Meeting of the Council of the London Borough of Barnet

TO BE HELD ON

TUESDAY 4TH NOVEMBER, 2014 AT 7.00 PM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

SUMMONS AND A G E N D A

All Councillors are hereby summoned to attend the Council meeting for the transaction of the business set out.

Andrew Nathan
Head of Governance

Agenda and Timetable
Tuesday 4th November, 2014

Item	Subject	Timing	Page Nos
	Part 1 - Statutory formalities/Announcements (15 minutes)		
1.	**Apologies for absence**		
2.	**Elect a Member to preside if the Mayor is absent**		
3.	**Prayer**		
4.	**Declarations of Interest**		
5.	**Minutes of the last meeting**		1 - 46
6.	**Official announcements**		
7.	**Any business remaining from last meeting**		
	Part 2 - Question Time (30 minutes or until 7.45pm whichever is longer)		
8.	**Questions to the Leader (and Committee Chairmen if he/she has delegated)**		To Follow
	Part 3 - Statutory Council Business (60 minutes)		
9.	**Petitions for Debate (20 minutes). A petition organiser (up to 5 minutes) and Members responding (up to 15 minutes)**		
10.	**Reports from the Leader**		
11.	**Reports from Other Committees (if any)**		
11.1	Report from Policy & Resources Committee		47 - 82
11.2	Report from Adults & Safeguarding Committee		83 - 236
11.3	Any Other Referrals from Committees		
12.	**Reports of Officers**	**7.45pm - 9.30pm**	
12.1	Report of the Chief Operating Officer		237 - 246

12.2	Report of the Head of Governance		247 - 254
13.	**Questions to Council Representatives on Outside Bodies**		
	Break (15 minutes)		
	Part 4 – Business for Debate (45 minutes)		
14.	**Motions**		
14.1	Councillor Anne Hutton - Save our Library Service		255 - 256
14.2	Councillor Tom Davey - Protecting residents from domestic violence		257 - 258
15.	**Motions for Adjournment**		

Andrew Nathan, Head of Governance
Building 4, North London Business Park, Oakleigh Road South, N11 1NP

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Minutes

OF THE MEETING OF THE COUNCIL OF THE LONDON BOROUGH OF BARNET
held at Hendon Town Hall, The Burroughs, London NW4 4BQ, on 23 September 2014

AGENDA ITEM 5

PRESENT:-

The Worshipful the Mayor (Councillor Hugh Rayner)
The Deputy Mayor (Councillor David Longstaff)

Councillors:

Maureen Braun
Pauline Coakley Webb
Dean Cohen
Jack Cohen
Melvin Cohen
Philip Cohen
Geof Cooke
Alison Cornelius
Richard Cornelius
Tom Davey
Val Duschinsky
Claire Farrier
Anthony Finn
Brian Gordon
Eva Greenspan
Helena Hart
John Hart
Ross Houston
Anne Hutton
Andreas Ioannidis
Sury Khatri
Adam Langleben
Kitty Lyons
John Marshall
Arjun Mittra
Alison Moore
Ammar Naqvi
Nagus Narenthira
Graham Old
Charlie O-Macauley
Reema Patel
Bridget Perry
Wendy Prentice
Sachin Rajput
Barry Rawlings
Tim Roberts
Gabriel Rozenberg
Lisa Rutter
Shimon Ryde
Brian Salinger
Daniel Seal
Mark Shooter
Agnes Slocombe
Caroline Stock
Daniel Thomas
Reuben Thompstone
Jim Tierney
Laurie Williams
Peter Zinkin
Zakia Zubairi

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

- Councillor Joan Scannell
- Councillor Stephen Sowerby
- Councillor Kathy Levine
- Councillor Gill Sargeant
- Councillor Alan Or-Bach
- Councillor Rebecca Chalice
- Councillor Devra Kay
- Councillor Paul Edwards
- Councillor Kath McGuirk
- Councillor Alan Schneiderman
- Councillor Amy Trevethan

Apologies for lateness were received from:

- Councillor Philip Cohen
- Councillor Ammar Naqvi

- Councillor Andreas Ioannidis
- Councillor Reema Patel
- Councillor Kitty Lyons

2. ELECT A MEMBER TO PRESIDE IF THE MAYOR IS ABSENT

The Mayor was present.

3. PRAYER

The Mayor's Chaplain offered prayer.

4. DECLARATIONS OF INTEREST

It was noted that in circumstances in which dispensations were sought and granted were as set out in Agenda Item 11.3 Report of the Monitoring Officer.

Member:	**Subject:**	**Interest Declared:**
Councillor Dean Cohen	14.1: Administration Motion - Proposed introduction of an Article 4 Direction in relation to HMOs	Disclosable Pecuniary interest as a private landlord of property in the Borough.
	14.3: Opposition Motion - Permitted Development Rights	Non Pecuniary interest as Councillor Dean Cohen knows the landlord of the premises named in the Motion.
Councillor Melvin Cohen	14.1: Administration Motion - Proposed introduction of an Article 4 Direction in relation to HMOs	Disclosable Pecuniary interest as a private landlord of property in the Borough.
	14.3: Opposition Motion - Permitted Development Rights	Non Pecuniary interest as Councillor Melvin Cohen knows the landlord of the premises named in the Motion and who during his Mayoralty made contributions to the Mayoral Charity.
Councillor Claire Farrier	14.3: Opposition Motion - Permitted Development Rights	Non Pecuniary interest as a one of the tenants of Premier House. Due to a conflict of interest Councillor Farrier indicated she would leave the meeting for the consideration of this item.
Councillor Brian Gordon	14.3: Opposition Motion - Permitted Development Rights	Non Pecuniary interest as the firm he was a consultation for has been a tenant of Premier House.

Councillor Helena Hart	14.1: Administration Motion - Proposed introduction of an Article 4 Direction in relation to HMOs	Disclosable Pecuniary interest as a private landlord of property in the Borough.
Councillor Hugh Rayner	14.1: Administration Motion - Proposed introduction of an Article 4 Direction in relation to HMOs	Disclosable Pecuniary interest as a private landlord of property in the Borough.
Councillor Anne Hutton	14.1: Administration Motion - Proposed introduction of an Article 4 Direction in relation to HMOs	Non Pecuniary interest as a private landlord of property outside the Borough.
Councillor Tim Roberts	14.1: Administration Motion - Proposed introduction of an Article 4 Direction in relation to HMOs	Pecuniary interest as joint owner of a privately let property in the borough. Councillor Roberts had not sought dispensation and he indicated he would leave the meeting for the consideration of this item.
Councillor Brian Salinger	14.1: Administration Motion - Proposed introduction of an Article 4 Direction in relation to HMOs	Non Pecuniary interest as a private landlord of property in the borough. Councillor Salinger stated that properties were not affected by this Motion and as such would remain for the consideration of this item.
	14.3: Opposition Motion - Permitted Development Rights	Non Pecuniary interest as a private landlord of property in the borough. Councillor Salinger stated that properties were not affected by this Motion and as such would remain for the consideration of this item.
	Item 13 - Question to the Leader	Non Pecuniary interest as a School Governor at Moss Hall Nursery.
Councillor Mark Shooter	14.1: Administration Motion - Proposed introduction of an Article 4 Direction in relation to HMOs	Non Pecuniary interest as a private landlord of property outside the Borough.

Councillor Peter Zinkin	14.1: Administration Motion - Proposed introduction of an Article 4 Direction in relation to HMOs	Disclosable Pecuniary interest as a private landlord of property in the Borough.
	14.2: Administration Motion - Recognising the community contribution of the Chief Rabbi	Non Pecuniary interest as his wife is a Trustee of the United Synagogue.

5. MINUTES OF THE MEETING HELD ON 15 JULY 2014

RESOLVED – That the minutes of the meeting held on 15 July 2014 be approved as a correct record.

6. OFFICIAL ANNOUNCEMENTS

The Worshipful the Mayor made the following announcements:

With regret, the Worshipful the Mayor announced the passing of Mr. Kevin McKellar who was Head Teacher of Hendon School. The Mayor described Mr. McKellar as an inspirational Head Teacher who took the Hendon School from a failing school to becoming outstanding and was admired by both pupils and parents. The Mayor attended Mr. McKellar's funeral.

The Worshipful the Mayor, further regretfully announced that Mrs. Renee Davis who was Deputy Mayoress from 1993-1994 recently passed away. She was the wife of former Councillor Mr. Frank Liberal Davis a former Mayor of Finchley and Ward Councillor for Garden Suburb for 8 years.

The Chaplain offered a few words of prayer.

The Worshipful the Mayor paid tribute to former Mayor Mr. Don Goodman who passed away on Thursday 7 August. Mr. Goodman was Mayor of Barnet from 1988-89 and Deputy Mayor 1984-85. He was first elected to the Council as Ward Councillor for Brunswick Park in 1982 and served until 1998. During his time at the Council Mr. Goodman was Chairman of the Grants Committee and also served on a number of committees including the Appeals Committee and Public Works Committee.

At the invitation of the Worshipful the Mayor, Councillor Richard Cornelius and Councillor Geof Cooke also spoke in tribute to Mr. Goodman.

A minutes silence was held in remembrance of Mr. Goodman.

On behalf of Council the Worshipful the Mayor congratulated Natalie Evans on her appointment to the Peerage. Ms. Evans attended local school Henrietta Barnet, was a resident of North Finchley and a participant in the exchange programme with Twin Town Montclair in the United States.

The Worshipful the Mayor congratulated Mill Hill Music Club on their Diamond Jubilee and the Mill Hill Bowls club on their 95 year anniversary. He also welcomed the new Spike Milligan Bench at Avenue House.

Finally the Worshipful the Mayor wished Members of the Jewish faith a peaceful and happy New Year.

7. ANY BUSINESS REMAINING FROM LAST MEETING

There was none.

8. VARIATION TO THE ORDER OF BUSINESS

Under 6.2 of the Full Council Procedure Rules the Worshipful the Mayor moved that the order of business be varied so that Part 3, Questions to the Leader, be taken as the next item of business.

9. QUESTIONS TO THE LEADER (AND COMMITTEE CHAIRMEN AS DELEGATED)

The questions, together with the answers provided and the text of any supplementary questions and answers, are set out in Appendix 1 to the minutes.

10. EMERGENCY MOTION - SCOTTISH REFERENDUM

Under Council Procedure Rule 7.1 and 7.2 Councillor Brian Salinger moved the Suspension of Full Council Procedure Rules 2.1 and 23.1 asking Council to agree to take a motion in his name as a matter of urgency. This was duly seconded by Councillor Richard Cornelius. Upon being put to the vote the motion was agreed.

RESOLVED - That Council agree the suspension Full Council Procedure Rules 2.1 and 23.1 to enable allow debate on the Emergency Motion in the name of Councillor Brian Salinger

11. PETITIONS FOR DEBATE (IF ANY)

There were none.

12. REPORTS FROM THE LEADER (IF ANY)

There were none.

13. REPORT FROM CONSTITUTION, ETHICS AND PROBITY COMMITTEE

Councillor John Marshall introduced the report and moved reception and adoption. Councillor Marshall further moved the amendments in his name and accepted the first amendment in the name of Councillor Alison Moore but not the second. Councillor Moore moved her amendments. Debate ensued.

The Worshipful the Mayor advised Council that following legal advice he taken the decision to rule the amendment in the name of Councillor Geof Cooke out of order.

Upon being put the vote the amendments in the name of Councillor Marshall were declared carried.
Upon being put to the vote the first amendment in the name of Councillor Alison Moore was declared carried.
Upon being put to the vote the second amendment in the name of Councillor Alison Moore was declared lost

At least ten members called for a formal division on the voting on the second amendment in the name of Councillor Alison Moore. Upon the vote being taken the results of the Division were declared as follows:

	For	**Against**	**Absent**
Maureen Braun		✓	
Rebecca Challice			✓
Pauline Coakley-Webb	✓		
Dean Cohen		✓	
Jack Cohen	✓		
Melvin Cohen		✓	
Philip Cohen			✓
Geof Cooke	✓		
Alison Cornelius		✓	
Richard Cornelius		✓	
Tom Davey		✓	
Val Duschinsky		✓	
Paul Edwards			✓
Claire Farrier	✓		
Anthony Finn		✓	
Brian Gordon		✓	
Eva Greenspan		✓	
Helena Hart		✓	
John Hart		✓	
Ross Houston	✓		
Anne Hutton	✓		
Andreas Ioannidis			✓
Devra Kay			✓
Sury Khatri		✓	
Adam Langleben	✓		
Kathy Levine			✓
David Longstaff		✓	
Kitty Lyons	✓		
John Marshall		✓	
Kath McGuirk			✓
Arjun Mittra	✓		
Alison Moore	✓		
Ammar Naqvi			✓
Nagus Narenthira	✓		

Charlie O'Macauley	✓		
Graham Old		✓	
Alan Or-Bach			✓
Reema Patel	✓		
Bridget Perry		✓	
Wendy Prentice		✓	
Sachin Rajput		✓	
Barry Rawlings	✓		
Hugh Rayner		✓	
Tim Roberts	✓		
Gabriel Rozenberg		✓	
Lisa Rutter		✓	
Shimon Ryde		✓	
Brian Salinger		✓	
Gill Sargeant			✓
Joan Scannell			✓
Alan Schneiderman			✓
Daniel Seal		✓	
Mark Shooter		✓	
Agnes Slocombe	✓		
Stephen Sowerby			✓
Caroline Stock		✓	
Daniel Thomas		✓	
Ruben Thompstone		✓	
Jim Tierney	✓		
Amy Trevethan			✓
Laurie Williams	✓		
Peter Zinkin		✓	
Zakia Zubairi	✓		

For: 19
Against: 30
Absent: 14
TOTAL: 63

The second amendment in the name of Councillor Alison Moore was declared lost.

RESOLVED - The Council approve the following amendments

1. That in the Terms of reference of General Functions Committee at Appendix H (page 66 of report), the proposed bullet point 'request a ward boundary review by the Electoral Commission' should read 'request a ward boundary review by the Local Government Boundary Commission for England'.

2. That changes to Section 13 of Appendix M, Access to Info Procedure Rules, (pages 137 to 138 of report) be not adopted and the issue be referred back to the next meeting of CEP on 25 November 2014.

3. That under All Committees the Number of members required, add the words '3 where the Membership is less than 9 and' so that the full text reads: **'3 where the Membership is less than 9 and 4 where the Membership is 9 or more'**

RESOLVED - That subject to the amendments set out above the recommendations set out in the report be approved.

1. That Council approve the recommendations contained in the report from the Constitution Ethics and Probity Committee at Annexe A, and the track change versions attached at Appendix A to Appendix R.

2. That the Assurance Director (Monitoring Officer) be authorised to implement these revisions and publish a revised Constitution.

14. REPORT FROM AUDIT COMMITTEE

Councillor Brian Salinger introduced the report and moved reception and adoption. Upon being put to the vote the recommendations as set out in the report were declared carried.

RESOLVED - That Council approve the Annual Report of the Audit Committee 2013-14, as set out in Appendix A of the report.

15. AVENUE HOUSE, EAST END ROAD LONDON N3: DELEGATION OF DECISION MAKING PROCESS AND LANDLORD'S CONSENT FOR ALTERATIONS

The Chief Executive introduced the report. Upon being put to the vote the recommendations as set out in the report were declared carried

RESOLVED -

1. That Council gives its consent as corporate trustee landlord in accordance with the 2001 Scheme and in accordance with the terms of the Lease to the tenant's application for landlord's consent to carry out works of capital improvements to the Property as set out in Appendix A and delegates authority to the Chief Operating Officer to negotiate and execute a licence for alterations in respect of the same.

2. That Council note their responsibilities arising from The Charity Commissioners for England and Wales scheme which governs the charity called The Avenue House Estate (210345) dated 2 October 2001 (appendix B) and that it delegate its decision-making powers under this scheme and its responsibilities liabilities powers and duties under the Lease as corporate trustee landlord to the Policy and Resources Committee.

16. CHANGES TO THE CALENDAR OF MEETINGS

The Chief Executive introduced the item.

RESOLVED - That Council note the changes to the Calendar of Meeting as set out the report and Supplemental Report of the Head of Governance.

17. CHANGE TO COMMITTEE MEMBERSHIP - HEALTH AND WELL-BEING BOARD

The Chief Executive introduced the report;

RESOLVED - That Council note the recommendation of the Health and Well-Being Board to invite the Independent Chairman of the Adults and Children's Safeguarding Boards onto the Board as a non-voting observer with full speaking rights.

18. REPORT OF THE MONITORING OFFICER (IF ANY)

The Chief Executive introduced the item and advised Council as follows:

"Members must observe the provisions of the Localism Act 2011 and under the Code of Conduct, in regard to disclosure of disclosable pecuniary interests (DPIs) and non-pecuniary interests. Section 33 of the Act provides for dispensations to be granted to enable those with a DPI to be able to speak and/or vote in circumstances.

At the meeting of Council on 15 July 2014 it was agreed that the Monitoring Officer be delegated authority to consider and if appropriate grant such dispensations, which would be reported back to the relevant decision-making body.

Applications to stay, speak and vote have been made by the following
Councillors in respect of item 14.1 of this Council meeting.

- Councillor Dean Cohen
- Councillor Melvin Cohen
- Councillor Helena Hart
- Councillor Hugh Rayner
- Councillor Peter Zinkin

All these members are private landlords in the borough and it is in respect of this interest that the applications are made.

The Monitoring Officer has considered each application against the tests set out in the Localism Act and members Code of Conduct and concluded that, given the political balance of the Council, the representation of different political groups on the body transacting the business would be so upset as to alter the outcome of any vote on the matter."

Councillor Alison Moore, seconded by Councillor Geof Cooke formally moved the following Motion;
"In future reports the reasons for dispensations being granted is not dealt with by a blanket paragraph as set out in paragraph 2 of the report but deals with each application individual separately."

Councillor John Marshall, Chairman of the Constitution, Ethics and Probity Committee gave an assurance that should Councillor Moore's Motion be defeated it would be considered by the Constitution, Ethic and Probity Committee at their next meeting.

Upon being put to the vote the Motion in the name of Councillor Alison Moore was declared lost.

RESOLVED - That Council note the action taken by the Deputy Monitoring Officer in granting the dispensations for this meeting as set out in this report.

19. QUESTIONS TO COUNCIL REPRESENTATIVES ON OUTSIDE BODIES (IF ANY)

There were none.

20. MOTIONS

Councillor Richard Cornelius stated that of the two Administration Motions put Item 14.1 would be debated. Upon being put to the vote this was agreed.

RESOLVED - That Council agree to debate the Administration Motion 14.1 - Proposed introduction of an Article 4 Direction in relation to HMOs.

21. COUNCILLOR SHIMON RYDE - PROPOSED INTRODUCTION OF AN ARTICLE 4 DIRECTION IN RELATION TO HMOS

Councillor Tim Roberts left the meeting for consideration of this item as he said he would.

Councillor Shimon Ryde moved the Motion in his name. Councillor Jim Tierney moved his amendment. Debate ensued. Upon being put to the vote the amendment in the name of Councillor Jim Tierney was declared lost.

At least ten members called for a formal division on the voting on the amendment in the name of Councillor Jim Tierney. Upon the vote being taken the results of the Division were declared as follows:

	For	Against	Abstain	Absent
Maureen Braun		✓		
Rebecca Challice				✓
Pauline Coakley-Webb	✓			
Dean Cohen		✓		
Jack Cohen	✓			
Melvin Cohen		✓		
Philip Cohen	✓			
Geof Cooke	✓			
Alison Cornelius		✓		
Richard Cornelius		✓		
Tom Davey		✓		
Val Duschinsky		✓		
Paul Edwards				✓
Claire Farrier	✓			
Anthony Finn		✓		
Brian Gordon		✓		

Eva Greenspan		✓		
Helena Hart		✓		
John Hart		✓		
Ross Houston	✓			
Anne Hutton	✓			
Andreas Ioannidis	✓			
Devra Kay				✓
Sury Khatri		✓		
Adam Langleben	✓			
Kathy Levine				✓
David Longstaff		✓		
Kitty Lyons	✓			
John Marshall		✓		
Kath McGuirk				✓
Arjun Mittra	✓			
Alison Moore	✓			
Ammar Naqvi	✓			
Nagas Narenthira	✓			
Charlie O'Macauley	✓			
Graham Old		✓		
Alan Or-Bach				✓
Reema Patel	✓			
Bridget Perry		✓		
Wendy Prentice		✓		
Sachin Rajput		✓		
Barry Rawlings	✓			
Hugh Rayner		✓		
Tim Roberts				✓
Gabriel Rozenberg		✓		
Lisa Rutter		✓		
Shimon Ryde		✓		
Brian Salinger		✓		
Gill Sargeant				✓
Joan Scannell				✓
Alan Schneiderman				✓
Daniel Seal		✓		
Mark Shooter				✓
Agnes Slocombe	✓			
Stephen Sowerby				✓
Caroline Stock		✓		
Daniel Thomas		✓		
Ruben Thompstone		✓		
Jim Tierney	✓			
Amy Trevethan				✓
Laurie Williams	✓			

Peter Zinkin		✓		
Zakia Zubairi	✓			

For: 21
Against: 29
Absent: 13
TOTAL: 63

The amendment in the name of Councillor Jim Tierney was declared lost.

Upon being put the vote the motion in the name of Councillor Shimon Ryde was declared carried.

RESOLVED - Council notes the proliferation, across the borough, of residential properties being used as houses in multiple occupation (HMOs). Existing dwellinghouses (Planning Use Class C3) can be converted to a HMO (Planning Use Class C4), which provides shared accommodation for three to six unrelated individuals as their only or main residence, without the need for planning permission.

Concerns have been expressed by residents living near HMOs regarding excess noise, parking problems, forests of "To Let" boards, untidy gardens and refuse problems. The Council notes these concerns, as it does the loss of family accommodation through houses being used in this way.

The introduction of an Article 4 Direction removing permitted development rights for change of use from C3 dwellinghouses to C4 HMOs will bring this use under the direct control of the Council and in line with the requirement for planning permission for change of use for larger HMOs of more than six unrelated individuals. Once designated, an Article 4 Direction maybe implemented with an immediate or non-immediate effect.

Council notes that the implementation of an Article 4 Direction with an immediate effect would leave the Council at high risk of compensation claims from applicants for HMOs, who may be able to submit a claim for compensation within 12 months of an Article 4 Direction designation under section 108 of the Town and Planning Act 1990 (as amended). There is, however, no provision for compensation claims in respect of non-immediate Article 4 Directions that come into effect after a minimum 12-month period following designation. It is therefore considered prudent to introduce a non-immediate Article 4 Direction designation which has the added benefit of allowing proper public notification of this planning change.

Council further notes the work being undertaken on HMOs by the Housing Committee and will take account of this when implementing planning controls.

Council instructs officers to establish a robust evidence base outlining the impact of HMOs in order to support the introduction of a borough-wide Article 4 Direction removing permitted development rights for change of use from C3 dwellinghouses to C4 HMOs, which is to come into effect after a minimum 12-month period following designation. Officers are invited to bring forward proposals to mitigate the adverse effects of HMOs, in line with any forthcoming recommendations of the Housing Committee.

22. COUNCILLOR EVA GREENSPAN - RECOGNISING THE COMMUNITY CONTRIBUTION OF THE CHIEF RABBI

In accordance with Council Procedure Rule 23.5 the Motion in the name of Councillor Eva Greenspan was put the vote without discussion. Upon being put to the vote the item was declared carried.

RESOLVED - Council wishes to recognise the eminent services rendered by the Chief Rabbi, Ephraim Mirvis, within the borough, nationally and internationally, to the enhancement of the Jewish community and the promotion of inter-faith understanding and community cohesion.

Council is proud of the long association Ephraim Mirvis has had with the London Borough of Barnet, from his residency and leadership as Rabbi at the Finchley United Synagogue, or Kinloss, continuing today through his work as the Chief Rabbi.

Council notes his substantial contribution to the local community during this time, not least through his founding of the Kinloss Learning Centre and Morasha Jewish Primary School, alongside his work in supporting the inter-faith harmony that is such a strong feature of life in our borough.

Just as with his predecessor as Chief Rabbi, Lord Jonathan Sacks, it is the wish of Council to formally recognise these contributions and record the high esteem in which Ephraim Mirvis is held by the Council and the community.

Council therefore resolves to, at a suitable time, call an Extraordinary meeting of Full Council in order to confer upon the Chief Rabbi of the United Hebrew Congregations of The Commonwealth, Ephraim Mirvis, the Honorary Freedom of the London Borough of Barnet (being the most honourable award it is in the Council's privilege to bestow).

23. COUNCILLOR ADAM LANGLEBEN - PERMITTED DEVELOPMENT RIGHTS

Councillor Claire Farrier left the meeting for the consideration of this item as she said she would.

Councillor Adam Langleben moved the Motion in his name. Debate ensued.
Upon being put to the vote the Motion in the name of Councillor Adam Langleben was declared carried. Votes were as follows:

For: 20
Against: 1
Abstentions: 29
Absent: 13
TOTAL: 63

RESOLVED - Council notes that up to 150 businesses and charities which employ around 700 people based in Premier House in Edgware were given 4 weeks notice to quit the building following the landlord's decision to develop the property for luxury residential accommodation – a decision made without the need to apply for

planning permission as a result of the government's extension of permitted development rights.

Council notes that as a consequence there will be no opportunity to secure any affordable housing, Community Infrastructure Levy and S106 contributions to meet pressure on health, education and other services or apply conditions to mitigate the impact of the development on neighbours.

Council believes that this development could result in a net loss of revenue to the council in business rates even when any future council tax collected from the development is taken into account.

Council believes that the government's policy on permitted development rights damages local businesses and the council's stated objectives to support growth, local business and town centres and to maximise revenue from business rates.

Council therefore calls on the Leader of the Council to make representations to the government in response to their consultation on permitted development rights setting out LB Barnet's opposition to the rights that enable offices to be converted to flats without the need for planning permission; and that these rules should not apply to office blocks that are full or nearly full of businesses and should only apply to those that are empty or nearly empty.

24. EMERGENCY MOTION IN NAME OF COUNCILLOR BRIAN SALINGER - SCOTTISH INDEPENDENCE

Councillor Brian Salinger moved the Emergency Motion in his name. Debate ensued. Upon being put to the vote Motion was declared carried. Votes were recorded as follows:

For: 28
Against: 21
Abstentions: 1
Absent: 13
TOTAL: 63

RESOLVED - Council recognizes that the referendum on the future of Scotland's sovereignty held on 18th September was of great importance to many Barnet residents and the Council welcomes the result of the ballot which clearly confirmed that Scotland would remain a part of the United Kingdom for the foreseeable future.

Council further recognizes that the debate over the future of Scotland has also highlighted the need for further devolved powers to be given to nations of the United Kingdom and calls on Her Majesty's Government to bring forward plans that will ensure that legislation that affects only the interests of the people of England or England and Wales are voted on solely by Members of Parliament elected to represent those parts of the United Kingdom.

25. MOTIONS FOR ADJOURNMENT

There were none.

The meeting finished at 9.55 pm

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Council Questions to the Leader
23 September 2014
Questions and Responses

In accordance with the Council's Constitution, Full Council Procedure Rules 19.1, the Leader may delegate the responsibility for answering to any Chairman of a relevant committee.

Question 1 **Councillor Brian Gordon**

At the meeting in the previous session of the Council's Education Overview and Scrutiny Committee, representatives of Standing Advisory Council for Religious Education (SACRE) were invited to give a report. The committee felt that in view of the important work of SACRE, one of its representatives should be co-opted to the successor committee under the new system. Is it intended to implement this?

Answer by Councillor Reuben Thompstone (Chairman of Children, Education, Libraries and Safeguarding Committee).

The now decommissioned Education Overview and Scrutiny Committee's Membership included the following co-opted Members: three Voluntary Aided schools representatives from the Church of England, Roman Catholic and Jewish faiths, and two Parent Governor representatives. In anticipation of its decommissioning, the Committee requested the inclusion of co-opted Members in the proposed Children, Education, Libraries and Safeguarding Committee. The Committee's view was taken into consideration and the former OSC co-opted Members continue to be invited to attend the successor Committee and are able to speak, but not vote, as agreed by Council on 15 July 2014.

The Education Overview and Scrutiny Committee considered an item at their meeting on 19 March 2014 which provided a summary of SACRE's Forward Work Programme and a report of their activities over the last year. The Committee resolved only to note the report; no recommendations have been recorded in the minutes of the meeting requesting the involvement of a SACRE representative in the successor Committee.

Supplementary Question
Schools will continue to be co-opted to the successor to the Education Scrutiny Committee. Would Councillor Thompstone agree that this is a very important issue, especially as there are so many secular forces at work within our society set on trying to interfere adversely with faith education and undermine religion as a whole?

Supplementary Answer
I agree with the statement entirely.

Question 2 **Councillor Alison Moore**

After handing over £16m upfront of council tax payers' money to Capita for IT and related infrastructure would the Leader confirm if he is happy with Capita's performance managing the council and members' IT so far?

Answer by the Leader
Overall, CSG is performing well. The Council is paying £6m per year less for the provision of these services since go-live and upgrade work has been on-going. Obviously, there have been some difficulties with Members' IT, but when they work the I-Pads are wonderful things.

It is worth noting that the root cause of many IT issues that members have experienced has been the Council's ageing IT infrastructure, which is due to be upgraded by the end of October. Had the

Council not experienced a delay in entering into the CSG contract, these upgrades would have been in place by April.

Supplementary Question
It is clear that the council's IT system is still on its knees a full year after the start of the CSG contract. Does the Leader agree that this is because of the chronic lack of investment during the five years of the process to that outsourcing?

Supplementary Answer
It would be hard to disagree. Clearly an antique relic of the past is unfit for the job that we are asking of it. IT technology changes very quickly and it's very important that in the future we make a much greater effort to keep it up to date.

Question 3 **Councillor Brian Gordon**

Many Edgware residents object to the parking restrictions around the old cinema area of Edgware continuing to operate on Sundays and weekdays until 9pm. Are these restrictions likely to be reviewed in the future?

Answer by the Leader
As it stands there are no plan to review the 'K' CPZ further, although as part of the draft Parking Policy which is current at the consultation stage, the Council are proposing to carry out regular reviews of the CPZs in the borough to ensure that they continue to be fit for purpose, and continue to meet the needs of the community. The consultation on the policy ends this Autumn, and it is expected that the outcomes of the Policy will be known shortly thereafter.

Supplementary Question
The CPZ in Edgware was raised as a case in point; as it has been a thorny issue for some time and many residents do think that the long hours parking restrictions around the old cinema site are well over the top. But whatever CPZ schemes are considered and are reviewed whether it be for the purposes of introducing new ones, modifying those that exist or indeed removing them entirely, can decisions please be made as quickly as possible?

Supplementary Answer
I agree that all decisions should be done as quickly as possible.

Question 4 **Councillor Barry Rawlings**

Why is the administration determined to move its depot to Pinkham Way which is an inappropriate use for the site and vehemently opposed by local residents?

Answer by the Leader
The Council has been committed to relocating its depot operation from Mill Hill for some time. The former sewage works site is designated for employment use and has close proximity to the north Circular. The Council has a fiduciary duty to protect the value of public land on the site. If the site remained a waste land indefinitely, then this would mean a valuable public asset would be rendered worthless at a significant cost to the Barnet taxpayer.

Question 5 **Councillor Brian Gordon**

I have received complaints from residents whose applications for blue disabled badges have been rejected even though they are seriously disabled. It seems the criteria for assessing disability to walk far for the purpose of the permits have become increasingly harsh and uncompromising. Is there anything we as a Council can do about this?

Answer by the Leader
The criteria in which we follow is set out to us by the Department of Transport (DoT) and applies to all Councils. The guidance changed in April this year when the eligibility criteria applied was tightened by the DoT, this has unfortunately meant that some residents who previously qualified for a blue badge had to be reassessed.

The Council lead officer in the commercial team is currently undertaking a review of the Assisted Travel team process and will be checking that the assessment criteria being applied is in line with DWP guidance. This review will also ensure that the appeal process is working effectively for customers who feel the decision has been incorrectly applied.

Supplementary Question
With regard to the blue badges, whilst the law is the law and we have to work within the confines of that law it is not the question that there are quite a lot of people who really are disabled and ought to be getting blue badges but are not getting them. Can the officers of the council who deal with these issues act as leniently as possible where appropriate, within the law, in issuing the blue permits to people who really do need them and are disabled? And also perhaps in some way the council can take a view on this and if it feels this way, either individually or collectively, make representations to the government to look again at the law and ease up a little bit to make it fairer and more just to people who ought to blue badges.

Supplementary Answer
I agree that those who need blue badges must get them and should get them quickly and efficiently but there is and has been widespread corruption with regard to these and it does need to be put right. It is upsetting that some innocents would have been caught in this envelope and I'm sure that officers will look to make sure that only those who are entitled to them get them but that they do get them quickly.

Question 6 **Councillor Nagus Narenthira**

Will the Leader make a commitment to adopt the roads in the Pulse development so that a decent scheme of parking could be enforced by the council where the residents could benefit without having to pay a huge amount of money to secure a parking space.

Answer by the Leader
Only the main spine road through the Pulse development will be adopted. The planning application for the development included a Transport Assessment and a proposed package of mitigation measures, including a Car Parking Management Plan, and was approved on the basis of including a robust package of car parking management measures and controls associated with the development. These are already effectively managed by the council through the Section 106 and Planning Conditions imposed on the developer. The parking provision for the Pulse development is consistent with the policies set out in the Colindale Area Action Plan and the Barnet Local Plan and is considered appropriate given the sustainable location of the site close to Colindale tube station. Charging by the developer for parking spaces at Pulse is a matter for commercial negotiation and agreement between individual occupiers and the developer.

Supplementary Question
Does the Leader realise that the residents of the Pulse development are prisoners in their own homes because of the lack of suitable parking and isn't the council failing in its duty of care in this matter?

Supplementary Answer
The parking was part of the planning application and was agreed with the developer.

Question 7 **Councillor Mark Shooter**

Would the Leader please update Council on the work of the Corporate Anti-Fraud Team (CAFT) over the 2013/14 financial year?

Answer by the Leader
CAFT, the Council's fraud investigation squad, successfully detected frauds amounting to £11.9m during 2013/14. Over the same period, the council recovered 63 illegally sublet council properties via their successful investigations and a key amnesty. The team plays a critical role in detecting and prosecuting the instigators of fraud, returning properties to the housing stock for allocation to those most in need and recovering the taxpayer's money to support council services.

Supplementary Question
Can the join me in congratulating the Corporate Anti Fraud Team on their good work and ensure the team is supported to continue recovering money for the taxpayer.

Supplementary Answer
I agree. Clamping down on fraud is a way of saving money for the taxpayer and is the right thing to do.

Question 8 **Councillor Arjun Mittra**

How does the Council aim to support car clubs? There is a clear desire to expand services to Barnet, but no overall strategy from the council.

Answer by the Leader
In 2007 Council resolved to ask the Cabinet to support the provision of Car-Clubs in new developments and self-funded car club operations in off-street locations. Since then provision of car clubs has been encouraged through the planning application process generally and support to car clubs is identified as a potential means of meeting requirements in the Development Management Policies Development Plan Document and Planning Obligations Supplementary Planning Document.

Question 9 **Councillor Mark Shooter**

What has been the outcome of the work conducted so far by the multi-agency Benefit Cap Task Force – in particular, how successful has it been at getting people into work?

Answer by the Leader

- A multi-agency Benefit Cap Task Force, bringing together officers from across the Council, Barnet Homes, Job Centre Plus, was set up in July 2013. The team have made contact with 92% of all households affected by the Benefit Cap and offered them support to take steps to move into work.
- The team started working early with the 1,178 people who were at risk of becoming capped, before the reforms were introduced. By the time the cap came into force, only 682 of these people were affected.
- Barnet has been successful and 42% of capped households are no longer capped.
- The team have worked with 510 people who have since started working (1/3 of the caseload).

Supplementary Question
Does the Leader agree that this sort of approach that focuses on getting people into work is far more effective both for the residents involved and in terms of the public purse, than using council finances to undermine the government's welfare reforms as is being seen in some Labour authorities?

Supplementary Answer
Yes

Question 10 **Councillor Phil Cohen**

Residents of Victoria Road, New Barnet, are still waiting to hear when the council will begin its promised feasibility study into enforcing a 20 mph speed limit on the road and introduce other road safety measures, given the dangers to schoolchildren and users of the local community centre. Could they have a date please and an assurance they will be fully consulted?

Answer by the Leader
Feasibility study is in progress, a recommendations report is anticipated after which officers will proceed with the consultation.

Question 11 **Councillor Brian Salinger**

Is the Council still committed to supporting high quality nursery education in Barnet?

Councillor Reuben Thompstone
Yes. The Children's Service is working closely with Nursery headteachers to develop proposals for a sustainable nursery school model. These proposals are due to be taken to the CELS committee in October.

Supplementary Question
The Education Scrutiny Committee had it's meeting in January and unanimously agreed the recommendations of the Task and Finish Group that looked at Early Years and that he and the rest of the Cabinet at the meeting in February 2014 also unanimously endorsed the views of that group. This included a recommendation that the council should develop a sustainable funding solution for the nursery schools and that the Schools Forum should be informed of the view of the Task and Finish Group, thus these endorsements made this council policy. Can he explain how the nursery schools are still facing major upheavals which would see them lose large numbers of experienced teaching staff and why seven months on the Schools forum have still not been made aware of the decision of the cabinet?

Supplementary Answer
I met with each of the head teachers whilst visiting the nursery schools earlier in the year and there was a lot of work being undertaken by those head teachers in consultation with council officers to ensure that there is a sustainable model going forward.

Question 12 **Councillor Alison Moore**

Why does the Leader believe that it is necessary to exclude members of the public who pay council tax from meetings about the budget?

Answer by the Leader
I presume that Cllr Moore is referring to the working groups established by a number of the theme

committees, some of which are being held in public and others in private. It has been for each committee to decide its own arrangements and I know for a fact that a number of her members have been directly engaged in such private meetings. These groups provide members from both parties with the opportunity to ask silly questions and consider a whole range of ideas that may help them to better understand the challenges the committees face and their possible solutions. Cllr Moore and residents can be assured that all decisions related to the budget will be taken publicly in committee meetings. I see no harm in some of the preparatory work being held in private if that enables better outcomes and, in fact, a more bi-partisan approach. I do, however, take it from her question that Cllr Moore will be inviting a public gallery to all her meetings with officers, where budgetary matters are to be discussed, and that Labour Group meetings will henceforth be a spectacle open to all who wish to attend.

Question 13 **Councillor Brian Salinger**

How much money is the Council currently holding by way of bonds to cover possible damage to pavements and highways relating to properties or sites where building works are being done? Can the Leader (or the appropriate committee chairman) provide me with a list of the properties in Oakleigh Ward where we are holding such bonds?

Answer by Councillor Dean Cohen (Chairman of Environment Committee)
Currently we are holding approximately £680,000 as bond to cover possible damage etc. to highways, including £13,000 from Oakleigh Ward.

The single property which we are holding Bonds against is in 4 Oakleigh Park South.

Supplementary Question
Can I express concern that only one property in Oakleigh Ward has paid a bond. The council is fully aware that major works that are affecting the state of the pavements outside a number of properties in the ward. What criteria is used to determine which property owners or developers are required to pay these bonds?

Supplementary Answer
I share Councillor Salinger's concern. This is an issue which is being worked on now to ensure we have an effective operation to secure bonds just before work commences.

Question 14 **Councillor Barry Rawlings**
Given the Council's reputation is in tatters after the Group Leaders Panel, what plans does the Leader have to restore its integrity?
Answer by the Leader
The only thing in tatters after the Leader's Panel was the complainant's case. After examining the evidence submitted by the Labour London Assembly Member, and Prospective Parliamentary Candidate for Hendon, the Mayor was completely exonerated by the panel, with Cllrs Moore and Rawlings voting to acquit on a number of the charges.

Supplementary Question
The reputation of the council and the residents' belief in their council has been damaged by this process so, again, what plan if any does the Leader have to restore the integrity of the council?

Supplementary Answer
I agree that this issue needs to be looked at with regards to some of the complaints that have come forward and all needs to be considered calmly.

Question 15 **Councillor Brian Salinger**

What has been the impact on the collection of green waste by the change to fortnightly collections?

Answer by the Leader

The green waste service changed from a weekly service to a fortnightly service in October 2013.

	April - August 2011/12	April - August 2012/13	April- August 2013/14	April – August 2014/15 (provisional)
Green waste (tonnes)	10330.50	10453.08	10248.51	*8755.22*

The table above shows the tonnages of green waste for the last four years during the growing season. Tonnage for 2014/15 is lower than the previous three years, with 2014/15 tonnages to date having dropped by 1,500 tonnes compared to the average tonnage for the three previous years.

The green waste tonnages delivered to the Civic Amenity & Recycling Centre, Summers Lane have also been analysed. For the months of April to August 2014 the tonnages of garden waste delivered to the centre have increased by 19.2% compared to the same period the previous year. However this equates to only 182 tonnes which does not represent a significant shift in tonnage.

This year's season has not yet completed and therefore further analysis will be required once full data has been received and collated to further assess the impact of this change in service.

Supplementary Question

Given the reduction in green waste collected, does the Leader still think that the changes have delivered any benefit to the council and its residents and would he speculate as to where all the extra green waste might have gone?

Supplementary Answer

The green waste collected at Summers Lane is up 20% and I'm sure most of the boroughs are keen composters.

Question 16 **Councillor Geof Cooke**

Prior to the outsource to Capita did any member of the then Cabinet authorise or become aware of a reduction of 25% in the number of telephone lines by which the public could communicate with the Council?

Answer by the Leader

This was an operational decision that was taken by the service prior to the point at which the CSG contract went live. This was not a decision that was authorised by a Cabinet member.

Supplementary Question
The reduction in the number of telephone lines that were available to the public to contact the council was severe in 25% and significant change and reduction in the service available to residents of the borough. It was obviously ill-judged because when Capita came in they were forced to reverse it. Enquiries have been made and I was advised that there is no record of this decision being taken. Possibly an officer who has since left made the decision. The Leader has not addressed the question regarding whether anybody knew about this before Capita took over. Is this any way to run a council?

Supplementary Answer
Clearly when a mistake is made it is to be regretted. I added that it was not a completely unreasonable decision. If the calls are being handled at a call centre other than in Barnet, it is fairly logical to imagine that you would need fewer phone lines. The fact that because of our archaic equipment and the inefficiencies and bureaucracy of the telephone network that wasn't possible is quite another matter.

Question 17 **Councillor Brian Salinger**

The Leader will, I am sure, have seen the report about the problems of sexual exploitation of young people in Rotherham. Can he or the appropriate Committee chairman or chairmen) please advise the Council of his assessment of risks to young people in Barnet and is he satisfied that everything that could be done has been done to ensure that our own officers and other agencies are acting properly in dealing with issues of this nature if and when they are reported in Barnet.

Answer by the Leader
Barnet is committed to safeguarding and protecting children from child sexual exploitation (CSE). A range of recent reports, wide national media coverage and recent convictions in Oxfordshire, Derby and Rochdale highlight that this form of child abuse is often hidden from sight and preys on the most vulnerable in our society. Children and young people exploited are subject to significant long term risks to their physical, emotional and psychological wellbeing and Barnet is committed to work to prevent, detect and safeguard those children and young people affected.

In recognition of the local and national agenda, combatting child sexual exploitation is one of four top priorities of the Barnet Safeguarding Children's Board and Family Services and work is on-going in this area of complex work.

Through our multi-agency partnerships we have secured a better understanding of the prevalence of child sexual exploitation in Barnet, taking a proactive, co-ordinated child-centred approach to prevent, identify, protect and support children and young people being sexual exploited. Since January 2014 we have convened a monthly Multi-Agency Sexual Exploitation Meeting (MASE) with partners where cases are discussed and a plan to prevent and safeguard these young people is agreed and actioned. We also have commissioned training for staff across all agencies to raise awareness and further safeguard these vulnerable young people.

To move this vital work further on we have now appointed a CSE Co-ordinator who will drive the strategy and action plan forward, co-ordinate the working arrangements with partners, ensure support and services are in place to effectively safeguarding these young people and track impact and outcomes of those young people affected by or at risk of CSE.

Supplementary Question
The Leader states that controlling child sexual exploitation is one of the four top priorities for the Barnet Safeguarding Children's Board. What are the other three top priorities?

Supplementary Answer
Neglect, domestic violence and e-safety.

Question 18 **Councillor Arjun Mittra**

How much are you allowed to get away with if you are a Tory Councillor before proper sanction is applied?

Answer by the Leader

Nothing

Supplementary Question

Can I take it form the Leader's answer that Tory Councillors shouldn't be allowed to get away with anything but there is no sanction if they do?

Supplementary Answer

Councillor Mittra is fully aware of the verdicts that were passed down by the Leader's Panel. He's also fully aware that the only sanction that is available is that of censure. The whole process has been brought into disrepute.

Question 19 **Councillor Brian Salinger**

Given the continuing problems on the North Circular Road heading East out of the Borough in to Enfield and Haringey, and the knock on impact that the problem has on other roads in the area, can the Leader or appropriate committee chairman tell the Council exactly what representations have been made to Transport for London and the Mayor of London to find a long term solution to the problem.

Answer by the Leader

Recent concerns specifically on this matter have been expressed to TfL at an officer level as part of the Mayoral/TfL Roads Task Force initiative, which identified the North Circular Road (NCR) as a case study for further investigation. Unfortunately TfL disposed of the land needed to deliver the inherited road improvement schemes along the NCR in Enfield and this was ratified by LB Enfield in their NCR Area Action Plan (AAP), which is currently being adopted. Barnet objected to the NCR AAP in May 2013, but the Inspector found in favour of LB Enfield. Now that the TfL Bounds Green scheme has been implemented officers continue to press TfL for a new long term strategic approach to addressing congestion along this part of the A406, particularly in light of emerging development pressures and proposals such as the extension of Crossrail2 to New Southgate.

I have also continued to lobby the Deputy Mayor for Transport frequently.

Supplementary Question

Shall I take it from the reply given suggests that there is no likelihood of anything being done that will alleviate the misery of users of that particular stretch of the North Circular Road? Nor the misery of those living on roads that have become subject of rat-running traffic trying to avoid the daily lengthy delays on that stretch of road.

Supplementary Answer

Lack of funding would suggest that is the case and that is to be regretted but I continue to mention it to the Deputy Mayor for Transport.

Question 20 **Councillor Pauline Coakley Webb**

Months after the consultation for a 20mph limit on the roads to the west of Colney Hatch Lane there is still no action. When will it be introduced along with a new zebra crossing on Colney Hatch Lane itself?

Answer by Councillor Dean Cohen (Chairman of Environment Committee)
The 20mph Speed Limit on roads west of Colney Hatch Lane has entered the construction phase. Barnet contractor is currently mobilising to get this implemented subject to road works permits. As soon as a start date is confirmed it would be made available.

The feasibility study for pedestrian crossings on Colney Hatch Lane is being undertaken separately and the officer recommendations are anticipated at the October Area Committee meeting.

Supplementary Question
The 20mph speed limit that was requested was not the only thing that residents were bothered about. It was reported in the local paper, when the parents took a fake zebra crossing to show where it was needed, in what seems to be a perfectly obviously place: right by South Friern Library. When enquiries have been made, nothing has been found to suggest that this matter is being progressed. Is this going to be something that we can tell the residents is feasible and is going to be pursued or shall we tell them that it is off the scale and not going to be looked at all?

Supplementary Answer
Can I ask that the Member write to me on that point and I'll ask officers to advise.

Question 21 **Councillor Brian Salinger**

I am sure that the Leader (and the chairman of the Planning Committee) are aware that part of the approved plans for the Well Grove site in N.20 is a requirement for the developers to provide a community building. What will be the process for determining the use to be made for that new building and does he have any personal preference for its use?

Answer by the Leader
In relation to the community building, Condition 34 restricts the use to a multi-use community hub.

The local planning authority is currently in discussions with the new owners of the site to progress the detailed matters following the outline approval and will be working with corporate colleagues to explore uses for the community element of the development, but I am conscious that the use meets local requirements e.g. for nursery provision. Input from the ward councillors will be vital.

Question 22 **Councillor Alison Moore**

Would the Leader support the many businesses and charities in Barnet that stand to lose their premises at Premier House by opposing the Government's extension of permitted development?

Answer by the Leader
The Council had raised strong concerns in relation to the to the relaxation of the permitted development regulations prior to being implemented last year and it will be raising further concerns in response to a current Government consultation exercise seeking to relax the legislation further based on cases such as Premier House.

Supplementary Question
Will the extension of permitted development right be opposed or not?

Supplementary Answer
I have already opposed it

Question 23 **Councillor Wendy Prentice**

We are nearly one year on from the launch of the re-vamped bin service. Can the Leader confirm that

residents are mostly satisfied with this service?

Answer by the Leader

The most recent Resident Satisfaction Survey was carried out in Spring 2014. The refuse collection service received a satisfaction rating of 75% Good/Excellent, and the doorstep recycling service received a satisfaction rating of 76% Good/Excellent (an increase of 7% since before transformation). These two services are now the top two performing services in terms of satisfaction levels within the Council's services.

Question 24 **Councillor Zakia Zubairi**

Residents and Colindale councillors have been campaigning for a crossing on Colindeep Lane for years now, and it was agreed some time ago but has been delayed by utility works in the area and the danger that the TfL contractor stops working for TfL on 30 September. Officers undertook to try and resolve the contractor issue so the crossing could be completed quicker – would the Leader reassure me that this crossing will happen eventually, that ward councillors will be kept up to date with progress and informed as soon as an implementation date is agreed?

Answer by the Leader

This will happen. Ward councillors will be informed when all the permits and contractors are in place.

Supplementary Question

For the last two and a half years councillors have asked for a pelican crossing on Colindeep Lane and every time a date is given nothing happens. The Leader replied 'this will happen Ward councillors will be informed when all the permits and contractors are in place. Again, is this the way to run the council?

Supplementary Answer

Councillor Zubairi is aware that after the last Labour Government there is a great legacy of incompetent bureaucracy that has to be waded through.

Question 25 **Councillor Wendy Prentice**

I understand that the council reviews its performance against other local authorities using the LGA benchmarking tool. What percentage of relevant services see Barnet exceed the benchmark?

Answer by the Leader

The Council uses benchmarking tools, such as the Local Government Association's LG Inform tool, to monitor overall performance and identify areas where we can improve service.

As reported in the Quarter 1 2014/15 Monitoring Report, LB Barnet exceeds the benchmark (median performance) when compared with similar authorities, across 94% of the relevant service areas.

Supplementary Question

Does the Leader agree that this information shows that services can be delivered that are both high performing and low cost?

Supplementary Answer

Yes.

Question 26 **Councillor Arjun Mittra**

Will the Leader of the Council support a review of the make-up of the Leader's Panel to ensure it is not politically weighted and independent members are listened to as part of the investigation and hearing process?

Answer by the Leader

It is important that this is reviewed.

Supplementary Question
Does the Leader think that the panel should be entitled to read all papers containing legal advice?

Supplementary Answer
I would find that hard to object to.

Question 27 **Councillor Wendy Prentice**

What has been the trend across the borough in terms of the number of robberies and residential burglaries over the last year?

Answer by the Leader
During the last year there have been significant reductions in both Residential Burglary and Robbery in Barnet:

- Residential burglary reduced by 16% (In total there were 2684 Residential burglaries, 523 fewer than the previous year)
- Robbery reduced by 35% (in total there were 624 robberies, 339 fewer offences than the previous year)

The above data is based on the 12 months: Aug 2013 to July 2014.

Question 28 **Councillor Alison Moore**

Why does the Leader think that just restating the current discredited parking policy in a document will make residents more satisfied with parking in Barnet?

Answer by the Leader
Local authority parking enforcement is defined in detail in legal requirements and statutory guidance and therefore the new policy reflects that statutory framework.

Supplementary Question
Isn't time that the council supported town centres by rolling out free 30 mins parking in all those town centres as has been done in other boroughs like Redbridge to great public acclaim and it is working well there?

Supplementary Answer
Councillor Moore is perfectly aware of the process that is continuing at the moment and a solution will have to be found to the question of parking. I am sure Labour members will join Conservative colleagues in finding a just and equitable, affordable solution.

Question 29 **Councillor Maureen Braun**

Can the Leader or Chairman of the Housing Committee explain how the changes to the Housing Allocations Policy, currently being consulted on, will impact local people in housing need?

Answer by Councillor Tom Davey
There is a high demand for housing in Barnet. The changes that are being consulted on at the moment will help to ensure that priority for limited housing is given to local people in housing need who are long-standing residents of the borough. This will include households living in long-term

temporary accommodation on the regeneration estates.

Question 30 **Councillor Barry Rawlings**

Will the Leader and his group support us in lobbying for more money to implement the Care Act, including asking for the support of MPs and PPCs?

Answer by Councillor Sachin Rajput (Chairman of Adults and Safeguarding Committee)
At the July meeting of the Adults and Safeguarding Committee, the committee resolved that the council should, following on from an analysis of the financial implications of the Care Act, undertake lobbying to ensure that the council receive under the 'New Burdens' principle, sufficient funding to discharge the new statutory responsibilities of the Care Act which comes into force from the 1st of April 2015. We have received an indicative new burdens allocation of £1.7 million for 2015/16 with funding allocations for the implications of the cap on care which comes into force on 1st April 2016 still to be announced.

The levels of additional demand that will come forward to the council as a result of the Care Act are difficult to predict. In 2015/16 alone, the council could face financial pressures of £2.9 million whilst in later years our modelling indicates that the pressure could rise to £14 million per year, peaking at £20 million by 2020.

The Council submitted a response to the national Department of Health (DH) consultation on the Care Act regulations in August, where the principle point made was our concern about the costs to Barnet of carrying out the new and additional duties created by the Act. We will also be responding to the current DH consultation on the funding formula for implementation of parts of the Care Act, making the case for the best option for Barnet. Through London Councils' representations are being made to ensure that the specific needs of London are addressed in the funding formula.

The Adults and Safeguarding Committee through its cross party membership is well placed to undertake lobbying on behalf of the Council to ensure adequate funding. We were successful in making our case in respect of Public Health funding levels for Barnet and we need to ensure that we are effective in respect of the Care Act.

Question 31 **Councillor Val Duschinsky**

Can the Leader explain why the council is looking into building a new office building to house itself in Colindale?

Answer by Councillor Daniel Thomas (Chairman of Assets Regeneration and Growth Committee)
The Council is always looking for ways to improve efficiency and reduce cost. The proposed move to Colindale will enable the Council to make further savings on accommodation costs by vacating the current offices at Barnet House and North London Business Park. In addition to savings of circa £3m per annum on accommodation guaranteed in the CSG contract, a further saving is being targeted of £2m per annum as recently proposed by the Assets, Regeneration and Growth Committee, and this move will contribute to that. The proposed move will also support the wider regeneration in this area.

Question 32 **Councillor Reema Patel**

Will the Leader withdraw the proposal that victims of domestic violence get punished under changes

in housing allocations by being forced to declare themselves homeless and maybe moved into temporary accommodation out of the borough? Would he agree that a better proposal would be instead to have the perpetrator lose the tenancy for anti-social behaviour?

Answer by the Leader
The proposed change to the Allocations Scheme to remove the Band 1 status for this group was prompted by concerns that the existing policy is encouraging residents to stay in unsafe accommodation where their lives are put at risk. By being placed in Band 1, applicants are given the impression that they will be rehoused immediately but this is not necessarily the case. It is therefore safer to move them into emergency accommodation immediately so that they are no longer at risk. As a responsible organisation, the council does not want to encourage residents to put themselves at risk and this is why the change has been suggested. The residents are able to claim housing benefit on the existing home and the temporary home for up to 52 weeks while a more permanent solution is found. The process of evicting perpetrators of ASB is not straight forward and will depend on their legal status in the property which includes tenancy and matrimonial rights of occupation. Courts are unlikely to end someone's rights of occupation unless there is strong evidence of the ASB which can be difficult to prove.

Question 33 **Councillor Val Duschinsky**

How does Barnet compare with other areas for cancer survival rates?

Answer by Councillor Helena Hart (Chairman of Health and Well-Being Board)
One year survival for all cancers in people diagnosed aged 15-99 is 69.1% for Barnet compared to 67.7% for England. One year cancer survival rates are a good indicator of whether cancer is being diagnosed early and whether access to optimal treatment is available.

Latest data from the National Cancer Intelligence Network Q4 2013-14 for specific cancers:

1year relative survival
Breast cancer is 96.3% - national average is 96.5%
Lower GI cancer is 79.6% - national average 76.4%
Lung cancer is 35.9% - national average is 32.8%

5 year survival
Breast is 88.6% - national average is 85.3%
Lower GI is 55.9% - national average is 53.8%
Lung is 10.7% - national average is 8.7%

Supplementary Question
Whilst the survival rates are better than average, is there anything that can be done to improve them yet further?
Supplementary Answer
Whilst we do well in 1-5 year cancer survival rates there is always more that we and the NHS can and must do to improve these rates. Firstly, we have to try to stop the 40% of cancers caused by poor lifestyle choices and, secondly, we need to continue to press NHS England to improve and extend the less than stellar cancer screening services. The borough has just set up the second 'get to know cancer' pop up shop at the B oardwalk Centre, Edgware. Hoped to be every bit as successful as the one ran at the Spires in Barnet in June which had contact with over 1000 residents wanting to know more about how cancer can be prevented. Secondly, the Health and Wellbeing Board has asked the Overview and Scrutiny Committee to follow up with NHS England in screening coverage.

Question 34 **Councillor Alison Moore**

Does the Leader recognise that the constitution of the Group Leaders Panel with a Conservative majority rather than exempting it from political balance as had been the case previously, removes its integrity and credibility in the eyes of the residents of Barnet. Will the Leader agree to change the balance of the Group Leader's Panel so that it is not politically weighted and so that all parties are represented on it?

Answer by the Leader
The election result threw up all sorts of anomalies. These will have to be worked through.

Supplementary Question
Is the Leader going to support a review of the flawed Standards Committee process or not?

Supplementary Answer
I will support a review but I will not necessarily support all of Councillor Moore's observations and recommendations.

Question 35 **Councillor Anthony Finn**

How is the new Housing Allocations Policy set to complement the government's welfare reforms and the council's work encouraging people to get into employment or training?

Answer by the Leader
People in housing need who are working or training may gain additional priority for housing through the community contribution element of housing allocations scheme. This scheme has operated since April 2011 and in practice most applicants who are rehoused are now making a community contribution, for example they are working, volunteering or undertaking training.

It is proposed now that applicants should work, train or volunteer for at least 16 hours per week in order to gain the additional priority for housing. This aligns with the government's welfare reforms as this is the amount of hours a single parent needs to work to be exempted from the overall benefit cap (couples and single people need to work more).

Supplementary Question
How important is it to develop a coherent policy across service areas to deal with the consistent message on welfare reform?

Supplementary Answer
It is absolutely essential that everybody is 'on message' with reforming the welfare system in this country, the reform of which has been delayed for decades and is now finally being addressed.

Question 36 **Councillor Nagus Narenthira**

Can the Leader assure me that Barnet Council will not recommend that any planning application for new development is approved unless the following are satisfied?

- Sufficient parking is provided. Not just 0.7 spaces per dwelling.

- TA thorough traffic assessment is made in the area.

- At least 40% affordable dwellings are agreed.

- Sufficient transport links and road networks are planned.

Answer by the Leader
No. All applications are dealt with on their individual merits having regard to national, regional and local planning policy and other material considerations including public and statutory representations.

Supplementary Question
Does the Leader not think that the criteria mentioned is an absolute necessity for reasonable living especially for Colindale residents because of the over development that's taking place?

Supplementary Answer
Councillor Narenthira is well aware of the planning requirements in this borough and we aim to achieve many of these objectives. It is very important that we do get on and create the housing that is needed for the people of this borough and this country. Anything that delays that is to be regretted as well. We have a housing crisis and we need to build housing.

Question 37 **Councillor Anthony Finn**

Should the council decide to increase the proportion of people's council tax liability they are expected to pay under the Council Tax Support Scheme (CTS), how will this compare to our neighbouring Labour-run authorities?

Answer by the Leader
Barnet is consulting on three options for its Council Tax Support Scheme from 2015/16 onwards. These are: A minimum contribution of 8.5% (the current rate); minimum contribution of 15%; or minimum contribution of 20%. These options are in line with the 2014/15 rates of most of neighbouring authorities but lower than LB Harrow (currently consulting on an increase to 25%).

Borough	Contribution rate for 2014/15
Harrow	22.5%
Brent	20.0%
Haringey	19.8%
Enfield	19.5%

Supplementary Question
Do these figures not show that so far we have been far more generous than our neighbouring Labour boroughs?

Supplementary Answer
Yes.

Question 38 **Councillor Reema Patel**

The administration recently announced that the impact of moving the depot to Pinkham Way would be 'minimal'. Ward councillors and residents were not spoken to or consulted about the impact of the proposals before this announcement was made. What evidence does the administration have to substantiate these claims?

Answer by the Leader.
The Council has identified Pinkham Way as the site for its depot following the move from Mill Hill for a number of years. The depot will be located on a site that is designated for employment use. The site provides direct links onto the A406 so council vehicles would not pass local homes, unless they were collecting the household waste of those homes. Vehicles will use the A406 at non-peak times. A detailed report on the depot relocation is scheduled for the Assets, Regeneration and Growth Committee meeting in December. Any planning application would be consulted upon and officers will be happy to brief ward members ahead of any application or indeed the December meeting of the ARG Committee.

Question 39 **Councillor Caroline Stock**

Based upon provisional results, would the Leader indicate the percentage of GCSE pupils in Barnet who achieved 5 A*-C grades and how this compares to the national average?

Answer by Councillor Reuben Thompstone (Chairman of Children, Education, Libraries and Safeguarding Committee)
Indicative provisional GCSE results collated from 95% (20/21) of Barnet schools indicate 70.9% of Barnet pupils attained 5 A*-C grades including English and Maths, which is expected to be above the national average (60% in 2013). Provisional results indicate that 82.4% of Barnet pupils attained 5 A*-C grades, above the national average which is currently reported as 68.8%. These results are subject to change through validation and confirmation through the DfE.

Supplementary Question
Would the Chairman join me in welcoming these results and the fact that more of the borough's young people are choosing to study at both GCSE and A Level, the strong academic discipline so vital to future job prospects?

Supplementary Answer
I certainly would.

Question 40 **Councillor Anne Hutton**

It has been reported in the press that Barnet had a shortfall of £70m to fund the extra school places. From which budget has that come from and has the council asked the government to refund the shortfall?

Answer by Councillor Reuben Thompstone (**Chairman of Children, Education, Libraries and Safeguarding Committee)**
New school places are provided as part of the council's overall capital programme which is funded through a mix of government grant, council borrowing, asset disposals and contributions from housing developers. Barnet, along with other London boroughs, has been lobbying since 2009 to ensure that London gets its fair share of government grant funding available for school places and in the last settlement, the higher costs facing London boroughs were recognised.

Ultimately it is all taxpayer's money and what is important is that we are able to provide the required places – a challenge this council has so far met.

Question 41 **Councillor Caroline Stock**

Would the Leader like to comment on the council's work with Capita, one year on from the CSG and Re ventures going live?

Answer by the Leader
CSG

The Key success have been:

- An increase in customer satisfaction from 52% to 77%
- An increase in First Contact Resolution from 50% to 58%
- Savings of £1.2m procurement savings to date against a target of £1m
- All CSG contracted income and savings guarantees met or exceeded
- ICT are now resolving 88% of incidents first time (80% when transferred)
- 89% of Council Tax Support scheme collected against a 70% forecast
- Barnet is the best performer for processing New Benefit Claims and second best for changes in circumstances for all Outer London Boroughs

Challenges have arisen from the Council's ageing existing IT infrastructure, with implications for Members' IT for example, but this is in the process of being updated and rectified.

RE

Some of the key highlights in the first 11 months of the contract are:

- Since April, the transformation of the IT systems and the establishment of the Customer Service hub to field calls has meant the service for the first time has a 100% view of all requests; it is also taking more calls than ever before.
- Planning Service now ranked 2nd within London Boroughs for speed of decision making
- Land Charges Team shortlisted for the 2014 National Local Land Charges Awards for Excellence - most improved service category

In the background we remain focused on growth and we are pro-actively seeking new opportunities to sell our services across the region. We have already had some success and in year two we hope to yield the benefits of the strong track record built in the first year.

Question 42 **Councillor Arjun Mittra**

In the last 6 months has there been an increase in A) anti-semitic incidents reported to police B) other hate crimes?

Answer by the Leader
Yes, whilst the actual number of incidents remains low, there has been an increase in the amount of reported Hate Crime. The below figures are for the last 12 months (Aug 2013 to July 2014) compared to the previous year (Aug 2012 – July 2013):

Anti-Semitic crime: 2.3 more reports per month

Homophobic crime: 0.5 more reports per month

Islamophobic crime: 0.4 more reports per month

Racist and religious hate crime: 9.3 more reports per month

Hate crime and encouraging reporting will remain a priority for the Safer Communities Partnership in their forthcoming Community Safety Strategy.

Community and faith leaders, notably from the Muslim and Jewish communities in light of the recent conflict in the Middle East, have been quick to respond to this increase, condemning intolerance of any kind and committing themselves to promoting harmony and strong community cohesion.

Question 43 **Councillor Graham Old**

Does the Leader agree that the Empty Properties Grant could prove a win-win policy by increasing housing supply to those in need and tackling the issues associated with run-down and derelict properties?

Answer by the Leader
Yes. One grant has already been approved and there are 7 more in the pipeline. There are currently 596 properties on the Empty Property Data Base in the Private Sector Housing Team who are all being approached in relation to the scheme. The extended period of nomination rights from 3 to 5 years will also ensure that the impact is sustained over a longer period.

Supplementary Question
Does the Leader know what the financial implications of this policy might be?

Supplementary Answer
I don't have the actual figure but anything done will be helpful towards the council's finances and added that it's very important that revenue collected is maximised in order to minimise the tax level imposed.

Question 44 **Councillor Alison Moore**

Does the Leader not agree that it is a scandal that tenant victims of domestic violence, in being forced to move out of the family home to seek safety will have to register as homeless and thus lose their long term tenancy rights, and what is he going to do about it?

Answer by the Leader
This is not the case. Where the applicant is an existing secure tenant, they would not necessarily have to apply for rehousing. Rather their Housing Officer can highlight the case as having an exceptional need to move and apply to have the tenant moved as a management transfer. Once moved, the tenant will sign a secure tenancy on the same conditions as the previous tenancy that they held.

Supplementary Question
In your answer you say '… would not necessarily have to re-apply.' What about those domestic violence victims tenants who do necessarily have to re-apply for housing. Will they lose their long term permanent tenants' rights when they do?

Supplementary Answer
That would depend on circumstances but the most important thing is that we do get people out of a situation where they are at risk as quickly as possible and that has to be the overwhelming priority and it is also very important that scare stories are not raised about this matter which might lead someone to stay in an unsafe environment.

Question 45 **Councillor Graham Old**

How does Barnet's Planning team, part of the Re joint-venture, now compare to other London Boroughs in terms of the speed of processing applications?

Answer by the Leader
According to the Communities & Local Government published statistics for period Jan-March 2014,

Barnet ranked 2nd best in London (out of 34 local planning authorities) in respect of percentage of applications decided within statutory time periods. As part of the Planning Services drive to improve customer satisfaction resources are focussed on ensuring planning decisions are made as quickly as possible.

Question 46 **Councillor Pauline Coakley Webb**

Will the Leader ensure neighbourhood budgets are allocated according to residents' wishes rather than being in the patronage of local councillors?

Answer by the Leader
The process for allocating the area budgets was agreed by the Community Leadership committee at their last meeting. It is right that, as the democratically elected representatives of the residents, councillors have a role to play in this process as they possess a mandate to take decisions on behalf of all their local residents.

Supplementary Question
Given the lengthy presentation of these area budgets that happened at the last area forums, do you think that the public have been duped into believing that they would have some say and influence about how this money is spent? And apart from the Area Forums, how is the rest of the electorate being informed about this allocation?

Supplementary Answer
This should be publicised in the councillors' own bulletins now this has been agreed. It is important to realise that as elected members we do have to make decisions ourselves and we can't always rely on 'rent-a-mob' who turn up at meetings. We should listen to concerned residents who come to our area Forums.

Question 47 **Councillor Graham Old**

Can the Leader update Council on the progress of the Brent Cross Cricklewood redevelopment scheme?

Answer by the Leader
Following the resolution of the Planning Committee earlier this year to approve the revised proposals contained in the Section 73 application, the section 106 agreement has now been signed and decision notice issued.

In July this year, the Assets, Regeneration and Growth Committee approved the Procurement and Delivery Strategy to secure a partner to deliver the southern parts of the masterplan in partnership with the Council. It is anticipated that a shortlist will be selected in early October, with a view to selecting a preferred development partner by March 2015. Approval will be sought from the Assets, Regeneration and Growth Committee to select the preferred development partner.

The Council is working with our colleagues at City Hall and in Whitehall, along with Network Rail, to explore ways to bring forward the Thameslink Station within the programme to support the comprehensive regeneration.

Supplementary Question
How important does the Leader think that proposals at Brent Cross / Cricklewood have gained the political support of both the Mayor of London and the Chancellor of the Exchequer in bringing forward these very bold and adventurous schemes.

Supplementary Answer
I agree with Councillor Old's observations. It is vital that the three levels of government do agree in this matter and show a completely joined up view when dealing with partners or contractors. It is vital that this complex development comes through in a coherent way. I am confident that the close working between the various tiers of government will lead to that working through.

Question 48 **Councillor Barry Rawlings**

Will the Leader ensure the ring-fenced Public Health money is used for its proper purpose rather than, as in 2014/15, plug a financial hole in leisure services when their own report states it was not delivering Public Health outcomes?

Answer by the Leader
Whilst it is the case that the council is looking to achieve better value from its leisure contracts, maintaining leisure provision makes an important contribution to public health. Promoting physical activity is a significant priority for the borough. The proposed public health commissioning priorities through to 2020 will be presented to the next Health and Well-Being Board in November where the plans will be subject to debate and consideration by not just Councillors but also by the CCG and Healthwatch who are members of the Board.

Supplementary Question
The Conservative group have got three places on the Health and Welbeing Board thus ensuring you can't have cross-party agreement over health and wellbeing, which is a sadness. On the main point, promoting physical activity is important. He misses the point that the PLL weren't delivering any public health outcomes. So to give money, £600,000, to waste that money on providing a service that what you've said isn't delivering was a ridiculous waste of public money. Can we ensure that will not happen again because this is not the proper use of public money?

Supplementary Answer
The money will be used for proper public health objectives.

Question 49 **Councillor Joan Scannell**

Has the Leader yet discovered who funds Barnet Alliance for Public Services (BAPS)?

Answer by the Leader
I do not know definitively.

Question 50 **Councillor Reema Patel**

Would the Leader sign my petition calling for the withdrawal of the proposed change to housing allocations that forces victims of domestic violence to declare themselves homeless while the perpetrators of violence against them are allowed to remain in the family home?

Answer by the Leader
No. The reasons for the policy have been set out. I fear the councillor has misunderstood the implications of the policy. We are looking to protect, not penalise, those at risk.

Question 51 **Councillor Joan Scannell**
Do those unions that support council employees fund individual political candidates for election and do they fund the Labour Party?

Answer by the Leader
I understand they do.

Question 52 **Councillor Alison Moore**

How much more income is the Leader prepared to lose from the Special Parking Account before he agrees to change his disastrous parking policy?

Answer by the Leader

I would hope that Cllr Moore is aware that parking controls have to be entirely for the purpose of traffic management and that income into the Special Parking Account is strictly limited in its use. The draft parking policy makes this very clear. If she were to base her policy on income it would be liable to legal challenge.

Question 53 **Councillor Joan Scannell**

Does the council still collect union subs from staff?

Answer by the Leader

Yes. These are collected as payroll deductions where requested by staff.

Question 54 **Councillor Anne Hutton**

The independent chair of Safeguarding has said that Barnet's Safeguarding needs improvement. What steps are the council taking to ensure that the process is in place for this to happen?

Answer by the Leader

The independent chair highlighted that the Barnet Safeguarding Children's Board is always on a journey of continuous improvement. Our statutory function is to ensure that we have a multi-agency co-ordinated response, that this is effective and that we strive to continuously improve performance to secure the best outcomes for children, young people and their families.

The Council's and the Children's Safeguarding Board's vision is to make Barnet a place where all children and young people thrive, receive protection and feel safe. In order to improve outcomes for children and young people, we have:

- Secured sustained improvement in multi-agency safeguarding performance and practice through thematic auditing to better understand our position and the work needed.
- Improved the way that partners share information, resources and expertise in day to day business of safeguarding children and young people.
- Embedded a culture of continuous learning through audits, reviews and data to examine what works well and what needs to change and improve.

Ofsted now reviews the safeguarding board as a separate entity and the board quite rightly is required to evidence improvement in performance and the impact we have in making a difference to children's lives. We have a robust two-year business plan with four clear priorities in addition to the core business of the board and we are aligned to the adults safeguarding board to ensure robust strategic oversight of all safeguarding practice.

Question 55 **Councillor Bridget Perry**

Does the Leader welcome the service improvements in the Youth Offending Service, highlighted by its recent strong inspection report?

Answer by Councillor Reuben Thompstone (Chairman of Children, Education, Libraries and Safeguarding Committee)

Yes. The council is extremely pleased with the positive and validating inspection report which described our Youth Offending Service as "well performing" and which identified the "highly skilled

staff, good leadership and the contribution of all partners".

The inspection demonstrates that we are providing a high quality service to young people and residents in the Borough.

Question 56 **Councillor Charlie O'Macauley**

What are the council's plans for helping the Burnt Oak Business Community?

Answer by Councillor Daniel Thomas (Chairman of Assets Regeneration and Growth Committee)
The council and its partners are currently consulting on proposals to support the small business community in Barnet, including in Burnt Oak, with the aim of making Barnet the best place in London to be a small business. The proposals include reducing red tape and bureaucracy, improving the borough's town centres and infrastructure through regeneration, and offering targeted support to small businesses and business sectors where they would benefit from it. Details about the proposals, entitled "Entrepreneurial Barnet", can be found at the council's consultation portal: http://engage.barnet.gov.uk/.

Supplementary Question
What is his view on regeneration in Burnt Oak?

Supplementary Answer
Any regeneration is to be welcomed. It improves businesses, it improves accommodation, it increases the tax base and Councillor O'Macauley should be encouraged to speak to businesses in Burnt Oak to respond to the consultation on the Entrepreneurial Barnet Strategy.

Question 57 **Councillor Bridget Perry**

Could the Leader comment on the council's continued investment into the borough's parks?

Answer by Councillor Dean Cohen (Chairman of Environment Committee)
Parks and Open spaces are an important part of the boroughs infrastructure, with a third of the borough comprising of Greenspace and parks, this being one of the key reasons people want to live in Barnet. Satisfaction ratings with parks have reached their highest levels since 2000 at 70%, which is a reflection of the consistent standards of cleanliness and grounds maintenance and specifically to the increased levels of investment and improvements to the parks delivered by working closely with residents, key partners and capitalising on external funding opportunities.

The following projects were completed in 2013 and 2014 to date:

- Refurbishment of Highlands Gardens pond
- Replacement of Oakdene Park Footpath (Dollis Valley Greenwalk) – Part One & Two
- Installation of outdoor gyms and marked and measured routes
- Complete renovation of Kara Way playground
- Replacement of Northway Gardens play area
- Pitch drainage works to Copthall Playing Fields and new extended car park
- New play equipment at Hendon Park play area
- Replacement of Malcolm Park play area
- New play equipment at Childs Hill Park
- New play area at Brunswick Park

The projects above total £2 million of investment, £1.4 million of external funding and £600k of S106 / Capital expenditure.

The following schemes, totalling a further £350k are due to be delivered in 2014/2015:

- New play equipment at Stonegrove Park
- Complete renovation of Percy Road play area
- Final phase of Oakdene Park footpath replacement
- Replacement tennis courts at Victoria Park

In addition to the above there may be a further number of new outdoor gyms. It should also be noted that there are major redevelopments planned for parks within the major regeneration areas that will see the provision of new additional public parks and the enhancement of the existing park stock with new facilities, infrastructure etc

Question 58 **Councillor Alison Moore**

What pressure is the council putting on the CCG, in the face of the closure of local GP practices, to ensure that there is sufficient GP capacity in the Borough, given that there is already a shortage?

Answer by Councillor Helena Hart (Chairman of Health and Well-Being Board)
Primary care services are commissioned by NHS England and not by Barnet CCG. However the CCG's plans to reduce unnecessary reliance on hospital based services requires that there is sufficient capacity in primary care services to support care closer to home.

Council members, CCG and NHS England representatives sit on the Health and Wellbeing Board where the need for expanded capability and capacity has been noted. Should a trend be established regarding the closure of local GP practices, this is a matter that would also be picked up by the Health Overview and Scrutiny Committee.

Question 59 **Councillor Bridget Perry**

What has been the trend in youth unemployment in the borough?

Answer by Councillor Daniel Thomas (Chairman of Assets Regeneration and Growth Committee)
Over the last 12 months we have seen a small reduction in the numbers of young people who are aged 16-19 and who are not participating in education, employment or training (NEET)

In July 2014, 2.8% (278 young people) of the cohort were NEET compared to 3% (296 young people) in July 2013.

Overall, youth unemployment fell by 25% last year (JCP, April 2014).

The Department for Education publish annual NEET figures each June and nationally, Barnet's performance was the fourth best in the country.

Question 60 **Councillor Geof Cooke**

Why did it take 5 months to correct all FN CPZ zone permits and vouchers in Limes Avenue that were incorrectly placed in zone BZ, how many PCNs were issued incorrectly as a result of this and have all PCNs been cancelled and fines reimbursed?

Answer by Councillor Dean Cohen (Chairman of Environment Committee)
This was a system configuration issue and a consequence of changing from one parking system to another. It only impacted a small number of permits and where PCN's have been issued these have been cancelled.

Supplementary Question
The error on the part of officers issuing parking permits led to a very distressing harassment to quite a number of residents of Woodhouse Ward, specifically in Limes Avenue. Anybody can make a mistake but to restate the question: why did it take five months to sort this out?

Supplementary Answer
The answer is as stated. It was a system error that had to be corrected. Five months is a long time but it had to be right the second time.

Question 61 **Councillor John Marshall**

Could the Leader comment on the declaration forms submitted by members that register their interests?

Answer by the Leader
Some of them seem curiously short on detail.

Question 62 **Councillor Nagus Narenthira**

Is the Leader aware of the hardship the existing tenants are facing during the building works due to the regeneration in Grahame Park, and can he assure me that only a minimum disruption, if any, is caused to parking, noise, litter etc. during these building works?

Answer by Councillor Daniel Thomas (Chairman of Assets Regeneration and Growth Committee)
Inevitably there will be some disruption during the delivery of this regeneration programme, but the council and Genesis Housing Association are taking measures to keep residents and councillors informed of progress and help minimise any disruption. This is an important scheme that we do have to get on and deliver, to the benefit of residents old and new.

Supplementary Question
Does the Leader think that it's his duty to value residents' everyday life while the regeneration is on-going. We are not against regeneration. We are just asking whether it could be done with the comfort of the existing residents.

Supplementary Answer
The construction and development partners are part of the considerate construction schemes and they do all they can to minimise disruption. Short term discomfort is for the long term good.

Question 63 **Councillor John Marshall**

Could the Leader update Members on the progress of the Claer Lloyd-Jones report regarding the investigation into the governance issues arising leading up to the Annual Council meeting?

Answer by the Leader
The independent investigator's report will be coming to Policy and Resources Committee in October where members will be able to ask specific questions. The report will be published.

Question 64 **Councillor Arjun Mittra**

Is it standard practice for the Council's Capita-subsidiary bailiff not to provide a breakdown of the charges they are seeking to recover?

Answer by the Leader
Prior to issuing instruction to a bailiff a liability order is issued to the customer by the Revenues and Benefits Service setting out the overdue payments and costs awarded. The back of the liability order also sets out the potential enforcement routes that can be pursued and a Schedule of Bailiff fees that will be charged.

If no further payment is received or the Council Tax payer defaults on an arrangement the Council may opt to send the case to the bailiff as the chosen enforcement route.

On receipt of the instruction, the bailiff, in this case Equita will issue a Notice of Enforcement to all customers within 24 hours of receipt of the case being referred to them.

The Notice of Enforcement sets out in line with the regulations: the debt, any interest, the compliance fee of £75 and the date the debt has to be paid by. The Notice also sets out the "possible additional fees and expenses of enforcement" that could become payable if the debt is not paid or an arrangement made within the timescale set.

A customer can receive 3 to 4 notices before an enforcement agent attends their property.

When the enforcement agent actually attends he brings very little documentation as this would already have been sent to the customer. Any fee breakdown will be provided upon written request.

A customer receives a number of recovery notices from Barnet at each stage prior to any referral to the Bailiffs. At any stage there is an opportunity to make a suitable payment arrangement, before the debt is passed to the enforcement agents. An enforcement agent will only attend if there has been no contact following the notice of enforcement letters or if a payment arrangement has been broken.

Equita and all bailiff firms are governed by the prevailing National Standards for Enforcement Agents, best practice and in line with Council Policies around debt collection.

Question 65 **Councillor John Marshall**

Would the Committee Chairman join me in congratulating the borough's students, teachers and schools on their excellent public examination results and welcome the fact that Barnet continues to significantly outperform the national averages in this regard?

Answer by Councillor Reuben Thompstone (Chairman of Children, Education, Libraries and Safeguarding Committee)

Yes. Once again our pupils, parents, teachers and school leaders have worked hard and attained terrific results. I congratulate them all on their achievements. We know that the high quality of education in the borough continues to be a significant draw and source of pride. We continue to work supportively with all involved to maintain these high standards.

Question 66 **Councillor Reema Patel**

Considerable damage has been done to Coppetts Wood nature reserve as a consequence of some recent sewage works. Will the Council commit to rectifying this damage in the event that the third party does not?

Answer by the Leader

Thames Water have been on site for some 12 months and are still on site currently undertaking extensive works to a major sewer. These works commenced as an emergency response following the major failure of the sewer which flooded and closed the north circular and sections of Coppetts Wood, thus no prior notification and agreement to the works was sought or required from the Council.

Thames Water have agreed a series of works, which they are undertaking. There are legislative mechanisms to ensure that the reinstatement works are all completed, any failure to do so would be pursued by Officers.

Question 67 **Councillor Alison Cornelius**

Can the Leader, or the Committee Chairman, update Council on the progress of our Troubled Families Programme?

Answer by Councillor Reuben Thompstone (Chairman of Children, Edcuation, Libraries and Safeguarding Committee)
As at the end of May 2014, Barnet had identified all 705 of its cohort of families. Of these a total of 390 had been 'turned around' according to central government criteria. This achievement places Barnet as one of the best performing London Boroughs, leading DCLG to invite Barnet to pilot the 2nd phase of the national Troubled Families programme.

Question 68 **Councillor Agnes Slocombe**

What progress is there on the Way-2-Save (former Woolworths store) site, and can the fly-posted advertising be stopped?

Answer by the Leader
In order to investigate and provide a detailed response to this question the team would be grateful if you would provide an exact location for the mentioned site. Once provided we will be happy to provide further details.

Question 69 **Councillor Alison Cornelius**

Does the Leader agree that treating those at risk of violence in their home as homeless and offering temporary accommodation is an important safeguarding step that will help protect vulnerable people?

Answer by the Leader
This is precisely why the proposal has been made. Remaining in their existing accommodation may put vulnerable people in further danger. It is better to place them in safety in temporary accommodation while a more long-term solution is arranged.

Question 70 **Councillor Zakia Zubairi**

Was the Leader aware that the Everglade Medical Practice at the Grahame Park Health Centre have had serious health and safety concerns for staff and patients attending the practice because of problems with repairs arising from asbestos, damage from water leaks and having no hot water for 2 weeks? Barnet Homes have said the repairs will be completed by the 9 September, would he reassure me that any future problems with the building will be addressed more swiftly so the centre is not left operating in such conditions for weeks on end?

Answer by the Leader
A waste water notice was served by Affinity Water on LBB Property Services due to a large underground burst underneath the medical centre. Affinity Water engaged contractors to excavate the floor of the medical centre but had to halt works due to finding asbestos underneath the floor. The water pressure to the flats in Block Kemp was reducing due to the leak and Flat 26 had an intermittent water supply for some weeks.

Barnet Homes became heavily involved at this point to assist LBB Property Services and arranged for the asbestos to be removed to allow Affinity Waters contractors to safely repair the burst. Unfortunately the burst was too deep underground to repair so a new water main had to be run in through the medical centre to provide a water supply to the flats above. The majority of the works had to be undertaken during the evenings or weekends to allow the health centre to continue to operate a day service.

Once this was completed and the water main re-pressurised, the flats above developed a number of leaks. There was also a leak on the district heating system and a leak on a pump, unrelated to the water mains renewal. Barnet Homes have since undertaken a survey of all flats above the health centre to confirm all pipe work being fed by the mains is free from defects.

This caused damage to a number of areas in the health centre affecting ceiling tiles, plasterwork and decorations. All of these jobs have been attended to within target timeframes and Barnet Homes are in the process of carrying out remedial works to the health centre to return it to its previous state.

Completion is imminent.

Following reports of a lack of hot water, this was referred to LBB Property Services who have responsibility for managing the commercial premises and who engage the services of an alternative contractor to resolve this issue.

Following meetings with NHS Practice Managers, NHS Facilities Managers, Affinity Water, Barnet Homes and their contractors, we believe much clearer lines of communication have been established to report issues of this nature in future. The main delays in this instance were a lack of clear signposting on who was responsible for each element of the repairs under the lease.

Question 71 **Councillor Alison Cornelius**

What proportion of those who applied on time received one of their top three choices for primary and secondary school admissions this year?

Answer by Councillor Reuben Thompstone (Chairman of Children, Education, Libraries and Safeguarding Committee)
92% of applicants received an offer of a primary place at one of their top three schools of preference.

91% of applicants received an offer of a secondary place at one of their top three schools of preference.

Question 72 **Councillor Arjun Mittra**

Does the Leader of the Council believe that he can judge a case impartially, having made comments dismissing the case?

Answer by the Leader
I think I was very cautious in my comments and certainly did not pre-judge the case. I made no pre-determination of innocence or guilt in the way some Labour supporters appeared to do.

Question 73 **Councillor Charlie Omacauley**

In the last three months, how many crimes have been reported from Burnt Oak?

Answer by the Leader
In the three months June-August 2014 there were 319 crimes in Burnt Oak ward (an increase of 21 compared to the same period a year ago).

Question 74 **Councillor Pauline Coakley Webb**

Will the Leader support the partial implementation of 20mph limits on those roads in Friern Barnet Village that have been adopted by the council while we wait for the rest of the roads to be adopted?

Answer by the Leader
The Council can consider such a proposal, but the introduction of 20 mph limits are based on surveys of traffic and pedestrian movements/volumes/incidents as well as consultation.

Question 75 **Councillor Charlie O'Macauley**

How many community halls do the council own in Burnt Oak? How many are occupied and by which groups?

Answer by the Leader
The Council has seven community halls in Burnt Oak which are listed below. All the community halls owned by the council in Burnt Oak are leased out.

1. Stag House, 94 Burnt Oak Broadway, HA8 –leased to the trustees of Rex Chosen Ministries for 10 years from 23/12/2009

2. 210 Burnt Oak Broadway, HA8 – leased to Sangam Association of Asian Women for 99 years from 23/06/1992

3. North Road Community Centre, HA8 - leased to the trustees of the North Road Community Association for 5 years from 25/03/2013

4. Community Hall, Market Lane, HA8 - leased to Faith Community Ltd for 25 years from 10/08/2011

5. Watling Community Centre, Orange Hill Road HA8 – leased to the trustees of Watling Community Centre for 37 years from 18/03/1997

6. Burnt Oak Spiritualist Church (Adjacent Watling Community Centre), Orange Hill Road HA8 – leased to Burnt Oak Spiritualist Church for 20 years from 18/03/1997

7. Former Bowling Green and Pavilion, Watling Park – leased to TAVR (Territorial Army) for 25 years from 29/02/1988

Question 76 **Councillor Arjun Mittra**

How many planning applications are refused by officers on the grounds of objections from Transport and Traffic officers?

Answer by Councillor Melvin Cohen (Chairman of Planning Committee)

In the month of August, 62 planning applications were refused planning permission, 3 of which included highways reasons as a result of an objection raised by transport planners.

Question 77 **Councillor Alison Moore**

Will the Leader tell us how many resident CPZ permit holders who submitted renewal applications on time through the on-line system were subsequently issued with PCNs because the system failed to work properly and their permits were not re-issued on time? How much has it cost the council rectifying this situation?

Answer by the Leader

The recent issue where a number of PCN's were issued was not related to a system problem but was due to a short term service failure where reminder letters were not printed and sent to permit holders to warn them that their existing permit was due to expire within four weeks. When this failure became apparent letters were issued immediately but some residents would have had no or very little advanced warning due to the delay in printing the letters. There is no obligation on the council to send such reminders and therefore this has up to now been carried out on a discretionary basis, however where PCNs have been issued they have subsequently been cancelled. Due to the manner in which cancellations are recorded in the IT system we are unable to identify the exact number of PCN's cancelled due to this issue, however it is not thought to be any greater than twenty based on complaints received. Since this service failure a new process has been implemented to ensure that reminder letters are routinely sent out on a daily basis and there has been no additional cost to the council.

Question 78 **Councillor Agnes Slocombe**

Who is responsible for cleaning the riverbank under the flyover on the Edgware Road opposite Vauxhall Cars at Staples Corner where fishing takes place?

Answer by the Leader

The ownership of the land adjacent to the river bank (south of Priestly Way and north of the Industrial units) is unclear. This matter is being investigated by the property services team with HM land registry and an update will be provided to Councillor Slocombe with the findings.

Question 79 **Councillor Charlie O'Macauley**

How many council flats or houses are vacant or empty in Burnt Oak?

Answer by Councillor Tom Davey (Chairman of Housing Committee)
There is only 1 empty council property in Burnt Oak at present. It is a house and voids works are currently underway.

Question 80 **Councillor Arjun Mittra**

How many planning enforcements are made, out of how many reported?

Answer by the Leader
Between 1 September 2013 and 30 August 2014, the council received 1746 planning enforcement complaints and in the same period served 132 enforcement notices of various types. The rate at which complaints have been received in 2014 is at an historic high and it is likely that the number of notices will rise accordingly.

Question 81 **Councillor Arjun Mittra**

Does the Leader not agree that it is an appalling dereliction of responsibility for Westminster Council to hire out the Church in St Marylebone Cemetery on East End Road, then show no interest in managing the parking problems that occur at Easter and Christmas in the area?

Answer by the Leader
In order to investigate and provide a detailed response to this question Officers would be grateful if you would provide specific details relating to the parking problems. Once provided they will be happy to provide further details and investigate in consultation with Westminster Council to put measures in place for the future.

Question 82 **Councillor Alison Moore**

Some years ago the mini roundabout at the junction of Squires Lane and Station Road N3 was removed, along with other road safety measures in the area that had been installed following extensive local consultation. This gave local residents problems crossing safely. The roundabout has finally been re-instated. Would the Leader tell me how much it cost in traffic orders, signage and other costs to remove and now to re-install the roundabout?

Answer by the Leader
The mini roundabout and ancillary items removal cost was largely contained within the major carriageway resurfacing scheme.

The final bill for safety improvements at this location are expected to be contained within £50k. It will be noted that this is not being done on a like-for-like basis and a fully-fledged design process to introduce other safety features currently under construction has been done.

AGENDA ITEM 11.1

Council

4 November 2014

Title	**Report from Policy and Resources Committee – Referral to Council**
Report of	Head of Governance
Wards	All
Status	Public
Enclosures	Policy and Resources Committee - 14 October 2014 Agenda Item 7: **Annexe One:** Annual Council – External Investigation **Appendix 1:** First report of Claer Lloyd-Jones **Appendix 2:** Second report of Claer Lloyd-Jones
Officer Contact Details	Andrew Charlwood, Head of Governance (Acting) andrew.charlwood@barnet.gov.uk 020 8359 2014

Summary

Agenda Item 7 of the Policy and Resources Committee on 14 October 2014 was referred up to Full Council by five members in accordance with the Constitution. Council is therefore requested to consider the recommendations and take a decision on them.

Recommendations

That Council consider and vote on the recommendations contained in Agenda Item 7 of the Policy and Resources Committee on 14 October 2014.

1. WHY THIS REPORT IS NEEDED

1.1 The Constitution allows a certain number of members to refer a matter on which a Committee had proposed to take a decision to its parent body. At the meeting on 14 October 2014, the required number of members of the Policy and Resources Committee referred Agenda Item 7 (Annual Council 2014 – External Investigation) up to the next meeting of Full Council.

1.2 As the Policy and Resources Committee did not take a decision, the procedures to be followed will be those set out in Paragraph 20 of Full Council Procedure Rules (Rules of Debate). For reports of Committees (including Overview and Scrutiny Committees), the Chairman of the relevant committee, or the Vice-Chairman in their absence, will move reception of the report and adoption of the recommendations. This report need not be seconded. The leader of each of the other groups, or another member of their group, will then have an opportunity to comment on the recommendation, and at the end of the time allowed the Mayor will bring this part of the debate to an end, whether or not all those entitled have spoken or completed their speeches.

2. REASONS FOR RECOMMENDATIONS

2.1 As set out in the substantive report.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 As set out in the substantive report.

4. POST DECISION IMPLEMENTATION

4.1 As set out in the substantive report.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**
As set out in the substantive report.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**
As set out in the substantive report.

5.3 **Legal and Constitutional References**

5.3.1 Constitution, Responsibility for Functions- Paragraph 6 - Members Rights to Refer Matters to Parent Body.

5.3.2 Constitution, Full Council Procedure Rules, Paragraphs 20 and 21 - Rules of Debate and Time for Debate

5.4 **Risk Management**

5.4.1 As set out in the substantive report.

5.5 **Equalities and Diversity**

5.5.1 As set out in the substantive report.

5.6 **Consultation and Engagement**

5.6.1 None

6. BACKGROUND PAPERS

6.1 None.

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	Policy and Resources Committee **14 October 2014**
Title	**Annual Council 2014 – external investigation**
Report of	**Andrew Travers – Chief Executive**
Wards	**All**
Status	**Public**
Enclosures	**Appendix 1: First report of Claer Lloyd-Jones** **Appendix 2: Second report of Claer Lloyd-Jones**
Officer Contact Details	**Andrew Travers** **andrew.travers@barnet.gov.uk** **020 8359 7850**

Summary

Following the unsatisfactory nature of the Annual Council meeting on 2 June 2014, and in particular the lack of appropriate legal clearance of the reports presented, Claer Lloyd-Jones was appointed as external investigator. Ms Lloyd-Jones has produced two reports: in the first she examines the events in the run-up to the meeting, and in the second she considers options to improve corporate governance. Ms Lloyd-Jones makes several recommendations for improvement in her first report, and Policy and Resources Committee is invited to endorse these. In terms of the options for future governance, it is recommended that the Council retains its current overall governance arrangements, but that a limited scope of high level corporate legal support is removed from the scope of the services provided by HB Law, and is instead provided 'in-house' and/or through separate external arrangements.

Recommendations

1. **That the recommendations set out in section 6 of appendix 1 are agreed.**

2. **That the Council retains its own Monitoring Officer.**

3. **That a limited scope of high level corporate legal support is removed from the scope of the Inter-Authority Agreement with Harrow Council, and is instead provided 'in-house' and/or through separate external arrangements.**

4. **That the Council's integrated Assurance Function is retained.**

5. **That the outcome of negotiation with Harrow Council in respect of these matters is reported to this Committee in due course, along with detailed proposals for amendments to the Shared Legal Service Inter-Authority Agreement.**

1. WHY THIS REPORT IS NEEDED

1.1 The Annual Council meeting on 2 June 2014 was notable, both in respect of the organisation of the meeting and the flawed reports presented for decision in respect of Members' Allowances and Political Proportionality.

1.2 Following the meeting, Clear Lloyd-Jones was appointed to conduct an external investigation of the matter, and make recommendations for improvements to the Council's governance arrangements.

1.3 In Ms Lloyd-Jones first report, the events in the run up to the Annual Council meeting are analysed and conclusions drawn. Ms Lloyd-Jones then makes recommendations for improvement to current processes. These recommendations flow clearly from the analysis and therefore are in turn recommended for the agreement of Policy and Resources Committee. It will be necessary to consider whether human resources or contract management processes (albeit the latter are limited in scope within the Inter-Authority Agreement) should be invoked in the light of Ms Lloyd-Jones' conclusions.

1.4 In Ms Lloyd-Jones second report, options for strengthening future governance arrangements are suggested in respect of the role of the Monitoring Officer, governance support, and the Shared Legal Service.

1.5 In respect of the Monitoring Officer role, it was a decision of the Council in 2012 not to specify that a legal qualification was required, and the appointment was made on that basis. For the future, the role profile and requirements can be considered when the post next becomes vacant.

1.6 In respect of the option to have a shared Monitoring Officer, this would represent a significant shift of approach in respect of the Council's shared services agenda and is not recommended for consideration at this time.

1.7 In respect of the other Monitoring Officer options mentioned in Ms Lloyd-Jones report, the suggestion of increased, directly-controlled legal capacity to support the Monitoring Officer is accepted. It is therefore recommended that a limited scope of high level corporate legal support should be provided outside the Shared Legal Service in-house and/or through a panel of external suppliers. This will need to be negotiated with Harrow Council, and in so doing the arrangements for the delivery of a Deputy Monitoring Officer function can be clarified and the potential for a shared Head of the Shared Legal Service considered.

1.8 In respect of governance support, the integrated Assurance Function is a key part of the operating model and architecture of the commissioning Council, enabling robust and comprehensive governance and assurance of commissioning and diverse delivery arrangements. It is recommended therefore that the Council's Assurance Function remains as currently structured.

1.9 In respect of the Shared Legal Service, the Inter-Authority Agreement provides for oversight of the arrangement by a Strategic Monitoring Board which includes from Barnet Council the Chief Executive, the Assurance Director, and the Contract Manager. Performance reports to that Board have indicated that the Shared Legal Service is providing a good quality of service to both organisations. In respect of the options mentioned in Ms Lloyd-Jones report, the designation of the Monitoring Officer as the client for the Shared Legal Service is a helpful clarification of the existing arrangements. Further, it is recommended above that a limited scope of high level corporate legal support should be provided outside the current agreement with Harrow Council. This arrangement will enable the Monitoring Officer to have increased capacity to manage the Inter-Authority Agreement. The side agreement to the Inter-Authority Agreement and the section 101 delegation will need to reviewed as necessary through negotiation with Harrow Council.

2. REASONS FOR RECOMMENDATIONS

2.1 The recommendations in this report are designed to improve the robustness of the Council's governance arrangements and provision for the delivery of legal services.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The report of the external investigator sets out options for improving governance arrangements and provision for the delivery of legal services. The recommended option is considered to best reflect the requirements of the organisation for robust corporate governance.

4. POST DECISION IMPLEMENTATION

4.1 Should the recommendation be approved, any necessary human resources and contract management procedures will be followed, and the new

arrangements for corporate and legal governance will be put in place, including through negotiation with Harrow Council.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The report is concerned with ensuring that the Council's corporate governance arrangements are robust, and that the Inter-Authority Agreement with Harrow Council meets the Council's requirements for legal services and is monitored effectively.

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

5.2.1 The proposals set out within this report can be contained within the relevant existing budgets of the Council.

5.2.2 Following this report, the Chief Executive will consider whether or not there is a requirement for further formal action against individuals. The report does not consider matters of conduct or competence, and no inference should be drawn regarding individual officers of the Council. Such matters will be addressed in line with the Council's Human Resources policies.

5.3 Legal and Constitutional References

5.3.1 The Council needs to make appropriate arrangements for corporate governance, including via the appointment of a Monitoring Officer with resources sufficient to deliver statutory functions.

5.3.2 The Inter Authority Agreement for the delivery of legal services delegates the provision of the function from Barnet to Harrow. The proposals recommended in this report will remove an element of legal support from the scope of the Inter Authority Agreement in favour of alternative provision or direct provision by Barnet.

5.4 Risk Management

5.4.1 The Council's structure and operating model as a Commissioning Council are novel, as are the arrangements for the delivery of legal services. The Council's risk management arrangements have acknowledged this through the stages of organisational design and implementation.

5.4.2 The events described in this report represent the crystallisation of certain of those risks, and it is necessary for the Council to consider the lessons learned and make changes as appropriate.

5.5 **Equalities and Diversity**

5.5.1 The proposals set out in this report are not perceived to have equalities and diversity implications.

5.6 **Consultation and Engagement**

5.6.1 Harrow Council has been consulted in the preparation of this report. Both Councils have reaffirmed their commitment to the continued success of the Shared Legal Service.

6. BACKGROUND PAPERS

6.1 None.

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INVESTIGATION REPORT
LONDON BOROUGH OF BARNET
COUNCIL MEETING 2ND JUNE 2014-
Reports on Political Proportionality and Members Allowances

Claer Lloyd-Jones, LLB Solicitor

PREPARED FOR ANDREW TRAVERS
CHIEF EXECUTIVE, LONDON BOROUGH OF BARNET

August 2014

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Report Contents

1. Executive Summary

1.1 I was appointed to be the external independent investigator at Barnet on Friday 20th June 2014. I was asked to investigate and establish the facts around the processes leading up to and after the presentation of reports to the Annual Meeting of the council on 2nd June 2014.

1.2 Barnet is keen to understand how it came about that two reports presented to Councillors as part of the agenda for that Annual Council meeting were incorrect or misleading. These reports were the 'political proportionality report' and the 'members allowances report'.

1.3 The voting on 'wrong' reports, and the subsequent unraveling of the decision-making structure caused Barnet to be mocked in the local press with headlines using words such as "*disgrace*" and "*chaos*". No Local Authority would wish to be subject to such avoidable public criticism.

1.4 The truth is more complex. There was a general risk of underperformance in the area of Barnet's governance, culminating in these 'wrong' reports, due to a combination of factors:

- There is no-one who understands local government law in depth at Barnet. Barnet employs no lawyers.
- There are staff in key roles in the Governance structure in Barnet who are inexperienced in governance matters.
- There was no clear protocol for clearing council reports through taking external legal or other specialist advice.
- Barnet was moving to a very different Constitution at the Annual Council and needed to have given detailed consideration to the implications of moving back to the Committee system. It is not just a question of making amendments to the Constitution.

1.5 Legal Advice was requested on both the reports, but was not forthcoming on either in time for them to be printed. No-one at Barnet queried this or noticed anything was wrong.

1.6 This report examines these events and makes recommendations.

1.7 I find that there was a joint but not necessarily equal responsibility on Barnet's Governance Team as well as the Council shared Legal Service with Harrow, HBPL, for allowing the reports containing incorrect advice to be presented to Councillors as though they were correct.

2. Terms of Reference

2.1 The chief executive has set the following terms of reference for this investigation:

a) To investigate and establish the facts around the processes leading up to the production of reports for the Annual Council Meeting.

b) To consider the conduct and capability of the members of staff involved within the Council's Assurance Service and Shared Legal Service, and to indicate any action which the Council should consider.

c) To make recommendations to strengthen future governance arrangements.

2.2 This report concentrates on the first of those, on a) above. It does make some findings in relation to capability of Barnet staff members, but the Council's HR advisers will need to look at issues relating to conduct of staff which therefore falls outside the scope of this report.

2.3 A subsequent report will address the longer term implications and make some practical suggestions as to how Barnet's governance arrangements can be strengthened.

3. Methodology

3.1 With the help of Chief Executive of Barnet, we identified a list of 9 relevant people to interview. A list of those people is to be found in Appendix One. I interviewed those 9 people personally and took my own notes. No-one else was present at those interviews, except in the case of the interviews of Hugh Peart and Jessica Farmer where they were accompanied by Iain Miller, a partner at Bevan Brittan, who took a note.

3.2 I would like to thank everyone I interviewed who made themselves available sometimes at very short notice.

3.3 I undertook to all who I interviewed that what they told me and our discussion would remain confidential. I have therefore been able to obtain some candid information about what happened. If individuals are quoted in this report it is with their consent, or because that information is already in the public domain.

3.4 I have also been given a large number of documents to read, some of which are confidential. I have read them carefully and have felt able to quote from those documents where the information itself is in the public domain.

3.5 I have used my own judgement and experience to reach the conclusions and recommendations in this report, based on the evidence I have collected and the perceptions of the witnesses I interviewed. Where accounts conflicted about a particular event, I have relied on my own judgement and experience to reach a particular conclusion.

3.5 I am grateful to all the staff at Barnet who have given their time to help me with this investigation, and in particular Kar Lai Lee and Nichola Felstead.

3.6 If I have misunderstood anything, or misrepresented anything, the fault is entirely mine.

4. Background and context

4.1 Barnet has undergone huge changes in the last 2 to 3 years. It has fully embraced the concept of the commissioning council and has let large contracts for council services to external providers. It has restructured its internal staffing resources to reflect the commissioning model. It has changed its Leadership and has a relatively new Leader and a relatively new chief executive. It has moved back to the Committee system from Leader and Cabinet with effect from June 2014. Arguably, these changes have yet to settle down and bring stability to the Council's processes. However, despite the revolution undergone by the Council, Barnet has been subject to little successful challenge. This fact arguably shows that the risks have been well managed.

4.2 The risks inherent in any change process are present in Barnet and include the loss of corporate memory through changing relevant staff, putting Barnet in the position where 'it does not know what it does not know'.

4.3 The Council was keen to externalise Barnet's legal work along with other of its corporate services, and a solution had been found in principle in early 2012 through discussion with Harrow, one of Barnet's neighbouring boroughs. The Legal work was transferred to the Shared Legal Service with Harrow, Harrow and Barnet Public Law (HBPL), with effect from 1st September 2012 for an initial period of 5 years. The decisions to enter into the shared legal services arrangement were made by Barnet and Harrow separately on 4th April 2012. Barnet delegated all its legal functions to Harrow using section 101 of the Local Government Act 1972. This means that whilst this decision is in force only Harrow will be able to make decisions about Barnet's legal function.

4.4 The Inter Authority Agreement (IAA) which governs the joint legal service provides that legal work done by Barnet's Monitoring Officer (MO) or Director of Corporate Governance (or successors), is excluded from the IAA unless a further agreement is made (see 4.13 below).

4.5 The IAA provides that Barnet's legal work will be undertaken by HBPL and defines those categories of work. Corporate Governance work includes – 'Advice to Council, Cabinet, Committees……..to the extent that it is not excluded' (by being MO or DCG work). The Barnet MO was also to be the legally qualified professional client in Barnet for the purposes of monitoring the IAA.

4.6 HBPL is ambitious and confident about its future. It has already taken on a private sector legal partner, Bevan Brittan. It has applied to the Solicitors Regulation Authority to become an Alternative Business Structure (ABS). The approval for an ABS licence has now been granted with effect from 1st

December 2014. The ABS will be a separate legal identity to Harrow and I am told it would become a wholly owned Harrow Company. The management of the ABS is yet to be settled, although Barnet need not be involved in its management. HBPL also anticipates through its business plan that it may work for another or more than one other local authority.

4.7 Barnet's governance structure and arrangements changed in April 2013 as part of the restructure of the Council. The new structure contains no post of Director of Corporate Governance. In May 2013 Barnet's legally qualified MO left the Council. He had been the Director of Corporate Governance in the previous structure and was the last lawyer employed by the Council. The other Barnet in-house lawyers had transferred in September 2012 to HBPL.

4.8 There is no legal requirement to appoint a lawyer as MO, although in practice most Local Authorities do so by appointing their most senior lawyer to the role. Often the MO will sit on the top table as one of the most senior group of officers. The role was created in 1989 by the Local Government and Housing Act, although it received prominence from 2000 onwards when MOs dealt with the Standards Regime introduced under Part 111 of the Local Government Act 2000. They serviced the compulsorily established Standards Committees, and handled complaints of poor behaviour against councillors. The Localism Act 2011 considerably watered down the local government standards regime and thereby reduced the perceived significance of the MO in many authorities. However, it should be remembered that the role of the MO extends not just to governance and member behaviour but also to vires issues eg is the Council using the correct law? Is its exercising its discretion lawfully, appropriately and reasonably? Will this change programme lead to any unintended legal problems?

4.9 During 2013 Barnet appeared in cases which on occasion reached the High Court and/or the Court of Appeal. It lost the case on one of those. High level legal advice needs to be made available to the most senior officers and members during and before decisions are made internally, assessing the risk of legal challenge. This is a role usually carried out by the MO.

4.10 The MO's statutory role remains as the person who polices the lawfulness of an authorities conduct and decisions. In extremis, the statute enables the MO to issue a report to full council which has the effect of an injunction. Barnet may need to reassess how this role is carried out in Barnet.

4.11 It is unclear whether the advantages of appointing a shared legally qualified MO with Harrow were looked at before the departure of the Barnet MO. There are examples in London of where shared legally qualified MOs work well and where they have come into existence by the voluntary departure of one or other Borough MO.

4.12 The new MO in Barnet is the Director of Assurance, an accountant. She was appointed in April 2013. The Assurance Group was newly set up as part of the Council's restructuring arrangements and includes Barnet's

Governance team (BG) who are responsible for democratic, committee and members services. This includes all the administration, publication and compliance arrangements around the Agendas and reports for decision-making at committees and full Council. The MO is also responsible for Legal Services provided by HBPL. The MO role is no longer part of the corporate management of the Council because the role is not part of the top table of the most senior officers. However this MO role is part of the corporate arrangements by having a dotted line of accountability directly to the Chief Executive.

4.13 A side Agreement to the IAA was drafted at this time which adds acting as DMO, corporate, governance and MO support to the services to be provided under the IAA. This agreement remains unsigned by Harrow. It is imperative for the document to be signed as much of the work it refers to is being carried out in practice.

4.14 Despite the Side Agreement remaining unsigned, it seems to have been agreed by Harrow and Barnet in practice. In practice, HBPL have implemented the changes required by Barnet from no longer employing any lawyers. They have been providing support to the MO eg in redrafting the Constitution, they have been acting as DMO in the absence of the MO, they have given support to the MO in clearing reports for Council, the Harrow MO attends Barnet Council call-over meetings and attends Barnet Council Meetings. I have no doubt that his role there should be to provide the same level of legal advice and support to Councillors and Senior Officers in Barnet as he would do at Harrow Council meetings.

4.15 Since the beginning of the shared legal services arrangement HBPL have been providing a very rigorous clearing system for Committee reports. It has a spreadsheet arrangement keeping track of who was allocated the work, and ensuring that the 5 clear working days performance standard is adhered to.

4.16 HBPL is monitored quarterly at a meeting attended by officers including the 2 MOs and the 2 Chief Executives. HBPL is viewed as successful in dealing with the vast bulk of transactional legal work. However, there is feedback that they can be slow, and that they spend little time at Barnet outside of pre-arranged meetings. There had also been some discussion that a number of corporate lawyers would stay on site at Barnet. I was told that these lawyers would be treated as Barnet's lawyers under section 113 of the Local Government Act. However, this has not happened and there is a perception in Barnet that HBPL do not give Barnet the same priority as Harrow, due to not being on site and therefore not being available for the quick advice and discussions that tend to take place in corridors and at water coolers. These criticisms may not be well known in Harrow.

4.17 During Autumn and Winter 2013, a member led panel at Barnet devised a new Constitution which would implement alternative arrangements. This meant a move away from a Cabinet and scrutiny system back to a committee system. It required "unlearning' the 2000 Act. Political

proportionality on the new Committees, and a change in Members Allowances, could (and should) have been brought to members' attention by officers as part of that process. BG and HBPL were both involved in advising members throughout that process, which is regarded as having been successfully supported by those officers.

4.18 The Annual Meeting of the Council on June 2nd 2014 took place only 4 working days after the Council elections on 22nd May. This must have put pressure on all the staff involved because it meant preparing election result-sensitive reports very quickly. Planning for this meeting therefore should have started very early to minimize the risk of reports being wrong.

4.19 The Annual Meeting was due to be a particularly important meeting because of a number of significant events:

- Election of a new Mayor for the Council
- Election of a new Leader of the Council for a period of 4 years
- Commencement of a new Constitution reintroducing a new committee structure
- Appointment of Committee chairs and membership of all new committees reflecting group size and status after the council elections on May 22nd and giving effect to the political proportionality principles contained in the 1989 Act.
- A new members allowances scheme reflecting the new roles in the Constitution

4.20 The legal principles of political proportionality are to be found in sections 15-17 of the Local Government and Housing Act 1989. In essence, it requires that the majority of the number of seats on a committee should reflect the political group that holds a majority on the Council, to ensure that political groups have proportionate representation overall. These rules can be disapplied from a committee or sub-committee if there is a unanimous vote at full council.

4.21 The legal requirements to be reflected in the members' allowances scheme are to be found in the Local Authorities Members Allowances (England) Regulations 2003. Regulation 5 covers the basic allowance and a scheme is required to be made before 31st March each year.

4.22 Neither of the reports dealing with these two issues was correct. Below I set out the chronology of events which explains how this all came about in 2014.

4.23 Chronology of events (2014) :

- 29th April – Barnet Governance (BG) requests legal advice from HBPL by email about payments to councillors/members allowances- advice given

- 16th May- Further advice requested by BG and given from HBPL on members allowances noting that scheme expired on 31st March

- 16th May – draft political proportionality (PP) report sent by email from BG to HBPL. No numbers against Committees as election not held yet. "*can you let me know asap if you have any comments*"

- 16th May – HBPL internal email allocating report to lawyer and asking '*can you look at this please*?'

- 20th May – Legal advice from HBPL to BG and AT on only 60 as opposed to 63 councillors being elected on 22nd May due to Colindale ward election being delayed to June 26th. This is not in response to draft report sent by BG on 16th May. The advice quotes the need to have majority on committees from political group holding 31 seats.

- 20th May – email HBPL to BG – asking for BG to call HBPL re PP report- no response and no follow up

- 22nd May – Election- 60 rather than 63 councillors elected as Colindale election delayed to 26th June. 32 Conservative, 27 Labour, 1 Lib Dem

- 27th May- Draft PP report (with numbers) sent by BG to group leaders and political assistants. No comments received from HBPL

- 29th May – Draft PP report (with numbers) sent to HBPL by BG

- 29th May- HBPL internal email sending draft PP report (with numbers) to allocated lawyer

- 30th May – BG sends draft Members Allowances report to Leader of Council cc HBPL

- 2nd June – BG prints reports without legal clearance. Taken to Council.

- 2nd June - Pre-meeting with Mayor, and Barnet and Harrow MOs.

- 2nd June - Council meeting itself described as a '*shambles*' because for example not all members had the same papers and amendments.

- 13th June – Advice from HBPL to AT that decision made by Barnet re Members Allowances are lawful- further report will go to July Council

- 13th June – AT asks HBPL for advice reviewing PP

- 16th June – Advice HBPL to AT PP report wrong so committees cannot go ahead. AT asks for advice from Leading Counsel

- 17th June – James Goudie QC instructed and advises: Calculations for committee memberships are wrong, errors should be corrected asap, no proceedings of committees will be invalidated in the meantime due to the savings provisions in the 1972 Act.

- 17th June- AT advises all members of James Goudie's advice and that he will appoint an external reviewer

- 20th June – AT advises all members that all meetings will go ahead except Pensions, and external reviewer appointed. Brief for the external review is set.

- 26th June – Colindale election – 3 Labour members elected. C = 32, Labour = 30, Lib Dem = 1

- 15th July – Council meeting subject to a very tight procedure and process, takes reports on Members Allowances and PP – all reports cleared by James Goudie QC

5. Findings

5.1 In this part of the report I answer some key questions that have arisen or have been asked by people during the course of this investigation, and then I provide my findings, based on the facts as I have found them. Recommendations follow in the next section.

5.2 **Who is responsible for Council reports**?
Barnet's governance team and their line manager, the MO are responsible for the production of Council reports. They need to be quality controlled and BG must control the process of ensuring quality. The reports need to be correct, in the correct format, containing the financial, legal and other relevant advice, meet the correct deadlines and preferably be in plain English.

5.3 **Who is responsible for the correctness of council reports**?
BG must own the quality control process and inform all others affected by it of deadlines and expectations. A failure to reply by a key contributor should not be taken that the contributor has no comments. The failure to reply should be escalated to the MO and Chief Executive if necessary. If the failure is by an external contractor, this may constitute a breach of contract.

5.4 **Was 2nd June Council any different due to it being the Annual Meeting**?
Yes – the Annual Meeting is a mixture of formal events, such as the election of the Mayor, and decisions which open the municipal year such as election of the Leader, establishing the members allowance scheme and memberships of committees and external bodies. An early draft agenda and early draft reports are essential to ensure all involved appreciate the significance of the Annual Meeting. Annual Meetings are often described as too long and too boring. This describes a meeting that has usually been so well prepared that nothing is left to chance.

5.5 **What were the risk issues? How can they be mitigated**?
Barnet failed to recognize when things are going wrong and how they could be put right. It failed to anticipate how much time and what effort needed to be put into getting the issue right first time. The risks could be minimized through

clear roles, systems and processes, combined with experience and judgement. These risks remain.

5.6 **Why was the Council given wrong advice on Political Proportionality and members allowances**?
Both reports were repeated from previous reports and therefore did not address current legal issues which had arisen in the meantime, and were not subject to legal scrutiny as to whether they remained correct.
In the case of political proportionality, the report which went to the Annual Meeting was copied from the previous year 's Annual meeting. The 2014 situation was different in two key respects a) in 2013 Barnet had a cabinet and scrutiny structure, so there were fewer committees which were non-executive because all executive decisions were taken at Cabinet, b) The Conservative group , Labour group composition was 58.73% to 34.92%. With 10 member committees, a 6 - 4 spilt was therefore correct.

In June 2014 the proportion held by political groups after the election was much closer - 54.25% to 45.76%. Therefore, in order to reflect the fact that the conservatives have a majority of seats, albeit a reduced majority, they must have a majority on each committee. Changing 6-4 to 5-5 failed to reflect that principle.

The 2014 Members Allowances scheme needs to reflect the new political managements arrangements of Chairs of Committees, rather than Cabinet postholders. The 2010 scheme had not been taken to Council for annual decision since it was made, had not considered the London Councils Independent Remuneration Panel findings, and had actually expired on 31st March 2014. None of this was made clear in the June 2nd report. However, the Harrow MO advised that the subsequent report to July 15th Council would be able to make a new lawful scheme.

5.7 **Is Barnet at longer term risk in its legal and governance arrangements**?
Yes, probably. Barnet must make some changes in its governance and legal arrangements to ensure that it has access to pro-active professional and expert advice at all relevant times in future. In this way it can rebuild the trust and confidence of members and officers in those services.

Findings

5.8 I find that Barnet's Governance Team were responsible for the reports being sent to print in their incorrect form and subsequently voted on by members at June 2nd Council meeting. Members were not advised that the reports had no legal clearance, and the form of the report gave no indication of whether the report had been cleared or not.

5.9 I also find that Barnet's Governance team were jointly responsible with the shared legal service, HBPL, for those reports going to print containing misapplications of the correct law, and allowing members to vote on them as

though they were correct. Copies of the reports had been sent to HBPL at an early stage. They gave no comments or advice. The Harrow MO attends Barnet Council meetings in order to advise the MO and Chief Executive.

5.10 I further find that Barnet is at risk of a subsequent similar governance failing. There are changes that need to be made to both the IAA and Barnet's internal governance arrangements to prevent this. There are options that are available to Barnet to facilitate those changes. My subsequent report will address those.

6. Recommendations

6.1 That BG implements the same high level of control over its council reports as it does over other Committee reports.

6.2 That it takes early legal advice before drafting reports, as well as taking legal advice for clearance purposes.

6.3 That HBPL provides early legal advice outlining the legal principles to be involved in council reports.

6.4 That HBPL extends its actions of clearance within 5 days towards council reports in the same way as it does towards committee reports.

6.5 That BG informs HBPL well in advance of the subject matter of reports likely to be submitted to council meetings.

6.5 That Barnet and Harrow review and sign the 2nd or side agreement to the IAA.

6.6 That Barnet looks carefully at the options to strengthen its governance arrangements, including looking at the contract with HBPL, addressing the issue of professional clienting of the IAA, addressing the issue of lawyers not being on site at Barnet, considering the implications of having exercising s101 of the Local Government Act 1972 to delegate all its legal functions to Harrow.

7. Conclusion

7.1 Barnet Council was ridiculed in the local press for finding itself in the position of having misapplied the political proportionality rules and thereby failing to keep member decision-making safe from challenge. The Chief Executive was subsequently given advice that committees that were not properly and lawfully constituted, an could not continue to meet and make decisions prior to the next Council meeting on July 15th. Leading Counsel's opinion was taken and he advised that although the political proportionality rules had been misapplied, the committees could continue to meet and make lawful decisions due to the savings provisions in the Act. Leading Counsel's opinion was preferred.

7.2 The facts leading up to these events demonstrate that there was no clear protocol or process between Barnet Governance Team and HBPL for providing legal clearance of council reports to ensure that they were correct. In the case of both the political proportionality report and the members allowances report, legal advice was asked for from HBPL. It was not forthcoming, and the absence of legal advice in the reports was not escalated nor chased by Barnet Governance Team.

7.3 The risk of either of those reports being wrong was therefore high, given that Barnet does not employ any lawyers itself, and the relevant governance staff responsible for these reports are relatively inexperienced.

7.4 This high reputational risk to the council was multiplied by the change to alternative political management arrangements, ie a return to the Committee system. This risk was further aggravated by a very close election result.

7.5 Mitigation of the risk would necessitate early consideration of the legal principles, and close and careful attention being paid to the compilation of reports, in draft, and when submitted to council for decision. This would require at the very least, close collaboration between HBPL and Barnet Governance Team.

7.6 All parties involved were capable of spotting that something was wrong with the reports, but no-one did. To those members involved, the perception was that no-one was in charge.

7.7 I find that Barnet's Governance Team were responsible for the reports being sent to print in their incorrect form and subsequently voted on by members at June 2nd Council meeting. Members were not advised that the reports had no legal clearance, and the form of the report gave no indication of whether the report had been cleared or not.

7.8 I also find that Barnet's Governance team were jointly responsible with the shared Legal Service, HBPL, for those reports going to print containing misapplications of the correct law, and allowing members to vote on them as though they were correct. Copies of the reports had been sent to HBPL at an early stage. They gave no comments or advice. The Harrow MO attends Barnet Council meetings in order to advise the Barnet MO and Chief Executive.

7.9 In order to prevent the risk of some other governance failing attributable to the absence of legal advice or misapplication of legal advice, a number of changes need to be made to both the IAA and to Barnet's internal governance arrangements.

Appendix One – Evidence

Interviews:
Andrew Travers - Chief Executive, London Borough of Barnet
Maryellen Salter – Director of Assurance and Monitoring Officer, London Borough of Barnet
Councillor Richard Cornelius - Leader of the Council, London Borough of Barnet
Councillor Alison Moore – Leader of the Opposition, London Borough of Barnet
Andrew Nathan – Head of Governance, London Borough of Barnet
Matthew Rose – Political Assistant, Conservative Group, London Borough of Barnet
Hugh Peart – Director of law and Corporate Governance, London Borough of Harrow
Jessica Farmer – Head of Practice, HBPL, London Borough of Harrow
James Goudie QC – 11 Kings Bench Walk

I also spoke with Paul Najsarek, interim Head of Paid Service at London Borough of Harrow, but this was by way of update, and was not an interview.

Documents
Proportionality Report taken at June 2nd 2014 Council meeting
Draft report with no numbers of members dated 16th May 2014
Draft report with numbers of members dated 29th May 2014
Emails from Andrew Travers to members about the developing situation
Email exchanges between HPBL, Barnet Governance team, Barnet MO, Andrew Travers
Advice from James Goudie QC dated 17th June 2014
Miscellaneous press cuttings
Constitution of London Borough of Barnet

Report on Members Allowances to Council dated
Draft Members Allowances report 29th April 2014
Various emails between HBPL, Barnet Governance team, Barnet MO, Councilllors and Political Assisstants

Committee report to Barnet Council establishing the shared legal service 4th April 2012
Committee report to Harrow Council establishing the shared legal service 4th April 2012
Inter Authority Agreement re HBPL 17th August 2012
Committee report to Barnet Council establishing Deputy Monitoring Officer as HBPL- 29th January 2013
Unsigned and undated Side agreement re Deputy Monitoring Officer and additional support to Barnet Monitoring Officer
HBPL Business Plan 2014-17

OPTIONS FOR
STRENGTHENING FUTURE GOVERNANCE ARRANGEMENTS

1. Introduction

1.1 The third of the terms of reference set for this investigation is:

> *' To make recommendations to strengthen future governance arrangements.'*

This requires consideration of options available to Barnet for changes to the management arrangements of its governance functions as specified in paragraph 6.6 of the my initial report.

> *' That Barnet looks carefully at the options to strengthen its governance arrangements, including looking at the contract with HBPL, addressing the issue of professional clienting of the IAA, addressing the issue of lawyers not being on site at Barnet, considering the implications of having exercised s101 of the Local Government Act 1972 to delegate all its legal functions to Harrow.'*

1.2 In this report I set out the options for Barnet to consider under the headings of the Monitoring Officer, Governance Support and the Shared Legal Service (HBPL).

1.3 In writing this report I have interviewed a number of people and examined a number of documents. These are set out in the Annex to this report. In general there has been considerable agreement amongst those I have interviewed:

- That Barnet needs to consider whether it should revert to appointing a legally qualified Monitoring Officer and/or ensure that the Monitoring Officer has quick and comprehensive access to strategic and confidential legal advice on behalf of the Council.
- Corporate legal advice could be procured by Barnet and delivered either by a small in-house team of qualified lawyers or by a small number of external legal providers through a panel run by the Montoring Officer.
- The function of Governance Support needs greater management input in order to properly focus on Barnet's strategic priorities as expressed through its newly enlarged committee structure and its full council.
- The clienting of the shared legal services contract should include some element of professional legal assessment.

1.4 Whichever options Barnet decides, there are likely to be amendments to be made to the Constitution to reflect those required changes to its governance arrangements.

2. The Role of the Monitoring Officer

2.1 The role of the Monitoring Officer (MO) in Barnet is defined in Barnet's Constitution and is allocated to the Director of Assurance. The Monitoring Officer is appointed under section 5 of the Local Government and Housing Act 1989 and has a number of statutory functions. The MO is the guardian of the Constitution and the member decision – making process. The MO is responsible for advising the Council on the legality of its decisions and providing guidance to Councillors on the Constitution and its powers. After consulting the Head of the Paid Service (Barnet's Chief Executive) and the section 151 officer (Barnet's Chief Operating Officer) the MO can report to full Council is s/he considers that unlawfulness or maladministration is likely to arise. This report prevents the proposal or decision being made until the MO's report is considered. The MO is also responsible for maintaining high ethical standards, conducting investigations and contributing to corporate management.

2.2 The MO post is assigned to the Director of Assurance who also manages governance services, internal audit, external audit, risk management and anti- fraud. The post is not held by a lawyer. There is no requirement for the Monitoring Officer to be a lawyer, although in practice most Local Authorities do appoint their most senior lawyer (eg Director of Legal and Governance Services) as MO. The reasons for doing so is that it is thought that the statutory requirement for the duties to be performed personally is best satisfied by a senior and experienced lawyer.

2.3 Where the MO is unable to act personally due to absence or illness section 5 (7) of the Act requires that s/he shall nominate a deputy from amongst her/his staff.

2.4 Barnet will also wish to consider the options available for legal support for the MO in discharging the function of providing legal advice in the most sensitive and high profile matters, which it wishes to control directly itself. The task of interpreting externally procured legal advice is best done by another qualified lawyer, as is the task of working out how to ask the right questions. This could be done by a small team (1,2 or 3) of in-house lawyer(s) with expertise in corporate law, and/or by Barnet appointing its own legal panel of specialist Barristers and Solicitors to be operated by the MO.

2.5 Barnet will also wish to consider how the MO functions can best be carried out given the commissioning structure now adopted by the Council. For the MO to carry out the role most effectively, there needs to be a proactive involvement with the future direction of all council services and activities. The MO needs to be 'in the loop', having early access to key issues, thereby enabling timely and well-planned advice to be taken, and so identifying and reducing risk.

2.6 As there is a shared legal service provided by HBPL, there is also an opportunity to consider a shared MO. This arrangement has proved successful in some London Boroughs. Another option would be to consider a shared Head of HBPL. A shared post of this kind does give some 'ownership' of the arrangements to each party. Harrow would need to agree to either of these options.

2.7 Options:

2.7.1 To leave all arrangements as currently described in Barnet's Constitution

2.7.2 To appoint an experienced, legally qualified Monitoring Officer

2.7.3 To review the arrangements for the appointment of the Deputy Monitoring Officer as currently decided by Remuneration Committee on 29th January 2013

2.7.4 To appoint a small team (1, 2 or 3) of in-house lawyer(s) to support the MO (from whom the DMO could be appointed)

2.7.5 To appoint a panel of specialist external barristers and Solicitors, to be operated by the MO, to provide advice on sensitive and high-profile legal matters.

2.7.6 To consider a shared MO, or shared Head of HBPL jointly with Harrow.

3. Governance support

3.1 The function of governance support includes responsibility for all committee and council papers and reports, ensuring all relevant contributions, including legal contributions are made, and that all protocols and legal requirements are followed, in order that councillors are properly prepared before meetings start, and that members of the public can access documents in advance of meetings.

3.2 It is vital in this process that staff in the team can access speedy and correct advice, including legal advice, often at short notice.

3.3 Members of the team will also be the focal point for members enquiries and constitutional queries including declarations, exemptions etc. It is imperative that the Governance staff receive proper updates and training to ensure that a high calibre service is delivered.

3.4 It is vital, particularly with the increase in workload as a result of the move from the Cabinet system to the Committee system, that there is

a clear line of sight from ideas to committee reports. A senior management focus is required to ensure consistent high performance by this team. The team forms part of the Assurance section, along with a number of other functions, and it is an option open to Barnet to narrow the focus of the Monitoring Officer to ensure that other calls on the MOs time are minimised.

3.5 Options:

3.5.1 To leave the current arrangements intact

3.5.2 To ensure that sufficient senior management focus is given to this function to enable consistent high performance.

4. Shared Legal Service (HBPL)

4.1 The Shared Legal Services arrangement between Barnet and Harrow came into effect from 1st September 2012, a little over two years ago. The issues raised with me during the course of my investigations are:

- The visibility of lawyer from HBPL on site in Barnet
- The provision of Corporate legal work
- Support for the Monitoring Officer
- The clienting by Barnet of the contract
- Delegating legal functions to Harrow by Barnet under section 101 of the Local Government Act 1972

I deal with these in turn and set out the options for change at the end of this section.

4.2 The 5 year contract between Barnet and Harrow is contained in the Inter Authority Agreement. At the time of its drafting, Barnet had in post a legally qualified MO, the Director of Corporate Governance. The IAA provides that work done by the MO is excluded from the IAA unless a further agreement is made. The IAA defines the category of corporate governance as including 'Advice to Council, Cabinet, Committees……to the extent that it is not excluded by being MO work. The MO was also to be the legally qualified professional client in Barnet for the purposes of monitoring the IAA.

4.3 The side agreement drafted to cover legal support to Barnet's new non-legally qualified MO, albeit unsigned by both parties, is being used for charging and monitoring purposes. Between April and August 2014 200 hours were charged under the side agreement as opposed to 16,000 hours charged under the main agreement.

4.4 The provision of routine and transactional work under the contract comprises the vast majority of work done by HBPL, and the monitoring information demonstrates that it is being done to a high standard. The Quarter 1 2014/15 performance report states:

> "HB Public Law – 100% of targets met
> *13 of the 13 performance targets were met, successes include: The Dollis valley Compulsory Purchase Order initially made in January that covers over a thousand property interests on the estate was confirmed by the secretary of state in June and the two remaining objections have been withdrawn.*
> *Satisfaction of Barnet employees with the service provided by Public Law was 100% across all categories".*

4.5 Corporate Legal work comprises the most high profile and sensitive legal issues, which may concern vires, difficult constitutional issues with significant impact, or which may be commercially confidential, or which may concern sensitive litigation. It is legal work that the Chief Officers and Leading politicians will want to be kept regularly informed about. It is usually legal work that the MO would handle personally, or be personally involved in the selection of outside lawyers and supervise instructions. Barnet will wish to review how this work is undertaken in future so that it has direct control of those legal issues that matter most to the Council. The issue of direct control is not just an issue of direct contact, but also one which avoids any potential conflict of interest.

4.6 Support for the MO is important and will continue to be important in future. The work is often unpredictable and often is required to be done at speed. Whilst under some options the MO will instruct external lawyers direct, there will be many circumstances where the MO will require HBPL to assist. The opportunity must therefore be taken to review the side agreement to the IAA in the light of whichever options Barnet chooses for its governance arrangements so that it reflects the legal requirements Barnet will need in future.

4.7 The issue of visibility of HBPL lawyers on site in Barnet has been raised as an issue in this investigation, however, I believe this is best dealt with as part of the contract monitoring arrangements.

4.8 The clienting of the HBPL service has had no professional legal input looking at the quality of legal advice given for 18 months. A number of people I spoke to commented on the difference between contract management, which is carried out by the commercial team, and clienting. Clienting includes taking ownership of the service delivered overall, and is not just looking at outputs and performance indicators but also at the quality and effectiveness of legal advice and legal work. If Barnet chooses the option of a legally qualified MO then this would form part of her/his responsibilities. Alternatively, if Barnet

chooses to establish its own legal panel, it could use one of those external providers to perform this function, albeit at some cost.

4.9 I am aware that Barnet's procurement model is to use a thin client, however it was the original intention of the IAA that the then legally qualified MO should also be the client for the contract, and it is clear from those to whom I have spoken that this remains a preferred option. Without a legally qualified client, it is difficult to challenge whether the legal advice given is wrong.

4.10 Finally, the issue of the use of s101 of the Local Government Act 1972 to delegate Barnet's legal functions to Harrow. This seems to have been done because HBPL is delivered by Harrow, not jointly with Barnet. The IAA 'carves out' MO work and functions and it was agreed that section 101 would not apply to that legal work, and therefore Barnet would be able to exercise its own legal functions in relation to MO work. This needs clarifying. It is highly unusual to have used section 101 in this manner in any event, when a contractual arrangement would suffice.

4.11 Options:

4.11.1 To leave current arrangements intact.

4.11.2 To require the MO to be the client for the shared legal service.

4.11.3 To review the side agreement to the IAA and the IAA to ensure they fulfill the current requirements of Barnet and reflect the options chosen from this report.

4.11.4 To ensure that Corporate legal issues are dealt with direct by Barnet.

4.11.5 To revoke the section 101 delegations of all legal functions to Harrow

4.11.6 To replace the current decision to delegate all legal functions to Harrow under section 101 and to limit the delegation of functions to routine and transactional legal work under the contract, excluding all corporate legal work and that carried out by or under the direction of the MO.

Annex

I have interviewed:
Councillor Richard Cornelius
Councillor Alison Moore
Andrew Travers

Chris Naylor
Claire Symonds
Paul Najsarek (Head of the paid Service at Harrow)
Tom Whiting (Corporate Director of Resources at Harrow)
Hugh Peart (Director of Legal and Governance Services)

I have read the following documents:
Quarter 1 Quarterly performance report to Performance and Contract Monitoring Committee
Barnet Cabinet Resources Committee – 4th April 2012- set up of Joint Legal Services with Harrow
Barnet Remuneration Committee 29th January 2013 – Deputy Monitoring Officer functions to HBPL
Inter Authority Agreement- HBPL
Constitution of London Borough of Barnet

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AGENDA ITEM 11.2

Council

4 November 2014

Title	**Report from Adults and Safeguarding Committee- Referral to Council**
Report of	Head of Governance
Wards	All
Status	Public
Enclosures	Adults and Safeguarding Committee - 2 October 2014 Agenda Item 8: **Annexe One:** Delivery of Health and Social Care Integration including through the Better Care Fund **Appendix 1:** Business Case for Barnet Health and Social Care – Integration of Services **Appendix 2:** Better Care Fund Narrative Plan
Officer Contact Details	Andrew Charlwood, Head of Governance (Acting) andrew.charlwood@barnet.gov.uk 020 8359 2014

Summary

Agenda Item 8 of the Adults and Safeguarding Committee on 2 October 2014 was referred up to Full Council by four members in accordance with the Constitution. Council is therefore requested to consider the recommendations and take a decision on them.

Recommendations

1. **That Council consider and vote on the recommendations contained in Agenda Item 8 of the Adults and Safeguarding Committee on 2 October 2014.**

1. WHY THIS REPORT IS NEEDED

1.1 The Constitution allows a certain number of members to refer a matter on which a Committee had proposed to take a decision to its parent body. At the meeting on 2 October 2014, the required number of members of the Adults and Safeguarding Committee referred Agenda Item 8 up to the next meeting of Full Council.

1.2 As the Adults and Safeguarding Committee did not take a decision, the procedures to be followed will be those set out in Paragraph 20 of Full Council Procedure Rules (Rules of Debate). For reports of Committees (including Overview and Scrutiny Committees), the Chairman of the relevant committee, or the Vice-Chairman in their absence, will move reception of the report and adoption of the recommendations. This report need not be seconded. The leader of each of the other groups, or another member of their group, will then have an opportunity to comment on the recommendation, and at the end of the time allowed the Mayor will bring this part of the debate to an end, whether or not all those entitled have spoken or completed their speeches.

2. REASONS FOR RECOMMENDATIONS

2.1 As set out in the substantive report.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 As set out in the substantive report.

4. POST DECISION IMPLEMENTATION

4.1 As set out in the substantive report.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**
As set out in the substantive report.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**
As set out in the substantive report.

5.3 **Legal and Constitutional References**

5.3.1 Constitution, Responsibility for Functions- Paragraph 6- Members Rights to Refer Matters to Parent Body

5.3.2 Constitution, Full Council Procedure Rules, Paragraphs 20 and 21- Rules of Debate and Time for Debate

5.4 **Risk Management**

5.4.1 As set out in the substantive report.

5.5 **Equalities and Diversity**

5.5.1 As set out in the substantive report.

5.6 **Consultation and Engagement**

5.6.1 None

6. BACKGROUND PAPERS

6.1 None.

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	Adults and Safeguarding Committee 02 October 2014
Title	**Business Case for Barnet Health and Social Care – Integration of Services**
Report of	Dawn Wakeling, Adults and Communities Director
Wards	ALL
Status	Public
Enclosures	*Appendix 1:* Business Case for Barnet Health and Social Care – Integration of Services *Appendix 2*: Better Care Fund Narrative Plan
Officer Contact Details	Karen Spooner karen.spooner@barnetccg.nhs.uk Rodney D'Costa rodney.dcosta@barnet.gov.uk

Summary

This report presents the full business case for health and social care integration. This report will also be presented to the Barnet Clinical Commissioning Group (CCG) Board on the 23rd October for approval.

This business case represents an ambitious statement for achieving a transformation in integrated health and social care in Barnet. The business case provides the local system with the tools to implement a programme of work that will deliver the objectives of the high level model for integrated care set out in this paper. These same objectives have also been submitted to NHS England in the form of Barnet's Better Care Fund (BCF) submission. The BCF is a national initiative that requires local areas to move towards a single pooled budget to support health and social care services to work more closely together in local areas. The Better Care Fund, which replaces existing Section 256 (s256) funding arrangements, has required local areas to submit plans for joint working for the period 2014-16.

The business case presents the integrated care model in detail, with a financial and non-financial benefit analysis modelled up to the 2019/20 financial year. This business case shows that by integrating health and social care services for the frail elderly and those living with long term conditions, it will be possible for the Council to realise the £1m saving from integrated care hypothecated in the Priorities and Spending Review (PSR), provided the right level of invest-to-save funding can be made available during the period to allow for people to be treated in the community and at home, outside of acute and residential care settings.

Recommendations

1. That the Committee approves the full business case for integrated care, subject to the agreement of budget pooling and risk sharing between the Council and NHS Barnet CCG (recommendation 3 refers).

2. To note, that subject to approval, the full business case is to be used by the Policy & Resources Committee to inform budget setting processes.

3. To note the work taking place between the Council and NHS Barnet CCG to develop an approach to budget pooling for older people, under the Better Care Commissioning Partnership, led by the Chief Executive and Strategic Director for Communities.

4. To note that, subject to the approval of the full business case, implementation of the integrated care model will continue through the work programme of the Adults and Communities Delivery Unit, working in partnership with NHS Barnet CCG.

1. WHY THIS REPORT IS NEEDED

1.1 The £3.8bn Better Care Fund (BCF) (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. BCF starts in April 2015 as one pooled budget to support health and social care services to work more closely together in local areas. The Fund is an important enabler to take the integration agenda forward at scale and pace.

1.2 Barnet has been working on the integration of health and social care services for some time. This includes the member Task & Finish group to define a local vision for integration, setting up an integrated care programme reporting to the Health and Wellbeing Board (HWB) and agreeing an Integrated Care Concordat between Barnet commissioning and provider partners. The Barnet BCF plan and the full business case for health and social care integration are the culmination of local work on integrated care for frail older people and those aged 55 and over with long term conditions.

1.3 Most BCF funding is not new or additional resources, but the reallocation of existing Council and Barnet CCG budgets for health and social care service provision to a new, single pooled budget format. This is £23.4m in total and includes: s.256 funding; NHS funding for Carers Breaks and Enablement services; the Adult Social Care (ASC) Capital Grant and Disabled Facilities Grant (both ring-fenced); funding to meet the requirements of the Care Act; and NHS funding provided via Barnet CCG.

1.4 The attached full business case for integrated health and social care has been developed to ensure that locally, Barnet will implement a model of integrated care for frail elderly people and those with long term conditions, which has a clear financial and non-financial case for the Council and NHS Barnet CCG (CCG), which will enable the Council to meet longer-term aims and challenges.

1.5 The business case sets out a clear, analytically driven understanding of how the Council will use the BCF together with budgets for core services to improve care for frail, elderly people in Barnet by integrating health and social care services.

1.6 It details the Barnet 5 tier integrated care model and demonstrates how investment from Public Health, s.256, CCG and Council adult social care will be used to develop and deliver this new model of care. It also shows how the integrated care model is a key delivery vehicle for achieving Council Priorities and Spending Review (PSR) priorities and savings and CCG Quality, Innovation, Productivity, Prevention (QIPP) savings. To develop this business case, we have consulted and agreed our plans with all key stakeholders in the Barnet health and social care economy.

1.7 Using this investment from 2014/15 to 2019/20 (six years) the business case illustrates an indicative, estimated saving of £12.2m, resulting by 2019/20 in a annual shift in spending away from acute hospital and residential and nursing care home services of £5.7m. The modelling has factored in the proportion of agreed medium term financial strategy (MTFS) savings for Adults and Communities of £17m (rounded) for 2014 – 16; plus £13m savings for 2016 – 2020 allocated through the Council PSR process related to older people and long term conditions.

2. REASONS FOR RECOMMENDATIONS

2.1 The business case demonstrates that the hypothecated PSR savings of £1m from Adult Social Care budgets (£150,000 in 2016/17; £250,000 in 2017/18 and 2018/19 respectively; and then £350,000 in 2019/20) can be achieved by delivering this programme of work, provided the right level of invest-to-save funding can be made available during the period to allow for people to be treated in the community and in their own homes, outside acute and residential care settings.

2.2 The Policy and Resources Committee will subsequently use the financial and benefits modelling in this business case to inform the setting of budgets and so the level of investment available.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Doing nothing is not recommended. The Council and CCG need to integrate health and social care services to meet the anticipated needs of frail, elderly people to achieve better outcomes and improve user experience in a financially sustainable way.

3.2 The business case builds on the local vision developed for health and social care integration through the work already done under the auspices of the HWB. The full business case is closely aligned with the BCF, which is a mandatory requirement for Councils and CCGs nationally.

4. POST DECISION IMPLEMENTATION

4.1 The Council has previously set its strategic vision for integrated care for older people, through its published vision statement and the Barnet integrated care Concordat. To this end, officers have been working to implement new models of integrated care, such as multi-disciplinary case management and integrated locality care teams, on a pilot basis. The business case analysis is based on a combination of new services in pilot form and services yet to be implemented. An agreed programme structure is in place to develop and evaluate integrated care, led by the Council/CCG Joint Commissioning Unit based in Adults and Communities and reporting into the HWB through the HWB Financial Planning Group. Subject to Committee approval, implementation of the Business Case will be delivered through this agreed programme structure. This work will also be aligned with parallel work to develop wider strategic arrangements for integrated commissioning between the Council and CCG.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The business case aligns with the 2012-15 Health and Wellbeing Strategy's twin overarching aims (Keeping Well; and Keeping Independent). Clear links are also made to: the Barnet Council Corporate Plan; PSR; the outline aims of the Council's 5 year commissioning intentions for adult social care, published in draft at Committee in July; and Barnet CCG 2 and 5 year Strategic Plans. Barnet Council and the CCG will play key roles in delivering the plan through the Joint Commissioning Unit (JCU) and Public Health.

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

5.2.1 The business case sets out the overall investment required to implement the 5 tier integrated care model and the links between the model and published QIPP schemes and PSR proposals.

5.2.2 The national allocation of BCF to Barnet is £23.4 million (rounded) in 2015/16. The Business Case considers the totality of local spend on older people with physical frailty and/or long terms conditions, amounting to a total of £136.5 million across health and social care, with £77.9 million forming the core spend within the model (divided between 46% Council spend and 54% CCG spend) and £58.6 million of 'influence-able' spend. Influence-able spend is money spent in the acute health care and nursing care sectors, where it is anticipated that savings will be made as a result of activity reductions arising from the impact of the integrated care model. All Council adult social care spend on older people, both direct care costs and staffing, has been included in the £77.9 million core spend.

5.2.3 The majority of the savings will be made within acute hospital spend. It should be noted that due to acute health care payment rules (Payment by Results or PBR), strong commissioning will be required to deliver the savings in reality. Senior leaders within the Council and the CCG have been considering how closer working on commissioning can be developed to support the achievement of financial benefit for Barnet. This work is being led by the Chief Executive and the Strategic Director of Communities. This work on integrated commissioning gives the Council the opportunity to consider whether the size of the BCF pool should be increased to include higher levels of adult social care spend. Further proposals on this will be brought to Committee in the future.

5.2.4 The business case details the financial contributions from Barnet CCG and the Council which comprise the single pooled budget to be used to support health and social care working more closely together to deliver integrated outcomes for patients and service users. Table 1 below provides a breakdown of the 2015/16 Better Care Fund funding that will deliver the projects set out in the business case. Of this total, the allocation for *protecting social care* is £4.20m (rounded) plus £846,000 for Care Act implementation. It can be seen that most of the BCF is not new or additional resources, but the re-allocation of existing service provision budgets to a new pooled budget format. Aligned budgets will be brought alongside this pooled budget, including an agreed public heath contribution to support delivery of the model. It should also be noted that existing 2014/15 s256 funding (£6.634m) previously agreed by Health and Well-Being Board will be continued into 2015/16.

Table 1 – 2015 /16 BCF

	£000
ASC Capital Grant (ring-fenced)	806
s256	6,634
Carers Breaks	806
Enablement	1,860
Disabled Facilities Grant (ring-fenced)	1,066
NHS funding	12,240
(includes £846,000 for implementation of the Care Act)	*846*
Total	**23,412**

5.2.5 The majority of funding for the business case is contained in the s256 and NHS funding streams, alongside an element from Public Health not contained in the BCF. This includes baseline funding and additional incremental funding for investing in the projects and services described.

5.2.6 Planned initiatives are estimated to deliver a net annual recurring benefit to budgets of £5.7m by 2019/20. This is a result of £4.1m additional revenue expenditure per year, generating £9.8m per year of avoided expenditure in acute hospital and care home services. There are also one-off investments upfront totalling £1.4m.

5.2.7 The £5.7m in benefits realised includes £3.1m QIPP savings for Barnet CCG QIPP savings, £1m PSR savings for the Council plus £1.6m in other savings for both organisations across the delivery of integrated services.

5.3 Legal and Constitutional References

5.3.1 In 2015/16 the BCF will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between CCGs and councils. (Note: Section 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets). A condition of accessing the money in the Fund is that CCGs and Councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

5.3.2 The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

5.3.3 The Council and Barnet CCG already have an overarching s75 agreement in place for health and social care integration, within which the Barnet BCF work will be included, with clear service schedules.

5.3.4 DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund.

5.3.5 The terms of reference of Health and Well Being Board include a commitment '*To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social well-being. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; and Section 75 partnership agreements between the NHS and the Council*.'

5.3.6 The responsibilities of the Adults and Safeguarding Committee are contained within the Council's Constitution - Section 15 Responsibility for Functions (Annex A). Specific responsibilities for those powers, duties and functions of

the Council in relation to Adults and Communities including the following specific functions:

- Promoting the best possible Adult Social Care services.

5.3.7 The Adults and Safeguarding Committee is responsible for the following:

- Working with partners on the Health and Well-being Board to ensure that social care interventions are effectively and seamlessly joined up with public health and healthcare, and promote the Health and Well-being Strategy and its associated sub strategies.
- Ensuring that the local authority's safeguarding responsibilities are taken into account.

5.4 Risk Management

5.4.1 Barnet Council / CCG projects are delivered following programme and project management methodologies and governance frameworks and arrangements that enable project and programme level risks to be identified, reported and managed by the Programme Management Offices and senior management teams of CCG and Adults & Communities Delivery Unit (A&CDU).

5.4.2 Specific risks relating to the delivery of work detailed in the business case are included, together with mitigating actions. These will be monitored regularly in accordance with the aforementioned governance process.

5.4.3 Barnet CCG and the Council will assess and implement the most appropriate contracting models and over-arching governance arrangements to enable the set up and delivery of pooled budgets and shared risk. This is required to be in place for April 2015 and it will be essential to ensure robust management of the BCF, especially as the size and scope of BCF and the pooled budgets increases, subject to necessary due diligence.

5.5 Equalities and Diversity

5.5.1 Equality and Diversity issues are a mandatory consideration in decision-making in the Council pursuant to the Equality Act 2010. This means the Council and all other organisations acting on its behalf must have due regard to the equality duties when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business, requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

5.5.2 The specific duty set out in s149 of the Equality Act is to have due regard to need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.5.3 The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.5.4 As new services are developed resulting from the full business case, they will be subject to appropriate equality impact assessments and mitigation plans. A requirement of the BCF is to guarantee that no community is left behind or disadvantaged – the commissioning system therefore needs to be focused on reducing health inequalities and advancing equality in its drive to improve outcomes for service users and patients.

5.6 Consultation and Engagement

5.6.1 To develop the 5 Tier Model for integrated health and social care, the Council and CCG have engaged with residents, commissioning and provider partners and voluntary sector groups across three areas:

- To validate the outcomes, modelling and other elements of direction of travel described in the business case.
- To co-design and develop the detailed model and services that will deliver our target outcomes and vision for integrated care.
- To test a variety of ideas addressed in the case at forums such as the residents' consultation facilitated by 'HealthWatch' and the Older Peoples Partnership Board.

5.6.2 More details of the stakeholder consultation and engagement undertaken to date and planned for the future are set out in Council and Barnet CCG BCF Plan appended to this report, in Section 8 of the BCF plan. Specific consultation will take place with staff in line with Council and CCG/NHS HR policies as required, as implementation plans for the full business case are developed.

6. BACKGROUND PAPERS

6.1 None.

Appendix 1

Barnet Health and Social Care

Integration of Services

Business Case

October 2014

Document Information

Source

Update from 'Barnet Health and Social Care Economy - Integration of Health Social Care Services Outline Business Case' (v7 Final, 07 March 2014).

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Approvals

By signing this document, the signatories below confirm that they have fully reviewed and accept this completed this Updated Outline Business Case for integrated health and social care services.

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Version History

Version	Date	Author(s)	Summary of Changes
0.1	29 July 14	LBB A&C	First Draft (proposed structure and changes/updates)
0.2	28 Aug 14	LBB A&C	First full draft (content, revised layout) bar financials
0.3	04 Sep 14	LBB A&C	Revised draft (content edited, additional data added)
0.4	05 Sep 14	LBB A&C	Revised draft (content edited, additional data added)
0.5	09 Sep 14	LBB A&C	Completed full draft for review at HWBB 18 Sept 14
0.9	22 Sep 14	LBB A&C	Revised full draft following HWBB comments 18 Sept

Note: This latest draft is a DRAFT version. It is not complete or verified.

This draft business case has been reviewed at the Health and Well-Being Financial Planning Sub-Group on the 7th August and 4th September 2014.

Contents

Executive Summary

This Business Case updates and develops the 'Barnet Health and Social Care Economy - Integration of Health Social Care Services Outline Business Case (OBC)', published 07 March 2014 (v7 Final).

Our vision is a single, shared approach to integrated health and social care for frail elderly people and those living with long-term conditions in Barnet, delivered through a '5 Tier Model' of care, to achieve better outcomes and improve user experience in a financially sustainable way.

Our 5 Tier Model consists of a range of initiatives, designed to move the delivery of services from acute or long-term nursing and residential care, to community based services that enable people to live happily, healthily and independently. The 5 Tiers, including example services are:

1. Developing greater self-management, e.g. Expert Patient Programmes.
2. Promoting Health and Wellbeing, e.g. Dementia Friendly Communities.
3. 'No Wrong Door' approach to access, e.g. the Care Navigation Service.
4. Investing in community intensive support, e.g. Rapid Response Services.
5. Acute, residential and nursing home care, e.g. Quality in Care Homes.

As the number of frail elderly people that require health and social care support increases, it is essential they are offered services that help them to remain independent and live healthily in their own homes for as long as possible. They need access to crisis response services, and support to recover quickly from illness. Services in Barnet do not currently always fulfil these objectives, and as result there is an over-reliance on hospital services and residential care. Plus there has been an increased take-up of adult social care support to respond to changes in acuity and urgency.

The 5 Tier Model will therefore enable us to reduce the forecast gap in funding for services in the next six years, by rebalancing the delivery and take up of services towards self-management and prevention and reducing activity in acute, residential and nursing care home services.

The projects and services detailed here are estimated to deliver a net annual recurring benefit to budgets of £5.7m by 2019/20. This is a result of £4.1m additional revenue expenditure per year, generating £9.8m per year of avoided expenditure in acute hospital and care home services. There are also one-off upfront investments totalling £1.4m.

The £5.7m in benefits realised includes £3.1m QIPP savings for Barnet CCG QIPP savings, £1m PSR savings for the Council plus £1.6m in other savings for both organisations across the delivery of integrated services.

The total savings of £9.7m as illustrated above include savings to health of £8.9m, from a reduction in acute activity of 2,268 avoided non-elective admissions, 501 fewer excess bed days and 10,896 avoided outpatient and A&E attendances. This level of activity is within the potential benefits set out in the recently published Better Care Fund Fact Pack for Barnet. Savings to social care of £1m come from 62 avoided residential care admissions from 2018/19 to 2019/20.

Our analysis of the costs and benefits involved are an indicative view of the benefits available. We have taken a prudent approach, i.e. modelling costs at the higher end of the range of forecasts and benefits at the lower end. We anticipate that the initiatives in place have the potential to impact more positively on social care than stated so far. However, at this stage evidence to support this remains inconclusive and further development is required through the Programme to determine the maximum scale of operations and therefore benefits possible.

We have made excellent progress. The Care Navigation Service (CNS) and Multi-Disciplinary Team (MDTs) case conferences started in July 2013. We launched the Rapid Response service in August 2013 and Community Point of Access (CPA) in April 2014. The Risk Stratification Tool is now live in all GP Practices and our Integrated Co-Locality Pilot Team became operational in August 2014.

This Business Case demonstrates the significant progress we have made so far. The new services now in place and projects in delivery are beginning to return financial savings and benefits and the best outcomes for frail elderly people and those with LTCs.

We realise however there is much more work to do. The scope of work to date has focused on health services to address pressures on acute services. Our initial review of the benefits realised so far reflects this, showing that we are reducing unplanned emergency admissions to hospital and so enabling people to live independently and healthily at home.

While the net recurring budget savings modelled of £5.7m represents positive progress, it does not eliminate the £19.2m funding gap identified.

We now need to assess the maximum scale to which we can operate the services in this model and so maximise such available savings and benefits. We also need to understand the long-term impact on and benefits to the cost and make up of social care services. We need to be sure that by giving people access to preventative, community based services or supporting them to self manage LTCs; this model will also reduce the level of social care support needed.

Continuing to monitor the progress and impact of the projects described here will validate the core principles of our vision and model for integration and our ongoing investments, plus enable us to identify future opportunities to increase and enhance integration through new services.

1. Introduction

This Business Case updates and develops the 'Barnet Health and Social Care Economy - Integration of Health Social Care Services Outline Business Case (OBC)', published 07 March 2014 (v7 Final).

The OBC detailed our vision to drive forward integrated working and implement a single, shared approach to integrated care in Barnet, through a '5 Tier Model', to answer the critical question:

> *'How do we achieve better health and wellbeing outcomes and improve user experience for the frail, older population in Barnet in a financially sustainable way?'*

Our 5 Tier Model reflects our ethos of self-management and prevention as foundations for the integrated care systems of the future. It consists of a range of initiatives, designed to move the delivery of services from acute or long-term nursing and residential care, to community based services that enable people to live happily, healthily and independently.

The 5 Tier model is integral to our plans for delivering on our Better Care Fund (BCF) objectives and will enable us to meet the challenges of:

1. Improving outcomes for frail elderly residents, patients, service users in Barnet and those living with long-term conditions (LTCs) and their carers.
2. Increased expectations from people regarding their experience of the care received, e.g. better quality, integrated care that meets their needs appropriately.
3. Forecast gaps in funding available for the expenditure expected to meet the needs of people and demand for services, as the population of frail elderly people and those with LTCs in Barnet grows in the future.
4. Meeting ambitious but necessary external QIPP and BCF or internal Medium Term Financial Savings (MTFS) and Priority Spending Review (PSR) targets.
5. Structural financial deficits inherited from legacy organisational structures.

We have made excellent progress. The Care Navigation Service (CNS) and Multi-Disciplinary Team (MDTs) case conferences started in July 2013. We launched the Rapid Response service in August 2013 and Community Point of Access (CPA) in April 2014. The Risk Stratification Tool is now live in all GP Practices and our Integrated Co-Locality Pilot Team became operational in August 2014.

We believe there is much more to do to integrate the care system for frail elderly people and those with LTCs, removing fragmentation by joining up organisations and practitioners.

Our ongoing delivery of the 5 Tier Model will also enable us to address the impact of and harness opportunities presented by changes in organisational and commercial structures across LBB and BCCG and the commissioning and provider landscape and the anticipated impact of the Care Act.

This Business Case includes:

- Our strategy for integrating health and social care services to improve outcomes and experiences and anticipated increases in demand for our target cohort of people.
- Our vision for integrated care through the experience of a fictitious resident "Mr Colin Dale", who represents frail elderly people and those living with long term conditions in Barnet.
- The best outcomes for "Mr Colin Dale" and the new model of care we have established to deliver them.
- Detailed descriptions of the work we are undertaking to deliver our vision and model, including the objectives, outputs, costs, benefits and timescales to implement.
- A profile of the likely financial envelope in scope and the impact of future funding and demographic challenges on this amount.
- An understanding of the commercial options available to the council and a sense of direction on an innovative, pragmatic approach with regard to the local context.
- Financial models tested against agreed standards and quality criteria, to provide a recommendation to the Adults & Safeguarding Committee and CCG Board.
- A description of the governance arrangements and principles and key implementation considerations, critical to the next steps to progress and deliver work successfully.

2. Strategic Case

Barnet will experience one of the largest increases in elderly residents out of all London boroughs over the next five to ten years. There are currently 52,000 people in Barnet over the age of 65, and this will increase to 59,800 by 2020. Barnet's Health and Wellbeing Strategy sets out the Borough's ambition to make Barnet 'a place in which all people can age well'. The challenge is to make this a reality in the context of rising health and social care needs among older people, and the financial pressures facing both the NHS and the Council.

Despite the many positives that come from growing older, there is also a higher risk of deteriorating health, reduced wellbeing and lack of independence. At present, there is estimated to be 23,355 people aged 65 or over in Barnet with a limiting, long term illness. This particular cohort is expected to increase by more than 20% over the next ten years. Plus this cohort overlaps with an estimated 17,922 over 65s unable to manage at least one self-care activity on their own.

As expected, a correlation exists between age and self reported health conditions in the borough. Under the age of 15, 97% of residents report their health to be good or very good (only 0.7% report bad or very bad health). This percentage rapidly decreases as residents grow older. For example, by age 65 only 50% of the population are reporting that they are in good health, whilst 15% say that they have bad or very bad health. [1]

The chances of developing dementia are significantly increased in old age. Barnet will experience an increase in the volume of dementia cases reported, because the life expectancy of its residents is continually increasing. In 2012, Barnet had a higher population of adults with dementia than any other London Borough (the 2012 percentage was also significantly higher than national averages). In 2014, there was estimated to be 4,000 people living in Barnet with dementia. This number is rapidly increasing (1.5 times faster than other London locations) making this a key challenge for health and social care.

Period 2011/12. Key:
Red = Significantly worse than England
Orange = Not Significantly Different to England
Green = Significantly Better than England

Figure 1 – Percentage of adults (18+) with Dementia, 2011/12 [2]

[1] Barnet JSNA
[2] Barnet Community Mental Health Profile, PHO, DH, 2013.

Many older residents remain in good health well into old age. The individuals within this cohort often become carers. For example, it has been estimated that there are 6,988 over 65s providing unpaid care to family or friends within the borough. Without adequate support, these individuals experience unnecessary strain and hardship. In addition, the added stress and pressure of being a carer can cause rapid deteriorations in health. This represents another key challenge for health and social care.

Other conditions associated with ageing

The conditions most commonly associated with ageing are: coronary heart disease and stroke, diabetes, cancer, chronic pulmonary obstructive disease, incontinence, Alzheimer's disease and other forms of dementia, osteoporosis and osteoarthritis. Older people may also experience some decline in hearing, vision, physical strength and balance and there may be some loss in mental acuity. However, many of the health conditions experienced in old age are preventable. For example, obesity increases the risk of Type 2 diabetes twenty-fold and doubles or triples the risk of other chronic conditions including high blood, pressure, heart disease, and colon cancer. Smoking accounts for nearly one-fifth of all deaths from cardiovascular disease. Men who smoke increase their risk of dying from lung cancer by 22 times, and women by nearly 12 times.

As the number of older people requiring health and social care support increases, it is essential they are offered services that help them to remain independent and live healthily in their own homes for as long as possible. They need access to crisis response services, and support to recover quickly from illness. The current service provision in Barnet does not always fulfil these objectives, culminating in an over-reliance on hospital services and residential care. Plus there has been an increased take-up of adult social care support to respond to changes in acuity and urgency.

Ensuring that the required community provision is in place will enable older adults to be better managed at home, avoiding the need for hospital admissions and the rapid deterioration that often follows. In addition, residents will receive high quality, compassionate care that is designed to meet their personal needs[3]. Such provision will also delay and reduce the potential requirement for a higher cost traditional package of care. When a hospital admission does become necessary, the system will support patients to be discharged and returned to their home as quickly and as efficiently as possible. This will reduce the need for care home placements.

When implemented successfully, an integrated care system for frail elderly and those with long-term conditions in Barnet should deliver:

- **Better patient and carer experience**
- **Better clinical outcomes**
- **Lower cost, better productivity** (supporting the Council and BCCG to deliver on their medium and longer term financial savings strategies)

[3] *Kings Fund (2012) Integrated care for patients and populations: Improving outcomes by working together*

This business case sets out the work that is required to implement a successful integrated care model that will achieve these ambitions for Barnet. This work will also support those under the age of 65 living with LTCs.

The Vision for Integrated Care in Barnet

Barnet's vision for integrated care is detailed in the Health and Social Care Integration Concordat through a description of a fictitious resident ("Mr Colin Dale") and his experience with health and social care services. He is representative of the frail elderly and long terms conditions population in scope. The Concordat Vision agreed by all parties of the Barnet Health and Social Care Integration Board states:

> Care integration in Barnet will place people and their carers at the heart of a joined up health and social care system that is built around their individual needs, delivers the best outcomes and provides the best value for public money. Integrated care will be commissioned by experts in collaboration with care providers and delivered seamlessly by a range of quality assured health, social care, voluntary and private sector organisations.

What does this vision mean in practice for Mr Colin Dale and residents of Barnet?

The development of the integrated care model will mean that Mr Dale has:

- A single point of contact.
- Access to quick and responsive services in the community.
- To only tell his story once.
- The support of professionals and services that talk to each other.
- Support options for his family and carer.

Mr Dale will feel supported to manage his own health and wellbeing wherever he can and for as long as possible.

Objectives of the integrated care model

To ensure Colin Dale receives the support he needs, the integrated care model set out in this business case will need to deliver on a number of core objectives:

Objectives
Better patient and carer experience: • The provision of a local, high quality service that targets those most at need. • Enable people to remain at home, where essential care can be delivered and monitored. • Reduce duplication in assessment and provision through the use of an integrated locality team approach to case management. • "No wrong door" for frail older people and those with long term conditions. • Increase the number of people who have early interventions and proactive care to manage their health and wellbeing. • Increase satisfaction levels (individuals, families, cares, etc) by providing opportunities to develop and agree care plans including access to appropriate care services. • Provide support and stability for family carers so they can remain in their role.
Improved older adult outcomes (health and social care)**:** • Ensure quality long term care is provided in the most appropriate setting by a workforce with the right skills. • Encourage/facilitate pro-active care to ensure long term conditions do not deteriorate – this will reduce the demand on acute/long-term residential care, repeat interventions and crisis services such as emergency departments. • Increased use of health and social care preventative programmes that maintain people's health and wellbeing. • Improved practice in use of medication leading to a reduction in unplanned and emergency admissions to hospital and A&E.
Lower cost, better productivity (achieved through the ability to improve future resource planning and 'needs' predicting): • Utilising risk stratification to manage the care of those individuals most at risk of an escalation in their health and social care needs. • Utilise a joint approach to care – this will result in an improved customer journey and better management of service resources. • Increased information and signposting to ensure preventative services are fully utilized. • Supporting people to stay living at home for as long as possible and enable them to take more responsibility for their own health and wellbeing – this will reduce rising admissions to residential care.

Benefits

All of the work being undertaken, and planned, as part of the HSCI programme is intended to contribute to at least one of the following top level outcomes:

1. Improved user experience
2. Improved user outcomes
3. Reduced funding requirements

The Better Care Fund (BCF) translates the top level outcomes into quantifiable measures i.e. an objective demonstration that the top level outcomes are being delivered. The current national BCF metrics are:

Measure	Baseline	Planned 2015	Planned 2016 (Q1)
(Reduced) avoidable non-elective and/or emergency admissions per 100,000 population (average per month).	1,935	1,838	1,898
Measure	**Baseline**	**Planned 2014/15**	**Planned 2015/16**
(Reduced) permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.	486.9	417.6	354.1
(Increased) proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services.	71.9%	76.8	81.5
(Reduced) delayed transfers of care (delayed days) from hospital per 100,000 population (average per month).	635.3*	492.3*	379.3*
(Improved/minimum) Patient/service user experience (national metric).	0.7	0.8	0.8
(Increased) Self directed support.	1.0	1.0	1.0

* - Average Quarterly Rate

Only the first measurement, 'reduction in non-elective admission (general and acute)', will be linked to payment for performance, therefore focus should be on the population segments and schemes that will impact on this. All other metrics will still be monitored.

Developing a single agreed list of outcome measures for the HSCI programme will ensure that everyone locally (both commissioners and providers) is working towards a universal set of outcomes.

Intermediate Outcomes

Some projects or initiatives are unable to demonstrate a direct causal link between project outputs/outcomes and the top level outcomes. In these instances, there is still value in delivering the project if it can demonstrate an alignment to an 'intermediate outcome' i.e. one of the interim steps on the path towards achievement of the top level outcomes.

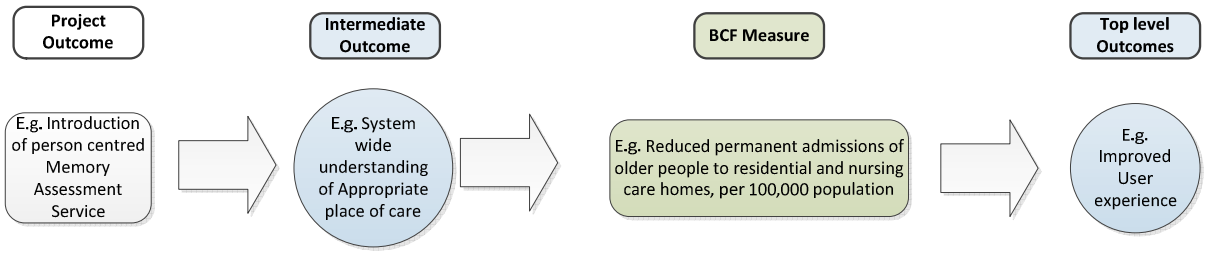


Figure 2 – Outcome Relationship Map

Individual project outcomes (and associated measures) should therefore be considered within the overall context of achieving the top level outcomes/vision.

Business Strategy

People in Barnet already benefit from integrated Learning Disabilities (LD) and Mental Health (MH) services. This business case develops an integrated care '5 Tier Model' for frail and elderly people aged 65 and over and those with long term conditions/dementia. In addition, the model aligns with the national requirements for integrated care and is driven by the Better Care Fund (BCF)[4]. Recognising a significant element of the pressure in the current health and social care system is a result of demand from some specific user groups[5], the scope of this programme includes all LBB and BCCG budgeted expenditure for the following groups of people:

1. Frail elderly people: those over 65 who suffer from at least three of the 19 recognised ambulatory care sensitive (ACS) conditions.
2. People with Long term conditions: those aged 55-65 who suffer from any of the following long term conditions: angina, asthma, congestive heart failure, diabetes, hypertension, iron deficiency anaemia, COPD, dehydration, cellulitis.
3. People living with Dementia.

The Health and Wellbeing Board has already developed a vision for health and social care integration in Barnet and prioritised a programme of opportunities to deliver this. This business case provides details on how each of these opportunities will be implemented, and how this programme of activity will improve outcomes and reduce costs.

Barnet has also started to make progress on developing a system of integrated care for older people. This will provide an excellent platform for further development. Examples include:

- **Social care Multi-disciplinary teams and GP localities - co-terminus:** designed to support and manage care e.g. crisis self-management and end of life pathways.
- **Care Navigators:** enable access to local services including community care assessments, and advice on use of personal budgets.

[4] Definition of BCF
[5] National Evidence

- **Multi-disciplinary case conference meetings:** social care professionals with specialist knowledge, skills and experience will work together to assess the needs of frail and elderly patients identified as at high risk of hospital attendance or significant deterioration in health.
- **Risk stratification tool in primary care:** GPs will use this tool to identify frail and elderly patients at risk of future unplanned hospital attendance or deterioration in health.
- **7 day social work service** at Barnet General Hospital and the Royal Free NHS Foundation Trust Hospital, which increases the opportunities for social workers to support people out of hospital.
- **Rapid care service:** provide intensive, home-based packages of care to support people in periods of exacerbation or ill-health.
- **Falls services**: focus on preventing falls in the community by facilitating education and exercise. This service will work with/offer treatment from the multi-disciplinary teams to ensure a holistic approach to preventing further falls.
- **Dementia services:** including re-designed Memory Assessment Service (MAS) to identify and support people with dementia as early as possible. In addition, qualified advisors will be based in the community to help people manage their dementia.
- **Ageing Well:** a multi-agency, community-asset based programme that supports older people to age healthily and happily in their local community.

The Government's Better Care Fund (BCF) sets the requirement for local authorities to develop a holistic, integrated model which includes the services detailed above. It should be delivered via pooling/aligning health and social care budgets and overseen by shared leadership across health and social care.

The strategic case for change is about improving outcomes and delivering a better user experience in a more financially sustainable way. Barnet will achieve this by moving to a model that invests more funding in lower level and preventative support. The result of this action will almost certainly be a shift in demand away from hospitals and long term residential care[6].

[6] London Borough Barnet (LBB) and Barnet Clinical Commissioning Group (BCCG) are fully committed to working in partnership to deliver integrated health and social care services. The ambitions set out in this business case sit within a wider set of proposals being developed by LBB, BCCG and Capita to integrate the entire suite of commissioning functions across social care and health, effectively creating a new integrated commissioning entity in the borough. The aspiration of this joint venture is to drive high quality cost effective care for the whole population, utilising an innovative partnership approach to managing risk.

3. Economic Case

As set out in the strategic case for change, Barnet needs to find a cost effective way to redesign services so that they:

- **Meet the needs of an ageing population.**
- **Improve outcomes from care.**
- **Reduce** system spend

To achieve these objectives, local partners have developed the **5 Tier integrated care model**.

The 5 Tier model provides a framework for investment and delivery of integrated care over the next 5 years across the whole borough for the totality of the target population. It outlines the ambition, and articulates the scale and pace of change required to meet the needs of Barnet residents. It also builds on successful experiences in winter planning e.g. the 2013/14 commitment by health and social care to a 7 day working week.

The core aspects of this model include a focus on prevention, a single point of access, risk stratification and appropriate care at the right time through locality based integrated care teams/rapid care provision. The diagram below illustrates the co-ordinated care system that this model will deliver. Key components include:

1. Developing greater self-management (Tier 1)
2. Promoting Health and Wellbeing and building the capacity of individuals and communities (Tier2)
3. 'No Wrong Door' approach to access (Tier 3)
4. Investing in community intensive support (Tier 4)
5. Reducing the demand for hospital based, residential and nursing home care (Tier 5)

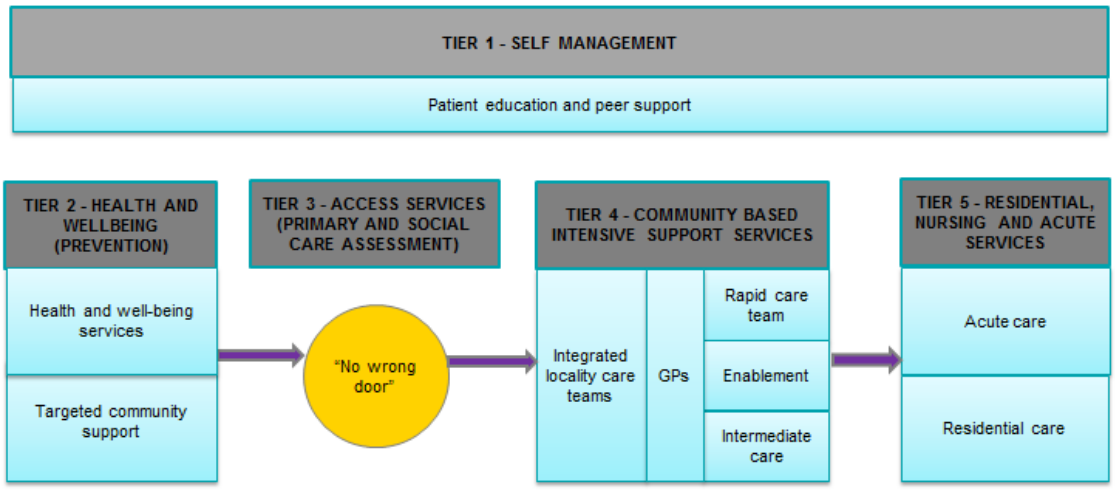


Figure 3 – Overview of the 5 Tier Model

The 5 Tiers

Tier 1: self management

Self-management is a critical component of integrated care models for frail elderly people and those with LTCs. It supports a shift in the focus of health and social care delivery away from formal institutions and towards a person's own home environment, where a lot of self-management can occur. "Self-management" takes place in the context of a recognised medical condition (such as diabetes or heart disease) and will normally include a level of formal health service input often focused on patient education, monitoring of disease indicators and skills mastery.

The vision for Tier 1 in the model is that all individuals in the cohort group who would benefit will be offered some form of self management education, training, or support (this will be based on an individual's preference). These opportunities will help to up-skill people and improve their health literacy so that they are more confident about looking after their own health. Furthermore, individuals will be able to access structured education, support from a long-term condition mentor or health champion and online support forums/innovative online support tools to help them manage their long-term condition(s) effectively.

Residents will also be encouraged to access one of the Borough's Older People's Healthy Living Pharmacies. Here they will be able to review their medication use with a pharmacist, be referred directly into community based preventive services, and work with a health champion to adopt healthier behaviours that will help them manage their long-term condition(s).

To achieve this goal, professionals across health and social care will be offered training that will enable them to support and empower residents to manage their long-term conditions independently. Furthermore, they will have access to social prescribing support tools to refer individuals into Tier 2 (preventive services).

The initiatives above will help meet the Tier 2 objectives of keeping people well and independent. They will also reduce pressure on Tier 3, 4 and 5 services.

Tier 1: Case Study

When Mr Colin Dale was 56, he went to his GP because he was experiencing extreme tiredness, had blurred vision, and was also thirsty a lot of the time. Mr Dale's GP told him he had Type 2 diabetes. The GP told Mr Dale that many older people get Type 2 diabetes and that for Mr Dale, this was probably linked to the fact he had been overweight for years.

The GP decided Mr Dale did not yet need specialist support, but that he should have a care and management plan put in place for his diabetes. Mr Dale was asked whether he would be interested in attending the Expert Patient Programme (EPP) course for older people that was starting next week. Mr Dale wasn't sure, but he did like the sound of the health champion who was based at his local pharmacy, which could help him increase his physical activity. The GP also wrote Mr Dale a social prescription for a healthy eating session being run by Age UK. The GP gave Mr Dale tools and resources to complement his care and management plan, and advised Mr Dale that his local pharmacy could be accessed between 8am and 6pm Monday-Friday to provide additional advice, support and remote monitoring of blood glucose.

Mr Dale left the surgery and went home with his plan of action. On his way home he received a text from his surgery with a summary of the key information the GP had given him, links to the Diabetes UK website, the phone number of his local health champion, and information about the dates of future EPP courses he could join.

Six weeks later, Mr Dale had been into his pharmacy for advice on how to check his blood sugar, met his health champion who had accompanied him to a local swimming class, and had made contact with other residents who had diabetes via an online support forum hosted by his GP practice. Six months later, Mr Dale had lost a significant amount of weight but still wasn't feeling very confident about how to manage his condition. His health champion made a referral for him into the next EPP course which he attended for 6 weeks. He discovered a lot about the disease progression of diabetes and what to expect at each stage of the disease, which built his confidence. He also made 2 close friends on the course, and began daily walks with them.

Twelve months later, Mr Dale returned to his GP for his care plan review and the GP was really pleased with the actions Mr Dale had put in place to manage his own condition. The GP suggested to Mr Dale that he become a long term condition mentor for the practice - a role he would be supported to fulfil and which would build the size of Mr Dale's network even further.

Tier 2: health and wellbeing (prevention)

An effective Tier 2 will offer a range of services that align with the needs and preferences of individual Barnet residents. This tier will focus on preventing the onset of ill health and improving people's social well-being, reducing the demand for social and health care services. These services will be publically recognisable, readily available, understandable and easy to access. This will ensure that people are aware of the numerous services that currently exist across all sectors, including those that are commissioned by the Council.

The introduction of the Tier 2 services will be supported by a recognisable brand and a joined up approach to commissioned services. This approach will build on the "hubs approach" developed in older peoples and carers commissioned services and ensure that services are joined up across the Tier using an easily identifiable and unified "brand" e.g. Prevention Matters in Buckinghamshire, Staying Well in Bolton.

Information on what support is available will be easily accessible through a "no wrong door approach". The cohort population in the model will be signposted to information sources and advice as early as possible, so that they can proactively identify support that meets their needs (this aspect of the model overlaps with the objectives of Tier 1). Further help and guidance will be offered to people who still struggle to access these services. In addition, expert advice will be readily available for more complex issues such has moving into new accommodation, housing adaptations and financial planning.

Residents who are identified as at risk of needing Tier 3 and 4 services will need further assessment. This will ensure they receive specific support from particular services (dictated by personal circumstances, health condition, etc). Strong links will need to exist between all Tiers to ensure that people get the right support, and are able to fully utilise Tier 2 services no matter how complex their condition might be. A good evidence base of what works at a system/individual level will be developed and this will inform future commissioning.

Community resilience and peer support will form a key strand of this approach. Dementia friendly communities will be a key tool for the development of community resilience around an important theme. Initiatives will support the individual to live well and take responsibility for maintaining and managing their own health and well-being. Formal services will be commissioned to fill the gaps, e.g. Ageing Well, home care support, but will always be working to enable people to take responsibility for their own lives.

Carers will be supported to be as effective and sustainable as possible alongside achieving their ambitions. The development of a health education package for carers which supports safe caring and is promoted by GPs, the Council, carer's services and hospitals will be a key development in this Tier.

Tier 2: Case Study

Mr Dale visits the GP with his daughter who is caring for him. She also works part-time. Ms Dale is finding it hard to cope and she is worried that Mr Dale is becoming increasingly isolated and forgetful. This places a bigger strain on her. The GP listens attentively to both her and Mr Dale and suggests that Mr Dale is booked in for a full health check. He does this immediately at a venue near Mr Dale's house which he can easily get to without help from his daughter.

The GP tells Mr and Ms Dale that there is a lot of support available for them. He is the Carer's Champion for Barnet CCG and immediately refers Ms Dale to the Carers Centre where they develop a workability package to support her staying in work – she is shown how to use Jointly, a free mobile phone app to manage caring, she finds out about back-up care schemes to help her out in an emergency and she also finds out about the ways in which her employer can support her to stay in work and continue caring. The Carers Centre directs her to a website, Ask Sara, which Ms. Dale looks at one evening and she is amazed at the things that are available to support both her and Mr Dale. They also tell her about different kinds of technology which could help Mr Dale to be more independent at home – she likes the idea of a memo minder to make sure Mr Dale remembers his keys when he leaves the house. The Carers Centre tells her about carers support meetings. However, Ms Dale feels that she does not have the time to go at the moment - but was interested to learn about the Facebook page that has been set up for carers in Barnet.

The Carers Centre also tell her about "An Apple A Day" (the local prevention offer), which they are part of – this is the name for lots of different services which help people stay well for longer – they suggest that she goes on the Council website and find out about all the different activities – they suggest she contact the voluntary sector provider for information and advice, who can talk to Mr Dale about what he is interested in and what is available.

Mr and Ms Dale look at the website together – Mr Dale is interested in MenSheds, joining a choir and going fishing again – but he doesn't want to go fishing by himself. They e-mail a local choir and MenSheds to find out more. The choir responds a few days later by saying that someone who is a regular member lives nearby so they can go together for the first time. MenSheds does not have any vacancies but they suggest that Mr Dale goes on the waiting list – they are planning to open another day centre later on that year. Mr and Ms Dale cannot find anything out about someone to go fishing with Mr Dale but they find out that there is an Open Day for the local Barnet Angling Club – so they contact the voluntary sector provider for information and advice and find about timebanks and volunteer befrienders – this voluntary sector provider makes a referral to the timebanks and volunteer befrienders and explain how to do this so that Mr and Ms Dale can do it themselves. Mr Dale offers to show people how to upholster chairs in exchange as this was his trade. As they are chatting voluntary sector provider also tells Mr Dale about Casserole Club who are looking for diners – this means that one night a week Ms Dale will not need to rush over to help Mr Dale with his evening meal – and Mr Dale meets someone new!

Tier 3: access services (primary and social care assessment)

There is a need to make a series of step changes towards both a more integrated care approach for people with long term conditions and older adults, and a model that acknowledges the need for prevention based on the following principles:

Early Identification of at risk Older Adults using risk stratification software: to better ensure that the right people receive proactive case management in a cost effective manner. This system will allow users to focus case management on individuals that will benefit most. It will also support population profiling; predictive modelling of high risk patients; disease profiling to enable early identification and navigation to the appropriate prevention services; and effective resource management.

Shared view of information about the care Older Adults receive: there is a requirement for one shared multiagency view of the relevant patient information (e.g. a "shared care record") that will be accessible to anyone providing care, all professionals across health and social care and relevant agencies.

Operating a "No wrong door" approach to services: older adults will be provided with a community access point, which will provide quick and easy access to support, and signposting to further services. It will also feature a direct referral route to existing community health services.

Tier 3: Case Studies

Using a shared risk stratification approach to identify and deliver care

As is case study – Mr Colin Dale has Heart failure, COPD and Diabetes and receives an annual review for each of the conditions. Mr Dale also has a social care package to assist with shopping and cleaning. He currently receives continence products and has in the past received help to administer eye drops following a cataract operation.
To be case study – The practice review the information of current health activity provided within the risk profiling tool, liaise with the Barnet Integrated Locality team (BILT) to agree an approach for supporting Mr Dale in the community. A single review is organised for all Mr Dale's long term conditions and his social care needs and is delivered by the most appropriate member of the BILT team. A care plan detailing the steps that have been agreed is provided to the patient's GP and the information is logged within the appropriate organisations systems (Swift for Social care, RIO for CLCH and BEH). Attendance at the pulmonary rehabilitation programme is organised and following this, Mr Dale is able to manage his breathlessness and increase his exercise. He is now able to leave his home and join a support group. Mr Dale is making good progress and with the support of his family is able to take advantage of short trips to the shops and on-line shopping. As a result his social care package is amended.
Impact – reduced visits to General Practice, Increased co-ordination of health and social care services. Increased independence and mobility. Reduction in care package**.**

Greater integration of GPs, Primary, Acute and Community Nursing with Social Care

As is case study – Mr Colin Dale is a frail and elderly gentleman who has reduced mobility due to osteoarthritis. He also has heart failure, diabetes and an enlarged prostate. He receives three social care visits a day and from time to time is incontinent. Recently he was admitted to hospital following a fall in his home. He was dehydrated and had a UTI. Prior to admission Mr Dale had limited contact with community health services.
To be case study – Mr Dale's care worker is concerned that he appears less stable on his feet. She notices that the drink she has left the previous day has not been touched. She contacts the Barnet Community Point of Access for assistance and an urgent district nursing visit is arranged. Following the DN visit, Mr Dale is transferred to the Ambulatory Treatment centre where a course of intravenous antibiotics are commenced by the ENP and community geriatrician. Mr Dale is monitored for the next 6 hours and returns home later that day. A night sitting service is organised for the next 48 hours. Mr Dale's care plan is reviewed, his continence care is amended, a commode is supplied and information about the importance of drinking is provided and reinforced by his care worker.
Impact – The care worker has immediate access to urgent support, DNs can initiate urgent treatment that can be delivered in the community, Mr Dale can be stabilised quickly and return home without a hospital admission. Mr Dale retains his independent living.

Impact of dementia early diagnosis supported by a network of dementia services in the community

As is case study Ms Clare Dale is the 77 year old sister of Mr Colin Dale, who lives with her husband in a council flat. Both she and her husband recognise that she is starting to lose her memory, and she presents to her GP with low mood and deteriorating memory. They received some advice on how to manage her condition but don't receive a formal diagnosis of dementia. Ms Clare Dale's dementia starts to deteriorate and she has become restive at night and agitated, constantly following her husband around the house. Her husband is becoming stressed mentally and emotionally. He decides he cannot look after his wife any longer and makes the decision to send her to a residential care home.
To be case study The GP is aware of the importance of early diagnosis in dementia and undertakes screening for dementia, and a referral to the Memory Assessment Service. The GP adds Ms Clare Dale to the practice register for people with suspected dementia and mild cognitive impairment. Following the visit to the MAS, Ms Clare Dale receives a diagnosis of dementia; Medication for the early stages of dementia is prescribed. Whilst at the MAS she and her husband also meet the Dementia Advisor (DA), who arranges to see them both the following week. Through the DA they learn about the various services for people with dementia and their carers. The DA also provides them with information and advice generally about the condition and what to expect. They decide to attend the local Dementia Café in order to meet other people in the same position as them, so they can share views, gather information and participate in arts and crafts activities in an informal, relaxed setting. Her husband also attends a series of training sessions for carers which he finds very helpful. Ms Clare Dale is also seen by her GP annually for a review.

With these interventions, over the next 18 months, Ms Clare Dale generally manages well at home, with the support of her husband. However her dementia starts to deteriorate and she has become restive at night and agitated, constantly following her husband around the house. Her husband is becoming stressed mentally and emotionally. They make an appointment to see both the DA and GP. The GP contacts the MAS for advice, and a review of medication. Following discussions, her medication is adjusted. A referral is made to the Marilac day activities centre, and as a result she starts to attend for 3 days a week. The DA also suggests some telecare to help in the home.

As a result of these interventions Ms Clare Dale:

- Is sleeping and eating better.
- Her mood is happier.
- She is talking and singing more and her speech has improved slightly.
- Her cognitive skills have improved slightly, including her language.
- She is more stimulated by organised projects and events; she has become much for sociable and interacts with people better. She has made 'special friends' with one or two people.

For her husband:

- He feels less stressed mentally and emotionally.
- He feels better physically.
- He is sleeping better.

Impact – Ms Clare Dale remains living safely in her home, in the community with support for her condition, reduced spend on residential care

Tier 4: community based intensive support services

Community support services increase independence and manage people within the community e.g. at home. They are overseen by integrated locality-based teams who can move resources around flexibly to maintain people in their homes or in other care settings e.g. residential care.

Having integrated locality based care teams is one of the means by which essential support can be coordinated around the adults in the community who are living with multi-morbidity and complex long term conditions. The teams will incorporate health and social care functions and will address patient needs by a shared approach to assessment and care planning. The locality based teams, in partnership with GPs, will be designed to support and manage care from self-management through periods of crisis, and into end of life pathways where necessary.

A weekly Multi-Disciplinary Team (MDT) meeting will provide a more intensive approach to managing complex cases by planning care across multiple providers. This will link to Integrated Locality Teams, particularly care navigators, to ensure that they can move resources around flexibly to avoid crises and maintain people in their homes or in other care settings within the community. This will be under-pinned by a rapid care service that will provide intensive home-based packages of care to support people in periods of exacerbation or ill-health. Close working with housing, using Disabled Facilities Grants, and the voluntary sector will be a key part of community support.

Tier 4: Case Studies

Development of the Locality Integrated Teams and MDT approach into one integrated system

As is case study – Mr Colin Dale lives in a care home. He has heart failure and COPD. He also has a leg ulcer that is currently managed by the district nursing service. He is often breathless which results in increased anxiety levels for Mr Dale and the Care home staff. This triggers the care home to dial 999. He is frequently admitted to hospital.
To be case study – The district nurse (as part of the integrated locality team), while managing his leg ulcer, identifies increased ankle swelling. During her visit she records vital signs which show low oxygen levels and increased respiratory rate. As a result, and with the patient's permission she refers Mr Dale to the weekly multi-disciplinary meeting where a wider range of professionals (social care, mental health, London ambulance, GPs, geriatric consultant, pharmacy and end of life) meet. They agree that Mr Dale's medication will be titrated and that an education session will be delivered in the home by the long term conditions generic nurse (within the Rapid Care Team). In 5 days Mr Dale returns to his normal baseline. At a follow up meeting including the care home staff and Mr Dale's family, agrees to commence the use of telehealth, to better assess and monitor Mr Dale's needs, and communicate changes to the locality team and the practice in order to take rapid action.
Impact – reduced hospital activity, increased skills of district nurse and care home staff, targeted use of the specialist staff, reduced or better managed exacerbations.

Access to care following the expansion of the Rapid Response Service to include short term crisis care at home and 'trials' to facilitate more effective rehabilitation.

As is case study – Mr Colin Dale is living with a terminal illness, in a nursing home. One Saturday evening he is feeling unwell, and the nurse in charge of the shift talks on the phone to his daughter, who is understandably concerned. The nurse feels uncertain, and is concerned to resolve the situation safely. The Out of Hours GP visits, and notes that he is safe and warm. However, by 11pm, Mr Dale's daughter has arrived and is very anxious. The nurse calls an ambulance. Mr Dale arrives at hospital, and the A&E staff receives a brief handover. They start intravenous antibiotics and admit him to a ward. When he is reviewed the next day, the team discover that there had been conversations with the relatives about not seeking active interventions if he became ill. However, by this time Mr Dale has had a therapy assessment, and is being fed by a tube. Mr Dale stays in hospital for some days before dying in the hospital ward.
To be case study – The nurses in the home have been receiving training in end of life care and have regular in-reach visits from specialist nurses as part of the Rapid Care in-reach support to homes. Mr Dale was reviewed by the GP as part of the regular weekly ward round. The team and family have discussed the options for his care should he fall ill, and an anticipatory care plan has been prepared. As the nurse is still concerned, she rings the Rapid Care service, and talks to a specialist nurse who is on-call covering a large area by phone. If desired, the nursing home is supported in administering intravenous antibiotics with the on-site help and monitoring of the Emergency Nurse Practitioner. When Mr Dale dies, he does so in the familiar surroundings of the nursing home.
Impact – reduced hospital activity, increased skills of nursing home staff, targeted use of the specialist staff, reduced or better managed exacerbations.

Access to enablement as part of care provision at early stages in service user, patient pathways.

As is case study – Mr Colin Dale is 75 and lives in his own home. He had a stroke a number of years ago and has made a very good recovery but does struggle to go out on his own although can do many tasks in his own home. He is determined to be as independent as possible. On a Friday night whilst making his night time drink he had a fall in his own home. He is hurt and has a cut to his head but is able to notify the Assist service. He is taken to A&E, they assess him, treat the wound and he has not suffered any fractures but is visibly shaken and lacking confidence to return home. He is sent home with an enablement package. He has the visits from the enablement provider for 6 weeks and he regains his confidence and there is no further action. 4 weeks later he has another fall and unfortunately suffers a fracture and ends up in hospital for 8 weeks. He loses many of his skills and confidence and loses that determination to be independent that has meant he has remained in his own home with no support for so long. He receives a further enablement package for 6 weeks and then has on going home care. His condition deteriorates, can't cope at home. After 12 months he is admitted into residential care where he dies after couple of years.
To be case study – The A&E team notify the enablement service and he is initially assessed by an Occupational Therapist who drafts a support plan and talks to the enablement team and the intermediate care team (falls). He has his enablement package for 4 weeks alongside input from Physiotherapist to build up his strength, he is seen by the Falls Clinic to look at his overall health needs to help him keep his independence and prevent a fall. Following these interventions he remains independent at home for a further two years without a homecare package.
Impact – improved quality support for Mr Colin Dale; reduced hospital activity, more effective use of enablement and a holistic support package to enable Mr Colin Dale to remain as independent as possible in his own home.

Tier 5: residential, nursing and acute services

The focus of this the Integrated Model is balanced towards Tiers 1 – 4 to reduce demand for residential and acute care. Residential, nursing and acute services support intensive care where individuals cannot be maintained at home. These services are drawn on where they are most appropriate and where community based services cannot provide a safe environment in which to receive care.

Efforts in Tier 5 will be focused on ensuring residents are supported by the 'no wrong door' principle. This will ensure people can gain rapid access to critical services and a clear pathway into the integrated model. Where an individual enters Tier 5 (possibly in crisis) they will be transitioned to community intensive support as quickly and appropriately as possible.

Benefits

Indicative benefit maps have been produced to establish how existing projects map to common benefits. They capture how the individual projects contribute to a standard set of intermediate outcomes, BCF measures and ultimately the top level aims of this Programme.

The integration of health and social care services is designed to deliver three top level outcomes:

1. Improved user experience
2. Improved user outcomes

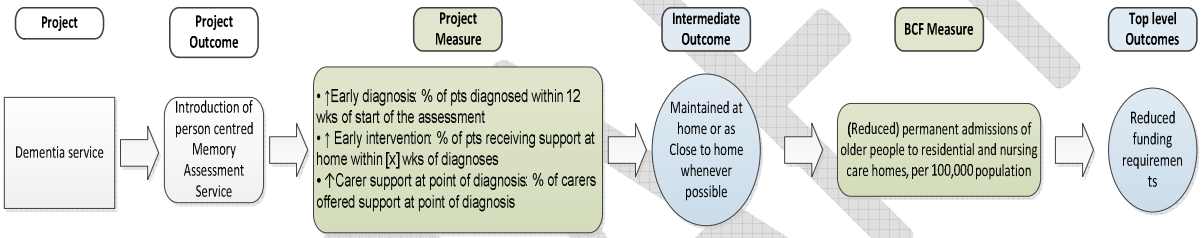
3. Reduced funding requirements

These outcomes are the reason for undertaking any investment and using resources. All projects in this Programme must therefore continually demonstrate a link to these top level outcomes, either directly or via an intermediate outcome, to remain valid and viable for the Programme.

By mapping all projects to these three outcomes, we have established a single consistent view of both the contribution of individual projects to those aims deemed important and the current suite of activity in place to deliver our agreed priorities.

We therefore assess and review all projects and activities in terms of how they contribute to the agreed outcome hierarchy to ensure the maximum effectiveness and best value use of work and resources.

Below is an example of this view for one pathway of Dementia services. The project measures are yet to be finalised, but it shows how specific activities impact on intermediate measures and in turn one or more of the top level outcomes.



For a copy of the benefits maps produced, please see Annex 1.

4. Project Descriptions

Tier 1 Specification – Self-Management

Structured Education	**New Service**
Service Description: Pilot generic and disease-specific structured education programmes, followed by wider roll out of the programme which may be: • Locality-based generic programme (i.e. available to those with any long term condition (LTC)). • Disease specific (Diabetes/Dementia/Falls/Stroke/Chronic pain/COPD/depression. NB diabetes structured education is already run through the CLCH contract). Standard structured education courses run for 6 weeks with 10-16 attendees per course. **Objectives:** • Empower patients to self-care and manage their condition. • Optimise individual patient's health status. • Increase knowledge and understanding of LTC and lifestyle/behavioural influences. • Improve the patient's experience. • Mitigate for unnecessary A&E attendances and unplanned hospital admissions. **Deliverables:** • Structured education offer to cohorts of patients with LTC (see service finance section). • Development of relationships between primary care professionals, patients, specialists and carers.	
Service Start Date	Pilot of generic programme: work commences **September 2014 (pilot runs from January 2015)** Pilot of disease specific programme: **February 2015**
Project (Inter)dependencies	Structured education needs to be supported by relationships between primary care professionals, specialists, carers and patients. Professional development and support from LTC specialists is important and training courses run for professionals on supporting expert patients will need to be developed as the model progresses.
Current status and key achievements	Relationship established with CCG on approach to developing self-management offer. Commissioning of structured education pilot commencing in September 2014.
Service Finance	
Funding	Public Health
Estimated Activity	**PILOTS:** • 1 generic structured education pilot and 1 disease specific pilot in Q4 2014/15. • 48 people in each pilot (16 people x 3 localities per pilot) = 96 people engaged in 2 x pilots in 2014/15. **ROLL OUT:** • Roll out of further structured education courses begins in April 2015 (dependent on evaluation). • Roll out to 5% of 23,555 (POPPI projection no of over 65s with life-limiting LTC).

	OUTPUT: • 1,178 people supported by structured education programmes over 2015/16-2019/2020 period.
Cost of Service provision	**PILOT** • £15,000 for each pilot = £30,000 (+ £5,000 post pilot evaluation) = £35,000 in Year 1 • For the first generic pilot, the CCG have received £10,000 from HENCL and Public Health will contribute £5,000. • The second pilot and evaluation of the pilot will be funded by the public health team (£15,000). **ROLL OUT** • Cost of rolling out the service as described (based on an average cost of £240 per person, plus £10,000 for professional training costs, and £19,520 for administrative costs) = £87,120 per year for 5 years. **Total cost** of pilot and roll out = £470,600
Net Benefits	Benefits have been calculated based on evidence from Self-Management UK. The benefits set out below are likely to be achieved only if the structured education courses and the long-term condition mentors/ health champions are fully funded for the duration of the project. It is estimated that once the programme is running at full capacity i.e. 18 structured education courses per year (in 2016/17), the total annual financial benefit of running the programme, in conjunction with the LTC mentors/health champions, will be £318,092.

LTC mentors/ Health champions (run in conjunction with structured education courses)	**New Service**

Service Description:

LTC mentors (volunteers who have personal experience with LTC's) will support people with LTC in a variety of ways:

- Providing one-to-one peer mentoring support.
- Acting as self-management champions.
- Motivating and supporting people with their own self-management aims.
- Developing individual's self-management skills.
- Advice people about the risk factors to LTCs and how risk can be reduced.
- Helping people to accept their condition (if newly diagnosed).
- Uses modelling as peers, inspiring people.
- Helping individuals overcome their loneliness and reducing isolation.
- Leading self-help groups.
- Signposting to local services.
- Encouraging individuals to retain or regain employment at an earliest opportunity and signposting to employment services.

Mentors will provide telephone support at times (sometimes peer mentor will make the phone as part of an intervention, other times the telephone call will compliment exiting programme). Similarly, web and email-based support will be used here by mentors to overcome the problem some patients have with face-to-face contact. Internet-based support groups sometimes called "e-communities" can increase effectiveness of self-management programmes, and will be developed over the course of the programme.

Community Health Champions are volunteers who will work in their communities and neighbourhoods to raise awareness of various health issues, especially in relation to LTCs, and help signpost people with concerns or conditions to the relevant services.

They are peers to the populations they serve not by having a LTC but speaking the same language, sharing culture and/or living in the location. Key roles will also include accompanying someone along to an activity such as exercise or a weight management session and encouraging their participation.

Objectives:

- Empower patients to self-care and manage their condition.
- Optimise individual patient's health status.
- Increase knowledge and understanding of LTC and lifestyle/behavioural influences.
- Improve the patient's experience
- Provide peer support to patients with a new or existing diagnosis
- Support patients in accessing weight management, physical activity, smoking cessation support, giving them confidence to manage their LTC, reducing stress/anxiety, links with support services/social care.

Deliverables:

- Mentoring and peer support available to people with LTCs
- Long term vision is to recruit 240 active mentors/ health champions by 2019/20.

Service Start Date	Recruitment of mentors through structured education courses commences: **Winter 2014** Recruitment of LTC health champions from: **Spring 2015**
Project (Inter)dependencies	Interdependent with Structured Education and professional support initiatives. Good partnership between the peer support service and the wider health and social care system is important to the successful delivery, particularly with regards to appropriate referrals to and from peer support.
Current status and key achievements	Draft paper on peer-support models has been produced and further discussions are now required.
Service Finance	
Funding	Public Health
Estimated Activity	**PILOT:** • Structured education pilot to commence in November 2014- recruitment drive of mentors to begin at this time. **ROLL OUT:** • Mentors begin work with the people who have just come through the first structured education pilot in January 2015. Mentors recruit additional mentors by March 2015. • 2nd wave of structured education recruitment complete by May 2015, following completion of 2nd structured education pilot in March 2015. • 6 Health champions recruited by April 2015 to commence roll out of health champion programme. • 3 Health trainers to coordinate programme and provide training to volunteers, recruited by March 2015.
Cost of Service provision	• LTC mentors and health champions will be volunteers so will need expenses (£10,000 each year from 2015/16) • Health trainer costs of £70,000 per year plus administration support at 30,000 per year= £100,000 per year from 2015/16.

Net Benefits	N/A. These benefits are to be grouped with the structured education programme– consideration will need to be given to additional activity re GP referrals outside of structured education, which might increase the benefits obtained from this programme.

Targeted Healthy Living Pharmacy Model for people with long-term conditions	**New Service**
Service Description: Development of the Healthy Living Pharmacy concept to support the Barnet model for integrated care. Provides a potential framework for commissioning public health services. Model encompasses a minimum of 1 health champion (link to above); clinical expertise and training; medicines use review. **Objectives:** • Empower patients to self-care and manage their condition. • Optimise individual patient's health status. • Develop selected pharmacies as a focus for LTC support. • Contribute to the community led model of LTC support. • Increase knowledge and understanding of LTC and lifestyle/behavioural influences. • Improve the patient's experience. **Deliverables:** • Additional support available to people with LTC, as an alternative to other components of the offer for people with LTC. • Promotion of pharmacies as part of 'front door'. • New referral routes into services.	
Service Start Date	Design of approach by: **March 2015** Implementation of pilot (2x pilots overall): **April 2015 - April 2016** Evaluation for pilot 1 by: **June 2016** Roll out to 12 pharmacies for programme: **March 2017 - March 2020**
Project (Inter)dependencies	Interdependent with Structured education, Tier 2 services and professional support
Current status and key achievements	Pharmaceutical needs assessment (PNA) currently underway and will inform development of this piece of work (NB supplementary statements to the PNA will be required if changes are made under the integrated care model).
Service Finance	
Funding	London Borough of Barnet
Estimated Activity	**PILOT:** • Development of proof of concept of Barnet model, testing with pharmaceutical advisors, community pharmacists, LTC. • Design and testing of 2 pilots. **ROLL OUT:** • Implementation across 12 Healthy Living Pharmacies for Older People (evenly distributed across the 3 localities), reaching 4200 people by 2020.
Cost of Service provision	**ROLL OUT:** • Implementation costs of £4,000 per pharmacy = 47 hours of project leader time/month (based on Pathfinder programme). • £4,000 x 12 pharmacies = £48,000

	ONGOING COSTS: • £1000 per pharmacy to support training and development of promotional materials (NB resources will be used more efficiently if budgets are not allocated to each individual pharmacy)
Net Benefits	1000 person survey (as part of the Pathfinder national evaluation) suggested Healthy Living Pharmacy model can support 60% GP avoidance. Extrapolating this data, it is estimated that a potential 2520 older people with LTCs will not access their GP as frequently who would otherwise have done so as a result of 12 HLPs being in place.

Workforce training and development	**Enabler**

Enabler Description:

1. Development of training programme and learning sets funded by HENCL. Multi-professional learning sets focusing on older people and training programme, comprised of professional groups including community pharmacy, community nursing and health visiting, mental health, secondary care, social workers, palliative care services, general practice and lay involvement through HealthWatch (to be established). Supported by professional facilitation for up to 4 sessions per group – the purpose of the facilitation will be to develop group cohesiveness, break down barriers, deal with group dynamics, clarify and resolve differences around language and terminology; testing participation support through the use of technologies (especially web-based approaches e.g. WebEx conferencing) for a small number of the learning sets (1-2).

2. Educational programme to support Integrated Care (Learning opportunities that cover the following (not exhaustive or finalised list) of key areas:

   - Effective use of case management.
   - Principles underpinning coordination of care.
   - Introduction to coaching for health.
   - Principles in planning for end-of-life care.
   - Prescribing issues in those with complex care needs.
   - Coping with uncertainty and complexity in healthcare decision making).

3. Patient pathway management Locally Commissioned Service (LCS): 31 practices have signed up to the LCS (i.e. c45% of Barnet's practices) – 100% new patients on LTC register will be worked with through the LCS. The LCS will assign designated GPs/ Nurse Practitioners to undertake a Prevention Assessment and Self-Management Consultation for all newly diagnosed patients in the long term condition register for clinical conditions and record this in patients' notes.

Objectives:

- Empower patients to self-care and manage their condition.
- Optimise individual patient's health status.
- Increase knowledge and understanding of LTC and lifestyle/behavioural influences.
- Assist in ensuring co-ordination and consistency across Tiers of training and workforce development.
- Increase opportunities for workforce development in LTC and promote innovations.
- Improve the patient's experience.

Deliverables:

- 100% new patients on LTC register to be supported through new LCS

Service Start Date	LCS begins in September 2014.

Project (Inter)dependencies	Interdependent with all elements of Tier1 and cascades throughout all Tiers.
Current status and key achievements	All programmes to begin in 2014/15.
Service Finance	
Funding	Public Health
Estimated Activity	To be defined from September 2014 as services are introduced and the scale of workforce training and development activities are determined.
Cost of Service provision	• Budget for locality-based multi-professional learning sets; Educational programme to support Integrated Care; and implementation of learning/evaluation of arrangements = £220,000 up to 2015. • CCG annual budget to support self-management component of the LCS across all practices is £113,600 (For this component of the LCS, practices will be paid on the basis of per 1000 registered population. For a practice with the list size of 1000, one annual payment of £285.91 will be made on successful achievement of component 4).
Net Benefits	Enabler project, therefore none anticipated/quantified at this stage. Any identified cashable or non-cashable benefits to be measured from this project once services are introduced and the scale of workforce training and development activities are determined.

Public Media Campaigns/ Patient information and education	**Enabler**
Description of Enabler: Public media campaigns and education materials targeted via primary care and community venues and in liaison with NHS England on increased self management. **Objectives:** • Empower patients to self-care and manage their condition. • Optimise individual patient's health status. • Increase knowledge and understanding of LTC and lifestyle/behavioural influences. • Raise awareness of the opportunities/ways to access for self management, health volunteering and behaviour change. • Improve the patient's experience. **Deliverables:** • Scheduled Public media campaigns. • Patient decision aids. • Apps and other technology-based education and information sources.	
Service Start Date	**April 2016 - April 2018**
Project (Inter)dependencies	Interdependent with all elements of Tiers1 and 2, and cascades throughout all Tiers.
Current status and key achievements	No activity at present.
Service Finance	
Funding	Public Health

Estimated Activity	• Use of social media, NHS England resources, local written media and LBB resources to promote key messages to LTC cohort. • Supporting activity for health champions, HLP, and structured education.
Cost of Service provision	£60,000 over 24 months
Net Benefits	Enabler project, therefore none anticipated/quantified at this stage. However the project is expected to enable low cost targeted promotion of the range of Tier 1 activities direct to the target cohort, thereby facilitating the realisation of benefits from other services. Any identified cashable or non-cashable benefits from this project to be measured once services are introduced.

Evaluation Framework	**Enabler**
Description of Enabler: Evaluation framework designed for this Tier that will set out: • Definitions of what success looks like for self-management. • Modelling of the potential for self-management activities to reduce demand for services completely, and delay the need for services in the short/medium/long-term. • Clarification about the investment and resources required to deliver Tier 1 of the integrated care model. **Objectives:** • Clarify the patient outcomes and individual benefits that can be obtained through investment in self-management initiatives. **Deliverables:** Accessible evaluation framework.	
Service Start Date	**April 2015 - April 2018**
Project (Inter)dependencies	Interdependent with all elements of Tier1 and 2, and cascades throughout all Tiers.
Current status and key achievements	No activity at present
Service Finance	
Funding	Public Health
Estimated Activity	• Longitudinal evaluation of 2% patients impacted by the programmes. • Evaluation of every initiative.
Cost of Service provision	£100,000 over 3 years.
Net Benefits	Enabler project, therefore none anticipated/quantified at this stage. However the project is expected to improve the ability to define with greater certainty what the net benefits of self-management interventions are. Any identified cashable or non-cashable benefits from this project to be measured once services are introduced.

Tier 2 – Health & Wellbeing (Prevention)

Joined up Prevention Offer

An Apple a Day	**Enhancement to existing services**
Description of Enhancement: Existing prevention services are joined up and launched under one brand so that the public recognise and understand the brand. Protocols are developed to enable information and data sharing on service use. Clear shared outcomes are agreed and built into contract monitoring. **Objectives:** • Prevent unnecessary A&E attendances and unplanned hospital admissions • Reduce GP attendance • Optimise individual patient's health status • Optimise individual patient's social support • Prevent or delay elderly admissions to long term care and packages of care • Empower patients to self-care and manage their condition • Improve the service user/patient's experience **Deliverables:** • Services in Barnet know what Tier 2 services are available and are able to signpost people appropriately • Shared information on service use and impact of service developed • Take up of prevention services increased.	

Service Start Date	**June 2015**
Project (Inter)dependencies	Close links with development of mapping of prevention services and database Shared care record.
Current status and key achievements	Not started.
Service Finance	
Funding	Allocation from baseline or incremental funding to be confirmed.
Estimated Activity	• Existing 3,000 (Appx 1 activity data) service users and 3,000 active carers (BCC info) – 6,000 in total • Up to 9,000 carers (based on Insight data) • Up to 5,000 people with limiting life long illness (guestimate).
Cost of Service provision	• Project manager 6 months (£33k) • Contract variation costs (estimated £50k) • Publicity campaign and branding material (£7k).
Net Benefits	Any identified cashable or non-cashable benefits from this project to be measured once services are introduced.

Developing targeted approach to prevention

Identification of people who would benefit from prevention services	**Enabler - Enhancement to existing services**
Description of Enabler: Use risk stratification tool to identify people on cusp of Tier3/4 services or who come into contact with the Council's front door. **Objectives:**	

- Prevent unnecessary A&E attendances and unplanned hospital admissions.
- Optimise individual patient's health status.
- Optimise individual patient's social support.
- Prevent or delay elderly admissions to long term care and packages of care.
- Empower patients to self-care and manage their condition.
- Improve the patient's experience.

Deliverables:

- Identification of a cohort of people who would benefit from prevention.
- Increased take up of prevention services.
- Reduced demand for health and social care services.
- Test out the impact of prevention services on care pathways.
- Raise GP awareness of the range and potential of prevention services.

Service Start Date	**April 2015**
Project (Inter)dependencies	Close links with development of mapping of prevention services and database.
Current status and key achievements	Not started.
Service Finance	
Funding	Allocation from baseline or incremental funding to be confirmed.
Estimated Activity	To be confirmed following analysis of the level of use of the Risk Stratification Tool to support high risk patients/service users receiving Tier 3 and 4 services.
Cost of Service provision	To be confirmed based on the likely, agreed estimate activity.
Net Benefits	Any identified cashable or non-cashable benefits from this project to be measured once services are introduced.

Strengthened Information, Advice and Support Offer

Information Plus – procurement opportunity	**Enabler – enhanced and new service**

Description of Enabler: There is a single point of access for those wishing to refer to or take up prevention services. The service will offer signposting, information, advice and advocacy for those that need it. Referrals will be made to LaterLife planners or to community navigators for those people who require complex prevention care planning or an element of prevention as part of a re-ablement/health or social care plan.

2 year pilot: 2 Community Navigators will offer advice, support and help to develop prevention plans, linking people with services, supporting hospital discharge and developing social networks (see Appendix 2)

New contract: Increase capacity of service to manage referrals from healthcare professionals

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions.
- Reduce call on GP time.
- Optimise individual patient's health status.
- Optimise individual patient's social support.
- Prevent or delay elderly admissions to long term care and packages of care.
- Empower patients to self-care and manage their condition.
- Improve the service/users patient's experience.

Deliverables: • Single point of access for prevention to support professionals, particularly GPs. • Single point of access for residents with range of tiered support for resident. • Robust prevention plans to support people at cusp of care or moving down from Tier 5. • Development of social networks which provide a more sustainable cost-effective service. • Additional time limited support for people who are unable to navigate the prevention offer without help.	
Service Start Date	Pilot: **April 2015** (enhanced information offer from April 2015).
Project (Inter)dependencies	Later-life Planning Support Brokerage Care Navigator Information database
Current status and key achievements	• Community navigators - not yet commissioned • I&A service – supported 800 people last year
Service Finance	
Funding	London Borough of Barnet
Estimated Activity	1&A – 1,200 Community Navigators 100
Cost of Service provision	Current contract value £100,000 p/a. Enhanced element - £50,000 p/a. Community Navigators £90,000 p/a.
Net Benefits	Community Navigators Minimum of £29,500. Any additional identified cashable or non-cashable benefits from this project to be measured once services are introduced.

Health and social care volunteers

Procurement Opportunity	**Being tendered**
Description of service: Barnet Council is currently tendering for a voluntary and community sector development partner. Part of this bid includes the commitment of a one off payment of £20,000 from the Better Care Fund in 2015/16 to develop a volunteer offer which supports health and social care integration and prevention. The project will be developed in conjunction with the CCG and Barnet Council and will be mainstreamed into the wider volunteer offer post 2016. **New contract:** Increase capacity of volunteering to support health and social care services. **Objectives:** • Prevent unnecessary A&E attendances and unplanned hospital admissions. • Reduce call on GP time. • Optimise individual patient's health status. • Optimise individual patient's social support. • Prevent or delay elderly admissions to long term care and packages of care. • Empower patients to self-care and manage their condition. • Improve the service/users patient's experience. **Deliverables:** • Testing out the use of volunteers to support the delivery of health and social care integration and prevention. • Enhanced capacity to support patients and carers to remain independent. • Development of innovative solutions to prevention.	
Service Start Date	Contract award date 4 January 2015 Service to start once agreed

Project (Inter)dependencies	Wider volunteering offer
Current status and key achievements	• Tender underway
Service Finance	
Funding	London Borough of Barnet
Estimated Activity	To be scoped
Cost of Service provision	Main contract £80,000 p/a Additional element: £20,000
Net Benefits	Any identified cashable or non-cashable benefits from this project to be measured once services are introduced.

Implement the Dementia Manifesto

Dementia Friendly Communities	**Enabler – enhanced and new service**

Description of Enabler: Implementing the Dementia Manifesto requires the setting up of a Dementia Action Alliance to co-ordinate raising awareness and providing training across the borough. This organic community based approach will complement commissioned services, enabling people with dementia and their carers to remain living independently in the borough, supported by an aware and accepting community.

1 year set up costs: A part time project manager will develop the Alliance; promote training and awareness across businesses and organisations using the Dementia Friends and Dementia Champions approach and skill up local providers. Consideration will be given to developing a chartermark and a sticker which identifies those organisations which have met a certain standard of training. The intention is to mainstream this and hand over to local stakeholder once fully established.

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions.
- Reduce call on GP time.
- Optimise individual patient's health status.
- Optimise individual patient's social support.
- Prevent or delay elderly admissions to long term care and packages of care.
- Empower patients and carers to self-care and manage their condition.
- Improve the service/users patient's experience.

Deliverables:

Barnet is a Dementia Friendly Community where people with dementia and carers are supported by the wider community.

Service Start Date	Pilot: October 2014 (subject to recruitment to post)
Project (Inter)dependencies	Dementia Cafes Dementia Advisors
Current status and key achievements	• Project commitment scoped and initial work undertaken • Report going to Health and Wellbeing Board for decision in September 2014
Service Finance	
Funding	Section 256 (Better Care Fund from April 2015), Barnet Clinical Commissioning Group

Estimated Activity	Up to 4,000
Cost of Service provision	£27,000
Net Benefits	Rationale – Alzheimer's Society quote £11k saving per person with dementia for every year person remains in the community. Any actual identified cashable or non-cashable benefits from this project to be measured once services are introduced.

Strengthening Carers' Offer

Health education for carers as part of carer support plans	**Scoping**
Service Description: Pilot a range of targeted interventions as part of carers support plans which help carers develop basic health skills (good care of people with long term conditions), offer on-going professional support and links to peer support groups (possibly virtual). Access to small pieces of equipment and assistive technology will form part of this project. The service will be piloted for a year, ideally located within the Carers Hub with links to integrated locality teams. **Objectives:** • Prevent unnecessary A&E attendances and unplanned hospital admissions. • Optimise individual patient's health status. • Optimise individual patient's social support. • Prevent or delay elderly admissions to long term care and packages of care. • Empower patients to self-care and manage their condition. • Improve the patient's experience. **Deliverables:** • Carers who feel confident about the care they are providing and the level of knowledge about the LTC that their relative has. • Carers who feel supported in their role. • Cared for who receive good care. • Reduced pressure sores/reduced cases of poor nutrition.	

Service Start Date	**June 2015**
Project (Inter)dependencies	Carers Centre services
Current status and key achievements	Not started
Service Finance	
Funding	Allocation from baseline or incremental funding to be confirmed.
Estimated Activity	Target - minimum of 9 training sessions with 8 carers each.
Cost of Service provision	One year pilot – secondment - £75,000 – district nurse sc6, plus on-costs and project costs.
Net Benefits	Any identified cashable or non-cashable benefits from this project to be measured once services are introduced.

Tiers 3 & 4 – Assessment, Care Planning & Intensive Support

Barnet Community Point of Access (BCPA)	**Live Service**

Service Description:

To establish and implement a Community Point of Access to receive and manage referrals for adult community health services, ensuring urgent and non-urgent referrals and requests are pro-actively managed to enable rapid co-ordinated care and effective planned care. This will be a community enabler in supporting a reduction in unplanned admissions.

Objectives:

Provide a Community point of contact for health care professionals enabling clear and responsive communications between health care professionals across all sectors by April 2014. This will involve access to specialist clinicians for clinical advice, referral information and appointment confirmation, as well as general advice on service offered.

Deliverables:

Phase 3 & Phase 4 Barnet Community Point of Access go live date (urgent care and routine community health care):

Service Start Date	• **Phase 1** - Barnet Community Point of Access go live date (rapid care): April 2014. • **Phase 3 & 4** - Barnet Community Point of Access go live date (urgent care & routine Community health care): August 2014. • **Phase 5** - Barnet Community Point of Access go live date (community partners): **October 2014.**
Project (Inter)dependencies	• CLCH will work with local health and social care providers (emergency care) to develop revised care pathways to better manage acute exacerbations of long-term conditions. • Clinical reference groups and stakeholder engagement work will develop clinical protocols and the patient pathway in line with the next specification review. There is an expectation that intensive work will go into developing the protocols and pathways in time for next year's sign off. • Stakeholder engagement work around how the BCPA will specifically work with Housing 21(enablement) and non-statutory agencies.
Current status and key achievements	• The community point of access is live and is triaging all rapid and urgent referrals as part of the Service Level agreement with CLCH. • New telephony system in place with individually call handlers assigned to each new call. • Substantial communication plan and system wide update of referral forms in progress.

Barnet Community Point of Access Referral to appropriate service		Target	Apr-14	May-14	Jun-14	Jul-14
Telephone Calls	Total no. Calls received by BCPA		**1778**	**1936**	**1747**	**2490**
	No. Calls received for Rapid Response		**28**	**85**	**138**	**415**
	% Rapid & Urgent calls answered within specified time	**40% - 70%**	**60%**	**95%**	**96%**	**97%**
	% of breaches in call answering time threshold (40-70%)		**40%**	**5%**	**4%**	**3%**

Service Finance	
Funding	Section 256 (Better Care Fund from April 2015), Barnet Clinical Commissioning Group.

Estimated Activity	Increase in total F2F patient time in Community services outlined in business case - 4267 (hours spent).
Cost of Service provision	£298, 065 per year. This is new investment.
Net Benefits	Together with other integrated care projects the project is expected to contribute to overall forecast total savings of up £7.1m from 2014/15 – 2019/20, and up to £3.1m in savings per year by 2019/20.

Older Peoples Integrated Care Programme – Multi Disciplinary Team Meeting	**Live Weekly meeting**

Service Description:

The MDT meetings bring together health and social care professionals with specialist knowledge, skills and experience to assess the needs of frail and elderly patients identified as at higher risk of hospital attendance or significant deterioration in health.

The MDT meeting considers the patient as a whole and develops integrated care plans to meet assessed needs in order to reduce the requirement for hospital attendance and prevent significant deterioration in health. Patient care plans are implemented and co-ordinated by case managers/care navigators.

The MDT does not replace other formal health and social care provision for the patient.

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions.
- Optimise individual patient's health status.
- Optimise individual patient's social support.
- Prevent or delay elderly admissions to long term care and packages of care.
- Empower patients to self-care and manage their condition.
- Improve the patient's experience.

Expected Outcomes:

- A reduction in crisis admission to hospitals.
- A reduction in 30 day re-admissions.
- Reduction in social care interventions particular long term care admissions –particular prevention services and enablement will be used.
- Improved patient and carer experience.
- Reduction in outpatient appointments for the MDT.
- Reduction in GP appointments required by the patients in the MDT as their care is being better coordinated.

Service Start Date	Pilot started: **July 2013**
Project (Inter)dependencies	The Multi- disciplinary Team can operate independently and is not a single point of failure, however to maximise the opportunity to reduce hospital admittance, there are interdependences.
Current status and key achievements	• 1 year pilot end date (July 2013 - June 2014) • Extended for 1 year
Service Finance	
Funding	Section 256 (Better Care Fund from April 2015), Barnet Clinical Commissioning Group.
Estimated Activity	See the corresponding table for Case Navigation Service below.
Cost of Service provision	£112,592 per year, rising to £394,073 per year by 2019/20. This is new investment.
Net Benefits	Together with other integrated care projects the project is expected to contribute to overall forecast total savings of up £7.1m from 2014/15 – 2019/20, and up to £3.1m in savings per year by 2019/20.

Older Peoples Integrated Care Programme – Case Navigation Service	Live Service

Service Description:

The overall aim of the Care Navigation Service is to improve the health, wellbeing and independence of frail and elderly patients through the provision of personalised integrated health and social care support.

The frail and elderly are defined as patients aged 65 and over.

Objectives

- Prevent unnecessary A&E attendances and unplanned hospital admissions.
- Prevent admissions to long term care and reduce the need for care packages.
- Optimise individual patient's health status through case managed healthcare interventions.
- Optimise individual patient's community support through case management as well as access to social care.
- Empower patients to self-care and manage their condition.
- Enhance the patient's experience.

The Care Navigation service in Barnet will identify frail and elderly individuals at the greatest risk of hospital admission or significant deterioration in health and put in place personalised and time-limited health and social care interventions aimed at preventing this occurrence.

The service is led by Case Managers and the team will, at all times, work in conjunction with the patient's GP. The team, working with GPs, will use the Risk Stratification tool to identify patients at risk and develop personalised health and social support plans to match the needs of identified patients. The team will oversee and co-ordinate the implementation of patient support plans.

Support plans will be time-limited, multi-disciplinary and may consist of single or multiple interventions and may be carried out in the patient's home, GP surgeries and clinics, day hospitals, residential and nursing homes, social care settings and acute settings.

The team are organised in 3 geographically based units.

Service Start Date	Pilot: **July 2013**
Project (Inter)dependencies	The Care Navigation can operate independently and are not a single point of failure, however to maximise the opportunity to reduce hospital admittance, there are interdependences.
Current status and key achievements	1 year pilot end date (July 2013-June 2014).
Service Finance	
Funding	Section 256 (Better Care Fund from April 2015), Barnet Clinical Commissioning Group.
Estimated Activity	60 people identified and a care plan coordinated each month.

Forecast	New patients managed by service	Senior Care Navigators WTE required at year end	Admissions avoided
2013/14	460	3	64
2014/15	720	3	307
2015/16	720	3	374

Complex cases are referred to MDT.

Cost of Service provision	£497,366 per year (of which £157,366 per year is new investment).

Net Benefits	Together with other integrated care projects the project is expected to contribute to overall forecast total savings of up £7.1m from 2014/15 – 2019/20, and up to £3.1m in savings per year by 2019/20. A saving of £337,000 (gross) was achieved in 2013/14 by these projects.

Barnet Integrated Locality Teams	**Mobilising Service**

Service Description:

Having Integrated locality based care teams is one of the means by which essential support can be coordinated around the adults in our community who are living with multi-morbidity and complex long term conditions, and enable the goals set out in the Better Care Fund to be realised.

- The objective is to utilise an assessment and care planning model that will promote independence and wellbeing, avoid duplication (e.g. multiple assessments), and reduce unnecessary admission to acute or nursing/residential care settings. It encompasses key aims to improve outcomes and the quality and timeliness of care provided to older adults in the community.

The teams will incorporate health and social care functions and will address patient need by a shared approach to assessment and care planning. The locality based teams, in partnership with the GP, will be designed to support and manage care from self-management through periods of crisis, and into end of life pathways where necessary.

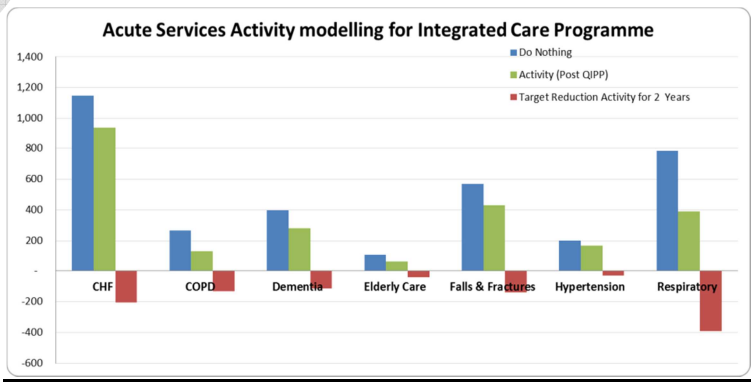
Deliverables:

The team will, on instigation from the GP or other referring agencies:

- Undertake an assessment and agree with the GP, older person, carer (where appropriate) a person-centred, co-ordinated care plan. The plan will be made available to the GP and every other health and social care professional facilitating joint working towards the delivery of a personalised care plan. The support provided will potentially include working with third sector service providers and link into the end of life pathway where necessary.
- Maximise opportunities to enable older adults and people with long term conditions to maximise their capabilities by developing and delivering integrated Anticipatory Care plans. This will be based on the early identification of patient cohorts via the risk tool.
- Signpost and navigate older adults towards the prevention and voluntary sector services. All members of the locality teams will be trained to identify and signpost carers, enabling access to the support required to sustain their caring role:
  - It is expected that as a first point of call, the teams will access the support provided via the prevention services in Tier 2 of the Better Care Fund model as part of the anticipatory care planning process, with the aim of building up and growing the personal and physical resilience of the older adults within their care by encouraging healthy lifestyles and support from the families and friends who provide care.
- The team will play a pivotal role in coordinating, promoting and enabling independence of Older Adults through self-management and where applicable using the common access process provided by the Community point of access to organise Enablement services or call in specialist end of life support when required.

Expected Outcomes:

- That frail, elderly and vulnerable older people are enabled to be as healthy, active and independent as possible in their own home with the support needed to do this.
- In a care crisis or health emergency the person is supported as effectively as possible, and that there is an efficient transfer of care between agencies with any necessary health and social care supports to them and to their carer.
- That the treatment and care provided is right for the person's needs in the right setting and respects the person's individuality and dignity.

Service Start Date	Initial pilot of trailblazer team with 7 practices went live on the 4th of August. Team are currently mobilising
Project (Inter)dependencies	• This project is dependent on support from the Community Services, Adult Social Services, secondary care clinicians and GPs to shift the balance of care to primary and community settings. This will impact on the unscheduled attendances at A&E, attendances at the TREAT clinics. • Community and London Borough of Barnet IT strategies. • Data sharing agreement projects within primary care. • Shared Care records project. • The programme of works is spread across Tier 3 and 4 but has clear interdependencies with self-management (Tier 1) and health and wellbeing services (Tier 2). • Demand pressures associated with the Care Act.
Current status and key achievements	• Co-location of team took place on 4th of August • GP workshop with 7 pilot practices – 21st August • Workgroup to progress project plan to build team to full complement (refer to milestone plan on next page
Service Finance	
Funding	Section 256 (Better Care Fund from April 2015), Barnet Clinical Commissioning Group.
Estimated Activity	The trailblazer team will be working with at most, 2% of the over 65s of the risk profiled patients for the 7 practices. The aim is to review the requirements 3 months into service deliver to gain a better understanding of the activity requirements of the west locality.
Cost of Service provision	The pilot is anticipated to cost £454,677 in 2014/15. The cost of the full Integrated Teams service is currently estimated at £1m per year from 2015/16. This is new investment. This cost will be confirmed once the design of the service is agreed based on the findings and results of the pilot and once costs associated with any double running of services during implementation and the expected reallocation of existing resources and integration with the Care Navigation Service are finalised.
Net Benefits	For illustrative purposes the graph below provides a pictorial representation of the financial implications associated with the proposed model. Similar projections can be made regarding social care costs and a reduced activity for care packages; this will be worked up as part of the MTFS savings plan. Together with other integrated care projects the project is expected to contribute to overall forecast total savings of up £7.1m from 2014/15 – 2019/20, and up to £3.1m in savings per year by 2019/20. 

Falls	Live Services

Service Description:

- Identifying patients susceptible to falls.
- Providing measures for recovery after fall
- Engaging patients in activities that reduce repeat falls

Objectives:

- Reducing the risk of falling in older people and enabling greater independence and self-care leading to overall reduction in falls related admissions and social care needs.
- A key objective of this service is to reduce A&E, LAS and secondary care admissions for falls-related incidents. Reduction in falls-related events; enabling people to become and remain independent which will also reduce social care needs including long term residential care.
- Reducing the number of people having falls and fractures.
- Reducing inpatient and outpatient activity through preventative and self-care developments.
- An increase in the proportion of older people being supported in their own homes.
- A reduction in unscheduled admissions from nursing and residential care as a result of falls.

Deliverables:

- Falls Clinic - The Falls service is expected to provide a seamless patient-cantered, integrated and comprehensive service. The aim is to reduce the risk of falling in older people and enabling greater independence and self-care leading to overall reduction in falls related admissions and social care needs.
- Fracture Liaison Service - aims to identify people who may be at risk of further falls or fractures. The service is multi-disciplinary and involves a highly skilled team (Consultant, Nurse Specialist, Radiographer) to undertake comprehensive assessment and deliver specific treatment recommendations.

Service Start Date	• Services have always been in existent for Fall Clinic. • Fracture Liaison Service started August 2013.
Project (Inter)dependencies	The services can operate independently however to maximise the opportunity to reduce hospital admittance , there are interdependences with preventative services like Tai Chi classes, and risk stratification by GPs for people at risk of falls.
Current status and key achievements	• Falls Clinic and Fracture liaison services are live services, provided as part of the Service Level agreement with CLCH. • Services have been remodelled and KPI's redefined.

Year	Activity
2011/12	3372
2012/13	2019
2013/14	1757

Service Finance	
Funding	Barnet Clinical Commissioning Group.
Estimated Activity	887 patients – Falls Clinic. 500 – Fracture Liaison service.
Cost of Service provision	£393,691 in 2014/15, rising to £557,691 per year by 2019/20 (of which £164,000 is new investment).
Net Benefits	Together with other integrated care projects the project is expected to contribute to overall forecast total savings of up £7.1m from 2014/15 – 2019/20, and up to £3.1m in savings per year by 2019/20.

End of Life – Procurement opportunity	**Live Services**

Service Description:

A range of services provided to patients towards the end of life, aimed at enabling them to die in their place of choice. End of life if defined as:-

1. The final 12 months of a patient's life – stable sick. This service is now integrated with the work programme for integrated locality teams. It is expected that these patients will be managed as part of the case load for integrated locality teams.
2. Patients in their final 4 to 12 weeks where a patient requires intensive service in the community (own home or hospice). Support also provided to their carer.

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions.
- Increase in the number of the patients achieving their preferred place of care.
- Emotional or psychological support to Carers - counselling.
- Meet clinical needs of patients at the time of death through provision of specialist palliative services.

Deliverables:

- Case management by locality integrated teams following identification of patients through GP practices, MDT's and or referrals from Acute.
- Palliative Care Support Service in the Community (PCSS).
- Inpatient services, Day therapy unit and Outpatient attendances at hospices.

Service Start Date	On-going services, previous service level agreements signed in 2012/13
Project (Inter)dependencies	The service is dependent on Risk Profiling and identification by GPs, Multi-disciplinary Teams. To maximise the opportunity to reduce hospital admittance, there are interdependences with social care and voluntary sector service provision.
Current status and key achievements	• The services are live in the community • Integrated locality teams, currently being piloted
Service Finance	
Funding	Allocation from baseline or incremental funding to be confirmed.
Estimated Activity	Dependent on case load.
Cost of Service provision	£1,280,000 (from baseline budgets).
Net Benefits	Any identified cashable or non-cashable benefits from this project to be measured once services are introduced.

Rapid Care	**Live Services**

Service Description:

The aims of the Rapid Care Service extension are to reduce unnecessary hospital admissions and to improve the access to quality acute health care community intervention for frail and elderly patients in Barnet. They will provide urgent care for older people and people with long term conditions has been developed so that acute exacerbations or complications are better managed, end of life care is well organised and people can remain in their own homes or community.

Objectives – to put in place the following services

- Rapid Response Team Extension: extend hours service that provides full rapid assessment of health and social care need.

Part of the Rapid Care Service extension will be the provision of a number of new services:

- Ambulatory Assessment Diagnostic and Treatment Service.
- Health Failure Service (Rapid).
- Telehealth Care Service.

- People accepted by Rapid Care service will be experiencing an acute alteration in their physical wellbeing or social circumstance.

Service Start Date	• Original rapid response team from 2012 • Extended rapid response service faced elements from December 2013 to April 2014
Funding	
Project (Inter)dependencies	CLCH will work with local health and social care providers of emergency care to develop revised care pathways to better manage acute exacerbations of long-term conditions. Clinical reference groups and stakeholder engagement work will develop clinical protocols and the patient pathway in line with the next specification review. There is an expectation that intensive work will go into developing the protocols and pathways in time for next year's sign off.
Current status and key achievements	• Rapid response service is live and key elements of extension are live e.g. increased LTC specialist support, ambulatory care and telehealth in care homes as part of the Service Level agreement with CLCH. • KPI's have been redefined and referral capacity was more than doubled with new investment - currently at 70% (July figures not in official report until next week) and increasing. • Increase in diverse referral sources linked to substantial communication drive and partnership working with LAS, 111, mental health and acute. Further work required with out of hours and acute.

The ambulatory care service started from April 2014 is up to 89% capacity, the telehealth care project has met the 25 patients per quarter target.

Rapid Response		Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14
Planned Referrals % Received and Accepted Referrals		**60**	**120**	**120**	**120**	**120**	**120**	**120**	**120**
	Referrals received					**62**	**60**	**76**	**103**
	Referrals accepted	63	80	71	61	**53**	**56**	**73**	**98**
	% of target achieved against accepted referrals	105%	66%	59%	51%	**44%**	**47%**	**61%**	**82%**
	No. weekend referrals accepted					**1**	**4**	**5**	**8**

Service Finance	
Estimated Activity	Rapid response team - 120 new referrals per month Ambulatory care – 65 referrals per month Telecare - 25 patients connected to hub per quarter.
Cost of Service provision	£1,316,464 per year (of which £636,171 per year is new investment).
Net Benefits	Together with other integrated care projects the project is expected to contribute to overall forecast total savings of up £5.5m from 2014/15 – 2019/20, and up to £1m in savings per year by 2019/20.

Care Home Locally Commissioned Service (LCS)	Mobilising

Service Description:

Many GP practices provide care to people within care homes; however, it is acknowledged that this group have higher needs than the general population. Therefore, a locally agreed service has been commissioned by Barnet CCG, in addition to the essential and specialised services within the GMS/PMS contract.

The service includes all care homes, including homes for elderly people and people with learning disabilities or multiple disabilities. The expected input from GPs is:

- Increased proactive GP input into care homes.
- Introduction of weekly GP ward rounds (with care home nurses as appropriate) in particular focussing on new admissions to the home and patients who have been recently discharged from hospital, ensuring that a medical review is carried out and a care plan is in place.
- Introduction of a 6 monthly holistic review of all patients under the care of the GP.
- Support the home with planning and delivery of end of life care, meeting the gold standards for such care.
- Closer working with the home to promote high standards of clinical care within the home.

Objectives:

- Improved care in care homes through the locally commissioned service.
- Enabling more to live and die where they choose, reducing avoidable hospitalisation and cost.
- Improved communication and coordination of care between the GP and Care home.
- Increase in satisfaction of patient and family.
- Closer working relationship between the care home and the GP practice.
- Reduction in unscheduled admissions from care homes.

Deliverables:

- 50% of GP practices who work with care homes to sign up to the LCS.

Service Start Date	Service in place from September 2014 – service review in March 2015 with a view to extending the service until March 2016 if the outcomes are being met.
Project (Inter)dependencies	This locally commissioned scheme from General Practice is an enabler for the overall business case and QIPP plan 'Managing Crisis Better', it is anticipated that this scheme will contribute to the overall savings identified through this business case. To maximise the opportunity to reduce unplanned hospital admissions or premature residential and nursing admissions, there are interdependences with the whole range of intermediate care service provision, home care support, disease specific interventions for dementia, the medicines management care home pilot, enhanced dietician support and the Rapid Care service.
Current status and key achievements	• A launch event took place on 4th September to answer questions from GPs and hear from key speakers around the service specification, safeguarding and death certification. • The deadline for sign up from practices is 10th September. • Practices are expected to commence the service from 17th September, though for some practices this will not be possible and a later start date will be agreed.
Service Finance	
Funding	Barnet Clinical Commissioning Group.
Estimated Activity	Based on 50% of GP practices signing up, this would equate to 1,525 patients (3,051 in total as of May 2014) although it is not clear how many practices will sign up currently.

Cost of Service provision	The payments are per bed and will therefore depend on the number of practices signed up to the service as well as the achievement of the expected outcomes. Total pilot costs are estimated at £457,500 in 2014/15 and £915,000 in 2015/16. This is new investment. The payments per bed are as follows: • **Part 1 - £200** – all practices are expected to receive this payment on a monthly basis on delivery of the scheme. • **Part 2 - £100** – practices will only receives this payment at the end of the financial year, on achievement of the outcomes. • **Total - £300 per bed, on achievement of both parts.**
Net Benefits	This locally commissioned scheme from General Practice is an enabler for the overall business case and QIPP plan 'Managing Crisis Better', it is anticipated then, that this scheme will contribute to the overall savings identified through this business case. The expected benefits of the service are: **Improving GP care and support to care homes to -** • Enhance clinical input into all care homes. • Increase proactive care in care homes. • Meet clinical needs in the homes leading to admissions avoidance and reduction in avoidable A&E attendances. • Increase use of preventative services (Rapid Response and TREAT) and reduce calls to the London Ambulance Service. • Improve the relationship between the GP and the home.

Dementia services	**Live Service**
Service Description: This project is a re-design of the existing memory service provided by BEHMHT; to create a discrete fully functioning memory service to meet the Memory Service National Accreditation Programme (MSNAP) and National Dementia Strategy standards. The follow up of patients will be done in primary care. The service will work closely with Dementia Advisors and be a key component of a network of dementia services in the community. The aim of the MAS is to deliver early diagnosis and intervention for people with mild to moderate dementia. It will provide all patients with a person centred service, which will empower people with dementia and their carers to make informed decisions about care and which will help to maximise their quality of life. The service will help to reduce the risk of crisis later in the illness and enable the person with dementia to be cared for at home for as long as possible. The service will be underpinned by the current work to ensure that community support is underway via the Barnet Dementia hub; carers support via the dementia café and Dementia Advisor (DA) service, voluntary sector support and planned improvements in intermediate care. Dementia presents a significant challenge to health and social care in terms of the numbers of people that will be affected and projected anticipated costs. Early diagnosis of dementia is a government priority and the National Dementia Strategy evidences the business case: early diagnosis and support can reduce institutionalisation by 22% even in complex cases.	
Service Start Date	July 2014

Project (Inter)dependencies	Key to achieving long term savings will be the joining up of health and social care services to prevent deterioration and increase preventative action. A key success factor of this service will be its integration with other initiatives; the MAS will be a key component of a resource network of Barnet dementia services, in particular, the Dementia Advisor service, which is located alongside the MAS. This suite of services also supports the frail elderly pathway. It is the overall 'offer' that will deliver the benefits in the long term.
Current status and key achievements	• Successful negotiation of contract variation with BEHMHT. • GP management guide to dementia drugs updated and approved, transfer letters to primary care approved. • Dementia directory finalised. • Dementia Advisor recruited. • Launch steering group underway and launch planned for Nov 14 (launch of MAS and associated services, dementia advisor etc). • Dementia advisor recruited; have commenced co-location working. • MAS clinic recruited.
Service Finance	
Funding	Section 256 (Better Care Fund from April 2015), Barnet Clinical Commissioning Group
Estimated Activity	780
Cost of Service provision	£151,425 in 2014/15 (of which £21,000 is new investment), rising to £334,034 by 2019/20 (of which £84,000 per year is new investment).
Net Benefits	• More patients to receive early diagnosis; will enable quicker access to services and support to manage dementia. • Early provision of support at home can decrease institutionalisation. • Carer support and counselling at point of diagnosis can reduce care home placements. • Decreased length of stay in acute episodes

Further interventions for dementia

Following a dementia mapping exercise, a Dementia Action plan has been drafted, key areas include:

- Improving dementia diagnosis in primary care – a separate Action Plan has been submitted to NHSE and is in the process of being updated.
- A programme of further training for primary care.
- Barnet Dementia Event planned for Nov 14 to launch new services and initiatives and raise awareness of early diagnosis and intervention; event aimed at GP's, social workers, other professionals.
- Dementia friendly communities – plans are in progress for Barnet to become a Dementia Friendly Community.
- Development of a Barnet Dementia dashboard.

Project milestones – monitoring and project evaluation (from commencement of service)

Review arrangements for tracking progress monthly via KPI's, including any IT changes: Create mechanism for tracking benefit realisation	**August 14**
Conduct review of plan against progress review QIA and EIA to ensure still applicable	**November 14**
Review monthly monitoring reports from provider based on agreed monitoring mechanism	**Ongoing**

Review impact of the addition of new staff and determine whether waiting times have reduced	**October 14**
Conduct 6 month review and write evaluation report	**January 15**

Stroke services – early stroke discharge and stroke review	**Live Service**

Service Description:

The introduction of Early Stroke Discharge teams (ESD) challenged the traditional stroke pathway model in bringing forward the time of discharge and providing a continual period of rehabilitation in the home. Stroke survivors, their carers and families, report feeling abandoned post stroke and many of them miss the opportunity to regain their maximum functioning, and adjust to the health, social and emotional needs following a stroke.

The National Stroke Strategy requires all stroke survivors to receive regular reviews of their health and social care need. Without a co-ordinated review process there is a risk that the recovery potential for a group of people following a stroke is missed out on resulting in higher and more expensive levels of need and poorer outcomes for individuals.

Various reviews in Barnet have demonstrated a lack of capacity in the stroke specific community rehabilitation services in Barnet, including limited access to therapies.

Early stroke discharge. The object of this project is to increase the provision of specialist intermediate care/ rehabilitation for stroke in the patient's home by increasing early supported discharge capacity, reducing the length of stay in hospital and acute activity and freeing up resources. This will be achieved by:

- Reduced length of stay in hyper acute stroke unit and stroke unit
- Reduced re-admission rates to acute
- Reduced entry to residential/long term care

The new service will also comply with national stroke standards, which the previous service had not attained.

Stroke reviews. Good practice shows that establishing a formal review stroke service will result in better outcomes for patients whilst delivering savings for CCGs. The aim of the project is to establish a formal stroke review service: every stroke survivor in Barnet to receive a 6 month review using the GM-SAT tool to prevent further strokes which will result in better outcomes for patients. This will bring about savings through:

- Reduced emergency admissions from patients suffering from a second stroke
- Reduced adult care packages and care home placements

The review service has been dual commissioned by BCCG and LBB from CLCH and the Stroke Association (SA)

A third initiative (not part of this Tier) is to support an increase in the recorded prevalence of Atrial Fibrillation in primary care, and treat them with anticoagulation across the sector using the GRASP AF tool. This is a preventative measure that will reduce the number of people having a stroke and avoiding admissions etc.

Service Start Date	Service commenced November 2013.
Project (Inter)dependencies	Some of the savings for ESD in the stroke units will accrue to the acute provider. Work will be undertaken with the stroke units to release some of these savings

Current status and key achievements	• Successful contract negotiation with CLCH and Stroke Association (SA) (stroke reviews are commissioned from both CLCH and SA). • Acute (stroke units) noted positive impact of enhanced ESD. • Good partnership working between SA and CLCH.
Service Finance	
Funding	Barnet Clinical Commissioning Group.
Estimated Activity	140 for ESD 400 for stroke reviews Est. 400 people in Barnet have a stroke.
Cost of Service provision	£547,691 per year (of which £195,000 per year is new investment).
Net Benefits	**ESD:** • Reduced length of stay in hyper-acute and stroke unit. • Reduced readmission rates to acute. • Reduced entry to residential/long term care. • Better outcomes for patients. **Stroke review** Evidence shows this will assist to prevent people from having a second stroke. • Reduced emergency admissions from patients suffering from a second stroke. • Reduced adult care packages and care home placements. • More equitable system than hitherto e.g. everyone in Barnet who has had a stroke will be offered a review. Addressing unmet needs and supporting people regain home and community roles. Service proposal quality assured to comply with national stroke standards.

Project milestones – monitoring and project evaluation (from commencement of service)

Review monthly monitoring reports from provider based on agreed monitoring mechanism, track progress monthly via KPI's, including any IT changes	**Ongoing**
Conduct review of plan against progress review QIA and EIA to ensure still applicable	**November 14**
Conduct 12 month review and write evaluation report	**November 14**

Further interventions for stroke

Stroke acute wards inspection – monitor progress on recommendations, ensue/facilitate liaison with community services. Re-establish local stroke network.

Barnet Shared Care Record	**Scoping**
Service Description: The Shared Care Record will provide a single view of the individual's care. It will not replace local systems, but will provide a single location for care providers, and later individuals themselves, to view information from all care providers. The information will be available in a secure and controlled way. It will be accessible via a web browser to care providers across Barnet. Information in the Shared Care Record will be available instantly from all contributing systems. Following an initial roll out to care organisations, the service will expand to include access by private sector, third sector, the individual and their carers.	

Project objectives

This project has the following key objectives:

- Gather information from a variety of care providers in Barnet to provide a single view of the individual's care. This must be provided in a secure and appropriate way on a 24/7 basis with multi-channel access supporting use in all care environments.
- Provide secure and appropriate access to the Shared Care Record to care providers across health and social care in Barnet.
- Expand the access to the Shared Care Record to enable secure and appropriate access by third sector and private care providers.
- Expand the access to the Shared Care Record to enable secure and appropriate access by individuals and their carers.
- Provide a commissioning view of combined, anonymised data.

Desired outcomes

The project will realise the following core outcomes:

- Professionals across a number of organisations can access a single shared view of an individual's care.
- Individuals (and their carers) can securely access their own care information in one location.
- Access will be available on a 24/7 basis, irrespective of location, whilst still maintaining a suitable level of security and control over the information viewed.
- The shared care record solution will not impede the use of existing systems and processes but will work with them to improve the provision of care.

Deliverables:

- A shared care record with care information about Barnet residents.
- Information available from all the main care providers.
- Secure, controlled access to information on a 24/7 basis, available from any location.
- A robust audit and monitoring solution.
- Ability for individuals and their carers to access the record.

Service Start Date	Project started in June 2014. Initial implementation by March 2015
Project (Inter)dependencies	The service is dependent on other case management/patient record systems being able to send information to the Shared Care Record (e.g. GP Systems (EMIS), the new Adult Social Care case management system). An NHS N3 connection will be required for access to the full service. The Shared Care Record will be an enabler for other services where information is shared between teams, where someone from another team would normally be given access to a local system and in supporting self management by providing individuals with access to their own record.
Current status and key achievements	Project has started, although waiting for formal sign off for PID.
Service Finance	
Funding	Section 256 (Better Care Fund from April 2015)
Estimated Activity	All staff who may benefit from using the system to assess needs and deliver services. See the table in Net Benefits below.

<table>
<tr><td>Cost of Service provision</td><td>£1.4m total set up costs (from 2014 to 2016). £35,679 running costs per year, rising to £154,937 per year by 2019/20. This is new investment.</td></tr>
<tr><td>Net Benefits</td><td>The following table shows projected Annual Productivity Savings across all main care organisations in Barnet using the Shared Care Record. Based on saving an average of only 60 minutes per member of staff per week through more efficient sharing of and access to information.
<table>
<tr><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>2017/18</th><th>2018/19</th></tr>
<tr><td>£14,104</td><td>£683,029</td><td>£805,400</td><td>£910,874</td><td>£932,423</td></tr>
</table></td></tr>
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Tier 5 – Acute & Long-Term Care

Tier 5 includes residential, nursing and acute services for frail elderly people and people with LTCs who can no longer be supported effectively at home. At this point community services are likely to be neither the most appropriate nor safe environment for these people to receive support. These services are accessed where and when necessary.

The current service provision in Barnet for community services does not fully enable people to live healthily and independently in their own homes for as long as possible. As a result there is an over-reliance on hospital services and residential care. This increases financial pressures in providing services in this Tier. It is from where we need to move activity out long-term to other Tiers.

Scope & Status

Although the focus of our work to deliver the 5 Tier Model is in Tiers 1 to 4, we are also working to reduce the use of acute beds and residential care services as a result of more effectively reducing and managing demand for Tier 5 services.

We have also recently completed the first part of a project to invest in improving quality in care homes. This project is aimed at developing and increasing the skills of the care home workforce and increasing the role and work of GPs in supporting people in acute and residential services, to prevent unplanned admissions.

We also have a number of other priorities for developing and improving services in this Tier to integrate closely with services in Tiers 3 and 4. To move activity away from Tier 5 long-term and deliver financial savings and desired outcomes, Tier 5 services must facilitate and enable us to support more people through Tiers 3 and 4 instead. This also facilitates providing the best possible care for those people only for whom acute or residential support is required.

Priorities include:

1. Better discharge planning to ensure services are in place to support people stay at home and to receive targeted interventions from Tier 3 and 4 services if required.
2. Using hospital networks to provide improved access to centres of excellence.
3. Partnering with acute providers to maximise and optimise the use of available, specialist resources and facilities.

4. Developing clear, joint referral and escalation protocols.
5. Enhancing the medical skills of care home staff to reduce referrals to acute services.

Areas of focus for new projects and work packages to meet these priorities include, e.g.:

1. Transitions in and out of A&E, including the effectiveness of PACE & TREAT services, DTOC and pending DTOC services and 7 day working.
2. Continued, targeted work in residential and nursing homes, including care home access to Rapid Response services, anticipatory care planning, additional ongoing quality in care homes initiatives and links with GP LIS work.

Acute service providers are critical to the successful design and delivery of Tier 5 services. We are working closely with them to embed ownership of these services. This includes:

1 Delivering services that fit our vision and strategy for the model and Tier.
2. Using relevant, key data sets to inform setting priorities for future work.
3. Monitor and review current service provision and identify any gaps, to help define and prioritise new projects and services.
4. Identifying interdependencies with existing work in this and Tiers 3 and 4 and considering opportunities to join operations join where appropriate.

Risks & Dependencies (All Tiers)

The following tables sets out the major risks and dependencies to delivering the 5 Tier model identified to date.

Key - Likelihood / impact ratings definitions:

H	There is a high probability of this risk materialising/ it will have a major impact on the project should it occur
M	There is a significant probability of this risk materialising/ it will have a significant impact on the project should it occur
L	This risk is unlikely to materialise/ it will have a minor impact on the project should it materialise

Tier 1

Risk description	Likelihood	Impact	Mitigation
Leaders within all partner organisations do not have a shared commitment to the aims and objectives of Tier 1, or an understanding of the impact it will have on their own services leading conflicts whilst the project is being delivered.	L	H	Extensive stakeholder engagement already taken place. Each project will have a communications work stream with planned stakeholder engagement activities.
Poor communication between lead organisations which prevents information sharing between stakeholders which limits their ability to work collaboratively and deliver joined-up care.	M	H	Promote shared objectives at all levels of organisations and agreed sharing of activity and information.
A lack of understanding and buy-in from practitioners that need to be involved means that they do not understand their own contribution or embrace the new ways of working that are required to deliver the integrated health and social care offer.	H	H	Engage with key practitioners during the development of the new model. Begin early communications and deliver joint training on service changes.
Culture differences and lack of understanding between different professions means that practitioners continue to work in isolation rather than collaboratively.	M	H	Encourage early communication between practitioners and hold joint engagement events to promote collaboration.
The major transformational changes occurring across LBB and Health disrupt the project, causing delays or reducing the ability of new service models to deliver their objectives of integrated health and social care offer.	M	M	Engage with projects likely to impact on the deliverables outlined to understand potential disruptions and take mitigating action.

Tier 2

Risk description	Likelihood	Impact	Mitigation
Leaders within all partner organisations do not have a shared understanding of the aims and objectives of Tier 2, or the impact it will have on their own services leading to a lack of investment.	M	H	Develop evidence base which meets validity requirements of local stakeholders.
Voluntary sector organisations are unable/unwilling to work together to develop a joined up approach.	M	H	Develop joined-up approach collaboratively, ensuring that each organisation I not disadvantaged. Consider retendering offer as a whole with clear contractual requirement to work collaboratively.
CCG and Council develop different approaches or the same approach separately to advice, information, advocacy and support and there is no single point of access for information.	H	H	A separate approach is already in operation. It may be necessary to develop a staged approach to reaching this position.
Services/initiatives are unable to demonstrate desirable benefits, including cost-effectiveness.	M	M	Develop a shared understanding with voluntary sector providers and others of benefits. Ensure commissions are based on outcome-specs to enable flexing of service. Ensure valid easy measures in place.

Tiers 3 & 4

Risk description	Likelihood	Impact	Mitigation
Leaders within all partner organisations do not have a shared understanding of the aims and objectives of Tier 3 and 4, or the impact it will have on their own services leading conflicts whilst the project is being delivered.	L	H	Extensive stakeholder engagement has already taken place. Each project will have a documented communications work stream with planned stakeholder engagement activities.
Lack of support (IT or shared work space) to facilitate communications and information sharing between practitioners limits their ability to work collaboratively and deliver joined-up health and social care.	M	H	Promote the use of Skype and other video conferencing.

Risk description	Likelihood	Impact	Mitigation
A lack of understanding and buy-in from practitioners that need to be involved means that they do not understand their own contribution or embrace the new ways of working that are required to deliver the integrated health and social care offer	H	H	Engage with key practitioners during the development of the new model. Begin early communications and deliver joint training on changes to service
Culture differences and lack of understanding between different professions means that practitioners continue to work in isolation rather than collaboratively	M	H	Encourage early communication between practitioners and hold joint engagement events to promote collaboration
The major transformational changes occurring across LBB and Health disrupt the project, causing delays or reducing the ability of new service models to deliver their objectives of integrated health and social care offer	M	M	Engage with projects likely to impact on the deliverables outlined to understand potential disruptions and take mitigating action

5. Financial Case

This section develops the Financial and Investment Case for the integration of health and social care, described in the 'Barnet Health and Social Care Economy - Integration of Health Social Care Services OBC' (v7 Final, 07 March 2014). This includes the latest view of the anticipated gap in the funding required to deliver services and the likely costs and benefits of delivering the integration described in Section 4 and how this impacts this gap.

Context – The Funding Gap

Integrating health and social care services will include and affect 'core' and 'influenced' services.

Core services are those provided in the community and non-acute bed based care, e.g. residential care, community healthcare, homecare, and self-management or preventative services. We will redesign core services for integration, investing resources as necessary.

To deliver the desired benefits and outcomes we also need to influence areas of spend in other services, which are not intended to be redesigned but which may see a movement in activity (and therefore cost) as a result of the changes in core services. This includes, e.g. all acute services, and inpatient mental health services.

We anticipate that savings will come predominantly from reduced activity in influenced services.

The total value of core services in scope is £77.9m, of which 46% is LBB spend and 54% BCCG. The total value of influenced services is £58.6m, of which 1% is LBB spend and 99% BCCG.

The table below shows the relevant 'core' and 'influenced' financial resources in scope today. The total resource envelope is £136.5m, of which more than 62% is spent on acute and residential care services. Less than 3% is currently spent on self-management and health and wellbeing services. This shows that resource in the system is not sufficiently weighted towards preventative services.

	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Total
Core LBB	£100,000	£3,401,471	£3,744,002	£14,394,221	£14,132,946	£35,772,640
Core BCCG	£272,000	£27,237	£502,500	£28,888,927	£12,440,000	£42,130,664
Influenced LBB	£0	£0	£0	£344,401	£0	£344,401
Influenced BCCG	£0	£0	£0	£63,538	£58,205,929	£58,269,467
Total	**£372,000**	**£3,428,708**	**£4,246,502**	**£43,691,087**	**£84,778,875**	**£136,517,172**
%	0.27%	2.51%	3.11%	32.00%	62.10%	

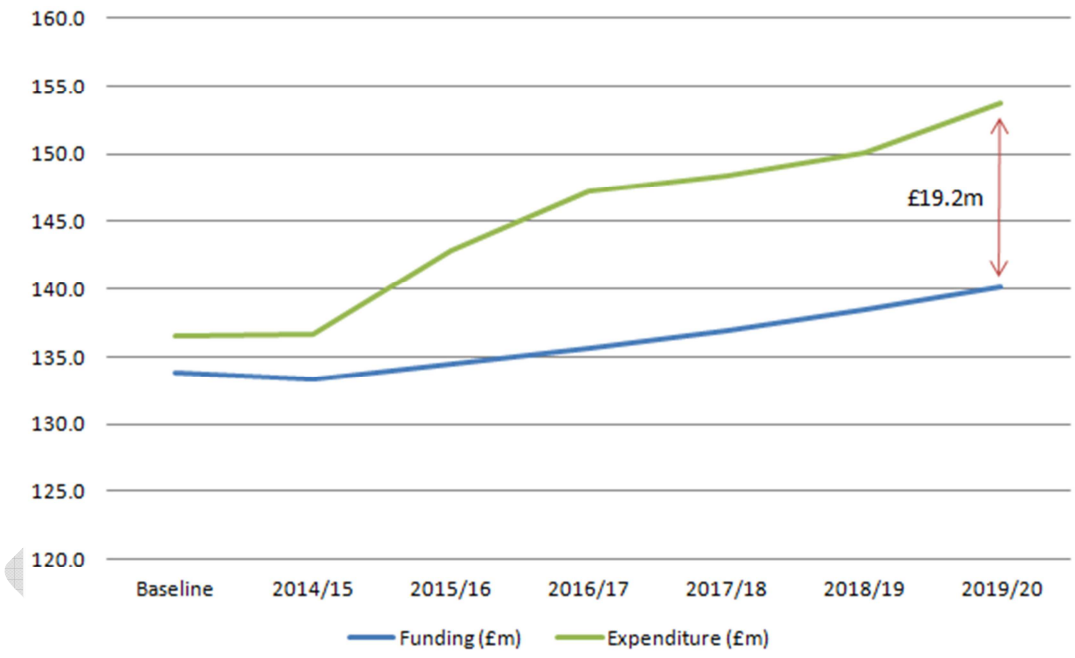
Table 1 – Value of Core and Influenced Services across the 5 Tier Model

If we take no action to redesign our core services, all these resources will become expenditure. The combined effect of reduced funding and our projected increases to this expenditure will create a significant financial gap over the next six years. The table and graph below illustrates this:

	Baseline	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Funding	£133,817,172	£133,272,272	£134,496,516	£135,647,160	£136,973,858	£138,482,170	£140,177,586
Net Exp	£136,517,172	£135,659,985	£142,319,805	£148,905,981	£151,623,446	£155,526,033	£159,414,184
Gap (pa)	**-£2,700,000**	**-£2,387,713**	**-£7,823,288**	**-£13,258,821**	**-£14,649,588**	**-£17,043,862**	**-£19,236,598**
Cumulative	*-£2,700,000*	*-£5,087,713*	*-£12,911,001*	*-£26,169,823*	*-£40,819,411*	*-£57,863,273*	*-£77,099,871*

Table 2 – Forecast Funding Gap for Health and Social Care Services 2014 – 2020

The graph below illustrates this project funding gap as set out in the Outline Business Case:



Graph 1 – Forecast Funding Gap 2014 – 2020 in Graph Form

Cost Benefit Analysis

The projects and services detailed above are estimated to deliver a net annual recurring benefit to budgets of £5.7m by 2019/20. This is a result of £4.1m additional revenue expenditure per year, generating £9.8m per year of avoided expenditure in acute hospital and care home services. There are also one-off upfront investments totalling £1.4m.

The £5.7m in benefits realised includes £3.1m QIPP savings for Barnet CCG QIPP savings, £1m PSR savings for the Council plus £1.6m in other savings for both organisations across the delivery of integrated services.

	One-off investment	Net recurring budget shift 2014/15 to 2019/20		
		Total additional running costs	Total financial benefits	Net Cost / (Benefit)
s256 Funding	£1,370,950	£2,670,539	£0	£2,670,539
Public Health	£48,000	£310,720	£0	£310,720
LBB Funding	£0	£12,000	-£918,733	-£906,733
CCG Funding	£0	£1,109,607	-£8,865,717	-£7,756,110
Total	**£1,418,950**	**£4,102,866**	**-£9,784,450**	**-£5,681,584**

Figure 4 – Summary Cost Benefit Analysis

The total savings of £9.7m as illustrated above include savings to health of £8.9m, from a reduction in acute activity of 2,268 avoided non-elective admissions, 501 fewer excess bed days and 10,896 avoided outpatient and A&E attendances. This level of activity is within the potential benefits set out in the recently published Better Care Fund Fact Pack for Barnet. Savings to social care of £1m come from 62 avoided residential care admissions from 2018/19 to 2019/20.

Our analysis of the costs and benefits involved are an indicative view of the benefits available. We have taken a prudent approach, i.e. modelling costs at the higher end of the range of forecasts and benefits at the lower end. We anticipate that the initiatives in place have the potential to impact more positively on social care than stated so far. However, at this stage evidence to support this remains inconclusive and further development is required through the Programme to determine the maximum scale of operations and therefore benefits possible.

While the net recurring budget savings modelled of £5.7m represents positive progress, it does not eliminate the £19.2m funding gap detailed above. After deducting the £5.7m in savings this leaves a gap of £13.6m.

To close this gap the scale and scope of existing and future services and projects need to be more ambitious. The Programme today concentrates on projects that are deliverable for relatively small cohorts of the population in the first two years of delivery. It is recognised that future work could be done to expand the existing initiatives and increase the pipeline of projects commencing in Year 3 and beyond.

Further work is needed to determine the impact on the savings modelled here as a result of the implementation of the Care Act. This includes, e.g. the impact of any change in contributions from service users as they move from residential and nursing to community services or assumptions for the level of demand for services. We also need to analyse the wider implications of changes to services. For example, if we support people following a stroke in the community more quickly, what is the impact of any resulting homecare, enablement or intense short-term support services?

For more details of the assumptions and risks for this Cost Benefit Analysis, see Annex 2.

6. Commercial Case

This section summarises our latest view of the likely contracting model, payment mechanisms and risk sharing and Pooled Budget arrangements to deliver integrated health and social care services.

Approach

End-to-end integrated care is likely to require a complex structure of contracting models, payment mechanisms and risk and budget sharing arrangements. For example the care pathway, locality or service and benefit/outcome desired at any point in or across Tiers may require one or more (lead) providers in wider alliances delivering packages of care coordinated around the individual.

Other factors today affect our understanding of the most appropriate commercial arrangements to implement long-term. For example, the pace of change required to meet QIPP and BCF targets, or the complexity of health systems. The merger of the Barnet General Hospital and Royal Free NHS Foundation Trust Hospital may create some short-term uncertainty in the market. Plus, we need to understand how best to use the savings generated from reducing activity in Tier 5, e.g. reinvest in Tiers 1 to 4 or allocate them to QIPP, MTFS or PSR savings targets?

Commercial arrangements are currently set via contractual changes or special projects. However we need to build long-term commercial arrangements fit for purpose for the 5 Tier Model through partnering with providers and other stakeholders to services hands-on. Furthermore we must align this work with our plans for strategic integrated commissioning for health and social care, because it will define the commercial platform from which we can go to market for services.

This means we can retain a shared consensus on the vision and delivery of integrated care, avoid a disjointed, inconsistent delivery of benefits and outcomes and identify and manage risks to long-term success, e.g. resilient governance to keep relatively disconnected providers working together, or maintaining visibility within the supply chain.

This approach will also help us to set up clear contract management frameworks, e.g. performance or quality targets and be clear on accountability and funding mechanisms. This will mean services are more likely delivered consistently, giving people a common, quality experience.

Contracting Model Options

We are therefore appraising four possible options for a new contracting model:

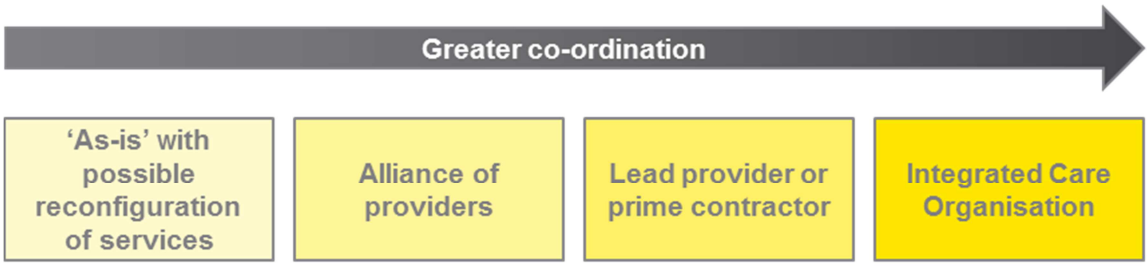


Figure 5 – Potential Contracting Models for Integrated Services

Potential payment mechanisms for the delivery of services against a preferred contracting model include single payments for full cycles of care and outcomes based capitation.

A preferred or recommended contracting model and payment mechanism are not yet identified.

Funding Arrangements

We will manage the funds to commission the integrated services to deliver the 5 Tier Model using a 'Section 75 Agreement' (National Health Services Act 2006). This is an agreement between us to undertake joint commissioning or provision using pooled budgets, single organisational structures and other resources. It may include BCF monies and core budgets and any preferred contracting model must align with this arrangement. We may also use Section 256 funding for specific Programme resources or service set up costs (such as procurement or training).

Pooled Budgets and Risk Sharing

To ensure benefits are jointly realised we will pool and/or align some core and influenced budgets against clear performance metrics, monitored through joint governance arrangements. We plan to start this with the planned allocation of Better Care Fund monies, submitted 19 September 2014, for the delivery of integrated services from April 2015. We anticipate the proportion of our core and influenced Budgets that moves to the Pooled Budget will grow in time as the scope and scale of the integrated services increases.

We face financial and system pressures from 2014/15 to 2019/20 that may constrain the level of pooled funding we can both contribute to pooled or aligned budgets, e.g.:

1. For BCCG need to reduce budget deficits may require us to allocate any financial benefits derived to this purpose first, rather than reinvest in the 5 Tier Model for further benefit.
2. For LBB the Care Act could lead to significant increased demand for social care services and therefore may requires us to allocate resources to meet these needs.

These pressures require funding arrangements that allow us to share ('cash') benefits derived from integrating our services proportionally against them, while enabling us to cap our exposure to the other's financial risk if so desired.

This will enable us to identify, quantify and track how much of the financial benefits derived from the services detailed for each Tier in this Business Case:

1. Are retained in the Pooled Budget and reinvested in further, future services for each Tier.
2. Contribute to reducing financial deficits, funding reductions or other financial pressures.
3. Provide for individual exposure to other relevant risks, e.g. new ICT systems for service delivery or the reallocation of money for local 'specialist' commissioning activity.

Options under discussion to achieve this and share such risks include, e.g. a 50/50 split in reducing influenced services, reduced current or future spend on services (or our contribution to Pooled Budgets) relative to the original joint funding pool, reconciliation or closure of budgets or cashing benefits in proportion to funds invested against target investments or against the agreed size of the financial challenge we each face.

We will also factor in mechanisms to monitor and map benefits realised outside the Pooled Budget back to it and then agree reinvestment back into or outside the Pooled Budget accordingly.

Further work is required to develop and finalise Lead Commissioner roles (e.g. by service), holding of the Pooled Budget(s) and accountabilities and governance arrangements necessary to control and monitor spend and returns. This may include:

1. Determining the appropriate number of Section 75 Agreements to deliver services across the whole 5 Tier Model and appraising the use of pooled versus aligned budgets for some individual services.
2. The shared ownership and management of any risks to the success of the pooled budget, proportional to contributions, such as below minimum contributions for planned or actual spend or individual evolving strategy, objectives or financial/organisational risks.
3. Duties and responsibilities for one partner to manage commissioning for specific services on behalf of the other or to commission the services from single pooled funds.
4. Establishing the Terms of Reference of the Programme Board and other involved Boards, including decision making processes, schemes of delegation and reporting arrangements.
5. Processes for deciding the expenditure permitted against Pooled Budgets and monitoring subsequent spend against the costs and benefits in this Business Case.
6. Defining the set up and use of non-financial pooled or non-pooled resources, e.g. capital assets or single management structures for combined staff.
7. Designing arrangements to fit BCF governance requirements while increasing integration, delivery and value and creating further operational or care pathway efficiencies.

Summary and Next Steps

We will align work to confirm our preferred contracting model and Pooled Budgets and risk sharing and payment mechanism arrangements with parallel work to develop the OBC for integrated commissioning for health and social care. This will enable us to integrate strategy with the tactical

delivery of integrated commissioning to create the best platform for increasing efficiencies and continuous improvement long-term.

Other considerations include:

1. Understanding the scope and mechanisms for allocating and/or transferring risk, contract management approach, skills transfer and any required exit strategies.
2. Resolving issues arising from differing financial regulations or accounting parameters, e.g. VAT, budget surplus/deficit tolerances and how to 'cash' (reimburse) benefits.
3. Implementing new arrangements with existing ones that we cannot change and anything else not considered to date.

Plus it is important to make sure the timing of and the time it is likely to take to set everything up is best placed and does not conflict with competing demands for resources.

We expect arrangements to evolve as we design and build the operating arrangements. We will conduct detailed options appraisal for each element as required (e.g. to include market testing) to evaluate if services in the 5 Tier Model will suit a standard or a mix of commercial arrangements for the desired level of integration and appetite for risk.

This will include partnering with providers to identify an approach to facilitate building and safely and smoothly moving to new operating arrangements and new ways of working. Early engagement with providers and the community will be vital, to inform stakeholders, allay any fears and listen to feedback and adjust our proposals accordingly to obtain buy-in for our strategy.

This will enable LBB and BCCG to maximise opportunities to:

1. Align and integrate joint corporate strategy with service delivery, creating one, coherent, stable, predictable and unified approach for the community and the market.
2. Re-invest benefits into end-to-end care, giving additional opportunities to improve care quality and outcomes for people and reduce costs and create long-term financial stability.
3. Move away from payment based on activity towards payment based on the outcomes of Values Based Commissioning as the platform for integrated care, a key enabler in moving activity away from costly acute and residential and nursing care.
4. Implement contracting arrangements or payment mechanisms that incentivise providers to share in the risks and available rewards from integrating services.
5. Commission and procure services efficiently and effectively against a shared consensus of future needs of the community, through one procurement strategy and operation.
6. Define and realise benefits and long-term outcomes for the community.

7. Management Case

This section describes the Programme we have set up to deliver integrated services and financially sustainable better health and wellbeing outcomes. This includes the organisation and scope of the Programme and work to set up effective delivery and operations, e.g. governance, resources and timetables and benefits realisation.

It demonstrates that all the work detailed in the Business Case is achievable, implemented through a clear, structured and managed environment.

The Programme

The HSCI Programme is a structured, managed set of change projects, business as usual work and communications and stakeholder engagement, to implement the 5 Tier Model.

Aims & Objectives

The aim of the Programme is to enable us and partners to develop and commission sustainable integrated care that understands and meets the needs of the frail and elderly and people with long-term conditions in Barnet.

The main objectives of the Programme are to:

1. Embed the 5 Tier Model as the default strategy for the design and delivery of all current and future integrated health and social care services.
2. Embed in people a perception and expectation that they will live independently in their community, only using care services designed to protect and extend this if necessary.
3. Move as much activity as possible from acute, residential or nursing care to people self-managing their conditions and accessing services in the community.
4. Design and commission integrated services which:
   - Promote and support self-management and health and wellbeing in the community.
   - Operate end-to-end across all Tiers as required and respond quickly to plan, deliver and track re-ablement focused care wherever possible.
5. Put in place operational infrastructures, systems and working arrangements to facilitate integrated working and partnership working between commissioners and providers.
6. Continually improve the appropriateness and quality of care services in meeting needs.
7. Reduce the amount of activity and cost of acute and residential or nursing care.
8. Reduce the total amount of financial resources used to deliver integrated care.

Outline (Structure & Scope)

Figure 6 below illustrates the current and proposed scope of the HSCI Programme.

Projects comprise a defined change (output) for one or more tiers, e.g. the Shared Care Record to implement a new IT system for sharing information about the care people receive, or a suite of defined changes by theme or condition, e.g. Strokes, to deliver end-to-end integrated services.

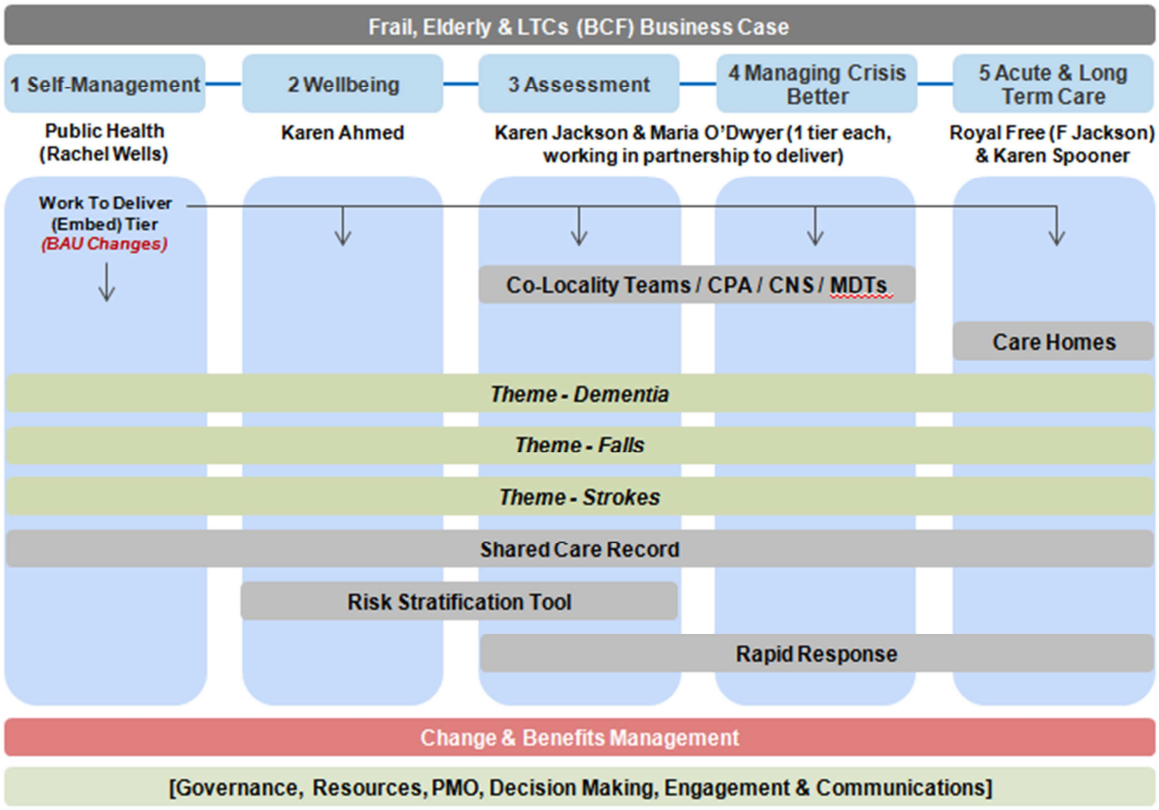


Figure 6 – Proposed BCF Programme Structure

Business As Usual (BAU) work comprises incremental changes or improvements to existing services designed to enable, support or integrate projects or embedding the 5 Tier Model.

The Programme will deliver and manage change, benefits management work centrally. Governance will complement wider arrangements in place as appropriate, e.g. where decision making is to be escalated to or made directly by the Health and Wellbeing Board (HWB).

A Programme Management Office (PMO) will coordinate and manage Programme operations. This will include governance, administration, project/work delivery and reporting, benefits realisation, documentation and information control and communications and engagement with stakeholders.

Governance Arrangements

Figure 7 below illustrates the governance and board structure for the HSCI Programme.

Initial governance arrangements were agreed and put in place in April 2013. This included gateway review and approval processes for projects and work, project and programme reporting, roles and responsibilities, Programme Management Office (PMO) functions, risk, change, issue management processes and information governance and terms of reference.

The governance and board structure in Figure 6 supersedes the original governance arrangements. We are now working to revise and refresh Programme governance to reflect this Business Case.

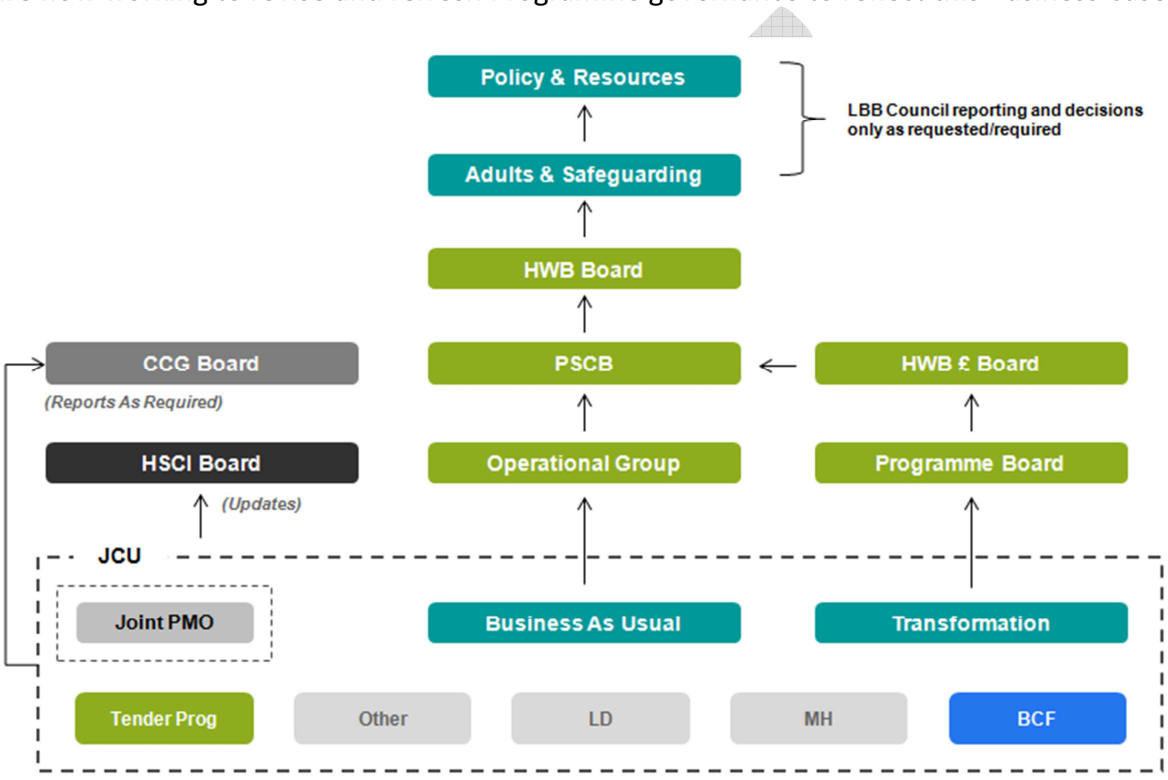


Figure 7 – Proposed BCF Programme Structure

The LBB A&C Director of Adults & Communities and BCCG Chief Executive Officer will act as joint Programme Sponsors. The A&C Associate Director of Health and Wellbeing, Adults & Communities and BCCG Director of Integrated Commissioning will act as joint Programme Directors and Project or Theme Sponsors.

Each Tier will have a Lead and Subject Matter Expert. Each Project or Theme will have a Project Manager and prioritised work, aligned to Programme aims & objectives, and desired benefits and outcomes. Tier Leads will partner to define strategies for delivering end-to-end services.

We will deliver and manage all Programme and project work using LBB and BCCG programme and project management methodologies. Work will be grouped and delivered work in tranches based on priority (e.g. by its contribution to desired benefits or outcomes and how achievable the work is against other competing demands for resources).

We will deliver and manage work and define, validate and track the realisation of desired benefits using our programme/project management methodologies and benefits management tools and techniques from other recognised methodologies, e.g. PRINCE2 or MSP.

This will give enable our and independent scrutiny and assurance of work down, with scheduled reporting and reviews to monitor the delivery of desired benefits and to retain tight management and financial control of Programme spend against this Business Case.

Proposed new projects must have a viable Business Case that clearly states the financial and non-financial benefits of putting in place the changes described.

The Programme Board (Operational Group) will consider the Business Case and approve or reject it against agreed evaluation criteria, e.g. whether it meets the vision, aims and objectives of the 5 Tier Model, meets one of the six core BCF target benefits and outcomes, improves on the quality of services and commissioning for outcomes, or meets commercial criteria such as lower costs (i.e. reduced duplication or acute activity).

If accepted the Programme will deliver the project, tracking progress and outputs against similar quality assurance criteria. Once completed, the business will manage work to measure all benefits realised, with support from the Programme as required.

Delivery Resources

The JCU is responsible for delivering the Programme (e.g. Project and Programme Management roles) with support from LBB, BCCG as required, e.g. Tier Leads or Subject Matter Experts (SMEs). If additional capacity is required the JCU will draw from in-house resources or use other available Programme funding as appropriate, e.g. Section 256 funding.

The Cost Benefit Analysis in the Financial Case in Section 5 account for all known required delivery resources identified to date. However the delivery resources required will evolve in line with the scope of the Programme and ongoing delivery. We will also use additional external resources, e.g. commissioners, providers, the community or other stakeholders to help inform plans and support specific functions, e.g. change management, training or evaluation.

Communications & Stakeholder Management

The Programme will design and execute a detailed communications and stakeholder engagement plan to inform all interested parties about the scope, progress and positive impact of our work. We will base this on and align it with other parallel internal and external campaigns, e.g. to inform people about changes resulting from the introduction of the Care Act from April 2015.

This will enable us to lead and manage the change anticipated and respond to feedback. It will also form the platform for changing the perceptions and expectations of practitioners and community members long-term. We aim to move the mind set for health and social care staff from providing standard packages of care to taking a values based approach to help people follow an asset based approach to consider what they can do rather than what they cannot.

Planning, Risks, Issues & Dependencies

Projects hold and manage work and milestone plans and risk, issue and dependency registers, with exceptions and individual entries escalated and managed at Programme level as necessary. The Programme also holds a separate Programme level register, reported to the Programme Board, LBB Portfolio Management Office and CCG regularly.

Project plans are reviewed and revised and work is planned for the next period against progress, resource availability and priority of desired benefits and outcomes.

Projects and the Programme will cost risks accordingly to understand and account for their impact on the Business Case, to monitor that the Business Case remains viable and to retain management and financial control.

Areas/types of risks, issues and dependencies tracked include, e.g.:

1. Internal and external factors that prevent successful delivery, such as a lack of providers or immature market, insufficient staff, skills or expertise.
2. The impact of non-delivery of operational and technical infrastructures, e.g. Shared Care Record or replacement case management systems, or co-location/accommodation.
3. Changes to corresponding but separately managed functions in LBB or BCCG, such as the introduction of a broader 'Front Door' service and how this affects the Financial Case or the understanding in the community of when and how to access services.
4. Dependencies on existing providers, other partners or interested/influential stakeholders.
5. Potential higher demand as a result of the requirements of the Care Act and how this may our ability or likelihood to realise the desired benefits.

8. Conclusions and Next Steps

This Business Case demonstrates the significant progress we have made so far to implement and embed our vision and 5 Tier model for integrated health and social care services. The new services now in place and projects in delivery are beginning to return financial savings and benefits and the best outcomes for frail elderly people and those with LTCs.

We realise there is much more work to develop and embed our end-to-end integrated system. The scope of work to date has focused on health services to immediately address pressures on acute services. Our initial review of the benefits realised so far validates this approach, showing that as expected we are starting to deliver on our aim to reduce unplanned emergency admissions to hospital and so enable people to live independently and healthily at home.

We now need to assess the maximum scale to which we can operate the services in this model and so maximise such available savings and benefits. We also need to understand the long-term impact on and benefits to the cost and make up of social care services. We need to be sure that by giving people access to preventative, community based services or supporting them to self manage LTCs, this model will also reduce the level of social care support needed.

Continuing to monitor the progress and impact of the projects described here will validate the core principles of our vision and model for integration and our ongoing investments, plus enable us to identify future opportunities to increase and enhance integration through new services.

Structural integration and new commercial models are complex and challenging to achieve. We need to consider options for new contracting models, pooled budget and risk share and payment mechanisms local in more detail. We will want to minimise transition costs where possible and put in place one or more arrangements as appropriate. For example, we may need to use a number of lead providers for different service packages, form alliances to coordinate pathways or use some arrangements to manage bundle of services rather than as the main delivery platform.

To further develop our strategy, deliver the work and implement the commercial and operational models detailed here our programme will need to draw on expertise in stakeholder engagement, pathways redesign, clinical standards, service specification design, equality impact assessments, procurement, contract management, finance, legal, IT and project and programme management.

There is a consensus amongst key stakeholders to deliver our model in a staged process. Next steps and ongoing work will include, e.g.:

1. Extending and implementing existing operating arrangements like the Care Navigator and Multi-Disciplinary Team services and piloting and rolling out new services such as Integrated Locality Teams, all in partnership with stakeholders.
2. Partnering with parallel work to establish strategic integrated commissioning and so enter into dialogue with providers to identify appropriate commercial models.

3. Developing our draft service specification to market test appropriate 'segments' of the model in more detail to determine what scope and scale of services is achievable and to select the right contractual model and provider accordingly.
4. Identifying and managing future risks to success, such as ensuring the scope and scale of services can grow in line with forecast demographic trends.
5. Delivering integrated services that facilitate us to exceed published savings targets.

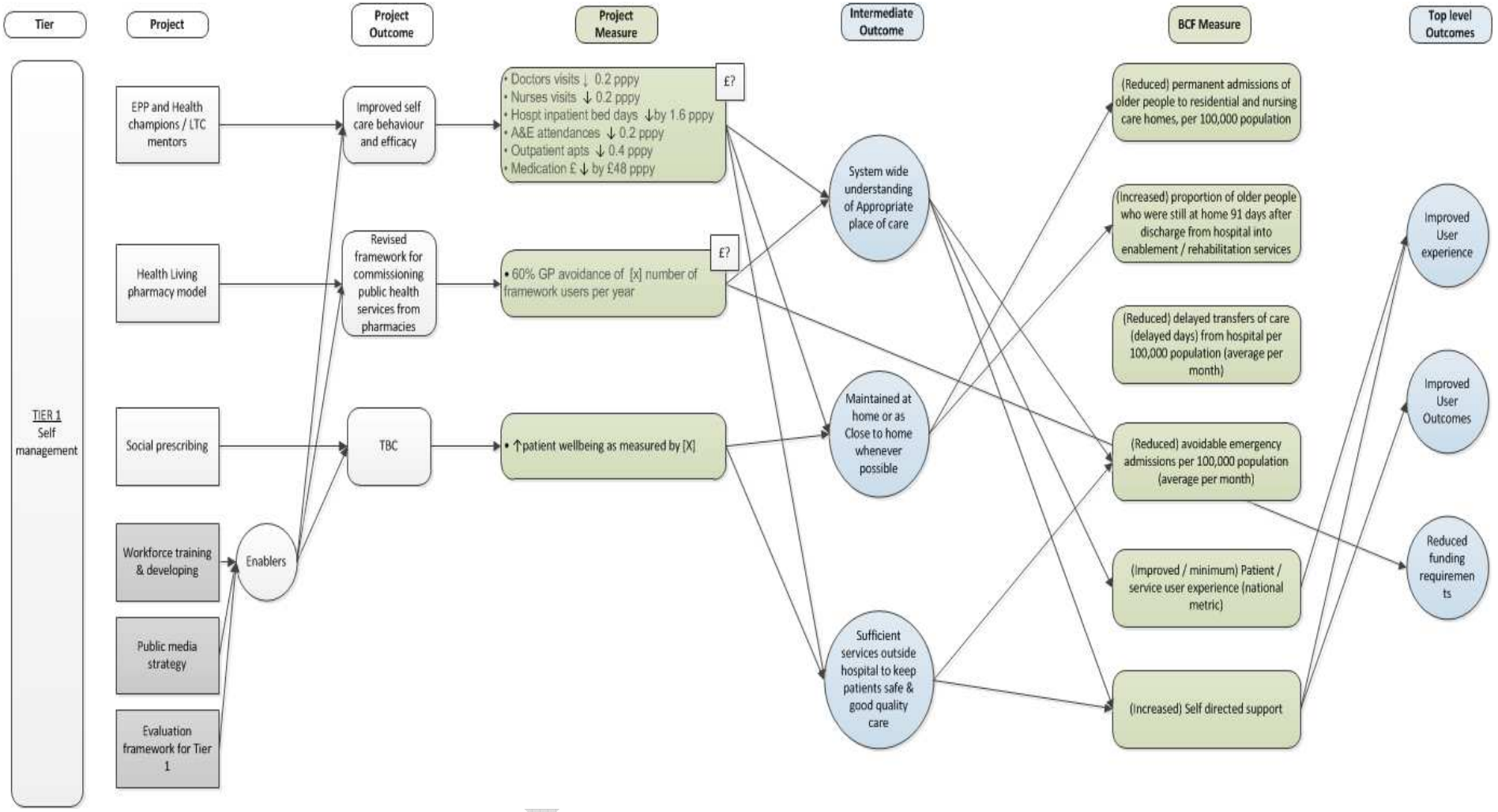
Future updates to this Business Case will provide more detail on the status of work to deliver our vision for integrated health and social care services and to close the funding gap identified.

9. Annexes

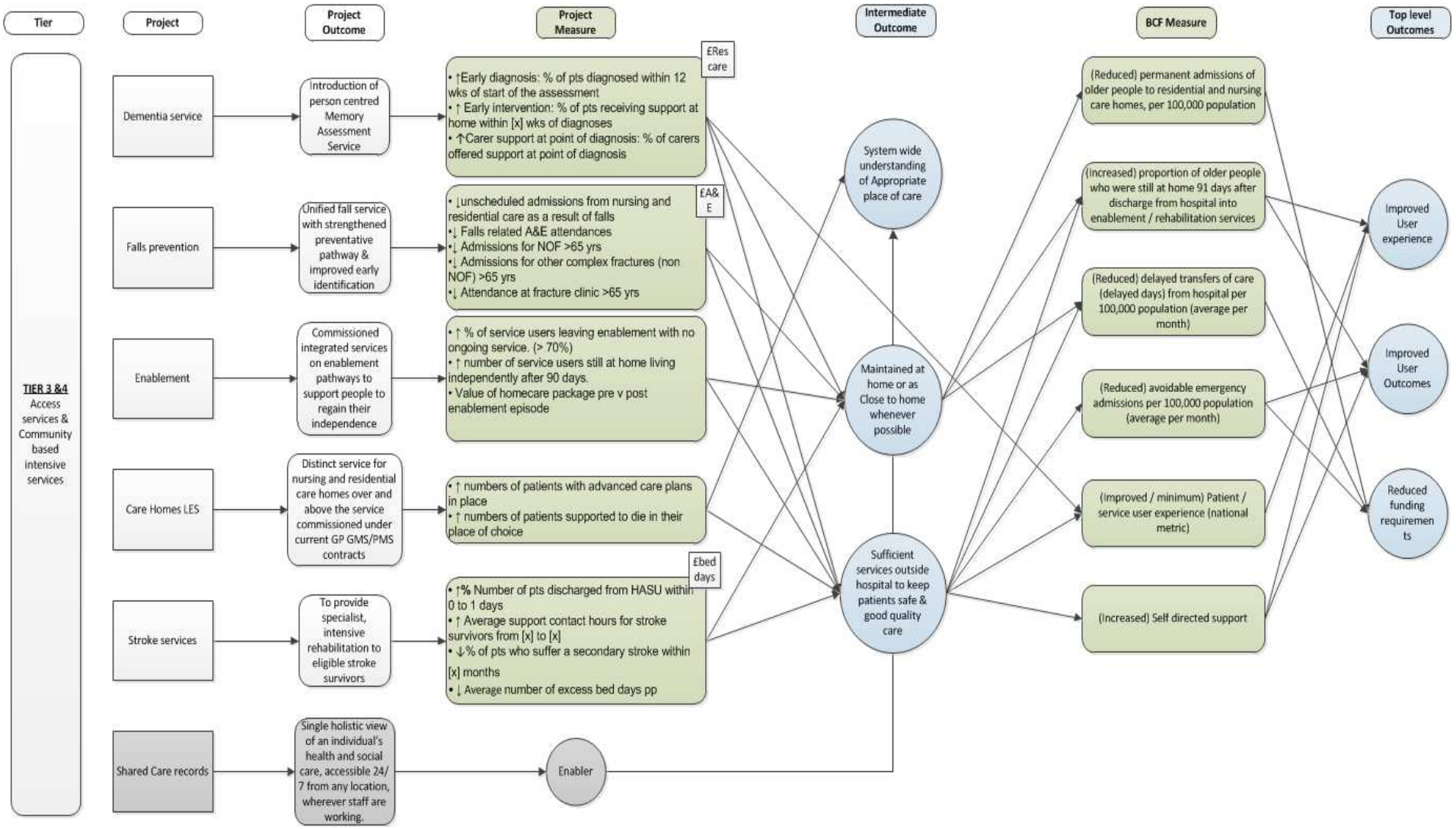
Annex 1 – Benefits Map

The following pages illustrate the benefits maps developed for Tiers 1, 3 and 4 of the 5 Tier Model.

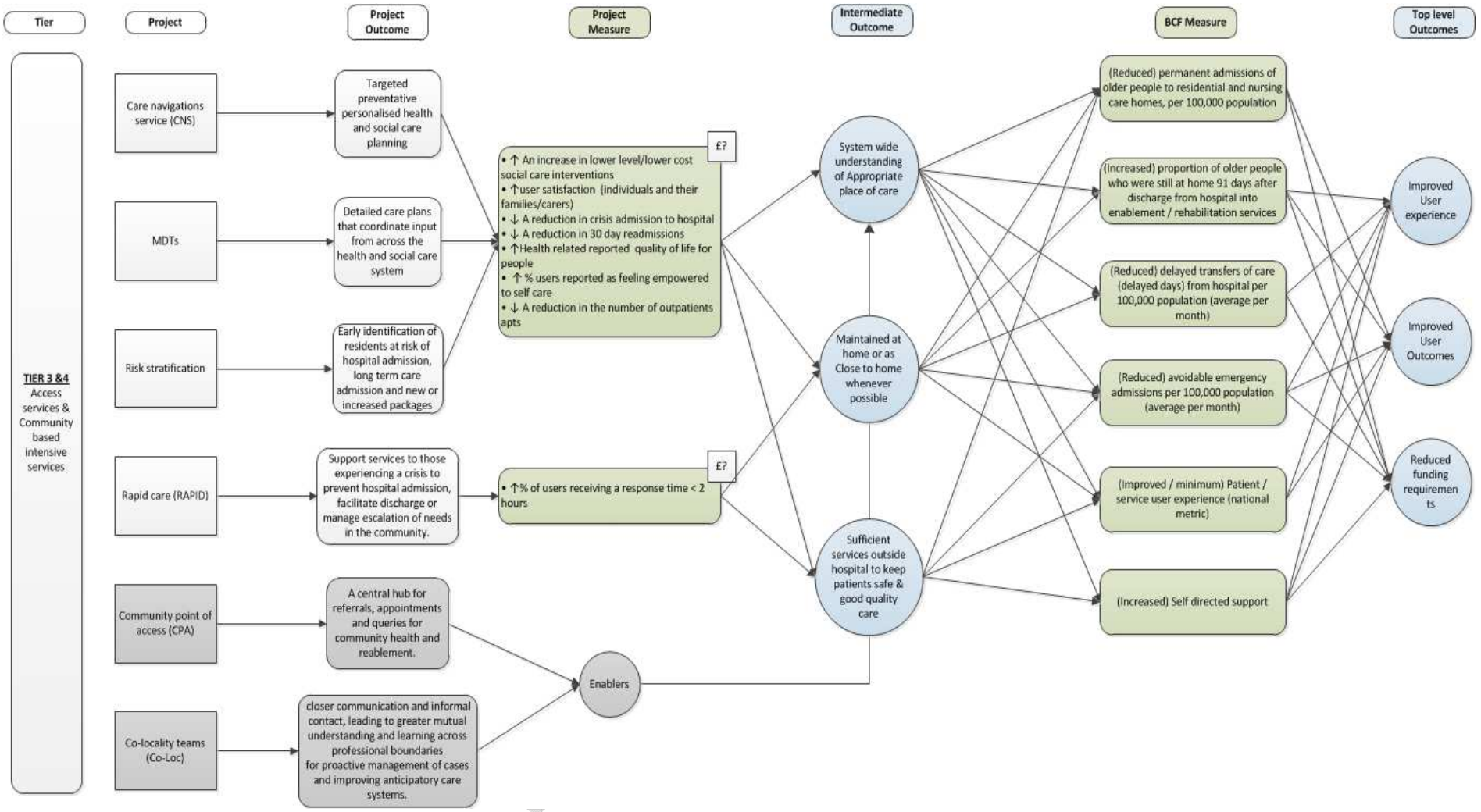
Tier 1 Benefits Map



Tier 3 and 4 (New Projects) Benefits Map



Tier 3 and 4 (Existing Projects) Benefits Map



Annex 2 – Cost Benefit Analysis

The tables below describe the assumptions, risks and opportunities identified in developing the cost benefit analysis for this business case.

Assumptions

Assumption	Impact / Notes
It is anticipated that there will be social care benefits from the projects over the longer term. However, the evidence to support this currently is inconclusive.	Modest social care benefits have been quantified within the model at this stage.
All identified Tier 2 projects are already incorporated within the baseline figures. The minor shifts in expenditure are immaterial given the scale of the model.	No additional expenditure has been incorporated for Tier 2 and no benefits have been incorporated at this stage.
Enablement project excluded from the model.	Although part of the cost is included within the baseline (£1m p.a. Vs current spend of £1.3m p.a.) the potential benefits have been accounted for within the Front Door business case. Incorporating them within the model is considered to result in a double count of benefits.
OPIC benefits based on national evidence base (30% reduction) applied to 90% of the high risk cohort from the risk stratification tool over 4 years.	This equates to a saving of £3k per person within the 1900 person cohort. The 6 month review suggested £8k saving per person but this was based on data from just 32 people. Using the national evidence base – although prudent - mitigates the risk of using a small cohort.
Rapid Care benefits include a 60% optimism bias, as there is insufficient evidence to assume that 100% of service users would avoid a non-elective admission.	The model assumes that every user of the service equates to an avoided non-elective admission. However, because there is a risk that some of these users may have already been included in Falls benefits or that users may be admitted at a later stage, a 60% optimism bias has been applied.
Shared Care Record is included as a cost only.	Potential productivity benefits have been identified within the business case. However, it is unclear whether these are cashable.
Integrated Locality Teams still being scoped so estimate cost assumed.	£1m p.a. Of incremental costs included. This is considered prudent as largely expected to come from existing workforce.

Risks

Risks	Mitigation
OBC baseline was based on a point in time, so may have shifted.	Review for future iterations.
BCF assumptions for average cost of admission is assumed to be c.£1,900 compared to the £2,900 average used within the model.	The BCF average relates to all admissions. The financial model uses average related directly to cohort and maps to QIPP.
Assumes all additional funding will be available and will continue.	
Assumes all financial benefits are cashable.	Work required to establish how savings can be realised from budgets.
Potential for overlapping benefits between some projects (specifically OPIC, Rapid Care, Falls, and Home Care LIS).	The optimism bias included within the individual projects is considered sufficient to mitigate this risk. Total impact on activity shift is considered to be largely in line with BCF, QIPP, and the beneath the potential reductions identified within the BCF Fact Pack.

Opportunities

Opportunity	Actions To Realise
Social care savings not yet quantified in OPIC projects.	Further and longer term monitoring of service users to identify / quantify benefits.
Telecare.	Review opportunities for expanding telecare offering as not currently incorporated.
Enablement.	Establish whether the overlap of benefits is a significant risk and whether this should be incorporated future iterations.
Scale of projects.	Work to identify whether existing projects can be extended to wider cohort and what additional value that could generate.
Optimism Bias.	The optimism bias applied to many of the projects (in particular OPIC and Rapid Care) is considered prudent. Review as evidence becomes available from monitoring activity levels and performance.

Opportunity	Actions To Realise
Better Care Fund 'Fact Pack' for Barnet suggests significant extra savings possible for outpatient attendances of £7m-£17m in addition to those within the model now.	Work required to understand how this can be achieved and whether this can be linked with existing projects or if new projects required.

Updated July 2014 – 15/09/2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

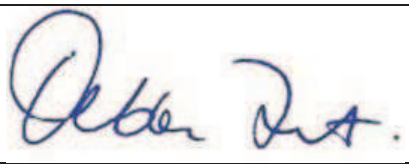
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

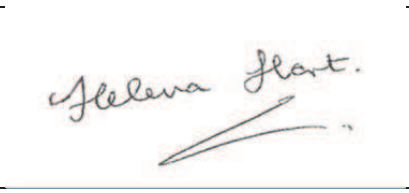
a) Summary of Plan

Local Authority	**Barnet Council**
Clinical Commissioning Groups	**Barnet Clinical Commissioning Group**
Boundary Differences	**Coterminous, however, the GP-registered population includes patients who reside in another LA's area. Barnet's integrated care model includes these patients.**
Date agreed at Health and Well-Being Board:	**18.09.2014**
Date submitted:	**19.09.2014**
Minimum required value of BCF pooled budget: 2014/15	**£6,634,000**
2015/16	**£23,412,000**
Total agreed value of pooled budget: 2014/15	**£6,634,000**
2015/16	**£23,412,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Debbie Frost
Position	Chair
Date	18.09.2014

Signed on behalf of the Council	
By	Andrew Travers
Position	Chief Executive
Date	18.09.2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Helena Hart
Date	18.09.2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Links
Barnet Health and Social Care Concordat	HSCIB concordat signed.pdf
Barnet Integrated Health and Social Care Model 2013	
Barnet Health & Well-Being Strategy	
Barnet Council Corporate Plan 2013	
Barnet Council Priority & Spending Review 2014	Barnet Health Social Care Integrati
Barnet CCG 2 Year Operational and 5 Year Strategic Plan	
Barnet Joint Strategic Needs Assessment (JSNA) 2011-2015	Barnet Health Social Care Integrati
Health and Social Care Integration Board Terms of Reference	
Health and Social Care Integration Board Programme Governance	Barnet Health & Social Care Program
Barnet, Enfield & Haringey Clinical Strategy	
Health & Social Care Integration business case (Sept 2014)	HSCI Business Case Update Oct 014 v0 5

	Others available upon request

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

The Vision for integrated care in Barnet is articulated in the Health & Social Care Integration Concordat and states:

Care integration in Barnet will place people and their carers at the heart of a joined up health and social care system that is built around their individual needs, delivers the best outcomes and provides the best value for public money. Integrated care will be commissioned by experts in collaboration with care providers and delivered seamlessly by a range of quality assured health, social care, voluntary and private sector organisations.

In **3-5 years' time,** we will have developed a fully integrated health and social care system for the frail and elderly population through implementation of our model so that it:

- Delivers on expected patient outcomes meeting the changing needs of the people of Barnet.
- Enables people to have greater choice and autonomy on where and how care is provided.
- Empowers the population to access and maximise effectiveness of preventative and self-management approaches to support their own health and wellbeing.
- Creates a sustainable health and social care environment, which enables organisations to work within resource limits.
- Reduces overall pressures in hospital and health budgets as we shift from high-cost reactive to lower cost prevention and self-management services.
- Listens and acts upon the view of residents and providers to make continued improvement.

Our plans are informed by the **Barnet Joint Strategic Needs Assessment** (JSNA). This provides a framework for **commissioning informed by insight,** through **prioritised need and managed demand** and **based on evidence.** We will focus on tackling the areas of greatest need and highest impact, which include:

- **A growing ageing population:** above average growth rate (5.5%) in the elderly population, 3,250 more residents aged over 65 (+7.4%) and 783 more residents aged over 85 (+11.3%). As a result we expect the prevalence of dementia to increase.
- **Specific health trends:** While many people in Barnet experience good health, some issues remain significant obstacles. Although mortality associated with **cancers** remains relatively low, improving take-up of screening could ensure that more cancers are identified and treated earlier, increasing the likelihood of survival and decreasing the need for more radical treatment. Death rates related to both, **chronic obstructive pulmonary disease (COPD)** and **cardiovascular**

disease are generally falling however we recognise that early identification of undiagnosed COPD remains a priority, as does smoking cessation. Of significance, is the '**obesity epidemic**. Almost 25,000 Barnet residents aged 18 plus are **obese**. Although this represents a lower prevalence than nationally (15.4% versus 24.5%) it is still a significant number, especially considering that those who are obese are at greater risk of premature death and are more likely to suffer from conditions such as diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases, infertility and respiratory disorders.

- **Improving independence:** with the increased pressures from a rising population and reduced financial resources, it will be essential to **enable more people to manage their own health** responsibly particularly through prevention schemes.

The **Barnet Health & Well-Being Strategy** centres on reducing health inequalities by focusing on how more people can 'Keep Well' and 'Keep Independent':

- **Keeping Well:** focus on supporting people to adopt healthy lifestyles to prevent avoidable disease and illness.
- **Keeping Independent:** when extra support and treatment is needed, it is delivered in a way which enables people to get back up on their feet quickly, supported by health and social care services working together.

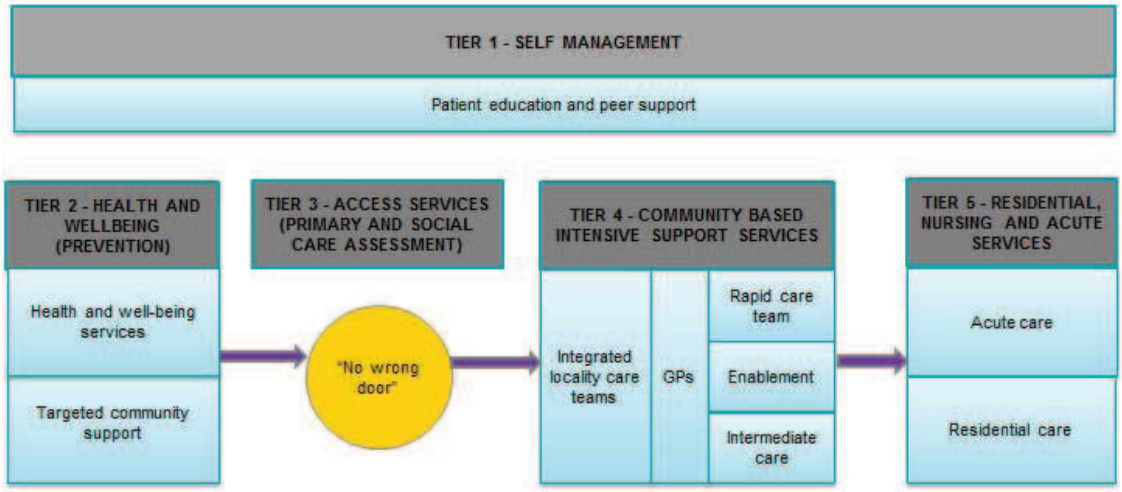
The strategy recognises we can only achieve this through a partnership between residents and public services.

As outlined in more detail in section 8a, patient and service user views are integral to the vision for integrated care in Barnet with extensive involvement of a wide range of individuals and organisations including Healthwatch Barnet, Older Adults Partnership Board , Age UK (Barnet) and the Alzheimer's Society.

Taking into account the call from local residents to increase co-ordinated care to enable them to live better for longer we have built the Vision around Mr Colin Dale, a fictitious representative user of health and social care services. Central to success will be development of a model that will mean that Mr Dale has:

The London Borough of Barnet (LBB) and Barnet CCG have been working for many months on our jointly agreed Integrated Health & Social Care Model

The Better Care Fund (BCF) plan has its foundations in the **Barnet Health & Social Care Concordat** – a clearly articulated vision for integrated care co-designed and agreed by all parties of the **Barnet Health and Social Care Integration Board (HSCIB)**.The model forms the foundation of our future transformation and has 5 components:



The BCF will be an important enabler to take the integration agenda forward at scale and pace

It supports the aim of providing people with the right care, in the right place, at the right time through a significant expansion of care in community settings and championing of prevention and self-management. Our schemes therefore comprise:

- **Self management and Health and Wellbeing Services**: People and their families are supported to manage their own health and wellbeing wherever they can and for as long as possible
- **Access services including primary care and social care assessment**: identify early and proactively target those at risk of becoming frail or unwell. When necessary a support package focused around the individual will be put in place that optimises his skills, increases quality of life and prevents deterioration.
- **Community based intensive services**: Intensive community based support services are readily accessible and react quickly to need

These are supported by a range of enablers that, although they do not deliver direct benefit, ensure that the system operates as planned including delivery of a number of business as usual components.

Implementing the Vision for the BCF will be challenging especially in the context of the required 3.5% reduction in emergency admissions, and against a backdrop of a financially challenged CCG and a Local Authority under the financial constraints applying to local government, and with the emerging additional costs of the Care Bill. Local demographic and infrastructure changes, including re-configuration of acute services and a high number of residential and nursing homes create additional pressures, which must

be addressed. There is also the local recognition that much of the BCF funding will come with services already provided.

The plan is currently aligned to the NHS Barnet CCGs Draft Delivery Plan that was presented to the Board on 28 August 2014. This is currently under review and any re-alignment will occur in due course so that it remains part of the overall plan to manage pressures and improve long term sustainability

b) What difference will this make to patient and service user outcomes?

All of the work being undertaken, and planned, as part of the BCF programme is intended to contribute to improved user experience, improved user outcomes and reduced funding requirements. The Better Care Fund (BCF) translates these top level outcomes into the following quantifiable measures, ensuring everyone locally (both commissioners and providers) is aiming to deliver a common set of outcomes:

	Current level	Target next year	Benchmark (ONS peer group)	Comment
Non-elective admissions	29,094 80 per 1,000 population	28,069 3.5% reduction	64 per 1,000 population	• Barnet is already in the top quartile on NEL performance • Aiming for 10% international improvement benchmark • 20% improvement from reducing GP variation and increased us of risk stratification
Care homes	487	354	410.9 (for current level and based on Barnet Council comparator group)	• Aim for top quartile performance
At home after 91 days	71.9%	81.5%	85%	• Move from bottom quartile to second
Delayed transfer of care	7 per 1000,000 population	5 per 100,000 population	6 per 100,000 population	• Move from second quartile to top quartile
Patient experience	0.9	0.78	0.81	• The metric is based on the Annual Social Care User Survey (2013/14), Question 4: Overall how satisfied or dissatisfied are you with the support or services you have received from social services in the last 12 months?

Improved Outcomes

Better patient and carer experience:

- The provision of a local, high quality service that targets those most at need. In addition, it will enable people to remain at home, where essential care can be delivered and monitored
- Reduction of duplication in assessment and provision through use of an integrated locality team approach to case management
- "No wrong door" for frail, older people and those with long term conditions
- Increase in the number of people who have early interventions and proactive care to manage their health and wellbeing

Improved older adult outcomes (health and social care):

- Ensuring quality long term care is provided in the most appropriate setting by a workforce with the right skills
- Pro-active care to ensure long term conditions do not deteriorate, leading to reductions in the need for acute or long-term residential care, and reducing the demand for repeat interventions and crisis services such as emergency departments
- Increased use of health and social care preventative programmes that maintain people's health and wellbeing, and improved practice in use of medication leading to a reduction in unplanned and emergency admissions to hospital and A&E

Lower cost, better productivity - achieved through the ability to improve future resource planning and needs by way of:

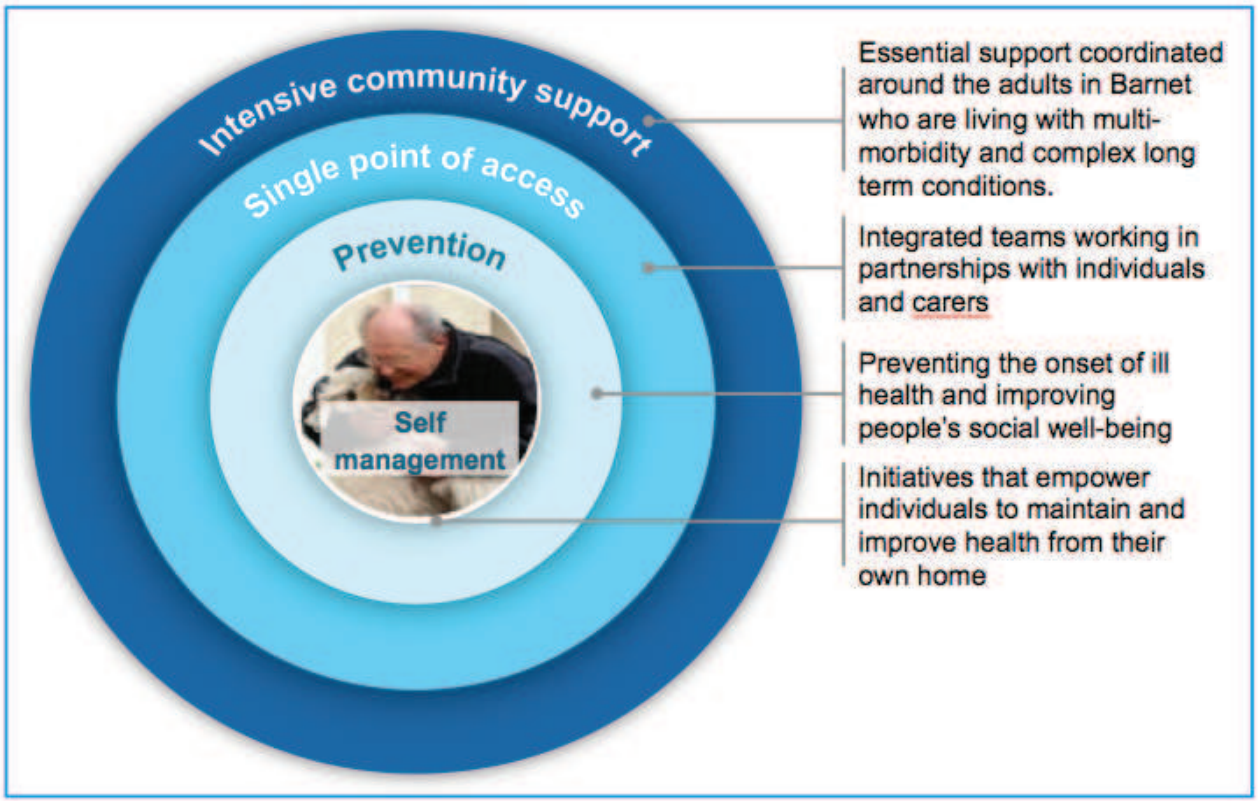
- Utilising risk stratification to manage the care of those individuals most at risk of an escalation in their health and social care needs.
- Utilising a joint approach to care will ensure a better customer journey and led to better management of resources providing the services.
- Increased information and signposting to ensure preventative services are fully utilized.
- Supporting people to stay living at home for as long as possible and enabling them to take more responsibility for their own health and wellbeing, which in turn will help reduce or delay the rising admissions to residential care.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

There will be significant changes to the delivery of services over the next 5 years

Transforming services through integrated care will ensure that we are improving outcomes for patients and service users, gaining the best value for money in services

and are maximising opportunities arising from joint commissioning. This section outlines the operating arrangements for each of the tiers of the integrated care model.



Tier 1: Self management: shifting the focus of health and social care delivery away from formal care and institutions and towards developing a personal resilience to seek own solutions and manage circumstances.

- All individuals with a recognised medical condition (such as diabetes or heart disease) will be offered self-management education, training or support
- Up-skilling people and improving their health literacy so that they are more confident about looking after their own health.
- Access to support from a long-term condition mentor or health champion, or access to online support forums tools.
- Development of Healthy Living Pharmacies, to review medication, access community based preventive services and to work with a health champion to adopt healthier behaviours.
- Training for health and social care professionals to better enable them to support and empower people to manage their long-term conditions independently.

Tier 2: Health and wellbeing will focus on preventing the onset of ill health and improving people's social well-being

- Target on primary and secondary prevention as required
- Encouraging healthy lifestyles and lend support to both families, friends and carers

who provide either formal or informal care.

- Strong Information and Advice offer, with branding, so that these services will be publically recognisable, readily available, understandable and easy to access. Increased use of social media, mobile and internet technology to support delivery.
- Early contact made with people identified as at risk of needing Tier 3 and 4 services, to link with advice and support to help keep them well. Examples include the Falls Clinic, Dementia Hub, Dementia Cafes, Dementia Advisors, Day Care and Stroke Support Services.
- Evidence base of what works at a system and individual level will be developed to inform future commissioning.
- Health education package for carers, which supports safe caring, promoted by GPs, the Council, carer's services and hospitals. Dedicated carer's centres
- Implementation of the Ageing Well Programme, including greater investment in volunteering to support people in the community

Tier 3: Access services (primary and social care assessment) for people with a long term condition, aimed at preventing unnecessary admissions

- **Identification of at risk Older Adults using risk stratification software:** population profiling; predictive modelling of high-risk patients; disease profiling to enable early identification and navigation to the appropriate prevention services.
- **Community Point of Access**: single common access to advice and support for Older Adults and those with long term conditions to signpost them quickly to the services that they require. It will also provide a direct referral route to existing community health services.
- **Shared care record**: An information repository providing a single holistic view of an individual's health and social care that will be accessible 24/7 from any location, wherever staff are working. A key system enabler.

Tier 4: community based intensive support services to increase independence and manage people within the community e.g. at home.

- **Care Co-ordination & Case Management:** Delivered through **Integrated Locality Teams** in partnership with GPs, designed to support and manage care from self-management through periods of crisis, into end of life pathways where necessary. They will review and assess complex patients living with multi-morbidity and long term conditions at risk of admission to introduce care plans and link to services to keep them at home. Building from an initial framework of a team based with each of the 3 localities, they will move resources around flexibly to avoid crisis and maintain people in their homes or in other care settings.
- **Weekly MDT** meetings will provide a more intensive approach to managing the most complex cases by planning care across multiple providers.
- **Care navigators** supporting these groups with implementation and delivery of care plans through care co-ordination and signposting

- **Rapid care** service that will provide intensive home-based packages of care to support people in periods of exacerbation or ill-health.
- **Enablement services** working more effectively with facilitated discharge to provide holistic care packages seamlessly with other care providers.

Tier 5: Reduce demand for residential, nursing and acute services

Residential, nursing and acute services support intensive care where individuals cannot be maintained at home. These services are drawn on where they are most appropriate and where community based services cannot provide a safe environment in which to receive care. The focus of the Integrated Model is balanced towards tiers 1 – 4 to reduce demand for residential and acute care.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Our BCF plan needs to be delivered in the context of a challenging health and social care environment

- The CCG with an inherited debt of £34.1m and the Revenue Resource Limits (RRL) announced for 2014/15 and 2015/16 that continue to disadvantage Barnet CCG by providing funding below the 'fair share' target. Significant ongoing QIPP challenges will continue for the CCG in the foreseeable future.
- The Barnet Council Priorities and Spending Review (PSR) forecasted a gap in the council's finances of £72 million between 2016 and 2020 and has identified a package of options for the council to save money and raise revenue, with a potential to provide a financial benefit of approximately £51 million. Adults & Communities share of the PSR package of savings represents £12.6m. This includes proposals for organisational efficiency, reducing demand and promoting independence and service redesign.

- Meeting the needs of 32,000 informal carers especially given implementation of the Care Act and changes which mean that carers may significantly enhanced entitlements.
- Significant change in the Acute provider landscape related to strategic change and re-configuration.
- Over 100 care home establishments with net import of residents from other areas.

Our case for change centres on five issues:

1. **A challenging financial environment with significant uncertainty**
2. **An ageing population with a growing burden of disease**
3. **High levels of variation in primary care**
4. **Outcomes which are not as good as we aspire to**
5. **We are not spending enough on those areas which support integrated care**

We have undertaken a detailed analysis of the **affordability and deliverability of the Health & Social Care Integration Model** to address the critical question for the Barnet economy of how we can achieve better health and wellbeing outcomes and improve user experience for the frail, older population in Barnet in a financially sustainable way.

The combined effect of reduced funding and our projected increases in expenditure will create a significant financial gap over the next six years. The table and graph below illustrates this for the £133m of funding relevant to older people (in scope):

Forecasted Funding Gap for Health and Social Care Services 2013 – 2019

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Funding	£133,817,172	£133,272,272	£134,496,516	£135,647,160	£136,973,858	£138,482,170
Net exp	£136,517,172	£135,659,985	£142,319,805	£148,905,981	£151,623,446	£155,526,033
Annual Gap	-£2,700,000	-£2,387,713	-£7,823,288	-£13,258,821	-£14,649,588	-£17,043,862
Cumulative	-£2,700,000	-£5,087,713	-£12,911,001	-£26,169,823	-£40,819,411	-£57,863,273

Date source: OBC April 2014.

There has also been significant change in the local provider landscape through implementation of the Barnet, Enfield & Haringey clinical strategy. This has created shifts in capacity and demand throughout the local system that continues to have knock-on impacts. Some implications are clearly visible and are being managed e.g. demand pressures on community beds; and others are still emerging. Until the local health economy has fully settled post-implementation it will be difficult to gain a true understanding of the new baseline for Barnet. Similarly, the recent acquisition of **Barnet & Chase Farm hospital by the Royal Free** will inevitably change operational practice and hence demand models. The impact of this is only just starting to be manifested in the system but is likely to impact over the next 12 months and beyond.

The population cohort most likely to represent a pressure on the system is ageing. Overall the population is expected to increase by nearly 5% over the next 5 years (an increase of 17,308), with disproportionate growth in both the young and old cohorts. The effects of an ageing population will become most acute, with the over-65 population forecast to grow by 10.4% over the next 5 years and 24% over the next decade, placing increased pressure on social services and health budgets. Barnet will have one of the largest increases in elderly residents out of all the London boroughs over the next five to ten years. There are currently 52,000 people in Barnet over the age of 65, and this will increase to 59,800 by 2020. Barnet's Health and Wellbeing Strategy sets out the

Borough's ambition to make Barnet 'a place in which all people can age well'. The challenge is to make this a reality in the context of rising health and social care needs among older people, and the financial pressures facing the NHS and the Council.
As seen in the table below, segmentation of the population identifies that £95.5m per annum is spent on 21,900 over 70 year olds with one or more long-term conditions (LTCs) or dementia. In addition £114.3m is spend on 46,600 adults with one or more LTCs. There are currently over 1,600 people over 65 with Long Term Conditions or physical frailty receiving community based care services in their home through Adult Social Care in Barnet.

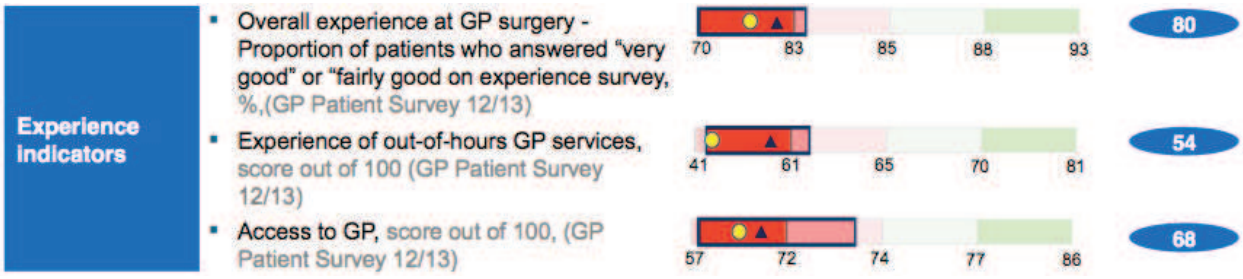
Population Segmentation Model.

2012/13 — Number of people x k £m Total annual spend £xx Average spend per capita — Relative size of spend per capita

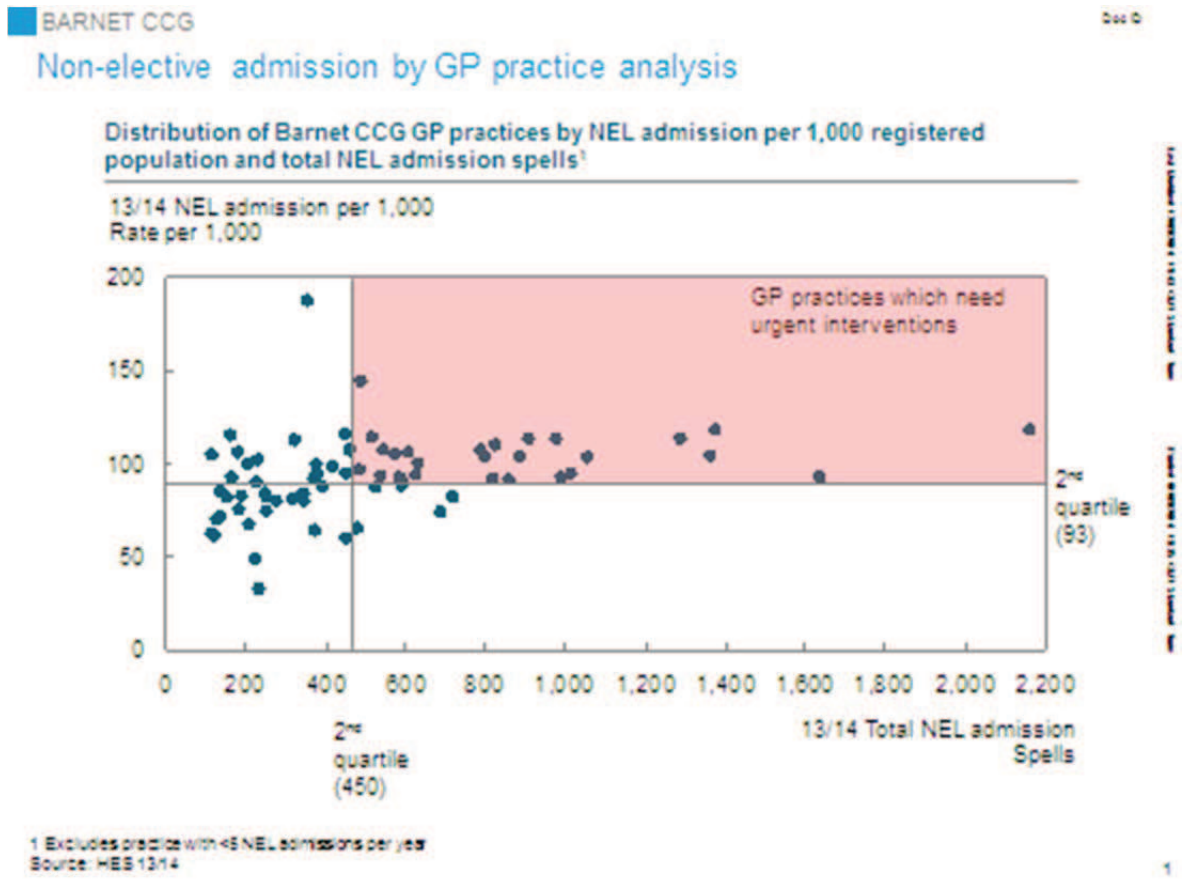
	Mostly healthy	1 LTC	2+ LTCs	Severe Enduring Mental Illness	Dementia	Cancer	Learning disability	Severe Physical Disability
Children 0-16	Mostly healthy children 675 75.3 50.8	Children with 1 LTC 1,096 3.3 3.6	Children with more than 1 LTC 2,676 0.1 0.2	Children with SEMI 3,222 0.1 0.4	Children with dementia n/a - -	Children with active cancer 7,750 0.0 0.2	Children with learning disability n/a - -	Children with physical disability n/a - -
Adults 16-69	Mostly healthy adults 778 205.9 160.1	Adults with 1 LTC 1,898 32.0 60.8	Adults with more than 1 LTC 3,660 14.6 53.5	Adults with SEMI 10,611 3.4 36.0	Adults with dementia 14,325 0.1 1.3	Adults with active cancer 4,658 3.0 13.9	Adults with learning dis-ability 46,448 0.7 31.0	Adults with physical disability 19,437 0.3 5.6
Elderly 70+	Mostly healthy elderly 2,418 8.0 19.4	Elderly with 1 LTC 2,271 7.4 16.7	Elderly with more than 1 LTC 4,491 13.1 58.8	Elderly with SEMI 14,602 0.5 6.8	Elderly with dementia 14,534 1.4 20.1	Elderly with active cancer 4,932 4.1 20.1	Elderly with learning disability 38,265 0.0 1.7	Elderly with physical disability 20,421 1.2 24.5

Source: McKinsey Integrated Care Model

Closing the current variation in primary care and improving performance represents a significant opportunity for Barnet. Benchmarking shows that Barnet currently performs poorly against peers in terms of experience of and access to primary care:

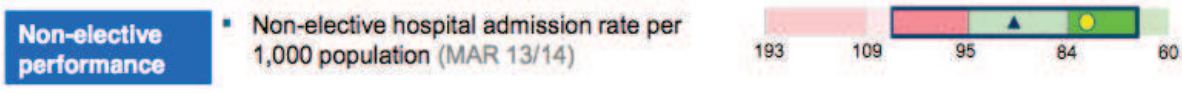


In addition there is wide variation across the borough's GP practices in terms of non-elective admissions performance as can be seen below. Closing these gaps represents a strong opportunity to meet challenging reduction targets:



There are opportunities to improve on BCF metrics and to improve outcomes.

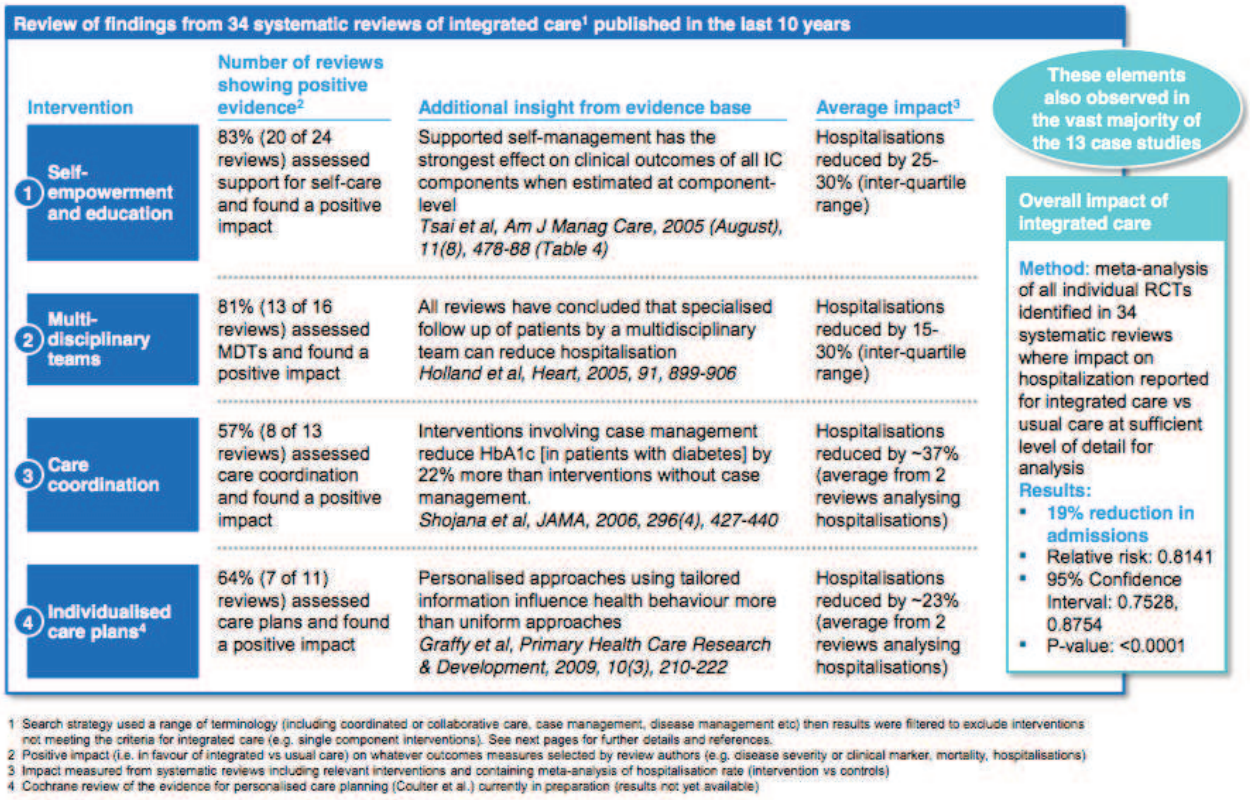
Barnet has made progress in reducing **non-elective admissions** over recent years with a **2.2% decrease** between 2009/10 and 2013/14. This has been reinforced in the HWB fact pack and baseline data that states Barnet performs significantly better than peers and most of England on non-elective admission rates and that activity growth is significantly better than peers and top quartile for England as a whole.



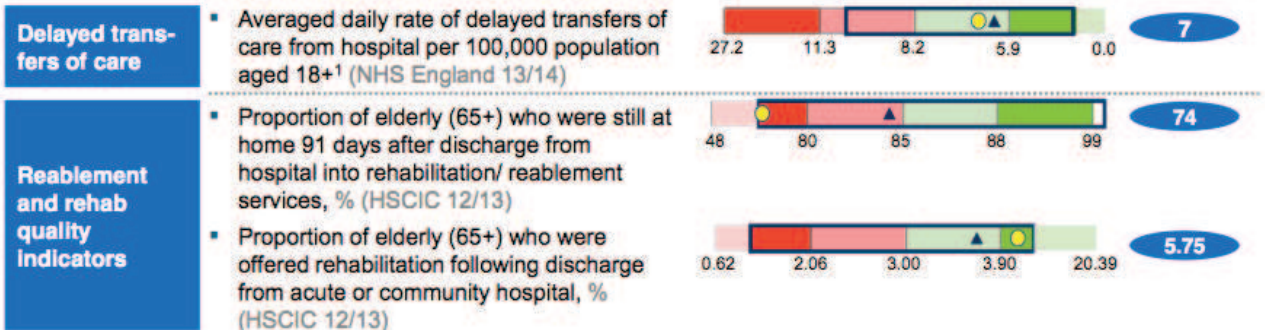
While this is encouraging, it should be noted that the reduction is not consistent and reflects unusual trends in activity during specific periods in 2013/14 related to known

changes in the provider landscape. We therefore need to take a cautious approach to assumptions that this reduction was as a result of integrated care activity and hence is replicable and sustainable at the same level.

When considering benchmarking and target setting it can be noted that HWB fact pack identified a limited opportunity for non-elective admissions for Barnet compared to our ONS and peer group (currently top decile). However, the international scientific evidence and case examples for fully operational delivery of best-practice integrated care suggests that full delivery of the four key components of integrated care outlined below could impact as a reduction of up to 37% in hospitalization. Taking into account growth and current performance it is suggested that this represents a potential opportunity for Barnet of a **10-19% reduction in non-elective admissions over 3-5 years**.



Compared to peers Barnet has scope to improve **delayed transfers of care**, to move into the top quartile, and the proportion of elderly (65+) who were still at home 91 days after discharge from hospital into **rehabilitation/ reablement services**:



Critically, it is recognised locally that the resource in the current system is not sufficiently weighted towards key services to achieve this. Of the total £133m resource envelope over 61% is spent on acute and residential care services. Less than 3% is currently spent on self-management and health and wellbeing services, with the remainder in the other two tiers.

The BCF provides an opportunity to target investment in a more holistic, integrated model and accelerate the process of whole system reconfiguration.

Barnet will address the challenges set out in this case for change by moving to an integrated care model, investing in lower level and preventative support, through shifting the balance of care and activity over time from hospital and longer term residential care. It will focus on the following groups of people:

1. **Frail elderly people**: those over 65 who suffer from at least three of the 19 recognised ambulatory care sensitive (ACS) conditions
2. **People with Long term conditions:** those aged 55-65 who suffer from any of the following long term conditions: angina, asthma, congestive heart failure, diabetes, hypertension, iron deficiency anaemia, COPD, dehydration, cellulitis
3. People living with **Dementia**

The target for the BCF pay for performance element is set at 3.5% (or 1025 less non-elective admissions) in 2015-16. This supports a longer term plan to deliver a continued downward trend in non-elective admissions at a controlled and sustainable pace as indicated in the 5 year strategic plans.

There remains a focus on supporting the requirement for initiatives that are designed to enhance the ways in which people are supported to remain as independent as possible for as long as possible, meeting statutory social care needs whilst still delivering on the efficiencies required by the council. This includes a requirement to ensure that more people can stay in their own homes with support to be as independent as possible and reduce their needs for formal services.

The transformation programme will continue as planned and through the extensive capacity and demand modelling we will re-assess how we can deliver fully on this

trajectory. We also understand that there is still work to do particularly in relation to improving the patient experience to primary care and access to a GP that will directly impact on successful delivery of the transformation programme.

We have planned our BCF to deliver the model within limited financial resources. Given the funding allocations of the CCG and the Council, there may a requirement for additional investment into Barnet to deliver the maximum benefit from the model identified.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

A phased approach is being taken to service development over the next 5. The core services are those that we will be redesigning for integration, investing and re-allocating resources as necessary. These include residential care, community healthcare, homecare, and self-management or preventative services.

The accelerated programme of work will create efficiencies and financial benefits for health and social care through a reduction in non-elective admissions and length of stay for the frail and elderly population. It will achieve a step change in care delivery over a period of 2-5 years, leading to fewer crises, and more planned care for the frail elderly, encompassing a number of services now designated under the BCF scheme of work.

The key milestones are outlined below:

Tiers	Progress to date	2014/15	2015/16
Overall	Full Business Case approved and further validated in the context of separate modelling to support CCG QIPP and the payment for performance element of the BCF. The CCG has analysed in detail its current and planned spend on non-elective admissions. Development of the programme of work and PMO function Governance arrangements in place	Develop Business Case to support Integrated Care model and strategic approach to future commissioning /contracting for approval Co-design detailed operational delivery models including phasing of delivery, funding streams, future capacity and workforce requirements. Determine outcome measures and regular monitoring mechanism with assurance Test current governance arrangements for BCF particularly in relation to agreement and monitoring of risks and benefits Agree shared PMO arrangements to support delivery programme Develop a communications strategy, including a mechanism to capture user views to effectively feed in user	Test outputs of current service delivery and scope further plans Fully functional benefits tracking and financial monitoring model in place Implement communications strategy Establish and monitor financial flows to and from the pooled budget including those contributed from parties outside health and social care Develop feedback mechanism to interested parties to promote success and share learning.

		perspective to inform progress and continued improvement.	
1	Expert Patient Programmes planned for Autumn 2014 Telehealth pilot underway as part of Rapid Care project Engagement with range of stakeholders including voluntary sector in development of tier specification	Deliver project plans in line with tier specifications: priority focus on self management, e.g. defined roles of health champions and long-term condition mentors; and healthy living pharmacy Design and deliver carers support programmes Design and implement structured education offer Pilot programmes for Telecare and Telehealth	Deliver project plans in line with tier specifications: priority focus on self management Mainstream programmes for Telecare and Telehealth if appropriate
2	Ageing Well project operational in 3 areas Clear links established between BCF programme and public health Carers service re-design being taken forward in the context of the BCF	Implement early phase plan: Ageing Well Design Health education package for carers Design preventative services and develop the market/ strategic partnerships in voluntary and commercial sectors to deliver. Link into Public Health team initiatives (e.g. NHS Healthchecks, healthy eating and physical activity promotions, smoking cessation) Link into "universal offer" to older people through preventative services Link into Council's carer support services	Develop an evaluation model to support development of a local evidence base to support future commissioning Unified branding for prevention tier Use learning from care pathways re-design for Stroke, Dementia and Falls to scope, design and extend wider Tier 2 – 4 end-to-end services, in line with work programme.
3	Community Point of Access (CPA) opened April 2014 Risk Stratification Tool live in all GP Practices.	Phased roll out of Community Point of Access. Embed use of the risk stratification model as the default method for design and delivery of services for targeted cohorts, in stages by level of risk. Develop early phase plan: Shared Care Record (business case to be signed off)	Develop a single assessment process, using findings from the Risk Stratification Tool and other projects. Incorporate service redesign projects: dementia and end of life pathways. Implementation of the Shared Care Record
4	Integrated locality Teams trail-blazer team mobilised in August 2014 The Care Navigation Service (CNS) and Multi-Disciplinary Team (MDTs) case conferences started in July 2013. Expanded Rapid Care service in August 2013, now	Implement and monitor early phase plan: Rapid Care Finalise the design and delivery model of borough wide Integrated Locality Teams. Extend the scale and operations of Multi Disciplinary Teams, including assessment of higher risk individuals and planned co-ordination of care. Implement Care Homes LIS for GPs and monitor outcomes.	Rapid Care pathway development linked to PACE. TREAT and other front door services in acute settings. Embed Integrated Locality Team model expanding across service areas as required Explore role of existing Older Peoples Assessment Unit (OPAU) to offer increased clinical capacity and expertise. Develop Enablement, Intermediate and Respite Care offer to meet need.

	available 7a.m to 10p.m 7 days a week		

Interdependencies and existing programme alignment:

- Establishment of aligned budgets for CCG, council and other parties, e.g. public health, into the Health and Social Care model to influence delivery of the BCF.
- On a North Central London CCG level, the establishment of Integrated Provider Units (IPUs) and value based commissioning.
- Integration with new and re-designed Council systems and services designed to meet the requirements of the Care Act, including Council first point of contact and assessment services, information and advice offer, enablement services and new, upgraded case management and other ICT systems.
- Link into 'Integrated Quality in Care Homes' team to improve standards of care and co-ordination between health professionals and care homes, especially with regard to discharge of residents, inappropriate placements within homes and lack of understanding of the role of care homes.

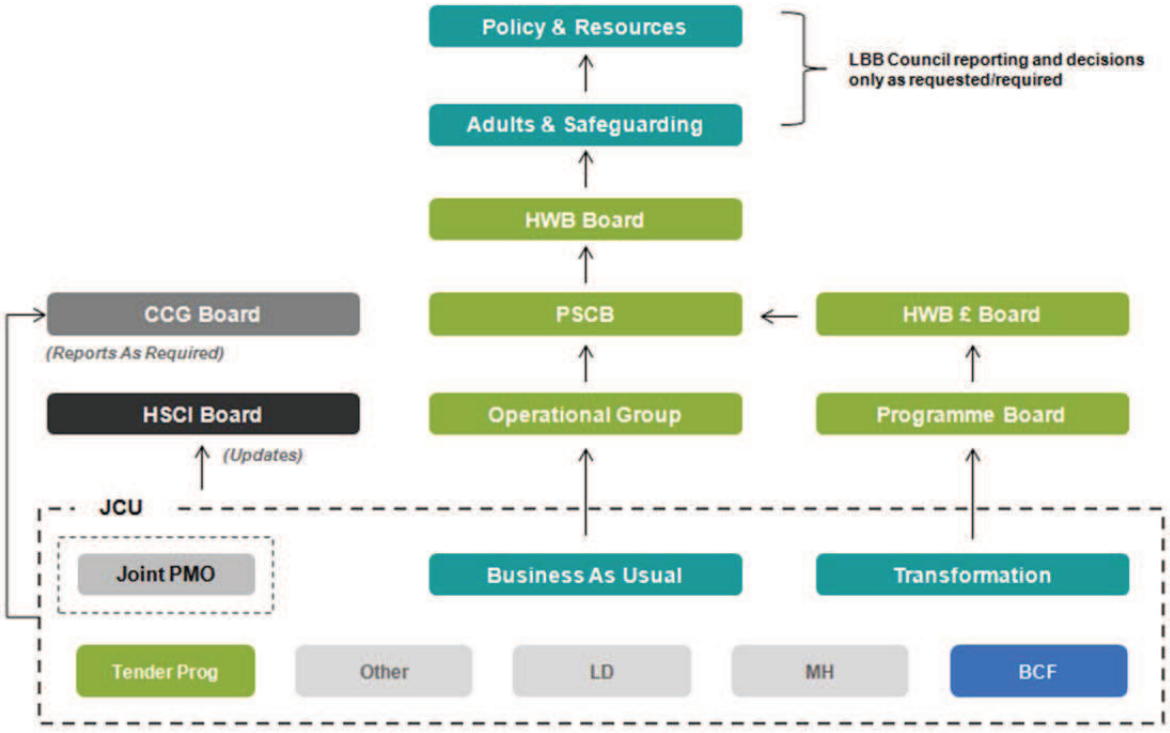
b) Please articulate the overarching governance arrangements for integrated care locally

The figure below illustrates the proposed governance and board structure for the HSCI/BCF Programme.

Initial governance arrangements were agreed and put in place in April 2013. This included gateway review and approval processes for projects and work, project and programme reporting, roles and responsibilities, the Programme Management Office (PMO), risk, change and issue management processes and information governance and terms of reference.

This governance and board structure supersede the original governance arrangements and the terms of reference are currently being updated. We are also working to revise and refresh Programme governance to reflect the updated programme of work.

Proposed HSCI/BCF Programme Structure



The LBB Director of Adults & Communities and BCCG Chief Officer act as joint Programme Sponsors for the BCF. The LBB Associate Director of Health and Wellbeing, Adults & Communities and BCCG Director of Integrated Commissioning will act as joint Programme Directors and Project or Theme Sponsors.

Each Tier will have a lead and subject matter expert. Each project or theme will have a project manager and prioritised work, aligned to programme aims & objectives, and desired benefits and outcomes. Tier leads will partner to define strategies for delivering end-to-end services.

We will deliver and manage all Programme and project work using LBB and BCCG programme and project management methodologies. Work will be grouped and delivered in tranches based on priority (e.g. by its contribution to desired benefits or outcomes and how achievable the work is against other competing demands for resources).

We will deliver and manage work and define, validate and track the realisation of desired benefits using our programme/project management methodologies and benefits management tools.

This will enable an objective and independent scrutiny and assurance of work done, with scheduled reporting and reviews to monitor outputs and to retain tight management and financial control of Programme spend and delivery.

Proposed new projects must have a viable Business Case that clearly states the strategic fit to the BCF, and financial and non-financial benefits of putting in place the changes described.

The Programme Board (Operational Group) will consider the Business Case and approve

or reject it against agreed evaluation criteria, e.g. whether it meets the vision, aims and objectives of the 5 Tier Model, meets one of the six core BCF target benefits and outcomes, improves on the quality of services and commissioning for outcomes, or meets commercial criteria such as lower costs (i.e. reduced duplication or acute activity). If accepted the Programme will deliver the project, tracking progress and outputs against similar quality assurance criteria.

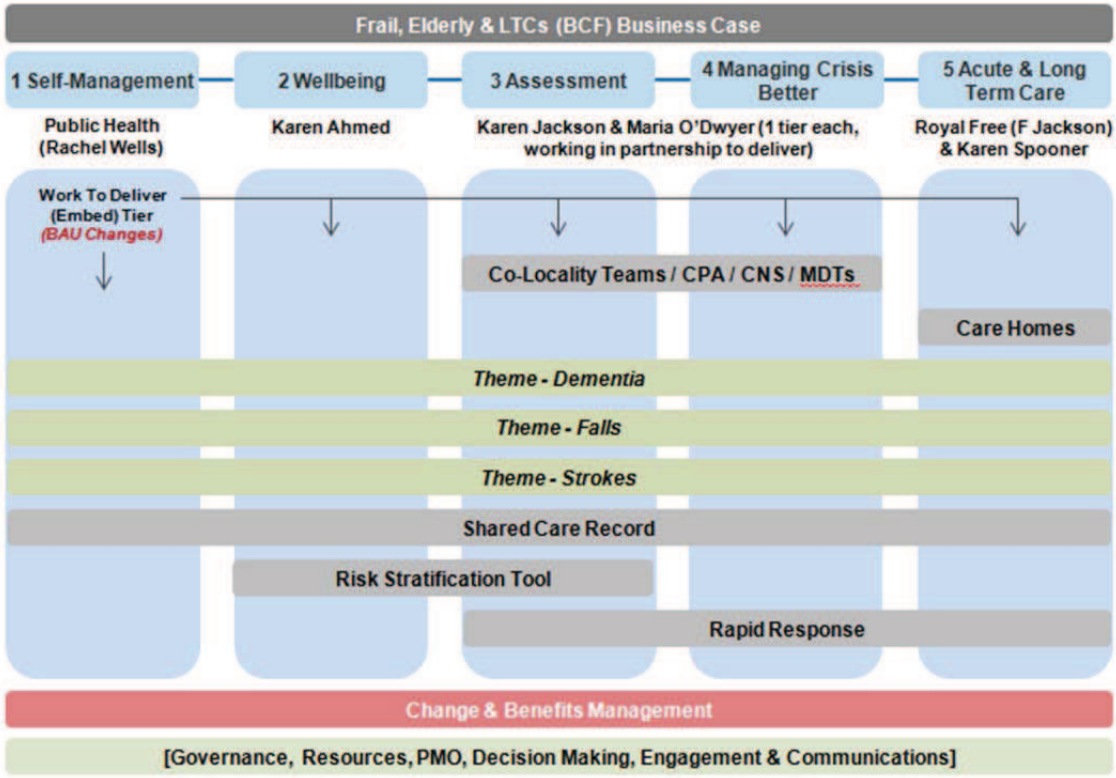
A well established system is in place where current S256 plans are jointly agreed through the Health and Wellbeing Board finance group. Section 75 agreements are in place for integrated services and these will be built on over the next few months to manage the changes associated with the BCF pooled budget. This will include all aspects of financial governance of the new pooled arrangements from April 2015.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

A programme approach is in place to support planning and delivery of the HSCI and BCF work streams and projects. The figure below illustrates the current and proposed scope of the Programme.

Projects comprise a defined change (output) for one or more tiers, e.g. the Shared Care Record to implement a new IT system for sharing information about the care people receive, or a suite of defined changes by theme or condition, e.g. Stroke, to deliver end-to-end integrated services.

BCF Programme Structure



A Programme Management Office (PMO) will coordinate and manage Programme operations. This will include governance, administration, project/work delivery and reporting, benefits realisation, documentation and information control and communications and engagement with stakeholders. Governance will complement wider arrangements in place as appropriate, e.g. where decision making is to be escalated to or made directly by the Health and Wellbeing Board (HWB).

As indicated in the previous sub-section the Health & Social Care Operational Group oversees operational implementation of the BCF. It currently meets bi-weekly and has set its terms of reference to flex meet the emerging needs of the BCF plan. Membership includes director level roles from the CCG and LBB, Joint Commissioning staff, tier leads, finance and PMO.

A key role of this group will be to monitor delivery including early identification of risks and issues. If plans go off track, project leads will be expected to work with the PMO to assess the scale of any problem and to develop a remedial plan, where necessary, to re-align service delivery. If the project requires a revised approach this will be managed via a formal change request agreed with the PMO and the operational group. Direct linkages with the over-arching governance structure through senior management will facilitate this mechanism as required.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Tier 1 & 2. Self-management and prevention
2	Tier 3 & 4. Assessment & Care Planning
3	Tier 4. Community Intensive Support
4	Enablers

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

Risk	Impact (1-5)	Likelihood (1-5)	Overall risk (I*L)	Mitigating actions and steps
3.5% reduction in non-elective admissions target is undeliverable in the context of significant local challenge and past performance	4	4	16	• Routine monitoring of activity shifts and remedial action as required • Continued analysis of interdependencies to fully understand impact and consequences • Regular updates to management teams • Governance arrangements to include risk and benefits share
Shifting resources to fund new joint interventions and schemes could de-stabilise current service providers and create financial and operational pressures.	2	2	4	• Impact assessment of Health & Social Care Integration model to allow for greater understanding of the wider impact across the health economy • Ongoing stakeholder engagement including co-design and transitional planning with providers • Ongoing review of impact
The recent acquisition of Barnet and Chase Farm hospital by Royal Free and subsequent change in the NHS provider landscape could impact the implementation of BCF services	2	3	6	• Provider engagement • Robust commissioning plans with contingency arrangements
Front line /clinical staff leads do not deliver integrated care due to organisational and operational pressures or lack of buy-in to the proposed agenda	4	3	12	• Increased focus on workforce development and organisational development with all providers • Front line/ clinical staff engagement and input in developing integrated care model and plans • Communications strategy with staff across the system • Incentivise provider to develop workforce models
The capacity within commissioning and provider organisations to deliver changes is limited and prevents progress	3	3	9	• Develop the business case to include resource to deliver the BCF plan. This could include CCG and Council initialisation resources to support delivery and implementation of schemes/work streams.
The baseline data used to inform	4	3	12	• Validation of assumptions and savings

Risk	Impact (1-5)	Likelihood (1-5)	Overall risk (I*L)	Mitigating actions and steps
financial model is incorrect and thus the performance and financial targets are unrealistic/unachievable				target with respective finance departments • Close monitoring and contingency planning • Define any detailed mapping and consolidation of opportunities and costs to validate plans. • Develop strong patient and service user engagement plans to ensure current information so as to flex and tailor plans to meet needs
Preventative, self-management and improved quality of care fail to translate to reduced acute, nursing and care home expenditure, impacting the level of funding available in future years.	5	2	10	• Assumptions are modelled on the best available evidence of impact, including metrics from other areas and support from the National Collaborative • Use 2014/15 to test and refine assumptions with a focus on developing more financially robust business cases.
The local authority's financial position is challenging and significant savings from all service areas are needed to deliver cost savings and realise benefits within the planned timeline	4	3	12	• Managed and phased approach to spend and save model • Robust governance in place to support risk and benefits share • Clear identification and monitoring of saving opportunities • BCF could be the catalyst to savings in other areas of council spending, ie Adult Social Care.
The Care and Support Bill will increase costs from April 2015 and again from April 2016 resulting in increased cost pressures to the local authorities and CCGs.	4	4	16	• Undertake an initial impact assessment with a view to refining assumptions. • Explore and develop opportunities and benefits arising from the introduction of this legislation that may help to offset negative financial consequences. • Define the impact of the Care Bill and the potential pressures on the council and CCG budgets as a result. • Ensure appropriate utilisation of allocated funds within BCF to meet need
An underlying deficit in the health economy impacts on service delivery and/or investment	4	4	16	• Develop a managed and phased approach to spend and save model • Ensure robust governance is in place to support risk and benefits share
Social care is not adequately protected due to increased pressure impacting the delivery of services	4	3	12	• Work with partners on developing plan for protection of services
Resources cannot be shifted from the acute sector due to members of the public presenting themselves to A&E directly or requiring emergency admissions (through pressures in other parts of the health economy) resulting in no overall shift in numbers	4	4	16	• Engage with colleagues in adjust HWBB to determine their strategic changes and how it will impact Barnet • Discussions with key stakeholders including acute sector, social care community care, etc. to explore linkages and why shift is not taking place • Invest in re-educating public on use of

Risk	Impact (1-5)	Likelihood (1-5)	Overall risk (I*L)	Mitigating actions and steps
				acute sector. • Public communications strategy, including targeting primary care settings
Population characteristics and demographics adversely impact on deliverability of the model (eg population growth and continued net importation of over 75's into Care Homes from other areas)	3	3	9	• Focus on high impact project to target populations • Factor growth into planning assumptions and monitor trends
Differing discharge arrangements between Barnet and surrounding Trusts means patients receive and inconsistent service	2	2	4	• Stakeholder engagement with surrounding Trusts and GP networks • Consider working with neighbouring trusts to develop common discharge plans in line with borough specifications • MDT to monitor eligibility for services and ensure appropriate referrals
Acceptability of 7 day services impacting on Integration model	2	2	4	• Stakeholder engagement on 7 day working • Cross system sharing of good practice

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Given the financial position of the Barnet health economy, significant emphasis will be applied to delivery of targets related to a reduction in emergency admissions. Non-delivery must be seen in the context of an anticipated funding gap in Health and Social Care, and will manifest itself as cost pressures within organisations and potential reduced services.

The amount of BCF pooled funding at risk is £2,054,100. This equates to 3.5% reduction in non-elective admissions and has been calculated with the support of informatics and finance using agreed methodologies. It builds from and existing CCG QIPP plan, particularly related to Integrated Care and Ambulatory care and reflects a 2 year plan (2014-16) with increasing ambition for 15-16. Year 2 modelling has recently been undertaken and has followed the recognised Newham/ Tower Hamlets methodology.

The services within the BCF plan that directly support achievement of this target are:

- Expert patient programme
- Long term conditions services – Dementia, stroke and falls
- Older peoples integrated care - Risk stratification, care navigators, MDT and integrated locality teams

- Rapid care
- GP Care Homes LIS

A number of enabling and business as usual services lie beneath these, such as the Community (single) Point of Access and Shared Care Record, which enable continued delivery of the integrated care model. As with all ongoing programmes of work the services above are at different stages of delivery with reflected funding arrangements – a number are fully live and others are currently being planned or mobilised.

Part of the ongoing strategic approach to the BCF pool will be to ensure sustainability in the key services that will deliver the outcomes and targets that we require. This will involve continual monitoring and review of all services being funded under these arrangements linked to robust commissioning decisions based on evidence. Outline priority investments have already been agreed for 15-16 and mobilisition plans will reflect availability of funding. This is supported by demand and capacity modelling in the Full Business Case. The risk of non-achievement will be mitigated where possible through contractual arrangements and we will work closely with providers to deliver in line with expectations. Where appropriate, additional contingencies will be identified from within the pool itself or from other organisational funds. This could include the use of underspend, reserves or re-prioritisation of forward spend.

Under the remit of the HWB finance sub-group discussions are underway in relation to agreed approaches to management of the BCF pooled budget encompassing pay for performance arrangements, and risk and benefits sharing. At this stage it is anticipated that these over-arching principles will be agreed within the next few months and will be enacted via amendments to the existing section 75 agreement. Both executive board and finance leads are members of the sub-group.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The Better Care Fund is integral to delivery of the Barnet Health and Social Care Integration model. It consolidates existing work being undertaken and provides a clear direction of priorities and delivery for the future.

The Better Care Fund is also aligned to the following initiatives and is a critical element of both the CCG's and the Council's longer term strategic plans (CCG 2 and 5 year plan; Council Medium Term Financial Strategy and Priorities and Spending Review (PSR)):

Initiative	Dependency
Clinical service re-design particularly in relation to urgent care and long term conditions pathways	• An enabler to shifting settings of care and improving integration between care settings

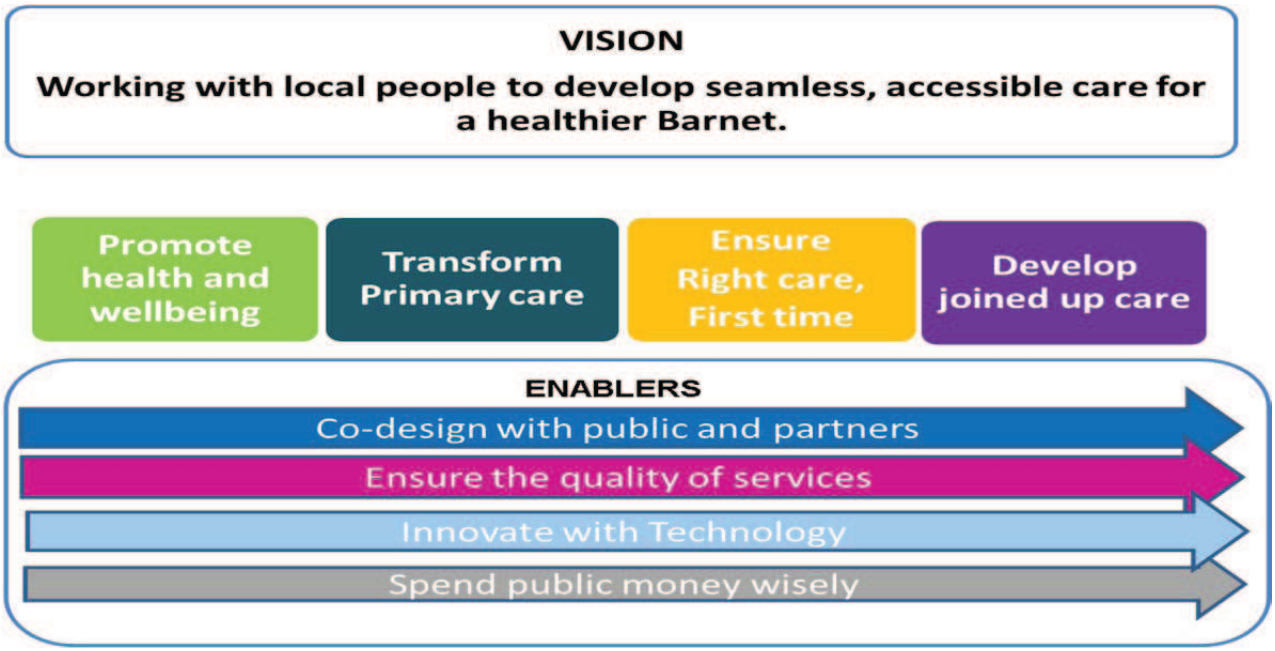
Changes to social care statutory responsibilities and service delivery. For example, increased Care Act duties and the re-modelling of the 'first contact for social care of LBB to increase the capacity to manage demand	• Demand manage new statutory responsibilities of the Council • Impact on BCF metrics and current spend • New flow of users resulting in change of legislation
System-wide operations resilience planning and delivery	• Impact on non-elective activity • Manage seasonal demand and surges in line with BCF strategy • Cross-system stakeholder understand of issues and solutions
Acute service reconfiguration particularly the continuing implications of the Barnet, Enfield & Haringey clinical strategy and the recent acquisition of Barnet & Chase Farm Hospital by the Royal Free NHS Trust	• Impact on non-elective activity • New flow of patients resulting in shifts in capacity and demand throughout the local system • Other implications such as demand pressures on community beds
Refresh of the Joint Strategic Needs Assessment	• Identification of new demand for services in future and alignment of our plans to meet this need
Value based commissioning approach	• Identification and exploration of alternative contracting models
HSCI Full Business Case	• Critical enablers for demand and capacity modelling for delivery and future investment • Corporate sponsorship of HSCI and BCF programme of work

The dependencies and alignment of these related initiatives will be managed through the Health and Social Care integration board and governance described in section 4.

Local interest in the BCF is high and as plans develop in related areas consideration will be given to how best to strategically link where necessary. This is anticipated over the next few months in relation to user engagement/ voluntary sector services and telecare. Additional work is required to align plans with Housing strategy.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The BCF vision for delivery of integrated care is fully aligned with Barnet **CCGs 2 year operating plans and 5 year strategic plans**. They are built around the same **vision** for services with over-arching values and a set of **strategic goals:**



These strategic goals set the direction of travel for the CCG whilst providing a framework, which is flexible enough to encompass new local and national priorities. They also focus on the organisational development that needs to take place to engage our stakeholders, strengthen our governance and financial management to deliver our challenging agenda.

Similarly, the **Barnet Council Corporate Plan (2013)** and **Priority & Spending Review (PSR) 2014** outline a commitment to integration and the BCF. Specifically the PSR has identified further savings opportunities totalling £1m through integrated working with the NHS and redesigning services to ensure that older people receive co-ordinated, joined up care services that reduce duplication and better anticipate and responds to their needs. The PSR states that the council will take a sensible and managed approach to managing finances against a recognition that it must continue to achieve its core priorities and statutory duties in relation to adult social care and health, including:

- The council and the Clinical Commissioning Group (CCG) makes effective use of the Better Care Fund to integrate health and social care services, providing greater choice and more coordinated services to residents whilst generating efficiency savings.
- The council implements its vision for adult social care, which is focused on providing personalised, integrated care with more residents supported to live in their own home.

Key links with the 5-tier **Health & Social Care Integration model** are evident in both plans with priorities and programmes of work are shared across both areas for delivery:

- Developing strategies, which empower patients to take control of their own health and improve their ability to manage health conditions at home
- Improving access to care through single assessment, integrated care teams and community hubs, ensuring the right care is provided first time

- Joining up care through multi-disciplinary teams and care navigators with a focus on to providing care out of hospital and prevent admissions

The BCF plan is crucial in supporting the delivery of the **long-term financial plan** for the health and social care economy through the redesign of core services. It facilitates moving activity away from Tier 5 as re-designed services in Tier 1 to 4 would capture and support people to reduce or prevent the need for acute or nursing/residential care. The level of reductions needs to be significant. We have modelled 2% and 3% shifts per year for five years from 2014/15 to 2018/19:

Revised Funding Gap for a 2% Reduction in Tier 5 Activity

	2014/15	2015/16	2016/17	2017/18	2018/19
Revised expenditure	£134,990,390	£139,454,394	£141,997,598	£144,503,476	£143,687,250
Budget	£133,817,172	£133,272,272	£134,496,516	£135,647,160	£136,973,858
Revised (gap)/funds available to invest	-£1,173,218	-£6,182,122	-£7,501,082	-£8,856,316	-£6,713,392

Revised Funding Gap for a 3% Reduction in Tier 5 Activity

	2014/15	2015/16	2016/17	2017/18	2018/19
Revised expenditure	£134,177,130	£137,717,656	£139,343,928	£140,939,361	£139,315,301
Budget	£133,817,172	£133,272,272	£134,496,516	£135,647,160	£136,973,858
Revised (gap)/funds available for investment	-£359,958	-£4,445,384	-£4,847,412	-£5,292,201	-£2,341,443

A 3% reduction in activity per year takes us towards closing the gap identified in section 3.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Barnet CCG has, as part of North Central London CCG's group, submitted an expression of interest for primary co-commissioning to NHS England. Following confirmation of receipt the NCL CCG's group has met with the NHSE NCL Area team Assistant Head of Primary Care, and are pursuing further development of the plan.
The plans for the development of primary care complement the BCF plan by:

- Recognising and supporting the critical link with general practice in delivering integrated care, designing and delivering services around patients and service users
- Enhancing the ability to commission integrated services along whole pathways, supporting in particular tiers 3 and 4
- Providing a platform for innovation, improvement and investment in primary care, particularly in the development of GP networks
- Focussing on improving prevention of illness and the prevention of morbidity (or delay in onset) in clients with long-term conditions, through improving the level and range of preventative interventions within health and social care, and improving support for self-management by clients will be delivered in primary care settings
- Developing and supporting services that deliver on the BCF metrics such as the specific local service specification for GP practices to support improved care within care homes
- Feeding in work programmes linked to delivery of the London Primary Care Strategic Commissioning Framework (formerly known as the London GP Development Standards) relating to delivering within primary care: accessible care – better access to routine and urgent care from primary care professionals, at a time convenient and with a professional of choice; coordinated care – greater continuity of care between NHS and social care services, named clinicians, and more time with patients who need it; Proactive care – more health prevention by working in partnerships with other health and social care service providers to reduce morbidity, premature mortality, health inequalities.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) **Protecting social care services**
i) Please outline your agreed local definition of protecting adult social care services (not spending)

In Barnet, protecting social care services means:

- Maintaining current FACs eligibility of substantial and critical for adult social care, and enabling the authority to meet new national eligibility criteria from April 2015.
- Ensuring that additional demand for Social Care Services which supports the delivery of the integrated care model and which delivers whole system benefits and savings will be funded.

It is recognised that the priorities for spending against the BCF are likely to be greater than the available BCF funds. The London Borough of Barnet and Barnet CCG agree to plan and review on an annual basis the allocation of the BCF to these priorities.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The BCF includes identified funds to support the implementation of new statutory requirements contained within the Care Act. The Barnet BCF allocation includes specific funding to cover aspects of the increased demand relating to new eligibility regulations and new duties in relation to safeguarding, wellbeing, prevention and carers. Whilst this funding will not cover all the demands arising from the Act, it will be used as part of our local work to ensure that we are prepared for the implementation of the Act in April 2015.

There is a clear synergy between better access, improved care planning and community support for frail older people contained within our BCF integrated care model and the enhanced duties on local authorities in relation to supporting people to plan how to meet their care needs early on through enhanced advice, information and prevention. Barnet has a Care Act preparation programme in place and the dependencies between this and the BCF plan are being scoped.

The principles for protecting local social care services will be delivered through the following:

- Strategic direction for the BCF to take into account existing and future commissioning plans of the CCG and Local Authority and to have due regard to the Joint Strategic Needs Assessment (JSNA).
- An agreed shared governance framework for spend and management of the BCF with membership from health and social care. To include an approval process for services with appropriate input from relevant parties. Oversight and governance provide by the Health & Well-Being Board.
- Services delivered through a jointly owned integrated care model with emphasis on maintaining people with health and social care needs in the community. Modelling to measure impact upon and reflect changes in demand to social care services e.g. enablement with a view to maintaining or increasing where necessary.
- Maintaining and developing services for carers.
- Maintaining current FACs eligibility of substantial and critical, and through meeting needs of national eligibility criteria from April 2015.
- Where possible move to joint commissioning of services via an agreed framework e.g. care home beds, enablement.
- Working with Local Authority and providers to manage demand to ensure optimal usage of social care service provision.
- Embed social care services within integrated delivery models to flex operational efficiencies and build services with greatest impact on people utilising the most appropriate care choice. Example would be delivery of enablement services through locality based integrated care teams.
- Ensuring that additional demands for social care which can be attributed to increased out of hospital healthcare are considered for funding as part of the pooled budgets.
- By ensuring that personalisation and self-directed support continue in integrated

arrangements through selecting this as our local performance indicator.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total set aside for the protection of social care is £4,141,357.

In addition we have identified £846,000 which represents Barnet's proportion of the £135m for the implementation of the new Care Act duties.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Barnet has a clear and mutually agreed definition on what constitutes "protecting adult social care services". It is recognised that the priorities for spending against the BCF are likely to be greater than the available BCF funds, in the context of on-going austerity in the public sector and demographic change. However, to date the plans delivered and the work between health and social care support this approach.

Barnet has a Care Act Implementation Project Board which oversees work streams relating to the national and local requirements and to assess the impact of the Care Act reforms on Adult Social Care services in Barnet. The implementation of our tiered approach to integrated care will underpin the local authority's ability to fulfil its statutory responsibilities, in particular in relation to prevention, assessment, care planning and carers.

The work of the Project Board is focused on 7 work streams, each with a dedicated lead manager and implementation plan, as follows:

- Demand Analysis and Modelling: delivering a picture of what the total impact of the Care Act on the Council's finance and resources will be;
- Prevention, Information & Advice: refreshing and updating prevention, information and advice initiatives and catalogues;
- Carers: ensuring that LBB carer's services are compliant with Care Act regulations;
- First Contact, Eligibility, Assessment and Support Planning: ensuring readiness for national eligibility criteria, developing and implementing new approaches to assessment and support planning, ensuring sufficient capacity and effective risk mitigation arising from the likely increased take up of assessment due to the funding reforms and creating a first contact service that is able to manage demand efficiently and effectively and enable costs to be reduced;
- Finance: delivering a universal deferred payment offering and making any necessary changes to charging and debt collection processes.
- Marketplace: updating existing and developing new policies and processes related to market shaping and provider failure;

- Communications, Workforce Development and Governance: developing and delivering internal and external communications related to the Care Act, delivering a comprehensive workforce development plan and staff training to prepare the social care workforce and co-ordinating public consultation and corporate decision making

v) Please specify the level of resource that will be dedicated to carer-specific support

Carers are critically important in Barnet. The borough has over 32,000 carers with over 6000 providing over 50 hours of care a week. This is the second highest number of carers in the London region. As part of the modelling work for Care Act Implementation (Section 7a[iv] refers) Barnet has estimated that the financial cost for carrying out additional carers assessments (including the cost of related support) would cost a projected £962k - £1.44m, against a backdrop of a financial challenge for the CCG and Local Authority.

Our priorities for carers are:

- Early recognition and support for carers
- Information and advice offer for carers
- Supporting carers to fulfil their employment potential
- Carers as expert partners in care

We are developing a suite of performance and monitoring tools and reports to improve our infrastructure, capacity to track contracts and performance activity in Adult Social Care and key partners relating specifically to carers. This will help us deliver improved insight and analysis about what works best, highlight risks, and inform how we optimise allocation of our BCF resources going forward.

We have reviewed our Carers Strategy Partnership Board arrangements strengthening the carer's voice in service development and commissioning, and we plan to further strengthen the role of health here working closely with the Joint Commissioning Unit.

All of the above work is being coordinated through a project dedicated to Carers as part of the Care Act Implementation Project Board (section 7a [iv] refers). It highlights dependencies too, which include Health and Social Care Integration and Family Services (Children and Families Act requirements around young carers and transition).

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Overall the impact has not changed significantly compared to original submission (the Barnet BCF allocation includes approximately £1.206m to cover some aspects of the increased demand relating to new eligibility regulations and new duties in relation to safeguarding, wellbeing, prevention and carers).

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Barnet has made reasonable progress to establish seven day working, however we recognise the need to enhance further the scope and reach of services already in place.

We have engaged with a variety of stakeholders to get agreement and commitment to seven day service delivery particularly during the design phase of the Health and Social Care Integration Model through:

- Co-design working sessions for integrated care in 2013-14. These sessions included patients, the Local Authority, GPs and Acute & Community service providers as outlined in section8.
- North Central London wide sessions to share development plans, ideas and best practice

We are working towards implementing the **national standards for seven day services in urgent and emergency care over next three years.** Our intention is to develop a programme across three years to **embed seven day services into core contracts for services** and the intention is for all of the clinical standards to be incorporated into the national quality requirements section of the NHS Standard Contract for Barnet's provider services.

High level delivery plan associated with the move to 7 day services:

Priority action	**Milestone**
Acute services	
Extension of hours of tracker nurse provision to support identification of those who could be discharged	Nov 13
Supported assessment, triage and discharge arrangements within local acute trusts including Urgent Care Centre (UCC), ambulatory care pathways, PACE, TREAT and RAID to extend over 7 days.	Ongoing
Operational resilience plans agreed to test some 7 day delivery. Outputs to be evaluated to inform future planning. Examples include occupational therapy and access to pharmacy.	Awaiting plan sign off
Undertake action in service development and improvement plan identifies 7 day working to assess current position and develop forward plan for delivery for national seven day standards	2014-15 onwards
Community & Primary Care services	
Extension of 7 day provision of core community services to 7 days – district nursing, intermediate care and Rapid Care. To include night sitting where	Nov 13

required	
Links established between services above and current providers of seven day services (eg out of hours GPs and London Ambulance Service (LAS))	May 14
Barnet community point of access operational providing an effective and safe referral point to facilitate access to rapid response and nursing teams over 7 days.	April 14
Refresh of current alternative care pathways with LAS to facilitate avoided admissions.	Ongoing
Social Care	
Social work and Occupational Therapy teams operational 7 days per week within A&E departments at both main Acute hospitals to support care planning for transfer home	Jan 14
Access to new and amended packages of care throughout the weekend	Jan 14
Other	
Ongoing managed system for Delayed Transfers of Care involving all providers facilitating and unblocking reasons for delay and allowing for transfer throughout the 7 days period.	Ongoing
A communication strategy with over-arching view of the services available and to stream-line referrals and transitions across interfaces.	Tbc

Collectively, this delivery plan will result in:

- A consistency of service delivery over 7 days that will even out pressure points and lead to reduced non-elective admissions including at weekends
- More integrated approach to individual care with clear pathways from assessment to care planning and delivery
- Increased discharges over the weekend with confidence of appropriate support

The key risk associated with delivery of 7 day services will be implementation of the clinical standards for 7 day services by acute providers, acceptability amongst staff and population demographics related to acuity.

c) **Data sharing**

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Locally we recognise the importance of joint working across all health and social care services. The NHS Number will be used as the primary identifier for integrated case management, data exchange and care reviews. It is already used as the unique identifier for most NHS organisations across Barnet.

Social Care includes the NHS Number with some client records; however, this is not currently required for all client information. Adult Social Care is in the process of procuring a new case management system, which will be implemented by April 2015 and will result in the recording of the NHS Number for all social care clients from this point forwards.

To further support this integrated care, we are implementing the Barnet Shared Care Record. This project, which has been agreed and approved by the Health & Social Care Integration Board, will be a key enabler for sharing information between care providers:

- The Barnet Shared Care Record Project will first implement the service in early 2015.
- It will not replace local systems, but will provide a single view of an individual's care by combining information from all the care providers in the Barnet area.
- NHS Number will be used as the unique identifier to combine data about individuals and data submitted to the Shared Care Record will need to be using it
- Initial data providers have been identified as those that will already have the NHS Number included in their records (e.g. GP Records, Community Health).
- Change in business processes will reinforce the use of the NHS Number as the primary method for identifying individuals alongside the roll out of the Shared Care Record in early 2015.

Following initial roll out of the service, the project will work to increase the data in the Shared Care Record and to improve the process of sharing. The project plan outlines an approach to work with these care organisations during 2015/16 to where the NHS Number is not currently in use to undertake the preparatory work required to move to routine use of the NHS number as the primary identifier in the process of information sharing.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The use of Open Standards and Open APIs is a principle that is adopted and built in to the procurement of any new system (e.g. the recent Adult Social Care procurement of a new case management system includes the requirement to use Open APIs and Open Standards (e.g. ITK) both in the mechanisms used to connect to local systems and the method for interfacing with external systems).

Requirements also include the adoption of common formats for information/data (e.g. CDA). From a technical perspective a system that securely uses Open Standards/Interfaces will be prioritised over an identical system that does not.

Where existing systems are required to be enhanced or changed specifications always include the use of Open Standards and non-bespoke development whenever possible. Where new development is required (e.g. new messaging interfaces) LBB will always seek to publish these and have them approved

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

LBB / CCG operate within an established Information Governance framework, including compliance with the IG Toolkit requirements and the seven principles in Caldicott 2.

The contract documents used by Barnet CCG to commission clinical services conform to the NHS standard contract requirements for Information Governance and Information Governance Toolkit Requirement 132.

Barnet CCG as a commissioner and to the extent that it operates as a data controller is committed to maintaining strict IG controls including mandatory IG training for all staff, and has a comprehensive IG Policy, Framework, IG Strategy and other related policies.

Information Governance arrangements and the IG Framework conform to the IG Toolkit requirements in Version 11 of the IG Toolkit, including clinical information assurance as set out in requirement 420 and the requirements for data sharing and limiting use of Personal Confidential Data in accordance with Caldicott 2.

In addition to maintaining a current PSN Code of Connection, LBB is working towards compliance with the latest NHS IGT V12 which will be completed by the start of 2015. All new projects / business process changes complete an IG Impact Assessment prior to initial approval and activity is routinely reported to Information Management and Governance Groups.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Barnet CCG uses the **United Health HealthNumerics-RISC® tool** and has supported an accelerated programme of implementation in GP practices and training in GP practices through July and August 2014. The tool identifies patients at risk of a future unplanned hospitalisation within the next 12 months due to chronic conditions. It predicts future health risk based on recent patient activity using predictive models.

The following data sets are used to determine the relative risk of patients within a given population:

- Primary Care (GP Registry, GP Medication and GP Activity Data) and
- Secondary Care (SUS PbR/SEM datasets including in-patient, out-patient and A&E activities)

The data links to the Kaiser Long Term Conditions triangle by classifying patients into 3 levels and then assigns the RISC level of a patient following a scoring process:

Total Population Level	RISC % Range	RISC % of total population	LTC Triangle population (top 26% of total PCT Population)	LTC Triangle % of total population
3	0% to 1/2%	1/2%	5%	1.3%
2	>1/2% to 5%	4-1/2%	15%	3.9%
1	>5% to 25%	20%	80%	20.8%
0	>25% to 100%	75%	Not Included in LTC Triangle	74%

We have completed the 'first cut' stratification of the Barnet CCG population with the following results:

Risc Level	Population Percentile	Number of Patients	Risk Ratio Range	Ave Risk Ratio	Average In Patient Admission (planned same day care activity)	Average Unplanned In Patient Admission	Average Unplanned Chronic In Patient Admission
3	0% to 0.5%	1992	26.101 - 40.22	32.305	11.51	3.79	2.66
2	> 0.5% to 5%	17928	4.826 - 26.099	10.303	2.03	0.78	0.38
1	> 5% to 25%	79683	0.809 - 4.826	1.833	0.34	0.09	0.02
0	> 25% to 100%	298811	0.05 - 0.809	0.311	0.08	0.01	0
Total Population		398414		1.225	0.28	0.08	0.03

The tool has identified 1,992 in the highest risk cohort and 17,928 in the next. The data also indicates that the PbR costs associated with people in levels 2 and 3 are £79m representing approx. 50% of total spend.

Our approach moving forwards will include:

- Supporting GP practices to use the tool regularly to inform care planning and case management in line with the GP Admissions avoidance DES from NHS England as part of the GMS contract for 2014-15.
- Embed use of the tool as a partnership approach with the Integrated Locality Teams to implement a framework for implementing and integrating joint assessments and the role of the accountable lead professional.
- To link risk stratification to current service provision, and where necessary, re-align to target those patients identified through the risk stratification model to maximise clinical and financial impact.
- Agreeing an approach for risk stratification for future years to ensure continuity.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

A number of existing and planned models will ensure that local people at high risk of hospital admission have an agreed accountable lead professional and that health and

social care use a joint process to assess risk, plan care and allocate a lead professional.

Key elements include:

- Use of risk stratification in primary care (as above) to identify those most at risk of admission to ensure that they are actively case managed.
- A weekly multi-disciplinary team meeting that provides a formal setting for multidisciplinary assessment and health and social care planning for very complex high risk patients who require specialist input. This accepts referrals from multiple sources including primary, secondary and social care and results in collective ownership of a planned care approach.
- A care navigation service that provides a care co-ordination role following MDT assessment.
- Admissions avoidance DES as per GP contract for 2014-15 where new responsibilities for the management of complex health and care needs for those who may be at high risk of unplanned admission to hospital have been introduced. In particular, to case manage vulnerable patients (both those with physical and mental health conditions) proactively through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator.
- Planned introduction of Integrated Locality Teams incorporating health and social care with anticipated streamlining of care according to patient need rather than referral point. This will also bring into play a generic long term condition approach which will enable early identification and care planning for future management of exacerbations.
- An enhanced GP service focussed on Care Homes to provide a much more holistic management approach to supporting homes to reduce admissions.

Barnet has an agreed format for assessment, allocating lead professional, planning care and monitoring success measures of interventions. To date this has been a paper-based approach operated on a small scale led by the MDT. It has fed directly from risk stratification that was, until recently, being undertaken manually by GP.

With the roll-out of the risk stratification tool and the introduction of the Integrated Locality Team trailblazer during the summer of 2014 we will see a shift in approach and activity targeted to those most at risk. We will have an increased ability to target those most at risk of admission. A key principle of using the bottom-up build operational model is to provide the freedom and the permission for partners, including GP practices, to work together to develop and agree a robust framework for joint assessment and care planning. To remove potential barriers to success we have focussed the work around the needs of the patient and, in particular, are advocating an outcomes based approach to make the benefits tangible to those delivering care. We have also created an environment that supports innovation and ownership of the model with the commissioner only providing high level outlines of requirements to allow for innovation and advocating a hands off commissioner position to allow for problem solving and planning by the teams themselves. Development of a risk and issues log will identify clearly the possible barriers to implementation of the model on a longer term or wider basis that can then be addressed as part of ongoing implementation. It is intended that this work taken forward will include:

- Working directly with GP practices to jointly assess risk stratification data to determine a prioritisation approach to the numbers of people who require care planning and case management to address those most at need and high climbers (those with a significant change in risk score over a short period of time).
- agreeing an ongoing outcomes-based mechanism to allocating of accountable lead professional across a range of providers and clinicians. This is envisaged as the single contact point for the patient and other professionals in relation to the ongoing care plan for an individual. They may not be fully responsible for the delivery of all care to that patient but will have an overview of what the care plan encompasses, what next steps may be required for the patients and can support timely decision making.
- developing a fit for purpose joint assessment framework that can be utilised and is accepted across the system
- developing and introducing a standard care plan
- assessing and evaluating the inter-dependency between the team and the Admissions Avoidance DES to ensure that GPs are supported in being accountable for co-ordinating patient centred care.
- Identify any gaps in service, including evaluating whether current systems accommodate to the needs of those with dementia and mental health problems adequately
- active consideration and challenge to crossing boundaries of care to reduce the numbers of people working directly with the patients and to explore possible opportunities and efficiencies
- evaluating the need for a 'watching brief' approach for a proportion of the population
- outlining how often patients should have their care plan re-evaluated and hence could move within the framework

Utilisation of an exemplar framework as below may be beneficial.

	Requires Care Plan?	Joint assessment	Active Management & accountable lead professional (ALP)
Very High Risk	Yes – Plan may include action points to be picked up by community, social or specialist services.	Yes for some.	Yes for some. ALP agreed as part of assessment and care planning. May be allocated via MDT approach across GP, community services, social or specialist services
High Risk	Possibly – particularly for 'high climbers' with identified significant change in risk score	Possibly high climbers	Possibly high climbers. ALP – generally GP with some managed under MDT
Medium Risk	Not generally	No	No ALP - GP
Low risk	Not required. Patient may benefit from information via navigation services	No	No ALP - GP

The pilot team will work with 7 GP practices in one locality for approximately 4 months. This will be followed by a planned roll out across the area over the next year.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

In the period July 2014-July 2014 233 people were managed via the MDT and all had a jointly agreed care plan. These figures are expected to increase as indicated above.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

A range of individuals and organisations have been involved in developing the constituent services within the BCF plan, and the over-arching plan itself, making patient and service user views integral to the Vision for Integrated Care in Barnet.

The patient engagement and service user groups we approached to shape our vision were **Healthwatch Barnet, Barnet Older Adults Partnership Board** (a resident and service user engagement group)**, Age UK (Barnet), Alzheimer's Society** and others.

We also drew on experiences and feedback gained at **Council** and **CCG public engagement** events and in broader project-based consultation exercises such as **Guiding Wisdom for Older People**.

Our care model incorporates universal preventative and self-management services, such as the **Barnet Ageing Well** project. This initiative was developed in response to needs identified by the community.

The **Integrated Health & Social Care Model** was developed from feedback from local residents. Ongoing involvement and oversight by the co-chair of the Older Adults Partnership Board keep the strategy grounded and progressive.

We have not only used requirements feedback from engagement groups to inform strategy but also used groups to test the practical implementation of that model. Workshops were held with Older Adults Partnership Board members, Older Adults Assembly meetings and public forums. These were facilitated by Healthwatch, and enriched with interviews and surveys.

Feedback from patients and service users was key in helping us develop our vision in particular:

- Meeting the changing needs of the people
- Allowing for greater choice on where and how care is provided
- Promoting individual health and wellbeing to be managed by that person
- Listening to and acting upon the views of residents and providers to improve patient experience and care

Further under-pinning this, and picking up the work of National Voices, Barnet CCG is participating in a **value-based outcomes commissioning programme** with other CCGs in North Central London. Patient and service users have been involved from the outset through multi-disciplinary workshops to develop an agreed outcomes hierarchy and as part of expert reference groups to test and validate the findings. The continuing work with Camden CCG, focussing on frail and elderly populations, will equip health commissioners to change the way in which they do business to achieve patient-centred goals.

Continued patient, service user, carer and public engagement is essential to bring momentum to the implementation of the **Integrated Health & Social Care Model.** Moving forward, we will continue to use the existing **Older Adults Partnership Board** framework as the key patient and public representative group with involvement from service users, carers, Healthwatch and the voluntary sector. We will develop an engagement strategy with this forum at the core that will allow us to ensure in-depth engagement, and involvement in planning and monitoring, from residents as we implement the model. This will include:

- Tier specific workshops
- Engagement with experience panel or reference groups, the **Barnet Seniors' Assembly**, a group of over 150 older local residents supported by LBB
- Engagement with other partnership boards eg carers
- Membership of relevant steering groups
- Links with other organisations communications strategies e.g. Barnet CCG and Age UK
- Engagement with voluntary sector and existing services (e.g. Neighbourhood model) to engage hard to reach communities
- Co-production approaches to new specifications

External scrutiny has been given to the over-arching plans for Integrated Care through presentation at CCG public board meetings and through an elected member scrutiny exercise at Barnet Council.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Key NHS partners include **Royal Free NHS Foundation Trust** (following the recent merger with Barnet & Chase Farm NHS Trust), **Barnet, Enfield & Haringey Mental Health Trust**, our community health services provider, **Central London Community Healthcare NHS Trust**, hospices and **London Ambulance Service**.

The **Better Care Fund (BCF)** plan has its foundations in the **Barnet Health & Social Care Concordat** – a clearly articulated vision for integrated care agreed by all partners at the Health & Wellbeing Board (HWB). The concordat itself was co-designed by the partner members of the **Health & Social Care Integration Board (HSCIB)** and hence provides the over-arching strategy for delivery endorsed fully by service provider recognition and support. The Integrated Health and Social Care Model has been formally supported by providers as above as key members of the HSCIB and is embedded within organisational plans.

The plan brings together work in progress in individual organisations (health, social care and voluntary sector), joint work being undertaken through the work programme of the HSCIB and emerging priorities as identified in a newly developed **Integrated Health &**

Social Care Model co-produced with partners.

For key schemes already underway, such as the Older People's Integrated Care project and Rapid Response, service providers are active participants within established frameworks to work collaboratively to design, implement and manage services with commissioners. This occurs through a variety of mechanisms such as operational co-production, steering group memberships and front-line delivery. This has been taken a step further with development of locality base integrated care teams (July 2014) through a bottom-up build approach via a shared trail-blazer team.

Service provider involvement in the Integrated Health & Social Care Model has been achieved through participation in the 'as-is' mapping of current provision and spend, development of a target operating model, and by involvement in a series of design workshops which focussed on opportunities and operational deliverables. This has brought realism to the plan and shared ownership through a commitment to improve care for the people of Barnet. This continues with providers being actively involved in developing the plans for implementation including acting as tier sponsors in relevant areas. A key development has been the establishment of the bi-weekly Barnet Integrated Care Strategy steering group. This is co-chaired by the sponsors for tiers 3 and 4 and encompasses projects being delivered in tiers 3-5. It provides the forum to influence operational delivery and explore the implications of the BCF, in detail, beyond the high level principles and financial models that are embedded within existing operational plans.

A joint commissioner and provider forum exists in the form of the **Clinical Commissioning Programme for Integrated Care**. This will be further aligned to form a core part of the service provider engagement vehicle moving forwards. With the Health and Social Care Integration Board running alongside, our plan embeds service provider engagement at both operational and strategic levels.

ii) primary care providers

The primary care infrastructure in Barnet includes 67 GP practices, our out-of-hours provider Barndoc and 77 community pharmacies. GP practices are structured in localities with designated CCG board member and management leads. In additional to practices operating individually we are seeing an increasing shift towards network development resulting in increased service delivery on this basis. This will be explored further in terms of a future delivery model.

GPs were involved in the development of the **Integrated Health & Social Care Model** with a number providing input and challenge to the OBC process. These included CCG board member GPs and others with a specific interest in older adults. We also value the support of GP clinical leads to provide expertise and clinical advice in relation to service re-design and operational plans.

The wider GP network has been engaged through presentations at locality meetings and through discussions with the LPC. There is an ongoing programme of communications and engagement underway with events targeting the Integrated Locality Teams and the introduction of the Care Homes service. GP leads have been identified for key services to

ensure that their views are integral to operational standards and fit for purpose.

We recognise that extensive engagement is essential to implement integrated care and will develop a primary care facing plan on a broader basis over the next few months.

iii) social care and providers from the voluntary and community sector

Current plans have been jointly developed with anticipated delivery largely expected through Joint Commissioning.

Strong working partnerships exist between commissioners and provider side teams within LBB (e.g. social work) with sponsorship of key projects and with an established co-production approach. This is now most visibly seen within the bottom-up build Integrated Locality team where a number of staff are central to leading the change management process. In terms of service re-design they are active stakeholders in informing direction of travel and providing feedback on suitability.

The ongoing work has also supported a facilitative approach to building key stakeholder partnerships across the system, particularly between social care and community services, and collectively we are now working collaboratively to understand respective organisational perspectives, concerns and issues. By fostering joint ownership of the model and centring the work around the needs of Barnet patients and service users we aim to adopt a shared approach to innovation and problem solving.

Other key partners have been in included in the Health and Social Care Integration development process such as Housing 21, other care agencies, Barnet Homes, and various voluntary sector providers (Healthwatch Barnet, Age UK, Alzheimers Society and British red Cross). There is very much a growing interest in this area from partners and we are harnessing the energy, enthusiasm and skill by inclusion in steering groups and experts by experience panels as appropriate.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Our main acute provider is now Royal Free NHS Foundation Trust working through 2 key sites in Hampstead and Barnet. Extensive re-configuration of local infrastructure and service provision has recently be completed with changes to the Chase Farm hospital site, as outlined in the Barnet, Enfield & Haringey Clinical Strategy, and the acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free Hospital. This has resulted in shifts in demand and activity through 2013-14 which will impact for this year and beyond.

The ongoing financial position of Barnet CCG is well known by acute partners including a recognition that extensive service re-design and a robust QIPP programme is required to deliver a stable system in financial balance. In this context we have a very strong focus on:

- Transformational change of the health system through provision of integrated care for patients with complex needs as defined in the BCF plan. Through proactive identification, care planning and integrated management of care for patients with complex needs we will seek to avert crises, thus reducing the unplanned use of acute care;
- Reduction in elective acute care through robust management of referrals, and redesign of care pathways to provide upstream early intervention, a greater range of care in a primary care setting, and community based alternatives to acute care.

Relationships with acute providers are constructive and they actively demonstrate support for the over-aching strategic drive behind the BCF and its aims.

The current CCG QIPP plans for Integrated Care (2014-16) represented savings of approximately £3.1m as outlined in contract negotiations and agreed plans. The revised BCF guidance (July 2014) requires greater ambition in terms of movement of costs and services away from acute, primarily in the form of emergency admissions, and hence the savings methodology and projections for the second year of this plan have been scaled up. It has also used information from the 'Appropriate Place of Care Audit' and the modelling associated with the full business case to understand the numbers of non-elective patients who are receiving care in an inappropriate location, and the capacity and demand limits of current provision.

Revised savings equate to 1025 less non-elective admissions in 2015-16 with a relative estimated impact on the acute sector as outlined in the table below. This reflects the 3.5% ambition in line with the BCF but should be noted as being a significant challenge in light of the wider financial, demographic and environmental issues in Barnet. The figures below are based on a different costing model to above (as derived from the BCF guidance) and simply represent indicative workings that require further validation.

	Estimated Activity Reduction 15/16	Estimated impact at £2420 (amended to reflect local cost with MFF)
Royal Free (Barnet site)	656	1,314,626
Royal Free (Hampstead site)	307	616,230
Other	62	123,244
Total	**1025**	**2,054,100**

With current CCG contractual arrangements funding will follow the patient so any additional acute activity resulting from non-delivery of the target will be reimbursed in accordance with agreed tariffs. This will mitigate the risk somewhat for providers although it is recognised that deviation from plan could be operationally problematic. Current systems will continue in terms of demand management and urgent planning and these will directly support reductions in emergency admissions and capacity and surge management.

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
1
Scheme name
Expert Patient Programme **(**Tier 1 & 2. Self-management and prevention)
Scheme description
Pilot and roll out of generic and disease-specific Expert Patient programmes (EPP) – organised by individuals who have existing long term conditions (LTC).
What is the strategic objective of this scheme?
The objectives of this scheme are to: • empower patients to self-care and manage their condition • optimise individual patient's health status • increase knowledge and understanding of LTC and lifestyle/behavioural influences • Improve the patient's experience, and • Mitigate for unnecessary A&E attendances and unplanned hospital admissions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme will enable community social care professionals (health and primary care) to refer older people who have just been diagnosed with a long-term condition, into the Expert Patient's Programme. The scheme will be organised by people with existing long-term conditions, and who are therefore sensitive towards individual issues and needs. In addition, these trainers will have the ability to signpost the patient to other local support services. The primary objectives of the EPP are to up-skill people and improve health literacy. This will make individuals with LTC's more confident about looking after their health. Structured patient education programmes based on specific long-term conditions will also be introduced alongside the EPP generic programme. The content and structure of these courses will be determined by a systematic review of needs evidence and service piloting results. The outcome of this analysis will highlight which course subjects will have the biggest impact on particular cohorts within Barnet. It is envisioned that the disease specific pilots will focus on one or more of the following long-term conditions: diabetes, CHD, pain management, respiratory conditions, dementia or depression. The generic and disease specific programmes will be launched (staggered) according to the schedule below: • Pilot of generic programme: **November 2014** • Pilot of disease specific programme: **January 2015** Evaluation of the various pilots will help to determine an optimum programme for Barnet's residents. The generic programme, the disease-specific programme, or a combination of both will be rolled out to up to 5% of the eligible population of older people with long-term conditions should the pilots prove to be successful (currently 1,778 older people with long-term conditions).

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Project lead: Claire Mundle/Lisa Jacob

Project plan in place to deliver programme 1 from November 2014. This will be provided by SM:UK and is partly funded on the basis of successful bid last year.

The first programme will be delivered through 3 cohorts of 16 people each based in community venues in each of the 3 localities.

Plans for January 2015 are in development and we are currently exploring links with existing structured education programmes in Barnet.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

Research into the success of EPP's has produced mixed results. For example, a number of papers have suggested that further analysis and a review of comparator schemes is necessary before the full effectiveness of an EPP can be gauged. However, despite some criticism, there exists a general consensus that EPP's reduce both costs and service utilisation e.g. GP's.

Background paper on the Expert Patients' Programme for NICE Expert Testimony (A. Rogers) – This expert paper reviews the effectiveness of the EPP launched by the Department of Health in 2001. Although the results are very mixed, it is reported that there was a moderate increase in self-efficacy amongst the patients who joined the programme. In addition, overnight hospital stays reduced across the EPP cohort, and there was an overall reduction in service utilisation. These factors are likely to offset the costs of intervention, making the EPP a cost effective alternative to usual LTC care. To summarise, the paper states that any EPP should be able to meet a wide range of LTC patient's needs, rather than focusing on one course.

In addition, the HWB Fund Fact Pack highlights the importance of self-empowerment and education to a successful integrated care system. Significantly, the average impact of support for self care was estimated at 25-30% reduction in hospitalisation (impact measured from systematic reviews).

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

To ensure the EPP is fulfilling its primary objectives, we have planned for an evaluation of the first cohort. This will assess local impact/programme outcomes and will be measured against key success criteria's/KPI's. It is intended that the results of this review, will inform future commissioning. On this basis we have currently not assigned any benefits to it within the BCF plan.

Assumed Benefit Map – Expert Patient Programme:

Benefits Map 1 - Expert Patient Progra

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

What are the key success factors for implementation of this scheme?

- Structured education needs to be supported by relationships between primary care, specialists, carers and patients
- Professional development and support from LTC specialists is important.

Scheme ref no.
2a
Scheme name
Long Term Health Conditions (LTC's)
Scheme description
Increase the scale of services to support people with Long Term Conditions
What is the strategic objective of this scheme?

The objectives of this pilot scheme are to:

- Improve clinical outcomes across the cohort of individuals with the specific long term conditions identified
- Invest in community and other services to provide better care for patients with long term conditions, keeping them out of hospital and creating financial savings
- Reduce the number of emergency admissions for people with LTCs
- Provide patients with services closer to home

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme forms part of tier 3 and represents a family of services targeted at long term conditions – primarily dementia, stroke and falls.

01 Dementia Services:

Two key service developments are being taken forward in relation to dementia at this stage.

1. **Memory assessment service** - re-design of the existing memory service to create a discrete fully functioning memory service to meet the Memory Service National Accreditation Programme (MSNAP) and National Dementia Strategy standards.

2. Development of a **Community support offer for people with dementia and their carers**. To include dementia hub with resource centre, dementia advisors and dementia cafes. Dementia Friendly Communities project.

02 Stroke Services:

Suite of three services to focus on prevention of stroke, and improved outcomes post-stroke through early supported discharge (with appropriate rehabilitation at home) and robust review.

1. **Early stroke discharge** -increase the provision of specialist intermediate care / rehabilitation for stroke in the patient's home by increasing early supported discharge capacity, reducing the length of stay in hospital and acute activity and freeing up resources.
2. **Stroke reviews** - to establish a formal stroke review service: every stroke survivor in Barnet to receive a 6 month review using the GM-SAT tool to prevent further strokes which will result in better outcomes for patients.
3. **Stroke prevention** - to support an increase in the recorded prevalence of Atrial Fibrillation in primary care, and treat them with anticoagulation across the sector using the GRASP AF tool. This is a preventative measure that will reduce the number of people having a stroke and avoiding admissions etc.

03 Falls Service:

The Falls Service will focus on preventing falls in the community by indentifying susceptible patients and facilitating education, exercise and fall recovery. Furthermore, it will work with/offer treatment from the multi-disciplinary teams to ensure a holistic approach to preventing further falls.

1. **Falls Clinic** – re-configured clinic modelled to best practice standards focussing on therapy led interventions (with medical support) to provide a seamless patient-centered, integrated and comprehensive service. Targeted to those who have fallen or those at risk of falling. To act as a the central hub for a co-ordinated falls offer in Barnet linked to primary care, falls co-ordinator and fracture liaison service. To establish clear pathways into ongoing voluntary sector strength and balance classes.
2. **Fracture Liaison Service** - aims to identify people who may be at risk of further falls or fractures within acute setting providing comprehensive assessment and specific treatment recommendations.

3. **Falls co-ordinator -** To support the development of an integrated falls system in across

Barnet and promote this across the whole health and social care economy linking voluntary sector, health and social care sector falls prevention initiatives.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All projects noted are within the workplan for the Joint commissioning unit and hence have nominated service commissioners and project plans.

Service area	Commissioning lead	Provider	Progress
Dementia – Memory assessment service	Caroline Chant	Barnet. Enfield & Haringey MHT	Operational to new spec from May 2014
Dementia - community support service	Caroline Chant	Alzheimer's Society	Operational. Re-procurement planned
Stroke – Early Stroke Discharge	Caroline Chant	Central London Community Health	Operational to new spec from April 2014
Stroke – Reviews	Caroline Chant	Central London Community Health/ Stroke Association	Operational since Summer 2013. Ramping up activity
Stroke - Prevention	Caroline Chant	Primary Care	Ongoing
Falls – Falls clinic	Ette Chiwaka	Central London Community Health/ Age UK (Barnet)	New service expected Dec 2014
Falls – Fracture Liaison Service	Ette Chiwaka	Royal Free NHS Trust	Operational since July 2013
Falls – Falls Co-ordinator	Ette Chiwaka		Recruitment underway

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

Despite the many positives that come from growing older, there is also a higher risk of deteriorating health, reduced wellbeing and lack of independence. At present, there is estimated to be 23,355 people aged 65 or over in Barnet with a limiting, long term illness.

01 Dementia service – The elderly cohort is expected to increase by more than 20% over the next ten years. The chances of developing dementia are significantly increased in old age. Barnet will experience an increase in the volume of dementia cases reported, because the life expectancy of its residents is continually increasing. In 2012, Barnet had a higher population of adults with dementia than any other London Borough (the 2012 percentage was also significantly higher than national averages). In 2014, there was estimated to be 4,000 people living in Barnet with dementia. This number is rapidly increasing (1.5 times faster than other London locations) making this a key challenge for health and social care.

02 Stroke service. - There are approximately 400 strokes per year in Barnet with an estimated health cost of £5,743 per patient (2011-12). In 2013 we identified that although mortality rates is good compared to England and London averages, hospital admission rates were significantly higher than the national average and in addition Barnet patients were significantly more likely to be readmitted

to hospital within 28 days of discharge. Evidence suggests that an appropriately resourced Early Supported Discharge service provided to a selective group of stroke patients can reduce long term dependency and institutional care (Langhorne, P. 2005; 2007) as well as being cost effective (Beech et al 1999). Alignment with the National Stroke Strategy would also require all stroke survivors and their carers to receive regular reviews of their health and social care needs.

In relation to stroke prevention the Barnet JSNA states that "unless we take steps 16% more people will suffer from strokes by 2020". This links to a growing and ageing population. In Barnet there were 4,168 cases of AF on QOF registers in Barnet (2010/11), this gives Barnet an AF prevalence of 1.1% (370,335-total list size). The national average is 1.43% and hence identifies an opportunity to close the gap. Evidence suggests that optimal management of AF in the population could reduce overall risk of stroke by 10%[i].

02 Falls service - Falls and the related injuries are amongst the most common medical problems experienced by older adults. Around 30% of over 65's living at home experience at least one fall a year, rising to 50% of adults over 80, who are living at home, or in residential care. The burden of falls is equally felt in both the acute and social care setting as it involves LAS, A&E, primary care, urgent care providers, community services, local authority and third sector. Barnet identified a growing trend in falls related admissions; with an FY 11/12 spend of £3.3m, an increase in of 10.5% since FY 09/10. This is illustrated below:

Table1: Spend on falls related activity by age group and provider in Barnet ,2011/12

	Fractured neck of femur		Other codes related to Falls		Total	
Age Band	**No of Patients**	**Cost**	**No of Patients**	**Cost**	**No of Patients**	**Cost**
65-69	8	£46,621	62	£144,273	70	£187,894
70-74	15	£114,902	57	£126,242	72	£244,143
75-120	203	£1,333,940	757	£1,543,352	960	£2,877,292
Total	**226**	**£1,462,463**	**876**	**£1,816,867**	**1102**	**£3,309,330**

Due to the preventable nature of falls, it is felt that this is an area where cost savings can be made by ensuring that there is a focus on preventing and managing falls, as well as having a seamless pathway that can deliver appropriate care to our population closer to their homes.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Note that there is overlap between a number of these services and others listed in scheme xxx. The aggregated benefits are detailed under this scheme description.

01 Dementia Service:

Locally developed Integrated Care financial model has been used to map benefits and identifies:

780 new diagnoses of dementia per year within the memory assessment service. Of which the combination of early diagnosis, and community support will lead to a 22% reduction in admissions to Care Homes based on the "Department of Health (2009) Living well with dementia: A National Dementia Strategy".

This would deliver a benefit of 44-62 care home admissions over time. With optimism bias for the time lag this has been risk adjusted to 20-25 for 15-16.

It also identifies a reduction in excess bed days (DTOC) that link into the aggregated model in scheme 2b

Key assumptions made include:

1. 22% reduction from national case but mitigated with optimism bias until local evidence supports trend
2. Assumes care reduction in care home admission of 28% assuming all 780 would otherwise enter care home, less 28% self funders)
3. Time lag in realising savings of MAS (Care home avoidance) with growing benefit over 5 years.

Total cost in BCF: £395,632

02 Stroke service:

Total cost in BCF is: £475,530

Locally developed Integrated Care financial model identifies benefits related to admissions avoidance and excess bed days (DTOC) in line with supporting business case. This is achieved through managing stays at the HASU and ASU in line with tariffs and trim points. As there is significant overlap the total numbers are outlined in scheme 2b. Cohort size for early stroke discharge is 140 per annum.

03 Falls Service:

Total cost in BCF is: £331,337. Estimates of reach of the combined falls clinic and fracture liaison service are 984 people per annum.

The financial model identifies benefits related to admissions avoidance and excess bed days (DTOC) in line with supporting business case. This relies on evidence that suggests that the various interventions can result in savings of between 25% and 35%. This is also supported by evidence from other areas of the country and NICE. The benefits model estimates relative impacts of 10%, 25% and 35% over the next 3 years. Given the overlap with other services the total numbers are outlined in scheme 2b.

Non-financial benefits are included in the embedded benefits map:

Benefits map LTC.docx

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then

prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

What are the key success factors for implementation of this scheme?

- Improved LTC management for in-scope services
- Interdependencies between service elements and other schemes (self-care) need to operate appropriately to deliver full benefits
- Professional development and support from LTC specialists is important.

Scheme ref no.
2b
Scheme name
Older Peoples Integrated Care Programme
Scheme description
The Older Peoples Integrated Care Programme, or OPIC, is the combined view of a number of different existing projects/services: Multi Disciplinary Team Case Conference (MDT), Care Navigation Service (CNS), Barnet, Community Point of Access (CPA), Risk Stratification Tool (RST), Barnet Integrated Locality Team. All focus on the delivery of assessment, care planning and co-ordination.
What is the strategic objective of this scheme?
The over-arching objectives of the services above are to: • ensure that the right people receive proactive case management in a cost effective manner • allow care providers to focus case management on individuals that will benefit most • avoid duplication e.g. multiple assessments, by providing co-ordinated care • provide a Community point of contact for health care professionals (HCP) enabling clear and responsive communications between HCP's across all sectors. • prevent unnecessary A&E attendances and unplanned hospital admissions • optimise individual patient's health status through case managed healthcare • optimise individual patient's community support through case management as well as access to social care • prevent or delay elderly admissions to long term care and packages of care • empower patients to self-care and manage their condition • improve the patient's experience. •
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
01 Multi Disciplinary Team Case Conference (MDT)

The MDT conference brings together health and social care professionals into a weekly case conference to assess and agree a care plan for the individual needs of frail and elderly patients identified as at highest risk of hospital attendance or significant deterioration in health. This is targeted at the most complex cases where standard measures have been unsuccessful or a particular risk is identified.

02 Care Navigation Service (CNS)

The Care Navigation is the interface between the MDT, the ILT and the patient. They improve the health, wellbeing and independence of frail and elderly patients through the provision of case management, care co-ordination and signposting. Target cohort generally originates from the MDT or the ILT. Over time the team will become an integral part of the ILT.

03 Barnet Integrated Locality Team

Currently being piloted as a trail- blazer team, this is an MDT comprising health and social care professionals, mental health support and end of life support and voluntary sector input. The teams will come together into a single unit to develop a joint assessment and care planning approach that links directly with users and carers. They will support adults in the community, in partnership with local GPs, who are living with multi-morbidity and complex long term conditions. This is based on the successful models based in Greenwich and other areas.

04 Risk Stratification Tool (RST)

A software based risk stratification tool is being used to indentify frail and elderly patients at risk of future unplanned hospital attendance or deterioration in health.

05 Barnet Community Point of Access (CPA)

The Barnet Community Point of Access acts as a central point to receive and manage referrals for adult community health services, ensuring urgent and non-urgent referrals and requests are pro-actively managed to enable rapid co-ordinated care and effective planned care. Urgent calls are identified quickly and services deployed to prevent admissions and to support longer term care.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All projects noted are within the workplan for the Joint commissioning unit and hence have nominated service commissioners and project plans.

Service area	Commissioning lead	Provider	Progress
MDT	Muyi Adekoya	Various across health & social care	Operational since July 2013
CNS	Muyi Adekoya	Central London Community Health	Operational since May 2013
ILT	Muyi Adekoya	Various across health & social care	Trail blazer team live – August 2014
Risk stratification	Muyi Adekoya	United Health	Accelerated deployment July/Aug 2014
Community Point of Access	Muyi Adekoya	Central London Community Health	Operational since April 2014

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

A systematic review of integrated care (IC) report findings (over the last 10 years) as outlined in the HWB fact pack showed that of the 16 services that had assessed support for MDT's, 81% found that interventions had a positive impact on their IC programme. In addition, all reviews concluded that specialised follow ups by a multidisciplinary team reduces hospitalisations. The average impact of an MDT was a 15-30% reduction in hospitalisation (impact measured across systematic reviews).

57% (8 out of 13) of those who assessed care coordination said that it was an important component of integrated care. An average taken from two reviews showed that care coordination reduced hospitalisations by 37%.

64% (7 out 11) of those who assessed care plans found a positive impact. An average from 2 reviews suggested that hospitalisations were reduced by 23%.

This evidence is also backed up by feedback and benchmarked activity from areas such as Tower Hamlets, Torbay and Liverpool which have seen significant reductions in acute activity.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Aggregated benefits of a number of services are aggregated in the table below:

Avoided admissions	**activity**	**1099**
	value	**£2,004**
		£2,246,356
Excess bed days reduction	**activity**	**501**
	value	**£265**
		£132,765
Reablement	**activity**	**21**
	value	**£3831**
		£80,451
Total	**value**	**£2,359,572**

Key assumptions from the financial model:

- Service lines included are Dementia (non-elective admissions), Falls, Stroke, MDT, care navigation, Integrated Locality Team and Rapid Care**.** Overlap from various service elements is evened out through aggregating the data as a single benefit across multiple service lines
- No benefits from CPA and RST included
- Benefits model based on evidence based reduction of most at risk cohort identified from risk stratification (1992 people). This is supported by the financial model.

- Optimism bias applied to account for service user interventions where there would not have been an admission
- This approach is in keeping with local planning and monitoring of QIPP plans
- Approach will accommodate planned changes to service structure over 14-15 in line with the development of ILT.

Costs in BCF: £992,961

Benefits Map – OPIC:

Benefits Map 3 - OPIC (Annex 3).docx

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

What are the key success factors for implementation of this scheme?

- Fully integrated OPIC service with seamless transition between elements
- Interdependencies with other services in terms of benefits
- Primary care engagement in care co-ordination and MDT role

Scheme ref no.

2c

Scheme name

Care Home Locally Commissioned Service - LCS

Scheme description

A locally commissioned service to provide increased resource to GPs to improve the level of care provided in care homes throughout the borough.

What is the strategic objective of this scheme?

<u>The objectives of the LCS scheme include:</u>

- To improve the **quality of care** in homes and improve the relationship between the care

home and the GP

- To commission a distinct service for care homes including a fortnightly ward round, 6 monthly holistic reviews, post-admission reviews and medication reviews (over and above the service commissioned under current GP GMS and PMS contracts).
- To increase the level of **proactive and preventative care** given in care homes, anticipating when issues may arise and preventing crisis
- To increase management of patients to reduce **avoidable emergency admissions**
- To support people's preference of place of death through advanced care planning.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Many GP practices provide care to people within care homes; however, it is acknowledged that this group have higher needs than the general population. Therefore, a locally agreed service has been commissioned by Barnet CCG, in addition to the essential and specialised services within the GMS/PMS contract.

The service includes all care homes, including homes for elderly people and people with learning disabilities or multiple disabilities. The expected input from GPs is:

- increased proactive GP input into care homes
- introduction of weekly GP ward rounds (with care home nurses as appropriate) in particular focussing on new admissions to the home and patients who have been recently discharged from hospital, ensuring that a medical review is carried out and a care plan is in place
- introduction of a 6 monthly holistic review of all patients under the care of the GP
- support the home with planning and delivery of end of life care, meeting the gold standards for such care, and
- closer working with the home to promote high standards of clinical care within the home.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioning lead: Emma Hay

Service has been launched in September 2014 and we are currently undertaking implementation with GPs.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

The ageing population in Barnet poses major challenges to the health and social care sector, in particular how we continue to allocate resources to meet needs. The care market in Barnet is dominated by residential care; there are **104 nursing and residential homes for elderly care and 45 care homes** that cover mental health, learning disability and multiple disability. In total, these homes provide approximately **3,051 beds** for a range of older people and those with mental health issues or learning disabilities. Please see the 'Integrated Care – Managing Crisis Better' business case for the full background.

Many GP practices (44 in Barnet) provide care to people within care homes, however, it is

acknowledged that this group have **higher needs** than the general population and therefore, a service is required in addition to the essential and specialised services within the GMS/PMS contract. The LCS is distinct to the 'Avoiding Unplanned Admissions Enhanced service' commissioned by NHS England and focuses primarily on increased medical care into homes.

Based on the evidence available and the results of the recent care home pilot in Barnet, investment is required in order to raise standards of care and reduce admissions to secondary care. This LCS service therefore, aims to address concerns around the levels of proactive care currently received by residents in homes which leads to high levels of emergency admissions and people dying unnecessarily in hospital.

The Care Home Pilot - 2013

The recent 'care home pilot' in 2013, worked with 5 care homes, with the main objective of focusing on improving outcomes for Care/ Nursing Home residents within Barnet. The pilot focused on the implementation of changes to the way in which health and social care practitioners work within care homes. A key recommendation was for a consistent approach to daily management of medical input to care homes (in particular where support is provided by more than one GP practice) and the introduction of a weekly minimum half day round per care home (£18,000 per year).

The data

Data analysis of admissions into hospital from care homes conducted for 2012/13 revealed that, emergency admissions increased by 5% compared to the previous year (2011/12), costing an additional 27% on the back of more expensive mix of HRGs and unfavourable adjustments to the national tariff which totalled £6,618,774 (A&E and emergency admissions). Of the 2,328 people in care homes (2012/13), there were 1,394 A&E admissions with an average of 2 attendances at A&E for those with at least 1 attendance at A&E per year. In addition, the total cost of secondary care usage (A&E, outpatient, follow up, procedures) in 2012/13 amounted to £7,104,408.31 for patients with an NHS number who were living in care homes[1].

Due to changes in data access, a similar analysis has not been available in 2013/14, although data revealed that over a 10 month period (April 2013-January 2014) there were 554 inpatient admissions of the 3,051 residents in care homes costing a total of £1,830,414;

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Benefits will manifest primarily in terms of reduced accident and emergency attendances and admissions avoidance; and it is assumed that will accrue from December 2014 onwards. The scheme will be available for all GP practices and hence has an estimated target cohort of 2328 people. Optimism bias has been applied to account for those homes/GP practices that do not participate.

Given the overlap with other schemes the target reduction is included in scheme 2b.

[1]Report produced by Barnet PCT, Informatics team

Benefits Map – Care Home Locally Commissioned Service

Benefits Map 5 - LCS (Annex 5).docx

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

What are the key success factors for implementation of this scheme?

- GP engagement and delivery of scheme
- Buy in from care Homes and change in practice in terms of managing a higher proportion of care in the home environment

Scheme ref no.

3

Scheme name

Rapid Care - **Tier 4**

Scheme description

The Rapid Care Service works to deliver an immediate response to a health crisis. The duties they perform include:

- arranging appropriate services
- assessing for delivering nursing care as required e.g. provision of IV antibiotics,
- enablement services.

What is the strategic objective of this scheme?

<u>The objectives of this scheme are to put in place the following services:</u>

- extended hours service that provides full rapid assessment of health and social care need
- Ambulatory Assessment Diagnostic And Treatment Service
- Telehealth pilot in Care Homes.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The primary aims of the Rapid Care expansion are to reduce unnecessary hospital admissions, better manage acute complications, and support end of life care so that people can remain in their own homes as long as possible. This will be achieved by providing urgent care for older people/people with LTC's and improving crisis response/support services. In addition, the expanded service will also work to improve frail and elderly access to quality acute health care community intervention.

Key service deliverables:

- Triaged response via Community Point of Access
- 2 hour response time
- 7 day service
- Use of skill mix including emergency nurse practitioners
- Consultant cover

Target groups are all over 65s at risk of admission. Operational delivery is targeted towards those conditions that we have identified as high volume e.g. pneumonia, urinary tract infection and heart failure.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioning lead: Muyi Adekoya

Rapid Response has been operational for a number of years but a significant planned expansion occurred between October 2013 and April 2014. This included a move to 7 day provision and availability later into the evening. It also introduced the emergency nurse practitioner role and telehealth pilot. The provider in Central London Community Health.

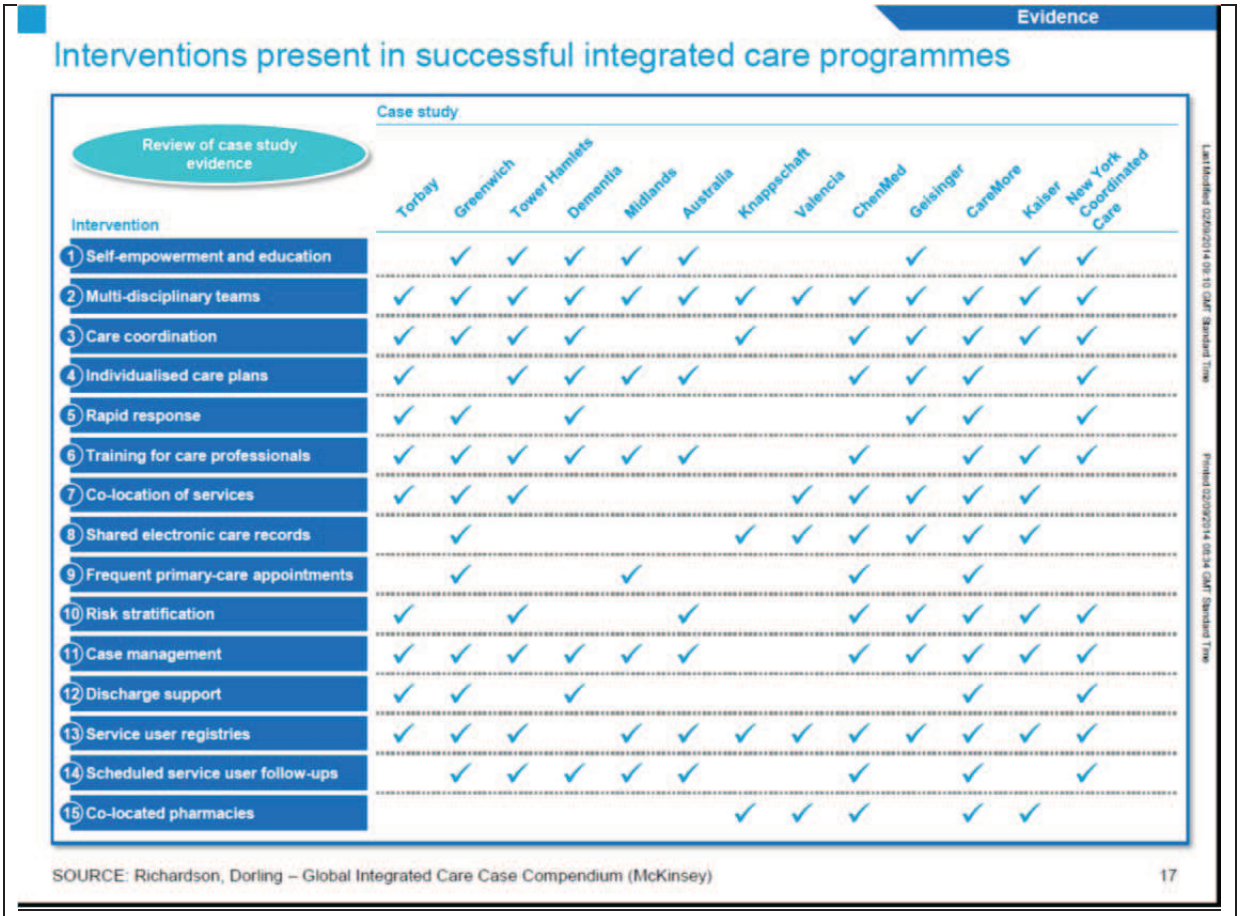
The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

Rapid response is identified as key intervention present in a successful integrated care programme (see below).



Evidence also suggests that hospital admissions can be reduced through active management of ambulatory care-sensitive conditions (ASC). Five conditions account for half of all ASC admissions, of which three disproportionately affect older people (urinary tract infection/pyelonephritis, pneumonia and chronic obstructive pulmonary disease (COPD)).

The evidence (Purdy S (2010)) highlights key three factors for reducing avoidable admissions:

- Early identification of ambulatory care-sensitive conditions. This may be through clinical knowledge, threshold modelling (rules based, where people are judged against certain criteria) and in particular predictive modelling (using risk stratification).
- Increased continuity of care with a GP
- Early senior review in A & E, and structured discharge planning

The combination of OPIC and Rapid Care therefore target this cohort for maximum impact by providing the immediate response to the crisis and then managing ongoing care and preventing recurrence.

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Benefits will manifest primarily in terms of reduced accident and emergency attendances and admissions avoidance. It will also contribute to the reablement target as it links very robustly with

our PACE and TREAT teams operating in the acute hospitals and intermediate care. The service expanded from October 2013 and we are seeing benefits accruing now.

Given the overlap with other schemes the target reduction is included in scheme 2b.

Benefits Map – Rapid Care:

Benefits Map 4 - Rapid Care (Annex 4)

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

What are the key success factors for implementation of this scheme?

- Stakeholder buy in to support referrals particularly primary care
- Interdependencies with other services such as PACE and TREAT

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Barnet
Name of Provider organisation	Royal Free NHS Foundation Trust
Name of Provider CEO	David Sloman, however report is signed off by Kim Fleming (Director of Planning)
Signature (electronic or typed)	Kim Fleming

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	29135
	2014/15 Plan	29502
	2015/16 Plan	30002
	14/15 Change compared to 13/14 outturn	+367(+1.2%)
	15/16 Change compared to planned 14/15 outturn	+500 (+1.6%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	134
	How many non-elective admissions is the BCF planned to prevent in 15-16?	891

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We are aware of Barnet CCG plans and have been engaged in the Better Care Fund discussions. We are committed to working with Barnet CCG both now and in the future on this plan, however we are not in a position to sign off these activity reductions as we need to understand how the individual schemes explicitly link to the reductions planned.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	As above
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	As above

[i] *Commissioning for Stroke Preventon in Primary Care -The Role of Atrial Fibrillation June 2009*
http://www.improvement.nhs.uk/heart/Portals/0/documents2009/AF_Commissioning_Guide_v2.pdf

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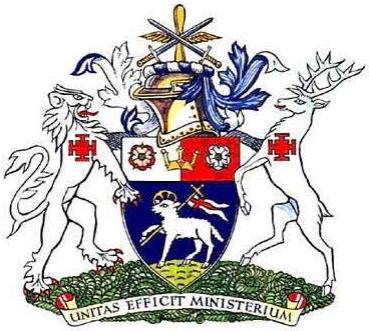
AGENDA ITEM 12.1

	**Council** **4th November 2014**
Title	**Proposed disposal of former Park Keepers Lodge, Victoria Park, Long Lane, Finchley, N3**
Report of	Chief Operating Officer
Wards	West Finchley
Status	Public
Enclosures	Site Plan 24158
Officer Contact Details	James Goodchild Phone: 020 8359 2937 Email : james.goodchild@barnet.gov.uk

Summary

Victoria Park Lodge is a two-bedroom detached former park keeper's lodge located on the periphery of Victoria Park.

The Lodge is a Trust property and was previously used as a park keeper's cottage in accordance with the requirements of the Trust. The Trust limits the use of the building to this purpose and as there is no requirement for a park keeper's lodge. Disposal of the building was sought from Cabinet Resources Committee (CRC) in 2009.

Following CRC approval to dispose of the property there has been significant correspondence with the Council's lawyers and Charity Commission in order to ensure that any disposal accords with the requirements of the Trust.

A significant amount of money, estimated at £100,000, is needed to bring the lodge up to decent homes standards that would allow it to be used as residential accommodation; however, use for residential accommodation other than that of a park keeper is not consistent with the requirements of the Trust. If the Full Council agrees to the sale of the property in accordance with the Charity rules, the property will then be removed from the

Trust.

The decision to dispose will need to be taken by Full Council as advice obtained from the Council's solicitors is that the decision to dispose of Victoria Park Lodge can only be taken by the Full Council, acting collectively as Trustee.

Recommendations

That Council as Trustee of the Victoria Park Trust :-

1. **Agrees that the Lodge is no longer required for the purposes of the Trust.**

2. **Agrees that the interests of the Trust would be better served by investing the proceeds of sale in the continuing maintenance and improvement of Victoria Park.**

3. **Authorises the marketing of the Lodge for disposal in the manner that will secure the best price as advised by the independent surveyor required to be appointed under charity law.**

4. **Authorises the Chief Operating Officer to take all steps necessary to secure the sale of the freehold or long leasehold interest in the Lodge in accordance with the Charity Commission's requirements and the recommendations of the appointed surveyor, to negotiate terms with prospective purchasers and to approve the final terms of any sale contract and transfer deed.**

5. **Authorises the Chief Operating Officer to appoint the necessary professionals to conduct the sale, in accordance with charity law, the fees of such professionals to be discharged from the sale proceeds.**

6. **Notes that the proceeds of sale of the Lodge must be held in a ring-fenced fund to defray future running costs relating to Victoria Park and carry out improvements.**

1.0 WHY THIS REPORT IS NEEDED

1.1 Victoria Park Recreation Ground, including the Lodge, was gifted to the Council in February 1900, following donations received by public subscription to create a park commemorating the diamond jubilee of Her Majesty Queen Victoria. The conveyance creating the Trust recites that the land is to be held "on trust as a public ground … for the purposes of the Recreation Grounds Act 1859". As this is a Charitable Trust administered by the Council, a decision by the council as Trustee is required in order to dispose of the park keeper's lodge.

1.2 Victoria Park Lodge is a two-bedroom detached former park-keeper's lodge located on the periphery of Victoria Park.

1.3 In accordance with the Trust the Lodge was used as a park keeper's cottage and subsequently was used as temporary hostel accommodation pending a decision on its future. Following Cabinet Resources Committee on 2nd November 2009 where consent to dispose was approved, there has been significant correspondence with the Council's lawyers and the Charity Commission in order to ensure that any disposal accords with the requirements of the Trust and of charity law, which requires all proceeds to be used for the benefit of the park and the local populace.

1.4 The building needs an estimated £100,000 expenditure to bring it to decent homes standard which would be required to be able to use it as housing. However, housing accommodation, other than that of a park keeper, is not permitted within the requirements of the Trust and the lodge should not have been used as temporary accommodation in the past.

1.5 The maintenance and management budget for the Park is currently provided by the Council, and any funds from the sale of the Lodge will be ring-fenced to maintain and improve the Park, particularly addressing works that have been on hold due to the funding gap.

1.6 Works that could be carried out are:

- Improvements to the play areas in terms of both the variety and quantum of equipment available. It is hoped that this could pay for replacement and additional play equipment in the children's play area.
- Refurbishment of the tennis courts, two of which are currently closed as they are unsafe and require a complete re-build. The remaining four require a new top coat of acrylic sports surface and new lines.

1.7 The extent of the works and details of their implementation will be known once the disposal figure has been secured. Approval to carry out the work will be sought from the Trustee at this time.

1.8 Delegating the Trustee's powers to a committee is not permissible for Victoria Park Trust. The power to delegate has to be expressly set out in the instrument creating the trust. A Charity Commission Scheme was not used and therefore there is no document which allows the Trust to delegate its powers to a committee of the Council.

2.0 REASONS FOR RECOMMENDATIONS

2.1 There is no longer a requirement for a park keeper to oversee the running of Victoria Park and within the rules of the trust the lodge can only be used for this purpose. Disposal of the lodge is sought in order that the lodge is removed from the restraints of the Trust and the proceeds of sale can be applied to improve Victoria Park.

2.2 The capital receipt from the sale of the lodge will be ring-fenced and the Trust will be able to use the money to maintain and improve the Park.

2.3 The Full Council who are the Trustees are able to make the decision to sell the property and this report seeks approval to dispose of the lodge in accordance with the recommendations.

3.0 ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 To use the Lodge as temporary general needs housing. However, investigations found that this was not allowed within the objects of the Trust.

3.2 Barnet Homes reviewed the possibility of them acquiring the property, which, in keeping with the requirements of the Trust, would have to be at market value. There would also have to be a process to demonstrate best consideration. However after review Barnet Homes reported that an investment at market value plus the cost to refurbish would not make this a viable proposition. In addition and more importantly, the location of the property is not suitable for the provision of affordable or indeed temporary accommodation which would lead to increased management costs.

4.0 POST DECISION IMPLEMENTATION

4.1 An independent surveyor will be appointed, in liaison with the Charity Commission, to advise on the value, marketing strategy and appropriate basis of disposal for the property.

4.2 The proceeds from the sale of the Lodge will be reinvested by the Full Council, as Trustee of Victoria Park, in accordance with the objects of the charitable trust, namely the preservation and upkeep of Victoria Park as a public recreation ground.

5.0 IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Council should make its decision based on the best interests of the Trust alone, disregarding factors that are irrelevant to the Trust. The Council's own interests are therefore not a material consideration.

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

5.2.1 The property is held under a charitable trust and does not form part of the Council's corporate estate. The Lodge would require approximately £100,000 to make the property habitable to decent homes standards, which the Trust does not have.

5.2.2 Any capital receipt obtained from the disposal of the Lodge will be used solely for the funding of infrastructure improvements to Victoria Park.

5.2.3 The Council presently funds all the maintenance to the Park.

5.3 Legal and Constitutional References

5.3.1 Victoria Park Recreation Ground, including the Lodge, was transferred to the Council in February 1900, to be held on trust as a public ground for the purposes of the Recreation Grounds Act 1859 and is held on charitable trust. The Recreation Grounds Act 1859 required such land to be held as "open public grounds for the resort and recreation of adults, and as playgrounds for children and youth, or either of such purposes". The Recreation Grounds Act 1859 was repealed by the Charities Act 1960, which was repealed by the Charities Act 2006. The Charities Act 2011 consolidated the majority of the Charities Act 2006.

5.3.2 The Council is the sole corporate trustee of this land. It is clear from the 2nd November 2009 Cabinet Resources Committee minutes that the Committee, at that time, were unaware that the Lodge was a Trust asset. The Committee resolved to sell the Lodge on the basis it was a Council asset which is inaccurate. As this land is held on trust by the Council as corporate trustee, whatever decisions the Council makes it must do so as the corporate trustee, rather than in its usual capacity as beneficial owner. In brief, this means that decisions taken must be in the best interests of the Trust and in accordance with the objects of the Trust.

5.3.3 Charity Commission's "best practice" advice is to keep the management of the charity separate, as far as possible, from the business of the local authority. Moreover, the finances of the Trust must be kept separate from those of the Council. The assets must be accounted for separately and income and expenditure should be channelled through discrete cost centres. The local authority may top up the finances of the Trust but **no funds may pass from the trust into the Council's own accounts**.

5.3.4 As the whole of Victoria Park Recreation Ground is designated land of the charity - meaning that the whole or most of the land cannot be disposed of and not replaced without effectively preventing the fulfilment of the charity's objects - the sale of Victoria Park Lodge must be advertised in accordance with section 121 of the Charities Act 2011. The Trustee also needs the authority of the Charity Commission to dispose of designated land. Previous correspondence with the Charity Commission has stated that their formal consent is not required, owing to the very small area of the Lodge by

comparison with the total area of the Park. It is not necessary therefore to make any further application to the Commission prior to the Lodge being marketed for disposal.

5.3.5 The notice period must be for at least a month and all representations have to be considered. Notices will be posted on the property and in the local newspaper. This requirement is separate to the requirement for advertising for the purposes of obtaining the best price, which is discussed below at para. 5.3.7.

5.3.6 The public open space requirements do not need to be followed in addition, notwithstanding that this land is held for the purposes of public recreation, as the Trustee will not be disposing of it pursuant to section 123 of the Local Government Act 1972. The power on which the Trustee is relying when it disposes of the land is in fact the power of sale found in section 6 of the Trusts of Land and Appointment of Trustees Act 1996.

5.3.7 Under s. 117 - 120 of the Charities Act 2011 the Trustee must comply with the following procedures:

a) it must obtain a written report from a qualified surveyor independent from the council - see below;

b) it must advertise the disposal (unless the surveyor recommends not to);

c) the Trustee must decide that it is satisfied that the terms for the disposal are the best that can reasonably be obtained.

5.3.8 In addition, certain statements and certificates have to be made in the agreement for sale and the transfer deed confirming compliance with the above statutory procedures.

5.3.9 The qualified surveyor chosen by the Trustee must be a person who:

a) is professionally qualified; for example, a Member or Fellow of the Royal Institution of Chartered Surveyors (RICS); and

b) the Trustee reasonably believes to have the ability in, and experience of, valuing land of the particular kind and in the particular area in question.

5.3.10 The contents of the report to be provided by the surveyor must conform to certain regulations - the Charities (Qualified Surveyors' Reports) Regulations 1992 - which the surveyor if he or she has experience of acting for charities, should be familiar with.

6.0 Risk Management

6.1 Due to its relatively isolated location, the property is vulnerable to squatting, vandalism and fly-tipping. The property has been boarded up with perforated metal security screens, and regular inspections have been undertaken to

ensure this risk is minimised.

6.2 Failure to dispose of the freehold or grant a long lease would result in the building remaining empty for the foreseeable future leading to further deterioration of the property, as there are currently no funds available within the Trust to maintain it, and alternative uses are required to be consistent with the objects of the Trust.

7.0 Equalities and Diversity

7.1 The Council is committed to improving the quality of life and wider participation for all in the economic, educational, cultural, social and community life of the Borough.

7.2 It is considered that the proposal will not give rise to any issues under the Council's Equalities Policy and will not compromise the Council in meeting its statutory equalities duties.

8.0 Consultation and Engagement

8.1 The following relevant West Finchley Ward Councillors have been notified:

- Cllr Ross Houston,
- Cllr Jim Tierney, and
- Cllr Kath McGuirk.

9.0 BACKGROUND PAPERS

9.1 Cabinet Resources Committee, 2 November 2009 (Decision item 12) – resolved that Victoria Park Lodge be declared surplus to the Council's requirements; that the occupiers be decanted into suitable alternative accommodation; that the Council's freehold interest in the property be offered for sale by non-binding tender on the open market; and that the sale be completed to the highest bidder; subject to the price exceeding £370,000.

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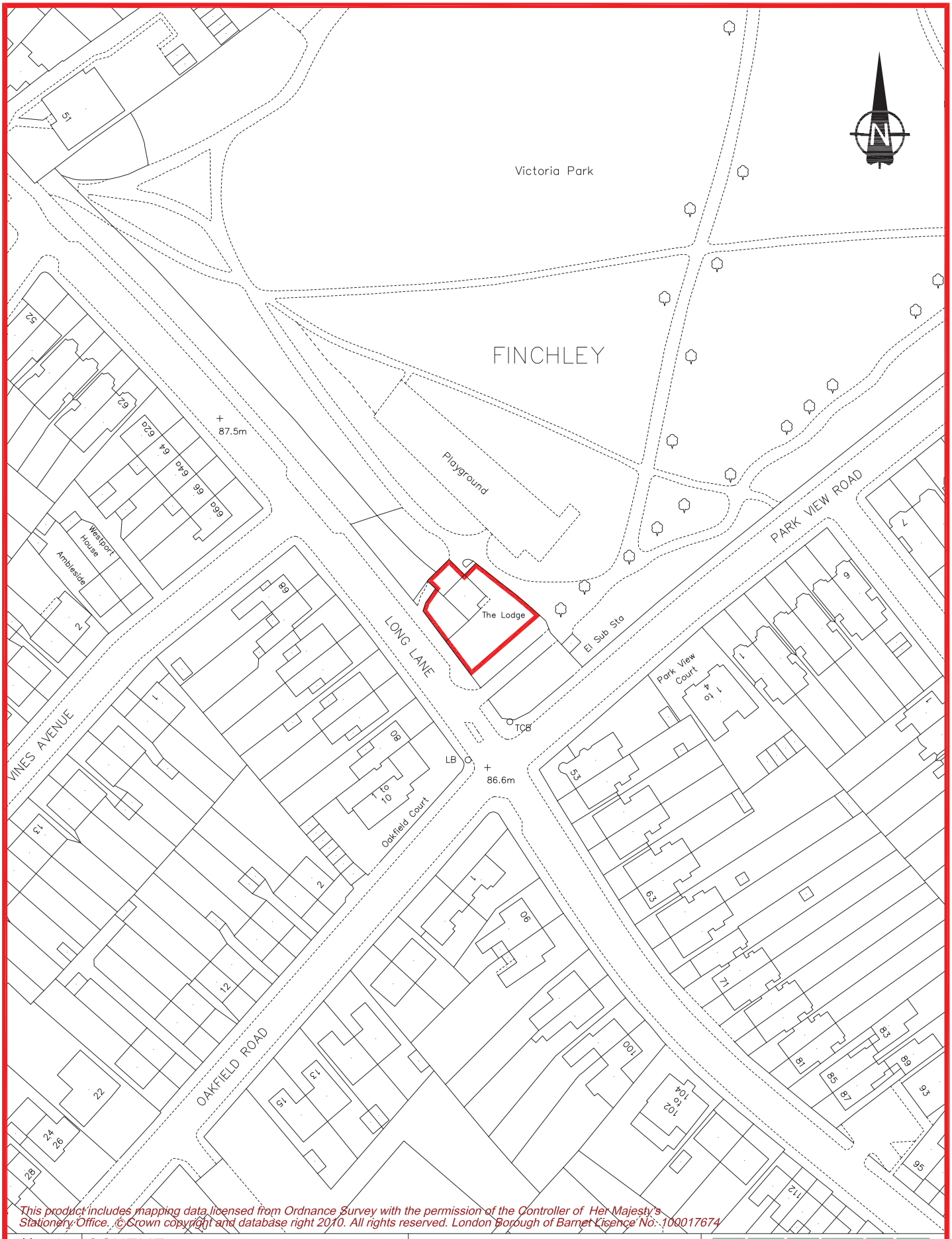

Initiated by A.S.	SCHEME: VICTORIA PARK LODGE LONG LANE, FINCHLEY, N3 2PY	Craig Cooper, Commercial Director.	BARNET LONDON BOROUGH VALUATION SECTION
Drawn by K.E.B.	TITLE: PROPOSED DISPOSAL	London Borough of Barnet, North London Business Park, Oakleigh Road South, New Southgate, London, N11 1NP. Tel. 020 8359 2000	DRAWING No. 24158 245
Checked by A.S.			
Date 21/06/10	Scales 1:1250		

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AGENDA ITEM 12.2

COUNCIL

4 November 2014

Title	**Report of the Head of Governance**
Report of	Head of Governance
Wards	All
Status	Public
Enclosures	Appendix A – Resignation of Independent Member of the Audit Committee Appendix B – Designation of the Monitoring Officer Appendix C – Change to the Calendar of Meetings
Officer Contact Details	Andrew Charlwood, Head of Governance (Acting), 020 8359 2014, andrew.charlwood@barnet.gov.uk

Summary

This item presents various constitutional and administrative matters for Council's agreement. Full details are as set out in the appended reports.

Recommendations

1. WHY THIS REPORT IS NEEDED

1.1 The Head of Governance report seeks Council's approval for various matters of business relating to the Council's statutory and constitutional functions.

2. REASONS FOR RECOMMENDATIONS

As set out in the attached Appendices.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 N/A

4. POST DECISION IMPLEMENTATION

4.1 Council decisions will be minuted and implemented through the Head of Governance.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 As set out in attached Appendices.

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

Any specific implications are set out in the attached Appendices.

5.3 **Legal and Constitutional References**

5.3.1 Constitution- Article 4-The Full Council and Responsibility for Functions- Section 1- Functions of Full Council

5.4 **Risk Management**

5.4.1 As set out in attached Appendices.

5.5 **Equalities and Diversity**

5.5.1 As set out in attached Appendices.

5.6 **Consultation and Engagement**

5.6.1 None specifically arising from this report.

6. BACKGROUND PAPERS

6.1 None.

Appendix A

RESIGNATION OF INDPENDENT MEMBER OF THE AUDIT COMMITTEE

Council have received notification that the Debra Lewis, an Independent Member of the Audit, has resigned her position with immediate effect. A recruitment exercise to fill the vacancy will be completed as soon as practicable.

RECOMMEND – That Council note the resignation of the Independent Member of the Audit Committee.

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Appendix B

DESIGNATION OF THE MONITORING OFFICER

Council are requested to note the decision of the Chief Executive to designate Peter Large, currently seconded to the Council as Interim Legal and Governance Adviser, as the Council's Monitoring Officer for the purposes of Section 5 of the Local Government Act 1989 for an interim period. Details of the decision can be accessed here: http://barnet.moderngov.co.uk/ieDecisionDetails.aspx?ID=5487

The Chief Executive's decision to designate the Monitoring Officer included a provision that the decision taken in the report, together with recommendations regarding any consequential changes to the Constitution, would be reported to the Full Council on 4 November.

RECOMMEND – That Council note the designation of Peter Large as the Council's Monitoring Officer for the purposes of Section 5 of the Local Government Act 1989 for an interim period.

RECOMMEND – That Council approve the following consequential changes to the Constitution:

Article 9 – Chief Officers Amend 9.01 (c) – delete "Assurance Director" and replace with "Interim Legal and Governance Adviser"

Responsibility for Functions, Annex B, Scheme of Delegated Authority to Officers Under 'Delegated Authority to the Monitoring Officer' delete the following provision and allocate to the Chief Operating Officer for an interim period:

"The delivery of all assurance functions for the Council including the functions of the Corporate Anti-Fraud Team and Internal Audit."

For the avoidance of doubt, Council are requested to note that functions relating to Risk Management will also be allocated to the Chief Operating Officer.

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Appendix C

CHANGE TO THE CALENDAR OF MEETINGS

The following changes have been made to the Calendar of Meetings in accordance with Section 4.2 of Meeting Procedure Rules.

Committee	**Date of Meeting**
Remuneration Committee	11 November 2014

RECOMMEND – That Council note the changes to the Calendar of meetings as set out in the above table.

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Council: Tuesday, 4 November 2014

Motion: Councillor Anne Hutton

AGENDA ITEM 14.1

Save our Library Service

Council condemns the administration's proposals published recently to cut our public library service budget by 60% by closing up to 6 libraries, drastically reducing the square footage of libraries and severely cutting staff to leave libraries unattended 50% of the time.

Council notes the Conservative administration's poor record on libraries, including their closure of Totteridge library despite the current Leader of the Council standing for election to 'save' it, the failed attempt to axe South Friern Library, the shambolic attempt to close Friern Barnet library resulting in the occupation of the building and subsequent costly court case, and the money wasted on a feasibility study to 'reprovide' Friern Barnet library in the Artsdepot.

Council believes that our valued local libraries are not safe in the Barnet Conservatives' hands, and that these current plans will decimate our library service and deprive the local communities they serve.

Council therefore demands that the Conservative administration withdraw the proposals and present plans that fully support Barnet's excellent library service.

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Council: Tuesday, 4 November 2014

Motion: Councillor Tom Davey

AGENDA ITEM 14.2

Protecting residents from domestic violence

Council abhors domestic violence and notes the severe and sometimes life-long impacts it has upon victims. Council recognises it has a duty to help safeguard against abuse, protecting those at risk and supporting efforts to prosecute perpetrators.

This is a duty the council takes seriously and has sought to reflect in its Housing Allocations Policy. Council notes that the proposed changes are designed and intended to help remove residents at risk of domestic violence from immediate harm. Council recognises that the previous policy encouraged people at risk to remain in harm's way by giving them a false sense of imminent housing through being in Band 1. Alternative accommodation was not always readily or swiftly available. The new scheme gives victims the option of presenting for immediate shelter where the level of threat means they are at risk by remaining where they are. Council believes giving people access to immediate accommodation is an important safeguarding step.

Council further notes that, once safe, more permanent re-housing arrangements can be explored, with existing secure tenancies being retained.

Council regrets that this change to the Allocations Policy has been misunderstood or misrepresented and used for political campaigning.

Council calls for the implementation of the policy to enable immediate access to safe accommodation for residents who are at risk, or victims, of domestic violence and for the council to work with partner organisations to ensure people are fully aware of their options should the situation sadly arise.

Under Full Council Procedure Rule 23.5: if my item is not dealt with by the end of the meeting I ask that it be voted upon at the Council meeting.

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