MEETING
ADULTS AND SAFEGUARDING COMMITTEE
DATE AND TIME
THURSDAY 2ND OCTOBER, 2014
AT 7.00 PM
VENUE
HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4AX

TO: MEMBERS OF ADULTS AND SAFEGUARDING COMMITTEE (Quorum 3)

Chairman: Councillor Sachin Rajput
Vice Chairman: Councillor Tom Davey

Councillors

Tom Davey
Barry Rawlings
Philip Cohen
Pauline Coakley Webb
Helena Hart
David Longstaff
Reema Patel
Reuben Thompstone

Substitute Members

Councillor Anthony Finn BSc (Econ) FCA
Councillor Anne Hutton
Councillor Brian Gordon
Councillor Ammar Naqvi
Councillor Daniel Thomas BA (Hons)
Councillor Jim Tierney

You are requested to attend the above meeting for which an agenda is attached.

Andrew Nathan – Head of Governance

Governance Services contact: Anita Vukomanovic 020 8359 7034
anita.vukomanovic@barnet.gov.uk

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	MINUTES	1 - 4
2.	ABSENCE OF MEMBERS	
3.	DECLARATIONS OF MEMBERS DISCLOSABLE PECUNIARY INTERESTS AND NON-PECUNIARY INTERESTS	
4.	REPORT OF THE MONITORING OFFICER (IF ANY)	
5.	PUBLIC QUESTIONS AND COMMENTS (IF ANY)	
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12.	ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT	

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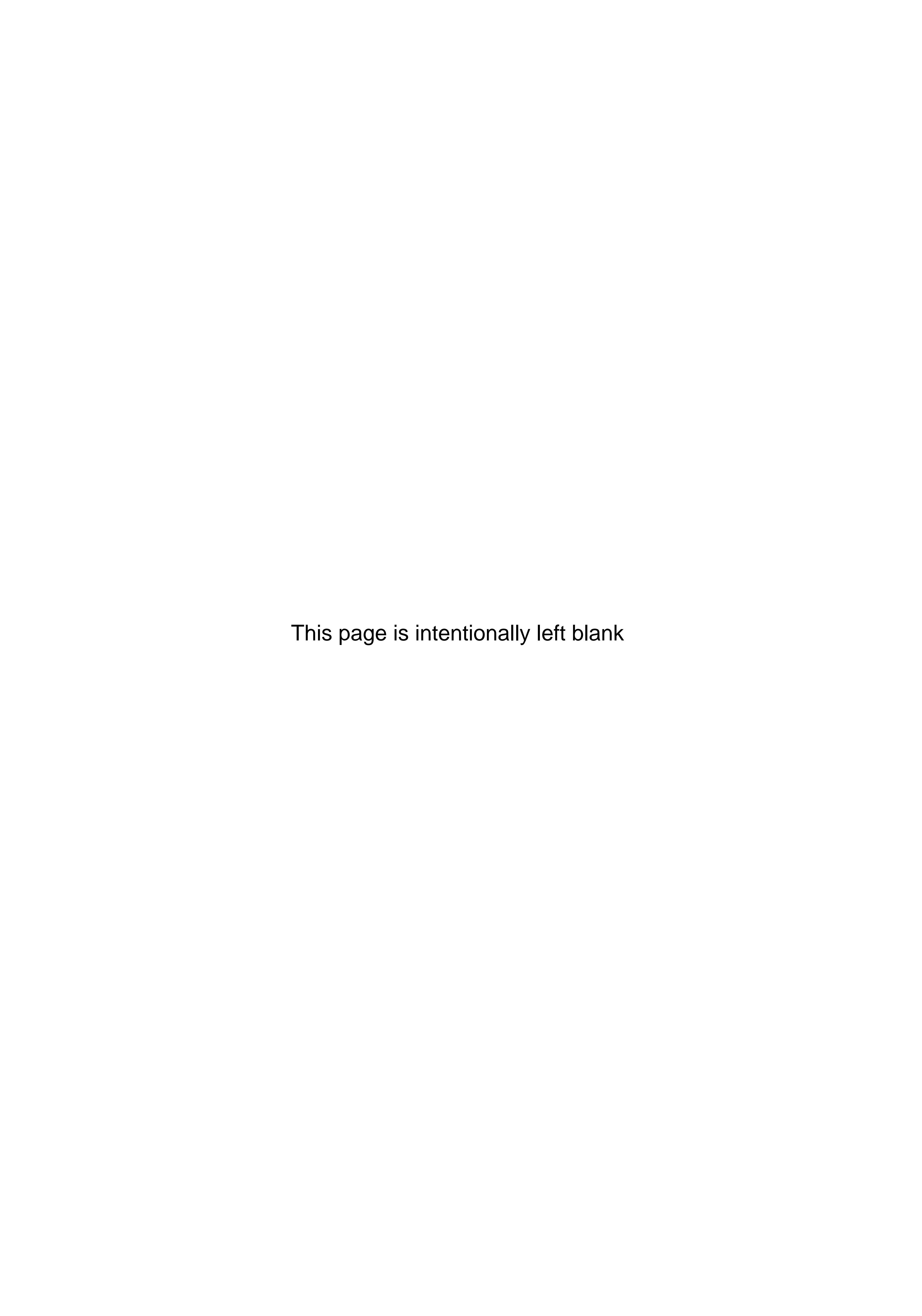

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Decisions of the Adults and Safeguarding Committee

31 July 2014

Members Present:-

AGENDA ITEM 1

Councillor Sachin Rajput (Chairman)
Councillor Tom Davey (Vice-Chairman)

Councillor Barry Rawlings
Councillor Philip Cohen
Councillor Pauline Coakley Webb
Councillor Helena Hart
Councillor David Longstaff
Councillor Reema Patel
Councillor Reuben Thompstone

1. MINUTES

RESOLVED that the minutes of the meeting of 2 July 2014 be agreed as a correct record.

2. ABSENCE OF MEMBERS

There were none.

3. DECLARATIONS OF MEMBERS DISCLOSABLE PECUNIARY INTERESTS AND NON-PECUNIARY INTERESTS

There were none.

4. REPORT OF THE MONITORING OFFICER (IF ANY)

There were none.

5. MEMBERS' ITEMS (IF ANY)

At the invitation of the Chairman, Councillor Barry Rawlings introduced the Member's Item in his name, and provided an overview of the Member's Item, which sought to establish a working group that took evidence from service users and people involved within service delivery.

The Chairman proposed the following motion, which was seconded by Councillor Helena Hart:

"To establish a working group to inform the development of the specification for adult mental health social care. The working Group should take evidence from Health Partners, the Police, the Department for Work and Pensions, housing providers, voluntary organisations, and users and carers.

Votes were recorded as follows:

Agreed	10
Opposed	0
Abstentions	0

The motion was carried.

RESOLVED that the Committee request that Officers make arrangements for a working group to inform the development of the specification for adult mental health social care, which will take evidence from Health Partners, the Police, the Department for Work and Pensions, housing providers, voluntary organisations, and users and carers.

6. PUBLIC QUESTIONS AND COMMENTS (IF ANY)

Details of the questions asked and the published answers were provided with the agenda papers for the meeting. Verbal responses were given to the supplementary questions at the meeting.

There were no public comments.

7. ADULTS AND COMMUNITIES BUSINESS PLANNING

The Committee considered the report.

Referring to the report, a Member commented that they would want to see more information within the paper in relation to the priority of Early Intervention and Prevention in the respect of:

- Prevention of illness and disease; and
- An emphasis on lifestyle choices.

Votes were recorded as follows:

Agreed	10
Opposed	0
Abstentions	0

RESOLVED that:

The Adults and Safeguarding Committee note the report and consider the outcomes and challenges outlined below and provide a steer to inform the development of the Commissioning Plan.

8. BARNET MULTI-AGENCY SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2013/14

The Committee considered the report.

The Chairman MOVED that the Recommendation One be amended to read:

"The Committee note the information contained within the Draft Barnet Multi-Agency Safeguarding Adults Board Report 2013-14" The amendment was seconded by Councillor Thompstone.

Votes were recorded as follows:

Agreed	10
Opposed	0
Abstentions	0

The motion was carried.

The Chairman MOVED that the Recommendation Three be amended to read: "That the Committee note the contents of the agreed Safeguarding Adults Board Business Plan 2014-16." The amendment was seconded by Councillor Thompstone.

Votes were recorded as follows:

Agreed	10
Opposed	0
Abstentions	0

RESOLVED that:-

1) The Committee note the information contained within the Draft Barnet Multi-Agency Safeguarding Adults Board Report 2013-14.
2) The Committee agree to make recommendations to ensuring a robust multi-agency approach to Safeguarding Barnet Residents with involvement from the Council, NHS Barnet Health Trusts, the Police and the Voluntary Sector.
3) That the Committee note the contents of the agreed Multi-Agency Safeguarding Adults Board Business Plan 2014-16.

9. ADULTS AND COMMUNITIES ANNUAL COMPLAINTS REPORT 2013/14

The Committee considered the report.

RESOLVED that:-

The Committee note the information contained within the Adults and Communities Annual Complaints Report 2013-2014 and the arrangements for the report's publication and post decision implementation.

10. RESPONSE TO CONSULTATION ON THE CARE ACT GUIDANCE

The Committee considered the report.

3

The Chairman MOVED the Recommendation One be amended as follows:

"That the Committee note Adult Social Care's approach to the consultation and require that The Strategic Director for Communities be instructed to submit a response on behalf of the London Borough of Barnet to the Consultation by 15 August 2014 and that this response be circulated to Members of the Adults and Safeguarding Committee" The motion was SECONDED by Councillor Rawlings.

Votes were as follows:

Agreed	10
Opposed	0
Abstentions	0

The motion was carried.

RESOLVED that:-

That the Committee note Adult Social Care's approach to the consultation and require that The Strategic Director for Communities be instructed to submit a response on behalf of the London Borough of Barnet to the Consultation by 15 August 2014 and that this response be circulated to Members of the Adults and Safeguarding Committee

11. COMMITTEE FORWARD WORK PROGRAMME

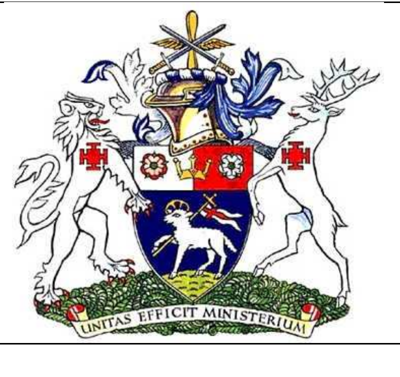
The Committee considered the report.

James Mass, the Family and Community Well-being Lead Commissioner advised that Members would be canvassed outside of the meeting for their availability for a special meeting of the Committee in November 2014.

12. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT

There were none.

The meeting finished at 9.33 pm

	AGENDA ITEM 7 **Adults & Safeguarding Committee** **2 October 2014**
Title	**Business planning**
Report of	Strategic Director for Communities
Wards	All
Status	Public
Enclosures	None
Officer Contact Details	Karen Ahmed, Later Life Lead Commissioner, 020 8359 5186, karen.ahmed@barnet.gov.uk James Mass, Family & Community Well-being Lead Commissioner, 020 8359 4610, james.mass@barnet.gov.uk

Summary

The Adults and Safeguarding Committee agreed to develop a five-year Commissioning Plan and savings proposals and this will be considered by the Committee on 20 November 2014. This report seeks to support the Committee as it begins to address this task, setting out suggested outcomes for the Commissioning Plan and identifying the major challenges for which this Committee will need to make commissioning decisions over the coming five years.

Recommendations

1. **That the Adults and Safeguarding Committee agree the outcomes and commissioning intentions detailed in this report to inform the development of the Commissioning Plan.**

1. WHY THIS REPORT IS NEEDED

1.1 On 2 July 2014 the Adults and Safeguarding Committee noted the savings target allocated by the Policy and Resources Committee and agreed to complete a Commissioning Plan and savings proposals by December 2014. This report builds on the outcomes reviewed at the meeting of 31 July 2014 to support the Committee as it addresses this task. It sets out suggested commissioning intentions for the Commissioning Plan, the intended impact of these and how they link to the strategic outcomes.

Outcomes

1.2 The outcomes reviewed at the meeting of 31 July 2014 were as follows:

Priority	Key Outcomes
Safeguarding	Older people are supported to live safely through strategies which maximise independence and minimise risk. Where older people acquire vulnerabilities as they age, every effort is made to enable older people to remain in familiar surroundings, being cared for by people who know and love them.
Planning for Life	Older people live a healthy, full and active life and their contribution to society is valued and respected. Older people have sufficient finances to meet the full range of their needs and are able to access advice to make sure they spend wisely. Older people live in homes that meet their needs and are well connected socially.
Early Intervention and Prevention	Older people have timely access to diagnosis and are provided with the tools/ enabled to manage their condition and continue to live a full life. Older people know what is available to increase and maintain their well-being and independence and can obtain/ access it when they need to. Older people are well-connected to their communities and engage in activities that they are interested in.

Person centred Integrated support	Older people are able to access help when needed for as long as they need it. Older people are supported to get back on their feet when they have a crisis and to identify ways of preventing further crises Older people have timely access to health and social care support that maintains independence and avoids the trauma of hospital admission Person centred support plans inform the delivery of support in the most appropriate place (usually someone's home or community) that best meets older people's needs in the most cost-effective way possible. Older people who have health or social care needs can still expect to live an independent life and have relationships based on reciprocity.
Carers	Carers are supported to continue caring for as long as they wish Carers are valued as expert partners in supporting older people to live independent lives Carers are supported to achieve their ambitions whilst continuing to care

Commissioning intentions:

1.3 Commissioning intentions have been developed for the following service components that make up the Adults and Safeguarding Committee's remit:

- Adults with learning disabilities.
- Adults with mental health needs.
- Adults with physical or sensory impairments.
- Older people: feeling well, enjoying life.
- Older people: ageing well, high quality health and care services
- Carers.

1.4 In addition, there are a number of cross-cutting intentions summarised in the final section.

1.5 **Adults with learning disabilities.**

	Commissioning intention	**Intended impact**
1	Implement a 0-25 disabilities service that better brings together health, care and education.	- Growth is enabled for young people with disabilities. - Improved relationships between families and the local authority. - Reduced cost to adult social care arising from lower care package costs for those transitioning. - Some rebalancing of cost from expensive intensive provision to preventative and enabling services.
2	Increase the supply and take-up of supported living and independent housing opportunities supporting transitions from those currently in residential settings.	- Improved outcomes for adults supported to live more independent lives. - Reduced cost of care.
3	Develop a more creative and cost effective review and support planning process. Ensure that this considers how technology can enable people with learning disabilities to live more independently.	- Improved outcomes for adults supported to live more independent lives. - Reduced cost of care.
4	Improve the carer's offer and support planning process to ensure carers feel able to continue to support an individual for as long as they can.	- Reduction in the number of carer breakdowns. - Improved family satisfaction from sustaining the family environment. - Reduced cost of care.
5	Stimulate the market to encourage providers who can effectively focus on enablement and development.	- Improved outcomes for adults supported to live more independent lives. - Reduced cost of care.
6	Develop the employment support offer for adults with learning disabilities and ensure there are sufficient employment opportunities available in the borough.	- Increase the number of people with learning disabilities in work. - Reduced cost of care.

1.6 **Adults with mental health needs.**

	Commissioning intention	Intended impact
1	The re-focusing of social care on recovery, social inclusion and enablement. This will require a phased transition from the current integrated services model with the mental health trust to enable both parties to focus on core competencies and develop effective partnership practice. A small number of social workers would be co-located with the Mental Health Trust to support effective crisis resolution and effective management of people subject to community treatment orders and section 117	- Stronger working with primary care. - Redefined mental health social work role to provide a move away from delivery of the approved mental health professional (AMPH) role and care co-ordination to one which focuses on promoting recovery and social inclusion with individuals and families. - Increased focus on social responses that safeguard and promote enablement / recovery. Increased focus on safeguarding.
2	Review delivery models to ensure that the social work service for working age people with mental health issues can best focus on the quality of services and strengthen the voice of both workers and service users.	- We will have a model for social work which is rewarded to promote recovery, maximise inclusion and reduce long term care costs. This will require working co-productively and innovatively with local communities, primary care and housing providers to support community capacity, personal and family resilience, earlier intervention and active citizenship. - Staff are effectively incentivised to ensure that their way of working achieves these outcomes.
3	Introduce a 'Consultant Social Worker' role to work with acute mental health services and children's social care.	- The role will provide independent review and challenge to support plans and proposed changes to ensure all appropriate support opportunities are explored and provided in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity.
4	Align social work delivery model with community development, whole family approaches and wider wellbeing, particularly focusing on tackling social exclusion and worklessness.	- Working more closely with other public sector agencies such as Job Centre Plus will provide a clear pathway to support people with mental health problems back into work.

	Commissioning intention	Intended impact
		- The social work delivery model could be jointly commissioned by DWP to ensure people are work ready and supported back into work.
5	Increase the range of sustainable accommodation options for people with mental health problems in conjunction with the NHS.	- There is a compelling evidence base that where we live has a significant impact on our mental health. For the NHS, inadequate access to housing increases costs and demand for acute services. Supported housing for people with a mental illness could benefit the NHS year in and year out to a suggested annualised return of investment of 7% when compared to inpatient care or residential provision.
6	Promoting mental well-being and reducing stigma through establishing joint commissioning of social care with public mental health provision.	- Including mental health within the preventative agenda as an equal to physical health, and targeting support at those with known risk factors, will create reduced demand and allow earlier intervention.

1.7 **Adults with physical or sensory impairments.**

	Commissioning intention	Intended impact
1	Implement a 0-25 disabilities service that better brings together health, care and education.	- Growth is enabled for young people with disabilities. - Improved relationships between families and the local authority. - Reduced cost to adult social care arising from lower care package costs for those transitioning. - Some rebalancing of cost from expensive intensive provision to preventative and enabling services.
2	Increase the supply and take-up of supported living and independent housing opportunities supporting transitions from those currently in residential settings.	- Improved outcomes for adults supported to live more independent lives. - Reduced cost of care.
3	Develop a more creative and cost effective review and support planning process. Ensure that this considers	- Improved outcomes for adults supported to live more independent lives.

	Commissioning intention	Intended impact
	how technology can enable people with learning disabilities to live more independently.	- Reduced cost of care.
4	Commission an integrated health and social care service for those with long term conditions.	- Working age adults with long term conditions receive a seamless service that fully meets their needs in a timely way and in the best location.
5	Commission high quality flexible specialist home support services including personal assistants.	- Working age adults with a disability receive specialist help at home that meets their needs.

1.8 **Older people: feeling well, enjoying life**

	Commissioning intention	Intended impact
1	To develop improved information, advice and planning services	- Older people are able to obtain good advice and support at key transition points which helps them plan for the future
2	To promote digital inclusion, assistive technology, equipment, adaptations	- Older people are aware of the full range of help that can enable them to stay in control of their own lives
3	To increase social networks and community connections	- Older people play an active and valued part in their communities and are able to give and receive help when needed
4	To commission and influence the development of opportunities for older people to continue working or offer mentoring	- Older people are economically active for as long as they want to be. Older peoples' skills are valued and contribute to local economic development
5	To develop a joined up prevention offer which is easy to recognise and use	- Older people are able to make best use of community resources and social networks to help live life to the full
6	To commission the best delivery vehicle possible to support older people who need a little bit of help.	- Older people are able to access extra help when they need it to help stay independent and for as long as they need it. This help keeps people connected to their local communities instead of becoming dependent upon services

1.9 Older people: high quality health and care services

	Commissioning intention	Intended impact
1	Commission an integrated health and social care service for frail older people and those with long term conditions. Consider alternative models of delivery to ensure best fit.	- Older people receive a seamless service that fully meets their needs in a timely way and in the best location
2	Increase housing choices for older people where the existing accommodation is not suitable	- Older people remain living in the community for longer , reducing inappropriate use of residential care
3	Commission high quality flexible specialist home support services including personal assistants	- Older people receive specialist help at home that meets their needs
4	Increase the use of enablement services for all older people	- Older people are supported to be as independent as possible at key points in their lives
5	All support plans will increase the ability of older people to access community resources and social/family networks	- Older people remain connected to their communities rather than separated as a result of receiving services

1.10 Carers

	Commissioning intention	Intended impact
1	To prioritise meeting the needs of carers, including young carers, through the assessment and support planning process.	- Carers feel supported in their role and can continue caring for as long as they wish. - Reduced cost pressure on ASC arising from carer breakdown
2	To strengthen the current carers' support offer e.g. assistive technology, intensive support for carers of people with dementia.	- Carers feel supported in their role and can continue caring for as long as they wish
3	To better support carers to balance work and caring commitments. Local small businesses know how to retain carers in their workforce.	- Carers are able to continue both working and caring

1.11 **Cross-cutting**

	Commissioning intention	Intended impact
1	Ensure that the voice of people who use adult social care and carers contributes to the design and delivery of services.	- Services that better meet the needs of local people.
2	Promote and maintain the quality and consistency of social work. Ensure that the workforce development programme is focused on strengthening the quality and consistency of practice.	- Maintain the safety of vulnerable adults. - High quality decision making. - Effective working with individuals and their families / carers. - Improved staff retention.
3	Constrain inflationary pressure on procured goods and services to 0.5% from 16/17 – 19/20.	- Avoidance of cost pressures from third party spending.
4	Identify measures to reduce the cost of the workforce employed by LBB.	- Achieve workforce efficiency savings. -
5	To adopt new policies on eligibility, contributions and deferred payments.	- Compliance with requirements enacted by the Care Act. - Greater ability for individuals to delay asset sales through use of deferred payments.

2. REASONS FOR RECOMMENDATIONS

2.1 This report is a step in the process of agreeing a Commissioning Plan and a set of business planning proposals. Further work needs to be done by the working groups and Council officers to inform the corporate business planning process and the report to Policy and Resources Committee on 2 December 2014.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 N/A

4. POST DECISION IMPLEMENTATION

4.1 Officers will bring a paper on the Commissioning Plan to the next Adults and Safeguarding Committee meeting on 20 November 2014.

5. IMPLICATIONS OF DECISION

5.1 **Resources (Finance & Value for Money, Procurement, Staffing, IT,**

Property, Sustainability)

5.1.1 In addition to continued austerity, demographic change and the resulting pressure on services poses a significant challenge to the Council. The organisation is facing significant budget reductions at the same time as the population is increasing, particularly in the young and very old population cohorts. Given that nearly two thirds of the Council's budget is spent on Adult Social Care and Children's Services, this poses a particular challenge as these services are predominantly 'demand led'.

5.2 **Legal and Constitutional References**

5.2.1 All proposals emerging from the business planning process will need to be considered in terms of the Council's legal powers and duties and mechanisms put into place to ensure compliance with legal obligations and duties both current and set out in the Care Act 2014 when those proposals are brought into effect..

5.2.2 The responsibilities of the Adults and Safeguarding Committee are contained within Annex A of the Constitution - Responsibility for Functions.

- Ensuring that the local authority's safeguarding responsibilities are taken into account;
- Promoting the best possible adult social care service

5.3 **Risk Management**

5.3.1 The Council has taken steps to improve its risk management processes by integrating the management of financial and other risks facing the organisation. Risk management information is reported quarterly to the Board and to Committees and is reflected, as appropriate, throughout the annual business planning process.

5.4 **Equalities and Diversity**

5.4.1 All proposals emerging from the business planning process will need to be considered in terms of including, the public sector equality duty under s149 of the Equality Act 2010

5.4.2 Equality and diversity issues are a mandatory consideration in the decision-making of the Council. This requires elected Members to satisfy themselves that equality considerations are integrated into day to day business and that all proposals emerging from the finance and business planning process have properly taken into consideration what impact, if any, there is on any protected group and what mitigating factors can be put in train.

5.4.3 Consideration will be given to developing Equality Impact Assessments when proposals are being formulated.

5.4.4 The projected increase in the borough's population and changes in the demographic profile will be key factors that need to be considered when

determining both the corporate strategy and service responses. Both of these need to also reflect the aspirations and contributions of current residents

5.4.5 Similarly, all human resources implications will be managed in accordance with the Council's Managing Organisational Change policy that supports the Council's Human Resources Strategy and meets statutory equalities duties and current employment legislation.

5.5 **Consultation and Engagement**

5.5.1 As proposals are developed in response to the challenges raised in this paper, an appropriate consultation and engagement plan will be developed and implemented. The work will be informed by the extensive consultation work that has been carried out already as part of the Priorities and Spending Review process.

5.5.2 Over the last twelve months the council has been reviewing its priorities and spending. To help inform the council's future long term spending plans the council commissioned the Office for Public Management (OPM), an independent research organisation, to run a comprehensive series of residents engagement activities to understand their priorities for the local area and look at how residents and organisations can support services going forward.

6. BACKGROUND PAPERS

6.1 Adults and Safeguarding Committee, 2 July 2014. Item 5 – Business Planning

6.2 Children, Education, Libraries and Safeguarding Committee, 31 July 2014. Item 7 – Business Planning

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AGENDA ITEM 8

	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

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Document Information

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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
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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)
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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.

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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.

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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.

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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.

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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.

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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.

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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.

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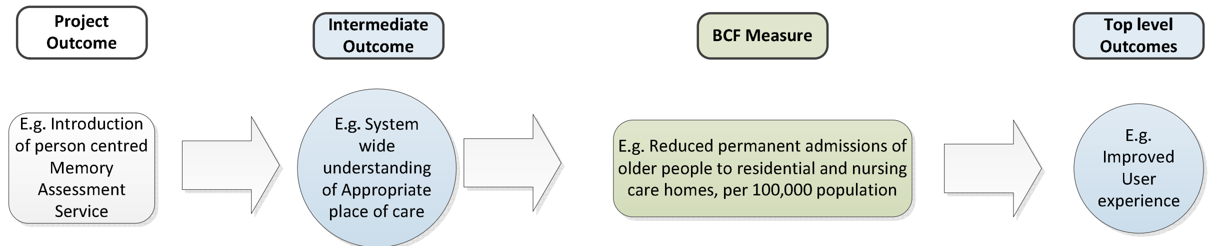

Figure 2 – Outcome Relationship Map

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

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- **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)

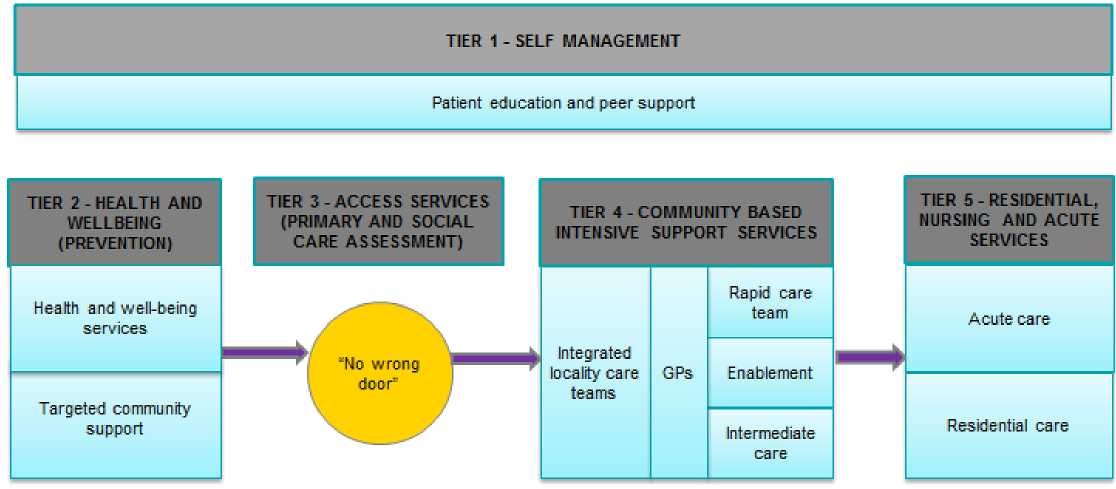

Figure 3 – Overview of the 5 Tier Model

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.

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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.

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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!

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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.

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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.

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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.

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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

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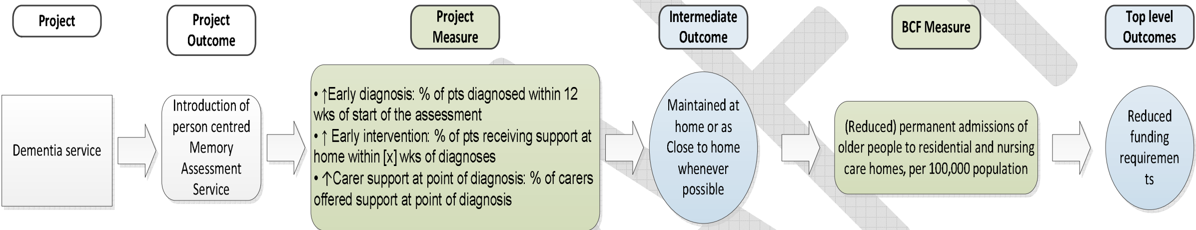
3. Reduced funding requirements

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.

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4. Project Descriptions

Tier 1 Specification – Self-Management

<table>
<tr><td colspan="2">Structured Education</td><td>New Service</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Service Start Date</td><td colspan="2">Pilot of generic programme: work commences September 2014 (pilot runs from January 2015)
Pilot of disease specific programme: February 2015</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Project (Inter)dependencies</td><td colspan="2">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.</td></tr>
<tr><td>Current status and key achievements</td><td colspan="2">Relationship established with CCG on approach to developing self-management offer.
Commissioning of structured education pilot commencing in September 2014.</td></tr>
<tr><td colspan="3">Service Finance</td></tr>
<tr><td>Funding</td><td colspan="2">Public Health</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Estimated Activity</td><td colspan="2">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).</td></tr>
</table>

	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.	

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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.

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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.

<table>
<tr><th colspan="2">Targeted Healthy Living Pharmacy Model for people with long-term conditions</th><th>New Service</th></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Service Start Date</td><td colspan="2">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</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Project (Inter)dependencies</td><td colspan="2">Interdependent with Structured education, Tier 2 services and professional support</td></tr>
<tr><td>Current status and key achievements</td><td colspan="2">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).</td></tr>
<tr><td colspan="3">Service Finance</td></tr>
<tr><td>Funding</td><td colspan="2">London Borough of Barnet</td></tr>
<tr><td>Estimated Activity</td><td colspan="2">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.</td></tr>
<tr><td>Cost of Service provision</td><td colspan="2">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</td></tr>
</table>

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	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.

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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

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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.

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Tier 2 – Health & Wellbeing (Prevention)

Joined up Prevention Offer

<table>
<tr><td colspan="2">An Apple a Day</td><td>Enhancement to existing services</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Service Start Date</td><td colspan="2">June 2015</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Project (Inter)dependencies</td><td colspan="2">Close links with development of mapping of prevention services and database
Shared care record.</td></tr>
<tr><td>Current status and key achievements</td><td colspan="2">Not started.</td></tr>
<tr><td colspan="3">Service Finance</td></tr>
<tr><td>Funding</td><td colspan="2">Allocation from baseline or incremental funding to be confirmed.</td></tr>
<tr><td>Estimated Activity</td><td colspan="2">• 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).</td></tr>
<tr><td>Cost of Service provision</td><td colspan="2">• Project manager 6 months (£33k)
• Contract variation costs (estimated £50k)
• Publicity campaign and branding material (£7k).</td></tr>
<tr><td>Net Benefits</td><td colspan="2">Any identified cashable or non-cashable benefits from this project to be measured once services are introduced.</td></tr>
</table>

Developing targeted approach to prevention

<table>
<tr><td>Identification of people who would benefit from prevention services</td><td>Enabler - Enhancement to existing services</td></tr>
<tr><td colspan="2">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:</td></tr>
</table>

<table>
<tr><td colspan="2">

- 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.

</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Service Start Date</td><td>April 2015</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Project (Inter)dependencies</td><td>Close links with development of mapping of prevention services and database.</td></tr>
<tr><td>Current status and key achievements</td><td>Not started.</td></tr>
<tr><td colspan="2">Service Finance</td></tr>
<tr><td>Funding</td><td>Allocation from baseline or incremental funding to be confirmed.</td></tr>
<tr><td>Estimated Activity</td><td>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.</td></tr>
<tr><td>Cost of Service provision</td><td>To be confirmed based on the likely, agreed estimate activity.</td></tr>
<tr><td>Net Benefits</td><td>Any identified cashable or non-cashable benefits from this project to be measured once services are introduced.</td></tr>
</table>

Strengthened Information, Advice and Support Offer

<table>
<tr><td>Information Plus – procurement opportunity</td><td>Enabler – enhanced and new service</td></tr>
<tr><td colspan="2">

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.

</td></tr>
</table>

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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

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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

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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.

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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).

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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.

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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. Acute Services Activity modelling for Integrated Care Programme Do Nothing; Activity (Post QIPP); Target Reduction Activity for 2 Years CHF, COPD, Dementia, Elderly Care, Falls & Fractures, Hypertension, Respiratory

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.	

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- 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.

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<table>
<tr><th colspan="2">Care Home Locally Commissioned Service (LCS)</th><th>Mobilising</th></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Service Start Date</td><td colspan="2">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.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Project (Inter)dependencies</td><td colspan="2">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.</td></tr>
<tr><td>Current status and key achievements</td><td colspan="2">• 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.</td></tr>
<tr><td colspan="3">Service Finance</td></tr>
<tr><td>Funding</td><td colspan="2">Barnet Clinical Commissioning Group.</td></tr>
<tr><td>Estimated Activity</td><td colspan="2">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.</td></tr>
</table>

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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.

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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**

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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

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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.	

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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.

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<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>
</table>

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.

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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.

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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

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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

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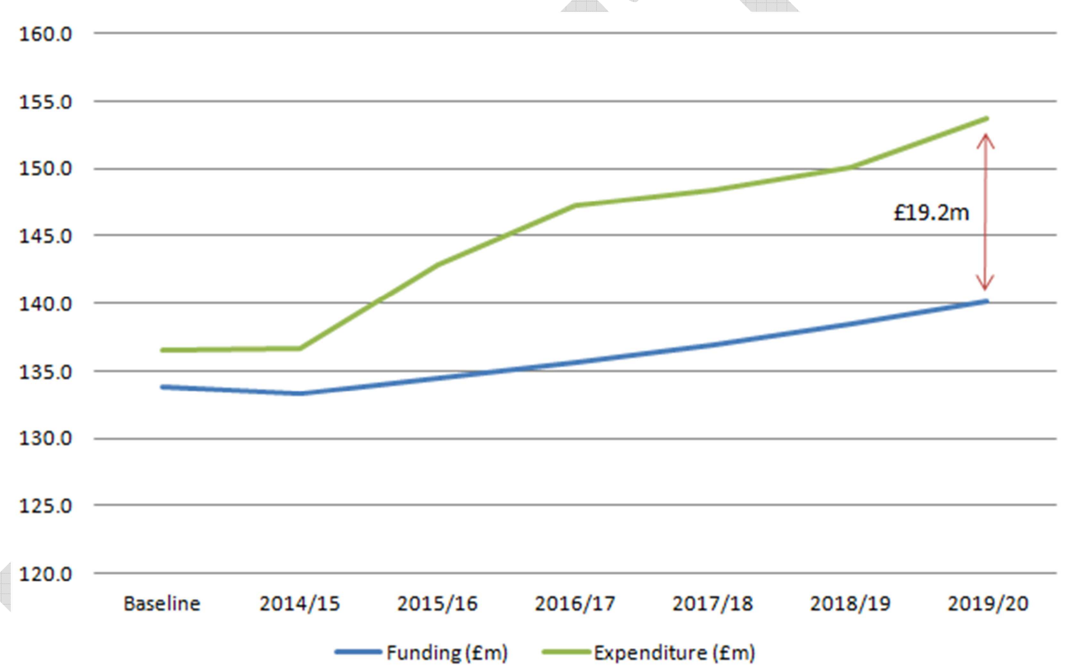
If we take no action to redesign our core services, all these resources will become expenditure. The combined effect of reduced funding and our projected increases to this expenditure will create a significant financial gap over the next six years. The table and graph below illustrates this:

	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.

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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.

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Contracting Model Options

We are therefore appraising four possible options for a new contracting model:

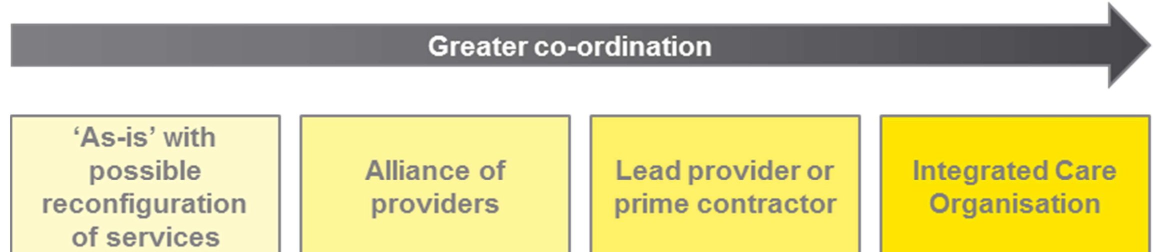

Figure 5 – Potential Contracting Models for Integrated Services

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.

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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

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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.

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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.

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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.

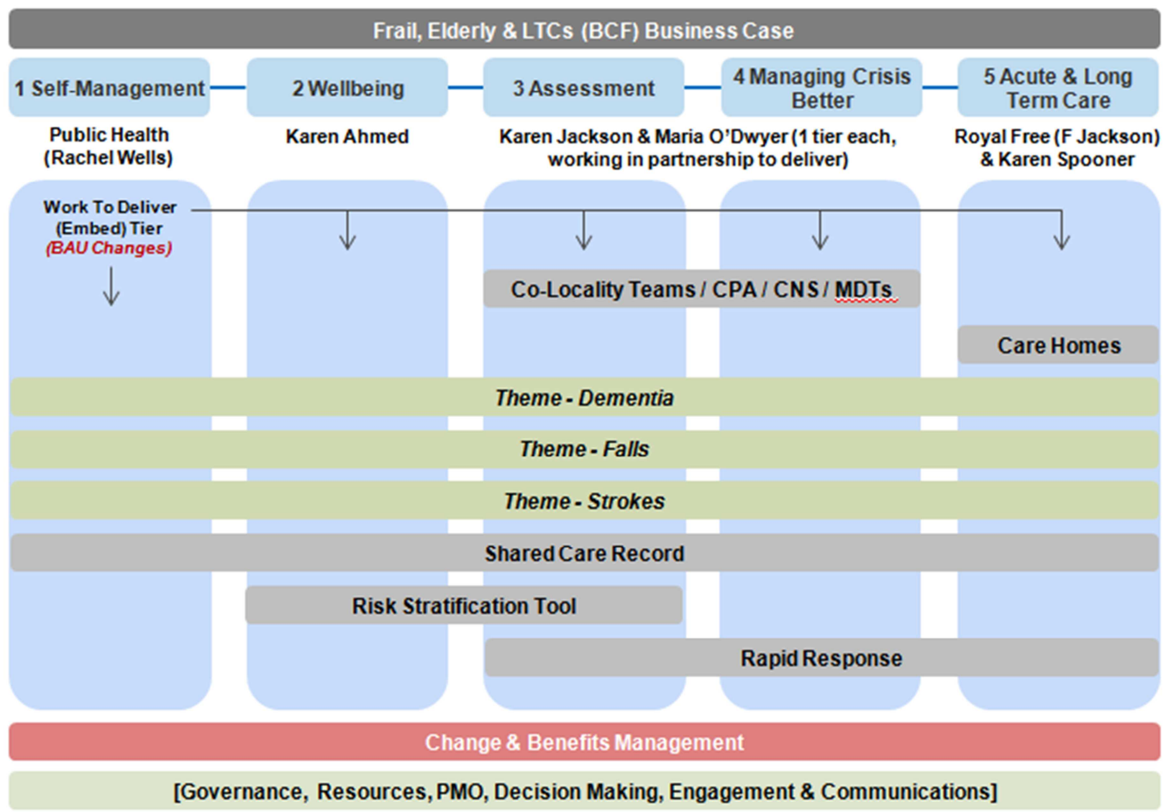

Figure 6 – Proposed BCF Programme Structure

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.

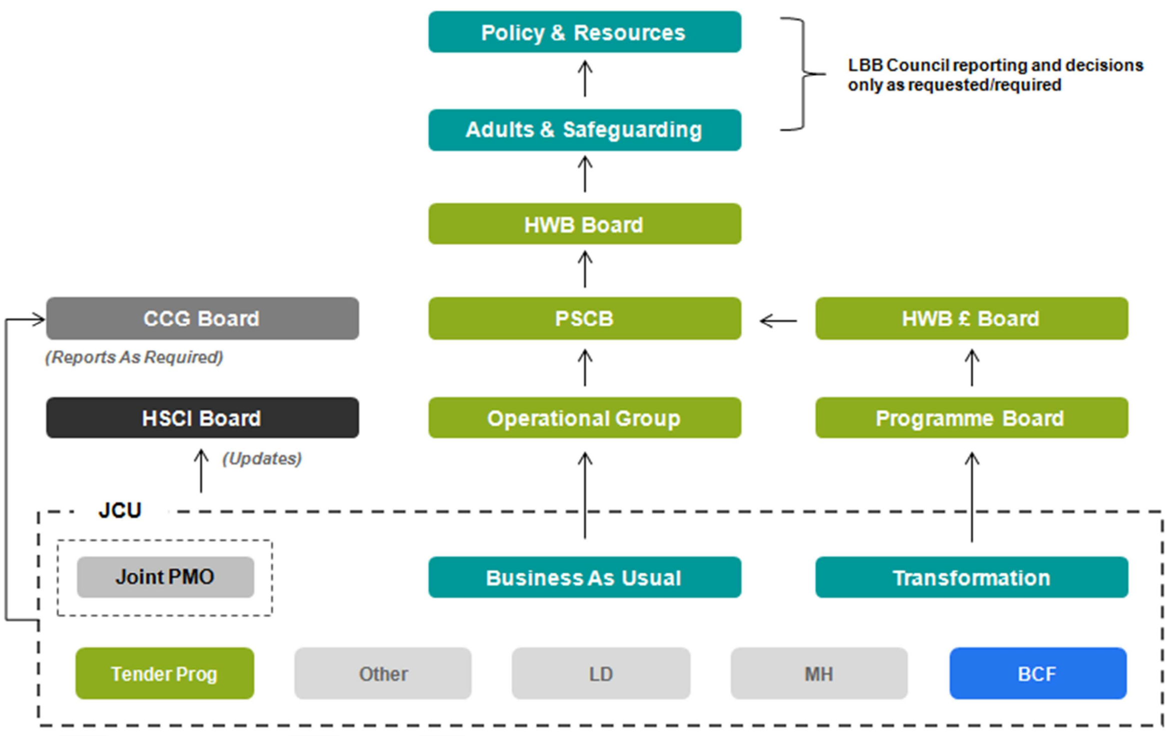

Figure 7 – Proposed BCF Programme Structure

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.

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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.

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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.

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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 | Project | Project Outcome | Project Measure | Intermediate Outcome | BCF Measure | Top level Outcomes

TIER 1
Self management

EPP and Health champions / LTC mentors

Health Living pharmacy model

Social prescribing

Workforce training & developing

Public media strategy

Evaluation framework for Tier 1

Enablers

Improved self care behaviour and efficacy

Revised framework for commissioning public health services from pharmacies

TBC

- Doctors visits ↓ 0.2 pppy
- Nurses visits ↓ 0.2 pppy
- Hospt inpatient bed days ↓by 1.6 pppy
- A&E attendances ↓ 0.2 pppy
- Outpatient apts ↓ 0.4 pppy
- Medication £ ↓ by £48 pppy

£?

- 60% GP avoidance of [x] number of framework users per year

£?

- ↑patient wellbeing as measured by [X]

System wide understanding of Appropriate place of care

Maintained at home or as Close to home whenever possible

Sufficient services outside hospital to keep patients safe & good quality care

(Reduced) permanent admissions of older people to residential and nursing care homes, per 100,000 population

(Increased) proportion of older people who were still at home 91 days after discharge from hospital into enablement / rehabilitation services

(Reduced) delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)

(Reduced) avoidable emergency admissions per 100,000 population (average per month)

(Improved / minimum) Patient / service user experience (national metric)

(Increased) Self directed support

Improved User experience

Improved User Outcomes

Reduced funding requiremen ts

Tier 3 and 4 (New Projects) Benefits Map

Tier | Project | Project Outcome | Project Measure | Intermediate Outcome | BCF Measure | Top level Outcomes

TIER 3 &4 Access services & Community based intensive services

Dementia service → Introduction of person centred Memory Assessment Service →
- ↑Early diagnosis: % of pts diagnosed within 12 wks of start of the assessment
- ↑ Early intervention: % of pts receiving support at home within [x] wks of diagnoses
- ↑Carer support at point of diagnosis: % of carers offered support at point of diagnosis

£Res care

Falls prevention → Unified fall service with strengthened preventative pathway & improved early identification →
- ↓unscheduled admissions from nursing and residential care as a result of falls
- ↓ Falls related A&E attendances
- ↓ Admissions for NOF >65 yrs
- ↓ Admissions for other complex fractures (non NOF) >65 yrs
- ↓ Attendance at fracture clinic >65 yrs

£A&E

Enablement → Commissioned integrated services on enablement pathways to support people to regain their independence →
- ↑ % of service users leaving enablement with no ongoing service. (> 70%)
- ↑ number of service users still at home living independently after 90 days.
- Value of homecare package pre v post enablement episode

Care Homes LES → Distinct service for nursing and residential care homes over and above the service commissioned under current GP GMS/PMS contracts →
- ↑ numbers of patients with advanced care plans in place
- ↑ numbers of patients supported to die in their place of choice

Stroke services → To provide specialist, intensive rehabilitation to eligible stroke survivors →
- ↑% Number of pts discharged from HASU within 0 to 1 days
- ↑ Average support contact hours for stroke survivors from [x] to [x]
- ↓% of pts who suffer a secondary stroke within [x] months
- ↓ Average number of excess bed days pp

£bed days

Shared Care records → Single holistic view of an individual's health and social care, accessible 24/7 from any location, wherever staff are working. → Enabler

Intermediate Outcomes:
- System wide understanding of Appropriate place of care
- Maintained at home or as Close to home whenever possible
- Sufficient services outside hospital to keep patients safe & good quality care

BCF Measures:
- (Reduced) permanent admissions of older people to residential and nursing care homes, per 100,000 population
- (Increased) proportion of older people who were still at home 91 days after discharge from hospital into enablement / rehabilitation services
- (Reduced) delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)
- (Reduced) avoidable emergency admissions per 100,000 population (average per month)
- (Improved / minimum) Patient / service user experience (national metric)
- (Increased) Self directed support

Top level Outcomes:
- Improved User experience
- Improved User Outcomes
- Reduced funding requirements

Tier 3 and 4 (Existing Projects) Benefits Map

Tier | Project | Project Outcome | Project Measure | Intermediate Outcome | BCF Measure | Top level Outcomes

Tier: TIER 3 &4 Access services & Community based intensive services

Projects and Project Outcomes:

- Care navigations service (CNS) → Targeted preventative personalised health and social care planning
- MDTs → Detailed care plans that coordinate input from across the health and social care system
- Risk stratification → Early identification of residents at risk of hospital admission, long term care admission and new or increased packages
- Rapid care (RAPID) → Support services to those experiencing a crisis to prevent hospital admission, facilitate discharge or manage escalation of needs in the community.
- Community point of access (CPA) → A central hub for referrals, appointments and queries for community health and reablement.
- Co-locality teams (Co-Loc) → closer communication and informal contact, leading to greater mutual understanding and learning across professional boundaries for proactive management of cases and improving anticipatory care systems.

Project Measures:

£?
- ↑ An increase in lower level/lower cost social care interventions
- ↑user satisfaction (individuals and their families/carers)
- ↓ A reduction in crisis admission to hospital
- ↓ A reduction in 30 day readmissions
- ↑Health related reported quality of life for people
- ↑ % users reported as feeling empowered to self care
- ↓ A reduction in the number of outpatients apts

£?
- ↑% of users receiving a response time < 2 hours

Enablers

Intermediate Outcomes:

- System wide understanding of Appropriate place of care
- Maintained at home or as Close to home whenever possible
- Sufficient services outside hospital to keep patients safe & good quality care

BCF Measures:

- (Reduced) permanent admissions of older people to residential and nursing care homes, per 100,000 population
- (Increased) proportion of older people who were still at home 91 days after discharge from hospital into enablement / rehabilitation services
- (Reduced) delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)
- (Reduced) avoidable emergency admissions per 100,000 population (average per month)
- (Improved / minimum) Patient / service user experience (national metric)
- (Increased) Self directed support

Top level Outcomes:

- Improved User experience
- Improved User Outcomes
- Reduced funding requirements

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.

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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.

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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 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 CCG 2 Year Operational and 5 Year Strategic Plan Barnet Joint Strategic Needs Assessment (JSNA) 2011-2015 Health and Social Care Integration Board Terms of Reference Health and Social Care Integration Board Programme Governance Barnet, Enfield & Haringey Clinical Strategy Health & Social Care Integration business case (Sept 2014)	HSCIB concordat signed.pdf Barnet Health Social Care Integrati Barnet Health Social Care Integrati Barnet Health & Social Care Program 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.

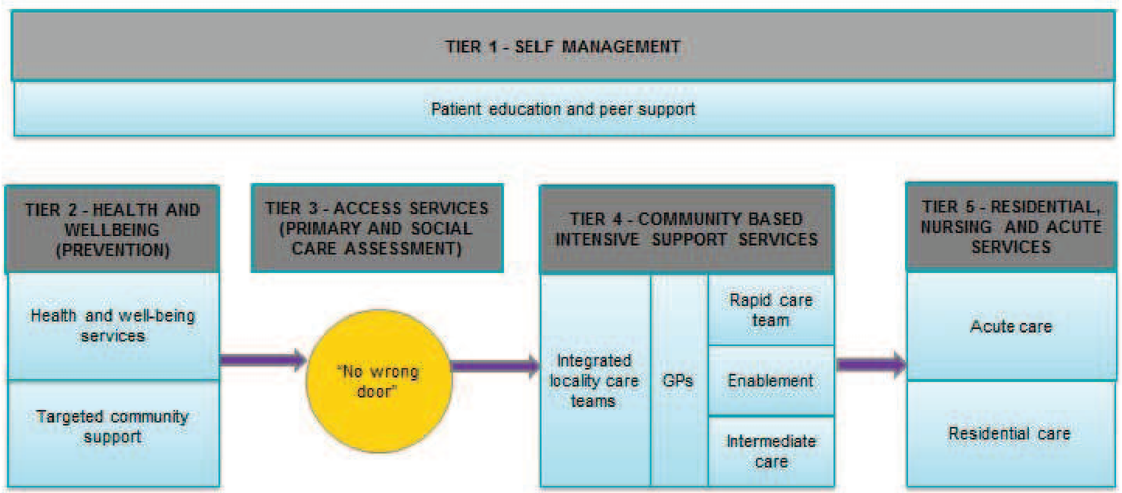
The strategy recognises we can only achieve this through a partnership between residents and public services.

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:

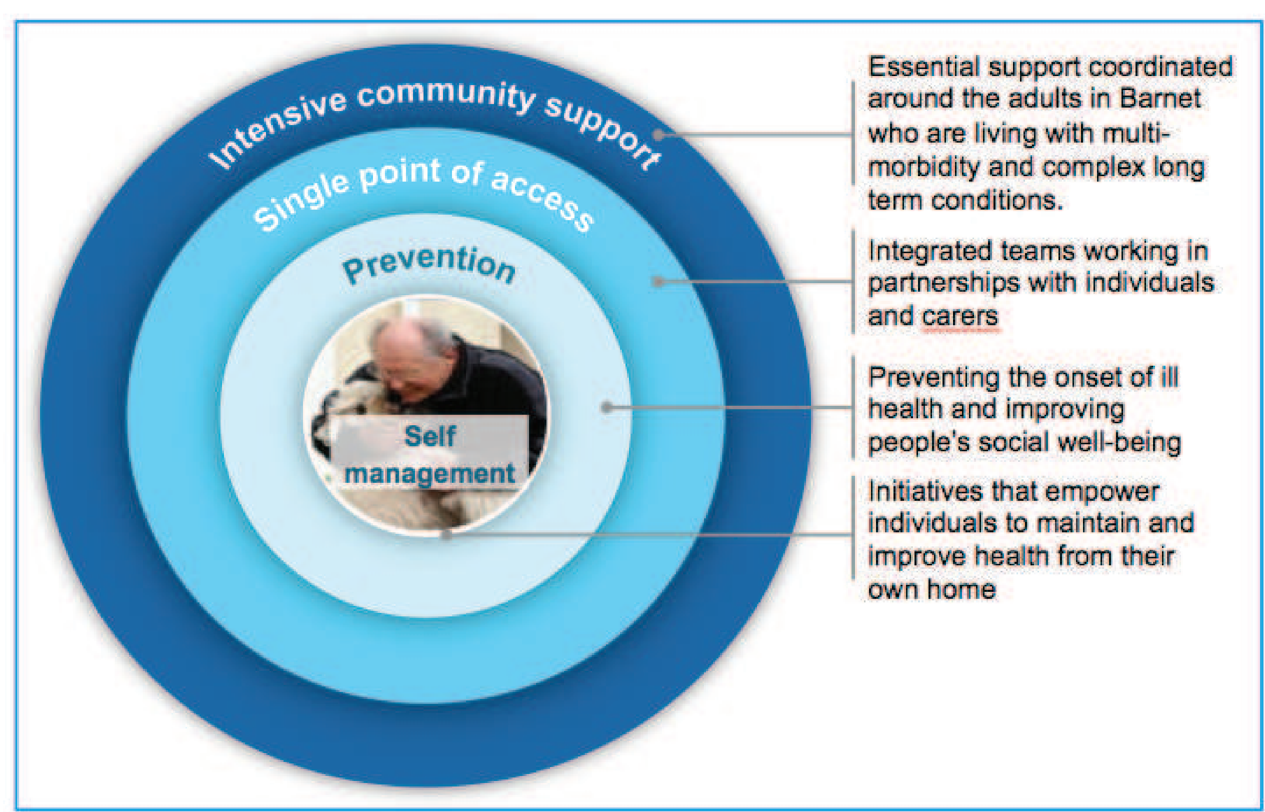
- Utilising risk stratification to manage the care of those individuals most at risk of an escalation in their health and social care needs.
- Utilising a joint approach to care will ensure a better customer journey and led to better management of resources providing the services.
- Increased information 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

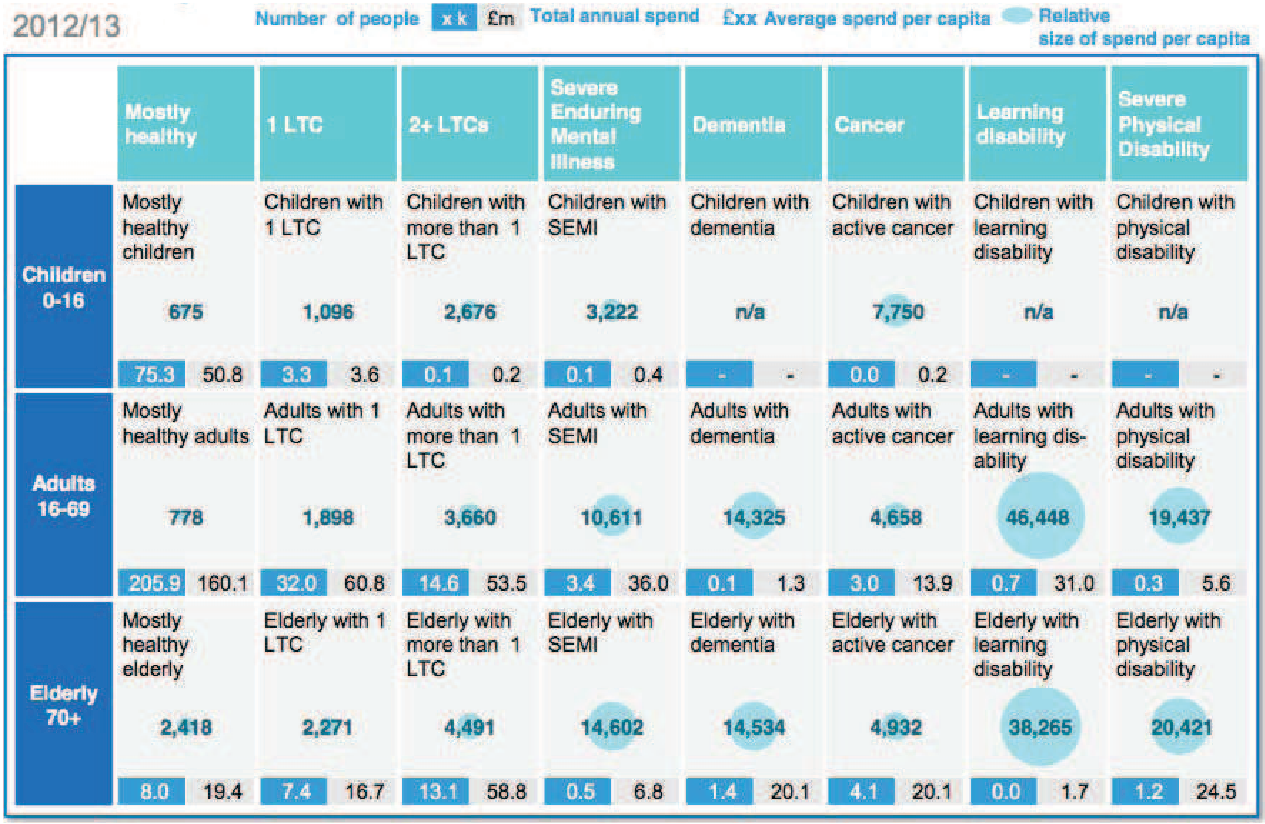
Date source: OBC April 2014.

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.

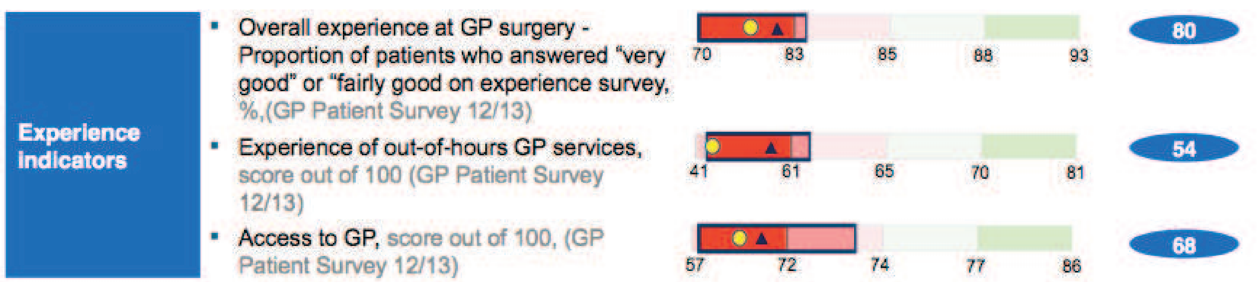

2012/13

Number of people | x k | £m Total annual spend | £xx Average spend per capita | Relative size of spend per capita

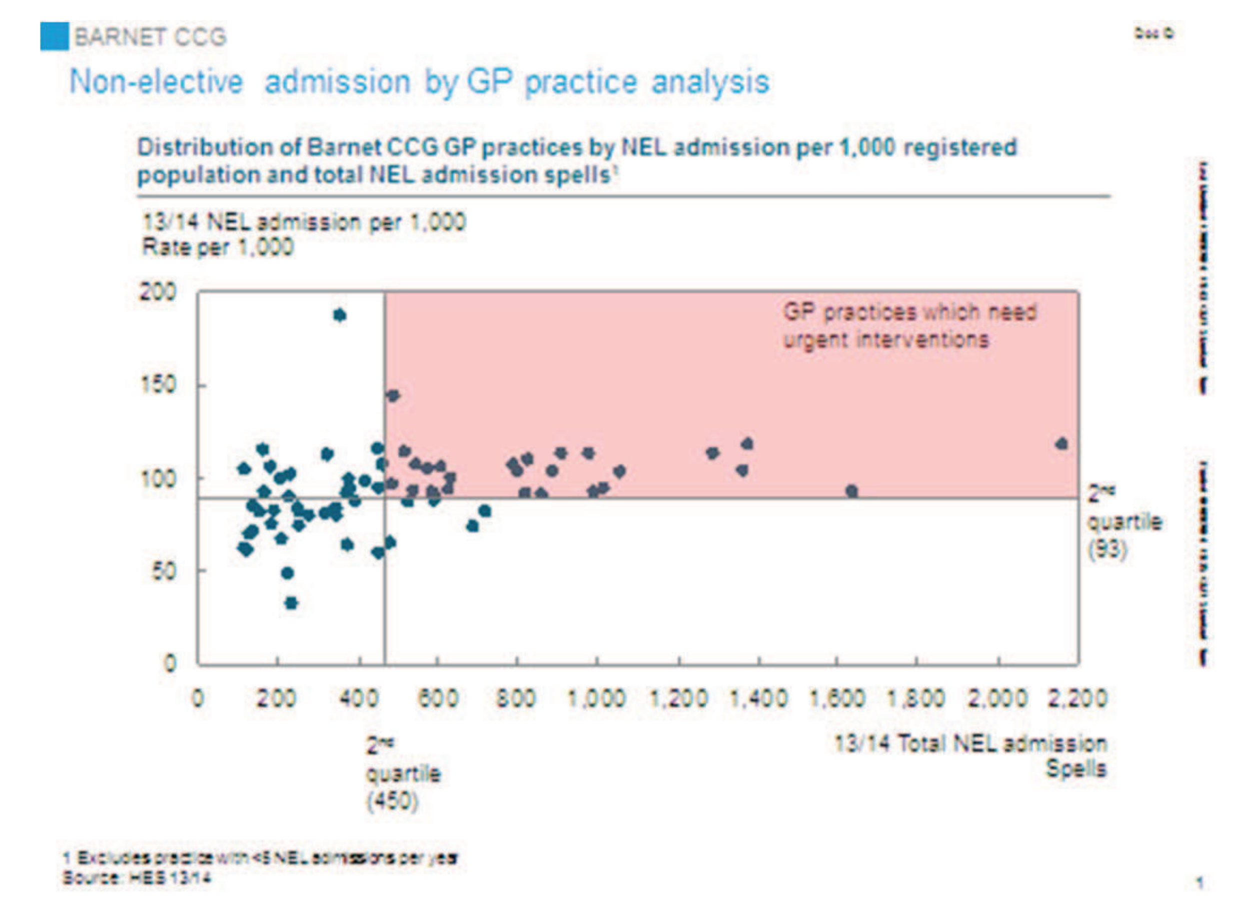
		Mostly healthy	1 LTC	2+ LTCs	Severe Enduring Mental Illness	Dementia	Cancer	Learning disability	Severe Physical Disability
Children 0-16	Segment	Mostly healthy children	Children with 1 LTC	Children with more than 1 LTC	Children with SEMI	Children with dementia	Children with active cancer	Children with learning disability	Children with physical disability
	Average spend per capita (£)	675	1,096	2,676	3,222	n/a	7,750	n/a	n/a
	Number of people (k)	75.3	3.3	0.1	0.1	-	0.0	-	-
	Total annual spend (£m)	50.8	3.6	0.2	0.4	-	0.2	-	-
Adults 16-69	Segment	Mostly healthy adults	Adults with 1 LTC	Adults with more than 1 LTC	Adults with SEMI	Adults with dementia	Adults with active cancer	Adults with learning dis-ability	Adults with physical disability
	Average spend per capita (£)	778	1,898	3,660	10,611	14,325	4,658	46,448	19,437
	Number of people (k)	205.9	32.0	14.6	3.4	0.1	3.0	0.7	0.3
	Total annual spend (£m)	160.1	60.8	53.5	36.0	1.3	13.9	31.0	5.6
Elderly 70+	Segment	Mostly healthy elderly	Elderly with 1 LTC	Elderly with more than 1 LTC	Elderly with SEMI	Elderly with dementia	Elderly with active cancer	Elderly with learning disability	Elderly with physical disability
	Average spend per capita (£)	2,418	2,271	4,491	14,602	14,534	4,932	38,265	20,421
	Number of people (k)	8.0	7.4	13.1	0.5	1.4	4.1	0.0	1.2
	Total annual spend (£m)	19.4	16.7	58.8	6.8	20.1	20.1	1.7	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:



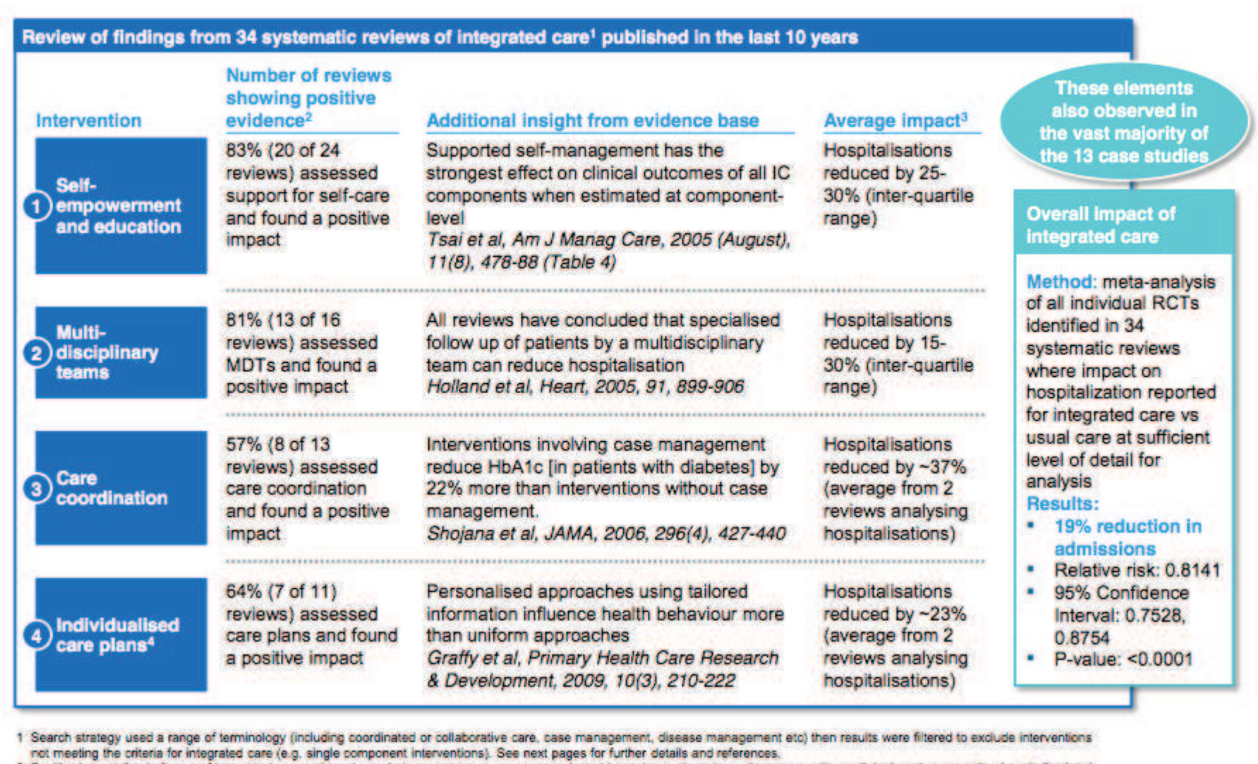
There are opportunities to improve on BCF metrics and to improve outcomes.

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**.



Review of findings from 34 systematic reviews of integrated care[1] published in the last 10 years

Intervention	Number of reviews showing positive evidence[2]	Additional insight from evidence base	Average impact[3]
1 Self-empowerment and education	83% (20 of 24 reviews) assessed support for self-care and found a positive impact	Supported self-management has the strongest effect on clinical outcomes of all IC components when estimated at component-level *Tsai et al, Am J Manag Care, 2005 (August), 11(8), 478-88 (Table 4)*	Hospitalisations reduced by 25-30% (inter-quartile range)
2 Multi-disciplinary teams	81% (13 of 16 reviews) assessed MDTs and found a positive impact	All reviews have concluded that specialised follow up of patients by a multidisciplinary team can reduce hospitalisation *Holland et al, Heart, 2005, 91, 899-906*	Hospitalisations reduced by 15-30% (inter-quartile range)
3 Care coordination	57% (8 of 13 reviews) assessed care coordination and found a positive impact	Interventions involving case management reduce HbA1c [in patients with diabetes] by 22% more than interventions without case management. *Shojana et al, JAMA, 2006, 296(4), 427-440*	Hospitalisations reduced by ~37% (average from 2 reviews analysing hospitalisations)
4 Individualised care plans[4]	64% (7 of 11) reviews) assessed care plans and found a positive impact	Personalised approaches using tailored information influence health behaviour more than uniform approaches *Graffy et al, Primary Health Care Research & Development, 2009, 10(3), 210-222*	Hospitalisations reduced by ~23% (average from 2 reviews analysing hospitalisations)

These elements also observed in the vast majority of the 13 case studies

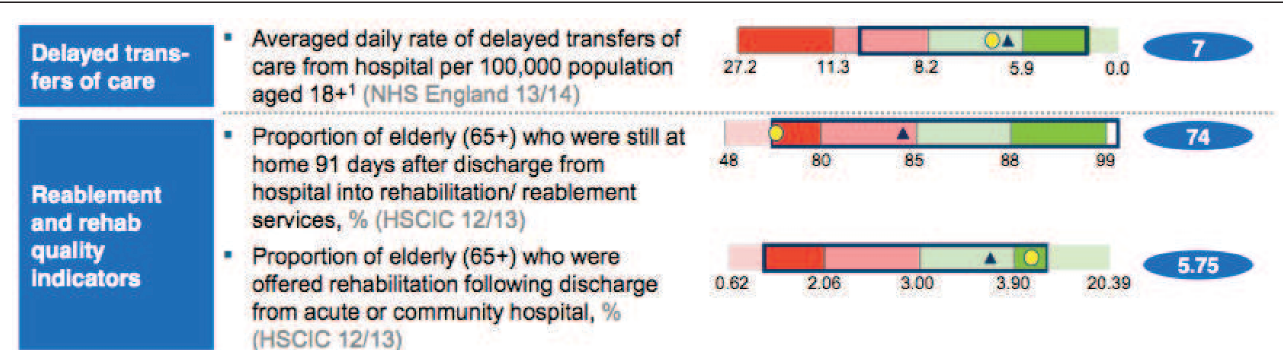
Overall impact of integrated care

Method: meta-analysis of all individual RCTs identified in 34 systematic reviews where impact on hospitalization reported for integrated care vs usual care at sufficient level of detail for analysis

Results:
- 19% reduction in admissions
- Relative risk: 0.8141
- 95% Confidence Interval: 0.7528, 0.8754
- P-value: <0.0001

1 Search strategy used a range of terminology (including coordinated or collaborative care, case management, disease management etc) then results were filtered to exclude interventions not meeting the criteria for integrated care (e.g. single component interventions). See next pages for further details and references.
2 Positive impact (i.e. in favour of integrated vs usual care) on whatever outcomes measures selected by review authors (e.g. disease severity or clinical marker, mortality, hospitalisations)
3 Impact measured from systematic reviews including relevant interventions and containing meta-analysis of hospitalisation rate (intervention vs controls)
4 Cochrane review of the evidence for personalised care planning (Coulter et al.) currently in preparation (results not yet available)

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.

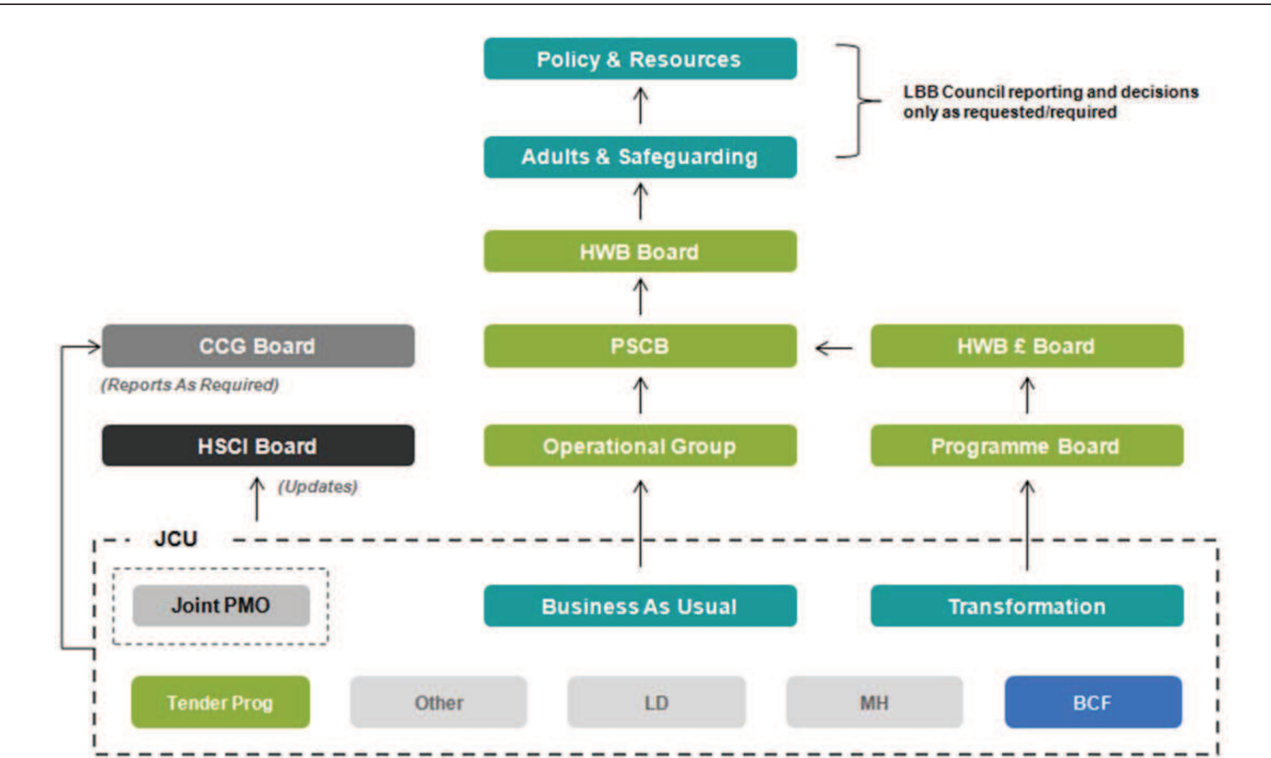
b) Please articulate the overarching governance arrangements for integrated care locally

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.

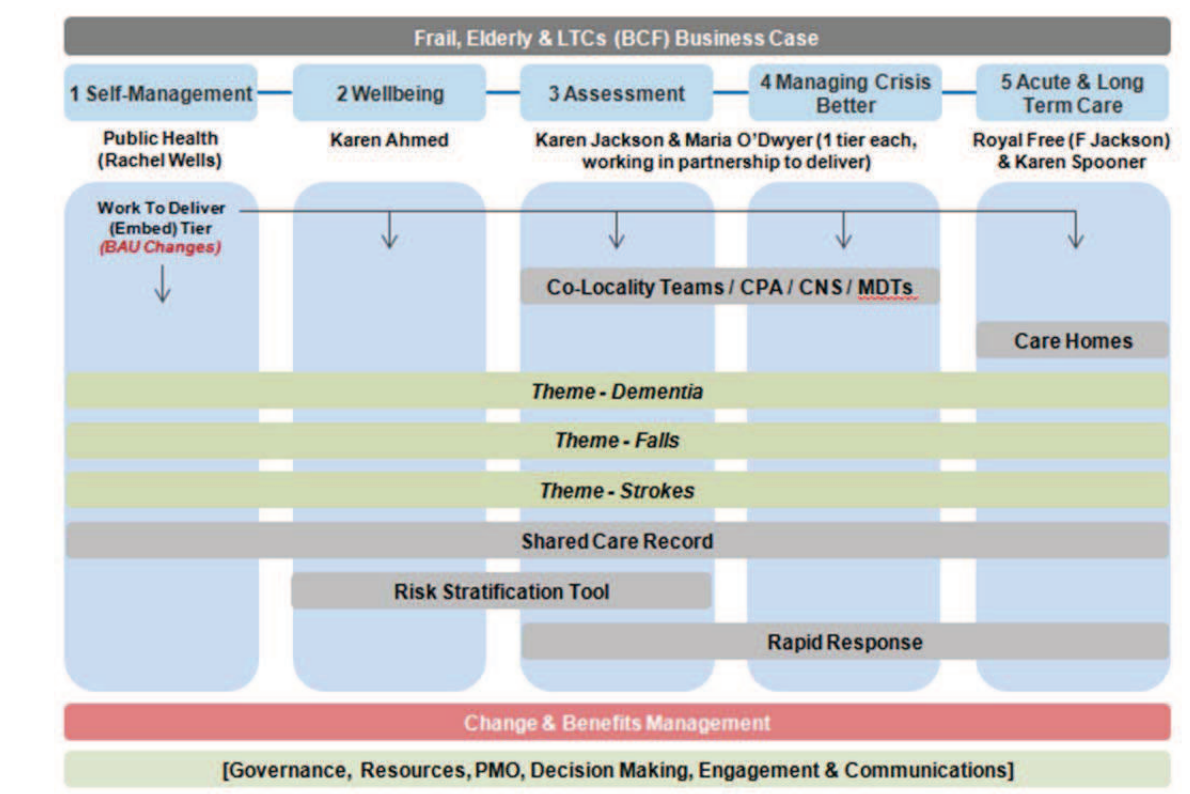
A well established system is in place where current S256 plans are jointly agreed through the Health and Wellbeing Board finance group. Section 75 agreements are in place for integrated services and these will be built on over the next few months to manage the changes associated with the BCF pooled budget. 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

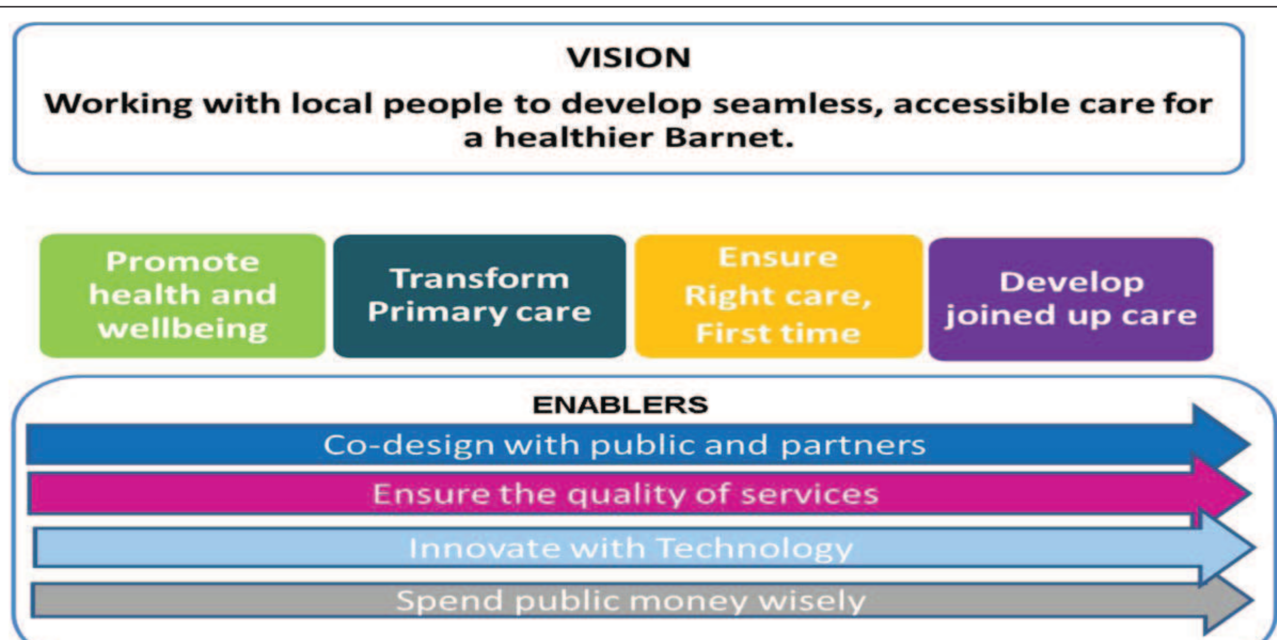
Changes to social care statutory responsibilities and service delivery. For example, increased Care Act duties and the re-modelling of the 'first contact for social care of LBB to increase the capacity to manage demand	• Demand manage new statutory responsibilities of the Council • Impact on BCF metrics 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:

<table>
<tr><td>
Benefits Map 1 -
Expert Patient Progra</td></tr>
<tr><td>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?</td></tr>
<tr><td>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</td></tr>
<tr><td>What are the key success factors for implementation of this scheme?</td></tr>
<tr><td>Structured education needs to be supported by relationships between primary care, specialists, carers and patients
Professional development and support from LTC specialists is important.</td></tr>
</table>

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?

The objectives of the LCS scheme include:

- 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

<u>Why have we selected this scheme?</u>

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;

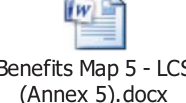
Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

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?
The objectives of this scheme are to put in place the following services: • 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

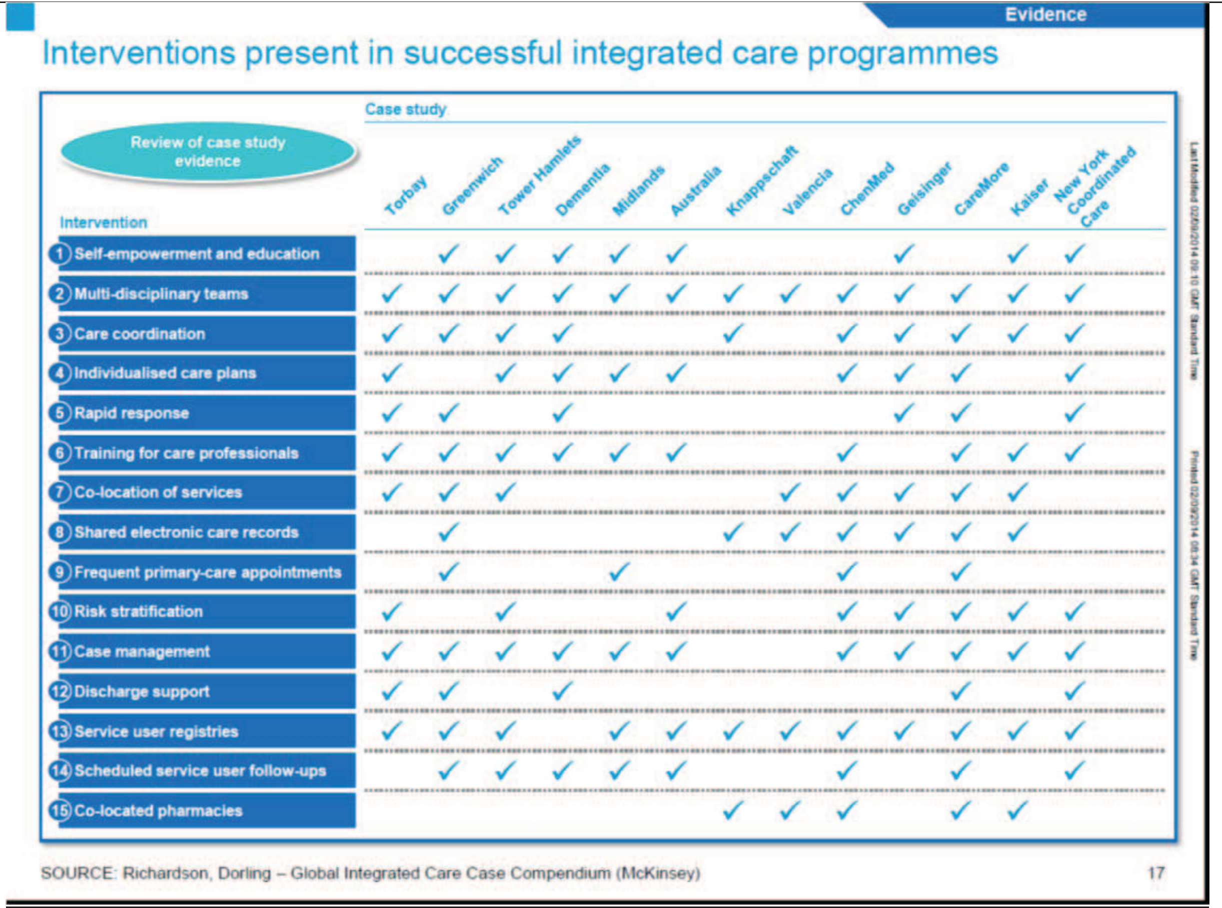
Commissioning lead: Muyi Adekoya

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).



Interventions present in successful integrated care programmes

Intervention	Torbay	Greenwich	Tower Hamlets	Dementia	Midlands	Australia	Knappschaft	Valencia	ChenMed	Geisinger	CareMore	Kaiser	New York Coordinated Care
1 Self-empowerment and education		✓	✓	✓	✓	✓				✓		✓	✓
2 Multi-disciplinary teams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3 Care coordination	✓	✓	✓	✓			✓		✓	✓	✓	✓	✓
4 Individualised care plans	✓		✓	✓	✓	✓			✓	✓	✓		✓
5 Rapid response	✓	✓		✓						✓	✓		✓
6 Training for care professionals	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓
7 Co-location of services	✓	✓	✓					✓	✓	✓	✓	✓	
8 Shared electronic care records		✓					✓	✓	✓	✓	✓	✓	
9 Frequent primary-care appointments		✓			✓				✓		✓		
10 Risk stratification	✓		✓			✓			✓	✓	✓	✓	✓
11 Case management	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
12 Discharge support	✓	✓		✓							✓		✓
13 Service user registries	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
14 Scheduled service user follow-ups		✓	✓	✓	✓	✓			✓		✓		✓
15 Co-located pharmacies							✓	✓	✓		✓	✓	

SOURCE: Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

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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	Adults & Safeguarding Committee **2 October 2014**
Title	**Implementing the Care Act 2014**
Report of	Dawn Wakeling, Adults & Communities Director
Wards	All
Status	Public
Enclosures	Appendix A – Department of Health: The Care Act 2014 – consultation on draft regulations and guidance – London Borough of Barnet response
Officer Contact Details	Alan Mordue email: alan.mordue@barnet.gov.uk telephone: 020 8359 2596

Summary

The Adults and Safeguarding Committee received a report on the implementation of the Care Act on 2 July 2014. This report contained a summary of the financial impact modelling undertaken for the Council.

This report provides an update on progress made towards meeting the statutory requirements of the Care Act, updates the financial modelling and seeks to inform members of the policy decisions required.

Recommendations

That the Committee:

1. Note the progress made towards meeting the statutory requirements of the Care Act.
2. Note the update on the financial impact modelling.
3. Note the timing and number of decisions required to be taken.

BARNET LONDON BOROUGH

1. WHY THIS REPORT IS NEEDED

1.1 This paper identifies the major policies needing decisions of the Adults & Safeguarding Committee based on the Care Act and its draft regulations and guidance for implementation in 2015. There may also be other policy decisions which cannot be determined until final guidance is issued and analysed. Officers are unable to say at this time what the policy implications are from the regulations and guidance for implementation in 2016 as these have not yet been published. There is a suite of operational policies, which cover areas such as Safeguarding, Direct Payments, Personal Budgets and Ordinary Residence that will also need to be refreshed.

1.2 The Department of Health's consultation on the draft regulations and guidance for implementation in 2015 ended on 15 August 2014 and LBB has submitted a response. The Department of Health intends to publish the final documents in October 2014 and the draft regulations will be laid before Parliament at the same time. The draft regulations and guidance for implementation in 2016 are scheduled to be published in October 2014.

1.3 Barnet-specific financial impact modelling was completed in July 2014. Since then, the Deferred Payments modelling has been refined and LBB has undertaken additional financial analysis as part of a national exercise. A further iteration of modelling is scheduled to be delivered in October 2014 and this will form the basis of LBB's budget planning. At that point there will also be a greater degree of certainty about the impact and the funding available from central Government.

1.4 The Department of Health is consulting on the funding formulae for implementation of the Care Act in 2015/16. The consultation closes on 9th October 2014. There are three distinct formulae to consider:

- Cap (on care costs) Additional Assessment Relative Needs Formula - additional assessments for the cap (plus capacity building and local awareness) and paid as a Department for Communities and Local Government revenue grant.

- Deferred Payment Allocation Relative Needs Formula - new demand resulting from the introduction of the new deferred payments scheme and paid as a Department for Communities and Local Government revenue grant.

- Social Care in Prisons - meeting care and support needs in prisons and paid as a Department of Health revenue grant.

1.5 There are choices in the formulae presented for the Cap Additional Assessment Relative Needs Formula and Deferred Payment Allocation Relative Needs Formula. LBB is currently preparing a response to this consultation.

2. REASONS FOR RECOMMENDATIONS

2.1 Update on Progress

2.1.1 The Council has responded to the consultation on the draft regulations and guidance and a copy of Barnet's response is attached as Appendix A.

2.1.2 The Adults and Safeguarding Committee has established a Care Act working group made up of Cllr. Cohen, Cllr. Longstaff, Cllr. Rajput and Cllr. Rawlings, supported by Karen Ahmed (Later Life Lead Commissioner) and Dawn Wakeling (Adults and Communities Director).

2.1.3 The implementation is being managed through seven work streams and implementation plans are now in place for:

- Demand Analysis and Modelling: forecasting 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 carers' 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.

2.1.4 The Department of Health (DH) in collaboration with the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), the County Councils Network and London Councils has initiated further work to support councils in understanding their local costs. Key decisions about implementation will be made by the national Care and Support Reform Programme Board.

2.1.5 To support this process, DH, LGA and ADASS have taken steps to integrate modelling from all local authorities into a national risk assessment. A single model, known as the Lincolnshire model, has been adopted for this exercise. It focuses on three key cost areas covering 2015 only:

- Early assessments towards the cap on care costs,
- Carers assessments,

- Carers support.

2.1.6 Barnet has completed the Lincolnshire model and used it to refine the local cost model which covers all aspects of the Act.

2.1.7 The First Contact, Eligibility, Assessment and Support Planning workstream is developing proposals for a cost-effective business process which will meet the increase in demand and deliver the eligibility, assessment and support planning requirements. The business case envisages a new approach to assessments to enable LBB to deliver a significantly greater number of assessments by:

  - A new range of assessment models.
  - Increased self-assessment.
  - More assessments at the first contact service.
  - Third party assessors for simple/straightforward assessments.

2.1.8 New IT tools and processes have been set out and will be developed by the Investing in IT Project. Full proposals will be presented to Committee for approval at a future meeting.

2.1.9 The Finance workstream has drafted a Universal Deferred Payment Policy. This is now out for public consultation until 21 October 2014. The consultation documents and online survey are available on Barnet's Citizen Space: (http://engage.barnet.gov.uk/adult-social-services/consultation-on-deferred-payments-scheme/consult_view).

2.1.10 A public internet page aimed at all social care users and carers has been prepared and will be launched in September 2014. This will provide an overview of the changes arising from the Care Act, Easy Read Care Act information, Frequently Asked Questions and a dedicated email address for questions.

2.1.11 DH, LGA and ADASS are undertaking the second of a series of Care Act stocktakes to inform the LGA's understanding of council's concerns. This survey builds on the first stocktake in Spring 2014, which clearly highlighted IT, workforce, funding and communications as key areas requiring further work. In response to this a number of tools and support materials have been developed by the National Care Act Programme team, with further support also in development.

2.2 Policies and Key Decisions

2.2.1 The policy and key decisions so far identified as needing consideration by the Committee are detailed below together with the meeting dates proposed for the forward plan. These decisions have been developed jointly by the statutory director and the Council's legal team, HBPL.

Report Title	Brief Description	Public Consultation Required
Adults and Safeguarding Committee - 4 December 2014		
Young Carers & Transitions Paper	FOR NOTING: A paper describing the new duties for young carers and people transitioning to adult social care arising from the Care Act 2014	No
Adult Social Care Deferred Payments Policy	FORMAL POLICY FOR ADOPTION: Updates the current Deferred Payments Policy to meet the requirements of the Care Act 2014.	Yes
Adults and Safeguarding Committee - 19 March 2015		
Remodelling Adult Social Care to meet Care Act requirements and pressures	FORMAL DECISION: A paper proposing changes to the ASC process that will enable it to comply with the Care Act 2014	Yes
Market Failure Policy	FORMAL POLICY FOR ADOPTION: A new policy arising from the Care Act 2014 formalising the new duties of the council where a care provider fails.	
Market Shaping Paper	FORMAL Decision: A paper proposing how council can develop a sustainable social care market place to meet the new duties of the Care Act 2014.	
Information & Advice Policy	FORMAL POLICY FOR ADOPTION: Stating Barnet's approach to Information & Advice and Advocacy services in relation to the requirements of the Care Act 2014	
Prevention Policy	FORMAL POLICY FOR ADOPTION: Stating Barnet's approach to preventative services in relation to the requirements of the Care Act 2014	
Care and Support Contributions Policy	FORMAL POLICY FOR ADOPTION: Replaces the current Fairer Contributions Policy with a new policy in line with the requirements of the Care Act 2014. Potentially minor changes covering charges for Self Funders, Carers and preventative services.	
Adult Social Care Eligibility (Cared for People) Policy and Adult Social Care Eligibility (Carers) Policy	FORMAL POLICIES FOR ADOPTION: Adopts the following changes introduced by the Care Act 2014: ○ The new National Eligibility Criteria. ○ The changes to the definition of Ordinary Residence. ○ The new duties of the council in relation to people who move in or out of the Borough.	
Adults and Safeguarding Committee – later in 2015		
Adult Social Care Contributions Cap & Care Accounts Policy	FORMAL POLICY FOR ADOPTION: Formally adopts the Contributions Cap & Care Account introduced by the Care Act 2014 and describes how it will be applied in LBB.	6 weeks public consultation.
Adult Social Care Appeals and Complaints Policy	FORMAL POLICY FOR ADOPTION: Revisions to the appeals and complaints policy to take account of the independent complaints procedure being introduced by the Care Act 2014.	

2.2.2 Public consultation will be undertaken on policies where required. Public consultation on the proposed Deferred Payments Scheme started on 9 September 2014 for 6 weeks. The new proposed scheme together with the outcome of the consultation and the equalities impact assessment will be put to members at their 4 December 2014 meeting for a decision.

2.3 Financial Modelling

2.3.1 The financial model presented to the Committee in July has been updated and refined in order that the Council can identify a single amount to use in its long term financial planning. It is anticipated that new burdens money will be allocated to the Council in order to meet Care Act demand. At the time of writing, the Council are being consulted on the allocation for 2015/16 which is between £1.767m and £1.887m for assessments and deferred payment. An additional £847k has been allocated to the Council through the Better Care fund for the cost of the Care Act. It is anticipated that in 2016/17 a higher amount of funding will be allocated to the Council to manage the increase in demand.

2.3.2 The model below illustrates the council's best estimate of the costs likely to arise as a result of the Care Act. The assumptions used in this modelling have been further refined by the Council's Finance Team and triangulated against the Lincolnshire national modelling tool and other resources. It should be noted that the modelling is still based on a number of assumptions and it is therefore possible that actual costs may be higher or lower. A review of future demand going forward will be modelled and presented to Committee in October 2014.

2.3.3 The Barnet modelling is presented in the following table:

	Medium Volume (£k)							
	15/16	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**21/22**	**22/23**
Carer Assessments	1,055	1,055	1,055	1,055	1,055	1,055	1,055	1,055
Carer Packages Costs	1,161	1,161	1,161	1,161	1,161	1,161	1,161	1,161
Residential & Nursing Assessments	44	292	292	292	292	292	292	292
Residential & Nursing Care Package Costs	0	6,908	6,908	6,908	9,331	11,755	11,755	11,755
Community Based Assessments	669	4,462	4,462	4,462	4,462	4,462	4,462	4,462
Community Based Care Package Costs	24	771	771	771	1,585	1,585	1,585	1,874
Deferred Payments	0	0	0	66	132	199	199	199
Existing Clients - Residential	0	0	0	0	107	107	91	0
Existing Clients - Community Based	0	181	54	25	7	0	4	0
Financial Impact	**2,953**	**14,830**	**14,702**	**14,740**	**18,133**	**20,616**	**20,603**	**20,797**

2.3.4 Current modelling has shown that Barnet can expect between 30 and 44 deferred payment applications a year once changes to the Care Act are implemented. Based on current government estimates of arrangement and administration costs, once the scheme is fully utilised the arrangement and administration costs for deferred payments will be between £24k and £36k per year.

37 clients p.a. and average deferral of £36k p.a. (£k)	2015/16	2016/17	2017/18
Cashflow implications of Deferred Payments	£1,038	£3,477	£4,372

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None

4. POST DECISION IMPLEMENTATION

4.1 When the DH publishes the final version of the regulations and guidance in October 2014, officers will revise local policies accordingly. At the same time, the draft regulations and guidance for implementation in 2016 will be published for consultation and officers will be analysing this and preparing a response.

A refreshed financial impact model will be delivered in October which takes account of the final version of the regulations and guidance

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Successful implementation of the Care Act will help to support and deliver the following 2013/16 Corporate Plan priority outcomes:

- "To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health".
- "To promote a healthy, active, independent and informed over 55 population in the borough so that Barnet is a place that encourages and supports residents to age well".
- "To promote family and community well-being and encourage engaged, cohesive and safe communities".

5.1.2 The Health and Well-being Strategy 2012-15 echoes many themes of the new policy framework with its emphasis on promoting independence and well-being whilst ensuring care when needed. The reform agenda links directly with three of the main strands of the strategy: Well-being in the community; How we live; and Care when needed. In particular, 'Care when needed' identifies plans for developing increased independence for older people, improving support for residents in care homes and improving support for carers.

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

5.1.3 It is clear that the Care Act will have a significant financial impact on social care locally as detailed in the previous report to Committee and this report. Modelling is continually being refreshed to identify the impact of this.

5.2 Legal and Constitutional References

5.2.1 The Care Act is an overarching piece of legislation which brings together legislation, practice and case law which has developed over the decades. It has put on a statutory footing for the first time good practice such as the establishment of adult safeguarding boards and has repealed legislation which has been determined as incompatible with the European Convention on Human rights. It is intended to be less complex and easier to apply for practitioners within the local authority, their legal advisers and, in the case of legal challenges, the Courts. However, it does have a significant impact on existing policies as highlighted in this paper.

5.2.2 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.

5.3.3 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.

5.3 Risk Management

5.3.1 The Care Act sets out a number of new statutory requirements and duties and hence provides a legal basis for challenges where duties are not met. A successful implementation of the Care Act mitigates against the likelihood of this risk.

5.4 Equalities and Diversity

5.4.1 An Equality Impact Assessment will be carried out on all new policies, services and processes proposed for implementation as a result of the Care Act Implementation Project.

5.5 Consultation and Engagement

5.5.1 The requirement for public consultation is addressed within this document.

5.7 BACKGROUND PAPERS

5.7.1 Special Safeguarding Overview and Scrutiny Committee on 24 September 2012 received a report on the 3 key adult social care policy documents published in July 2012: Caring for Our Future (White Paper); the draft Care and Support Bill; and the Government's interim statement on funding reform for Adult Social Care. The Committee endorsed Officers undertaking further work to assess the potential impact of these policy changes on Barnet. Adult Social Care and Health (1.1)

5.7.2 Cabinet on 18 April 2013 received a report describing the main impact of the White Paper, Caring for our Future, and the draft Care & Support Bill, both published in July 2012; and of the policy statement on Care and Support Funding Reform, presented to Parliament on 11 February 2013. The report set out the implications for Barnet based on empirical data and modelling where appropriate. Social Care Funding Reform and the Draft Care and Support Bill: Implications for the London Borough of Barnet (3.1)

5.7.3 Health and Well-being Board on the 27 June 2013 received a report which summarised the implications of the Care Bill and a further report on 21 November 2013 to update the Board on progress made locally to prepare for the implementation of the new legislation. Social Care Funding
Care and Support Bill Update (1.1)

5.7.4 The Safeguarding Overview and Scrutiny Committee on the 10 April 2014 received a report setting out the main points from the forthcoming changes to social care legislation as set out in the Care Bill, the implications for Barnet and the approach being taken to prepare for the new requirements. The Care Bill Update Report (2.1)

5.7.5 The Adults and Safeguarding Committee received a report on the implementation of the Care Act on the 2 July 2014. The Implementation of the Care Act

5.7.6 The Adults and Safeguarding Committee received a report on the Consultation on the Statutory Guidance on the 31 July 2014. Response to Consultation on the Care Act Guidance

Department of Health: The Care Act 2014. Consultation on draft regulations and guidance for implementation of Part 1 of the Act in 2015/16

Response by the London Borough of Barnet

August 2014

Introduction

The London Borough of Barnet is pleased to have the opportunity to respond to the Department of Health's consultation on the draft regulations and guidance for implementation of Part 1 of the Act in 2015/16.

We have actively participated in developing the London ADASS response to the consultation. The Barnet response should be read alongside that document. Barnet is one of the largest London Boroughs with a high proportion of residents aged over 65. Barnet's population is set to increase significantly, with increases in people living with dementia and younger adults with complex disabilities. Barnet is also home to a large number of care providers, with 103 registered care and nursing homes in the borough. This response focuses on aspects of the regulations and guidance in respect to our local context and in the climate of financial austerity.

We welcome the degree to which the regulations and guidance enshrine existing good practice into the legal framework for social care. From a service user perspective, we welcome the move towards national consistency in quality, care safeguarding and personalisation. However, a key concern is that the new responsibilities are appropriately financially resourced in order that Barnet can meet its duties under the Act. Our current modelling suggests that notified new burdens funding for Barnet will not be sufficient to meet the true costs of delivering the reforms enshrined in the Care Act and the draft regulations and guidance.

The impact of the Act and regulations

- Barnet's modelling indicates that the 2015 legal changes will bring significantly increased volumes of assessments, which in turn will lead to increased support plans and reviews. Our research indicates that:
  - Up to 6,000 additional self-funders living in the community could come forward requesting a service user assessment, in addition to an average of 2,500 service user assessments.
  - Up to 9,620 additional people may come forward requesting a carer's assessment, in addition to an average of 2,000 carer assessments.
  - Up to 1,000 self-funders living in nursing and care homes who will request an assessment in advance of the capped costs system going live in 2016.

BARNET LONDON BOROUGH

- Detailed analysis of the Barnet population indicates that Barnet residents are likely to be early adopters of the reforms, as they have key characteristics of liking to be well informed, concerned about health and wellbeing and aware of their rights. We therefore anticipate that the majority of the numbers listed above will come forward.
- We therefore have significant concerns regarding the costs to Barnet of carrying out the new and additional duties created by the Care Act, such as:
  - The additional costs of undertaking service users and carers' assessments with the additional packages of care required would be up to £4 million in 2015/16 and £16 million in 2016/17.
  - The capital amount of funding tied up in deferred payments, once the scheme is fully utilised, will fall between £3 million and £5.2 million (average estimate £4M) at any point in time.
  - There are as yet unknown financial implications to cover the provision of advocates and to pay family members for managing and/or providing administrative support of direct payments. There is no existing funding in place to cover these.
  - The increase in the cost of care to local authorities as a direct result of enabling self-funders to request that the local authority arranges their care at local authority rates. Providers are likely to raise their prices to local authorities to compensate for the loss of these people paying private market rates.
  - The substantial and unpredictable costs of meeting needs in the case of business failure. Due to the high number of care homes in the Borough, there is a higher likelihood of this happening in Barnet than almost any other London Borough.
- The Care Act carries significant implications for the workforce. The social care workforce in and around London is very mobile and people can easily commute to most London Boroughs. With the anticipated increase in demand for assessments for self-funders and carers, we are concerned that competition for staff will increase Councils' direct and indirect workforce costs.
- The wording of the draft regulations and guidance needs amendment in order to avoid the potential for high levels of costly legal challenges for Councils. A search in Word (the IT programme) shows 674 'must's and 1343 'should's in the guidance. Any of these which are not adhered to therefore create an opportunity for legal challenge. There should be absolute clarity about what is statutory guidance and what is best practice guidance re-drafting should take place to ensure that the statutory guidance only uses the words 'must' and 'should' when these relate to clear statutory requirements.

General responsibilities and universal services

1. Whilst the guidance generally provides us with the information we need to embed wellbeing, we are concerned about the cost of implementation and the impact on the whole social care workforce. There is no cost implication attached to the wellbeing principle in the Department of Health impact assessment. However, it is likely that there will be significant costs to Councils of meeting this principle and that Council's will face legal challenge on this principle, increasing risk further.
2. Identifying the different approaches to prevention is helpful although from an individual's perspective it might be seen as a continuum without necessarily a progression to higher levels. It is unclear where the example and case study provided in the guidance fit in terms of the levels described. In any case, they appear to be from later on in the prevention pathway. We would welcome examples of evidence-based interventions from earlier in the prevention pathway, that is to say primary and secondary prevention.
3. We see prevention as key to an individual's wellbeing. We also see it as an important mechanism for reducing demand for resources in an environment of increasing demand and financial austerity.
4. It appears that prevention and well-being as described in the guidance are seen as being driven, commissioned or provided by the local authority and as a result do not recognise the role and contribution of, for example, local support networks and the role of the local authority in developing community-based resources.
5. We anticipate that there will be some challenges in demonstrating the effectiveness of preventative services. We would welcome guidance on how this might be done.
6. The Barnet approach of using Later Life Planners for older people on the cusp of becoming eligible for state funded care is an example of good prevention and advice. Later Life Planners can be seen as a 'triage' service to assist in a healthy and active lifestyle for older people. When the person's needs become greater than they can manage themselves the Later Life Planner is then able to refer them to the necessary services.
7. The guidance places a duty on local authorities to ensure that information and advice services have due regard to people who do not have English as their first language. We feel that this places a disproportionate burden on London Boroughs because of the high diversity of spoken languages when compared with other local authorities. This guidance also appears to conflict with guidance from the DCLG which advises local authorities to stop translating documents into community or foreign languages to make savings and because translation undermines community cohesion by encouraging segregation. There should be consistency between the guidance from DH and DCLG and a clear message to local authorities, consistent with the Localism agenda.

First contact and identifying needs

8. We believe that the guidance on the national eligibility threshold needs to have greater detail to ensure that it is applied consistently.
9. Based on Barnet's participation in the recent ADASS/LSE survey on the new eligibility criteria, we feel that more people are likely be eligible under the new eligibility criteria than under the Council's current FACS threshold of critical and substantial. The professional opinion of social workers taking part in the study was that it could lead to an increase of 15%-20%, in turn leading to an increased pressure on our budgets.
10. In addition to more people meeting eligibility criteria, we believe that the number of people's eligible needs is likely to increase. For example, including cleaning and maintenance of the home as an essential care task is likely to greatly increase support for stand-alone domestic services. This will also lead to increased budgetary pressures. Barnet's understanding is that the new national threshold was intended to be equivalent of FACS substantial and critical, which indicates that the current draft eligibility thresholds need to be revisited in order to achieve this level. The alternative is that sufficient new burdens funding is given to Councils to meet this increased demand.
11. For the carers' eligibility criteria, we are concerned that there is no threshold in terms of the amount of care being given and that this will result in a significant number of people becoming eligible for support as carers. In addition, identifying child care as an essential task is likely to increase the need for additional child care services and demands on Council budgets. Again, this is an area that needs to be recognised in new burdens funding for Councils.
12. The list of tasks underpinning the national eligibility criteria is felt to be too prescriptive and that there should be a focus on outcomes which enable the tasks to be defined by individual circumstances.
13. We feel that greater clarity is needed on the status of advocates and their role and responsibilities. There also needs to be clarity on the relationship between the advocate, the nominated individual and the practitioner and how advocacy would work across health and social services. We would appreciate some guidance on what qualifications and experience a suitable advocate should possess.

Charging and financial assessment

14. The regulations and guidance are generally clear and offer the flexibility to decide locally whether to charge for preventative services or not. This flexibility is welcomed.
15. Whilst the option to charge carers has always been available to local authorities, this is not something that councils have routinely done and most, if not all, do not charge carers. This is different to the situation for service users. However, with the anticipated increase in demand for carers' assessments and support, it is likely that some councils will reconsider this position in the future in order to meet the financial challenge this creates, but this remains a flexibility. There is potential for a postcode lottery in terms of charging for carers, which is at odds with the spirit of the Act in terms of national consistency.
16. The Act requires local authorities, when requested, to arrange the care and support of those people with eligible needs whose financial resources are above the financial limit. Such care and support would be arranged through the authority's contracted providers. Because of the amount of care and support procured, we are able to purchase this at a discount. Many providers cross–subsidise their discounted prices with their full priced offerings sold on the open market. If sufficient self-funders choose to take advantage of local authority discounted rates, we predict that this will push providers to raise their discounted prices to compensate, thereby putting pressure on local authority budgets. They may also reduce their prices on the open market to encourage self-funders to purchase through that route.
17. The Regulations and Guidance state that interest charged under a DPA should not exceed the maximum amount specified in the regulations and that this would be between 3.5% and 5%. They do not specify how frequently interest can be compounded. We would like to have the ability to compound daily.
18. We feel that the Act misses an opportunity to strengthen the powers of local authorities in instances of fraud and financial mismanagement. We think that it is important that local authorities should still be able to use their HSSA powers and that any debts underwritten/carried by a local authority should be protected.

Person-centred care and support planning

19. We support the approach of people being in control of their own care and their active involvement in the support planning process. We support Personal Budgets for carers as this reinforces carers' rights and the support given to them in their caring roles.
20. We welcome the emphasis that the Draft guidance places on the use of approval panels acting in a timely manner that minimises bureaucracy. We also agree that approval panels should not operate for purely financial reasons. However, we think that the guidance should also emphasise the role that approval panels have to play in quality control, managing risks and ensuring consistency of provision and decision taking.
21. The proposed use of advocacy in support planning means that local authorities must ensure a good local supply of quality advocacy services. The success of efforts to this end cannot be guaranteed and there should be work at a national level to develop sufficient capacity in the system.
22. We think that there should be some national direction on calculating the indicative personal budget. Whilst we acknowledge there are variations between local authorities and that costs and prices vary, a consistent approach is needed if local authorities are to avoid disputes and legal action, especially in the light of the Act's emphasis on continuity and consistency of care across local authority boundaries.
23. We welcome the innovation of paying close family members to administrate/manage direct payments although this will have cost and monitoring implications that are currently unbudgeted for and which should be recognised in new burdens funding.

Adult safeguarding

24. We welcome the regulations and guidance on Adult Safeguarding and see them as enshrining good practice in law.
25. The Act and regulations place a range of duties on Councils. Safeguarding is also the responsibility of partners such as the NHS and the Police. There is a need to ensure that adult safeguarding requirements for partner agencies are also embedded in legislation, guidance and national performance arrangements.

Integration and partnership working

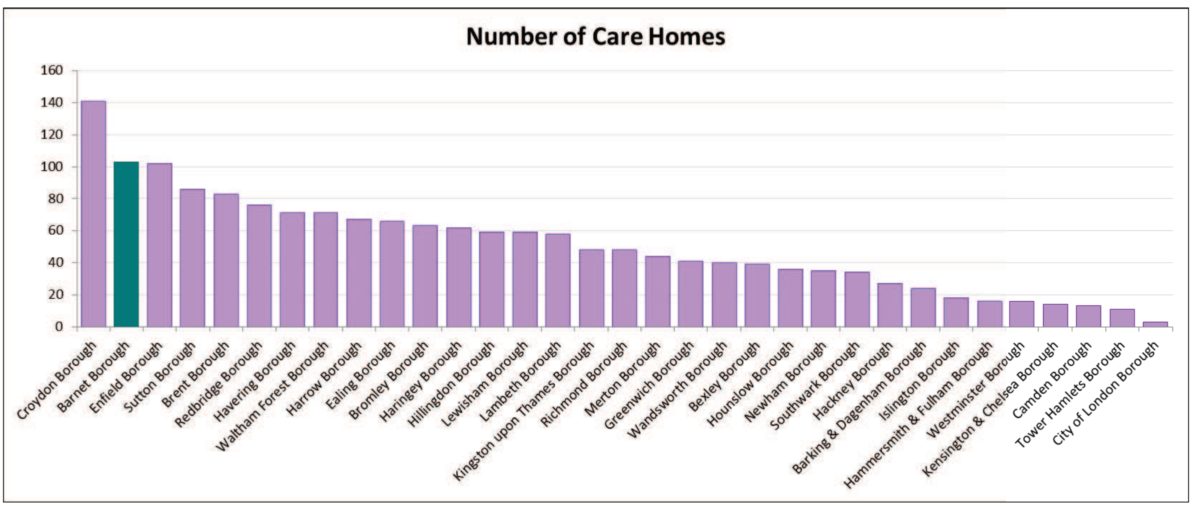
26. We feel that it is very helpful to have the guidance surrounding integration brought together in one chapter. The regulations and guidance make explicit what is generally regarded as best practice such as in transitions between adults and childrens services. However, there needs to be more clarity about how integration between health and social care should be achieved, with clear responsibilities on all partners.
27. We feel that there should be more in the guidance about joint commissioning as a key mechanism for achieving integration and co-operation and that there should be a direct reference to Section 75 of the National Health Service Act (2006) and its role in integration.
28. We welcome the duty of local authorities and the Department for Work and Pensions (i.e. JobCentre Plus) to cooperate. This was a successful component of the Right to Control pilots. We know from Barnet's experience that employment is a major contributor to the wellbeing of people with learning disabilities, physical disabilities or mental health issues. Their needs in accessing employment are very different from the general population and cannot best be met from the existing contracts JobCentrePlus has with the prime providers. Much greater operational flexibility is needed from partners and the guidance needs to be much clearer on the type of cooperation expected and the responsibilities that partners have to work with local authorities.
29. We recognise that there are some opportunities for implementation in London, for example, the Mayor's interest in mental health and employment, and that there could be a pan-London approach on some issues.

Moving between areas: inter-local authority and cross-border issues

30. We feel that the guidance and regulations about ordinary residence disputes provide clearer guidance than in the past and should reduce the numbers of disputes.
31. However, as one of the London Boroughs with the highest number of residential care homes within its boundaries, we feel that there should be specific guidance on the ordinary residence of self-funders who arrange residential accommodation in an area other than that in which they had previously been resident.

Annex A: Market oversight and business failure

32. We welcome the new duty of the local authority to meet needs in the case of business failure. The very threat of an interruption to care and support services can impact severely on the wellbeing of people using services. Nevertheless, Barnet has 103[1] residential and nursing homes, the second-highest in London, and the likelihood is high that the Council will have to exercise these functions and expend considerable resources when it is called upon to do so. We have recent experience of having to move all the packages of care from one home care provider to another. Approximately 200 people were affected and it cost us in excess of £100k in management, procurement, stand-by services and reviewing costs. We would suggest that the government considers providing funding to meet the costs of provider failure when it does occur.



[1] Source: http://www.carehome.co.uk/

AGENDA ITEM 10

Adults and Safeguarding Committee

2 October 2014

Title	**Mental Health Services in Barnet**
Report of	Family & Community Well-being Lead Commissioner
Wards	All
Status	Public
Enclosures	Appendix A - Mental health commissioning intentions – additional detail
Officer Contact Details	James Mass, Family & Community Well-being Lead Commissioner, 020 8359 4610, james.mass@barnet.gov.uk

Summary

Adult mental health services across the NHS and social care are under considerable pressure. As the number of acute in-patient beds decreases, the pressure on social care budgets for adult mental health services now represents the fastest area of demand-led spend.

This paper sets out a draft approach for the delivery of adult mental health services provided by the local authority to re-focus social care on recovery, social inclusion and enablement in the form of commissioning intentions. It outlines the steps needed to achieve this specification and the positive impact this should have for residents of Barnet. If the proposed approach is approved, this will then need to be tested and worked through with partners as it is developed into an implementation approach and plan.

Recommendations
1. That the Adults and Safeguarding Committee approve the proposed commissioning intentions for mental health services contained within this paper.
2. That the Adults and Safeguarding Committee instruct officers to develop an implementation approach and plan to be brought back to this Committee for approval in spring 2015.

1. WHY THIS REPORT IS NEEDED

Vision

1.1 The Business Planning report that was noted by the Committee on 31 July 2014 set out a vision that all adults will be given the opportunity to live well, age well and stay well. This means that all adults will feel safe and be safe in their environment. Financial constraints should not hinder the delivery of good outcomes for all. There will be a strong sense of community that supports personal growth and independence and an overall focus on early intervention and prevention with a reshaped specialist care offer for those that need it.

1.2 Our overall vision, therefore, could be summarised as to:

- Achieve more, with less.
- Move away from ‘professionalised’ models of care towards more community, home-based, peer-led models of support.
- Reinforce relationships and community connections.
- Rebalance the model: orientate professionals towards prevention and early intervention for both carers and users; integrate community and peer groups into specialist care.
- Help providers, users and carers to be better at long-term planning, managing and supporting demand rather than rationing supply.
- Focus on the quality of relationships (between users and those who support them) and depth of our knowledge about users’ needs and assets.

Context

1.3 Adult mental health services across the NHS and social care are under considerable pressure. As the number of acute in-patient beds decreases, the pressure on social care budgets for adult mental health services now represents the fastest area of demand-led spend. There is a risk that social work is operating in the context of the containment model, with the social work task reduced to a care management role and securing placements to meet housing and support needs.

1.4 The role of the local authority in adult mental health services includes social care assessment and interventions, safeguarding vulnerable adults, public

health early intervention and prevention services and work with partners on employment to enable recovery and mental health improvement. This paper does not focus on the authority's commissioning intentions regarding dementia which forms part of the frail elderly health and social care business case. The Committee's Commissioning Plan will detail intentions to support older adults with dementia and working age adults with early onset dementia.

1.5 Barnet CCG is currently undertaking a review of mental health services to inform their future commissioning intentions alongside a 5 year North Central London Commissioning Plan to guide commissioning in the 5 CCGs in the region. A Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) Transformation Board has been established by the three CCGs and councils to improve services and respond to the financial challenge of the Trust.

1.6 The CCG's South Locality Network is currently developing plans to pilot an 'Integrated Primary Care Mental Health' model to run until July 2015. The pilot has been supported by the CCG through the Primary Care Strategy Grant and aims to increase the capacity and capability of primary care to manage mental health care and treatment, provide high quality care closer to home improving the experience and outcomes of patients through delivery of integrated mental health and physical health care to patients who otherwise fall between the gaps and who hitherto may have been difficult to manage in primary care because of the complexity of their mental health conditions.

1.7 The Public Health team are commissioning schemes that support people with mental health problems into employment. These include an Individual Placement and Support model that will be integrated into the Community Mental Health teams and a service that co-located psychological support with JCP. These services will be in place from October 2015 and they will be independently evaluated by the National Development Team for Inclusion.

1.8 Job Centre Plus (JCP) support a range of multi-agency initiatives including the Welfare Reform Task Force, Troubled Families, Integrated Offender Management, Care Leavers Hub and Burnt Oak Jobs Team. All recognise mental health barriers to employment and a number have specialist support co-located within the team. In February 2014 there were 10,830 people claiming either Employment Support Allowance or Incapacity Benefit in Barnet - 40% of these claims are for mental health problems (over 4,000 people). The proportion of disabled people in employment in Barnet is below the London average.

Challenges

1.9 With social care services integrated into secondary care mental health services, specialist assistance and advice is not always readily available in the community for low level issues. This risks assistance only being provided following a crisis situation. There are opportunities to redefine the role of mental health social workers to focus on more protective factors located outside of a medical model and to provide independent challenge and review of support proposals for people with mental health needs. These opportunities

have been published in the College of Social Work's paper on 'The Role of the Social Worker in Adult Mental Health Services'[1].

1.10 Adults with a severe and enduring mental illness face considerable social exclusion. This is evidenced through high rates of worklessness, social isolation, poorer physical health and insecure housing arrangements all of which create demand on other elements of the state for support. Health and social care services have over time created dependency through not having the capacity or focus to work with the natural support systems and the capabilities that people through being part of their local community can bring to resolve their own problems and make their own sustainable support arrangements.

1.11 In some instances individuals are being placed in residential settings because of a lack of local supply of alternatives. There is scope to consider the development of a wide range of accommodation options, including home ownership schemes, with a varying spectrum of support to meet the differing needs of the adult mental health population. The quality and availability of community mental health support will drive demand for restrictive and traditional placements where quality is poor or where support is not provided in a timely and accessible manner.

1.12 Mental health and substance misuse continues to be a key risk factor in respect of child development. The separation of adult mental health social work from children's social work can result in support and interventions not sufficiently joined up around a family. This can result in missed opportunities to put in place effective and sustainable safeguards to enable a child to thrive and remain with their family.

1.13 Councils need to ensure that there is an Approved Mental Health Professional (AMHP) workforce to discharge responsibilities under the Mental Health Act. It would be expected that within a modern AMHP service there would be a multi-disciplinary workforce with professionals from both health and social care.

1.14 The Local Authority is responsible for the provision of the Approved Mental Health Practitioner Service which is intended to safeguard the rights of those subject to the Mental Health Act 1983. Within a service which is demand and crisis led, there is a risk that this statutory requirement will dominate mental health investment within Barnet. Without effort from both health and social care, the current configuration of services which manage crisis, acute and AMHP service care, there is increased risk that Social work time will be diverted from activity that is focussed on social inclusion and recovery.

[1] http://www.tcsw.org.uk/uploadedFiles/TheCollege/Policy/MH%20Launch%20Document%20April%202014.pdf

2. REASONS FOR RECOMMENDATIONS

2.1 The table below sets out recommended commissioning intentions for the Committee. These are expanded upon in Appendix 1 at the end of this document. These are all intended to promote recovery, social inclusion and enablement so that individuals with mental health issues in Barnet are able to live fuller, better lives in society.

	Commissioning intention	Intended impact
1	The re-focusing of social care on recovery, social inclusion and enablement. This will require a redefining of the integrated services model with the mental health trust to enable both parties to focus on core competencies and develop effective partnership practice. A smaller number of social workers would be based within with the Mental Health Trust to support effective crisis resolution and effective management of people subject to community treatment orders and section 117	- Stronger working with primary care. - Redefined mental health social work role to provide a move away from delivery of the approved mental health professional (AMPH) role and care co-ordination to one which focuses on promoting recovery and social inclusion with individuals and families. - Increased focus on social responses that safeguard and promote enablement / recovery. - Increased focus on safeguarding.
2	Review delivery models to ensure that the social work service for working age people with mental health issues can best focus on the quality of services and strengthen the voice of both workers and service users.	- We will have a model for social work which is commissioned to promote recovery, maximise inclusion and reduce long term care costs. This will require working co-productively and innovatively with local communities, primary care and housing providers to support community capacity, personal and family resilience, earlier intervention and active citizenship. - Staff are effectively incentivised to ensure that their way of working achieves these outcomes.
3	Introduce a ‘Consultant Social Worker’ role to work with acute mental health services and children’s social care.	- The role will provide independent review and challenge to support plans and proposed changes to ensure all appropriate support opportunities are explored and provided in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity.

	Commissioning intention	Intended impact
4	Align social work delivery model with community development, whole family approaches and wider wellbeing, particularly focusing on tackling social exclusion and worklessness.	- Working more closely with other public sector agencies such as Job Centre Plus will provide a clear pathway to support people with mental health problems back into work. - The social work delivery model could be jointly commissioned by DWP to ensure people are work ready and supported back into work.
5	Increase the range of sustainable accommodation options for people with mental health problems in conjunction with the NHS.	- There is a compelling evidence base that where we live has a significant impact on our mental health. For the NHS, inadequate access to housing increases costs and demand for acute services. Supported housing for people with a mental illness could benefit the NHS year in and year out to a suggested annualised return of investment of 7% when compared to inpatient care or residential provision.
6	Promoting mental well-being and reducing stigma through establishing joint commissioning of social care with public mental health provision.	- Including mental health within the preventative agenda as an equal to physical health, and targeting support at those with known risk factors, will create reduced demand and allow earlier intervention.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The alternative options considered but subsequently rejected have included:

- Renewing the current section 75 agreement and continuing as-is but with an improvement plan in place.
- Commissioning a new service jointly with the CCG.

4. POST DECISION IMPLEMENTATION

4.1 If the recommendations of this paper are agreed implementation planning work will commence, to be led by the Council but working closely with the CCG. A worked up proposal and implementation plan would then be brought back to this Committee for approval.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Corporate Plan 2013-2016 includes priorities to “sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health” and to promote family and community well-being and encourage engaged, cohesive and safe communities”.

5.1.2 The Health and Wellbeing Strategy for Barnet 2012-2015 includes priorities to increase the proportion of adults with mental health problems in employment and better support perinatal mental health problems.

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

5.2.1 The budget for adult social care mental health is £7.6m p.a The current s75 agreement for seconded mental health social work staff is worth £2.0m p.a. and expires in July 2015. It is anticipated that the proposal will be revenue neutral in the short term and in the medium to long term should deliver total system savings through a shift to more effective, lower cost interventions. This will need to be modelled in greater detail as the implementation approach is developed.

5.3 **Legal and Constitutional References**

5.3.1 The Mental Health Act 1983, the current community care legislation and the Care Act 2014 when it comes into effect impose duties on local authorities to provide services to those with eligible unmet needs.

5.3.2 Additional statutory duties are imposed by the Mental Health Act 1983 particularly for those detangled under the Act and who qualify for after care services under s117.

5.3.3 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.
- 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 A significant risk to the achievement of these intentions is that Barnet Council, the CCG, BEH Mental Health Trust and other partners fail to co-ordinate their activities effectively. Without a shared vision and approach there is a strong risk of poorer outcomes and an increase in demand and so cost. As such the development of the implementation approach will need to be a partnership piece of work involving the joint commissioning team to ensure that plans and incentives will be aligned.

5.4.2 There is a risk of undermining local partnerships with the NHS at a time when national policy direction is for health and social care integration through the Better Care Fund. Under the Care Act 2014, Local authorities must carry out their care and support responsibilities with the aim of joining-up the services provided or other actions taken with those provided by the NHS and other health-related services (for example, housing or leisure services). It is therefore necessary to set out how the new arrangement will support the integration of social work with other aspects of NHS service delivery, notably primary care.

5.4.3 Appendix A details risks identified for each of the commissioning intentions.

5.5 **Equalities and Diversity**

5.4.1 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.

5.4.2 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.

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

orientation.

5.5.1 An Equality Impact Assessment will be completed as part of the development of the implementation approach.

5.6 **Consultation and Engagement**

5.6.1 The development of these proposals has drawn on consultation with mental health service users undertaken by the Council and by Healthwatch Barnet. The implementation approach will need to be developed through testing, and consultation where appropriate, with service users and those who have received services in the past.

6. BACKGROUND PAPERS

6.1 Health and Well- Being Board- held on 20th March 2014 received, commented on and noted the Barnet, Enfield and Haringey Mental Health Trust: Implementation of the CQC action plan/ implementation of the BEH CCG`s mental health commissioning strategy. This updated the Board on progress being made to address quality issues identified following CQC inspections of Trust services.

6.2 Health and Well-Being Board- held on 19th September 2013 received, commented on and noted the ‘Tri-borough Mental Health Commissioning Strategy for Adult and Older Adult Services- 2013-2015’, and Operational Plan 2013 – 2015 and agreed that the Chairman and Chief Executive of the Barnet, Enfield and Haringey Mental Health Trust attend the Board’s meeting in March 2014 to discuss progress at implementing the Strategy.

6.3 Health and Well-Being Board- held on 23rd January 2014- the Board discussed the quality and safety concerns raised by the CQC reports with senior managers at the Barnet, Enfield and Haringey Mental Health Trust. Prior to this, senior officers across the NHS and Council met with the executive team at the Trust to ensure that there was clarity of expectations across commissioners and the Trust as to the actions that are being undertaken and how progress will be monitored. The Board requested an update on progress from the Trust at the March 2014 meeting.

6.4 Special Meeting, Joint Health Overview and Scrutiny Committee- held on 7th February, 2014 received presentations from Barnet, Enfield and Haringey Mental Health Trust and Enfield CCG as lead commissioner of services from the Trust on behalf of Barnet and Haringey CCGs including other associates CCGs.

6.5 Joint Health Overview and Scrutiny Committee- held on 7th February, 2014, received reports on funding of mental health services across the North Central London sector.

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Appendix A – Mental health commissioning intentions – additional detail

1: Re-focusing of social care on recovery, social inclusion and enablement

What is the idea?

Promote a social work role which focuses on protective factors located outside of a medicalised model with much stronger working with primary care.

Where in the customer journey will this idea have an impact?

Focused on all adults with mental health problems

How will it work?

- Social Workers (SWs) will work in a social work community team, closely aligned to primary care and community services, which focuses on social inclusion and recovery.
- Social Workers focus on developing and maintaining protective factors during periods of crisis (e.g. job, family, accommodation) and promoting social inclusion and recovery for those people with severe and enduring mental health problems, acting as care co-ordinators only for those whose primary presenting need is for social care.
- Planning will be supported by a cross-system definition of aftercare with agreed timeframes.
- The home treatment model will be redefined towards an enablement approach.
- Develop and utilise peer led support networks and recovery approaches.
- Create a hub of community support with community and primary care to develop an enablement offer.

What are the policy assumptions?

- The majority (if not all) of the Social Work roles will sit outside of the Mental Health Trust working alongside primary care, children's social care, Job Centre Plus and housing.

What are the risks?

- Mental Health Social Workers need re-training to operate effectively outside of a health model.
- CMHTs do not have capacity to deliver required level of CPA and approved mental health service without social workers.
- A move away from singly managed health and social care teams could result in fragmented care and support arrangements across health and social care and hence increase service user risk.
- Undermining local partnerships with the NHS at a time when national policy direction is for health and social care integration through the Better Care Fund. Under the Care Act 2014, Local authorities must carry out their care and support responsibilities with the aim of joining-up the services provided or other actions

taken with those provided by the NHS and other health-related services (for example, housing or leisure services). It is therefore necessary to set out how the new arrangement will support the integration of social work with other aspects of NHS service delivery, notably primary care.

Mechanisms to make it happen

Commissioning for social care outcomes through explicit social care commissioning strategy (including housing) focused on recovery and inclusion and a whole family approach.

Commissioners to describe model of service which is not diagnosis based but based around risk and need and with right incentives to work to reducing long term dependency on all public services arising from mental ill-health.

Lead Commissioning approach for continuing healthcare and section 117 led by the LA based on principles of personalisation and choice.

Section 75 agreements to underpin lead commissioning and pooled budget arrangements where appropriate.

Consider alternative models of community-based treatment focused around enablement model of care.

Consolidation and alignment of employment support initiatives with social work teams

Potential Delivery Vehicles

1. Separate social work teams for adult mental health, hosted by the Local Authority working alongside NHS teams and aligned to primary care localities / practices.
2. Housing needs staff and JCP to work within or aligned to social work teams working to shared assessments and joint outcomes aligned with the Mental Health outcomes star.
3. Mental Health specialist services commissioned to provide an explicit health and social care enablement service which provides the gateway into funded packages of support from social care.
4. Day services reshaped to become community-led initiatives for peer support groups.

2: Renewing our focus on the quality of services through strengthening the voice of workers and service users through the delivery model

What is the idea?

Too many people who have a severe and enduring mental illness find themselves socially excluded, discriminated against and disempowered to make positive long term decisions about their lives. Their experience of illness can result in a series of losses – job, home, family life - all of which can create a vicious cycle within which a state of long term dependency is created. The key to empowerment is the removal of formal and informal barriers and the transformation of power relations between individuals, communities and public services.

We want to develop a model for social work which is seen as the guiding force in improving a person's life, environment and independence, which, with the housing service is rewarded to empower individuals and promote their recovery and inclusion. This should reduce long term care costs through working co-productively and innovatively with local communities and housing providers to support community capacity, personal and family resilience, earlier intervention and active citizenship.

Where in the customer journey will this idea have an impact?

Focused on all adults with mental health problems

How will it work?

- An options appraisal will be undertaken to review which delivery model will best support the shift in approach to social work that is required.
- Consideration will be given to how the delivery model can:
    - Establish a new relationship with service users to promote co-production.
    - Sustain longer term relationships with service users focused around achievement of recovery based outcomes.
    - Develop specialisms in supporting individuals to become job ready.
    - Create stronger day to day links with GP practices, providing opportunities for earlier family and community based support during a period of ill-health.
    - Allow social workers to focus on developing and maintaining protective factors during periods of crisis (e.g. job, family, accommodation) and promote social inclusion and recovery for those people with severe and enduring mental health problems, acting as care co-ordinators only for those who primary presenting need is for social care.
- Employ social work consultants who will work within Children's Services and specialist mental health services to ensure co-ordinated care and social work outcomes.
- Ensure that all people subject to section 117 and Continuing Healthcare are afforded maximum choice and control over their care and support arrangements.

What are the policy assumptions?

- The Care Act 2014 requires local authorities to co-operate with local partners generally when performing their functions and this includes housing authorities and welfare and employment organisations.
- The Care Act 2014 allows for Local Authorities to commission an independent social work practice to undertake local authority functions in relation to social work.
- The welfare reform agenda has highlighted the challenges of moving people from incapacity related entitlements back into work and this now forms a key risk for the welfare reform agenda. JCP will therefore be seeking and welcoming innovative approaches to addressing this challenge in relation to mental health services with Local Authorities utilising flexibilities through Community Budgets and local 'growth' deals

What are the risks?

- Local Authorities are not able to secure a local joint commissioning partnership with sufficient incentives with Job Centre Plus in order to maximise the opportunity to progress the employment agenda.
- Social workers are not bought into the future delivery model.
- Local authorities will be reliant on strong commissioning to ensure effective delivery of statutory responsibilities in respect of social work.

Mechanisms to make it happen

Commissioners	Providers	Individuals
Commissioning for social care outcomes through explicit social care commissioning strategy (including housing and employment) focused on recovery and inclusion and a whole family approach. Outcomes based commissioning framework provides incentives for social work delivery model whilst allowing sustainability of funding to ensure core functions are delivered.	Consolidation and alignment of employment support initiatives with social work teams JCP / Housing providers might want to consider hosting the social work delivery model in order to ensure sufficient linkages between housing, employment and social care outcomes. Social work delivery model to be aligned to primary care with identification of agreed referral and communication protocols.	Service users to be actively engaged in designing the outcomes framework for the social work delivery model and determining what role they would like to play in both commissioning and delivery.

Potential Delivery Vehicles

1. To be determined

3: Introduce a ‘Consultant Social Worker’ role into adult mental health services

What is the idea?

Create a new role similar to that of an Independent Reviewing Officer (IRO) in children’s social care which will provide independent challenge and review of support proposals for people with mental health needs and will work in specialist mental health services. A Consultant Social Worker could also be based within Children’s Social Care to support the Early Help and Children in Need service ensure that the mental health needs of parents are being addressed as part of family support planning.

Where in the customer journey will this idea have an impact?

Focused on all adults with mental health problems – post crisis

How will it work?

- Experienced and senior mental health social workers could take on role of Consultant Social Worker – they will not be case holding directly but will act as professional leads for adult mental health social work within specialist mental health services and children’s social care.
- Consultant Social workers would be involved in reviewing packages of support being proposed by NHS colleagues to ensure all potential avenues have been considered appropriately.
- Consultant Social Workers will be able to provide independent reports to support s117 aftercare panel reviews and discharge arrangements.
- Consultant Social Worker role will be to provide advice and guidance to other social work functions who may be less experienced working with MH service users e.g. children’s social care where a parent has MH problems.
- Social work consultants will provide professional supervision for social workers working within the social work delivery model.

What are the policy assumptions?

- The Social Work Consultant role will be aligned with the Social Work Professional Capabiltities Framework for Advanced Social Work Practitioner level. Workforce development approaches and reward and recognition policies of Local Authorities will support the establishment of this level of practitioner within the pay structures.
- Resource allocations will not be exceeded in mental health social care.

What are the risks?

- Health will not accept the role of the Consultant Social Worker in challenging support plans or requesting alternative treatment proposals.
- Cost of employing a Consultant Social Worker at similar grade to IRO.
- That the establishment of Mental Health Social Work Consultant roles will diminish the opportunities to recruit AMHPs as will be fishing in the same pool for experienced practitioners.

Mechanisms to make it happen

Commissioners	Providers
To develop a joint policy and protocol across adult services and children's social care for working with and providing support for parents with mental ill-health. To develop a single workforce plan for mental health social work which supports the establishment of new roles and responsibilities across adult services and children's. Work with Health Education England and The College of Social Work to develop the framework within which the new Mental Health staff can be supported to lead.	Role of social work consultants to be formally recognized in the delivery of mental health services by the professional leads within local NHS Mental Health services. Clinical and practice governance frameworks to be developed which are signed off across the system.

Potential Delivery Vehicles

1. Social work workforce strategies and pay scales within local authorities
2. Establishment of mental health strategic partnership board involving commissioners and providers for each patch to sign off practice and clinical governance arrangements and schemes of delegation regarding consultant social work posts

4: Integrated pathways across the wider public sector

What is the idea?

Develop pathways which link MH social care to the wider public sector, and specifically Job Centre Plus (JCP), and establish a 'hub' which provides coordinated support to help people with MH problems (back) into work.

Where in the customer journey will this idea have an impact?

Focused on all adults with mental health problems – recovery phase.

How will it work?

- Social care will work in partnership with JCP to provide support to ESA claimants with a primary cause of mental health to help them return to or commence paid employment.
- Social care to refer mental health service users to JCP for re-assessment and support when social care assessment indicates the service user is ready to return to work. Social work will be incentivised to work towards ensuring that the service user and their support network identifies as being 'work ready'.
- A 'hub' which has multi-agency support from social care, JCP, voluntary sector to support the achievement of social inclusion through work and employment outcomes.
- Professionalisation of the peer-support model to recognise this as a paid position to support people into employment.

What are the policy assumptions?

- People with mental health problems will be affected by the welfare reform agenda and should be proactively supported by specialist mental health staff to have expectations of being in paid employment whether this is support to start, remain in or return to work
- The number of people claiming ESA due to mental health issues in future will be lower than the current benchmark of 44% of ESA claimants
- Whole culture around Mental Health social work system is re-focused on recovery and social inclusion and specifically in getting adults with a severe mental illness work ready

What are the risks?

- No one will underwrite the risk of 'whole place' funding – in order for JCP to commission social workers to work with people to get work ready, each system will need a Community Budget in place between DWP and Local Government with high levels of local discretion to commission local service responses.
- Current Mental Health system geared towards keeping people static and not moving them through the pathway into employment. Neither the NHS nor Social Care has responsibility for ensuring employment outcomes and reducing expenditure on welfare benefits.

Mechanisms to make it happen

Commissioners	Providers
Develop a business case to understand value of worklessness of MH claimants to JCP and build an investment case for partners to work together utilising mechanisms such as Community Budgets Different use of current funding for supported employment schemes Utilise fully the JCP grants to test out approach to build case for change Lobbying DWP for work programme funding	Consortia based approach to bring together the plethora of providers involved in employment opportunities to create a standardized pathway for employment support for people with mental health issues. All NHS providers to ensure that with the consent of the patient that there is effective and positive liaison with patient's employer as part of care and treatment plans. Shared assessment protocols developed between Work Capability Assessments and Social Work assessments.

Potential Delivery Vehicles

1. Formal partnership between JCP and Council through a 'growth deal' or Community Budget
2. Social Impact Bonds to fund the hub or schemes, based on value of ESA saved

5: Increased range of accommodation options

What is the idea?

There is a compelling evidence base that where we live has a significant impact on our mental health. Living in safe, secure environment over which you have personal control provides a perceived buffer to the negative impacts of mental ill health. The inter-relationship between the type, condition or location of housing, with unemployment or low fixed income and health can be demonstrated through a lack of choice, with many people with a mental illness trapped into renting poor accommodation in more deprived neighbourhoods. Poor housing can be described in terms of individual premises, in relation to the physical conditions, and at a community level in terms of lack of community facilities, crime levels, employment and social support networks. Such accommodation does not offer the perceived "buffer" described above.

It would appear however that whichever comes first the poor housing causing mental ill health or those suffering from mental ill-health drifting to poor housing that such conditions negatively impact on mental well-being. Housing policies need to recognise the mental health impact of poor housing and to identify housing options which are affordable and provide support networks that will promote mental well-being. This needs to include home ownership options as part of a wider range of accommodation, including more supported living arrangements.

The Smith Institute (think tank) published a paper in July 2014, setting out the case for NHS surplus land being used for supported housing for people with mental illness. Rather than selling land off for general needs housing, supported housing for people with a mental illness could benefit the NHS year in, year out, to a suggested annualised return of investment of 7% when compared to inpatient care or residential provision.

Where in the customer journey will this idea have an impact?

Transitions and whole adult pathway.

How will it work?

- New types of supported living, connected to communities and with a flexible level of support.
- Effective advocacy and support to help people maintain their homes and family life while in hospital due to mental health crisis.
- Develop a Shared Lives scheme particularly to support young people aged 18-25 with mental health problems and weak social networks to build up their confidence to live independently and safely.
- Accommodation providers will be incentivised to move service users through a pathway of decreasing need from highly supported to independent living.
- Development of affordable housing stock for which adult social care have nomination rights.

What are the policy assumptions?

- There will be no residential or nursing placements for adults with mental health problems.
- People will not necessarily be housed within their local authority area but will be supported to move where this will promote better longer term outcomes particularly in respect of good, secure housing and employment.

What are the risks?

- Benefits system may act as a disincentive – Local Housing Allowance could continue to place vulnerable mental health service users into challenging neighbourhoods which do not promote mental well-being or recovery.
- No suitable land for new development identified by Council or NHS partners.

Mechanisms to make it happen

Commissioners	Providers
Use demand figures to enable providers to unlock lending for supported housing options which underpinned by care and support budgets. Where suitable housing costs exceed LHA rates, voluntary work opportunities allow for care and support budgets to top up rent levels as part of pathway into employment. Social Value Act to be used to secure employment and training opportunities for people with mental health problems including consideration of \sweat equity' to enable people to have a stake in new housing developments through being involved in building of their new home to facilitate a long term affordable housing option.	Housing specialists to work alongside social work practitioners to a single assessment and support planning framework. NHS Surplus land to be used to develop supported housing options for people with mental illness based on long term ROI model through reduced health and social care costs. Actively promote the HOLD scheme for shared home ownership for people with mental illness facilitating wider housing choice and security. Residential and nursing home provision to reduce with sites released for housing options.

Potential Delivery Vehicles

1. Mutual of shared lives providers supported by peer support advisers funded through social impact bond linked to achievement of employment options.
2. Council / NHS becomes a housing developer and or provider, either in or out of borough securing long term ROI through reductions in health and care costs
3. Joint Venture between housing provider and community based social enterprise to develop 'sweat equity' models for housing developments

6: Promoting mental well-being and reducing stigma through establishing joint commissioning of social care with public mental health provision

What is the idea?

Mental health determines and is determined by a wide range of social and health outcomes at individual, community and societal levels and has an impact on all aspects of our lives. Poor mental health contributes to socio-economic and health problems such as higher levels of physical morbidity and mortality, lower levels of educational attainment, poorer work performance/productivity, greater incidence of addictions, higher crime rates and poor community and societal cohesion.

Stigma and discrimination too often play their part in increasing inequalities and can stop people with a mental illness and their carers - engaging in everyday activities – going shopping, visiting the local pub, taking a holiday, obtaining insurance, making new friends, joining a local club, talking openly with family about problems – as well as preventing effective engagement with health professionals, applying for work for fear of discrimination from colleagues or employers and accessing educational opportunities.

Since local authorities became responsible for public health from April 2013, Health and Well-Being Boards have been looking at how the wider determinants of health can be addressed to reduce health inequalities and improve well-being. With a refocusing of social care towards recovery and inclusion, it is crucial that public health commissioning and social care commissioning are aligned in order to create the societal context within which people with a mental illness can be fully included in their local communities and stigma and discrimination is addressed across all stages of the life course. Concepts of joint commissioning between health and social care for mental health will need to be extended to include public health ensuring that there is a single outcomes framework for mental health covering NHS services, social care and public health measures overseen through the Health and Well-Being Board.

Where in the customer journey will this idea have an impact?

Across all stages of the life-course, both at a mental health promotion and through positive interventions to address the social determinants of mental ill health through a whole Council approach.

How will it work?

- All public health preventative activity will include mental health and be led by Public Health to understand areas of need and the gap which must be narrowed.
- Adult social care and Public Health to jointly commission services, particularly in respect of children’s emotional well-being programmes and substance misuse to ensure those at risk of developing poor mental health are provided with advice and information in a targeted way.
- Early intervention in psychosis (EIP) approach will be scaled-up to be offered to a larger cohort through effective working with CAMHs; School Nursing services and JCP.

- Mental Health expertise will be embedded within children's social care in order to raise awareness of risk factors for children living with parents with mental health problems.
- Health-checks will address mental as well as physical health including advice on addressing key risk factors such as alcohol intake and physical activity levels.

What are the policy assumptions?

- Prevention offer will give equal resource and consideration to promotion of good mental health as to good physical health.
- Preventative initiatives will be evidence-based.

What are the risks?

- Value of preventative measures can be difficult to define and quantify return on investment.
- Health campaigns do not necessarily alter behaviours that lead to the development of longer term mental health conditions.
- Prevention activity is not aligned under one strategy so doesn't achieve prevention outcomes.

Mechanisms to make it happen

Commissioners	Providers	Individuals
Outcomes based commissioning strategy for mental health combining NHS, Social Care and Public health outcomes Commission Healthy Workplace Accreditation to promote healthy workplaces and address discrimination from the employment market. Commission specific mental health training and awareness programmes across range of universal services.	Commercially incentivised to embed a model of mental health prevention and well-being Specialist mental health workforce to be required as part of role to increase mental health awareness and skills among a range of public and private sector staff, such as health visitors, teachers, employers and prison officers	Individuals could be incentivised to adopt healthy behaviours.

Potential Delivery Vehicles

1. Jointly commission public mental health services and adult social care support through bringing together of public health commissioning with adult social care.

2. Build disease prevention/joint public health and social care outcomes into contracts and procurements for range of council provision utilising the Social Value act to increase employment opportunities and reduce stigma.
3. Commission primary care, with the voluntary and community sector to deliver all prevention services including the offer for younger adults.
4. Investigate Social Impact Bonds to fund long-term return on investment of prevention.

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Adults & Safeguarding Committee

2 October 2014

Title	**Adults & Safeguarding Committee Work Programme**
Report of	Later Life Lead Commissioner Family and Community Well-being Lead Commissioner
Wards	All
Status	Public
Enclosures	Appendix A - Committee Work Programme June 2014 - April 2015
Officer Contact Details	Anita Vukomanovic, Governance Service Email: anita.vukomanovic@barnet.gov.uk Tel: 020 8359 7034

Summary

The Committee is requested to consider and comment on the items included in the 2014/15 work programme

Recommendations

1. **That the Committee consider and comment on the items included in the 2014/15 work programme**

1. WHY THIS REPORT IS NEEDED

1.1 The Adults & Safeguarding Committee Work Programme 2014/15 indicates forthcoming items of business.

1.2 The work programme of this Committee is intended to be a responsive tool, which will be updated on a rolling basis following each meeting, for the inclusion of areas which may arise through the course of the year.

1.3 The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

2. REASONS FOR RECOMMENDATIONS

2.1 There are no specific recommendations in the report. The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 N/A

4. POST DECISION IMPLEMENTATION

4.1 Any alterations made by the Committee to its Work Programme will be published on the Council's website.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Committee Work Programme is in accordance with the Council's strategic objectives and priorities as stated in the Corporate Plan 2013-16.

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

5.2.1 None in the context of this report.

5.3 Legal and Constitutional References

5.3.1 The Terms of Reference of the Policy and Resources Committee is included in the Constitution, Responsibility for Functions, Annex A.

5.4 **Risk Management**

5.4.1 None in the context of this report.

5.5 **Equalities and Diversity**

5.5.1 None in the context of this report.

5.6 **Consultation and Engagement**

5.6.1 None in the context of this report.

6. BACKGROUND PAPERS

6.1 None.

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Public Document Pack

London Borough of Barnet Adults and Safeguarding Committee Work Programme September 2014 - May 2015

Contact: Anita Vukomanovic 020 8359 7034 anita.vukomanovic@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)
2 October 2014			
Adults and Communities Delivery Unit Business Planning	To receive an update following the report to the June committee meeting.	Strategic Director for Communities	Family and Community Well-being Lead Commissioner, Later Life Lead Commissioner
Delivery of Health and Social Care Integration including through the Better Care Fund	To approve the full Business Case for implementation of integrated health and social care.	Adults and Communities Director, Later Life Lead Commissioner	
Implementation of The Care Act	To note the implications of The Care Act for new policies and the requirements for public consultation	Adults and Communities Director, Later Life Lead Commissioner	
Mental Health	To approve a specification for mental health social care.	Family and Community Well-being Lead Commissioner	
20 November 2014			
Home Care Commissioning Strategy	To approve the Home Care Commissioning Strategy. *This report will consider the Unison Ethical Care Charter and other relevant consideration as per the Resolution made by the Committee on 2 July 2014.*		

Subject	Decision requested	Report Of	Contributing Officer(s)
Business Planning	To approve five year commissioning priorities, proposals for meeting financial targets set out in the MTFS and proposed Management Agreements.	Family and Community Well-being Lead Commissioner, Later Life Lead Commissioner	Karen Ahmed, Later Life Lead Commissioner, James Mass, Family & Community Well-being Lead Commissioner
4 December 2014			
Your Choice Barnet Task and Finish Group	To consider a six-month update report from Officers on the approved recommendations of the Your Choice Barnet Task and Finish Group.	Housing and Environment Lead Commissioner, Later Life Lead Commissioner	
Implementation of the Care Act - Young Carers & Transitions Paper	To note the new duties for young carers and people transitioning to Adults Social Care arising from the Care Act 2014.	Adults and Communities Director, Later Life Lead Commissioner	
Implementation of the Care Act - Adult Social Care Deferred Payments Policy	To approve an updated Deferred Payments Policy to meet the requirements of The Care Act 2014.	Adults and Communities Director, Later Life Lead Commissioner	
19 March 2015			
Commissioning Priorities	To agree commissioning priorities for 2015/16.	Family and Community Well-being Lead Commissioner, Later Life Lead Commissioner	

Subject	Decision requested	Report Of	Contributing Officer(s)
Implementation of the Care Act	To receive an update on progress with the implementation of the Care Act.	Adults and Communities Director, Later Life Lead Commissioner	
Implementation of the Care Act - Remodelling Adult Social Care	To agree changes to the ASC process that will enable it to comply with the Care Act 2014. To agree a new policy arising from the Care Act 2014 formalising the new duties of the council where a care provider fails. To agree an approach to how councils can develop a sustainable social care market place to meet the new duties of the Care Act 2014.	Adults and Communities Director, Later Life Lead Commissioner	
Implementation of the Care Act - Prevention , Information & Advice Policy	To agree an approach to Information & Advice and Advocacy services in relation to the requirements of the Care Act 2014	Adults and Communities Director, Later Life Lead Commissioner	
Implementation of the Care Act - Prevention Policy	To agree new policies in line with the requirements of the Care Act	Adults and Communities Director, Later Life Lead Commissioner	
Implementation of the Care Act - Eligibility and Contributions	To agree new policies in line with the requirements of the Care Act.	Adults and Communities Director, Later Life Lead Commissioner	

Subject	Decision requested	Report Of	Contributing Officer(s)
Management Agreements	To review management agreements for the commissioning and delivery of Adult Social Care services.	Adults and Communities Director, Later Life Lead Commissioner	
23 April 2015			
Your Choice Barnet Task and Finish Group	To consider a 12-month update report from Officers on the approved recommendations of the Your Choice Barnet Task and Finish Group.	Adults and Communities Director	
Implementation of the Care Act	To review progress made against the implementation plan.	Adults and Communities Director, Later Life Lead Commissioner	
Healthwatch Barnet Enter & View Reports	To receive Enter & View reports from Healthwatch Barnet which relate to the provision of adult social care services.	Adults and Communities Director	

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