Annex A - Integrated Commissioning Plan

1. Background

The need for increased integration between health and social care in how they both commission and deliver services has been identified in a number of recent national strategies including "A Vision for Adult Social Care: Capable Communities and Active Citizens" and within the amended white paper "Equity and Excellence: Liberating Health".

Benefits include a more seamless service for service users with a reduction in omission and duplication of care and a corresponding improvement in service user experience and outcomes. This in turn leads to better value for money services.

This Integrated Commissioning Plan acts as one of two key delivery vehicles for the Barnet Joint Health and Wellbeing Strategy the second being the Integrated Prevention Plan. The Joint Health and Wellbeing Strategy identifies four key themes:

- **preparation for a healthy life** – that is, enabling the delivery of effective pre-natal advice and maternity care and early-years development;
- **wellbeing in the community** – that is creating circumstances that better enable people to be healthier and have greater life opportunities;
- **how we live** – that is enabling and encouraging healthier lifestyles; and
- **care when needed** – that is providing appropriate care and support to facilitate good outcomes.

This document reflects the first and fourth key themes and the previously agreed intention that an integrated approach should be taken to all areas where health and social care overlap or are interdependent. It is intended to be read alongside the Joint Health and Wellbeing Strategy and the Integrated Prevention Plan and uses as its evidence base the JSNA, national examples and evaluations and the views of local stakeholders.

The document is divided into two distinct halves. The first half sets out our vision for integration, what we mean by integration in Barnet and the case for change. The second half sets out our shared integration plans and the service areas that form the focus of this work for the next three years.

2 Vision statement

Vision Statement:

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.

2.1 **What this means for people who use care and treatment**

- 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

2.2 What this means for care commissioning and provider organisations

An integration summit is planned with providers in July 2012. What this means for providers and how they might best engage with this agenda will be agreed at that meeting.

3. Principles of integrated working

Partners have agreed that the following principles will underpin this integrated commissioning plan. These principles are based on national evidence and locally identified requirements.

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

At a local level we would also include the following two principles:

g) Integration should as a minimum maintain quality and safety and ideally improve the quality and safety of services

h) Integration should represent value for money for all organisations leading to a more sustainable public sector.

4. What do we mean by integration?

For the purposes of this plan we divide integration in health into three areas:

- Integration in commissioning and planning
- Integration in service delivery
- Integration of commissioning and provision of services

Further detail on each level is included as appendix 1.

5. Evidence base underpinning integration

There is a growing body of research into the impact of increased integration between health service providers and between health and social care commissioning and provision however; much of this evidence relates to health care and there is a need for Barnet to develop a local evidence base through large scale pilots of key initiatives. Some of the key findings from national examples are included in appendix 2.

General lessons emerging from the evidence include the need for:

a) Supportive leadership;
b) A suitable culture;
c) Strong local partnerships;
d) Effective IT and;
e) Effective administration systems

Locally experience has demonstrated a need for:

f) Incentives to be aligned;
g) Good information sharing;
h) Patients to be fully engaged and
i) Clear decision making and governance processes.

There is a need to develop locally owned models that meet local needs. This entails full and early engagement of clinicians, social care professionals, service users and their carers.

The literature also notes that realising the opportunities associated with greater integration takes significant time, energy and collective leadership from across all partner organisations.

6. Case for change and evidence base

The case for change is based on demographic changes identified in the Barnet Joint Strategic Needs Assessment (JSNA); a drive to improve outcomes and experience for service users and their carers, the financial constraints within the public sector and the need to build a sustainable public sector for the future. In these respects the

Council, Barnet CCG and NHS NCL aspirations are aligned and increased integration as a tool for achieving these aspirations is accepted locally.

Appendix 3 sets out in more detail the case for change.

7. Engagement with service users and stakeholders

Two engagement initiatives were undertaken in September 2011 with service users and carers to support development of this integrated commissioning plan.

Voluntary sector representatives were invited in recognition of the fact that they may provide roles and / or act as advocates. There was good attendance at both events with the provider event including representation from across acute, community and primary health care, social care and the voluntary sector.

The aim of the events was to identify areas where integrated commissioning and service delivery would be most beneficial and which the Health and Wellbeing Board should seek to prioritise through this integrated commissioning plan.

Service users were asked about where it worked well, where it didn't and what might the possible solutions look like. The key themes identified by service users and their carers were:

- The need to consider carers and their needs (including the impact of moving care out of the acute setting and into a person's home);
- Communication between providers including the number of "hands off" between providers, the need for single teams and "one stop shops";
- Continuity and the need to see people as a whole person;
- The importance of connecting people and reducing isolation; this included ideas such as befriending services;
- Easily accessible advice and support through a range of sources and better use of the voluntary sector.

Service providers were asked to consider where their work overlapped, what could we do to make it work better for service users and what should we be prioritising. The key themes identified by providers were:

- That the areas of greatest overlap and interdependence between health and social care are:
    - Elderly people including those in care homes
    - People with complex needs including LD, mental health and continuing health care
    - Hospital discharge and A&E
    - End of life care
    - Rehabilitation

- Areas where we could make things by being more integrated include:
    - Better discharge processes and not discharging too early
    - Communication ++ with IT a key feature
    - Having a clearly identified lead professional for complex needs
    - More multi disciplinary teams, integration and one stop shop style services

- Better information on other services available to support advice and signposting
- Help people to be more self caring which includes the use of crisis plans, greater input from the voluntary sector and use of befriending schemes
- Plan transitions from children to adult services earlier
- Be more proactive through use of care planning and prevention services etc.
- End of life care
- Care homes and older people

8. Engagement of Barnet Council, Barnet CCG and NHS NCL

Commissioners and leaders within health and the Council have been developing their ideas and thoughts in preparation for working together to define the vision and scale of integration in Barnet.

For the Council this has been taken forward as part of the Wave 2 Barnet Partnership programme. This has included a Member Task and Finish Group intended to identify political support and leadership for an integration agenda and a wider Member meeting to share findings from the task and finish group. The outputs of these two related pieces of work are set out in the "Strategic Outline Case: Joint Health and Social Care Integration Programme".

The Barnet CCG included a session on integration in its development programme. The focus was on developing an understanding of what integration could mean, scale and scope, the commissioning tools available to support an integrated system and the CCG GP Board member leadership role within an integration agenda.

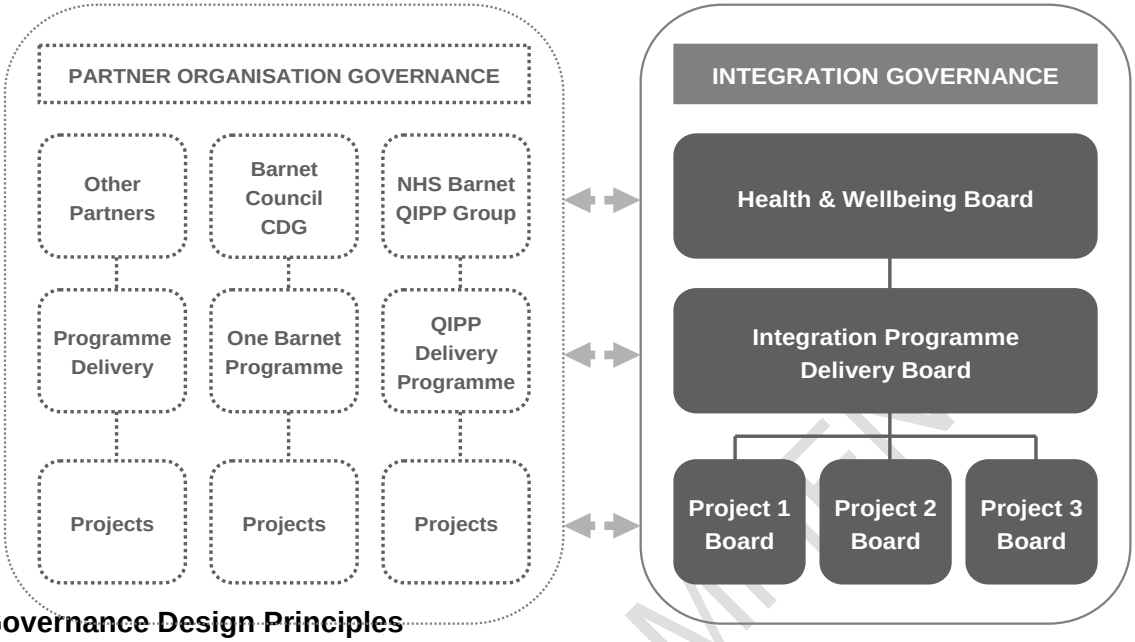
NHS NCL has also been exploring the opportunities within an integrated system with a particular focus on how an Integrated Care Organisation might support increased integration of service delivery. This work is closely linked to development of the NHS NCL Primary Care Strategy. Implementation of this work is expected to be at a local level and in Barnet this will be in partnership with Council colleagues and integral to the integrated commissioning plan.

In March 2012 a workshop was held with commissioners from Barnet CCG, NHS NCL and the Council to identify the key service areas to be included in the integrated commissioning plan. Proposals were based on the stakeholder feedback, needs identified within the JSNA, national evidence and local knowledge and are set out in part 2 of this document.

9. Governance

The scale of change required to move to a more integrated system is significant and will provide cultural and logistical challenges for commissioners and providers alike. These challenges include workforce development, premises, financial arrangements and information systems to underpin an integrated system. Change on this scale cannot happen overnight and requires strong leadership, commitment at all levels and a shared governance system to oversee integration.

Set out below is the governance structure that will support implementation of this plan.



9.1 Governance Design Principles

The proposed integration governance and delivery structure takes account of the following design principles and assumptions:

9.2 Health and Wellbeing Board

- The Health and Wellbeing Board sets the strategic direction for a local system of health and social care integration which is informed by the Health and Wellbeing Strategy and Joint Strategic Needs Assessment
- 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

9.3 Integration Programme Delivery Board

- There will be a shared integration programme delivery board which will have operational responsibility for the delivery of integration work programmes that have been approved by the Health and Wellbeing Board
- The programme delivery board membership will include lead Health and Wellbeing Board member sponsors and any providers that are identified as critical to the delivery of the work programme and benefits.

- Programme delivery will use existing structures where possible, ensuring the most efficient use of time
- The programme board is responsible for tracking project delivery against the approved business case and ensuring benefits are realised and optimised across the local system of care
- The programme board will define the necessary resources and skills requirement to deliver the integration programme and secure the necessary resources and investment via the Health and Wellbeing Board
- The board will implement agreed programme and project management processes including change control, risk and issues management within agreed tolerances set by the Health and Wellbeing Board
- The board will oversee programme and project reporting and ensure this is provided to the appropriate Health and Wellbeing Board member organisations
- The establishment and resourcing of a shared programme management office function where necessary to support and accelerate delivery of integration work programmes

9.4 Health and Wellbeing Finance Sub-group

- Each member of the Health and Wellbeing Board Financial Sub-group 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)
- It will approve individual project commissioning business cases, definition documents and plans within the scope and tolerances defined within the integration programme plan approved by the Health and Wellbeing Board
- It is anticipated that providers will follow their normal approval routes.

9.5 Project Delivery Boards

The proposal suggests that depending on the complexity of a specific project and its dependency on input from multiple organisations, individual project boards will be set up to oversee the development and delivery of certain integration projects. The design of project delivery boards is informed by the following principles and assumptions:

- Utilise existing Health and Wellbeing member organisation project delivery board structures where possible, ensuring the most efficient and effective use of time focused on management by exception
- Defines and approves the project brief and signs of the project definition document and plan
- Defines the necessary resources and skills requirements to deliver specific integration projects and secures the necessary resources and investment via the integration delivery board

- Implements agreed project management processes including change control, risk and issues management within agreed tolerances set by the integration delivery board
- Oversees project reporting and ensures this is provided to the appropriate Health and Wellbeing Board member organisations
- Approves individual project business cases, definition documents and plans within the scope and tolerances defined within the integration programme plan approved by the Health and Wellbeing Board
- Establishment and resourcing of a project management office function where necessary to support and accelerate delivery of the approved integration project

This structure recognises that organisations will also have reporting requirements that are specific to their own organisation. The level of delegation to the Boards may vary over time as the new NHS structure embeds.

The structure also recognises the important role that provider organisations, including the voluntary sector, have in shaping integration in Barnet.

10. Integration Plan 2012/13 – 2014/15

Action	Expected outputs	Outcome success measures	Interdependencies / Governance	SRO/Project manager
Preparing for a healthy life				
Children's services				
Develop integrated "teams around the setting"	• 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)	• 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	Primary care strategy	
Develop a single point of entry (SPOE) for referral to children's services that encompasses a MASH (multi agency safeguarding hub)	• 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	• Reduced inter and intra agency referrals and children are directed to right service first time • Increased use of CAF by all agencies involved in CYP care leading to reduced duplication of care/assessments/costs	LBB Customer Service Organisation NHS 111 Service	

Action	Expected outputs	Outcome success measures	Interdependencies / Governance	SRO/Project manager
Care when needed				
Mental Health				
Commission whole pathway	• 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	• Reduction in percentage of population requiring acute mental health care • 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	Housing Employment	Associate Director of Joint Commissioning.
Develop pathways for dual diagnoses	• Pathways agreed with all stakeholders for a) Mental health / Substance Misuse b) Mental health / Learning Disabilities c) Mental Health / Autism	• Clear pathways in place for people with dual diagnoses • 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	Housing Employment Voluntary sector	Associate Director joint Commissioning / JCM: Mental Health / JCM: Substance Misuse
Older Adults (professional lead/s				
Develop and deliver	• Integrated frail elderly	• Reduced avoidable	Integrated Prevention	Associate Director

Action	Expected outputs	Outcome success measures	Interdependencies / Governance	SRO/Project manager
programme of service developments to reduce admissions amongst the elderly to hospital and residential care and to reduce the need for care packages	service comprising rapid response, complex case management and rehabilitation (includes consideration of night time services) • Implement fracture liaison service & falls pathway • Develop and implement community dementia pathway • Develop and implement 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	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	Plan Carers strategy Voluntary sector Frail Elderly Pathway (FEP) Management Board	Joint Commissioning / Commissioning Manager /AD Public Health and JCM: Older People JCM: Older People Commissioning Manager Commissioning Manager
Adults (including learning disabilities and Physical Sensory Impairment)				
Develop clear pathways for people with PSI that span health and social care	• Clearly defined pathways in place which begin with transition planning	• Improved satisfaction rates with transition to adult services process • Reduction in number of	Integrated health and social care transition planning	Deputy Director ASCH / Head of Service

Action	Expected outputs	Outcome success measures	Interdependencies / Governance	SRO/Project manager
		people in residential care	Housing Employment Education Business Improvement Board (LBB)	
Increase alternatives to residential care	• 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	• Reduction in percentage of people with PSI or LD living in residential care • Reduction in overall spend on residential care	Prevention plan Carers strategy Move on Board (LBB)	Associate Director Joint Commissioning / Head of Strategic Commissioning and Transformation
Improve/ensure quality provision within social care services	• 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	Increased satisfaction with care expressed by service users and their carers Reduced admissions to hospital for pressure sores		Deputy Director of ASCH / Deputy Head of Strategic Commissioning and Supply Management / Commissioning Manager

Action	Expected outputs	Outcome success measures	Interdependencies / Governance	SRO/Project manager
	agreements			
Long Term Conditions				
Develop integrated multidisciplinary teams to support range of LTCs	• MDTs in place for each primary care network (population 30,000) • Care co-ordinator included in MDT • Single assessment in place	• 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	Links to implementation of primary care strategy Prevention elements reflected in Integrated Prevention Plan	
Develop telecare and telehealth strategy and associated implementation plan Planning for life change	• Telecare and telehealth procured and targeted at population groups where most benefit can be gained	• 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	FEP and LTC work. Telecare and Medicine Management Board to be established	Associate Director of Joint Commissioning / Head of Strategic Commissioning and Transformation

Action	Expected outputs	Outcome success measures	Interdependencies / Governance	SRO/Project manager
		attendance for exacerbation of LTC • Reduction in delayed discharge from hospital • Reduction in complications of LTC (measured over time and disease specific)		
Jointly procure continuing care	• All continuing care jointly procured • Budgets are aligned	• Reduction in people required to change providers if funding source changes • Overall costs are reduced as commissioner procurement leverage is increased	tba	Associate Director Joint Commissioning / Head of SCT and Commissioning Manager
Structural enablers				
Primary care strategy				
Develop integrated primary care networks that encompass social care and community services	• MDTs in place for each primary care network (population 30,000) • Care co-ordinator included in MDT • documentation in place • Social care and health teams (MDTs) co-located • Single assessment	• Reduction in avoidable admissions to hospital and A&E attendances • Reduced requirement for social care packages • Reduced delayed discharges • Patients and service users report improved satisfaction with services	Links to LTCs LBB and NCL premises strategies HR processes Primary Care Strategy Group (NHS)	Programme Manager Primary Care Strategy / Deputy Director of ASCH

Action	Expected outputs	Outcome success measures	Interdependencies / Governance	SRO/Project manager
	processes and			
Embed Right to Control (RTC) in Primary Care	GP practices and Community services are able to explain RTC to	• Increased number of people exercise their right to control	Information Advice Advocacy and Brokerage Service (IAAB) Information and Advice Board	Assistant Director of Transformation and Resources / Head of Strategic Commissioning and Transformation
Information Systems				
Develop information system that facilitates integrated service delivery across multiple providers	• Integrated IT system in place that can accommodate a number of organisations and take on new organisations over time to deliver a shared care record		Primary Care strategy SWIFT re-procurement	Head of Strategic Commissioning and Transformation / Programme Manager Primary Care Strategy
Develop information sharing agreement that covers all service areas	• Data sharing agreement that is approved by LBB, NHS Commissioners and providers of care	• Integrated services utilise same IT system and can share records • Evaluation of service impact measured across health and social care		NHS NCL
Communications				
Develop a shared communication plan and tools between the CCG and LBB	• Shared web site • Development of links on uni-organisational websites • Programme of regular	• Better understanding by GPs of services commissioned by LBB and available to their patients leading to increased		AD Transformation and Resources / Deputy Director Clinical Commissioning

Action	Expected outputs	Outcome success measures	Interdependencies / Governance	SRO/Project manager
	information sharing events	uptake of services • Better understanding of how to access health services and services available by social care staff		
Governance				
Develop robust and shared governance structure for all integration projects	• Senior oversight and support of all projects • Successful implementation of all projects • Robust evaluation of project outcomes		One Barnet SOC Individual organisation governance arrangements	Borough Director / Director of ASCH

Appendix 1

Levels of integration

Integration of commissioning and planning

Traditionally integration between health and social care had been made more difficult through the existence of different cultures, organisational complexity, separate information systems, different eligibility criteria and funding streams. Whilst these constraints still exist the legal powers to overcome them are available to local authority and health commissioners through Section 75 of the National Health Service Act 2006. This set out three flexibilities or powers:

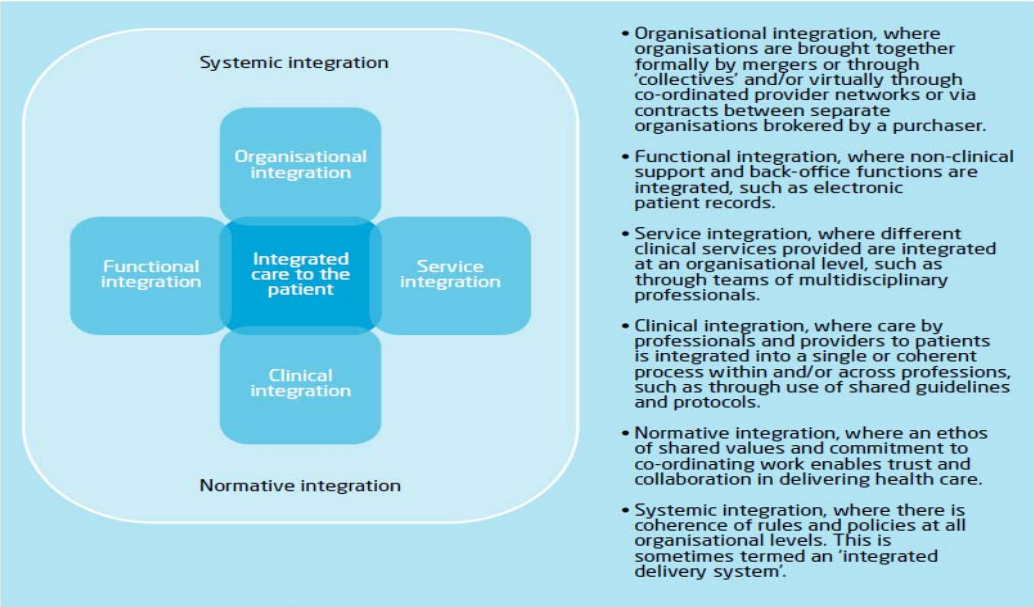
a) Pooled funds – under this arrangement the funding loses its identity and is spent on agreed projects and designated services;
b) Lead commissioning – allows one organisation to delegate responsibility for commissioning agreed services to the other.
c) Integrated provision – allows partners within the agreement to join together their staff and resources so that structures are integrated from management through to front line service delivery.

The first two flexibilities above underpin integrated commissioning which is overseen by the shadow Health and Wellbeing Board. The Health and Wellbeing Strategy and Integrated Commissioning Strategy Scoping Document of May 2011 clearly set out the intention of the London Borough of Barnet (the Council), Barnet Clinical Commissioning Group and NHS NCL to be permissive in its use of these two flexibilities.

a. Integration of service delivery

As set out in figure 1, integration of service delivery may range from sharing common protocols and working within networks through to full organisational merger. It is the third flexibility set out in section 2.1 that allows this level of integration between health and social care providers.

Figure 1 Fulop's typologies of integrated care (from Lewis *et al* 2010)



Source: Adapted from Fulop *et al* (2005)

Ham and Curry (2011)[1] divide integration of service delivery into three levels, these are:

a) Macro level where providers deliver integrated services to whole populations. This would include models such as Kaiser Permanente in the USA;
b) Meso level where providers deliver integrated care for a group of people with the same disease or common conditions using for example managed clinical networks ;
c) Micro level where integrated care is delivered to individual service users using tools such as care co-ordination and care planning approaches.

b. Integration of commissioning and provision of services

Commissioning and providing roles have been largely separated in the NHS since April 2011. Local Authorities have also been outsourcing much of the service provider function and now focus more on strategic commissioning and "micro commissioning". Micro commissioning encompasses the role of social workers who plan and approve the care people will receive from providers.

Integration of commissioning and provision allows clinicians to use budgets to either provide services directly or to commission services from others through "make or buy" decisions. An example of this is Kaiser Permanente where health insurers and providers are part of a single organisation. There are clear parallels to the new commissioning role of GPs envisaged in the white paper "Equity and Excellence: Liberating the NHS"

c. Maintaining competitive tension in an integrated environment

NHS funded healthcare and social care exist within a market environment. In health the market consists of NHS trusts, Foundation Trusts and private providers that

[1] Integrating health and social care: Ham and Curry 2011. Kingsfund

compete for certain services against each other. Social care may be provided by Councils through in house services or private providers. A market depends on demand and competition to drive up quality and productivity. However, it is acknowledged that for people with complex needs a more integrated approach is required. This will often, but not exclusively mean working with existing providers to provide a seamless service.

Competitive tension may be maintained by having more than one provider that can provide services within the integrated system. This requires a sound understanding by commissioners of the local market and the levers and constraints within it. It also requires a focus on relationship management to maintain trust, openness and a sense of shared endeavour in a competitive environment.

Appendix 2

Evidence Base

The achievement of Torbay[2], which became a Care Trust in 2005 is often quoted as an example of where integration improves outcomes for service users and reduces spend on hospital beds and residential care.

Since the **Torbay** project started it has delivered:

a) The second lowest percentage of people aged 65 or over discharged to a residential care home in the southwest;
b) Second in the region in the proportion of expenditure on direct payments;
c) The lowest rate of emergency bed day use for older people with two or more admissions in the southwest;
d) After adjusting for deprivation, the standardised emergency admission ratio for people aged 65 and over is the third lowest in the southwest.

In **Wales** the introduction of co-ordinated care across 3 locations, focusing on people with multiple chronic diseases led to:

a) A reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent respectively between 2007 and 2009
b) This represented an overall cost reduction of £2,224,201 (NHS Wales 2010)

Northamptonshire introduced Pro Active Care (PAC)[3] as a model of case management to deliver services to patients at highest risk of admission to hospital. PAC includes a bespoke care plan co-produced by clinicians and patients/carers, with interventions that are designed to keep patients safely at home. The service supports 62 practices and has led to a 53 per cent reduction in the number of hospital admissions amongst the patients being cared for in this way.

Brent Partnerships for Older People Projects (POPPs)[4] also focused on level 2 and 3
through an integrated care coordination service (ICCS). The ICCS was not associated with an improvement in health or reduction in mortality. It did however demonstrate a reduction in health service usage. This included 2.4 to 5.9 fewer admissions; 14.2 to 28.7 fewer bed-days and 2.8 to 7.8 fewer A&E attendances.

[2] Joined-up Care Literature Review, November 2010 – NHS Institute for Innovation and Improvement
[3] Joined-up care delivering seamless care Case Studies – NHS Institute for Innovation and Improvement
[3] National Evaluation of Partnerships for Older People Projects: Final Report. PSSRU. December 2009

Appendix 3

Case for Change

1. Demographic changes

Barnet's JSNA identifies significant demographic pressures in Barnet arising from a general increase in population across all age groups (19,400 by 2016). Of particular note for integrated commissioning is the increase expected at either end of the age bandings as these will place pressure on health and social care services.

It is anticipated that over the next five years the 0 – 19 years age cohort will grow by 6.8% (nearly 6000) and in the 5 – 9 years age cohort by 22%.

There is a projected increase in people aged 65 and over of 3,250. Of these 783 will be over 85 years. Figure 1 below indicates the potential impact on uptake of social care services.

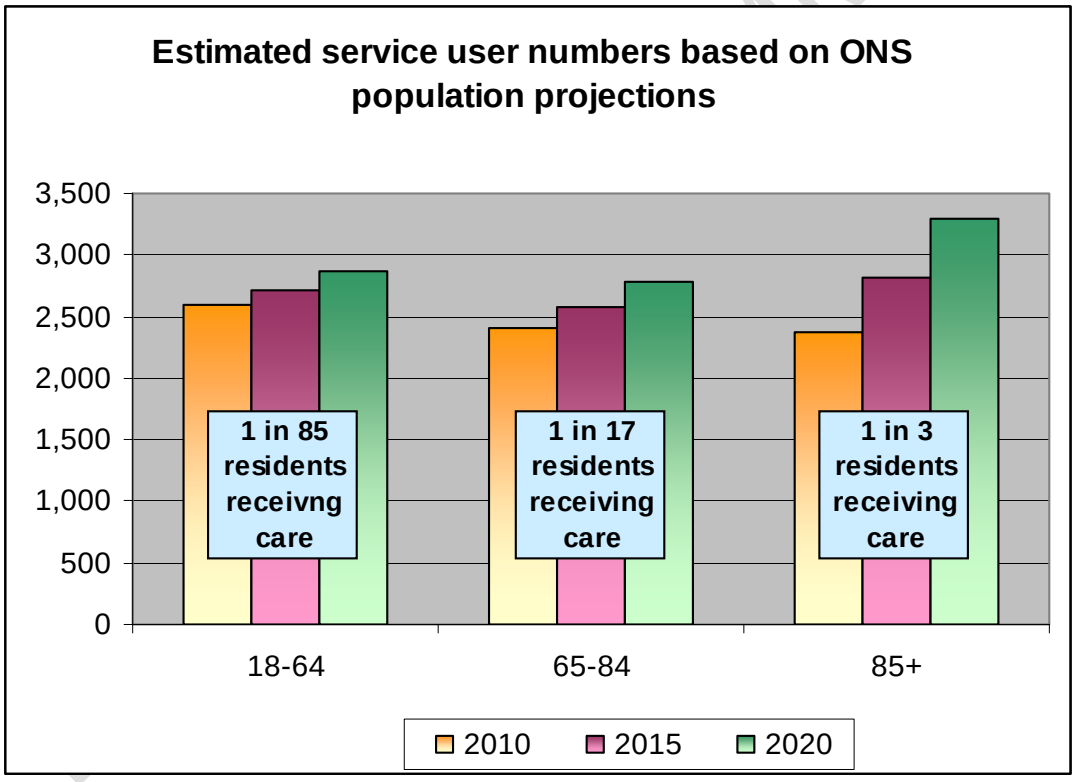


Figure 1

An increasingly diverse population will also generate new pressures on health and social care and we can expect an increase in the prevalence of certain long term conditions such as diabetes which is projected to increase from 8.1% prevalence to 10.3% prevalence by 2025.

The increasing diversity is driven primarily by new births in the BME community. For example, almost 50% of all 0-4 year olds are BME.

2. Funding constraints

The current general economic environment is impacting negatively on funding available across the public sector. In local terms this translates into a 26% cut in the allocation to the Council in this 3 year spending review period. If the population trends above translate into an equivalent increase in the cost of Adults Social Care and Children's Services, coupled with decreasing funding from central government, the Council could find it has no funding for any other services by 2022.

Whilst the NHS has not seen a cut in funding, in real terms there is only limited growth and huge pressure on health budgets from increasing costs, demand and need. In addition to this NHS NCL Barnet is in financial turnaround with a QIPP target in 2012/13 of £38m.

2.1 Adults

Using the POPPs triangle in figure 2 as a framework it is possible to demonstrate that current spending in health and social care for older people is focused on the acute and complex end of the care spectrum through higher than average planned and unplanned attendances at hospital and FACs criteria limited to substantial and critical need. To deliver a sustainable public sector economy it is necessary to move this pattern spend to a more preventative model. Evidence from the POPPs evaluation showed that for every £1 invested there was a £1.20 return in bed days avoided. A Bristol study estimated that if just 1% of the people presenting to the crisis response service primarily with health needs had gone into hospital, people would have required residential care, representing a cost to the local authority of £208,000 and that had 5% of those people who in fact avoided a hospital admission, required additional domiciliary support on discharge from hospital, the cost to the local authority would have been £340,000 per year.

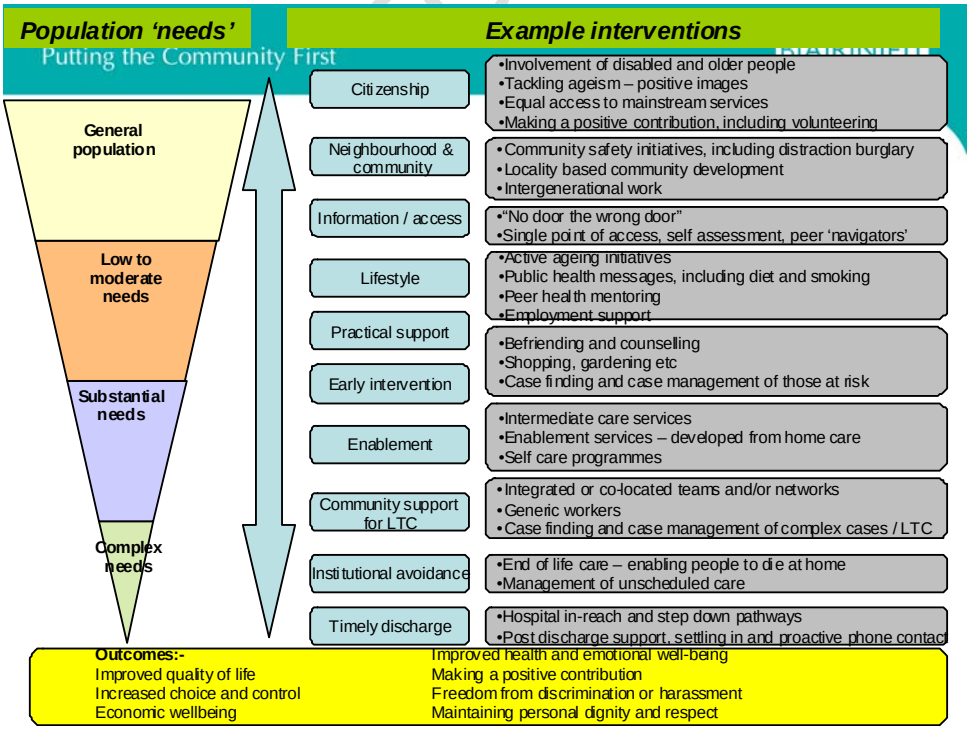


Figure 2

This integrated commissioning plan will seek to release funding from the complex/acute needs end of the triangle for investment in prevention and early intervention. The Integrated Prevention Plan will ensure that this investment is targeted at the general population and those with low to moderate needs thereby sustainably reducing costs overall across the health and social care system.

2.2 Children

The funding of children's services is, to a much greater extent than adult services, set out in national statutory requirements. This presents significant funding pressures in adult services as young people transition from children's to adult services. It is also a source of anxiety to parents and young people as levels of support from the public sector inevitable reduce.

Children's services are considered within the divisions set out in figure 3 below.

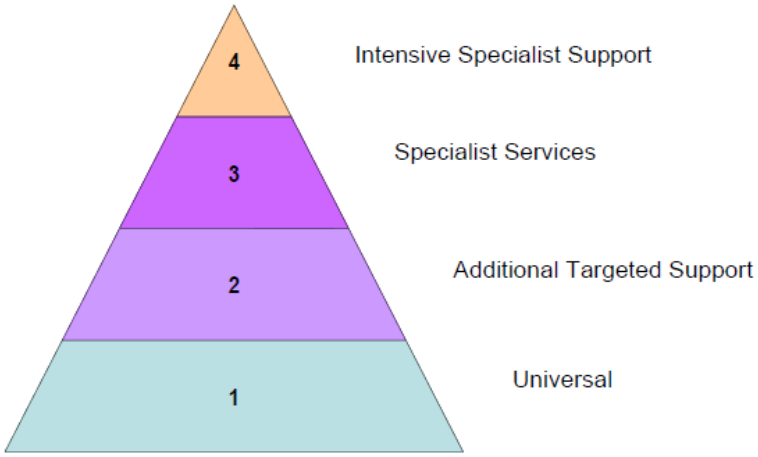


Figure 3

Children's Services in Barnet are already seeking to reduce need within the intensive and specialist end of the triangle through implementation of a "community budgets" programme that has a focus on prevention in families with the most complex needs.

This integrated commissioning plan will seek to release funding at the intensive and specialist end of the triangle for further investment in prevention and early intervention and thereby reduce funding across the health and social care system. In addition there will be a focus on ensuring universal services and funding is utilised in the most efficient manner to reduce the need for more targeted support.

2.3 A shared problem

The interplay between health and social care has long been recognised and is reflected in the Health and Wellbeing Strategy. For example, table 1 below identifies that the 42.6% of all adult new contacts in adult social care result from health service referrals.

Primary / community health	1,461
Secondary health	2,650
Self referral	1,720
Family / friend / neighbour	1,818
Other Adult Social care teams	512
LA housing dept or Housing Assoc	152
Other LA departments or LAs	273
Other agencies	1,058

Table 1

It is also worth noting that the Institute of Public Care study on care pathways[5] showed that 73% of people admitted to a care home from hospital had been living alone previously compared to 46% of those living with others.

A review of 124 frequent flyers (patients that are admitted as emergencies three or more times in a year) revealed that 83 of these people were known to Social Services already and that 53 of these were are also known to the DN service

These examples clearly demonstrate the need for a more integrated approach to planning, commissioning and delivering services.

[5] Oxfordshire County Council Support to the Early Intervention and Prevention Services for Older People and Vulnerable Adults Programme. March 2010