MEETING
HEALTH & WELLBEING BOARD
DATE AND TIME
THURSDAY 15TH NOVEMBER, 2018
AT 9.00 AM
VENUE
HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

Dear Board Members,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
7.	SECTION 75 AGREEMENTS ANNUAL REPORT	3 - 16
12.	CARE CLOSER TO HOME NETWORKS DEEP DIVE: INVESTMENT AND DELIVERY ROAD MAP AND BOROUGH-WIDE SOCIAL PRESCRIBING MODEL	17 - 34

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AGENDA ITEM 7

	Health and Wellbeing Board **15 November 2018**
Title	**Section 75 Agreements: 2017-2018 Annual Report**
Report of	Strategic Director for Adults, Communities and Health Strategic Director for Children and Young People, Chief Operating Officer, – NHS Barnet CCG
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None
Officer Contact Details	Helen Cavanagh, Commissioning and Policy Lead, Health and Wellbeing Email: Helen.cavanagh@barnet.gov.uk, Tel: 020 8359 4588

Summary

Under Section 75 of the NHS Act 2006 Local Authorities and NHS bodies can enter into partnership arrangements to provide a more streamlined service and to pool resources, the aim of this is to improve services for residents and patients.

Barnet has Section 75 agreements covering services for adults and children. The Joint Commissioning Executive Group monitors the delivery of the agreements.

The Health and Wellbeing Board is responsible for overseeing the delivery of the Section 75 agreements to ensure they are operating effectively and having maximum impact. The Health and Wellbeing Board have the opportunity to review key achievements, risks and mitigations, financial information and commissioning intentions.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on the Section 75 agreements for Barnet's residents.**

1. WHY THIS REPORT IS NEEDED

1.1 Under Section 75 of the NHS Act 2006 local authorities and NHS bodies can enter into partnership arrangements to provide a more streamlined service and to pool resources, the aim of this is to improve services for residents and patients.

1.2 Section 75 (S75) agreements allow for Local Authorities and health to pool funding to develop improved services and to maximise resources. Section 75s are a tool to facilitate joint working to improve outcomes for residents.

1.3 The Joint Commissioning Executive Group (JCEG) receives quarterly Section 75 progress reports. The progress reports allow JCEG to oversee the delivery of the services within the Section 75 agreements including risks and mitigations, finances and commissioning intentions (including the end dates of the agreements themselves). JCEG makes recommendations to the relevant decision making bodies in the CCG and the Council or officers for future joint arrangements.

1.4 The report covers key achievements, risks and mitigations, finances and commissioning intentions from 2017-18 for each agreement and schedule. The key achievements across all of the agreements are:

- The commissioning of community equipment that allows people to remain in their own home.
- The prevention and wellbeing voluntary services contracts have been reviewed, updated and key performance indicators agreed.
- The Integrated Learning Disability Service have implemented a “blue light” and community care and treatment review policy to prevent hospital admissions adopting best practice from the Transforming Care Programme.
- The planned outcomes of the Better Care Fund are on target.
- Following a tender process for Children’s speech and language therapy, a new provider was appointed to provide integrated therapy services (Occupational Therapy/Physiotherapy/Speech and Language Therapy (SALT)) from 1 September 2018.
- The Looked After children’s nursing team which undertakes reviews for children and young people out of the borough has been deemed good practice by Office for Standards in Education (OFSTED)/Care Quality Commission (CQC).

The Agreements And Schedules – Service For Adults

1.5 **Overarching Agreement**

1.5.1 The overarching agreement in adults has been in place since August 2013. The original agreement was extended in 2016 with no end date whilst specific agreements/schedules now have end dates.

1.5.2 The overarching agreement details the terms for collaborative working, between Barnet Council and Barnet CCG, relating to the establishment of management of jointly commissioned services pursuant to Section 75. The following outcomes and objectives are expected from this agreement.

- Improve outcomes for members of the community in relation to their physical and mental health and emotional wellbeing.
- Consolidate and improve joint commissioning between the parties to the agreement to improve the services received by members of the community.
- Commission Services in a co-ordinated manner by identifying the benefits and options of further integrated service provision, service commissioning and support services between the Council and the Clinical Commissioning Group.
- Raise standards by improving the quality and responsiveness of the Services and providing a wider pool of knowledge and experience for staff working.
- Support the development of the Joint Strategic Needs Assessment.
- Make more effective use of resources and where appropriate shift resources to focus on prevention and early intervention, and the extension of universal services, rather than high cost specialist provision.
- Seek to secure more seamless service provision across both parties (to the agreement) and also across different types of services to meet needs holistically and promote easy access to Services.

1.5.3 Specific services are set out in schedules under this agreement. Currently the following are schedules under the overarching agreement.

- Community equipment
- Prevention and wellbeing services voluntary sector
- Health and social care integration (covering the Better Care Fund)
- Integrated Learning Disability Service
- Campus re-provision; this agreement covers the care of a small number of individuals

1.5.4 There is also a separate section 75 agreement between LBB and Barnet, Enfield, Haringey Mental Health Trust (BEHMHT) covering integrated provision of mental health services. This agreement enables LBB employees to work in integrated teams with BEHMHT staff.

1.6 Lead Commissioning For An Integrated Community Equipment Service Schedule

1.6.1 The current schedule for Community Equipment has been in place from April 2017. The current schedule expires in March 2021 and has a pooled fund of £3,642. The key outcomes of the current schedule are:

- To maximise economies of scale and deliver cost saving opportunities through effective commissioning of community equipment.

- To commission good quality community equipment services which allow service users to remain safely in their own homes for as long as possible. To provide appropriate support to retain individuals independence upon hospital discharge and provide appropriate support to maintain good health or support recovery in the case of long-term illness or complex conditions.

1.6.2 The key highlights from this schedule are:

- The implementation of the new contract did not go as smoothly as expected and required significantly more management time embedding the new service and managing relationships. Performance of the service has now improved although this took some time to achieve.
- There was an overspend on Community Equipment mainly due to an increase in demand and expenditure on pressure care. This service has had an over spend for several years. This can be broken down as follows.

Section 75 agreement in respect of Community Equipment Services	**2017/18**	2016/17
Expenditure met from the pooled budget	**£000**	£000
London Borough of Barnet	1,230	1,038
Barnet Clinical Commissioning Group	2,412	1,663
	3,642	**2,701**
Net deficit arising on the pooled budget during the year	**(1,075)**	**(134)**

1.6.3 Given the overspend the following activities are being undertaken urgently to address the overspend and to improve processes:

- Regular reviews of the catalogue and the authorisations needed when ordering, to ensure value for money is balanced against need.
- Develop the catalogue for new and innovative equipment that will reduce the need for two carers, reducing on-going costs.
- Implement more customer focused delivery options, which ensures less urgent deliveries are arranged around the needs of the individual and can be arranged directly.
- Complete detailed analysis and validation of performance more closely.
- Consideration of longer term strategy for commissioning service.

1.6.4 The Community Equipment schedule has been incorporated into the Health and Social Care Integration (covering the Better Care Fund) schedule for 2018-19.

1.7 **Prevention And Wellbeing Services – Voluntary Sector Schedule**

1.7.1 The current schedule for Voluntary and Community Sector Commissioning has been in place from April 2016. The current schedule expires in March 2022 and has a pooled fund of £3,064,000. The schedule covers funding for nine voluntary sector organisations to provide a range of services contributing to improved health and wellbeing for Barnet residents. These include:

- Age UK Barnet provides
  - the Community Advice Service - Generalist advice to the community via face to face, telephone and online - financial, legal, employment and housing. Over 9,300 people contacted the Citizens Advice Bureau seeking information and advice.
  - Co-ordination of community activities for 55+ residents Services include: neighbourhood (10,125 people supported), handyman (729 people supported), later life planning (1,275 people supported) & home from hospital services (259 people supported). There has also been an expansion of befriending service and 'Silver ICT' classes this has led to closer community engagement between young and old.
- Barnet Mencap provides support to people with learning disabilities and/or autism or Asperger's. The establishment of autism services has reduced the timeline for local resident initial assessments and subsequent support. Space. The employment Service has supported 54 supported individuals and 2,067 individuals have attended Community Opportunities.
- Alzheimer's Society provides a dementia support service. Support has been provided to over 1,000 individuals. The Dementia Day Support Activities have over 1,500 people attending. The outreach activity at Barnet Hospital (Springwell) has resulted in service users newly diagnosed with dementia being able to access support at the earliest opportunity.
- Middlesex Association for the Blind provides a low level visual Impairment service. 104 individuals received active support throughout the year. The service has provided ICT training to service users, which has included the use of smartphones.
- Barnet's Citizens Advice Bureau provides a community advice service and a specialist information advice and advocacy service. The service has expanded its outreach activities within borough in order to extend community engagement.
- Barnet Depression Alliance offers a depression support group.
- Genesis Housing Association provides Housing Related Support (HRS) for safe and sustained accommodation to residents of Barnet, with 1,423 people contacting their generic/floating service for information & advice. 417 people started the programme for 1-2-2 support in 2017-18. Full stop

- London Borough of Southwark/PoHwer manage NHS Complaints Advocacy for Barnet. The service provides a voice for health advocacy services, 159 cases were dealt with in 2017/18.
- Community Barnet provide Healthwatch which is a statutory service to improve and shape local health and social care services - residents' opinions. Healthwatch's Enter & View reports have encouraged care, nursing and residential homes visited to raise standards in service user care e.g. security, mealtimes, medication procedures and staff.

1.7.2 The key highlights from this schedule are:

- Two voluntary sector contracts ended in 2017-18: Inclusion Barnet and The Stroke Association (this service is being developed by the CCG as a part of Early Supported Discharge provision).
- The contract monitoring processes across all providers has been reviewed to include measures and ways of evaluating prevention benefits, plus to ensure quality measures are in place.
- A plan has been developed to implement an annual comprehensive review of all providers. The review includes the use of mystery shopper, customer experience, audit visits and feedback from all parties. The aim is for the annual review to capture more than just statistical data, to enable the evaluation of the quality and prevention benefits of the service
- Some of the contracts with the voluntary sector are due to end in 2019.

1.8 Integrated Learning Disability Service Schedule

1.8.1 The Barnet Integrated Community Learning Disability Service is an integrated service between health and social care. This means that the service will deliver health and social care services and interventions in a holistic and person centred way, and will be resourced in order to meet the holistic needs of the service users, with health and social care staff working together with the aim of providing services and/or coordinating services around each individual service user. The service works with approximately 1240 clients across all disciplines.

1.8.2 The current agreement for the Integrated Learning Disability. The pooled fund is £2,785. The key outcomes of the current agreement are to:

- Improve the quality of services for people with learning disabilities by drawing on strong professional expertise through joint working between health and social care to ensure a seamless response in meeting need and achieving personal outcomes.
- Progress multi-disciplinary discharge plans for all people under the Winterbourne (Transforming Care) cohort and support people to be treated in the community.

- Further embed progress on the national Self-Assessment Framework targets, including Health Action Plans and Health Passports. These documents are a part of a Person Centred Plan, developed with the individual, carers, and professionals. The health passport provide information about an individuals health needs and also contains other information, such as interests, likes, dislikes and preferred method of communication.
- Ensure that the service is working closely with the new 0-25 disabilities service.

1.8.3 The key highlights from this agreement are:

- The actions relating to the Winterbourne cohort are managed through regular meetings with the Lead commissioner for Learning Disabilities. There are currently no patients in hospitals (with the exception of the clients subject to the court of protection).
- Links with the 0-25 Service have been developed with representatives of the learning disability service now attending the weekly referral meeting.

1.9 Campus Re-Provision Schedule

1.9.1 The current agreement for Campus re-provision has been in place from April 2010. The current agreement has no expiry date and has a pooled fund of £1,709. The proposed outcomes of the current agreement is to:

- To support people with learning disabilities who have been living in long stay NHS accommodation.

1.9.2 In depth care and support reviews have been carried out and new care and support plans have been developed with patients, families and staff. The S75 schedule will be kept under review.

1.10 Health And Social Care Integration (Including The Better Care Fund) Schedule

1.10.1 The current schedule for Health and Social Care Integration has been in place since 2018. The pooled fund is £30,272,581. The main aim of the schedule is to oversee the Better Care Fund pooled budget and associated work programmes to integrate health and social care for frail elderly people and people with long term conditions.

1.10.2 Barnet's Better Care Fund (BCF) aimed to:

- Deliver a more person focused system to improve patient and service user experience.
- Deliver a care and support system focused on wellness, instead of reactive care.

- Develop support for people to manage their conditions, live well independently and so reduce or avoid the need for care services in future.
- Respond to changes in the population of Barnet or requirements for providing care, such as The Care Act 2014.
- Deliver better, effective and sustainable services using limited funds.

1.10.3 The BCF has four national metrics

- A reduction in non-elective admissions. - The Q4 target for NEL admissions was missed by 7% .This represents an improvement in Q3 performance when the target was missed by 12%.
- Delayed Transfers of Care (DTOC) – The total Barnet Delayed Transfer of Care in 2017/18 (3354) were 2% lower than Barnet DTOCs in 2016/17 (3434).
- Residential Admissions - Following an increase in admissions between December and January 2018, February 2018's older adult residential admissions decreased by 43% from 14 to 8 admissions. This continues to mirror trend reported in 2016/17, but with a 50% reduction on the same period last year. February 2018's admissions (8) are equivalent to 14.5 admissions per 100,000 residents (aged 65+), compared with 25 in January. Based on trends over the last 3 years, it is expected that the number of admissions will continue to decrease during the last month of the FY 2017/18.
- Reablement – The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services, is on target at 73.6%

1.11 Integrated Provision Of Mental Health Services For Adults Of Working Age And Older Adults

1.11.1 The S75 Integrated Mental Health schedule sets out the agreement to deliver integrated services for people with mental ill health in Barnet and their carers; through joint working between the London Borough Barnet and Barnet Enfield Haringey Mental Health Trust (BEHMHT). The aim is to ensure that people with mental ill health and their carers are supported to achieve good outcomes and receive high quality services. The key outcomes to be achieved through the current agreement are: -

- To increase the number of people with mental ill health in stable accommodation.
- To increase the number of people with mental ill health in employment.

1.11.2 Key areas of focus for BEHMHT and LBB in the coming year include consider new ways to strengthen and improve support offered via secondary mental health teams to improve outcomes. Further developing our enablement and recovery model and developing the support offered via the Wellbeing Hub to support more people to maintain and improve their health and wellbeing.

1.11.3 Currently work is underway to vary the current S75 to strengthen the focus on early intervention and prevention and agree new performance indicators to measure the work being delivered.

The Agreements And Schedules – Children Services

1.12 Overarching Agreement

1.12.1 The overarching agreement in children services has been in place since August 2013 and has been extended with no end date (specific agreements/schedules have end dates).

1.12.2 The overarching agreement details the terms for collaborative working, between Barnet Council and Barnet CCG relating to the establishment and management of jointly commissioned services pursuant to Section 75. The agreement details the same terms as the adults agreement (as detailed in 1.5.2).

1.12.3 Currently the following services are covered by schedules under the overarching agreement:

- Speech and Language Therapy (SALT)
- Occupational Therapy (OT).
- Looked After Children (LAC)

1.13 Speech And Language Therapy (SALT) And Occupational Therapy Schedules (OT)

1.13.1 The current schedule for Speech and Language has been in place from April 2014. The current schedule expires in March 2019 and has a pooled fund of £2,097,635. The key outcomes of the current schedule are to provide a comprehensive range of interventions within a universal, targeted and specialist framework, which:

- Maximise the speech, language and communication skills of all children and young people in Barnet, from birth to their nineteenth birthday.
- Maximise the extent to which parents, carers and staff are able to support children and young people in Barnet to develop speech, language and communication skills.
- Use an early identification and intervention approach to working with all children and young people.

1.13.2 The current schedule for Occupational Therapy has been in place from April 2014. The current schedule expires in March 2019 and has a pooled fund of £401,000. The key outcomes of the current schedule are to:

- Provide a consistent high quality assessment and treatment service that is child and family centred at all points of the treatment pathway.
- Work with children and their families, in order to attain highest independence and maximal physical potential, promote learning and

sharing and assist children and families to integrate activities into their daily life.

- Provide specialist therapy to optimise functional motor skills.
- Provide equipment and aids to support daily life for home and school.
- To provide timely reports as requested for a child's statutory assessment of their Special Educational Needs.

1.13.3 The key headlines for these schedules are:

- The current provider contracts came to an end on 31st August 2018. NHS North East London Foundation trust was the successful bidder in a joint procurement undertaken by LBB and CCG for provision of an integrated children's therapy service (Occupational Therapy, Physiotherapy, Speech and Language Therapy), including the provision of Social Care OT services, from 1st September 2018 - 2021 plus the option to extend for 2 years.
- In the run up to procurement and during mobilisation staff rentention was closely monitored by commissioners including liaising with the new provider to address risks.

1.13.4 A Mobilisation Board is in place and is ensuring collaborative, robust governance during mobilisation across the transition.

1.13.5 Amendments to the current section 75's schedules are being drawn up to reflect the new provide, services and funding arrangements.

1.14 Looked After Children Schedule

1.14.1 The current schedule for Looked after children (LAC) has been in place from April 2014. The current schedule expires in March 2019 and has a pooled fund of £131,941. The key outcomes of the current schedule are to:

- Jointly commissioning a Looked-after children (LAC) Nursing Service. The term 'looked after' refers to children under the care of the Local Authority, including unaccompanied asylum seeking children and those children where the agency has authority to place a child for adoption.
- The Looked After Children (LAC) Service aims to ensure the health of looked after children by providing holistic health care from birth to 18 years of age.
- Providing statutory health assessments, information and a link to health for looked after children and young people, parents, carers and other professionals working with LAC.
- The LAC Nursing Service is provided by Specialist Nurses who ensure that health (initial and review) assessments of looked-after children are undertaken on time and to a high standard. The service is provided by Central London Community Healthcare (CLCH).

1.14.2 The key highlights from this schedule are:

- All children who enter the care of LBB receive an Initial Assessment of their health needs (an IHA) within 28 days, to inform their care plan.
- Children who remain in care for 12 months or more receive an annual review (a Review Health Assessment or RHA) of their health needs to inform their care plan. The RHA is required 6-monthly for under 5's.

1.14.3 Training has been completed by GPs completing assessments regarding unaccompanied asylum seeking minors. The LAC Designated Nurse and lead commissioner are working on an improved health pathway to support unaccompanied asylum seeking minors.

1.14.4 Further work needs to be undertaken to ensure that the Designated Nurse has enough time to undertake strategic responsibilities instead of completing review health assessments.

1.14.5 The Section 75 schedule ends in March 2019, the contract will be reviewed in line with this agreement.

2. REASONS FOR RECOMMENDATIONS

2.1 This report allows the HWBB to comment on the performance of the agreements.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 N/A

4. POST DECISION IMPLEMENTATION

4.1 CCG and LBB officers will continue to monitor the effectiveness of the agreements and performance reports will be taken to JCEG.

4.2 A number of the Section 75 agreements will be varied and extended or reviewed in the next 12 months.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities And Performance

5.1.1 Ensuring that our section 75 agreements are operating effectively and supporting local health and social care integration, which is a key priority of the Joint Health and Wellbeing Strategy as well as the NHS England's Five Year Forward View.

5.2 Resources (Finance & Value For Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 The pooled fund for the agreements are summarised below:

Agreement title	Pooled budget (17/18 unless stated)
Adults	
Lead Commissioning for an Integrated **Community Equipment** Service	£3,642
Voluntary and Community Sector Commissioning (prevention and early support)	£3,064
Integrated Learning Disability Service	£2,785
Learning Disability Services for service users – subject to the **campus re- provision** programme	£1,709
Health and social care integration (covering the Better Care Fund)	£30,272,581
Children's	
Speech and Language Therapy	£2,053
Looked After Children	£131,941
Occupational Therapy	£401,000

5.3 Social Value

5.3.1 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 Legal And Constitutional References

5.4.1 Under Section 75 of the NHS Act 2006 local authorities and NHS bodies can enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to improvements in how functions are exercised.

5.4.2 The Council's Constitution Article 7 (Committee Forums Working Groups and Partnerships) sets out the Terms of Reference of the Health and Wellbeing Board which include:

- To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet Joint Strategic Needs Assessment (JSNA) to all relevant strategies and policies.

- To agree a Health and Well-Being Strategy for Barnet taking into account the findings of the JSNA and performance manage its implementation to ensure that improved outcomes are being delivered.
- To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children). Achieving thisby both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social wellbeing. Specific resources to be overseen include money for social care being allocated through the NHS, dedicated public health budgets, the Better Care Fund and Section 75 partnership agreements between the NHS and the Council.
- To promote partnership and as appropriate integration across all necessary areas, including the use of joined up commissioning plans across the NHS, social care and public health. To explore partnership work across North Centrsl London where appropriate.
- Specific responsibilities for:
  - Overseeing public health.
  - Developing further health and social care integration.

5.5 Risk Management

5.5.1 Section 1 outlines the specific risks (and mitigations) associated with each Section 75.

5.5.2 Risks with the contraced providers are managed through the appropriate contract management processes.

5.5.3 Risk are managed through progress updates at the Joint Commissioning Executive Group (JCEG) and reported to the HWBB as necessary.

5.6 Equalities And Diversity

5.6.1 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010. Advance equality of opportunity between people from different groups and foster good relations between people from different groups. Both the Local Authority and the CCG are public bodies. The relevant protected characteristics are age, disability, gender reassignment, pregnancy and maternity; race, religion, or belief, sex, sexual orientation.

5.6.2 The contracts and the services (under the section 75) are closely monitored to ensure that equalities duties are met. Equalities information is considered in making commissioning decisions and identifying the requirement for Section 75 agreements.

5.6.3 The JHWB Strategy has used evidence presented in the JSNA to produce an evidence based resource which has equalities embedded at its core, explicitly covering the current and future needs of people in Barnet from each equalities group.

5.7 Corporate Parenting

5.7.1 In order to thrive, children and young people have certain key needs that good parents generally meet. The corporate parenting principles set out seven principles that local authorities must have regard to when exercising their functions in relation to looked after children and young people, as follows:

- to act in the best interest of and promote the physical and mental health and well-being of those children and young people.
- to encourage those children and young people to express their views, wishes and feelings.
- to take into account the views, wishes and feelings of those children and young people.
- to help those children and young people gain access and make the best use of delete services provided by the local authority and its relevant partners.
- to promote high aspirations and seek to secure the best outcomes for those children and young people.
- for those children and young people to be safe and for stability in their home lives, relationships and education or work.
- to prepare those children and young people for adulthood and independent.

5.7.2 Section 1 outlines the specifics that may have a direct or indirect impact on children in care and the steps taken to mitigate them.

5.8 Consultation and Engagement

5.8.1 N/A

5.9 Insight

5.9.1 In making commissioning decisions and identifying the requirement for Section 75 agreements, insight is employed.

6 BACKGROUND PAPERS

6.1 None

Appendix 2: Investment and Delivery Road Map

The Care Closer to Home programme has made significant progress during 2018/19 and this paper summarises the key areas for the Health and Wellbeing Board:

Care and Health Integrated Networks (CHINs)

At the start of the year there were three CHINs in Barnet that had come together through an organic process and were beginning to design transformative services around their patient populations through qualitative and quantitative analysis. The overall population coverage was 38% of the registered patient population in the borough.

In order to build on and maximise our transformation efforts, the most important objective for the Care Closer to Home programme is to have all of the Barnet GP practices being part of a CHIN. This would enable a borough-wide approach to transformation and new integrated ways of working that cross organisational boundaries and builds an at scale primary care model.

In order to achieve this objective, a number of engagement activities took place with GP Practices and wider primary care and social care provers to promote the programme and the benefits of working in integrated networks. These are detailed below:

1. **Multi-Collaborative Learning Groups (MCLG):** The primary care team attended 9 meetings across the month of June 2018 and reached an audience of 40+ practices. All questions asked were captured and subsequently answered.
2. **Barnet Federated GP's Membership Event:** The federation and clinical commissioning group (CCG) jointly presented the programme to the whole GP Federation membership
3. **Barnet Clinical Commissioning Group Annual General Meeting (AGM):** The primary care team hosted an area where individual practices could ask questions and be furnished with information on how to become part of a CHIN.
4. **Joint Meeting with Barnet Clinical Commissioning Group, Barnet Federated GP's and Community Provider Education Network (CPEN):** 145 clinicians and non-clinicians from primary care attended the event and the Care Closer to Home programme was promoted.

Following the MCLG meetings, a CHIN Frequently Asked Question (FAQ) document was developed and disseminated to all GP Practices within the borough. The engagement process helped shape the new process for becoming part of a CHIN or creating a new one and resulted in a CHIN Infrastructure Locally Commissioned Service (LCS) being developed, which was open to all GP practices.

This was launched in October 2018 and provided funding of £1,500 per practice, an overall investment of £90,000, to stimulate CHIN development. The outputs expected from this process are a nominated CHIN Lead and Quality Improvement lead, a signed memorandum of information (MoI) between the practices for working together and a commitment to undertake a baseline assessment across workforce, estates and digital.

At the time of writing this paper, we have received responses from 48 out of the 54 GP Practices within the borough and there are six proposed CHINs within Barnet. This also means that our population coverage has moved from **38%** to **89%**.

To support the development of the CHINs and also to undertake targeted engagement with any practices yet to respond to the infrastructure LCS, a CHIN Steering Group (CSG) has been created and the CCG and Barnet Federated GP's have jointly appointed a clinical lead to undertake this role. We are confident that we will achieve full borough wide coverage by the end of December 2018 and this will allow the CHINS to become the innovation and transformation hubs for the communities that they serve during 2019/20.

A new delivery plan for the programme in 2019/20 is currently under development, underpinned by agile principles, to ensure we meet our key short and medium term objectives and deliverables.

Further details in respect of the CHINs within Barnet can be found in the accompanying CHIN Deep Dive enclosure.

System Integration

In Barnet, the Care Closer to Home Programme is being jointly developed by the CCG and the Council, in recognition of the importance of a coordinated and integrated approach to promote local health and social care delivery in ways that best meet the needs of the residents and registered population of Barnet.

The primary care element of the CHINs are now beginning to take shape within the borough and the next important objective is to begin the health and social care integration and transformation element within the CHINs and the communities they serve. In order to understand the council offer to the CHINS, an extremely helpful guide titled "*GP guide to Council services that support wellbeing and independence for adults, children and families"* was produced by the council. This has been shared with all GP practices within Barnet and is informing the discussions around the 'wrap around' of council services and increasing awareness of the services that patients can be signposted to.

Opportunities for linking public and patient engagement groups and community groups around the CHINs is currently being explored so that the communities can have a voice in shaping their health and social care services and be at the heart of service and pathway redesign.

Wider integration of the programme is also underway with continued engagement with the acute and community healthcare providers, who are represented at the Care Closer to Home board, and we are now exploring how these providers can support the pipeline ideas .

Access to Primary Care services

Extended Access

Barnet CCG has commissioned a primary care extended access service, which has been in operation since April 2017. This service provides GP appointments to all registered patients of Barnet CCG between 8.00am and 8.00pm, 7 days a week (including Bank Holidays).

This service is provided by the Barnet GP Federation – a local GP Federation that has a membership of the 55 Barnet GP practices. This enables whole CCG registered population coverage. The CCG has commissioned 48,000 appointments during 2018/19 as part of the Extended Access Service.

This equates to approximately 920 additional primary care appointments each week. This service offers extra GP appointments:

- During weekday evenings between 6.30pm and 8.00pm
- During the weekend and on Bank Holidays between 8.00am and 8.00pm

Improved Access Locally Commissioned Service (LCS)

The CCG has in addition commissioned an Improved Access Locally Commissioned Service (LCS) which is being delivered by practices between 1st October 2017 and 31st March 2019. This LCS has been invested into general practice as part of the GP Five Year Forward View (GPFV) £3 per head funding.

The Improved Access LCS is being delivered in two stages: the first stage is for practices to review their capacity including how they offer appointments and to develop an improvement plan; and the second stage (to be delivered by GP practices from late July 2018 / early August 2018) is for practices to implement their improvement plan. The outcomes will vary by practice depending on the content of the action plan submitted as part of stage one, but it is anticipated that the following outcomes will be achieved:

- Improving access to general practice services for the Barnet population
- Manage the demand on primary care services, encouraging active signposting to other support services where appropriate
- Support the future sustainability of primary care in Barnet through collaboration and resilience
- Improved patient experience to demonstrate high levels of patient satisfaction with the service
- Improved staff satisfaction within the practice
- Improved skill mixed workforce to demonstrate high levels of staff, releasing GP time for care
- Improved appointment availability within the practice, including utilisation of ‘new consultation types’

Investment into the Programme

The Care Closer to Home programme is receiving investment from centrally funded non-recurrent NHS England programmes and recurrent local investment from the CCG's Primary Care allocation. The budget for the programme during the 2018/19 operating year just over £2m with £1.3m being invested from local budgets.

This is in addition to the core primary budget and the investment into the GP Extended Access Service (EAS),

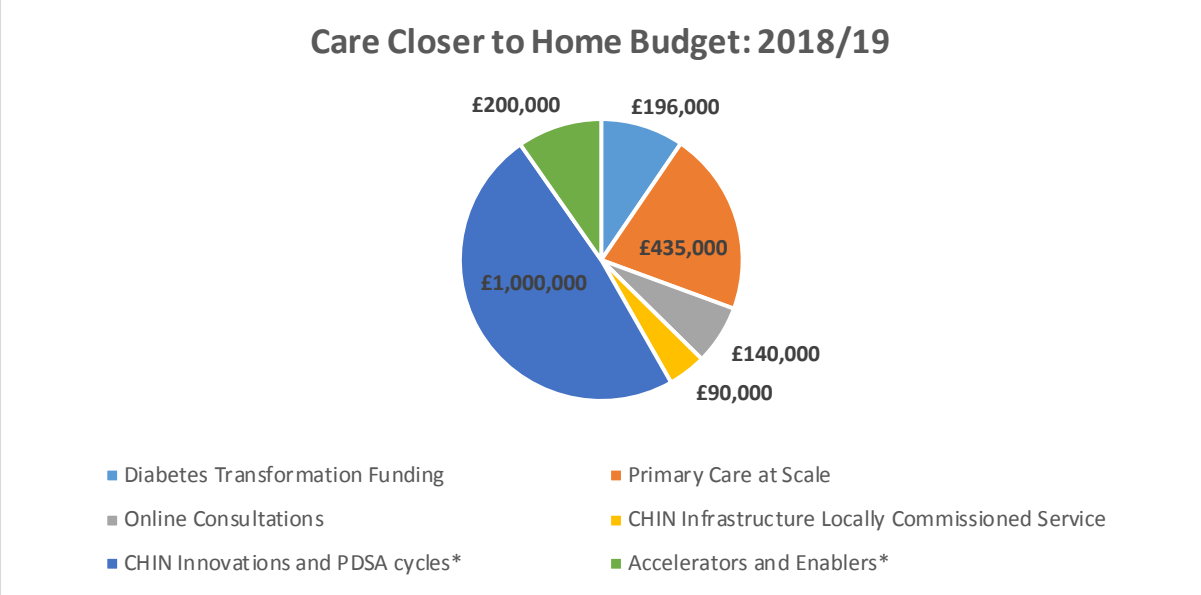
The breakdown of the budget is shown below:

Table 1: Care Closer to Home Budget

Budet Line	Type	Duration	Source	Value
Diabetes Transformation Funding	Recurrent	2 years	NHS England	£ 196,000
Primary Care at Scale	Non-recurrent	N/A	NHS England	£ 435,000
Online Consultations	Recurrent	2 years	NHS England	£ 140,000
CHIN Infrastructure Locally Commissioned Service	Non-recurrent	N/A	Barnet CCG	£ 90,000
CHIN Innovations and PDSA cycles*	Recurrent	5 years	Barnet CCG	£ 1,000,000
Accelerators and Enablers*	Recurrent	5 years	Barnet CCG	£ 200,000
Grand Total				£ 2,061,000

* = These figures are due to increase, year on year, based on the success of the program

Chart 1: Care Closer to Home Budget



The expectation is that each one of the CHINs within the borough will review data and unwarranted variation and design new pathways and services that will benefit their patient

population. Each innovation will require a business case to be developed and following the appropriate governance routes, investment will be released for a Plan, Do, Study, Act (PDSA) cycle to test the assumptions, measure impact and outcomes and inform whether the pathway or service can be scaled to be delivered at a borough wide level.

All decisions for the scaling up of services will be dependent on the outcomes of the PDSA cycle and if the assumptions are validated and the impact measurable, this investment will be in addition to the Care Closer to Home programme budget.

Resourcing

Each CHIN will be allocated and supported by Barnet CCG and Barnet Federated GP's resources from pipeline idea generation through to mobilisation. This end to end approach will be beneficial for each CHIN to ensure that relationships mature and there is a consistent offer.

The CCG has fully recruited a highly skilled and substantive primary care transformation team to support the delivery of the programme and each CHIN is assigned a Senior Primary Care Transformation Manager as their Specified Point of Contact (SPoC) and will work with the CHINs to harness their pipeline ideas into something tangible and deliverable.

Summary

We are excited about the future of the programme and the progress made in the past three months and we must now capitalise on the enthusiasm of General Practice, in the short term, to deliver new and innovative models of care services and to positively engage with the wider system partners and deliver a sustainable, integrated care and health model across the borough.

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NHS
Barnet
Clinical Commissioning Group

Care Closer to Home

Deep Dive for Health and Wellbeing Board

FOR DISCUSSION

Colette Wood, Daniel Glasgow

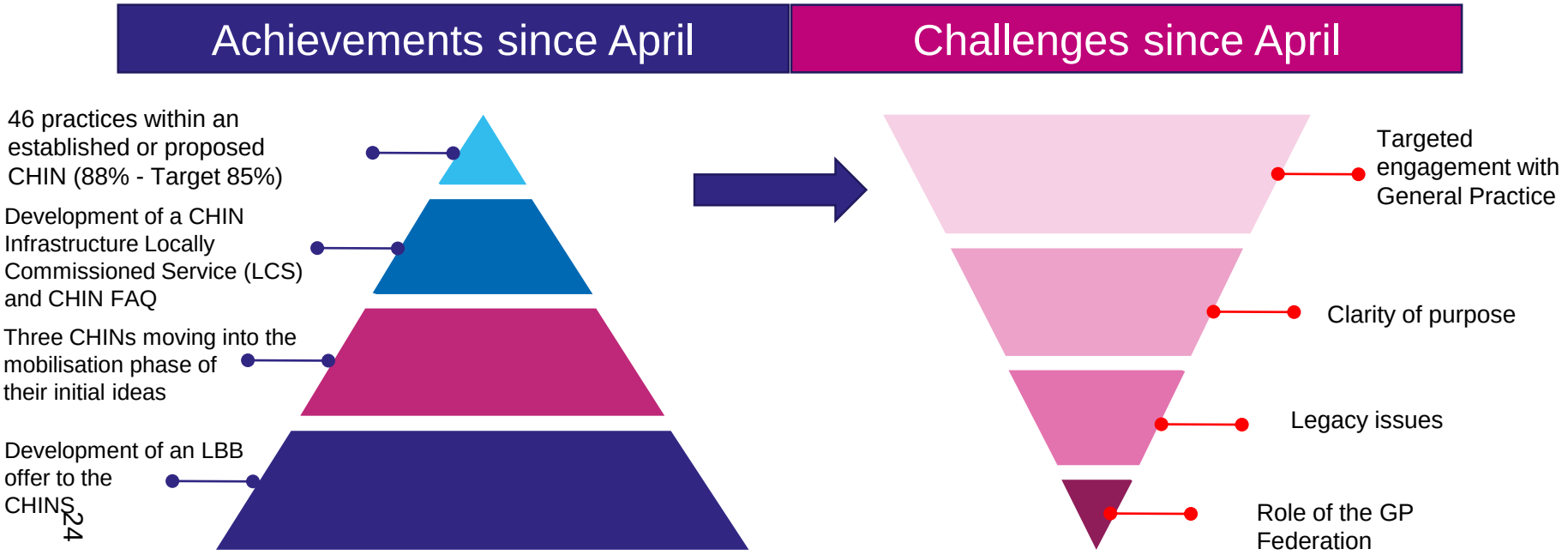
31st October 2018

Overview

The Care Closer to Home Programme (CCTH) within Barnet has made significant and tangible progress to date during the 2018/19 operating year. We are very close to achieving our population coverage target and we are moving into the mobilisation phase of a number of new innovative projects.

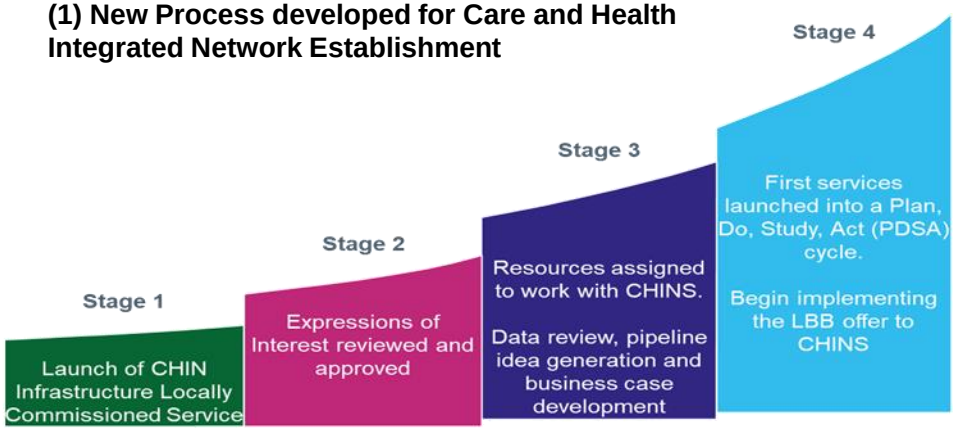
Our ultimate aim for the remainder of this operating year is to have achieved our population coverage target and have all Care and Health Integrated Networks (CHINs) either in service delivery or business case development by March 2019.

A snapshot of our achievements and challenges are shown below:

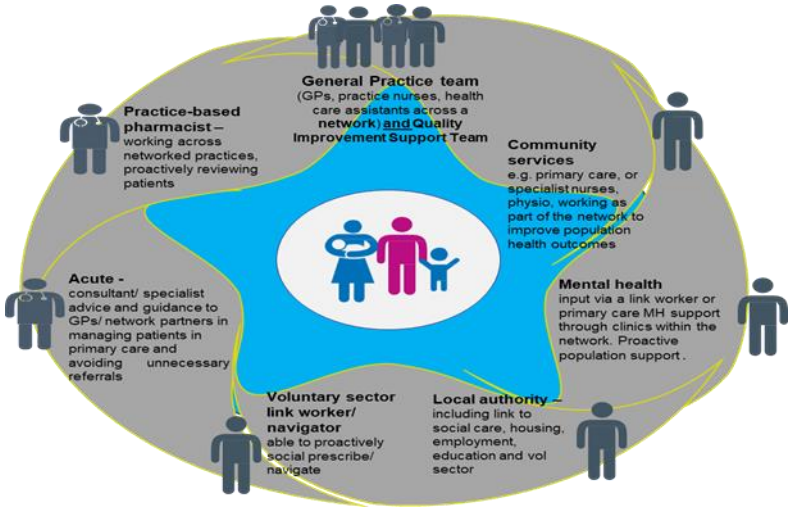


Current Position in Barnet

(1) New Process developed for Care and Health Integrated Network Establishment



(2) Typical Care and Health Integrated Network structure



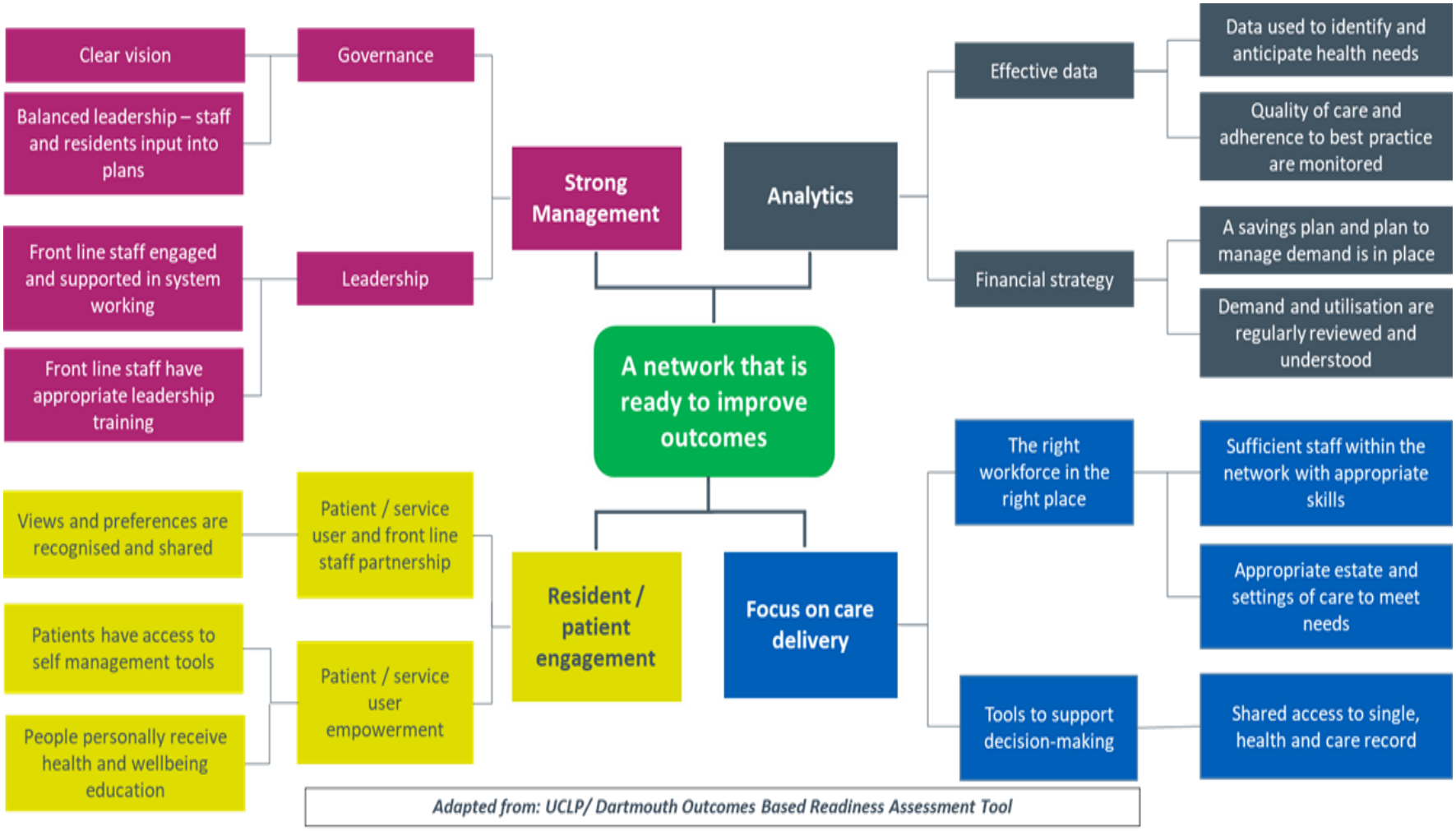
(3) Current Position within Barnet

Integration networks in place – infrastructure in place			Integration networks in plan			QIST
No. of CHINs	Population size (k)	Clinical focus	No. of CHINs	Population size (k)	Clinical focus	
3	CHIN 1: 48,473 CHIN 2: 50,575 CHIN 3: 86,146	CHIN 1: Paediatric Hot Clinics CHIN 2: Frailty MDT CHIN 3: Diagnostics and Near Patient Testing	3	CHIN 4: 44,618 CHIN 5: 39,154 CHIN 6: 41,324	CHIN 4: Digital and MyMHealth CHIN 5: Dementia CHIN 6: TBC	Diabetes

Care and Health Integrated Networks (CHINs)

CHIN development model to deliver improved outcomes for their populations

Source: North Central London (NCL) Primary Care Strategy



Deep Dive into Care and Health Integrated Networks (CHINs) in Barnet

CHIN Deep Dive - Established

CHIN One

Clinical lead: Dr Aash Bansal

Focus: *Diabetes and Paediatrics*

Population: *48,473*

Involving: 5 *practices*

Road map: *All system partners involved by April 2019*

Current Project: *Paediatric Hot Clinics*

We are proposing to establish a Paediatric Primary Care Hot Clinic within the Burnt Oak CHIN for three to six months to undertake a Plan, Do, Study, Act (PDSA) cycle. The purpose is to test our assumptions, bring care closer to home and inform future new models of paediatric care across Barnet. The specific objectives for this proposal are:

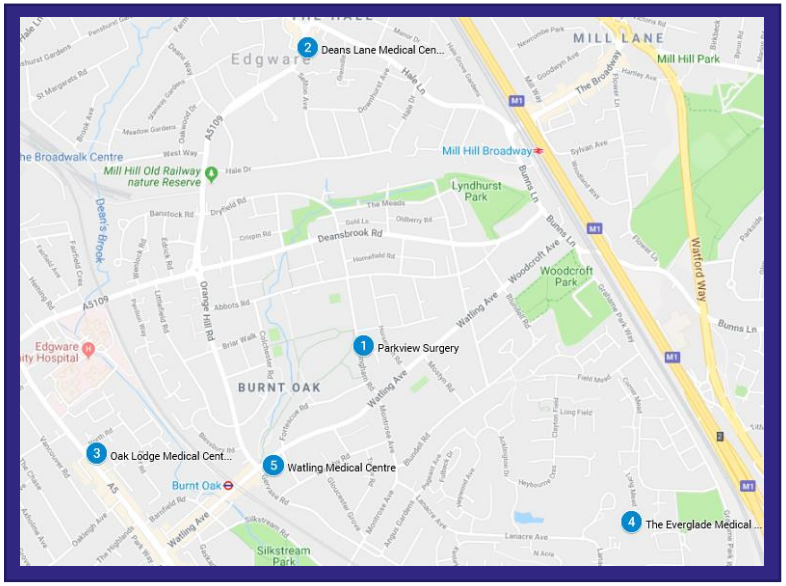
To undertake a PDSA cycle with a Paediatric Hot Clinic being based within a Care and Health Integrated Network:

- To reduce the current number of patients within the 0-9 patient cohort attending the Emergency Department and resulting in a HRG Code of VB09Z and VB11Z
- To evaluate the PDSA cycle and inform commissioning intentions for 2019/20 in terms of "scaling up" this model or resulting in a new model of care

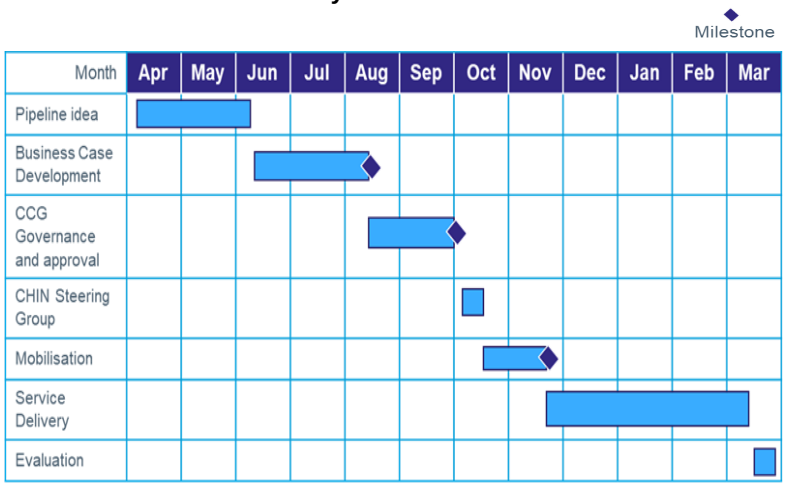
Paediatric Hot Clinic Logic Model

Resources	Activities	Outputs	Outcomes
Advanced Nurse Practitioner / Prescriber (ANP)	Hold 3-5 sessions / clinics per week depending on level of demand	Patients will be seen within a primary care setting where waiting times are far shorter than the Emergency Department	Improved patient experience
General Practitioner			Fewer A&E attendances to improve overall waiting times
EMIS community platform	Develop and implement communications plan. Including for practices to undertake assertive outreach using text messaging from the EMIS platform, informing the 0-9 patient cohort, of the hot clinics that are available and how to access them.		

GP Practices and Location of CHIN



Paediatric Hot Clinic Delivery Timetable



CHIN Deep Dive - Established

CHIN Two

Clinical Lead: Dr Anita Patel

Focus: *Frailty*

Population: 50,575

Involving: 8 *practices*

Road map: *All system partners by April 19*

Current Project: *Frailty MDT*

The objectives of this proposal are:

To enable patients to benefit from a range of integrated services and new pathways delivered through a CHIN that works across health and social care boundaries, specifically:

- To introduce models of care that will reduce avoidable non-elective admissions for the frail and elderly population of Barnet, focused on pneumonia and UTIs
- To promote the use of end of life care plans to enable a greater number of Barnet residents to die in their place of choice.

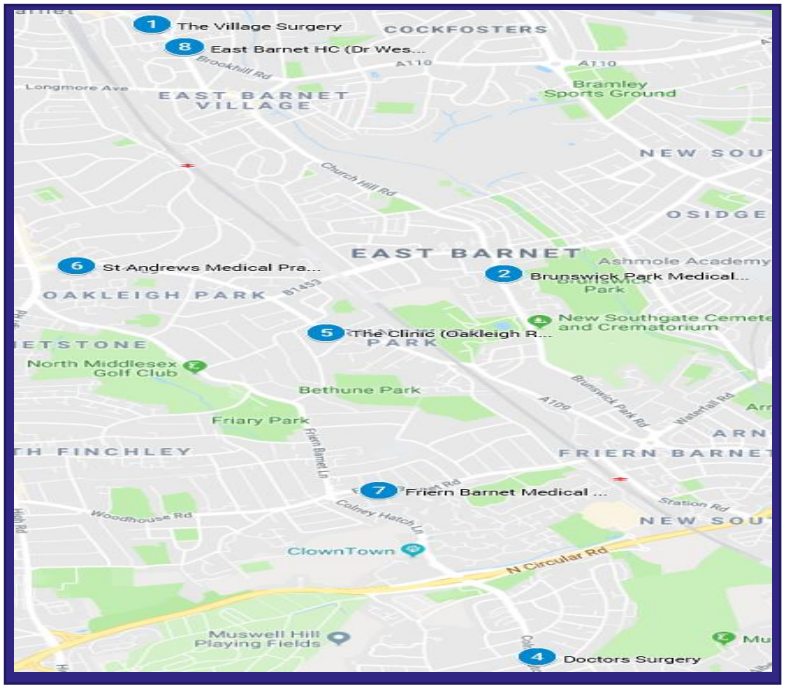
To support GP Practices to work together effectively and successfully deliver a specific Care Closer to Home initiative during 2018/19

To support Barnet CCG to deliver the ambition set out in the North Central London (NCL) STP Local Care Strategy

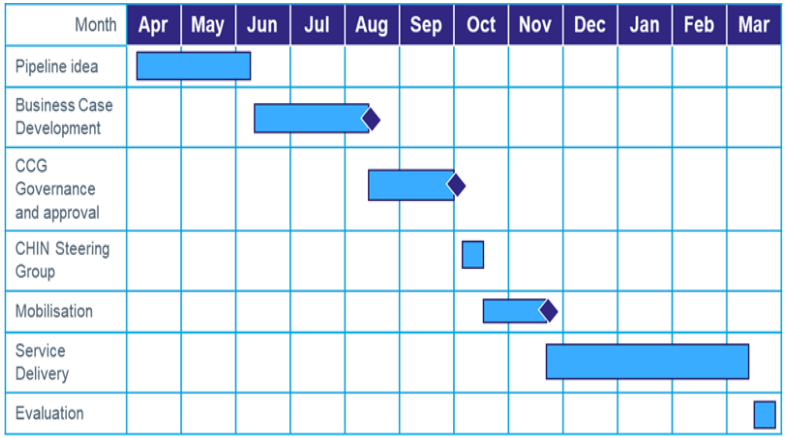
The proposal would be to adopt a PDSA approach to implementing a Frailty and Palliative MDT-model with CHIN Two practices over a 6-month period. This approach will provide an opportunity to review and refine the model and enable anticipated outcomes and savings to be identified. Following a PDSA evaluation, a Full Business Case (FBC) will be developed outlining the cost and impact of full rollout across all CHINs via a Locally Commissioned Service (LCS). This approach would help CHIN Two to form and provide an initial function.

There is a wider programme of work across Barnet on frailty which is a key area of focus for the CCG and will be linked in to the Royal Free CPG programme's frailty workstream.

GP Practices and Location of CHIN



Frailty Multi Disciplinary Team (MDT) Delivery Timetable



CHIN Deep Dive - Established

CHIN Three

Clinical Lead: *Dr Alexis Ingram*

Focus: Diagnostics

Population: *86,146*

Involving: *12 practices*

Road map: *All system partners by Apr 19*

Current Project: *Diagnostics*

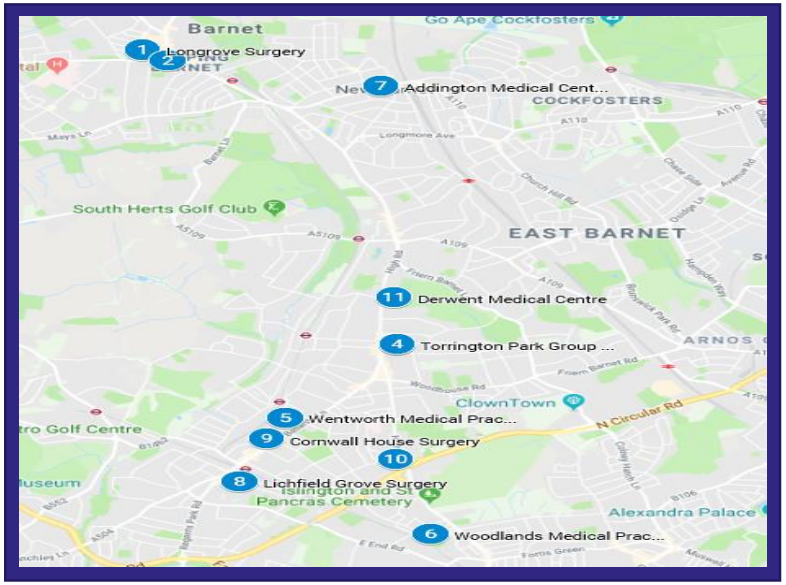
The Diagnostics in Primary Care service aims to provide patients with timely and clinically effective access to investigative tests in a setting where they receive other aspects of their care. This would initially include the following tests:
Simple 12 lead ECG
24 hour ECG monitoring
24 hour blood pressure monitoring
Spirometry
Feno Testing
Phlebotomy

These tests are currently performed in a variety of settings across Barnet. Providers include Royal Free Hospital Trust (RFHT) including Barnet Hospital, Chase Farm Hospital, Royal Free Hospital and Edgware Community Hospital, Central London Community Healthcare (CLCH), InHealth and Barnet GP Practices. Patients access these tests in a number of ways, including:

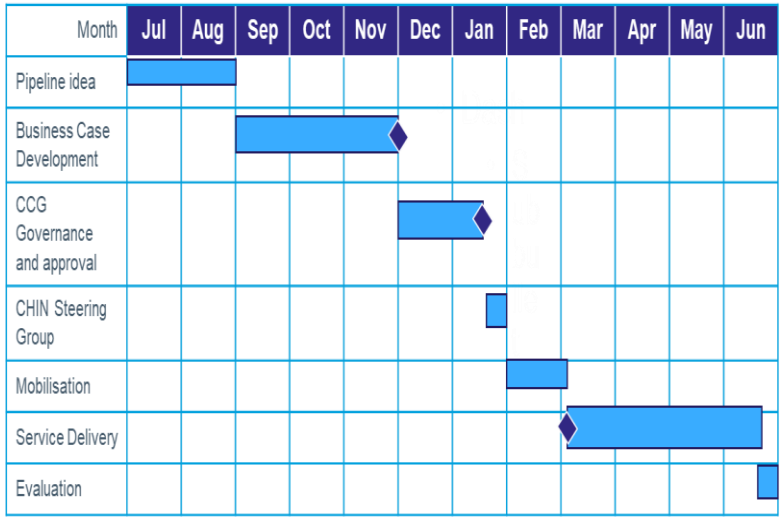
RFHT provide a walk-in ECG service between 9am-4.30pm Monday to Friday, whereby patients provide the referral from the GP.
InHealth provide bookable appointments (initiated by the GP practice) for ECGs and 24 hour blood pressure monitoring
CLCH (for COPD patients) and GP practices will provide Spirometry
CLCH provide pre bookable appointments for Phlebotomy

The diagnostics service that will be provided would enable patients to have their test in a setting where they receive other aspects of their care at the same time. The test result would be recorded in the practices and would be directly imported into EMIS. They would then be interpreted by clinicians within the practice who will have access to the patient records so that the results will be contextualised and reported directly into the notes.

GP Practices and Location of CHIN

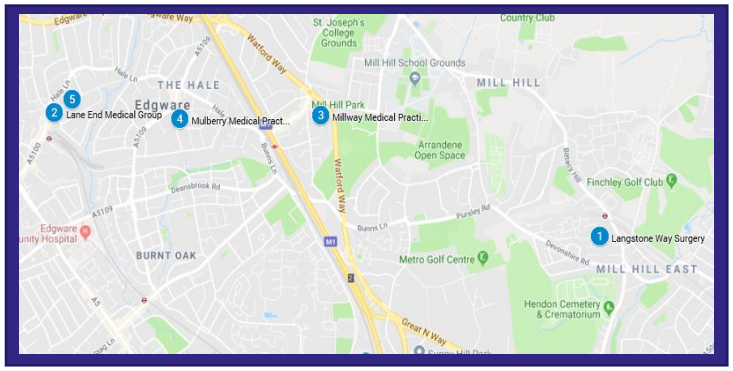


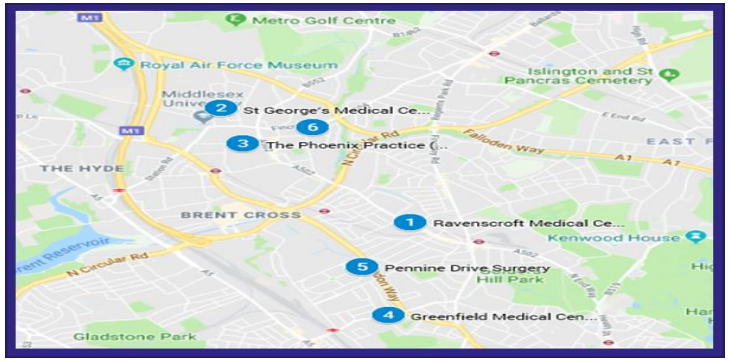
Diagnostics Delivery Timetable

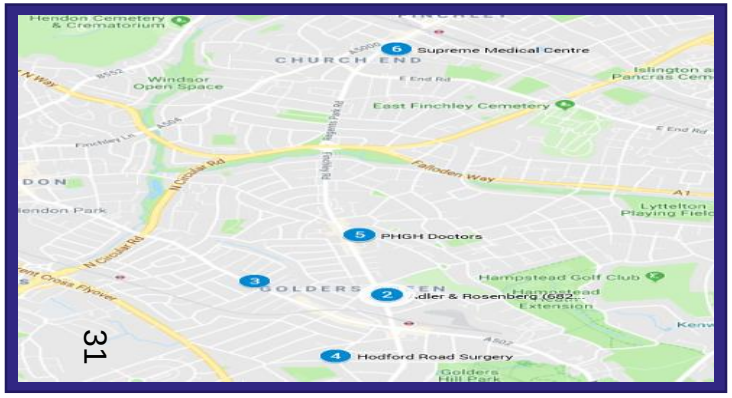


CHIN Deep Dive - Proposed

CHINs Four, Five and Six







CHIN Four

Clinical Lead: Dr Daniela Amasanti-DeBono

Focus: *Digital*

Population: *44,168*

Involving: *5 practices*

Road map: *All system partners by Jun 19*

CHIN Five

Clinical Lead: *TBC*

Focus: *Dementia*

Population: 39,154

Involving: 6 *practices*

Road map: *All system partners by Jun 19*

CHIN Six

Clinical Lead: *TBC*

Focus: *TBC*

Population: 34,134

Involving: 6 *practices*

Road map: *All system partners by Jun 19*

CHIN Four Delivery Timetable

Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
CHIN Formation												
Business Case Development												
CCG Governance and approval												
CHIN Steering Group												
Mobilisation												
Service Delivery												
Evaluation												

CHIN Five Delivery Timetable

Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
CHIN Formation												
Business Case Development												
CCG Governance and approval												
CHIN Steering Group												
Mobilisation												
Service Delivery												
Evaluation												

CHIN Six Delivery Timetable

Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
CHIN Formation												
Business Case Development												
CCG Governance and approval												
CHIN Steering Group												
Mobilisation												
Service Delivery												
Evaluation												

CHINs Next Steps for LBB and CCG

Key Areas of Focus for 2019/20

	Workforce	Primary Care at Scale	CHIN Development	Accelerators / Enablers
Funding Streams	To be determined. Potential national funding or programmes to support this.	£10m top sliced from Extended Access Funding across London Barnet Allocation is £435k	CCG Primary Care Headroom	CCG Primary Care Headroom NHS England central transformation funding Estates and Technology Transformation Funding (ETTF)
Delivery Partners	Primary Care providers Acute and Community Care providers Community Education Provider Network (CEPN)	Barnet Federated GPs Care and Health Integrated Networks (CHINs)	CCG LBB Barnet Federated GPs CHINs CLCH and Royal Free VCSE	CCG LBB Barnet Federated GPs Care and Health Integrated Networks (CHINs) NHS Digital
Overview	New workforce models: MDT workforce with acute and community provider staff working within the Care and Health Integrated Networks (CHINs)	Infrastructure Resources for CHINs Systems and Efficiency QI Capability and Analytical skills 10 High Impact Actions	Pipeline idea generation Develop New Models of Care Operationalising New Models 10 High Impact Actions	Digital Enablers Social Prescribing / Self Care 10 High Impact Actions Transformative Estate
Objectives	Improved Access to Primary Care ED Redirection Direct booking from NHS 111 Paediatric Hot Clinics	Embedded Resources in CHINS QIST function established CHIN Level Functions	Assess QI Findings Engage wider CHIN partners Build into Business Cases Plan, Do, Study, Act (PDSA) and then scale up	Embed digital into all projects (i.e. Apps for prevention, support, etc.) Work-streams mapped to 10 High Impact Actions Implement social prescribing model

Discussion

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