Appendix 1

Summary of LBB and BCCG shared position on integrated care: Better Care Fund, Care Closer to Home (CC2H), new delivery models

Report of Dawn Wakeling and Kay Matthews

1. Introduction

NHS Barnet CCG, Barnet council and NHS providers have been working together, on the Barnet footprint and as part of the NCL STP, to progress integration in the commissioning and the delivery of integrated care. This report sets out the current status of integration and the shared ambition and agreement regarding further development of integration. The substance of this report has been taken from CCG governing body discussions, Health and Wellbeing Board (HWB) discussions and additional meetings between chief executives of BCCG, LBB and NHS providers. (Note: the main focus of the report is on adult services.)

2. Current status of integration

General

- A range of integrated services is in place, jointly commissioned by the CCG and LBB. These are governed through JCEG and managed through S75 agreements. Progress on these is regularly reviewed at JCEG (a full list of S75s is available from Zoe Garbett). The value of these services across adults and children's, excluding BCF, is circa £11M per annum. JCEG is accountable to the HWB.
- Two joint commissioning teams are in place between LBB and BCCG, one for adult services and one for children's services. These teams lead on commissioning community services, mental health, voluntary sector, therapies, & social care provision. The JCEG has within its terms of reference the responsibility for signing off the work programmes for both teams. These are then reported through to the HWB.
- Both BCCG and LBB are responsible for the work programme of the HWB and the Health and Wellbeing strategy. The HWB is chaired by a Cllr from LBB, with the chair of the CCG as vice-chair.

Better Care Fund

- LBB and BCCG have a Better Care Fund plan with a total BCF pooled budget of c. £24M per annum. The core elements of the BCF plan are services for the frail elderly and those with long term conditions (LTCs), such as: Barnet Integrated Locality Team (BILT), Rapid Response Team, risk stratification, 7 day hospital social work, and community equipment. This plan will be updated over the next 3 months, in line with national requirements from DH/DCLG and NHSE.
- **It has been agreed by the HWB, LBB and BCCG that the BCF plan for 2017-19 should be more ambitious and should include the delivery of STP-driven initiatives (such as CC2H) and other local plans, so there is one plan for integrated care and commissioning (particularly for adults). The working title for this is the local care strategy**

3. STP local initiatives

Care Closer to Home (CC2H)

- The NCL STP gives local areas responsibility for the delivery of the care closer to home (CC2H) workstream, with the establishment of CHINs (CC2H integrated networks) and QISTs (quality improvement support teams) a core deliverable for 2017/18.
- The JCEG's refreshed terms of reference and membership gives it the programme board role for CC2H and reflects the triumvirate leadership of the NCL STP.
- **It has been agreed by BCCG, LBB and the HWB that the CC2H work programme will be jointly led by BCCG and LBB.**
- **The agreed plan currently is to develop CHINs and QISTs across Barnet, with the intention that the first three come on stream in 17/18.**

New delivery models/accountable care

- The NCL STP has already considered the potential for new delivery models (accountable care approaches) across NCL and within NCL. No model or firm plan has been agreed by the NCL STP but this work will be picked up again with a view to acceleration in 2017/18. It is expected that all STPs will consider the potential for new delivery models, in line with the Five Year Forward View (FYFV). To ensure an appropriate approach and model for Barnet as this work is taken forward at the STP level, the CEOs of LBB, BCCG, Royal Free, CLCH, BEH, the GP Federation and the BCCG chair, have already met to discuss their shared aspirations for new delivery models on the Barnet footprint.
- The partner organisations have identified that there are potential patient/service user benefits from new delivery models and that the challenges in the health and care system necessitate partnership working and whole system solutions.
- The group of CEOs/the chair of the CCG have identified the Primary Care Home (PCH) model as a preferred model of accountable care for Barnet because of its alignment with the CC2H model and the overall benefits associated with it.
- **The CEOs have collectively confirmed their support for exploring the potential of new delivery models and have tasked directors from each organisation to take this work forward. The agreement is to trial, on a small scale, a Primary Care Home pilot, as part of the roll out of CHINs. This will take into account the necessary design of funding, risk-sharing and accountability arrangements. Timescales are to be confirmed and are subject to design and agreement of the trial. Plans for a pilot will be developed during 2017/18. Further work will be dependent on the learning from the trial. A report back to the CEO group will take place in May 2017.**

Other

- The JCEG will also oversee the delivery of other STP-driven initiatives that require local delivery. This work will be developed over time and is likely to include prevention, children and young people, mental health, elective care.

4. The Better Care Fund 2017-19

This year Barnet will have to submit a 2-year BCF plan. The national conditions of the BCF are:

1. Plans to be jointly agreed, approved by the Health and Wellbeing Board.
2. NHS contribution to adult social care is maintained in line with inflation
3. Agreement to invest in NHS commissioned Out of Hospital services, which may include 7 day services and adult social care
4. Managing transfers of care (MTOC): implement the high impact change model for MTOC to support system wide improvements in transfers of care

Plans will also need to set out the area's vision for integrating health and social care by 2020.

A key change to the new BCF policy framework is the increased emphasis on reducing delayed transfers of care (DTOC) from acute hospital. This links the BCF plan with the Barnet A&E delivery board and the recovery programme for the A&E 4 hour target, led by Neil Snee. The A&E Delivery Board will have lead responsibility for action to reduce DTOCs, through the recovery programme. The A&E recovery programme will be governed through the A&E delivery board. Work to reduce DTOCs will not be duplicated by the JCEG. However, the actions to improve DTOCs within the A&E recovery programme will be set out in the BCF plan submission to demonstrate how BCF national condition 4 is being met. Dependencies between the two plans will be logged in both sets of project documentation.

5. The scope of local care strategy

(Note – this covers the adult health and care perspective; content on children and young people and public health to be added)

CC2H

- Delivery of CHINs and QISTs; and CHIN – primary care home pilot
- Realignment and remodelling of BILT and other current BCF and community health initiatives, developing an enhanced and expanded model of multi-disciplinary working across Barnet for older people and those with LTCs.
- CHINs will need to have, as the centre of a network, links and pathways to all the following:

Strength based adult social care

- Continued expansion of the new model of social work in community hubs; alignment and linkage with CHINs.

Early intervention

- Introduction of Local Area Co-ordination model (the progression of Ageing Well) to deliver more early intervention and build community capacity.
- Prevention and early intervention services commissioning: older people.
- Alignment of prevention services and community participation activity with integrated care model: information, advice, signposting, use of VCS database, volunteer matching, links to and the role of community groups.
- Self-care and social prescribing: linking to public health and leisure services.

Support for specific conditions

- Living with and beyond cancer.
- Stroke, dementia, end of life care.
- Mental health: better links between employment support, wellbeing hub, the Network.

Redesign of partnerships

- Increasing the scale of pooled budget and commissioning across BCCG and LBB.
- Joint approach to co-production, engagement/comms and patient/user participation between LBB and BCCG.
- Integrated commissioning of CHC and ASC care placements and packages; joint approach to care market sustainability and development.
- Integrated care provider quality improvement function across LBB and BCCG.
- Integration of CHC and ASC functionality

6. Summary

- The HWB has agreed to develop a local care strategy. This will be a single strategic plan that will develop and deliver improved integrated care in Barnet. The plan will sit underneath the Joint Health and Wellbeing Strategy and support the delivery of published commissioning intentions. The strategy will include the establishment of CHINs in Barnet and developing accountable care. It will include local implementation of STP initiatives and reference existing integration. It will set out the links with the local A&E recovery programme and reference actions on DTOCs. The intention is that this strategy is submitted as the Barnet Better Care Fund plan for 2017-19.
- Further consideration of the elements of the strategy covering children's health and public health is required.
- The working groups and project/programme boards for previously separate integrated care projects therefore been brought together into the refreshed JCEG, to lead the creation and delivery of the new strategy.
- Two core tasks for the new JCEG are to oversee the development and implementation of the CHIN model through effective programme management and to explore and develop the work on the primary care home pilot in 17/18.

7. Next steps

- Officers from BCCG, LBB and the Federation will develop a joint resourcing and programme delivery plan to support the development of CHINs and QISTs across Barnet and, subject to further design, proposals for the primary care home pilot within the CC2H programme.
- Officers from LBB and BCCG will progress the development of the care strategy.
- The intention is to present a draft care strategy to the HWB in June 2017.