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   Health And Social Care Integration Strategic Outline Case

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   <u>Local Authority Investment In Integration</u>

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   <u>Integrated Commissioning Plan</u>

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	2012				
		MAY	JUN	JUL	AUG	SEP
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 <u>What this means for care commissioning and provider organisations</u>

- *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*
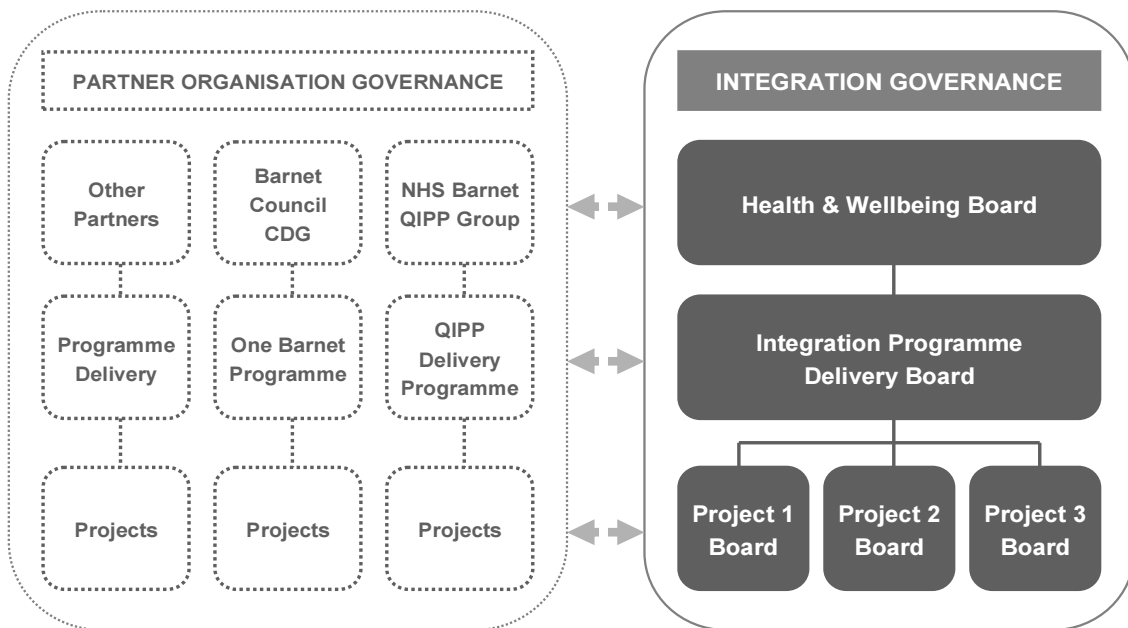
12. PROPOSED GOVERNANCE STRUCTURE

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   <u>Integration Programme Delivery Board</u>

- 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   <u>Project Delivery Boards</u>

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:
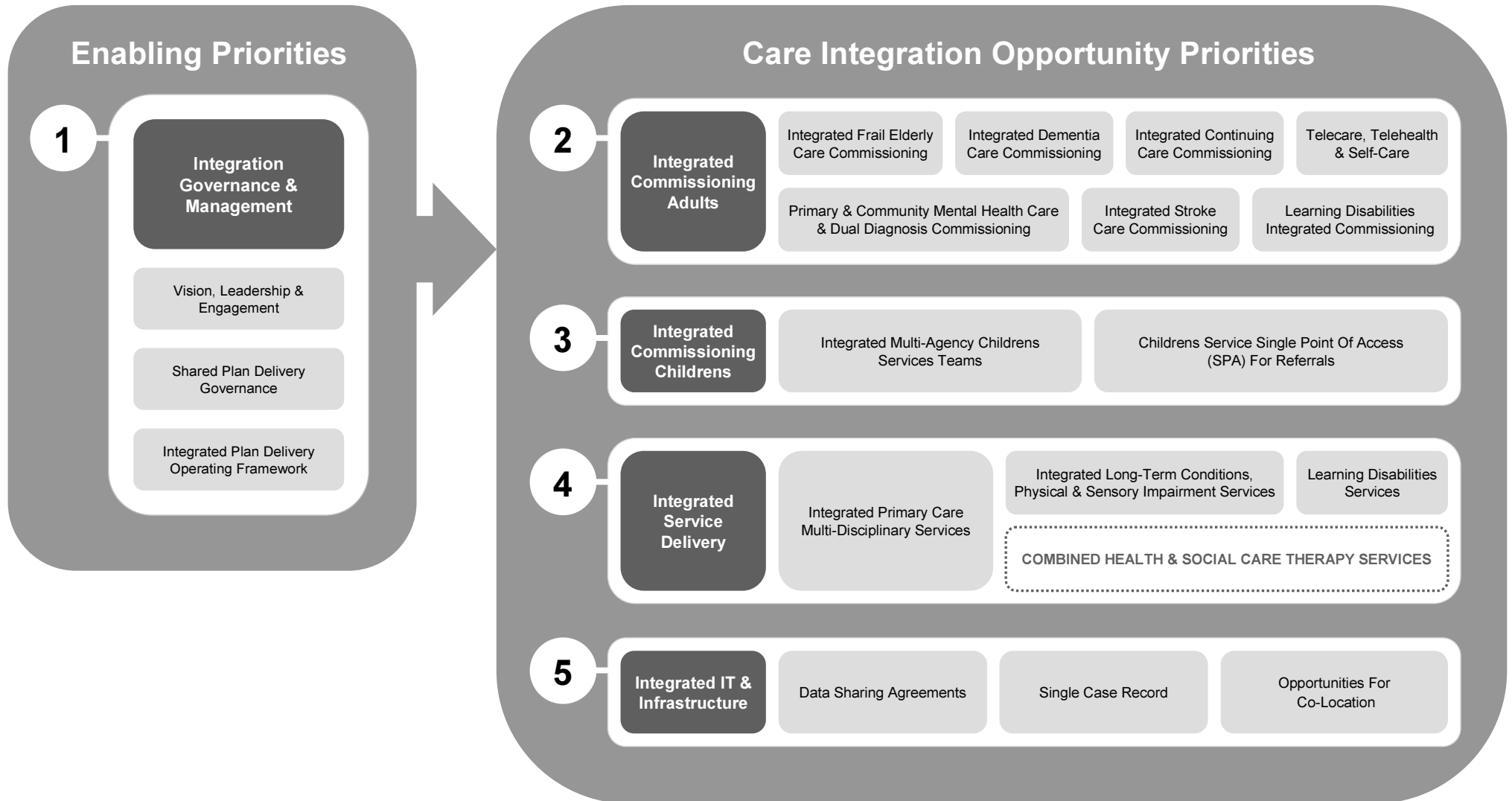
- Utilise existing Health and Wellbeing member organisation project delivery board structures where possible, ensuring the most efficient and effective use of time focused on management by exception

- 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

Enabling Priorities

1

Integration Governance & Management

Vision, Leadership & Engagement

Shared Plan Delivery Governance

Integrated Plan Delivery Operating Framework

Care Integration Opportunity Priorities

2 **Integrated Commissioning Adults**

Integrated Frail Elderly Care Commissioning

Integrated Dementia Care Commissioning

Integrated Continuing Care Commissioning

Telecare, Telehealth & Self-Care

Primary & Community Mental Health Care & Dual Diagnosis Commissioning

Integrated Stroke Care Commissioning

Learning Disabilities Integrated Commissioning

3 **Integrated Commissioning Childrens**

Integrated Multi-Agency Childrens Services Teams

Childrens Service Single Point Of Access (SPA) For Referrals

4 **Integrated Service Delivery**

Integrated Primary Care Multi-Disciplinary Services

Integrated Long-Term Conditions, Physical & Sensory Impairment Services

Learning Disabilities Services

COMBINED HEALTH & SOCIAL CARE THERAPY SERVICES

5 **Integrated IT & Infrastructure**

Data Sharing Agreements

Single Case Record

Opportunities For Co-Location

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 Requirement 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	Outcomes • 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 Outputs • 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 Links To Health & Wellbeing Strategic Themes • Care when needed	Section 256 Funding £300K	SRO Ceri Jacob Project Lead Caroline Chant
2.2	Dementia Care Commissioning Requirement	Outcomes • People with dementia will remain independent and in their own	Section 256 Funding	SRO 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

2. INTEGRATED COMMISSIONING OPPORTUNITIES – ADULT SERVICES

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

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
		• Services to deliver pathways commissioned Links To Health & Wellbeing Strategic Themes • Wellbeing in the community • Care when needed		
2.5	Learning Disabilities And Physical And Sensory Impairment Care Service Commissioning Requirement Develop clear pathways for people with PSI that span health and social care and increase alternatives to residential care	Outcomes • 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 Outputs • 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 Links To Health & Wellbeing Strategic Themes • How we live	One Barnet Funding £400	SRO Project Lead 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 <u>Requirement</u> Development and commissioning of integrated teams organised around care delivery setting	<u>Outcomes</u> • 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 <u>Outputs</u> • 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) <u>Links To Health & Wellbeing Strategic Themes</u> • Care when needed	TBD	<u>SRO</u> TBD <u>Project Lead</u> TBD
3.2	Childrens Service Single Point Of Access (SPA) For Referrals <u>Requirement</u> Development of a single point of access for referral to children's services that	<u>Outcomes</u> • 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	<u>SRO</u> TBD <u>Project Lead</u> 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.	<u>Links To Health & Wellbeing Strategic Themes</u> • How we live • Care when needed		
4.2	Learning Disabilities Services <u>Requirement</u> 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.	<u>Outcomes</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>Outputs</u> • Integrated care pathway and services • Combined therapy services <u>Links To Health & Wellbeing Strategic Themes</u> • How we live • Care when needed	TBD	<u>SRO</u> Dawn Wakeling <u>Project Lead</u>
4.3	Integrated Primary Care Multi-Disciplinary Services <u>Requirement</u> Establishment of multidisciplinary (MDT) health and social care assessment and delivery teams as part of locality based integrated primary care networks.	<u>Outcomes</u> • Health and social care delivery organisation efficiency and capacity gains from a single assessment, admissions, review and discharge process • Improved customer experience <u>Outputs</u> • MDTs in place • Single assessment process in place	<u>One Barnet Funding</u> £100K <u>NHS NCL Primary Care Strategy Funding</u> TBD	<u>SRO</u> TBD <u>Project Lead</u> TBD

4. INTEGRATED DELIVERY OPPORTUNITIES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
		<u>Links To Health & Wellbeing Strategic Themes</u> • Care when needed		

5. INTEGRATED IT & INFRASTRUCTURE OPPORTUNITIES

Ref:	Opportunity Area	Outcome and Output Benefits	Investment	Ownership
5.1	Data Sharing Agreements <u>Requirement</u> 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.	<u>Outcomes</u> • 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 <u>Outputs</u> • Data sharing agreement in place that encompasses health and social care providers and commissioners <u>Links To Health & Wellbeing Strategic Themes</u> • Care when needed	TBD	<u>SRO</u> TBD <u>Project Lead</u> TBD
5.2	Single Case Record <u>Requirement</u> Development of a client enabled and web	<u>Outcomes</u> • 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	<u>SRO</u> TBD <u>Project Lead</u>

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

Authors:	Rohan Wardena, Dawn Wakeling, Ceri Jacob
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
Ceri Jacob	Joint Associate Director of Joint Commissioning, London Borough of Barnet		06/03/12	1.0
Kate Kennally	Director of Adult Social Care and Health, London Borough of Barnet		06/03/12	1.0

DOCUMENT CONTROL

Version History

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

Contents

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

<u>Key messages from case studies and the literature review are:</u>

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

<u>Key enablers and barriers to integration</u>

KEY ENABLERS

Supportive Leadership

Collaborative Cultures & Behaviours

Strong Local Partnerships

Effective IT & Admin Systems

KEY BARRIERS

Performance Regimes

Financial Pressures

Organisational Complexity

Changing Leadership
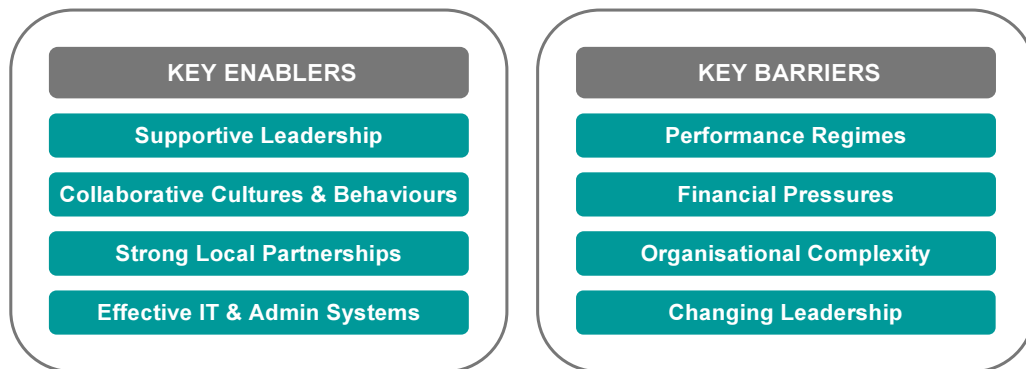
NHS Institute for Innovation and Improvement: Joined-Up Care November 2010

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:

- Integrated Commissioning Plan -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.

- Integrated Prevention Plan - 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.
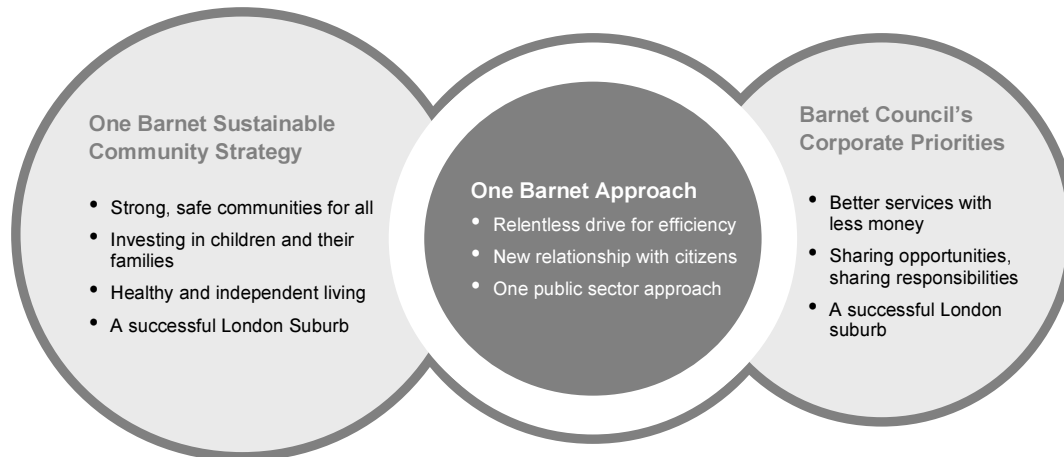
The integration of health and social care services to promote better outcomes, increase independence and reduce bureaucracy is a key objective for the Council in delivering its priority for better services with less money. In particular, key actions for social care are to ensure targeted investment of 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

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[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 £000	2013/14 £000	2014/15 £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
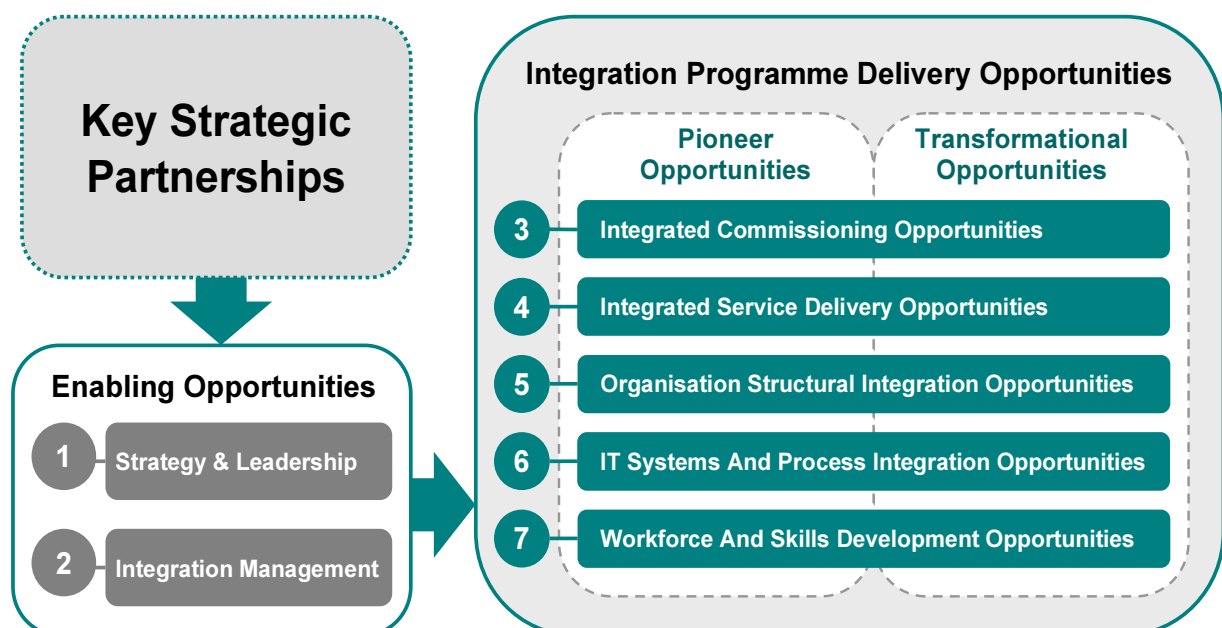
The scope of integration opportunities is extremely broad. It covers exploring an overall vision for the whole system of integrated health and social care, identifying shared opportunities in specific operational areas and establishing coordinated ways of working across multiple partner organisations 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
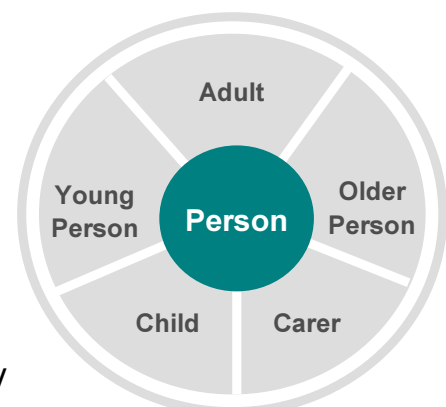
It is important now for partners to agree and prioritise the list of opportunities and make sure that interdependencies, scheduling, resources and expectations about input requirements are clearly understood by each contributing partner organisation so these can be planned for effectively. The development 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.
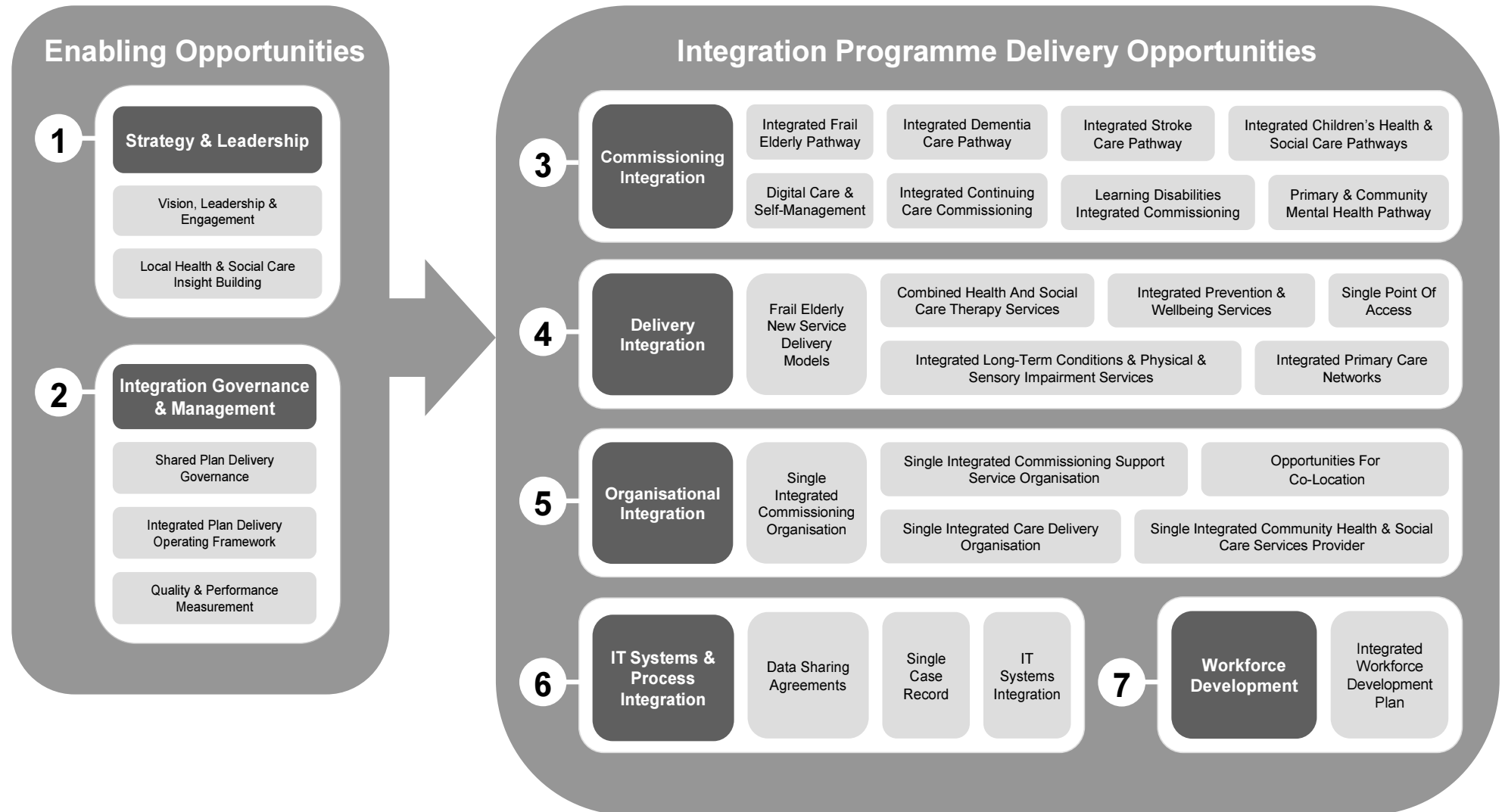
5.5.1   Integrated Strategy and Leadership

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 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 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. Current Status 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 Investment Requirements

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. Current Status 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. Investment Requirements 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. Current Status	• 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 Investment Requirements

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 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

Opportunity	Benefits And Investment Description
Current Status 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. Current Status 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 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

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 Current Status 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 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
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 Current Status 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. 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

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
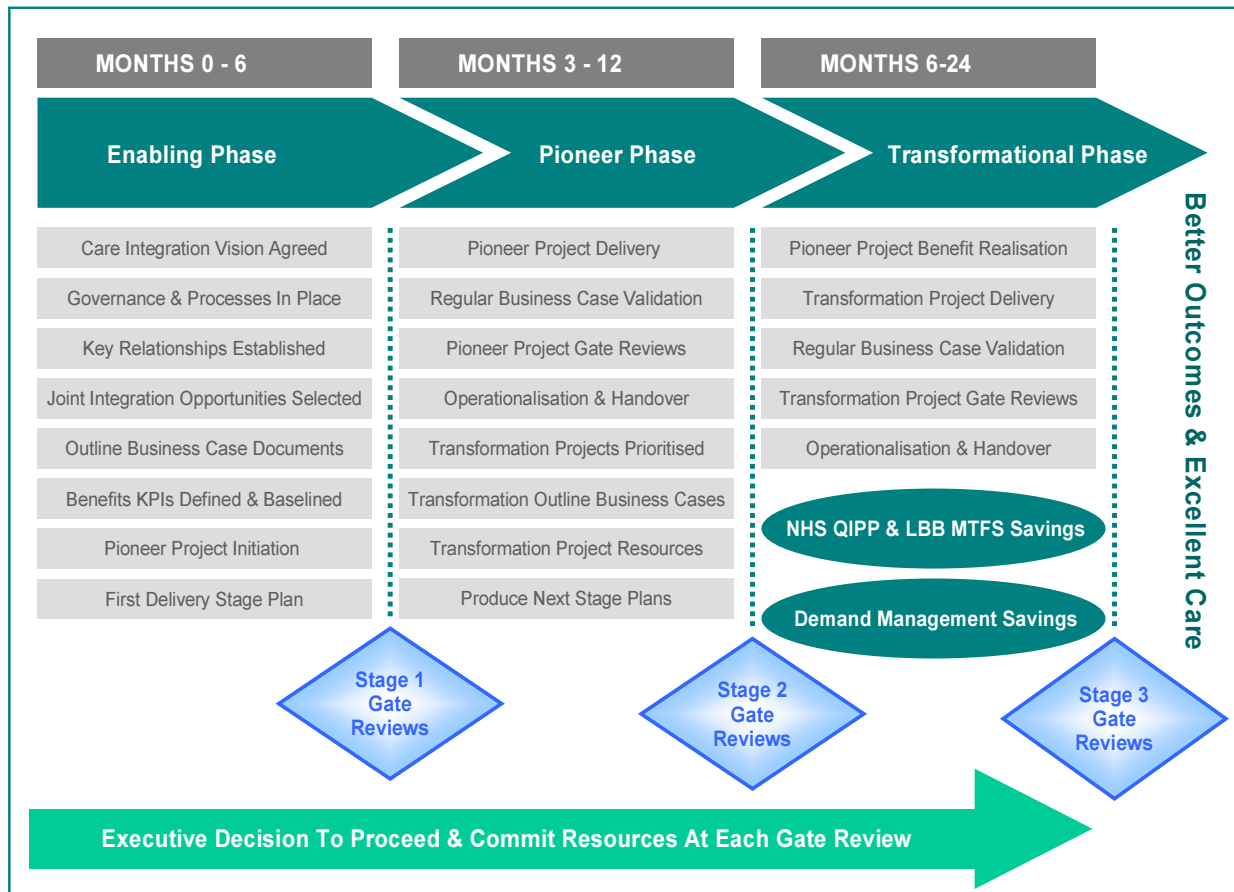
A three phased approach is proposed to progress the opportunities set out in the SOC, however this will be dependent on agreement and support from the local partner organisations.

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

Key Activities

• Enabling stage plan work package development		Apr 12

Outputs

- Agreed work package resource plan and budget produced
- Enabling stage plan produced and approved by partner organisations

Activity & Output Description	Effort Estimate (Days)	Target Date
2. Vision, leadership building and engagement	60 Days	May 12 to Jul 12

Key Activities

• Work package development		May 12
• Health and social care leadership summit		May 12
• Prioritisation framework development for joint integration initiatives		Jun 12
• Programme plan development and integration opportunity prioritisation		Jun 12
		Jun 12
• Roles and expectations definition and development of Memorandum of Understanding		Jul 12

Outputs

- 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

Activity & Output Description	Effort Estimate (Days)	Target Date
3. Local health and social care insight building	30 Days	May 12 to Jun 12

Key Activities

• Work package development		May 12
• Local health and social care mapping and cost and activity		Jun 12

1. ENABLING PHASE

Activity & Output Description	Effort Estimate (Days)	Target Date

Outputs

- 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

Key Activities

• Work package development	May 12
• Integration governance review and development	Jun 12
• Quality assurance review and development	Jun 12
• Governance structures (Joint Integration Programme Board) and processes set up	Jul 12
• Quality assurance structures and processes set up	Jul 12

Outputs

- 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

Key Activities

• Work package development	Jun 12
• Integration Programme Delivery Office (PDO) design and development	Jun 12
• PDO Resource plan development	Jun 12
• Shared project management processes, systems and tools definition and development	Jul 12
• Recruitment (if required)	Aug 12

Outputs

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
<u>Key Activities</u>	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

<u>Outputs</u>

- 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
<u>Key Activities</u>	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.
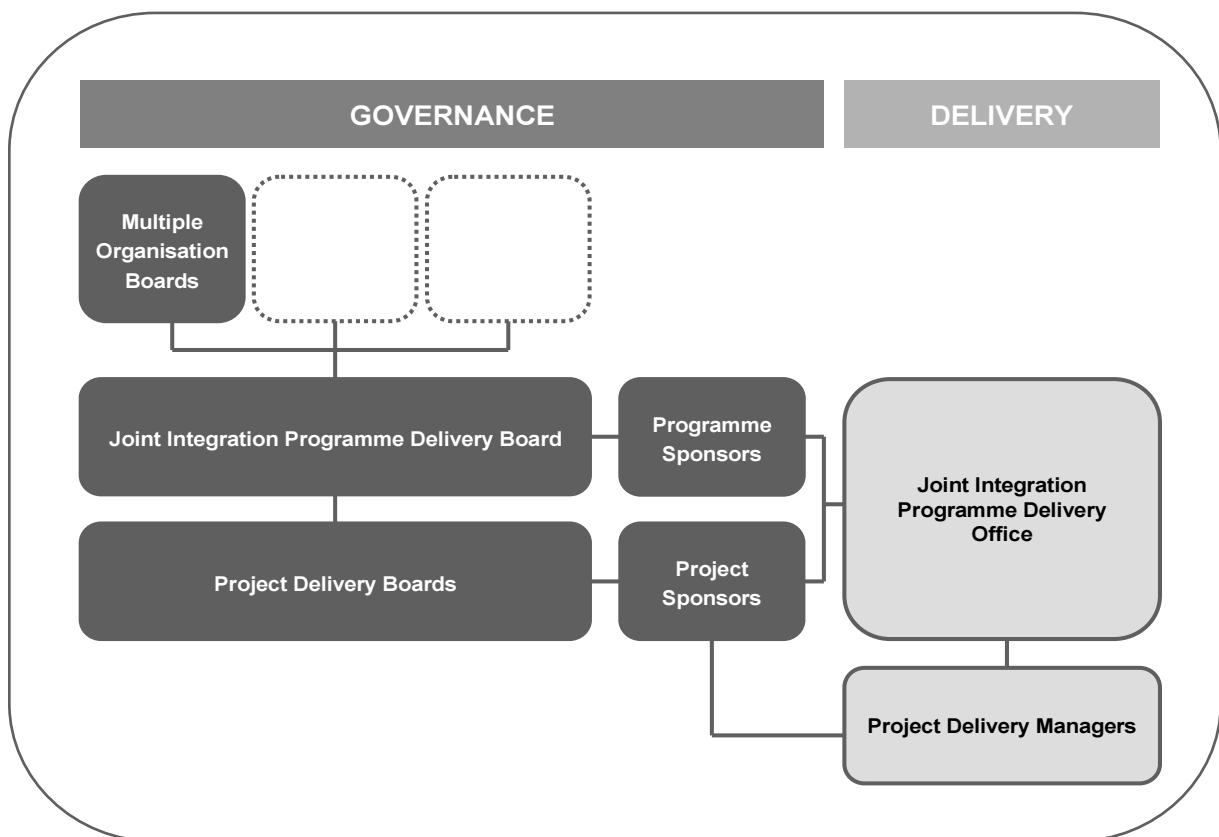
7. Risks

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