Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Health and Social Care Integration**
Report of	Dawn Wakeling, Adults and Communities Director Dr Sue Sumners, Chair NHS Barnet Clinical Commissioning Group
Summary	This reports progress of Health and Social Care Integration projects, with specific reference to addressing delayed hospital discharges

Officer Contributors	Karen Spooner, Head of Joint Commissioning, Barnet Clinical Commissioning Group Rodney D'Costa, Head of Joint Commissioning Adults and Communities, LBB Mark Hourston, Programme Manager Health and Social Care Integration
Status (public or exempt)	Public
Wards Affected	All
Key Decision	No
Reason for urgency / exemption from call-in	Not applicable
Function of	Health Overview Scrutiny Committee
Enclosures	Appendix 1: Briefing paper from London Councils on the Integration Transformation Fund Appendix 2: Barnet Health and Social Care Concordat
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1. RECOMMENDATIONS

1.1 That the Health Overview and Scrutiny Committee considers the information set out in the report in relation to the following key areas and make appropriate comments and/or recommendations to the responsible Cabinet Member(s) and/or the Barnet Clinical Commissioning Group (CCG):

- **The Health and Social Care Integration programme and the progress of the projects.**
- **The work to develop a high level Health and Social Care integration target operating model to support Barnet's submission for the Integration Transformation fund.**
- **The work to date on national delayed transfer of care.**

2. RELEVANT PREVIOUS DECISIONS

2.1 Cabinet 4 April 2012, Health and Social Care Task and Finish Group – the Cabinet endorsed the recommendations which proposed a vision for integration; a shared governance structure and integration initiatives, and endorsed the initial commitment of £1.1m by Barnet Council to fund the delivery of a local health and social care integration work programme. A Strategic Outline Business Case for Integration was also endorsed by the Cabinet and by the Health and Wellbeing Board in May 2012.

2.2 Health and Well-Being Board, 31 May 2012, Health and Social Care Integration Strategic Outline Business Case and Investment Priorities report – the Strategic Outline Business Case for Integration was also endorsed by the Health and Wellbeing Board.

2.3 Health and Well-Being Board, 27 June 2013, Barnet CCG Integrated Care Plan for 2013/14 – the Board agreed the Barnet CCG proposals to further develop integrated care, and these were also endorsed by the Health and Social Care Integration Board on the 19th July 2013.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 Link to Sustainable Community Strategy

3.1.1 Health and Social Care Integration projects support the Council's Sustainable Community Strategy 2010-2020 which is committed to achieving its objectives through working "together to draw out efficiencies, provide seamless customer services; and develop a shared insight into needs and priorities, driving the commissioning of services and making difficult choices about where to prioritise them." The integration of Health and Social Care services embodies this approach to partnership working.

3.1.2 The Health and Social Care Integration Board, which brings together a range of local health and social care partners, has as part of its development work already developed and approved an integrated care concordat that sets out a shared vision for integrated care in Barnet.

3.1.3 Successful integration of health and Social care services should promote the Sustainable Community Strategy priority of “healthy and independent living”.

3.2 Link to Health and Wellbeing Strategy

3.2.1 The Health and Wellbeing Strategy sets out the aspirations of the Health and Wellbeing Board and its member organisations. The Health and Wellbeing Board is responsible for promoting greater co-ordination of planning across Health, Public Health and Social care. This is recognised in the Health and Wellbeing Strategy. The Health and Social Care Integration Task and Finish Group recommendations which underpin the Health and Social Care Integration Programme, supports the Health and Wellbeing strategic intentions.

4. RISK MANAGEMENT ISSUES

4.1 The evidence base for health and social care integration continues to grow. However, there is a need to pull together the various strands of local evidence and data into one place to ensure that there is a comprehensive evidence base from which to make decisions about the use of an integrated care budget. To ensure sound decision making, this risk will be mitigated by the development of a target operating model for integration which will consider both the costs and the expected shifts across both health and social care activity ahead of operationalising any further projects in Barnet. This model will consider evidence of best practice and results from other integration projects, in order to inform its development.

4.2 Barnet CCG is recognised as one of the most financially challenged in the country. The CCG is likely to continue with a small number of conditions and directions in relation to financial plans. The CCG has a five year recovery plan which maintains spending levels in community and mental health services and reduces secondary care costs. The cost reduction is based on detailed analysis of activity and returning specific areas of over activity to expected norms. It is evidence based and has been accepted by NHS England. In addition it is recognised that Barnet and Chase Farm hospitals are not independently financially viable. Barnet and Enfield CCGs are considering a possible acquisition by the Royal Free Hospitals NHS Foundation Trust which will require commissioner transitional support for up to five years. There is a risk therefore that savings from Health and Social Care Integration will accrue more to the NHS than Social Care and that costs will be transferred from Health to Social Care.

4.3 Funding cuts to Local Government continue to present significant challenges. Planned 10% reductions to budgets in 2015-16 follow the 28% reductions in the period 2011-15. The planned cuts form the biggest part of the Public Sector funding reductions and, together with increasing demands due to an ageing population, present a number of challenges with regard to preserving Social Care in the Borough. The evidence base suggests that there is a risk therefore that local integration could carry demand or financial risks for the council. This will be mitigated by robust benefits modelling and measurement and the development of shared risk systems for the target operating model.

5. EQUALITIES AND DIVERSITY ISSUES

5.1 The approach taken by the Programme is predicated on the principle that any integration of health and social care services and pathways should only be considered if there is clear evidence that this will substantially benefit Barnet's citizens by improving the experience and outcomes of people who use care. However, it is likely that the areas identified as opportunities for integration may focus on particular groups and communities, for example the care of frail elderly people and their carers and people with complex health and social care needs, as this is where most benefit can be realised for service users.

5.2 Recommendations from the Health and Social Care Integration Programme continue to be informed by an analysis of local and national evidence. Any subsequent work on integration will be informed by a clear understanding of local need identified in the Joint Strategic Needs Assessment (JSNA), and what has been proven to work elsewhere. Future recommendations should support the Council, CCG and partner organisations to identify effective ways of working together to deliver integration and address the needs of all people who use care.

5.3 The integration of health and social care services could have a differential impact on different groups of citizens and communities within Barnet. This could include people with protected characteristics as defined by the Equality Act 2010, such as older people and carers of older people or disabled people. An Equalities Impact Assessment will be undertaken for all health and social care projects to ensure that the approach and solutions are inclusive and the local authority discharges its duties under the Equality Act 2010.

5.4 The integration of health and social care services could also impact staff involved in the commissioning and delivery of local care services. The impact on staff will be included within the scope of all project Equalities Impact Assessments.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 The Health and Social Care Integration update to the Health and Well-Being Board, 19th September 2013, outlined the work being undertaken to estimate the health and adult social care savings that integration across these services will bring, which will be completed in October 2013. These savings, once calculated, will be factored into the Quality, Innovation, Productivity and Prevention (QIPP) and CCG Recovery Plan in the NHS, and the Council savings requirements in the Medium-Term Financial Strategy and Priorities and Spending Review. Current spend to date on the Programme (since January 2012) is £282k which is a combination of programme support and project delivery.

7. LEGAL ISSUES

7.1 The Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed functions of the NHS and health-related functions of local authorities for the commissioning, planning and provision of staff, goods or services under Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. This legislative framework for partnership working allows for funds to be pooled into a single budget by two or more local authorities and NHS bodies in order to meet local needs and priorities in a more efficient and seamless manner. Funds pooled by the participating bodies into single budget can be utilised flexibly to support the implementation of commissioning strategies and improved service delivery. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions. The Council and CCG now agreed two overarching section 75 agreements for the Health and Social Care Integration Programme, relating to Adults and Children's' services. These are in addition to the existing five section 75 agreements already in place.

7.2 Section 6c of the 2006 National Health Act now allows for local authorities to provide services which improve the health of the population.

7.3 NHS organisations also have the power to transfer funding to the Council under Section 256 of the National Health Service Act 2006, and the Council similarly has the power to transfer money to the NHS under Section 76 of the NHS Act 2006. These powers enable NHS and Council partners to work collaboratively and to plan and commission integrated services for the benefit of their population.

8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

i) To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

9. BACKGROUND INFORMATION

9.1 Local Health and Social Care Integration

9.1.1 The Council, CCG and Partner organisations have developed a shared vision and priorities for health and social care integration in Barnet and a firm commitment to achieve these through the Health and Social Care Integration Board.

"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."

The vision is articulated through the experience of the fictitious character of Mr Colin Dale and is outlined more fully in the Concordat, signed by all Health and Social Care Integration partners in Barnet, and shown in Appendix 2.
The statements below define how he experiences integrated health and social care.

My primary contact will always take responsibility for making sure my care is coordinated and I am kept informed along with my family.

I will be able to get the right care and treatment quickly without having to deal with a lot of people

I will feel like I am dealing with one care organisation, and only have to tell my story once, rather than to multiple health clinicians

I will receive care provided by well-trained teams, at home or at a place that is convenient for me

9.1.2 Two projects have now been mobilised and the expected outcomes are:

- Improved quality of care and better quality of life for residents
- Reductions in safeguarding related incidents
- Reduction in unplanned and emergency admissions to hospital and A&E

9.1.3 The Older People Integrated Care Project (OPIC) seeks to achieve savings to health of over £1.26 million over 3 years by providing proactive care based on risk stratification to identify residents on the cusp of care.

OPIC consists of a Multi-Disciplinary Team service and Care navigation service which went "Live" on 1st July 2013. Two Care Navigators and two Case Managers have been recruited who are working with GPs and Social

Care to develop and implement personalised integrated health and social care support plans to meet the needs and outcomes of older people identified as at risk. Weekly Multi-disciplinary Team (MDT) meetings are taking place for multidisciplinary assessment and health and social care planning for people with very complex high risk needs who require specialist input. This will be enhanced by the use of risk identification software. A pilot has begun in the West of the Borough, with rollout across the Borough expected by the end of 2013.

9.1.4 The Care Home Improvement project aims to improve care in residential homes to reduce hospital admissions and safeguarding alerts from care homes. Activities include sharing good practice, buddying with homes with low rates of admissions, interventions to reduce pressure sores, improve foot care and reduce admissions due to dementia.

9.1.5 Training for care Home staff in pressure care and dementia has now been delivered. Feedback received from Care Home Managers has been very positive, staff have said that the training sessions have been exceptional, for example one said "the course has given me a better understanding of dementia and how I can better communicate with the residents". One home has implemented pressure care strategies and has purchased specialist heel protectors as a result of the session.

9.1.6 The Health and Social Care Integration Programme is now developing an overarching target operating model for integrated health and social care for older people that supports the realisation of the vision for integrated care in Barnet and identifies the next steps for the local integration programme.

9.2 Update on national policies: Spending round health settlement 2015-16

9.2.1 The June 2013 Spending Round announced that the NHS, Department for Communities and Local Government and the Department of Health will pool £3.8bn of funds for investment in the integration of health and social care (the "Integration Transformation Fund"). However, there is very little new money being allocated to support integration. Appendix 1 contains the detail of this funding. The new integrated budgets arrangements replace the current use of Section 256 money although Section 256 will remain in place

9.2.2 The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". This Integration Transformation Fund does not come into full effect until 2015/16; however a further £200m (in addition to the planned £900m transfer) is due in 2014/15 to be transferred to local government from the NHS to support transformation. To access the Integration Transformation Fund, a local plan must be developed by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum. Appendix 1 outlines the Integration Transformation Fund in more detail.

9.2.3 CCGs and Councils will need to jointly develop a two-year locality plan that details how the pooled budget will be spent. This plan will need to be assured and signed-off by the Health and Well-Being Board in early 2014 and by central government by March 2014. Plans must demonstrate how they meet the national conditions, set out below. At which point part of the funding for integration will be released. The second part will only be released once central government is satisfied with local performance achieved from use of the money.

Conditions for the plans

Funding will only be given on the condition that services are commissioned jointly and seamlessly between the CCG and councils, on the basis of their agreed local plan.

The following national conditions will need to be addressed in local plans:

- Protection for social care services (not spending);
- As part of agreed local plans, 7-day working in health and care to support patients being discharged and prevent unnecessary admissions at weekends;
- Better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health);
- Ensure a joint approach to assessments and care planning;
- Ensuring that, where funding is used for integrated packages of care, there will be an accountable professional
- Risk-sharing principles and contingency plans if targets are not met – including redeployment of funding if local agreement is not reached; and
- Agreement on the consequential impact of changes in the acute sector.

9.2.4 The broad timetable for the plans as set out in the London Councils briefing paper is:

- Initial local planning discussions and further work nationally to define conditions. August – October 2013
- NHS planning framework issued further development of local plans. November – December 2013
- Completion of local plans and local sign- off. December – January 2014
- Plans assured and signed off by Government. March 2014

9.3 Financial challenges

9.3.1 This national direction has been given at a time when there are significant financial challenges facing the local authority and CCG in Barnet, which will last until at least 2020. Both organisations have already recognised the role that the integration of health and social care will play, not only in improving health outcomes for people who live in Barnet, but also in driving financial efficiencies and securing economic sustainability, as documented in their core financial savings plans:

- The Council's Medium-Term Financial Strategy makes reference to the savings that can be realised through health and social care integration: the

Council needs to reach its c£75m savings target by 2015, before undertaking a further c£70m saving programme (known as the Priorities and Spending Review) between 2016 and 2020.

- The CCG financial recovery plan contains plans for integration in frail elderly; urgent care; and continuing care pathways: Barnet CCG needs to make up to £50m savings over the next 5 years to reach financial balance.

9.3.2 There is a risk that the financial savings plans set out above will not be achieved unless there is a focus on integrated commissioning and delivery, which will, among other areas, involve actively exploring estate rationalisation; the opportunities for sharing back-office functions; and the development of a shared care record.

9.4 The Health and Social Care Integration Programme

9.4.1 Barnet has already spent a substantial period of time developing its integration agenda between health and social care locally, which means there is information data and on-going work already available to support the development of the target operating model. For example, the Health and Social Care Integration Board, which brings together a range of local health and social care partners has, as part of its development work, already developed and approved an integrated care concordat that sets out a shared vision for integrated care in Barnet. A Joint Commissioning Unit has been established and is being operationalised so that it can deliver on the plans approved by the Integration Board. Existing Learning Disabilities and Mental Health Services are currently integrated in Barnet and the two spearhead projects for the Health and Social Care Integration programme have commenced.

9.4.2 The target operating model referred to in 9.1.4 will build on the existing projects that are already taking place as part of the Health and Social Care Integration programme. By being aware of national requirements in the plans to address A&E activity and 7 day working, the model is anticipated to have a positive impact on delayed transfer of care, and also promote a shift of healthcare activity from crisis to preventative responses.

9.4.3 Overarching Section 75 agreements for both Adults' and Children's health and social care services have also been developed between the Council and the CCG. This will provide a mechanism for the Council and the CCG to robustly manage and finance new integrated services. Specific arrangements for each integrated service will be covered in schedules that will be appended to the overarching agreement.

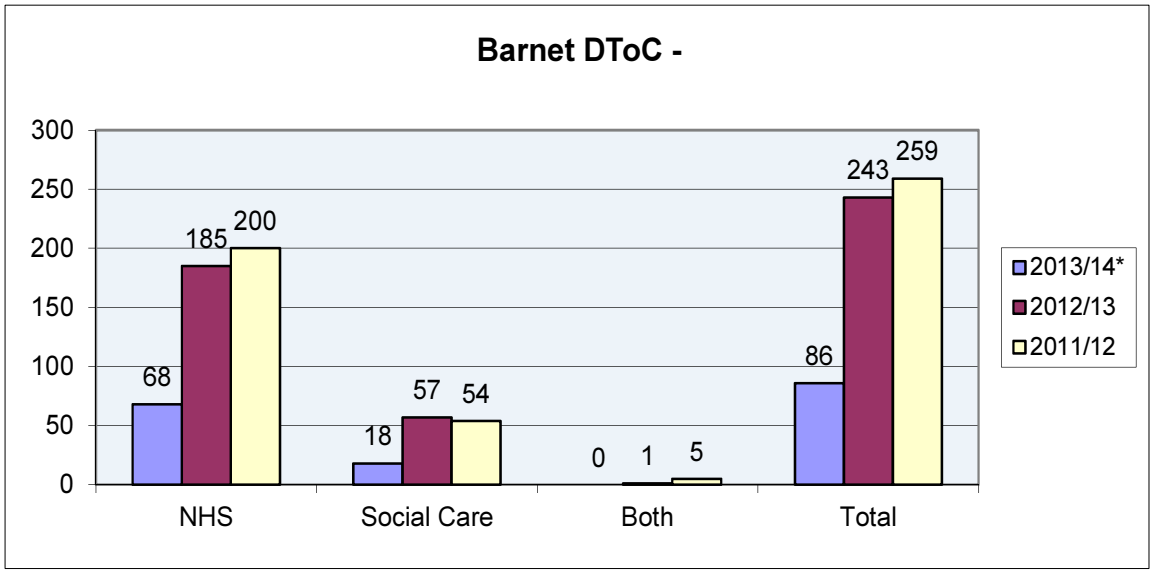
9.5 Delayed Transfers of care

9.5.1 A particular focus for the Integration Programme has been on delayed transfers of care. The following table illustrates the Barnet performance over the past three years and there are a number of initiatives underway to improve performance in this critical area.

Delayed Transfer of Care, NHS Organisations, Barnet

Year	NHS	Social Care	Both	Total
2013/14*	68	18	0	86
2012/13	185	57	1	243
2011/12	200	54	5	259

*April - July 13 data



This data represents performance across Barnet Hospital, Royal Free Hospital, Edgware Community Hospital and Finchley Memorial Hospital.

9.5.2 A workshop, focussing on Delayed Transfers of Care, was facilitated by Barnet and Chase Farm Hospital on the 20th June with attendance from senior officers in Health and Social Care from both Barnet and Enfield. Recommendations from the workshop will be progressed through the Urgent Care Network Board and the Health and Social Care Integration Board.

Part of this work includes inter-organisational approaches being developed to identify and address specific challenges and opportunities via integrated solutions. As mentioned previously, the target operating model will also incorporate the contribution to system-wide local priorities such as delayed transfer of care and winter pressures.

9.5.3 A Delayed Transfer of Care working group has been established, led by John Morton, Chief Officer Barnet CCG. This is attended by the Assistant Director of Social Care and meets on a monthly basis to action improvements to the service.

9.5.4 The Royal Free Hospital has for some time operated key services which facilitates rapid discharge and is called Post-Acute Care Enablement (PACE). PACE has now been reintroduced into Barnet from September. The PACE service will be provided by the same team which operates at the Royal Free Hospital. Patients selected for PACE will be discharged earlier and supported by the service for 3-5 days. The PACE team will work closely with the allocated social worker to provide support and monitor the person's functioning and care needs.

9.5.5 A vital part of preventing delayed transfers of care is also to prevent hospital admissions in the first place. A number of initiatives to prevent admissions into hospital are underway. The Royal Free Hospital has been operating a Triage and Rapid Elderly Assessment Team (TREAT) since 2011. The role of TREAT is to thoroughly assess elderly patients who have come to A&E, identifying those who are well enough to be discharged from A&E, and ensuring that support is put in place so that they can receive all of the care they require at home.

9.5.6 The recently established Integrated Quality in Care Homes Team is working towards improving the quality of care provided by the Borough's Care Homes and through this aim to prevent admissions into hospitals. A number of workshops have been arranged with Care Home staff to train them in areas such as pressure care management and other areas that lead to admissions into hospital.

9.5.7 The two spearhead Integration projects are also focussing on the prevention of admissions into hospital. The Older Persons Integration Project is introducing Care Navigators, risk profiling to identify those patients in need of complex care, and a Multidisciplinary team, which meets weekly to discuss the most complex cases and provide a holistic approach to patient care. This approach will help to ensure the most appropriate care is given to our residents in need, in a timely manner and therefore help prevent admissions into hospital. The Care Home pilot is similarly focussed on this aim. Working closely with the Integrated Quality in Care Homes Team, this is looking to improve the standards of care provision through training in areas such as pressure care and dementia.

10. LIST OF BACKGROUND PAPERS

10.1 None attached to this report

Cleared by Finance (Officer's initials)	**JH/AD**
Cleared by Legal (Officer's initials)	**LC**

Appendix 1: Briefing paper from London Councils on the Integration Transformation Fund

£3.8BN INTEGRATION TRANSFORMATION FUND 2015/16

LONDON COUNCILS BRIEFING NOTE

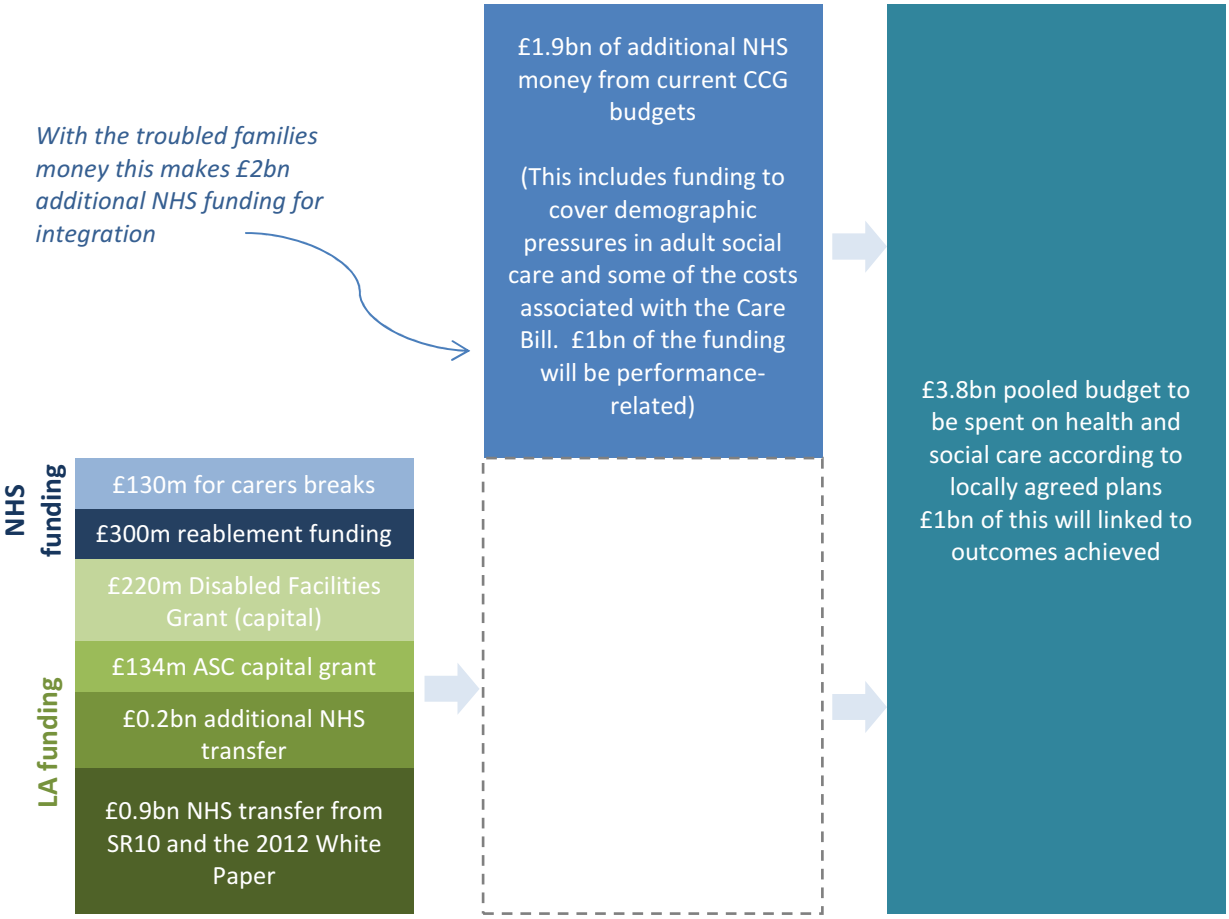
The Spending Round 2013 announced a pooled budget of £3.8 billion for local health and care systems in 2015/16. This is now being referred to as the "Integration Transformation Fund".

What is the Integration Transformation Fund for?

The government's stated goal is to get local health and care partners to work more closely, through creating a pooled budget in every area. This follows the publication of the National Vision on health and care integration, which defined integration from the perspective of the individual. The fund is intended to support an increase in the scale and pace of integration. It is clearly also a mechanism for promoting joint planning for the sustainability of local health & care economies.

Where does the money come from?

In reality, little of this is new money. The fund is made up as follows:



The additional £1.9 billion NHS funding will be drawn from current CCG budgets. Given existing demographic pressures & efficiency requirements, CCGs are likely to have to make cuts in existing services to release this money. Although the basis on which this will be taken from individual CCGs is not yet clear, as an initial rough planning guide CCGs have been advised to start considering how to free up around £10 million each.

In addition to this £3.8bn, DCLG have included in the overall grant settlement for local authorities £188m for pressures from the closure of the Independent Living Fund and £285m for the introduction of deferred payments from April 2015 and the transition to the capped cost funding policies flowing from the Dilnot report that will take effect from April 2016 once the Care Bill has been passed into law. The NHS has also contributed £70m to the Troubled Families programme.

The Spending Round also announced a further £200m transfer from the NHS to social care in 2014/15, in addition to the £900m already committed.

How the funding will come to local areas?

The 2015/16 funding will be a pooled budget between local authorities and CCGs. CCGs will use funds from their normal allocation to create it.

This means that there will be no automatic transfers of any funding to boroughs, as has been the case with the NHS c.£900m annual transfers in recent years (s256 transfers). However, it will be possible for money to be transferred to councils by local agreement, as part of local plans.

The basis for determining local shares of the £3.8bn has not yet been decided. However, it has been suggested that the same broad splits as used for the s256 allocations is a reasonable planning proxy for most of the funding.

DCLG are specifically considering how to handle the Disable Facilities Grant capital element of the fund allocations, in the light of local authorities' statutory responsibilities.

Local partners will be able to put additional funding into the pooled budget from their existing allocations if they want to do so.

Two year plans

Access to the Integration Transformation Fund in 2015/16 will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. The plans will need to be agreed by March 2014.

As well as covering the way in which the Integration Transformation Fund will be used locally in 2015/16, the plans will also need to set out how the £200m additional transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

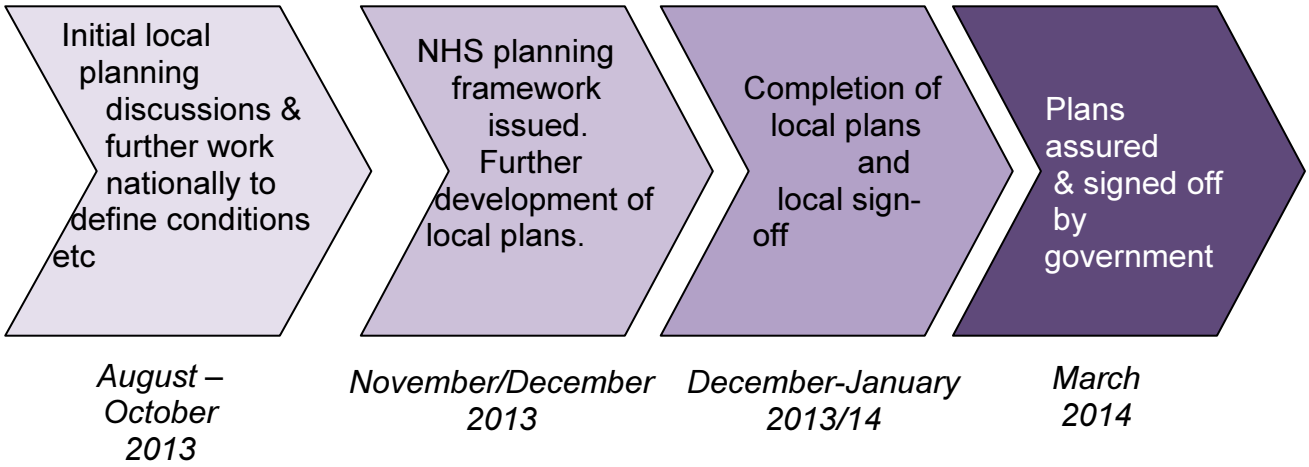
The plans will need to be jointly agreed between key partners – as well as local authorities and CCGs, this will include local clinicians. Health & Well-Being Boards will have to sign off the plans.

As well as being locally agreed, Ministers have decided that they will oversee and sign off the plans (DH, DCLG and HM Treasury Ministers all have an interest in this). The LGA and NHS England are developing proposals about how this can be done in an efficient and proportionate way. NHS England's role in either local or national agreement has not yet been clarified.

Joint LGA/NHS England guidance has been published clarifying that the plans should be developed in the context of:

- local joint strategic plans;
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term – currently expected to be 3-5 years – strategic plans as part of the NHS Call to Action);
- the announcement of integration pioneer sites in October, and forthcoming integration roadshows.

The broad timetable for the plans is:



Conditions for the plans

Funding will only be given on the condition that services are commissioned jointly and seamlessly between the CCG and councils, on the basis of their agreed local plan.

The following national conditions will need to be addressed in local plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health);
- ensure a joint approach to assessments and care planning;
- ensuring that, where funding is used for integrated packages of care, there will be an accountable professional (ref. Jeremy Hunt's recent request for views on improving care for the vulnerable elderly, that will culminate in some announcements expected in October)
- risk-sharing principles and contingency plans if targets are not met – including redeployment of funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

How will the £1bn performance-related element work?

As part of their plans, local areas will need to set outcome goals and monitor delivery against these during 2014/15 and 2015/16. £1bn of the total fund will be based on achievement of these goals. This funding is likely to be unlocked in two tranches – half in April 2015 on the

basis of performance in 2014/15, and the second half in autumn 2015 on the basis of performance in the first part of the financial year.

The outcome measures will be a mix of national requirements and local choice. The national requirements are yet to be determined, but early discussions include e.g. delayed discharges.

Issues that still need to be resolved

There are a range of issues that still need to be clarified on which the government, LGA , NHS England and other national partners are working – and which London Councils will continue to seek to influence. These include:

- allocation of funds;
- national conditions, including definition, metrics and application (including whether the performance-related element of the funding will be based on 'all-or-nothing' achievement of outcomes);
- risk-sharing arrangements;
- assurance arrangements for national sign-off of the plans and subsequent monitoring;
- analytical support, e.g. shared financial planning tools and benchmarking data packs.

Action that boroughs and their partners can start to take now

Given the timescale for the preparation and agreement of plans on which this will all hang, and the aspirations for the strategic ambition of these plans, the earlier local thinking and discussions start the better.

Some of the issues that boroughs should start considering with their partners are:

- the basis that existing local plans and priorities – joint and individual – provide as a starting point for their Integration Transformation Fund plan, and early identification of further analytical needs and joint strategy development so these can be got underway as soon as possible;

- the implications of the way the fund has been drawn together on current planning and budgeting intentions e.g. in CCGs the need to free up the additional money to put into the fund and for local authorities the need to recognise that the s256 monies will no longer form an automatic transfer;

- the process for developing the plan and securing local sign-off, including through the Health & Well-Being Board;

- how to handle engagement with clinicians and acute trusts – particularly given that in most parts of London individual trusts will need to engage in several local area plans;

- what community and patient engagement to include as part of the development of the plan.

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Appendix 2: Barnet Health and Social Care Concordat

Barnet Health and Social Care Integration: our vision
A concordat to guide the integration programme

Mr. Dale is an 82 year old gentleman living in Oakleigh. He has multiple needs and medical conditions and is receiving a range of services and support from health, social care and the voluntary sector. He has been admitted to hospital twice in the last year and on both occasions his family have felt that the system has not worked very well together and that the responsibility for his overall care and support is not properly co-ordinated and they find it difficult to know who is responsible for what. Mr. Dale's wife died 10 years ago and he lives alone with his dog, Sally. His daughter, Louise and her family live in East Finchley.

What do Mr. Dale and his family want for him when he needs help?

- A single point of contact
- Quick and responsive services
- To tell their story once
- Professionals and services that talk to each other.

We will work together tirelessly to deliver the Barnet vision of integrated care so that Mr. Dale and others like him enjoy better and easier access to services. This is our vision for integrated care:

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 mean for Mr. Dale?

Mr. Dale deserves the best care, at the right time and the right place. When Mr. Dale needs treatment, support or care, he will cross organisational boundaries effortlessly, supported by professionals who take responsibility for his whole care and treatment journey, regardless of who they work for. Services offered to Mr. Dale will be personalised to his individual needs and will promote his independence. Mr. Dale and his family can expect to be at the heart of what we offer.

We want to deliver excellence for everyone through integrated care. These are our integrated care commitments:

- People in Barnet will feel like they are dealing with one care organisation
- They will have access to accurate information which will enable them to make informed choices and take responsibility for their health and wellbeing
- They will be able to get the right care and treatment quickly without having to deal with lots of people

- Personal information will only have to be provided once and will be shared securely with other organisations involved in the person's care
- Care will be provided safely by well-trained teams, at home or at a place that is convenient for them
- Someone will always take responsibility for making sure care is coordinated and the person being cared for, their family and carers, are kept informed
- People will be supported to be as independent of public services as possible through a local care system that encompasses prevention, self-care and supportive communities

How will we ensure we deliver on these commitments?

We, the leading organisations of the health and social care system in Barnet are committed to working together through the Barnet Integration Programme to make a difference to Mr. Dale, his family and others like them. Through the Programme, we aim to deliver the vision for integration in Barnet and through this, create substantially improved outcomes for patients, service users and their families and carers.

We commit to remove the barriers and to develop momentum and pace for health and social care integration in Barnet for the benefit of patients, service users and their families and carers.

All the undersigned organisations have committed to participate in the leadership and delivery of integration in Barnet and to strive for the best solution, so that Barnet offers Mr. Dale and his family world class care and support.

Agreement

The following Organisations have agreed to work together within the terms of this Concordat and adhere to its principles:

Organisation	Signatory Name And Position	Signature
Barnet and Chase Farm Hospitals NHS Trust		
NHS Barnet Clinical Commissioning Group		
Barnet Council		
Central London Community Health NHS Trust		
Community Barnet including Barnet Link		
Enara		
Housing 21		
Personnel and Care Bank		
Barnet Enfield and Haringey Mental Health Trust		
Royal Free London NHS Foundation Trust		
London Care		

Singed: October 2012
Review date: October 2013.