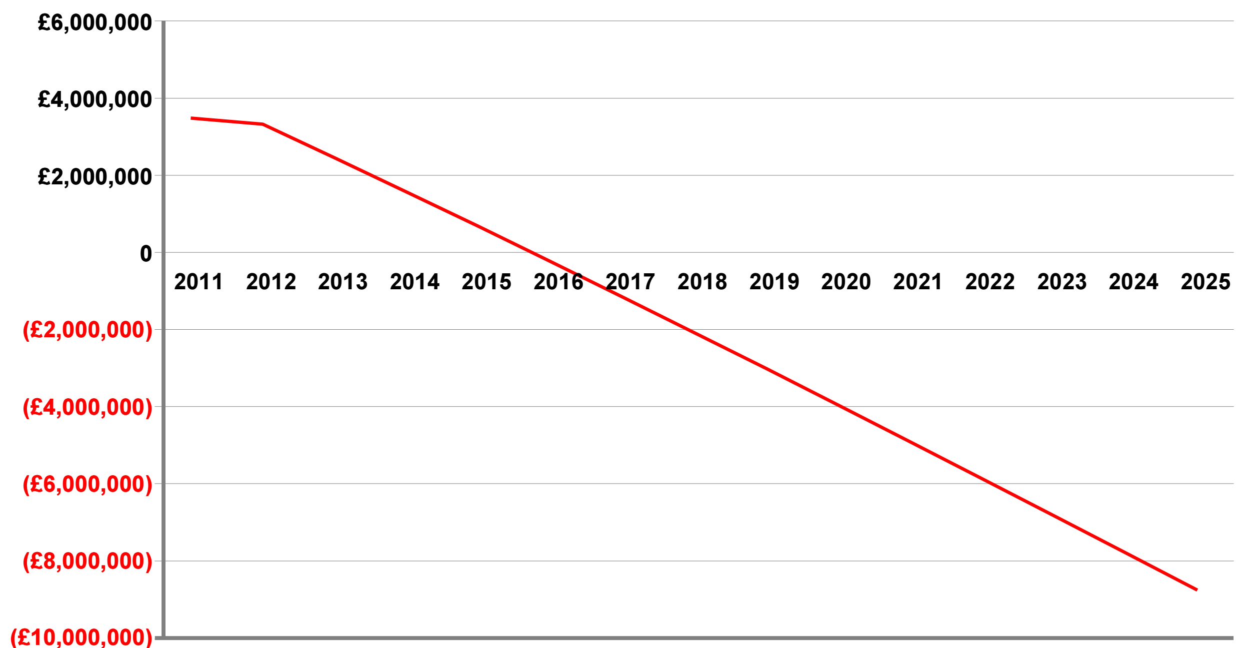


Figure 17: Modelled financial impact of stopping all NHS-funded bariatric surgery in the North Central London area



3.4 How is this relevant to Barnet?

Currently, the proportion of adults who are obese in Barnet is below the national average (17.9% vs 24.2%), albeit our levels of obesity in Year-6 children is closer to the national average (17.5% vs 18.7%).[4] However, there is no room for complacency; the proportion of children and adults who are overweight and obese in Barnet will continue to rise if we fail to take effective action to deal with this. In turn, this will lead to greater levels of obesity-associated disease and requirements for long-term care. As Guh and colleagues noted, this will "carry a profound health burden and will have a significant impact on health expenditure"[41] and, we can infer, t will do so on social care spending too.

Obesity is a significant cause of health inequality. Men and women in unskilled manual occupations are more likely to be obese than those in professional occupations; Asian children are four times more likely to be obese compared to children of white background; Black Caribbean women have obesity levels 50% higher than the national average and Pakistani women 25% higher than the national average.[74]

Unless we enable people to avoid overweight, and unless we help people to manage established overweight and obesity, then we can expect health inequalities to widen in Barnet. There is evidence for this: a 28-year prospective cohort study of 8,353 women and 7,049 men in Scotland undertaken by Hart and colleagues found that the death rate in women in lower social classes who were never-smokers was a third higher than for those in higher social classes and that this was partly due to obesity.[75] As suggested by Mackenbach, commenting on Hart and colleagues' paper, if smoking were to be eliminated, there would still be substantial health inequalities, in the main attributable to obesity.[76] It is most unlikely that we will eliminate smoking in Barnet (or anywhere else), but this study tells us that obesity in itself is a significant cause of health inequalities.

Whilst Barnet's obesity figures currently do not vary significantly from the national average, I also consider it of concern that so many children starting school in Barnet are already overweight or obese, and that even more are overweight and obese by the time they reach year 6. The proportion of overweight and obese children in our schools is shown in Figure 18 and Figure 19. If there is one encouraging feature from these data, it is that there has not been a significant upward trend in the proportion of overweight and obsess children in these classes in Barnet schools since 2006/07. But there is no downward trend either. If we are to address the overweight and obesity epidemic in Barnet then we need to take action to reduce the proportion of children in the borough starting school who are either overweight or obese and reduce – even more – the proportions who enter year-6 as overweight or obese.

I consider it particularly important to note that, as shown by Figure 18 and Figure 19, the proportion of children who are overweight and who are obese is higher in year 6 than in reception class. This means that more children are developing this problem in their early school years. We have a greater opportunity to influence this than we do the proportion of children who are overweight and obese entering our school system and it is important that we do so.

Figure 18: The prevalence of overweight and obesity in reception class children in Barnet schools

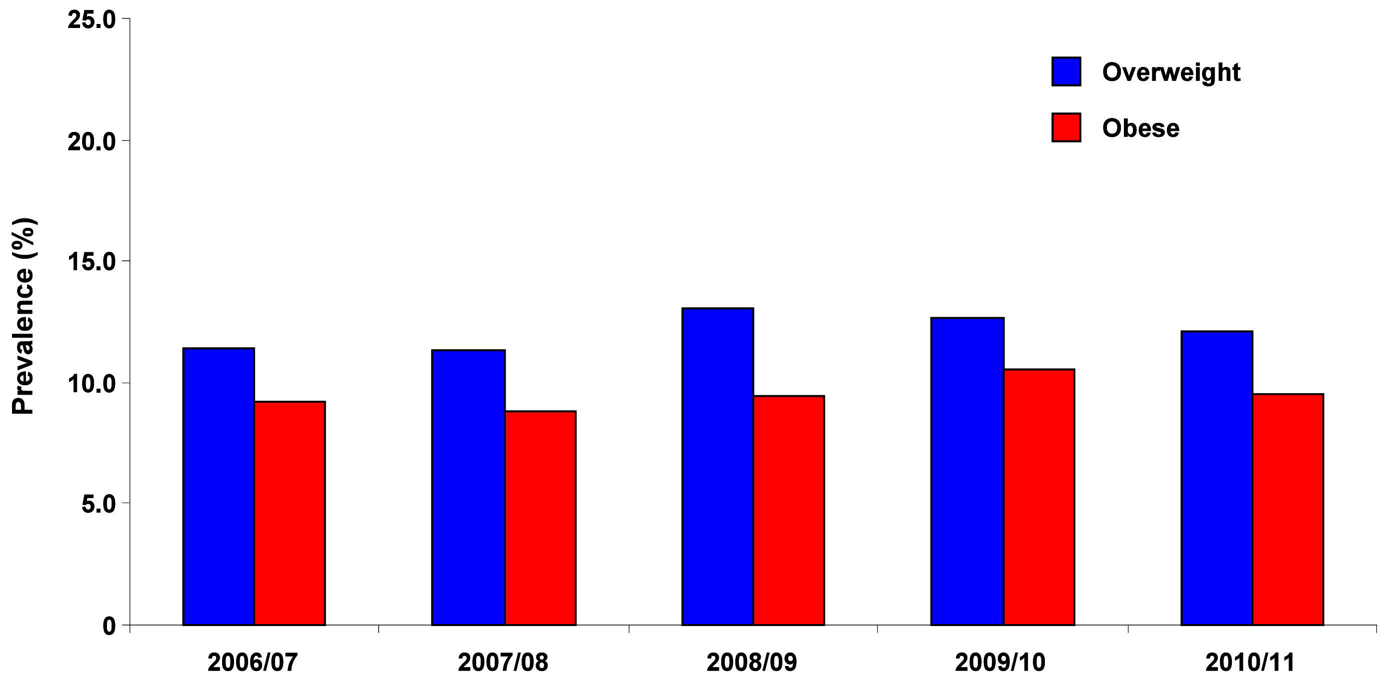


Figure 19: The prevalence of overweight and obesity in year-6 children in Barnet schools

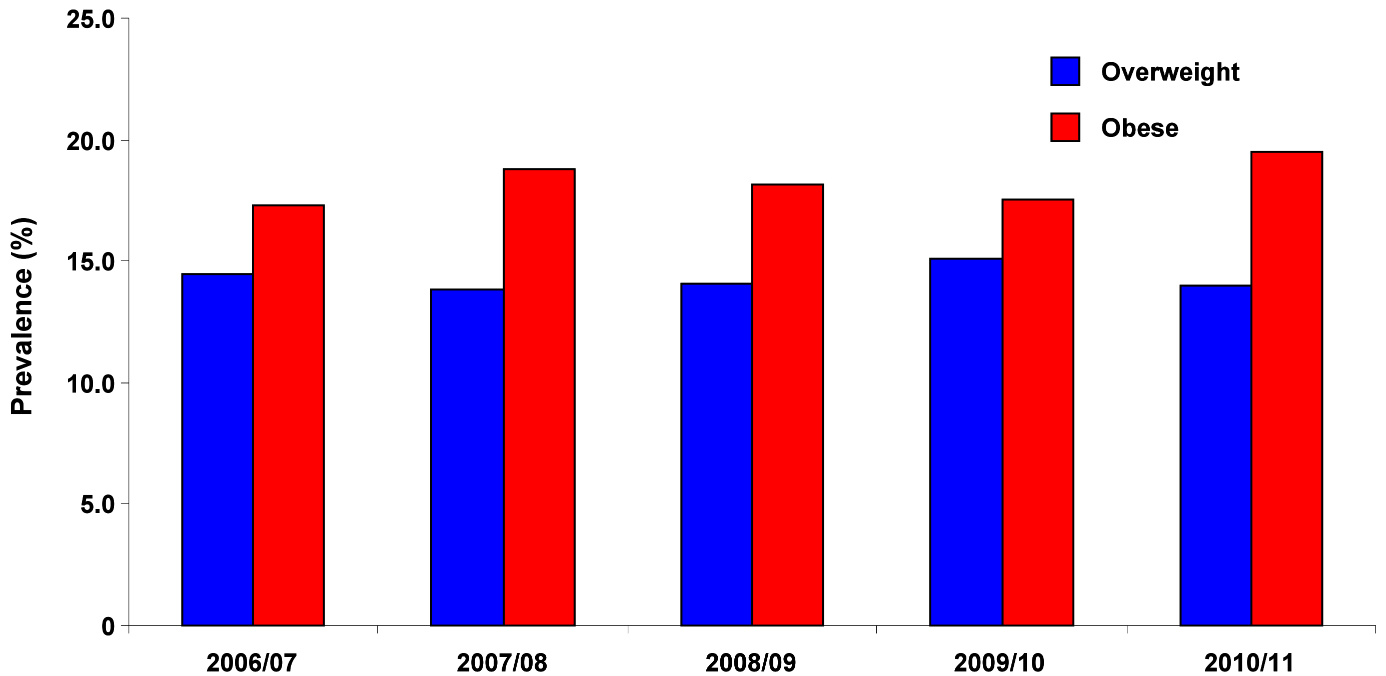
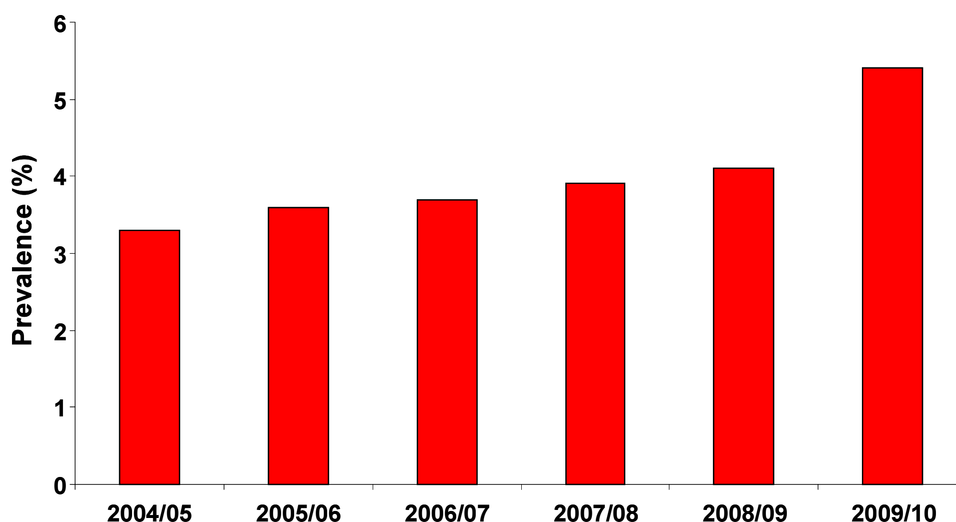


Figure 20 shows the increasing prevalence of diabetes recorded on GP registers in England in people aged over 17 years. The combined prevalence of diagnosed and undiagnosed diabetes in England is forecast to rise to 8.5% by 2020, but in Barnet, it is forecast to reach 8.5% seven years before this, by 2013, and to reach 9.6% by 2020.[77] The above-average prevalence of diabetes in Barnet, the most significant cause of which is obesity, is of concern: even with below-average obesity levels in the borough there is clearly much to be done to address a major health risk and future health and social care cost pressure.

Figure 20: The increasing prevalence of diabetes mellitus in England (2004/05 – 2009/10



We currently have no strategic approach to the management of overweight and obesity in Barnet akin to our approach to smoking cessation. This needs to be rectified if we are to improve people's well-being and help to reduce future health and social care costs. We also need to take a more systematic approach to enabling people to avoid overweight in the first place.

3.5 What do we need to do in Barnet?

First and foremost, we need to recognise obesity as a problem of epidemic proportions that is increasing the incidence of various diseases and thus increasing health and social care costs, increasing health inequalities, and causing substantial reductions in people's well-being.

We need to encourage and enable people to:

- be more physically active in their everyday lives;
- eat sensibly to avoid becoming overweight;
- to lose weight if they are overweight or obese;
- to seek specialised help to lose weight if necessary.

We also need to ensure that there are services available to support people to lose weight (and these might be commercial organisations) as well as ensure that front line health and social care staff are enabled to raise the subject with patients/clients effectively and signpost them to clinically appropriate services.

4 Reducing the health inequality impact of child poverty

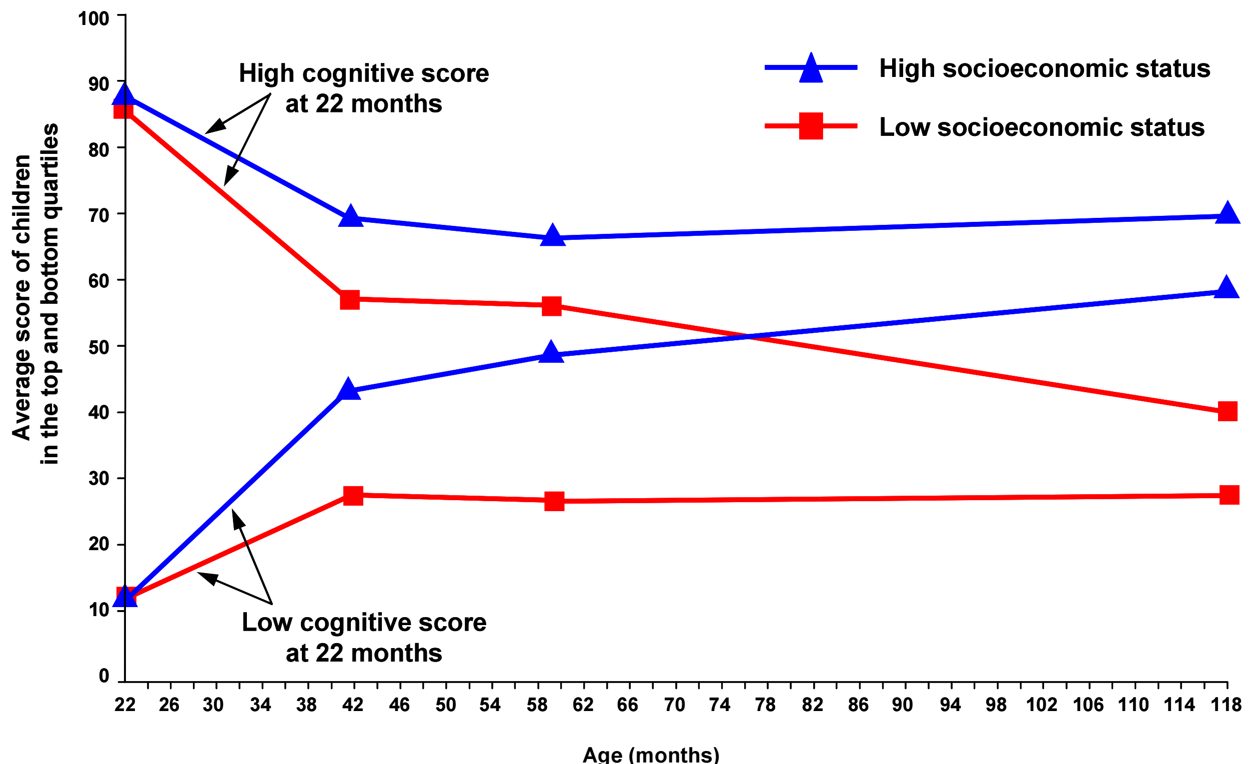
4.1 Background

We know from The Marmot review, *Fair Society Healthy Lives*, that people in higher socioeconomic groups generally experience better health; there is a 'social gradient' in health.[78] The Marmot review also tells us that the relationship between educational achievement and health shows a similar gradient: people with better educational achievement generally enjoy better health, a point confirmed by others.[79]

The Marmot review also shows the impact of child poverty on cognitive ability in a diagram taken from work by Feinstein.[80] This is shown in Figure 21**,** and shows that children born into families with high socioeconomic status, whether their cognitive scores at ten months of age are, on average, high or low, generally have higher cognitive scores by the age of about ten years. In contrast, those born into lower socioeconomic group families, on average, have lower cognitive scores at the age of 10 years, irrespective of their scores at ten months. These differences are statistically significant.

Such educational inequalities persist at secondary age: children eligible for free school meals are half as likely to achieve 5 GCSEs A*-C (including English and maths) compared to those not eligible for free school meals (30.9% vs. 58.9%).[81] For many, we can expect these educational achievement differences to translate into health inequalities in later life.

Figure 21: Inequality in early cognitive development in children in the 1970 British Cohort Study, at 22 months and 10 years



4.2 The importance of the home learning environment

Dearden and colleagues identified that improving health, and improving parenting skills and the home learning environment, could have short and long-term benefits for children,[82] although this is not the whole explanation of the differences between the

cognitive skills gap between children from affluent backgrounds and those from deprived backgrounds nor will it completely eliminate such differences.[83] That said, he most significant factor in a child's achievement at school is the home learning environment, as shown in Table 5.[84]

Table 5: Effect sizes for socio-economic status, mother's and father's education, and home learning environment on 5, 7 and 10 year outcomes

	5-year olds		7-year olds		10-year olds	
	Literacy	Numeracy	Reading	Maths	Reading	Maths
Socio-economic status	0.29	0.43	0.37	0.39	0.26	0.32
Mother's education	0.35	0.23	0.33	0.33	0.46	0.27
Father's education	NS	NS	0.19	0.16	0.25	0.23
Earned income	0.31	0.28	0.15	0.15	0.24	0.23
Home learning environment	0.73	0.65	0.60	0.60	0.49	0.45

NS = not statistically significant

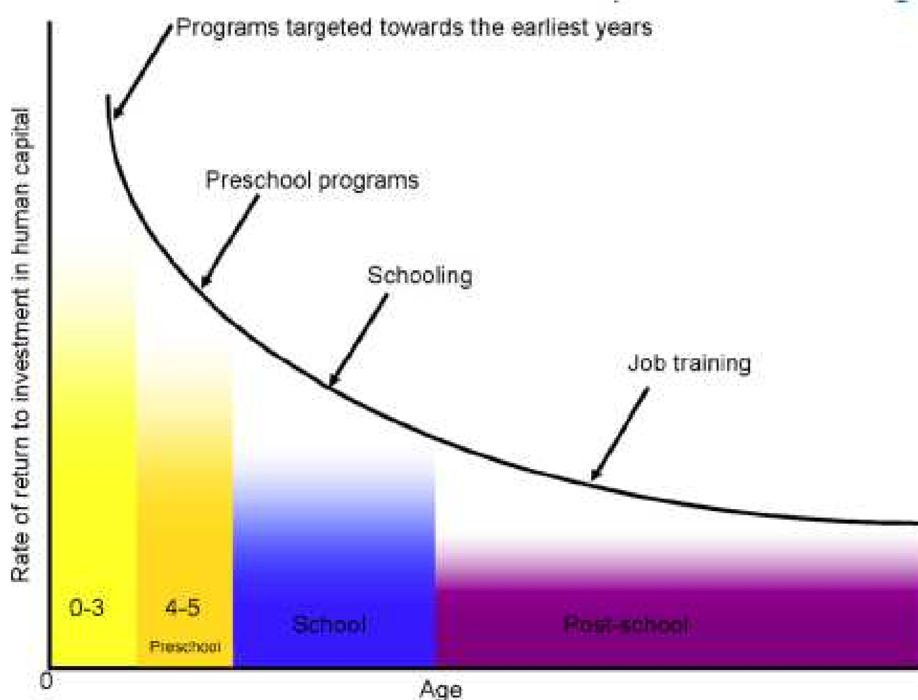
The importance of the home learning environment on future educational achievement has been confirmed by others. For example Gregg and colleagues, whose researches into outcomes for children in middle childhood (such as cognitive ability (IQ and school performance), socio-emotional outcomes (self esteem, locus of control and behavioural problems) and physical health (risk of obesity)) has shown that children in low-income households are 'disadvantaged across the full spectrum of outcomes compared with their better-off counterparts' and that '*the child care and school environments are negligible in importance compared with the role of the home environment* provided by low income parents for outcomes at ages up to eight years' [emphasis added].[85] Byford and colleagues, who reviewed cohort studies concerning parenting practices and outcomes found particularly that the 'intellectual home environment', parental aspiration and cognitive stimulation of children at home were all positively and independently associated with childhood cognitive ability (and that coercive discipline was negatively and independently associated with it [which one might interpret as 'spare the rod and support the child']).[86] This has been borne out by others: cognitively stimulating materials and activities at home are especially important in influencing a child's cognitive development;[87,88] the children of mothers who are 'more warm and supportive' and who provide cognitive stimulation at home have better language abilities as assessed by their teachers;[89] and children's verbal and intelligence scores are higher when their parents are more supportive and less authoritarian.[90,91]

Various studies, including controlled ones (that is, one group receiving an intervention and the other not), have shown that early childhood intervention programmes, such as providing parental support and training, learning activities and structured experiences for children and enhancing the home environment lead to statistically significant improvements in the intervention groups including improved developmental and intelligence quotient,[92] cognitive development,[93] creative thinking[94] and concept development.[95]

According to a report from the European Expert Network on Economics of Education, experimental evidence from a variety of sources shows that interventions that

supplement the early lives of children of disadvantaged families are beneficial and can improve cognitive and socio-emotional ability, and that such interventions promote schooling, reduce crime, foster work productivity, reduce teenage pregnancy, and have high benefit-cost ratios and rates of return.[96] The benefit against investment is greatest for interventions in the early years of life, as depicted in **Error! Reference source not found.** taken from this report.

Figure 22 Rate of return on investment in human capital[96, xviii]



Diamond and colleagues evaluated the *Tools of the Mind* programme in the USA, which integrates supportive activities and training into almost all pre-school classroom activities.[97] It includes a 'buddy reading' activity in which all children are given a picture book and take turns to tell a story about this in pairs, turning the pages and pointing to the pictures as they do so. It also includes 'clean-up' activities which encourages self-discipline by requiring the children to clear up quickly at the end of an activity in preparation for the next. Other aspects of the programme include role play, and training for teachers. Diamond and colleagues found that children on the *Tools* programme showed 'impressive gains' in executive functions (also called cognitive control), which are considered to be critical for success in future school life.

In a review of the research on reading aloud to children, Duursma and colleagues identified 'ample research evidence' that this promotes the development of language and emergent literacy skills which, in turn, helps to prepare children for school.[98] They found evidence that parent-child literacy activities, such as shared book reading, stimulate children's oral language skills and vocabulary and that this is likely to enable language development more than toy play or other adult-child interactions. This is not to belittle these other activities, but it emphasises the great importance of reading to and reading with pre-school children, which, according to Duursma and colleagues, not only helps children to 'develop solid language and literacy skills' but

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xviii For further evidence see: James J. Heckman, Schools, skills, and synapses, *Economic Inquiry*, Vol. 46, Iss. 3, pp. 289-324, 2008. See http://ftp.iza.org/dp3515.pdf (accessed 12 March 2012)

promotes children's 'understanding of the world, their social skills and their ability to learn coping strategies'.

In a review of the research literature concerning parental involvement, parental support and family education on school achievement for the then Department of Education and Skills, Desforges and Abouchaar identified that parental involvement shapes how children perceive school education and bolsters their motivation to succeed and, for younger children, this is supplemented by parents helping their children to develop skills, such as early literacy.[99] Desforges and Abouchaar also looked at family learning through literacy and numeracy schemes established by the then *Adult Literacy and Basic Skills Unit* (now the *Basic Skills Agency*).[xix] They found that, for example, the *Family Literacy Scheme*, a 96-hour intensive teaching programme over 12 weeks, targeted at at-risk children (aged 3-6 years) and their parents, led to sustained, statistically significant improvements in the children's and the parent's reading and writing skills and to 'significant boosts' in parental achievement, confidence and competence in helping their children. Teachers rated the children on these courses to be superior to peers in classroom behaviour and equal to peers in other academic and motivational respects. Desforges and Abouchaar described these outcomes as 'striking for cohorts whose attainments on entering the programmes was significantly less than the average'. They also found evidence that similar results were obtained with numeracy schemes and, based on initial evaluations, with literacy schemes for ethnic minority families.

Feinstein and colleagues drew similar conclusions, that parenting skills in terms of warmth, discipline and educational behaviours are all major factors in contributing to a child's success or otherwise at school, and that parents reading to their pre-school children, especially, is associated with higher scores in language, pre-reading, early number concepts and non-verbal reasoning at school entry.[100]

Significantly, a study undertaken by Hunt and colleagues for the Department for Education found that whilst the majority of parents maintained the same level of early home learning once their child started in a childcare place, in families where the adults are not in employment, parents undertake *less* early home learning once their child starts in a childcare place.[101]

4.3 How is this relevant to Barnet?

Barnet is rightly proud of its schools and their attainments, but if we are to reduce health inequalities, one area that we must concentrate on is enabling children in Barnet's poorest families to be able to take full advantage of what our schools have to offer.

Twenty-three point seven per cent of children in Barnet (more than 18,000) are living in poverty, against a national average of 20.9%.[102] There are more children living in poverty in Barnet than in Camden (14,640),[103] which is more deprived than Barnet, and more than in Islington (16,710), which is substantially more deprived than Barnet.[104]

There is a substantial body of research showing that children living in more deprived areas are less able to take full advantage of school education (and consequently achieve less) and that this impacts on their health. Put another way, not only will they experience poorer health but, proportionately, there will be higher health and social

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xix See http://www.skillsforlifenetwork.com/?atk=2530 (accessed 12 March 2012)

care costs because of this. Whilst this may not be entirely avoidable, there is also a large amount of evidence that a number of different interventions, primarily aimed at improving parenting skills (principally parent literacy and numeracy, and thus child literacy and numeracy) and improving the home learning environment can lead to sustained and statistically significant improvements in educational attainment. We can reasonably expect this to reduce future health inequalities and to reduce the need in this group for health and social care services.

There are a lot of children in Barnet (more than 18,000) who are much less likely than their peers to be able to take advantage of the excellent school education available in the borough and who are more likely to experience health inequality as a consequence.

Finally, it is also important to recognise that smoking is a particular issue in families living in poverty:

- households with the lowest tenth of income spend six times as much of their income on tobacco as do households in the highest tenth;
- more than 70% of two-parent households on Income Support buy cigarettes, spending 15% of their disposable income on tobacco;
- excluding money spent on tobacco, Income Support alone is insufficient to support a minimum standard of living, especially in homes with children; and
- low-income households where parents smoke are much more likely to lack adequate basic amenities, such as food, shoes, coats, than non-smoking parents on Income Support.[105,106,107]

Targeting families living in poverty in non-stigmatising ways to enable smokers to quit will improve their health directly and make more money available for both basic amenities and an improved home learning environment for children.

4.4 What do we need to do in Barnet?

Barnet Council is running an early intervention programme to provide support to families in greatest need. Through the Family Nurse Partnership, other families are being supported from a health perspective. And there are a number of children's centres in the borough. However, there are still many families living in poverty that are not able to access these services. In addition, and especially, we need to enable more parents and carers of children living in poverty to be able to read to their children; there is an adult literacy issue here. We also need to enable parents and carers of these children to develop greater parenting skills and to provide their children with a more effective home learning environment.

We therefore need to:

- work with the statutory, voluntary and commercial sector to enable greater literacy and numeracy skills in parents and carers in families living in poverty to improve the pre-school literacy and numeracy competence in children;
- provide parenting support so that parents and carers of children living in poverty can improve the home learning environment to give children a better start in life;
- use the resources of the *Basic Skills Agency* and programmes such as the *Family Literacy Scheme* and numeracy schemes to give children a better start in life; and
- make special efforts to target and to enable smokers in families living in poverty to quit.

5 Conclusions and recommendations

Whilst the health of Barnet people is generally better than average, we have to ask ourselves whether we are content with this or whether we could (and should) do better. There are significant health inequalities in the borough and the people affected experienced below-average health, and poorer health than, for example, the majority of those people living in the Borough's most affluent areas. And, as local research has shown, there are a large number of people in Barnet with unrecognised – and thus unmanaged – risk factors for avoidable ill-health. For some, these risks are direct, for example, smoking, obesity; for others, they are 'indirect', for example poor educational achievement (principally attributable to a poor home learning environment) which significantly increases the risk of poorer health in youth, adulthood and older life. I therefore suggest that the answer to the question should be 'Yes! We can do better and we should!' If we take large-scale action in these areas we can improve the health of Barnet's people further. Not only will this improve people's well-being, it will both reduce health and social care costs[xx] and contribute to improving the borough's prosperity; people who are fit and well are more able to work and to pay taxes and are less reliant (if at all) on state benefits and publically-funded services such as health and social care.

5.1 'Direct' ill-health prevention

We have two very significant opportunities for disease prevention; adequately addressing these two areas will lead to significant further improvements in people's well-being in Barnet and reduce the future need for health and social care services:

1. tobacco control – that is, encouraging and enabling people, principally children, not to start smoking and, for smokers, encouraging and enabling them to quit; and
2. reducing the prevalence of overweight and obesity, that is, encouraging and enabling people not to become overweight, and for those who are overweight and for those who are obese, to encourage and enable them to lose a significant amount of weight.

Both of these lifestyle choices, for which there are clinically and cost-effective interventions to enable people to be healthier, need to involve primary, secondary and tertiary prevention. However, in the main, our interventions so far have

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xx Aneurin Bevan, the government minister responsible for the creation of the NHS in 1948, hoped that, as people's health improved, the cost of the NHS would fall. [See http://www.nationalarchives.gov.uk/cabinetpapers/alevelstudies/management-1950.htm (accessed 14 March 2012)]. Indeed, it was the rising cost of the NHS that led to the introduction of prescription charges in 1952. The NHS (and probably social care) has always cost more each year as the potential to provide services and demand for them has increased. If Northcote Parkinson had been writing about the NHS rather than the Civil Service in his article on 'Parkinson's Law' in *The Economist* in 1955, he might have said that 'Patient demand expands to fill the resources available'. {A copy of Parkinson's original paper can be found at http://www.berglas.org/Articles/parkinsons_law.pdf (Accessed 14 March 2012)] Of course, we know that patient demand for NHS care *exceeds* the resources available. But, crucially, we need to remember Sir Derek Wanless's exhortion that we should create a national health service rather than continue with a national sickness service. This means, I suggest, that we should invest savings into more disease prevention activities rather fund things that previously have not been funded. Only in this way, as anticipated by Wanless, do we stand any chance of levelling-off the proportion of gross domestic product required for the health service. I suggest that the same principle is likely to apply to social and children's care services

concerned those who are already smokers and/or who are already overweight or obese (that is, secondary and tertiary prevention).

5.1.1 *Tobacco control*

We need to put more effort into stopping children from taking up smoking because most smokers start to do so before they turn 18 years of age and smoking is as addictive as taking heroin. Put another way, most smokers become nicotine addicts as children ; it is easier not start smoking than it is to give up.

We need to put more effort into helping people who smoke to give up. This will benefit both them and others, whose exposure to second-hand smoke will be reduced. To have the greatest impact, we need to concentrate our efforts especially on:

- women who smoke when they are pregnant;
- people living in more deprived areas, especially those who are living in poverty; and
- people who have additional risk factors, such as –
  - overweight and obesity,
  - diabetes,
  - high blood pressure,
  - raised cholesterol levels,
  - a family history of cardiovascular disease.

I would encourage the NHS in Barnet and Barnet Council to aim for Californian and Swedish levels of smoking prevalence. This will be a considerable challenge but, as shown in Table 1, we would substantially reduce mortality (and thus morbidity and the health and social care costs associated with this) if we were to achieve this.

5.1.2 *Enabling people to avoid overweight and obesity*

We need put more effort into helping people avoid becoming overweight and obese. We also need to put more effort into helping people who are overweight avoid becoming obese, and more effort into helping those who are obese to lose a significant amount of weight to reduce their health risks. To have greatest impact we need to concentrate our efforts especially on:

- people living in more deprived areas; and
- people who have additional risk factors, such as –
  - smoking,
  - diabetes,
  - high blood pressure,
  - raised cholesterol levels,
  - a personal history of cardiovascular disease,
  - a family history of cardiovascular disease and/or diabetes.

I would encourage the NHS in Barnet and Barnet Council to develop and, crucially, to implement, a strategy that reduces overweight and obesity significantly across the borough. This needs to address both enabling children and adults to avoid becoming overweight and obese in the first place as well as enabling and supporting children

and adults who are overweight or obese to lose a significant amount of weight. I also consider it important to recognise the benefits of bariatric surgery in eliminating, long-term, the signs and symptoms of diabetes in a very high proportion of people with obesity and diabetes. By inference, enabling people to control their weight effectively will also contribute to reducing the risks of diabetes in people whose weight is not so high that the only viable management option is bariatric surgery.

5.2 'Indirect' ill-health prevention: enabling greater educational attainment amongst children living in poverty in Barnet

Educational attainment is one of the most significant determinants of health. An inadequate home learning environment of pre-school children significantly reduces their ability to benefit from the subsequent educational opportunities offered at schools, no matter how good those schools are.

A major component of the home learning environment is parents and carers reading to and reading *with* their children. Another is parental aspiration and the degree of cognitive stimulation that they provide for their children at home.

There is a large body of evidence that interventions that lead to improvements in the home learning environment of children living in some of the poorest families, principally by improving parenting skills (especially parent literacy and numeracy, and thus child literacy and numeracy), statistically significantly improve their children's cognitive, emotional and social ability. Importantly, such interventions have been shown to improve promote school performance, reduce crime, foster work productivity and reduce teenage pregnancy and to do so cost-effectively.

I would encourage the NHS in Barnet and Barnet Council to actively identify families with children living in poverty and to take specific actions to improve parenting capability and confidence and, thereby, to improve the home learning environment for children in these families.

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Meeting	Health and Well-Being Board
Date	31 May 2012
Subject	**Health & Well-Being Implementation Group Action Plan**
Report of	Director for Public Health
Summary of item and decision being sought	The Health and Well-being Implementation Group consists of senior officers who are responsible for ensuring the implementation of various actions to help to deliver the intentions of the Health and Well-being Board. Health & Well-being Board members are asked to note the group's current action plan

Officer Contributors	Andrew Burnett- Director for Public Health
Reason for Report	To keep Health & Well-Being Board members abreast of actions being taken to enable delivery of the board's intentions
Partnership flexibility being exercised	N/A
Wards Affected	All

Contact for further information: Andrew Burnett- andrew.burnett@nclondon.nhs.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board note the action plan attached at Appendix 'A'.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well Being Board- 22 September 2011: item 4- proposal to establish a Health and Well Being Implementation Group

2.2 The implementation group meets twice between Health & Well-being Board meetings

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

This group is responsible for taking actions to enable delivery of the Health & Well-being Strategy and related plans and policies to improve health and well-being in the borough

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The actions of this group should be based upon assessed need and equality issues identified in the JSNA, the Health and Well-being Strategy and related plans and policies

5. RISK MANAGEMENT

5.1 The actions of this group include consideration of risk and its mitigation

6. LEGAL POWERS AND IMPLICATIONS

6.1 The Health and Social Care Bill received Royal Assent on 27 March 2012. Barnet's Health and Wellbeing Board has been operating in shadow form in readiness for the legislative changes. The Health and Wellbeing Implementation Group as noted in this report is tasked with implementing decisions and strategy formulated by the Board.

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

7.1 Resource implications for each topic area need to be identified as part of the development of implementation plans

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Communication with others is an integral part of most of the actions undertaken by this group

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Communication with others is an integral part of most of the actions undertaken by this group

10. DETAILS

10.1 At its meeting of 22 September 2011. the Health and Well being Board agreed to establish a Health and Well Being Implementation Group, as a formal senior officer group to ensure that the Health and Well Being Strategy and related strategies were being implemented efficiently.

10.2 It was agreed that the Group, to be chaired by the Director of Public Health, develop a work plan and meet every 6-8 weeks, and report to each meeting of the Health and Well-Being Board. The current action plan is attached at Appendix 'A' for the Board's information and comment. This was updated following the meeting of the Group on 25 April 2012.

11 BACKGROUND PAPERS

11.1 JSNA (at http://www.barnet.gov.uk/info/930089/plans_performance_and_partnerships/900/plans_performance_and_partnerships

11.2 Draft Barnet Health and Well-being Strategy

11.3 Annual Report of the Barnet Director for Public Health (see report elsewhere on this agenda)

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CFO – JH

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Health and Well-Being Implementation Group actions to be taken following meeting on 25 April 2012

Topic	Responsible officer	By when	Comment
DPH annual report implementation plans based on report recommendations:			Proposed implementation plans need to be discussed at SMT (health) before submission to Health & Well-being Board
■ Tobacco control	Cynthia Folarin	draft plans by end May	
■ Overweight and obesity	Rachel Wells	draft plans by end May	
■ Home learning environment for children living in poverty	Cynthia Folarin	draft plans by end May	
Obesity:			
■ Healthy catering commitment	Rachel Wells	operational by beginning of September	To discuss with Chris Carabine by mid May
■ Walk to school week	Rachel Wells	draft plans by mid May	To discuss with Declan Hoare
■ Catering at NLBP	Rachel Wells	draft plans by end May	To discuss with Val
■ Healthy eating in schools and academies	Rachel Wells	draft plans by end May	To discuss with Jay Mercer
■ Healthy eating in high street food outlets	Rachel Wells	draft plans by end May	To discuss with Lucy Shomali
Olympic legacy	Rachel Wells	draft plans by mid June	To discuss with Tom Burton. Note that Olympic torch is coming to Barnet on 25 July. Opportuntiy to run health checks and to promote healthy lifestyles in Friary Park, ? also Victoria Park

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AGENDA ITEM 8

Meeting	Health and Well-Being Board
Date	31 May 2012
Subject	**North Central London Primary Care Strategy**
Report of	Chair, Barnet Clinical Commissioning Group
Summary of item and decision being sought	In January 2012 the Joint Boards of NHS North Central London approved a primary care strategy: ‘Transforming the primary care landscape in North Central London’. This paper introduces Board members to the key themes of the strategy; the full strategy is attached as an appendix. Board members are asked to note the strategy and comment on the way in which the Board can support implementation in Barnet.

Officer Contributors	Becky Kingsnorth, GP Commissioning Development Senior Manager, Barnet Borough Team, NHS North Central London.
Reason for Report	To share the NHS North Central London Primary Care Strategy and provide an opportunity for discussion of the opportunities afforded by the strategy.
Partnership flexibility being exercised	Not applicable
Wards Affected	All

Contact for further information

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1 RECOMMENDATION

1.1 That the Health and Well Being Board note the North Central London Primary Care strategy and comment on the way in which the Board can support implementation in Barnet.

2 RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Meeting of the Joint Boards of NHS North Central London, 26 January 2012: approval of the Primary Care Strategy.

2.2 Meeting of the Joint Boards of NHS North Central London, 29 March 2012: update on proposed approach to implementation, with some aspects of implementation being led across North Central London.

3 LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS

Link to Commissioning Strategies

3.1 One of the four overarching programmes set out within the NHS North Central London Commissioning Strategic Plan and Quality, Innovation, Productivity and Prevention plan (QIPP) is the improvement of primary care through the primary care strategy. However the primary care strategy will also support the three other programmes of:

- **clinical and cost effectiveness**, by supporting a re-profiling of investment in healthcare between acute, and community and primary care to rebalance the health economy;
- **prevention,** by supporting a reduction in the gap between diagnosed long term conditions, and expected prevalence, and by supporting healthy lifestyles; and
- **integrated care,** by supporting closer working between health and social care professionals in a range of settings.

3.2 There is an important link between the Primary Care Strategy and the Barnet, Enfield, and Haringey Clinical Strategy, as developments in primary care, in particular improvements in access to primary care, will support the agreed system changes, such as the consolidation of accident and emergency services onto the Barnet Hospital site.

Link to Health and Wellbeing Strategy

3.3 The draft Health and Wellbeing Strategy sets out the aspirations of the Health and Wellbeing Board and its member organisations. Particular health outcomes are identified as local priorities for improvement and these will inform the focus of the local Primary Care Strategy implementation plan.

Link to Sustainable Community Strategy

3.4 The London Borough of Barnet's Sustainable Community Strategy contains strategic objectives for:

- investing in children, young people, and their families, one part of which is preventing ill health and unhealthy lifestyles; and

- healthy and independent living, through: better health and healthy lives for all; better access to local health services; and promoting choice and maximising the independence of those needing the greatest support.

3.5 The Primary Care Strategy describes a vision for primary care that will support these objectives through greater integration between primary care practices and local health and social care providers; easier transfer, with patient permission, of patient information through web-based systems to ensure providers have timely access to information about the patient's needs; a greater role for primary care in supporting improvements in the health of the population; improvements to access to primary care; and support to patients to take responsibility for their own health.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 As noted above, the focus for implementation of the primary care strategy in Barnet will be informed by the Health and Wellbeing Strategy, which has in turn been informed by the Joint Strategic Needs Assessment.

4.2 An equality impact analysis was undertaken in January 2012. This indicated that: "the EQIA demonstrates the policy / change is robust and there is no potential for discrimination or adverse impact"[1].

5 RISK MANAGEMENT

5.1 A local risk assessment will be undertaken as part of planning for local implementation of the strategy. However initial risks to the success of the strategy have been identified as[1]:

5.1.1 that GPs may not engage with the implementation of the strategy, thus preventing anticipated improvements in patient safety, clinical effectiveness and the patient experience. This risk is being mitigated through a focus on engagement of GPs in the development of the strategy and forthcoming implementation plan, and through a mutually beneficial investment in primary care which will support practices to achieve explicit quality standards;

5.1.2 a financial risk that the time-limited investment in primary care does not deliver the required rebalancing of the health system to enable continued investment beyond the initial three year period. This risk will be mitigated by embedding within a local implementation plan a robust process for allocating the available investment to initiatives with demonstrable potential to support the desired transformational change.

[1] Cover paper to the North Central London Primary Care Strategy 2012/16, Meeting of the Joint Boards of NHS North Central London, Thursday, 26 January 2012.

6 LEGAL POWERS AND IMPLICATIONS

6.1 The Health and Social Care Bill was given Royal Assent on 27 March 2012. The Health and Social Care Act 2012 provides for the abolition of Primary Care Trusts and Strategic Health Authorities and the establishment of the NHS Commissioning Board and Clinical Commissioning Groups. . This means that on 1 April 2013, the commissioning functions of NHS North Central London will pass to a number of organisations, primarily: Clinical Commissioning Groups (CCG), the NHS Commissioning Board, Local Authorities and NHS Property Services Ltd. Responsibility for implementation of the primary care strategy will be divided between these organisations. While CCGs will take responsibility for securing continuous improvements in the quality of services commissioned, reducing inequalities, enabling choice and promoting patient involvement, securing integration and promoting innovation and research, the NHS Commissioning Board will be responsible for managing the contracts and performance of primary care contractors. This creates some uncertainty about the management of implementation of the Primary Care Strategy beyond April 2013 however responsibility for implementing the majority of the strategy will remain with Barnet CCG. Until April 2013 implementation will be managed jointly between Barnet CCG and NHS North Central London.

7 USE OF RESOURCES IMPLICATIONS

7.1 A total of £47m has been made available for investment in primary care across North Central London, over three years. In 2012/13, £2.9m will be invested in primary care in Barnet. Part of this will be invested in improving information technology and in strengthening the performance management of primary care contractors, and part of this will be available locally to support integration between primary care practices, workforce development, and the provision of an extended range of services in primary care.

7.2 It is expected that time-limited investment in primary care will support reductions in the use of secondary care, thus reducing costs by more than the total initial investment.

8 COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 During the process of development, the primary care strategy was shared with Local Involvement Networks (LINk) and the Joint Health Overview and Scrutiny Committee.

8.2 A Barnet Primary Care Strategy Implementation Group has been formed to:

- Champion the opportunities provided by the strategy to:
  - improve the quality of primary care as a major part of the overall health system; and
  - improve health outcomes for the population of Barnet;
- Support development and delivery of an implementation plan that builds on the particular strengths, and addresses the particular challenges, of primary care in Barnet;
- Develop and / or comment on proposals relating to particular aspects of the strategy, for subsequent approval by the CCG Board and/or North Central London Primary Care Strategy Programme Board;

- Identify, assess, manage, and where relevant; escalate, risks and issues that without mitigation, would impede progress;
- Quality assure the process of implementation;
- Share experience and best practice relating to each member's area of expertise;
- Consult with those groups represented by BPCSIG members; and
- Ensure a full range of stakeholders is engaged in the strategy implementation process.

8.3 Membership of the group comprises:

Chair, Barnet CCG, and joint clinical lead for Primary Care Strategy
Chair, Barnet Professional Executive Committee (PEC), and joint clinical lead for Primary Care Strategy
Barnet Borough Director, NHS North Central London (NHS NCL)
Practice Manager, Millway Practice, and Co-Chair, Barnet Practice Managers Group
Deputy Director, Adult Care and Health, London Borough of Barnet (LBB)
Barnet Local Medical Committee (LMC)
Barnet Local Involvement Network (LINk)
Community pharmacy representative
Associate Director of Joint Commissioning, NHS NCL & LBB
Director for Public Health, NHS NCL & LBB
CCG Board member, West Locality
CCG Board member, South Locality
CCG Board member, North Locality
Barnet Programme Manager, Primary Care Strategy, NHS NCL

8.4 A LINk representative is a member of the Barnet Primary Care Strategy Implementation Group and it is planned that the implementation plan will be discussed with the wider LINk membership.

9 ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The Primary Care Strategy signals a potentially transformational change for practices in Barnet. Building local momentum is vital and it will therefore be important to provide opportunities throughout implementation, for practices and local 'champions' to become

engaged. This was initiated at an event on 3 May 2012. The Local Medical Committee will also be an important partner in engaging practices.

9.2 The primary care strategy is acknowledged to be focused primarily on general practice. There is great potential, however, for closer working between GP practices and community pharmacies. Barnet CCG has begun the process of engaging with primary care partners as part of its communications and engagement work; an event with community pharmacies took place in February 2012, and an event with dentists is planned for June 2012.

9.3 Using a broad definition of primary care, it is clear that the voluntary sector and other provider organisations will have an important role in defining the integrated care networks.

9.4 It will therefore be vital to provide opportunities for the Local Authority, and NHS and voluntary sector providers to support the implementation plan in its early stages; in this way we will gain maximum benefit from the knowledge and wide range of perspectives of our partners.

9.5 A representative of the Local Authority is a member of the Barnet Primary Care Strategy Implementation Working Group.

10 DETAILS

10.1 The North Central London Primary Care Strategy was developed between August 2011 and January 2012. The strategy covers Barnet, Enfield, Haringey, Camden and Islington, and sets out the current position of primary care in each borough, describing the legacy created in some areas by previous strategies and the extent to which they have been implemented. The vision for primary care is described, and a number of 'vehicles for change' are identified to support achievement of this vision.

10.2 The NHS North Central London Primary Care Strategy was developed in recognition that the current health economy is unbalanced towards hospital care with insufficient and inconsistent development of primary care. Currently, the quality of primary care is variable across North Central London as a whole and within boroughs, with some examples of some very good quality services which we would wish to see made available in all practices. A transformation of primary care services is necessary to support NHS North Central London's Strategic Goals and Values:

- To enable our population to live longer, healthier lives, in particular tackling the significant health inequalities that exist between communities;
- To provide children with the best start in life;
- To ensure patients receive the right care, in the right place, first time; and
- To deliver the greatest value from every NHS pound invested;
  - By actively engaging local people in decisions about their own and their community's health and wellbeing; and
  - Through working collaboratively with partners to deliver seamless care

10.3 Key themes of the Primary Care Strategy are:

- Greater work between practices and community services in ‘networks’ serving the local population
- The introduction of web-based primary care information systems to allow information sharing across services
- A focus on the role of primary care in improving health outcomes for the population
- Making sure services are delivered from premises that are of an acceptable level
- Ensuring easier access to primary care – through use of different technologies and a focus on increasing patient-facing time
- Workforce development for the full primary care team; and
- Production of greater levels of patient information

10.4 The strategy looks beyond the GP contract, which is nationally negotiated.

10.5 Consistently high quality Primary Care has a pivotal role to play in reducing use of secondary care for basic healthcare provision, and improving population health.

10.6 Each Borough team has been asked to develop a local plan for implementation of the primary care strategy.

10.7 The combined strategy and implementation plans will guide investment in primary care in each of the five Boroughs over the coming three years. The outcome will be an improvement in clinical and service quality (as defined by safety, effectiveness and patient experience) and a reduction in ineffective and inappropriate secondary care usage and costs.

11 BACKGROUND PAPERS

11.1 *Transforming the primary care landscape in North Central London* (NHS North Central London, 2012) is attached as an appendix.

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Finance- JH

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NHS

North Central London

Transforming the primary care landscape in North Central London

January 2012

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Foreword

NHS North Central London

Dr Douglas Russell, Medical Director (Primary Care)

This is the underpinning Primary Care Strategy that has been developed since August 2011 in NHS North Central London. The strategy has been shaped by our aspirational vision "The Future Landscape of Primary Care – A patient's perspective". While many practices are already delivering some of that vision, we want to raise the standard across the board so that all patients have access to the very best in primary care.

Addressing quality, safety, and improving patient experience are the key aims in our primary care strategy. The strategy recognises that transformational changes are needed to support the development and capacity of primary care, and describes the steps towards implementing that transformation, but it will take time and resource.

We have therefore devised a major programme of transformational change requiring commitment and/or investment by all parties involved in the commissioning and delivery of primary care services, in order to make our vision a reality by 2016.

The process of developing the strategy has already included borough-based stakeholder workshops and direct engagement of GP and other independent contractor representatives. This is a co-production by many of the people directly involved in delivering primary care services.

Although it is strongly focused on the role of general practice in primary care, the implementation of the strategy will require the support of all independent contractors, nurses, therapists, hospital doctors and all other clinicians and managers involved in the delivery of primary and community care.

Currently, the quality and accessibility of primary care is variable across North Central London as a whole, and within individual boroughs. Allied to this, there is too much hospital activity in terms of Accident and Emergency attendances and unscheduled care admissions.

Primary Care has a pivotal role to play in reducing use of secondary care for basic healthcare provision and in improving population health. Radical change is required to improve quality, capability and productivity further, and to create capacity within primary care.

In this document we start by exploring what the primary care environment is in each borough, and acknowledge the legacy created in some areas by previous strategies and the extent to which they have been implemented. We then describe aspects of the care we aspire to provide, the vehicles for change that each borough will be able to draw upon as they set out their devolved implementation plans, and ultimately, what are the outcomes by which we will measure the success of this strategy in our future delivery of care.

It is my belief, shared by many primary care colleagues, that the high quality primary care we want to provide requires resourcing through upfront investment. Therefore this strategy is predicated on a substantial investment of pump-priming investment in the primary care strategy in Barnet, Camden, Enfield, Haringey and Islington. At the end of three years, we anticipate that the net savings of this strategy will more than cover any major investment.

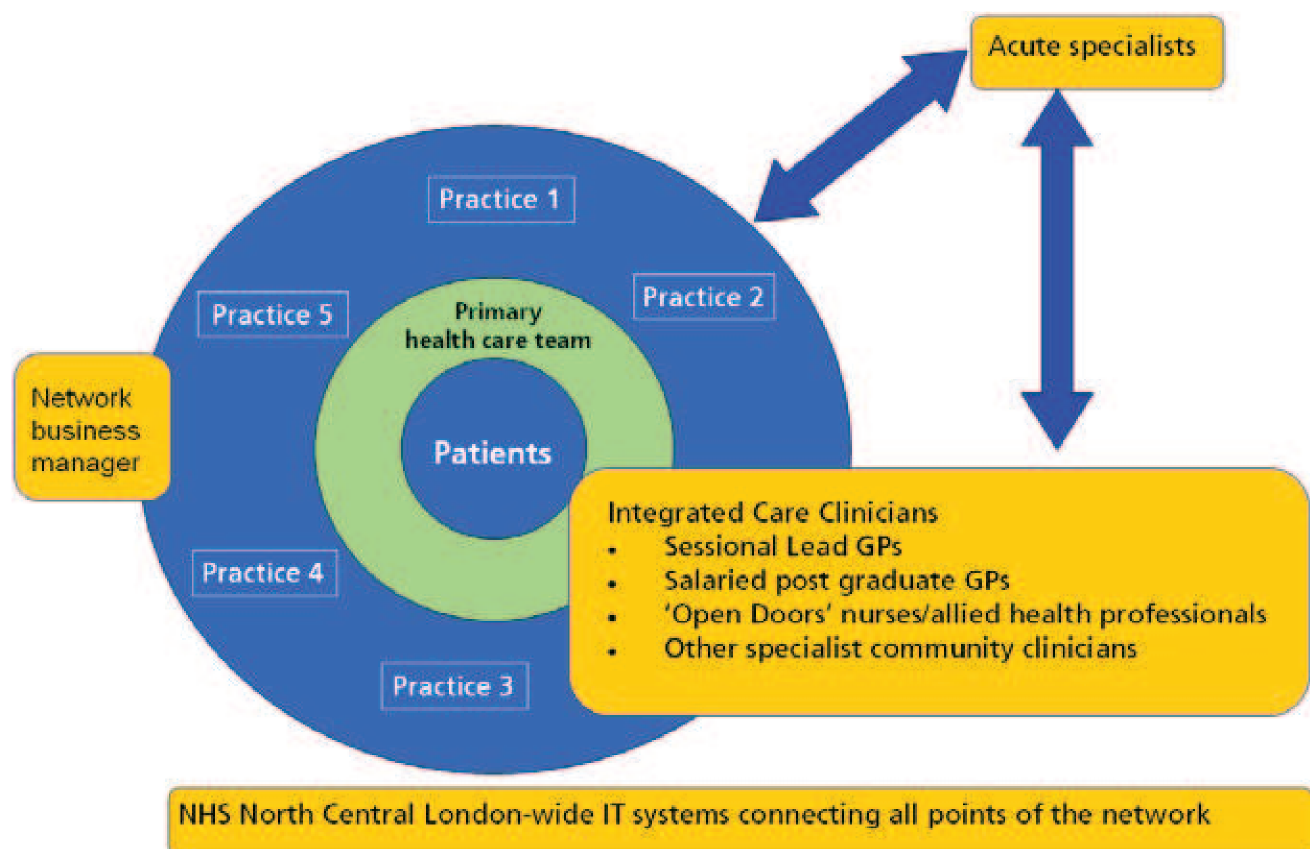
We are proposing nine strategic investment domains, of which the first three will form the Integrated Care Network (ICN) which is the heart of our new care delivery model.

We are asking practices to work together in local natural communities (of varying sizes) to create Integrated Care Networks, all the time retaining their autonomy as independent contractors. We will then provide funding for integrated care packages with community-based clinicians working along patient pathways from primary, through community and reaching into secondary care, where our hospital colleagues will provide professional clinical support to the networks and less hands-on care to those patients who can, and should, be seen in primary care.

Each network will be supported by an interactive, web-based, clinical information management network across NHS North Central London which will enable all healthcare providers to share patient records and to communicate electronically directly with each other to ensure that individual patient needs are met.

We are offering an example of what an Integrated Care Network may look like, but the actual design will be determined by each network.

WHAT MIGHT AN INTEGRATED CARE NETWORK LOOK LIKE?



The Integrated Care Network is not merely a theoretical construct. It is based on solid evidence (The King's Fund Report "Improving the Quality of Care in General Practice" March 2010), including demonstrable results from other London boroughs. But the success will come from the primary care community embracing both the concept of integrated care and

the investment to create locally-based effective networks. It is a framework and we have not set out the micro-detail of how the networks should operate because we want those decisions to be made at a local level. This is the next stage of development.

Having provided the investment and devolved authority to the networks, NHS North Central London has a duty to ensure that it is spent as intended and that it delivers the desired results. We will work with our independent contractors to motivate, incentivise and support them on the transformational journey. But we will also monitor their performance to ensure that our contractors do deliver those higher standards of quality, safety and patient experience.

Our intention is not to create any contractual changes. We are seeking to promote a change in "how things are done" rather than "what is done". We are therefore proposing a mutually beneficial investment in primary care which requires independent contractor practices to achieve explicit quality standards of inputs and outcomes in return for the financial investment. Our message to our independent contractors is "If you do these things well with our investment, then together we will achieve the desired outcomes".

Those outcomes, will have explicit quality markers by GP practice and network, agreed with GPs, whereby in return for the investment we can expect to achieve improvements in:

- Patient safety } Health outcomes
- Clinical effectiveness }
- The experience of patients.

I recognise that this primary care strategy is but one of many such initiatives in the current environment and that there is a real danger of change fatigue. Clinical leadership has never been more in demand, particularly from, and for, GPs. We need to separate our new role and responsibilities as commissioners from our traditional role as providers.

This strategy is about GPs in North Central London taking the opportunity to lead change in that traditional role. I am confident that secondary care colleagues, local authority colleagues, patients and the public will all respond positively to the successful implementation of this strategy.

In his foreword to The King's Fund Report "Improving the Quality of Care in General Practice", Chief Executive Chris Ham states:

> "The gauntlet thrown down by this report is to accelerate the pace of improvement in general practice and to develop a system that is fit for the future".

I invite all independent contractors, other clinicians and managers in both health and social care to join me and rise to this challenge in North Central London over the next three to five years.

Dr Douglas Russell

1. Introduction

In August 2011, NHS North Central London set up a project to develop a North Central London-wide Primary Care Strategy. This document describes a major programme of transformational change which will require commitment and/or investment by all parties involved in the commissioning and delivery of primary health care services. Its aim is to improve quality, capability and productivity further, and to create capacity within primary care.

The need for a strategy is in recognition that primary care services across North Central London are currently so variable in so many aspects that we need to transform our primary care services to raise the standard across the board so that all patients have access to the very best in primary care.

Through working with local people and partners we will improve the health and wellbeing of our population, reduce inequalities and maximise value in terms of outcomes, quality and efficiency from services provided to patients. We will:

- Enable our population to live longer, healthier lives, in particular tackling the significant health inequalities that exist between communities
- Provide children with the best start in life
- Ensure patients receive the right care, in the right place, first time
- Deliver the greatest value from every NHS pound invested.

We will achieve this:

- By actively engaging local people in decisions about their own and their community's health and wellbeing
- Through working collaboratively with partners to deliver seamless care.

This strategy underpins the development of our five borough-based implementation plans by defining the medium/long term goals, priorities, principles, investment criteria and performance expectations. It is a strategic shift from the previous premises-led agenda to one that is quality-led, and which focuses on:

- Promoting health, wellbeing and illness prevention
- Addressing health inequalities
- Further improving the quality of primary care services, particularly in General Practice, to enhance the patient experience with better outcomes.

The combined strategy and implementation plans will determine how the NHS in north central London will invest in primary care in each of the five boroughs over the coming years. The payback will be in the improvement in clinical and service quality and in a reduction in hospital usage and costs.

The strategy has been developed using, amongst others, the following inputs:

- The case for change in primary care in north central London
- The Barnet, Enfield and Haringey Clinical Strategy
- The King's Fund Report "Improving the Quality of Care in General Practice" (March 2011), which includes best practice examples in similar health economies, including Tower Hamlets
- "Value-Based Health Care Delivery", Michael Porter, Harvard (UCLP January 2011)
- "Improving access, responding to patients - A 'how-to' guide for GP practices" (Practice Management Network- August 2009).

The process of developing the strategy has already included borough-based stakeholder workshops and direct engagement of GP and other independent contractor representatives. This is not a top down imposition, but rather a co-production by many of the people directly involved in delivering primary care services.

Throughout the strategy, the definition of primary care should be assumed to be the independent contractor groups of GPs, dentists, pharmacists and optometrists, who all form a vital part of our primary care services. Community-based services such as district nursing, health visiting and therapy services are partners with the primary care independent contractors as members of the Extended Primary Care Team. This strategy describes how the partnership will work within an integrated network model.

The aspirational "vision" is set out from a patient perspective in the section "The future landscape of primary care - A patient's view of primary care in North Central London in the boroughs of Barnet, Camden, Enfield, Haringey and Islington in the year 2016". This is a deliberately challenging way of creating a vision, by starting from a single patient's view of the local healthcare system. It concludes with the following statement of purpose:

> **"Our aim, and that of all our practices, is to offer you a high quality primary care team service, linked, when necessary, to more specialist services; all of which will enable you to live the best possible lifestyle in respect of your personal health and wellbeing."**

2. Background

"This is how it was and how it is"

NHS North Central London

In our first NHS North Central London-wide strategy document Commissioning Strategy Plan 2010/14 (CSP) dated January 2010, we noted that:

> "The primary care landscape in North Central London is characterised by a significant variation in general practice size. There are a significant number of single handed GPs and many are in old buildings and estate that is not fit for purpose." (Page 35)

There were then 269 practices serving a registered population size of 1,374,253, at an average of 5,109 patients per practice.

The central theme of the plan was to implement the London-wide strategy set out in "Healthcare for London - A Framework for Action" (2007) and to support our PCTs in developing polysystems. This was a major investment in a premises-led strategy.

In January 2011, we published the first version of the NHS North Central London cluster Commissioning Strategy and QIPP Plan 2011/12 – 2014/15. This was subsequently issued as an updated version 30 June 2011. The foreword to the plan reflects a move away from the emphasis on the premises-led polysystems approach towards a more qualitative approach based on patient research:

> "The plan builds on our previous Commissioning Strategy Plan (CSP) published in January 2010 and retains the key themes of that plan of transferring care, where appropriate, from hospitals to community and primary care settings. Our discussions with General Practitioner (GP) commissioners as part of the planning process highlighted this as a key priority for them, along with improving services for mental health patients. Other priorities in the plan reflect work undertaken across London to improve patient outcomes in specialist services such as cancer and cardiovascular, local services such as maternity, and areas where we have benchmarked our performance against others and identified improvement opportunities.
>
> "Our plan takes account of the approval of the Barnet, Enfield and Haringey (BEH) Clinical Strategy in January 2011 and assumes that the consultation on the reduction of mental health bed capacity with Camden and Islington NHS Foundation Trust leads to bed closures taking place. At this point, our plan does not include other major service or provider reconfigurations other than those agreed across London in specialist services. Throughout the course of our planning we have continued to discuss and review with providers the implications of our plan on them both in the short and longer terms. Potentially, these discussions may conclude that there is a need for further changes to the pattern of services within North Central London."

The plan included a number of initiatives within primary care including list maintenance, reviewing enhanced services, pan-London performance management and review of the personal medical services. The 2011/12 programme of work has been focused on delivery of these initiatives.

By mid-2011, there were a total of 258 general practices with 1,413,086 registered patients, excluding the three GP-led health centres and PCT Special Practice.

FIGURE 1 - NUMBER OF PRACTICES, BY LIST SIZE, BY BOROUGH, AT JULY 2011

List size	Barnet	Camden	Enfield	Haringey	Islington	Totals
< 2,000	9	2	4	7	2	24
2-5,000	27	19	35	28	14	123
5-10,000	23	9	16	12	17	77
10,000-15,000	7	8	5	4	4	28
>15,000	2	1	0	3	0	6
Number of practices	68	39	60	54	37	258
Total registered patients	373,715	251,016	299,119	272,236	217,000	1,413,086

FIGURE 2 - THE AVERAGE NUMBER OF PATIENTS PER PRACTICE VARIES FROM UNDER 5,000 IN ENFIELD TO ALMOST 6,500 IN CAMDEN:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

FIGURE 3 - A MORE DETAILED ANALYSIS SHOWS THE VARYING NUMBER OF PATIENTS REGISTERED BY SIZE OF PRACTICE:

Number of patients by practice Size at 1 July 2011	Barnet	Camden	Enfield	Haringey	Islington	Totals
Practices <2,000	16,148	4,541	6,878	8,424	3,959	39,950
% of total patients	4%	2%	2%	3%	2%	3%
Practices 2-5,000	89,126	63,356	121,098	87,331	44,714	405,625
% of total patients	24%	25%	40%	32%	21%	29%
Cumulative	28%	27%	43%	35%	22%	32%
Practices 5-10,000	158,129	68,078	112,386	82,142	120,588	541,323
% of total patients	42%	27%	38%	30%	56%	38%
Cumulative	70%	54%	80%	65%	78%	70%
Practices 10-15,000	76,949	96,759	58,757	45,843	47,739	326,047
% of total patients	21%	39%	20%	17%	22%	23%
Cumulative	91%	93%	100%	82%	100%	93%
Practices >15,000	33,363	18,282	0	48,496	0	100,141
% of total patients	9%	7%	0	18%	0	7%
Cumulative	100%	100%	100%	100%	100%	100%
Total registered patients	373,715	251,016	299,119	272,236	217,000	1,413,086

From Figure 3 we can see that:

- Fewer than 40,000 patients (ie 3%) in North Central London are registered in practices which have fewer than 2,000 patients, with the largest number (16,000) in Barnet (but still only 4% of Barnet total)
- 43% of Enfield patients are registered in practices with fewer than 5,000
- In Islington, the comparable figure is 22%
- In Camden, 46% of patients are registered in the larger practices with over 10,000, compared with the North Central London average of 30%
- Across North Central London there are six practices with over 15,000 registered patients and three of those are in Haringey, accounting for 18% of their total patients.

FIGURE 4 - NUMBERS OF DENTISTS, OPTOMETRISTS AND PHARMACISTS

April 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Dental Practices	70	42	44	51	23	230
Optometrists	88	77	72	33	53	323
Pharmacies	71	65	61	56	46	299

3. The case for change

"Why do we need to change?"

In July 2011, recognising the need for more fundamental and transformational change, Dr Douglas Russell, NHS North Central London Medical Director of primary care, produced a discussion paper titled "Starter for 10 - NHS North Central London case for a primary care strategy" to frame a further discussion about the need to develop a new primary care strategy for the five boroughs of north central London. He set out the argument for the definition and measurement of both activity and quality before engaging in a developmental programme with primary care contractors and concluded:

> "We need to engage the clinical leadership with a new vision of a transformed, supported and developed high quality GP and primary care landscape across the whole cluster attracting and retaining the highest quality staff, both clinical and support. There are a set of core documents published recently that fill out a lot of background detail and evidence of the vision of what we would like to achieve over the next five years, from sources such as the Royal College of General Practitioners, Kings Fund, Information Centre, Primary Care Commissioning. The King's Fund report on "Improving quality in general practice" is a key resource document."

There is a common theme that five years ago most strategies were looking to develop care pathways based on hub and spoke models. Healthcare for London led to most plans being re-packaged as polysystems, including new-build locality centres. Over the past year, without any new build financing, plans have been modified to take account of the original hub and spoke model plus any polysystem developments that were approved.

Undoubtedly, the strategic focus and planning over the past five years has been premises-led. However, despite the elaborate planning, implementation has been slow. Strategically the picture across NHS North Central London has not changed dramatically.

Everything in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield and Haringey Clinical Strategy. First developed in 2006, it has now been ratified by the Secretary of State and implementation has recommenced. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

Any new developments in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield and Haringey Clinical Strategy, which was given the green light for implementation by the Secretary of State for Health in September 2011. We are in the process of developing an integrated implementation plan which will recognise the close relationship between the two strategies and bring together the work to implement each.

The Primary Care Strategy supports delivery of better services in Camden and Islington as well as Barnet, Enfield and Haringey and, while there have been many recent developments in primary care in each of the five boroughs, many more are being developed or are planned. We will make the changes in hospitals when clinicians tell us that the primary care system is sufficiently developed to provide better and safer care than in hospitals.

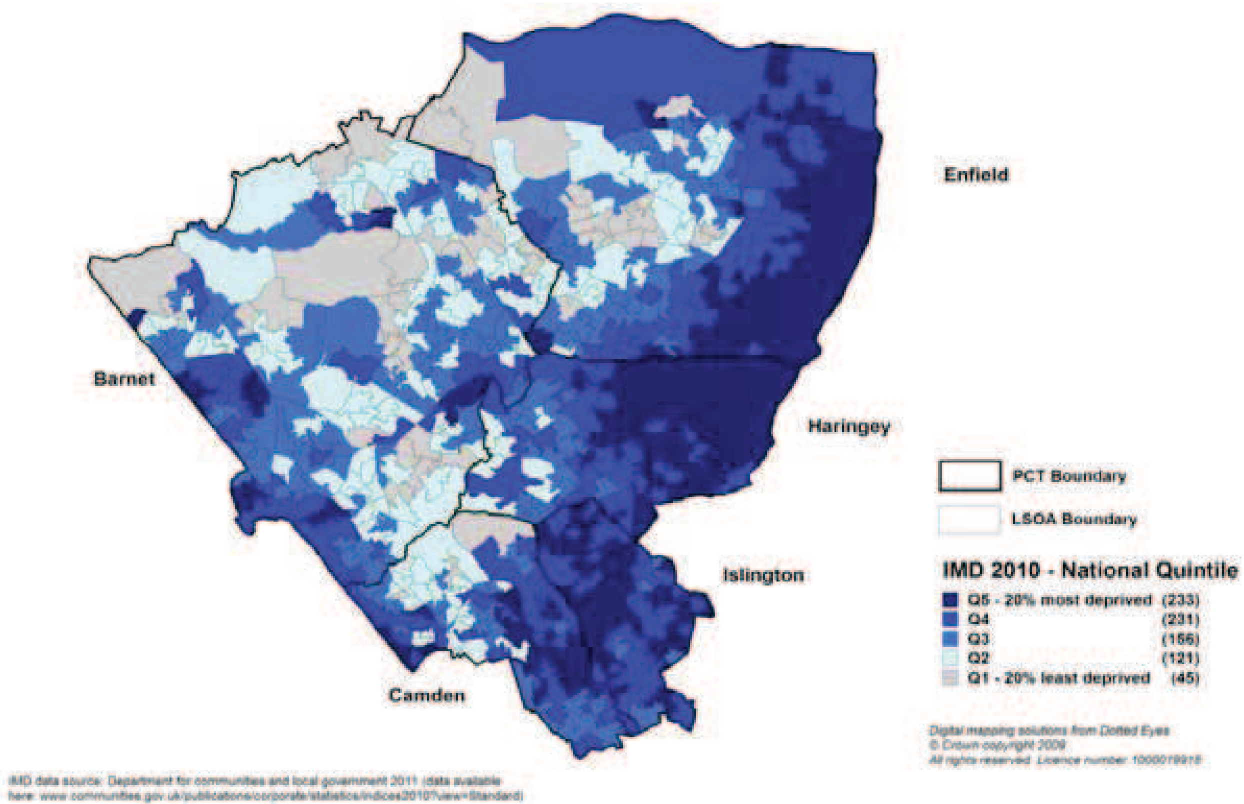
At its best, Practice Based Commissioning has tended to focus on pathway redesigns and has delivered improvements in some areas, but it has been variable across North Central London.

DEPRIVATION

There are significant differences in levels of deprivation between NHS North Central London's boroughs as well as marked differences within the boroughs.

In general, deprivation in North Central London increases as one goes from west to east, with the greatest concentrations of deprivation across most of Islington, the eastern half of Haringey, eastern edge of Enfield and parts of Camden.

IMD 2010 national quintile of overall deprivation score by North Central London sector LSOAs



LIFE EXPECTANCY

At 76.0 years, the male life expectancy at birth in Islington was the lowest in London, and in Haringey (at 77.4) was also significantly below the national and London averages. Enfield (79.5) and Barnet (80.4) were significantly above. The rate in Camden (78.5) was in line with the national and London rates, however there is a 10-year difference in male life expectancy between the south and north of the Borough.

Female life expectancy is generally higher than that for males. Whilst Islington's female life expectancy of 81.4 is significantly below the London average, Enfield's of 83.0 is not. Barnet's life expectancy of 84.4 is above both London and national averages, whilst Camden (83.8) and Haringey (83.7) are in line with London but significantly above the England average.

For both men and women, deprivation and lifestyle factors account for much of the difference in life expectancy between and within boroughs.

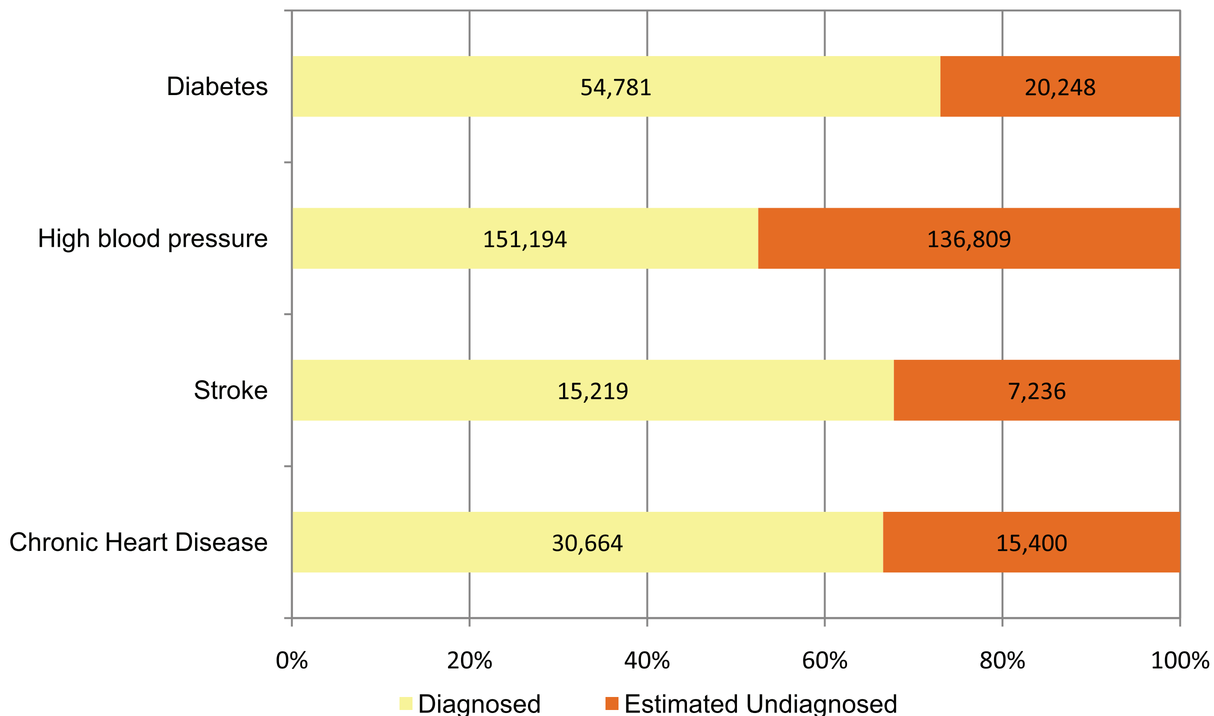
MORTALITY

There are approximately 8,000 deaths per year in North Central London. The three leading causes of death - cardiovascular disease (CVD), cancer, and respiratory disease - account for approximately 75% of all deaths, including 70% of all premature deaths (deaths under the age of 75).

PREVALENCE OF LONG-TERM CONDITIONS

There is significant under-diagnosis of long-term conditions across NHS North Central London, therefore many individuals cannot benefit from prevention and early intervention, resulting in poorer long term outcomes, higher use secondary care (including for emergency care). This includes cancer, chronic obstructive pulmonary disease (COPD), HIV and the following estimates of undiagnosed cases of diabetes, high blood pressure, stroke and coronary heart disease (CHD).

NUMBERS WITH LONG-TERM CONDITIONS – DIAGNOSED AND ESTIMATED UNDIAGNOSED. NORTH CENTRAL LONDON 2009/10



LIFESTYLES AND PREVENTION

There is some evidence to show that those living in the most deprived areas of London are likely to have a concentration of people with lifestyle choices which can be changed such as alcohol intake or smoking.

- Smoking is responsible for 20% of deaths in the sector
- Obesity is strongly linked to diabetes, cardiovascular disease and cancer. Over 200,000 adults are estimated to be obese (estimated to be below national levels)
- Physical activity. Nearly a million people across North Central London are considered not to be engaging in sufficient physical activity. Adult physical activity levels are above the London average in Camden and Haringey, but lower in Barnet, Enfield and Islington
- Alcohol. Across North Central London, less than 5% of the 54,000 estimated harmful drinkers are in treatment, ranging from 2.2% in Enfield to 8.7% in Islington
- Health Checks. Across North Central London, 16,744 people received a health check in 2010/11, 4.2% of the eligible population (though 13% was achieved in Islington).

Quality in NHS North Central London Primary Care - How can we really measure true quality?

> "Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality in general practice"
> (Improving the quality of care in general practice The King's Fund March 2011)

We have had Balanced Scorecards (five very different), Quality and Outcomes Framework (generally good), MORI Survey (not so good) and prescribing data. We have trialled and will be implementing the London-wide GP Outcomes Framework from April 2012.

OVERALL QUALITY AND OUTCOMES FRAMEWORK ACHIEVEMENT SCORES BY BOROUGH PCT 2010/11

Borough PCT	Number Practices	Exception Reporting	Number of Practices by overall QOF scores 2010/11 and % of total practices								PCT Ave
			<50%	50-80%	80-90%	90-93.3%		93.4-94.6%		>94.7%	
Barnet	69	4.5%	0	2	6	7	93.3 London Ave.	12	94.7 England Ave.	42	93.7%
			22%					17%		61%	
Camden	40	5.4%	0	1	3	6		8		22	93.8%
			28%					20%		55%	
Enfield	62	4.0%	1	5	12	15		8		21	90.4%
			53%					13%		34%	
Haringey	53	5.2%	0	5	6	11		6		25	92.0%
			42%					11%		47%	
Islington	38	6.0%	0	0	2	4		7		25	95.0%
			16%					18%		66%	
NHS North Central London	262		1	13	29	43		41		135	
			33%					16%		52%	
London		4.9%									
England		5.4%									

Better than London and England Averages

Better than London / Worse than England Averages

Worse than London and England Averages

Key points to note:

- 52% of NHS North Central London practices score higher than London and England averages
- Islington overall score higher than London and England averages
- Enfield and Barnet have low Exception Reporting

- 67% score higher than London average
- Barnet and Camden overall score higher than London

- One in three practices (86) score less than London average
- Of those 86 practices, 33 are in Enfield, equating to over half of the Enfield practices
- Enfield and Haringey overall score less than London average
- Islington has the highest Exception Reporting at 6%

MORI PATIENT SURVEY MARCH 2011

Overall Satisfaction Levels by Borough PCT

MORI 2010/2011 Scores	Satisfaction with care received	Recommending a GP surgery to someone moved into area
Results – England as a whole	89%	84%
London SHA	85%	77%
Barnet	85%	80%
Camden	83%	79%
Enfield	85%	77%
Haringey	81%	74%
Islington	85%	79%

Worse than England but better than London average	Worse than both England and London Average

On the two overall satisfaction questions, none of the boroughs achieve the England average, but Barnet, Enfield and Islington all equal or better the London average. Haringey fails to achieve the London average in both areas.

ACCESS

	Barnet	Camden	Enfield	Haringey	Islington	London	England
Ease of getting through on the phone	62%	63%	66%	65%	66%	67%	**69%**
No appointments available	84%	81%	84%	80%	83%	82%	**84%**
Times didn't suit	19%	20%	16%	17%	18%	18%	**15%**
Satisfied with opening hours	74%	74%	79%	76%	74%	78%	**80%**
Know how to access out of hours care	**56%**	**52%**	**55%**	**52%**	**52%**	**54%**	**62%**

Source: GP Survey 2010/11

PRIMARY CARE CONTRACT COSTS (SEE APPENDIX A FOR FULL ANALYSIS)

These costs are provided to illustrate the variations across NHS North Central London. A key issue from this data is that there seems to be no direct correlation between costs and outcomes.

General Practice

- Total GP costs range from £119 per capita (Barnet) to £140 (Camden).
- Total costs per practice range from £606k (Haringey) to £898k (Camden)
- General Medical Services contract costs are from £104 per capita (Haringey) to £124 (Camden)
- Ignoring Islington with only two PMS practices, PMS contract costs are from £128 (Haringey) per capita to £168 (Barnet)
- Barnet GMS contract costs are £109 compared to PMS contract costs of £168 per capita.

Dental, optometrists and pharmacists contractor costs:

- Total dental, optometrist and pharmacist contractor costs per capita:
    - Dental from £38 (Islington) to £56 (Haringey)
    - Optometrists from £6 (Islington) to £10 (Barnet)
    - Pharmacists from £19 (Camden) to £26 (Barnet).

- Number of dental contractors varies from 23 (Islington) to 70 (Barnet)
- Haringey dental costs are an outlier at £56
- Number of optometrists in Haringey is only 33
- Optometrist costs per capita from £6 (Islington) to £10 (Barnet).

Total costs of all independent contractors range from £184 (Islington) to £215 (Enfield), while prescribing costs range from £101 (Camden) to £160 (Barnet). The data on Astro PU costs indicates a range from £21.94 (Camden) to £25.47 (Barnet).

In summary, the quality and accessibility of primary care is variable across North Central London as a whole and within borough PCTs. Primary care has a pivotal role to play in reducing use of secondary care for basic healthcare provision, as well as improving population health. Radical change is required to develop primary care capacity and capability and ensure higher quality and productivity in primary care.

4. The future landscape of primary care - A patient's perspective

"This is how we want it to be"

A patient's view of what primary care in North Central London will be like in the year 2016 in the boroughs of Barnet, Camden, Enfield, Haringey, and Islington.

Hi - I've just moved into the area and I'd like to find out about what's available to me from the local NHS. I've got friends who used to live in North Central London back in 2011 and they've told me some worrying stories about how variable the availability and quality of primary care used to be. Apparently it was something of a lottery with many really good general practices and some, allegedly, barely fit for purpose. At its very best it was fantastic and compared well with anywhere in the country. At its very worst, you could experience any or all of the following:

- Great difficulty in finding a practice with which to register
- Not being able to get through on the phone to make an appointment
- Very difficult to get an appointment suited to your lifestyle
- Unwelcoming reception staff
- Premises in poor condition, not clean and very uncomfortable
- Despite having an appointment, you often had to wait ages to see the doctor
- When you did get to see a doctor, apparently some of them didn't know anything about you as a person, didn't seem to have relevant history notes and didn't really sort out the problem.

I understand at that time too many patients took the easy option of going to the urgent care services – A&E, Walk in Centres and Urgent Care Centres. That can't have been the best solution for them or the NHS.

So my first question is – has anything actually changed since 2011?

Welcome to North Central London from the primary care part of the NHS. Yes things have changed greatly for the better. You're right – back in 2011 it was a very variable quality service with some excellent practices side by side with some not-so-good. In those days the "better" practices (as perceived by patients) were sought after and couldn't cope with the rising demand.

Then in 2011/12 we introduced a primary care strategy and development plan to improve poor performance and to ensure that all of our practices now meet explicit high quality standards. It is only fair to say that many of them already did meet those standards back in 2011 and what we have done is to ensure that all patients can now get that high quality service.
So, firstly, we want to get you registered as a patient in our area, and we don't want you to wait until you actually need our services. We aim to make it as easy as possible. You may already have had an information pack from your estate agent or letting landlord, giving you details of our services and a range of different ways to register with us.

For online registration, go to our website and click on the "I want to register as a new patient" link and just follow the on-screen instructions on the application form if you want to send us your details in that way (please read the internet security caution).

If you don't want to register online, call in at any of our NHS-signed premises – doctors, pharmacies, optometrists, dentists, community-based health services or clinics - or at any of your local council offices, Job Centre Plus, Citizens Advice Bureau, Libraries, and some local estate agents. You do not need to bring anything with you and we'll get you signed up straight away. When you arrive at the practice we will ask you to sign the form as a legal requirement and that is it – you will be registered. At the surgery you will be able to find a complete list of all of the services available both at your base surgery and in the NHS and social care network locally. (All of this information will also be available via our website as well and is available in different languages). This will include:

A. NAMES AND ADDRESSES AND FULL INFORMATION ABOUT LOCAL GENERAL PRACTICES WITH THEIR RANGE OF SERVICES AND DETAILS OF THEIR STAFF AND OPENING TIMES

Generally speaking, you should be able to find a choice of practices within 20 to 30 minutes travel time from wherever you live in Barnet, Camden, Enfield, Haringey, or Islington. You can then choose the one that best meets your personal lifestyle preferences. Be assured that the quality of care is uniformly high at all of our practices, and that the differences in location, premises, size, opening hours, languages and/or translation service and the range of clinical services available on-site are the criteria by which we want you to choose, according to what suits you.

We know that many patients prefer a small practice where they will know, and be known by, all the staff. Because there are fewer clinicians it should be easy to get personalised continuity of care. But, depending on the range of services offered by that practice, sometimes it may mean that patients have to go to another nearby practice for care that cannot be delivered safely and effectively in every practice. We also know that other patients do prefer a larger "one stop" centre where they may not always know, or be known by, all the staff but a wider range of services may be available. It's really your choice!

B. AN OPPORTUNITY FOR YOU TO GET A CHECK-UP BY BOOKING A NEW PATIENT HEALTH CHECK AT THE PRACTICE OF YOUR CHOICE

We want to ensure that the practice gets to know about you so that it can work with you on your total health service. This opportunity will also be extended to your family members if you are also registering them. We understand that your time is valuable so as much detail as possible can be filled in online through a health questionnaire, and some of the detail can be filled in later, possibly at a self-check station in one of our community pharmacies or other NHS premises. If there are any gaps we will fill them in next time you come in. You will be able to access care straight away, but the more we know about you from the outset the better and safer it will be for you.

C. A LIST OF PHARMACIES IN YOUR AREA, WITH OPENING TIMES AND ADDITIONAL SERVICES

Our practices operate a "standing order" system of repeat dispensing of many medications, (with some exceptions) which means that you may not have to get a repeat prescription from your GP every time you need your regular medication. Do note that our pharmacists are able to provide advice and a wide range of services which could save you having to go to your doctor at all. These include general health promotion, dealing with minor illnesses such as colds, hay fever, allergies, tummy upsets, emergency contraception, travel advice, medicines advice, NHS Health Checks and some immunisations and smoking cessation. Plus lots more – it's all in the leaflet.

D. AN INFORMATION PACK ON THE FULL RANGE OF SERVICES AVAILABLE AND HOW TO ACCESS THEM, FROM DENTISTS AND OPTOMETRISTS

Dentists can provide advice on oral health, nutrition and smoking cessation. Optometrists can advise you on colour blindness, cataracts, glaucoma, "acute red eye" and early eye disease signs of some long term conditions. Again, full details of these and other services are in the leaflet.

E. ALSO THE INFORMATION LEAFLET WILL EXPLAIN HOW TO FIND YOUR WAY THROUGH THE LOCAL NHS WHEN YOU NEED US URGENTLY

We offer a range of urgent care services. The hospital accident and emergency department is reserved for the most serious cases. The majority of urgent care can be delivered by your doctor, pharmacist, dentist or optometrist. If you're not sure you can always phone us on 111, the NHS one stop phone number service, who will help you access the right people for your care.

Do be aware that if you do go straight to the hospital A&E, they may re-direct you back to your local primary care service for the type of care that you need. If you are unwell out of normal working hours, many of our surgeries offer extended opening hours including evenings and weekends. We have the 24 hour 111 telephone helpline and you can visit an urgent out of hours centre or, if housebound, a home visit is available for those who really need it. Remember, patients attending in person can be seen much more quickly than those on home visits.

F. DETAILS OF THE SOCIAL SERVICES AVAILABLE FROM YOUR LOCAL COUNCIL ARE ALSO IN THE PACK

This will include guidance on how to access those services and how they work in an integrated way with our primary health care teams and the voluntary sector.

SO, AS A NEW PATIENT, WHAT CAN I EXPECT FROM MY GENERAL PRACTICE?

Firstly, we can assure you that the premises will be fit for purpose, irrespective of the age and type of building. We have a mix of new and old, large, and small buildings; but they are all clean, bright, and tidy and will display only current relevant information about our services. The building will be accessible for all, including the disabled, and will conform to all health and safety requirements and be a safe environment. There will be a comfortable waiting area and all of our practices are child friendly, understanding the needs of both parents and children, at what may be a stressful time. All consulting and treatment rooms will be appropriate for their use, and there will be decent toilet facilities should you need them.

All practice premises are open and staffed, as a minimum, all day from 8am to 6.30pm Monday to Friday and some are open in the evenings and at weekends. When you contact them, you will be offered an appointment or telephone consultation with a healthcare professional relevant to your needs, which, depending on clinical urgency, may include same day access. From the information we sent you, you will already be aware of your choice of clinician, including gender and language preferences.

On arrival, the practice reception staff will be welcoming and you will be able to check-in confidentially, either face to face, or electronically. As a new patient, you will be introduced to our “Self care management and co-creating health programme” either face-to-face or electronically, to guide you through the things that you may find useful including:

- How to get your personal health profile
- Self-care and lifestyle advice
- Exercise on prescription
- Housing, benefits, employment, healthy foods and cookery advice
- Specialist advice on drugs and alcohol abuse
- Details of how to access all our services.

Your practice healthcare team will view you as a member of the local health community and will provide you with public health information about disease patterns, likelihood and symptoms. We know the expected patterns of ill-health in a community and can advise you on healthy living, prevention and early diagnosis. Health promotion and illness prevention is as much a part of our service as care and treatment.

AFTER MY INITIAL VISIT, HOW WILL I BE ABLE TO CONTACT THE PRACTICE?

Weekdays between 8am and 6.30pm, you can contact any of our practices by phone, online appointment booking or in person. Some of our practices are open until 8pm and at weekends. Occasionally, a practice may close for a half-day staff training session, but they will have arranged for a nearby practice or an urgent care provider to cover any patient needs.

We offer consultations with doctors and nurses face to face, by phone and sometimes by e-mail. When you enquire about making an appointment the practice will agree with you which is the most suitable option for you, or you can just book online, if you know which clinician you need to see.

If you prefer continuity of care, then practices will always try to offer you an appointment with the clinician of your choice. Sometimes, particularly if you require an urgent consultation, they will offer you an appointment with the first available clinician. If you sign up for our "Reminder" service, the practice will always send you a text message to your mobile phone 24 hours before your appointment. If you are unable to attend, please let us know immediately so that we can offer your slot to another patient.

Outside these surgery hours, please ring 111 for the Out-of-Hours Doctor Service.

Whichever type of consultation you have, and whatever the time of day or night, with your permission, we can arrange for your medical records to be available to the clinician so that they can see all relevant information. If you have an out-of-hours consultation, we will ensure that your registered practice is aware of it, and they will update your records accordingly within 12 hours.

WHAT SERVICES DO YOU OFFER THROUGH YOUR PRACTICES?

All our practices work within a local primary care network across a number of practices in a "natural community". The network principle is that you will always be able to access, within the network, all of the services that we offer as part of our guaranteed standard services list (see enclosed).

Every practice offers on-site, as a minimum, the range of core services that you would expect from any general practice. Some practices offer a wider and growing range of additional services. If you are registered with a practice that does not offer the full range of guaranteed services, you may have to attend another nearby practice in the local network for some of those services. Here are some examples of how the network functions:

- All practices offer a range of patient diagnostic tests in-house. If you need a blood test, then the sample may be taken in your own or a nearby network practice, and the samples sent away for analysis. You will then be able to contact the practice for your results within 72 hours and they will be available to you online on your health record
- Some practices offer more specialised testing, such as ultrasound scanning, for their own patients, and for those from nearby practices in the network
- If you require more specialist support and advice for a condition such as diabetes, your GP may refer you to attend an appointment with a diabetes GP or nurse locally in the network
- If you need more specialised diagnostics, such as an x-ray, your GP has direct access to order tests as required, usually within the borough.

The local primary care network includes a wide range of community–based clinicians known as the Extended Primary Health Care Team. The team will service the network patients across a number of practices. The services include:

- District nursing, including community matrons to help you plan and support you in your care
- Specialist nursing including school nurses, paediatric nurses and other clinical specialties
- Health visiting
- Midwifery
- Physiotherapy
- Podiatry
- Speech and language therapy
- Occupational therapy
- Primary mental health services, including psychology and a range of counselling and therapy services
- Social services care.

The local network includes a team of Integrated Care Clinicians who manage the care pathways, (how you move through the NHS during your treatment) liaising with the hospital specialists, community services and the network GPs to ensure rapid and effective delivery of the services along those pathways. Each network has differently skilled and specialised Integrated Care Clinicians according to local needs.

Communication between practices is usually electronic. Most practices use the same computer system, but those few who have a different system can still communicate with each other across the IT network. Practices are also able to communicate directly with other community-based clinicians and hospitals to ensure effective transfer of relevant patient information across organisational boundaries.

In line with national policy, you will also be able to log on to the same system to check your own health summary care record at any time. If you don't have a computer or smart phone available to you, you can use the surgery patient computer to check your records, make future appointments or re-order your medication.

In addition to the above services, all practices provide home visits for housebound patients. When appropriate, we can also offer some patients self-monitoring equipment to measure blood pressure, blood sugar levels and other routine regular monitoring tests. The clinicians will teach you how to use the equipment, what the results mean, how to care for yourself if your condition changes, and when to contact your healthcare team. Supported self-care is a key part of our total healthcare service. If you are a patient who has a full or part-time carer, this also includes support for your carer.

We are very pleased that children in North Central London rarely get measles. GPs have been working closely with the community in ensuring that over 90% of the children in our area have received their childhood immunisations. With this excellent coverage we have minimised the risk of children developing measles, mumps, rubella or tetanus, diphtheria, whooping cough and polio. You are no longer restricted to a specific clinic on a specific day as immunisations are offered in a range of settings.
We have also have excellent flu vaccination rates amongst our elderly and people with long term conditions, meaning there are less complications as a result of the flu.

Dentists, pharmacists and optometrists are all an important part of our primary care services and you can contact them directly. Our information pack will give you full details of your nearest practitioners and how to access them both routinely and in an emergency. Sometimes they will be co-located with our general practices or will be in nearby premises, offering a range of services to support your health and wellbeing.

Our GPs will only ever do what they know they can do safely in their own practice, and sometimes it will be necessary to refer you for further diagnostic tests and/or treatment. Your GP will be able to offer you a consultation locally, often with a specialist community-based service, or will arrange a hospital appointment for you. Our integrated care pathways mean that your GP, the community services and the hospital consultants can communicate electronically to share information and agree on the best course of action to meet your particular needs.

In addition to their role as specialist clinicians in the primary care team, our GPs are also the skilled navigators to guide you through the care system to ensure that you receive the right care, in the right place, first time.

WHAT IF I NEED TO GO IN TO HOSPITAL FOR AN OPERATION?

Our GPs will do as much as they can in primary care to avoid unnecessary hospital admissions. However, following your consultation with the specialist, if you and they decide that an operation is necessary, your GP will:

- Advise you on what to expect
- Offer you a choice of hospitals, if you wish to go elsewhere
- Have the technology to place you on the appropriate waiting list and be able to update you on your list status, as hospital waiting lists are now fully accessible by our GPs
- Increasingly, arrange for you to be a day case patient without any overnight stay
- Liaise with the hospital to ensure that, if you do stay in, it will only be for the minimum time and that they get you discharged as soon as it is safe to do so
- Have access to information to confirm that the hospital makes all parties aware of your discharge arrangements and discharge plan details
- Support your rehabilitation and convalescence at home or in a community setting
- Work with the hospital to arrange any follow up consultations with the most appropriate clinician, who may be the GP, the hospital consultant or another specialist clinician.

WHAT ABOUT PATIENTS LIVING WITH A LONG TERM CONDITION – HOW DO YOU MANAGE THAT?

A long term condition is one that will require monitoring and treatment over a long time such as asthma or diabetes. Firstly, we aim to achieve an early diagnosis of any such condition so that we can start treating it as soon as possible.

When a patient is first diagnosed with a long term condition, our practices will:

- Provide you with full educational information about your condition soon after diagnosis
- Introduce you to our nursing team who lead much of our long term conditions management
- Advise you of additional support services, which will often be patient groups or charities, who are expert in the management of your condition
- Agree a package of care with you based on your needs. This will include a written Care Plan with mutually agreed goals and periodic and annual reviews.
- Agree with you what you can do for yourself as supported self-care and when to seek the help of your healthcare team. We want you to become confident in managing your own condition as much as possible.

If you have a complex condition, or set of conditions, our team will appoint a named care co-ordinator, to work with you and the rest of the team. They will then help you to implement your Care Plan; you will have one integrated plan, not many disconnected ones.

All community members of our teams have modern technology, including telephones with GPS navigation, so that colleagues can locate them and they can locate you as quickly as is necessary. You will also be able to e-mail and text them whenever you need to do so. Our staff will respond as soon as they can within time periods that we will publish and on which we will be monitored on.

The primary care team is professionally integrated with specialist hospital consultants, who can advise the team, and you, on your individual case management as well as providing ongoing education, training and clinical supervision. Occasionally, the team may decide that you need a review with the consultant and will offer you an appointment. The team will aim to provide you with as much of your routine care as close to home as possible.

WHAT SERVICES DO YOUR PRACTICES OFFER TO PREGNANT WOMEN?

Hopefully, your practice will already know you and have offered you pre-conception advice as part of our normal service. The practice will want you to confirm your pregnancy as early as possible and can advise you on locally available pregnancy testing. Then, at no later than 12 weeks, they will offer you, and your partner, a range of ante-natal services including exercise and parenting classes. Our team of midwives will work closely with you and your GP to monitor your pregnancy and to support you in a safe birth including your choice of birth settings.

After the birth, the practice team of doctors, nurses, midwives and health visitors will provide additional support services for the first two years. This will include:

- Post-natal classes

- Immunisations
- Child development monitoring
- Parenting skills support
- Ongoing conception advice.

WHAT IF I HAVE FAMILY MEMBERS WITH SPECIAL NEEDS?

The specific needs of the patient groups concerned are reviewed against the latest evidence and take advantage of shared knowledge from consultants, specialist nurses and therapists across the wider primary care team based in a highly integrated way rather than in a purely reactive way.

For example with patients with learning disabilities, who as a group have significantly reduced life expectancy, the network and each individual practice are fully up to date with the special needs of each registered group with ready access to the appropriate expertise and advice. They also identify individuals at increased risk and agree individual care plans with the patients, and where appropriate, their carers.

WHAT SUPPORT CAN YOU OFFER ME IF I AM DIAGNOSED WITH A TERMINAL ILLNESS?

It is important that your GP knows your wishes for your care soon after your diagnosis. They will then develop a Care Plan with you based on the Macmillan Gold Standard Framework (GSF) for end-of-life care. In addition to your GP, our extended primary health care team will help to look after you and support and advise you on your options requiring decisions.

Through the team you will have direct and speedy access to specialist clinicians most qualified to advise on your care.

WHAT ABOUT THE RISKS OF CANCER?

In spite of significant advanced of treatment in cancer, UK survival rates remain disappointing compared to Europe. But we know that much of this difference is accounted for by the differences in one-year survival and that strongly suggests that delayed diagnosis is a significant contributory factor.

Therefore, all our practices take a multi-strand approach, firstly to prevent, and secondly to diagnose as early as possible through:

- Continued emphasis on prevention (smoking cessation, reducing obesity, healthy diet, regular exercise)
- Improving the uptake of screening
- Targeted social marketing to increase awareness and encourage earlier presentation by patients
- Clinician awareness of early presenting features suggesting possible cancer.

WILL I STILL HAVE A GP IF I HAVE TO GO INTO A NURSING/RESIDENTIAL HOME?

You'll certainly have access to the full range of services that we've described. We have contracts with selected practices to provide primary care services to the nursing/residential homes in our area and they have particular knowledge and experience in meeting the needs of those residents. So you'll be able to choose whether to stay registered with your existing practice or whether to transfer to one of those other practices.

WHAT ABOUT PRESCRIPTIONS AND MEDICINES – HOW DOES THAT WORK?

For those patients who need repeat prescriptions such as those for long term conditions or oral contraception, our practices operate a "standing order" system of repeat dispensing of prescriptions (with some exceptions), from your named pharmacy, without the need to request a repeat prescription from your GP. The pharmacist is an expert in medicines management and will advise when you need to see your doctor again for a review of your clinical condition.

Your pharmacist runs a New Medicines Service. When you are prescribed new medications, they will spend time with you teaching you about the new medicine. Many patients say that they find this service really helpful in understanding their new medicines.

Your pharmacist is also available to advise you on any side-effects or concerns that you have arising from your medication and will consult with your doctor about any recommended changes.

HOW DO YOU ASSURE THE QUALITY OF YOUR GPS TO KNOW WHETHER THEY ARE DOING A GOOD JOB FOR THEIR PATIENTS?

In accordance with best practice, we define and monitor the quality of primary care under three headings - patient safety, clinical effectiveness and the experience of patients.

The NHS in London, working with GPs, has developed a set of standards, often known as indicators, for GP practices which give you the information you need to make decisions about your healthcare.

There are 22 standards, covering areas like diagnosis, screening, vaccinations for children, and ease of getting appointments, making it easier for you to:

- See how effective your GP services are in areas of healthcare that matter to you
- Understand what your practice is doing to meet the healthcare standards required by you and your family
- Make a decision about registering with a practice that best suits your particular needs.

You can compare the performance of individual practices on the Myhealthlondon website.

All practices have to be registered with the Care Quality Commission (CQC).

All our GPs are committed to ongoing professional development. They all have written personal development plans, and take part in an annual appraisal of their performance with a qualified GP appraiser. They attend regular education and development programmes on key GP skills. Since 2012/13, all GPs have been required to apply for professional revalidation every five years. Many of our practices are also qualified to train new GPs.

In addition, GPs arrange for their practice staff to attend regular professional development training and education programmes suitable to their role. In addition to professional clinical training for our clinicians, this includes customer service training for our reception teams. Our practices aim to build a culture of high standards of clinical care and service.

As part of all of the above there are a number of contractual measures by which we assess the overall quality of service provision by our primary care colleagues.

We encourage a culture of incident reporting and group learning. Our practices actively seek and welcome feedback from patients on their experience of services, and view complaints as an opportunity to improve services. For that reason ask you to speak directly to, or send any complaints to, the Practice Manager at your registered practice. They will acknowledge your complaint within 48 hours and keep you advised of progress.

If you are unhappy with any aspect of the service that you have received, but don't want to engage directly with the practice then please contact our Patient Advice and Complains Service (PALS).

We undertake regular patient surveys at all practices and the results are published on our website. In addition, patients can go on to the NHS Choices website practice page and leave comments about their experience. Practices are required to develop action plans to address any areas where potential improvements have been identified.

Many of our practices engage directly with their patients through Patient Participation Groups. These provide a forum for local feedback and improvements by practice users.

We also engage in more formal public involvement through Local Involvement Networks (LINks, or their successor HealthWatch), the independent consumer organisation. They have the statutory right of entry to visit the premises of service providers and to report their findings.

Our aim, and that of all our practices, is to offer you a high quality primary care team service, linked, when necessary to more specialist services; all of which will enable you to live the best possible lifestyle in respect of your personal health and wellbeing.

5. Transformation Strategy

"This is what we're planning to do to make it happen"

NHS North Central London

The "Future landscape of primary care – a patient's perspective" in the previous chapter is our aspiration for the future. Many practices are already delivering some of that vision. We want to raise the standard across the board so that all patients have access to the very best in primary care.

The rest of this document describes our plans to transform primary care over the next five years to make the aspirational future landscape a reality. This section sets out our transformation strategy, explains our thinking and identifies specific areas for investment.

Addressing quality, safety and improving patient experience are key aims in the North Central London primary care strategy. This strategy recognises that transformational changes are needed to support the development and capacity of primary care, and describes the steps towards implementing that transformation. It will take time and resource. We want to work with our independent contractors to motivate, incentivise and support them on the transformational journey. But we will also manage their performance to ensure that our contractors do deliver those higher standards of quality, safety and patient experience.

The strategy aims to improve the quality, capability, capacity and productivity in primary care. The focus will be on promoting health, wellbeing and illness prevention and addressing our health inequalities. It will enhance patient experience and outcomes by improving clinical and service quality and life expectancy. Operating across the traditional boundaries it will begin to integrate the delivery of care, reduce the variation between practices, and increase the number of people registered with a GP in a way that is culturally appropriate.

We recognise this will need upfront investment. As part of this strategy, we are submitting a Business Case to NHS London for three years of pump-priming financial investment to cover additional and/or double running costs. At the end of three years, we anticipate that the savings in acute care will more than cover the then ongoing recurrent higher costs of primary care. This is set out in the strategic cost/benefit analysis in Section 9. We are proposing nine strategic investment domains:

1. Integration
2. Clinical services
3. Information technology

} = Integrated Care Network (items 1–3)

4. Public Health
5. Premises
6. Productivity
7. Workforce, leadership and team development
8. Commissioning
9. Communications.

STRATEGIC DOMAIN 1 - INTEGRATION

The long term aim is to overcome organisational boundaries and to replace them with networks of service delivery along care pathways. There are five identified levels of integration:

1. PRACTICE TO PRACTICE.

Individual GP practices grouped geographically into networks of natural communities of registered patients. Each practice will retain its own GMS/PMS contract for delivery of core services. The network (or a nominated lead practice) will contract by "Super local enhanced service" (or possibly alternative provider of medical services) to provide all additional services on a guaranteed list, and decide at which locations the services will be available. In some networks, all practices may choose to provide all services. The patient guarantee is that all patients within all networks will be able to access the same guaranteed primary care services, which will address the previous issues of inequity of provision.

2. EXTENDED PRIMARY HEALTH CARE TEAMS ATTACHED TO THE GP NETWORKS PROVIDING THE STANDARD RANGE OF COMMUNITY SERVICES.

This can be facilitated by Clinical Commissioning Groups specifying and commissioning community services as complete teams.

3. INTEGRATION AT APPROPRIATE POPULATION LEVEL (BASED ON DISEASE PREVALENCE), OF ALL SERVICES – AND INCREASINGLY MOVING TO NON PAYMENT BY RESULTS (PBR) TARIFF "WHOLE PATHWAY" FUNDING.

The integrated pathway will include specialists and additional clinical resources drawn from a local Clinical Pathway Pool comprising:

- Lead experienced GPs working on a part-time sessional basis (replacing the current sessional lead GP arrangements)
- "Open doors" specialist long term conditions nurses/allied health professionals recruited from secondary care to liaise with the hospital specialists, community services, GPs and practice nurses to ensure rapid and effective delivery of the services along those pathways
- Recent post-graduate GPs to provide flexible, additional capacity in the network
- Other community specialist clinicians as required.

The Pool will be borough-wide and will be designed by the network practices. It could be populated by clinicians from practices, community services, acute services, voluntary sector and other expert organisations. Each network will have a budget to buy in resources as required from the Clinical Pathway Pool on a not-for-profit basis.

The combined network budgets in a borough will pay for the total resources in the pool. Payment will be made to the employing organisation who will informally lend clinicians into the pool, either full or part time in line with demand. If, as expected, local practice GPs wish to become part of the pool, their practices will be reimbursed from the pool budget.

The design and operation of the networks and Clinical Pathway Pools will require more development. We want to work with GP colleagues to create the most effective models for each network.

4. INTEGRATION BETWEEN HEALTH AND ENHANCED SELF CARE AND SOCIAL CARE.

We want to build the a personal network around individual patients, combining the right level of professional input from both health and social care, with pro-active support for the highest level of self care suitable to individual circumstances.

5. INTEGRATION WITH ACUTE SPECIALIST

Input may include:

- Fewer and highly selective face-to-face individual patient consultations (might still be in a hospital setting or a community based consultation)
- Case based discussion of selected individual cases using records and data in multi-disciplinary teams occurring on a regular basis
- Sharing of knowledge, teaching, research findings, new drugs, new interventions and new technologies
- Clinical governance, clinical audit, clinical supervision of network clinical leads
- Outcomes /metrics management of one network compared with another using dashboards data, and within networks with outlier individual practice(s)
- Outreach to support poorly performing networks.

STRATEGIC DOMAIN 2 - CLINICAL SERVICES

People are living longer, but rather than being healthy for longer with the same health issues and costs concentrated at the end of life, they are tending to develop long term conditions earlier in life and live with them for longer, with physical and mental health problems for many years consuming ever escalating costs of health resources.

It is unusual to have a single long term condition, the majority of patients have more than one, often inter-related conditions most of which are linked to or exacerbated by lifestyle choices, which in turn are linked to deprivation and lower income. These lifestyle factors include smoking, obesity, physical inactivity, excessive alcohol intake and poor diet.

Diseases include diabetes (type 2), coronary heart disease, hypertension, stroke, COPD, heart failure, renal impairment, liver disease, muscular-skeletal problems, degenerative joint disease, chronic pain, depression and anxiety. Traditional primary care has tended to address these problems at the level of the individual in a reactive way that has often been centred on the clinician rather than the patient and certainly not on the population.

Our ambition is to transform this to a much more proactive, population view, patient centred service based on a transformed approach to health status monitoring of the population and

much earlier and more patient friendly interventions. The Kings Fund Report describes the required change:

> "The required modernisation agenda for general practice has been described in the United States as 'the transformation from cottage industry to post-industrial care'. This is because it combines three key elements – standardising care, measuring performance, and transparent reporting – and eliminates unwarranted clinical variation, waste, and defects.
>
> "At its heart, general practice in much of England remains a cottage industry, and we believe that this must change radically."

The King's Fund Report also describes the changing role of the GP:

> "General practice needs to see itself at the hub of a wider system of care, and must take responsibility for co-ordination and signposting to services beyond health care – in particular, social care, housing and benefits.
>
> "General practice needs to move from being the gatekeeper to specialist care to being the navigator that helps steer patients to the most appropriate care and support.

Combining this redefinition with all the other component parts of this strategy, it all adds up to what may be a significant culture change for many GPs. However, our intention is not to create any contractual changes. We are seeking to promote a change in "how things are done" rather than "what is done".

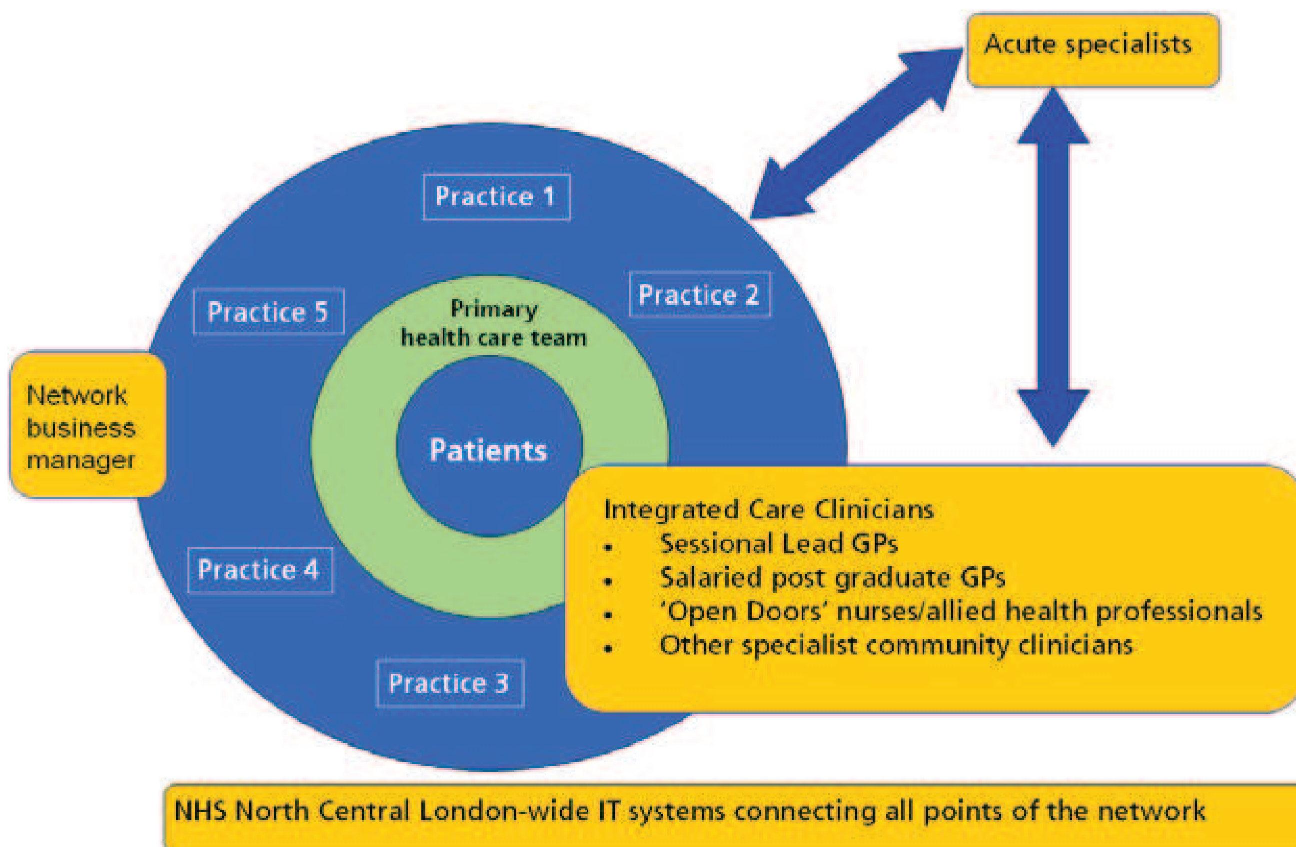
This will be achieved through an education programme, based on the King's Fund Report, designed to support GPs in becoming system navigators whilst retaining the essential parts of their traditional role as gatekeeper.

STRATEGIC DOMAIN 3 – INFORMATION TECHNOLOGY

This is a major theme which will require significant investment. The ideal end state will be to have all health care providers able to share patient records and to communicate electronically directly with each other to ensure that individual patient needs are met. We intend to commission an interactive web-based clinical information management network across NHS North Central London.

The first three domains, as described above, are combined together to create an Integrated Care Network (ICN). We are offering an example of what an ICN may look like but the actual design will be determined by each network.

WHAT MIGHT AN INTEGRATED CARE NETWORK LOOK LIKE?



STRATEGIC DOMAIN 4 - PUBLIC HEALTH

Public health intelligence is vital to health care planning. We want each network service delivery unit to have tailored disease-specific prevalence data by practice for their area. Each network will then be able to take a more proactive population view, using public health status monitoring of the population. The target will be to address health inequalities by closing the gap between expected and actual prevalence.

STRATEGIC DOMAIN 5 - PREMISES

Rather than focusing on premises-led strategies, primary care providers must now focus on the quality of clinical care, patient pathways or packages of care, and patient experience, where premises will be an essential enabler. Practice size will not be an issue but delivery of high quality care and patient experience will be.

Traditionally there has been an overlapping relationship between PCTs as both commissioners and often as landlords, and GPs as both service providers and as tenants. This dual role for PCTs will end when PCT-owned premises are transferred to providers, leaving the NHS North Central London cluster PCTs as purely primary care commissioners and

contractors. It is this role that will then transfer to the NHS Commissioning Board in April 2013.

NHS North Central London intends to commission only high quality primary care as defined in the strategy. In support of this aim, the primary care strategy will include the following principles relating to practice premises:

- If any practices in unsuitable premises are unable to achieve the premises quality standards, but wish to remain as contracted providers, NHS North Central London may require, and will support them, to relocate within a given time period. If they are unable to improve or find suitable alternative premises, NHS North Central London may require them to move into NHS-owned premises on a resource-sharing basis, subject to NHS landlord approval.

- If any practices in unsuitable premises are unable to achieve the required quality standards and decide to exit from provision, NHS North Central London will not necessarily replace them like for like.

- If any practice wishes to relocate and the relocation will impact on the GMS cost/rent reimbursement, then NHS North Central London will require a business case to be submitted before the relocation occurs. Providing the business case meets the required quality delivery markers, NHS North Central London will approve the financial reimbursement.

- NHS North Central London, in the role of primary care commissioners, is not responsible for providing or maintaining premises for independent contractors. However, after many years of supporting general practice through primary care premises development programmes, NHS North Central London recognises the mutual benefit to be gained from premises improvements. We intend to invest in additional premises management expertise to work with GPs who are proactively seeking renovation or relocation. We will seek to appoint and/or contract with entrepreneurial business development specialists who can work with GPs to put together innovative commercial development projects.

- Premises developments have both capital and revenue implications. It must be assumed that there will some, but limited, NHS capital for new premises. NHS North Central London will welcome innovative schemes from stakeholders to create new and/or modernised premises for GPs and primary care teams. This could include third party developers, GPs, other independent contractor groups, local authorities and not-for-profit organisations. Development planning gain may present opportunities. Normal NHS rent reimbursement arrangements will apply, but in order to manage the cost pressures on revenue, all such developments must demonstrate value for money and will be subject to the prior approval of business cases by NHS North Central London.

STRATEGIC DOMAIN 6 – PRODUCTIVITY

Access is always reported as a key issue for patients, although they are often prepared to trade-off immediate availability in order to receive continuity of care, particularly with long term conditions management. The reality is that both access and continuity are dependent on the ability of a practice to balance demand and supply. Some years ago much work was done on balancing through programmes such as Advanced Access. But it is not a one-off adjustment – it must be continuously refreshed.

We propose to undertake a programme to audit access and create improvements by supporting system redesign where necessary. This will include defining the number of GP and nurse appointments that should be available in every practice to meet the reasonable needs of their registered population – in line with the national GP contract.

We also propose to invest in general practice productivity improvement programmes and we will encourage and incentivise practices to take part in, for example:

- "Improving access, responding to patients - A 'how-to' guide for GP practices" (Practice Management Network- August 2009)
- The RCGP Practice Accreditation award
- The Productive General Practice programme "Releasing Time" from the NHS Institute for Innovation and Improvement
- "Doctor 1st" Telephone Access.

STRATEGIC DOMAIN 7 - WORKFORCE, LEADERSHIP AND TEAM DEVELOPMENT

The (re)establishment of the extended primary health care team will require leadership and team development to focus on:

- Agreeing roles and responsibilities
- Sharing clinical skill sets
- Understanding network accountability
- Defining the challenges and opportunities in the network
- Creating a shared vision for the network
- Agreeing on who will deliver what, where and when
- Metrics reporting.

In addition there will be topic-specific development programmes for GPs, practice nurses, practice managers and reception staff, covering clinical and non-clinical skills development.

STRATEGIC DOMAIN 8 – COMMISSIONING

It is clearly understood that primary care contracting and performance management will be the responsibility of the new NHS Commissioning Board. However, Clinical Commissioning Groups (CCGs) will have a role to play in primary care commissioning, when as the strategic commissioners, they will want to define their expectations of primary care services. This will include decisions on specifying Local Enhanced Services (LES) to be contracted by the NHS Commissioning Board. This primary care strategy also requires CCGs to commission

community services on a network team basis. It is also likely that CCGs will want to shift the provision of some services from hospital to a community setting and will seek bids from primary care contractors to provide parts of, or whole, new pathways.

In this way, with CCG leadership, investment will be redirected from secondary to primary care.

STRATEGIC DOMAIN 9 – COMMUNICATIONS

We will invest in a communications programme designed to inform the public about primary care services available to the population and how to access them as easily as possible. This will be combined with self-care and healthy living advice.

6. Managing the Transformation

"Making sure that the right things are done well"

NHS North Central London

Having provided the investment to create the transformation, for implementation, NHS North Central London has a duty to ensure that the investment is spent as intended and that it delivers the desired results. We have already stated that our intention is not to create any contractual changes. We are seeking to promote a change in "how things are done" rather than "what is done".

We are therefore proposing a mutually beneficial investment in primary care which requires independent contractor practices to achieve explicit quality standards of inputs and outcomes in return for the financial investment. Our message to our independent contractors is "If you do these things well with our investment, then together we will achieve the desired outcomes". This section now focuses on defining and monitoring the inputs and actions that are required to implement the strategy.

STANDARDS BY STRATEGIC DOMAIN

DOMAIN 1 - INTEGRATION

- To be signed-up member of the local practices network
- Explicitly connected into the local Integrated Care Network
- Full participation in a Primary Health Care Team development programme.

DOMAIN 2 - CLINICAL SERVICES

- To provide as a practice, or jointly provide within the network through a Super LES, the full range of additional services in line with the patient guaranteed list
- Set up repeat dispensing arrangements with pharmacies
- Produce and manage long term conditions care plans, including self-care
- Produce and manage MacMillan GSF Plans
- Participation in patient surveys and development of improvement plans based on those surveys.

DOMAIN 3 – INFORMATION TECHNOLOGY

- Switch over to the NHS North Central London web-based system within the required timescale
- Install patient self check-in system
- Provide a designated patient computer terminal
- Have a practice website with online appointment booking and electronic repeat prescribing
- Patient access to health care records in line with national policy.

DOMAIN 4 - PUBLIC HEALTH

- Proactively use the network/practice disease profiles to case find and maintain practice disease registers
- Plan services as part of the network based on the disease profiles and create plans to improve population health including measurement of outcomes.

DOMAIN 5 - PREMISES

- Health and safety compliant
- Disability Discrimination Act compliant
- Care Quality Commission ready
- NHS external signage
- Internal cleanliness and patient friendly
- Patient toilet facilities.

DOMAIN 6 – PRODUCTIVITY

- Undertake access audit/improvement programme
- Offer agreed number of appointment slots per week/month/year based on access audit calculations *
- Take part in a productivity improvement programme
- Practice opening hours minimum 8am to 6.30pm *
- Same day urgent access available *
- SMS text reminder service.

* There will be no additional funding for these elements, which are already funded as part of the GP contract.

DOMAIN 7 - WORKFORCE, LEADERSHIP AND TEAM DEVELOPMENT

- Full participation in all GP/practice manager/practice nurse/receptionist training and development programmes
- Undertake appraisals
- Achieve revalidation.

DOMAIN 8 - COMMISSIONING

- To be a signed-up member of the Clinical Commissioning Group.

DOMAIN 9 – COMMUNICATIONS

- To display and distribute all NHS North Central London patient literature.

CONTRACT PERFORMANCE MANAGEMENT

All independent contractors are subject to routine contract performance management of their practices against national/local contracts. It is this function that will transfer from NHS North Central London to the new NHS Commissioning Board. This strategy does not propose any changes to the agreed national contract and performance management requirements.

In addition to existing contracts, and where required, Integrated Care Networks will be held accountable by Super LES contracts for their delivery of the guaranteed services in their network. Borough teams will be involved in the setting up of non-core contract elements (i.e. those wrapped into the super LES contracts) and it is expected that the performance management aspect will then be carried out by NHS North Central London primary care contracting and performance staff, although future management arrangements are not yet finalised.

NHS North Central London has a comprehensive performance management process to support GPs in improving their care. This is key to supporting the transformational change. NHS North Central London will invest in additional staff, including clinicians and managers, to provide additional capacity for the performance management of core contracts and individual performer concerns.

PERFORMANCE MANAGEMENT OF THE PRIMARY CARE STRATEGY

Performance management and the implementation of the strategy will be the responsibility of NHS North Central London primary care contracting and performance staff. Clear programme governance arrangements will be put in place to ensure that the primary care strategy is delivered to time and provides the inputs/actions set out above in return for the investment in each strategic domain in order to deliver the outcomes listed in the next section.

7. Outcomes

"Getting the right results"

> "Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality in general practice"
> (Improving the quality of care in general practice - The King's Fund, March 2011)

There will be explicit quality markers by practice and network, agreed with GPs, whereby in return for the investment, we can expect to achieve improvements in:

- Patient safety
- Clinical effectiveness
- The experience of patients.

(Patient safety and Clinical effectiveness: Health Outcomes)

HEALTH OUTCOMES

A full list of target outcomes will be developed within each borough's implementation plan and based on local practice population profiles. It should include:

MEDIUM TERM:

- Improved early detection and management of long term conditions leading to improved outcomes, in particular: diabetes, HIV, hypertension, COPD and CVD
- Improved cancer early detection and survival rates
- Increased smoking cessation
- Reduced obesity
- Improved self-care management, e.g. COPD Pulmonary Rehabilitation.

LONG TERM:

- Sustained top quartile performance against national quality metrics
- Improved life expectancy
- Closed gap for observed and predicted disease
- Herd immunity immunisation levels leading to reduced incidence
- Improved quality of dental care.

INNOVATIONS IN PATIENT CARE

SHORT TERM:

- Defined care packages for different stratification of disease risk.

MEDIUM TERM:

- Network of practices delivering comprehensive primary care.

LONG TERM:

- Integration across all providers of health system
- Transformation of the primary care brand in north central London – a demonstration to local stakeholders that we are serious about improving primary care.

PRODUCTIVITY

MEDIUM TERM

- GPs as systems navigators increasing both General Practice and system productivity
- Reduction in A&E attendances
- Fewer non-elective admissions for patients with long term conditions
- Improving biological measures for long term conditions e.g. HBA1C, Blood pressure control.

PATIENT EXPERIENCE

This could be described as customer care, but that label does not represent the true nature of the relationship between GP and patient. Traditional models of customer care imply that the onus and obligations are all exclusively on the service provider and that the customer has full rights and no responsibilities.

In order to work to its fullest potential, the GP/patient relationship needs to be more collaborative and to recognise the mutual benefits to be gained from working together with explicitly agreed rights and responsibilities for both parties. However, GPs must accept that the ultimate verdict on the total experience will be delivered by the patient based on their perception and as reported in:

- High scores on MORI and GPAQ surveys
- Positive feedback on NHS Choices website
- Positive performance as reported on the Myhealthlondon website
- Positive feedback from PPG/LINKs/HealthWatch/Local Health and Wellbeing Board
- Increase in access through core minimum hours of offering appointments using existing contract
- Fit for purpose premises – improving patient experience, quality and productivity
- Increased proportion of the population of North Central London registered with a GP practice
- Management of complaints.

BARNET

BACKGROUND

Barnet has by far the largest registered patient population number (373,715 at July 2011) in North Central London, but a much lower capitation funding of 327,404. Much of the demography of Barnet is closer to that of the Home Counties than to inner London boroughs, although there are pockets of significant deprivation. This mixed profile introduces different challenges.

GPs report that their health-aware residents are very high consumers of any/all services offered. Additionally, there is anecdotal evidence to suggest that, with a generally older age profile, many retired residents have switched from using private insurance provision to NHS services, and that much of this workload is in general practice supporting long term conditions management.

Like Enfield and Haringey, primary care in Barnet, must be viewed in the light of the BEH Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State and is being implemented. The implications for primary care have been emphasised in many documents.

Any new developments in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield and Haringey Clinical Strategy, which was given the green light for implementation by the Secretary of State for Health in September 2011. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

The Primary Care Strategy supports delivery of better services in Camden and Islington as well as Barnet, Enfield and Haringey and, while there have been many recent developments in primary care in each of the five boroughs, many more are being developed or are planned. We will make the changes in hospitals when clinicians tell us that the primary care system is sufficiently developed to provide better and safer care than in hospitals.

In 2007, the primary care strategy stated that there were too many (then 73), and too small, practices, operating from unsatisfactory premises. The strategy set out plans to move to a "hub and spoke" model and to reduce both practices and premises. Most of the focus has been on the health system infrastructure, yet little seems to have actually changed for most practices. The re-building of Finchley Memorial Hospital (due to open in 2012) is the most significant and tangible achievement. Along with the existing Edgware Community Hospital, the health economy will be unusual in London by having two community hospitals.

The key challenges now facing primary care in Barnet would seem to be:

- To rise to the BEH Clinical Strategy challenge, particularly given the high number of smaller practices which lack the capacity to expand their services
- To ensure that all practices are capable of achieving the highest quality standards
- As part of that quality drive, to improve the overall premises standard
- To establish the re-built Finchley Memorial Hospital as a fully functioning community hospital
- The need to get into financial balance.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

CAMDEN

BACKGROUND

Previous Camden strategy documents refer to a strong reputation for innovation and for delivering continuous performance improvement. The April 2010 CSP reflects broader whole system thinking and it introduces QIPP and robust performance management measurement. In terms of general practice, the PCT always maintained that:

> "NHS Camden is committed to supporting and developing a diverse provider landscape for general practice and believes that patients want to see a mixed economy of small, medium and large practices."

However, with just 39 practices, it is interesting to note that Camden has the highest number of registered patients per practice at almost 6,500 compared with Enfield, below 5,000, and the North Central London average of 5,500.

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

The CSP notes that 80% of practices have received investment to improve premises over recent years, and that, although there are a few problem sites, the overall state of GP premises has been improved considerably.

Camden, along with Islington, is one of the few PCTs in the country to have published a GP balanced scorecard on its website. It is set out as a RAG-rated league table and is perceived by practices themselves to have been a very effective performance improvement driver for all practices.

Camden GPs are considered to be among the most cost-effective prescribers in England and will continue to maintain this by working with their strong Medicines Management Team.

Camden is also one of the few PCTs who agreed (three) APMS contracts with new providers, but these contracts have not been without their problems which has included a change of provider.

The growth of Haverstock Healthcare, the Camden GP Provider Federation, means that there is now a single provider organisation through which NHS North Central London can communicate directly with most of their GP practices.

Camden is projecting a financial surplus at the end of 2011/12.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

ENFIELD

BACKGROUND

Enfield has the second largest registered patient population number (292,819 at July 2011) in North Central London. The demography of Enfield is similar to much of Barnet in the west and significantly more like the most deprived inner London Boroughs to the east. Both demographically and in terms of service provision it is a two-tier health economy.

With 60 practices, Enfield has the lowest average number of registered patients per practice in NHS North Central London:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

43% of Enfield patients are registered in the 39 practices which have fewer than 5,000 patients. Many of these smaller practices are in sub-standard premises. This is an issue that is mentioned in all of the previous strategic planning documents and one that those strategies have sought to address, but little seems to have changed in terms of numbers or premises conditions. As a result, the primary care scene in Enfield seems to be the most under-developed in North Central London.

Like Barnet, primary care in Enfield must be viewed in the light of the BEH Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

The challenges facing primary care in Enfield seem to be:

- The ongoing issues arising from previous failed primary care premises strategies

- To rise to the BEH Clinical Strategy challenge, particularly given the high number of very small practices which lack the capacity to expand their services and are working in totally unsuitable premises
- To ensure that the high number of PMS contracts (31) and the high cost (£143 unified weighted population) are delivering commensurate value
- To ensure that all practices are capable of achieving the highest quality standards.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

HARINGEY

BACKGROUND

Haringey is unusual in London in that it does not have a District General Hospital site within the borough boundary. North Middlesex University Hospital NHS Trust lies to the north east and Whittington Health to the south west. The demography places Haringey on the cusp of outer and inner London. The relatively well and wealthy west gives way to more areas of deprivation and inequality as you move eastwards, and the hospital landscape means the two trusts cater for two very different Haringey populations.

Having been one of the early implementers of polysystems, Haringey does benefit from new and modern estate - Hornsey Central, The Laurels and Lordship Lane. All are now becoming fully operational but there is more opportunity and there is potential for some major investment decisions to be made about upcoming developments in Tottenham and on the St Ann's site.

As with Barnet and Enfield, Haringey must be viewed in the light of the BEH Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

General practice in Haringey is still characterised by large numbers of small practices. The registered practice population has reduced by 7,500 (-3.2%) over the past year, mainly as a result of list cleaning. Average list size is just over 5,000.

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

This extract from the overview in the January 2010 CSP provides a good description of the primary care scene in Haringey:

"Haringey has a diverse provider base with a large number of both GP and dental practitioners but the number and size of practices means this is a potentially fragmented system.

CHARACTERISTICS

- There are a large number of single handed GPs
- Despite the introduction of the polysystem model there is a fragmented provider base
- There are 270,000 GP registrations in Haringey, higher than the estimated population figures of 226,000. This could mean that patients are registering from neighbouring boroughs
- GP services vary significantly depending on the practice in terms of access, quality, and condition of premises and range of services available.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

ISLINGTON

BACKGROUND

The growing population combined with the low number of practices means Islington has the second highest average patient population per practice in north central London:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

The Primary Care SWOT analysis in the January 2010 CSP still provides a good description of the primary care scene in Islington:

- General Practitioners account for approximately 50% of the PCT primary care budget. The majority of the 38 GP practices provide services in core hours. 12 single handed practices, five of which are within the central locality. Out of hours care is provided by CAMIDOC. (Now provided by Harmoni)

- Pharmacy and prescribing accounts for 38% of the total budget and operates from 45 locations spread across the borough

- Dental practices offer NHS treatment to Islington residents from 25 locations accounting for 13% of the overall primary care budget. 49% of residents access an NHS dentist

- There are 49 contracted optometrists operating in Islington operating from 27 practices. Services are centrally purchased.

CHALLENGES

- Providing accessible and modern facilities given some of the primary care estate
- Lower than anticipated poor outcomes on patient experience
- Inequitable access to enhanced services for the population
- Supporting a high proportion of single handed GP practices - 10 out of 38
- Disparities in the quality of care across some of our practices
- Limited capacity to respond to urgent care needs in and out of hours
- Multiple demands to respond to enhanced service requirements
- Attaining CQC registration status
- Improving the oral health of children
- Differentials in expected and recorded numbers on disease registers.

STRENGTHS

- Good coverage of GP and pharmacy services throughout the borough
- Mix of experienced and new GPs
- Offers a range of enhanced services
- Good QOF outcomes, but high levels of exception reporting.

IMPLICATIONS FOR CSP/CHOICE

- Strengthen commissioning of GPs for quality, support access
- Tender for additional dentistry including oral health promotion focus
- Introduce services to provide more comprehensive urgent response

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

9. Strategic cost/Benefit analysis

"How we justify the investment"

NHS North Central London

The Primary Care Strategy pump priming investment to deliver the transformational strategy is £46.7m (risk adjusted) across three years. In common with all PCTs, until our annual operating plan is approved by the Department of Health, we cannot confirm the spend for 2012/13. However, we are currently optimistic that our plans will be approved by the end of March 2012.

Investment will be across the nine strategic domains of:

1. Integration
2. Clinical services
3. Information Technology

(items 1–3) = Integrated Care Network

4. Public Health
5. Premises
6. Productivity
7. Workforce, leadership and team development
8. Commissioning
9. Communications

As well as strengthening general practice performance monitoring and analysis and programme management costs.

PRIMARY CARE PUMP PRIMING 2012/13 – 2014/15 (£M)

	2012/13	2013/14	2014/15	Total £m
Total spend	12.0	17.5	17.3	46.7

The gross savings will be a multiple of the investment in the strategy and represents less than 1.5% of acute expenditure. The savings will be confirmed as part of the work that is being undertaken as part of the Integrated Care financial analysis.

APPENDIX A - FACTS AND FIGURES

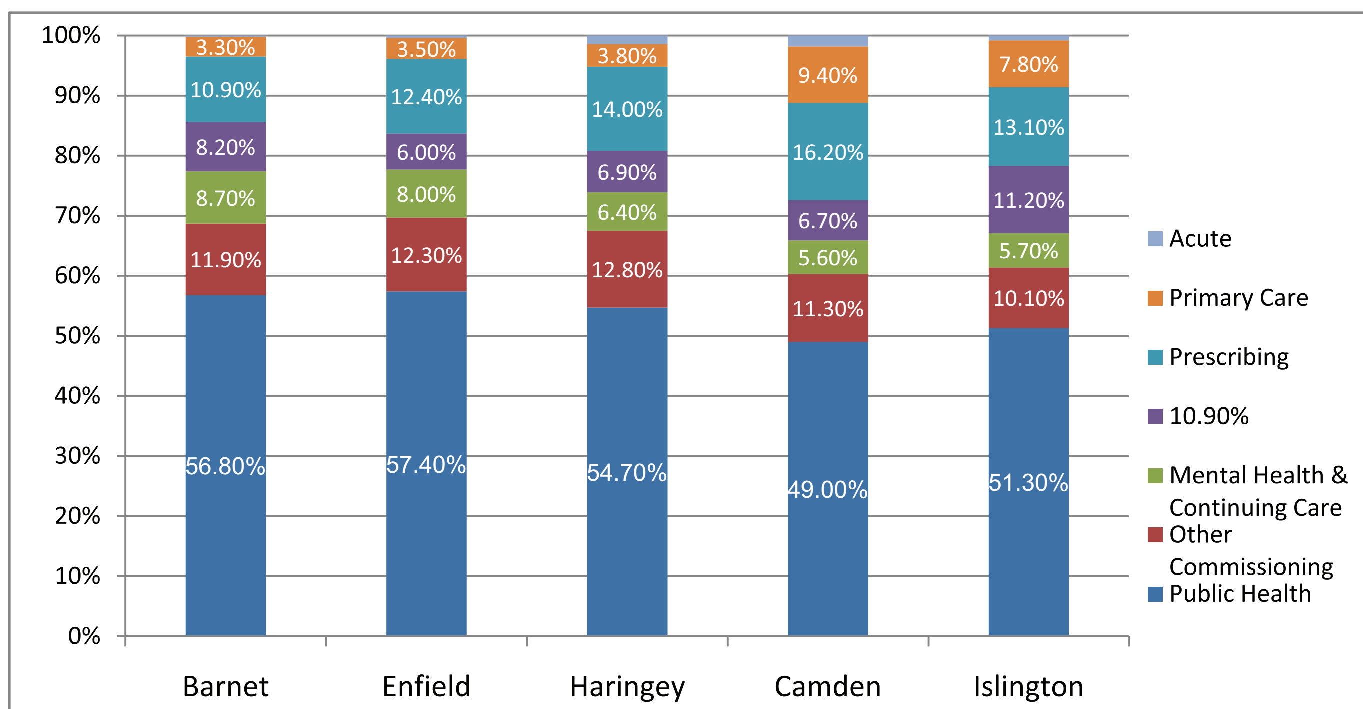
FIG 1 - GENERAL PRACTICES (WITH LISTS) BY TYPE OF CONTRACT

	Barnet	Camden	Enfield	Haringey	Islington	Total
GMS	42	20	28	23	35	**148**
PMS	26	16	31	30	2	**105**
APMS	0	3	1	1	0	**5**
Totals	68	39	60	54	37	**258**

FIG 2 - GP PRESCRIBING COSTS PER WEIGHTED AVERAGE LIST SIZE (RANK ORDER)

2010/11	Camden	Haringey	London Average	North Central London Average	Enfield	Barnet	Islington
Cost per Astro PU	£21.94	£22.06	**£23.40**	**£24.15**	£25.33	£25.47	£25.93

FIG 3- NORTH CENTRAL LONDON EXPENDITURE – VARIATION IN 2011/12 FORECAST EXIT RATE SPEND BY CATEGORY - % OF SPEND (EXCLUDING CONTINGENCY AND OTHER CORPORATE)



There is a significant variation in acute spend as a percentage of total spend across NHS North Central London PCTs, ranging from 49% to 57.4%. Across London the average PCT spend is 47.6%.
Note: Public Health spend includes the running costs associated with the Public Health function

FACTS AND FIGURES

FIG 4 - FUNDING AND POPULATION NUMBERS

How much money will North Central London/PCTs spend in 2011/12?	£000s					
	Barnet	Camden	Enfield	Haringey	Islington	NCL
Total spending by PCT 2011/12 as at Month 6 projected to full year	£579,500	£518,499	£482,704	£469,554	£481,540	£2,531,797
How much is that per head "crude population"?						
"Crude Population" numbers @ 1st July 2011	351,286	247,303	277,429	244,489	191,810	1,312,317
£s per head "Crude Population"	£1,650	£2,097	£1,740	£1,921	£2,511	£1,929
How much is that per head "registered patients"?						
"Registered patient" numbers @ 1st July 2011	373,715	251,016	299,119	272,236	217,000	1,413,086
£s per head "Registered Patients"	£1,551	£2,066	£1,614	£1,725	£2,219	£1,792
How much is that per "unified weighted population"?						
"Unified Weighted Population" numbers 2011/12	327,404	256,243	289,265	275,792	236,084	1,384,787
£s per head "Unified Weighted Population"	£1,770	£2,023	£1,669	£1,703	£2,040	£1,828
% difference between "Registered patients" and "Unified Weighted Population"	*-12.4%*	*2.1%*	*-3.3%*	*1.3%*	*8.8%*	*-2.0%*

a) Department of Health funding can be viewed on a per capita basis in various ways. The weighted capitation formula produces a PCT 'Unified Weighted Population'. This is a hypothetical population that DH uses as a target to guide most of the PCT's allocation. It is based on a weighted combination of 19 socio-economic factors that are seen as convenient proxies for health needs.
b) The apparent massive funding differential using "Crude" or "Registered" populations is significantly reduced to the range of £1,669 per capita in Enfield to £2,040 in Islington. Using UWP means that the Barnet population theoretically reduces whilst Camden, Enfield, Haringey and Islington theoretically increase.
c) The difference between Registered Patients and UWP also highlights a funding challenge in Barnet.

FIG 5 - EXPENDITURE PER CAPITA (UNIFIED WEIGHTED POPULATION) ON PROVIDERS AND PRESCRIBING

Commissioned Services spend per capita UWP	Barnet	Camden	Enfield	Haringey	Islington	North Central London
Acute	£1,014	£887	£979	£938	£955	£958
% of total projected spend on Providers and Prescribing	57.3%	51.3%	58.0%	55.9%	51.7%	55.0%
Mental Health	£119	£225	£147	£176	£222	£173
% of total projected spend on Providers and Prescribing	6.7%	13.0%	8.7%	10.5%	12.0%	10.0%
Community	£150	£122	£103	£116	£212	£139
% of total projected spend on Providers and Prescribing	8.5%	7.0%	6.1%	6.9%	11.5%	8.0%
Other	£115	£191	£107	£131	£166	£139
% of total projected spend on Providers and Prescribing	6.5%	11.0%	6.3%	7.8%	9.0%	8.0%
Total Commissioned Services per capita	**£1,399**	**£1,424**	**£1,336**	**£1,361**	**£1,556**	**£1,410**
% of total projected spend on Providers and Prescribing	**79.0%**	**82.4%**	**79.2%**	**81.0%**	**84.2%**	**81.0%**

Independent Contractor Services spend per capita UWP	Barnet	Camden	Enfield	Haringey	Islington	North Central London
GP	£136	£137	£132	£119	£118	£129
% of total projected spend on Providers and Prescribing	7.7%	7.9%	7.8%	7.1%	6.4%	7.4%
Dentists, optometrists and pharmacists	£77	£66	£83	£86	£66	£76
% of total projected spend on Providers and Prescribing	4.3%	3.8%	4.9%	5.1%	3.6%	4.4%
Total Independent Contractor Services per capita	**£212**	**£203**	**£215**	**£205**	**£184**	**£205**
% of total projected spend on Providers and Prescribing	**12.0%**	**11.7%**	**12.7%**	**12.2%**	**10.0%**	**11.8%**

	Barnet	Camden	Enfield	Haringey	Islington	North Central London
Prescribing spend per capita UWP	**£160**	**£101**	**£137**	**£114**	**£107**	**£126**
% of total projected spend on "Providers and Prescribing"	9.1%	5.8%	8.1%	6.8%	5.8%	7.2%
£s per capita UWP spent on "Providers and Prescribing"	**£1,771**	**£1,728**	**£1,688**	**£1,680**	**£1,847**	**£1,740**
% of total projected spend on "Providers and Prescribing"	100%	100%	100%	100%	100%	100%

FIG 6 - DENTISTS, OPTOMETRISTS AND PHARMACISTS (£000S)

How do we spend the dentists, optometrists and pharmacists funding?	Barnet	Camden	Enfield	Haringey	Islington	North Central London
Dentists	£13,160	£10,010	£13,514	£15,546	£9,018	£61,248
Number of Contractors	70	42	44	51	23	230
£s per contract	£188,000	£238,333	£307,136	£304,824	£392,087	£266,296
£s per capita UWP	£40	£39	£47	£56	£38	£44
Optometrists	£3,345	£2,183	£2,550	£2,368	£1,531	£11,977
Number of Contractors	88	77	72	33	53	323
£s per contract	£38,011	£28,351	£35,417	£71,758	£28,887	£37,080
£s per capita UWP	£10	£9	£9	£9	£6	£9
Pharmacists	£8,574	£4,751	£7,816	£5,755	£5,065	£31,961
Number of Contractors	71	65	61	56	46	299
£s per contract	£120,761	£73,092	£128,131	£102,768	£110,109	£106,893
£s per capita UWP	£26	£19	£27	£21	£21	£23
Total Dentists, optometrists and pharmacists	**£25,079**	**£16,944**	**£23,880**	**£23,669**	**£15,614**	**£105,186**
% of total projected spend on Providers and Prescribing	**4.3%**	**3.8%**	**4.9%**	**5.1%**	**3.6%**	**4.4%**
£s per capita UWP	**£77**	**£66**	**£83**	**£86**	**£66**	**£76**

FIG 7 GENERAL PRACTICE (£000S)

How do we spend the general practice funding?	Barnet	Camden	Enfield	Haringey	Islington	North Central London
Total GMS	£20,863	£15,273	£12,916	£10,952	£26,526	£86,530
Number of practices	42	20	28	23	35	148
£s per practice	£496,734	£763,650	£461,286	£476,174	£757,886	£584,662
Registered patients at 1st July 2011	217,695	120,664	117,557	104,334	207,468	767,718
£s per registered patient	£96	£127	£110	£105	£128	£113
Estimated Unified Weighted Patient population (using % difference)	190,701	123,198	113,678	105,690	225,725	758,992
Estimated £s per capita UWP	£109	£124	£114	£104	£118	£114

Total PMS	£23,013	£18,043	£24,090	£21,786	£1,103	£88,035
Number of practices	26	16	31	30	2	105
£s per practice	£885,115	£1,127,688	£777,097	£726,200	£551,500	£838,429
Registered patients at 1st July 2011	156,020	118,717	173,862	167,902	9,532	626,033
£s per registered patient	£148	£152	£139	£130	£116	£141
Estimated Unified Weighted Patient population (using % difference)	136,674	121,210	168,125	170,085	10,371	606,464
Estimated £s per capita UWP	£168	£149	£143	£128	£106	£145

Total General Practice Budgets	£44,399	£35,019	£38,251	£32,738	£27,864	£178,271
Number of practices	68	39	60	54	37	258
£s per practice	£652,926	£897,923	£637,517	£606,259	£753,081	£690,973
Registered patients at 1st July 2011	373,715	251,016	299,119	272,236	217,000	1,413,086
£s per registered patient	£119	£140	£128	£120	£128	£126
Unified Weighted Patient Population	327,404	256,243	289,265	275,792	236,084	1,384,787
£s per capita UWP	£136	£137	£132	£119	£118	£129

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AGENDA ITEM 9

Meeting	Health and Well-Being Board
Date	31 May 2012
Subject	**Barnet Clinical Commissioning Group - Update**
Report of	Chair, Barnet Clinical Commissioning Group
Summary of item and decision being sought	Board members are asked to note progress on developing the Clinical Commissioning Group (CCG) and comment on the way in which the Board can support the CCG authorisation process in Barnet.

Officer Contributors	Alison Blair, Borough Director, NHS North Central London.
Reason for Report	To update the Board on progress with the development of local clinical commissioning arrangements and provide an opportunity to discuss the authorisation process.
Partnership flexibility being exercised	Not applicable
Wards Affected	All

Contact for further information

Alison Blair, 020 8937 7631

1 RECOMMENDATION

1.1 Board members are asked to note progress on developing the Barnet Clinical Commissioning Group and comment on the way in which the Board can support the authorisation process in Barnet.

2 RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Discussions have taken place at monthly CCG Board meetings as well as internal NHS events. In addition progress is regularly monitored via NHS North Central London.

3 LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS

Link to Commissioning Strategies

3.1 From 2013 the CCG will have responsibility for local NHS health commissioning (acute, mental health and community services) which is a budget over £500m. An effective CCG is essential to the development and implementation of commissioning strategies across health and social care.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The CCG views the Joint Strategic Needs Assessment as the document which sets out health needs and from which to develop strategic priorities.

5 RISK MANAGEMENT

5.1 A high level local risk assessment has been undertaken as part of planning for local development of the CCG. Initial risks have been identified as:

5.1.1 That GPs and member practices may not all engage with the development of the CCG and the implementation of its commissioning plans. This risk is being mitigated through a focus on engagement of GPs in the development of the CCG via localities particularly;

5.1.2 That the CCG does not have effective commissioning arrangements in place to support its development. Work is underway on developing effective support as set out in section 10.

5.1.3 That the CCG does not have the partnership arrangements and relationships in place to work effectively across the health and social care system. The CCG has developed a communications plan and is an integral part of the Health and Wellbeing Board.

6 LEGAL POWERS AND IMPLICATIONS

6.1 The Health and Social Care Bill was given Royal Assent on 27 March 2012. The Act provides for the abolition of Primary Care Trusts and Strategic Health Authorities and the

establishment of the NHS Commissioning Board and Clinical Commissioning Groups. This means that on 1 April 2013, the commissioning functions of NHS North Central London will pass to a number of organisations, primarily, Clinical Commissioning Groups (CCG), the NHS Commissioning Board, Local Authorities and NHS Property Services Ltd. The CCG will take responsibility for securing continuous improvements in the quality of services commissioned, reducing inequalities, enabling choice and promoting patient involvement, securing integration and promoting innovation and research.

7 USE OF RESOURCES IMPLICATIONS

7.1 The CCG will receive an allocation of approximately £500m from which to commission acute, mental health and community services.

8 COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Communications arrangements for the CCG are set out in section 10.

8.2 A LINks member and the Local Authority Director of Adult Social Services and Health are observers with speaking rights on the CCG Board.

9 ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Engagement events with local providers have been undertaken and more are planned.

10 DETAILS

10.1 Introduction

The development of Barnet CCG is progressing well and the CCG is on track to be authorised and established for April 2013. This report sets out progress in some key areas of work.

The CCG has been up and running since July 2011. We have experienced clinical leaders along with those new to the role which provides a great combination. We work hand in hand with an excellent local team. From the discussions so far key themes that the CCG wishes to embed locally are:

- Strong primary care involvement and leadership
- Clear messages to providers
- Emphasis on primary care education and development
- The use of end-to-end care pathway design
- The development of integrated models of care.

We have some key opportunities to bring about change locally with the opening of the new Finchley Memorial Hospital in October 2012, the implementation of the Barnet, Enfield and Haringey Clinical Strategy and the delivery of the primary care strategy.

10.2 The Vision of Barnet Clinical Commissioning Group:

Local clinicians working with local people for a healthier future.

We will work in partnership with local people to improve the health and well-being of the population of Barnet, find solutions to challenges, and commission new and improved collaborative pathways of care which address the health needs for the Barnet population.

10.3 Our commitments:

- We will continue to improve the health and well-being of the local population by focusing on preventative services, reducing health inequalities, and enabling the population to take responsibility for their own health.
- We will ensure the provision of high quality, efficient and effective health services for the population, within available resources, recognising that Barnet faces considerable financial pressures.
- We will facilitate integration between health and social care services.
- We will ensure good quality, safe healthcare in all settings.
- We will have a Barnet Strategy that is clinically led, draws on evidence, and uses innovative, radical solutions to deliver the best possible care to patients and their carers within allocated resources.
- We will focus on education and development support to clinicians to improve care and ensure that high quality services are delivered.
- We will take action when we are not receiving high quality, efficient and effective health services.

10.4 Delegation of Commissioning Responsibilities

As CCGs develop they can request to take on delegated responsibilities from Primary Care Trusts. Following approval for the delegation of responsibilities for commissioning medicines management to the CCG in February; Barnet CCG has been working with the NHS North Central London to ensure that all the remaining responsibilities are signed off by the beginning of June 2012. Plans are being finalised to take on this responsibility locally which includes a sound approach to managing the financial challenges faced locally.

10.5 Commissioning Support Service Development

Barnet CCG is in the process of determining its commissioning support arrangements in discussion with the North Central East London Commissioning Support Service (NCEL CSS). Following further discussion the CCG will be asked to sign a detailed service level agreement. In the meantime a high level memorandum of understanding has been agreed which indicates that NCEL CSS and the CCG have worked together to agree which core commissioning support services the CCG will require, how these should be delivered locally and what the price will be.

NCEL CSS is expected to begin full service delivery in October 2012, in line with the wider NHS staff transfer and selection timetables. Signature of the SLA will support CCG authorisation and NCEL CSS' delivery of services in line with CCG requirements. Between October 2012 and April 2013 the CCG and NCEL CSS will agree Key Performance Indicator (KPI) targets, having agreed metrics.

10.6 Public Health Commissioning Support

With the transfer of public health functions to the Local Authority, public health support to commissioning will be provided back to the CCG. The CCG is developing an understanding of its requirements with regard to this in line with the national guidance which will then be discussed locally as the basis of an agreement.

10.7 Clinical Commissioning Group Structure

A draft structure has been produced for the Borough CCG support team and agreed with the CCG Board. The principles underpinning this draft structure are:

- That it is self-sufficient i.e. that the structure can stand independently and, in the main, functions are not shared with other CCGs
- That it is affordable
- That it as far as possible addresses identified current resource gaps (i.e. finance, information, children's commissioning, administration and communications)
- That it will provide the CCG with continuity but also, where possible, gives current staff opportunities to progress and/or take on new responsibilities
- That it is manageable and conforms with good leadership practice
- That there is some flexibility over the next few months to take account of changing circumstances in the CCG
- That it takes the CCG through authorisation in 2012/13 and provides the broad direction of travel for subsequent years.

10.8 Senior Post holders

Draft guidance has been issued by the Department of Health which sets out role descriptions for senior CCG post holders and additional Board members (chair, lay members, accountable officer and chief finance officer, specialist doctor and nurse), as well as core competences, skills and experience. Recruitment to the posts of accountable officer and chief financial officer is underway and should be concluded by June 2012.

10.9 Organisational Development

The CCG has a development plan which it is working through supported by KPMG. The key areas of this in the next few months are:

1. Individual professional coaching for Board members

2. Development days from May to July 2012 to include: finance, performance and risk, governance and engagement, corporate and clinical quality and the planning and implementation of the Board Assurance Framework (BAF) and Strategic Operating Plan

3. Wider member practice engagement.

10.10 Education Strategy

Statement 6 of the CCG Board vision states "We will focus on education and development support to clinicians to improve care and ensure that high quality services are delivered"

We are currently working to develop an overarching educational strategy for the CCG which will take into account the wider arena of primary care and stakeholders. This strategy will align with key strategies and programmes of work for Barnet such as:

Learning through Peer Review, the Primary Care Strategy and the Medicines Optimisation Strategy among others.

10.11 Communications Update

Since the CCG Board was established it has led a programme of communications.

The Barnet GP intranet went live on the 2nd April 2012. This tool will enable the immediate communication of updates and news to GPs and practice managers. It will be supported by SMS messages.

The NHS Barnet public website dedicated to the CCG is being refined to include pen portraits of Board members, the Board vision and values, events, news and in the future access to papers and key documents.

The CCG Communications Strategy is currently being updated and a draft action plan has been devised.

A series of events have been undertaken with local providers and stakeholders. A second engagement event for patients and carers is being planned for early July, and will be co-hosted with Barnet LINks.

10.12 Authorisation

In April 2012 the NHS Commissioning Board Authority (NHS CBA) ratified the Clinical Commissioning Group: Draft Guidance for Authorisation. The document sets out the process for authorisation including the evidence that CCGs will be required to provide to ensure that they are above the "threshold", based on six domains. The document also clearly defines the pipeline, including key dates that CCGs will need to work towards. A link to the full document can be found at https://www.wp.dh.gov.uk/commissioningboard/files/2012/04/ccg-auth-app-guide.pdf

There are four waves for CCG authorisation over the next few months. Barnet have been confirmed as being in wave three submitting an application for authorisation in September 2012. The CCG have begun to collate evidence to support the CCG's case against the six domains.

In addition a Barnet CCG performance and population health profile will be provided by the NHS CBA one month before the application process. Initial guidance suggests that the profiles will contain the following data:

- Configuration at CCG level:
- Geography – including the relationship between the CCG and local authorities, and the relationship between a CCGs registered and resident population;
- Demographic and socio-economic profile – e.g. age/ sex/ Index of Multiple Deprivation;
- Population level outcomes data;
- Activity and outcomes data (e.g. the latter from inpatient survey) split by main provider;
- Performance data;
- Financial data.

The profiles will be used by the assessment team to understand Barnet's challenges in more detail and will form part of the triangulation process for track record, planning, prioritisation and financial management.

360° stakeholder surveys will also be undertaken in August/September 2012. This short web based survey will be sent to a range of stakeholders shortly before Barnet's entry into

wave 3. This will include the Health and Well-Being Board and will ask for views on "the CCGs willingness and ability to be involved in partnership working and their relationship to their local population".

The application phase will commence in September 2012 with a signed self certification by the Chair and Accountable Officer. This will certify that the CCG is ready, willing and has plans in place to discharge its duties and responsibilities in key areas. Once received the process will commence with:

- A review of the evidence, data from the CCG profile and the findings of the 360° stakeholder survey.
- A one day site visit with the explicit purpose of meeting the CCG and assessing their capability to deliver as individuals and as a team. The Health and Wellbeing Board and other stakeholders may also be part of this day.

The NHS CBA will then inform the CCG of their final decision. Guidance suggests that aspirant CCGs can be approved without condition or with conditions if the NHS CBA are not fully satisfied that the CCG has met all the thresholds for authorisation.

11 Background papers

None

Legal - HP

Finance - JH

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Meeting	Health and Wellbeing Board
Date	31 May 2012
Subject	**Health and Social Care Integration Strategic Outline Business Case and Investment Priorities**
Report of	Cabinet Member for Adult Social Care Cabinet Member for Public Health
Summary of item and decision being sought	This report presents the health and social care integration strategic outline business case (SOC), previously the subject of an Health and Well-Being Board workshop on the 22 March 2012, for formal endorsement. It also includes a summary of the outputs from this workshop for comment and agreement: • A vision statement for care integration in Barnet • An initial set of integration initiatives and investment priorities, which will be progressed through the integrated commissioning plan and the governance structure referenced below • A shared governance and delivery structure The report seeks agreement from the Health and Wellbeing Board to proceed with the development of business cases and detailed plans and to strengthen delivery capacity for those integration opportunities that are already in progress. The Health and Wellbeing Board is asked to: endorse the Health and Social Care Integration Strategic Outline Case; comment on the proposed vision for integration; agree the shared governance structure and integration initiatives; and endorse the initial commitment of £1m by Barnet Council to fund the delivery of a local health and social care integration work programme.
Officer Contributors	Dawn Wakeling, Deputy Director, Health and Adult Social Care, LBB

	Ceri Jacob, Associate Director, Joint Commissioning, LBB and NHS NCL London Rohan Wardena, Project Lead, Adult Social Care and Health, LBB
Reason for Report	To endorse the health and social care integration SOC and to agree the items listed in the summary section above.
Partnership flexibility being exercised	None apply to the proposals in this report. However, the programme will seek to develop business cases for integration projects that will benefit partners and these may include use of the flexibilities available under section 75 of the National Health Service Act 2006.
Wards Affected	All

Contact for further information: Rohan Wardena, ☎ 020 8359 3877; email rohan.wardena@barnet.gov.uk

1. RECOMMENDATIONS

1.1 That the Board endorses the Strategic Outline Case for the integration of health and social care.

1.2 That the Board agrees the proposed shared governance and delivery structure for implementing joint health and social care integration projects.

1.3 That the Board comments on and agrees the proposed vision for health and social care integration in Barnet.

1.4 That the Board endorses the proposed health and social care integration programme and investment priorities.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The agreement of the Health and Wellbeing Strategy and integrated commissioning strategy scoping document by the Board on 26 May 2011 proposed that integration in commissioning and / or service delivery should be considered in any area where health and social care overlap or are interdependent. This proposal was accepted by the Council, the Barnet Clinical Commissioning Group and NHS North Central London. The draft Health and Wellbeing Strategy was subsequently endorsed by the Board on the 22 March 2012.

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

3.1 Links to Sustainable Community Strategy

3.1.1 The Sustainable Community Strategy 2010-2020 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 Links to Health And Wellbeing Strategy

3.2.1 The 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 coordination of planning across health, public health and social care. This is recognised in the Health and Wellbeing Strategy and the linked draft Integrated Commissioning Plan.

3.3 Links to Commissioning Strategies

3.3.1 As noted above, a draft Integrated Commissioning Strategy is being developed as one of two delivery vehicles for the Health and Wellbeing Strategy. This commissioning plan will form part of the Barnet Clinical Commissioning Group's overall commissioning plans for 2012/13.

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 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Needs Assessment Implications

4.1.1 Any integration of health and social care services needs to be done where this is the most appropriate option to improve outcomes and the customer experience and where there is firm evidence that this will benefit people using care in Barnet. The available research does not support a view that integration is always beneficial, but rather that it provides positive results for certain groups within society, such as those with multiple or long term conditions and complex care needs.

4.1.2 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.

4.1.3 The benefits from the proposed programme of integration initiatives should enable partner organisations to identify more effective ways of meeting some of the 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.

4.2 Equalities Implications

4.2.1 The integration of local health and social care services could have a disproportionate impact on different groups and communities in Barnet. This could include 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. An Equalities Impact Assessment will be conducted for each health and social care integration initiative to determine its impact and the requirement for any reasonable adjustment.

4.2.2 The integration of health and social care services may also have a disproportionate impact on staff with protected characteristics. An Equalities Impact Assessment will be conducted for each health and social care

integration initiative to determine its impact on staff and the requirement for any reasonable adjustment.

5. RISK MANAGEMENT

5.1 The Strategic Outline Case document includes an initial risk register for the proposed health and social integration work programme.

5.2 Resourcing constraints are expected to impact local NHS organisations that are undergoing major transitions during the next 12 months. This is partially mitigated through the commitment of NHS organisations and Barnet Council to provide resources to support the delivery of social care and health integration initiatives and the investment of Section 256 monies.

5.3 There is little documented evidence that demonstrates the measurable return on investment for social care integration and the timescale for benefit realisation. This risk is mitigated by building local insight through the piloting and evaluation of integration initiatives prior to a large scale commitment or long-term investment decision. Insight building and the definition of benefits measurement will be an essential component of integration project development and delivery.

5.4 There is a risk that partner organisations may be unwilling to commit to support and invest in integration projects that do not deliver an equal distribution of benefits and where they do not see a proportionate return on their investment. This risk is mitigated through a programme management approach which will ensure that the mix of benefits across the portfolio of projects are fairly distributed at programme level.

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. 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 outline business case will be explored as part of the development of specific proposals. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions.

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

7.1 Financial Implications

7.1.1 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 people who use care, reducing demand for repeat interventions and crisis services such as emergency departments
- Increasing the opportunities for whole system efficiencies
- Reduction of duplication in assessment and provision
- Preventing demand for more intensive and high cost services such as acute hospital and residential care, through coordinated use of prevention and early intervention services

7.1.2 The strategic outline business case identifies that health and social care integration initiatives will contribute £3.3m savings in adult social care expenditure over three years and will contribute towards the local health economies £4.2m recurrent integrated care Quality, Innovation, Productivity and Prevention (QIPP) 2012/13 savings requirements. This represents the minimum expected savings that will be delivered by integration initiatives. Full business case development and benefits modelling will be conducted for each health and social care integration project as part of the initiation and assurance phase.

7.2 **Investment Commitments**

7.2.1 The London Borough of Barnet is proposing to commit £1.1m for health and social care integration in 2012/13 through its One Barnet Programme, subject to the agreement of the Cabinet Resources Committee. This will be in addition to the Section 256 funding for social care integration investment which has already been endorsed by the Health and Wellbeing Board.

7.2.2 The London Borough of Barnet is also currently funding a project manager (3 days per week) to support delivery of health and social care integration projects.

7.3 **Staffing Implications**

7.3.1 It is expected that the integration of health and social care services will impact staff currently working for the Local Authority and NHS organisations. This will be defined as part of the development of specific project business cases and through the equalities impact assessment process described in. section 4.2.2 above.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 A list of key stakeholders involved in the development of a shared position statement on health and social care integration is included in the strategic outline case. This work recognises that stakeholders have different strategic requirements and this is reflected in the shared position described in the outline business case.

8.2 Service users, carers and key stakeholders have been involved in the development of the integrated commissioning plan through a series of engagement events. The output from these events has informed the development of the strategic outline case and the integration opportunity priorities. Local service user and voluntary groups will be included in the

membership of programme and project delivery boards and will provide input and assurance on all health and social care integration projects.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Provider organisations have been involved in the development of both the strategic outline case and 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.

9. BACKGROUND AND PURPOSE

9.1 This report draws together the key documents that describe the commitment, intentions and priorities of Barnet Council and its elected members, the Barnet Clinical Commissioning Group and local NHS and social care key stakeholders, for the integration of the local system of care in Barnet. These are described in detail in the Health and Social Care Integration Strategic Outline Case and the draft Integrated Commissioning Plan documents and are informed by the Health and Wellbeing Strategy and Joint Strategic Needs Assessment (JSNA).

9.2 A Health and Wellbeing Board integration workshop was held on the 22nd March for members of the Board to consider the content of the Health and Social Care Strategic Outline Case and the draft Integrated Commissioning Plan and to use this as the starting point to develop its vision for integration and agree a set of actions that will progress integrated working. The output from the workshop has informed the following proposals which are set out in this report:

- A Health and Wellbeing Board vision for health and social care integration in Barnet
- Shared governance and delivery structure to lead and manage the implementation of health and social integration programmes and projects
- An initial roadmap of opportunities and investment priorities for health and social care integration in Barnet

9.3 <u>Health And Social Care Integration Strategic Outline Case</u>

The strategic outline case document (SOC) takes the expressed ambitions for health and social integration of the health and social care community as its starting point, based on published statements and interviews with key health and social care leaders. It builds on the aspirations set out in Barnet's draft Health and Wellbeing Strategy and complements the draft integrated commissioning plan. It sets out Barnet Council’s commitment to investing in integration and provides an opening position statement on the opportunities for joint working across health and social care in Barnet. It focuses on the enabling structures and processes required to ensure jointly delivered

integration initiatives involving multiple organisations are effectively implemented and expected benefits are fully realised. The SOC is complementary to the integrated commissioning plan, in that it sets out the approach to manage the delivery of the service development initiatives described in the commissioning plan.

9.4 It also has a wider purpose as a discussion document to start a productive dialogue between the NHS, Local Authority and all relevant local voluntary and private sector partners, around the various approaches to integration and the scale of ambition to transform the way in which care is commissioned and delivered in Barnet.

9.5 Local Authority Investment In Integration

The health and social care integration outline business case has secured agreement in principle for the commitment of £1.1m non-recurrent funding for investment from the LBB One Barnet Wave 2 Programme. This is available in 2012/13 for new integration opportunities prioritised by the Health and Wellbeing Board and to strengthen and accelerate the delivery of existing health and social care integration initiatives.

9.6 Integrated Commissioning Plan

The Integrated Commissioning Plan sets out the local commissioning opportunities to shape and support integration across the local health and social care system in Barnet. It acts as one of two key delivery vehicles for the Barnet Health and Wellbeing Strategy; the second being the Integrated Prevention Plan. The Health and Wellbeing Strategy identifies four key themes around which integration opportunities are clustered:

- **Preparation for a healthy life** –enabling the delivery of effective pre-natal advice and maternity care and early-years development;
- **Wellbeing in the community** –creating circumstances that better enable people to be healthier and have greater life opportunities;
- **How we live** –enabling and encouraging healthier lifestyles; and
- **Care when needed** –providing appropriate care and support to facilitate good outcomes.

10. NEXT STEPS FOR CARE INTEGRATION

10.1 The following milestone plan provides an overview of the proposed next steps and timeline to progress a Health and Wellbeing Board sponsored integration work programme. One of the critical next steps will be the integration leadership summit meeting which will provide the platform to share the Health and Wellbeing Board's vision and priorities for health and social care integration with providers and key strategic stakeholders.

KEY INTEGRATION PLAN MILESTONES	DATE
Health & Wellbeing Board Vision For Integration Agreed	MAY 12
Shared Integration Programme Governance & Delivery Arrangements Set Up	JUN 12
Integrated Commissioning Plan Signed Off By Health And Wellbeing Board	JUL 12
Benefits Assurance Gate Review For Existing Integration Projects Conducted	JUL 12
Shared Integration Programme Delivery Office & Process Requirements Defined	JUL 12
Integration Leadership Summit Meeting Held	JUL 12
Business Cases Produced For All New Prioritied Integration Projects	SEPT 12

11. PROPOSED VISION STATEMENT FOR CARE INTEGRATION

11.1 As part of the health and social care integration workshop, Members of the Health and Wellbeing Board were asked to define their vision for health and social care integration in Barnet and to highlight the features which they felt were of most importance. This has been used to produce the following proposed Health and Wellbeing Board vision statement for health and social care integration in Barnet:

11.2 <u>Proposed Vision For Health And Social Care Integration In Barnet</u>

Care integration in Barnet will place people and their carers at the heart of a joined up health and social care system that is built around their individual needs, delivers the best outcomes and provides the best value for public money. Integrated care will be commissioned by expert commissioners in collaboration with care providers and delivered seamlessly by a range of quality assured health, social care, voluntary and private sector organisations.

11.3 <u>What this means for people who use care and treatment</u>

- *People in Barnet will feel like they are dealing with one care organisation*
- *They will have access to accurate information which will enable them to make informed choices and take responsibility for their health and wellbeing*
- *They will be able to get the right care and treatment quickly without having to deal with lots of people*
- *Personal information will only have to be provided once and will be shared securely with other organisations involved in the person's care*
- *Care will be provided safely by well trained teams, at home or at a place that is convenient for them*

- *Someone will always take responsibility for making sure care is coordinated and the person being cared for, their family and carers, are kept informed*
- *People will be supported to be as independent of public services as possible through a local care system that encompasses prevention, self care and supportive communities*

11.4 What this means for care commissioning and provider organisations

- *Barnet will overcome obstacles to collaborative working through the development of trusted relationships*
- *The system of care in Barnet will provide the best value for public money and will deliver excellent care outcomes*
- *Agreements, structures and processes will be in place to enable the sharing of local knowledge and will inform the design and commissioning of integrated services*
- *Joint commissioning of integrated health and social care services and pooling of budgets will be standard practice*
- *Commissioners and providers will have combined their workforce, functions and operating structures where this makes sense*
- *IT systems will have been harmonised to support integrated working.*
- *Patient/service user assessment processes will have been joined up into a single assessment process which is carried out by multi-disciplinary teams*
- *Integrated care will be delivered by a range of one-stop, face-to-face, telephone and online service channels that provide more flexibility for people using care services and make the best use of resources*

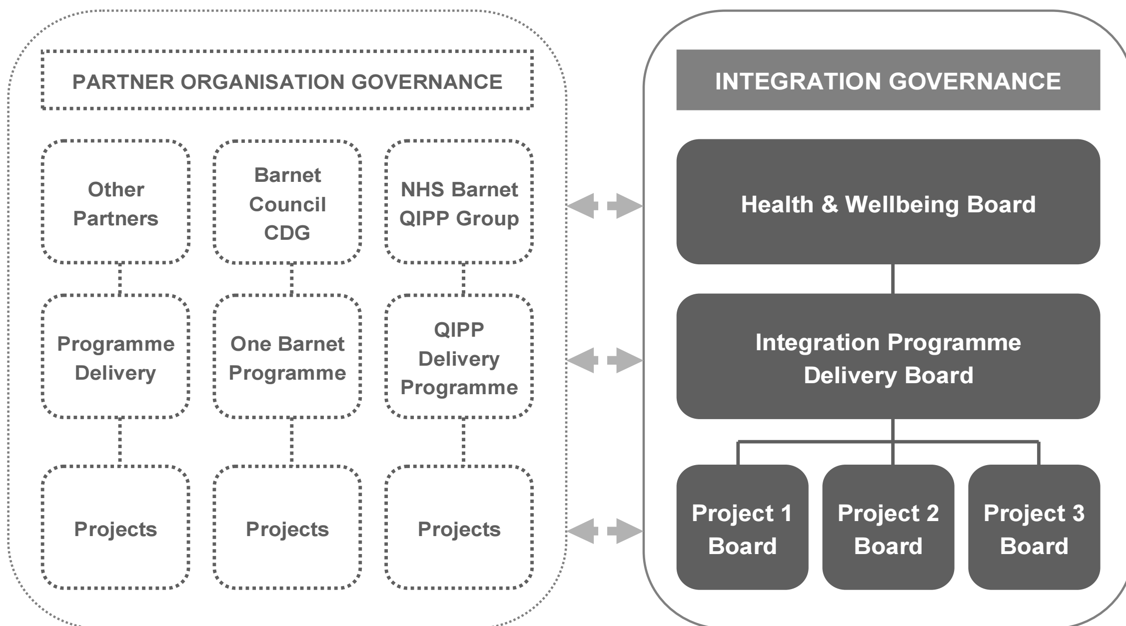
12. PROPOSED GOVERNANCE STRUCTURE

12.1 Both the Health and Social Care Outline Business Case and Integrated Commissioning Plan emphasise the importance of shared leadership, governance and programme delivery arrangements in the successful delivery of integration projects and in ensuring that benefits are fully realised. All of the integration opportunities that have been identified are dependent on the support and collaboration of multiple health and social care commissioning, provider and stakeholder organisations. Each organisation has its own corporate governance and project structures and processes to manage the delivery of change programmes.

12.2 This section sets out a governance, programme and project structure proposal to oversee the management and delivery of the Health and

Wellbeing Board's priorities for health and social care integration. This is described in the following diagram and highlights the multiple interfaces with member organisation governance and delivery structures:

Multi-agency programme delivery governance structure



12.3 Governance Design Principles

The proposed integration governance and delivery structure takes account of the following design principles and assumptions:

12.4 Health and Wellbeing Board

- The Health and Wellbeing Board sets the strategic direction and is the design authority for a local system of health and social care integration which is informed by the Health and Wellbeing Strategy and Joint Strategic Needs Assessment
- Each member of the Health and Wellbeing Board has a mandate from their respective organisations with delegated authority to approve care integration business cases on their behalf (subject to the agreement of their organisation and within defined tolerances and criteria, which are to be agreed)
- The Health and Wellbeing Board sets the local priorities for health and social care integration, approves the work programme and secures commitment and resources from Board members, to set up the integration programme and project boards to manage the delivery of plans and realisation of benefits
- The Health and Wellbeing Board is responsible for agreeing the shared programme and project management processes and reporting, ensuring these meet the requirements of their respective organisations
- Board members are responsible for securing the necessary input from their organisation's strategic partners and stakeholder networks to support the delivery of integration work programmes and realisation of benefits

12.5 Integration Programme Delivery Board

- There will be a shared integration programme delivery board which will have operational responsibility for the delivery of integration work programmes that have been approved by the Health and Wellbeing Board

- The programme delivery board membership will include lead Health and Wellbeing Board member sponsors and any providers that are identified as critical to the delivery of the work programme and benefits.

- Programme delivery will use existing structures where possible, ensuring the most efficient use of time
- The programme board is responsible for tracking project delivery against the approved business case and ensuring benefits are realised and optimised across the local system of care
- The programme board will define the necessary resources and skills requirement to deliver the integration programme and secure the necessary resources and investment via the Health and Wellbeing Board
- The board will implement agreed programme and project management processes including change control, risk and issues management within agreed tolerances set by the Health and Wellbeing Board
- The board will oversee programme and project reporting and ensure this is provided to the appropriate Health and Wellbeing Board member organisations
- It will approve individual project business cases, definition documents and plans within the scope and tolerances defined within the integration programme plan approved by the Health and Wellbeing
- The establishment and resourcing of a shared programme management office function where necessary to support and accelerate delivery of integration work programmes

12.6 Project Delivery Boards

The proposal suggests that depending on the complexity of a specific project and its dependency on input from multiple organisations, individual project boards will be set up to oversee the development and delivery of certain integration projects. The design of project delivery boards is informed by the following principles and assumptions:

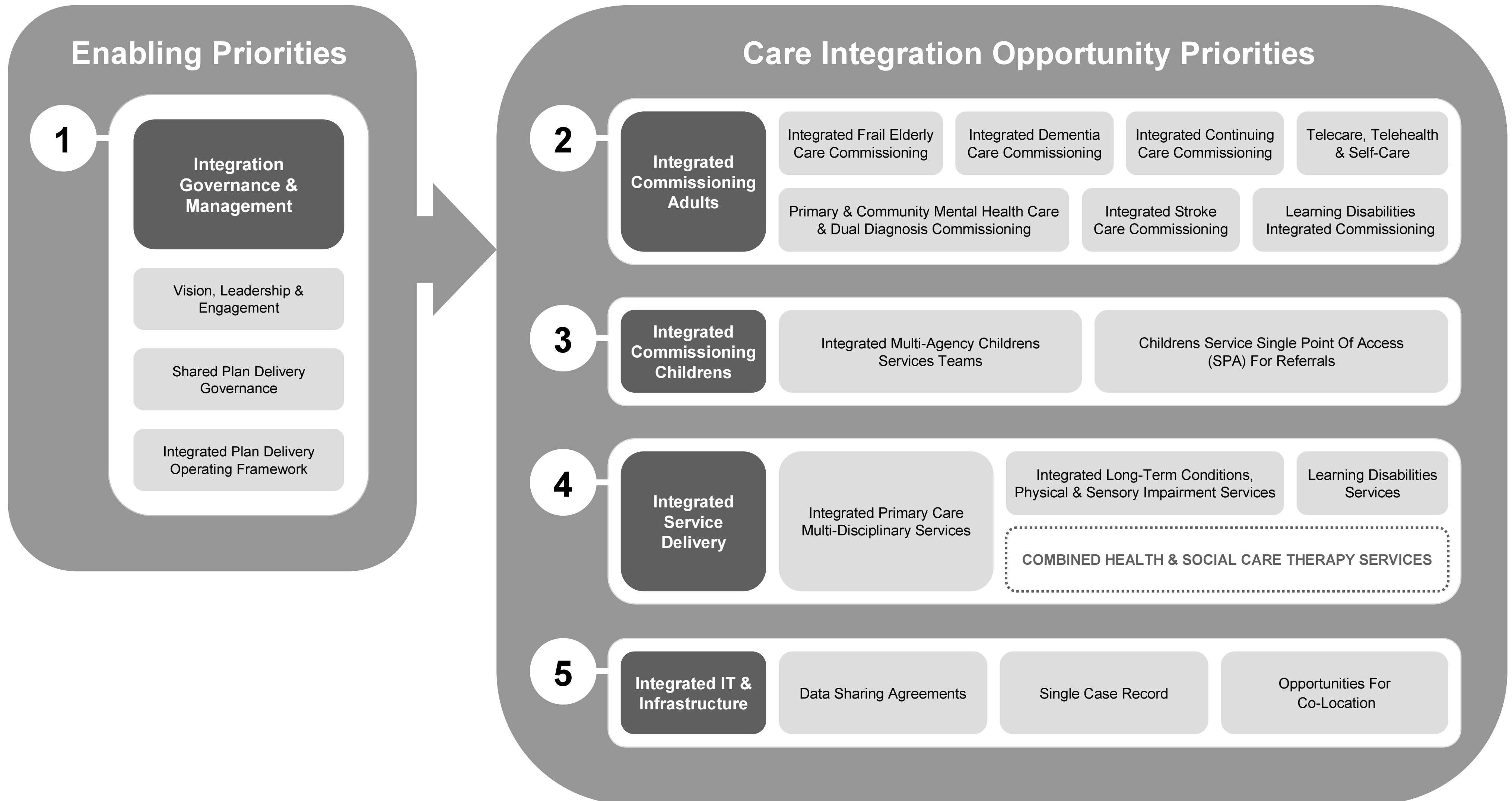
- Utilise existing Health and Wellbeing member organisation project delivery board structures where possible, ensuring the most efficient and effective use of time focused on management by exception
- Defines and approves the project brief and signs of the project definition document and plan
- Defines the necessary resources and skills requirements to deliver specific integration projects and secures the necessary resources and investment via the integration delivery board

- Implements agreed project management processes including change control, risk and issues management within agreed tolerances set by the integration delivery board
- Oversees project reporting and ensures this is provided to the appropriate Health and Wellbeing Board member organisations
- Approves individual project business cases, definition documents and plans within the scope and tolerances defined within the integration programme plan approved by the Health and Wellbeing Board
- Establishment and resourcing of a project management office function where necessary to support and accelerate delivery of the approved integration project

13. CARE INTEGRATION OPPORTUNITY PRIORITIES

This section sets out the suggested care integration opportunity priorities based on the output and priorities that were identified by Health and Wellbeing Board members at the integration workshop on the 22nd March 2012. This has been produced from the opportunities identified in the Health and Social Care Integration Strategic Outline Case and the Integrated Commissioning Plan.

CARE INTEGRATION OPPORTUNITY PRIORITIES OVERVIEW



INTEGRATION GOVERNANCE AND MANAGEMENT PRIORITIES

1. INTEGRATION GOVERNANCE AND MANAGEMENT OPPORTUNITIES				
Ref:	**Opportunity Area**	**Outcome and Output Benefits**	**Investment**	**Ownership**
1.1	Integrated Plan Delivery Capacity And Capability Requirement Provision of programme and project delivery, administrative support and technical specialist resources to enable the delivery of integration work programmes. Develop, agree and implement integrated programme and project management structures, processes and systems to support the delivery of joint integration work programmes across multiple organisations.	Outcomes • Integration project benefits realised through the effective coordination, coping and delivery of project work programmes • Project benefit delivery accelerated or increased • Integration projects completed on time and within budget • Reduce project delivery risk Outputs • Specialist resources for project delivery • Project business case documents • Defined project plan outputs such as redesigned pathway specifications and commissioned services • Procurement of services (if included in project scope) Links To Health & Wellbeing Strategic Themes • Wellbeing in the community • How we live • Care when needed	One Barnet Funding £100K	SRO Dawn Wakeling Project Lead Rohan Wardena

** SRO – Senior Responsible Owner*

INTEGRATION OPPORTUNITY DELIVERY PLAN PRIORITIES

2. INTEGRATED COMMISSIONING OPPORTUNITIES – ADULT SERVICES				
Ref:	**Opportunity Area**	**Outcome and Output Benefits**	**Investment**	**Ownership**
2.1	Frail Elderly Commissioning <u>Requirement</u> Develop and deliver programme of service developments to reduce admissions amongst the elderly to hospital and residential care and to reduce the need for care packages	<u>Outcomes</u> • Reduced avoidable emergency admissions to hospital • Reduction in number of people (all ages) dying in an acute hospital bed • Reduced percentage of elderly population (75+) requiring care home placements • Reduction in long term social care interventions / care packages • Increased percentage of older people report being satisfied with services and achieving agreed goals within care plans • More people supported to plan for their future <u>Outputs</u> • Integrated frail elderly service comprising rapid response, complex case management and rehabilitation (includes consideration of night time services) • Implemented a fracture liaison service • Developed and implemented a community dementia pathway • Developed and implemented a community stroke pathway • Improved clinical support to care homes including medicines management • Procurement of services to support people (all ages) to die in the place of their choice • Implementation of Advance Care Planning <u>Links To Health & Wellbeing Strategic Themes</u> • Care when needed	<u>Section 256 Funding</u> £300K	<u>SRO</u> Ceri Jacob <u>Project Lead</u> Caroline Chant
2.2	Dementia Care Commissioning <u>Requirement</u>	<u>Outcomes</u> • People with dementia will remain independent and in their own	<u>Section 256 Funding</u>	<u>SRO</u> Ceri Jacob

2. INTEGRATED COMMISSIONING OPPORTUNITIES – ADULT SERVICES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
	Initiative to identify and define an ideal community delivered pathway and will include prevention and outcome modelling to determine where investments should be made to achieve the greatest return for both health and social care funding.	homes for longer, entering the care system at a later stage in their illness. • Carers will feel supported in their caring role • Contained costs across the care system Outputs • Integrated community dementia pathway that encompasses prevention and support of carers • Services commissioned to deliver the pathway Links To Health & Wellbeing Strategic Themes • Care when needed	£200K	Project Lead Caroline Chant
2.3	Stroke Care Commissioning Requirement Initiative to identify and define an ideal community delivered pathway and will include prevention and outcome modelling to determine where investments should be made to achieve the greatest return for both health and social care funding.	Outcomes • There is an increase in the percentage of people who have had a stroke that return to full independence • Reduced costs across the care system Outputs • Integrated community stroke pathway that encompasses prevention and support of carers • Services commissioned to deliver the pathway Links To Health & Wellbeing Strategic Themes • How we live • Care when needed	TBD	SRO Ceri Jacob Project Lead Caroline Chant
2.4a.	Primary And Community Mental Health Care - End-to-end integrated pathway and integrated model of care	Outcomes • Reduction in percentage of population requiring acute mental health	One Barnet Funding	SRO Ceri Jacob

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
	Requirement Develop a primary and community mental health care end-to-end pathway which encompasses prevention, early intervention, treatment and recovery.	care • A pathway that recognises the importance of housing, education and employment • Increased rates of recovery amongst those that enter the mental health care system • More people living independently in the community • Reduced activity and costs within the system Output • An agreed pathway that encompasses prevention, treatment and recovery. • A costed service specification that supports procurement of a single service to deliver the whole pathway • Reduction in overall costs within the pathway resulting from incentives that promote prevention and recovery Links To Health & Wellbeing Strategic Themes • Wellbeing in the community • Care when needed	£100K	Project Lead Temmy Fasegha Michele Williams
2.4b	Mental Health Dual Diagnosis Integrated Care Pathways Requirement Development and commissioning of dual-diagnosis care pathways	Outcomes • Reduction in crisis presentation in people with dual diagnoses • Reduction in costs within health and social care system resulting from more proactive management and clearer pathways of care Output • Pathways agreed with all stakeholders for a) Mental health / Substance Misuse b) Mental health / Learning Disabilities c) Mental Health / Autism	One Barnet Funding £300K	SRO Ceri Jacob Project Lead Temmy Fasegha

2. INTEGRATED COMMISSIONING OPPORTUNITIES – ADULT SERVICES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
		• Services to deliver pathways commissioned <u>Links To Health & Wellbeing Strategic Themes</u> • Wellbeing in the community • Care when needed		
2.5	Learning Disabilities And Physical And Sensory Impairment Care Service Commissioning <u>Requirement</u> Develop clear pathways for people with PSI that span health and social care and increase alternatives to residential care	<u>Outcomes</u> • Improved satisfaction rates with transition to adult services process • Reduction in number of people in residential care • Reduction in percentage of people with PSI or LD living in residential care • Reduction in overall spend on residential care • Increased satisfaction with care expressed by service users and their carers • Reduced admissions to hospital for pressure sores <u>Outputs</u> • Clearly defined pathways in place which begin with transition planning • Housing needs assessment for next 5 years completed and shared with planning department • Sufficient housing stock to support projected increase in people with PSI and LD in Barnet • Quality assurance processes embedded within new Quality and Performance Teams • Referral points for concerns (quality and safeguarding) widely advertised and promoted • Include requirements to report safeguarding and quality concerns in related GP Local Enhanced Service agreements <u>Links To Health & Wellbeing Strategic Themes</u> • How we live	<u>One Barnet Funding</u> £400	<u>SRO</u> <u>Project Lead</u> Caroline Chant

2. INTEGRATED COMMISSIONING OPPORTUNITIES – ADULT SERVICES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
		• Care when needed		
2.6	Continuing Care Commissioning Requirement Initiative to identify opportunities to jointly commission continuing care. This will include definition of an ideal community delivered pathway and prevention and outcome modelling to determine where investments should be made to achieve the greatest return for both health and social care funding.	Outcomes • Reduction in people required to change providers if funding source changes • Overall costs are reduced as commissioner procurement leverage is increased Outputs • All continuing care jointly procured • Budgets are aligned / pooled Links To Health & Wellbeing Strategic Themes • Care when needed	TBD	SRO Ceri Jacob or Dawn Wakeling (TBC) Project Lead Alan Brackpool or Eryl Davies (TBC)
2.7	Telehealth And Telecare Integrated Service Commissioning Requirement Telecare and Telehealth initiative to extend the uptake and usage of existing telephone delivered health and social care services. This will include the development of an integrated telecare and telehealth strategy and associated implementation plan.	Outcomes • Reduction in the number of people admitted to care homes • More people remain in own home with no or reduced need for care package • Reduction in emergency admission or A&E attendance for exacerbation of LTC • Reduction in delayed discharge from hospital • Reduction in complications of LTC (measured over time and disease specific) Outputs • Telecare and telehealth procured and targeted at population groups where most benefit can be gained	Section 256 Funding £500K	SRO Ceri Jacob Project Lead External Partner

2. INTEGRATED COMMISSIONING OPPORTUNITIES – ADULT SERVICES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
		Links To Health & Wellbeing Strategic Themes • Care when needed		

3. INTEGRATED COMMISSIONING OPPORTUNITIES – CHILDRENS SERVICES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
3.1	Integrated Multi-agency Children's Services Teams Requirement Development and commissioning of integrated teams organised around care delivery setting	Outcomes • Universal provision is supported to utilise existing resources more effectively • Pressure is reduced on targeted services and budgets • Reduced acute hospital costs as a result of increased focus on earlier intervention / prevention Outputs • Multi Agency Teams co-located under single management structure in key settings. May include schools, children's centres and GP practices (as part of GP provider network) Links To Health & Wellbeing Strategic Themes • Care when needed	TBD	SRO TBD Project Lead TBD
3.2	Childrens Service Single Point Of Access (SPA) For Referrals Requirement Development of a single point of access for referral to children's services that	Outcomes • Reduced inter and intra agency referrals and children are directed to right service first time • Increased use of CAF by all agencies involved in Children and Young Peoples care leading to reduced duplication of care/assessments/costs	TBD	SRO TBD Project Lead TBD

3. INTEGRATED COMMISSIONING OPPORTUNITIES – CHILDRENS SERVICES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
	encompasses a MASH (multi agency safeguarding hub).	Outputs • CSO level 3 calls / 111 calls directed to SPOE • Co-located MASH team • Professional trusted assessors (working across health and social care boundaries) triage and give advice or direct service users into appropriate service • Pre CAF and CAF initiated where appropriate Links To Health & Wellbeing Strategic Themes • Care when needed		

4. INTEGRATED DELIVERY OPPORTUNITIES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
4.1	Long-Term Conditions And Physical And Sensory Impairment Services Requirement Integrated LTC/PSI teams to support the most complex users including neurological conditions, complex physical disabilities. An integrated multi-professional team that would include social workers, therapists (including occupational health, physio and speech and language (SALT) therapists), nursing. Service could be governed by right to control (RTC) principles, drawing together NHS personal health budgets with social care/RTC funding streams (including	Outcomes • Reduction in the number of people admitted to care homes • More people remain in own home with no or reduced need for care package • Reduction in emergency admission or A&E attendance for exacerbation of LTC • Reduction in complications of LTC (measured over time and disease specific) • More people supported to plan for their future Outputs • MDTs in place for each primary care network (population 30,000) • Care co-ordinator included in MDT • Single assessment in place	TBD	SRO Alison Blair Project Lead Becky Kingsnorth

4. INTEGRATED DELIVERY OPPORTUNITIES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
	employment support). The team would also facilitate community integration and access to mainstream supports for users.	Links To Health & Wellbeing Strategic Themes • How we live • Care when needed		
4.2	Learning Disabilities Services Requirement Initiative to identify and define an ideal community delivered pathway and will include prevention and outcome modelling to determine where investments should be made to achieve the greatest return for both health and social care funding. This will also include identifying opportunities to combine therapy services.	Outcomes • Increased opportunities to optimise health and social care funding and further improve care outcomes through the commissioning of integrated care packages and pathways • Reduced likelihood of cost shunting and organisational funding disputes • Contract efficiency savings Outputs • Integrated care pathway and services • Combined therapy services Links To Health & Wellbeing Strategic Themes • How we live • Care when needed	TBD	SRO Dawn Wakeling Project Lead
4.3	Integrated Primary Care Multi-Disciplinary Services Requirement Establishment of multidisciplinary (MDT) health and social care assessment and delivery teams as part of locality based integrated primary care networks.	Outcomes • Health and social care delivery organisation efficiency and capacity gains from a single assessment, admissions, review and discharge process • Improved customer experience Outputs • MDTs in place • Single assessment process in place	One Barnet Funding £100K NHS NCL Primary Care Strategy Funding TBD	SRO TBD Project Lead TBD

4. INTEGRATED DELIVERY OPPORTUNITIES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
		Links To Health & Wellbeing Strategic Themes • Care when needed		

5. INTEGRATED IT & INFRASTRUCTURE OPPORTUNITIES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
5.1	Data Sharing Agreements Requirement Development of an overarching data sharing agreement for health and social care providers to support improved care management and integration of workflow processes within the existing system of care.	Outcomes • Improved customer experience through reduced requirement to repeat the same personal information to multiple organisations and departments • Enable more seamless hand-offs to multiple organisations involved in the care of a particular client • Support more responsive care and reduce delays because all organisations will have access to client information and history. Substantial benefits for the delivery of emergency care Outputs • Data sharing agreement in place that encompasses health and social care providers and commissioners Links To Health & Wellbeing Strategic Themes • Care when needed	TBD	SRO TBD Project Lead TBD
5.2	Single Case Record Requirement Development of a client enabled and web	Outcomes • Improved customer experience through reduced delays in organisations collecting client and accessing care plans • Enable more responsive and effective case management across both	NHS NCL Primary Care Strategy Funding	SRO TBD Project Lead

5. INTEGRATED IT & INFRASTRUCTURE OPPORTUNITIES				
Ref:	**Opportunity Area**	**Outcome and Output Benefits**	**Investment**	**Ownership**
	hosted single case record for clients with complex care needs. The client record could be accessed by all organisations on a client permission basis via a web based portal anywhere in system.	health and social care providers • Reduced administrative effort to maintain multiple case management information systems Outputs Share record system in place Links To Health & Wellbeing Strategic Themes • Care when needed	TBD	TBD
5.3	Co-Location Opportunities Requirement Consider opportunities for co-location and physical integration as premises leases become due for renewal or review.	Outcomes • Improved opportunities for care co-ordination and service development as commissioning or delivery organisations are co-located in shared premises • Estates optimisation and efficiencies • Opportunities to bring care closer to communities enabled Outputs • Improved customer experience • Reduced waiting times Links To Health & Wellbeing Strategic Themes • Care when needed	TBD	TBD

Legal-HP
Finance- JH

APPENDIX 1

Project Brief including Strategic Outline Case (SOC): Joint Health and Social Care Integration Programme

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Date:	06 March 2012
Service / Dept:	Adult Social Care and Health

Approvals

By signing this document, the signatories below are confirming that they have fully reviewed the Strategic Outline Case (SOC) for Health and Social Care (H&SC) Integration programme and confirm their acceptance of the completed document.

Name	Role	Signature	Date	Version
Dawn Wakeling	Deputy Director Adult Social Care and Health, London Borough of Barnet		06/03/12	1.0
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DOCUMENT CONTROL

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Version	Date	Author(s)	Summary of Changes
1.1	14/03/2012	Rohan Wardena	Revised NHS QIPP financials and adjustments based on feedback from Alison Blair, NHS NCL Borough Director

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1. Executive Summary

1.1 Overview

This strategic outline case (SOC) document takes the expressed ambitions for health and social integration of the health and social care community as its starting point. It builds on the aspirations set out in Barnet's draft Joint Health and Wellbeing Strategy and complements current work in progress such as the draft integrated commissioning plan. It summarises and broadens the need for investment and provides an opening position statement on the aspirations, approach and opportunities for joint working across health social care in Barnet.

It also has a wider purpose as an opening discussion document to start a productive dialogue between NHS and local authority organisations and all relevant local voluntary and private sector partners, around the various approaches to integration and the scale of ambition to transform the way in which care is commissioned and delivered in Barnet.

A preliminary scoping review has been recently carried out by LBB with local health commissioning and service delivery partners, to understand the current local health and social care stakeholder environment, appetite for integration, national and local pressures; and to identify what activity is already in progress or planned between partner organisations to support integrated commissioning and delivery of health and social care services in Barnet.

The scoping review has identified that because of the complexity of the work, the circumstances under which it will need to be undertaken and the number of organisations involved to realise the potential benefits of integration, it will require a series of multiple projects and an integrated programme management approach to coordinate delivery and oversee benefits realisation.

There are a number of examples of integration that have received national attention, such as Torbay, with many claims about the benefits that are being delivered in terms of improved outcomes and customer experience. Most of the evidence identifies benefits relating to health rather than to social care. There are no large scale or controlled examples that provide a set of robust modelling assumptions and tested measures and indicators that can be applied to illustrate the benefits of particular options for social services and within the context of this outline business case.

There are already a number of local initiatives that are planned or underway. The scale of some of these initiatives and the number of partners involved highlights the need for a well coordinated approach to minimise the risk of confusion and delay, and to ensure that health and social care work programmes deliver their full benefit potential.

The National Health Service is undergoing one of the biggest changes in its sixty year history, with fundamental changes to the way in which health care is commissioned, delivered, funded and regulated. LBB is currently undergoing substantial change

through the implementation of the One Barnet Programme, to transform the way its services are commissioned and delivered. While these changes provide fertile conditions to rethink the way care is designed, purchased and delivered, it also creates a number of practical challenges that an integration programme will need to take account of to ensure plans are successfully implemented and benefits realised. This includes anticipating that a number of the strategic partner organisations which need to agree the plans at the outset will either not exist following the implementation of the health and social care reforms, or will no longer have the authority to make the necessary decisions. The agreed governance and delivery approach for this programme will need to be both flexible and sufficiently robust to be able to positively respond to these changes as they occur.

1.2 Summary conclusions and recommendations

The scoping review has concluded that there is strong local support for integration, with a recognition among partners that more dialogue is needed to build trust and shared agreement on the precise scope and shape of integration in Barnet health and social care.

There is a need for robust multi-agency governance and programme management to oversee integration initiatives and ensure all partners maintain an overview of developments. This will bring co-ordination and resources to existing initiatives as well as ensuring delivery of new projects.

Given the changes to local organisations, there is a need to focus the integration programme on the achievement of measurable goals in the short to medium term, e.g. 2012/13, as well as planning for the longer term.

Partner organisations have identified a long list of potential opportunities that could deliver benefits. This SOC draws these together and sets out the current status of each. The benefits that will accrue to individual or multiple organisations or to Barnet as a community will need to be clarified at the outset of each project and measured throughout implementation.

1.3 Recommendations

This SOC asks for agreement to the following:

1. Setting up a health and social care integration ‘summit’ with further strategic dialogue to create a precise vision for Barnet integration
2. Establishment of shared governance and programme management arrangements overseeing all health and social care integration initiatives
3. A multi-agency prioritisation and selection exercise to agree which integration projects are taken forward
4. Approaching the work with two layers of projects: pioneer projects which will deliver measurable results in the short to medium term; plus transformational projects which will deliver benefits over the longer term.

The programme aims to improve health and wellbeing outcomes for Barnet's citizens and achieve substantial efficiency savings for partner organisations, through better coordination and integration of health and social care commissioning and service delivery.

The preliminary scoping review has identified four overarching objectives that will underpin delivery of the expected programme outcomes and benefits should be prioritised as part of the next steps:

1. Develop a common vision, joint integration plan, shared governance and leadership arrangements and a framework to coordinate and manage the delivery of joint health and social care integration projects – To be achieved within the first 3 months
2. Develop the necessary local indicators and tools to accurately baseline and measure the benefits of health and social care integration and build the evidence base to inform integration investment decisions – To be achieved within the first 3 months
3. Identify, prioritise and deliver a portfolio of projects or planned initiatives that will build the momentum for integration within the local system of care and amongst partner organisations and that will establish and strengthen the key relationships, framework for joint working and capacity, systems and processes to support this – To be achieved within 12 months
4. Within the context of the common vision and agreed operating model (described above), establish a pipeline of strategic projects to develop a more integrated and affordable system of care, deliver better outcomes for Barnet's citizens, improve the customer experience, and address the substantial cost pressures that both LBB and local NHS commissioners and providers need to resolve over the next three years.

1.4 Expected outcomes

The expected outcomes can be grouped into those that will be delivered during the early stages of the programme within the first three to six months and those that will be delivered during the lifecycle of the programme and the defined benefits realisation stage once project delivered work programmes and outputs have been completed.

The following outcomes will be delivered during the initial stages of the health and social care integration programme and are the key enablers for programme delivery and benefits realisation:

Vision and Governance

- Partner organisations have a shared vision and priorities for health and social care integration in Barnet and there is a firm commitment to achieve this

- There are open and trusted relationships in place to enable and support meaningful collaborative working and realise the full benefit potential that integration can deliver
- There are collaborative leadership and governance arrangements in place between partner organisations, with the mandate to make the necessary decisions and commit resources to deliver the vision and these are clearly defined within the context of the Health and Wellbeing Board and existing local joint programme leadership and delivery arrangements

Programme Delivery

- A joint plan has been developed, prioritised and agreed by the key partner organisations to identify and deliver a portfolio of health and social care integration projects
- An integration management and project delivery approach has been agreed between partner organisations to implement integration plans and deliver joint projects
- A pipeline of joint integration projects has been defined, agreed and implemented by partners to deliver the necessary efficiency savings, quality improvement commitments and performance targets during 2012/13

Investment Decisions

- Investment opportunities for health funds for social care are identified, that enable integration and the delivery of recurrent cashable benefits and improved customer outcomes and experience
- Evidenced based business cases have been produced to inform investment options and decisions for the prioritisation and delivery of a programme of health and social care integration projects
- There is an agreed set of benefits matrices and indicators developed and in place to baseline, measure and track the benefits and return on investment from integration initiatives for all partners

Communication

- There is an understanding of all integration initiatives that are currently being progressed across the health and social care system in Barnet and these are aligned to ensure benefit opportunities are optimised

The following outcomes are expected to be delivered during the lifecycle of the programme and during the term of the benefits realisation phase following completion of the project work:

- More people with complex health and social care needs are able to live more independently in their own homes for longer and as a result fewer people require long term residential care or high cost care packages
- Where care is provided by multiple organisations, this looks and feels seamless to the person receiving care and the processes, IT systems and policies are designed to support data sharing and workflow management
- New integrated models of care deliver cashable net savings to partner organisations. £4.2m has been identified within the Council's current Medium Term Financial Strategy and there are local NHS plans (QIPP plan) to deliver a £38.6m saving in 2012/13.
- More care is delivered in the home or closer to home and people who are most at risk of needing urgent care are actively case managed by defined accountable owners across health and social care
- People are only admitted to hospital when this is the safest and most appropriate option to best meet their care needs and they are supported by a well coordinated team of professionals and carers to quickly regain their health and independence and return home
- People are able to access both health and social care at first point of contact and in most instances from easy to use one stop single points of access and where referrals are required the number of hand-offs is minimised
- Care is assessed and delivered by multidisciplinary teams which include both health and social care expertise and there is a clearly defined mainstream care offer which all staff understand and are trained to be able to deliver
- People have more scope to personalise their health and social care and have more choice about how and when they access care
- The local model of care is rebalanced with an increased focus and allocation of resources on self-management, prevention, early intervention and crisis avoidance pathways and services and care is delivered through a range of cost effective and quality assured on-line, telephone and face-to-face channels

1.5 Benefits Indicators

This section identifies a range of illustrative indicators that could be used to measure and evidence the benefits that will be delivered through the implementation of a health and social care integration programme. These will need to be validated and baselined as part of the leading business case development phase of each prioritised integration project and in some instances, joint benefits measurement methodologies, data recording and reporting systems will need to be defined and agreed. However, the overarching principle will be that established indicators and existing reporting systems will be used rather than attempting to develop something completely new unless this is considered to be absolutely necessary.

Benefit Category	Benefit Indicator Description
Quality and care outcomes	• increase in the number of people requiring care who are able to remain in their own home • increase in customer and patient satisfaction • increase the proportion of carers who feel supported in their caring role • increase in the number of people who are terminally ill who are able to die their place of choice • increase in the proportion of direct payments • reduction in the number of contacts required from initial contact to care package being in place • reduction in the number of people in care homes requiring treatment for pressure sores • in the number of people completing reablement plans with no further care needs • reduction in inappropriate A&E attendances • reduction in length of stay in acute hospital bed for frail elderly and people with long-term conditions • Conformance with NICE guidelines and national pathways e.g. national dementia strategy and stroke pathways
Efficiency and resource utilisation	• reduction in the number of people in local authority funded residential care • reduction in the number of people requiring high intensity 24/7 packages of care • reduction in the number of people attending hospital Accident and Emergency (A&E) Departments whose needs could have been appropriately met in Primary Care (e.g. GP Practice, Community Health Care Provider, Urgent Care Centre, Community Pharmacy) • reduction in the number of people with long-term conditions attending A&E more than once within a 12 month period • reduction in the number of older people over 65 admitted to hospital via A&E • reduction in avoidable readmissions to hospital within 28 days from discharge

Benefit Category	Benefit Indicator Description
	• reduction in the number of people referred for a care home placement following an emergency admission to hospital • reduction in the number of hospital excess beddays relating to delayed discharge • reduction in the number of hospital admissions from care homes
Financial	• longer term cost containment through demand management of demographic growth • adult social care recurrent cost savings by 2014/15 • reduction in adult social care transaction unit costs (e.g. higher productivity for the same or less funding) • reduction in adult social care management and back office costs • upper quartile position in London and National local authority funded social care financial performance rankings • NHS recurrent cost savings by 2014/15 • reduction in NHS transaction unit costs (e.g. higher productivity for the same or less funding) • increase in the proportion of funding allocated to primary and community care • reduction in NHS back office costs

1.7 Key target dates

The key dates relate to the next stage of the programme and indicative milestones for subsequent stages of programme delivery through to full benefits realisation. This will be dependent on the scale and complexity of the work programme, availability of resources and agreement from all partner organisations involved in the delivery of the plan.

Date	Key Milestone
May 2012	Health and social care integration leadership summit held
June 2012	Joint integration work programme and project portfolio options and priorities agreed by health and social care partners

Date	Key Milestone
July 2012	Integration programme governance and delivery arrangements in place and resources secured and committed
September 2012	Integration project pipeline defined, business cases produced and options selected and approved
December 2012	Pioneer project completion and full benefit realisation starts
December 2012	Transformational project business cases produced and options selected and approved
April 2013	Pioneer projects delivered and full benefit realisation starts
April 2014	Transformation projects delivered and full benefit realisation starts
March 2015	Programme benefits fully realised

Benefits realisation timelines will be dependent on the scope and complexity of the project. Phase 1 pioneer project delivery assumes that at least 3 months of benefits delivery will be required to meet any 2012/13 in-year savings requirements (e.g. local authority MTFS and NHS QIPP commitments).

2. The Strategic Position

This section covers the following areas:

2.1 Benefits of integration

2.2 Local strategic vision and support for integration

2.3 Current state of integration in Barnet

2.1 The benefits of integration

Integrated care describes the coordinated delivery of support to individuals in a way that enables them to maximise their independence, health and wellbeing. The literature suggests that whilst integrated care is not needed for everyone, it is particularly effective in terms of streamlining service input to people who are intensive users of services; and it helps the service user navigate the health and social care system. For public services, greater efficiency can be achieved through reducing duplication and for service users, there should be a reduction of risk and better access to services and advice. An integrated approach to commissioning, planning and investment in health and social care has been shown to deliver benefits in preventing and delaying the demand for higher intensity or residential care.

Integration can operate at the levels of: clinical pathway; care team; client group; functional unit; or whole organisation. It can operate vertically within the healthcare sector e.g. from community health care to hospital care; or horizontally, between health and social care sectors. This table summarises some different approaches that have been applied.

Integration Type	Example	Applied Examples	Benefits
HORZONTAL	Health and social care integration	Whittington Health (Integration of Whittington Hospital, Haringey Community Health Services, and Islington Community Health and Social Services for Older People and Physical Disability) Wye Valley NHS Trust (Integration of Hereford Hospitals NHS Trust, NHS Herefordshire Primary Care Trust and Provider Services, Herefordshire Council Adult Social Care)	• Improved customer journey and experience • Improved access to services • Services joined up and customer centred • Better use of resources and sustainable model of care through pooled funding • Process efficiencies • Multidisciplinary teams and single assessment process • Faster decision making and easier communication
VERTICAL	Integration of NHS community and hospital provider organisations	Many community healthcare service providers have merged with hospital providers	• Improved the coordination of care for patients • Strengthened intermediate care pathways and made these more seamless • Enabled more specialist care to be delivered closer to home • Strengthened community delivered urgent care and rapid response capability • Improved discharge planning and reablement capability
SERVICE INTEGRATION	Older peoples services	Torbay Care Trust integrated care for older people	• Care designed around the needs of older people • Integrated teams empowered to arrange and fund more individualised care packages • Reduction in emergency hospital admissions and bed usage • Reduction in demand for residential and nursing care provision
CLINICAL PATHWAY	Cardiac networks Emergency care	London stroke care pathway	• Faster access to care and improved patient outcomes

Integration Type	Example	Applied Examples	Benefits
INTEGRATION	networks Rehabilitation services	North West London care at home project	• Clinical best practice • Improve clinical quality and patient safety • Clinical engagement and buy-in

As part of developing this outline case, evidence was obtained from the following integrated services and organisations and from a desktop review of the literature on health and social care integration (more information can be found in appendix 9.2):

- Torbay
- Northamptonshire
- Herefordshire
- Barnet learning disability service
- Islington
- Buckinghamshire

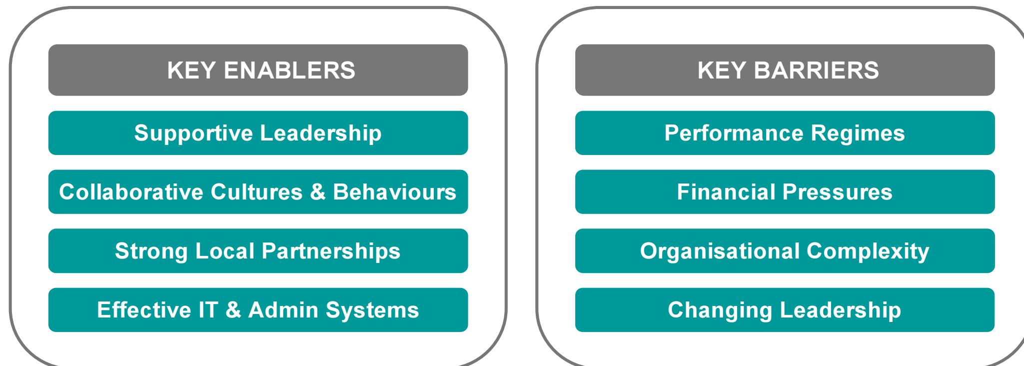
Key messages from case studies and the literature review are:

No single best practice model of integrated care is exists, either in the health service or in integrated health and social care. The literature and modelling of benefits is more extensive in the area of vertical health care integration. There is a comparative lack of literature detailing the financial benefits to social care. However, the National Evaluation of Partnerships for Older People Projects (POPPS) identified that investment in community initiatives delivered cost reductions for both health and social care, as well as improvements in quality of life and outcomes for older people using health and social care.

Integrated care can be a more expensive option for some types of care and therefore should be targeted at more complex service users where there will be most benefits:

- Frail older people
- Children and adults with disabilities
- People with chronic addictions
- People with multiple chronic and mental illnesses
- Certain urgent care conditions where a fast and well coordinated response substantially improves care outcomes (e.g. strokes and cancers)
- End of Life Care

Key enablers and barriers to integration



NHS Institute for Innovation and Improvement: Joined-Up Care November 2010

2.2 Local strategic vision and support for integration

Locally, the principal strategies relating to public service and health and social care share two common themes, which are relevant to this outline case. The first is that the scale of the demographic challenge facing the borough will require radical and transformational change, in order to meet increased demand with reduced funding. The second is that integration is seen as key in terms of meeting this challenge.

Organisation/Body	Strategic Reference Documents
Barnet Partnership Board (Local Strategy Partnership)	• Sustainable Community Strategy 2010-2020
Barnet Health & Wellbeing Board (reports to the Barnet Partnership Board)	• Barnet Joint Strategic Needs Assessment 2011-15 • Health and Wellbeing Strategy (In Draft) • Integrated Commissioning Plan (In Draft) • Integrated Prevention Plan (In Draft)
Barnet Council	• One Barnet Programme – Corporate Plan 2011-13
Barnet Clinical Commissioning Group/ NHS North Central London PCT Cluster	• Commissioning Strategy and QIPP Plan 2012/13-14/15 • Primary Care Strategy

2.2.1 Joint Strategic Needs Assessment

The Joint Strategy Needs Assessment for Barnet identifies a number of key health and social care challenges that need to be managed and addressed and recognises the huge pressures that are being placed on the local system through substantial

reductions in public sector funding and changes to the way in which NHS services will be commissioned and delivered.

- People are living longer with significant proportional growth expected over the next five years among the over 65s (7.4% increase) and over 85s (11.3% increase). These increases will see a sharp rise in the demand for long-term care of the elderly and support for their carers and the prevalence of age related health conditions including dementia.
- Significant actual growth is expected in the population of children over the next five years, particularly within the 5-9 age group (23% increase) is likely to lead to a sharp increase in the demand for support to children with complex needs and their families.
- Although the population is living longer, there is a substantial difference in life expectancy within the borough with a gap of seven years between people living in the most deprived and most affluent areas, and a significant growth in long term conditions.

2.2.2 Sustainable Community Strategy

The Sustainable Community Strategy is the overarching plan that sets out the vision, core values and priorities for Barnet, which have been agreed by local partners including NHS commissioners. Key priority areas are healthy and independent living for all and greater choice.

The Barnet Partnership recognise that in order to achieve the vision and deliver the strategy, public services must work together as 'One Barnet' and that organisations must work together to realise efficiencies, provide seamless customer services and develop a shared insight into the needs and priorities to inform commissioning of services and prioritisation of scarce resources.

2.2.3 Health and Wellbeing Strategy

Barnet's Health and Wellbeing Board (H&WB) has been in operation since May 2011 and is an early implementer of the new local leadership and accountability arrangements to support a more collaborative approach to the health, public health and social care commissioning and strengthen democratic accountability. Health and Wellbeing Boards will become statutorily operational in all unitary and upper tier local authorities from the 01 April 2013, subject to Parliamentary approval of the Health and Social Care Bill.

The Health and Wellbeing Board is chaired by the Cabinet Member for Public Health and includes representatives from Barnet Clinical Commissioning Group, NHS North Central London PCT Cluster, LINk, Public Health and Barnet Council.

A key responsibility of the H&WB is to produce a Joint Health and Wellbeing Strategy (JHWS) that spans health, social care, public health and considers the wider

determinants of health such as housing, education, leisure, transport and the environment. A JHWS has been produced in draft. The JHWS sets out a common vision and priorities for health and wellbeing in Barnet that will contribute towards delivering the objectives for healthy and independent living that are prioritised in the Sustainable Communities Strategy.

The JHWS identifies four priority areas:

- **Preparation for a healthy life** –enabling the delivery of effective pre-natal advice and maternity care and early-years development
- **Wellbeing in the community** –creating circumstances that better enable people to be healthier and have greater life opportunities
- **How we live** –enabling and encouraging healthier lifestyles
- **Care when needed** –providing appropriate care and support to facilitate good outcomes

The JHWS is underpinned by two cross cutting themes: prevention and early intervention, and the need for integrated care pathways and services to deliver the best care outcomes within the health and social care resources available. This will be delivered through two key joint integration plans:

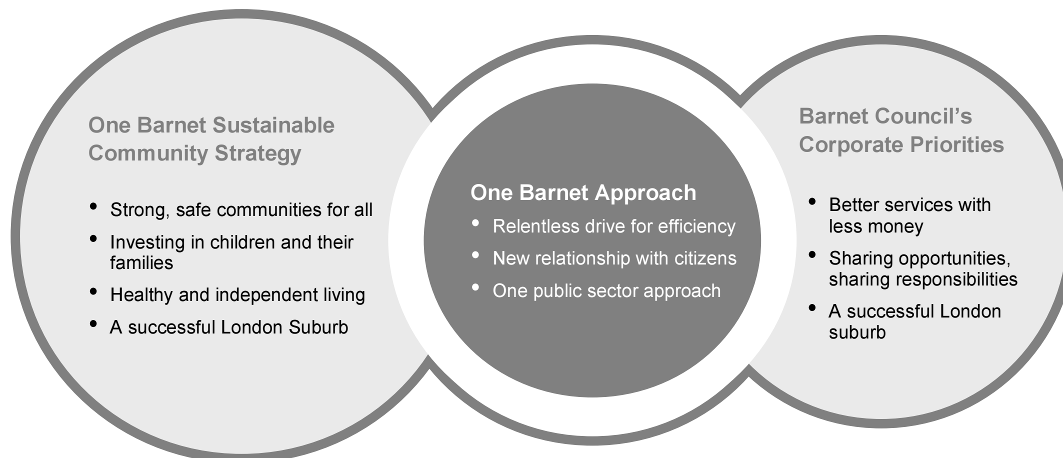
- <u>Integrated Commissioning Plan</u> -This will deliver the outcomes of the JHWS and is currently in draft form. It sets out the joint commissioning priorities and intentions for health and social care and a set of principles and framework for integration that will need to be agreed with all partners. The plan proposes a broad scope for both the integration of commissioning and provision of health and social care services and recommends integration in any area where there is overlap in terms of delivering care.

- <u>Integrated Prevention Plan</u> - The draft Integrated Prevention Plan focuses on the different aspects of prevention which includes stopping things from happening in the first instance and delaying the onset and consequences of long-term conditions and the effects of aging.

An event in early March is planned that will seek to obtain agreement across health and social care commissioners (including the Clinical Commissioning Group) on the key service areas and/or population group to be included.

2.2.4 One Barnet Programme – LBB Corporate Plan

The One Barnet Programme is the Council's Corporate Plan to drive the transformation of local public services.



The integration of health and social care services to promote better outcomes, increase independence and reduce bureaucracy is a key objective for the Council in delivering its priority for better services with less money. In particular, key actions for social care are to ensure targeted investment of the social care allocations from the NHS to improve the whole system's response for care closer to home and deliver efficiencies through joint commissioning and procurement of services in social care and health

2.2.5 Barnet CCG Commissioning Strategic Plan

Barnet Clinical Commissioning Group is due to assume its statutory responsibilities in 2013, subject to authorisation by the NHS Commissioning Board, which is dependent on the passing of the Health and Social Care Bill by Parliament. It has produced its local commissioning strategy and QIPP plan for 2012/13 – 2014/15 which forms part of the NHS North Central London PCT Cluster commissioning strategy and QIPP plan and supports achievement of the following vision

Through working with local people and partners we will improve the health and wellbeing of our population, reduce inequalities and maximise the value in terms of outcomes, quality and efficiency from service provided to patients.

The commissioning strategy identifies that care for the most vulnerable people is unplanned, fragmented and disorganised and 40% of people using accident and emergency departments could have their needs met safely and appropriately in primary care by a GP or community health practitioner. The following areas are identified as priorities for better coordinated care and integration:

- Frail elderly (including dementia care and stroke pathways)

- Long-term conditions
- Mental health
- Unscheduled care (including benefits realisation from 111 single point of access)
- Primary Care Networks
- Integrate prevention into all care pathways

In addition the commissioning strategy identifies that there is an imbalance in the distribution of resources with an over reliance on acute services in Barnet (56.8% of total spend compared with the London average of 47%) and underdeveloped primary and community health services.

2.2.6 Outcomes from the outline case scoping review

The position of local health commissioner and providers

As part of the development of this Strategic Outline Business Case, a series of meetings were held with the Council, NHS commissioning and provider partners to capture all perspectives and aspirations for integration within health and social care in order to identify common opportunities and themes for engagement. These discussions built on the existing statements of strategic intent, set out above, and aimed to build consensus for a structured programme of work on health and social care integration. A discussion was also held at the Health and Well being board.

There was broad support and endorsement from all local acute, community and mental health providers and commissioners for the principle of integration, which reflected the statements in the various strategic documents. However, it was acknowledged that integration meant different things to the various organisations and that there was a need to establish a shared understanding and common language to describe this. There was a question for a number of interviewees about how the leadership of integration should work. No single organisation had a clear overview of all the current initiatives. A need to continue the dialogue to build increased trust and consensus between partners has emerged. Our assessment is therefore that more work to build a shared vision and to bring existing work into a structured picture and programme of integration would be beneficial.

Development of a shared vision and a structured programme will also help the leaders of health and social care in Barnet manage potential tensions between the aspirations of different organisations, including across commissioning and provision where these are not in alignment. The creation of new organisations in the NHS and the move to Foundation Trust status creates new leadership arrangements and substantial change, which local organisations are navigating whilst at the same time forming or re-forming. Barnet Council is a single organisation playing multiple roles in this environment (e.g. statutory social care authority, commissioner, provider of social work and Occupational Therapy functions in provider settings). The impact of change

and potential tensions between different organisations presents a complexity challenge which will need to be carefully managed through a structured programme.

There were some clear themes where all or most interviewees were in agreement. These themes include aspects of individual or care group service delivery, processes and location of care delivery. The majority of interviewees did not suggest structural integration as an option at this stage of the process but this is something that could be explored further in the future.

Care processes

- Current services are fragmented and there is significant duplication, which would be addressed through clearly signposted single points of access and a single integrated health and social care assessment processes
- Recognition of the benefit of multidisciplinary health and social care teams and need for cross training on the more general aspects of the assessment processes and care delivery
- The need for alignment of services especially out-of-hours within health and with social care providers
- The need for IT systems or IT based case management tools that talk to each other and support better workflow management and data sharing across health and social care
- Use of telecare and telehealth and more use of remote or self-care channels to free up capacity for more specialist and complex care needs

Individual care delivery

- Recognition that better coordination is required at the level of individual service user/patient and client group care delivery, with a need for a coordination lead to actively own responsibility for supporting the navigation of the customer journey

Client groups

- The need for a focused approach for meeting the care needs of frail elderly people, a major demand pressure locally
- Prioritisation of targeted support to help working age adults with disabilities or long-term conditions back into paid employment

Care models

- Need to shift the model of care to a more home-centred, community delivered model; for example, hospital in the home and community outreach services

A message from the strategic engagement work is that the benefits of health and social care whole system integration cannot be realised in isolation by any single organisation. The full benefit potential of integration is wholly dependent on the willingness and ability of partners in health and social care to agree and commit to pursuing a common integration agenda. The level of partner commitment and support for integration will determine the scale of benefits that a joint integration programme will be able to deliver.

The scoping review has sought to develop trust and commitment among partners and has highlighted that a joint health and social care programme will also have an important and substantial communication role in strengthening this. Trust, openness and excellent communication will be critical as it likely that certain integration opportunities may challenge existing leadership, organisational and professional boundaries and established ways of working. This will need to be handled sensitively and in a supportive environment.

2.2.7 Barnet Council Overview and Scrutiny Task and Finish Group

As a related piece of work to this scoping review, the Council's Business Management Overview and Scrutiny Committee established a councillor led Task and Finish group to investigate a range of approaches to integration and develop a set of recommendations to inform the Council's vision and approach to the integration of health and social care. The group's task was to develop a vision for the development of integration, alongside principles and benefits to underpin any integration initiatives the Council may pursue.

The vision and other recommendations[i] from the group supports the Health and Wellbeing Board's Integrated Commissioning Plan. Both advocate integration of service provision and commissioning, both suggest an approach that is focused on key groups of service users and seek to engage service users and other stakeholders in service design. The Task and Finish Group have supported the integration of both commissioning and delivery of care. The group also supports structural integration.

Task and Finish Group vision statement *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 by people who provide care and people who use it.*

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

2.2.8 Community Insight

[i] Please refer to Appendix for full recommendations

Two engagement exercises where held in 2011 with service users/patients, to identify where integrated commissioning and service delivery would be most beneficial. The following key themes were identified:

Key Customer Themes

- Providing continuity and the need to see people as a whole person
- Consider carers and their needs alongside the person receiving care, including the impact of moving care out of hospital and providing it in the person's home
- Communication between providers and the number of hand-offs between and within organisations and the need for single teams and one-stop services
- Easily accessible advice and support through a range of sources and better use of the voluntary sector
- Importance of connecting people and reducing isolation

2.3 Current status of integration in Barnet

The following sets out the current level of integration between health and social care in Barnet.

- There is a joint commissioning assistant director post, shared between LBB and NCL NHS, with other joint commissioning posts for mental health and learning disabilities.
- There is a joint director of public health, shared between LBB and NCL NHS, and the public health team is now based with the Council, prior to its formal transfer in April 2013.
- There is an aligned budget and joint commissioning of community equipment.
- There is an aligned budget and an integrated Barnet mental health service team based in Barnet Enfield and Haringey Mental Health Trust (BEH MHT) under a Section 75 agreement.
- Under a 2 year Section 75 agreement, NHS voluntary sector funding has been pooled with Council voluntary sector funding, with the Council assuming the role of Lead Commissioner.
- Service delivery and some commissioning for learning disabilities has been integrated under a Section 75 agreement. Staff budgets have been pooled; the Council holds contracts for services with the relevant health and social care providers and the team is integrated and co-located under a single management structure within the Council.
- Health and social care commissioners and providers have been working together on a range of projects designed to improve outcomes and maintain

independence for the frail elderly. The Council commissioned enablement service has been working to an integrated pathway with health commissioned Intermediate Care Services (ICS) which has led to recent expansion of these services to support admission avoidance to the two main acute hospitals that serve Barnet and facilitate early discharge. The second phase of this work will be the development and implementation of a health and social care integrated community service that encompasses rapid response complex case management and rehabilitation. It is anticipated that this will be established through the use of Section 75 flexibilities.

- Child and Adolescent Mental Health (CAMHs). A shared approach to the market between health and children's social care commissioners will be undertaken in 2012/13. This will support achievement of efficiencies and increased integration of CAMHS services.
- Speech and Language Therapy (SALT) for children and young people. A shared approach to the market between health and children's social care commissioners will be undertaken in 2012/13. This will support achievement of efficiencies and increased integration of SALT services.

3. Background

This section covers:

3.1 National changes to the NHS and social care

3.2 Services in scope

3.3 Work which has been undertaken to produce the SOC

3.1 National changes to the health and social care landscape

The White Paper 'Equity and Excellence: Liberating the NHS' outlined the following key changes to the NHS over the next 2 years. The bill is currently making its way through parliament. Whilst there is a possibility that some aspects of the bill may change, this is likely to affect the provisions relating to competition and nationally the NHS is working to deliver the following:

- Public Health will transfer to the Local Authorities, but will continue to advise health care commissioners – 01 April 2013
- Health and Wellbeing Boards will be set up to coordinate health, public health and social care – 01 April 2013
- NHS Commissioning Board will commission health services not commissioned by CCGs and oversee CCG commissioning.
- Healthcare providers must either become Foundation Trusts or be taken over by one - 2014.

- Strategic Health Authorities and Primary Care Trusts will be abolished in April 2013 and replaced by:
  - Clinical Commissioning Groups (CCG) made up of local GP practices and clinical practitioners to commission most local healthcare – statutorily operational in 2013 subject to authorisation by NHS Commissioning Board.
  - Commissioning Support Services (CSS) to support CCGs in their commissioning role 2013.

Increased health and social care integration is assumed as part of these changes and is encouraged in a variety of ways, but no model or definition of integration is mandated. However, the structural changes and resultant uncertainty reduces the ability and capacity of health organisations to engage with social care on integration, especially where that engagement involves committing to long term plans.

3.2 Services in scope

The main services in scope for joint health and social care integration are: adult social care, planned and urgent primary health care, community health care, hospital care and public health improvement, protection and prevention. The programme will also focus on specific care pathways including long-term conditions (Cardiovascular Disease (CVD), Chronic Obstructive Pulmonary Disease (COPD), diabetes), dementia, fracture and end-of-life care (EOL).

Opportunities have also been identified in children's health and social care services, but these have not been reviewed in detail within the scope of this strategic outline case.

The scope also includes all aspects of commissioning and delivery by local authority, NHS, voluntary and private sector partners. Services or functions that are outside of health and social care will be considered within the scope of the wider determinants of health including leisure, housing, environment, employment and education, where this contributes to better health and wellbeing outcomes for the population of Barnet.

3.2.1 Adult social care budget allocation profile by service area

The following table summaries the profile of the Council's planned spend on adult social care services over the next three years and highlights the level of savings required in response to the expected reductions in central government funding during this period. The budget profile assumes that demand for funded social care services will be managed within a reduced financial envelope and cost savings will be realised through substantial efficiency savings in home care, residential and nursing care and back office costs. This is expected to be partially achieved through improvements in demand management, an increased focus on prevention and early intervention and greater integration of health and social care commissioning and delivery.

Service Area	2011-12 Budget £	2012-13 Budget £	2013-14 Budget £	Planned Incremental Run Rate Saving 2011/12 - 2013/14	Percentage Reduction
Residential Care Placement	34,635,732	34,515,732	33,865,732	770,000	0.77%
Home Care	17,637,319	16,387,894	15,882,894	1,754,425	1.76%
Assessment & Care Management	9,243,865	9,193,865	8,703,865	540,000	0.54%
Direct Payments	8,404,702	8,278,702	8,258,702	146,000	0.15%
Back Office	7,737,080	6,647,530	5,854,530	1,882,550	1.89%
Day Care / Day Services	6,616,678	6,523,678	6,523,678	93,000	0.09%
Nursing Home Placements	5,866,267	5,666,267	5,666,267	200,000	0.20%
Supporting People	4,439,569	3,947,569	3,605,569	834,000	0.84%
Voluntary Organisation & Carers	2,373,226	1,892,776	1,892,776	480,450	0.48%
Equipment & Adaptations	1,119,219	992,644	992,644	126,575	0.13%
Other Services	679,579	659,579	649,579	30,000	0.03%
Meals	341,715	331,715	331,715	10,000	0.01%
Aids Support Grant	263,360	263,360	263,360	0	0.00%
Asylum Seekers	231,386	231,386	231,386	0	0.00%
Grand Total	**99,589,697**	**95,532,697**	**92,722,697**	**6,867,000**	**6.90%**

The profile of social care by care group identifies that Learning Disabilities (35%) and Older Adults (30%) receive the highest proportion of the social care budget and the greatest cost pressure is in the physical disabilities care group. This also highlights that the greatest benefits from integrating health and social care are in care for older people.

3.2.2 Social care Medium Term Financial Strategy (MTFS)

The following table sets out the £4.2m MTFS cost saving assumptions that will be realised through health and social care integration opportunities.

Ref:	Service Area	Integration Saving Description	Saving Type	Incremental Annual Savings		
				2012/13	2013/14	2014/15
				£000	£000	£000
E5	Commissioning & Transformation	Integrating similar functions across health and social care commissioning to reduce management costs and support joined up services.	Efficiency		(40)	
E6	Integration Across The Council	Integrating similar functions across health and social care teams and provision to reduce management costs and deliver joined up services.	Efficiency		(300)	
E7	Social Work - Long Term Conditions	Closer working with the NHS on long term conditions.	Efficiency	(40)	(40)	
E16	Continuing Care	Efficiencies through joint procurement with the NHS for Continuing Health Care.	Efficiency	(200)		
E27	Younger Adults: Mental Health	Enabling people to move from residential care into a home of their own with support.	Efficiency	(150)	(150)	
E29	Younger Adults: Learning Disabilities	Learning Disabilities service redesign	Efficiency			(1,900)
E30	Older Adults and Younger Adults (All groups)	Increased use of Telecare, Aids and Equipment	Efficiency			(739)
E32	Older Adults	Development of a fracture service follow up, reducing home care placements resulting from hip and spine fractures.	Efficiency			(71)
E33	Older Adults	Reduce short term use of residential placements while people are having their home adapted, or are being rehoused, following release from hospital.	Efficiency			(39)
E38	Older Adults and Younger Adults (All groups)	Introduction of adult placement and shared lives schemes into the borough, decreasing need for residential care.	Efficiency			(330)
E40	Younger Adults: Mental Health	Mental health service redesign	Efficiency			(180)
R4	Younger Adults - Mental Health -	Better use of Mental health day opportunities.	Service Reduction	(8)		
R5	Drugs & Alcohol Service	Greater use of non residential rehab placements for people with substance misuse.	Service Reduction	(20)	(10)	
TOTAL INCREMENTAL SAVINGS £000				**(418)**	**(540)**	**(3,259)**

3.2.3 NHS healthcare budget allocation profile

The following table sets out the main NHS NCL Barnet PCT Quality, Innovation, Productivity and Prevention (QIPP) programmes that are planned to deliver the £38.6m savings required to achieve financial control targets by March 2013.

NHS QIPP Programme Category		2012/13 Total £'000s
Integrated Care	Older People	1,003
	Unscheduled Care	755
	Mental Health	1,605
	Continuing Care	440
	Community Services	1,332
	Care Closer To Home	607
	Palliative Care	541
	Children's Services	188
Primary Care	Productivity	781
Clinical & Cost Effectiveness	Acute Productivity	5,491
	Medicines Management	5,347
	Out Of Sector Providers	1,445
	Demand Management	6,000
	Procedures Of Limited Clinical Effectivenss	1,188
	Sexual Health Tariff	847
Other clinical priorities	Maternity	3,224
	Pathology	200
	Cancer	35
	Stretch	7,571
TOTAL NHS NCL BARNET QIPP PLAN - 2012-13		**38,600**

3.2.4 Illustrative Cost Benefits Modelling Scenarios

The following data tables provide a snapshot comparison of Barnet local authority expenditure, funded service users and population size against a number of local authority areas where health and social care integration initiatives have been implemented.

The data sample is full year cost and activity information for 2010-11 and has been sourced from the National Adult Social Care Intelligence Service (NASCIS) which is part of the NHS Information Centre for Health and Social Care. NASCIS collates a range of standard social care and health data that is routinely reported by local authorities and NHS organisations.

The data does not take account of how long a particular integration initiative has been in operation and where it is in the benefits realisation cycle; for example, the benefits may not have been expected in 2010/11. It also does not take account of the scope of

the initiative or scale of the expected impact on particular care groups and the overall effect this would have on total expenditure; for example, it may have been focusing on rebalancing the allocation of resources rather than delivering cost reductions.

The percentage of adult service users receiving local authority funded social care as a proportion of the total adult population will be impacted by the local application of Fair Access to Care Services eligibility criteria bandings. The reported percentage of people receiving funded care does not reflect the number of people who are self-funding their care.

The following table provides a snapshot of funded adult social care expenditure as a proportion of the total local authority spend. It highlights that Barnet spends a higher proportion of its total funding on adult social care compared with the majority of London boroughs, including Islington where integration is established, although it appears to be similar to some areas identified as innovators in health and social care integration e.g. Torbay and Herefordshire. However, while both these two authorities spend a similar proportion of their total funding on adult social care they still have a substantially lower unit spend per user than Barnet.

Local Authority Expenditure 2010-11	Total Net Local Authority Spend On Services £000	Total Adult Social Care Spend £000	Percentage Adult Social Care Spend of Total Services	Number of Adults Receiving Funded Social Care	Spend Per Adult Service User	Percentage of Adult Population Receiving Funded Social Care	Total Population	Total 18+ Population	Percentage Adult Population
Herefordshire	£ 268,275	£ 54,536	20.3%	6,415	£ 8,501	4.4%	181,200	146,000	80.6%
Northamptonshire	£ 942,446	£ 186,302	19.8%	13,470	£ 13,831	2.5%	701,200	545,500	77.8%
Torbay	£ 229,265	£ 44,646	19.5%	5,870	£ 7,606	5.3%	136,000	110,400	81.2%
Barnet	**£ 539,051**	**£ 103,848**	**19.3%**	**7,395**	**£ 14,043**	**2.7%**	**349,800**	**270,400**	**77.3%**
Bolton	£ 424,008	£ 70,991	16.7%	9,310	£ 7,625	4.6%	265,500	203,400	76.6%
Croydon	£ 577,410	£ 94,998	16.5%	8,690	£ 10,932	3.3%	347,000	266,300	76.7%
Islington	£ 456,540	£ 73,525	16.1%	4,845	£ 15,175	3.0%	192,900	159,600	82.7%
Buckinghamshire	£ 690,616	£ 108,780	15.8%	13,785	£ 7,891	3.6%	499,600	384,700	77.0%
IPF Group Average	£ 453,302	£ 73,722	16.3%	6,625	£ 10,007	3.2%	266,300	205,600	77.2%
Outer London Average	£ 455,148	£ 70,040	15.4%	6,618	£ 10,196	3.6%	235,300	184,200	78.3%
London Average	£ 472,841	£ 76,093	16.1%	6,050	£ 13,275	3.2%	237,500	186,400	78.5%

The following data table provides an illustration of effect on total adult social care spend if various unit spend scenarios are applied to the number of adults receiving funded care in Barnet.

Local Authority Expenditure 2010-11 Adult Social Care Unit Spend Modelling	Number of Adults Receiving Funded Social Care Barnet Baseline	Spend Per Adult Service User	Total Adult Social Care Spend £000	Modelled Cost Reduction Based On Number Of Barnet Service Users £000	Estimated Modelled Percemtage Cost Reduction
Barnet	**7,395**	**£ 14,043**	**£ 103,848**	**£ 0**	**0%**
Croydon Unit Spend Scenario	7,395	£ 10,932	£ 80,841	£ 23,007	22%
Herefordshire Unit Spend Scenario	7,395	£ 8,501	£ 62,867	£ 40,981	39%
Bolton Unit Spend Scenario	7,395	£ 7,625	£ 56,389	£ 47,459	46%
Torbay Unit Spend Scenario	7,395	£ 7,606	£ 56,245	£ 47,603	46%
London Average Unit Spend Scenario	7,395	£ 13,275	£ 98,171	£ 5,677	5%
Outer London Average Unit Spend Scenario	7,395	£ 10,196	£ 75,401	£ 28,447	27%
IPF Comparator Group Average Unit Spend Scenario	7,395	£ 10,007	£ 74,002	£ 29,846	29%

3.3 Development of the strategic outline case

The SOC has been jointly developed by the assistant director for joint commissioning, (LBB and NHS NCL), the deputy director for adult social care and health (LBB), and the programme lead, Rohan Wardena.

The SOC has been developed using desk based research covering:

- Barnet health and social care partner agencies - public statements / strategy, financial position, relevant services
- Best practice case studies and literature review
- Finance and activity analysis for Barnet Council and NCL NHS

It has also been developed through engagement with the following NHS commissioners and providers:

- Barnet Clinical Commissioning Group
- NHS North Central London Primary Care Trust Cluster
- NHS providers: Barnet and Chase Farm Hospitals NHS Trust; Royal Free Hampstead NHS Trust; Central London Community Healthcare Trust; Barnet, Enfield and Haringey Mental Health Trust

Individual interviews with stakeholders have covered the following areas:

- Common areas of focus
- Current services, projects and aspirations in relation to health and social care integration

- Alignment between the organisation's aspirations and the Council's corporate priorities (One Barnet approach)

Councillors have contributed to the development of the thinking in this outline case through:

- The work of the Overview and Scrutiny Task and Finish group, which was supported by the SOC development team at the same time as the development of this document
- A councillor development event held in February 2012, sponsored by the lead Cabinet members for adult social care and public health, and attended by the Leader of the Council

4. Reasons For Change

4.1 Issues to be resolved

There are four main local challenges driving integration in health and social care.

- Demographic – An ageing population and an increasing number of people living for longer with long-term health conditions and more complex care needs
- Savings – National and local cost pressures and requirements to make further savings across all publicly funded services
- Expectations – Increased expectations from people who use care around levels of care, choice, better quality, personalisation and independence
- Sustainability - The need to rebalance the focus of care and resources away from a reactive, high cost emergency led system to one that delivers more through active prevention, early intervention and planned care.

Integration between health and social care is seen as a core plank in the response to these challenges and has in principle been agreed by all partners. However, the form that integration will take, when, and how it will be implemented, now all need to be worked through in a coordinated way. This is a major programme of complex activity that requires significant resource and focus.

4.2 Cost saving targets and investment objectives

In taking forward the work to the business case stage, it is important to acknowledge that further work on integration will need to deliver financial benefits for local health and social care, covering:

- Barnet CCG and NHS NCL Barnet efficiency (QIPP) savings
- Barnet Council medium term finance strategy (MTFS) requirements

- Recurrent additional savings to address longer term emerging cost pressures through changes to demography and local population
- Recurrent cost savings to cover the loss of short term funding such as winter pressures and NHS Section 256 funding that currently is used to address pressures in the health and social care system

Whilst integration will deliver some direct cost savings by making the supply of care more efficient, for example removing duplication (e.g. two professionals visiting to do two initial assessments when it could be done by one person through a single integrated process), the most significant savings potential that it offers are by avoiding demand or reducing it.

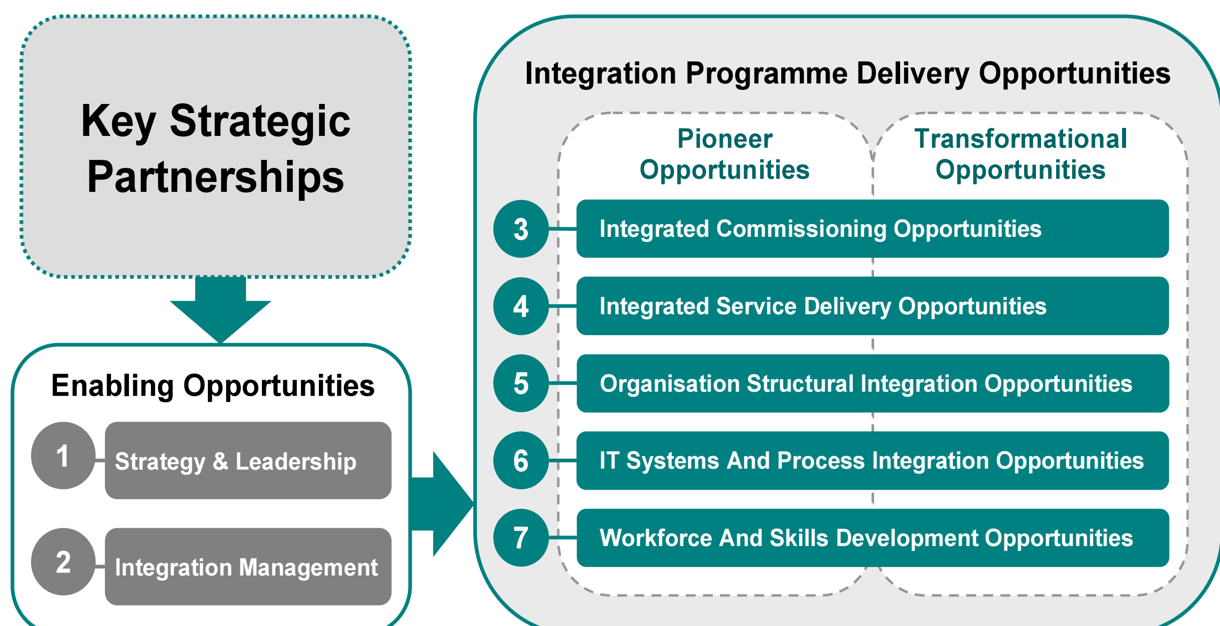
5. Project Definition

5.1 Strategic Outline Case Process Outcomes

The aims of the SOC are to secure Councillor, One Barnet Programme Board and Health and Wellbeing Board support and agreement for the following:

- Initial priorities for local integration
- Proposed approach to progress a joint integration programme between strategic partners
- Commitment of LBB resources to support the next stage of an integration programme

5.2 Programme scope



The scope of integration opportunities is extremely broad. It covers exploring an overall vision for the whole system of integrated health and social care, identifying shared opportunities in specific operational areas and establishing coordinated ways of working across multiple partner organisations to improve the local system of care.

The programme has three integration opportunity streams that will enable, build and transform:

1. Enabling opportunities that will define strategic intentions and translate these into programmes of work, establish governance structures, ways of working and a common framework to deliver joint projects.
2. Pioneer opportunities to build momentum, mainstream ways of working and deal with immediate cost pressures and outcome quality and performance issues. This will include strengthening coordination and harnessing the momentum of existing health and social care integration projects to deliver savings and build capacity for reinvestment in the definition and delivery of transformational opportunities.
3. Transformational opportunities to deliver large scale benefits across multiple partner organisations.

The overall programme opportunities can be grouped into two discrete categories which are enabling and delivery opportunities.

5.3 Programme delivery constraints

The benefits and opportunities for local health and social care integration set out in this strategic outline business case are entirely dependent on the strength of the relationships between the key partner organisations to collaborate and commit to a common vision for health and social care in Barnet. It will require trust and tenacious leadership to agree and implement a joint programme of integration during a period of unprecedented change and austerity. The pace of progress and timing of the implementation of a joint programme of integration will be dependent on the following factors:

- Commitment of strategic partner organisations to agree a joint vision, priorities and approach for the local integration of health and social care
- Immediate cost, performance and quality pressures on each partner organisation
- Impact and timing of organisational change and implementation of transition plans within each partner organisation (e.g. LBB One Barnet Programme, NHS NCL transition of PCT functions to CCG, Commissioning Support Service Organisations and public health to local authorities)
- Resources to fund integration projects which are not already planned and budgeted for 2012/13

- Impact of the 2012 Olympics on the availability of resources and timing of project delivery
- Requirements of the new Health and Social Care Bill and changes to national and local governance and assurance structures, statutory bodies and funding arrangements
- Alignment of benefits realisation timelines with immediate cost pressures
- Lead times for public consultations and engagement requirements
- Lead time for unwinding contracts and timeline for commissioning and procurement

5.4 Ownership of investment planning process

The investment planning process will be owned by the programme senior responsible owners (SRO) for health and social care, Dawn Wakeling, Deputy Director, Adult Social Care and Ceri Jacob, Associate Director, Joint Commissioning. The investment planning process for joint funded integration projects will need to be defined and agreed with partner organisations as part of the enabling activity.

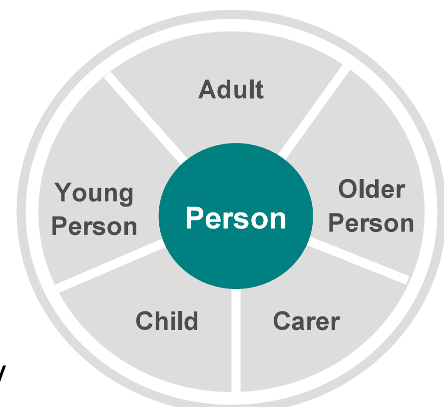
5.5 Integration opportunities

The strategic outline case identifies seven discrete opportunity areas that enabling and integration delivery initiatives can be grouped into and they are explained in more detail in this section. A long list of opportunities has been developed and it also includes existing approved projects which are already in progress and initiatives that are planned for 2012/13.

Although the opportunity listing contains twenty six opportunities, there are a small number of underlying themes that apply to all customer groups:

Commissioning

- Pooled budgets
- Integrated end-to-end care pathways
- Combined commissioning teams, procurement and contract management functions

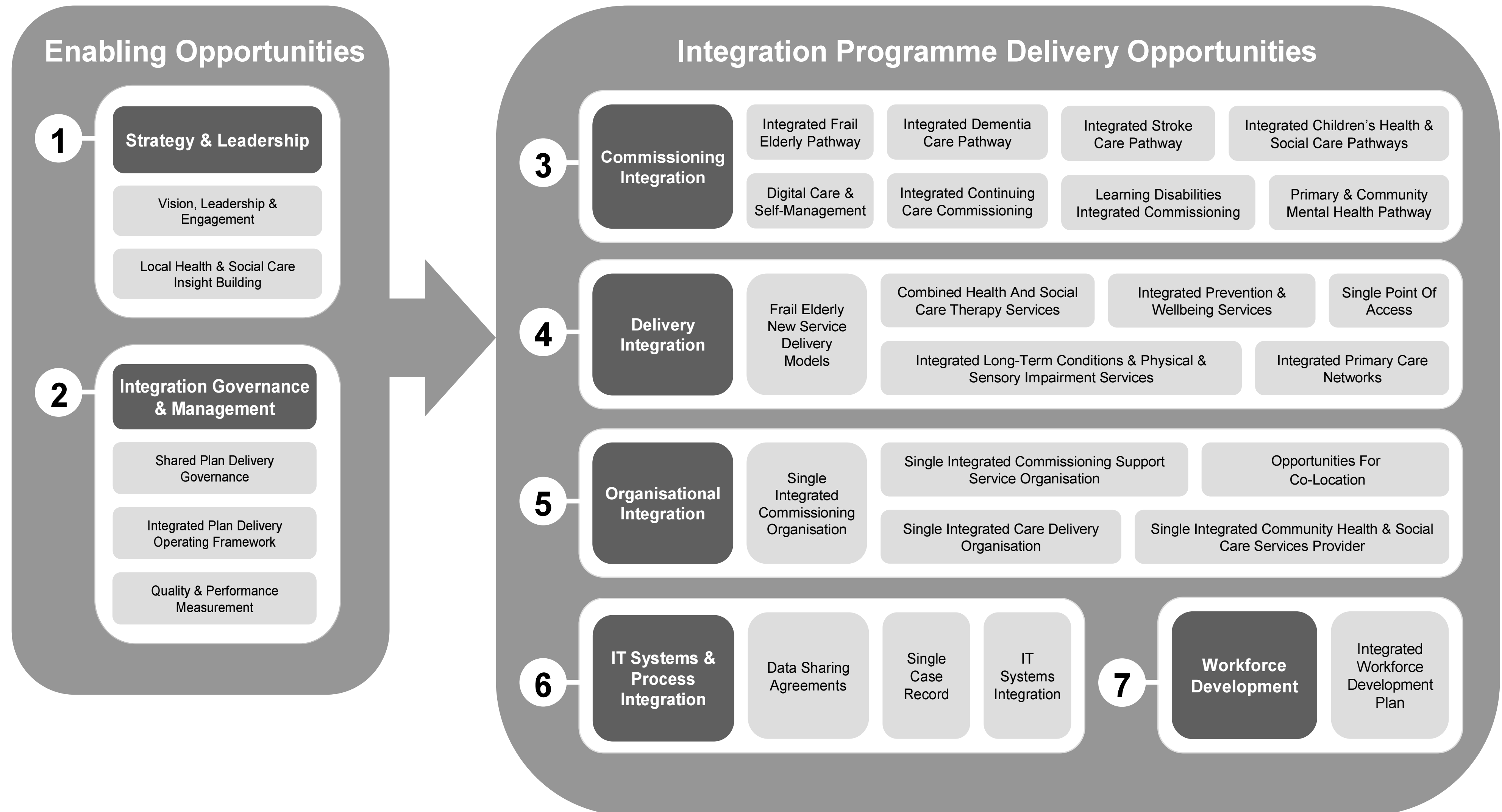


Service Delivery

- Integrated health and social care service delivery
- Combined health and social care teams
- Integrated health and social care delivery networks
- Single points of access
- Single combined health and social care assessment processes
- Integrated advice, information and brokerage services

It is important now for partners to agree and prioritise the list of opportunities and make sure that interdependencies, scheduling, resources and expectations about input requirements are clearly understood by each contributing partner organisation so these can be planned for effectively. The development of a clear, shared vision for integration and a clear governance and management structure for delivering integration projects are essential enablers to support prioritisation and progress integration locally.

Integration Opportunities



5.5.1 Integrated Strategy and Leadership

Opportunity	Benefits And Investment Description
1. Vision, Leadership Building And Engagement Shared local vision for health and social care integration with clearly defined aims and priorities. Define a common language to describe the vision and the journey to achieve it that is understood by all partner organisations, people who use care and key stakeholders. Joint integration programme plan to be scoped and agreed. This will provide the common terms of reference to coordinate effort and resources and deliver the necessary enabling initiatives, seed projects and transformation programmes to establish a sustainable and integrated local system of care. This plan is intended to complement and support the delivery of the HWBS and integrated commissioning plan. Hold an integrated care leadership summit including representation from care commissioners, providers and public, voluntary and private sectors, to secure local commitment to progressing an integration agenda. Development of agreements including Memorandum of Understanding (MOU) to clearly define commitments and expectations required from each strategic partner organisation to enable achievement of a shared vision and implementation of	• Agreed local vision and goals for health and social care integration in Barnet • Key strategic partners identified and relationships established • Leadership commitments and input requirements clearly defined • Individual and shared benefits from integration defined and agreed • Plans and priorities defined and agreed and incorporated into a single overarching plan that all partner organisations recognise and own • Improved coordination of existing integration initiatives and benefits opportunities maximised <u>Investment Requirements</u> Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the work programme • Project management and specialist Input from each partner organisation to scope and deliver the work programme • Resources to plan and deliver a health and social care integration leadership summit including event hosting and facilitation costs

Opportunity	Benefits And Investment Description
integration plans. <u>Current Status</u> Barnet Joint Health and Wellbeing strategy, Joint Integrated Commissioning Plan and Joint Integrated Prevention Plan are currently being developed by the NHS NCL PCT Cluster and LBB. Work is still required to complete and sign-off these strategic reference documents and joint plans. An integration workshop event is being held on the 08 March 2012 to further develop these plans and test assumptions. Extended engagement is required with NHS and social care providers and voluntary and private sector organisations. This strategic outline case has been produced in addition to the above plans, for LBB's One Barnet Programme Board and will be considered by the Health and Wellbeing Board in March 2012.	
2. Local Health And Social Care Insight Building Audit and map current local health and social care demand and delivery to clearly identify and evidence market gaps, system failure and opportunities for improvement across the entire local system of care to inform a more transformational and coordinated approach to integration and build the local evidence base for whole system improvement and investment.	• Deeper understanding of local health and social care system failure with supporting evidence • Clear understanding of the current profile of demand and delivery, distribution of resources across and gaps in provision • Evidenced based investment decisions <u>Investment Requirements</u>

Opportunity	Benefits And Investment Description
Current Status The production of the SOC document has identified significant gaps in the availability of local insight to validate and evidence both health and social care system failures and model investment opportunities across both all areas of care.	Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the work programme • Project management and specialist Input from each partner organisation to scope and deliver the work programme • System and workflow mapping specialist • Clinical input to map clinical pathways and evaluate opportunities • Health and social care economist and financial and activity analytics

5.5.2 Integration Governance and Management

Opportunity	Benefits And Investment Description
1. Shared Governance and Quality Assurance Structures And Processes Establish single integration programme delivery governance structure and decision making processes that are mandated by all integration delivery partner organisations. Establish and independent Quality Assurance Board that ensures that all joint integration initiatives are fit for purpose and meet the quality specifications set out in approved project and programme business cases and project documentation. A Quality Assurance Board would have a supporting advisory role to the Joint Programme Board and membership would include Non-Executive Directors, nominated Council Members and other key stakeholders such as patient and carer representatives. Current Status The Barnet Partnership Board and Health and Wellbeing Board are the current examples of local shared governance structures but the scope of these boards is strategic rather than operational and does not currently include representation from all of the key strategic partner organisations that are likely to be involved in the effective implementation.	• Clear lines of accountability and responsive and efficient decision making • Single programme board with clear ownership for change control, exception and risk management processes • Improved coordination of integration activity and risk of duplication and fragmentation minimised • Improved coordination of project resources Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme to set up integration delivery governance and implementation structures. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care. The current additional resourcing assumptions are as follows: • Project management office resources to scope and deliver the work programme • Project management and specialist Input from each partner organisation to scope and deliver the work programme • Resources to set up and fund the operation of an independent health and social care integration Programme Board • Resources to set up and fund the operation of an independent health and social Quality Assurance Board

Opportunity	Benefits And Investment Description
2. Integrated Plan Delivery Processes And Systems Develop, agree and implement integrated programme and project management structures, processes and systems to support the delivery of joint integration work programmes across multiple organisations. Current Status There are currently no agreed and shared project delivery operational structures, processes and systems in place to support the management and delivery of joint integration plans across multiple health and social care organisations.	• Lean and efficient programme and project delivery processes and optimised use of delivery resources • Clearly defined and owned change control, exception and risk management processes and systems • Improved coordination of integration activity with risk of duplication and fragmentation minimised • Improved communication and reporting systems and processes Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care. The current additional resourcing assumptions are as follows: • Project management office resources to scope and deliver the work programme • Project management and specialist Input from each partner organisation to scope and deliver the work programme • Resources to set up and fund the operation of a joint programme delivery board and programme delivery office for integration projects • Resources to fund the development and implementation of joint project delivery processes, systems and standard project management, reporting and communication tools

Opportunity	Benefits And Investment Description
3. <u>Integration Quality And Performance Measurement</u> Develop a set of integration quality and performance management tools, indicators and reporting processes and systems to baseline and measure the benefit output and outcomes delivered through joint integration projects and programmes. <u>Current Status</u> Both LBB and local NHS commissioners and providers are required to collect and report quality and performance data and information as part of national health and social care quality and performance management frameworks which include a range of indicators. However the historical focus has been output and process measurement rather than outcomes	• Clearly defined and measurable benefits for each integration initiative • Quality assured common set of indicators that can be used by all strategic partners to baseline, measure and track and compare the benefits from integration initiatives across the local system of care. <u>Investment Requirements</u> Resource requirements and funding contributions need to be defined as part of the work programme definition phase to develop benefits indicators and measurement tools, processes and systems. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care. The current additional resourcing assumptions are as follows: • Project management office resources to scope and deliver the work programme • Project management and specialist Input from each partner organisation to scope and deliver the work programme • Health and social care informatics

5.5.3 Integrated Commissioning Opportunities

Opportunity	Benefits And Investment Description
1. Integrated Frail Elderly Care Pathway Target Group: People over 75 years with more than one medical condition and complex social care needs Review and design and commissioning of an integrated frail elderly pathway that includes all aspects of care: • Prevention services • Urgent response for people at risk of being admitted to hospital • Active case management of people with long-term conditions in the community • Community rehabilitation services • Community end-of-life care • Local agreed tariff and block contract services Current Status Initiative already in progress with a shared commitment from strategic commissioning partners via the Health and Wellbeing Board.	• Reduction in care home placements as a result of reduced hospital admissions • Strengthened community and more proactive case management across providers • Reduction in care home placements as more rehabilitated in their own home by integrated health and social care teams • Reduction in the number of assessments through the establishment of shared health and social care assessments • Reduction in social care funded requirements because more people remain independent as a result of proactive prevention management and early intervention • Tariff and contract efficiencies for both health and social care commissioners . Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Programme management and programme management office support resources • Project management resources for each project to scope and

Opportunity	Benefits And Investment Description
	deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Clinical assurance input to evaluate and assure clinical pathway design
2. Integrated Dementia Care Pathway Initiative to identify and define an ideal community delivered pathway and will include prevention and outcome modelling to determine where investments should be made to achieve the greatest return for both health and social care funding. Current Status Initial project work is about to begin	• Identifies people with dementia early so that they and their carers are effectively supported and care is actively managed to reduce the risk of crisis and demand for emergency care or highly intensive packages of care. • Aligns community care provision with acute dementia pathways developed by hospitals and ensures the whole system works together leading to a reduction in emergency hospital admissions and referrals for long-term residential care placements. Promotes enablement of people with dementia. Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the work programme • Project management and specialist Input from each partner

Opportunity	Benefits And Investment Description
	organisation to scope and deliver the work programme • Clinical assurance input to evaluate and assure clinical pathway design
3. Integrated Stroke Care Pathway Initiative to identify and define an ideal community delivered pathway and will include prevention and outcome modelling to determine where investments should be made to achieve the greatest return for both health and social care funding. Current Status Initial project work is about to begin	• Strengthen community rehabilitation pathway to minimise the impact of significant physical and sensory impairments (PSI) caused by stroke and enable people with PSI to remain independent for as long as possible without the need for intensive packages of care Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the work programme • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Clinical assurance input to evaluate and assure clinical pathway design
4. Primary and Community Mental Health Pathway Review	• More people with mental illness live independently, are in employment and their physical health needs are more effectively

Opportunity	Benefits And Investment Description
Pathway review and evaluation to identify the specific opportunities for greater integration and alignment with the Frail Elderly Integrated Care Pathway Programme and local Primary Care Strategy to establish primary care networks. Integrate commissioning budget for health and social care with pooled budget and lead commissioning arrangements. <u>Current Status</u> Social Care staffing integration with mental health trust already in place. A QIPP initiative designed to strengthen support to and integration across acute, primary, social and voluntary sector services will be delivered in 2012/13 focusing on people whose conditions do not require acute care. There may be scope to further integrate services and resources are required to map and evaluate existing primary and community mental health and social care pathways to identify further opportunities.	managed leading to a reduction in the risk of crisis and the need for emergency or long-term or intensive packages of care. <u>Investment Requirements</u> Investment funding for primary and community care pathway development to be included within the scope of NHS NCL Primary Care Strategy investment as part of local implementation.
5. Learning Disabilities Integrated Commissioning Extend existing integrated health and social care pooled operational and staffing budgets to include pooled commissioning budgets to support integrated service commissioning. <u>Current Status</u>	• Increased opportunities to optimise health and social care funding and further improve care outcomes through the commissioning of integrated care packages and pathways • Reduced likelihood of cost shunting and organisational funding disputes • Contract efficiency savings <u>Investment Requirements</u>

Opportunity	Benefits And Investment Description
Integrated health and social care teams established through a Section 75 agreement with Central London Community Healthcare Foundation Trust. Feasibility analysis needs to be conducted to determine the benefits and options for extending the integrated arrangements already in place to include integrated commissioning budgets. Joint Commissioning post already in place that could lead this work and manage a pooled care commissioning budget.	Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the work programme • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Clinical assurance input to evaluate and assure clinical pathway design
6. Integrated Continuing Health Care (CHC) Commissioning Pooled Continuing Health Care/ Funded Nursing Care commissioning budgets and a single shared process and an integrated CHC team and assessment process. Current Status Some agreed procedures and provision for joint assessments in place. Separate budgets held by NHS NCL and LBB. In practice, many assessments take place separately, duplicating work and lengthening the process for staff and users/patients.	• Increased opportunities to optimise health and social care funding and further improve care outcomes through the commissioning of integrated care packages and pathways • Reduced likelihood of cost shunting and organisational funding disputes • Reduced likelihood of service users needing to change provider if their funding source changes i.e. from health to social care funded • Increased influence on provider market from combined market share through pooled funding and joint commissioning of provision • Streamlined and shorter assessment and decision making process, reducing workload for staff and speeding up decisions for users/patients. Investment Requirements

Opportunity	Benefits And Investment Description
There is a planned NHS NCL QIPP initiative to improve procurement of continuing care Services. An opportunity for joint use of this facility may exist and will need to be explored.	Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the work programme • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Clinical assurance input to evaluate and assure clinical pathway design
7. Commissioning Integrated Children's Health And Social Care Pathways Potential opportunities to commission integrated health and social care pathways for children and young people in the following: • Integrated universal services • Integrated complex care services • Speech and language therapies • Children and Adolescent Mental Health Services (CAMHs) • Transition pathways and services	• Improved care outcomes for children and young people • Commissioning of integrated health and social care pathways to deliver seamless care • Contract efficiency savings through pooled resources and integrated care provider contracts • Improved coordination of transition pathways through integrated commissioning <u>Investment Requirements</u> Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner

Opportunity	Benefits And Investment Description
<u>Current Status</u> The Council is reviewing its pathway for users of its Transitions Team (young people with complex disabilities who may move to adult social care) and is developing a new strategy for this client group. The timing is appropriate to consider the health and social care integration aspects of this. Work has commenced on joint commissioning of SALT and CAMHs. Other opportunities will be explored during final development of the integrated commissioning plan	organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the work programme • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Clinical assurance input to evaluate and assure clinical pathway design
8. Digital Healthcare and Self-Management Telecare and Telehealth initiative to extend the uptake and usage of existing telephone delivered health and social care services. Delivery Channel shift review to identify alternative low cost channels and options for the delivery of local health and social care services. <u>Current Status</u> LBB provides telecare as a routine part of its social services offer and has ambitious savings targets set based on increased use of telecare and decreased use of more traditional options. It is timely to consider how telecare and telehealth can be	• Increased independence for service users and opportunities to self-manage their care • Cost and capacity savings through the shift of services delivery to lower cost channels <u>Investment Requirements</u> Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Programme management and programme management office support resources

Opportunity	Benefits And Investment Description
expanded to achieve greater benefits for Barnet.	• Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Extended Telecare and Telehealth products, support and infrastructure costs

5.5.4 Integrated Care Delivery Opportunities

Opportunity	Benefits And Investment Description
1. Frail Elderly New Service Delivery Models Accelerate implementation of proposed integrated frail elderly community service and identify further opportunities: • Increase investment in staffing and resources to mainstream and integrate the new frail elderly care delivery model into business-as-usual operations • Embed integrated ICS and enablement response including a single point of access utilising Trusted Assessor roles • Improved identification of frail elderly in the system and management in primary and community care as part of a health and social care multidisciplinary complex case management service • Develop rehabilitation services that are delivered via community hospital bed based care and in the person's own home • Single health and social care assessment processes supported delivered by a health and social care trained Trusted Assessor Current Status Initiative already in progress that covers some aspects of the above (i.e. points 1-3)with a shared commitment from strategic commissioning partners via the Health and Wellbeing Board and providers via the Frail Elderly Provider Network..	• Reduced emergency attendances at hospital A&E departments • Reduced hospital admissions • Reduction in referrals and residential care placements • Reduction in long-term packages of care • Reduction in short-term to residential care admissions and demand for post hospital discharge bed based rehabilitation services • Health and social care delivery organisation efficiency and capacity gains from a single assessment, admissions, review and discharge process • Improved customer experience Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Programme management and programme management office support resources • Project management resources for each project to scope and deliver the work programmes

Opportunity	Benefits And Investment Description
	• Project management and specialist Input from each partner organisation to scope and deliver each work programme • Clinical assurance input to evaluate and assure clinical pathway design
2. Integrated Primary Care Networks • Establishment of multidisciplinary (MDT) health and social care assessment and delivery teams as part of locality based integrated primary care networks Current Status This is the cornerstone of the local Primary Care Strategy and business case which has been submitted to NHS London for invest to save funding.	• Health and social care delivery organisation efficiency and capacity gains from a single assessment, admissions, review and discharge process • Improved customer experience Investment Requirements Investment funding for primary and community care pathway development to be included within the scope of NHS NCL Primary Care Strategy investment that is being requested from NHS London as part of an invest to save business case.
3. Integrated Advice, Information And Brokerage Services • Integrated advice, information and brokerage services for social care self-funders that can be accessed in GP surgeries or following enablement from hospital. The scope of the service includes healthy living, self-help/ management/ arrangement of care and support that is self-funded. Enhances current work on frail elderly model by providing enhanced information resources to support self-managed and preventative care. Current Status	• Improved customer experience • Increased level of self-directed care and reduction in funded care packages • Back office cost efficiencies and capacity savings from a shift to low cost service delivery and information channels Investment Requirements Allocation of pump priming/pilot investment funding through Health funds for social care or from NHS investment funding for the implementation of NHS NCL's Primary Care Strategy.

Opportunity	Benefits And Investment Description
This is concept would form part of the social care proposition in the primary care networks which are described in the local Primary Care Strategy and business case which has been submitted to NHS London for invest to save funding.	
4. Single Point Of Access • Integrated health and social care single point of access and gateway to services with care navigation for vulnerable people and people with complex care needs Current Status There are a number of initiatives within LBB and the NHS to develop single points of access. LBB is due to launch its Customer Service Organisation in April 2012 and the Social Care Direct currently provides a single point of access to Adult Social Care Services in Barnet. The NHS in London is currently developing an urgent care single point of access 111 service which includes local directories of services and this is due to be in operation in all London regions by January 2013. As part of the Frail Elderly service design work listed above, NHS Intermediate Care and Housing 21 Enablement are developing a single point of access to that service.	• Improved customer experience • Increased level of self-directed care and reduction in funded care packages • Back office cost efficiencies and capacity savings from improved coordination of the customer journey and workflow management Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Programme management and programme management office support resources • Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme

Opportunity	Benefits And Investment Description
	• Clinical assurance input to evaluate and assure clinical pathway design
5. Combined Health And Social Care Therapy Services • Combine health and social care occupational therapy services <u>Current Status</u> Barnet currently has NHS and Social Services occupational therapy teams. Whilst the value of these teams is acknowledged, the service user journey can include separate OT assessments from both Health and Social Care teams, and hence a delay in the user getting what they need.	• Efficiency savings through reduction in duplication and increased capacity • Cross skilling of Occupational Therapists in different service locations in both rehabilitation and equipment and adaptations. • Improved customer experience and consistency through the streamlining of access and delivery of therapy services <u>Investment Requirements</u> Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Clinical assurance input to evaluate and assure clinical pathway design
6. Integrated Long-Term Conditions (LTC) And Physical And Sensory Impairment (PSI) Services	• Improved customer experience • Reduction in residential placements and high cost packages

Opportunity	Benefits And Investment Description
Integrated LTC/PSI teams to support the most complex users including neurological conditions, complex physical disabilities. An integrated multi-professional team that would include social workers, therapists (including occupational health, physio and speech and language (SALT) therapists), nursing. Service could be governed by right to control (RTC) principles, drawing together NHS personal health budgets with social care/RTC funding streams (including employment support). The team would also facilitate community integration and access to mainstream supports for users. This is a small client group that can require high cost support and there is currently a lack of specialist facilities. The team would work with a small cohort of patients/clients where a multi-professional approach would have substantial cost and quality benefits through better coordination of high intensity specialist care and alignment with the Continuing Health Care Team Current Status Currently services for this client group are provided separately by the NHS and LBB. The Council is a national trailblazer site for Right to Control and Barnet PCT is a member of the national pilot scheme for personal health budgets.	of care • Operational efficiency savings and increased capacity through lean processes • Reduced risk of emergency hospital attendances and admissions through better coordinated care and crisis avoidance • Potential for improved access to employment for service user group if RTC principles and a focus on community access are adopted Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Clinical assurance input to evaluate and assure clinical pathway design
7. Integrated Prevention And Wellbeing Services	• Increased uptake of immunisation including winter flu amongst high risk group such as older people and people with

Opportunity	Benefits And Investment Description
• Targeted immunisation for high risk groups • Falls prevention • Targeted health screening • Support for carers • Adaptations and equipment • Voluntary sector befriending schemes • Health and lifestyle checks • Aging well programme <u>Current Status</u> Responsibility for Public Health is planned to be transferred to local authorities from the 01 April 2013. The NHS NCL Barnet Public Health team have led the development of the local Joint Integrated Public Health Plan which alongside the Joint Integrated Commissioning Plan, will underpin delivery of the local Joint Health and Wellbeing Strategy. Both plans are in the development stage and require completion and sign-off by the Health and Wellbeing Board and implementation partners. A shared Carers plan is being developed and will be published September 2012 in line with the NHS Operating Plan requirement	long-term conditions • Improved infection control amongst high risk groups leading to a reduction in emergency admissions and demand for intermediate care • Reduction in the risk of exacerbations of long-term conditions and chronic health conditions leading to a reduction in the demand for high intensity packages of care and residential care • Reduction in the number of falls leading to reduced demand for emergency and intermediate care. <u>Investment Requirements</u> Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Clinical assurance input to evaluate and assure clinical pathway design

5.5.5 Organisational Integration Opportunities

Opportunity	Benefits And Investment Description
1. Single Integrated Commissioning Organisation Establishment of a single local integrated care commissioning function. Current Status Clinical Commissioning Group established and Health and Wellbeing Board in operation. The governance and operational structures that will become statutorily operational from the 01 April 2013 (subject to Parliament passing the Health and Social Care Bill) may have the scope to deliver the potential benefits of a single commissioning function. The Council and NCL NHS currently deliver joint commissioning in the areas of mental health, learning disabilities.	• Improved customer experience • Integrated care pathway and service commissioning is part of the core operating model • Equal focus on both health and social care elements of the pathway, able to commission a whole system of care • Join-up and consistent commissioning decisions • Reduction in local commissioning management and overhead costs • Pooled commissioning budgets and increased market influence Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Resources to conduct an options review and evaluation to scope and determine the benefits potential of this opportunity. • Programme management and programme management office support resources • Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner

Opportunity	Benefits And Investment Description
	organisation to scope and deliver each work programme • HR specialist resources including TUPE • Legal and procurement resources
2. Single Integrated Commissioning Support Service Establishment of an integrated health and social care Commissioning Support Service. Current Status Clinical Commissioning Support Services will be established from the 01 April 2013 (subject to Parliament passing the Health and Social Care Bill) and when statutory commissioning responsibilities transfer from NHS PCT Cluster organisations to CCGs and the NHS Commissioning Board. Current plans are for NHS PCT cluster organisations to offer commissioning support on a multi-borough basis until 2014/15 when it is expected that all CCGs will be authorised and in a position to procure commissioning services support services.	• Improved customer experience • Integrated care pathway and service commissioning is part of the core operating model • Reduction in local commissioning operating and overhead costs Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Resources to conduct an options review and evaluation to scope and determine the benefits potential of this opportunity. • Programme management and programme management office support resources • Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme • HR specialist resources including TUPE

Opportunity	Benefits And Investment Description
	• Legal and procurement resources
3. Single Integrated Community Health and Social Care Service Provider Establishment of a single integrated health and social care community provider organisation delivery services for older people and people with complex care needs. <u>Current Status</u> Health and social care provision is integrated for specialist mental health and learning disabilities teams under Section 75 agreements. Acute and community Health providers and the Council are working together to develop new models of service for frail elderly people (listed above). Whilst there is communication, some case co-ordination and some co-location of community health and social care (e.g. social workers based in acute and community hospitals) service provision is separately managed and assessment and care delivery processes are separate. NHS London has expressed interest in development of Integrated Care Organisations locally. These have tended to be vertically integrated ICOs within health locally. However, there is scope through NCL work to look at horizontal and vertical integration	• Improved customer experience • Pooled and optimised care delivery budgets • Streamlined and lean care delivery processes and systems • Improved active case management and coordination of care for clients with complex care needs • Operational efficiencies and capacity gains from integrated operating model and delivery team structures • Reduction in emergency admissions through improved coordination of care and integrated active case management <u>Investment Requirements</u> Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Resources to conduct an options review and evaluation to scope and determine the benefits potential of this opportunity. • Programme management and programme management office support resources • Project management resources for each project to scope and deliver the work programmes

Opportunity	Benefits And Investment Description
	• Project management and specialist Input from each partner organisation to scope and deliver each work programme • HR specialist resources including TUPE • Legal and procurement resources
4. Single Integrated Care Delivery Organisation Establishment of a single integrated health and social care provider organisation that provides the full spectrum of care from prevention through to end-of-life care across a range of primary, community and secondary care settings. Current Status Health and social care provision is integrated for specialist mental health and learning disabilities teams under S75 agreements. Acute and community Health providers and the Council are working together to develop new models of service for frail elderly people (listed above).	• Improved customer experience • Pooled and optimised care delivery budgets • Streamlined and lean care delivery processes and systems • Improved active case management and coordination of care for all clients across the spectrum of need • Operational efficiencies and capacity gains from integrated operating model and delivery team structures • Reduction in emergency admissions through improved coordination of care and integrated active case management • Optimised bed based services and capacity with increased opportunities to decommission unutilised capacity and reinvest this in prevention services. Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows:

Opportunity	Benefits And Investment Description
	• Resources to conduct an options review and evaluation to scope and determine the benefits potential of this opportunity. • Programme management and programme management office support resources • Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme • HR specialist resources including TUPE • Legal and procurement resources
5. Opportunities For Co-Location Consider opportunities for co-location and physical integration as premises leases become due for renewal or review. Current Status Learning disabilities and mental health services are co-located. Public Health is now co-located with the Council. Hospital Social Work based at Royal Free, BCH and community hospitals. Finchley Memorial Hospital provides an opportunity to consider further co-location of care.	• Improved opportunities for care co-ordination and service development as commissioning or delivery organisations are co-located in shared premises • Estates optimisation and efficiencies • Creates opportunities to bring care closer to communities Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Resources to conduct an options review and evaluation to scope and determine the benefits potential of this opportunity.

Opportunity	Benefits And Investment Description
	• Programme management and programme management office support resources • Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme • HR specialist resources including TUPE • Legal and procurement resources

5.5.6 IT System And Process Integration Opportunities

Opportunity	Benefits And Investment Description
1. Data Sharing Agreements Development of an overarching data sharing agreement for health and social care providers to support improved care management and integration of workflow processes within the existing system of care. Current Status Data sharing agreements are in operation for some of those services that have been integrated through Section 75 Agreements such as the Integrated Learning Disability and Mental Health Services functions.	• Improved customer experience through reduced requirement to repeat the same personal information to multiple organisations and departments • Enable more seamless hand-offs to multiple organisations involved in the care of a particular client • Support more responsive care and reduce delays because all organisations will have access to client information and history. Substantial benefits for the delivery of emergency care Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the project work programme • Project management and specialist Input from each partner organisation to scope and deliver each work programme • Legal specialist to advise on data sharing agreements and conditions

Opportunity	Benefits And Investment Description
2. Single Case Record Development of a client enabled and web hosted single case record for clients with complex care needs. The client record could be accessed by all organisations on a client permission basis via a web based portal anywhere in system. Current Status There are a number of web based client record products already in use such as EMIS web which is used by GP Practices.	• Improved customer experience through reduced delays in organisations collecting client and accessing care plans • Enable more responsive and effective case management across both health and social care providers • Reduced administrative effort to maintain multiple case management information systems Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement and primary care strategy investment. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the project work programme • Project management and specialist Input from each partner organisation to scope and deliver each work programme • IT specialist resources • Legal specialist to advise on information security conditions
3. IT Systems Integration Harmonisation and integration of health and social care information and workflow management IT systems to support the streamlining	• Improved customer experience and streamlined customer journey • Improved workflow and lean systems with expected efficiencies savings an capacity gains across partner

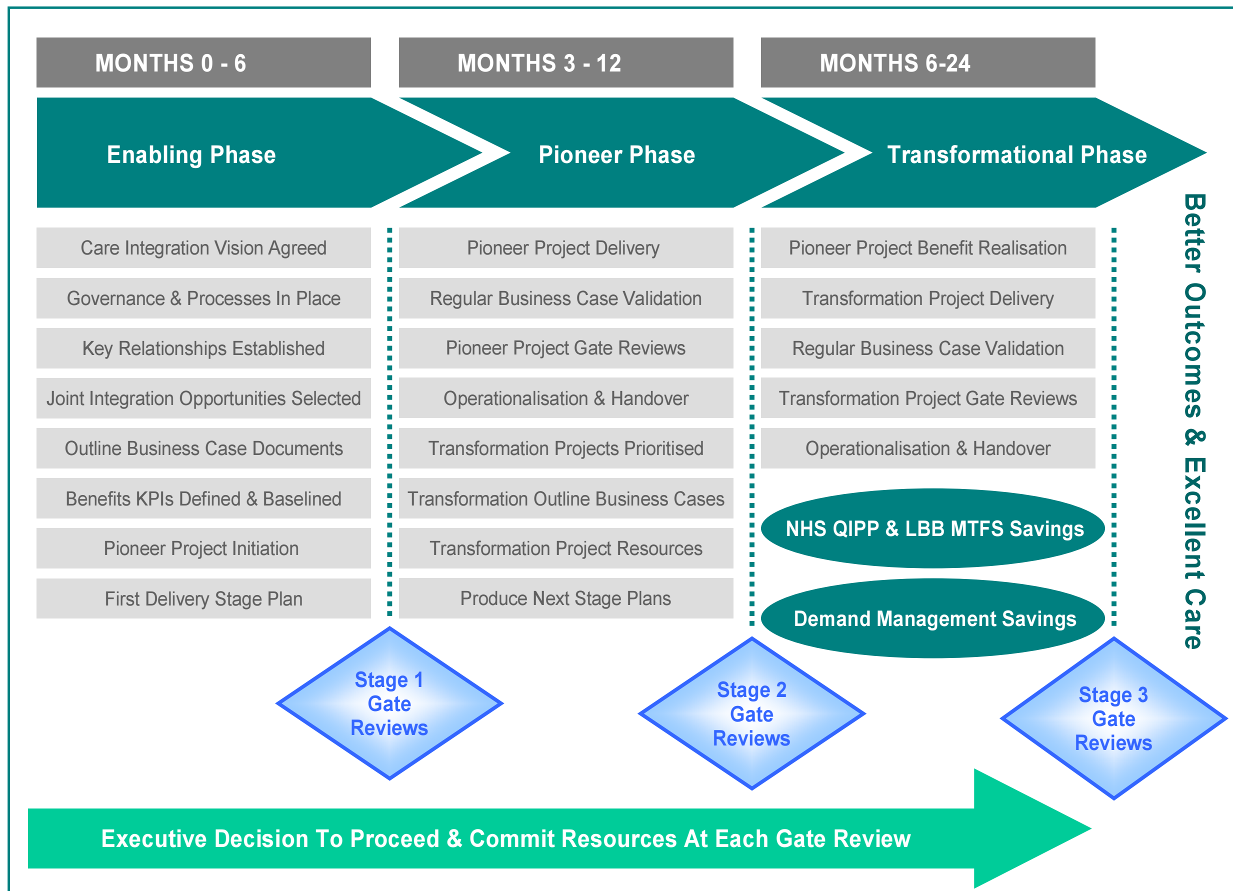
Opportunity	Benefits And Investment Description
and integration of operating processes and client information management across multiple care provider organisations. This could include the development of a customer/patient relationship management system to enable active case management and more effect navigation around the entire local system of care. Current Status LBB is currently transforming its Customer Support Organisation and Adult Social Care IT systems. This includes the replacement of the social care management system and rollout of the Right To Care web portal to support and enable more people to be able to self-manage their social care. Both projects are due to be completed during the 2012/13.	organisations • IT contract efficiencies • IT infrastructure, maintenance and support efficiencies and cost savings Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Programme management and programme management office support resources • Project management resources for each project to scope and deliver the work programmes • Project management and specialist Input from each partner organisation to scope and deliver each work programme • IT specialist resources • IT hardware, infrastructure and licensing costs • Legal and procurement resources

5.5.7 Workforce Development And Skills Integration Opportunities

Opportunity	Benefits And Investment Description
1. Integrated Workforce Development Plan Skills development plan and delivery of a training programme to cross train health and social care staff across multiple organisations on new ways of working, including integrated processes and systems, as these are developed and rolled out. Workforce development plan and delivery of skills training to support the adoption of a consistent approach to programme and project management. Current Status There are some areas such as safeguarding where multi-agency training and development is already well established. Workforce and skills development is also implemented as part of individual integration projects. There are opportunities to include wider cross training through implementation of the primary care strategy. The importance of workforce and organisation development (OD) plans is recognised within the SOC as an essential component of all integration initiatives and will need to be jointly developed and coordinated to ensure staff are equipped with the appropriate skills and knowledge to enable new ways of working.	• Improved customer experience through reduction in the number of hand-offs between organisations • Increased capacity and reduction in duplication because staff across multiple organisations are trained to carry out shared processes e.g. health and social care needs assessments Investment Requirements Resource requirements and funding contributions need to be defined as part of the work programme definition phase. Any additional resourcing costs that cannot be absorbed by each partner organisation are expected to be prioritised and met from allocated health funds for social care and enablement. The current additional resourcing assumptions are as follows: • Project management resources to scope and deliver the project work programme • Project management and specialist Input from each partner organisation to scope and deliver each work programme • HR specialist resources • Training programme delivery

6. Project Approach

Overall approach



A three phased approach is proposed to progress the opportunities set out in the SOC, however this will be dependent on agreement and support from the local partner organisations.

The process assumes that there will be at least one stage gate review to assess progress against agreed objectives, outputs and outcomes but these are expected to occur after each major milestone within each phase to maintain momentum and to take account of the structural and legislative changes that have already been highlighted.

The following outline plan provides a detailed listing of the key activities and outputs that would be delivered during the initial Enabling Phase. The estimated effort provides an illustration of the assumed mandays to deliver each work package, but this would be validated as part of the detailed work package plan.

1. ENABLING PHASE		
Activity & Output Description	**Effort Estimate (Days)**	**Target Date**
1. Enabling phase 1 stage plan development	10 Days	Apr 12 to Apr 12
<u>Key Activities</u>		
• Enabling stage plan work package development		Apr 12
<u>Outputs</u>		
• Agreed work package resource plan and budget produced • Enabling stage plan produced and approved by partner organisations		
2. Vision, leadership building and engagement	60 Days	May 12 to Jul 12
<u>Key Activities</u>		
• Work package development • Health and social care leadership summit • Prioritisation framework development for joint integration initiatives • Programme plan development and integration opportunity prioritisation • Roles and expectations definition and development of Memorandum of Understanding		May 12 May 12 Jun 12 Jun 12 Jun 12 Jul 12
<u>Outputs</u>		
• Agreed work package resource plan and budget produced • Work package delivered to time and budget • Health and social care vision statement produced and agreed • Signed-off Integration programme plan • Agreed resource plan • Sign-off Memorandum of Understanding between partner organisations		
3. Local health and social care insight building	30 Days	May 12 to Jun 12
<u>Key Activities</u>		
• Work package development • Local health and social care mapping and cost and activity		May 12 Jun 12

1. ENABLING PHASE		
Activity & Output Description	**Effort Estimate (Days)**	**Target Date**
<u>Outputs</u>		
• Agreed work package resource plan and budget produced • Local insight data packs produced to support business case development and validate opportunity assumptions		
4. Shared governance and quality assurance structures and process development	25 Days	May 12 to Jul 12
<u>Key Activities</u>		
• Work package development • Integration governance review and development • Quality assurance review and development • Governance structures (Joint Integration Programme Board) and processes set up • Quality assurance structures and processes set up		May 12 Jun 12 Jun 12 Jul 12 Jul 12
<u>Outputs</u>		
• Agreed work package resource plan and budget produced • Agreed and established governance structure for joint integration programme • Integration quality assurance function set up • Terms of reference documents produced and signed off		
5. Integrated plan delivery processes and systems development	25 Days	Jun 12 to Aug 12
<u>Key Activities</u>		
• Work package development • Integration Programme Delivery Office (PDO) design and development • PDO Resource plan development • Shared project management processes, systems and tools definition and development • Recruitment (if required)		Jun 12 Jun 12 Jun 12 Jul 12 Aug 12
<u>Outputs</u>		

1. ENABLING PHASE		
Activity & Output Description	**Effort Estimate (Days)**	**Target Date**
• Agreed work package resource plan and budget produced • Joint Integration Programme Delivery Office set up and operational • Shared project management processes mapped and documented		
6. Integration project quality and performance measurement development	20 Days	Jul 12 to Aug 12
Key Activities		
• Work package development • Development of an agreed set of benefits measurement matrices and reporting for integration project and programme benefits		Jul 12 Aug 12
Outputs		
• Agreed work package resource plan and budget produced • Benefits measurement indicators and tools • Benefits reporting		
7. Pioneer project prioritisation and business case review		Jul 12 to Dec 12
• Prioritised pioneer project business case development • First wave pioneer project business case evaluation and sign-off gate review meetings		Sep 12 Oct 12
Outputs		
• Produced and signed-off pioneer project business cases • Pioneer project delivery starts • Equalities impact assessments		
8. Enabling Phase Gate Review		Sep 12 to Sep 12
Key Activities		
• Hold gate review meeting		
Outputs		

1. ENABLING PHASE		
Activity & Output Description	**Effort Estimate (Days)**	**Target Date**

- Decision to proceed and commit further resources

2. PIONEER PROJECT DELIVERY PHASE		
Activity & Output Description	**Effort Estimate (Days)**	**Target Date**
Key Activities	TBD	Sep 12 to Apr 13

- Implementation of pioneer project delivery plans
- Pioneer project gates reviews
- Pioneer project delivery benefits monitoring
- Transformational project business case development
- Lessons learnt reviews
- Equalities impact assessments

Outputs

- Completed pioneer projects
- Pioneer project benefits reported and evidenced
- Transformational project business cases produced
- Project gate reviews held
- Resource plans produced

3. TRANSFORMATIONAL PROJECT DELIVERY PHASE		
Activity & Output Description	**Effort Estimate (Days)**	**Target Date**
Key Activities	TBD	Dec 12 to Apr 14

- Implementation of transformational project delivery plans
- Transformational project gates reviews
- Transformational project delivery benefits monitoring
- Programme benefits tracking (pioneer and transformational projects)
- Lessons learnt reviews
- Equalities impact assessments

3. TRANSFORMATIONAL PROJECT DELIVERY PHASE		
Activity & Output Description	**Effort Estimate (Days)**	**Target Date**
Outputs • Completed transformational projects • Transformational project benefits reported and evidenced • Project gate reviews held • Resource plans produced		

Project controls

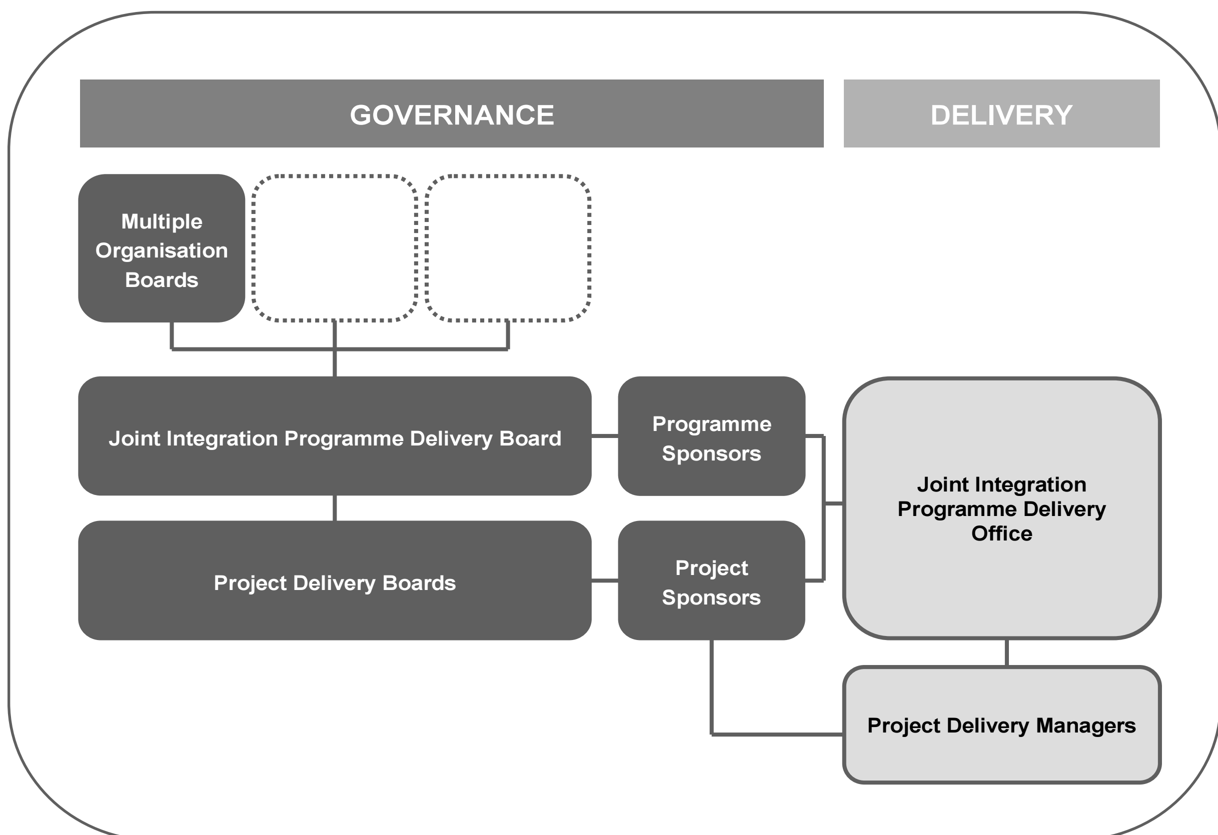
The project will be managed in line with a toolkit and approach agreed by all delivery partner organisations. This will include the following:

Area Of Control	Strategy	Key Tools
Risk and issue management	The project manager will co-ordinate risks, updating the risk and issue logs regularly. These will be reported on monthly to programme board, highlighting any new or changing risks and all issues. The risk log will have risk reference, title, description, likelihood, impact, mitigation, action, owner, date	Risk log Issue log
Progress monitoring	The project manager will manage against the PID and project plan. Highlight reports will be provided to the programme board monthly. Other programme management tools will be completed as requested. Reports through to partner governance will be completed as required	PID Highlight report Exception reporting process
Stakeholder engagement	A stakeholder engagement strategy and plan will be managed against and regularly reviewed. This is supported by a stakeholder map that includes all stakeholders	Stakeholder map Stakeholder engagement plan
Benefits tracking	A simple benefits tracker will be developed for the prioritised projects during the Enabling stage. The project manager will monitor against this and will agree who	Integration Project benefits tracker

Area Of Control	Strategy	Key Tools
	completes it. Benefits will be reported to programme board monthly. Benefits tracking for the strategic direction will be more complex and will be agreed at DBC stage.	

Project structure

The project structure is outlined below.



7. Risks

Risks will be managed in line with a toolkit agreed by all partner organisations. Key risks are outlined below. A full risk log will be maintained as part of the project.

Name	Description	P	I	Mitigation
NHS de-stabilisation	Uncertainty or change in NHS reforms could cause delay, inertia or change in direction	M	H	Key milestones will be built into the joint plans. Strategic case and business case will be

Name	Description	P	I	Mitigation
				based on local need and benefits, not dependent on policy change.
Key contacts leave	Change in direction, loss of momentum as key stakeholders leave organisations or roles change	H	M	Clear stakeholder map and planning that is regularly reviewed. This will include documentation of the dates of organisational changes
Insufficient resources	Partner organisations do not have sufficient resources or capacity to invest in integration initiatives	H	H	Agree an approach that delivers leading projects that build capacity and resources to reinvest in integration initiatives. Ensure integration plans have robust business cases that are aligned to partner organisation priorities and take account of cost and capacity pressures.
De-prioritised of integration initiatives by partners	Lack of commitment or capacity from partners due to other pressures such as cost or restructures	M	H	Clear defined business case that takes account of individual organisational changes and pressures and processes to regularly review these.
Lack of co-ordination	Need to coordinate a range of initiatives led by multiple organisations and involving multiple stakeholders	M	H	Clearly defined and agreed project plans with joint governance and project delivery arrangements agreed by all partner organisations and key strategic stakeholders.
Benefits savings dispute	Disputes about how cashable benefits are distributed between partners organisations	L	M	Agree governance and benefits allocation treatment at the outset as part of an agreed set of engagement and operating principles. Aim to ensure that project portfolio contains benefits for all parties
Benefits/ savings not delivered	There is a risk that, were we to proceed with new forms of integration, they may not deliver the intended benefits to Barnet people.	L	H	Clear business case and plans. Regular review points. Delivery of change through small, practical projects as well as major change.
No strategic	Failure to agree a strategic	L	H	Strong stakeholder engagement

Name	Description	P	I	Mitigation
direction agreed	direction on integration with key partners			to ensure a common position is found. Clear work on benefits definition as part of business case development to demonstrate measurable benefits for all partners.

P = Probability
I = Impact

8. Dependencies and Relationships

Project / Programme	Dependency / Impact
Adult Social Care and Health Transformation Programme	This programme involves fundamental changes to the way in which adult social care is delivered and the processes to support this. The work programme to deliver these changes is dependent on substantial input from adult social care teams and may create some resourcing constraints if integration activity is not aligned. The shift to increased personalisation of care packages is likely to create some additional complexity in the design of integrated health and social care functions, processes and systems.
One Barnet Customer Service Organisation (CSO)	The new local authority CSO customer gateway will impact on any proposals relating to the development and integration of single points of access for health and social care services.
One Barnet Programme Stage 2 Early Prevention and Intervention	One of the key benefits of integration is changing the pathway/customer journey including increasing early intervention and prevention. The projects will therefore be closely interlinked.
Public health transfer	Public health activities are a key part of an integrated approach to health and social care. Although public health transition is a separate project, there is a clear dependency.

Project / Programme	Dependency / Impact
Commissioning Council and organisation design	Continuing work on definition of the commissioning council and the high level organisation design will have an impact on integration options available.
One Barnet Programme Stage 2 Leisure	The Leisure Review will play a key role in providing a coherent picture of the infrastructure and capacity available to support the promotion and implementation of greater opportunities for individuals to become more physically active. The emphasis on increased signposting, improved information sharing and coordination of resources will be fundamental to achievement of health outcomes.

9. Appendix

9.1 Task and Finish Group

9.2 Recommendations, including summary of evidence

9.3 Key documents to support the SOC

9.1 Task and Finish Group report and recommendations

In October 2011, the Business Management Overview and Scrutiny agreed to establish a time-limited Task and Finish Group 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.

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.

1. 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.

2. 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.

9.2 Summary of evidence presented to the Task and Finish Group

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.

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 lessons 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 benefited 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.

9.3 Key documents to support the SOC

- Integrated Care For Patients And Populations: Improving Outcomes By Working Together - King's Fund And Nuffield Trust: A Report To The Department Of Health And NHS Future Forum – January 2012

- Where Next For The NHS Reforms: The Case For Integrated Care – The Kings Fund – 2011
- Transforming Our Health Care System: Ten Priorities For Commissioners – The Kings Fund – 2011
- Routes For Social Care And Health Care: A Simulation Exercise – The Kings Fund - 2011
- Joined-up Care: A Rapid Review Of The Literature – NHS Institute For Innovation And Improvement - November 2010
- Joined-up Care: Delivering Seamless Care Case Studies – NHS Institute For Innovation And Improvement – 2010
- Joining Up Health And Social Care: Improving Value For Money Across The Interface – Audit Commission – December 2011
- The National Evaluation of Partnerships for Older People Projects – PSSRU, 2009

Meeting	Health and Well-Being Board
Date	31 May 2012
Subject	**Minutes of Financial Planning Subgroup**
Report of	Director of Adult Social Care and Health
Summary of item	This report is a standing item which presents the minutes of the Financial Planning Subgroup and updates the Board on the joint planning of health and social care funding in accordance with the Council's Medium Term Financial Strategy (MTFS) and the NHS Quality Improvement and Productivity Plan (QIPP).

Officer Contributors	Kerry Anne- Smith, Head of Finance, LBB Ahmet Koray, Head of Finance, Barnet, NHS NCL
Reason for Report	To note the minutes of the Financial Planning Group.
Partnership flexibility being exercised	The report encompasses partnership flexibilities such as those under Sections 75 and 256 of the NHS Act 2006.
Wards Affected	All
Appendices	Appendix One – Minutes of the Financial Planning Group – 23rd April 2012

Contact for further information: Kate Kennally, Director of Adult Social Care and Health 020 8359 4808

1. RECOMMENDATION

1.1 To note the minutes of the Financial Planning Group of 23rd April 2012 as set out in appendix 1.

1.2 That Barnet Clinical Commissioning Group identify their representative on the Financial Planning Group in line with the CCG now having responsibility for delegated commissioning budgets.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Cabinet, 14 February 2011– agreed partnership working for health in Barnet that proposed to delegate responsibility for the social care allocation through the NHS to the shadow HWBB via a section 256 agreement.

2.2 Cabinet Resources Committee, 2 March 2011 – approved criteria for the allocation of funds within the section 256 agreement and agreed high level spending areas to be overseen by the HWBB

2.3 Health and Well Being Board, 26th May 2011 – item 5 approved the establishment of the Financial Planning Group as a subgroup of the HWBB.

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

3.1 The Medium Term Financial Strategy (MTFS) of the Council and the NHS Quality Innovation, Productivity and Prevention Plan (QIPP) for Barnet are aligned to the achievement of the Sustainable Community Strategy objective of 'Healthy and Independent Living.', and will be aligned to the Health and Well-Being Strategy that is in development. Underpinning the achievement of these strategies is the requirement to shift resources to the community with statutory services working alongside people to take greater responsibility for their own and their families' health.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The MTFS and QIPP have both been subject to equality impact assessments considered by Cabinet and NHS Barnet Board respectively.

5. RISK MANAGEMENT

5.1 There is a risk that without aligned financial strategies across health and social care of financial and service improvements not being realised or costs being shunted across the health and social care boundary. The financial planning group has identified this as a key priority risk to mitigate through work to align timescales and leadership of improvement plans which affect both health and social care through the HWBB.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 256 of the National Health Service Act 2006 enables Primary Care Trusts to make payments to social services authorities towards expenditure incurred or to be incurred by local authorities in connection with social services functions or any local authority function that affects the health of people in the area.

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

7.1 All of the section 256 and enablement schemes have been reviewed and the Council as part of the financial year end earmarked reserves will be established to resource the programmes which have a clear programme of work or an agreed business case. The final outturn position will reported at the next meeting of the Health and Well-Being Financial Planning Group in June 2012.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 None specifically arising from the last Health and Well-Being Board, other than to note that the Older Adults Assembly are keen to be involved in the development of the work on the frail elderly care pathway. The Associate Director for Joint Commissioning will have the responsibility for taking this forward.

9 DETAILS

9.1 The Barnet Health and Well-Being Board on the 26th May 2011 agreed to establish a Financial Planning Group to co-ordinate financial planning and resource deployment across health and social care in Barnet. The financial planning group meets bi-monthly and is required to report back to the Health and Well-Being Board.

9.2 Minutes of the meeting of the Group held on 23rd of April 2012 are attached at Appendix 1.

10. BACKGROUND PAPERS

10.1 None

Legal – HP
CFO – JH

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BARNET LONDON BOROUGH

Barnet NHS
Primary Care Trust

Minutes from the Health and Wellbeing Board – Financial Planning Group

23rd April 2012
Meeting Room, Sycamore Room - Ground, Building 4, NLBP
10.30 -12:00

Present: Kate Kennally, Director of Adult Social Care and Health, LBB
Anisa Darr, Finance Manager for Kerry Anne-Smith, Head of Finance, Children and Adults, LBB
Ceri Jacob, Associate Director – Joint Commissioning, LBB, NCL
Ahmet Koray, Finance Lead, NCL Barnet
Dawn Wakeling, Deputy Director, Adult Social Care and Health

Apologies: John Hooton, Assistant Director, Strategic Finance, LBB
Alison Blair, Borough Director, NCL Barnet
Robert McCulloch-Graham, Director of Children's Services, LBB

In Attendance: Rohan Wardena, Public Health Programme Manager

	ITEM	ACTION	BY WHEN
	Minutes from last meeting The minutes of the 8th of March 2012 were agreed as forming an accurate record.		
1.	Matters Arising from minutes of last meeting. It was noted that • CJ to confirm that section 256 agreement for 2011/12 has physically been signed by both the Council and Barnet PCT.	CJ	
2.	**Update on Outturn Positions for financial year 2011/12** *Barnet CCG / NHS Barnet* Ahmet Koray reported that NHS Barnet have achieved the financial plan for 2011/12 with a predicted outturn of a £15.8million deficit against an agreed planned deficit outturn of £17.2m. This outturn has been achieved through delivery of £25m of the £30m QIPP savings which have included reductions in referrals to secondary care reversing previous trends and achievement of stretching medicines management savings of £3m. For 2012/13, at the start of the year, Ahmet Koray reported that there is an underlying deficit of £40m with QIPP plans of £38.6m of which £11.7m is still not fully defined. Additional savings plans to close this £11.7m will be considered following the outcome of the finalised contract negotiations for 2012/13.		

Ahmet Koray identified that the closure of £11.7m gap will need to include discussions with the HWBB finance group especially in respect of quantifying any cashable savings arising from business cases into telecare / telehealth and dementia/stroke pathway work.

With respect to children's health issues, the CCG will be seeking to ensure that a £150k service risk in relation to children's home peg feeding service is found during 2012/13 in order to fund a new service. If this £150k is not found, it will add to the £11.7m gap.

Ahmet Koray reported that the contract negotiations and savings plans will be finalised by the end of May 2012 so that there is a clear plan for the delivery of a balanced budget for 2012/13

Barnet Council – Adult and Children's Services

Anisa Darr reported that whilst the final outturn has not been confirmed, both Children and Adult Services are reporting a balanced outturn at year end. Anisa Darr reported that as the section 256 monies have not been fully spent the directorate will be required to make a case for a dedicated reserve to be created at year end in order for these monies to continue to be delegated to the Health and Well-Being Board for spend.

For 2012/13, Adult Social Care and Health has agreed savings totalling £4.7m which form part of a three year MTFS savings plan of £14.3m. Dawn Wakeling reported that robust plans have been developed for 2012/13 which include savings resulting from health and social care integration covering:-

- Integrated continuing health care commissioning
- Workforce savings from integration
- Productivity savings arising from service redesign.

DW further reported that key risk areas for 2012/13 continue to relate to dementia; autism which will need to be mitigated through close working with the NHS.

Robert McCulloch-Graham reported that the Children's service were continuing to manage pressures within the children's social care budget, however the biggest opportunity for addressing long term children's costs needs to stem from greater levels of joined up commissioning and working with the NHS. RMcG identified that there is a need to work through with the Children's Trust and Barnet CCG to develop an integrated approach to commissioning children's services. RMcG reported that work is being undertaken to develop a new commissioning structure for children's services involving Vivienne Stimpson with the aim to develop shared

funding arrangements to support Family Nurse Partnership and CAMHs. RMcG identified that there is a need to more formally recognise the family nurse partnership through a partnership agreement which will bought back to the HWB Financial Planning Group for agreement.

RMcG reported that an ex DCS has been appointed to look at SEN / and health services for children with complex needs with a view to establishing a pooled budget which the Children's Trust will oversee.

The following actions were identified

- Detailed report setting out outturn position for NHS Barnet and Adult Social Care and Health to be available for next HWBB Financial Planning Group and will form the substantive agenda item from which to develop the forward work plan of the group. This will need to set out the position regarding carry forward of section 256 monies.
- Ceri Jacob / Ahmet Koray / Anisa Darr to prepare a report setting out the savings; investments (section 256; enablement); and performance metrics linked to all aspects of the frail elderly work with approval through financial planning group with clear proposal regarding monitoring
- Continuing Care business case to be produced to take account of developments in the CSS; savings targets within NHS Barnet and Council at next HWB Financial Planning Group

3. Update on Fracture Liaison Service Implementation

Ceri Jacob reported that since the business case had been agreed by the HWBB Financial Planning group contract negotiations have commenced and are in the process of being concluded to establish FLS service through RFH and BCF. The group noted that the development at RFH will be partnership with Camden and this will influence the timescales. However it is anticipated that the FLS service will be operational by July 2012. **CJ**

4. Section 256 Monies and Expenditure Plan for 2012/13

Ceri Jacob spoke to report setting out the details of the investments proposed utilising the NHS monies for social care and identifies where each proposal is in the process of development and implementation of each priority investment area.

The RAGG rating against each of the schemes was noted and it was requested that further work is done on each of the scheme identified to ensure that benefits realisation measures are set and

tracked following on from the work to review each business case, its milestones, timescales and governance. Activity has been aligned to four overarching areas of focus that complement the overarching health and well being strategy, integrated commissioning plan and adult social care business plan deliverables.

The group noted that the Older Peoples Assembly has expressed a clear interest in being involved in work that may lead to more integration between health and social care services. Sharing proposals for 2012/13 with the Assembly will facilitate this involvement and allow the Council to take account of concerns or issues that are important to older people in Barnet and it was agreed that this should be taken forward. This will be considered through the development and sign off of the integrated commissioning plan and health and social care integration SOC.

The group noted the report and the update on the NHS enablement funds and noted that, whilst final approval of NHS enablement funds will need to remain with Barnet QIPP in this year, the HWBB Finance Group review how the funding is utilised through the year alongside the NHS funding for social care.

Public Health baseline allocation and representations

Rohan Wardena briefed the group on work that has been undertaken to verify the baseline allocation for Barnet Public Health services and to seek the agreement of the group to the proposed adjustments identified by Public Health colleagues for submission to DH by NCL and for representations by the Cabinet Member. This work has identified that there is a potential shortfall of £724,000 in the budget to deliver the LA statutory PH responsibilities.

5. The following actions were identified to allow for a Council response to Caroline Taylor from NCL and Robert Creighton and DH

- Ceri Jacob to clarify what the level of drug and alcohol contract management and procurement resource is necessary to manage the 6 contracts (BEH, Turning Point, Equinox, Westminster Drug Project, HAGA – The PH team believe the shortfall is approximately 1 WTE effort. — **CJ** — **25th of April 2012**
- Ahmet Koray to confirm if there is an alternative basis to calculate the contract management and procurement shortfall – e.g. x% of the contract value less management costs as an alternative to the analysis presented by public health of a WTE shortfall of 4 staff estimated at costing — **AK** — **25th of April 2012**

	£400k: • Rohan Wardena will circulate final proposed submission to HWBB Financial Planning Group	**RW**	**25th of April 2012**
	Group agreed that an update on this would come forward to the next Health and Well-Being Financial Planning Group.		
6.	**Equipment S75 Agreement – Sign off arrangements** Noted that this still has not been signed off although CJ reported that all legal issues have now been resolved. KK advised that progress now has to be made and that this needs to be going forward to the next NCL Board for agreement to allow signing. If a signed partnership agreement is not in place by end of June 2012, KK advised that the Council would cease to act as the lead commissioner for community equipment services.	CJ	By end of June 2012
7.	**Any Other Business** Noted that there is now a need for a CCG Board member to be represented on the HWBB Financial Planning Group. Agreed that Ceri Jacob would discuss this with the Chairman of the Barnet CCG and Alison Blair with a view that a representative would be confirmed at the next HWBB. The next financial planning group of the HWBB is on 13th June 2012, NLBP and will focus on development of shared HWBB financial planning group work plan for the year ahead based on the analysis of the issues, risks and projects across health and social care identified above.	CJ	31st of May 2012

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Meeting	Health and Well-Being Board
Date	31 May 2012
Subject	**Forward Work Programme**
Report of	Director of Adult Social Care and Health
Summary of item and decision being sought	To present an updated work programme of items for the Health and Well Being Board for 2012/13

Officer Contributors	Andrew Nathan- Chief Executive's Service
Reason for Report	To allow the Board to schedule a programme of agenda items that will fulfil its remit
Partnership flexibility being exercised	The items contained in the work programme will individually take forward partnership flexibilities including the powers Health and Well-Being Boards will assume under the Health and Social Care Act 2012.
Wards affected	All
Contact for further information	Andrew Nathan 020 8359 7029

1. RECOMMENDATION

1.1 To note and comment on the draft forward work programme attached at Appendix ‘A’.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Shadow Health and Well Being Board – 26 May 2011- agenda item 9

2.2 Shadow Health and Well-Being Board- 19 January 2012- agenda item 11

2.3 Shadow Health and Well-Being Board- 22 March 2012- agenda item 2

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; JOINT HWB STRATEGY; COMMISSIONING STRATEGIES)

3.1 The Work Plan has been designed to cover both the statutory responsibilities of health and Well-being Boards and key projects that have been identified as priorities by the Board at its various meetings and development sessions.

3.2 Approval and performance management of the Health and Well-Being Strategy has been included within the work plan and, when adopted, the Strategy will be the most significant determinant of future work programmes.

4. NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 None specifically arising from this report- but all items listed will demonstrate how the needs analysis contained in the Joint Strategic Needs Assessment (JSNA) has influenced the options chosen, including differential outcomes between different communities.

5. RISK MANAGEMENT

5.1 A forward work programme reduces the risks that the Health and Well-Being Board acts as a talking shop for the rubber stamping of decisions made elsewhere, or does not focus on priorities. It ensures that all decisions formally within the Board’s statutory duties, Terms of Reference and other key issues relating to local health and care services are considered.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The forward work programme has been devised to incorporate the legal responsibilities contained in the Health and Social Care Act 2012. The HWBB has been operating in shadow form in readiness for the proposed legislative changes.

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

7.1 None specifically arising from the report. The programme is co-ordinated and monitored by the Chief Executive's Service as part of their support to the Board.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The programme has been devised through consultation with Council and NHS managers, but the Barnet LINk through their membership of the Board have the opportunity to refer matters or suggest agenda items.

8.2 In addition, the Chairman of the HWBB met with the Co-Chairs of the Partnership Board which report into the HWBB on the 9th of February 2012. This provided an opportunity to discuss the forward plan of the HWBB.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 None at this stage, although feedback from providers should guide the choice of future agenda items.

10. DETAILS

10.1 At its last meeting on 22 March, the Board considered a forward work programme for the whole of 2012/13, with items reflecting the Board's future statutory responsibilities; key strategies and projects currently in progress; and the precedents set during the HWBB's first year in operation.

10.2 It was also agreed that future meetings should be divided into two parts, the first, as now, a public meeting which considers formal written reports for information and decision; and the second informal workshop style sessions between Board members which would take place on the conclusion of the formal meeting and not by themselves take any executive decisions. The work plan therefore marks with a 'B' items to be handled as formal business, and with a 'W' those which are discussion items to be handled through informal workshops at this stage.

10.3 An updated work programme is attached at Appendix 'A' for the Board's comments.

10.4 There is a key role for the LINk representative in pressing for the forward plan to take into account issues of community concern, as well as any specific LINk reports or requests for information.

11 BACKGROUND PAPERS

None

Legal – HP
CFO – JH

APPENDIX A

POSSIBLE SCHEDULE OF HEALTH AND WELL BEING BOARD BUSINESS 2012/13 (agreed at 22/3/12 HWBB and revised)

item	26 July 2012	4th October 2012	6 December 2012	7 February 2013	4 April 2013	Notes
STANDING OR GOVERNANCE ITEMS						
Financial Planning Group minutes	B	B	B	B	B	
HWB Implementation Group- minutes	B	B	B	B	B	
Governance arrangements, ie review Terms Ref Membership etc					B	4/4/13 will approve conversion from shadow to full statutory status
Development of HWBB					W	

	26 July 12	**4 Oct 12**	**6 Dec 12**	**7 Feb 13**	**4 Apr 13**	**Notes**
JSNA, HWBS AND RELATED STRATEGIES						
Joint Strategic Needs Assessment- update/review/refresh		W				Not sure what requirement is to refresh. Might benefit from a more discursive workshop format.
Health and Well Being Strategy- Sign off	B					26/7/12- final sign off post consultation
HWBS sub plan- Keeping Well (Prevention Plan)	B					
HWBS sub plan- Keeping Independent (Integrated Commissioning Plan)	B					
Substance Misuse Strategy	B					
Integrated Transitions Strategy	W?					Suitable for workshop to examine whole system and how we contribute? This might also be linked with the Integrated Commissioning Plan
PERFORMANCE MANAGEMENT						
Report against HWBS targets			B?		B?	
In depth report on one issue in DPH's Annual Report		B	B	B	B	
NEW PRIMARY CARE COMMISSIONING ARRANGEMENTS						
Clinical Commissioning Group- update on organisational progress		B			B	
Clinical Commissioning Group- sign off of commissioning plans etc for 13/14				B		
Commissioning Support Organisation- update on proposals		B				

	26 Jul 12	4 Oct 12	6 Dec 12	7 Feb 13	4 Apr 13	Notes
PUBLIC HEALTH/ DETERMINANTS/ PREVENTION MATTERS						
Public Health Transition Plan	B					Deferred from 31 May
Leisure Services- Strategic Review	W					
Annual Report of Director of Public Health					B	
Cancer prevention work plan		B				Already considered in draft- needs sign off
Other Children's issues						
H and SC- contribution to economic well being		W?	W ?			A possible idea, as high priority for council and partners in next year- how can the health and care system make its own maximum contribution to ensure people well enough and supported enough to retain or gain employment? The prevention plan will set out much of this but could benefit from a discussion of its own.
REPORTS OF PARTNERSHIP BOARDS						
Learning Disabilities Partnership Board- Annual Report	B					
Carers Partnership Board- Annual Report		B				
Mental Health Partnership Board- Annual Report			B			
Physical Sensory Impairment- Partnership Board Annual Report				B		
Older Adults Partnership Board- Annual Report					B	
Chair's meeting with Partnership Board chairs- minutes		B			B	

Discussion on how to work with and develop the voluntary sector (following the recent financial reductions)		W?	W?			

	26 Jul 12	**4 Oct 12**	**6 Dec 12**	**7 Feb 12**	**4 Apr 13**	**Notes**
SAFEGUARDING/QUALITY AND SAFETY ISSUES						
Safeguarding Adults Board- Annual Report	B					
Safeguarding Children Board- Annual Report	B					
Quality and Safety Matters in NCL	B			B		To be provided 6 monthly
Whole system working to reduce pressure ulcers		W				(identified in quality and safety discussion at Jan HWBB)- might be workshop format depending on complexity of issue/which providers need to be involved? Deferred from July to October
USER AND CARER ENGAGEMENT						
Local HealthWatch- spec and tender process	B			B		May slip to July. Feb 13- will be report of new contractor how service planned to be delivered
LINK- Annual Report	B				B	11/12 and 12/13 reports respectively- the latter as part of LINK/LHW handover
Carers Support Commissioning		B				Identified in corporate Plan
HEALTH AND CARE INTEGRATION						
HSC Integration Scoping project	B	B	B	B	B	Workshop was held Mar 2012. 26 July report needs to include response to referral from Business Management OSC
HSC Integration- specific projects that result						
Ageing Well			B			

New or amended Section 75 agreements						As identified through the Financial Planning Group
System Risk Assessment- MTFS and QIPP			B			
Allocation of Section 256 funds			B ?	B ?		Will we still be getting these on an annual basis?
BARNET ENFIELD HARINGEY CLINICAL STRATEGY						
Barnet, Enfield and Haringey Clinical Strategy Investment Plans	B					

HWBB will exercise statutory functions from 4 April 2013 meeting.

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