Updated July 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<Job Title>
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

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 Health & Social Care Concord
Barnet Integrated Health and Social Care Model 2013	
Barnet Health & Well-Being Strategy	Barnet Health Social Care Integrati
Barnet Council Corporate Plan	
Barnet Council Priority & Spending Review 2014	
Barnet CCG 2 Year Operational and 5 Year Strategic Plan	Barnet Health Social Care Integrati
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 Health & Social Care Program
Barnet, Enfield & Haringey Clinical Strategy	
Older People Integrated Care business case	Others available upon request
Shared Care Record outline business case	
Health & Social Care outline business case	

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

Background and Context

The **Better Care Fund (BCF)** is a single pooled budget to support health and social care services to work more closely together in local areas. In Barnet, it is an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings; and, in doing so, provide them with a better service and better quality of life.

Our BCF plan builds on the work already underway in Barnet, and strengthens the partnership working between Barnet Clinical Commissioning Group (CCG) and Barnet Council.

A principal challenge for Barnet is managing the aspirations of the BCF 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.

The Vision

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. The Concordat Vision co-designed and agreed by all parties of the Barnet Health and Social Care Integration Board (HSCIB) 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.

Mr. Colin Dale represents a typical user of health and social care services in Barnet. He 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. On both occasions his family have felt that the health and social care system has not worked very well together and that the responsibility for his overall care and support is not properly co-

ordinated. 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.

The Vision aligns with the over-arching aims of the BCF including the national conditions and is under-pinned by a number of key strategies owned both at an individual organisational level and through a system-wide approach. These include:

- **Barnet Joint Strategic Needs Assessment** (JSNA) that provides a framework to take forward **commissioning informed by insight** through **prioritised need and managed demand, commissioning of services based on evidence** to tackle the areas of greatest need and highest impact, and **identification of problems early** to reduce the severity and burden of the problem on both the individual and the state.

  Headline issues addressed within the BCF plan include:

  - **Implications of demographic change -** Over the next five years, there will be 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%). In addition to the traditional health risks of old age, dementia is a particular issue that we can expect to see increase in prevalence as more people live into advanced old age.

  - **Specific health trends -** It is recognised that the '**obesity epidemic**' and predicted growth in Barnet's middle aged population mean that we can expect more people to be at risk of complications associated with **Long Term Conditions** such as diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases, and respiratory disorders.

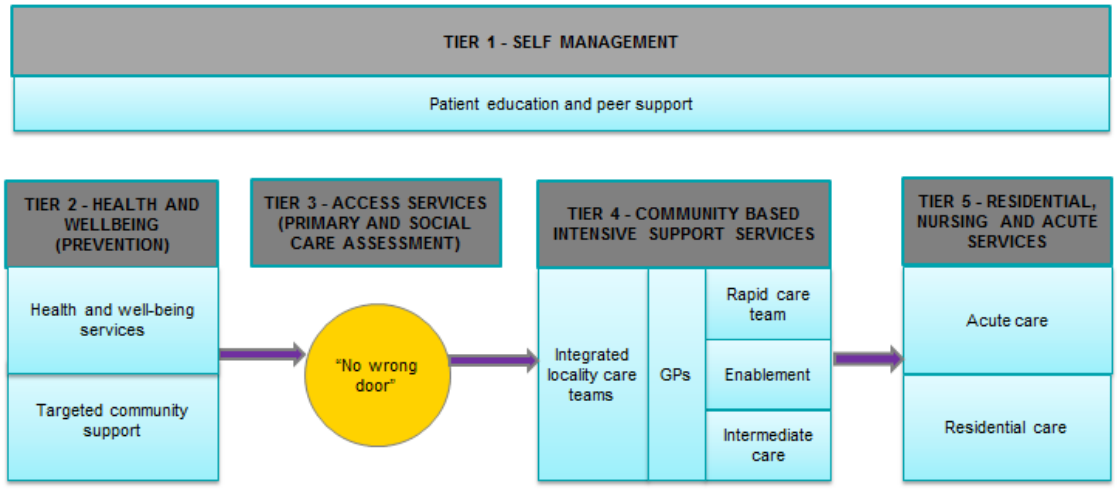
  - **Independence -** With the increased pressures from a burgeoning population and reduced financial resources, it will be essential to **enable more people to manage their own health** responsibly particularly through prevention schemes.

- **Barnet Health & Well-Being Strategy** that aims to reduce health inequalities by focusing on how more people can 'Keep Well' and 'Keep Independent'; recognising that this can only be achieved through a partnership between residents and public services. At the heart of this Strategy is the ambition that all Barnet's residents will be able to live as healthily and as independently as possible for as long as possible by:

- **Keeping Well -** A strong belief in 'prevention is better than cure' including a 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 on their feet as soon as possible supported by health and social care services working together.

The London Borough of Barnet (LBB) and Barnet CCG have been working on proposals to underpin the BCF for the many months. This has included the development of a new model of care **(Barnet Health and Social Care Integration model)** which forms the foundation for the delivery of this transformation. This is pictorially represented below. It consolidates existing work being undertaken and provides a clear direction of priorities and delivery for the future. This turns the Vision into a tangible reality for delivery via a 5 tiered model of care, with future-proofing to meet short and longer term health and social care strategic plans including those to deliver integrated care at scale and pace. It advocates a consequential shift of activity and costs from acute care and care home placements towards prevention and self-management.



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 from a wide range of individuals and organisations including **Healthwatch Barnet, Barnet Older Adults Partnership Board** (a resident and service user engagement group)**, Age UK (Barnet), Alzheimer's Society** and others. The **Integrated Health & Social Care Model**, has been built taking into account the call from local residents to increase co-ordinated care to enable them to live better for longer. The co-chair of the Older Adults Partnership Board, a local retired resident, was a core member of the design group for the integrated care model and continues to drive progress. The model has been tested in workshops with Older Adults Partnership Board members, public forums facilitated by Healthwatch, interviews and surveys.

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 and enables 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.

In addition, we will have fully explored the opportunities arising from the BCF from extension of the scope beyond the current target group; for example by further developing our current integrated health and social care model for people with learning disabilities, though the creation of extended joint commissioning across health and social care.

b) What difference will this make to patient and service user outcomes?

The person-centred aims and objectives for Integrated Care can be extracted from the Health & Social Care concordat:

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.

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

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 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 and 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):

- 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.

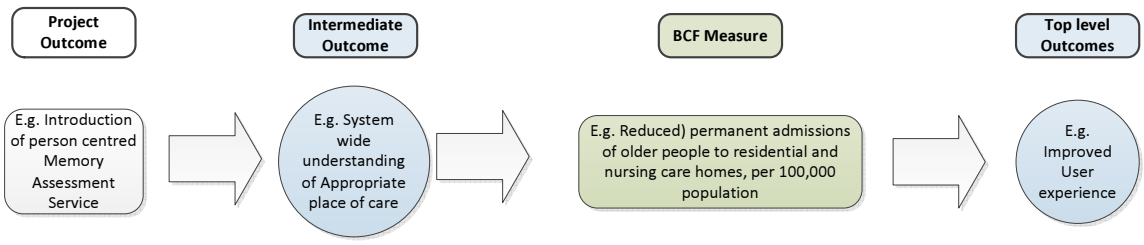
Benefits

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

- Improved user experience
- Improved user outcomes
- 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. By looking at these as a whole, we will make sure that everyone locally (both commissioners and providers) is aiming to deliver a common set of outcomes and we are able to test delivery outputs more robustly. An example outcome relationship map is seen below and demonstrates how individual project outcomes are linked into the over-arching agreed set of outcome measures:

Outcome relationship map



More detailed benefits maps related to each tier can be found in the Full Business Case

document.

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?

Programme Overview

The key components of the 5 tier integrated service model are:

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

Core to the model is a focus on prevention, single point of access, risk stratification and appropriate care at the right time through locality based integrated care teams and rapid care provision.

This section outlines the operating arrangements for each of the 5 tiers of this model.

The 5 Tiers

Tier 1: self management

Self-management is a critical component of integrated care models for frail elderly/ those with long-term conditions. 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, based on an individual's preference and choices. 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. Individuals will be able to access structured education, support from a long-term condition mentor or health champion, or access to online support forums or innovative online support tools to help them manage their long-term condition(s) effectively.

Individuals will also be encouraged to access one of the Borough's Older People's Healthy Living Pharmacies, where they can review their medication use with a

pharmacist, be referred directly into community based preventive services, and can work with a health champion to adopt healthier behaviours that will help them manage their long-term condition(s).

To enable this vision to materialise, professionals across health and social care will be offered training that will enable them to support and empower people manage their long-term conditions independently. They will have access to social prescribing support tools to refer individuals into Tier 2 preventive services that will help them stay independent and manage their long-term condition effectively, for longer.

All of these initiatives will help meet the Tier 2 objectives of keeping people well and independent, and will help to reduce the 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 Prpgramme (EPP) 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, who 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 a patient decision aid to complement his care and management plan, and advised Mr Dale that his local pharmacy could be accessed between 8am and 6pm Monday-Friday to provide additional advice, support and remote monitoring of blood glucose.

Mr Dale left the surgery and went home with his plan of action. On his way home he received a text from his surgery with a summary of the key information the GP had given him, links to the Diabetes UK website, the phone number of his local health champion, and information about the dates of future 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 older elderly 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 in line with individuals' needs and preferences that focus on preventing the onset of ill health and improving people's social well-being. These services will be publically recognisable, readily available, understandable and easy to access. This means that there will be a good understanding of what is available across all sectors, but particularly in the Council and the CCG, and to a lesser extent within the local population.

This will be supported by a recognisable brand and a joined up approach across commissioned services. This approach will build on the "hubs approach" developed in older peoples and carers commissioned services and ensure that there is join up across the tier using an easily identifiable unified "brand" e.g. Prevention Matters in Buckinghamshire, Staying Well in Bolton.

Information on what support is available will be easily accessible through a single point of contact and there will be help for people who need it to access those services. The cohort population in the model will be made aware of sources of information and advice early on so that they can proactively identify supports that suit them at the earliest stage – this area will have a clear overlap with self-management tools. Expert advice will be readily available for such things as moving into new accommodation, housing adaptations and/or financial planning.

Contact will be made with some people, who have been identified as at risk of needing Tier 3 and 4 services, to identify various forms of help that can keep them well. There will be good links between Tier3, 4 and 5 and Tier 2, to make sure that people get the right kind of service/support to meet their needs. A good evidence base of what works at a system level and at an individual level will be developed and this will inform future commissioning.

Community resilience and peer support will form a key strand of this approach. These 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 ambition. 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. Miss 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 show her 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 direct 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 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 tell 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 Brilliant in Barnet , 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 BCIL 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 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 BCIL and find about timebanks and volunteer befrienders – BCIL make 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 BCIL tell Mr Dale about Casserole Club who are looking for diners – this means that one night a week Ms Dale will not need to rush over to help Mr Dale with his evening meal – and Mr Dale meets someone new!

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

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

Early Identification of at risk Older Adults using risk stratification: to better ensure that the right people receive proactive case management in a cost effective manner. It will also allow them to focus case management on individuals that will benefit most. This approach 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 the required Older Adults information at the right time: There is a requirement for one shared multiagency view of the relevant patient information (ie a "shared care record") that will be accessible to anyone providing care, all professionals across health and social care and will be accessible to the relevant agencies for the person wherever they are being cared for.

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 advice and

support and signpost people quickly to the services that they require. It will also provide a direct referral route to existing community health services.

Tier 3: Case Studies

Using a shared risk stratification approach to identify and deliver care

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

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

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

hospital admission. Mr Dale retains his independent living.

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

As is case study

Mrs Colin Dale is a 77 year old, 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 doesn't receive a formal diagnosis of dementia. Mrs Colin Dale's dementia starts to deteriorate and she has become restive at night and agitated, constantly following her husband around the house. Mr Colin Dale is becoming stressed mentally and emotionally. Mr Colin Dale 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 Mrs Colin Dale to the practice register for people with suspected dementia and mild cognitive impairment.

Following the visit to the MAS, Mrs Colin 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 and relaxed setting. Mr Colin Dale also attends a series of training sessions for carers which he finds very helpful.

Mrs Colin Dale is also seen by her GP annually for a review.

With these interventions, over the next 18 months, Mrs Colin 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. Mr Colin Dale 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, Mrs Colin Dale's 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 Mrs Colin 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 Mr Colin Dale:

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

Impact – Mrs Colin 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. These services are provided in the community. They are overseen by integrated locality-based teams who can move resources around flexibly to avoid crisis and 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 our 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 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.

A weekly 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, e.g. residential care. 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 Care Service to include short term crisis care at home and 'trials' to facilitate more effective rehabilitation.

As is case study – Mr Colin Dale lives 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.

Tier 4: 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 and 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 and 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 services in this layer have access to the 'No wrong door' to support rapid access and a clear pathway into the integrated model. Where an individual enters Tier 5, in crisis, they will be transitioned to community intensive support as quickly as appropriately possible.

Progress:

We have made excellent progress. The Care Navigation Service (CNS) and Multi-Disciplinary Team (MDTs) case conferences started in July 2013. We significantly expanded the Rapid Care service in August 2013 and opened the Community Point of Access (CPA) in April 2014. The Risk Stratification Tool is now live in all GP Practices.

Further developments include:

- Trail-blazer Integrated locality Team mobilised from August 2014 incorporating district nursing, social care staff, care navigation (as above), acute and mental health team staff, end of life support and Age UK (Barnet). Further staff to be included as per needs identified but to include dementia advisors and carers support. Planned roll out of full model within 1 year.
- Shared care records project – awaiting notification of an external funding bid to accelerate. Planned go live date in spring 2015.
- Dementia and end of life pathway development

A phased approach will be taken to further service development over the next 5 years to

ensure that we are achieving the outcomes for patients/users that we expect, are gaining best value for money in services and are maximising opportunities arising from joint commissioning.

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.

Affordability and deliverability of the Health & Social Care Integration Model has been informed by a series of work including a jointly sponsored, outline business case (OBC) in April 2014, followed by a full business case (FBC) (September 2014) which digs deeper into financial delivery and sustainability.

Both aim to address the critical question for the Barnet economy of:

'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?'

The modelling within has included:

- Identifying the in-scope population and services to be included
- Base-lining of the current 'As–Is' spend across the five tier model including validation with service providers where appropriate
- Understanding the funding gap
- Developing funding portfolio and activity shift scenarios
- Identifying priority development areas

Target population -Recognising a significant element of the pressure in the system is as a result of demand from some specific user groups, the scope of this programme includes all Council and CCG budgeted expenditure 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**

Target 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. These are known as influenced services.

The total value of core services in scope is £77.6m, of which 46% is LBB spend and 54%

BCCG. The total value of influenced services is £55.8m, of which 1% is LBB spend and 99% BCCG.

The table below shows the relevant 'core' and 'influenced' financial resources in scope. The total resource envelope is £133m, of which over 61% 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.

Value of Core and Influenced Services across the 5 Tier Model

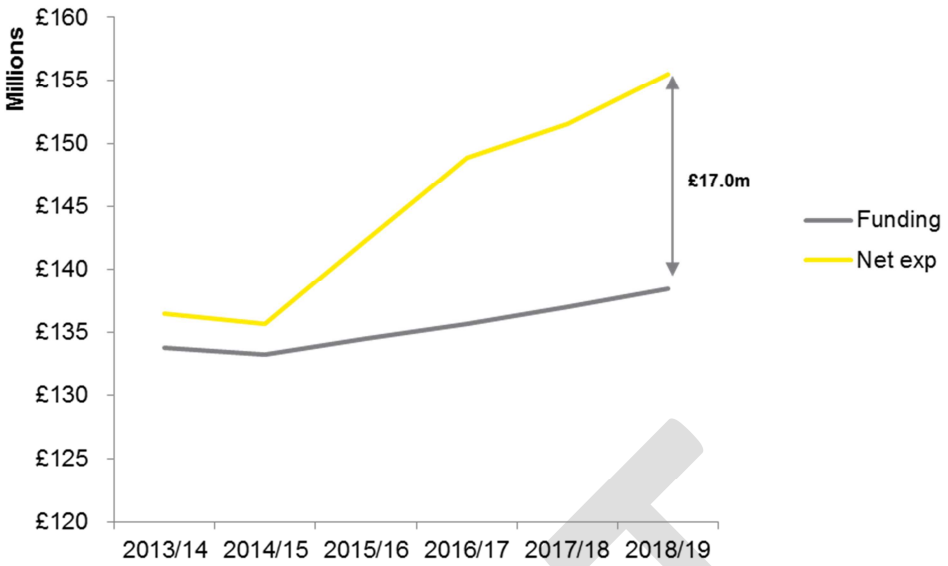
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Total
Core LBB	£100,000	£3,401,471	£3,744,002	£14,394,221	£14,132,946	£35,772,640
Core BCCG	£272,000	£27,237	£502,500	£28,888,927	£12,440,000	£42,130,664
Influenced LBB	£0	£0	£0	£344,401	£0	£344,401
Influenced BCCG	£0	£0	£0	£63,538	£58,205,929	£58,269,467
Total	**£372,000**	**£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%	

If we take no action to redesign our core services, 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:

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

The graph below illustrates this project funding gap:



The data used to build these projections was taken from the LBB MTFS and BCCG financial plans submitted in February 2014.

Closing the Gap

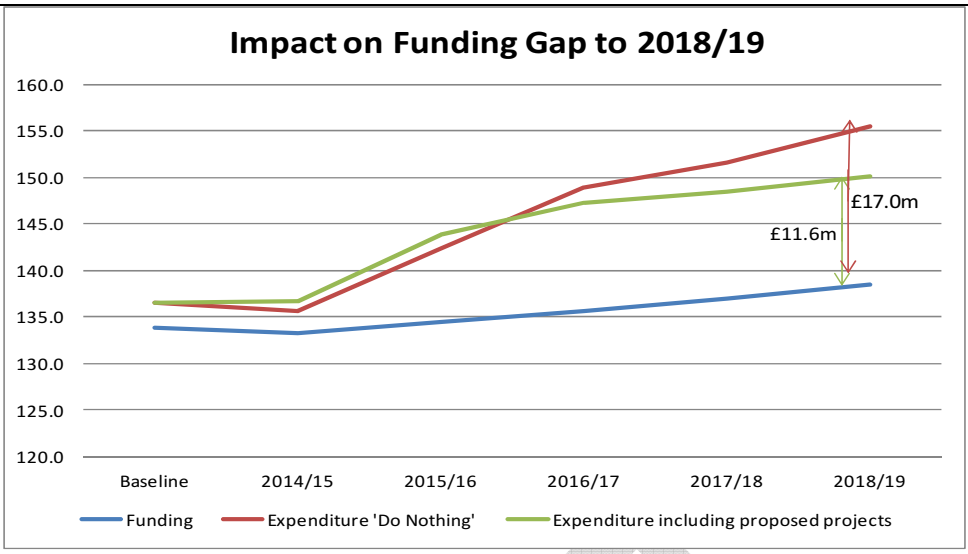
Original modelling in the OBC focussed on hypothetical models to reduce activity in Tier 5 (acute and nursing/residential care) to eliminate the forecasted funding gap and release funds to invest further in Tiers 1 to 4. This provides a high level view of the scale of ambition and change required.

The scenarios modelled are reductions in activity in Tier 5 of 2% and 3% per year for five years from 2014/15 to 2018/19. The work identified that neither scenario would close the gap but that a 3% reduction in activity per year would provide a greater pool for reinvestment and was therefore the desired scenario.

The full Business case took a different approach in terms of identifying how far existing and planned service transformation will contribute to the financial model in terms of closing the gap; and clearly identifying the scope of opportunity required for the future.

Findings indicate that:

- The projects outlined in the business case expect to contribute **£5.4m** towards closing the gap. There is significant cross-over between the projects in the business case and those included in the BCF programme.
- This results in a remaining gap of **£11.6m**.



Financial case for integration

The **Better Care Fund (BCF**) provides an opportunity to target investment in a more holistic integrated model and accelerate the process of whole system reconfiguration. The progress to date and acknowledgement of current challenges that need to be urgently addressed provide the optimal local condition to progress integration to the next stage. 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 the 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.

Cost Benefit Analysis

The underpinning modelling for the FBC analysed anticipated costs and benefits for each project covering the periods 2014/15 to 2019/20. They include detailed assumptions and inputs relevant to Barnet for the likely scale of integrated services and corresponding set up and running costs and funding streams. The models then show the unit and total savings/benefits for the proportion of people supported and timescale for realising them, plus non-cashable and recurring benefits. This informs the £5.4m contribution above.

The majority of the cost savings will be delivered through targeted integration projects, where relevant services (referred to as 'core' services) can be jointly commissioned as part of an integrated care pathway. The model also shows benefit opportunities by shifting activity and costs away from acute services into either preventative services or the community.

Further Validation

Indicative findings in the Full Business Case have been 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. Earlier analysis clearly indicated that the existing model of care for frail elderly was the root cause for some specific issues. This initiated an accelerated programme of work focussed to 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 urgent care over a period of two years (2014-16), 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.

An initial savings target in excess of £3million health spend has been set over the next two years (2014-2016), in order to begin to provide the 'headroom' and investment for further development of the integrated care model. This has been re-modelled for 2015-16 to meet the requirements of the BCF and to extend the scope from non-elective admissions, to include additional flex in relation to a reduction in excess bed days and to explore opportunities in delayed transfers of care and re-admissions.

Better Care Fund Pay for Performance Target

The target for the BCF pay for performance element is set at 2.5% (or 716 less non-elective admissions) in 2015-16.

This has been calculated with the support of informatics and finance and takes a balanced approach to forward planning taking into account taking modelling and indicative findings of FBC and CCG non-elective admissions data; and performance to date.

It also recognises that Barnet has individual and specific challenges facing it in relation to a very uncertain environs created by:

- Significant recent change in the provider landscape – Royal Free acquisition of Barnet & Chase Farm Hospital
- Unusual and possibly unreplicable changes to activity as a result of the Barnet, Enfield & Haringey Clinical strategy.
- Financial difficulties within commissioning and provider organisations.
- Significant demographic changes

<u>Performance to date and opportunity.</u>
Barnet has made progress in reducing non-elective admissions over recent years. This has been reinforced in the HWB fact pack and baseline data that states:

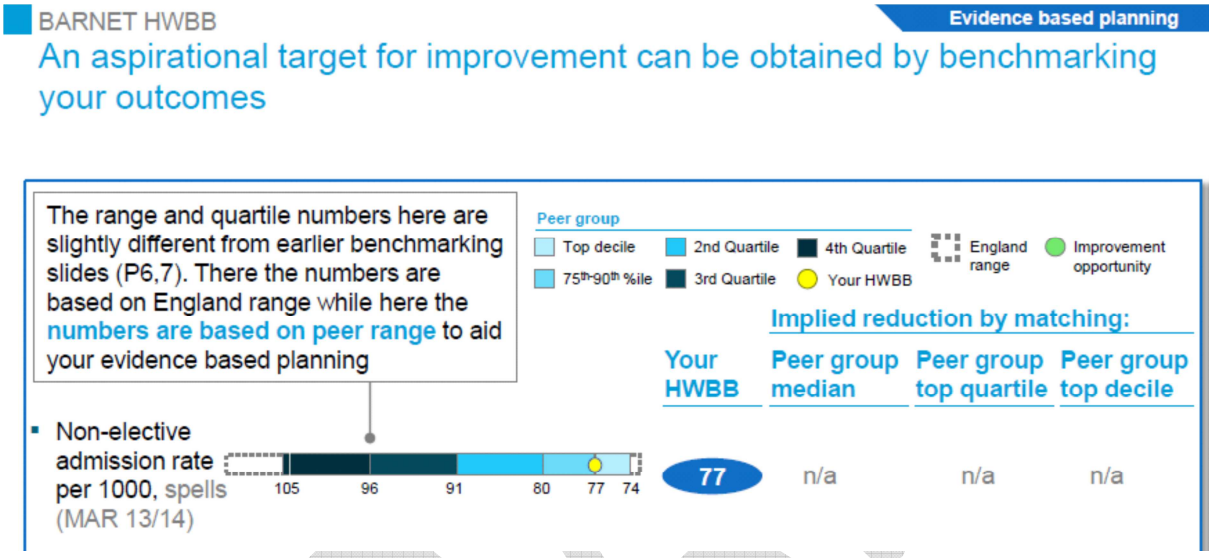
- Barnet performs significantly better than peers and most of England on non-elective admission rates
- Barnet's activity growth is significantly better than peers and top quartile for England as a whole.

Growth rate overall between Mar 09-10 and 13-15 has been **-2.2%.**

While this is encouraging, it should be noted that the reduction is not consistent and largely relates to a disproportionate reduction in activity during specific periods in 13-14. As these periods correlated to known changes in the provider landscape it is would be

imprudent to assume that this reduction was as a result of integrated care activity and hence is sustainable at the same level.

Notwithstanding this, using the published baseline for target setting the HWB fact pack identified that as we performed at top decile in comparison to our ONS and peer group thus indicating a smaller opportunity for Barnet in relation to ongoing impact. This is replicated below. An alternative approach was also outlined in the HWB fact pack based on scientific evidence and case examples of integrated care and this indicated a possible opportunity of 10-19% reduction in non-elective admissions over 3-5 years with fully operational delivery of best-practice integrated care.



Impact of Demographic Change

In 13/14, Barnet's total known population was 376,000, which makes us the highest populated borough in the Capital; yet the total number of GP registered patients at the start of 13/14 was 388,895 and is expected to rise to 402,748 by 15/16. With a history of an integrated diverse, migrant community, continued regeneration within the borough and recent high birth rates, our local population is expected to grow by 5.5% in the next 5 years.

Of particular note is the expected change to the generation profile changing with an anticipated 18% increase amongst 65-69 year olds and 17% growth in 90 year old plus category. This represents an additional pressure related to the in-scope cohort for the Better Care Fund.

Challenging Environment

There has 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 very recent acquisition of Barnet & Chase Farm hospital by the Royal Free

will inevitably change practice and 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.

BCF Target

The resultant impact of the above is that we are planning and delivering all services, including integrated care, in a very uncertain and challenging arena. Utilising the information available and supported by the modelling we have undertaken locally we favour a prudent approach for 2015-16 with a target of 2.5% reduction in non-elective admissions. Barnet believes that we can demonstrate a continued commitment to reducing admissions as a result of the integrated care programme of work, however we also recognise:

- That the opportunity for Barnet may be more limited than in some other areas based on past performance and unreliability of baseline
- A need to balance the additional pressures from a growing population against a target to change patterns in hospital usage
- That significant system challenges may impede our ability to deliver at above 2.5% reduction
- 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

Longer term plans focus on a continued downward trend in non-elective admissions at a controlled and sustainable pace as indicated in the 5 year strategic plans. The transformation programme will continue as planned and through the extensive capacity and demand modelling just completed as part of the FBC we will re-assess how we can further improve on this trajectory.

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

Given the complexity and reach of the Better Care Fund programme of work, it will require changes to be made in a phased and managed approach working with partners over a number of years. Our high level milestones over the next 2 years are:

Year 1 (14-15)

- Building on our programme governance framework, develop a programme approach for the integrated care model at the level of each tier, with specific working groups with identified sponsors and leads
- Develop tier specific plans with anticipated outcome measures, priorities (investment and quality) and milestones for implementation. To include incorporation of existing services and planned developments in addition to new service options.
- Develop a robust PMO support function with priority to establish benefits tracking mechanism to effectively monitor delivery of metrics and outcomes.
- Develop a full business case to support the Health & Social care Integration model and agree a future commissioning/ contracting approach.

- Continue with broader implementation of early phase plans such as rapid care, shared care records and Ageing Well. Incorporate regular monitoring and evaluation providing assurance of delivery outcomes and shared learning.
- Work with partners to co-design detailed operational delivery models including phasing of delivery and funding streams particularly focussed on investment priorities. To include mapping of future capacity and workforce requirements. Priority service model – Integrated locality teams.
- Test current governance arrangements for BCF particularly in relation to agreement and monitoring of investments. Amend if necessary. To include discussions regarding benefits and risk sharing and contingency plans.
- 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.
- Agree stretch to pooled/aligned budgets for future years.
- Establish a mechanism to capture user views to effectively feed in user perspective to inform progress and continued improvement.
- Develop a communications strategy
- On a North Central London CCG level continue with the value-based commission for outcomes work including establishment of Integrated Provider Units (IPUs).

Year 2 (15-16)

- Investment and delivery of agreed project plans in line with tier specifications. Particular focus on self-management and prevention and embedding of the locality team model
- Incorporate service re-design projects within framework as they develop. In particular, the dementia and end of life pathways.
- Use Full Business Case and other preparation from planning to test outputs of current service delivery and to scope further plans for future years
- Fully functioning benefits tracking and financial monitoring model to monitor progress and outcomes
- 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.

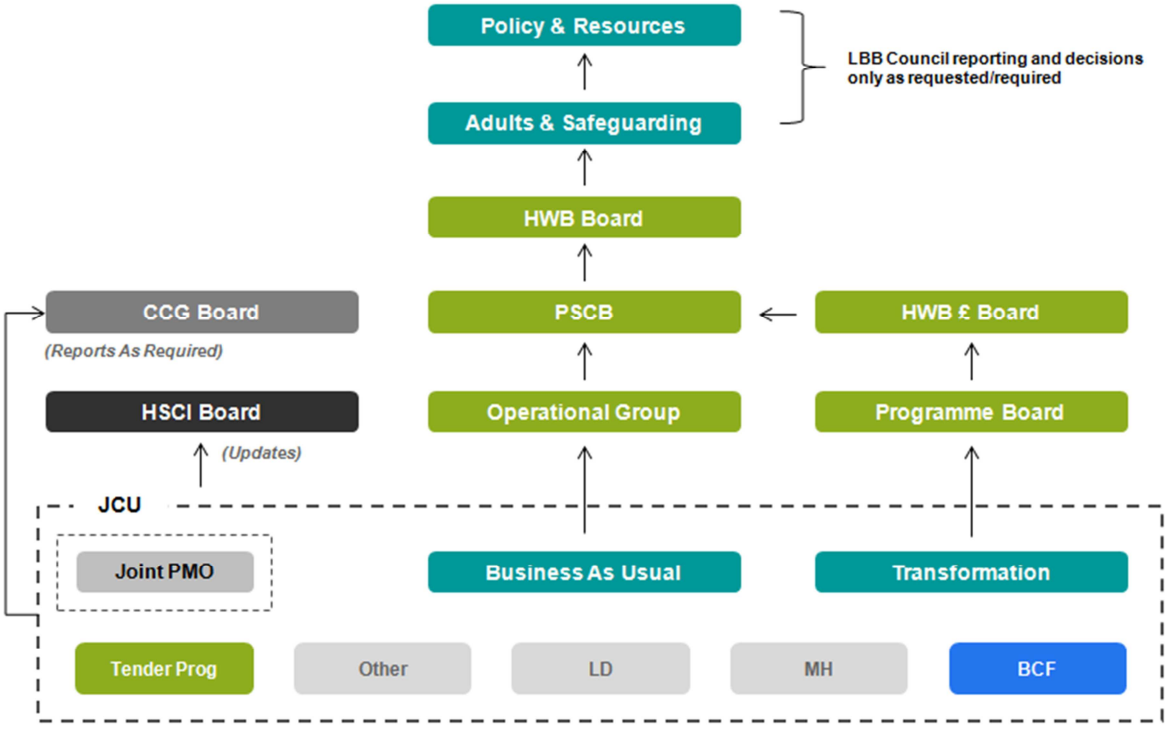
b) Please articulate the overarching governance arrangements for integrated care locally

The figure below illustrates the 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 being updated. We are now working to revise and refresh Programme governance to reflect this Business Case.

Proposed BCF Programme Structure



The LBB Director of Adults & Communities and BCCG Chief Officer act as joint Programme Sponsors. 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 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.

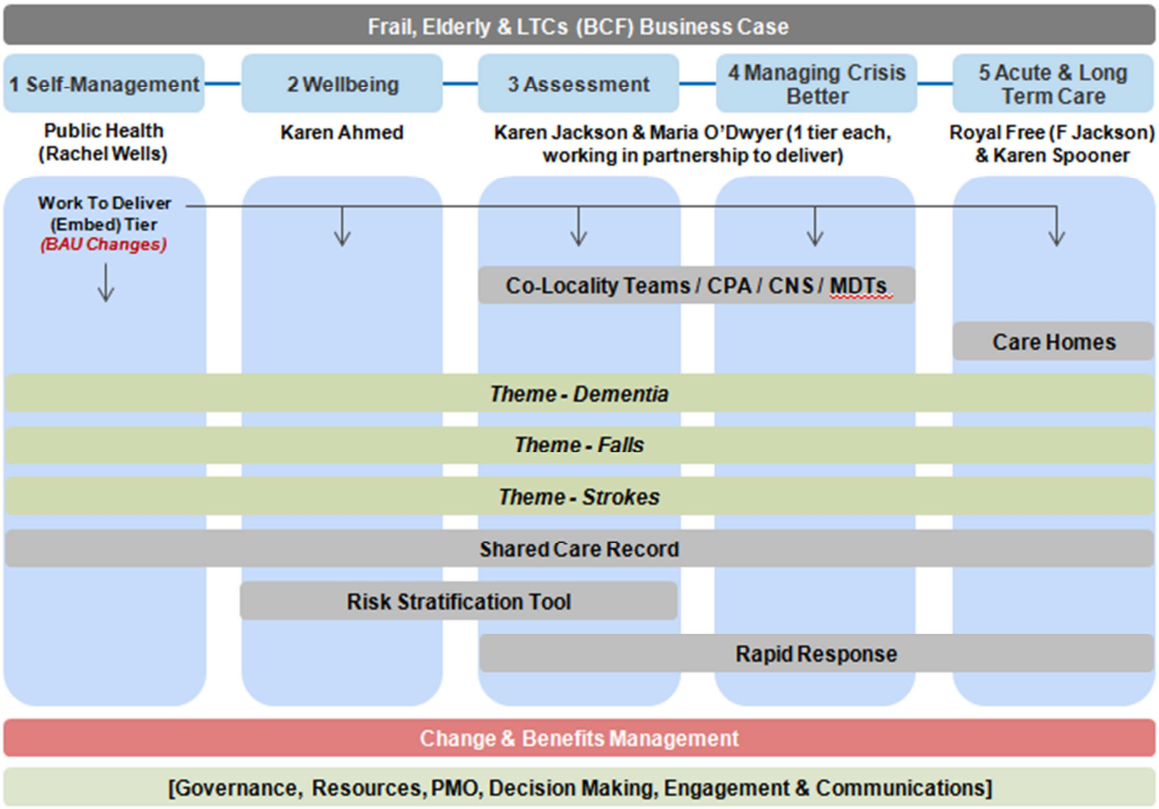
A well established system is in place where current S256 plans are jointly agreed through the Health and Wellbeing Board finance group. Section 75 agreements are in place for integrated services and these will built on over the next few months to manage the changes associated with the BCF pooled budget.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

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.

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 is in the process of re=setting its terms of reference to reflect the emerging and changing 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. Assessment & Care Planning
3	Tier 4. Community Intensive Support
4	Enablers
5	Contingencies
6	
etc	

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 Identification and Cause	Risk Consequence	Impact (e.g. 1-5 with 5 being very high)	Likelihood (e.g. 1-5 with 5 being very high)	Overall risk rating (1-3= low risk, 4-6 medium risk and 7-10 high overall risk)	Mitigating actions and steps
Shifting of resources to fund new joint interventions and schemes	Could de-stabilise current service providers, particularly in the acute setting, creating financial and operational pressures	3	2	5	• 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
Recent acquisition of Barnet and Chase Farm hospital by Royal Free	System change in NHS provider landscape iould impact implementation of BCF services	2	3	5	• Provider engagement • Robust commissioning plans with contingency arrangements

Organisational and operational pressures or lack of engagement from front line/clinical staff leads to lack of buy-in to the proposed integration agenda	Work force not engaged and not ready to deliver integrated care therefore hampering progress being made towards the delivery of integrated care	4	4	8	• Increased focus on workforce development with all providers • Increase engagement with staff on integration ensuring staff input in developing way forward • Possible incentivisation of provider to develop workforce models • Communications strategy with staff across the system • Clinical engagement in development of the model and plans (i.e as is being done in the integrated locality team pilot)
Financial assumptions in baseline data incorrect	As this has been used to support modelling if this is incorrect the financial and performance targets for 15/16 onwards are unreliable and potentially unachievable	4	3	7	• Validation of assumptions and savings target with respective finance departments • Close monitoring and contingency planning
High level of LA budget reduction impact on service delivery/ investment	Slower than expected progress and hence slower benefits realisation	2	3	5	• Managed and phased approach to spend and save model • robust governance in place to support risk and benefits share
Underlying deficit in the health economy impacts on service delivery/ investment	Slower than expected progress and hence slower benefits realisation	2	3	5	• Managed and phased approach to spend and save model • robust governance in place to support risk and benefits share
Social care not being adequately protected	Social care under increased pressure and struggling to deliver services	5	3	8	• work with partners on developing plan for protection of services
Inability to shift resources from acute sector because other members od the public present themselves, leading to no no overall shift in numbers	Increased pressures in other parts of the health economy particularly social care resulting in targets such as increase in emergency admissions, increase in hospital stay etc.	5	5	10	• 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 acute sector. • Public communications strategy, including targeting primary care settings
Population characteristics and demographics adversely impact on deliverability of the model (eg continued net importation of over 75's into cCre Homes from other areas)	Slower rate of benefits realisation	2	2	4	• Focus on high impact project to target populations
User and stakeholder acceptability of new joint schemes	Underuse of newly commissioned services and thus inability to	3	1	3	• Continued stakeholder engagement in design and co-production

	realise benefits				• Robust communications plan • Monitoring of usage and rescue plans

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 £1,336,056. This equates to 2.5% reduction in non-elective admissions and has been calculated with the support of informatics and finance using agreed methodologies. It should be noted that the average cost of an admission in Barnet is above the national average and has been included at a value of £1,866 as per the HWB fact pack. The target builds from 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:

- Falls
- Dementia
- Stroke
- Risk stratification, care navigators
- Rapid care
- Locality based integrated care teams
- GP Care Homes LIS
- Increased access to social work and enablement

A number of enabling services lie beneath these, such as the Community (single) Point of Access and Shared Care Record, which enable 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 the Full Business Case. Although, we expect the risk of non-achievement to be small we have mitigated where possible largely

through contractual arrangements and 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.

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

A number of key challenges face the Barnet health and social care system giving weight to alignment of Better Care Fund plans with other initiatives related to care and support. In summary, these challenges are:

- Very significant population growth – 45,000 over 5 years, fastest growth is children and elderly, 23% in 5 to 9 year olds 18% 65 to 69, and 17% in 90 plus.
- 373,000 registered patients across 67 CCG member GP practices
- Deprivation is lower than average, but 18,195 children are classified as living in poverty
- Mortality rates have fallen over the past 10yrs
- Adult obesity rates are worse than the England average
- Meeting the needs of the 32,000 informal carers in Barnet especially in the context of implementation of the Care Act where carers receive significantly enhanced entitlements.
- Recent reconfiguration and challenges in local Acute providers - Barnet & Chase Farm NHS, Royal Free (London) NHS Trust and Barnet, Enfield & Haringey Mental Health Trust
- Over 100 care home establishments with net importation of residents from other local areas

Of particular relevance is the financial challenge facing the local economy which sees 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. This is accompanied by a council forecast that its budget will reduce by a further £72 million between 2016/17 and 2019/20, in addition to the £72 million reduction in the first half of the decade. Overall, the council's spending power in 2020 will be roughly half of what was in 2010.

The Better Care Fund strategy and plan is 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)):

- Clinical service re-design particularly in relation to urgent care and long term

conditions pathways

- 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
- System-wide operations resilience planning and delivery.
- 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.
- Refresh of the Joint Strategic Needs Assessment
- Value based commissioning approach

We seek to ensure that BCF plans are aligned with these and where possible shared resources and approaches are agreed. 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 **Barnet Council Corporate Plan**, **PSR and 5 year commissioning plans;** and the **Barnet CCG Strategic Plans** echo the themes of the BCF through outcome-based commitments to work with partners and residents to :

- Promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.
- Commission and manage quality services focused on patients' needs.
- Manage demand in the most cost-effective way.
- Sustain a strong partnership between the local NHS and the Council, so that families and individuals can maintain and improve their physical and mental health.

The CCGs 2 year operating plans and 5 year strategic plans are under-pinned by a clear **Vision** for services with over-arching values and a set of **strategic goals**. This is supported by a transformation strategy. Collectively, these are intended to articulate clearly the direction of travel for the CCG whilst providing a framework which is flexible enough to encompass new local and national priorities. It is a transformation strategy signalling a change in how the CCG develops and delivers the local health agenda.

The figure below shows how the CCG Vision and goals support the delivery of a comprehensive health system in Barnet and how integrated care through the BCF has a critical role in supporting health and wellbeing across all our residents whatever their health status.

The strategic goals drive the agenda in meeting the health care challenges in Barnet, from preventative strategies for the population as a whole, through ensuring good services and access for the population with low health needs or simple high impact disease, to ensuring the right support for our patients with complex co-morbidities or a high disease burden. 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. Key links with the 5 tier **Health & Social Care Integration model** are evident, and key priorities and programme of work are shared across both areas for delivery.

Similarly, the **Barnet Council Corporate Plan (2013)** and **Priority & Spending Review (PSR) 2014** outline a commitment to integration and the BCF. 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.
-

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 the expression of interest by NHSE, Barnet CCG as part of the NCL CCG's group have met with the NHSE NCL Area team assistant head of primary care, and are pursuing further development of the expression of interest with NHSE.

The plans for the development of primary care are complementary to the BCF plans, and identify the importance of integrated care planning around clients health and social care needs, in achieving better health and social care outcomes for the Barnet population.

Primary care development will be supported by and complement the development of integrated health and social care provision within Barnet, with the objective of reducing health inequalities within the borough, through improved focus on health need and prevention.

In addition to improving prevention of illness, a clear focus is 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.

Recognising the very high number of care home beds in Barnet, the CCG has developed a specific local service specification for GP practices to support improved care within care homes.

Primary Care development also recognises the importance of pharmacists in Barnet in respect of offering advice to clients around a range of conditions
And the CCG has supported a number of initiatives around the management of minor illness episodes, improving clients' inhaler technique to improve their management of asthma and COPD.

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 the local area is prepared for the implementation of the Act in April 2015. There is a clear synergy between the 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. reablement 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 reablement 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.)

£1,206,000

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 Care Act Implementation Project Board which oversees various work streams relating to the Care Act requirements. The projects are currently "in-flight" and include: Front Door / Eligibility, Assessment & Support Planning; Prevention, Information & Advice; Carers; Demand Analysis & Modelling; Finance (Universal Deferred Payments; Charging and Debt Collection); Market Shaping; and Workforce Development.

v) Please specify the level of resource that will be dedicated to carer-specific support

We are currently evaluating some of our Carers services which focussed on health and funded by s256, and the outcome of this activity will inform our future commissioning intentions and use of the BCF pool as well as any variations to the Lead Provider Contract and / or work with Barnet CCG. The schemes include the Hospital Discharge Service / Co-ordinator (project ending in September 2014, GP prescription breaks service, emergency plans (end of year 1 of 3 years) and the carers' nurse post (contract has ended).

The following embedded document is a Position Statement which summarises the services that are being commissioned for carers as well as identifying work that will need to be developed in meeting the requirement of the Care Act.

Position Statement
v1.3 14.06.09 .docx

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 for carers, highlight risks, and inform how we allocate 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 (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

There are national and local drivers in place to establish 7 day working for health and social care, and to implement future plans which enable seamless transition of people into and out of hospital throughout the full week. This was clearly articulated at the design phase of the Health and Social Care Integration Model, both by service users and providers; and is a key theme through Health and Well-Being strategy and out of hospital care plans.

Although we have made significant progress, we recognise the need to enhance further the scope and reach of services already in place building from the learning from winter pressure initiatives for 13-14 and framing progress with providers in line with the clinical standards for 7 day services.

High level delivery plan associated with the move to 7 day services:

Priority action	**milestones**	**Status (RAG)**
Acute services		
Extension of hours of tracker nurse provision to support identification of those who could be discharged	Nov 13	A
Supported assessment, triage and discharge arrangements within local acute trusts including Urgent Care Centre (UCC), ambulatory care pathways, PACE, TREAT and RAID have recently been implemented and are all planned to offer 7 day provision from Jan 2014		
A number of initiatives have been implemented within the acute trusts that impact of 7 day staffing particularly to support discharge. Examples include occupational therapy and access to pharmacy. These will require evaluation for future planning.	Ongoing	A
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 required	Nov 13	G
Links established between services above and current providers of 7DS (eg out of hours GPs and London Ambulance Service (LAS)) with referral protocols where necessary	May 2014	G
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 2014	G
Refresh of current alternative care pathways with LAS to facilitate avoided admissions.	Ongoing	G
Social Care		
Social work and OT teams operational 7 days per week within A&E departments to support care planning for transfer home	Jan 2014	G
Access to new and amended packages of care throughout the weekend	Jan 2014	G

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	G
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 7DS 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

The NHS Number 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. The functionality in this system, combined with updated business processes and more complete work flow, will result in the recording of the NHS Number for all social care clients from this point forwards.

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.

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 is not intended to 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. In order to be able to combine data about the individual a unique identifier will be required for all information that can link the data to the individual – the NHS Number will be the unique identifier used.

The Barnet Shared Care Record Project will first implement the service in early 2015. Data submitted to the Shared Care Record will be required to include the NHS Number as the identifier. 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). This will mean that the project is able to focus on business processes, which will include using

the NHS Number as the primary mechanism for searching for an individual in the Shared Care Record. This change in business process 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 then work with other organisations and teams to increase the data in the Shared Care Record and to improve the process of sharing. Where the NHS Number is not currently used as the primary method of identifying individuals, the project will, during 2015/16 work with these care organisations to ensure it is used and included 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

Risk stratification of our population is key to enable us to better ensure that the right people receive proactive case management in a cost effective manner and to allow us to focus case management on individuals that will benefit most. It enables us to:

- Address the primary objective of Long Term Condition Management which is to know your population and stratify your risk
- Identify and assess patients most at risk of unplanned hospital admissions
- Focus resources to delivery pro-active care management
- Reduce avoidable secondary care admissions
- Make well informed commissioning decisions
- Review, monitor and measure patient care over time

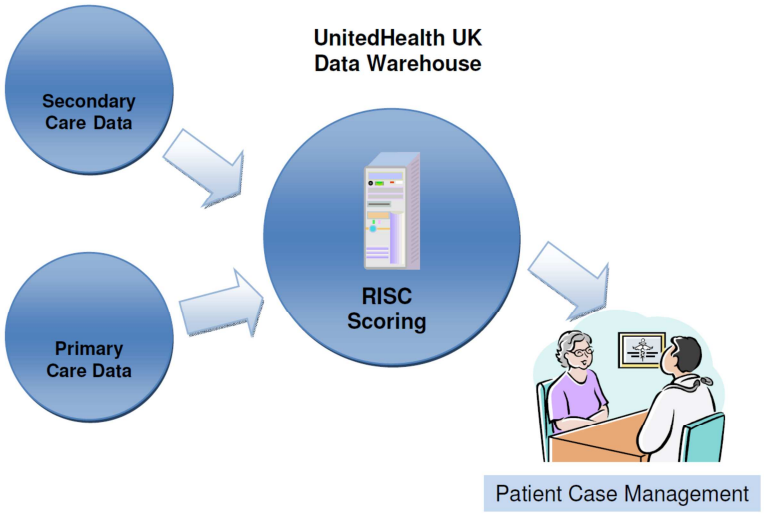
The most accurate method of identifying individuals at risk of a non-elective admission is through predictive models that use statistical algorithms to predict an individual's level of future risk. Barnet CCG has procured the automated **United Health HealthNumerics-RISC® tool** and, post-resolution of the national Information governance issues, we have supported an accelerated programme of implementation in GP practices and training through July and August 2014.

What is HealthNumerics-RISC

HealthNumerics-RISC is a risk identification and stratification tool which identifies patients at risk of a future unplanned hospitalisation due to chronic conditions within the next 12 months. 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 based as follows.

The following table identifies how the RISC product assigns the RISC level of a patient following the RISC scoring process and compares this to the Kaiser model.

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%

Important points to note are that the tool:

- provides more granular identification of patients in level 3 and 2 allowing clinicians to deep dive into an individuals usage patterns of services
- will help determine patients who are not only appropriate for intensive case management (level 3) but also disease management (level 2) and self-care programmes (level 1)

Using the parameters above we have completed the 'first cut' stratification of the Barnet CCG population with the following results. Data also indicates that the PbR costs associated with people in levels 2 and 3 are £79m representing approx. 50% of total spend.

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

As with all new systems, we are allowing time to for the system to embed and to address any technical issues that arise. This will include ensuring that the data is reliable and accurate.

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 changes for 2014-15.

- Embed the use of the tool as a partnership approach with the Locality Integrated Care Teams to implement a framework for implementing and integrating joint assessments and the role of the accountable lead professional.

- To test 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, 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 locality based integrated care 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 practices and has reduced initial expected throughput to the service. Despite this, a 6 month evaluation showed encouraging results.

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. 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. Examples include **Healthwatch Barnet, Barnet Older Adults Partnership Board** (a resident and service user engagement group)**, Age UK (Barnet), Alzheimer's Society** and others. We also regularly draw 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 develops local prevention and well-being services from the ground up, led by local people in response to needs identified by the community. To support implementation of a number of our key services, for example locality based integrated care teams, we have used best practice principles in patient and user engagement with high levels of user feedback on 'what good looks like' to inform specifications and key performance indicators.

The **Integrated Health & Social Care Model**, itself was developed from feedback from local residents that they wanted to see an increase in co-ordinated care to enable them to live better for longer. Ongoing involvement and oversight by the co-chair of the Older Adults Partnership Board, keep the strategy grounded and progressive. User and stakeholder interest in the BCF is high and the model, and its component services, have been extensively tested in workshops with Older Adults Partnership Board members, Older Adults Assembly meetings and public forums facilitated by Healthwatch, interviews and surveys. All of these have developed a shared view of the future shape of services.

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
- Experts by experience panel or reference groups
- Work thought 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
- Work with voluntary sector and existing services (e.g. Neighbourhood model) to

engage hard to reach communities
- Co-production approaches to new specifications

Moving forwards, our plans will involve a more strategic approach to relationships with the voluntary sector including a clear forward plan of the contributions that can be made and alignment with over-arching strategy. Where relevant we will develop the market and give support to facilitate the integration of services within emerging pathways rather than as a stand-alone add-on.

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.

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

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 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.

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.

ii) primary care providers

The primary care infrastructure in Barnet includes (add number) 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 Mode** 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.

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 Mr Dale 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. 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 are still impacting this year.

The ongoing financial position of Barnet CCG is well recognised 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.

The current CCG QIPP plans for Integrated Care in 2014-15 represent savings of approximately £1.7m 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 have been scaled up in accordance with the process outlined in section 3. 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 716 less non-elective admissions in 2015-16 (or 2.5%) with a relative estimated impact on the acute sector as outlined in the table below. It should be noted that this a based on a different costing model to above and represent initial workings that require further validation.

	Estimated Activity Reduction 15/16	Estimated cost at £1490 in BCF model	Estimated cost at £1866 revised cost (from HWB fact pack)
Royal Free (Barnet site)	458	£682,778	£855,076
Royal Free (Hampstead site)	236	£352,057	£440,898
UCLH	7	£10,668	£13,361
Whittington	14	£21,337	£26,721
Total	**716**	**1,066,840**	**1,336,056**

Although the original BCF ambition of 3.5% reduction may not be planned for 2015-16 it should be noted that we expect an overall downward trend over the next 5 years.

The impact of not delivering the BCF activity is mitigated somewhat by the reduced target presented although is recognised as problematic for providers should the plans not deliver as expected. With current CCG contractual arrangements funding will follow the patient so any additional acute activity will be reimbursed in accordance with agreed tariffs. Current operational 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.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
What is the strategic objective of this scheme?
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 delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
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
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
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?
What are the key success factors for implementation of this scheme?

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	
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

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?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	