**Updated July 2014 – 15/09/2014**

# Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

## 1) PLAN DETAILS

### a) Summary of Plan

| | |
|---|---|
| Local Authority | **Barnet Council** |
| | |
| Clinical Commissioning Groups | **Barnet Clinical Commissioning Group** |
| | |
| Boundary Differences | **Coterminous, however, the GP-registered population includes patients who reside in another LA's area. Barnet's integrated care model includes these patients.** |
| | |
| Date agreed at Health and Well-Being Board: | **18.09.2014** |
| | |
| Date submitted: | **19.09.2014** |
| | |
| Minimum required value of BCF pooled budget: 2014/15 | **£6,634,000** |
| 2015/16 | **£23,412,000** |
| | |
| Total agreed value of pooled budget: 2014/15 | **£6,634,000** |
| 2015/16 | **£23,412,000** |

## b) Authorisation and signoff

| | |
|---|---|
| **Signed on behalf of the Clinical Commissioning Group** |  |
| **By** | Dr Debbie Frost |
| **Position** | Chair |
| **Date** | 18.09.2014 |

| | |
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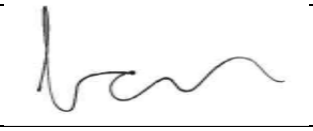
| **Signed on behalf of the Council** |  |
| **By** | Andrew Travers |
| **Position** | Chief Executive |
| **Date** | 18.09.2014 |

| | |
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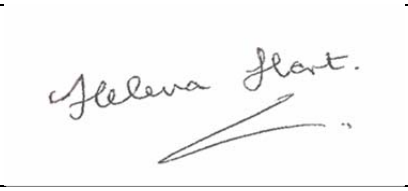
| **Signed on behalf of the Health and Wellbeing Board** |  |
| **By Chair of Health and Wellbeing Board** | Councillor Helena Hart |
| **Date** | 18.09.2014 |

## c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

| Document or information title | Links |
|---|---|
| Barnet Health and Social Care Concordat | HSCIB concordat signed.pdf |
| Barnet Integrated Health and Social Care Model 2013 | |
| Barnet Health & Well-Being Strategy | |
| Barnet Council Corporate Plan 2013 | |
| Barnet Council Priority & Spending Review 2014 | Barnet Health Social Care Integrati |
| Barnet CCG 2 Year Operational and 5 Year Strategic Plan | |
| Barnet Joint Strategic Needs Assessment (JSNA) 2011-2015 | Barnet Health Social Care Integrati |
| Health and Social Care Integration Board Terms of Reference | |
| Health and Social Care Integration Board Programme Governance | Barnet Health & Social Care Program |
| Barnet, Enfield & Haringey Clinical Strategy | |
| Health & Social Care Integration business case (Sept 2014) | HSCI Business Case Update Oct 014 v0 5 |

| | |
|---|---|
| | Others available upon request |

# 2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

**The Vision for integrated care in Barnet is articulated in the Health & Social Care Integration Concordat and states:**

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

In **3-5 years' time,** we will have developed a fully integrated health and social care system for the frail and elderly population through implementation of our model so that it:

- Delivers on expected patient outcomes meeting the changing needs of the people of Barnet.
- Enables people to have greater choice and autonomy on where and how care is provided.
- Empowers the population to access and maximise effectiveness of preventative and self-management approaches to support their own health and wellbeing.
- Creates a sustainable health and social care environment, which enables organisations to work within resource limits.
- Reduces overall pressures in hospital and health budgets as we shift from high-cost reactive to lower cost prevention and self-management services.
- Listens and acts upon the view of residents and providers to make continued improvement.

Our plans are informed by the **Barnet Joint Strategic Needs Assessment** (JSNA). This provides a framework for **commissioning informed by insight,** through **prioritised need and managed demand** and **based on evidence.** We will focus on tackling the areas of greatest need and highest impact, which include:

- **A growing ageing population:** above average growth rate (5.5%) in the elderly population, 3,250 more residents aged over 65 (+7.4%) and 783 more residents aged over 85 (+11.3%). As a result we expect the prevalence of dementia to increase.
- **Specific health trends:** While many people in Barnet experience good health, some issues remain significant obstacles. Although mortality associated with **cancers** remains relatively low, improving take-up of screening could ensure that more cancers are identified and treated earlier, increasing the likelihood of survival and decreasing the need for more radical treatment. Death rates related to both, **chronic obstructive pulmonary disease (COPD)** and **cardiovascular**

**disease** are generally falling however we recognise that early identification of undiagnosed COPD remains a priority, as does smoking cessation. Of significance, is the '**obesity epidemic**. Almost 25,000 Barnet residents aged 18 plus are **obese**. Although this represents a lower prevalence than nationally (15.4% versus 24.5%) it is still a significant number, especially considering that those who are obese are at greater risk of premature death and are more likely to suffer from conditions such as diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases, infertility and respiratory disorders.

- **Improving independence:** with the increased pressures from a rising population and reduced financial resources, it will be essential to **enable more people to manage their own health** responsibly particularly through prevention schemes.

The **Barnet Health & Well-Being Strategy** centres on reducing health inequalities by focusing on how more people can 'Keep Well' and 'Keep Independent':

- **Keeping Well:** focus on supporting people to adopt healthy lifestyles to prevent avoidable disease and illness.
- **Keeping Independent:** when extra support and treatment is needed, it is delivered in a way which enables people to get back up on their feet quickly, supported by health and social care services working together.

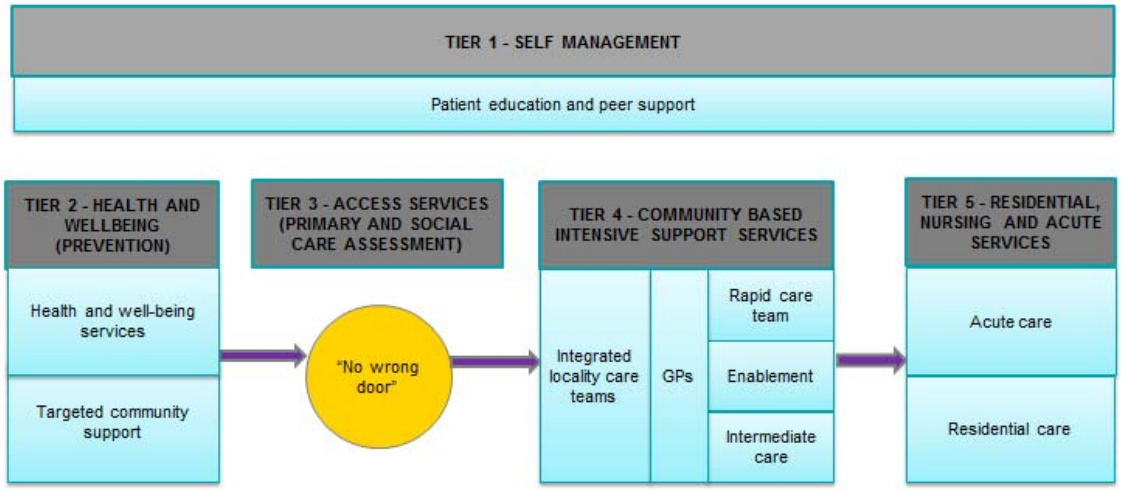
The strategy recognises we can only achieve this through a partnership between residents and public services.

As outlined in more detail in section 8a, patient and service user views are integral to the vision for integrated care in Barnet with extensive involvement of a wide range of individuals and organisations including Healthwatch Barnet, Older Adults Partnership Board , Age UK (Barnet) and the Alzheimer's Society.

Taking into account the call from local residents to increase co-ordinated care to enable them to live better for longer we have built the Vision around Mr Colin Dale, a fictitious representative user of health and social care services. Central to success will be development of a model that will mean that Mr Dale has:

**The London Borough of Barnet (LBB) and Barnet CCG have been working for many months on our jointly agreed Integrated Health & Social Care Model**

The Better Care Fund (BCF) plan has its foundations in the **Barnet Health & Social Care Concordat** – a clearly articulated vision for integrated care co-designed and agreed by all parties of the **Barnet Health and Social Care Integration Board (HSCIB)**.The model forms the foundation of our future transformation and has 5 components:




**The BCF will be an important enabler to take the integration agenda forward at scale and pace**

It supports the aim of providing people with the right care, in the right place, at the right time through a significant expansion of care in community settings and championing of prevention and self-management. Our schemes therefore comprise:

- **Self management and Health and Wellbeing Services**: People and their families are supported to manage their own health and wellbeing wherever they can and for as long as possible
- **Access services including primary care and social care assessment**: identify early and proactively target those at risk of becoming frail or unwell. When necessary a support package focused around the individual will be put in place that optimises his skills, increases quality of life and prevents deterioration.
- **Community based intensive services**: Intensive community based support services are readily accessible and react quickly to need

These are supported by a range of enablers that, although they do not deliver direct benefit, ensure that the system operates as planned including delivery of a number of business as usual components.

Implementing the Vision for the BCF will be challenging especially in the context of the required 3.5% reduction in emergency admissions, and against a backdrop of a financially challenged CCG and a Local Authority under the financial constraints applying to local government, and with the emerging additional costs of the Care Bill. Local demographic and infrastructure changes, including re-configuration of acute services and a high number of residential and nursing homes create additional pressures, which must

be addressed. There is also the local recognition that much of the BCF funding will come with services already provided.

The plan is currently aligned to the NHS Barnet CCGs Draft Delivery Plan that was presented to the Board on 28 August 2014. This is currently under review and any re-alignment will occur in due course so that it remains part of the overall plan to manage pressures and improve long term sustainability

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

All of the work being undertaken, and planned, as part of the BCF programme is intended to contribute to improved user experience, improved user outcomes and reduced funding requirements. The Better Care Fund (BCF) translates these top level outcomes into the following quantifiable measures, ensuring everyone locally (both commissioners and providers) is aiming to deliver a common set of outcomes:

| | **Current level** | **Target next year** | **Benchmark (ONS peer group)** | **Comment** |
|---|---|---|---|---|
| **Non-elective admissions** | 29,094<br><br>80 per 1,000 population | 28,069<br><br>3.5% reduction | 64 per 1,000 population | • Barnet is already in the top quartile on NEL performance<br>• Aiming for 10% international improvement benchmark<br>• 20% improvement from reducing GP variation and increased us of risk stratification |
| **Care homes** | 487 | 354 | 410.9 (for current level and based on Barnet Council comparator group) | • Aim for top quartile performance |
| **At home after 91 days** | 71.9% | 81.5% | 85% | • Move from bottom quartile to second |
| **Delayed transfer of care** | 7 per 1000,000 population | 5 per 100,000 population | 6 per 100,000 population | • Move from second quartile to top quartile |
| **Patient experience** | 0.9 | 0.78 | 0.81 | • The metric is based on the Annual Social Care User Survey (2013/14), Question 4: Overall how satisfied or dissatisfied are you with the support or services you have received from social services in the last 12 months? |

**Improved Outcomes**

**Better patient and carer experience:**

- The provision of a local, high quality service that targets those most at need. In addition, it will enable people to remain at home, where essential care can be delivered and monitored
- Reduction of duplication in assessment and provision through use of an integrated locality team approach to case management
- "No wrong door" for frail, older people and those with long term conditions
- Increase in the number of people who have early interventions and proactive care to manage their health and wellbeing

**Improved older adult outcomes (health and social care):**

- Ensuring quality long term care is provided in the most appropriate setting by a workforce with the right skills
- Pro-active care to ensure long term conditions do not deteriorate, leading to reductions in the need for acute or long-term residential care, and reducing the demand for repeat interventions and crisis services such as emergency departments
- Increased use of health and social care preventative programmes that maintain people's health and wellbeing, and improved practice in use of medication leading to a reduction in unplanned and emergency admissions to hospital and A&E

**Lower cost, better productivity -** achieved through the ability to improve future resource planning and needs by way of:

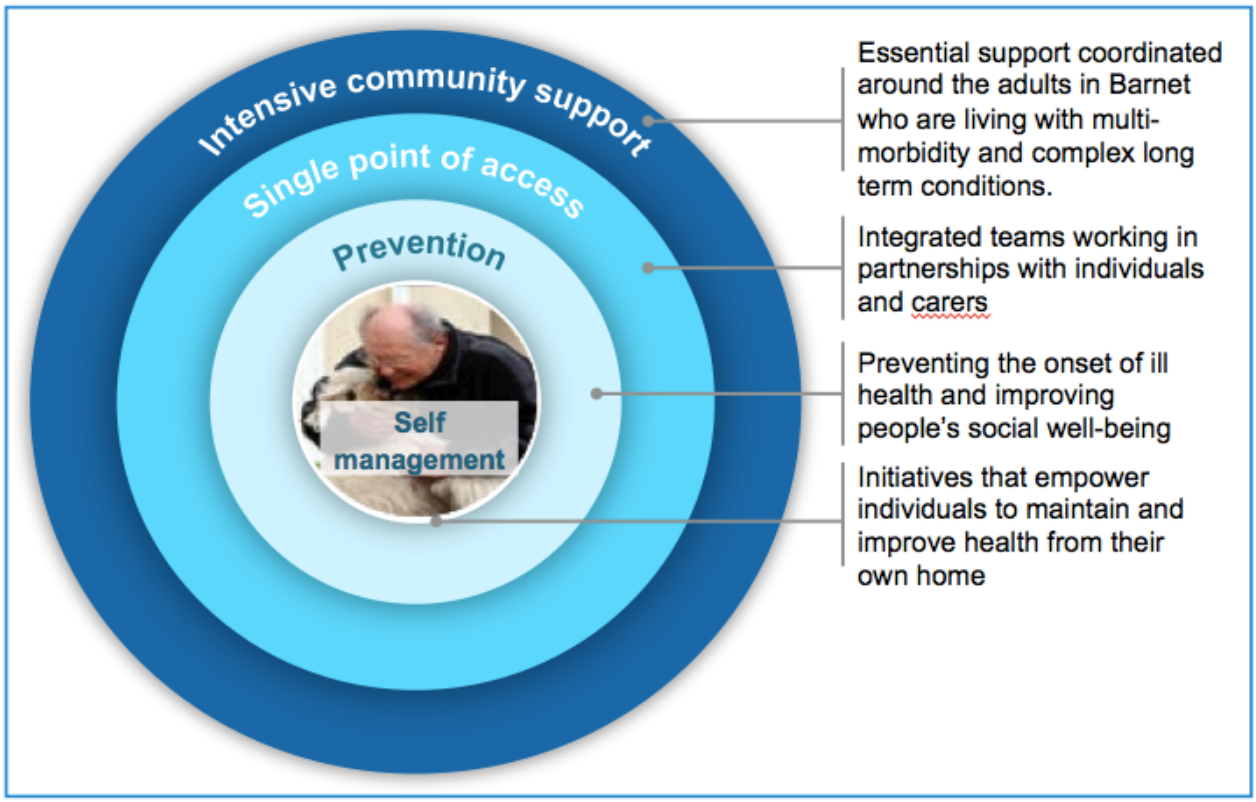
- Utilising risk stratification to manage the care of those individuals most at risk of an escalation in their health and social care needs.
- Utilising a joint approach to care will ensure a better customer journey and led to better management of resources providing the services.
- Increased information and signposting to ensure preventative services are fully utilized.
- Supporting people to stay living at home for as long as possible and enabling them to take more responsibility for their own health and wellbeing, which in turn will help reduce or delay the rising admissions to residential care.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

**There will be significant changes to the delivery of services over the next 5 years**

Transforming services through integrated care will ensure that we are improving outcomes for patients and service users, gaining the best value for money in services

and are maximising opportunities arising from joint commissioning. This section outlines the operating arrangements for each of the tiers of the integrated care model.




**Tier 1: Self management: shifting the focus of health and social care delivery away from formal care and institutions and towards developing a personal resilience to seek own solutions and manage circumstances.**

- All individuals with a recognised medical condition (such as diabetes or heart disease) will be offered self-management education, training or support
- Up-skilling people and improving their health literacy so that they are more confident about looking after their own health.
- Access to support from a long-term condition mentor or health champion, or access to online support forums tools.
- Development of Healthy Living Pharmacies, to review medication, access community based preventive services and to work with a health champion to adopt healthier behaviours.
- Training for health and social care professionals to better enable them to support and empower people to manage their long-term conditions independently.

**Tier 2: Health and wellbeing will focus on preventing the onset of ill health and improving people's social well-being**

- Target on primary and secondary prevention as required
- Encouraging healthy lifestyles and lend support to both families, friends and carers

who provide either formal or informal care.

- Strong Information and Advice offer, with branding, so that these services will be publically recognisable, readily available, understandable and easy to access. Increased use of social media, mobile and internet technology to support delivery.
- Early contact made with people identified as at risk of needing Tier 3 and 4 services, to link with advice and support to help keep them well. Examples include the Falls Clinic, Dementia Hub, Dementia Cafes, Dementia Advisors, Day Care and Stroke Support Services.
- Evidence base of what works at a system and individual level will be developed to inform future commissioning.
- Health education package for carers, which supports safe caring, promoted by GPs, the Council, carer's services and hospitals. Dedicated carer's centres
- Implementation of the Ageing Well Programme, including greater investment in volunteering to support people in the community

**Tier 3: Access services (primary and social care assessment) for people with a long term condition, aimed at preventing unnecessary admissions**

- **Identification of at risk Older Adults using risk stratification software:** population profiling; predictive modelling of high-risk patients; disease profiling to enable early identification and navigation to the appropriate prevention services.
- **Community Point of Access**: single common access to advice and support for Older Adults and those with long term conditions to signpost them quickly to the services that they require. It will also provide a direct referral route to existing community health services.
- **Shared care record**: An information repository providing a single holistic view of an individual's health and social care that will be accessible 24/7 from any location, wherever staff are working. A key system enabler.

**Tier 4: community based intensive support services to increase independence and manage people within the community e.g. at home.**

- **Care Co-ordination & Case Management:** Delivered through **Integrated Locality Teams** in partnership with GPs, designed to support and manage care from self-management through periods of crisis, into end of life pathways where necessary. They will review and assess complex patients living with multi-morbidity and long term conditions at risk of admission to introduce care plans and link to services to keep them at home. Building from an initial framework of a team based with each of the 3 localities, they will move resources around flexibly to avoid crisis and maintain people in their homes or in other care settings.
- **Weekly MDT** meetings will provide a more intensive approach to managing the most complex cases by planning care across multiple providers.
- **Care navigators** supporting these groups with implementation and delivery of care plans through care co-ordination and signposting

- **Rapid care** service that will provide intensive home-based packages of care to support people in periods of exacerbation or ill-health.
- **Enablement services** working more effectively with facilitated discharge to provide holistic care packages seamlessly with other care providers.

**Tier 5: Reduce demand for residential, nursing and acute services**

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

# 3) CASE FOR CHANGE

**Please set out a clear, analytically driven understanding of how care can be improved by integration in your area**, explaining the risk stratification exercises you have undertaken as part of this.

**Our BCF plan needs to be delivered in the context of a challenging health and social care environment**

- The CCG with an inherited debt of £34.1m and the Revenue Resource Limits (RRL) announced for 2014/15 and 2015/16 that continue to disadvantage Barnet CCG by providing funding below the 'fair share' target. Significant ongoing QIPP challenges will continue for the CCG in the foreseeable future.
- The Barnet Council Priorities and Spending Review (PSR) forecasted a gap in the council's finances of £72 million between 2016 and 2020 and has identified a package of options for the council to save money and raise revenue, with a potential to provide a financial benefit of approximately £51 million. Adults & Communities share of the PSR package of savings represents £12.6m. This includes proposals for organisational efficiency, reducing demand and promoting independence and service redesign.

- Meeting the needs of 32,000 informal carers especially given implementation of the Care Act and changes which mean that carers may significantly enhanced entitlements.
- Significant change in the Acute provider landscape related to strategic change and re-configuration.
- Over 100 care home establishments with net import of residents from other areas.

Our case for change centres on five issues:

1. **A challenging financial environment with significant uncertainty**
2. **An ageing population with a growing burden of disease**
3. **High levels of variation in primary care**
4. **Outcomes which are not as good as we aspire to**
5. **We are not spending enough on those areas which support integrated care**

We have undertaken a detailed analysis of the **affordability and deliverability of the Health & Social Care Integration Model** to address the critical question for the Barnet economy of how we can achieve better health and wellbeing outcomes and improve user experience for the frail, older population in Barnet in a financially sustainable way.

The combined effect of reduced funding and our projected increases in expenditure will create a significant financial gap over the next six years. The table and graph below illustrates this for the £133m of funding relevant to older people (in scope):

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

| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|---|
| **Funding** | £133,817,172 | £133,272,272 | £134,496,516 | £135,647,160 | £136,973,858 | £138,482,170 |
| **Net exp** | £136,517,172 | £135,659,985 | £142,319,805 | £148,905,981 | £151,623,446 | £155,526,033 |
| **Annual Gap** | -£2,700,000 | -£2,387,713 | -£7,823,288 | -£13,258,821 | -£14,649,588 | -£17,043,862 |
| **Cumulative** | -£2,700,000 | -£5,087,713 | -£12,911,001 | -£26,169,823 | -£40,819,411 | -£57,863,273 |

*Date source: OBC April 2014.*

**There has also been significant change in the local provider landscape through implementation of the Barnet, Enfield & Haringey clinical strategy.** This has created shifts in capacity and demand throughout the local system that continues to have knock-on impacts. Some implications are clearly visible and are being managed e.g. demand pressures on community beds; and others are still emerging. Until the local health economy has fully settled post-implementation it will be difficult to gain a true understanding of the new baseline for Barnet. Similarly, the recent acquisition of **Barnet & Chase Farm hospital by the Royal Free** will inevitably change operational practice and hence demand models. The impact of this is only just starting to be manifested in the system but is likely to impact over the next 12 months and beyond.

**The population cohort most likely to represent a pressure on the system is ageing.** Overall the population is expected to increase by nearly 5% over the next 5 years (an increase of 17,308), with disproportionate growth in both the young and old cohorts. The effects of an ageing population will become most acute, with the over-65 population forecast to grow by 10.4% over the next 5 years and 24% over the next decade, placing increased pressure on social services and health budgets. Barnet will have one of the largest increases in elderly residents out of all the London boroughs over the next five to ten years. There are currently 52,000 people in Barnet over the age of 65, and this will increase to 59,800 by 2020. Barnet's Health and Wellbeing Strategy sets out the

Borough's ambition to make Barnet 'a place in which all people can age well'. The challenge is to make this a reality in the context of rising health and social care needs among older people, and the financial pressures facing the NHS and the Council.
As seen in the table below, segmentation of the population identifies that £95.5m per annum is spent on 21,900 over 70 year olds with one or more long-term conditions (LTCs) or dementia. In addition £114.3m is spend on 46,600 adults with one or more LTCs. There are currently over 1,600 people over 65 with Long Term Conditions or physical frailty receiving community based care services in their home through Adult Social Care in Barnet.

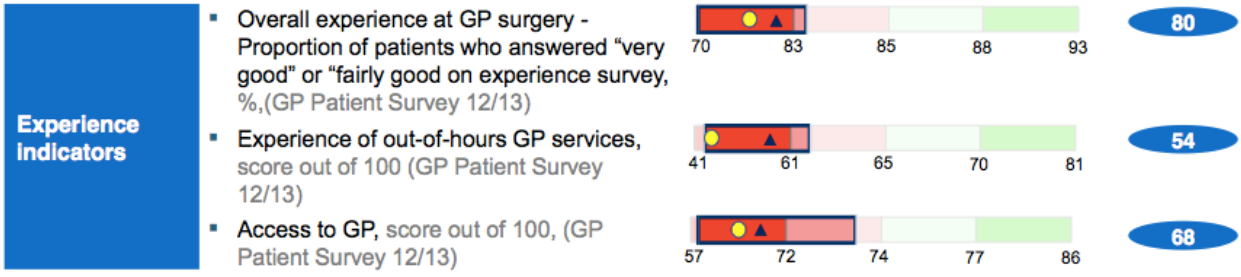
**Population Segmentation Model.**

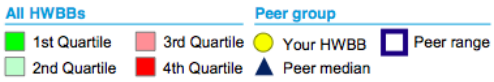
2012/13 — Number of people: x k | £m Total annual spend | £xx Average spend per capita | Relative size of spend per capita

| | Mostly healthy | 1 LTC | 2+ LTCs | Severe Enduring Mental Illness | Dementia | Cancer | Learning disability | Severe Physical Disability |
|---|---|---|---|---|---|---|---|---|
| Children 0-16 | Mostly healthy children<br>675<br>75.3 50.8 | Children with 1 LTC<br>1,096<br>3.3 3.6 | Children with more than 1 LTC<br>2,676<br>0.1 0.2 | Children with SEMI<br>3,222<br>0.1 0.4 | Children with dementia<br>n/a<br>- - | Children with active cancer<br>7,750<br>0.0 0.2 | Children with learning disability<br>n/a<br>- - | Children with physical disability<br>n/a<br>- - |
| Adults 16-69 | Mostly healthy adults<br>778<br>205.9 160.1 | Adults with 1 LTC<br>1,898<br>32.0 60.8 | Adults with more than 1 LTC<br>3,660<br>14.6 53.5 | Adults with SEMI<br>10,611<br>3.4 36.0 | Adults with dementia<br>14,325<br>0.1 1.3 | Adults with active cancer<br>4,658<br>3.0 13.9 | Adults with learning dis-ability<br>46,448<br>0.7 31.0 | Adults with physical disability<br>19,437<br>0.3 5.6 |
| Elderly 70+ | Mostly healthy elderly<br>2,418<br>8.0 19.4 | Elderly with 1 LTC<br>2,271<br>7.4 16.7 | Elderly with more than 1 LTC<br>4,491<br>13.1 58.8 | Elderly with SEMI<br>14,602<br>0.5 6.8 | Elderly with dementia<br>14,534<br>1.4 20.1 | Elderly with active cancer<br>4,932<br>4.1 20.1 | Elderly with learning disability<br>38,265<br>0.0 1.7 | Elderly with physical disability<br>20,421<br>1.2 24.5 |

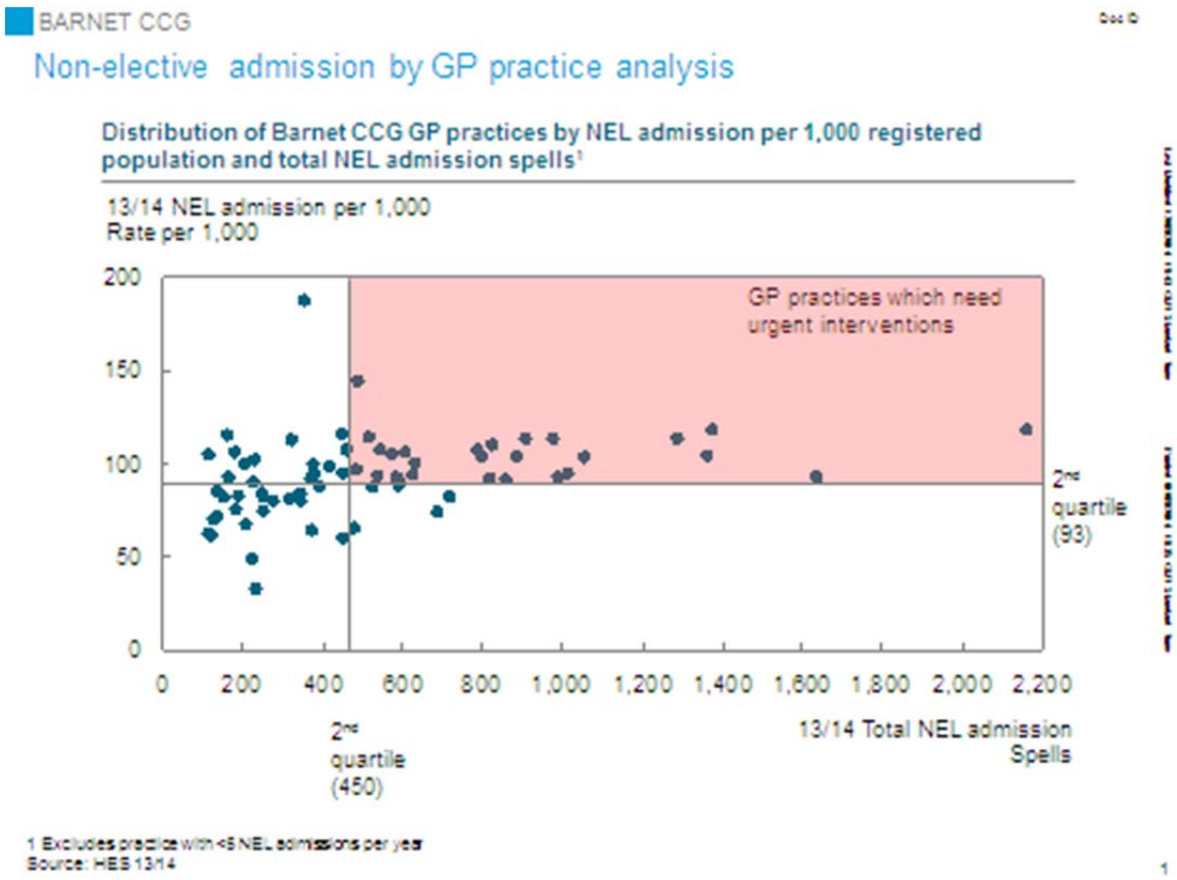
*Source: McKinsey Integrated Care Model*

**Closing the current variation in primary care and improving performance represents a significant opportunity for Barnet.** Benchmarking shows that Barnet currently performs poorly against peers in terms of experience of and access to primary care:






In addition there is wide variation across the borough's GP practices in terms of non-elective admissions performance as can be seen below. Closing these gaps represents a strong opportunity to meet challenging reduction targets:



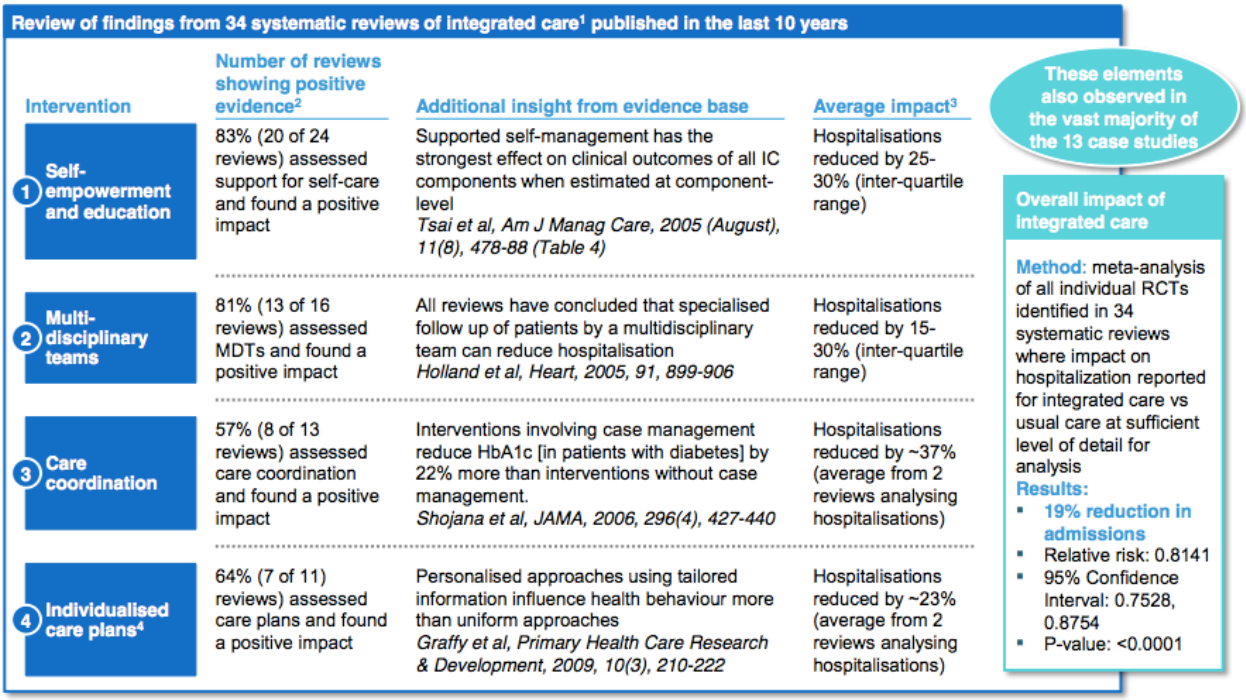

**There are opportunities to improve on BCF metrics and to improve outcomes.**

Barnet has made progress in reducing **non-elective admissions** over recent years with a **2.2% decrease** between 2009/10 and 2013/14. This has been reinforced in the HWB fact pack and baseline data that states Barnet performs significantly better than peers and most of England on non-elective admission rates and that activity growth is significantly better than peers and top quartile for England as a whole.

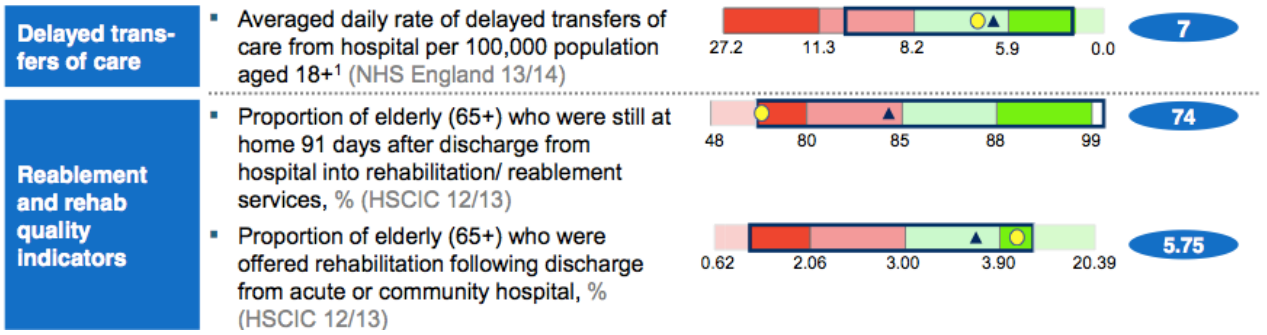

While this is encouraging, it should be noted that the reduction is not consistent and reflects unusual trends in activity during specific periods in 2013/14 related to known

changes in the provider landscape. We therefore need to take a cautious approach to assumptions that this reduction was as a result of integrated care activity and hence is replicable and sustainable at the same level.

When considering benchmarking and target setting it can be noted that HWB fact pack identified a limited opportunity for non-elective admissions for Barnet compared to our ONS and peer group (currently top decile). However, the international scientific evidence and case examples for fully operational delivery of best-practice integrated care suggests that full delivery of the four key components of integrated care outlined below could impact as a reduction of up to 37% in hospitalization. Taking into account growth and current performance it is suggested that this represents a potential opportunity for Barnet of a **10-19% reduction in non-elective admissions over 3-5 years**.




Compared to peers Barnet has scope to improve **delayed transfers of care**, to move into the top quartile, and the proportion of elderly (65+) who were still at home 91 days after discharge from hospital into **rehabilitation/ reablement services**:




**Critically, it is recognised locally that the resource in the current system is not sufficiently weighted towards key services to achieve this.** Of the total £133m resource envelope over 61% is spent on acute and residential care services. Less than 3% is currently spent on self-management and health and wellbeing services, with the remainder in the other two tiers.

**The BCF provides an opportunity to target investment in a more holistic, integrated model and accelerate the process of whole system reconfiguration.**

Barnet will address the challenges set out in this case for change by moving to an integrated care model, investing in lower level and preventative support, through shifting the balance of care and activity over time from hospital and longer term residential care. It will focus on the following groups of people:

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

The target for the BCF pay for performance element is set at 3.5% (or 1025 less non-elective admissions) in 2015-16. This supports a longer term plan to deliver a continued downward trend in non-elective admissions at a controlled and sustainable pace as indicated in the 5 year strategic plans.

There remains a focus on supporting the requirement for initiatives that are designed to enhance the ways in which people are supported to remain as independent as possible for as long as possible, meeting statutory social care needs whilst still delivering on the efficiencies required by the council. This includes a requirement to ensure that more people can stay in their own homes with support to be as independent as possible and reduce their needs for formal services.

The transformation programme will continue as planned and through the extensive capacity and demand modelling we will re-assess how we can deliver fully on this

trajectory. We also understand that there is still work to do particularly in relation to improving the patient experience to primary care and access to a GP that will directly impact on successful delivery of the transformation programme.

We have planned our BCF to deliver the model within limited financial resources. Given the funding allocations of the CCG and the Council, there may a requirement for additional investment into Barnet to deliver the maximum benefit from the model identified.

# 4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

A phased approach is being taken to service development over the next 5. The core services are those that we will be redesigning for integration, investing and re-allocating resources as necessary. These include residential care, community healthcare, homecare, and self-management or preventative services.

The accelerated programme of work will create efficiencies and financial benefits for health and social care through a reduction in non-elective admissions and length of stay for the frail and elderly population. It will achieve a step change in care delivery over a period of 2-5 years, leading to fewer crises, and more planned care for the frail elderly, encompassing a number of services now designated under the BCF scheme of work.

The key milestones are outlined below:

| Tiers | Progress to date | 2014/15 | 2015/16 |
|---|---|---|---|
| **Overall** | Full Business Case approved and further validated in the context of separate modelling to support CCG QIPP and the payment for performance element of the BCF.<br><br>The CCG has analysed in detail its current and planned spend on non-elective admissions.<br><br>Development of the programme of work and PMO function<br><br>Governance arrangements in place | Develop Business Case to support Integrated Care model and strategic approach to future commissioning /contracting for approval<br><br>Co-design detailed operational delivery models including phasing of delivery, funding streams, future capacity and workforce requirements.<br><br>Determine outcome measures and regular monitoring mechanism with assurance<br><br>Test current governance arrangements for BCF particularly in relation to agreement and monitoring of risks and benefits<br><br>Agree shared PMO arrangements to support delivery programme<br><br>Develop a communications strategy, including a mechanism to capture user views to effectively feed in user | Test outputs of current service delivery and scope further plans<br><br>Fully functional benefits tracking and financial monitoring model in place<br><br>Implement communications strategy<br><br>Establish and monitor financial flows to and from the pooled budget including those contributed from parties outside health and social care<br><br>Develop feedback mechanism to interested parties to promote success and share learning. |

| | | | |
|---|---|---|---|
| | | perspective to inform progress and continued improvement. | |
| **1** | Expert Patient Programmes planned for Autumn 2014<br>Telehealth pilot underway as part of Rapid Care project<br>Engagement with range of stakeholders including voluntary sector in development of tier specification | Deliver project plans in line with tier specifications: priority focus on self management, e.g. defined roles of health champions and long-term condition mentors; and healthy living pharmacy<br>Design and deliver carers support programmes<br>Design and implement structured education offer<br>Pilot programmes for Telecare and Telehealth | Deliver project plans in line with tier specifications: priority focus on self management<br>Mainstream programmes for Telecare and Telehealth if appropriate |
| **2** | Ageing Well project operational in 3 areas<br>Clear links established between BCF programme and public health<br>Carers service re-design being taken forward in the context of the BCF | Implement early phase plan: Ageing Well<br>Design Health education package for carers<br>Design preventative services and develop the market/ strategic partnerships in voluntary and commercial sectors to deliver.<br>Link into Public Health team initiatives (e.g. NHS Healthchecks, healthy eating and physical activity promotions, smoking cessation)<br>Link into "universal offer" to older people through preventative services<br>Link into Council's carer support services | Develop an evaluation model to support development of a local evidence base to support future commissioning<br>Unified branding for prevention tier<br>Use learning from care pathways re-design for Stroke, Dementia and Falls to scope, design and extend wider Tier 2 – 4 end-to-end services, in line with work programme. |
| **3** | Community Point of Access (CPA) opened April 2014<br>Risk Stratification Tool live in all GP Practices. | Phased roll out of Community Point of Access.<br>Embed use of the risk stratification model as the default method for design and delivery of services for targeted cohorts, in stages by level of risk.<br>Develop early phase plan: Shared Care Record (business case to be signed off) | Develop a single assessment process, using findings from the Risk Stratification Tool and other projects.<br>Incorporate service redesign projects: dementia and end of life pathways.<br>Implementation of the Shared Care Record |
| **4** | Integrated locality Teams trail-blazer team mobilised in August 2014<br>The Care Navigation Service (CNS) and Multi-Disciplinary Team (MDTs) case conferences started in July 2013.<br>Expanded Rapid Care service in August 2013, now | Implement and monitor early phase plan: Rapid Care<br>Finalise the design and delivery model of borough wide Integrated Locality Teams.<br>Extend the scale and operations of Multi Disciplinary Teams, including assessment of higher risk individuals and planned co-ordination of care.<br>Implement Care Homes LIS for GPs and monitor outcomes. | Rapid Care pathway development linked to PACE. TREAT and other front door services in acute settings.<br>Embed Integrated Locality Team model expanding across service areas as required<br>Explore role of existing Older Peoples Assessment Unit (OPAU) to offer increased clinical capacity and expertise.<br>Develop Enablement, Intermediate and Respite Care offer to meet need. |

| | | | |
|---|---|---|---|
| | available 7a.m to 10p.m 7 days a week | | |

Interdependencies and existing programme alignment:

- Establishment of aligned budgets for CCG, council and other parties, e.g. public health, into the Health and Social Care model to influence delivery of the BCF.
- On a North Central London CCG level, the establishment of Integrated Provider Units (IPUs) and value based commissioning.
- Integration with new and re-designed Council systems and services designed to meet the requirements of the Care Act, including Council first point of contact and assessment services, information and advice offer, enablement services and new, upgraded case management and other ICT systems.
- Link into 'Integrated Quality in Care Homes' team to improve standards of care and co-ordination between health professionals and care homes, especially with regard to discharge of residents, inappropriate placements within homes and lack of understanding of the role of care homes.

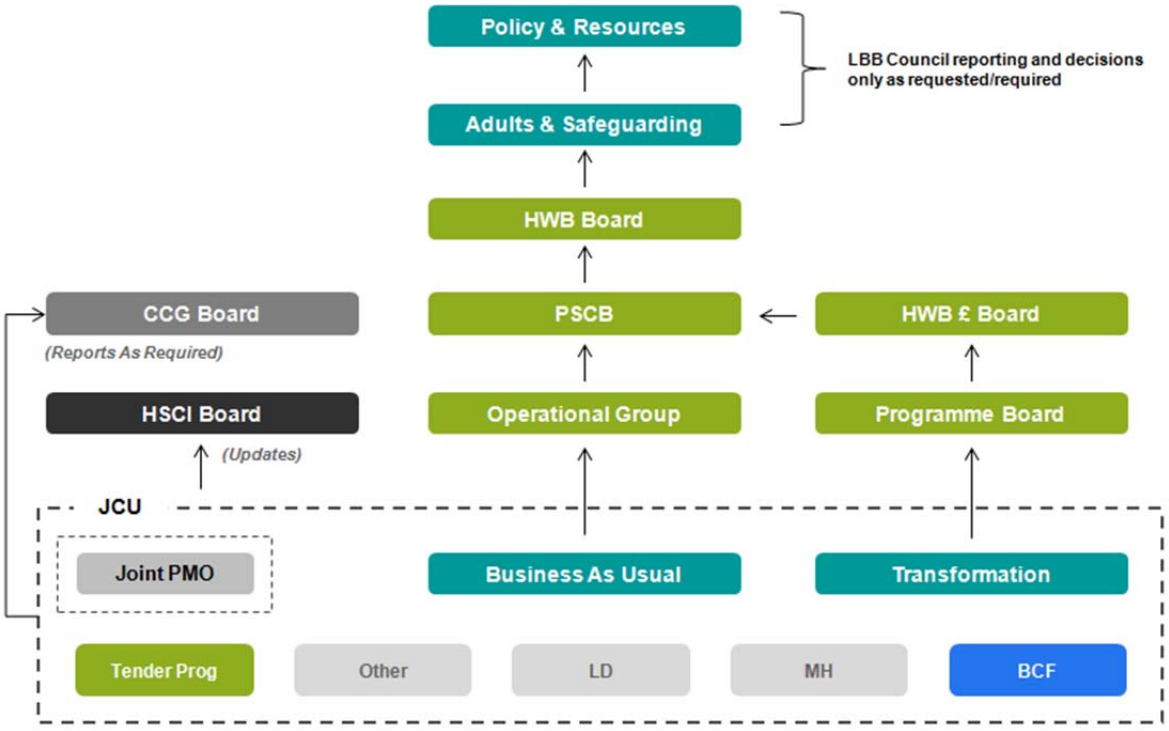
b) Please articulate the overarching governance arrangements for integrated care locally

The figure below illustrates the proposed governance and board structure for the HSCI/BCF Programme.

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

This governance and board structure supersede the original governance arrangements and the terms of reference are currently being updated. We are also working to revise and refresh Programme governance to reflect the updated programme of work.

***Proposed HSCI/BCF Programme Structure***




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

Each Tier will have a lead and subject matter expert. Each project or theme will have a project manager and prioritised work, aligned to programme aims & objectives, and desired benefits and outcomes. Tier leads will partner to define strategies for delivering end-to-end services.

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

We will deliver and manage work and define, validate and track the realisation of desired benefits using our programme/project management methodologies and benefits management tools.

This will enable an objective and independent scrutiny and assurance of work done, with scheduled reporting and reviews to monitor outputs and to retain tight management and financial control of Programme spend and delivery.

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

The Programme Board (Operational Group) will consider the Business Case and approve

or reject it against agreed evaluation criteria, e.g. whether it meets the vision, aims and objectives of the 5 Tier Model, meets one of the six core BCF target benefits and outcomes, improves on the quality of services and commissioning for outcomes, or meets commercial criteria such as lower costs (i.e. reduced duplication or acute activity). If accepted the Programme will deliver the project, tracking progress and outputs against similar quality assurance criteria.

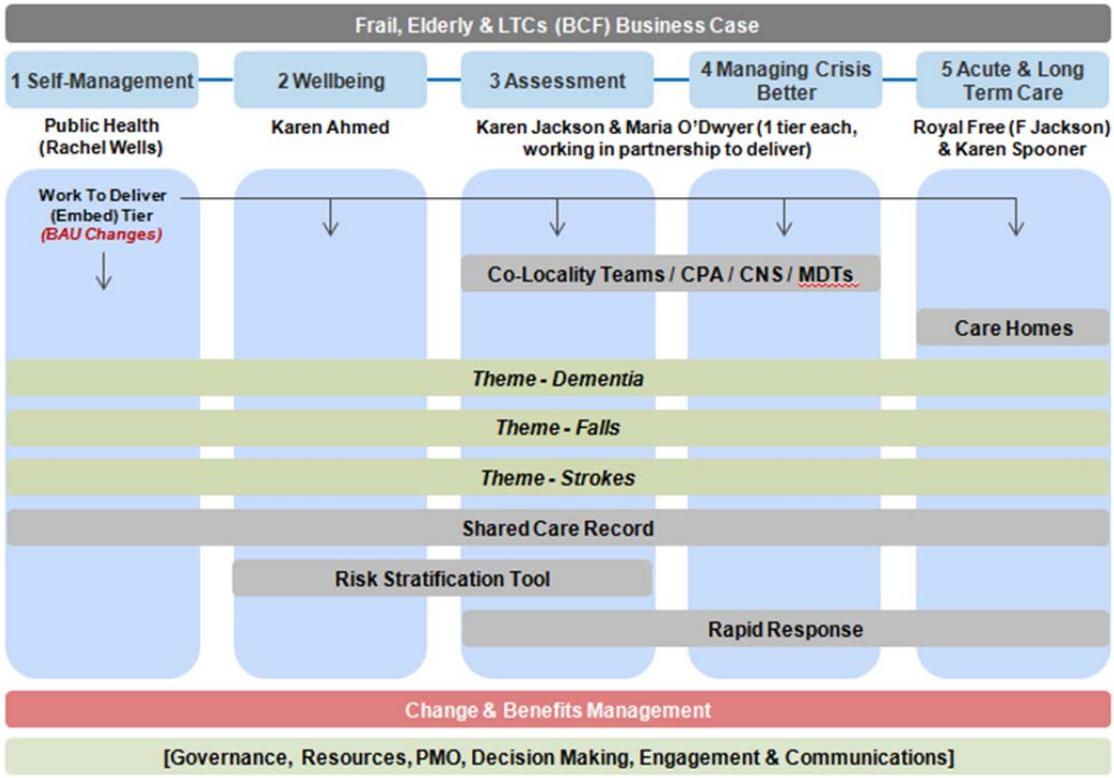
A well established system is in place where current S256 plans are jointly agreed through the Health and Wellbeing Board finance group. Section 75 agreements are in place for integrated services and these will be built on over the next few months to manage the changes associated with the BCF pooled budget. This will include all aspects of financial governance of the new pooled arrangements from April 2015.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

A programme approach is in place to support planning and delivery of the HSCI and BCF work streams and projects. The figure below illustrates the current and proposed scope of the Programme.

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

***BCF Programme Structure***




A Programme Management Office (PMO) will coordinate and manage Programme operations. This will include governance, administration, project/work delivery and reporting, benefits realisation, documentation and information control and communications and engagement with stakeholders. Governance will complement wider arrangements in place as appropriate, e.g. where decision making is to be escalated to or made directly by the Health and Wellbeing Board (HWB).

As indicated in the previous sub-section the Health & Social Care Operational Group oversees operational implementation of the BCF. It currently meets bi-weekly and has set its terms of reference to flex meet the emerging needs of the BCF plan. Membership includes director level roles from the CCG and LBB, Joint Commissioning staff, tier leads, finance and PMO.

A key role of this group will be to monitor delivery including early identification of risks and issues. If plans go off track, project leads will be expected to work with the PMO to assess the scale of any problem and to develop a remedial plan, where necessary, to re-align service delivery. If the project requires a revised approach this will be managed via a formal change request agreed with the PMO and the operational group. Direct linkages with the over-arching governance structure through senior management will facilitate this mechanism as required.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

| Ref no. | Scheme |
|---|---|
| 1 | Tier 1 & 2. Self-management and prevention |
| 2 | Tier 3 & 4. Assessment & Care Planning |
| 3 | Tier 4. Community Intensive Support |
| 4 | Enablers |

# 5) RISKS AND CONTINGENCY

### a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

| Risk | Impact (1-5) | Likelihood (1-5) | Overall risk (I*L) | Mitigating actions and steps |
|---|---|---|---|---|
| 3.5% reduction in non-elective admissions target is undeliverable in the context of significant local challenge and past performance | 4 | 4 | 16 | • Routine monitoring of activity shifts and remedial action as required<br>• Continued analysis of interdependencies to fully understand impact and consequences<br>• Regular updates to management teams<br>• Governance arrangements to include risk and benefits share |
| Shifting resources to fund new joint interventions and schemes could de-stabilise current service providers and create financial and operational pressures. | 2 | 2 | 4 | • Impact assessment of Health & Social Care Integration model to allow for greater understanding of the wider impact across the health economy<br>• Ongoing stakeholder engagement including co-design and transitional planning with providers<br>• Ongoing review of impact |
| The recent acquisition of Barnet and Chase Farm hospital by Royal Free and subsequent change in the NHS provider landscape could impact the implementation of BCF services | 2 | 3 | 6 | • Provider engagement<br>• Robust commissioning plans with contingency arrangements |
| Front line /clinical staff leads do not deliver integrated care due to organisational and operational pressures or lack of buy-in to the proposed agenda | 4 | 3 | 12 | • Increased focus on workforce development and organisational development with all providers<br>• Front line/ clinical staff engagement and input in developing integrated care model and plans<br>• Communications strategy with staff across the system<br>• Incentivise provider to develop workforce models |
| The capacity within commissioning and provider organisations to deliver changes is limited and prevents progress | 3 | 3 | 9 | • Develop the business case to include resource to deliver the BCF plan. This could include CCG and Council initialisation resources to support delivery and implementation of schemes/work streams. |
| The baseline data used to inform | 4 | 3 | 12 | • Validation of assumptions and savings |

| Risk | Impact (1-5) | Likelihood (1-5) | Overall risk (I*L) | Mitigating actions and steps |
|---|---|---|---|---|
| financial model is incorrect and thus the performance and financial targets are unrealistic/unachievable | | | | target with respective finance departments<br>• Close monitoring and contingency planning<br>• Define any detailed mapping and consolidation of opportunities and costs to validate plans.<br>• Develop strong patient and service user engagement plans to ensure current information so as to flex and tailor plans to meet needs |
| Preventative, self-management and improved quality of care fail to translate to reduced acute, nursing and care home expenditure, impacting the level of funding available in future years. | 5 | 2 | 10 | • Assumptions are modelled on the best available evidence of impact, including metrics from other areas and support from the National Collaborative<br>• Use 2014/15 to test and refine assumptions with a focus on developing more financially robust business cases. |
| The local authority's financial position is challenging and significant savings from all service areas are needed to deliver cost savings and realise benefits within the planned timeline | 4 | 3 | 12 | • Managed and phased approach to spend and save model<br>• Robust governance in place to support risk and benefits share<br>• Clear identification and monitoring of saving opportunities<br>• BCF could be the catalyst to savings in other areas of council spending, ie Adult Social Care. |
| The Care and Support Bill will increase costs from April 2015 and again from April 2016 resulting in increased cost pressures to the local authorities and CCGs. | 4 | 4 | 16 | • Undertake an initial impact assessment with a view to refining assumptions.<br>• Explore and develop opportunities and benefits arising from the introduction of this legislation that may help to offset negative financial consequences.<br>• Define the impact of the Care Bill and the potential pressures on the council and CCG budgets as a result.<br>• Ensure appropriate utilisation of allocated funds within BCF to meet need |
| An underlying deficit in the health economy impacts on service delivery and/or investment | 4 | 4 | 16 | • Develop a managed and phased approach to spend and save model<br>• Ensure robust governance is in place to support risk and benefits share |
| Social care is not adequately protected due to increased pressure impacting the delivery of services | 4 | 3 | 12 | • Work with partners on developing plan for protection of services |
| Resources cannot be shifted from the acute sector due to members of the public presenting themselves to A&E directly or requiring emergency admissions (through pressures in other parts of the health economy) resulting in no overall shift in numbers | 4 | 4 | 16 | • Engage with colleagues in adjust HWBB to determine their strategic changes and how it will impact Barnet<br>• Discussions with key stakeholders including acute sector, social care community care, etc. to explore linkages and why shift is not taking place<br>• Invest in re-educating public on use of |

| Risk | Impact (1-5) | Likelihood (1-5) | Overall risk (I*L) | Mitigating actions and steps |
|---|---|---|---|---|
| | | | | acute sector.<br>• Public communications strategy, including targeting primary care settings |
| Population characteristics and demographics adversely impact on deliverability of the model (eg population growth and continued net importation of over 75's into Care Homes from other areas) | 3 | 3 | 9 | • Focus on high impact project to target populations<br>• Factor growth into planning assumptions and monitor trends |
| Differing discharge arrangements between Barnet and surrounding Trusts means patients receive and inconsistent service | 2 | 2 | 4 | • Stakeholder engagement with surrounding Trusts and GP networks<br>• Consider working with neighbouring trusts to develop common discharge plans in line with borough specifications<br>• MDT to monitor eligibility for services and ensure appropriate referrals |
| Acceptability of 7 day services impacting on Integration model | 2 | 2 | 4 | • Stakeholder engagement on 7 day working<br>• Cross system sharing of good practice |

## b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Given the financial position of the Barnet health economy, significant emphasis will be applied to delivery of targets related to a reduction in emergency admissions. Non-delivery must be seen in the context of an anticipated funding gap in Health and Social Care, and will manifest itself as cost pressures within organisations and potential reduced services.

The amount of BCF pooled funding at risk is £2,054,100. This equates to 3.5% reduction in non-elective admissions and has been calculated with the support of informatics and finance using agreed methodologies. It builds from and existing CCG QIPP plan, particularly related to Integrated Care and Ambulatory care and reflects a 2 year plan (2014-16) with increasing ambition for 15-16. Year 2 modelling has recently been undertaken and has followed the recognised Newham/ Tower Hamlets methodology.

The services within the BCF plan that directly support achievement of this target are:

- Expert patient programme
- Long term conditions services – Dementia, stroke and falls
- Older peoples integrated care - Risk stratification, care navigators, MDT and integrated locality teams

- Rapid care
- GP Care Homes LIS

A number of enabling and business as usual services lie beneath these, such as the Community (single) Point of Access and Shared Care Record, which enable continued delivery of the integrated care model. As with all ongoing programmes of work the services above are at different stages of delivery with reflected funding arrangements – a number are fully live and others are currently being planned or mobilised.

Part of the ongoing strategic approach to the BCF pool will be to ensure sustainability in the key services that will deliver the outcomes and targets that we require. This will involve continual monitoring and review of all services being funded under these arrangements linked to robust commissioning decisions based on evidence. Outline priority investments have already been agreed for 15-16 and mobilisition plans will reflect availability of funding. This is supported by demand and capacity modelling in the Full Business Case. The risk of non-achievement will be mitigated where possible through contractual arrangements and we will work closely with providers to deliver in line with expectations. Where appropriate, additional contingencies will be identified from within the pool itself or from other organisational funds. This could include the use of underspend, reserves or re-prioritisation of forward spend.

Under the remit of the HWB finance sub-group discussions are underway in relation to agreed approaches to management of the BCF pooled budget encompassing pay for performance arrangements, and risk and benefits sharing. At this stage it is anticipated that these over-arching principles will be agreed within the next few months and will be enacted via amendments to the existing section 75 agreement. Both executive board and finance leads are members of the sub-group.

# 6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The Better Care Fund is integral to delivery of the Barnet Health and Social Care Integration model. It consolidates existing work being undertaken and provides a clear direction of priorities and delivery for the future.

The Better Care Fund is also aligned to the following initiatives and is a critical element of both the CCG's and the Council's longer term strategic plans (CCG 2 and 5 year plan; Council Medium Term Financial Strategy and Priorities and Spending Review (PSR)):

| Initiative | Dependency |
|---|---|
| Clinical service re-design particularly in relation to urgent care and long term conditions pathways | • An enabler to shifting settings of care and improving integration between care settings |

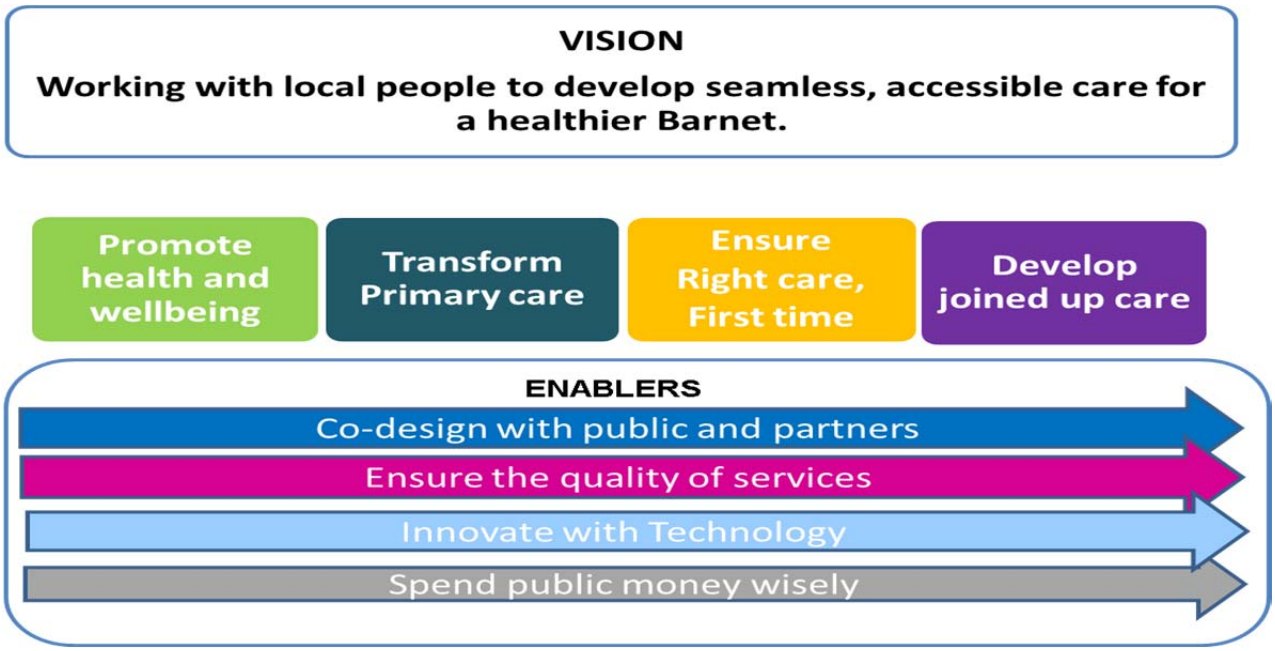
| | |
|---|---|
| Changes to social care statutory responsibilities and service delivery. For example, increased Care Act duties and the re-modelling of the 'first contact for social care of LBB to increase the capacity to manage demand | • Demand manage new statutory responsibilities of the Council<br>• Impact on BCF metrics and current spend<br>• New flow of users resulting in change of legislation |
| System-wide operations resilience planning and delivery | • Impact on non-elective activity<br>• Manage seasonal demand and surges in line with BCF strategy<br>• Cross-system stakeholder understand of issues and solutions |
| Acute service reconfiguration particularly the continuing implications of the Barnet, Enfield & Haringey clinical strategy and the recent acquisition of Barnet & Chase Farm Hospital by the Royal Free NHS Trust | • Impact on non-elective activity<br>• New flow of patients resulting in shifts in capacity and demand throughout the local system<br>• Other implications such as demand pressures on community beds |
| Refresh of the Joint Strategic Needs Assessment | • Identification of new demand for services in future and alignment of our plans to meet this need |
| Value based commissioning approach | • Identification and exploration of alternative contracting models |
| HSCI Full Business Case | • Critical enablers for demand and capacity modelling for delivery and future investment<br>• Corporate sponsorship of HSCI and BCF programme of work |

The dependencies and alignment of these related initiatives will be managed through the Health and Social Care integration board and governance described in section 4.

Local interest in the BCF is high and as plans develop in related areas consideration will be given to how best to strategically link where necessary. This is anticipated over the next few months in relation to user engagement/ voluntary sector services and telecare. Additional work is required to align plans with Housing strategy.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The BCF vision for delivery of integrated care is fully aligned with Barnet **CCGs 2 year operating plans and 5 year strategic plans**. They are built around the same **vision** for services with over-arching values and a set of **strategic goals:**




These strategic goals set the direction of travel for the CCG whilst providing a framework, which is flexible enough to encompass new local and national priorities. They also focus on the organisational development that needs to take place to engage our stakeholders, strengthen our governance and financial management to deliver our challenging agenda.

Similarly, the **Barnet Council Corporate Plan (2013)** and **Priority & Spending Review (PSR) 2014** outline a commitment to integration and the BCF. Specifically the PSR has identified further savings opportunities totalling £1m through integrated working with the NHS and redesigning services to ensure that older people receive co-ordinated, joined up care services that reduce duplication and better anticipate and responds to their needs. The PSR states that the council will take a sensible and managed approach to managing finances against a recognition that it must continue to achieve its core priorities and statutory duties in relation to adult social care and health, including:

- The council and the Clinical Commissioning Group (CCG) makes effective use of the Better Care Fund to integrate health and social care services, providing greater choice and more coordinated services to residents whilst generating efficiency savings.
- The council implements its vision for adult social care, which is focused on providing personalised, integrated care with more residents supported to live in their own home.

Key links with the 5-tier **Health & Social Care Integration model** are evident in both plans with priorities and programmes of work are shared across both areas for delivery:

- Developing strategies, which empower patients to take control of their own health and improve their ability to manage health conditions at home
- Improving access to care through single assessment, integrated care teams and community hubs, ensuring the right care is provided first time

- Joining up care through multi-disciplinary teams and care navigators with a focus on to providing care out of hospital and prevent admissions

The BCF plan is crucial in supporting the delivery of the **long-term financial plan** for the health and social care economy through the redesign of core services. It facilitates moving activity away from Tier 5 as re-designed services in Tier 1 to 4 would capture and support people to reduce or prevent the need for acute or nursing/residential care. The level of reductions needs to be significant. We have modelled 2% and 3% shifts per year for five years from 2014/15 to 2018/19:

***Revised Funding Gap for a 2% Reduction in Tier 5 Activity***

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

***Revised Funding Gap for a 3% Reduction in Tier 5 Activity***

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

A 3% reduction in activity per year takes us towards closing the gap identified in section 3.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Barnet CCG has, as part of North Central London CCG's group, submitted an expression of interest for primary co-commissioning to NHS England. Following confirmation of receipt the NCL CCG's group has met with the NHSE NCL Area team Assistant Head of Primary Care, and are pursuing further development of the plan.
The plans for the development of primary care complement the BCF plan by:

- Recognising and supporting the critical link with general practice in delivering integrated care, designing and delivering services around patients and service users
- Enhancing the ability to commission integrated services along whole pathways, supporting in particular tiers 3 and 4
- Providing a platform for innovation, improvement and investment in primary care, particularly in the development of GP networks
- Focussing on improving prevention of illness and the prevention of morbidity (or delay in onset) in clients with long-term conditions, through improving the level and range of preventative interventions within health and social care, and improving support for self-management by clients will be delivered in primary care settings
- Developing and supporting services that deliver on the BCF metrics such as the specific local service specification for GP practices to support improved care within care homes
- Feeding in work programmes linked to delivery of the London Primary Care Strategic Commissioning Framework (formerly known as the London GP Development Standards) relating to delivering within primary care: accessible care – better access to routine and urgent care from primary care professionals, at a time convenient and with a professional of choice; coordinated care – greater continuity of care between NHS and social care services, named clinicians, and more time with patients who need it; Proactive care – more health prevention by working in partnerships with other health and social care service providers to reduce morbidity, premature mortality, health inequalities.

# 7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) **Protecting social care services**
i) Please outline your agreed local definition of protecting adult social care services (not spending)

In Barnet, protecting social care services means:

- Maintaining current FACs eligibility of substantial and critical for adult social care, and enabling the authority to meet new national eligibility criteria from April 2015.
- Ensuring that additional demand for Social Care Services which supports the delivery of the integrated care model and which delivers whole system benefits and savings will be funded.

It is recognised that the priorities for spending against the BCF are likely to be greater than the available BCF funds. The London Borough of Barnet and Barnet CCG agree to plan and review on an annual basis the allocation of the BCF to these priorities.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The BCF includes identified funds to support the implementation of new statutory requirements contained within the Care Act. The Barnet BCF allocation includes specific funding to cover aspects of the increased demand relating to new eligibility regulations and new duties in relation to safeguarding, wellbeing, prevention and carers. Whilst this funding will not cover all the demands arising from the Act, it will be used as part of our local work to ensure that we are prepared for the implementation of the Act in April 2015.

There is a clear synergy between better access, improved care planning and community support for frail older people contained within our BCF integrated care model and the enhanced duties on local authorities in relation to supporting people to plan how to meet their care needs early on through enhanced advice, information and prevention. Barnet has a Care Act preparation programme in place and the dependencies between this and the BCF plan are being scoped.

The principles for protecting local social care services will be delivered through the following:

- Strategic direction for the BCF to take into account existing and future commissioning plans of the CCG and Local Authority and to have due regard to the Joint Strategic Needs Assessment (JSNA).
- An agreed shared governance framework for spend and management of the BCF with membership from health and social care. To include an approval process for services with appropriate input from relevant parties. Oversight and governance provide by the Health & Well-Being Board.
- Services delivered through a jointly owned integrated care model with emphasis on maintaining people with health and social care needs in the community. Modelling to measure impact upon and reflect changes in demand to social care services e.g. enablement with a view to maintaining or increasing where necessary.
- Maintaining and developing services for carers.
- Maintaining current FACs eligibility of substantial and critical, and through meeting needs of national eligibility criteria from April 2015.
- Where possible move to joint commissioning of services via an agreed framework e.g. care home beds, enablement.
- Working with Local Authority and providers to manage demand to ensure optimal usage of social care service provision.
- Embed social care services within integrated delivery models to flex operational efficiencies and build services with greatest impact on people utilising the most appropriate care choice. Example would be delivery of enablement services through locality based integrated care teams.
- Ensuring that additional demands for social care which can be attributed to increased out of hospital healthcare are considered for funding as part of the pooled budgets.
- By ensuring that personalisation and self-directed support continue in integrated

arrangements through selecting this as our local performance indicator.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total set aside for the protection of social care is £4,141,357.

In addition we have identified £846,000 which represents Barnet's proportion of the £135m for the implementation of the new Care Act duties.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Barnet has a clear and mutually agreed definition on what constitutes "protecting adult social care services". It is recognised that the priorities for spending against the BCF are likely to be greater than the available BCF funds, in the context of on-going austerity in the public sector and demographic change. However, to date the plans delivered and the work between health and social care support this approach.

Barnet has a Care Act Implementation Project Board which oversees work streams relating to the national and local requirements and to assess the impact of the Care Act reforms on Adult Social Care services in Barnet. The implementation of our tiered approach to integrated care will underpin the local authority's ability to fulfil its statutory responsibilities, in particular in relation to prevention, assessment, care planning and carers.

The work of the Project Board is focused on 7 work streams, each with a dedicated lead manager and implementation plan, as follows:

- Demand Analysis and Modelling: delivering a picture of what the total impact of the Care Act on the Council's finance and resources will be;
- Prevention, Information & Advice: refreshing and updating prevention, information and advice initiatives and catalogues;
- Carers: ensuring that LBB carer's services are compliant with Care Act regulations;
- First Contact, Eligibility, Assessment and Support Planning: ensuring readiness for national eligibility criteria, developing and implementing new approaches to assessment and support planning, ensuring sufficient capacity and effective risk mitigation arising from the likely increased take up of assessment due to the funding reforms and creating a first contact service that is able to manage demand efficiently and effectively and enable costs to be reduced;
- Finance: delivering a universal deferred payment offering and making any necessary changes to charging and debt collection processes.
- Marketplace: updating existing and developing new policies and processes related to market shaping and provider failure;

- Communications, Workforce Development and Governance: developing and delivering internal and external communications related to the Care Act, delivering a comprehensive workforce development plan and staff training to prepare the social care workforce and co-ordinating public consultation and corporate decision making

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

Carers are critically important in Barnet. The borough has over 32,000 carers with over 6000 providing over 50 hours of care a week. This is the second highest number of carers in the London region. As part of the modelling work for Care Act Implementation (Section 7a[iv] refers) Barnet has estimated that the financial cost for carrying out additional carers assessments (including the cost of related support) would cost a projected £962k - £1.44m, against a backdrop of a financial challenge for the CCG and Local Authority.

Our priorities for carers are:

- Early recognition and support for carers
- Information and advice offer for carers
- Supporting carers to fulfil their employment potential
- Carers as expert partners in care

We are developing a suite of performance and monitoring tools and reports to improve our infrastructure, capacity to track contracts and performance activity in Adult Social Care and key partners relating specifically to carers. This will help us deliver improved insight and analysis about what works best, highlight risks, and inform how we optimise allocation of our BCF resources going forward.

We have reviewed our Carers Strategy Partnership Board arrangements strengthening the carer's voice in service development and commissioning, and we plan to further strengthen the role of health here working closely with the Joint Commissioning Unit.

All of the above work is being coordinated through a project dedicated to Carers as part of the Care Act Implementation Project Board (section 7a [iv] refers). It highlights dependencies too, which include Health and Social Care Integration and Family Services (Children and Families Act requirements around young carers and transition).

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Overall the impact has not changed significantly compared to original submission (the Barnet BCF allocation includes approximately £1.206m to cover some aspects of the increased demand relating to new eligibility regulations and new duties in relation to safeguarding, wellbeing, prevention and carers).

**b) 7 day services to support discharge**

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Barnet has made reasonable progress to establish seven day working, however we recognise the need to enhance further the scope and reach of services already in place.

We have engaged with a variety of stakeholders to get agreement and commitment to seven day service delivery particularly during the design phase of the Health and Social Care Integration Model through:

- Co-design working sessions for integrated care in 2013-14. These sessions included patients, the Local Authority, GPs and Acute & Community service providers as outlined in section8.
- North Central London wide sessions to share development plans, ideas and best practice

We are working towards implementing the **national standards for seven day services in urgent and emergency care over next three years.** Our intention is to develop a programme across three years to **embed seven day services into core contracts for services** and the intention is for all of the clinical standards to be incorporated into the national quality requirements section of the NHS Standard Contract for Barnet's provider services.

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

| **Priority action** | **Milestone** |
|---|---|
| **Acute services** | |
| Extension of hours of tracker nurse provision to support identification of those who could be discharged | Nov 13 |
| Supported assessment, triage and discharge arrangements within local acute trusts including Urgent Care Centre (UCC), ambulatory care pathways, PACE, TREAT and RAID to extend over 7 days. | Ongoing |
| Operational resilience plans agreed to test some 7 day delivery. Outputs to be evaluated to inform future planning. Examples include occupational therapy and access to pharmacy. | Awaiting plan sign off |
| Undertake action in service development and improvement plan identifies 7 day working to assess current position and develop forward plan for delivery for national seven day standards | 2014-15 onwards |
| **Community & Primary Care services** | |
| Extension of 7 day provision of core community services to 7 days – district nursing, intermediate care and Rapid Care. To include night sitting where | Nov 13 |

| | |
|---|---|
| required | |
| Links established between services above and current providers of seven day services (eg out of hours GPs and London Ambulance Service (LAS)) | May 14 |
| Barnet community point of access operational providing an effective and safe referral point to facilitate access to rapid response and nursing teams over 7 days. | April 14 |
| Refresh of current alternative care pathways with LAS to facilitate avoided admissions. | Ongoing |
| **Social Care** | |
| Social work and Occupational Therapy teams operational 7 days per week within A&E departments at both main Acute hospitals to support care planning for transfer home | Jan 14 |
| Access to new and amended packages of care throughout the weekend | Jan 14 |
| **Other** | |
| Ongoing managed system for Delayed Transfers of Care involving all providers facilitating and unblocking reasons for delay and allowing for transfer throughout the 7 days period. | Ongoing |
| A communication strategy with over-arching view of the services available and to stream-line referrals and transitions across interfaces. | Tbc |

Collectively, this delivery plan will result in:

- A consistency of service delivery over 7 days that will even out pressure points and lead to reduced non-elective admissions including at weekends
- More integrated approach to individual care with clear pathways from assessment to care planning and delivery
- Increased discharges over the weekend with confidence of appropriate support

The key risk associated with delivery of 7 day services will be implementation of the clinical standards for 7 day services by acute providers, acceptability amongst staff and population demographics related to acuity.

c) **Data sharing**

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Locally we recognise the importance of joint working across all health and social care services. The NHS Number will be used as the primary identifier for integrated case management, data exchange and care reviews. It is already used as the unique identifier for most NHS organisations across Barnet.

Social Care includes the NHS Number with some client records; however, this is not currently required for all client information. Adult Social Care is in the process of procuring a new case management system, which will be implemented by April 2015 and will result in the recording of the NHS Number for all social care clients from this point forwards.

To further support this integrated care, we are implementing the Barnet Shared Care Record. This project, which has been agreed and approved by the Health & Social Care Integration Board, will be a key enabler for sharing information between care providers:

- The Barnet Shared Care Record Project will first implement the service in early 2015.
- It will not replace local systems, but will provide a single view of an individual's care by combining information from all the care providers in the Barnet area.
- NHS Number will be used as the unique identifier to combine data about individuals and data submitted to the Shared Care Record will need to be using it
- Initial data providers have been identified as those that will already have the NHS Number included in their records (e.g. GP Records, Community Health).
- Change in business processes will reinforce the use of the NHS Number as the primary method for identifying individuals alongside the roll out of the Shared Care Record in early 2015.

Following initial roll out of the service, the project will work to increase the data in the Shared Care Record and to improve the process of sharing. The project plan outlines an approach to work with these care organisations during 2015/16 to where the NHS Number is not currently in use to undertake the preparatory work required to move to routine use of the NHS number as the primary identifier in the process of information sharing.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The use of Open Standards and Open APIs is a principle that is adopted and built in to the procurement of any new system (e.g. the recent Adult Social Care procurement of a new case management system includes the requirement to use Open APIs and Open Standards (e.g. ITK) both in the mechanisms used to connect to local systems and the method for interfacing with external systems).

Requirements also include the adoption of common formats for information/data (e.g. CDA). From a technical perspective a system that securely uses Open Standards/Interfaces will be prioritised over an identical system that does not.

Where existing systems are required to be enhanced or changed specifications always include the use of Open Standards and non-bespoke development whenever possible. Where new development is required (e.g. new messaging interfaces) LBB will always seek to publish these and have them approved

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

LBB / CCG operate within an established Information Governance framework, including compliance with the IG Toolkit requirements and the seven principles in Caldicott 2.

The contract documents used by Barnet CCG to commission clinical services conform to the NHS standard contract requirements for Information Governance and Information Governance Toolkit Requirement 132.

Barnet CCG as a commissioner and to the extent that it operates as a data controller is committed to maintaining strict IG controls including mandatory IG training for all staff, and has a comprehensive IG Policy, Framework, IG Strategy and other related policies.

Information Governance arrangements and the IG Framework conform to the IG Toolkit requirements in Version 11 of the IG Toolkit, including clinical information assurance as set out in requirement 420 and the requirements for data sharing and limiting use of Personal Confidential Data in accordance with Caldicott 2.

In addition to maintaining a current PSN Code of Connection, LBB is working towards compliance with the latest NHS IGT V12 which will be completed by the start of 2015. All new projects / business process changes complete an IG Impact Assessment prior to initial approval and activity is routinely reported to Information Management and Governance Groups.

**d) Joint assessment and accountable lead professional for high risk populations**

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Barnet CCG uses the **United Health HealthNumerics-RISC® tool** and has supported an accelerated programme of implementation in GP practices and training in GP practices through July and August 2014. The tool identifies patients at risk of a future unplanned hospitalisation within the next 12 months due to chronic conditions. It predicts future health risk based on recent patient activity using predictive models.

The following data sets are used to determine the relative risk of patients within a given population:

- Primary Care (GP Registry, GP Medication and GP Activity Data) and
- Secondary Care (SUS PbR/SEM datasets including in-patient, out-patient and A&E activities)

The data links to the Kaiser Long Term Conditions triangle by classifying patients into 3 levels and then assigns the RISC level of a patient following a scoring process:

| Total Population Level | RISC % Range | RISC % of total population | LTC Triangle population (top 26% of total PCT Population) | LTC Triangle % of total population |
|---|---|---|---|---|
| 3 | 0% to 1/2% | 1/2% | 5% | 1.3% |
| 2 | >1/2% to 5% | 4-1/2% | 15% | 3.9% |
| 1 | >5% to 25% | 20% | 80% | 20.8% |
| 0 | >25% to 100% | 75% | Not Included in LTC Triangle | 74% |

We have completed the 'first cut' stratification of the Barnet CCG population with the following results:

| Risc Level | Population Percentile | Number of Patients | Risk Ratio Range | Ave Risk Ratio | Average In Patient Admission (planned same day care activity) | Average Unplanned In Patient Admission | Average Unplanned Chronic In Patient Admission |
|---|---|---|---|---|---|---|---|
| 3 | 0% to 0.5% | 1992 | 26.101 - 40.22 | 32.305 | 11.51 | 3.79 | 2.66 |
| 2 | > 0.5% to 5% | 17928 | 4.826 - 26.099 | 10.303 | 2.03 | 0.78 | 0.38 |
| 1 | > 5% to 25% | 79683 | 0.809 - 4.826 | 1.833 | 0.34 | 0.09 | 0.02 |
| 0 | > 25% to 100% | 298811 | 0.05 - 0.809 | 0.311 | 0.08 | 0.01 | 0 |
| Total Population | | 398414 | | 1.225 | 0.28 | 0.08 | 0.03 |

The tool has identified 1,992 in the highest risk cohort and 17,928 in the next. The data also indicates that the PbR costs associated with people in levels 2 and 3 are £79m representing approx. 50% of total spend.

Our approach moving forwards will include:

- Supporting GP practices to use the tool regularly to inform care planning and case management in line with the GP Admissions avoidance DES from NHS England as part of the GMS contract for 2014-15.
- Embed use of the tool as a partnership approach with the Integrated Locality Teams to implement a framework for implementing and integrating joint assessments and the role of the accountable lead professional.
- To link risk stratification to current service provision, and where necessary, re-align to target those patients identified through the risk stratification model to maximise clinical and financial impact.
- Agreeing an approach for risk stratification for future years to ensure continuity.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

A number of existing and planned models will ensure that local people at high risk of hospital admission have an agreed accountable lead professional and that health and

social care use a joint process to assess risk, plan care and allocate a lead professional.

Key elements include:

- Use of risk stratification in primary care (as above) to identify those most at risk of admission to ensure that they are actively case managed.
- A weekly multi-disciplinary team meeting that provides a formal setting for multidisciplinary assessment and health and social care planning for very complex high risk patients who require specialist input. This accepts referrals from multiple sources including primary, secondary and social care and results in collective ownership of a planned care approach.
- A care navigation service that provides a care co-ordination role following MDT assessment.
- Admissions avoidance DES as per GP contract for 2014-15 where new responsibilities for the management of complex health and care needs for those who may be at high risk of unplanned admission to hospital have been introduced. In particular, to case manage vulnerable patients (both those with physical and mental health conditions) proactively through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator.
- Planned introduction of Integrated Locality Teams incorporating health and social care with anticipated streamlining of care according to patient need rather than referral point. This will also bring into play a generic long term condition approach which will enable early identification and care planning for future management of exacerbations.
- An enhanced GP service focussed on Care Homes to provide a much more holistic management approach to supporting homes to reduce admissions.

Barnet has an agreed format for assessment, allocating lead professional, planning care and monitoring success measures of interventions. To date this has been a paper-based approach operated on a small scale led by the MDT. It has fed directly from risk stratification that was, until recently, being undertaken manually by GP.

With the roll-out of the risk stratification tool and the introduction of the Integrated Locality Team trailblazer during the summer of 2014 we will see a shift in approach and activity targeted to those most at risk. We will have an increased ability to target those most at risk of admission. A key principle of using the bottom-up build operational model is to provide the freedom and the permission for partners, including GP practices, to work together to develop and agree a robust framework for joint assessment and care planning. To remove potential barriers to success we have focussed the work around the needs of the patient and, in particular, are advocating an outcomes based approach to make the benefits tangible to those delivering care. We have also created an environment that supports innovation and ownership of the model with the commissioner only providing high level outlines of requirements to allow for innovation and advocating a hands off commissioner position to allow for problem solving and planning by the teams themselves. Development of a risk and issues log will identify clearly the possible barriers to implementation of the model on a longer term or wider basis that can then be addressed as part of ongoing implementation. It is intended that this work taken forward will include:

- Working directly with GP practices to jointly assess risk stratification data to determine a prioritisation approach to the numbers of people who require care planning and case management to address those most at need and high climbers (those with a significant change in risk score over a short period of time).
- agreeing an ongoing outcomes-based mechanism to allocating of accountable lead professional across a range of providers and clinicians. This is envisaged as the single contact point for the patient and other professionals in relation to the ongoing care plan for an individual. They may not be fully responsible for the delivery of all care to that patient but will have an overview of what the care plan encompasses, what next steps may be required for the patients and can support timely decision making.
- developing a fit for purpose joint assessment framework that can be utilised and is accepted across the system
- developing and introducing a standard care plan
- assessing and evaluating the inter-dependency between the team and the Admissions Avoidance DES to ensure that GPs are supported in being accountable for co-ordinating patient centred care.
- Identify any gaps in service, including evaluating whether current systems accommodate to the needs of those with dementia and mental health problems adequately
- active consideration and challenge to crossing boundaries of care to reduce the numbers of people working directly with the patients and to explore possible opportunities and efficiencies
- evaluating the need for a 'watching brief' approach for a proportion of the population
- outlining how often patients should have their care plan re-evaluated and hence could move within the framework

Utilisation of an exemplar framework as below may be beneficial.

| | Requires Care Plan? | Joint assessment | Active Management & accountable lead professional (ALP) |
|---|---|---|---|
| Very High Risk | Yes – Plan may include action points to be picked up by community, social or specialist services. | Yes for some. | Yes for some.<br><br>ALP agreed as part of assessment and care planning. May be allocated via MDT approach across GP, community services, social or specialist services |
| High Risk | Possibly – particularly for 'high climbers' with identified significant change in risk score | Possibly high climbers | Possibly high climbers.<br><br>ALP – generally GP with some managed under MDT |
| Medium Risk | Not generally | No | No<br><br>ALP - GP |
| Low risk | Not required. Patient may benefit from information via navigation services | No | No<br><br>ALP - GP |

The pilot team will work with 7 GP practices in one locality for approximately 4 months. This will be followed by a planned roll out across the area over the next year.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

In the period July 2014-July 2014 233 people were managed via the MDT and all had a jointly agreed care plan. These figures are expected to increase as indicated above.

# 8) ENGAGEMENT

### a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

A range of individuals and organisations have been involved in developing the constituent services within the BCF plan, and the over-arching plan itself, making patient and service user views integral to the Vision for Integrated Care in Barnet.

The patient engagement and service user groups we approached to shape our vision were **Healthwatch Barnet, Barnet Older Adults Partnership Board** (a resident and service user engagement group)**, Age UK (Barnet), Alzheimer's Society** and others.

We also drew on experiences and feedback gained at **Council** and **CCG public engagement** events and in broader project-based consultation exercises such as **Guiding Wisdom for Older People**.

Our care model incorporates universal preventative and self-management services, such as the **Barnet Ageing Well** project. This initiative was developed in response to needs identified by the community.

The **Integrated Health & Social Care Model** was developed from feedback from local residents. Ongoing involvement and oversight by the co-chair of the Older Adults Partnership Board keep the strategy grounded and progressive.

We have not only used requirements feedback from engagement groups to inform strategy but also used groups to test the practical implementation of that model. Workshops were held with Older Adults Partnership Board members, Older Adults Assembly meetings and public forums. These were facilitated by Healthwatch, and enriched with interviews and surveys.

Feedback from patients and service users was key in helping us develop our vision in particular:

- Meeting the changing needs of the people
- Allowing for greater choice on where and how care is provided
- Promoting individual health and wellbeing to be managed by that person
- Listening to and acting upon the views of residents and providers to improve patient experience and care

Further under-pinning this, and picking up the work of National Voices, Barnet CCG is participating in a **value-based outcomes commissioning programme** with other CCGs in North Central London. Patient and service users have been involved from the outset through multi-disciplinary workshops to develop an agreed outcomes hierarchy and as part of expert reference groups to test and validate the findings. The continuing work with Camden CCG, focussing on frail and elderly populations, will equip health commissioners to change the way in which they do business to achieve patient-centred goals.

Continued patient, service user, carer and public engagement is essential to bring momentum to the implementation of the **Integrated Health & Social Care Model.** Moving forward, we will continue to use the existing **Older Adults Partnership Board** framework as the key patient and public representative group with involvement from service users, carers, Healthwatch and the voluntary sector. We will develop an engagement strategy with this forum at the core that will allow us to ensure in-depth engagement, and involvement in planning and monitoring, from residents as we implement the model. This will include:

- Tier specific workshops
- Engagement with experience panel or reference groups, the **Barnet Seniors' Assembly**, a group of over 150 older local residents supported by LBB
- Engagement with other partnership boards eg carers
- Membership of relevant steering groups
- Links with other organisations communications strategies e.g. Barnet CCG and Age UK
- Engagement with voluntary sector and existing services (e.g. Neighbourhood model) to engage hard to reach communities
- Co-production approaches to new specifications

External scrutiny has been given to the over-arching plans for Integrated Care through presentation at CCG public board meetings and through an elected member scrutiny exercise at Barnet Council.

**b) Service provider engagement**

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Key NHS partners include **Royal Free NHS Foundation Trust** (following the recent merger with Barnet & Chase Farm NHS Trust), **Barnet, Enfield & Haringey Mental Health Trust**, our community health services provider, **Central London Community Healthcare NHS Trust**, hospices and **London Ambulance Service**.

The **Better Care Fund (BCF)** plan has its foundations in the **Barnet Health & Social Care Concordat** – a clearly articulated vision for integrated care agreed by all partners at the Health & Wellbeing Board (HWB). The concordat itself was co-designed by the partner members of the **Health & Social Care Integration Board (HSCIB)** and hence provides the over-arching strategy for delivery endorsed fully by service provider recognition and support. The Integrated Health and Social Care Model has been formally supported by providers as above as key members of the HSCIB and is embedded within organisational plans.

The plan brings together work in progress in individual organisations (health, social care and voluntary sector), joint work being undertaken through the work programme of the HSCIB and emerging priorities as identified in a newly developed **Integrated Health &**

**Social Care Model** co-produced with partners.

For key schemes already underway, such as the Older People's Integrated Care project and Rapid Response, service providers are active participants within established frameworks to work collaboratively to design, implement and manage services with commissioners. This occurs through a variety of mechanisms such as operational co-production, steering group memberships and front-line delivery. This has been taken a step further with development of locality base integrated care teams (July 2014) through a bottom-up build approach via a shared trail-blazer team.

Service provider involvement in the Integrated Health & Social Care Model has been achieved through participation in the 'as-is' mapping of current provision and spend, development of a target operating model, and by involvement in a series of design workshops which focussed on opportunities and operational deliverables. This has brought realism to the plan and shared ownership through a commitment to improve care for the people of Barnet. This continues with providers being actively involved in developing the plans for implementation including acting as tier sponsors in relevant areas. A key development has been the establishment of the bi-weekly Barnet Integrated Care Strategy steering group. This is co-chaired by the sponsors for tiers 3 and 4 and encompasses projects being delivered in tiers 3-5. It provides the forum to influence operational delivery and explore the implications of the BCF, in detail, beyond the high level principles and financial models that are embedded within existing operational plans.

A joint commissioner and provider forum exists in the form of the **Clinical Commissioning Programme for Integrated Care**. This will be further aligned to form a core part of the service provider engagement vehicle moving forwards. With the Health and Social Care Integration Board running alongside, our plan embeds service provider engagement at both operational and strategic levels.

ii) primary care providers

The primary care infrastructure in Barnet includes 67 GP practices, our out-of-hours provider Barndoc and 77 community pharmacies. GP practices are structured in localities with designated CCG board member and management leads. In additional to practices operating individually we are seeing an increasing shift towards network development resulting in increased service delivery on this basis. This will be explored further in terms of a future delivery model.

GPs were involved in the development of the **Integrated Health & Social Care Model** with a number providing input and challenge to the OBC process. These included CCG board member GPs and others with a specific interest in older adults. We also value the support of GP clinical leads to provide expertise and clinical advice in relation to service re-design and operational plans.

The wider GP network has been engaged through presentations at locality meetings and through discussions with the LPC. There is an ongoing programme of communications and engagement underway with events targeting the Integrated Locality Teams and the introduction of the Care Homes service. GP leads have been identified for key services to

ensure that their views are integral to operational standards and fit for purpose.

We recognise that extensive engagement is essential to implement integrated care and will develop a primary care facing plan on a broader basis over the next few months.

iii) social care and providers from the voluntary and community sector

Current plans have been jointly developed with anticipated delivery largely expected through Joint Commissioning.

Strong working partnerships exist between commissioners and provider side teams within LBB (e.g. social work) with sponsorship of key projects and with an established co-production approach. This is now most visibly seen within the bottom-up build Integrated Locality team where a number of staff are central to leading the change management process. In terms of service re-design they are active stakeholders in informing direction of travel and providing feedback on suitability.

The ongoing work has also supported a facilitative approach to building key stakeholder partnerships across the system, particularly between social care and community services, and collectively we are now working collaboratively to understand respective organisational perspectives, concerns and issues. By fostering joint ownership of the model and centring the work around the needs of Barnet patients and service users we aim to adopt a shared approach to innovation and problem solving.

Other key partners have been in included in the Health and Social Care Integration development process such as Housing 21, other care agencies, Barnet Homes, and various voluntary sector providers (Healthwatch Barnet, Age UK, Alzheimers Society and British red Cross). There is very much a growing interest in this area from partners and we are harnessing the energy, enthusiasm and skill by inclusion in steering groups and experts by experience panels as appropriate.

**c) Implications for acute providers**

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

**Our main acute provider is now Royal Free NHS Foundation Trust** working through 2 key sites in Hampstead and Barnet. Extensive re-configuration of local infrastructure and service provision has recently be completed with changes to the Chase Farm hospital site, as outlined in the Barnet, Enfield & Haringey Clinical Strategy, and the acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free Hospital. This has resulted in shifts in demand and activity through 2013-14 which will impact for this year and beyond.

The ongoing financial position of Barnet CCG is well known by acute partners including a recognition that extensive service re-design and a robust QIPP programme is required to deliver a stable system in financial balance. In this context we have a very strong focus on:

- Transformational change of the health system through provision of integrated care for patients with complex needs as defined in the BCF plan. Through proactive identification, care planning and integrated management of care for patients with complex needs we will seek to avert crises, thus reducing the unplanned use of acute care;
- Reduction in elective acute care through robust management of referrals, and redesign of care pathways to provide upstream early intervention, a greater range of care in a primary care setting, and community based alternatives to acute care.

Relationships with acute providers are constructive and they actively demonstrate support for the over-aching strategic drive behind the BCF and its aims.

The current CCG QIPP plans for Integrated Care (2014-16) represented savings of approximately £3.1m as outlined in contract negotiations and agreed plans. The revised BCF guidance (July 2014) requires greater ambition in terms of movement of costs and services away from acute, primarily in the form of emergency admissions, and hence the savings methodology and projections for the second year of this plan have been scaled up. It has also used information from the 'Appropriate Place of Care Audit' and the modelling associated with the full business case to understand the numbers of non-elective patients who are receiving care in an inappropriate location, and the capacity and demand limits of current provision.

Revised savings equate to 1025 less non-elective admissions in 2015-16 with a relative estimated impact on the acute sector as outlined in the table below. This reflects the 3.5% ambition in line with the BCF but should be noted as being a significant challenge in light of the wider financial, demographic and environmental issues in Barnet. The figures below are based on a different costing model to above (as derived from the BCF guidance) and simply represent indicative workings that require further validation.

| | **Estimated Activity Reduction 15/16** | **Estimated impact at £2420 (amended to reflect local cost with MFF)** |
|---|---|---|
| **Royal Free (Barnet site)** | 656 | 1,314,626 |
| **Royal Free (Hampstead site)** | 307 | 616,230 |
| **Other** | 62 | 123,244 |
| **Total** | **1025** | **2,054,100** |

With current CCG contractual arrangements funding will follow the patient so any additional acute activity resulting from non-delivery of the target will be reimbursed in accordance with agreed tariffs. This will mitigate the risk somewhat for providers although it is recognised that deviation from plan could be operationally problematic. Current systems will continue in terms of demand management and urgent planning and these will directly support reductions in emergency admissions and capacity and surge management.

# ANNEX 1 – Detailed Scheme Description

| **Scheme ref no.** |
|---|
| **1** |
| **Scheme name** |
| Expert Patient Programme **(**Tier 1 & 2. Self-management and prevention) |
| **Scheme description** |
| Pilot and roll out of generic and disease-specific Expert Patient programmes (EPP) – organised by individuals who have existing long term conditions (LTC). |
| **What is the strategic objective of this scheme?** |
| The objectives of this scheme are to:<br>• empower patients to self-care and manage their condition<br>• optimise individual patient's health status<br>• increase knowledge and understanding of LTC and lifestyle/behavioural influences<br>• Improve the patient's experience, and<br>• Mitigate for unnecessary A&E attendances and unplanned hospital admissions. |
| **Overview of the scheme**<br>Please provide a brief description of what you are proposing to do including:<br>- What is the model of care and support?<br>- Which patient cohorts are being targeted? |
| This scheme will enable community social care professionals (health and primary care) to refer older people who have just been diagnosed with a long-term condition, into the Expert Patient's Programme. The scheme will be organised by people with existing long-term conditions, and who are therefore sensitive towards individual issues and needs. In addition, these trainers will have the ability to signpost the patient to other local support services. The primary objectives of the EPP are to up-skill people and improve health literacy. This will make individuals with LTC's more confident about looking after their health.<br><br>Structured patient education programmes based on specific long-term conditions will also be introduced alongside the EPP generic programme. The content and structure of these courses will be determined by a systematic review of needs evidence and service piloting results. The outcome of this analysis will highlight which course subjects will have the biggest impact on particular cohorts within Barnet. It is envisioned that the disease specific pilots will focus on one or more of the following long-term conditions: diabetes, CHD, pain management, respiratory conditions, dementia or depression.<br><br>The generic and disease specific programmes will be launched (staggered) according to the schedule below:<br><br>• Pilot of generic programme: **November 2014**<br>• Pilot of disease specific programme: **January 2015**<br><br>Evaluation of the various pilots will help to determine an optimum programme for Barnet's residents. The generic programme, the disease-specific programme, or a combination of both will be rolled out to up to 5% of the eligible population of older people with long-term conditions should the pilots prove to be successful (currently 1,778 older people with long-term conditions). |

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Project lead: Claire Mundle/Lisa Jacob

Project plan in place to deliver programme 1 from November 2014. This will be provided by SM:UK and is partly funded on the basis of successful bid last year.

The first programme will be delivered through 3 cohorts of 16 people each based in community venues in each of the 3 localities.

Plans for January 2015 are in development and we are currently exploring links with existing structured education programmes in Barnet.

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Why have we selected this scheme?**

Research into the success of EPP's has produced mixed results. For example, a number of papers have suggested that further analysis and a review of comparator schemes is necessary before the full effectiveness of an EPP can be gauged. However, despite some criticism, there exists a general consensus that EPP's reduce both costs and service utilisation e.g. GP's.

**Background paper on the Expert Patients' Programme for NICE Expert Testimony** (A. Rogers) – This expert paper reviews the effectiveness of the EPP launched by the Department of Health in 2001. Although the results are very mixed, it is reported that there was a moderate increase in self-efficacy amongst the patients who joined the programme. In addition, overnight hospital stays reduced across the EPP cohort, and there was an overall reduction in service utilisation. These factors are likely to offset the costs of intervention, making the EPP a cost effective alternative to usual LTC care. To summarise, the paper states that any EPP should be able to meet a wide range of LTC patient's needs, rather than focusing on one course.

**In addition, the HWB Fund Fact Pack** highlights the importance of self-empowerment and education to a successful integrated care system. Significantly, the average impact of support for self care was estimated at 25-30% reduction in hospitalisation (impact measured from systematic reviews).

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

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

To ensure the EPP is fulfilling its primary objectives, we have planned for an evaluation of the first cohort. This will assess local impact/programme outcomes and will be measured against key success criteria's/KPI's. It is intended that the results of this review, will inform future commissioning. On this basis we have currently not assigned any benefits to it within the BCF plan.

**Assumed Benefit Map – Expert Patient Programme:**

Benefits Map 1 - Expert Patient Progra

**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

**What are the key success factors for implementation of this scheme?**

- Structured education needs to be supported by relationships between primary care, specialists, carers and patients
- Professional development and support from LTC specialists is important.

| **Scheme ref no.** |
|---|
| **2a** |
| **Scheme name** |
| Long Term Health Conditions (LTC's) |
| **Scheme description** |
| Increase the scale of services to support people with Long Term Conditions |
| **What is the strategic objective of this scheme?** |

The objectives of this pilot scheme are to:

- Improve clinical outcomes across the cohort of individuals with the specific long term conditions identified
- Invest in community and other services to provide better care for patients with long term conditions, keeping them out of hospital and creating financial savings
- Reduce the number of emergency admissions for people with LTCs
- Provide patients with services closer to home

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme forms part of tier 3 and represents a family of services targeted at long term conditions – primarily dementia, stroke and falls.

**01 Dementia Services**:

Two key service developments are being taken forward in relation to dementia at this stage.

1. **Memory assessment service** - re-design of the existing memory service to create a discrete fully functioning memory service to meet the Memory Service National Accreditation Programme (MSNAP) and National Dementia Strategy standards.

2. Development of a **Community support offer for people with dementia and their carers**. To include dementia hub with resource centre, dementia advisors and dementia cafes. Dementia Friendly Communities project.

**02 Stroke Services:**

Suite of three services to focus on prevention of stroke, and improved outcomes post-stroke through early supported discharge (with appropriate rehabilitation at home) and robust review.

1. **Early stroke discharge** -increase the provision of specialist intermediate care / rehabilitation for stroke in the patient's home by increasing early supported discharge capacity, reducing the length of stay in hospital and acute activity and freeing up resources.
2. **Stroke reviews** - to establish a formal stroke review service: every stroke survivor in Barnet to receive a 6 month review using the GM-SAT tool to prevent further strokes which will result in better outcomes for patients.
3. **Stroke prevention** - to support an increase in the recorded prevalence of Atrial Fibrillation in primary care, and treat them with anticoagulation across the sector using the GRASP AF tool. This is a preventative measure that will reduce the number of people having a stroke and avoiding admissions etc.

**03 Falls Service:**

The Falls Service will focus on preventing falls in the community by indentifying susceptible patients and facilitating education, exercise and fall recovery. Furthermore, it will work with/offer treatment from the multi-disciplinary teams to ensure a holistic approach to preventing further falls.

1. **Falls Clinic** – re-configured clinic modelled to best practice standards focussing on therapy led interventions (with medical support) to provide a seamless patient-centered, integrated and comprehensive service. Targeted to those who have fallen or those at risk of falling. To act as a the central hub for a co-ordinated falls offer in Barnet linked to primary care, falls co-ordinator and fracture liaison service. To establish clear pathways into ongoing voluntary sector strength and balance classes.
2. **Fracture Liaison Service** - aims to identify people who may be at risk of further falls or fractures within acute setting providing comprehensive assessment and specific treatment recommendations.

3. **Falls co-ordinator -** To support the development of an integrated falls system in across

Barnet and promote this across the whole health and social care economy linking voluntary sector, health and social care sector falls prevention initiatives.

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All projects noted are within the workplan for the Joint commissioning unit and hence have nominated service commissioners and project plans.

| Service area | Commissioning lead | Provider | Progress |
|---|---|---|---|
| Dementia – Memory assessment service | Caroline Chant | Barnet. Enfield & Haringey MHT | Operational to new spec from May 2014 |
| Dementia - community support service | Caroline Chant | Alzheimer's Society | Operational. Re-procurement planned |
| Stroke – Early Stroke Discharge | Caroline Chant | Central London Community Health | Operational to new spec from April 2014 |
| Stroke – Reviews | Caroline Chant | Central London Community Health/ Stroke Association | Operational since Summer 2013. Ramping up activity |
| Stroke - Prevention | Caroline Chant | Primary Care | Ongoing |
| Falls – Falls clinic | Ette Chiwaka | Central London Community Health/ Age UK (Barnet) | New service expected Dec 2014 |
| Falls – Fracture Liaison Service | Ette Chiwaka | Royal Free NHS Trust | Operational since July 2013 |
| Falls – Falls Co-ordinator | Ette Chiwaka | | Recruitment underway |

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Why have we selected this scheme?**

Despite the many positives that come from growing older, there is also a higher risk of deteriorating health, reduced wellbeing and lack of independence. At present, there is estimated to be 23,355 people aged 65 or over in Barnet with a limiting, long term illness.

**01 Dementia service** – The elderly cohort is expected to increase by more than 20% over the next ten years. The chances of developing dementia are significantly increased in old age. Barnet will experience an increase in the volume of dementia cases reported, because the life expectancy of its residents is continually increasing. In 2012, Barnet had a higher population of adults with dementia than any other London Borough (the 2012 percentage was also significantly higher than national averages). In 2014, there was estimated to be 4,000 people living in Barnet with dementia. This number is rapidly increasing (1.5 times faster than other London locations) making this a key challenge for health and social care.

**02 Stroke service. -** There are approximately 400 strokes per year in Barnet with an estimated health cost of £5,743 per patient (2011-12). In 2013 we identified that although mortality rates is good compared to England and London averages, hospital admission rates were significantly higher than the national average and in addition Barnet patients were significantly more likely to be readmitted

to hospital within 28 days of discharge. Evidence suggests that an appropriately resourced Early Supported Discharge service provided to a selective group of stroke patients can reduce long term dependency and institutional care (Langhorne, P. 2005; 2007) as well as being cost effective (Beech et al 1999). Alignment with the National Stroke Strategy would also require all stroke survivors and their carers to receive regular reviews of their health and social care needs.

In relation to stroke prevention the Barnet JSNA states that "unless we take steps 16% more people will suffer from strokes by 2020". This links to a growing and ageing population. In Barnet there were 4,168 cases of AF on QOF registers in Barnet (2010/11), this gives Barnet an AF prevalence of 1.1% (370,335-total list size). The national average is 1.43% and hence identifies an opportunity to close the gap. Evidence suggests that optimal management of AF in the population could reduce overall risk of stroke by 10%[i].

**02 Falls service -** Falls and the related injuries are amongst the most common medical problems experienced by older adults. Around 30% of over 65's living at home experience at least one fall a year, rising to 50% of adults over 80, who are living at home, or in residential care. The burden of falls is equally felt in both the acute and social care setting as it involves LAS, A&E, primary care, urgent care providers, community services, local authority and third sector. Barnet identified a growing trend in falls related admissions; with an FY 11/12 spend of £3.3m, an increase in of 10.5% since FY 09/10. This is illustrated below:

Table1: Spend on falls related activity by age group and provider in Barnet ,2011/12

| | Fractured neck of femur | | Other codes related to Falls | | Total | |
|---|---|---|---|---|---|---|
| **Age Band** | **No of Patients** | **Cost** | **No of Patients** | **Cost** | **No of Patients** | **Cost** |
| 65-69 | 8 | £46,621 | 62 | £144,273 | 70 | £187,894 |
| 70-74 | 15 | £114,902 | 57 | £126,242 | 72 | £244,143 |
| 75-120 | 203 | £1,333,940 | 757 | £1,543,352 | 960 | £2,877,292 |
| **Total** | **226** | **£1,462,463** | **876** | **£1,816,867** | **1102** | **£3,309,330** |

Due to the preventable nature of falls, it is felt that this is an area where cost savings can be made by ensuring that there is a focus on preventing and managing falls, as well as having a seamless pathway that can deliver appropriate care to our population closer to their homes.

**Investment requirements**

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

**Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Note that there is overlap between a number of these services and others listed in scheme xxx. The aggregated benefits are detailed under this scheme description.

**01 Dementia Service:**

Locally developed Integrated Care financial model has been used to map benefits and identifies:

780 new diagnoses of dementia per year within the memory assessment service. Of which the combination of early diagnosis, and community support will lead to a 22% reduction in admissions to Care Homes based on the "Department of Health (2009) Living well with dementia: A National Dementia Strategy".

This would deliver a benefit of 44-62 care home admissions over time. With optimism bias for the time lag this has been risk adjusted to 20-25 for 15-16.

It also identifies a reduction in excess bed days (DTOC) that link into the aggregated model in scheme 2b

Key assumptions made include:

1. 22% reduction from national case but mitigated with optimism bias until local evidence supports trend
2. Assumes care reduction in care home admission of 28% assuming all 780 would otherwise enter care home, less 28% self funders)
3. Time lag in realising savings of MAS (Care home avoidance) with growing benefit over 5 years.

Total cost in BCF: £395,632

**02 Stroke service:**

Total cost in BCF is: £475,530

Locally developed Integrated Care financial model identifies benefits related to admissions avoidance and excess bed days (DTOC) in line with supporting business case. This is achieved through managing stays at the HASU and ASU in line with tariffs and trim points. As there is significant overlap the total numbers are outlined in scheme 2b. Cohort size for early stroke discharge is 140 per annum.

**03 Falls Service:**

Total cost in BCF is: £331,337. Estimates of reach of the combined falls clinic and fracture liaison service are 984 people per annum.

The financial model identifies benefits related to admissions avoidance and excess bed days (DTOC) in line with supporting business case. This relies on evidence that suggests that the various interventions can result in savings of between 25% and 35%. This is also supported by evidence from other areas of the country and NICE. The benefits model estimates relative impacts of 10%, 25% and 35% over the next 3 years. Given the overlap with other services the total numbers are outlined in scheme 2b.

Non-financial benefits are included in the embedded benefits map:

Benefits map LTC.docx

**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then

prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

**What are the key success factors for implementation of this scheme?**

- Improved LTC management for in-scope services
- Interdependencies between service elements and other schemes (self-care) need to operate appropriately to deliver full benefits
- Professional development and support from LTC specialists is important.

| **Scheme ref no.** |
|---|
| **2b** |
| **Scheme name** |
| Older Peoples Integrated Care Programme |
| **Scheme description** |
| The Older Peoples Integrated Care Programme, or OPIC, is the combined view of a number of different existing projects/services: Multi Disciplinary Team Case Conference (MDT), Care Navigation Service (CNS), Barnet, Community Point of Access (CPA), Risk Stratification Tool (RST), Barnet Integrated Locality Team. All focus on the delivery of assessment, care planning and co-ordination. |
| **What is the strategic objective of this scheme?** |
| The over-arching objectives of the services above are to:<br>• ensure that the right people receive proactive case management in a cost effective manner<br>• allow care providers to focus case management on individuals that will benefit most<br>• avoid duplication e.g. multiple assessments, by providing co-ordinated care<br>• provide a Community point of contact for health care professionals (HCP) enabling clear and responsive communications between HCP's across all sectors.<br>• prevent unnecessary A&E attendances and unplanned hospital admissions<br>• optimise individual patient's health status through case managed healthcare<br>• optimise individual patient's community support through case management as well as access to social care<br>• prevent or delay elderly admissions to long term care and packages of care<br>• empower patients to self-care and manage their condition<br>• improve the patient's experience.<br>• |
| **Overview of the scheme**<br>Please provide a brief description of what you are proposing to do including:<br>- What is the model of care and support?<br>- Which patient cohorts are being targeted? |
| **01** Multi Disciplinary Team Case Conference (MDT) |

The MDT conference brings together health and social care professionals into a weekly case conference to assess and agree a care plan for the individual needs of frail and elderly patients identified as at highest risk of hospital attendance or significant deterioration in health. This is targeted at the most complex cases where standard measures have been unsuccessful or a particular risk is identified.

**02** Care Navigation Service (CNS)

The Care Navigation is the interface between the MDT, the ILT and the patient. They improve the health, wellbeing and independence of frail and elderly patients through the provision of case management, care co-ordination and signposting. Target cohort generally originates from the MDT or the ILT. Over time the team will become an integral part of the ILT.

**03** Barnet Integrated Locality Team

Currently being piloted as a trail- blazer team, this is an MDT comprising health and social care professionals, mental health support and end of life support and voluntary sector input. The teams will come together into a single unit to develop a joint assessment and care planning approach that links directly with users and carers. They will support adults in the community, in partnership with local GPs, who are living with multi-morbidity and complex long term conditions. This is based on the successful models based in Greenwich and other areas.

**04** Risk Stratification Tool (RST)

A software based risk stratification tool is being used to indentify frail and elderly patients at risk of future unplanned hospital attendance or deterioration in health.

**05** Barnet Community Point of Access (CPA)

The Barnet Community Point of Access acts as a central point to receive and manage referrals for adult community health services, ensuring urgent and non-urgent referrals and requests are pro-actively managed to enable rapid co-ordinated care and effective planned care. Urgent calls are identified quickly and services deployed to prevent admissions and to support longer term care.

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All projects noted are within the workplan for the Joint commissioning unit and hence have nominated service commissioners and project plans.

| Service area | Commissioning lead | Provider | Progress |
|---|---|---|---|
| MDT | Muyi Adekoya | Various across health & social care | Operational since July 2013 |
| CNS | Muyi Adekoya | Central London Community Health | Operational since May 2013 |
| ILT | Muyi Adekoya | Various across health & social care | Trail blazer team live – August 2014 |
| Risk stratification | Muyi Adekoya | United Health | Accelerated deployment July/Aug 2014 |
| Community Point of Access | Muyi Adekoya | Central London Community Health | Operational since April 2014 |

**The evidence base**

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Why have we selected this scheme?**

A systematic review of integrated care (IC) report findings (over the last 10 years) as outlined in the HWB fact pack showed that of the 16 services that had assessed support for MDT's, 81% found that interventions had a positive impact on their IC programme. In addition, all reviews concluded that specialised follow ups by a multidisciplinary team reduces hospitalisations. The average impact of an MDT was a 15-30% reduction in hospitalisation (impact measured across systematic reviews).

57% (8 out of 13) of those who assessed care coordination said that it was an important component of integrated care. An average taken from two reviews showed that care coordination reduced hospitalisations by 37%.

64% (7 out 11) of those who assessed care plans found a positive impact. An average from 2 reviews suggested that hospitalisations were reduced by 23%.

This evidence is also backed up by feedback and benchmarked activity from areas such as Tower Hamlets, Torbay and Liverpool which have seen significant reductions in acute activity.

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

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Aggregated benefits of a number of services are aggregated in the table below:

| | | |
|---|---|---|
| Avoided admissions | **activity** | **1099** |
| | **value** | **£2,004** |
| | | **£2,246,356** |
| Excess bed days reduction | **activity** | **501** |
| | **value** | **£265** |
| | | **£132,765** |
| Reablement | **activity** | **21** |
| | **value** | **£3831** |
| | | **£80,451** |
| | | |
| Total | **value** | **£2,359,572** |

Key assumptions from the financial model:

- Service lines included are Dementia (non-elective admissions), Falls, Stroke, MDT, care navigation, Integrated Locality Team and Rapid Care**.** Overlap from various service elements is evened out through aggregating the data as a single benefit across multiple service lines
- No benefits from CPA and RST included
- Benefits model based on evidence based reduction of most at risk cohort identified from risk stratification (1992 people). This is supported by the financial model.

- Optimism bias applied to account for service user interventions where there would not have been an admission
- This approach is in keeping with local planning and monitoring of QIPP plans
- Approach will accommodate planned changes to service structure over 14-15 in line with the development of ILT.

**Costs in BCF: £992,961**

**Benefits Map – OPIC:**

Benefits Map 3 - OPIC (Annex 3).docx

**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

**What are the key success factors for implementation of this scheme?**

- Fully integrated OPIC service with seamless transition between elements
- Interdependencies with other services in terms of benefits
- Primary care engagement in care co-ordination and MDT role

**Scheme ref no.**

**2c**

**Scheme name**

Care Home Locally Commissioned Service - LCS

**Scheme description**

A locally commissioned service to provide increased resource to GPs to improve the level of care provided in care homes throughout the borough.

**What is the strategic objective of this scheme?**

<u>The objectives of the LCS scheme include:</u>

- To improve the **quality of care** in homes and improve the relationship between the care

home and the GP

- To commission a distinct service for care homes including a fortnightly ward round, 6 monthly holistic reviews, post-admission reviews and medication reviews (over and above the service commissioned under current GP GMS and PMS contracts).
- To increase the level of **proactive and preventative care** given in care homes, anticipating when issues may arise and preventing crisis
- To increase management of patients to reduce **avoidable emergency admissions**
- To support people's preference of place of death through advanced care planning.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

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

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

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

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioning lead: Emma Hay

Service has been launched in September 2014 and we are currently undertaking implementation with GPs.

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Why have we selected this scheme?**

The ageing population in Barnet poses major challenges to the health and social care sector, in particular how we continue to allocate resources to meet needs. The care market in Barnet is dominated by residential care; there are **104 nursing and residential homes for elderly care and 45 care homes** that cover mental health, learning disability and multiple disability. In total, these homes provide approximately **3,051 beds** for a range of older people and those with mental health issues or learning disabilities. Please see the 'Integrated Care – Managing Crisis Better' business case for the full background.

Many GP practices (44 in Barnet) provide care to people within care homes, however, it is

acknowledged that this group have **higher needs** than the general population and therefore, a service is required in addition to the essential and specialised services within the GMS/PMS contract. The LCS is distinct to the 'Avoiding Unplanned Admissions Enhanced service' commissioned by NHS England and focuses primarily on increased medical care into homes.

Based on the evidence available and the results of the recent care home pilot in Barnet, investment is required in order to raise standards of care and reduce admissions to secondary care. This LCS service therefore, aims to address concerns around the levels of proactive care currently received by residents in homes which leads to high levels of emergency admissions and people dying unnecessarily in hospital.

**The Care Home Pilot - 2013**

The recent 'care home pilot' in 2013, worked with 5 care homes, with the main objective of focusing on improving outcomes for Care/ Nursing Home residents within Barnet. The pilot focused on the implementation of changes to the way in which health and social care practitioners work within care homes. A key recommendation was for a consistent approach to daily management of medical input to care homes (in particular where support is provided by more than one GP practice) and the introduction of a weekly minimum half day round per care home (£18,000 per year).

**The data**

Data analysis of admissions into hospital from care homes conducted for 2012/13 revealed that, emergency admissions increased by 5% compared to the previous year (2011/12), costing an additional 27% on the back of more expensive mix of HRGs and unfavourable adjustments to the national tariff which totalled £6,618,774 (A&E and emergency admissions). Of the 2,328 people in care homes (2012/13), there were 1,394 A&E admissions with an average of 2 attendances at A&E for those with at least 1 attendance at A&E per year. In addition, the total cost of secondary care usage (A&E, outpatient, follow up, procedures) in 2012/13 amounted to £7,104,408.31 for patients with an NHS number who were living in care homes[1].

Due to changes in data access, a similar analysis has not been available in 2013/14, although data revealed that over a 10 month period (April 2013-January 2014) there were 554 inpatient admissions of the 3,051 residents in care homes costing a total of £1,830,414;

**Investment requirements**

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

**Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Benefits will manifest primarily in terms of reduced accident and emergency attendances and admissions avoidance; and it is assumed that will accrue from December 2014 onwards. The scheme will be available for all GP practices and hence has an estimated target cohort of 2328 people. Optimism bias has been applied to account for those homes/GP practices that do not participate.

Given the overlap with other schemes the target reduction is included in scheme 2b.

[1]Report produced by Barnet PCT, Informatics team

**Benefits Map – Care Home Locally Commissioned Service**

Benefits Map 5 - LCS (Annex 5).docx

**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

**What are the key success factors for implementation of this scheme?**

- GP engagement and delivery of scheme
- Buy in from care Homes and change in practice in terms of managing a higher proportion of care in the home environment

**Scheme ref no.**

**3**

**Scheme name**

Rapid Care - **Tier 4**

**Scheme description**

The Rapid Care Service works to deliver an immediate response to a health crisis. The duties they perform include:

- arranging appropriate services
- assessing for delivering nursing care as required e.g. provision of IV antibiotics,
- enablement services.

**What is the strategic objective of this scheme?**

<u>The objectives of this scheme are to put in place the following services:</u>

- extended hours service that provides full rapid assessment of health and social care need
- Ambulatory Assessment Diagnostic And Treatment Service
- Telehealth pilot in Care Homes.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The primary aims of the Rapid Care expansion are to reduce unnecessary hospital admissions, better manage acute complications, and support end of life care so that people can remain in their own homes as long as possible. This will be achieved by providing urgent care for older people/people with LTC's and improving crisis response/support services. In addition, the expanded service will also work to improve frail and elderly access to quality acute health care community intervention.

Key service deliverables:

- Triaged response via Community Point of Access
- 2 hour response time
- 7 day service
- Use of skill mix including emergency nurse practitioners
- Consultant cover

Target groups are all over 65s at risk of admission. Operational delivery is targeted towards those conditions that we have identified as high volume e.g. pneumonia, urinary tract infection and heart failure.

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioning lead: Muyi Adekoya

Rapid Response has been operational for a number of years but a significant planned expansion occurred between October 2013 and April 2014. This included a move to 7 day provision and availability later into the evening. It also introduced the emergency nurse practitioner role and telehealth pilot. The provider in Central London Community Health.

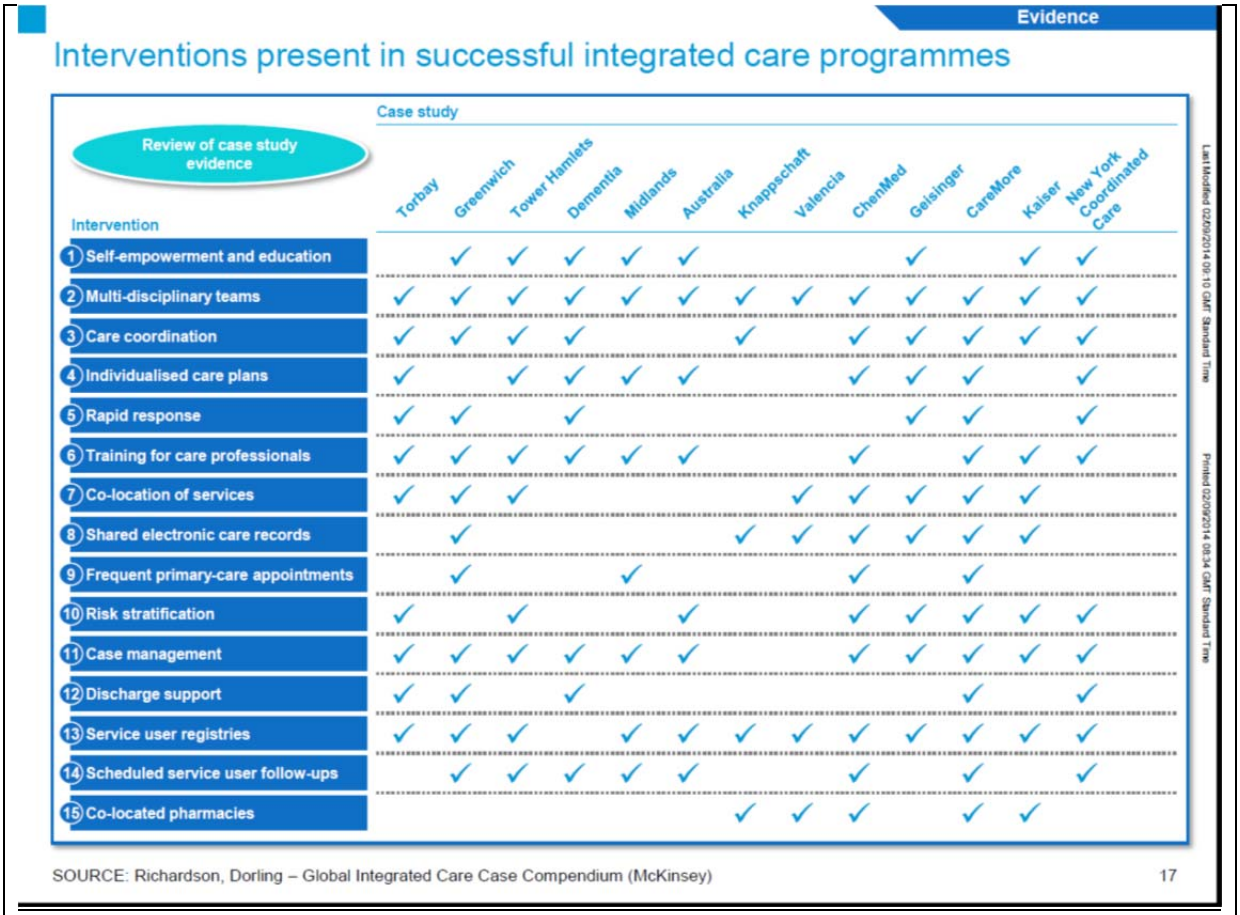
**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Why have we selected this scheme?**

Rapid response is identified as key intervention present in a successful integrated care programme (see below).




Evidence also suggests that hospital admissions can be reduced through active management of ambulatory care-sensitive conditions (ASC). Five conditions account for half of all ASC admissions, of which three disproportionately affect older people (urinary tract infection/pyelonephritis, pneumonia and chronic obstructive pulmonary disease (COPD)).

The evidence (Purdy S (2010)) highlights key three factors for reducing avoidable admissions:

- Early identification of ambulatory care-sensitive conditions. This may be through clinical knowledge, threshold modelling (rules based, where people are judged against certain criteria) and in particular predictive modelling (using risk stratification).
- Increased continuity of care with a GP
- Early senior review in A & E, and structured discharge planning

The combination of OPIC and Rapid Care therefore target this cohort for maximum impact by providing the immediate response to the crisis and then managing ongoing care and preventing recurrence.

**Investment requirements**

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

**Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Benefits will manifest primarily in terms of reduced accident and emergency attendances and admissions avoidance. It will also contribute to the reablement target as it links very robustly with

our PACE and TREAT teams operating in the acute hospitals and intermediate care. The service expanded from October 2013 and we are seeing benefits accruing now.

Given the overlap with other schemes the target reduction is included in scheme 2b.

**Benefits Map – Rapid Care:**

Benefits Map 4 - Rapid Care (Annex 4)

**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Validate and track the realisation of desired benefits using programme/project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver the benefits, remove any blockages to delivery and escalate and resolve them accordingly and engage with stakeholders.

- Define financial and non-financial benefits clearly to enable all stakeholders to understand the requirements for and advantages of achieving the benefits. Project teams can then prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project output achieves; we will use Benefit Cards, an important control document containing all the information for a benefit.

- A project work plan will be agreed with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if the project is on schedule, and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits once the project has been closed

**What are the key success factors for implementation of this scheme?**

- Stakeholder buy in to support referrals particularly primary care
- Interdependencies with other services such as PACE and TREAT

# ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

| | |
|---|---|
| **Name of Health & Wellbeing Board** | Barnet |
| **Name of Provider organisation** | Royal Free NHS Foundation Trust |
| **Name of Provider CEO** | David Sloman, however report is signed off by Kim Fleming (Director of Planning) |
| **Signature (electronic or typed)** | Kim Fleming |

**For HWB to populate:**

| | | |
|---|---|---|
| **Total number of non-elective FFCEs in general & acute** | **2013/14 Outturn** | 29135 |
| | **2014/15 Plan** | 29502 |
| | **2015/16 Plan** | 30002 |
| | **14/15 Change compared to 13/14 outturn** | +367(+1.2%) |
| | **15/16 Change compared to planned 14/15 outturn** | +500 (+1.6%) |
| | **How many non-elective admissions is the BCF planned to prevent in 14-15?** | 134 |
| | **How many non-elective admissions is the BCF planned to prevent in 15-16?** | 891 |

**For Provider to populate:**

| | Question | Response |
|---|---|---|
| **1.** | **Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?** | We are aware of Barnet CCG plans and have been engaged in the Better Care Fund discussions.<br><br>We are committed to working with Barnet CCG both now and in the future on this plan, however we are not in a position to sign off these activity reductions as we need to understand how the individual schemes explicitly link to the reductions planned. |
| **2.** | **If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?** | As above |
| **3.** | **Can you confirm that you have considered the resultant implications on services provided by your organisation?** | As above |

[i] *Commissioning for Stroke Preventon in Primary Care -The Role of Atrial Fibrillation June 2009*
*http://www.improvement.nhs.uk/heart/Portals/0/documents2009/AF_Commissioning_Guide_v2.pdf*