Barnet Health and Social Care

Integration of Services

Business Case

October 2014

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

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Version History

Version	Date	Author(s)	Summary of Changes
0.1	29 July 14	LBB A&C	First Draft (proposed structure and changes/updates)
0.2	28 Aug 14	LBB A&C	First full draft (content, revised layout) bar financials
0.3	04 Sep 14	LBB A&C	Revised draft (content edited, additional data added)
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Note: This latest draft is a DRAFT version. It is not complete or verified.

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

Contents

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

1. Introduction

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

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

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

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

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

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

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

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

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

This Business Case includes:

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

2. Strategic Case

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

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

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

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

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

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

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

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

Other conditions associated with ageing

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

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

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

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

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

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

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

The Vision for Integrated Care in Barnet

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

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

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

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

- **a single point of contact**
- **access to quick and responsive services in the community**
- **to only tell his story once**
- **the support of professionals and services that talk to each other**
- **support options for his family and carer**

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

Objectives of the integrated care model

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

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

Benefits

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

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

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

Measure	Baseline	Planned 14/15	Planned 15/16
(Reduced) avoidable non-elective and/or emergency admissions per 100,000 population (average per month).	To be confirmed following submission of revised BCF plans to NHS England.		
(Reduced) permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.	486.9	417.6	354.1
(Increased) proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services.	71.9%	75.3	80.2
Reduced) delayed transfers of care (delayed days) from hospital per 100,000 population (average per month).	635.3 *	492.3 *	379.3 *
(Improved / minimum) Patient / service user experience (national metric).	0.9	To be confirmed	
(Increased) Self directed support.	1.0	**1.0**	**1.0**

* - Average Quarterly Rate

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

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

Intermediate Outcomes

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

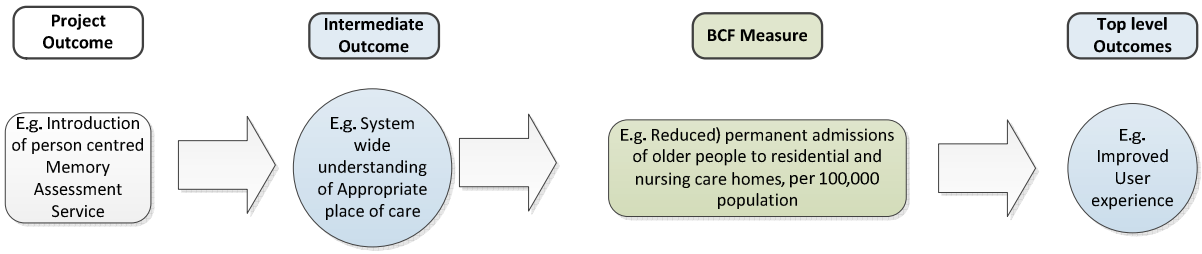


Figure 2 – Outcome Relationship Map

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

Business Strategy

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

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

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

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

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

[4] Definition of BCF
[5] National Evidence

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

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

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

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

3. Economic Case

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

- meet the needs of an ageing population
- improve outcomes from care, and
- reduce system spend

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

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

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

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

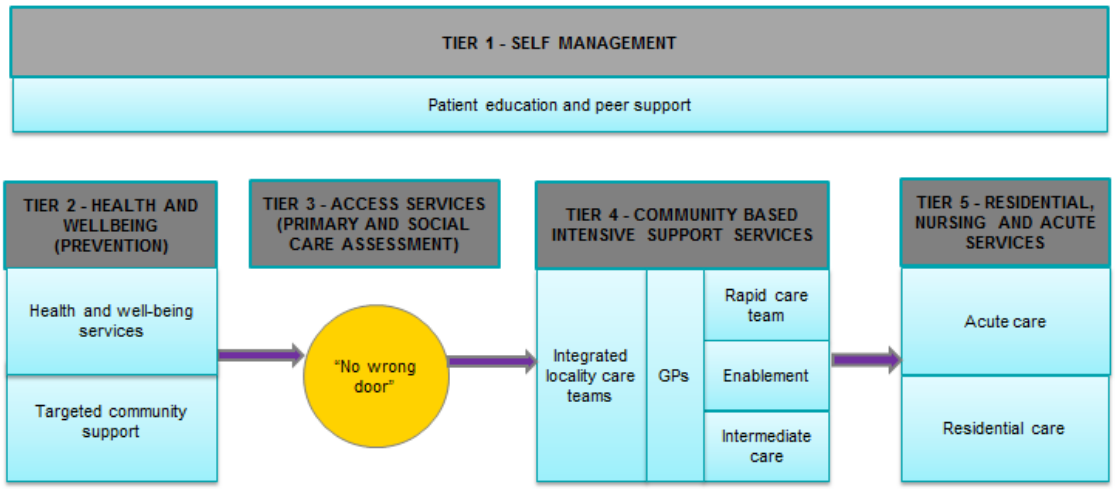


Figure 3 – Overview of the 5 Tier Model

The 5 Tiers

Tier 1: self management

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

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

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

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

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

Tier 1: Case Study

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

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

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

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

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

Tier 2: health and wellbeing (prevention)

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

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

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

Residents who are identified as at risk of needing Tier 3 and 4 services will need further assessment. This will ensure they receive specific support from particular services (dictated by personal circumstances, health condition, etc). Strong links will need to exist between all Tiers to ensure that people get the right support. A good evidence base of what works at a system/individual level will be developed and this will inform future commissioning.

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

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

Tier 2: Case Study

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

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

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

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

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

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

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

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

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

Tier 3: Case Studies

Using a shared risk stratification approach to identify and deliver care

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

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

As is case study – Mr Colin Dale is a frail and elderly gentleman who has reduced mobility due to osteoarthritis. He also has heart failure, diabetes and an enlarged prostate. He receives three social care visits a day and from time to time is incontinent.

Recently he was admitted to hospital following a fall in his home. He was dehydrated and had a UTI. Prior to admission Mr Dale had limited contact with community health services.

To be case study – Mr Dale's care worker is concerned that he appears less stable on his feet. She notices that the drink she has left the previous day has not been touched. She contacts the Barnet Community Point of Access for assistance and an urgent district nursing visit is arranged. Following the DN visit, Mr Dale is transferred to the Ambulatory Treatment centre where a course of intravenous antibiotics are commenced by the ENP and community geriatrician. Mr Dale is monitored for the next 6 hours and returns home later that day.

A night sitting service is organised for the next 48 hours.

Mr Dale's care plan is reviewed, his continence care is amended, a commode is supplied and information about the importance of drinking is provided and reinforced by his care worker.

Impact – The care worker has immediate access to urgent support, DNs can initiate urgent treatment that can be delivered in the community, Mr Dale can be stabilised quickly and return home without a hospital admission. Mr Dale retains his independent living.

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

As is case study

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 don'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. They are overseen by integrated locality-based teams who can move resources around flexibly to maintain people in their homes or in other care settings e.g. residential care.

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

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

Tier 4: Case Studies

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

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

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

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

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

As is case study – Mr.Colin Dale is 75 and lives in his own home. He had a stroke a number of years ago and has made a very good recovery but does struggle to go out on his own although can do many tasks in his own home .He is determined to be as independent as possible. On a Friday night whilst making his night time drink he had a fall in his own home. He is hurt and has a cut to his head but is able to notify the Assist service. He is taken to A 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

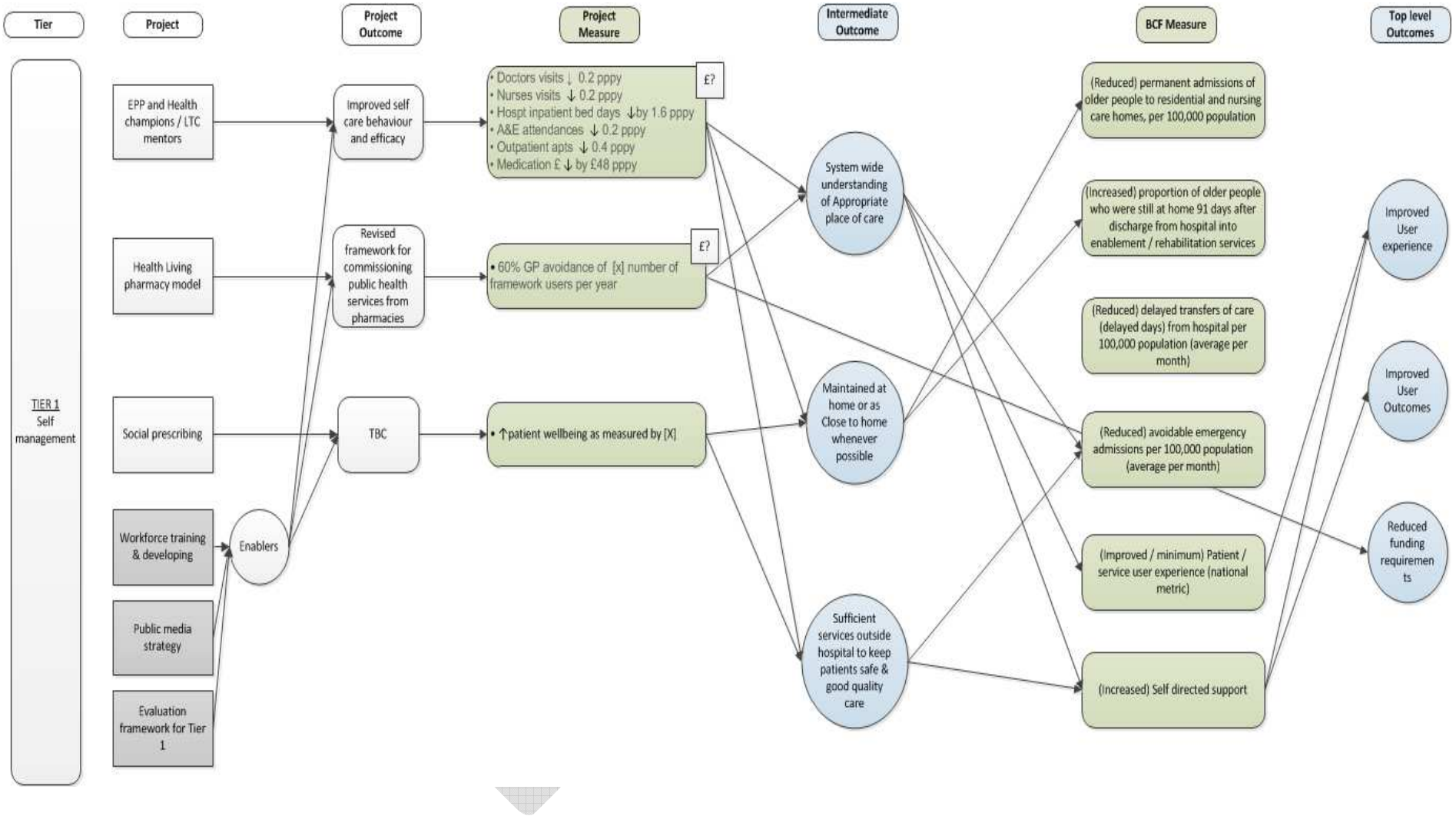
The focus of this the Integrated Model is balanced towards tiers 1 – 4 to reduce demand for residential and acute care. Residential, nursing and acute services support intensive care where individuals cannot be maintained at home. These services are drawn on where they are most appropriate and where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

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

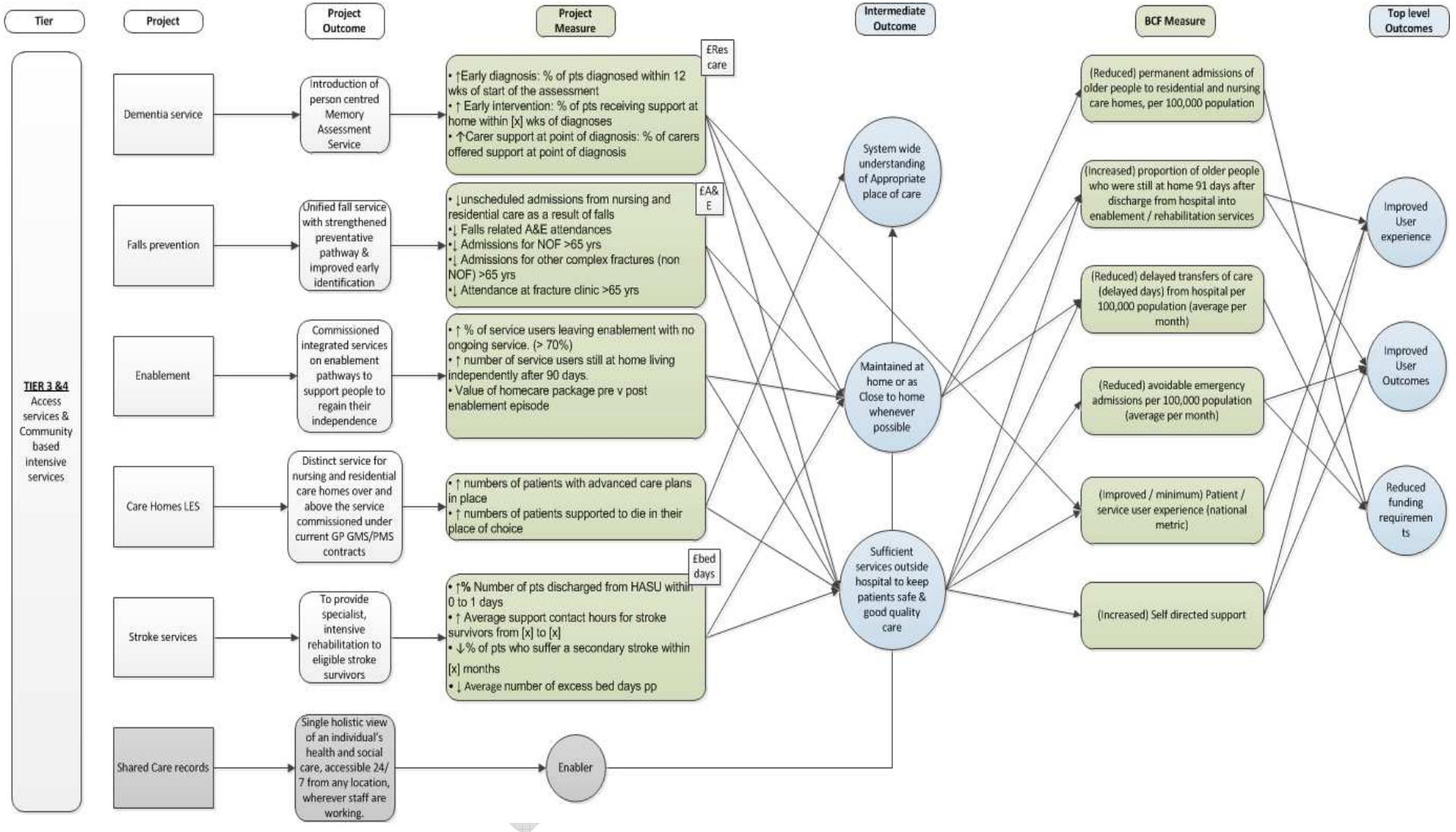
Benefits

The following benefit maps illustrate tier projects indicative contribution to top level outcomes:

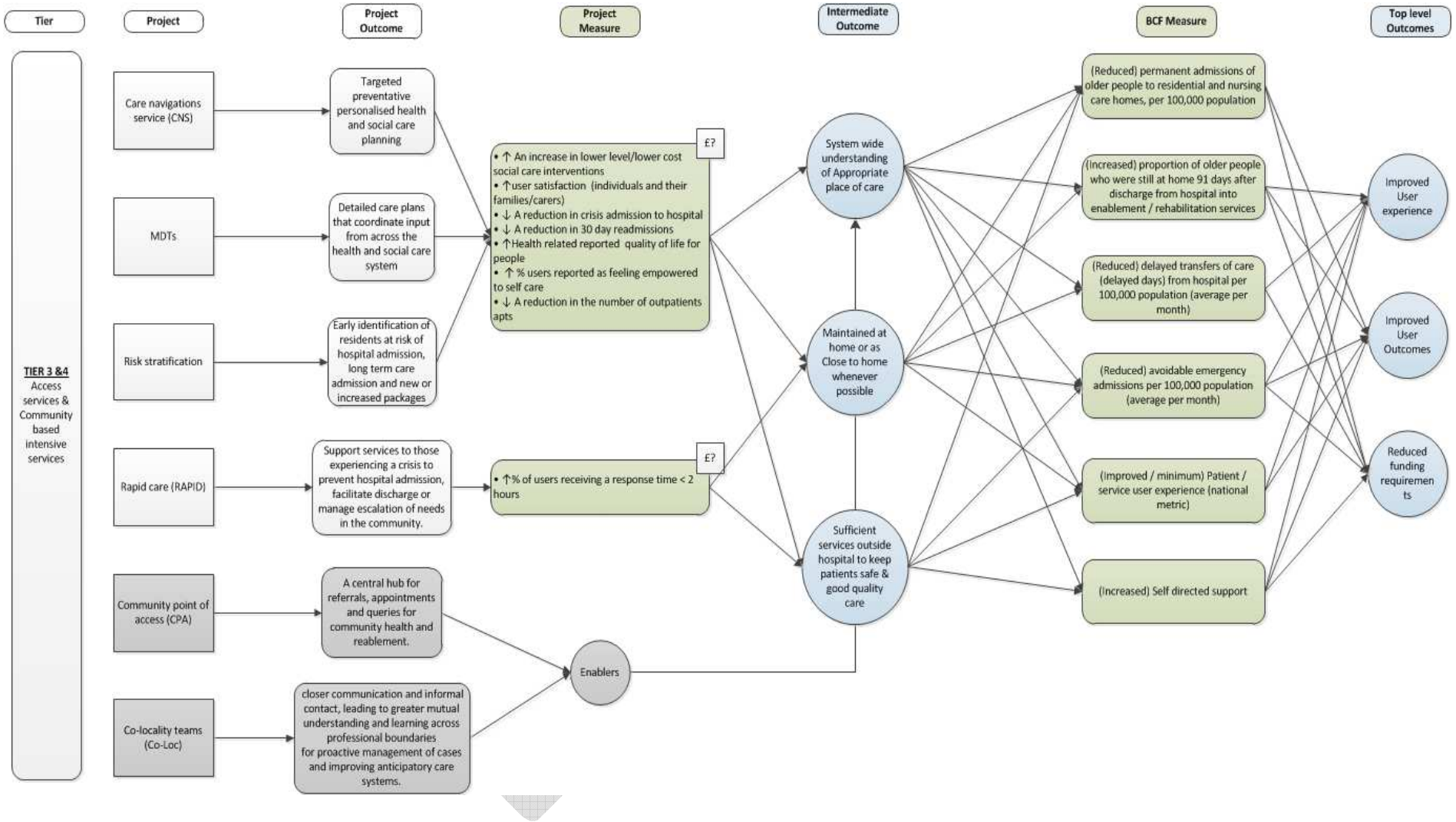
Tier 1 Benefits Map



Tier 3 and 4 (New Projects) Benefits Map



Tier 3 and 4 (Existing Projects) Benefits Map



4. Project Descriptions

Tier 1 Specification – Self-Management

Structured Education	**New Service**
Service Description: Pilot and roll out of generic and disease-specific Expert Patient programmes, followed by wider roll out which may be: • Locality-based generic • Disease specific (Diabetes/ Dementia/ Falls/ Stroke/ Chronic pain/ COPD/ depression). Standard courses run for 6 weeks with 10-16 attendees. **Objectives:** • Empower patients to self-care and manage their condition • Optimise individual patient's health status • increase knowledge and understanding of LTC and lifestyle/behavioural influences • Improve the patient's experience • Mitigate for unnecessary A&E attendances and unplanned hospital admissions. **Deliverables:** • Structured education offer to cohorts of patients with LTC (see service finance section) • Development of relationships between primary care professionals, patients, specialists and carers.	
Service Start Date	Pilot of generic programme: **November 2014** Pilot of disease specific programme: **January 2015**
Project (Inter)dependencies	Structured education needs to be supported by relationships between primary care, specialists, carers and patients. Professional development and support from LTC specialists is important.
Current status and key achievements	Relationship established with CCG on approach to developing self management offer. Commissioning of structured education pilot commencing in November 2014.
Service Finance	
Estimated Activity	**PILOTS:** • 1 generic structured education pilot and 1 disease specific pilot in Q4 2014/15 • 48 people in each pilot (16 people x 3 localities per pilot) = 96 people engaged in 2 x pilots in 2014/15. **ROLL OUT:** • Roll out of further EPP courses begins in April 2015 (dependent on evaluation) • Roll out to *5%* of 23,555 (POPPI projection no of over 65s with life-limiting LTC). **OUTCOME:** 1,778 people supported by structured education programmes over 2015/16-2019/2020 period If each course successfully works with 10 people, this equates to delivering 2 EPP courses per month for the next 5 years (or 6 courses in each locality each quarter, venues to be confirmed).
Cost of Service	**PILOT**

provision	• £15,000 for each pilot = £30,000 (+ £5,000 post pilot evaluation) = £35,000 in Year 1 • For the first pilot the CCG are funding with £10,000 of HENCL and £5,000 Public Health monies. Second pilot and evaluation of the pilot will be funded by the public health team (£15,000). **ROLL OUT** • Cost of rolling out the service as described (based on an average cost of £240 per person)= £426,720 • On-going administrative cost to support programme = £97,600. **Total cost** of pilot and roll out = £559,320
Net Benefits	DH figures suggest average net benefit across generic and disease specific programmes of £ £259.50 per person per year for 5 years (with cashable savings from secondary care = 194.75 per person, and non-cashable saving of £55.25 primary care saving) NB Until the pilot has been completed, assumed dropout rates haven't been factored into the calculation of benefits.

LTC mentors/ Health champions	**New Service**

Service Description:

LTC mentors – volunteers who have personal experience with LTC's/health champions will support people with LTC in a variety of ways:

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

Mentors will provide telephone support at times (sometimes peer mentor will make the phone as part of an intervention, other times the telephone call will compliment exiting programme).

Similar to telephone support outlined above, web and email-based support will be used here by mentors to overcome the problem some patients have with face-to-face contact. Internet-based support groups sometimes called "e-community" can increase effectiveness of self-management programmes. It recognises that people living with chronic illnesses have a great deal to offer each other and they share the knowledge and experience. Carefully designed web-based peer support can be a powerful way to help people with LTCs to live more fully.

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

Community Health Champions are community members who work as bridges between their ethnic, cultural and

geographical communities and health and social care providers to promote health usually among the groups that have traditionally lacked access to adequate health care.

They are peers to the populations they serve not by having a LTC but speaking the same language, sharing culture and/or living in the location.

Key roles will also include accompanying someone along to an activity such as exercise or a weight management session and encouraging their participation.

Objectives:

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

Deliverables:

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

Service Start Date	Recruitment of mentors through EPP courses commences: **Winter 2014** Recruitment of LTC health champions from: **April 2015**
Project (Inter)dependencies	Interdependent with Structured Education and professional support initiatives. Good partnership between the peer support service and the wider health and social care system is important to the successful delivery, particularly with regards to appropriate referrals to and from peer support.
Current status and key achievements	Draft paper on peer-support models has been produced and further discussions now required.
Service Finance	
Estimated Activity	**PILOT:** • EPP pilot to commence in November 2014- recruitment drive of mentors and health trainers. **ROLL OUT:** • Mentors begin work with the people who have just come through the first EPP pilot in January 2015. Mentors recruit additional mentors by March 2015. 2nd wave of EPP recruitment complete by May 2015, following completion of 2nd EPP pilot in March 2015. • 6 Health champions recruited by April 2015 to commence roll out of health champion programme. • 3 Health trainers to coordinate programme and provide training to volunteers, recruited by March 2015.
Cost of Service provision	• Minimal- LTC mentors will be volunteers so will need expenses (£1,000 for each of the first 2 years; £2,000 for 18/19 and 19/20) • Health trainer costs of £70k per year plus administration support at 30k per year= £100,000 per year.
Net Benefits	N/A. These benefits are to be grouped with the EPP programme, using the £259.50 average

	benefit per people – consideration will need to be given to additional activity re GP referrals outside of EPP.

Targeted Healthy Living Pharmacy Model for people with long-term conditions	**New Service**
Service Description: Development of the Healthy Living Pharmacy concept to support the Barnet model for integrated care. Provides a potential framework for commissioning public health services. Model encompasses a minimum of 1 health champion (link to above); clinical expertise and training in more complex model; medicines use review. **Objectives:** • Empower patients to self-care and manage their condition • Optimise individual patient's health status • Develop selected pharmacies as a focus for LTC support • Contribute to the community led model of LTC support • increase knowledge and understanding of LTC and lifestyle/behavioural influences • Improve the patient's experience. **Deliverables:** • Additional support available to people with LTC, as an alternative to other components of the offer for people with LTC. • Promotion of pharmacies as part of 'fat front door' • New referral routes into services.	
Service Start Date	Design of approach by: **March 2015** Implementation of pilot (2x pilots overall): **April 2015-April 2016** Evaluation for pilot 1 by: **June 2016** Roll out to 12 pharmacies for programme: **March 2017- March 2020**
Project (Inter)dependencies	Interdependent with Structured education, tier 2 and professional support
Current status and key achievements	Pharmaceutical needs assessment (PNA) currently underway and will inform development of this piece of work (NB Supplementary statements to the PNA will be required if changes are made under the integrated care model).
Service Finance	
Estimated Activity	**PILOT:** • Development of proof of concept of Barnet model, testing with pharmaceutical advisors, community pharmacy, LPC. • Design and testing of 2 pilots **ROLL OUT:** • Implementation across 12 Healthy Living Pharmacies for Older People (evenly distributed across the 3 localities), reaching 2174 people by 2020
Cost of Service provision	**ROLL OUT:** • Implementation costs of £26,000 per pharmacy = 47 hours of project leader time/month (based on Pathfinder programme. • £26k x 12 pharmacies = £312,000 • Additional training costs for pharmacists estimated at £5,000

	Total implementation costs = £317,000
Net Benefits	1000 person survey (as part of the national evaluation) suggested 60% GP avoidance. Extrapolating this data, it is estimated that a potential 2147 older people with LTCs will not access their GP as frequently who would otherwise have done so as a result of 12 HLPs being in place. Benefits should begin to be quantified by March 2018.

Social Prescribing	**Enabler**
Enabler Description: Prescribing through primary care (and potentially social care) of individuals meeting criteria for increased social interaction, supported self management and at risk of mental health decline due to LTC. **Objectives:** • Empower patients to self-care and manage their condition • Optimise individual patient's health status • Increase access to opportunities to engage in mental health promoting behaviours • Develop and increase social support and interaction • increase knowledge and understanding of LTC and lifestyle/behavioural influences • Improve the patient's experience. **Deliverables:** Sign-posting service based in community/primary care, that increases reach into the voluntary and community sector and offers people with long term conditions more choice and control over their treatment/ maintenance plans.	
Service Start Date	Pilot: **April 2016**
Project (Inter)dependencies	Interdependent with all elements of tiers 1 and 2, and cascades throughout all tiers.
Current status and key achievements	Models to be defined, timetabled.
Service Finance	
Estimated Activity	• Design and implement social prescribing pathway to link into post health check interventions pathway **ROLL OUT:** • Roll out of DXS software across all practices (c65 practices) to support social prescribing among GPs. This will offer social prescribing support to the majority of the cohort population (23,555). Uptake is expected to be c5000 patients from the cohort population.
Cost of Service provision	**PILOT:** • £50,000 to support 300 of high need individuals across the 3 localities (figures based on cost estimates from Bristol pilot). **SOFTWARE:** • Cost of the DXS pilot (18 practices) was £19,900 which includes set up costs (£5,000) training for 18 practices and provision for a maximum of 145,000 patients (12p per patient). Rolling this out more widely would cost an additional c£50,000.

Net Benefits	Evidence suggests 60% of people who engage with social prescribing services use GP services less as a result. In a pilot that works with 300 people, this would result in avoidance of 180 contacts in primary care. Other expected benefits include decreased mental health, depression and anxiety consultations due to LTC. Potential expansion of community led programmes, increase in volunteering.

Workforce training and development	**Enabler**

Enabler Description:

Development of training programme and learning sets supported by HENCL (see below), and a Co-Creating Health pilot. The Co-Creating health pilot will consist of:

- Self management programme (SMP) programmes for patients with LTCs
- Advanced development practitioner programme (ADP) for professionals
- Service Improvement Programme (SIP) which supports areas to change and improve the way their health services are designed and operated so that they better support self management.

Roll out of locally commissioned scheme (LCS) that supports professionals to self-manage. The LCS will assign designated GPs/ Nurse Practitioners to undertake a Prevention Assessment and Self-Management Consultation for all newly diagnosed patients in the long term condition register for clinical conditions and record this in patients' notes.

Objectives:

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

Deliverables:

- 100% new patients on LTC register to be supported through new LCS
- The co-creating health ADP pilot.

Service Start Date	Pilot of co-creating health to begin in Q1 2016/17 to run for 18 months minimum LCS On-going from September 2014.
Project (Inter)dependencies	Interdependent with all elements of tier1 and cascades throughout all tiers.
Current status and key achievements	Key elements established to date (first two initiatives are yet to begin but funding has been awarded through Health Education England): • Multi-professional learning sets focusing on older people and training programme: ○ Comprised of professional groups including community pharmacy, community nursing and health visiting, mental health, secondary care, social workers, palliative care services, general practice and lay involvement through HealthWatch (to be established); ○ Supported by professional facilitation for up to 4 sessions per group – the purpose of the facilitation will be to develop group cohesiveness, break down barriers, deal with group dynamics, clarify and resolve differences around

	language and terminology; ○ We intend to test participation support through the use of technologies (especially web-based approaches e.g. WebEx conferencing) for a small number of the learning sets (1-2). • Educational programme to support Integrated Care (Learning opportunities that cover the following (not exhaustive or finalised list) of key areas: ○ Effective use of case management ○ Principles underpinning coordination of care ○ Introduction to coaching for health ○ Principles in planning for end-of-life care ○ Prescribing issues in those with complex care needs ○ Coping with uncertainty and complexity in healthcare decision making) • Patient pathway management Locally Commissioned Service (LCS): • 31 practices have signed up to the LCS (i.e. c45% of Barnet's practices) – 100% new patients on LTC register will be worked with through the LCS.
Service Finance	
Estimated Activity	The Co-Creating Health ADP pilot will work with at least 56 clinicians.
Cost of Service provision	**PILOT:** • Cost of piloting co-creating health (or alternative model if preferred by clinicians) for 18 months c£100,000. • Budget for locality-based multi-professional learning sets; Educational programme to support Integrated Care; and implementation of learning/ evaluation of arrangements = £220,000 up to 2015. • £50k annual costs of self-management training and development project manager TO 2015/16. **Total** pilot costs= £370,000 **ONGOING COSTS:** CCG annual budget to support self-management component of the LCS across all practices is £113,600 (For this component of the LCS, practices will be paid on the basis of per 1000 registered population. For a practice with the list size of 1000, one annual payment of £285.91 will be made on successful achievement of component 4).
Net Benefits	Quantifiable evidence from elsewhere relates to patient outcomes that result from both the patient education and professional education components of the co-creating health programme e.g. In Haringey and Islington, people living with diabetes had improved clinical outcomes (glucose control, lipids and renal function) over one year after participating in Co-creating Health. Increased proportion of new patients in patient groups receive prevention and care plan. consultation and subsequently receive an individual prevention/self-management care plan, enabling them to report that they can self-manage more effectively. As a result, this should have a longer-term impact on reducing the number of GP consultations and emergency admissions (numbers TBC).

Public Media Campaigns/ Patient information and education	Enabler

Description of Enabler:

Public media campaigns and education materials targeted via primary care and community venues and in liaison with NHS England on increased self management.

Objectives:

- Empower patients to self-care and manage their condition
- Optimise individual patient's health status
- Increase knowledge and understanding of LTC and lifestyle/behavioural influences
- Raise awareness of the opportunities/ways to access for self management, health volunteering and behaviour change
- Improve the patient's experience

Deliverables:

- Scheduled Public media campaigns
- Patient decision aids
- Apps and other technology-based education and information sources.

Service Start Date	**April 2016-April 2018**
Project (Inter)dependencies	Interdependent with all elements of tier1 and 2, and cascades throughout all tiers.
Current status and key achievements	No activity at present.
Service Finance	
Estimated Activity	• Use of social media, NHS England resources, local written media and LBB resources to promote key messages to LTC cohort • Supporting activity for health champions, HLP, and structured education.
Cost of Service provision	£45,000 over 24 months
Net Benefits	Low cost targeted promotion of range of tier1 activities direct to cohort.

Evaluation Framework	Enabler

Description of Enabler:

Evaluation framework designed for this Tier that will set out:

- Definitions of what success looks like for self-management.
- Modelling of the potential for self-management activities to reduce demand for services completely, and delay the need for services in the short/medium/long-term.
- Clarification about the investment and resources required to deliver Tier 1 of the integrated care model.

Objectives:

- Clarify the patient outcomes and individual benefits that can be obtained through investment in self-management initiatives.

Deliverables:

Accessible evaluation framework.

Service Start Date	**April 2015-April 2018**

Project (Inter)dependencies	Interdependent with all elements of tier1 and 2, and cascades throughout all tiers.
Current status and key achievements	No activity at present
Service Finance	
Estimated Activity	• Longitudinal evaluation of 2% patients impacted by the programmes. • Evaluation of every initiative.
Cost of Service provision	£100,000 over 3 years.
Net Benefits	Ability to define with greater certainty what the net benefits of self-management interventions are.

Tier 2 – Health & Wellbeing (Prevention)

Joined up Prevention Offer

An Apple a Day	**Enhancement to existing services**
Description of Enhancement: Existing prevention services are joined up and launched under one brand so that the public recognise and understand the brand. Protocols are developed to enable information and data sharing on service use. Clear shared outcomes are agreed and built into contract monitoring. **Objectives:** • Prevent unnecessary A&E attendances and unplanned hospital admissions • Reduce GP attendance • Optimise individual patient's health status • Optimise individual patient's social support • Prevent or delay elderly admissions to long term care and packages of care • Empower patients to self-care and manage their condition • Improve the service user/patient's experience **Deliverables:** • Services in Barnet know what Tier 2 services are available and are able to signpost people appropriately • Shared information on service use and impact of service developed • Take up of prevention services increased.	
Service Start Date	**June 2015**
Project (Inter)dependencies	Close links with development of mapping of prevention services and database Shared care record.
Current status and key achievements	Not started.
Service Finance	
Estimated Activity	• Existing 3,000 (Appx 1 activity data) service users and 3,000 active carers (BCC info) – 6,000 in total • Up to 9,000 carers (based on Insight data) • Up to 5,000 people with limiting life long illness (guestimate).

Cost of Service provision	• Project manager 6 months (£33k) • Contract variation costs (£50k) guestimate • Publicity campaign and branding material (£7k).
Net Benefits	To be confirmed.

Developing targeted approach to prevention

Identification of people who would benefit from prevention services	**Enabler - Enhancement to existing services**

Description of Enabler:
Use risk stratification tool to identify people on cusp of Tier3/4 services or who come into contact with the Council's front door.

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions
- Optimise individual patient's health status
- Optimise individual patient's social support
- Prevent or delay elderly admissions to long term care and packages of care
- Empower patients to self-care and manage their condition
- Improve the patient's experience.

Deliverables:

- Identification of a cohort of people who would benefit from prevention
- Increased take up of prevention services
- Reduced demand for health and social care services
- Test out the impact of prevention services on care pathways
- Raise GP awareness of the range and potential of prevention services.

Service Start Date	**April 2015**
Project (Inter)dependencies	Close links with development of mapping of prevention services and database.
Current status and key achievements	Not started.
Service Finance	
Estimated Activity	To be confirmed.
Cost of Service provision	To be confirmed.
Net Benefits	To be confirmed.

Strengthened Information, Advice and Support Offer

Information Plus – procurement opportunity	**Enabler – enhanced and new service**

Description of Enabler: There is a single point of access for those wishing to refer to or take up prevention services. The service will offer signposting, information, advice and advocacy for those that need it. Referrals will be made to LaterLife planners or to community navigators for those people who require complex prevention care planning or an element of prevention as part of a re-ablement/health or social care plan.

2 year pilot: 2 Community Navigators will offer advice, support and help to develop prevention plans, linking people with services, supporting hospital discharge and developing social networks (see Appendix 2)

New contract : Increase capacity of service to manage referrals from healthcare professionals

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions
- Reduce call on GP time
- Optimise individual patient's health status
- Optimise individual patient's social support
- Prevent or delay elderly admissions to long term care and packages of care
- Empower patients to self-care and manage their condition
- Improve the service/users patient's experience.

Deliverables:

- Single point of access for prevention to support professionals, particularly GPs
- Single point of access for residents with range of tiered support for resident
- Robust prevention plans to support people at cusp of care or moving down from Tier 5.
- Development of social networks which provide a more sustainable cost-effective service
- Additional time limited support for people who are unable to navigate the prevention offer without help.

Service Start Date	Pilot: **April 2015** (enhanced information offer from April 2015).
Project (Inter)dependencies	Later-life Planning Support Brokerage Care Navigator Information database
Current status and key achievements	• Community navigators - not yet commissioned • I&A service – supported 800 people last year
Service Finance	
Estimated Activity	1&A – 1,200 Community Navigators 100
Cost of Service provision	Current contract value £100,000 p/a. Enhanced element - £50,000 p/a. Community Navigators £90,000 p/a.
Net Benefits	Community Navigators Minimum of £29,500.

Implement the Dementia Manifesto

Dementia Friendly Communities	**Enabler – enhanced and new service**

Description of Enabler: Implementing the Dementia Manifesto requires the setting up of a Dementia Action Alliance to co-ordinate raising awareness and providing training across the borough. This organic community based approach will complement commissioned services, enabling people with dementia and their carers to remain living independently in the borough, supported by an aware and accepting community.

1 year set up costs: A part time project manager will develop the Alliance, promote training and awareness across businesses and organisations using the Dementia Friends and Dementia Champions approach and skill up local providers, Consideration will be given to developing a chartermark and a sticker which identifies those organisations which have met a certain standard of training. The intention is to mainstream this and hand over to local stakeholder once fully established.

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions
- Reduce call on GP time
- Optimise individual patient's health status
- Optimise individual patient's social support
- Prevent or delay elderly admissions to long term care and packages of care
- Empower patients and carers to self-care and manage their condition
- Improve the service/users patient's experience.

Deliverables:

. Barnet is a Dementia Friendly Community where people with dementia and carers are supported by the wider community.

Service Start Date	Pilot: October 2014 (subject to recruitment to post)
Project (Inter)dependencies	Dementia Cafes Dementia Advisors
Current status and key achievements	• Project commitment scoped and initial work undertaken • Report going to Health and Wellbeing Board for decision in September 2014
Service Finance	
Estimated Activity	Up to 4,000
Cost of Service provision	£27,000
Net Benefits	Alzheimer's Society quote £11k saving per person with dementia for every year person remains in the community.

Health and social care volunteers

Procurement Opportunity	**Being tendered**

Description of service: Barnet Council is currently tendering for a voluntary and community sector development partner. Part of this bid includes the commitment of a one off payment of £20,000 from the Better Care Fund in 2015/16 to develop a volunteer offer which supports health and social care integration and prevention. The project will be developed in conjunction with the CCG and Barnet Council and will be mainstreamed into the wider volunteer offer post 2016.

New contract: Increase capacity of volunteering to support health and social care services.

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions
- Reduce call on GP time
- Optimise individual patient's health status
- Optimise individual patient's social support
- Prevent or delay elderly admissions to long term care and packages of care
- Empower patients to self-care and manage their condition
- Improve the service/users patient's experience.

Deliverables:

- Testing out the use of volunteers to support the delivery of health and social care integration and prevention
- Enhanced capacity to support patients and carers to remain independent
- Development of innovative solutions to prevention

Service Start Date	Contract award date 4 January 2015 Service to start once agreed
Project (Inter)dependencies	Wider volunteering offer
Current status and key achievements	• Tender underway
Service Finance	
Estimated Activity	To be scoped
Cost of Service provision	Main contract £80,000 p/a Additional element: £20,000
Net Benefits	To be scoped

Strengthening Carers' Offer

Health education for carers as part of carer support plans	**Scoping**
Service Description: Pilot a range of targeted interventions as part of carers support plans which help carers develop basic health skills (good care of people with long term conditions), offer on-going professional support and links to peer support groups (possibly virtual). Access to small pieces of equipment and assistive technology will form part of this project. The service will be piloted for a year, ideally located within the Carers Hub with links to integrated locality teams. **Objectives:** • Prevent unnecessary A&E attendances and unplanned hospital admissions • Optimise individual patient's health status • Optimise individual patient's social support • Prevent or delay elderly admissions to long term care and packages of care • Empower patients to self-care and manage their condition • Improve the patient's experience. **Deliverables:** • Carers who feel confident about the care they are providing and the level of knowledge about the LTC that their relative has • Carers who feel supported in their role • Cared for who receive good care • Reduced pressure sores/reduced cases of poor nutrition.	
Service Start Date	**June 2015**
Project (Inter)dependencies	Carers Centre services
Current status and key achievements	Not started
Service Finance	
Estimated Activity	Target - minimum of 9 training sessions with 8 carers each.
Cost of Service provision	One year pilot – secondment - £75,000 – district nurse sc6, plus on-costs and project costs.
Net Benefits	To be confirmed.

Tiers 3 & 4 – Assessment, Care Planning & Intensive Support

Barnet Community Point of Access (BCPA)	**Live Service**

Service Description:
To establish and implement a Community Point of Access to receive and manage referrals for adult community health services, ensuring urgent and non-urgent referrals and requests are pro-actively managed to enable rapid co-ordinated care and effective planned care. This will be a community enabler in supporting a reduction in unplanned admissions.

Objectives:
Provide a Community point of contact for health care professionals enabling clear and responsive communications between health care professionals across all sectors by April 14. This will involve access to specialist clinicians for clinical advice, referral information and appointment confirmation, as well as general advice on service offered.

Deliverables:
Phase 3 & Phase 4 Barnet Community Point of Access go live date (urgent care and routine community health care):

Service Start Date	• **Phase 1** -Barnet Community Point of Access go live date (rapid care): **April 2014** • **Phase 3 & 4** - Barnet Community Point of Access go live date (urgent care & routine Community health care): **August 2014** • **Phase 5** - Barnet Community Point of Access go live date (community partners): **October 2014**
Project (Inter)dependencies	• CLCH will work with local health and social care providers (emergency care) to develop revised care pathways to better manage acute exacerbations of long-term conditions • Clinical reference groups and stakeholder engagement work will develop clinical protocols and the patient pathway in line with the next specification review. There is an expectation that intensive work will go into developing the protocols and pathways in time for next year's sign off • Stakeholder engagement work around how the BCPA will specifically work with Housing 21(enablement) and non-statutory agencies.
Current status and key achievements	• The community point of access is live and is triaging all rapid and urgent referrals as part of the Service Level agreement with CLCH • New telephony system in place with individually call handlers assigned to each new call • Substantial communication plan and system wide update of referral forms in progress.

Barnet Community Point of Access Referral to appropriate service		**Target**	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**
Telephone Calls	**Total no. Calls received by BCPA**		**1778**	**1936**	**1747**	**2490**
	No. Calls received for Rapid Response		**28**	**85**	**138**	**415**
	% Rapid & Urgent calls answered within specified time	**40% - 70%**	**60%**	**95%**	**96%**	**97%**
	% of breaches in call answering time threshold (40-70%)		**40%**	**5%**	**4%**	**3%**

Service Finance	
Estimated Activity	Increase in total F2F patient time in Community services outlined in business case - 4267 (hours spent).
Cost of Service provision	£298,650 (2014/15)
Net Benefits	Expected to contribute to the overall integrated care projects - 1.7 million Savings, thus individual work stream will not have cost savings attached to them.

Older Peoples Integrated Care Programme – Multi Disciplinary Team Meeting	**Live Weekly meeting**

Service Description:

The MDT meetings bring together health and social care professionals with specialist knowledge, skills and experience to assess the needs of frail and elderly patients identified as at higher risk of hospital attendance or significant deterioration in health.

The MDT meeting considers the patient as a whole and develops integrated care plans to meet assessed needs in order to reduce the requirement for hospital attendance and prevent significant deterioration in health. Patient care plan are implemented and co-ordinated by case managers/care navigators.

The MDT does not replace other formal health and social care provision for the patient.

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions
- Optimise individual patient's health status
- Optimise individual patient's social support
- Prevent or delay elderly admissions to long term care and packages of care
- Empower patients to self-care and manage their condition
- Improve the patient's experience.

Expected Outcomes:

- A reduction in crisis admission to hospitals
- A reduction in 30 day re-admissions
- Reduction in social care interventions particular long term care admissions –particular prevention services and enablement will be used
- Improved patient and carer experience.
- Reduction in outpatient appointments for the MDT
- Reduction in GP appointments required by the patients in the MDT as their care is being better coordinated.

Service Start Date	Pilot started: **July 2013**
Project (Inter)dependencies	The Multi- disciplinary Team can operate independently and is not a single point of failure, however to maximise the opportunity to reduce hospital admittance, there are interdependences.
Current status and key achievements	• 1 year pilot end date (July 2013-June 2014) • Extended for 1 year
Service Finance	
Estimated Activity	See Below.
Cost of Service provision	See breakdown in table provided as part of the Case Navigation write up.
Net Benefits	Enabler project – Overall benefits outlined in Case Navigation Service line.

Older Peoples Integrated Care Programme – Case Navigation	Live Service

Service Description:

The overall aim of the Care Navigation Service is to improve the health, wellbeing and independence of frail and elderly patients through the provision of personalised integrated health and social care support.

The frail and elderly are defined as patients aged 65 and over.

Objectives

- Prevent unnecessary A&E attendances and unplanned hospital admissions
- Prevent admissions to long term care and reduce the need for care packages
- Optimise individual patient's health status through case managed healthcare interventions
- Optimise individual patient's community support through case management as well as access to social care
- Empower patients to self-care and manage their condition
- Enhance the patient's experience.

The Care Navigation service in Barnet will identify frail and elderly individuals at the greatest risk of hospital admission or significant deterioration in health and put in place personalised and time-limited health and social care interventions aimed at preventing this occurrence.

The service is led by Case Managers and the team will, at all times, work in conjunction with the patient's GP. The team, working with GPs, will use the Risk Stratification tool to identify patients at risk and develop personalised health and social support plans to match the needs of identified patients. The team will oversee and co-ordinate the implementation of patient support plans.

Support plans will be time-limited, multi-disciplinary and may consist of single or multiple interventions and may be carried out in the patient's home, GP surgeries and clinics, day hospitals, residential and nursing homes, social care settings and acute settings.

The team are organised in 3 geographically based units.

Service Start Date	Pilot: **July 2013**
Project (Inter)dependencies	The Care Navigation can operate independently and are not a single point of failure, however to maximise the opportunity to reduce hospital admittance, there are interdependences.
Current status and key achievements	• 1 year pilot end date (July 2013-June 2014)
Service Finance	
Estimated Activity	60 people identified and a care plan coordinated each month.

Forecast	New patients managed by service	Senior Care Navigators WTE required at year end	Admissions avoided
2013/14	460	3	64
2014/15	720	3	307
2015/16	720	3	374

Complex cases are referred to MDT.

Cost of Service provision	See table on next page.
Net Benefits	1.7 million Saving has been matched against all the works streams relating to frail and elderly projects, thus individual work streams will not have cost savings attached to them. A saving of £337,000 (gross) was achieved in 2013/14 by these projects.

Barnet Integrated Locality Teams	**Mobilising Service**

Service Description:

Having Integrated locality based care teams is one of the means by which essential support can be coordinated around the adults in our community who are living with multi-morbidity and complex long term conditions, and enable the goals set out in the Better Care Fund to be realised.

The objective is to utilise an assessment and care planning model that will promote independence and wellbeing, avoid duplication (e.g. multiple assessments), and reduce unnecessary admission to acute or nursing / residential care settings. It encompasses key aims to improve outcomes and the quality and timeliness of care provided to older adults in the community.

The teams will incorporate health and social care functions and will address patient need by a shared approach to assessment and care planning. The locality based teams, in partnership with the GP, will be designed to support and manage care from self-management through periods of crisis, and into end of life pathways where necessary.

Deliverables:

The team will, on instigation from the GP or other referring agencies:

- Undertake an assessment and agree with the GP, older person, carer (where appropriate) a person-centred, co-ordinated care plan. The plan will be made available to the GP and every other health and social care professional facilitating joint working towards the delivery of a personalised care plan. The support provided will potentially include working with third sector service providers and link into the end of life pathway where necessary.
- Maximise opportunities to enable older adults and people with long term conditions to maximise their capabilities by developing and delivering integrated *Anticipatory Care plans*. This will be based on the early identification of patient cohorts via the risk tool.
- Signpost and navigate older adults towards the prevention and voluntary sector services. All members of the locality teams will be trained to identify and signpost carers, enabling access to the support required to sustain their caring role:
    - It is expected that as a first point of call, the teams will access the support provided via the prevention services in Tier 2 of the Better Care Fund model as part of the anticipatory care planning process, with the aim of building up and growing the personal and physical resilience of the older adults within their care by encouraging healthy lifestyles and support from the families and friends who provide care
- The team will play a pivotal role in coordinating, promoting and enabling independence of Older Adults through self-management and where applicable using the common access process provided by the Community point of access to organise Enablement services or call in specialist end of life support when required.

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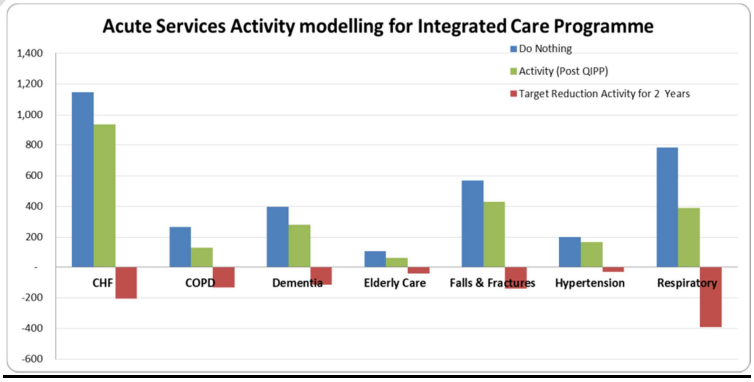
Expected Outcomes:

- That frail, elderly and vulnerable older people are enabled to be as healthy, active and independent as possible in their own home with the support needed to do this.

- In a care crisis or health emergency the person is supported as effectively as possible, and that there is an efficient transfer of care between agencies with any necessary health and social care supports to them and to their carer.
- That the treatment and care provided is right for the person's needs in the right setting and respects the person's individuality and dignity.

Service Start Date	Initial pilot of trailblazer team with 7 practices went live on the 4th of August. Team are currently mobilising
Project (Inter)dependencies	• This project is dependent on support from the Community Services, Adult Social Services, secondary care clinicians and GPs to shift the balance of care to primary and community settings. This will impact on the unscheduled attendances at A&E, attendances at the TREAT clinics. • Community and London Borough of Barnet IT strategies • Data sharing agreement projects within primary care • Shared Care records project • The programme of works is spread across Tier 3 and 4 but has clear interdependencies with self-management (Tier 1) and health and wellbeing services (Tier 2) • Demand pressures associated with the Care Bill
Current status and key achievements	• Co-location of team took place on 4th of August • GP workshop with 7 pilot practices – 21st August • Workgroup to progress project plan to build team to full complement (refer to milestone plan on next page
Service Finance	
Estimated Activity	The trailblazer team will be working with at most, 2% of the over 65s of the risk profiled patients for the 7 practices. The aim is to review the requirements 3 months into service deliver to gain a better understanding of the activity requirements of the west locality.
Cost of Service provision	The pilot team is based on pulling resources from existing services. The table on the next page denotes the current anticipated costs, which will be further worked up once the full complement of staff are in post.
Net Benefits	For illustrative purposes the graph below provides a pictorial representation of the financial implications associated with the proposed model. Similar projections can be made regarding social care costs and a reduced activity for care packages; this will be worked up as part of the MTFS savings plan. 

Enablement - Procurement Opportunity	Live Services

Service Description:

The essence of enablement is to work with individuals who have support needs to rebuild their confidence, support the development of daily living skills and promote community access and integration. This may be required following an acute medical episode or to reverse or halt a gradual decline in functioning in the community. It is intended to be a short-term intensive input.

An Enablement service:

- is about helping people to do things for themselves, rather than doing things to or doing things for people. is time-limited;
- is outcome-focused:
- involves setting and working towards specific goals agreed between the service user and the enablement team.
- is a personalised approach.
- involves providing intensive support to people.
- treats assessment as something that is dynamic not static.
- assumes that something should change by the end of the enablement intervention
- builds on what people currently can do, and supports them to regain skills to increase their confidence and independence.
- involves ensuring people are provided with appropriate equipment and/or assistive technology, and understand how to use it.

Objectives:

- helping people back into their own home or community.
- maximising users' long-term independence, choice and quality of life.
- reducing or minimising the need for on-going support after the enablement period
- Prevent unnecessary A&E attendances and unplanned hospital admissions
- Prevent or delay elderly admissions to long term care and packages of care
- Improve service user outcomes

Deliverables:

- Short term intensive support provided to service users in their own home for up to 6 weeks following an acute episode or deterioration in functionality and at risk of a unplanned hospital attendance, block contract of 1400 hours a week with Housing 21.

Service Start Date	Service in place from September 2010 - a 5 year contract.
Project (Inter)dependencies	This service operate independently however to maximise the opportunity to reduce unplanned hospital admissions or premature residential and nursing admissions, there are interdependences with the whole range of intermediate care service provision, home care support and preventative services like day opportunities, disease specific interventions for dementia, stroke, COPD and other long term conditions.

Current status and key achievements	• Contract ends 6 September 2015 • Tender of the service needs to start by September /October 2014 • The performance figures are high on the number of people that do not go onto an on-going package (@ 70%)

Forecast	Cost	Volumes	%No Further Action
2011/12	£1,357,200	1660	70%
2012/13	£1,357,200	1660	60%
2013/14	£1,170,624	1660	60%

Service Finance	
Estimated Activity	1660 service user
Cost of Service provision	Block contract at £18.76 an hour, £1,357,200 per year
Net Benefits	Further work required evidencing how enablement has reduced re-admission into hospital after 90 days of accessing enablement services; prevention of unplanned hospital admission and premature admission into residential care; and reduction of home care packages at the end of an enablement episode.

Falls	**Live Services**

Service Description:
Identifying patients susceptible to falls, providing measures for recovery after Fall, Engaging patients in activities that reduce repeat

Objectives:

- Reducing the risk of falling in older people and enabling greater independence and self-care leading to overall reduction in falls related admissions and social care needs.
- A key objective of this service is to reduce A&E, LAS and secondary care admissions for falls-related incidents. Reduction in falls-related events; enabling people to become and remain independent which will also reduce social care needs including long term residential care.
- Reducing the number of people having falls and fractures
- Reducing inpatient and outpatient activity through preventative and self-care developments
- An increase in the proportion of older people being supported in their own homes.
- A reduction in unscheduled admissions from nursing and residential care as a result of falls

Deliverables:

- Falls Clinic - This Falls service is expected to provide a seamless patient-cantered, integrated and comprehensive service. The aim is to reduce the risk of falling in older people and enabling greater independence and self-care leading to overall reduction in falls related admissions and social care needs.
- Fracture Liaison Service - aims to identify people who may be at risk of further falls or fractures. The service is multi-disciplinary and involves a highly skilled team (Consultant, Nurse Specialist, Radiographer) to undertake comprehensive assessment and deliver specific treatment recommendations.

Service Start Date	• Services have always been in existent for Fall Clinic. • Fracture Liaison Service started August 2013

Project (Inter)dependencies	The services can operate independently however to maximise the opportunity to reduce hospital admittance , there are interdependences with preventative services like Tai Chi classes, and risk stratification by GPs for people at risk of falls.
Current status and key achievements	• Falls clinic and Fracture liaison services are live services, provided as part of the Service Level agreement with CLCH • Services have been remodel KPI's redefined

Year	Activity
2011/12	3372
2012/13	2019
2013/14	1757

Service Finance	
Estimated Activity	887 patients – Falls Clinic 500 – Fracture Liaison service
Cost of Service provision	£477,000 (2014/15)
Net Benefits	Expected to contribute to the overall integrated care projects - 1.7 million Savings, thus individual work stream will not have cost savings attached to them.

End of Life – Procurement opportunity	**Live Services**

Service Description:

A range of services provided to patients towards the end of life, aimed at enabling them to die in their place of choice. End of life if defined as:-

i) The final 12 months of a patient's life – stable sick. This service is now integrated with the work programme for integrated locality teams. It is expected that these patients will be managed as part of the case load for integrated locality teams.

ii) Patients in their final four to 12 weeks where a patient require intensive service in the community (own home or hospice). Support also provided to their carer.

Objectives:

- Prevent unnecessary A&E attendances and unplanned hospital admissions
- Increase in the number of the patients achieving their preferred place of care
- Emotional or psychological support to Carers - counselling
- Meet clinical needs of patients at the time of death through provision of specialist palliative services

Deliverables:

- Case management by locality integrated teams following identification of patients through GP practices, MDT's and or referrals from Acute
- Palliative Care Support Service in the Community (PCSS)
- Inpatient services, Day therapy unit and Outpatient attendances at hospices.

Service Start Date	On-going services, previous service level agreements signed in 2012/13
Project (Inter)dependencies	The service is dependent on Risk Profiling and identification by GPs, Multi-disciplinary Teams. To maximise the opportunity to reduce hospital admittance, there are interdependences with social care and voluntary sector service provision.
Current status and key achievements	• The services are live in the community • Integrated locality teams, currently being piloted

Service Finance	
Estimated Activity	Dependent on case load
Cost of Service provision	£1,280,000
Net Benefits	The work streams do not have cost savings attached to them.

Rapid Care	**Live Services**
Service Description: The aims of the Rapid Care Service extension are to reduce unnecessary hospital admissions and to improve the access to quality acute health care community intervention for frail and elderly patients in Barnet. They will provide urgent care for older people and people with long term conditions has been developed so that acute exacerbations or complications are better managed, end of life care is well organised and people can remain in their own homes or community. **Objectives –** To put in place the following services • Rapid Response Team extension : extend hours service that provides full rapid assessment of health and social care need Part of the Rapid Care Service extension will be the provision of a number of new services: • Ambulatory Assessment Diagnostic And Treatment Service • Health Failure Service (Rapid) • Telehealth Care Service • People accepted by Rapid Care service will be experiencing an acute alteration in their physical wellbeing or social circumstance.	
Service Start Date	• Original rapid response team from 2012 • Extended rapid response service faced elements from December 2013 to April 2014
Project (Inter)dependencies	CLCH will work with local health and social care providers of emergency care to develop revised care pathways to better manage acute exacerbations of long-term conditions. Clinical reference groups and stakeholder engagement work will develop clinical protocols and the patient pathway in line with the next specification review. There is an expectation that intensive work will go into developing the protocols and pathways in time for next year's sign off.
Current status and key achievements	• Rapid response service is live and key elements of extension are live e.g. increased LTC specialist support, ambulatory care and telehealth in care homes as part of the Service Level agreement with CLCH • KPI's have been redefined and referral capacity was more than doubled with new investment - currently at 70% (July figures not in official report until next week) and increasing • Increase in diverse referral sources linked to substantial communication drive and partnership working with LAS, 111, mental health and acute. Further work required with out of hours and acute

The ambulatory care service started from April 2014 is up to 89% capacity, the telehealth care project has met the 25 patients per quarter target.

Rapid Response		Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14
Planned Referrals % Received and Accepted Referrals		**60**	**120**	**120**	**120**	**120**	**120**	**120**	**120**
	Referrals received					**62**	**60**	**76**	**103**
	Referrals accepted	63	80	71	61	**53**	**56**	**73**	**98**
	% of target achieved against accepted referrals	105%	66%	59%	51%	**44%**	**47%**	**61%**	**82%**
	No. weekend referrals accepted					**1**	**4**	**5**	**8**

Service Finance	
Estimated Activity	Rapid response team - 120 new referrals per month Ambulatory care – 65 referrals per month Tele care - 25 patients connected to hub per quarter.
Cost of Service provision	Extended rapid care £636,171 (2014/15).
Net Benefits	Expected to contribute to the overall integrated care projects - 1.7 million Savings, thus individual work stream will not have cost savings attached to them.

Care Home Locally Commissioned Service (LCS)	**Mobilising**

Service Description:

Many GP practices provide care to people within care homes; however, it is acknowledged that this group have higher needs than the general population. Therefore, a locally agreed service has been commissioned by Barnet CCG, in addition to the essential and specialised services within the GMS/PMS contract.

The service includes all care homes, including homes for elderly people and people with learning disabilities or multiple disabilities. The expected input from GPs is:

- Increased proactive GP input into care homes
- Introduction of weekly GP ward rounds (with care home nurses as appropriate) in particular focussing on new admissions to the home and patients who have been recently discharged from hospital, ensuring that a medical review is carried out and a care plan is in place.
- Introduction of a 6 monthly holistic review of all patients under the care of the GP
- Support the home with planning and delivery of end of life care, meeting the gold standards for such care.
- Closer working with the home to promote high standards of clinical care within the home.

Objectives:

- Improved care in care homes through the locally commissioned service
- Enabling more to live and die where they choose, reducing avoidable hospitalisation and cost.
- Improved communication and coordination of care between the GP and Care home
- Increase in satisfaction of patient and family
- Closer working relationship between the care home and the GP practice
- Reduction in unscheduled admissions from care homes

Deliverables:

- 50% of GP practices who work with care homes to sign up to the LCS.

Service Start Date	Service in place from September 2014 – service review in March 2015 with a view to extending the service until March 2016 if the outcomes are being met.
Project (Inter)dependencies	This locally commissioned scheme from General Practice is an enabler for the overall business case and QIPP plan 'Managing Crisis Better', it is anticipated that this scheme will contribute to the overall savings identified through this business case. To maximise the opportunity to reduce unplanned hospital admissions or premature residential and nursing admissions, there are interdependences with the whole range of intermediate care service provision, home care support, disease specific interventions for dementia, the medicines management care home pilot, enhanced dietician support and the Rapid Care service.
Current status and key achievements	• A launch event is taking place on 4th September to answer questions from GPs and hear from key speakers around the service specification, safeguarding and death certification. • The deadline for sign up from practices is 10th September • Practices are expected to commence the service from 17th September, though for some practices this will not be possible and a later start date will be agreed.
Service Finance	
Estimated Activity	Based on 50% of GP practices signing up, this would equate to 1,525 patients (3,051 in total as of May 2014) although it is not clear how many practices will sign up currently.
Cost of Service provision	The payments are per bed and will therefore depend on the number of practices signed up to the service as well as achievement of the expected outcomes. The payments per bed are as follows: • **Part 1 - £200** – all practices are expected to receive this payment on a monthly basis on delivery of the scheme • **Part 2 - £100** – practices will only receives this payment at the end of the financial year, on achievement of the outcomes. • **Total - £300 per bed, on achievement of both parts**
Net Benefits	This locally commissioned scheme from General Practice is an enabler for the overall business case and QIPP plan 'Managing Crisis Better', it is anticipated then, that this scheme will contribute to the overall savings identified through this business case. The expected benefits of the service are: **Improving GP care and support to care homes to -** ○ Enhance clinical input into all care homes ○ Increase proactive care in care homes ○ Meet clinical needs in the homes leading to admissions avoidance and reduction in avoidable A&E attendances ○ Increase use of preventative services (Rapid Response and TREAT) and reduce calls to the London Ambulance Service ○ Improve the relationship between the GP and the home.

Dementia services	Live Service

Service Description:

This project is a re-design of the existing memory service provided by BEHMHT; to create a discrete fully functioning memory service to meet the Memory Service National Accreditation Programme (MSNAP) and National Dementia Strategy standards. The follow up of patients will be done in primary care. The service will work closely with Dementia Advisors and be a key component of a network of dementia services in the community.

The aim of the MAS is to deliver early diagnosis and intervention for people with mild to moderate dementia. It will provide all patients with a person centred service, which will empower people with dementia and their carers to make informed decisions about care and which will help to maximise their quality of life. The service will help to reduce the risk of crisis later in the illness and enable the person with dementia to be cared for at home for as long as possible.

The service will be underpinned by the current work to ensure that community support is underway via the Barnet Dementia hub; carers support via the dementia café and Dementia Advisor (DA) service, voluntary sector support and planned improvements in intermediate care.

Dementia presents a significant challenge to health and social care in terms of the numbers of people that will be affected and projected anticipated costs. Early diagnosis of dementia is a government priority and the National Dementia Strategy evidences the business case: early diagnosis and support can reduce institutionalisation by 22% even in complex cases.

Service Start Date	July 2014
Project (Inter)dependencies	Key to achieving long term savings will be the joining up of health and social care services to prevent deterioration and increase preventative action. A key success factor of this service will be its integration with other initiatives; the MAS will be a key component of a resource network of Barnet dementia services, in particular, the Dementia Advisor service, which is located alongside the MAS. This suite of services also supports the frail elderly pathway. It is the overall 'offer' that will deliver the benefits in the long term.
Current status and key achievements	• Successful negotiation of contract variation with BEHMHT • GP management guide to dementia drugs updated and approved, transfer letters to primary care approved • Dementia directory finalised • Dementia Advisor recruited • Launch steering group underway and launch planned for Nov 14 (launch of MAS and associated services, dementia advisor etc) • Dementia advisor recruited; have commenced co-location working • MAS clinic recruited.
Service Finance	
Estimated Activity	780
Cost of Service provision	£234,551
Net Benefits	• More patients to receive early diagnosis; will enable quicker access to services and support to manage dementia • Early provision of support at home can decrease institutionalisation • Carer support and counselling at point of diagnosis can reduce care home placements • Decreased length of stay in acute episodes

Further interventions for dementia

Following a dementia mapping exercise, a Dementia Action plan has been drafted, key areas include:

- Improving dementia diagnosis in primary care – a separate Action Plan has been submitted to NHSE and is in the process of being updated.
- A programme of further training for primary care
- Barnet Dementia Event planned for Nov 14 to launch new services and initiatives and raise awareness of early diagnosis and intervention; event aimed at GP's, social workers, other professionals.
- Dementia friendly communities – plans are in progress for Barnet to become a Dementia Friendly Community.
- Development of a Barnet Dementia dashboard

Project milestones – monitoring and project evaluation (from commencement of service)

Review arrangements for tracking progress monthly via KPI's, including any IT changes: Create mechanism for tracking benefit realisation	**August 14**
Conduct review of plan against progress review QIA and EIA to ensure still applicable	**November 14**
Review monthly monitoring reports from provider based on agreed monitoring mechanism	**Ongoing**
Review impact of the addition of new staff and determine whether waiting times have reduced	**October 14**
Conduct 6 month review and write evaluation report	**January 15**

Stroke services – early stroke discharge and stroke review	**Live Service**

Service Description:

The introduction of Early Stroke Discharge teams (ESD) challenged the traditional stroke pathway model in bringing forward the time of discharge and providing a continual period of rehabilitation in the home. Stroke survivors, their carers and families, report feeling abandoned post stroke and many of them miss the opportunity to regain their maximum functioning, and adjust to the health, social and emotional needs following a stroke.

The National Stroke Strategy requires all stroke survivors to receive regular reviews of their health and social care need. Without a co-ordinated review process there is a risk that the recovery potential for a group of people following a stroke is missed out on resulting in higher and more expensive levels of need and poorer outcomes for individuals.

Various reviews in Barnet have demonstrated a lack of capacity in the stroke specific community rehabilitation services in Barnet, including limited access to therapies.

Early stroke discharge. The object of this project is to increase the provision of specialist intermediate care / rehabilitation for stroke in the patient's home by increasing early supported discharge capacity, reducing the length of stay in hospital and acute activity and freeing up resources. This will be achieved by

- Reduced length of stay in hyper acute stroke unit and Stroke unit
- Reduced re-admission rates to acute
- Reduced entry to residential/long term care

The new service will also comply with national stroke standards, which the previous service had not attained.

Stroke reviews. Good practice shows that establishing a formal review stroke service will result in better outcomes for patients whilst delivering savings for CCG's. The aim of the project is to establish a formal stroke review service: every stroke survivor in Barnet to receive a 6 month review using the GM-SAT tool to prevent further strokes which will result in better outcomes for patients. This will bring about savings through:

- Reduced emergency admissions from patients suffering from a second stroke
- Reduced adult care packages and care home placements

The review service has been dual commissioned by BCCG and LBB from CLCH and the Stroke Association (SA)

A third initiative (not part of this tier) is to support an increase in the recorded prevalence of Atrial Fibrillation in primary care, and treat them with anticoagulation across the sector using the GRASP AF tool. This is a preventative measure that will reduce the number of people having a stroke and avoiding admissions etc.

Service Start Date	Service commenced November 2013.
Project (Inter)dependencies	Some of the savings for ESD in the stroke units will accrue to the acute provider. Work will be undertaken with the stroke units to release some of these savings
Current status and key achievements	• Successful contract negotiation with CLCH and Stroke Association (SA) (stroke reviews are commissioned from both CLCH and SA) • Acute (stroke units) noted positive impact of enhanced ESD • Good partnership working between SA and CLCH
Service Finance	
Estimated Activity	140 for ESD 400 for stroke reviews Est 400 people in Barnet have a stroke.
Cost of Service provision	£200,000 for CLCH £37,000 for SA
Net Benefits	**ESD:** • Reduced length of stay in hyper-acute and stroke unit • Reduced readmission rates to acute • Reduced entry to residential/long term care • Better outcomes for patients **Stroke review** Evidence shows this will assist to prevent people from having a second stroke. • Reduced emergency admissions from patients suffering from a second stroke. • Reduced adult care packages and care home placements • More equitable system than hitherto e.g. everyone in Barnet who has had a stroke will be offered a review Addressing unmet needs and supporting people regain home and community roles Service proposal quality assured to comply with national stroke standards.

Project milestones – monitoring and project evaluation (from commencement of service)

Review monthly monitoring reports from provider based on agreed monitoring mechanism, track progress monthly via KPI's, including any IT changes	**Ongoing**
Conduct review of plan against progress review QIA and EIA to ensure still applicable	**November 14**
Conduct 12 month review and write evaluation report	**November 14**

Further interventions for stroke

Stroke acute wards inspection – monitor progress on recommendations, ensue/facilitate liaison with community services. Re – establish local stroke network.

Barnet Shared Care Record	**Scoping**

Service Description:

The Shared Care Record will provide a single view of the individual's care. It will not replace local systems, but will provide a single location for care providers, and later individuals themselves, to view information from all care providers. The information will be available in a secure and controlled way. It will be accessible via a web browser to care providers across Barnet. Information in the Shared Care Record will be available instantly from all contributing systems. Following an initial roll out to care organisations, the service will expand to include access by private sector, third sector, the individual and their carers.

Project objectives

This project has the following key objectives:

- Gather information from a variety of care providers in Barnet to provide a single view of the individual's care. This must be provided in a secure and appropriate way on a 24/7 basis with multi-channel access supporting use in all care environments.
- Provide secure and appropriate access to the Shared Care Record to care providers across health and social care in Barnet.
- Expand the access to the Shared Care Record to enable secure and appropriate access by third sector and private care providers
- Expand the access to the Shared Care Record to enable secure and appropriate access by individuals and their carers.
- Provide a commissioning view of combined, anonymised data

Desired outcomes

The project will realise the following core outcomes:

- professionals across a number of organisations can access a single shared view of an individual's care;
- individuals (and their carers) can securely access their own care information in one location;
- access will be available on a 24/7 basis, irrespective of location, whilst still maintaining a suitable level of security and control over the information viewed; and
- the Shared Care Record solution will not impede the use of existing systems and processes but will work with them to improve the provision of care.

Deliverables:

- A shared care record with care information about Barnet residents
- Information available from all the main care providers
- Secure, controlled access to information on a 24/7 basis, available from any location
- A robust audit and monitoring solution
- Ability for individuals and their carers to access the record.

Service Start Date	Project started in June 2014 Initial implementation by March 2015
Project (Inter)dependencies	The service is dependent on other case management/patient record systems being able to send information to the Shared Care Record (e.g. GP Systems (EMIS), the new Adult Social Care case management system). An NHS N3 connection will be required for access to the full service The Shared Care Record will be an enabler for other services where information is shared between teams, where someone from another team would normally be given access to a local system and in supporting self management by providing individuals with access to their own record
Current status and key achievements	Project has started, although waiting for formal sign off for PID.
Service Finance	
Estimated Activity	Implementation and project costs ~£1.4m
Cost of Service provision	Annual cost (post project): ~£145k
Net Benefits	The following table shows projected Annual Productivity Savings across all main care organisations in Barnet using the Shared Care Record. Based on saving an average of only 60 minutes per member of staff per week through more efficient sharing of and access to information.

2014/15	2015/16	2016/17	2017/18	2018/19
£14,104	£683,029	£805,400	£910,874	£932,423

Tier 5 – Acute & Long-Term Care

Tier 5 includes residential, nursing and acute services for frail elderly people and people with LTCs who can no longer be supported effectively at home. At this point community services are likely to be neither the most appropriate nor safe environment for these people to receive support. These services are accessed where and when necessary.

The current service provision in Barnet for community services does not fully enable people to live healthily and independently in their own homes for as long as possible. As a result there is an over-reliance on hospital services and residential care. This increases financial pressures in providing services in this Tier. It is from where we need to move activity out long-term to other Tiers.

Scope & Status

Although the focus of our work to deliver the 5 Tier Model is in Tiers 1 to 4, we are also working to reduce the use of acute beds and residential care services as a result of more effectively reducing and managing demand for Tier 5 services.

We have also recently completed the first part of a project to invest in improving quality in care homes. This project is aimed at developing and increasing the skills of the care home workforce and increasing the role and work of GPs in supporting people in acute and residential services, to prevent unplanned admissions.

We also have a number of other priorities for developing and improving services in this Tier to integrate closely with services in Tiers 3 and 4. To move activity away from Tier 5 long-term and deliver financial savings and desired outcomes, Tier 5 services must facilitate and enable us to support more people through Tiers 3 and 4 instead. This also facilitates providing the best possible care for those people only for whom acute or residential support is required.

Priorities include:

1. Better discharge planning to ensure services are in place to support people stay at home and to receive targeted interventions from Tier 3 and 4 services if required.
2. Using hospital networks to provide improved access to centres of excellence.
3. Partnering with acute providers to maximise and optimise the use of available, specialist resources and facilities.
4. Developing clear, joint referral and escalation protocols.
5. Enhancing the medical skills of care home staff to reduce referrals to acute services.

Areas of focus for new projects and work packages to meet these priorities include, e.g.:

1. Transitions in and out of A&E, including the effectiveness of PACE & TREAT services, DTOC and pending DTOC services and 7 day working.
2. Continued, targeted work in residential and nursing homes, including care home access to Rapid Response services, anticipatory care planning, additional ongoing quality in care homes initiatives and links with GP LIS work.

Acute service providers are critical to the successful design and delivery of Tier 5 services. We are working closely with them to embed ownership of these services. This includes:

1. Delivering services that fit our vision and strategy for the model and Tier.
2. Using relevant, key data sets to inform setting priorities for future work.
3. Monitor and review current service provision and identify any gaps, to help define and prioritise new projects and services.
4. Identifying interdependencies with existing work in this and Tiers 3 and 4 and considering opportunities to join operations join where appropriate.

Risks & Dependencies (All Tiers)

The following tables sets out the major risks and dependencies to delivering the 5 Tier model identified to date.

Key - Likelihood / impact ratings definitions:

H	There is a high probability of this risk materialising / it will have a major impact on the project should it occur
M	There is a significant probability of this risk materialising / it will have a significant impact on the project should it occur
L	This risk is unlikely to materialise / it will have a minor impact on the project should it materialise

Tier 1

Risk description	Likelihood	Impact	Mitigation
Leaders within all partner organisations do not have a shared commitment to the aims and objectives of Tier 1, or an understanding of the impact it will have on their own services leading conflicts whilst the project is being delivered.	L	H	Extensive stakeholder engagement already taken place. Each project will have a communications work stream with planned stakeholder engagement activities.
Poor communication between lead organisations which prevents information sharing between stakeholders which limits their ability to work collaboratively and deliver joined-up care.	M	H	Promote shared objectives at all levels of organisations and agreed sharing of activity and information.
A lack of understanding and buy-in from practitioners that need to be involved means that they do not understand their own contribution or embrace the new ways of working that are required to deliver the integrated health and social care offer.	H	H	Engage with key practitioners during the development of the new model. Begin early communications and deliver joint training on service changes.
Culture differences and lack of understanding between different professions means that practitioners continue to work in isolation rather than collaboratively.	M	H	Encourage early communication between practitioners and hold joint engagement events to promote collaboration.
The major transformational changes occurring across LBB and Health disrupt the project, causing delays or reducing the ability of new service models to deliver their objectives of integrated health and social care offer.	M	M	Engage with projects likely to impact on the deliverables outlined to understand potential disruptions and take mitigating action.

Tier 2

Risk description	Likelihood	Impact	Mitigation
Leaders within all partner organisations do not have a shared understanding of the aims and objectives of Tier 2, or the impact it will have on their own services leading to a lack of investment.	M	H	Develop evidence base which meets validity requirements of local stakeholders.
Voluntary sector organisations are unable/unwilling to work together to develop a joined up approach.	M	H	Develop joined-up approach collaboratively, ensuring that each organisation I not disadvantaged. Consider retendering offer as a whole with clear contractual requirement to work collaboratively.
CCG and Council develop different approaches or the same approach separately to advice, information, advocacy and support and there is no single point of access for information.	H	H	A separate approach is already in operation. It may be necessary to develop a staged approach to reaching this position.
Services/initiatives are unable to demonstrate desirable benefits, including cost-effectiveness.	M	M	Develop a shared understanding with voluntary sector providers and others of benefits. Ensure commissions are based on outcome-specs to enable flexing of service. Ensure valid easy measures in place.

Tiers 3 & 4

Risk description	Likelihood	Impact	Mitigation
Leaders within all partner organisations do not have a shared understanding of the aims and objectives of Tier 3 and 4, or the impact it will have on their own services leading conflicts whilst the project is being delivered.	L	H	Extensive stakeholder engagement has already taken place. Each project will have a documented communications work stream with planned stakeholder engagement activities.
Lack of support (IT or shared work space) to facilitate communications and information sharing between practitioners limits their ability to work collaboratively and deliver joined-up health and social care.	M	H	Promote the use of Skype and other video conferencing.

Risk description	Likelihood	Impact	Mitigation
A lack of understanding and buy-in from practitioners that need to be involved means that they do not understand their own contribution or embrace the new ways of working that are required to deliver the integrated health and social care offer	H	H	Engage with key practitioners during the development of the new model. Begin early communications and deliver joint training on changes to service
Culture differences and lack of understanding between different professions means that practitioners continue to work in isolation rather than collaboratively	M	H	Encourage early communication between practitioners and hold joint engagement events to promote collaboration
The major transformational changes occurring across LBB and Health disrupt the project, causing delays or reducing the ability of new service models to deliver their objectives of integrated health and social care offer	M	M	Engage with projects likely to impact on the deliverables outlined to understand potential disruptions and take mitigating action

5. Financial Case

This section develops the Financial and Investment Case for the integration of health and social care, described in the 'Barnet Health and Social Care Economy - Integration of Health Social Care Services OBC' (v7 Final, 07 March 2014). This includes the latest view of the anticipated gap in the funding required to deliver services and the likely costs and benefits of delivering the integration described in Section 4 and how this impacts this gap.

Context – The Funding Gap

Integrating health and social care services will include and affect 'core' and 'influenced' services.

Core services are those provided in the community and non-acute bed based care, e.g. residential care, community healthcare, homecare, and self-management or preventative services. We will redesign core services for integration, investing resources as necessary.

To deliver the desired benefits and outcomes we also need to influence areas of spend in other services, which are not intended to be redesigned but which may see a movement in activity (and therefore cost) as a result of the changes in core services. This includes, e.g. all acute services, and inpatient mental health services.

We anticipate that savings will come predominantly from reduced activity in influenced services.

The total value of core services in scope is £77.6m, 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.

	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Total
Core LBB	£100,000	£3,401,471	£3,744,002	£14,394,221	£14,132,946	£35,772,640
Core BCCG	£272,000	£27,237	£502,500	£28,888,927	£12,440,000	£42,130,664
Influenced LBB	£0	£0	£0	£344,401	£0	£344,401
Influenced BCCG	£0	£0	£0	£63,538	£58,205,929	£58,269,467
Total	**£372,000**	**£3,428,708**	**£4,246,502**	**£43,691,087**	**£84,778,875**	**£136,517,172**
%	0.27%	2.51%	3.11%	32.00%	62.10%	

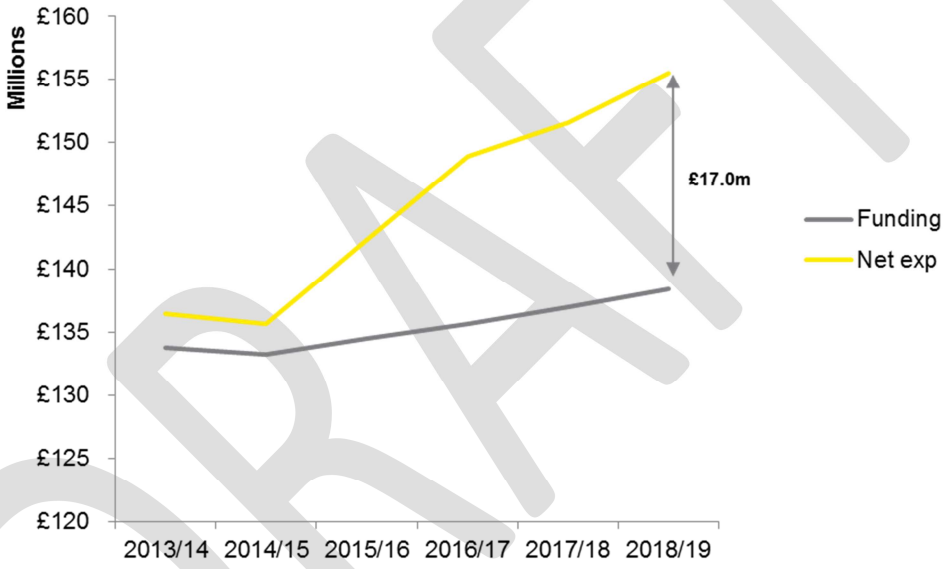
Table 1 – Value of Core and Influenced Services across the 5 Tier Model

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

	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

Table 2 – Forecasted Funding Gap for Health and Social Care Services 2013 – 2019

The graph below illustrates this project funding gap as set out in the Outline Business Case:



Graph 1 – Forecasted Funding Gap 2013 – 2019 in Graph Form

Cost Reduction Scenarios

We modelled how much we would need 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.

We would deliver this through targeted projects to redesign core services, jointly commissioned based on common features, care pathways or desired benefits and outcomes. This then facilitates moving activity away from Tier 5 as re-designed services in Tier 1 to 4 would capture and support people to reduce or prevent the need for acute or nursing/residential care.

The scenarios modelled are reductions in activity in Tier 5 of 2% and 3% per year for five years from 2014/15 to 2018/19. We believe this is a realistic, achievable target in this period.

Scenario 1 (2% Reduction)

Reducing activity (including outpatients, non-elective, A&E and elective activity) in Tier 5 by 2% per year reduces the funding gap but does not eliminate the gap or provide a surplus for reinvestment in the period:

	2014/15	2015/16	2016/17	2017/18	2018/19
Revised expenditure	£134,990,390	£139,454,394	£141,997,598	£144,503,476	£143,687,250
Budget	£133,817,172	£133,272,272	£134,496,516	£135,647,160	£136,973,858
Revised (gap)/funds available to invest	-£1,173,218	-£6,182,122	-£7,501,082	-£8,856,316	-£6,713,392

Table 3 – Revised Funding Gap for a 2% Reduction in Tier 5 Activity

Scenario 2 (3% Reduction)

Reducing activity (including outpatients, non-elective, A&E and elective activity) in Tier 5 by 3% per year reduces the funding gap further but still does not eliminate the gap or provide a surplus for reinvestment in the period:

	2014/15	2015/16	2016/17	2017/18	2018/19
Revised expenditure	£134,177,130	£137,717,656	£139,343,928	£140,939,361	£139,315,301
Budget	£133,817,172	£133,272,272	£134,496,516	£135,647,160	£136,973,858
Revised (gap)/funds available for investment	-£359,958	-£4,445,384	-£4,847,412	-£5,292,201	-£2,341,443

Table 4 – Revised Funding Gap for a 3% Reduction in Tier 5 Activity

Implications

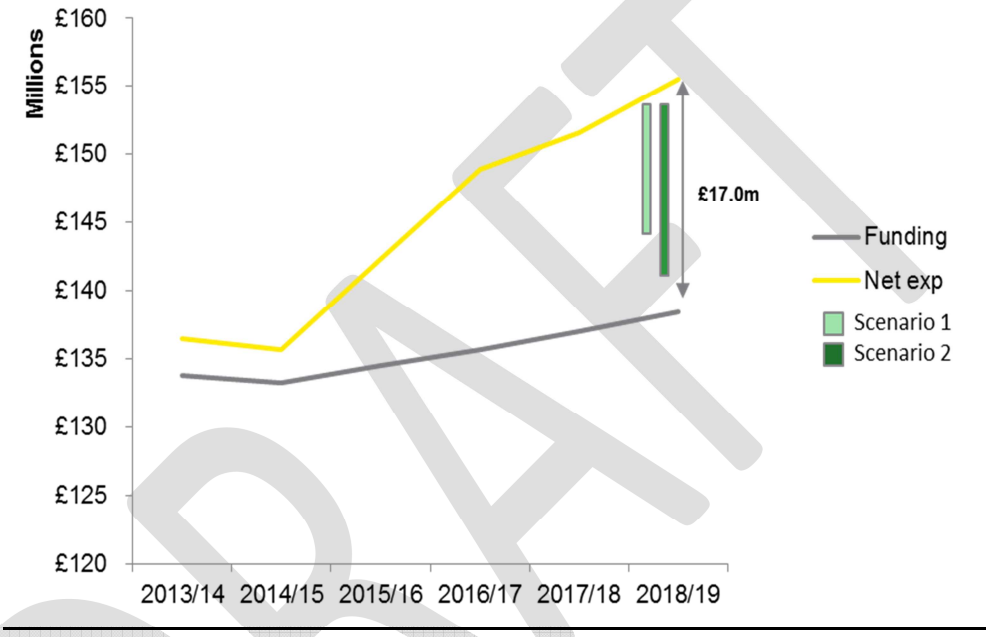
We can both share the benefits from a shift in activity from Tier 5, as discussed in the Commercial Case in Section 6. Comparing the original net expenditure versus in the revised expenditure above, the shift in activity would produce benefits in year 1 of £0.5m, giving an opportunity to invest in Tier 1 or 2 services. We therefore set aside £310k in 2014/15 for preventative services, comprising of £60k for Ageing Well projects and £250k for enhanced self-management services.

Additionally, we estimate the annual cost to LBB to respond to the requirements of the Care Act is £5 to 10m per annum for the target cohorts. For scenario 2 it is therefore likely LBB would need an additional £2 to 8m per annum savings to manage these additional financial pressures.

The move from activity in Tier 5 will underpin our investment to deliver the change described. For example for Scenario 2 the total benefit for 2014/15 and 2015/16 is £5.8m. This is modelled in the detailed Cost Benefit Analysis produced for each Tier below.

To include additional schemes (e.g. proposed specialist community long term conditions services at a cost of £10.3m) planned for BCF we would need to extend the 3% per year reduction in acute activity to encompass all acute services.

The graph below illustrates the impact of both scenarios modelled against the original forecasted funding gap (net expenditure vs projected budget). A 3% reduction (Scenario 2) in activity per year provides a greater pool for reinvestment and is therefore the desired scenario.



Graph 2 – Revised Funding Gap for a 3% Reduction in Tier 5 Activity

This is challenging to achieve but the return on investment from increased community support and health and wellbeing initiatives make it possible. We are also required to deliver this reduction in activity for the Better Care Fund, which provides some of the investment needed for the changes proposed in each Tier and which we have submitted plans for to NHS England.

Cost Benefit Analysis

We have analysed anticipated costs and benefits for each project in Section 4 above. The models cover 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 potential unit and total cashable benefits/savings for the proportion of people supported and timescale for realising them, plus non-cashable and recurring benefits.

The financial modelling underpinning the business case is made available as an exempt item to the Health and Wellbeing Board as it contains commercially sensitive information.

6. Commercial Case

This section summarises our latest view of the likely contracting model, payment mechanisms and risk sharing and Pooled Budget arrangements to deliver integrated health and social care services.

Approach

End-to-end integrated care is likely to require a complex structure of contracting models, payment mechanisms and risk and budget sharing arrangements. For example the care pathway, locality or service and benefit/outcome desired at any point in or across Tiers may require one or more (lead) providers in wider alliances delivering packages of care coordinated around the individual.

Other factors today affect our understanding of the most appropriate commercial arrangements to implement long-term. For example, the pace of change required to meet QIPP and BCF targets, or the complexity of health systems. The merger of the Barnet General Hospital and Royal Free NHS Foundation Trust Hospital may create some short-term uncertainty in the market. Plus, we need to understand how best to use the savings generated from reducing activity in Tier 5, e.g. reinvest in Tiers 1 to 4 or allocate them to QIPP, MTFS or PSR savings targets?

Commercial arrangements are currently set via contractual changes or special projects. However we need to build long-term commercial arrangements fit for purpose for the 5 Tier Model through partnering with providers and other stakeholders to services hands-on. Furthermore we must align this work with our plans for strategic integrated commissioning for health and social care, because it will define the commercial platform from which we can go to market for services.

This means we can retain a shared consensus on the vision and delivery of integrated care, avoid a disjointed, inconsistent delivery of benefits and outcomes and identify and manage risks to long-term success, e.g. resilient governance to keep relatively disconnected providers working together, or maintaining visibility within the supply chain.

This approach will also help us to set up clear contract management frameworks, e.g. performance or quality targets and be clear on accountability and funding mechanisms. This will mean services are more likely delivered consistently, giving people a common, quality experience.

Contracting Model Options

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

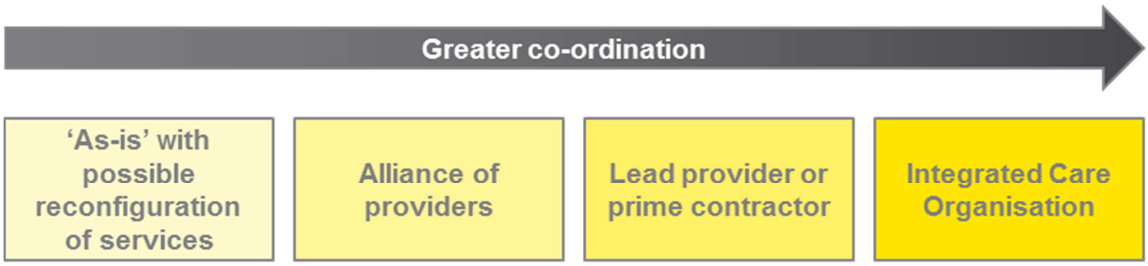


Figure 4 – Potential Contracting Models for Integrated Services

Potential payment mechanisms for the delivery of services against a preferred contracting model include single payments for full cycles of care and outcomes based capitation.

A preferred or recommended contracting model and payment mechanism are not yet identified.

Funding Arrangements

We will manage the funds to commission the integrated services to deliver the 5 Tier Model using a 'Section 75 Agreement' (National Health Services Act 2006). This is an agreement between us to undertake joint commissioning or provision using pooled budgets, single organisational structures and other resources. It may include BCF monies and core budgets and any preferred contracting model must align with this arrangement. We may also use Section 256 funding for, e.g. specific Programme resources or service set up costs (such as procurement or training).

Pooled Budgets and Risk Sharing

To ensure benefits are jointly realised we will pool and/or align some core and influenced budgets against clear performance metrics, monitored through joint governance arrangements. We plan to start this with the planned allocation of Better Care Fund monies, submitted 19 September 2014, for the delivery of integrated services from April 2015. We anticipate the proportion of our core and influenced Budgets that moves to the Pooled Budget will grow in time as the scope and scale of the integrated services increases.

We face financial and system pressures from 2014/15 to 2019/20 that may constrain the level of pooled funding we can both contribute to pooled or aligned budgets, e.g.:

1. For BCCG need to reduce budget deficits may require us to allocate any financial benefits derived to this purpose first, rather than reinvest in the 5 Tier Model for further benefit.
2. For LBB the Care Act could lead to significant increased demand for social care services and therefore may requires us to allocate resources to meet these needs.

These pressures require funding arrangements that allow us to share ('cash') benefits derived from integrating our services proportionally against them, while enabling us to cap our exposure to the other's financial risk if so desired.

This will enable us to identify, quantify and track how much of the financial benefits derived from the services detailed for each Tier in this Business Case:

1. Are retained in the Pooled Budget and reinvested in further, future services for each Tier.
2. Contribute to reducing financial deficits, funding reductions or other financial pressures.
3. Provide for individual exposure to other relevant risks, e.g. new ICT systems for service delivery or the reallocation of money for local 'specialist' commissioning activity.

Options under discussion to achieve this and share such risks include, e.g. a 50/50 split in reducing influenced services, reduced current or future spend on services (or our contribution to Pooled Budgets) relative to the original joint funding pool, reconciliation or closure of budgets or cashing benefits in proportion to funds invested against target investments or against the agreed size of the financial challenge we each face.

We will also factor in mechanisms to monitor and map benefits realised outside the Pooled Budget back to it and then agree reinvestment back into or outside the Pooled Budget accordingly.

Further work is required to develop and finalise Lead Commissioner roles (e.g. by service), holding of the Pooled Budget(s) and accountabilities and governance arrangements necessary to control and monitor spend and returns. This may include:

1. Determining the appropriate number of Section 75 Agreements to deliver services across the whole 5 Tier Model and appraising the use of pooled versus aligned budgets for some individual services.
2. The shared ownership and management of any risks to the success of the pooled budget, proportional to contributions, such as below minimum contributions for planned or actual spend or individual evolving strategy, objectives or financial/organisational risks.
3. Duties and responsibilities for one partner to manage commissioning for specific services on behalf of the other or to commission the services from single pooled funds.
4. Establishing the Terms of Reference of the Programme Board and other involved Boards, including decision making processes, schemes of delegation and reporting arrangements.
5. Processes for deciding the expenditure permitted against Pooled Budgets and monitoring subsequent spend against the costs and benefits in this Business Case.
6. Defining the set up and use of non-financial pooled or non-pooled resources, e.g. capital assets or single management structures for combined staff.
7. Designing arrangements to fit BCF governance requirements while increasing integration, delivery and value and creating further operational or care pathway efficiencies.

Summary and Next Steps

We will align work to confirm our preferred contracting model and Pooled Budgets and risk sharing and payment mechanism arrangements with parallel work to develop the OBC for integrated commissioning for health and social care. This will enable us to integrate strategy with the tactical

delivery of integrated commissioning to create the best platform for increasing efficiencies and continuous improvement long-term.

Other considerations include:

1. Understanding the scope and mechanisms for allocating and/or transferring risk, contract management approach, skills transfer and any required exit strategies.
2. Resolving issues arising from differing financial regulations or accounting parameters, e.g. VAT, budget surplus/deficit tolerances and how to 'cash' (reimburse) benefits.
3. Implementing new arrangements with existing ones that we cannot change and anything else not considered to date.

Plus it is important to make sure the timing of and the time it is likely to take to set everything up is best placed and does not conflict with competing demands for resources.

We expect arrangements to evolve as we design and build the operating arrangements. We will conduct detailed options appraisal for each element as required (e.g. to include market testing) to evaluate if services in the 5 Tier Model will suit a standard or a mix of commercial arrangements for the desired level of integration and appetite for risk.

This will include partnering with providers to identify an approach to facilitate building and safely and smoothly moving to new operating arrangements and new ways of working. Early engagement with providers and the community will be vital, to inform stakeholders, allay any fears and listen to feedback and adjust our proposals accordingly to obtain buy-in for our strategy.

This will enable LBB and BCCG to maximise opportunities to:

1. Align and integrate joint corporate strategy with service delivery, creating one, coherent, stable, predictable and unified approach for the community and the market.
2. Re-invest benefits into end-to-end care, giving additional opportunities to improve care quality and outcomes for people and reduce costs and create long-term financial stability.
3. Move away from payment based on activity towards payment based on the outcomes of Values Based Commissioning as the platform for integrated care, a key enabler in moving activity away from costly acute and residential and nursing care.
4. Implement contracting arrangements or payment mechanisms that incentivise providers to share in the risks and available rewards from integrating services.
5. Commission and procure services efficiently and effectively against a shared consensus of future needs of the community, through one procurement strategy and operation.
6. Define and realise benefits and long-term outcomes for the community.

7. Management Case

This section describes the Programme we have set up to deliver integrated services and financially sustainable better health and wellbeing outcomes. This includes the organisation and scope of the Programme and work to set up effective delivery and operations, e.g. governance, resources and timetables and benefits realisation.

It demonstrates that all the work detailed in the Business Case is achievable, implemented through a clear, structured and managed environment.

The Programme

The HSCI Programme is a structured, managed set of change projects, business as usual work and communications and stakeholder engagement, to implement the 5 Tier Model.

Aims & Objectives

The aim of the Programme is to enable us and partners to develop and commission sustainable integrated care that understands and meets the needs of the frail and elderly and people with long-term conditions in Barnet.

The main objectives of the Programme are to:

1. Embed the 5 Tier Model as the default strategy for the design and delivery of all current and future integrated health and social care services.
2. Embed in people a perception and expectation that they will live independently in their community, only using care services designed to protect and extend this if necessary.
3. Move as much activity as possible from acute, residential or nursing care to people self-managing their conditions and accessing services in the community.
4. Design and commission integrated services which:
   - Promote and support self-management and health and wellbeing in the community.
   - Operate end-to-end across all Tiers as required and respond quickly to plan, deliver and track re-ablement focused care wherever possible.
5. Put in place operational infrastructures, systems and working arrangements to facilitate integrated working and partnership working between commissioners and providers.
6. Continually improve the appropriateness and quality of care services in meeting needs.
7. Reduce the amount of activity and cost of acute and residential or nursing care.
8. Reduce the total amount of financial resources used to deliver integrated care.

Outline (Structure & Scope)

Figure 5 below illustrates the current and proposed scope of the HSCI Programme.

Projects comprise a defined change (output) for one or more tiers, e.g. the Shared Care Record to implement a new IT system for sharing information about the care people receive, or a suite of defined changes by theme or condition, e.g. Strokes, to deliver end-to-end integrated services.

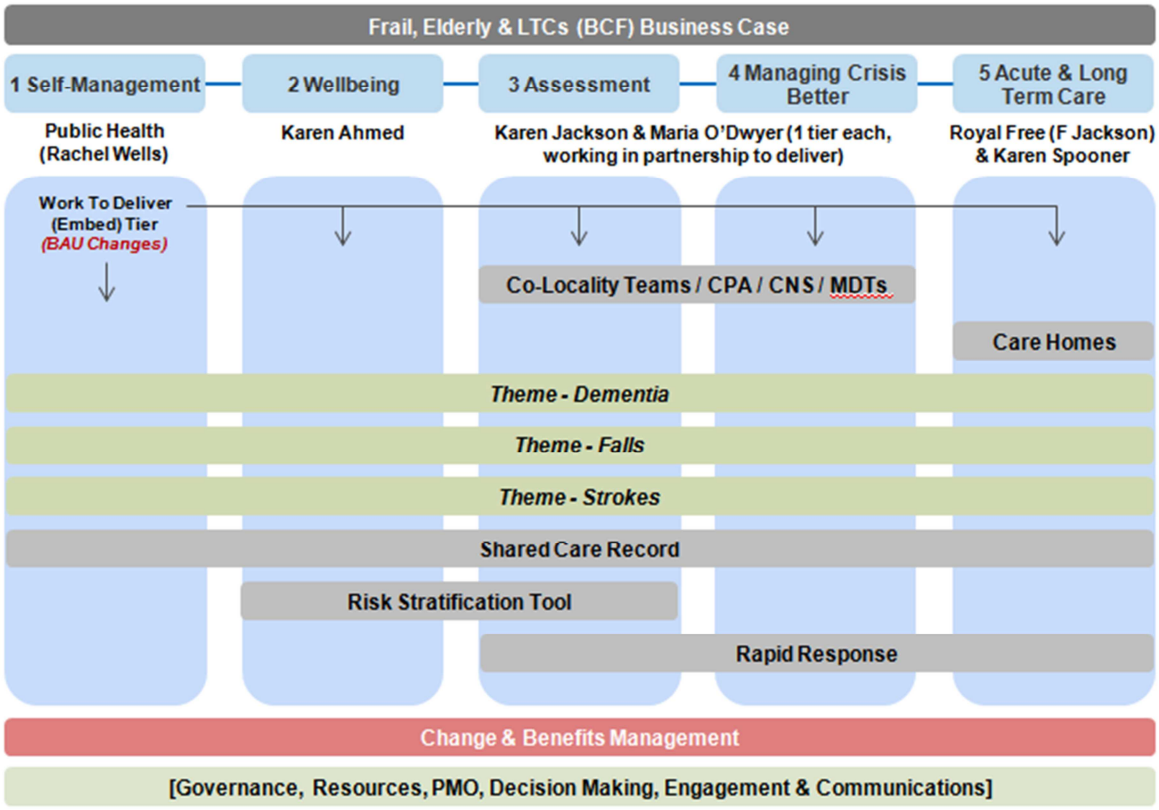


Figure 5 – Proposed BCF Programme Structure

Business As Usual (BAU) work comprises incremental changes or improvements to existing services designed to enable, support or integrate projects or embedding the 5 Tier Model.

The Programme will deliver and manage change, benefits management work centrally. Governance will complement wider arrangements in place as appropriate, e.g. where decision making is to be escalated to or made directly by the Health and Wellbeing Board (HWB).

A Programme Management Office (PMO) will coordinate and manage Programme operations. This will include governance, administration, project/work delivery and reporting, benefits realisation, documentation and information control and communications and engagement with stakeholders.

Governance Arrangements

Figure 6 below illustrates the governance and board structure for the HSCI Programme.

Initial governance arrangements were agreed and put in place in April 2013. This included gateway review and approval processes for projects and work, project and programme reporting, roles and responsibilities, Programme Management Office (PMO) functions, risk, change, issue management processes and information governance and terms of reference.

The governance and board structure in Figure 6 supersedes the original governance arrangements. We are now working to revise and refresh Programme governance to reflect this Business Case.

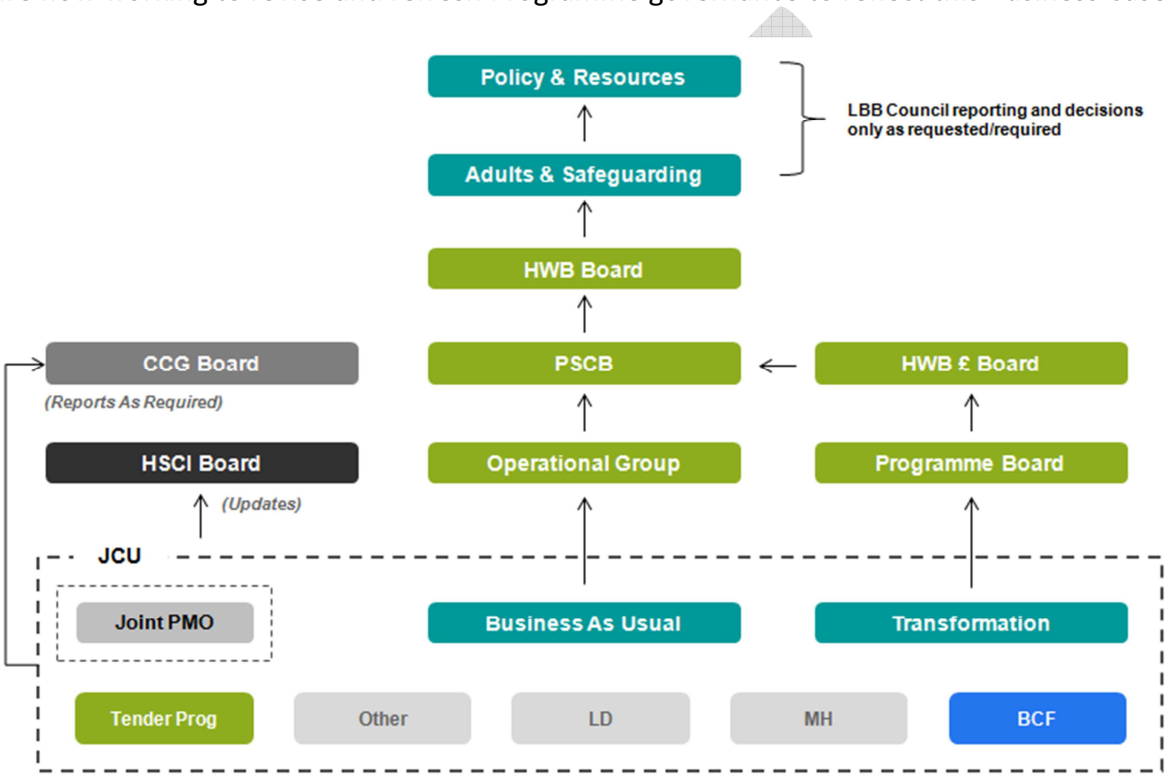


Figure 6 – Proposed BCF Programme Structure

The LBB A&C Director of Adults & Communities and BCCG Chief Executive Officer will act as joint Programme Sponsors. The A&C Associate Director of Health and Wellbeing, Adults & Communities and BCCG Director of Integrated Commissioning will act as joint Programme Directors and Project or Theme Sponsors.

Each Tier will have a Lead and Subject Matter Expert. Each Project or Theme will have a Project Manager and prioritised work, aligned to Programme aims & objectives, and desired benefits and outcomes. Tier Leads will partner to define strategies for delivering end-to-end services.

We will deliver and manage all Programme and project work using LBB and BCCG programme and project management methodologies. Work will be grouped and delivered work in tranches based on priority (e.g. by its contribution to desired benefits or outcomes and how achievable the work is against other competing demands for resources).

We will deliver and manage work and define, validate and track the realisation of desired benefits using our programme/project management methodologies and benefits management tools and techniques from other recognised methodologies, e.g. PRINCE2 or MSP.

This will give enable our and independent scrutiny and assurance of work down, with scheduled reporting and reviews to monitor the delivery of desired benefits and to retain tight management and financial control of Programme spend against this Business Case.

Proposed new projects must have a viable Business Case that clearly states the financial and non-financial benefits of putting in place the changes described.

The Programme Board (Operational Group) will consider the Business Case and approve or reject it against agreed evaluation criteria, e.g. whether it meets the vision, aims and objectives of the 5 Tier Model, meets one of the six core BCF target benefits and outcomes, improves on the quality of services and commissioning for outcomes, or meets commercial criteria such as lower costs (i.e. reduced duplication or acute activity).

If accepted the Programme will deliver the project, tracking progress and outputs against similar quality assurance criteria. Once completed, the business will manage work to measure all benefits realised, with support from the Programme as required.

Delivery Resources

The JCU is responsible for delivering the Programme (e.g. Project and Programme Management roles) with support from LBB, BCCG as required, e.g. Tier Leads or Subject Matter Experts (SMEs). If additional capacity is required the JCU will draw from in-house resources or use other available Programme funding as appropriate, e.g. Section 256 funding.

The Cost Benefit Analysis in the Financial Case in Section 5 account for all known required delivery resources identified to date. However the delivery resources required will evolve in line with the scope of the Programme and ongoing delivery. We will also use additional external resources, e.g. commissioners, providers, the community or other stakeholders to help inform plans and support specific functions, e.g. change management, training or evaluation.

Communications & Stakeholder Mgmt

The Programme will design and execute a detailed communications and stakeholder engagement plan to inform all interested parties about the scope, progress and positive impact of our work. We will base this on and align it with other parallel internal and external campaigns, e.g. to inform people about changes resulting from the introduction of the Care Act from April 2015.

This will enable us to lead and manage the change anticipated and respond to feedback. It will also form the platform for changing the perceptions and expectations of practitioners and community members long-term. We aim to move the mind set for health and social care staff from providing standard packages of care to taking a values based approach to help people follow an asset based approach to consider what they can do rather than what they cannot.

Planning, Risks, Issues & Dependencies

Projects hold and manage work and milestone plans and risk, issue and dependency registers, with exceptions and individual entries escalated and managed at Programme level as necessary. The Programme also holds a separate Programme level register, reported to the Programme Board, LBB Portfolio Management Office and CCG regularly.

Project plans are reviewed and revised and work is planned for the next period against progress, resource availability and priority of desired benefits and outcomes.

Projects and the Programme will cost risks accordingly to understand and account for their impact on the Business Case, to monitor that the Business Case remains viable and to retain management and financial control.

Areas/types of risks, issues and dependencies tracked include, e.g.:

1. Internal and external factors that prevent successful delivery, such as a lack of providers or immature market, insufficient staff, skills or expertise.
2. The impact of non-delivery of operational and technical infrastructures, e.g. Shared Care Record or replacement case management systems, or co-location/accommodation.
3. Changes to corresponding but separately managed functions in LBB or BCCG, such as the introduction of a broader ‘Front Door’ service and how this affects the Financial Case or the understanding in the community of when and how to access services.
4. Dependencies on existing providers, other partners or interested/influential stakeholders.
5. Potential higher demand as a result of the requirements of the Care Act and how this may our ability or likelihood to realise the desired benefits.

8. Conclusions and Next Steps

This Business Case demonstrates the significant progress we have made so far to implement and embed our vision and 5 Tier model for integrated health and social care services. The new services now in place and projects in delivery are beginning to return financial savings and benefits and the best outcomes for frail elderly people and those with LTCs.

We realise there is much more work to develop and embed our end-to-end integrated system. The scope of work to date has focused on health services to immediately address pressures on acute services. Our initial review of the benefits realised so far validates this approach, showing that as as expected we are starting to deliver on our aim to reduce unplanned emergency admissions to hospital and so enable people to live independently and healthily at home.

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

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

Structural integration and new commercial models are complex and challenging to achieve. We need to consider options for new contracting models, pooled budget and risk share and payment mechanisms local in more detail. We will want to minimise transition costs where possible and put in place one or more arrangements as appropriate. For example, we may need to use a number of lead providers for different service packages, form alliances to coordinate pathways or use some arrangements to manage bundle of services rather than as the main delivery platform.

To further develop our strategy, deliver the work and implement the commercial and operational models detailed here our programme will need to draw on expertise in stakeholder engagement, pathways redesign, clinical standards, service specification design, equality impact assessments, procurement, contract management, finance, legal, IT and project and programme management.

There is a consensus amongst key stakeholders to deliver our model in a staged process. Next steps and ongoing work will include, e.g.:

1. Extending and implementing existing operating arrangements like the Care Navigator and Multi-Disciplinary Team services and piloting and rolling out new services such as Integrated Locality Teams, all in partnership with stakeholders.
2. Partnering with parallel work to establish strategic integrated commissioning and so enter into dialogue with providers to identify appropriate commercial models.

3. Developing our draft service specification to market test appropriate 'segments' of the model in more detail to determine what scope and scale of services is achievable and to select the right contractual model and provider accordingly.
4. Identifying and managing future risks to success, such as ensuring the scope and scale of services can grow in line with forecasted demographic trends.
5. Delivering integrated services that facilitate us to exceed published savings targets.

Future updates to this Business Case will provide more detail on the status of work to deliver our vision for integrated health and social care services and to close the funding gap identified.