

London Health and Care Integration Collaborative

Integrated Care in London: Case for Change

1. What are we trying to achieve with this document?

Faced with growing demands from an ageing population and an increasing prevalence of long term conditions, this case for change sets out how the current fragmented model of care fails to meet the needs of Londoners and identifies a number of opportunities. This document has been prepared by the London Health and Care Integration Collaborative and forms part of a shared work programme to support the delivery of integrated care at scale and pace across the capital.

To assist the development of integrated care in London and the preparation of local Integration Transformation Fund plans – now known as the Better Care Fund - the Collaborative is also capturing a comprehensive account of the full London story to complement arguments made in the case for change. The fuller account will build on the jointly agreed narrative produced by National Voices, and provide a description of the key ingredients of an integrated care system developed from the narrative, London's learning, and the evidence base.

All three elements are intentionally designed to align with the following workstreams and to support the local strategic planning round:

- *NHS England: A call to action* sets out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. A call to action says clearly that the NHS must change to meet these demands and make the most of new medicines and technology. [<http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/tso-call-to-act.pdf>]
- *London Health Commission* is an independent inquiry established in September 2013 by the Mayor of London. The Commission is chaired by Lord Darzi and reports directly to the Mayor of London. The Commission will examine how London's health and healthcare can be improved for the benefit of the population. [<http://www.london.gov.uk/priorities/health/london-health-commission>]
- *Transforming primary care in London – general practice a call to action* sets out the challenges facing general practice and the priorities that doctors and patients have said are important [<http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/Call-Action-ACCESSIBLE.pdf>]

2. The importance of integrated care

National Voices - *Patient centred coordinated care overarching definition*

“Integrated care means person centred coordinated care [where...] I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

2.1 What is integrated care?

Having identified more than 175 different definitions of integrated care within the published literature, the NHS Future Forum¹ concluded that integrated care is used by different people in different settings to mean different things – “enthusing some, threatening others, bemusing many²” - thus making the case for a common language and shared understanding of what integrated care actually means.

National Voices, a grouping of 130 health and social care charities, co-developed with the health and care system a shared narrative on what matters to patients, service users and carers to enable us all - as individuals – to recognise what good integrated care looks like and what we should expect. This narrative has recently been adopted by the National Collaborative for Care and Support, endorsed by each individual partner organisation, with the expectation that all localities do the same.

For the purposes of this document we acknowledge the importance of National Voices’ work and its helpful definition that ***“care and support is integrated when it is person-centred and co-ordinated”³***.

2.2 Why is integrated care important?

Poor citizen experience and outcomes, increasing demand from an ageing population, increased prevalence of people with one or more long term conditions, unsustainable existing models of care and an unprecedented financial challenge underpin why integrated care is important.

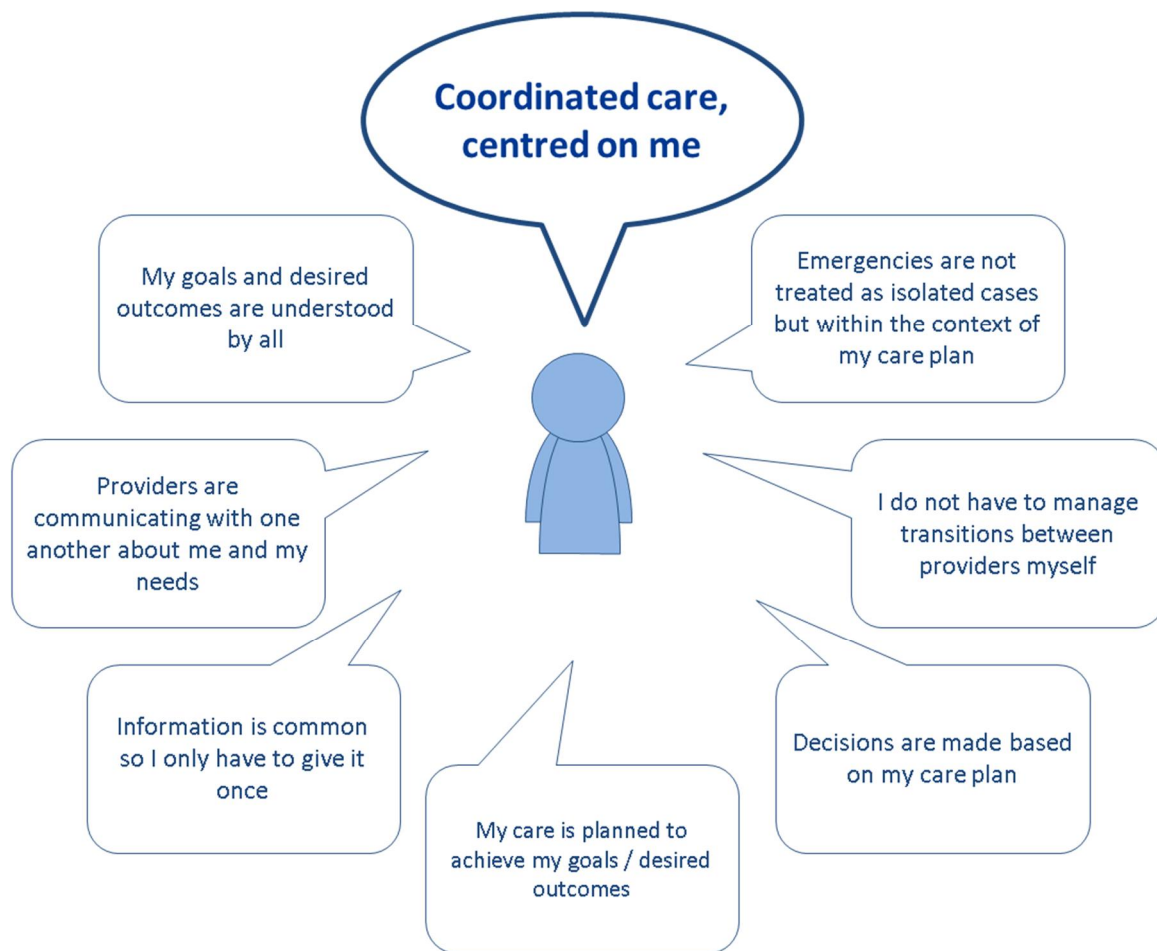
The lack of joined-up care within the existing model continues to be a major source of frustration for patients, service users and carers. People want continuity of care, smooth transitions between care settings, and services that are responsive to all their needs. With the care failings at Mid Staffordshire NHS Foundation Trust and Winterbourne View in the public consciousness, achieving health and social care integration could also make a significant contribution to improving quality and safety.

The agreed narrative provides an understanding of what the headline definition (see below) means, describing an individual’s experience of person-centred, coordinated care and support using a series of generic ‘I’ statements. National Voices developed the ‘I’ statements through consultations with patient and user organisations, and from patient experience indicators.

¹ <http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf>

² <http://www.kingsfund.org.uk/blog/2011/07/nhs-reforms-five-laws-integrated-care>

³ National Voices, May 2013



In May 2013, Care Minister Norman Lamb MP announced that the National Collaborative for Care and Support⁴ had signed up to a series of commitments on how they will help local areas integrate services. *Integrated care and support: our shared commitment* sets out plans on how national leaders and local areas will work together to make further progress towards integration. This includes:

- an ambition to make integrated care the norm by 2018 – with projects in every part of the country by 2015;
- adoption of the National Voices definition of integrated care to give localities a clear vision to work towards;
- the introduction of the first wave of Pioneer areas around the country with significant interest demonstrated nationally and across London evidencing the commitment from localities to move their integration agendas forward; and,
- the development of new measures to capture people's experience of integrated care to see whether people are feeling the benefits of the change.

⁴ The fourteen national partners forming part of the National Collaborative for Care and Support include the Association of Directors of Adult Services (ADASS), NHS England, Department of Health, the Association of Directors of Children's Services, the Care Quality Commission, Local Government Association, Monitor, NHS Improving Quality, Health Education England, the National Institute for Health and Care Excellence, Public Health England, the Social Care Institute for Excellence and Think Local Act Personal in association with National Voices.

“People don’t want health care or social care, they just want the best care. This [the document “Integrated care and Support: our shared commitment”] is a vital step in creating a truly joined-up system that puts people first. Unless we change the way we work, the NHS and care system is heading for a crisis. This national commitment to working together is an important moment in ensuring we have a system which is fit for the future.” – Norman Lamb, Minister for Care and Support⁵

The Government’s commitment to integrated care was reinforced by the Comprehensive Spending Review announcement in June 2013 of £3.8 billion worth of funding to ensure closer integration between health and social care. Locally agreed plans on the use of the Integration Transformation Fund (now the Better Care Fund) will need to demonstrate how people will be provided with improved care and support, reinforcing the need for robust and joined up plans to be developed locally. The Better Care Fund provides an important opportunity to take the integration agenda forward at scale and pace – and be a catalyst for significant change.

The Better Care Fund is also underpinned by the Care Bill which aims to bring care and support legislation into a single statute. It is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. To promote individual wellbeing, their needs, views, feelings and wishes should be considered in all aspects of their wellbeing from physical and mental health, through dignity and respect to control over their daily needs, access to employment, education, social and domestic needs and the suitability of their accommodation⁶.

Most significantly, Clause 3 of the Care Bill places a duty on local authorities to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other related services, such as supported housing. It is the counterpart to the duty on the NHS in the Health and Social Care Act 2012, to ensure that organisations work together to improve outcomes for people.

2.3 In summary

- The National Voices narrative defines and provides a shared understanding of what integrated care means by being orientated around the experiences, views and outcomes of patients, users and their carers.
- Poor citizen experience and outcomes, increasing demand from an ageing population, increased prevalence of people with one or more long term conditions, unsustainable existing models of care and an unprecedented financial challenge underpin why integrated care is important.
- All system leaders in London are asked to make the most of the opportunities presented through the national initiatives; the shared learning offered to all localities through the NHS Improving Quality support programme; and to actively

⁵Department of Health press release, 14 May 2013 available at: <https://www.gov.uk/government/news/national-partners-make-commitment-to-join-up-health-and-social-care>

⁶Health and Social Care Partnership, A summary of the key points of the Care Bill, 13 May 2013 <http://www.hscpartnership.org.uk/policy-and-consultancy/publications/care-bill-2013-key-points/>

engage their Health and Wellbeing Boards in the Better Care Fund planning round in order to move integrated care forward at scale and pace.

3. Why transformational change is necessary?

It is widely accepted that major progress has been made in improving the performance of the NHS in the past decade⁷. Despite this progress, the current health and social care delivery system has failed to keep pace with the needs of an ageing population, the changing burden of disease, and rising patient and public expectations. Fundamental change to the delivery system is needed in order to integrate care around the needs of people and populations.

3.1 The experience of patients and the public

“We are sick of falling through the gaps. We are tired of organisational barriers and boundaries that delay or prevent our access to care. We do not accept being discharged from a service into a void. We want services to be seamless and care to be continuous.”⁸

Individual’s Viewpoint

Health and social care services have had a long history of poor co-ordination and fragmentation of service delivery, with patients increasingly reporting dissatisfaction in their experience:

“They could stop passing the buck and start actually working together. For example, I have physical and mental health issues and the two sides fought like cat and dog over who should fund services that both agreed I needed to manage at home, but neither wanted to pay for. I was left feeling like an utter [parasite] for needing any help at all⁹

Service user

This dissatisfaction with the current fragmentation of services has been further evidenced through the research undertaken by National Voices¹⁰ where patients, users and carers reported an expectation of professionals to work together to deliver services that meet the needs of the individual. The latest available data shows significant variation of citizen experience across the capital, which sees London perform below the national average in terms of satisfaction for the care and support they receive.

Existing health and social care services are not currently meeting the needs of the local population providing the level of quality service that they should be, and are not sustainable or flexible enough to deliver the service fit for the future population.

⁷ Kings Fund (2012), Health policy under the coalition government: A mid-term assessment. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-policy-under-the-coalition-government-kingsfund-nov2012.pdf

⁸ National Voices, May 2013

⁹ *Caring for our Future: What service users say*, Joseph Rowntree Foundation, March 2012
<http://www.jrf.org.uk/sites/files/jrf/caring-for-our-future-peter-beresford.pdf>

¹⁰ *Integrated care: what do patients, service users and carers want?*, National Voices
http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/what_patients_want_from_integration_national_voices_paper.pdf

New models of delivery need to be developed working in partnership across a much broader spectrum of organisations with the service user at the centre of delivery.

In addition, users of services have consistently reported a desire to have more ownership and control over their care plans, and a more active role in managing their conditions. A recent study found that over 90 per cent of people with long term conditions expressed interest in being more active self managers and over 75 per cent would feel more confident about self-management if they had help from a healthcare professional or peer. Despite this, many people with long term conditions have limited knowledge of, or influence over their care, and experience lower quality of life¹¹.

In contrast integrated care systems have elicited positive responses from patients as a result of giving them a stronger role in planning their care. A survey of patients receiving care as part of the North West London integrated care pilot¹² showed that 69 per cent of patients were involved in the decision-making of their care; 65 per cent felt that they were involved in the design of their care plan in the way they wanted to be; and 79 per cent said that they had a clear understanding of how care planning works. In the same survey, only 9 per cent of respondents said that they only had low levels of involvement in the planning of their care.

The ability of health and social care to provide patients with greater choice and control brings into question current provision, and an over reliance of care provided in hospital and residential settings. Once in hospital, vulnerable patients are at increased risk from unfamiliar and confusing environments, infection, and loss of mobility and other day to day functionality. Long term care and inpatient stays frequently follows as the decline of the individual while in hospital means returning home is often viewed as not being an option for the frail person. This scenario is particular relevant to older people, who account for 68 per cent of all emergency bed days in the NHS. London hospitals have higher use of emergency bed days for this age group than the rest of the country.¹³

People frequently comment that they do not want to be in a hospital or residential setting unless it is necessary. There is a growing body of evidence¹⁴¹⁵ demonstrating that there are patients admitted to an acute hospital who could be more appropriately cared for in their own home or within a community facility. This is particularly relevant to older people and those with ambulatory care sensitive conditions.

Current service models continue to fail to meet the needs of their patients. For patients receiving end of life care this is particularly stark with London scoring much lower on the percentage of individuals who die in their usual place of residence (35 per cent) compared with a national average (42 per cent), with the proportion of

¹¹ *Care Planning: Improving the Lives of People with Long Term Conditions*, Clinical Innovation and Research Centre 2011

<http://www.rcgp.org.uk/clinical-and-research/clinical-resources/-/media/Files/CIRC/Cancer/Improving%20the%20Lives%20of%20people%20with%20LTC%20-%202012%2005%2009.ashx>

¹² Integrated care pilot in north-west London: a mixed methods evaluation, *International Journal of Integrated Care* – volume 13, June 2013 <http://www.ijic.org/index.php/ijic/article/view/URN%3ANBN%3ANL%3AUI%3A10-1-114735/2019>

¹³ *General Practice in London: Supporting Improvements in Quality*, The Kings Fund, 2012

¹⁴ Kings Fund (2012) Older people and emergency bed use: Exploring variation. Available at:

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/older-people-and-emergency-bed-use-aug-2012.pdf

¹⁵ Kings Fund (2011) Emergency Hospital Admissions for Ambulatory Care-sensitive Conditions: Identifying the potential for reductions. Available at: <http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/acs-conditions>

deaths in hospital following an admission in the last week of life from care homes higher in London than in other regions. Patients at the end of their lives (especially the elderly with multiple morbidities) interact with multiple health and social care professionals. When these multiple professional interfaces are not coordinated, the impact is more likely to be traumatic and costly and result in more deaths in hospital.

3.2 Population challenges

3.2.1 Demographic challenges

Projections suggest that London's estimated population of 8,431,500 in 2013¹⁶ will grow by 13 per cent by 2031. The profile of London's population is very different to the rest of England, it is younger, more transient, more ethnically diverse and growing more rapidly.¹⁷ Although the proportion of London's older population is not increasing at the same rates as other English regions, the total of those people aged 50 or over makes up a quarter of London's population - nearly 2.1 million people. 10.2 per cent of London's adult population is aged between 50 and 59, decreasing to 7.3 per cent aged between 60 and 69 and 2.6 per cent aged 80 and over¹⁸.

Demographic changes have been a key driver for health and social care reform, with demand expected to increase over the coming years. It is projected that there will be an increase in demand among 18 64 year olds with disabilities and an increase in the very elderly as the number of Londoners over the age of 90 is estimated to increase by 94 per cent, rising from 49,300 in 2012 to 95,700 by 2031¹⁹.

The ethnic make up of older people varies enormously for each age group, with black, asian and ethnic minority (BAME) people making up almost 33 per cent of Londoners aged 50 to 59, but less than 8 per cent of Londoners aged 90 and over. The difference in the ethnic makeup of London's older people is projected to become significantly narrower by 2031, when nearly 23 per cent of Londoners aged 90 and over are expected to be from BAME communities compared with 39 per cent of those aged 50 to 59²⁰.

While people living longer are a cause for celebration, it has major implications for health and social care services. The ageing population has resulted in rising demand for and use of health services. The number of elective and non-elective hospital admissions in the past 20 years has increased much more rapidly than the growth in population. This places in context the need to provide more care in settings other than hospitals and care homes in the future²¹.

¹⁶ <http://data.london.gov.uk/visualisations/2012-round-trend-based-sya-age-range-creator.xls>

¹⁷ Dixon A, Nick G, Raleigh V, Michael S, Hong T, Nick G, Anna D, Thompson J, Millett C (2012) General Practice in London: Supporting Improvements in Quality. The Kings Fund and Imperial College London.

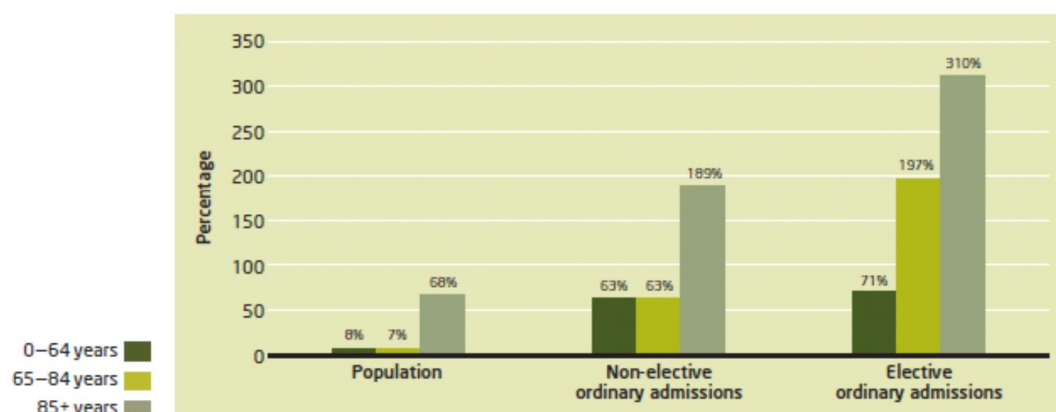
¹⁸ GLA, ASSESSMENT OF THE GLA'S IMPACT ON OLDER PEOPLE'S EQUALITY UPDATE 2013, March 2013 available at <http://www.london.gov.uk/sites/default/files/GLA%20Older%20people%27s%20equality%20assessment%202013%20final.pdf>

¹⁹ GLA, ASSESSMENT OF THE GLA'S IMPACT ON OLDER PEOPLE'S EQUALITY UPDATE 2013, March 2013 available at <http://www.london.gov.uk/sites/default/files/GLA%20Older%20people%27s%20equality%20assessment%202013%20final.pdf>

²⁰ GLA, ASSESSMENT OF THE GLA'S IMPACT ON OLDER PEOPLE'S EQUALITY UPDATE 2013, March 2013 available at <http://www.london.gov.uk/sites/default/files/GLA%20Older%20people%27s%20equality%20assessment%202013%20final.pdf>

²¹ The King's Fund (2012), Transforming the delivery of health and social care: The case for fundamental change available at http://www.kingsfund.org.uk/sites/files/kf/field/publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf

Figure 2 Increases in population by age and in elective and non-elective hospital admissions (%), England 1989/90–2009/10



Source: The King's Fund analysis of HES data and Office for National Statistics (2011e)

'Within London, there are significant variations in physical and mental health outcomes between and within London boroughs. These health inequalities are mostly avoidable and unfair... Socioeconomic status relates closely to health outcomes and high levels of deprivation are associated with poorer health'.

The Institute of Health Equity²²

Avoidable health inequalities related to socioeconomic deprivation exist between and within London boroughs. For example, male life expectancy ranges from 76 years in Islington to 85.1 years in Kensington and Chelsea and there are within-borough inequalities in male disability-free life expectancy (DFLE) of 18.1 years between the least and most deprived neighbourhoods within Kensington and Chelsea. Comparisons of average male and female life expectancy in each London borough by their rank on the Index of Multiple Deprivation has revealed that generally the greater a borough's average levels of deprivation, the lower its average life expectancy.

London's large and widening health inequalities are attributed to the inequalities in the social determinants of health, the social and economic factors which shape peoples' lives and their health. A recent study into the health impact of the economic downturn predicted that health inequalities would further widen and indicated a number of ways they would impact. These include an increase in mental health problems, including depression, and possibly lower levels of wellbeing; more suicides and attempted suicides; worse infectious disease outcomes; and possible negative longer-term health effects²³.

London needs urgent action to tackle health inequalities. As a result of such challenging circumstances facing many of our communities, the current fragmented model of care needs to adapt to coordinating care around the needs of people with complex needs. This includes responding to social issues like debt, housing, unemployment and substance misuse as part of an integrated approach.

²² Institute of Health Equity (2012) The impact of the economic downturn and policy changes on health inequalities in London

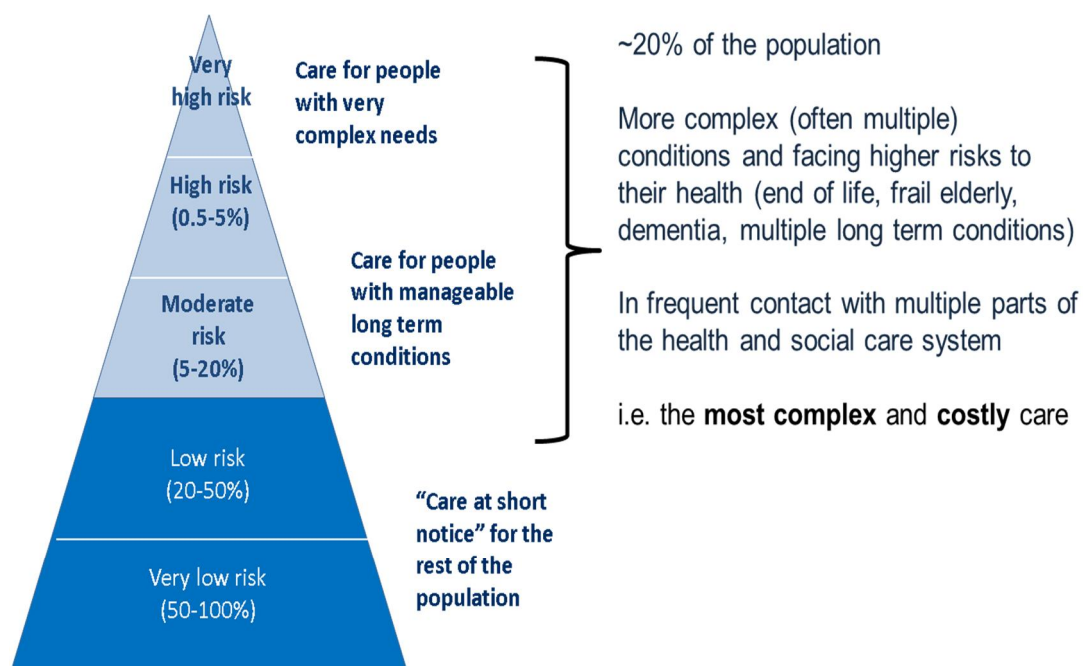
²³ Institute of Health Equity (2012) The impact of the economic downturn and policy changes on health inequalities in London

3.2.2 Burden of disease

Advances in medical care have turned many life-threatening conditions such as heart disease into long-term conditions, meaning people are surviving acute episodes of illness and living longer with their conditions. This helps to explain why the additional years of life people are living may not always be healthy years. In addition, increases in the prevalence of long-term conditions such as diabetes present many challenges to the health and social care system²⁴.

Gains in life expectancy have outstripped gains in Healthy Life Expectancy (defined as life spent in good or very good health, expressed as percentage of total life), meaning that increasingly life is lived in ill-health. Lower social classes continue to have shorter life expectancy and shorter healthy life expectancy.²⁵ A combination of an ageing population and changing disease burden mean that prevention is important at all ages, including among people aged 65 and over to ensure that further increases in life expectancy convert, whenever possible, into healthy years²⁶.

Utilising information on people's past interaction with health and social care to predict those who are at greater risk of hospitalization and need more coordinated support is an important part of integrated care. By risk stratifying the entire population it is possible to capture patients' needs by intensity and complexity.



SOURCE: NWL whole systems integrated care

²⁴ The King's Fund (2012), Transforming the delivery of health and social care: The case for fundamental change available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf

²⁵ The International Longevity Centre –UK (ILC-UK) July 2013, Ageing, longevity and demographic change. Available at www.ilcuk.org.uk

²⁶ The King's Fund (2012), Transforming the delivery of health and social care: The case for fundamental change available

As shown on the pyramid, by far the biggest patient group are the very low to low risk cohort which cover approximately 80 per cent of the population and only require care at short notice when needed. At the top of the pyramid is the estimated 20 per cent of the population, representing the very high, high and moderate risk patient cohorts, who have more complex conditions and face higher risks to their health because they have one or more long term condition, dementia, frail older people and people nearing the end of their lives. They are likely to be familiar with health and social care teams as they are in frequent contact with multiple parts of the system.

3.2.2.1 Frail older people

Longevity has implications for health and social care in terms of meeting the needs of an increasing frail older population. The most widespread conditions affecting frail older people are dementia, cancer, stroke, and heart disease.

Frailty is a clinical syndrome which is not defined by a specific condition, but frail older people have complex multiple conditions associated with physical, functional or cognitive impairments. With an increase in frailty, older people require more help with the basic activities of daily living such as eating, bathing, cleaning, dressing and walking short distances. Clinical assessment of frail older people is challenging as they often present non-specific ailments, which can make the immediate diagnosis obscure.

Meeting the health needs of the increasing numbers of older people is a high priority for health and social care leaders in London. Both the NHS and Adult Social Care Outcomes Frameworks aim to increase the proportion of frail older people who receive support to live independently at home for as long as possible, and prevent or postpone a person needing more intensive care packages or residential care and enable them to go home following hospital treatment. This has clear benefits to the individual, as most people prefer care in their own home, along with cost-benefits as home care is substantially less expensive than residential care or frequent hospital care.

Many frail older people do not receive a comprehensive geriatric assessment. Frequently, frail older people and their carers are left to negotiate multiple care organisations, which work independently with little continuity between them. There is no whole system approach and no single ownership of the issues facing this population.

The rise in the proportion of the population over 85 years old requires primary care to be integrated with community services and social care to prevent unnecessary and costly hospitalisations or admissions to care homes for frail older people. London has a higher percentage of households receiving intensive home care (35 per cent) compared with the England average (29 per cent) and most London local authorities (24 out of 33) have a higher rate than the national average. However, there is significant variation across London between 25 per cent and 48 per cent. The proportion of a practice's patients that are in nursing homes in London was similar to

other parts of England ranging from 0-5 per cent in London, with the vast majority of practices having 0 or 1 per cent²⁷.

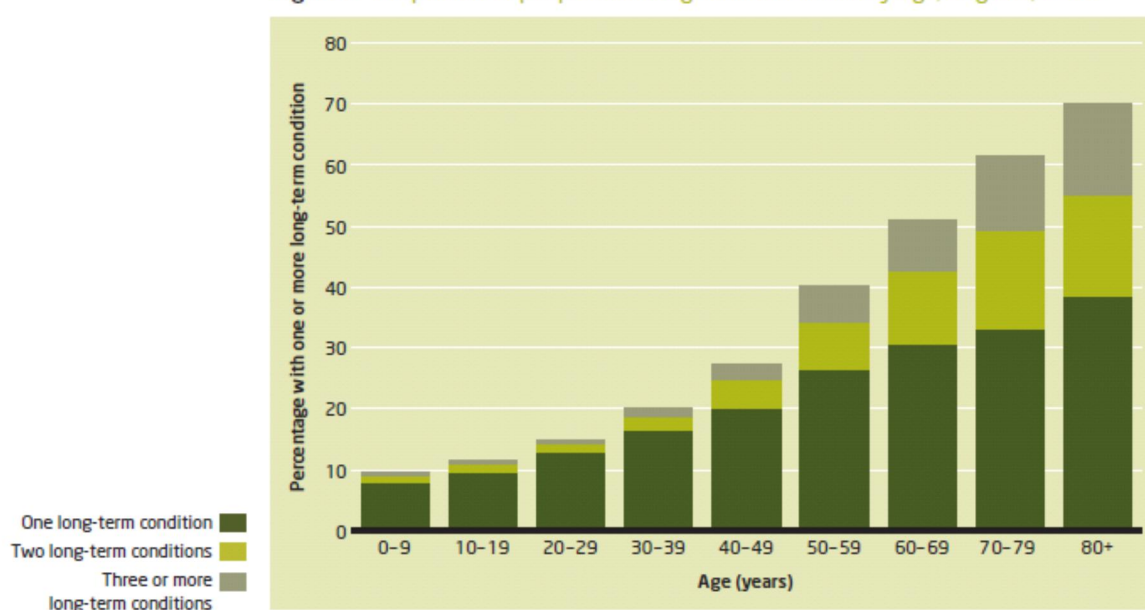
Older people account for 68 per cent of all emergency bed days in the NHS. London hospitals have higher use of emergency bed days for this age group than the rest of the country. Seven out of the 31 London PCTs were among the top 10 areas nationally with the highest emergency bed use²⁸.

London, as a region, is performing better than the national average in terms of the proportion of people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services. However, there is still considerable intra-London variation with thirteen boroughs below the London average.

3.2.2.2 Long and multiple long terms conditions

Around 15 million people in England have one or more long-term conditions, with the number of people with multiple long-term conditions predicted to rise by a third over the next ten years²⁹. The prevalence of cancers, chronic kidney disease and diabetes is expected to rise most quickly³⁰.

Figure 7 Proportion of people with long-term conditions by age, England, 2009



Source: Department of Health (2012a)

Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budget in England³¹. The traditional model of care has been organised by disease, and initiatives to integrate care across care settings have predominately focused on coordinating care for a single disease. Too often this has created silos, which leave the patient to navigate their own care, since living with

²⁷ General Practice in London: Supporting Improvements in Quality', The Kings Fund, 2012

²⁸ 'General Practice in London: Supporting Improvements in Quality', The Kings Fund, 2012

²⁹ Department of Health (2011). 'Ten things you need to know about long term conditions'.

Available at: www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm

³⁰ Department of Health (2012a). Long Term Conditions Compendium of Information, 3rd ed. London: Department of Health. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134486.pdf

³¹ Department of Health (2011). 'Ten things you need to know about long term conditions'. Available at: www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm

multiple conditions is the norm rather than the exception for many people. 50 per cent of 65 year olds have more than one long term condition, rising to 75 per cent of 75 year olds. Multiple co-morbidity is associated with poorer quality of life, more hospital admissions and higher mortality, and has a strong social gradient with more disadvantaged individuals and communities having poorer outcomes³². The likelihood of having a mental health problem increases as the number of physical morbidities a person has also increases.³³

By interacting with and exacerbating physical illness, co-morbid mental health conditions raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health condition. This suggests that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year³⁴.

Co-ordination of care for patients with complex needs and long-term illness is currently poor³⁵, and those with long-term conditions have a lower quality of life³⁶. London has the highest use of emergency bed days for people over 65 than the rest of the country. Although recent data shows London as a region performing better than the national average for emergency admissions that usually should not require a hospital admission, there is significant variation with almost two-thirds of London Boroughs having more admissions than the regional average. Furthermore, 22 out of 31 London PCTs had higher readmission rates than the national average.

3.2.2.3 Dementia

Dementia can affect people of any age, but it is most common in older people. Carers and other family members of people with dementia are often older and frail themselves, with high levels of depression, physical illness, and a diminished quality of life³⁷.

The rising prevalence of dementia will put a particular strain on services in London in the future and the estimated current £1billion health and social care spend for people with dementia³⁸. In 2007 it was estimated that around 64,600 people have dementia in London,³⁹ by 2011, the estimated number of people with dementia had risen to 79,876 people, with only 31,160 people (44.6 per cent) with a confirmed diagnosis.⁴⁰

³² UCLP, AHSN Prospectus, November 2012 available at <http://www.uclpartners.com/lotus/wp-content/uploads/2013/01/UCLPAHSNProspectusFINAL.pdf>

³³ The King's Fund (2012), Transforming the delivery of health and social care: The case for fundamental change available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf

³⁴ A joint publication from The King's Fund and the Centre for Mental Health gives an overview of the evidence base regarding long-term conditions and mental health: www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health

³⁵ The King's Fund (2011). Improving the Quality of Care in General Practice. Available at: www.kingsfund.org.uk/publications/improving-quality-caregeneral-practice

³⁶ Department of Health (2011). 'Ten things you need to know about long term conditions'. Department of Health website.

³⁷ Department of Health (2009) Living well with dementia: a National Dementia Strategy. London: Department of Health.

³⁸ Kings Fund (2013) General Practice in London: Supporting Improvements in Quality

³⁹ Commissioning Support for London, Dementia Services Guide 2009

⁴⁰ Alzheimer's Society England: Mapping the Dementia Gap 2012, Progress on improving diagnosis of dementia, 2011-2012

It is predicted that dementia prevalence will rise from 65,000 Londoners to 16 per cent up until 2021, and then by 32 per cent in the decade after that⁴¹.

It is estimated that dementia costs the English economy about £20 billion every year and is set to increase to over £27 billion by 2018⁴². Using a Dementia UK model, Commissioning Support for London calculated the figure as £353m (including £190m of care home costs) for London based on 2009/10 costs. There are also significant cost to social care which are estimated as £681m overall.⁴³

Whilst there are examples of good dementia care, this is not the case for everyone and there are unacceptable variations between different areas of London⁴⁴. Research suggests that around half of all people with dementia never receive a diagnosis, which prevents them from accessing the most appropriate health and social care services⁴⁵.

The London dementia diagnosis and coding rate has risen following the work of the NHS London dementia programme from an estimated 42 per cent of those expected to have dementia being recorded on GP registers in 2010/11⁴⁶ to 44.6 per cent. London still has areas where the diagnosis gap is a significant challenge; with Kensington & Chelsea and Harrow being in the bottom 10 areas in the country and 19 of London's 31 areas in the bottom 50 per cent⁴⁷.

A report by the Institute for Public Policy Research on dementia care in London concluded that there is a 'serious deficit' in GPs' awareness of dementia, which can result in a failure to diagnose and signpost, in turn risking crisis intervention at a later stage and increased costs in the longer term⁴⁸. Just 31 per cent of the capital's GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia⁴⁹.

Older people with dementia occupy 20 per cent of acute hospital beds across England, when in fact around 70 per cent of patients may be medically fit to be discharged⁵⁰. Currently 60 per cent of patients enter hospital from their own home, but just 36 per cent return after being discharged.⁵¹ It is further estimated that 80 per cent of people living in care homes have a form of dementia or severe memory problems⁵².

⁴¹ <https://www.myhealth.london.nhs.uk/health-communities/dementia/why-are-londons-health-services-focusing-dementia>

⁴² <https://www.myhealth.london.nhs.uk/health-communities/dementia/why-are-londons-health-services-focusing-dementia>

⁴³ Dementia Services Guide: appendix 6, Commissioning Support for London (2009)

⁴⁴ <https://www.myhealth.london.nhs.uk/health-communities/dementia/why-are-londons-health-services-focusing-dementia>

⁴⁵ NICE Commissioning Guidance (2013)

⁴⁶ NHS London, Terms of Reference Medical Directorate Dementia Clinical Network Board, 2012

⁴⁷ Alzheimer's Society England: Mapping the Dementia Gap 2012, Progress on improving diagnosis of dementia 2011-2012

⁴⁸ Sachrajda A (2011). Dementia Care in London. London: Institute for Public Policy Research. Available at: www.ippr.org/publication/55/1830/dementia-care-in-london

⁴⁹ Commissioning Support for London (2009). Dementia Services Guide. London: Healthcare for London.

⁵⁰ Commissioning Support for London (2009). Dementia needs assessment. Available at: www.dementiapartnerships.org.uk/wp-content/uploads/london-dementia-needs-assessment.pdf

⁵¹ Lakey, L (2009), Counting the cost: Caring for people with dementia on hospital wards. Alzheimer's Society, 14

⁵² <http://www.alzheimers.org.uk/statistics>

3.2.2.4 End of life care

Two-thirds of people would prefer to die at home, but in practice only about one-third of individuals actually do⁵³. The estimated annual number of deaths of around 500,000 is expected to rise by 17 per cent from 2012 to 2030⁵⁴, and the average age at death is also set to increase markedly⁵⁵.

The costs of caring for people at the end of their lives is estimated to run into billions of pounds⁵⁶. Care for the 27 per cent who die from cancer is around £1.8 billion in the last year of their life, or £14,236 per patient⁵⁷.

Wide variations exist in the quality of end-of-life care across England. Spending by PCTs on palliative care has varied from £154 to more than £1,600 per patient⁵⁸. Most deaths (58 per cent) occur in NHS hospitals, with around 18 per cent occurring at home, 17 per cent in care homes, 4 per cent in hospices and 3 per cent elsewhere. 89 per cent of those who die in hospital do so following an emergency admission. 32 per cent of these people die after a stay of 0-3 days, 18 per cent after a stay of 4-7 days and 50 per cent after a stay of 8 days or longer. Approximately 30 per cent of people use some form of local authority funded social care in the last year of life. If all people who die in hospital stayed only a maximum of eight days, then the total estimated cost to commissioners would be lower by approximately £357m pa⁵⁹.

London is particularly poor in comparison with other regions, with the five worst performing local authorities nationally in terms of deaths in hospital found in the capital. The proportion of deaths in hospital following an admission in the last week of life from care homes is also higher in London than in other regions. Taking a midpoint of the estimated inpatient at £3,065.50 per person, compared with £2,107.50 community based end of life care costs, there is an estimated potential net saving of £958 per person who dies in the community⁶⁰.

The focus of medical care for the elderly needs to shift from providing 'cure at all costs' to managing a gradual decline with an emphasis on well being, happiness and choice. More could be done to increase the coverage of Coordinate My Care across London which has supported 79 per cent of patients registered with the service to die in their preferred place⁶¹.

⁵³ Higginson IJ (2003). *Priorities and Preferences for End Of Life Care in England, Scotland and Wales*. London: National Council for Hospice and Specialist Palliative Care.

⁵⁴ The Kings Fund (2013). *Transforming our health care system: Ten priorities for commissioners*

⁵⁵ Gomes B, Higginson I (2008). 'Where people die (1974-2030): Past trends, future projections and implications for care.' *Palliative Medicine*, vol 22, pp 33–41.

⁵⁶ National Audit Office (2008). *End of Life Care*. London: National Audit Office.

⁵⁷ Hatziaandreu E, Archontakis F, Daly A (2008). *The Potential Cost Savings of Greater Use of Home- and Hospice-based End of Life Care in England*. Technical report. London: National Audit Office.

⁵⁸ National Audit Office (2008). *End of Life Care*. London: National Audit Office.

⁵⁹ 'What do we know now that we didn't know a year ago?', National End of Life Care Intelligence Network, May 2012

⁶⁰ 'What do we know now that we didn't know a year ago?', National End of Life Care Intelligence Network, May 2012

⁶¹ CMC Data Overview, 3 September 2013

3.3 Economic challenges

Faced with unprecedented economic challenge, the need for health and social care to deliver greater value is more pressing than ever.

A significant proportion of demand for public services comes from the increasing numbers of frail older people and from others with chronic, complex health problems who receive care from many different providers.⁶² Local authorities in London spend approximately 33 per cent (£2.8 billion) of their overall budgets on adult social care services and this is expected to increase⁶³. Following the spending review in 2010, local authorities were faced with a 28 per cent cut in their overall budgets, with a further 10 per cent cut announced in the spending review for 2015/16 (along with a two year council tax freeze).

The NHS in London has already implemented changes to make savings and improve productivity. These savings are expected to total £3.1 billion by 2015 which is 15.5% of the national £20 billion savings requirement. However, with NHS funding expected to remain flat in real terms over the next decade and a forecasted 4% annual growth in healthcare demand (10% for specialised services) the NHS is facing a funding gap of £30 billion by 2020. If London is to continue to bridge its estimated share of the national funding gap in future as it has done to date we will need to save an estimated £6.5 billion between 2015 and 2020. If shared equally over the next five years this equates to £1.3 billion of London's circa £15 billion annual budget, or approximately 8.6% each year. To achieve this would be unprecedented in London⁶⁴.

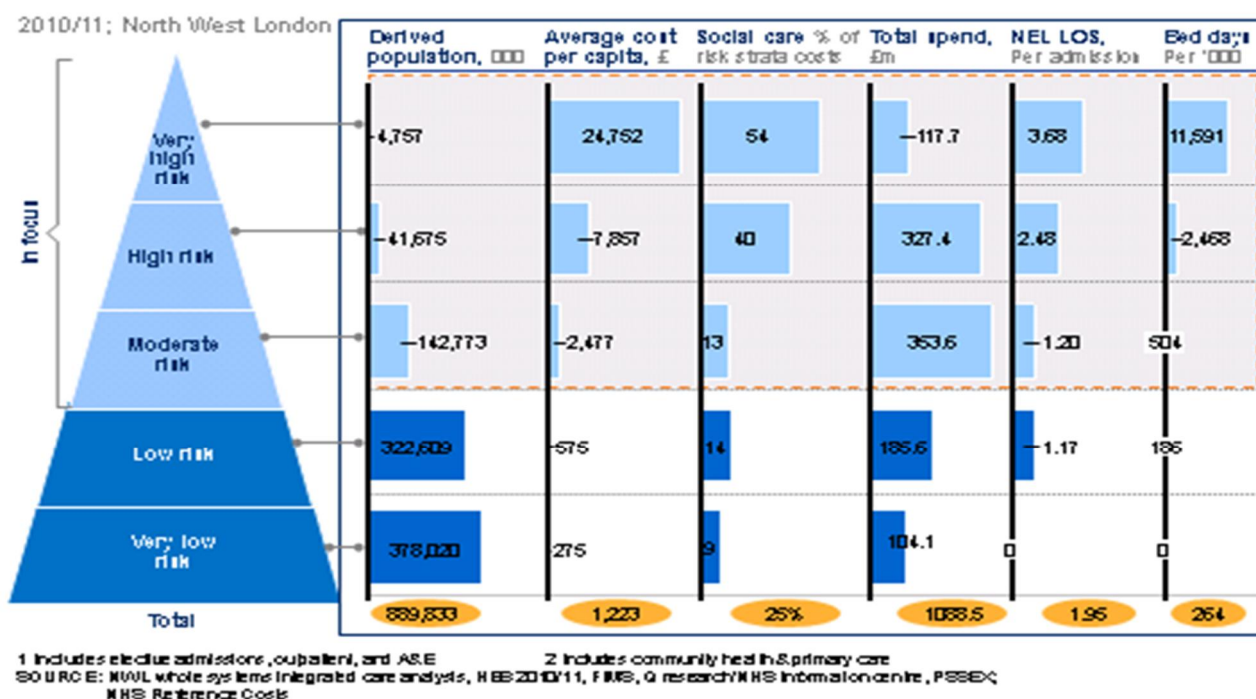
Integrated care is most effective when aligned to supporting those individuals who are risk stratified within the top 20 per cent of the population. Analysis from North West London (illustrated in the diagram below) demonstrates that the top 20 per cent of the population at highest risk consumes approximately 75 per cent of overall resources.

⁶² *Integration in action: four international case studies*, Nuffield Trust, July 2011

⁶³ *Making the Case for London*, paper to London Health Board

<http://www.londonhealthboard.org.uk/London%20Councils/LHB20132MakingthecaseforLondon.pdf>

⁶⁴ *London – A Call to Action*, NHS England, 2013



These costs will continue to rise in line with a growing population and consequent demand for services. Investment in community services has also not grown at the same rate as that of acute services with a much greater emphasis in recent years on the sustainability and development of acute organisations. This investment focus needs to shift with a much greater proportion of funding invested into the development of community services.

Whilst recognising the opportunities of care provided out of hospital, CCGs remain challenged with physically releasing funding from acute services in order to fund service developments in the community. Often local solutions have required double running costs at great risk and cost to the CCG.

The Better Care Fund process and the requirement for approved local plans to be in place by March/April 2014 offers a real opportunity to move the integrated care agenda forward. It also challenges health and social care leaders to demonstrate how closer partnership working will make improvements to care and support, which will be tested through an assurance process and conditions to the fund which has a performance related component. Addressing this level of economic challenge cannot be achieved by working in isolation.

3.4 System wide challenges

Close collaboration between commissioners and providers is needed to facilitate the necessary shift in the balance of care from acute settings to care closer to home, improve care coordination and make better use of limited resources. This document describes the key system challenges currently facing London in: the redesign of

hospital care and major acute reconfiguration programmes; workforce and information and data sharing.

3.4.1 Redesign of hospital care and major service reconfiguration programmes

In 2012, a set of quality and safety standards for acute medicine and general surgery in London was published⁶⁵. Delivering against these standards along with growing financial challenges have been major drivers in a number of acute reconfiguration programmes across London.

Service reconfigurations have now been agreed by the Secretary of State covering North West, North Central and North East London. These include a reduction in the number of hospitals providing accident and emergency (A&E) services, acute medical, surgical and paediatric care, and obstetric-led maternity services, and the concentration of planned surgery. This will mean the quality of emergency care will be improved across North London by the consolidation of A&E services from 21 to 15 units, which will continue to provide urgent and planned care and improved services for their communities. Commissioners in South East and South West sub-regions of the capital are developing plans to secure sustainable clinical improvements across their hospital landscapes.

London Region acute reconfiguration programmes

Shaping a Healthier Future

- Secretary of State has approved plans to consolidation develop 5 major acute hospitals providing full A&E services
- Ealing, Charing Cross, Hammersmith and Central Middlesex redeveloped as Local Hospitals with 24/7 UCC & elective. Ealing and Charing Cross A&E subject to further engagement
- Supported by primary and community services investment

Barnet, Enfield, Haringey Clinical Strategy

- A&E and obstetric services consolidated from Chase Farm to new facilities at North Middlesex and Barnet Hospitals.
- Implemented Nov/Dec 2013
- Chase Farm redeveloped as a UCC with 24/7 GP access and paediatric and elderly consultant support.
- Supported by primary and community services investment

Health for north east London

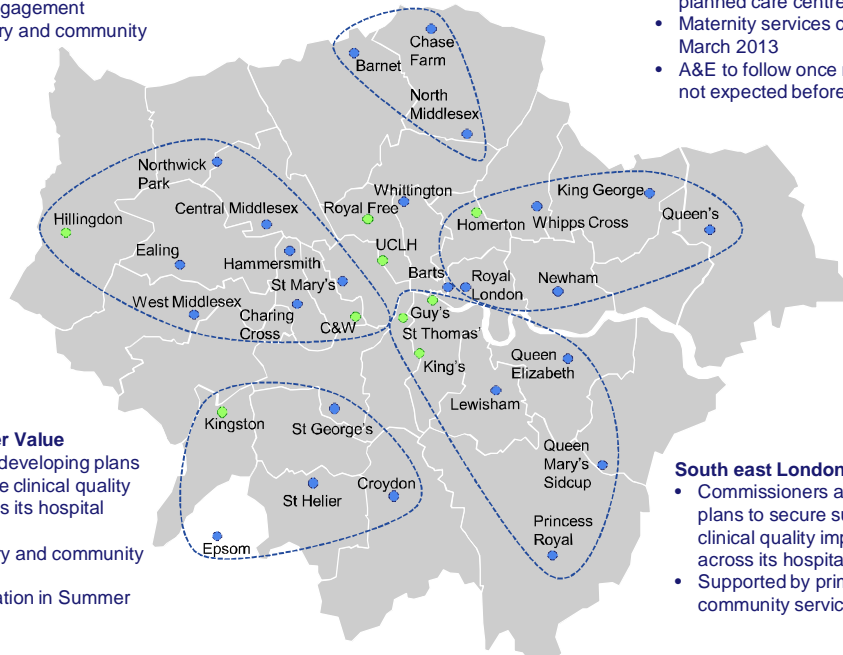
- Secretary of State has approved plans to consolidate A&E and maternity services mainly at Queen's from King George.
- King George to be redeveloped as planned care centre with UCC
- Maternity services consolidated in March 2013
- A&E to follow once new capacity built, not expected before 2015

Better Services, Better Value

- Commissioners are developing plans to secure sustainable clinical quality improvements across its hospital landscape
- Supported by primary and community services investment
- May lead to consultation in Summer 2014

South east London

- Commissioners are developing plans to secure sustainable clinical quality improvements across its hospital landscape
- Supported by primary and community services investment



⁶⁵ London Health Programmes (2013). Quality and Safety Programme: Audit of acute hospitals Pan-London findings. London Health Programmes website. Available at: www.webarchive.org.uk/wayback/archive/20130228190224/http://www.londonhp.nhs.uk/services/quality-and-safety-programme/audit/

All of these programmes recognise the role that primary and community services play in meeting the health needs of the existing and future population, as well as the need for developing new models of care beyond institutional boundaries as part of the out of hospital transformation agenda.

4. Conclusion

The case for change is clear. More ambitious plans for integration are needed to transform care around the needs of the patient and for progress to be made in London as a matter of urgency.

The London Health and Care Integration Collaborative are carrying out further work in capturing the full account of progress local systems are making, and are actively testing the key ingredients to support delivery on health and social care leaders.

Publication of the full account and the key ingredients through open source format is expected in January 2014. Health and social care leaders are encouraged to use this information in their local planning discussions through Health and Wellbeing Boards. A further update on the publication of this information will be released in December alongside a call to local areas to start collating evidence and preparing case studies to share learning.