Putting the Community First

MEETING ADULTS AND SAFEGUARDING COMMITTEE
DATE AND TIME MONDAY 7TH MARCH, 2016 AT 7.00 PM
VENUE COMMITTEE ROOM 1, HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

TO: MEMBERS OF ADULTS AND SAFEGUARDING COMMITTEE (Quorum 3)

Chairman: Councillor Sachin Rajput
Vice Chairman: Councillor Tom Davey

Councillor Paul Edwards
Councillor Dr Devra Kay
Councillor Helena Hart
Councillor David Longstaff
Councillor Reema Patel
Councillor Reuben Thompstone
Councillor Claire Farrier

Substitute Members

Councillor Anthony Finn BSc (Econ) FCA
Councillor Anne Hutton
Councillor Brian Gordon LLB
Councillor Arjun Mittra
Councillor Daniel Thomas BA (Hons)
Councillor Jim Tierney

In line with the Constitution's Public Participation and Engagement Rules, requests to submit public questions or comments must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore, the deadline for this meeting is **Wednesday 2nd March 2016** at 10AM. Requests must be submitted to Ola Dejo-Ojomo 020 8359 6326 ola.dejo-ojomo@barnet.gov.uk

You are requested to attend the above meeting for which an agenda is attached.

Andrew Charlwood – Head of Governance

Governance Service contact: Ola Dejo-Ojomo 020 8359 6326 ola.dejo-ojomo@barnet.gov.uk

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Minutes	1 - 8
2.	Absence of Members	
3.	Declarations of Members Disclosable Pecuniary Interests and Non-Pecuinary Interests	
4.	Report of the Monitoring Officer (if any)	
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FACILITIES FOR PEOPLE WITH DISABILITIES
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Decisions of the Adults and Safeguarding Committee

12 November 2015

Members Present:-

AGENDA ITEM 1

Councillor Sachin Rajput (Chairman)
Councillor Tom Davey (Vice-Chairman)

Councillor Barry Rawlings
Councillor Philip Cohen
Councillor Helena Hart
Councillor David Longstaff
Councillor Reema Patel
Councillor Reuben Thompstone
Councillor Claire Farrier

1. MINUTES

The Committee

RESOLVED that the minutes of the meeting of 16 September 2015 be agreed as a correct record.

2. ABSENCE OF MEMBERS

There were no apologies.

3. DECLARATIONS OF MEMBERS DISCLOSABLE PECUNIARY INTERESTS AND NON-PECUINARY INTERESTS

There were no declarations of interests.

4. REPORT OF THE MONITORING OFFICER (IF ANY)

There was none.

5. MEMBERS' ITEMS (IF ANY)

There were none.

6. PUBLIC QUESTIONS AND COMMENTS (IF ANY)

The Committee noted the details of the submitted public questions and the public answers which were provided with the agenda papers for the meeting. Responses to the supplementary public questions were given at the meeting.

There were no public comments.

7. BUSINESS PLANNING 2016-17

The Chairman introduced the report which set out a revised savings programme that would inform the consideration of the Council's Medium Term Financial Strategy (MTFS) in light of future financial challenges following the General Election in May 2015. In

addition to the £12.6m saving the Policy and Resources Committee set in June 2014, the Committee was asked to note the additional financial target of £5.9m set by the same Committee in July 2015. The Committee was also recommended to agree to engage with Barnet CCG on the options and implications for increasing the funding in the Better Care Fund for the protections of Adult Social Care.

In response to queries from the Committee, officers advised the following:

- The proposal to delete 42 FTE posts could change during the consultation with staffing groups. Staff would be consulted on a number of proposals including the creation of 20 new posts alongside the proposed deletions.
- Telecare is being offered to complement some care packages, rather than a substitute for more traditional means of communication. The savings from the use of Telecare are proposed to be delivered from 2017-18, thus giving the Council time it needs to work to develop the Telecare provision.
- The Committee commented that future reports of this nature might benefit from being in a larger font size. Officers advised this would be addressed in future reports.

The Chairman moved to the vote on each recommendation as set in the report.

Recommendation 1:
For 9
Against 0
Abstain 0

Recommendation 2:
For 9
Against 0
Abstain 0

Recommendation 3:
For 5
Against 4
Abstain 0

Recommendation 4:
For 5
Against 0
Abstain 4

Recommendation 5:
For 9
Against 0
Abstain 0

Recommendation 1:
For 9
Against 0
Abstain 0

The Adults and Safeguarding Committee RESOLVED that:

1. **the financial target of £12.6m set by Policy and Resources Committee in June 2014 be noted;**

2. **the additional financial target of £5.9m set by Policy and Resources Committee in July 2015 be noted;**

3. **the savings programme as set out in Appendix A to Policy and Resources Committee is recommended for approval;**

4. **the capital investment priorities set out in Appendix B to Policy and Resources Committee is recommended for approval;**

5. **public consultation on the priorities and revised savings proposals contained within the report commencing immediately following the Policy and Resources Committee on 16 December 2015 is agreed;**

6. **engagement with Barnet CCG is commenced immediately following Policy and Resources Committee on the 16 December 2015 on the options and implications for increasing the funding in the Better Care Fund for the protection of Adult Social Care from £4.2m to £6.6m.**

8. HOME MEALS SERVICE

The Chairman introduced the report which proposed that the Council did not enter into a further contract with a Home Meals service provider when the current contract expired on 1 April 2016. The report highlighted the decline in the number of people using the service and the rationale behind this. The report also included details of the consultation that had been carried out with stakeholders which had developed the Home Meals proposals. The Chairman noted that the Council did not have a statutory duty to provide the service, and in fact 52% of London boroughs did not currently provide the service. However, the Council would still arrange the most appropriate means to assess and support those clients considered to have a nutritional need under the Care Act 2014.

Further to queries from the Committee, officers advised the following:

- the feedback from the consultation with 153 service users had informed the proposals and highlighted the range of options available to them. This included having a private arrangement with the current provider, Sodexo.
- Sharing the service with neighbouring boroughs would not be feasible as the London Boroughs of Camden, Enfield and Harrow did not provide the service. These authorities signpost clients to other providers, which is what was proposed the Council also do.
- The appendices to the report set out a range of local food and meal options. Foodbanks were included for information rather than suggested as an alternative to the current service.
- There are plans for a Jewish Care meals service to be launched in April 2016.

In response to a comment from a Committee member, the Chairman advised that whilst there were negative responses to the consultation, a considerable number of people were no longer using the service

The Chairman moved to the vote on the recommendation as set in the report.

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Recommendation 1:
For 5
Against 4
Abstain 0

Recommendation 2:
For 5
Against 0
Abstain 4

Recommendation 3:
For 5
Against 0
Abstain 4

The Adults and Safeguarding Committee RESOLVED that:

1. **from 1st April 2016, on expiry of the Sodexo Home Meals Contract, that the Council does not enter into a further contract for the provision of a Home Meals Service and therefore by default that the Council discontinues it's Home Meals Service.**

2. **existing and new clients are immediately signposted and supported to find suitable alternative meals options.**

3. **where any existing or new clients are considered to have a nutritional need as part of an assessment and support plan under the Care Act 2014, that the Council arranges this through the most appropriate means, with client contributions in line with the published fees and charges for Adult Social Care.**

9. DELIVERING ADULT COMMISSIONING PRIORITIES THROUGH YOUR CHOICE BARNET

The Chairman introduced the report which proposed that the Committee approve the approach to review the services provided by Your Choice Barnet (YCB) for disabled and older people. YCB was currently under a five year "three plus two" contract from 1 February 2012 to 31 January 2017. The contract was in the first of the "plus two" period, so commissioners took the opportunity to review the range of services provided by YCB to deliver the Council's Commissioning priorities. As YCB was part of a Council-controlled wholly owned trading company, the "Teckal" exemption applied, meaning the Council could make a direct award of contract to YCB without a competitive procurement under the Public Contract Regulations 2015.

The report outlined the process for entering into dialogue with The Barnet Group and YCB to challenge them to bring forward fit for purpose and value for money service proposals which would achieve the reshaping of services as set out in the Committee's Commissioning Plan. Officers proposed that the Committee consider a further report at a future meeting which would set out the recommended longer term arrangements between the Council and YCB.

The Chairman moved to the vote and the Committee unanimously

RESOLVED that the Adults and Safeguarding Committee:

1. **approve the approach to review services provided by Your Choice Barnet, as set out in paragraph 2 of the report;**

2. **note that a further report will be presented at a subsequent meeting on the preferred option(s) for future delivery.**

10. EXTERNAL SUPPORT PLANNING AND BROKERAGE - CONTRACT NOVATION

The Chairman presented the report which sought the Committee's approval for the Council to enter into a Deed of Novation to release Barnet Centre for Independent Living (BCIL) from its obligations under the Contract with the Council and novate the Contract to Inclusion Barnet from 1 January 2016 for the remainder of the initial three year contract which expired 30 September 2017. The original contract had an option to extend for a further two years from 1 October 2017, and any novation would consider this also.

Inclusion Barnet (IB) was a company set up with charitable status and was effectively the parent company, with BCIL remaining in existence but as the trading arm of IB.

The Chairman moved to the vote and the Committee unanimously

RESOLVED that the Adults and Safeguarding Committee approve the novation of the Contract with the Council from BCIL to Inclusion Barnet from 1 January 2016 for the remainder of the initial term of the Contract and, if relevant, for any extension period of up to two years.

11. APPROACH TO CONCERNS WITHIN THE REGULATED CARE MARKET - UPDATE REPORT

The Chairman introduced the report which was subsequently presented by James Mass, the Assistant Director Community Wellbeing. The report outlined the lessons learnt further to the recent closure of a care home within the borough, and the ongoing work that the Council was undertaking in partnership with the Care Quality Commission (CQC) in Barnet and the Barnet Clinical Commissioning Group to safeguard against the circumstances that led to the closure in future.

The Committee noted that the CQC's new regime supported the Council's approach to ensuring the quality, safety and efficacy of the care services it provided.

The Chairman moved to the vote and the Committee unanimously

RESOLVED that the Adults and Safeguarding Committee note the on-going work to develop and improve the approach to responding to concerns with providers in the regulated care market.

12. A NEW OPERATING MODEL FOR ADULT SOCIAL CARE

The Chairman introduced the report which considered the outcomes of the first stage of a delivery model project to identify the best way to respond to the challenges facing adult social care services (ASC). This was in the face of unprecedented pressures in adult

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social care nationally and further to the Committee's approval of the project to consider alternative delivery models for ASC in January 2015.

The report considered a number of different models. Dawn Wakeling, Adults and Health Commissioning Director, in particular described the Shropshire model of using community hubs which implemented more preventative measures rather than more traditional care services..

During the course of the debate, the Committee requested that it be recorded that they were agreeing the principles and objectives behind the provision of adult social care. The Committee requested that future reports on ASC operating models would include the following:

- the principles behind the model for adult social care
- how the model would work, and that
- any future consideration would include an evaluation in-house option.

The Committee also agreed the strategic outline case would include:

- The scope of the model including the services in it and the client groups whom it would support
- The principles and if they will meet the objectives set by the committee
- The practice including cultural, process and systems aspects.

The Chairman moved to the vote on the recommendations as set in the report and the Committee unanimously

RESOLVED that the Adult and Safeguarding Committee

1. **approve the approach to the proposed new ASC operating model;**

2. **agree the proposed approach to developing an outline business case for an alternative model.**

THE CHAIRMAN AGREED TO VARY THE ORDER OF THE AGENDA

13. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT - ENABLEMENT HOME CARE STRATEGY

The Chairman advised the Committee that the Enablement Home Care Strategy was to be considered. He introduced the report which recommended that the Committee endorse the Council's approach to developing its enablement model and ensuring the targeted interventions support people to experience better outcomes, and reduce their reliance on other services.

The Chairman moved to the vote and the Committee unanimously.

RESOLVED that the Adult and Safeguarding Committee endorse the approach to enhancing the enablement offer in Barnet to support delivery of the Medium Term Financial Strategy and Care Act (2014) requirements.

14. COMMITTEE FORWARD WORK PROGRAMME

The Chairman introduced the Committee's Forward Work Programme, as set out in the report.

A member of the Committee suggested that the Committee should consider a report on the changes that had been implemented further to the Care Act 2014. Officers agreed that they would add a report to the forward work programme, having considered the most appropriate time for a progress report.

RESOLVED that the Committee note the Forward Work Programme.

The meeting finished at 9.30 pm

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	Adults and Safeguarding Committee **7th March 2016**
Title	**Adults and Safeguarding Commissioning Plan - 2016/17 addendum**
Report of	Commissioning Director Adults and Health
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A: Adults and Safeguarding Commissioning Plan - 2016/17 addendum
Officer Contact Details	Kirstie Haines – Strategic Lead, Adults and Health Tel:0208 359 2781. Email: Kirstie.Haines@Barnet.gov.uk Tom Pike – Strategic Lead, Programmes and Performance Tel: 0208 359 7058. Email: Tom.Pike@barnet.gov.uk Stephen Evans - Director of Strategy & Communications Tel: 020 8359 3021 Email: Stephen.Evans@barnet.gov.uk

Summary

In March 2015, the Adults and Safeguarding Committee approved a five year Commissioning Plan for the period 2015-20, which sets out the Committee's priorities and outcome performance measures across its core areas of responsibility. All Theme Committees agreed five year Commissioning Plans.

This report presents updated targets for 2016/17 in an addendum to the Commissioning Plan (Appendix 1).

Recommendations

1. **That the Committee review and approve the addendum to the Adults and Safeguarding Commissioning Plan for 2016/17 (Appendix A).**

1. WHY THIS REPORT IS NEEDED

1.1 The council's **Corporate Plan** 2015-20 was agreed by full Council in April 2015. It sets the strategic priorities and direction for the council to 2020 and targets against which progress is measured. These targets will be refreshed for 2016/17 and will be presented to Full Council in April for agreement. The Corporate Plan is structured around the council's priorities of:

- **Responsible growth and regeneration** – which is essential for the borough, to revitalise communities and provide new homes and jobs – and for the council to generate revenue to spend on local services. The council will approach regeneration in a responsible way – replacing what needs to be replaced and protecting the things that residents love about the borough, such as its green spaces.
- **Managing demand for services** – with a growing population, demand for services is increasing which puts pressure on resources. Since 2010, we've successfully met a 25% budget gap largely through efficiency savings and delivering services differently; in order to meet a further 25% budget gap to 2020, we'll focus on doing more to manage demand for local services.
- **Transforming services and doing things differently** – we will continue to look at how local services can be redesigned to make them more integrated and intuitive for the user, and more efficient to deliver.
- **Community resilience** – as the council does less in some areas, residents will need to do more. We're working with residents to increase self-sufficiency, reduce reliance on statutory services, and tailor services to the needs of communities.

1.2 Last year, each Theme Committee agreed a five year Commissioning Plan covering the period 2015-20. Commissioning plans set out the strategic priorities and outcome performance measures for each Committee, with targets to be refreshed annually. On 19 March 2015, the Adults and Safeguarding Committee agreed its five year Commissioning Plan, which set out the following priorities:

a) Alternative ways to deliver services, in partnership with other organisations and residents

- Integration of care and health services where this delivers the best outcomes.
- Develop a service which supports people with disabilities from the age of 0-25 to bring together health, care and education and support the development of more effective relationships of trust with families.

- Better support for individuals with mental health issues to retain or regain employment and suitable housing that supports their well-being.
- Stronger integration with customer services and public health to help people better self-manage and plan to age well.

b) Implementing the Care Act 2014

- Re-modelling the approach to assessment and support planning to meet the increase in demand predicted to arise from the new cap on care costs[1].
- Improved advice and advocacy services with a greater availability of helpful information to support ageing well.
- Greater support to enable carers to continue in their caring role.

c) Going further with personalisation – developing more creative approaches to meeting care needs

- More creative and personalised support plans.
- Increased use of new support and enabling technologies.
- A shift from specialist segregated services to community settings.
- Support to remain at home for longer.

d) Focus on efficiency, effectiveness, and impact

- Challenge all services we commission, our own workforce and our partners to evidence the impact they have.
- Explore alternative delivery models for adult social care to maximise the Council's ability to achieve the above.

1.3 As we move into the second year of delivery of these Plans, each Theme Committee will be asked to agree a 2016/17 addendum to their plans, which sets out the Q3 position against 2015/16 targets and updated targets for 2016/17. This will give Committees the opportunity to review and consider their priorities for the year ahead and the associated targets against which progress will be measured. The addendum to the Adults and Safeguarding Commissioning Plan for 2016/17 is provided at Appendix A.

1.4 Following the Chancellor's Autumn Budget Statement in November 2015 and the provisional Local Government Funding Settlement in December 2015, the council's overall budget forecast to 2020 worsened slightly. The updated 2016/17 targets, therefore, reflect the need for the Committee to make a more significant contribution to the council's overall savings in the next four years than previously anticipated.

Summary of the 2016/17 priorities and targets

1.5 The Committee's top priorities for 2016/17 are:

- **Planning for life -** working age adults and older people live a healthy, full and active life, in homes that meet their needs, and their contribution to society is valued and respected

[1] The cap on *care costs* was due to be introduced in April 2016, but has now been *delayed* to April 2020

- **Prevention and early intervention** - working age adults and older people are provided with the tools to manage their own health and wellbeing and maintain independence
- **Person-centred integrated support -** working age adults and older people have timely access to health and social care support that maintains independence and avoids hospital admission or admission to residential care
- **Safeguarding -** working age adults and older people are supported to live safely through strategies which maximise independence and minimise risk from abuse and neglect
- **Carers:** carers are valued as expert partners in supporting working age adults and older people to live independent lives
- **Sport and physical activity -** health and wellbeing outcomes are achieved in a manner that is sustainable.

Next steps

1.6 The proposed addendum to the Adults and Safeguarding Commissioning Plan, including updated targets for 2016/17, is set out in Appendix A. Members are invited to review and agree the document.

1.7 Following agreement, the Committee will receive a progress report during the year against this Plan and associated in-year targets. The Committee will be asked to agree updated targets for 2017/18 in March 2017 and this process will continue through to 2020.

1.8 Performance and Contract Management Committee will continue to review progress against the Council's Corporate Plan, and overview of the performance of both internal and external Delivery Units. This Commissioning Plan will enable Performance and Contract Management Committee to focus on the key areas of performance for different service areas.

2 REASONS FOR RECOMMENDATIONS

2.1 A key element of effective strategic and financial management is for the council to have comprehensive business plans in place that ensure there is a clear strategy for addressing future challenges, particularly in the context of continuing budget and demand pressures (resulting from demographic and legislative changes), delivering local priorities and allocating resources effectively.

3 ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 There is no statutory duty to publish Committee Commissioning Plans but it is considered to be good practice to have comprehensive business plans in place for each Committee – which set out priorities and how progress will be measured – to ensure that the council's vision for the future is clearly set out and transparent.

4 POST DECISION IMPLEMENTATION

4.1 Revisions to the Commissioning Plan will be communicated internally and with key stakeholders.

5 IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 This report invites Members to review and approve the addendum to the Commissioning Plan for 2016/17.

5.2 Resources (Finance and Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 In addition to continuing budget reductions, demographic change and the resulting pressure on services pose a significant challenge to the council. The organisation is facing significant budget reductions at the same time as the population is increasing, particularly in the young and very old population groups.

5.2.2 The addendum outlines the areas of focus for Adults and Safeguarding Committee which will be delivered within the Committees budget.

5.2.3 The Commissioning Plan has been informed by the council's Medium Term Financial Strategy. The budget gap for the period 2016-20 is estimated to be £81.1m of which Adults and Safeguarding have a target of £18.5m. The table below outlines how reductions in each year will contribute to the overall saving:

Theme Committee	2016–17	2017–18	2018–19	2019 – 2020	Total
Adults & Safeguarding	(3,383)	(5,412)	(5,161)	(4,497)	(18,453)

5.3 Social Value

5.3.1 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 Legal and Constitutional References

5.4.1 All proposals emerging from the business planning process must be considered in terms of the council's legal powers and obligations, including its overarching statutory duties such as the Public Sector Equality Duty.

5.4.2 The council's Constitution, in Part 15 Annex A, Responsibility for Functions, states the functions of the Performance and Contract Management Committee include (amongst other responsibilities):

a) Overall responsibility for quarterly budget monitoring, including monitoring trading position and financial strategy of Council Delivery Units.
b) Monitoring of Performance against targets by Delivery Units and Support Groups including Customer Support Group; Re; the Barnet Group (Including Barnet Homes and Your Choice Barnet); HB Public Law; NSL (Parking Contractor); Adults and Communities; Family Services; Education and Skills; Streetscene; Public Health; Commissioning Group; and Assurance.
c) Receive and Scrutinise contract variations and change requests in respect of external delivery units.
d) To make recommendations to Policy and Resources and Theme Committees on relevant policy and commissioning implications arising from the scrutiny of performance of Delivery Units and External Providers.
e) Specific responsibility for the following function within the Council:
   a. Risk Management
   b. Treasury Management Performance
f) Note the Annual Report of the Barnet Group Ltd.

5.5 Risk Management

5.5.1 The council has an established approach to risk management. Key corporate risks are assessed regularly and reported to Performance and Contract Management Committee on a quarterly basis.

5.6 Equalities and Diversity

5.6.1 The general duty on public bodies is set out in section 149 of the Equality Act 2010.

5.6.2 A public authority must, in the exercise of its functions, have due regard to the need to:
a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.6.3 Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:
a) Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
b) Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

c) Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

5.6.4 The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

5.6.5 Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, the need to tackle prejudice; and promote understanding.

5.6.6 Compliance with the duties in this section may involve treating some persons more favourably than others but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

5.6.7 The relevant protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

5.6.8 It also covers marriage and civil partnership with regard to eliminating discrimination.

5.6.9 In agreeing the Corporate Plan, the council is setting an updated strategic equalities objective and reiterating our commitment to delivering this. The strategic equalities objective is as follows:

- Citizens will be treated equally, with understanding and respect, and will have equal access to quality services which provide value to the tax payer.

5.6.10 As reported to Policy and Resources (16 February 2016) in the Cumulative and Individual Equalities Impact Assessment, the savings target for Adults & Safeguarding is £18.452m savings by 2019/20 whilst improving performance and overall quality and maintaining resident satisfaction. In 16/17 ASC propose savings of £3.383M. Efficiency savings will be achieved through the continuing review of 3rd party spend and staffing efficiencies. Approximately half of savings proposals relate to managing demand, doing more to support people to live at home for longer and reducing the requirement for residential care by supporting people in the community.

5.6.11 Nine EIAs have been conducted on Adult and Safeguarding proposals, of which 6 are showing positive impacts:

- Three relate to continuing savings introduced in previous years, two are showing a positive impact for supporting people in the community and new build housing for wheelchair users; older adults, disability facility grants is assessed as neutral impact.
- Six EIAs relate to new savings proposals to be introduced in 2016/17, of which four - Independence of young people, Personal Assistants, Support

for working age adults, and older people Homeshare are initially assessed as positive impact. Two of the new savings proposals are showing a negative impact; these are for Home meals, and anticipated negative impacts for staffing efficiencies. The review of 3rd Party Spend is indicating potential negative and neutral impacts for Over 65 and people with disabilities. This will be mitigated by establishing whether, on a contract by contract basis, how efficiencies affect services for different groups.

5.6.12 The negative impacts of Home Meals are for Jewish and other ethnic minority and over 85s. Mitigations are outlined in the EIA and include discussing the change with service users, exploring alternative provision (for culturally specific meals) from other community sources and clarifying where there is a statutory responsibility to continue to offer support. The saving will allow more choice and independence and the service is contacting all recipients and making links with faith communities to make people aware of lunch clubs and other initiatives in each locality.

5.6.13 Adults' proposals for supporting people in the community, Wheelchair Housing Independence of young people, Personal assistants, Support for working age adults, and the Homeshare proposals are initially assessed as Positive.

5.7 Consultation and Engagement

5.7.1 The original Corporate Plan and Commissioning Plans were informed by extensive consultation through the Budget and Business Planning report to Council (3 March 2015).

5.7.2 The consultation aimed to set a new approach to business planning and engagement by consulting on the combined package of the Corporate Plan, Commissioning Plans, and budget. In particular it aimed to:

- Create a stronger link between strategy, priorities and resources
- Place a stronger emphasis on commissioning as a driver of the business planning process.
- Focus on how the Council will use its resources to achieve its Commissioning Plans.

5.7.3 To allow for an eight week budget consultation, a consultation began after Full Council on 17 December 2014 and concluded on 11 February 2015. The consultation found that more respondents disagreed with the proposed savings within the Adults and Safeguarding Committee as 16 out of 25 respondents disagreed compared to 7 out of 25 who agreed. One respondent indicated they Neither agree nor disagree and one indicated Don't know/Not sure.

6 BACKGROUND PAPERS

6.1 Policy and Resources Committee, 16 February 2016. Item 8 – Business Planning:
https://barnet.moderngov.co.uk/mgAi.aspx?ID=13706#mgDocuments

6.2 Adults and Safeguarding Committee, 12 November 2016. Item 8 – Business Planning:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=698&MId=8362&Ver=4

6.3 Adults and Safeguarding Committee, 19 March 2015. Item 8 – Adults and Safeguarding Commissioning Plan 2015 – 2020:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=698&MId=7933&Ver=4

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ADULT & SAFEGUARDING COMMITTEE

Commissioning Plan 2015 – 2020

2016/17 addendum & targets

This document is an addendum to the **Adult & Safeguarding Committee Commissioning Plan 2015 – 2020**, which sets out an updated narrative and indicators/targets for 2016/17. The full Commissioning Plan can be found here:
https://barnet.moderngov.co.uk/documents/s22062/Appendix%20A%20-%20Adults%20and%20Safeguarding%20Commissioning%20Plan.pdf

1. CONTEXT FOR COMMISSIONING PLAN

Unlocking the opportunities of growth

Barnet is a growing borough, driven by a combination of a strengthening national and local economy and locally lead investment in regeneration, skills and economic development. Over the next five years, this growth will bring opportunities for residents, businesses and the council. The council will work to ensure that all residents can benefit from the opportunities that growth will bring – by helping people to help themselves – whilst protecting what people enjoy about Barnet: Its parks and open spaces; its excellent schools; and its diversity.

All parts of the public sector face the same challenges of reduced budgets and increasing demand for services. As the money received from Government reduces almost to zero over the next few years, all councils will need to become financially independent and generate revenue locally – through Council Tax, Business Rates and, where appropriate, by becoming more commercially minded. This means that growth – as well providing new homes, jobs, schools, transport infrastructure, parks, leisure centres and community facilities – is necessary to grow the local tax base and generate money to spend on local services.

Living within our means, with a renewed focus on managing demand for services

Most residents and businesses will benefit from a growing economy without too much interaction with the council. For those people, it is our responsibility to get the basics right: To provide an attractive environment; empty the bins; keep the streets clean; and make it as easier to make transactions such as requesting a parking permit online, at a time that suits them.

However, some residents will a need a little extra help to take advantage of the opportunities of a growing economy and we're working more closely with our local partners, such as the NHS, Barnet Homes, Jobcentre Plus, and our local colleges and university, to provide that. By working more closely with other parts of the public sector, providing more homes and helping people into work, we can also help to manage demand for local services and relieve some of the pressure.

We tackled the £75 million budget gap we faced between 2010 and 2015 head on and managed the challenge without a big impact on frontline services. We embraced the need to do things differently and have made some bold decisions to live within our means. In order to close a further budget gap of £81 million by 2020 we will continue to look at how we can reduce bureaucracy but, increasingly, our focus will turn to how we can help manage demand for services.

Transforming local services

Our 'Commissioning Council' approach means that we're not bound by the status quo. Our focus is less on who provides a service – the council, a private company, a national charity or group of local volunteers – and how it is provided, and more on ensuring that each service is necessary, meets the needs of residents and represents value for money. For every service, we will consider the case delivering them differently, focusing on the best outcomes for our residents.

For some services, this approach to service transformation has resulted in partnerships with the private sector, such as our contracts with Capita to provide our 'back office' and customer services,

and create a Joint Venture to provide our developmental and regulatory services – a model which sees a proportion of income generated by trading those services returned to the Barnet Taxpayer.

For other services, transformation means doing things differently with our in-house services, such as increasing the size and effectiveness of our foster care service to reduce the need for costlier residential care, or working in partnership with other parts of the public sector to deliver more intuitive services for residents which save us money, such as our joint employment programmes.

Investing for the future

Despite needing to reduce our day to day spending, we will continue to invest in the essential infrastructure of the borough. Our financial strategy will see £565 million of capital investment between 2016 and 2020, funded from capital receipts, borrowing, revenue and external grants.

Resources will be invested in transport (including roads, pavements and a new Thames Link station at Brent Cross); housing – with 20,000 to be built over the next decade, the most in outer London; schools – to ensure we continue to provide places for those that need them, building on the 7,500 new places created over in the last six years; leisure facilities – with new leisure centres built at Victoria Recreation Ground and Copthall – and the creation of 3 new 'community hubs' across the borough.

More resilient communities

Doing things differently will require the council to change its relationship with residents over the next few years. Where it will not be possible for the council to do as much as it has done in the past, we will support residents and community groups to be more resilient and do more for themselves and their neighbours. Across all of our services, we will look at opportunities for residents to get more involved – whether it's helping to maintain the borough's parks and green spaces, or volunteering in one of the borough's libraries.

2. OUR APPROACH TO MEETING THE 2020 CHALLENGE

The council's Corporate Plan sets the framework for each of the Theme Committees' five year commissioning plans. Whether the plans are covering services for vulnerable residents or about universal services such as the environment and waste, there are a number of core and shared principles, which underpin the commissioning outcomes.

The first is a focus on fairness: Fairness for the council is about striking the right balance between fairness towards the more frequent users of services and fairness to the wider taxpayer and making sure all residents from our diverse communities – young, old, disabled and unemployed benefit from the opportunities of growth.

The second is a focus on responsibility: Continuing to drive out efficiencies to deliver more with less. The council will drive out efficiencies through a continued focus on workforce productivity; bearing down on contract and procurement costs and using assets more effectively. All parts of the system need to play their part in helping to achieve better outcomes with reduced resources.

The third is a focus on opportunity: The council will prioritise regeneration, growth and maximising income. Regeneration revitalises communities and provides residents and businesses with places to

live and work. Growing the local tax base and generating more income through growth and other sources makes the council less reliant on Government funding; helps offsets the impact of budget reductions and allows the council to invest in the future infrastructure of the Borough.

Planning ahead is crucial: The council dealt with the first wave of austerity by planning ahead and focusing in the longer-term, thus avoiding short-term cuts and is continuing this approach by extending its plans to 2020.

3. CORPORATE PLAN PRIORITIES

We apply these principles to our Corporate Plan priorities of: **growth and responsible regeneration**; **managing demand for services; transforming services; and more resilient communities.**

Fairness	• Fairness for the council is about striking the right balance between fairness towards more frequent users of services and to the wider taxpayer • **Managing demand for services** – since 2010, we've successfully met a 25% budget gap largely through efficiency savings and delivering services differently; in order to meet a further 25% budget gap to 2020, we'll focus on doing more to manage demand for local services. • This will require a step change in the council's approach to early intervention and prevention, working across the public sector and with residents to prevent problems rather than just treating the symptoms	• Fairness in adult social care means that services respond to the needs of diverse communities • It means ensuring that older and disabled people, including adult social care service users and their carers, are able to participate in community life just as other residents can • It means that services provided by the council are accessible and welcoming to older and disabled people, adult social carer service users and carers.

Responsibility	• **More resilient communities** – as the Council does less in some areas, residents will need to do more. We're working with residents to increase self-sufficiency, reduce reliance on statutory services, and tailor services to the needs of communities. • In doing so, the council will change its relationships with residents, with residents becoming more resilient and doing more to keep Barnet a great place. All parts of the public service system must play their part in helping to achieve priority outcomes with reduced resources.	• Responsibility in adult social care means that services will work with older and disabled people to remain as independent and self-reliant as possible • It means that social Workers will always focus on what people can do, not on dependency, and will work with service users, and carers, to find ways to help them support themselves, using community resources and the support of their family and friends. • It means that social workers will work to ensure that people are able to move back to living independent lives as quickly as possible, ensuring a timely response to changing needs.
Opportunity	• The council will capitalise on the opportunities of a growing economy by prioritising regeneration, growth and maximising income. • **Growth, housing and responsible regeneration** is essential for the borough – revitalising communities, providing new homes and jobs, while protecting the things residents love – and for the Council, generating more money to spend on local services • As we continue to deal with budget reductions to 2020, we will explore the opportunity this presents to **transform local services** and redesign them, delivering differently and better. We will focus on making services more integrated and intuitive for the user, and more efficient to deliver for the Council.	• Opportunity in adult social care means that disabled people have the right to work as much as any other Barnet resident. The council's services will actively support adult social care service users to access employment and volunteering opportunities • It means ensuring people can stay living in their own homes for as long as possible. It means that all users are supported to have their own homes, and avoid residential care as much as possible • It means that council services will actively support carers to play a full part in their communities, accessing services and opportunities for employment and training.

4. VISION FOR ADULTS & SAFEGUARDING

- Social care services for adults have a key role to play in improving the lives of Barnet's most vulnerable residents, working with housing, education and health services to enable people to stay independent and live for longer in their own homes
- The integration of health and social care commissioning will make it easier for services to achieve this, while helping the NHS to manage demand on hospital services
- Transformation of social care services will empower more young people with complex disabilities to stay in Barnet, where they grew up, and people with mental health issues will receive support focused on helping with their whole life, for example, getting a job and a home of their own
- Improved leisure facilities, parks and open spaces will allow Barnet's residents to be some of the most active and healthy in London, helping to manage demand for adults' social services.

5. COMMISSIONING PRIORITIES

Summary

- We're **developing best practice social care**, focused on what people can do and how they can help themselves
- We're **diversifying Barnet's accommodation offer** to help more people live independently
- We're **transforming day care provision** to ensure that people remain active and engaged through access to employment and volunteering
- We're **integrating health and social care services** to prevent crises and help individuals stay well and in their own homes
- We're **improving the borough's leisure facilities** to support and encourage active and healthy lifestyles

Background

- **Barnet has a large proportion** of elderly residents – **0.4% of the UK's over-65 population.** 14% of Barnet's population are over 65, compared the 13.1% of the population of outer London. Furthermore, Barnet has a higher proportion of people aged 85 and over (3.1%) compared to Outer London (1.8%) and the UK (2.3%). The numbers of older people (over 65) in Barnet are predicted to grow by 10.7% by 2021 (more than twice the rate of the rest of the population)
- It is estimated that over **4,000 people in Barnet are living with dementia** and even greater numbers of families and friends are adversely impacted by the condition. By 2021 the number of **people with dementia in Barnet is expected to increase** by 24% compared with a London-wide figure of 19%
- In 2011 there were 32,256 residents who classified themselves as a carer in Barnet. On average carers are more likely to report having poor health (5.2%) than non-carers (4.2%), especially among carers who deliver in excess of 50 hours of care per week
- Compared to other Boroughs Barnet has a high proportion of care homes. There are 85 residential and 21 nursing homes in Barnet registered with the Care Quality Commission.

In total, these homes provide approximately 2,800 beds for a range of older people and younger people with disabilities

- The highest proportion of referrals into Adult Social Care are from hospitals (secondary health) which has risen by 49% between 2009 and 2015 up to 3,814 referrals in 2014/15
- The Adults and Safeguarding Committee has a target to **save £18 million between 2016 and 2020** (2016/17 net budget for the Committee is £86.3 million)

Planning for life

Working age adults and older people live a healthy, full and active life, in homes that meet their needs, and their contribution to society is valued and respected.

- Our Social Workers will work with older and working age adults to support them to remain independent, focusing on what they can do and how they can increase their resilience.
- We're working with Barnet Homes, developers and private landlords to ensure that accommodation supports people to live independently, through increased numbers of home adaptations, building more accessible and extra care housing; and use of assistive technology. We have invested £107,000 more of council capital funding into home adaptations and increased Occupational Therapist support for adaptations. We will also allocate £1.97m of the Better Care Fund into home adaptations in 2016/17, an increase of £105,000
- We are implementing a Shared Lives scheme, supporting disabled people to live in family homes, develop their independence and prevent the need for long-term residential care.
- We will roll out and promote Home Share schemes, to enable people to stay in their own homes with support
- Working with our recently commissioned dementia community services, we will develop a dementia network in 2016/17 supporting our commitment to become a dementia friendly community
- Our later life planners, dementia advisors, dementia cafes and memory assessment service will support older people, those with dementia and their carers to stay active and involved in their community
- Our neighbourhood model of community support for older people focuses on wellbeing and inclusion, and will continue to support over 5,000 people, a wide and expanding range of activities including gardening and lunch clubs, information and advice, digital inclusion, befriending, strength and balance (falls prevention) classes, yoga, walks, music groups and sing-alongs across 50 locations across the borough. The Neighbourhood Services will also continue to provide a Handyperson service, which provides support to older people to enable them to live safely and independently in their own homes.

Prevention and early intervention

Working age adults and older people are provided with the tools to manage their own health and wellbeing and maintain independence.

- We will make more information and guidance available at the first point of contact through the 'social care direct' service which has been enhanced with increased numbers of qualified Social Workers, Prevention Officers and an improved directory of services.
- Our enhanced Social Care Direct team is working faster and intervening earlier with people who have social care needs, reducing the need for safeguarding investigations and preventing crises

- We're intervening earlier, to help residents get back on their feet sooner and prevent crises through the roll out of our integrated health and care team for older people (BILT) to cover the whole of Barnet.
- Our new programme of support for carers of people with dementia will support carers to continue to care for their loved one and maintain their family together.
- Our commissioned prevention and services will focus on increasing wellbeing, reducing isolation and increasing ability to manage daily living and participate in the community through community development projects, the use of innovative technologies (such as VisBuzz which makes video calling simple) and supporting Public Health initiatives such as Community Centred Practice; using health volunteers to encourage resilience and self-management
- We are developing increased numbers of personal assistants, so that people with care and support needs can be more in control of their own support.
- To help people with learning difficulties and mental health issues play an active part in their communities, we're putting them in contact with support networks, and working with day services and employers to ensure access to employment, volunteering and training.

Person-centred integrated support

Working age adults and older people have timely access to health and social care support that maintains independence and avoids hospital admission or admission to residential care.

- Social care commissioning will be integrated with primary and secondary health services to deliver better outcomes for residents.
- Our Better Care Fund plan for 2016/17 will focus on the comprehensive roll out of our integrated care model, helping people get back on their feet through integrated teams, Rapid Response Care, Home From Hospital and Enablement services
- This will ensure that residents are able to access joined up services that are appropriate for their needs, with earlier intervention reducing the need for more intensive social care services
- Improved telecare provision, driven by advances in technology, will help people to care for themselves in their own homes
- We will develop a model of mental health social care focused on recovery and maximising inclusion
- Our integrated learning disability team will work across social care, community health and mental health to support people with complex needs remain safe, well and as independent as possible.

Safeguarding

Working age adults and older people are supported to live safely through strategies which maximise independence and minimise risk from abuse and neglect.

- Safeguarding concerns will be responded to quickly through our enhanced Social Care Direct Service, resolving the issues as quickly as possible
- With our partners in the Police, the NHS and the voluntary sector, we will continue to embed and champion the principles of Making Safeguarding Personal
- We will implement the new Pan-London Safeguarding procedures, ensuring a consistent approach to safeguarding across London

- We will work with partners to improve multi-agency responses to local needs, particularly in the areas of pressure ulcers, and self-neglect
- We will work with the police and other partners to improve Access to Justice for vulnerable adults.

Carers

Carers are valued as expert partners in supporting working age adults and older people to live independent lives.

- We will prioritise meeting the needs of carers, including young carers, through the support planning process, supporting carer's own physical and mental health needs to ensure carers feel able to continue to support an individual for as long as they can:
  - Commissioning a new support service for carers and young carers will allow for an integrated, holistic approach to support, the new service will:
    - Provide Care Act compliant carers assessments, bringing assessments in line with Adult Social Care assessments and case management
    - Provide more training for carers and young carers regarding understanding diagnosis and illnesses to help support carers and young carers in their caring role
    - Support plans for carers and young will be tailored to individuals needs and utilise community resources and that they are outcome focuses
    - Support will be offered to carers which will consider the needs of both the carer and the person who they are caring for (e.g. offering activities for both the carer and person being cared for or peer support groups for the carer and specific activity for person receiving care)
  - We will train our staff to ensure to improve the quality and numbers of carers assessments undertaken and work to ensure that support plans are helping carers to maintain and increase their own health and wellbeing and achieve the outcomes that they desire
- We will strengthen the current carers' support offer through the use of assistive technology and intensive support for carers of people with dementia; a new specialist dementia support team will be operational for 2016/17
- We will work to ensure that early identification of carers occurs and support provided is targeted and tailored to meet individual's needs through better support planning and applying a whole family approach aiming to reduce the number of carer breakdowns
- We will better support carers to balance work and caring commitments, working with employers to ensure they are aware of carers' employment rights and know how to support carers in their workforce to remain in employment

Sport and Physical Activity

Health and wellbeing outcomes are achieved in a manner that is sustainable.

- We aim to empower communities to support a sustainable sport and physical activity pathway which encompasses a multi-agency approach facilitated through the 'Fit & Active Barnet' Partnership Board, which will be re-introduced in 2016/17
- We will improve and enhance Barnet leisure facilities; developing schemes at Barnet Copthall Leisure Centre and in Victoria Recreation Ground

- We will promote a range of high quality, affordable and inclusive opportunities that raise awareness, highlighting the benefits of leading an active lifestyle; focusing on groups we know to be under-represented
- We will work in collaboration to achieve prevention and early intervention prohibiting the onset of/alleviate the onset of long term health conditions via our commissioned activity and integration of public health outcomes within a new leisure contract
- We will improve strategic alignment to ensure opportunities are concentrated in a range of settings to sustain future activity; via the workplace, community, leisure, education, travel and open environment
- We will facilitate local, regional and national partnerships that advocate strategic investment in Barnet, that encourage people to lead a more active and healthy lifestyle.

6. TRANSFORMATION PROGRAMME

The Council's *transformation programme* will help to deliver the £81 million savings required by the Medium Term Financial Strategy. The key benefits of the Adults and Safeguarding Portfolio, along with the expected costs of delivery and financial benefits are outlined in the tables below.

Key benefits

Area	Key benefit
Adults Transformation and ADM	Developing a new approach to adult social work that focuses on identifying people's strengths, what they can do for themselves and what support they can draw upon from family, friends and local community resources. The service will transition to a new delivery model, within which the new approach can flourish. Demand for Council-funded ASC services will fall as people are empowered to take control of their own lives and remain independent for as long as possible.
Older People and Adults with Physical Disabilities	Joining up health and social care services so that residents have a better experience and services are delivered more effectively and efficiently. Continue to improve the review and support planning process both for carers and service users including how housing, equipment and technology can increase independence.
Housing and Support projects	Work with Barnet Homes, developers and private landlords to ensure that accommodation supports people to live independently, through home adaptations and accessible housing; co-habitation with carers and peers; use of specialist home support services including personal assistance, integrated assistive technology; and access to networks of local services
Learning Disabilities	Developing the employment support opportunities for working aged adults with disabilities and ensure there are sufficient opportunities available in the Borough. Continue to improve the review and support planning process both for carers and service users including how housing, equipment and technology can increase independence.
Mental Health	Refocus mental health social care on recovery, maximise inclusion. Implement new social work delivery model, aligned with community development whole family approaches and wider well-being.
Sports and Physical Activity (SPA)	Develop a contract that can improve the participation levels in sport and physical activity across the borough, improving assets, while delivering sport and physical activity services at zero-cost for the council

Programme cost and financial benefits

Project	Total cost	Total financial benefit
Adults Social Care ADM	£1,260,000	Savings of £18.45m
Housing & Support projects	Funded from existing service budgets	
Your Choice Barnet		
Assistive Technology for care support		
Home and Community Support & Enablement project	£240,200 & service funded	
Case Review Activity	£385,000	
Health & Social Care Integration	s256 funded	
Independence of Young People with LD	£400,000	
Employment Support	£275,000	
Specialist Dementia Support Service	£260,000	
Service development investments (Mental Health, Housing, Front Door & Invest in IT, Personal Assistants	£759,000	
Sports and Physical Activity (SPA)	£1,476,000	Saving of £0.97m and improved participation & health outcomes
Total	**£5.85m[1]**	**£19.42m**

[1] Total portfolio costs includes an apportionment of central programme costs, contingency and legal advice

7. INDICATORS FOR 2016/17

The tables below outline how the Committee contributes to achieving the priorities of the Corporate Plan: Fairness - managing demand for services; Responsibility – more resilient communities; and Opportunity - transforming services and maximising the benefit of growth and responsible regeneration, along with the basket of indicators that will be used to monitor progress against these within the Corporate Plan (CPIs) and key indicators within Contracts and Management Agreements (SPIs). Some of the stretch targets for 2016/17 are concentrated on targets relating to working age adults to reflect priorities around prevention and the available budget.

Key:
CPI = Corporate Plan Indicator
SPI = Service Indicator

Fairness: Managing demand for services

PLANNING FOR LIFE - Working age adults and older people live a healthy, full and active life, in homes that meet their needs, and their contribution to society is valued and respected.

- Work with older and working age adults to support them to remain independent
- Ensure that accommodation supports people to live independently
- Implement Shared Lives scheme, supporting disabled people to live in family homes, develop their independence and prevent the need for long-term residential care.
- Roll out and promote Home Share schemes, to enable people to stay in their own homes with support
- Develop a dementia network to become a dementia friendly community and support older people, those with dementia and their carers to stay active and involved in their community
- Community support for older people focusing on wellbeing and inclusion

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
CPI	AC/S10 (ASCOF 1B)	Percentage of people who feel in control of their own lives	68.4% (Q2 2015/16)	Top 25% of comparable boroughs	**69% (within confidence interval)** [2]	Top 25% in England	Adults & Communities

[2] All indicators based on the Adult Social Care user survey are set using a 'confidence interval' which takes account of the margin of error which may result from surveying a small sample of the population.

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
SPI	AC/S2 (ASCOF 3D)	Service users who find it easy to get information	71.3%	74.5%	**71.3% (within confidence interval)**	Top 25% in England	Adults & Communities
SPI	AC/S27	Percentage of customer contacts into Social Care Direct resolved at first point of contact	61%	Monitor	**Monitor**	Monitor	CSG

PREVENTION AND EARLY INTERVENTION - Working age adults and older people are provided with the tools to manage their own health and wellbeing and maintain independence.

- Make more information and guidance available at the first point of contact through 'social care direct'
- Roll out integrated health and care team for older people (BILT)
- Ensure that accommodation supports people to live independently, including through use of integrated assistive technology
- New programme of support for carers of people with dementia
- Commissioned prevention services will focus on increasing wellbeing, reducing isolation and increasing ability to manage daily living and participate in the community
- Develop increased numbers of personal assistants, so that people with care and support needs can be more in control of their own support.

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
CPI	AC/S3 (ASCOF 1G)	Percentage of adults with learning disabilities who live-in their own home or with their family	61.8%	60%	**63%**	England average	Commissioning Group/ Adults & Communities
CPI	AC/S4 (ASCOF 1E)	Percentage of adults with learning disabilities in paid employment	9.5%	10.6%	**10.8%**	Top 10% in England	Commissioning Group/ Adults & Communities
CPI	AC/S5 (ASCOF 1F)	Percentage of adults with mental health needs in paid employment	5.4%	7%	**7.2%**	Top 25% of comparable boroughs	Commissioning Group/ Adults & Communities
CPI	AC/S6 (ASCOF 1H)	Percentage of adults with mental health needs who live independently, with or without support	82.9%	75%	**83%**	Top 25% of comparable boroughs	Commissioning Group/ Adults & Communities

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
CPI	CG/S21	Provide additional wheelchair housing*[3]	TBC	10% of new housing provision	**10% of new housing provision**	10% of new housing provision	Commissioning Group
SPI	AC/S17	Number of new telecare packages installed*	637	470	**800**	47% of all support packages	Adults & Communities
SPI	AC/S18	Percentage of service users receiving ongoing services with telecare*	12%	17%	**17%**	30%	Adults & Communities

PERSON-CENTRED INTEGRATED SUPPORT - Working age adults and older people have timely access to health and social care support that maintains independence and avoids hospital admission or admission to residential care.

- Integrate social care commissioning with primary and secondary health services, with support from the Better Care Fund
- Improve telecare provision, driven by advances in technology and increased use of personal budgets
- Develop model of mental health social care focused on recovery and maximising inclusion
- Integrated learning disability team will support people with complex needs to remain safe, well and as independent as possible

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
CPI	AC/S8	Percentage of new clients, older people accessing enablement	62.1%	50%	**63%**	70%	Adults & Communities
CPI	AC/S9 ASCOF2A (2)	Permanent admissions to residential and nursing care homes, per 100,000 population age 65+	467.7	399.0	**530[4] (new method)**	Top 10% of comparable boroughs	Adults & Communities

[3] All indicators marked with an asterisk* are also proxies for the Council's success in managing demand – the level of future need for social care services.

[4] Please note this measure has a new methodology and the baseline is not comparable with 2014/15 or 2015/16. The target for 16/17 is based on the same percentage reduction as with the previous measure – 15% reduction of caseload. To be reviewed at the end of Q2.

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
CPI	AC/C14	Permanent admissions to residential and nursing care homes, per 100,000 population age 18-64*	6.38	13.5	**16.6**	Top 10% in the country	Adults & Communities[5] In JHWBS
SPI	AC/S16	Proportion of service users with a direct payment (ASCOF 1C/2A)	39.5%	41%	**42%**	Top 10% in the country	Adults & Communities
SPI	AC/S25	Percentage of Social Care Direct customers who are satisfied or very satisfied with the service they have received post resolution	95%	85%	**85%**	85%	CSG

SAFEGUARDING - Working age adults and older people are supported to live safely through strategies which maximise independence and minimise risk.

- Respond to safeguarding concerns quickly through 'social care direct'
- With our partners, continue to embed and champion the principles of Making Safeguarding Personal
- Implement the new Pan-London Safeguarding procedures, ensuring a consistent approach to safeguarding across London
- Work with partners to improve multi-agency responses to local needs, particularly in the areas of pressure ulcers, and self-neglect
- Work with the police and other partners to improve Access to Justice for vulnerable adults

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
CPI	NEW (ASCOF 4A)	Percentage of people who use services who say those services make them feel safe and secure	80.1% (2014/15)	New Corporate Indicator	**80.1% (within confidence interval)**	Maintain performance	Adults & Communities

[5] Please note that this measure has a new methodology and the baseline is not comparable with 2014/15 or 2015/16. The target for 16/17 uses the same rationale as 14/15, which aimed to maintain the previous year's performance.

CARERS - Carers are valued as expert partners in supporting working age adults and older people to live independent lives.

- Prioritise meeting the needs of carers, including young carers, through the support planning process
- Strengthen the current carers' support offer through the use of assistive technology and intensive support for carers of people with dementia
- Work to ensure that early identification of carers occurs and support provided is targeted and tailored to meet individual's needs
- Better support carers to balance work and caring commitments

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
CPI	NEW	Number of instances of information, advice and guidance provided to carers	N/A	N/A	**TBC at end Q1[6]**	TBC	Adults & Communities

SPORT AND PHYSICAL ACTIVITY – Health and wellbeing outcomes are achieved in a manner that is sustainable.

- Empower communities to support a sustainable sport and physical activity pathway
- Improve and enhance Barnet leisure facilities; developing schemes at Barnet Copthall Leisure Centre and in Victoria Recreation Ground
- Promote opportunities that raise awareness of an active lifestyle
- Collaborate to achieve prevention and early intervention prohibiting the onset of/alleviate the onset of long term health conditions
- Concentrate opportunities in a range of settings to sustain future activity;
- Facilitate local, regional and national partnerships that advocate strategic investment

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
SPI	CG/S17	Percentage of people who take up leisure services – participation of over 45s		20.4%	**20.4%**	Increase	Commissioning Group – SPA

[6] This indicator requires submission of new data from partner organisations to baseline it. This process will take place at the end of Q1 2016/17.

Ref		Indicator	2015/16 Q3	2015/16 Target	2016/17 Target	2019/20 Target	Service
SPI	TBC	Increasing participation in sport and physical activity		Top 25% of comparable boroughs	**37.9%**	38.9% (increase by 1% by 2020) JHWBS	Commissioning Group - SPA

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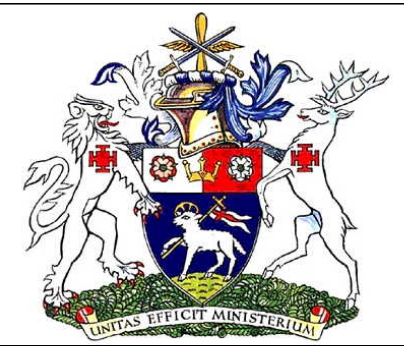
AGENDA ITEM 8

	**Adults and Safeguarding Committee** **7th March 2016**
Title	**Extension of Mental Health Day Opportunities Contract**
Report of	Adults and Health Commissioning Director
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	None
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Summary

This report requests acceptance to extend the contract with Richmond Fellowship for Mental Health Day Opportunities for a further two years until 13th January 2018 as provided for in the contract.

Recommendations

1. That the Adults and Safeguarding Committee approve an extension of the contract with Richmond Fellowship for Mental Health Day Opportunities for a further two years until 13th January 2018 as provided for in the contract.

1. WHY THIS REPORT IS NEEDED

1.1 A contract was awarded on the 19th December 2012 to Richmond Fellowship for provision of Mental Health Day Opportunities following a competitive procurement.

1.2 The contract started on 14th January 2013 for a period of three years with the option to extend for a further two years subject to review.

1.3 The Adults and Health Commissioning Director approved an emergency waiver of the Contract Procedure Rules to continue the service between the end of the contract on 13th January 2016 and Adults and Safeguarding Committee on 7th March 2016.

1.4 This report requests acceptance to extend the contract for a further two years until 13th January 2018 as provided for in the contract.

2. REASONS FOR RECOMMENDATIONS

2.1 The Service was reviewed in August 2015 and the provider is meeting the key performance indicators for the service. The service is currently delivering outcomes related to mental health and wellbeing promotion, peer support and recovery and inclusion. The service is a key demand management initiative which reduces demand on other services by enabling individuals to keep well and live more independently. It is therefore recommended that the service continues.

2.2 Continuing the service also allows for future recommissioning to take account of key development areas, specifically the Government's mandate to NHS England for 2016-17 and the Employment Support offer to Barnet residents with a mental health condition.

2.3 The Government's mandate to NHS England for 2016-17 was announced in December 2015. It is important that future recommissioning addresses the following aims:

- greater integration between health and social care, so that care is more joined up to meet people's physical health, mental health and social care needs
- reduce the health gap between people with mental health problems and the population as a whole, with support to live full, healthy and independent lives
- ensure there is measurable progress towards parity of esteem for mental health enshrined in the NHS Constitution

- improve care and outcomes through prevention, early intervention and improved access to integrated services

2.2 Two employment support initiatives are currently being piloted in the borough. Commissioners are now considering how to sustain and expand these promising interventions to support more people with long-term health conditions and disabilities back into employment.

2.3 This context will inform future commissioning of day opportunities in mental health. However, the extension is required to ensure service continuity whilst new national policy and guidance is incorporated into local commissioning intentions.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Ending the contract without an alternative offer is not recommended in order to ensure there is continuity of service.

3.2 Recommissioning the service at the end of the third year was not recommended as opportunities to take account of key development areas would be missed.

4. POST DECISION IMPLEMENTATION

4.1 Following the decision, a Deed of Extension will be issued by HB Public Law.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Council's Corporate Plan 2015-20 states that the council, working with local, regional and national partners, will strive to ensure that Barnet is a place:

- of opportunity, where people can further their quality of life
- where people are helped to help themselves, recognising that prevention is better than cure
- where responsibility is shared, fairly
- where services are delivered efficiently to get value for money for the taxpayer

5.1.2 The Joint Health and Wellbeing Strategy 2015 – 2020 includes the objective of creating circumstances that enable people to have greater life opportunities through a focus on improving mental health and wellbeing for all.

5.1.3 The Joint Strategic Needs Assessment tells us that in 2015, 56,333 people aged 18 – 64 were estimated to have a mental health problem.

5.1.4 The number of people with mental health conditions is predicted to increase as the population grows. In November 2014, the Health and Wellbeing Board identified prevention of and early intervention in mental health problems as a

priority. Mental health is the key priority in year one of the Joint Health and Wellbeing Strategy with partners coming together to make a positive impact for all of our residents

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 The service is funded through a Section 75 Agreement for Voluntary Services Prevention Commissioning between the London Borough of Barnet (LBB) and Barnet Clinical Commissioning Group (BCCG).

5.2.2 The table below (5.3) includes the annual value of the contract, including the annual contributions from both funding organisations. The table also includes the value of the two year extension.

5.3 **Contract Value**

Annual Contract Value	LBB Annual Contribution	BCCG Annual Contribution	Value of Two Year Extension
£530,000	£183,461	£346,539	£1,060,000

5.4 **Social Value**

5.4.1 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits.

5.4.2 Any future recommissioning will consider how additional social value can be secured for Barnet.

5.5 **Legal and Constitutional References**

5.5.1 The responsibilities of the Adults and Safeguarding Committee are contained within the Council's Constitution - Section 15 Responsibility for Functions (Annex A). Specific responsibilities of those powers, duties and functions of the Council in relation to Adults and Communities include the following specific function:

- Authorise procurement activity within the remit of the Committee and any acceptance of variations or extensions if within budget in accordance with the responsibilities and thresholds set out in Contract Procedure Rules.

5.5.2 This extension is permitted under Section 14.1 (b) of the Contract Procedure Rules.

5.5.3 Under Table A of Contract Procedure Rules - Authorisation and Acceptance Thresholds, the Adults and Safeguarding Committee must approve the extension to the contract.

5.5.4 The Contract permits for extension and the original authority to award the Contract approved such extension subject to a review prior to the expiry of the

Contract. Extension of the Contract therefore will not be in breach of the Public Contracts Regulations.

5.5.5 The Adults and Safeguarding Committee is also responsible for:

- Promoting the best possible Adult Social Care services
- Working with partners on the Health and Well Being Board to promote integration of social care with health
- Ensuring that the Council's safeguarding responsibilities are taken into account.

5.6 **Risk Management**

5.6.1 Continuing the service mitigates any impact of service disruption.

5.7 **Equalities and Diversity**

5.7.1 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

5.7.2 The protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

5.7.3 An Equalities Impact Assessment was completed as part of the procurement of the service. This showed a positive impact for residents and service users.

5.7.4 The contract for the service includes explicit requirements fully covering the Council's duties under equalities legislation.

5.8 **Consultation and Engagement**

5.8.1 Not applicable.

6 BACKGROUND PAPERS

6.1 Delegated Powers Report, 19th December 2012 - Contract Award – Mental Health Day Opportunities Service.

http://barnet.moderngov.co.uk/documents/s6537/1856%20-%20Contract%20Award%20Mental%20Health%20Day%20Opportunities%20Service%20Public.pdf

6.2 Delegated Powers Report, 12th January 2016 - Emergency Waiver to continue Mental Health Day Opportunities Service

http://barnet.moderngov.co.uk/ieDecisionDetails.aspx?ID=6071

6.3 Policy and Resources Committee, 16th February 2016 2016 - Extension of Mental Health Prevention and Supported Living Services

http://barnet.moderngov.co.uk/mgIssueHistoryHome.aspx?IId=28627&PlanId=313

AGENDA ITEM 9

	Adults and Safeguarding Committee **7th March 2016**
Title	**Outline business case for an alternative delivery model for adult social care**
Report of	Dawn Wakeling, Adults and Health Commissioning Director
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix: Adult social care alternative delivery model outline business case
Officer contact details	Joanne Humphreys, Project Lead, Commissioning Group joanne.humphreys@barnet.gov.uk

Summary

In November 2015 the Adults & Safeguarding Committee approved the approach to a proposed new operating model for adult social care (ASC) and agreed an approach to developing an outline business case for an alternative delivery model. This paper presents the recommendations from the outline business case. The case presents the final proposal for the operating model and options on the delivery model. From an initial set of six options, three options have been shortlisted as the best ways to deliver the cultural and process change needed to implement the new operating model, and with the greatest potential to deliver financial savings and additional income. This report proposes that these three options – a reformed in-house service; a shared service with the NHS and a public service mutual organisation – be developed in greater detail. In parallel with this work, there would be a period of public consultation, and activities already underway to prepare for the operating model would continue. A further Committee paper in September 2016 would then recommend a single delivery model option, taking into consideration, amongst other matters, the consultation results.

Recommendations
1. That the Adults and Safeguarding Committee approves the shortlisted options for an alternative delivery model.
2. That the Adults and Safeguarding Committee confirms its approval of the proposed new operating model and agrees to public consultation on the operating model and the delivery model options, starting in spring 2016.
3. That the Adults and Safeguarding Committee approves the approach to developing a further business case that will present a single recommended alternative delivery model option to the Committee in September 2016.

1. WHY THIS REPORT IS NEEDED

1.1 On 26 January 2015, the Adults and Safeguarding Committee agreed that Barnet's model for delivering social care needed to be transformed and approved the initiation of a project to consider alternative delivery models for adult social care (ASC).

1.2 On 12 November 2015, the first output of this project, a proposed new operating model for ASC, was presented to the Committee. The new operating model is based on a vision of shared responsibility between the state, the community and the person. It recognises that the role of ASC is to support people's independence and ability to be part of their communities for as long as possible. The model proposes changes to what ASC practitioners do (their processes) and to how they do it (their team and organisational culture and their working practices).

1.3 By helping people to stay healthy and well, supporting them to regain their independence after illness or injury, and encouraging them to make greater use of community resources, the new operating model aims to reduce demand for Council-funded care and support.

1.4 The second stage of this project is to consider the full range of alternative delivery models (ADMs) and identify the best ADM to deliver the new operating model.

1.5 This report presents the findings from an initial evaluation of alternative delivery models and proposes that three of those models - a reformed in-house service; a shared service with the NHS and a public service mutual organisation – be shortlisted and developed in greater detail.

2. REASONS FOR RECOMMENDATIONS

2.1 The reasons for the new operating model were set out in the report to this Committee on 12 November 2015 when the approach to the proposal was approved by the Committee. The outline business case (included as an appendix to this report) draws out the proposed new operating model and the changes required to implement it.

2.2 These are the ADM options that have been considered, with a brief summary of the feedback given on each option by stakeholder groups (staff, residents, service users, carers, and representatives of local community and voluntary sector organisations).

2.3 **Reforming and delivering the service in-house.** The in-scope services would continue to be delivered by the Council's Adults and Communities Delivery Unit, in partnership with Capita. A transformation programme would be undertaken to implement the new operating model and ensure the continued financial and operational sustainability of the service. Stakeholders acknowledged this option as a tried-and-tested model that was known to be an effective way to support people and keep them safe. However, some staff thought the necessary changes could not be made through an in-house service. Some service users and carers agreed: they thought that it would be too difficult to "turn the service around" under this model.

2.4 **Sharing services with public sector partner(s) such as local NHS organisations and/or other London Boroughs.** The Council would join up with one or more local NHS organisations to deliver integrated health and social care services. A single organisation would be responsible for the delivery of local health services and ASC services. This shared service could also include another local authority partner. Stakeholders saw the potential of a shared service to improve and accelerate health and social care integration and provide what they described as a more "holistic" service. However, they also expressed concern that a NHS organisation would be the much larger partner and would therefore "dominate" the partnership.

2.5 **A partnership outside the public sector.** This option could be implemented as an outsourcing arrangement, where an external provider delivers the services for the Council, or a joint venture (JV), where a JV company is created, jointly owned by the Council and an external provider. Some staff felt that they might have greater "freedom" from Council policies and procedures if they worked within a private sector organisation. However, other staff were concerned that a private sector organisation would not have a strong public service ethos and would be less focused upon meeting the needs of individual service users and carers. Service users questioned whether it would be more

difficult for the Council to manage a provider effectively when it was delivering a complex and sensitive service such as ASC.

2.6 **Transferring the in-scope services to The Barnet Group, the Council's Local Authority Trading Company (LATC).** The Barnet Group is wholly owned by the Council, which means any profits it generates can be returned to the Council. Stakeholders felt that some of the benefits of delegating services to The Barnet Group were the same as those that applied to delegating services to any external partner (such as "freedom" from Council policies and procedures). However some stakeholders also felt that some of the drawbacks associated with an external partner could also apply to this option, such as the risk that a partner would fail to deliver the level of service described in the procurement process.

2.7 **Establishing a public service mutual organisation.** In the strategic outline case this option was described as a social enterprise. This term has no legal definition in the UK and is used to describe a wide range of different organisational structures. Therefore in this paper the term 'public service mutual' (PSM) is used as it summarises the key features of this option – it is independent from the Council, any profits it generates are re-invested in the service and it is at least partially owned by its staff. This concept of shared ownership and meaningful representation of staff and local people at management board level was very attractive both to staff and to service users. However, amongst both staff and service users, some were concerned that a small organisation could be financially vulnerable, especially in an environment where social care budgets are reducing every year.

The following options appraisal criteria were applied to the options:

2.8 **Criteria 1: Is there appetite amongst potential partners to deliver this option?** Through informal market engagement, potential interest in delivering the ADM was identified amongst local NHS organisations and amongst organisations in the private and not-for-profit sectors. The opportunity was also explored with The Barnet Group. Staff in the Adults and Communities Delivery Unit expressed interest both in exploring the PSM option and in moving forward with a reformed in-house service.

2.9 **Criteria 2: Can statutory ASC functions be delegated under this option?** The Care Act 2014 gives Councils the ability to delegate most statutory ASC functions in relation to assessment and care management, although they cannot delegate their statutory duties, and some statutory functions would remain the responsibility of the Council under any ADM. Notwithstanding these limitations, at present there do not appear to be any legal barriers to any of the options carrying out delegated statutory ASC functions.

2.10 **Criteria 3: Could this option deliver the required cultural and process change?** In order to deliver the new operating model, the ADM needs to create an environment in which:

- People's expectations of what the Council will do for them are "reset" and they are encouraged to take responsibility for living as independently as possible.
- Amongst staff, trust, professional autonomy and positive risk taking and promoted and decision-making is swift and unhindered by bureaucracy.
- The service works closely with partners including health, housing and organisations from the community and voluntary sector (CVS).

2.11 There is good evidence from examples such as Focus in North East Lincolnshire and People2People in Shropshire, that a PSM can be a highly effective way to create this kind of environment. The opportunity for staff to own a financial 'stake' in the organisation, and the representation of staff on the PSM management board drives high levels of staff engagement. Local people can also be members of the PSM management board and directly influence its priorities and strategic direction.

2.12 A shared service with the NHS would present a significant opportunity to transform the way ASC services work with health services, both at a strategic level and in the way staff on-the-ground work together. If health and ASC services shared a pooled budget there would be more joined-up thinking around how people can be supported to lead more independent lives for longer.

2.13 It would be possible to deliver elements of the required level of change through a reformed in-house service but it would be a very slow and complex process. The service has a strong local identity and reputation as "the Council" and this could make it harder to persuade people and partners to change expectations and work with the Council in a different way.

2.14 Although The Barnet Group is a separate organisation, it also holds a strong identity as part of the Council. This could make it more difficult for The Barnet Group to reset expectations and develop new ways of working. The Barnet Group's status as a LATC (wholly owned by the Council) means there would not be an opportunity for staff and/or members of the community to share ownership of the ADM under this option.

2.15 Involving a partner from outside of the public sector in the ADM could help to accelerate implementation of the new way of working. However, there is no evidence of this model being used in other Councils to drive extensive culture and process change in ASC. There is also a risk that staff would feel

disengaged from the service and that partner organisations could be mistrustful and reluctant to work closely with the service if it were delivered by a private sector partner.

2.16 **Criteria 4: Could this option generate savings and/or additional income?** The ASC ADM project has a savings target of £1.96m between 2017/18 and 2019/20.

2.17 Under a reformed in-house service, savings would be generated through a reduction in employee-related costs and some reduction in management overheads. The staffing savings would be realised through actions to review the skills mix of staff, increase staff productivity, review support services and improve the overall efficiency of the service.

2.18 Given the importance of its role in delivering the new operating model, under a reformed in-house service the Social Care Direct service would be reviewed and integrated with the teams that deliver professional social work. The senior management team of the Delivery Unit estimates this integration could realise efficiency savings. Further savings could also be achieved by providing ASC transport and school transport through a single service. This initiative is still under development so a conservative estimate has been made that a saving could be achieved over the savings period. These two savings opportunities have been applied to all of the ADM options.

2.19 Most of the savings under a NHS shared service would be generated through economies of scale and procurement savings on supplies and equipment. Under a pooled health and social care budget there would also be increased investment in ASC as a more cost-effective alternative to NHS in-patient services. Additional net income from a pooled budget, combined with income through trading services with the private sector and/or individual citizens is assumed under this option.

2.20 Employee-related cost savings are assumed to be lower than those under a reformed in-house service because increasing the efficiency of the service will be more difficult as the service will be much larger and more complex than the current in-house service. However, the assumed saving on management overheads is assumed to be higher under a shared service because two services brought together would need only one senior management team.

2.21 Initial market testing intelligence indicates that in this context a private sector partner could realise efficiency savings equivalent to 10% of the in-scope services. Based upon the projected budget for employee-related costs and transport costs in 2017/18 (£14.6m) this gives an assumed total saving of £1.46m over the savings period.

ADM financial model

Assumed value of in-scope services, 2017/18	14,603,108

Saving opportunity	Risk	Reformed in-house service	NHS shared service	Partnership outside the public sector	The Barnet Group	Public service mutual
Review Social Care Direct provision and delivery with close integration with professional social work teams	Low	Initial analysis shows this option is likely to achieve 86% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 85% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 74% of the £1.96m savings target as providers are likely to guarantee savings equivalent to 10% of the value of in-scope services.	Initial analysis shows this option is likely to achieve 82% of the £1.96m savings target.	Initial analysis shows this option is likely to slightly exceed the £1.96m savings target.
Reduce employee-related costs through productivity improvements, efficiencies, reviewing skills mix	Low					
Management overhead savings	Low					
Review support functions within Delivery Unit	Medium					
Efficiencies in contracts with health	Medium					
Passenger transport saving	Medium					
Enablement service	High					
Additional income from trading and other sources	High					
Total savings		**1,677,660**	**1,662,833**	**1,460,000**	**1,611,186**	**2,105,898**
Revised budget		**12,925,448**	**12,940,275**	**13,143,108**	**12,991,922**	**12,497,210**
Level of confidence in delivering and facilitating wider MTFS savings target (£13.1m)		85%	85%	85%	85%	95%
Therefore level of MTFS savings delivered from 2017/18 onwards		**11,141,035**	**11,141,035**	**11,141,035**	**11,141,035**	**12,451,745**
Total benefit to the Council		**12,818,695**	**12,803,868**	**12,601,035**	**12,752,221**	**14,557,643**
Rank		2	3	5	4	1

2.22 The financial assumptions for the LATC option are very similar to those made for the reformed in-house service. The differences in the assumptions are 1) The Barnet Group is able to trade; and 2) savings through reducing employee-related costs are assumed to be lower because delivery of statutory ASC functions is a new service area for The Barnet Group.

2.23 As an organisation independent from the Council, a PSM could have a much more streamlined organisation structure with faster decision-making and reduced bureaucracy. Therefore it is assumed a PSM could deliver employee-related cost savings and savings on management overheads through implementation of a flat management structure. Trading income is assumed, because staff would have a high level of incentive to generate income through trading. As the PSM would have a high level of control over how it spends any trading surplus, staff would be able to see a direct link between the PSM's trading activities and the money it has available to invest in service improvement.

2.24 Under a PSM the Delivery Unit proposes to reform the enablement service, with a greater emphasis upon occupational therapy, and staff development to increase skills around behaviour changes and use of equipment and preventative services. These reforms could realise efficiency savings over the savings period.

2.25 The ADM project also needs to support the achievement of the Adults and Safeguarding Committee's overall savings target (£13.1m between 2017/18 and 2019/20, excluding the ADM project's own savings target of £1.96m). The level of confidence in meeting that target has been set at 95% if the service is delivered through a PSM, reflecting the high level of alignment between the operating model's aims and the key features of a PSM. The confidence rating for the other options has been set lower, at 85%, as these options are less well aligned with the operating model.

2.26 **Criteria 5: Has this option been tested by other Councils?** The in-house model is in use by the majority of Councils and is well tested for the delivery of statutory ASC functions. There are also examples of PSMs and NHS shared services successfully delivering the full range of statutory ASC functions. However, there are no examples of a LATC or a provider outside of the public sector delivering the full range of statutory ASC functions on behalf of a Council. Given the essential nature of the ASC service, and the vulnerable people it supports, the Council needs to consider whether the potential benefits of the untested options justify the risks associated with pioneering a new approach.

Options appraisal summary

	Is there market appetite for this option?	Could this option carry out statutory social care functions?	Could this option deliver cultural and process change?	Could this option generate savings and/or additional income?	Has this option been tested by other Councils?
Public service mutual organisation	✓	✓	HIGH	HIGH	✓
NHS shared service	✓	✓	HIGH	MEDIUM	✓
Reformed in-house service	✓	✓	MEDIUM	MEDIUM	✓
LATC (The Barnet Group)	✓	✓	LOW	MEDIUM	✗
JV with partner outside the public sector	✓	✓	LOW	LOW	✗

2.27 It is therefore proposed that the following options be taken forward to a detailed appraisal:

- A PSM appears to be the most effective way to deliver the required change, and also has the strongest financial business case.
- A shared service with the NHS presents potential benefits arising from the integration of health and social care that could be highly significant.
- A reformed in-house service could deliver the required change, albeit more slowly than could be delivered through other ADMs.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Three alternative delivery model options have been evaluated and are not recommended for further consideration.

- Outsourcing or a joint venture with a partner outside the public sector (two options, treated as a single option in the options appraisal). This is the worst performing option judged against both the ability to generate savings and the extent to which it can support the required process and cultural change. In this context there is no justification for accepting the risk of being the first Council to delegate such a wide range of statutory ASC functions to a provider outside of the public sector.
- Delegating the services to The Barnet Group. Although The Barnet Group has an excellent track record as a social care organisation, its strength lies in providing social care services, rather than delivering statutory ASC functions. Insufficient synergies have been identified between The Barnet Group and the in-scope ASC services to justify combining the services. There is also a significant potential conflict of interest arising from Your Choice Barnet's role as a major local provider of learning disability services, sheltered housing and, in the future, extra care sheltered housing. It would be very difficult for The Barnet Group to ensure sufficient separation between the role of assessing social care need and the role of providing social care services. This option also has a less strong financial case than the other three options.

3.2 This project has not considered a "do nothing" option. The Council could continue to provide social care through the current model. However over time this would lead to a situation of increasing risk, both financial and in terms of safety, as unit costs of care were driven lower and risk of considerable overspend increased. The current model is also not geared up to deliver preventative responses that will help keep people healthy and well and reduce demand in the longer term. Therefore the current model will not in the long

term achieve the outcomes in the Commissioning Plan and so would not be consistent with the Council's strategy.

4. POST DECISION IMPLEMENTATION

4.1 The next stage of this project will be delivered through three workstreams:

- Producing a revised business case that develops each of the three shortlisted options in greater detail.
- Continuing the work already initiated to prepare for the proposed new operating model through culture and process change.
- Public consultation on how the new operating model should be implemented and on the proposed shortlist of ADM options.

4.2 Based upon the findings from these three workstreams, a preferred ADM will be recommended to the Adults and Safeguarding Committee in September 2016.

4.3 The time taken to implement the ADM will depend upon which ADM is selected. Transformation of a reformed in-house service would take approximately 18 months to complete. A public service mutual could be established rapidly, within three months or more slowly, within 15-18 months, depending upon the implementation approach. A NHS shared service could be established within 12 months under a Section 75 Agreement. Implementation of a shared service as an Accountable Care Organisation would take longer as this is a new form of NHS organisation.

4.4 The Council's Medium Term Financial Strategy requires the ADM to start delivering savings from the financial year 2017/18. Therefore under each of the options a phased approach to savings realisation would be required, under which some savings can be realised while implementation of the ADM is still in progress.

5. IMPLICATIONS OF DECISION

Corporate Priorities and Performance

5.1 Successful implementation of the Commissioning Plan, of which this work is part, will help to support and deliver the following 2015 – 2020 Corporate Plan objectives for health and social care services:

- To make a step change in the Council's approach to early intervention and prevention as a means of managing demand for services.
- To remodel social care services for adults to focus on managing demand and promoting independence, with a greater emphasis on early intervention.

- To implement the Council's vision for adult social care, which is focused on providing personalised, integrated care with more residents supported to live in their own home.

5.2 This approach is consistent with the Joint Health and Wellbeing Strategy 2016-2020 which sets out a vision that includes continuing emphasis on prevention and early intervention; developing greater community capacity; increasing individual responsibility and building resilience.

Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.3 The Council's net revenue budget for Adults and Communities (including staffing costs, supplies and services, payments to external suppliers and client contributions) is £85.6m in 2016/17.

5.4 The ADM project has a savings target of £1.96m between 2017/18 – 2019/20 (£654,000 per annum in 2017/18, 2018/19 and 2019/20). Initial financial analysis shows that the reformed in-house service is likely to achieve 86% of this savings target; an NHS shared service 85% of the savings target; a joint venture with a partner outside of the public sector 74% of the savings target ; delegating the services to The Barnet Group 82% and a public service mutual organisation would slightly exceed the savings target.

5.5 The Adults and Safeguarding Committee has an overall savings target of £18.5m between 2016/17 and 2019/20. The Committee's savings proposals (approved by the Council's Policy and Resources Committee on 16 December 2015) assume total savings of £3.4m in 2016/17, and a saving of £1.96m to be delivered directly by the ADM project in the period 2017/18 to 2019/20. This leaves a saving of £13.1m between 2017/18 and 2019/20 that the ADM needs to enable and support by reducing need for Council-funded services. The level of confidence in meeting this target has been set at 95% if the service is delivered through a PSM, reflecting the high level of alignment between the operating model's aims and the key features of a PSM. The confidence rating for the other options has been set lower, at 85%, as these options are less well aligned with the operating model.

5.6 A total budget of £1.26m for the ADM project was approved by the Council's Policy & Resources Committee on 16 February 2016, to be funded from the Transformation Reserve Fund. This budget includes the cost of implementing the selected ADM model.

Legal and Constitutional References

5.7 The responsibilities of the Adults and Safeguarding Committee are contained within the Council's Constitution – Section 15 Responsibility for Functions (Annex A). Specific responsibilities for those powers, duties and functions of

the Council in relation to Adults and Communities include the following specific functions:

- Promoting the best possible ASC services.
- Working with partners on the Health and Well-being Board to ensure that social care interventions are effectively and seamlessly joined up with public health and healthcare, and promote the Health and Wellbeing Strategy and its associated sub strategies.
- Ensuring the Council's safeguarding responsibilities are taken into account.

5.8 The Care Act 2014 permits increased flexibility to Councils to delegate services and responsibilities to other parties, in comparison with previous legislation. This is contained in section 79 of the Act. Subsection 2, section 79 specifically excludes the following: promoting integration with Health; co-operation; charges; safeguarding adults at risk; and powers contained within section 79.

5.9 When making decisions around service delivery, the Council must consider its public law duties. This includes its public sector equality duties and consultation requirements as well as specific duties in relation to ASC.

Risk Management

5.10 The project has been and will continue to be managed within the Council's risk management framework.

Equalities and Diversity

5.11 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people from different groups.
- Foster good relations between people from different groups.

5.12 The protected characteristics are:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

5.13 The broad purpose of this duty is to integrate considerations of equality into day to day business and to keep them under review in decision making, the design of policies and the delivery of services.

5.14 An initial Equality Impact Assessment (EIA) was carried out on the proposed new operating model in October 2015, and included in the appendix to the Committee paper of 12 November 2015. It showed “impact unknown” for staff and “no impact anticipated” for residents and service users. This EIA was reviewed in February 2016 and no requirement to update it was identified. It will be reviewed again following public consultation on the proposed new operating model.

5.15 The shortlisted ADM options are unlikely to have an equalities impact upon ASC service users because all three options are structures through which the new operating model would be delivered. However, not enough is yet known about how the ADM options would be implemented to say for certain that the choice of ADM will not have an equalities impact upon service users. Therefore the potential impact on service users will be reviewed prior to submission of the further business case in September 2016.

5.16 The ADM options will affect Adults and Communities Delivery Unit employees, with reference to which organisation employs them, and potentially their terms and conditions of employment and their job roles. However, not enough is yet known about the ADM options to be able to say what the equalities impact would be under each option; which staff would be affected and in what ways they would be affected. Therefore the potential impact on employees will also be reviewed when the three shortlisted options have been developed in greater detail as part of the development of the further business case.

Consultation and Engagement

5.17 Both the Adults and Safeguarding Commissioning Plan and the Council’s plans for implementing the Care Act 2014 were subject to public consultation.

5.18 The new operating model and the ADM options have been shaped and refined through engagement with residents, service users, partner organisations and Council staff. A list of the stakeholder engagement events carried out to-date is provided in the appendix to this report.

5.19 Whilst there is no statutory requirement to consult on these proposals, the Council intends to do so in order to be transparent and to continue to involve residents in development of the project.

5.20 The proposed new operating model and the delivery model options will be subject to public consultation in spring 2016, and the consultation findings will be presented to the Adults and Safeguarding Committee in September 2016.

5.21 The reasons for the new operating model were set out in the report to this Committee on 12 November 2015 when the approach to the proposal was approved by the Committee.

6. BACKGROUND PAPERS

6.1 The Adults and Safeguarding Committee approved its Commissioning Plan on 20 November 2014, subject to consultation.
http://barnet.moderngov.co.uk/documents/s19320/Business%20planning.pdf
http://barnet.moderngov.co.uk/documents/s19321/Appendix%20A%20-%20Commissioning%20Plan.pdf

6.2 The Adults and Safeguarding Committee approved initiation of a project to identify an alternative delivery model for ASC on 26 January 2015.
http://barnet.moderngov.co.uk/documents/s20572/AS%20committee%20ADM%20report%20011v10.pdf

6.3 The Adults and Safeguarding Committee approved the final version of its Commissioning Plan on 19 March 2015.
http://barnet.moderngov.co.uk/documents/s22061/Adults%20and%20Safeguarding%20Commissioning%20Plan.pdf
http://barnet.moderngov.co.uk/documents/s22062/Appendix%20A%20-%20Adults%20and%20Safeguarding%20Commissioning%20Plan.pdf

6.4 The Adults and Safeguarding Committee approved the approach to a new operating model for ASC on 12 November 2015.
http://barnet.moderngov.co.uk/documents/s27171/A%20new%20operating%20model%20for%20adult%20social%20care.pdf

The appendix to this report (the strategic outline case) describes the proposed new operating model in detail.
https://barnet.moderngov.co.uk/documents/s27172/Appendix%20A%20Strategic%20outline%20case%20for%20a%20future%20operating%20model%20for%20adult%20social%20care.pdf

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Outline business case:
Adult social care alternative delivery model

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1. Executive summary

Adult social care (ASC) services across the country face unprecedented pressures from the need to make budget savings, combined with growing demand, the requirements of the Care Act 2014 and rising expectations of service users. In order to meet this challenge at the necessary scale and pace, the way ASC is delivered in Barnet needs to be radically redesigned.

The Adults and Safeguarding Committee approved the approach to a proposed new operating model for ASC in November 2015. This document draws out the proposed new operating model and the changes required to implement it; and presents the findings from the second phase of this project: identifying the best alternative delivery model (ADM) through which to deliver the proposed new operating model.

The scope of the ADM includes the core activities carried out by ASC practitioners, and other activities that are closely linked to and support delivery of these core activities. The range of care services that practitioners help people to identify and access are outside of the ADM scope.

The appraisal of the ADM options was informed by activities including informal market engagement; workshops and meetings with stakeholder groups; research into ADMs and development of a proposition for a reformed in-house service.

The ADM options under consideration are:

Reforming and delivering the service in-house. The in-scope services would continue to be delivered by the Council's Adults and Communities Delivery Unit, in partnership with Capita. A transformation programme would be undertaken to implement the new operating model and ensure the continued financial and operational sustainability of the service. Stakeholders acknowledged this option as a tried-and-tested model that was known to be an effective way to support people and keep them safe. However, some staff thought the necessary changes could not be made through an in-house service. Some service users and carers agreed: they thought that it would be too difficult to "turn the service around" under this model.

Sharing services with public sector partner(s) such as local NHS organisations and/or other London Boroughs. The Council would join up with one or more local NHS organisations to deliver integrated health and social care services. A single organisation would be responsible for the delivery of local health services and ASC services. This shared service could also include another local authority partner. Stakeholders saw the potential of a shared service to improve and accelerate health and social care integration and provide what they described as a more "holistic" service. However, they also expressed concern that a NHS organisation would be the much larger partner and therefore would "dominate" the partnership.

A partnership outside the public sector. This option could be implemented as an outsourcing arrangement, where an external provider delivers the services for the Council, or a joint venture (JV), where a JV company is created, jointly owned by the Council and an external provider. Some staff felt that they might have greater “freedom” from Council policies and procedures if they worked within a private sector organisation. However, other staff were concerned that a private sector organisation would not have a strong public service ethos and would be less focused upon meeting the needs of individual service users and carers. Service users questioned whether it would be more difficult for the Council to manage a provider effectively when it was delivering a complex and sensitive service such as ASC.

Transferring the in-scope services to The Barnet Group, the Council’s Local Authority Trading Company (LATC). The Barnet Group is wholly owned by the Council, which means any profits it generates can be returned to the Council. Stakeholders felt that some of the benefits of delegating services to The Barnet Group were the same as those that applied to delegating services to any external partner (such as “freedom” from Council policies and procedures). However some stakeholders also felt that some of the drawbacks associated with an external partner could also apply to this option, such as the risk that a partner would fail to deliver the level of service described in the procurement process.

Establishing a public service mutual organisation. In the strategic outline case this option was described as a social enterprise. This term has no legal definition in the UK and is used to describe a wide range of different organisational structures. Therefore in this paper the term “public service mutual” (PSM) is used as it summarises the key features of this option – it is independent from the Council, any profits it generates are re-invested in the service and it is at least partially owned by its staff. This concept of shared ownership and meaningful representation of staff and local people at management board level was very attractive both to staff and to service users. However, amongst both staff and service users, some were concerned that a small organisation could be financially vulnerable, especially in an environment where social care budgets are reducing every year.

The following options appraisal criteria were applied to the options:

Is there appetite amongst potential partners to deliver this option? Through informal market engagement, potential interest in delivering the ADM was identified amongst local NHS organisations and amongst organisations in the private and not-for-profit sectors. The opportunity was also explored with The Barnet Group. Staff in the Adults and Communities Delivery Unit expressed interest both in exploring the PSM option and in moving forward with a reformed in-house service.

Can statutory ASC functions be delegated under this option? The Care Act 2014 gives Councils the ability to delegate most statutory ASC functions in relation to assessment and care management, although they cannot delegate their statutory

duties, and some statutory functions would remain the responsibility of the Council under any ADM. Notwithstanding these limitations, at present there do not appear to be any legal barriers to any of the options carrying out delegated statutory ASC functions.

Could this option deliver the required cultural and process change? In order to deliver the new operating model, the ADM needs to create an environment in which:

- People's expectations of what the Council will do for them are "reset" and they are encouraged to take responsibility for living as independently as possible.
- Amongst staff, trust, professional autonomy and positive risk taking are promoted and decision-making is swift and unhindered by bureaucracy.
- The service works closely with partners including health, housing and organisations from the community and voluntary sector (CVS).

There is good evidence from examples such as Focus in North East Lincolnshire and People2People in Shropshire, that a PSM can be a highly effective way to create this kind of environment. The opportunity for staff to own a financial "stake" in the organisation, and the representation of staff on the PSM management board drives high levels of staff engagement. Local people can also be members of the PSM management board and directly influence its priorities and strategic direction.

A shared service with the NHS would present a significant opportunity to transform the way ASC services work with health services, both at a strategic level and in the way staff on-the-ground work together. If health and ASC services shared a pooled budget there would be more joined-up thinking around how people can be supported to lead more independent lives for longer.

It would be possible to deliver elements of the required level of change through a reformed in-house service but it would be a very slow and complex process. The service has a strong local identity and reputation as "the Council" and this could make it harder to persuade people and partners to change expectations and work with the Council in a different way.

Although The Barnet Group is a separate organisation, it also holds a strong identity as part of the Council. This could make it more difficult for The Barnet Group to reset expectations and develop new ways of working. The Barnet Group's status as a LATC (wholly owned by the Council) means there would not be an opportunity for staff and/or members of the community to share ownership of the ADM under this option.

Involving a partner from outside of the public sector in the ADM could help to accelerate implementation of the new way of working. However, there is no evidence of this model being used in other Councils to drive extensive culture and process change in ASC. There is also a risk that staff would feel disengaged from the service

and that partner organisations could be mistrustful and reluctant to work closely with the service if it were delivered by a private sector partner.

Could this option generate savings and/or additional income? The ASC ADM project has a savings target of £1.96m between 2017/18 – 2019/20.

Under a reformed in-house service, savings would be generated through a reduction in employee-related costs and some reduction in management overheads. The staffing savings would be realised through actions to review the skills mix of staff, increase staff productivity, review support services and improve the overall efficiency of the service.

Given the importance of its role in delivering the new operating model, under a reformed in-house service the Social Care Direct service would be reviewed and integrated with the teams that deliver professional social work. The senior management team of the Delivery Unit estimates this integration could realise efficiency savings. Further savings could also be achieved by providing ASC transport and school transport through a single service. This initiative is still under development so a conservative estimate has been made that a saving could be achieved over the savings period. These two savings opportunities have been applied to all of the ADM options.

Most of the savings under a NHS shared service would be generated through economies of scale and procurement savings on supplies and equipment. Under a pooled health and social care budget there would also be increased investment in ASC as a more cost-effective alternative to NHS in-patient services. Additional net income from a pooled budget, combined with income through trading services with the private sector and/or individual citizens is assumed under this option. Employee-related cost savings are assumed to be lower than those under a reformed in-house service because increasing the efficiency of the service will be more difficult as the service will be much larger and more complex than the current in-house service. However, the assumed saving on management overheads is assumed to be higher under a shared service because two services brought together would only need one senior management team.

Initial market testing intelligence indicates that in this context a private sector partner could realise efficiency savings equivalent to 10% of the in-scope services. Based upon the projected budget for employee-related costs and transport costs in 2017/18 (£14.6m) this gives an assumed total saving of £1.46m over the savings period.

The financial assumptions for the LATC option are very similar to those made for the reformed in-house service. The differences in the assumptions are 1) The Barnet Group is able to trade; and 2) savings through reducing employee-related costs are assumed to be lower because delivery of statutory ASC functions is a new service area for The Barnet Group.

ADM financial model

Assumed value of in-scope services, 2017/18	14,603,108

Saving opportunity	Risk	Reformed in-house service	NHS shared service	Partnership outside the public sector	The Barnet Group	Public service mutual
Review Social Care Direct provision and delivery with close integration with professional social work teams	Low	Initial analysis shows this option is likely to achieve 86% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 85% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 74% of the £1.96m savings target as providers are likely to guarantee savings equivalent to 10% of the value of in-scope services.	Initial analysis shows this option is likely to achieve 82% of the £1.96m savings target.	Initial analysis shows this option is likely to slightly exceed the £1.96m savings target.
Reduce employee-related costs through productivity improvements, efficiencies, reviewing skills mix	Low					
Management overhead savings	Low					
Review support functions within Delivery Unit	Medium					
Efficiencies in contracts with health	Medium					
Passenger transport saving	Medium					
Enablement service	High					
Additional income from trading and other sources	High					
Total savings		**1,677,660**	**1,662,833**	**1,460,000**	**1,611,186**	**2,105,898**
Revised budget		**12,925,448**	**12,940,275**	**13,143,108**	**12,991,922**	**12,497,210**
Level of confidence in delivering and facilitating wider MTFS savings target (£13.1m)		85%	85%	85%	85%	95%
Therefore level of MTFS savings delivered from 2017/18 onwards		**11,141,035**	**11,141,035**	**11,141,035**	**11,141,035**	**12,451,745**
Total benefit to the Council		**12,818,695**	**12,803,868**	**12,601,035**	**12,752,221**	**14,557,643**
Rank		2	3	5	4	1

As an organisation independent from the Council, a PSM could have a much more streamlined organisation structure with faster decision-making and reduced bureaucracy. Therefore it is assumed a PSM could deliver employee-related cost savings and savings on management overheads through implementation of a flat management structure. Trading income is assumed, because staff would have a high level of incentive to generate income through trading. As the PSM would have a high level of control over how it spends any trading surplus, staff would be able to see a direct link between the PSM's trading activities and the money it has available to invest in service improvement.

Under a PSM the Delivery Unit proposes to reform the enablement service, with a greater emphasis upon occupational therapy, and staff development to increase skills around behaviour changes and use of equipment and preventative services. These reforms could realise efficiency savings over the savings period.

The ADM project also needs to support the achievement of the Adults and Safeguarding Committee's overall savings target (£13.1m between 2017/18 and 2019/20, excluding the ADM project's own savings target of £1.96m). The level of confidence in meeting this target has been set at 95% if the service is delivered through a PSM, reflecting the high level of alignment between the operating model's aims and the key features of a PSM. The confidence rating for the other options has been set lower, at 85%, as these options are less well aligned with the operating model.

Has this option been tested by other Councils? The in-house model is in use by the majority of Councils and is well tested for the delivery of statutory ASC functions. There are also examples of PSMs and NHS shared services successfully delivering the full range of statutory ASC functions. However, there are no examples of a LATC or a provider outside of the public sector delivering the full range of statutory ASC functions on behalf of a Council. Given the essential nature of the ASC service, and the vulnerable people it supports, the Council needs to consider whether the potential benefits of the untested options justify the risks associated with pioneering a new approach.

Options appraisal summary

	Is there market appetite for this option?	Could this option carry out statutory social care functions?	Could this option deliver cultural and process change?	Could this option generate savings and/or additional income?	Has this option been tested by other Councils?
Public service mutual organisation	✓	✓	HIGH	HIGH	✓
NHS shared service	✓	✓	HIGH	MEDIUM	✓
Reformed in-house service	✓	✓	MEDIUM	MEDIUM	✓
LATC (The Barnet Group)	✓	✓	LOW	MEDIUM	✗
JV with partner outside the public sector	✓	✓	LOW	LOW	✗

It is proposed that the following options will not be taken further:

- A JV with a partner outside the public sector, as this is the worst performing option when judged against both the ability to generate savings and the extent to which it can support the required cultural and process change.
- Delegating the services to The Barnet Group, as although it has a track record as a social care provider organisation, its experience lies in providing social care services rather than delivering statutory ASC functions.

It is proposed that the following options will be taken forward to a detailed appraisal:

- A PSM appears to be the most effective way to deliver the required cultural and process change, and also has the strongest financial business case.
- A shared service with the NHS presents potential benefits arising from the integration of health and social care that could be highly significant.
- A reformed in-house service could deliver the required change, albeit more slowly than could be delivered through other ADMs.

The next stage of this project will be delivered through three workstreams:

1. Producing a further business case that develops each of the three shortlisted options in greater detail.
2. Continuing the work already initiated to prepare for the proposed new operating model through culture and process change.
3. Public consultation on how the new operating model should be implemented and on the proposed shortlist of ADM options.

Based upon the findings from these three workstreams, a preferred ADM will be recommended to the Adults and Safeguarding Committee in September 2016. The timescale for ADM implementation will depend upon which option is selected. Transformation of a reformed in-house service would take approximately 18 months to complete. A PSM could be established rapidly, within three months or more slowly, within 15-18 months, depending upon the implementation approach. A NHS shared service could be established within 12 months under a Section 75 Agreement. Implementation of a NHS shared service as an Accountable Care Organisation would take longer as this is a new form of NHS organisation.

2. Strategic context

The scale of the adult social care challenge

Adult social care (ASC) services face unprecedented pressures from:

- **The need to find significant financial savings.** The economic challenges the UK has faced over the past few years have meant Councils have needed to take some tough decisions in order to live within their means. In June 2014 the Council's Priorities and Spending Review (PSR) identified options to make savings and increase income by approximately £50.8 million between 2016/17 and 2019/20. £12.6m of savings were allocated to the Adults and Safeguarding Committee. A further £5.9m was added to the savings target in July 2015, bringing the total to £18.5m.

- **Growth in demand for ASC services.** Across the country rising life expectancies and medical advances are contributing to increased demand for ASC services. In Barnet the number of people aged 90 or above is projected to increase by 54.5% (an additional 1,900 people) between 2015 and 2025. There are also increasing needs among younger adults. In Barnet, the number of 18-24 year olds supported by ASC has increased by 25% in the last four years.

- **Requirements of the Care Act 2014.** The Care Act 2014 is the biggest reform of care and support in more than 60 years. Last year the Council estimated the cost of implementing the full Care Act 2014 in Barnet could be an additional £7.8m per annum[1].

- **Rising expectations of service users.** Advances in customer services and technology mean people have higher expectations of public services. This means many ASC service users, carers and their families will not be content with the Council's current service offer in the future. However, these advances also present opportunities for the Council to use new technologies to meet people's needs more effectively.

How the ASC challenge is being addressed in Barnet

In order to address these challenges the Council has made a number of changes[2] focused upon improving the efficiency, effectiveness and value for money of ASC services. These changes helped to deliver savings of £29.4m between 2010/11 and 2014/15.

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[1] Adults and Safeguarding Commissioning Plan, 2015 – 2020, Appendix A (19 March 2015). http://barnet.moderngov.co.uk/documents/s22061/Adults%20and%20Safeguarding%20Commissioning%20Plan.pdf

[2] Summarised in the strategic outline case for a future operating model for adult social care, presented to the Adults and Safeguarding Committee on 12 November 2015: http://barnet.moderngov.co.uk/documents/s27172/Appendix%20A%20Strategic%20outline%20case%20for%20a%20future%20operating%20model%20for%20adult%20social%20care.pdf

However, the Council is approaching the limit of savings that can be achieved through providing services more efficiently. In particular, there is very limited scope to further reduce the cost of care services provided by external suppliers, which account for more than 80% of the Council's ASC expenditure.

There is therefore a need to find ways to reduce demand for Council-funded ASC services by helping people to stay healthy and well, supporting them to regain their independence after illness or injury, and encouraging them to make greater use of community resources as an alternative to Council-funded care and support.

A new operating model for ASC

In order to reduce demand for Council-funded ASC services at the necessary scale and pace, the way ASC is delivered in Barnet needs to be radically re-designed. Therefore in January 2015 the Adults and Safeguarding Committee approved a project to develop a new ASC model[3] for Barnet, based on the principles of:

1. Enabling people to regain and maintain their wellbeing so they don't need to call upon ASC services. Where people do need ASC support, the Council helps them remain in their own community and home for as long as possible.
2. For all people who use ASC, intervening at a much earlier stage and in a different way.
3. Maintaining or improving the Council's ability to meet its statutory ASC duties and keep the most vulnerable adults and older people safe.

It was agreed that to meet these principles, any new model needs to:

- Change the pattern of demand through a focus on very early intervention and prevention. This requires a significant shift from the current model that focuses resources on assessment once someone has social care needs.
- Introduce new processes that reduce duplication of effort and increase use of technology, mobile working and self-service. In practice this means making it easier for residents to assess their own requirements, obtain information and advice, decide what to do and then put their own plans into action.
- Draw upon services, information and advice offered by community groups, volunteers, the voluntary sector and local health services.
- Deliver assessment and support planning that focuses on people's strengths and what they can do for themselves, and draws upon support from their families and local communities.
- Produce innovative care plans that include non-traditional support such as technology to help with daily living.

[3] The Implications of the Commissioning Plan and The Care Act 2014 for Adult Social Care in Barnet (26 January 2015). https://barnet.moderngov.co.uk/documents/s20572/AS%20committee%20ADM%20report%20011v10.pdf

In November 2015 an approach to a new operating model for ASC was approved by the Adults and Safeguarding Committee[4]. The operating model is based on shared responsibility between the state, the community and the person. It encourages people to recognise their strengths and identify the support that their family, friends and the local community can give them.

The model proposes fundamental changes to what ASC practitioners do and, more importantly, to how they do it, in order to deliver a greatly improved ASC service for people in Barnet:

Cultural change		Process change		Customer experience
• A culture based on trust, professional autonomy and positive risk taking. • Practitioners take a different approach to their work and apply new ways of thinking, new skills and new behaviours. • Strong staff teams support and motivate practitioners as the new culture develops. • Strong working partnerships are developed with CVS organisations, based on trust and transparency. • Residents and service users are willing to re-think their expectations and interact with the Council in a different way.	+	• Emphasis on preventative services to keep people as healthy and well as possible. • Emerging digital technology and innovation used to improve services and give residents 24/7 access to a range of information and services. • People whose issues cannot be resolved over the telephone and who do not need a home visit will be invited to a hub appointment. • An asset-based and community-led approach to supporting people. • Statutory activities are joined up with the rest of the service.	=	People in Barnet will experience a service that is: • Responsive. • Seamless. • Joined up with other agencies. • Effective. • Focused on continual improvement.

Individual practitioners would be asked to take a different approach to their work and apply new ways of thinking, new skills and new behaviours. They would be given greater autonomy and freedom to apply their professional judgment and develop new, better ways of working. The Council would also work differently with community and voluntary organisations, involving them as partners in the design, implementation and delivery of the new model.

A key feature of the operating model is a new way of responding to people whose issue cannot be resolved by Social Care Direct and who require more than a telephone conversation but do not necessarily need a home visit. These people would be invited to attend an appointment at a community hub, staffed by ASC workers and supported by voluntary organisations and other agencies.

[4] A New Operating Model for Adult Social Care: http://barnet.moderngov.co.uk/ieIssueDetails.aspx?IId=24852&PlanId=0&Opt=3#AI12597

The proposed new operating model will deliver a more personalised and person-centred customer experience:

A responsive service. People who contact Social Care Direct have their issue resolved straight away or are put in touch with other organisations that can help them, or offered an appointment at a community "hub" to take place within two weeks. They are asked which hub they would like to attend, receive directions and a follow-up letter confirming the details and what to expect. If a person needs a home visit this is arranged within a maximum of four weeks depending on their situation.

A seamless service. People who need ASC support get the same response and support if they approach their local voluntary organisation or attend any community hub. If they are already supported by or known to a voluntary organisation that support continues even if a person goes on to receive Council-provided services.

People who use services

A "joined-up" service. If, for example, someone has a health condition, is a tenant of social housing, or requires supported employment they experience a joined-up response and can talk to those other agencies when they visit a hub.

An effective service. People can have a conversation with someone who uses language they understand and is interested in knowing what is important to them in living a good life. They can also talk to someone who has experienced the service themselves and can relate to their situation and provide additional information and guidance. They leave the session feeling informed, listened to, satisfied with the outcome and feeling it has been a worthwhile experience.

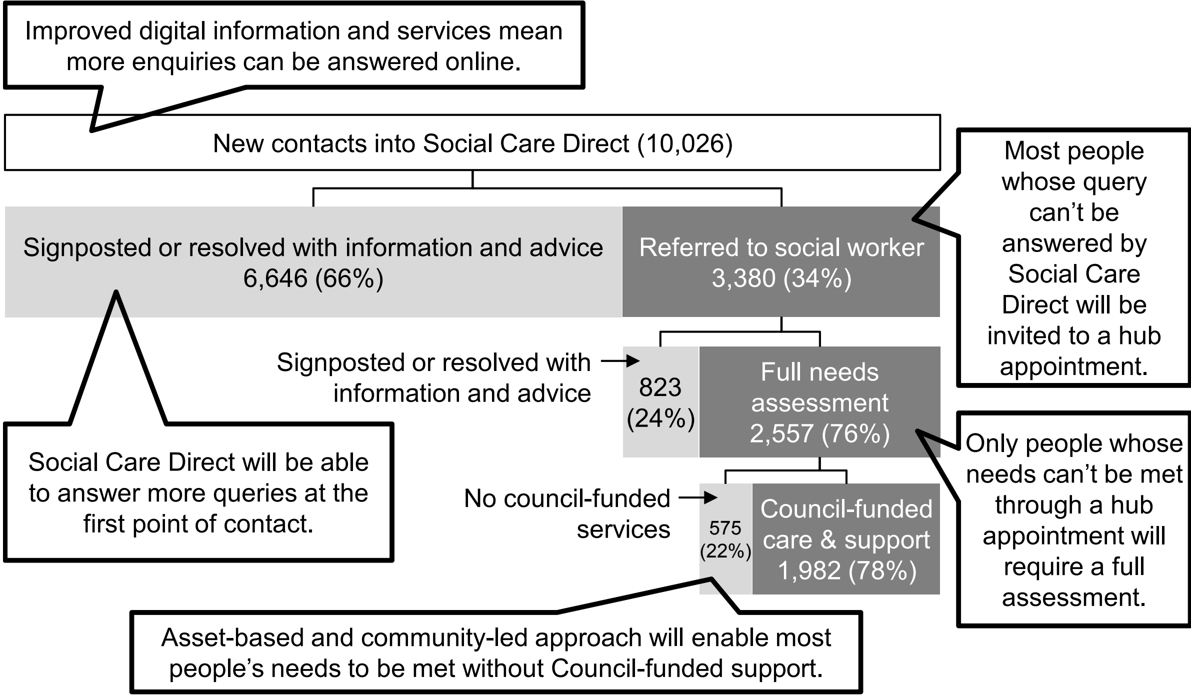
A service focused on continual improvement. People's views on how the service could be improved are listened to. Even if they only had one telephone conversation with the service, they are asked within a few weeks whether this successfully resolved the issue for them.

The proposed new operating model will enable changes in the way ASC is delivered across a number of elements of the service:

Area	Current status	What needs to change
Referrals	Approximately 38% of referrals to ASC come from secondary healthcare services.	Proactive social work in hospitals to promote higher take-up of enablement.
Assessments	Most people (76%) referred to a social worker by Social Care Direct receive a full needs assessment.	More people supported through asset-based “different conversations” without a full needs assessment.
Carers	Carer support services in place, but mostly following a reactive model.	More proactive carer support, with prevention plans in place for the most high risk cases.
Employment	5.2% of adults using MH services and 9.5% of adults using LD services are in paid employment.	Aim to have the highest employment rates for adults with learning disabilities / mental health needs in London.
Housing and support	Plans in place to develop more housing to support people’s independence.	Ensure an appropriate supply of housing to maximise independence.
Technology and adaptations	Telecare services focus on older adults with non-complex needs. Means-tested Disabled Facilities Grants (DFGs) are made available.	Significantly increase (at least double) the take-up of both telecare services and DFG grants across a range of different service user groups.
Community-led services	Some preventative services are commissioned from the CVS sector.	Greatly increased role in service development and delivery for local CVS organisations.
Hubs	Pilot of community hubs for assessments and reviews underway in three locations.	All assessments and reviews take place in a hub, unless a person cannot travel to a hub.
Productivity	Scope for improvement in practitioner productivity rates has been identified	Aim to have the highest practitioner productivity rates in London.
Reviews	Reviews are not always timely, and tend to recommend increased levels of support.	Reviews are asset-based, timely and always seek to maximise independence.

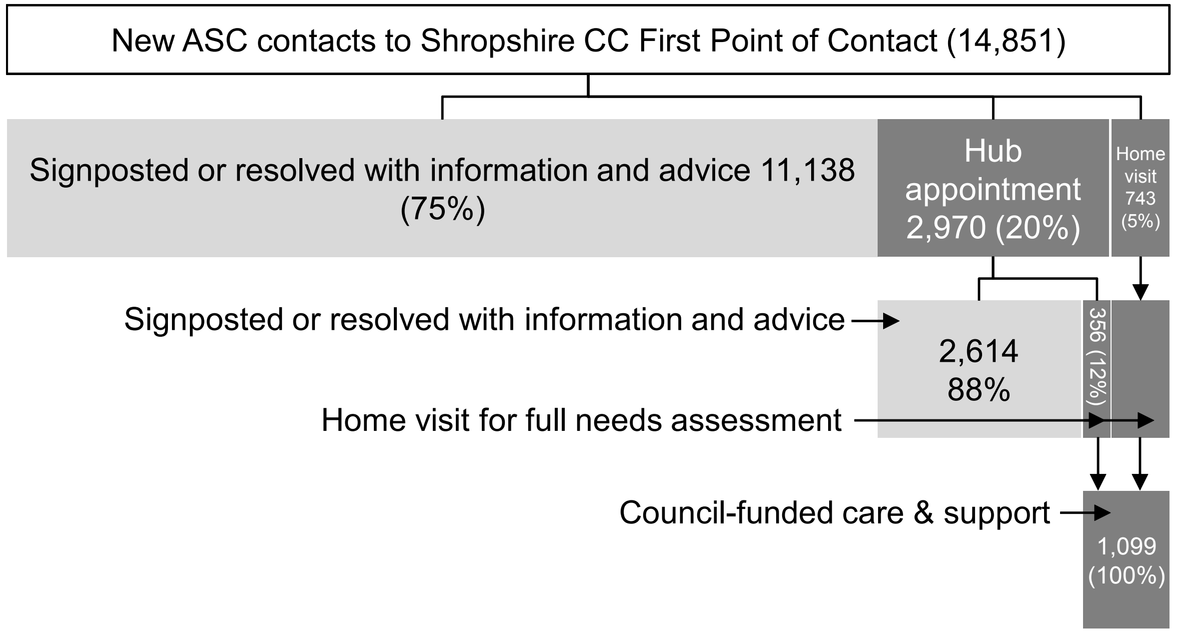
The evidence emerging from other Councils that have implemented similar approaches suggests this operating model would also support savings by reducing the number of new Council-funded care packages that are needed each year.

The following diagram, taken from the strategic outline case, shows the “flow” of people contacting Social Care Direct with ASC enquiries in 2014/15, and indicates the main ways in which the new operating model would change this flow:



Source: Referrals, Assessments and Packages of Care (RAP) return submitted by Barnet Council to the Health and Social Care Information Centre (HSCIC).

In Shropshire, a new operating model, focusing on cultural change to give staff greater professional autonomy and empower people to take responsibility for improving their lives, has enabled the following flow of ASC enquiries:



Source: People2People, Shropshire. Data reflects new ASC contacts in September 2015, excluding hospital referrals. Mental health enquiries that the First Point of Contact team cannot resolve with information and advice are signposted to Shropshire County Council's mental health team.

In Shropshire, 20% of people contacting the Council with an ASC enquiry are invited to attend an appointment at a community hub, and 88% of these people have their problems resolved through information and advice and/or signposting to local CVS groups, at no cost and without needing a full statutory ASC needs assessment. Only 5% of people contacting the Council with an ASC enquiry need face-to-face advice and are not able to attend a hub appointment (for example, because of a physical disability or caring responsibilities). These people receive a home visit from an ASC practitioner.

A new alternative delivery model for ASC

In January 2015 the Adults and Safeguarding Committee also agreed that the project should consider the full range of alternative delivery models (ADMs) through which the new operating model could be delivered:

- Reforming and delivering the service in-house. This could include bringing in specialists from other organisations (including the private sector) to support development of a new internal culture and ways of working.
- Extending the services provided through the Council's Local Authority Trading Company (LATC), The Barnet Group.
- Sharing services with public sector partner(s) such as other London Boroughs or local NHS organisations.
- Establishing a social enterprise or employee-led mutual organisation.
- Outsourcing or creating a joint venture with a third party supplier.

This list of options was based upon findings from previous Council projects exploring ADMs, combined with sector-wide best practice knowledge.

3. Project definition

Project objectives

The objectives of this project are to:

1. Develop a new ASC operating model, building upon the principles and characteristics agreed by the Committee in January 2015.
2. Identify the best ADM to deliver the new operating model, applying lessons learned from the Council's previous work on ADMs.

This project needs to realise savings of £1.96m[5] set out in the Council's medium term financial strategy (MTFS). It also needs to support the achievement of the remainder of the Adults and Safeguarding Committee's overall savings target (£13.1m between 2017/18 and 2019/20) by reducing need for Council-funded services.

The output of the first stage of work, a proposed new ASC operating model, was presented to the Adults and Safeguarding Committee[6] in November 2015.

This document draws out the proposed new operating model and the changes required to implement it (in section 2, above) and presents the findings from the second phase of work, identifying the best ADM to deliver the proposed new operating model.

Project scope: services to be included in the ADM

The following principles have been applied to define which services should be included within the scope of the ADM.

1. The core activities carried out by ASC practitioners are:
    - Identifying people who need social care support.
    - Working with those individuals and their families to agree what support each individual needs in order to live a good life.
    - Arranging that support, or helping the person to arrange support for themselves.
    - Monitoring the support to ensure that it is effective and enables the person to achieve their goals.

All these activities (across all service user groups) should be within the ADM scope.

2. Other activities that are closely linked to and support the delivery of these core activities should also sit within the ADM. For example:

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[5] £654,000 per annum in 2017/18, 2018/19 and 2019/20.

[6] A New Operating Model for Adult Social Care: http://barnet.moderngov.co.uk/ieIssueDetails.aspx?IId=24852&PlanId=0&Opt=3#AI12597

- Providing ongoing professional social work support for people with very complex needs.
- Arranging and providing short term enablement support as part of the process of identifying what long term support, if any, a person needs.
- Establishing a person's eligibility to receive Council-funded social care services (financial assessments) and associated financial services.

3. The range of ASC services that practitioners help people to identify and access are outside of the ADM scope.
4. Back office services (including IT, Finance, HR, Procurement and Estates) could be within or outside the ADM scope. This decision should be based upon specific practical and financial considerations.

Based upon these principles, the following services fall within the ADM scope.

- Services through which people who need social care support are identified:
  - First point of contact telephone and email services and online information and advice[7].
  - Urgent response team.
  - Hospital teams.
- Assessments and reviews, including needs assessments, conversations that don't constitute a full needs assessment, running the community hubs, financial assessments and home adaptation assessments.
- Occupational therapy and access to enablement services.
- Support planning and brokerage.
- Safeguarding activities, as these are aligned to identifying the need for ASC support and arranging ASC support. Also, all the channels through which safeguarding risks would be raised are within the ADM scope.
- Financial services: billing, deferred payments, Direct Payments monitoring, Care Accounts (from 2020).
- Gathering and maintaining good management information to inform decision making and ongoing improvement (business intelligence, performance, improvement). Best practice research suggests this function is most effective when it is a core part of the ADM.

Most of these services are delivered by the Council's Adults and Communities Delivery Unit but some are provided by external suppliers:

[7] Over time the Council's online platform will include more interactive services such as online self-assessment tools to enable people to assess their own social care needs and identify services and resources that they can access to meet those needs.

- Capita runs Social Care Direct (the “front door” to Barnet’s ASC services) as part of the Council’s wider customer services, and also manages the Delivery Unit’s online presence (including Social Care Connect, an online directory of ASC information, advice and services) as part of the Council’s wider information and communications technology (ICT) services.
- Enablement services are provided by Housing & Care 21, a not-for-profit care and housing provider.
- Barnet Centre for Independent Living’s Peer Support Planning and Brokerage Service helps people in Barnet to create their own support plans and arrange their support.

The customer services and ICT services provided to the Delivery Unit by Capita are provided under the Council’s corporate contract with Capita and it is assumed Capita would continue to provide these services under any ADM.

With the exception of these services, the ADM would hold the budget for all of the in-scope services, and be responsible for their delivery. It could sub-contract any of the services (partially or wholly) to other organisations. Processes would be needed to ensure the ADM had appropriate oversight of any sub-contracted services.

The following services would fall outside of the ADM and continue to be provided under the current delivery mechanisms.

<table>
<tr><th>Service</th><th>Interface with the ADM</th><th>Connections required with the ADM</th></tr>
<tr><td>Residential care, nursing care, home care, day care, respite care, telecare, Supported Living and home adaptations.</td><td rowspan="3">Practitioners help people to identify and access these services.</td><td rowspan="3">• Practitioners need detailed knowledge of these services.
• The ADM needs to contribute to the Council’s market shaping decisions, to ensure the right blend of services is available in the medium and long term.</td></tr>
<tr><td>Care market management – planning and monitoring the Council’s requirements for care services. This is a strategic function that should remain within the Council.</td></tr>
<tr><td>Services and support provided by CVS organisations.</td></tr>
</table>

Service	Interface with the ADM	Connections required with the ADM
Preventative services and interventions (e.g. addressing social isolation; providing support for carers; helping people to stay fit and healthy). Commissioned by the Council's Commissioning Group and delivered by a range of providers, including CVS organisations.	The ADM needs to be aligned with the Council's overall prevention approach to prevention.	• The Council may commission the ADM to deliver specific preventative services and interventions.
Back office services: Finance, ICT, Procurement, Insight, Customer Services, HR (including payroll and pensions administration), Estates and Health and Safety.	The ADM is the client for these services, which need to support the efficient and effective operation of the ADM.	• The ADM should be able to define its own service requirements within the constraints of the Council's corporate contract.

Statutory functions

The Care Act 2014 does not allow Councils to delegate the following ASC functions[8] to other parties:

- Promoting integration of ASC provision with health provision and health-related provision (including housing).
- Deciding what services will be charged for, and setting the level of charges.
- Co-operating with relevant partners and other appropriate people, both generally and in specific individuals' cases.
- Adult safeguarding.

Therefore responsibility for these functions would need to remain with the Council. However the Council may commission or arrange for other parties to carry out related activities to support it in discharging the above functions. For example:

- The Council has overall responsibility for safeguarding but can ask the ADM to receive safeguarding alerts, carry out safeguarding enquiries and take appropriate follow-up actions on the Council's behalf.
- The Council must decide its own charging policies but can ask the ADM to carry out the administration, billing and collection of fees on its behalf.

[8] Section 79 of the Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/section/79/enacted.

Best Interest Assessors and Approved Mental Health Practitioners do not need to be employees of the Council. However, if they are not employed by the Council they cannot take proceedings in their own name and the Council must indemnify their actions.

The Council is the supervisory body for Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 does not allow for any other body to take this role. Any application to the Court of Protection for a DoLS authorisation would need to be made by the Council. Although DoLS assessments could be carried out by staff who are not Council employees, the person signing-off DoLS applications would need to be employed by the Council.

Summary of ADM scope

Back office services

Care market management

Financial services

Barnet residents

Preventative services

Mental health services

Social Care Direct

Hospital team

Information & advice

Urgent response team

Learning disability services

Assessment and enablement

Care planning and brokering

Residential/ nursing care

Respite care

Supported Living

Home adaptations

Care at home

Day care

Direct Payments

Telecare

Occupational therapy

Ongoing professional social work support for people with very complex needs

Reviews

Adult safeguarding, including responsibilities under the Mental Capacity Act 2005

Key

In scope

Out of scope

4. Methodology

Using the proposed new operating model as a point of reference, the project board provisionally agreed the scope of services to be included within the ADM (described in section 3). A set of appraisal criteria against which to judge the ADM options were also developed (described in section 6).

A number of workstreams were established to inform the options appraisal:

- Workshops with staff from the Adults and Communities Delivery Unit; with service users and their carers; and with representatives from local CVS organisations. These sessions aimed to explore what each of the stakeholder groups thought would be the potential strengths and weaknesses of each option, both for the Council and for themselves. The workshops followed on from meetings held with staff, service users and carers and local CVS groups between August - November 2015, to inform and shape the proposed new operating model. Appendix A provides a full list of the stakeholder engagement meetings carried out as part of this project.

- Informal market engagement: conversations and meetings with a sample of 13 potential partners and suppliers (including the Council's own Delivery Unit and its LATC, The Barnet Group) to test the extent to which these organisations have the appetite and capability to work with the Council to develop and operate the ADM.

- The senior management team of the Adults and Communities Delivery Unit developed a proposition for a reformed in-house service. This included consideration of how the service would need to change, how it would deliver the proposed new operating model and savings target, and what support and resources would be required. Conversations were also held with Capita to establish what support could be provided under the Customer Support Group (CSG) contract to support a reformed in-house service.

- Research into ADMs currently being used to deliver ASC, to identify why each model was chosen and what factors contributed to their success.

- Investigation of the different organisational forms through which an ADM could be established. This work built upon the best practice research that was conducted to inform the development of the proposed new operating model.

- The cost saving and income generating methods available to each ADM option were identified and used to produce a high level assessment of each ADM's ability to achieve this project's savings target.

- Legal advice was taken to check whether there were any legal barriers to implementing any of the options, based upon the ADM scope as defined in section 3.

The evidence gathered through these workstreams was presented to the project board at meetings held in December 2015 and January 2016, where the project board agreed the scoring of each of the ADM options against the appraisal criteria.

The project has also started to prepare for the proposed new operating model by working with the Adults and Communities Delivery Unit to initiate projects that develop the culture and process change required. A pilot to test use of community hubs to carry out assessments and reviews in a community location started in December 2015. A consistent asset-based approach to assessments and reviews is being developed, building upon the current practice of the Community Offer team (a social work and occupational therapy support service helping people live independently in their own homes). Best practice research shows the cultural and process changes required to put the new operating model into practice take time to deliver. Therefore this project aims to transform the service as much as possible whilst the service is still in its current form, to prepare for the implementation of the proposed new operating model and any future ADM.

5. Description of options and stakeholder feedback

This section describes the options under consideration, outlining the key features of each option and how they would be implemented. It also summarises stakeholder feedback on the options, gathered through workshops held with service users, carers and residents; representatives from local CVS organisations; and staff from the Adults and Communities Delivery Unit.

A reformed in-house service

The in-scope services would continue to be delivered by the Council's Adults and Communities Delivery Unit, in partnership with Capita. Although no changes would be made to the overall governance of the services, this is not the "no change" option. A transformation programme would be undertaken to implement the new operating model and ensure the continued financial and operational sustainability of the service. This programme of transformation is described in Appendix B.

Ownership	• Retained by the Council.
Governance	• Multi-level officer structure including various boards. • Political structure, Committee system for decision making.

Potential benefits of a reformed in-house service

Some staff felt all of the changes described in the proposed new operating model could be delivered through an in-house service. They thought that as the in-house service is a tried-and-tested model and known to be an effective way to support people and keep them safe it was therefore the lowest risk option. Service users thought that retaining the in-house service would have the lowest "cost of change" and would enable continuity of the service.

Some staff felt that an in-house service can feel more "directly accountable" to the people it serves and others said they felt pride as Barnet Council employees.

Potential drawbacks of a reformed in-house service

Other staff thought that although it is possible to make the necessary changes through an in-house service, it would be a long process to make such significant changes, especially to change the working culture and "chisel away" at unnecessary bureaucracy. Some staff thought the necessary changes could not be made through an in-house service. Some service users and carers agreed: they thought that making change happen within the Council structure is hard, and that it would be difficult to "turn the service around" under the current model.

A shared service with one or more NHS partners

The Council would join up with one or more local NHS organisations to deliver integrated health and social care services. A single organisation would be responsible for the delivery of local health services and ASC services. There are a number of different governance structures through which a NHS shared service could be implemented. Examples of the different ways in which other Councils have implemented shared services with the NHS are provided in Appendix C.

Ownership	• Jointly owned by the Council and its NHS partner(s); or the Council could delegate ASC functions to the NHS partner.
Governance	• A number of governance structures could be considered, including creating an Accountable Care Organisation.

Alternatively, the Council could join up with one or more other Councils to deliver ASC services. This would deliver cost savings through economies of scale, but would not deliver any of the benefits that come from integrating health and social care. Given the growing momentum around health and social care integration[9], it would be a missed opportunity to develop a shared service with another Council that did not include at least one NHS partner. Therefore the options appraisal will consider a shared service with another local authority only as part of developing a shared service with one or more NHS partners.

Potential benefits of a NHS shared service

Staff, service users and local CVS representatives all saw the potential of a shared service to improve and accelerate health and social care integration and provide what they described as a more "holistic" service. One service user though that if health and social care services shared a single budget their objectives would be more likely to be aligned and they would be incentivised to work more effectively together. Some staff though that there could be economies of scale from joining up with a NHS partner, and identified some specialist services, such as the out-of-hours service, that could be delivered more efficiently at a larger scale.

Potential drawbacks of a NHS shared service

Staff, service users and local CVS representatives expressed concern that a NHS organisation would be the much larger partner and would therefore "dominate" the partnership, resulting in the social care agenda being subordinated to a health agenda.

[9] In particular, the announcement in the Government's Spending Review of November 2015 that each part of the country will be required to develop plans for the integration of health and social care services by 2017, to be implemented by 2020.

Some service users thought a shared service would be the most challenging option to implement, because it would require two (or more) organisations to be transformed instead of one. They felt the success of this option depended upon finding the right organisation to share services with. Some staff thought it would be difficult to find a local partner organisation that shared the Council's vision and was able to move at our pace. Other staff felt that integrating the working processes and ICT systems of two or more partner organisations would be complex and time-consuming.

A number of risks were also noted by staff and service users: what would happen if the other partner ran into financial difficulties? Could a shared service result in a loss of local accountability and a diminishing of Barnet's local individuality?

A partnership outside the public sector

This option could be implemented as an outsourcing arrangement, where an external provider delivers the services for the Council, or a joint venture (JV), where a JV company is created, jointly owned by the Council and an external provider. Given the complexity and risk inherent in the in-scope services, it is assumed that this option would be implemented as a JV, as this would give the Council a greater level of control over the day-to-day delivery of the services. Appendix D presents summary findings from conversations held with a sample of potential providers to test the appetite and capability of these organisations to work with the Council to develop and operate a JV partnership.

Ownership	• Jointly owned by the Council and an external provider.
Governance	• New company created with both the Council and external provider represented on the Board. Delivery Unit staff would transfer employment to the new company.

Potential benefits of a JV with a partner outside the public sector

Staff noted that the Council already manages external partners and therefore they thought it has the necessary experience and expertise in contract management. Some staff thought the private sector could bring additional funding to invest in service improvement, and that staff might have greater "freedom" from Council policies and procedures if they worked within a private sector organisation.

Potential drawbacks of a JV with a partner outside the public sector

Some staff were concerned that a private sector organisation would not have a strong public service ethos and would be less focused upon meeting the needs of individual service users and carers. Some service users also felt that an organisation outside of the public sector may not understand the specific issues affecting people

who use social care services. A question was raised by service users about whether it would be more difficult to manage a provider effectively when it was delivering a complex and sensitive service such as ASC, that potentially carries a high level of risk. Across all the different stakeholder groups (staff, service users and CVS representatives) there were some who felt that it was not appropriate for any organisation to generate a profit from providing ASC services.

Some staff also felt there were risks around suppliers failing to deliver the level of service described in the procurement process, and in the longer term, that the supplier may not share the Council's long term strategic vision.

Service users felt it would be important for any provider that was not based in Barnet to understand the local context, and to maintain a visible presence in Barnet.

Local Authority Trading Company (The Barnet Group)

Under this option, the in-scope services would transfer to The Barnet Group, which is the Council's LATC. The Barnet Group is wholly owned by the Council and this means any profits generated by The Barnet Group can be returned to the Council. The Barnet Group put forward a proposal for how it would deliver the in-scope services, which is summarised in Appendix E.

Ownership	• The Barnet Group is wholly owned by the Council.
Governance	• A subsidiary company would be created to hold the in-scope services of the ADM. Delivery Unit staff would transfer employment to the subsidiary company.

Reaction to LATC (The Barnet Group)

In comparison to the other ADM options, the option of moving services to The Barnet Group stimulated less reaction and discussion from stakeholders. Staff felt that some of the benefits of delegating services to The Barnet Group were the same as those that applied to delegating services to any external partner. For example, greater "freedom" from Council policies and procedures. However, some service users and staff also felt that a number of the potential drawbacks associated with delegating services to an external partner outside of the public sector could also apply to this option, such as the risk that a partner would fail to deliver the level of service described in the procurement process.

A public service mutual organisation

In the strategic outline case presented to the Adults and Safeguarding Committee in November 2015 this option was described as a social enterprise. The term "social

enterprise" has no legal definition in the UK and is used to describe a wide range of different organisational structures. Therefore in this paper the term "public service mutual" (PSM) is used, as it summarises the key features of this option – that it is independent of the Council; that any profits it generates are re-invested in the service; and that it is at least partially owned by its staff.

Appendix F contains further information about the features of a PSM; findings from research into PSMs delivering statutory ASC services; and a summary of the service development opportunities that could be explored under a PSM.

Ownership	• Could be 100% owned by the PSM staff; jointly owned by PSM staff and the local community; or jointly owned by PSM staff and the Council.
Governance	• New not-for-profit company created. Board membership would reflect the PSM's ownership structure. • Senior management team of Delivery Unit would become the leadership team of the PSM.

Potential benefits of a PSM

A number of staff felt a PSM could be the most effective way to restore some of the good social work practice that had been gradually eroded since the Community Care Act (1992), when practitioners were more embedded in their local communities and had greater freedom to implement innovative practice and autonomy to explore local solutions. There was scepticism amongst some staff that it would be possible to make these kinds of changes within an in-house service.

The concept of shared ownership and meaningful representation of staff and local people at management board level was very attractive both to staff and to service users. Representatives of Barnet's community and voluntary sector also liked the idea of practitioners being supported to develop their own, staff-led organisation. As their own organisations were charities or social enterprises they understood the potential benefits that these structures could have for the service, in particular, enabling much greater flexibility and creativity.

Staff thought a PSM presented an opportunity to build an organisation with a real focus on supporting people and where the staff share a set of common values. Some felt it had the potential to be the most "exciting" option in terms of the scale and pace of change to working practices that it could enable.

Potential drawbacks of a PSM

Both staff and service users were concerned that a small organisation could be financially vulnerable, especially in an environment where social care budgets are reducing every year. Both also thought that the Council would need to be sure there

was sufficient staff appetite to implement a PSM, in order to ensure the success of the new organisation, and to manage the risk of staff deciding to leave the service.

It was noted that the best practice examples of PSMs had a smaller scope than the proposed ADM scope for Barnet. Some staff asked whether there could be additional risks associated with the broad range of services within the scope of this project.

Some of the stakeholder feedback applied to all of the ADM options with the exception of a reformed in-house service.

Potential benefits of moving the service outside of the Council

Some staff, service users and CVS representatives thought that, in the short term, the process of moving outside of the Council could provide a "kick-start" for transformation and make it easier to make changes more quickly. In the longer term, some staff felt that moving outside of the Council could increase the flexibility and agility of the service.

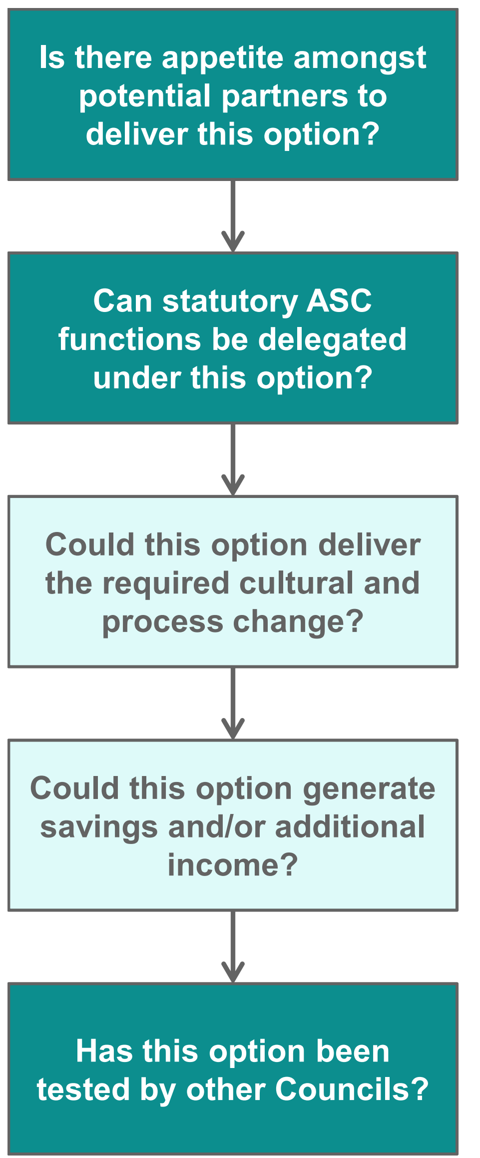
Potential drawbacks of moving the service outside of the Council

Some staff and service users questioned the extent to which a new model could reduce the bureaucracy of the in-house service, because the service would still have a responsibility to follow legal requirements. Some thought there could even be additional bureaucracy because the Council would need to monitor the performance of any externally-delivered service.

Other staff thought the process of implementing a new model could divert money and effort away from service improvement. In particular, they felt there was a risk that moving to a new model could have an adverse effect upon staff turnover and retention.

6. Options appraisal

The following options appraisal criteria have been agreed by the project board:



The first two criteria applied are gateway criteria, where the outcome is either pass or fail. An option that fails either of these criteria is not feasible and will not be taken forward in this process.

There are then two ranking criteria, where the outcome against each criterion is high, medium or low.

There is then a final gateway criterion. Any option that fails this criterion will not be taken forward unless it has achieved a "high" score in at least one of the two ranking criteria.

Is there appetite amongst potential partners to deliver this option?

Three of the ADM options depend upon the Council being able to find a partner or supplier organisation that is interested in providing the services.

- NHS shared service. In informal market engagement, conversations were held with two local NHS Trusts, which indicated interest in this option.
- A partnership outside the public sector. In informal market engagement, conversations were held with nine different organisations from the private and not-for-profit sectors. All of these organisations expressed potential interest in the opportunity, four as "prime contractors" leading a consortium bid, and five who expressed an interest in delivering some of the in-scope services as part of a consortium bid.
- Delegation of services to the Council's LATC. This has been explored with the Barnet Group, which has a track record of taking on the provision of services from the Council.

This suggests sufficient potential interest to consider each of these options further.

The PSM model would be staff-led and therefore is only feasible if staff are enthusiastic about developing and working within such a model. The leadership team of the Adults and Communities Delivery Unit has indicated its strong interest in exploring the PSM delivery model. In workshops held with staff from the Adults and Community Delivery Unit in December 2015, interest and enthusiasm was expressed about the PSM option. Other staff said that their preference was to move forward with a reformed in-house service.

Can statutory ASC functions be delegated under this option?

The Care Act 2014 gives Councils the ability to delegate statutory ASC functions in relation to assessment and care management (although Councils cannot delegate their statutory duties). The Act places no restrictions upon the type of organisation to which a Council may delegate its statutory ASC functions.

As described on pp20-21, some statutory functions and activities would remain the responsibility of the Council under any ADM.

Notwithstanding these limitations, at present there do not appear to be any legal barriers to any of the options carrying out delegated statutory ASC functions. Therefore all of the ADM options "pass" this criteria at this stage in the process. Exploration of the shortlisted options in greater detail in the next phase of the project may identify legal issues that need to be considered.

Could this option deliver the required culture and process change?

The proposed new operating model is a new way of working that aims to:

- Continue to keep people safe.
- Achieve better outcomes for individuals, so that people enjoy greater independence, feel more in control of their lives, are able to stay in their own homes, have a job and live close to friends and family.
- Help people to increase their own personal resilience and, where needed, to draw upon support from their family, friends, social networks and services provided by community groups and the local voluntary sector.
- Meet needs at lower cost.
- Support delivery of the Adults and Safeguarding Committee's overall savings target (£13.1m between 2017/18 and 2019/20, excluding the ADM project's own savings target of £1.96m).
- Establish a service that is financially sustainable in the long term.

In order to deliver the new operating model, changes need to be made to what ASC practitioners do (their processes) and, more importantly, how they do it (their culture and working practices). This means any ADM needs to address:

- The way people use the service. People's expectations of what the Council will do for them need to be "reset" and individuals need to be encouraged to take responsibility for living as independently as possible.
- The way staff work. A dynamic culture based on individual practitioner motivation and values should encourage staff to innovate and take the lead on developing practice and partnerships. Trust, professional autonomy and positive risk taking should be promoted and decision-making should be swift and unhindered by bureaucracy.
- The way the service works with its partners. The service should work closely with partners including health, housing and CVS groups, to deliver a seamless, joined-up service. There needs to be a greater role and a higher profile for CVS organisations, and for individual volunteers.

PSM: There is good evidence, from examples such as Focus in North East Lincolnshire and People2People in Shropshire, that a PSM can be a highly effective way to deliver the change described above. The opportunity for all staff members to own a financial "stake" in the organisation, and the representation of staff on the PSM management board drives high levels of staff engagement. A streamlined management structure means decisions can be taken much more quickly, which makes it much easier to introduce innovative practice. As a new organisation with its own identity a PSM is well-placed to "disrupt" pre-existing ideas of what people can

expect from social care. Local CVS organisations are much more likely to think of a PSM as "one of us" and be keen to share resources and work collaboratively with it. Local people can also be members of the management board of the PSM and directly influence its priorities and strategic direction.

NHS shared service: A shared service would present a significant opportunity to transform the way ASC services work with health services, both at a strategic level and in the way staff on-the-ground work together. Delivering health and social care support through a single service would encourage practitioners to think about what each person needs in order to lead a good life, rather than focusing upon a person's "health needs" and "social care needs". However, it would be important to ensure that a strengthened partnership between ASC and health services did not crowd out partnership working with other services such as housing and employment support.

Integrating health and social care services would also help to align financial incentives. If health and ASC services shared a pooled budget through an Accountable Care Organisation (ACO) model, there would be more joined-up thinking around how people can be supported to lead more independent lives for longer. This could lead to increased investment in social care as a more cost-effective alternative to NHS in-patient services and is in line with the national policy direction for health and care.

Reformed in-house service: It would be possible to deliver elements of the required level of change through a reformed in-house service but it would be a very slow and complex process. The current in-house service has delivered a number of service improvements that have moved the service towards the proposed new operating model, but these have been pockets of change rather than "whole system" transformation. There are no examples of a Council successfully transforming the culture of its ASC service in line with the model set out in the strategic outline case through an in-house delivery model.

The service has a strong local identity and reputation as "the Council". This means it already has strong partnerships with local partners and CVS organisations. However this identity could make it harder to persuade people and partners to change expectations and work with the service in a new way. As part of the Council, it is challenging to implement a community-led approach, where the strategic direction is set by staff, service users, carers, local CVS organisations and residents.

LATC: Although The Barnet Group is a separate organisation, there remains a strong perception amongst staff and service users that it is "part of the Council". This could make it more difficult for The Barnet Group to reset expectations and develop new ways of working with staff, service users and partner organisations. An additional challenge is presented by The Barnet Group's status as a LATC, which is 100% owned by the Council. This means there would not be an opportunity for staff and/or members of the community to share ownership of the ADM under this option.

This limits the extent to which staff and service users could be involved in setting the strategic direction and priorities of the new organisation.

JV with a partner outside the public sector: Involving a significant new partner in the service could help to accelerate implementation of the new way of working. The Council would also benefit from the partner's work beyond the Council. For example, if a partner has helped to implement innovative technology in another local authority, Barnet would benefit from the knowledge and experience the partner gained through delivering that work. However there is no evidence of this ADM being used in other Councils to drive extensive culture and process change in ASC. If the supplier is a private sector company[10] there is a risk staff could feel disengaged from the service and that partner organisations could be mistrustful and reluctant to work closely with the service. If the supplier did not have a strong track record in ASC it may lack credibility and struggle to develop strong relationships with partner organisations.

"Future proofing" the service

Any ADM must be able to adapt to any future changes made by central government to the way ASC is organised, funded or delivered. An in-house service has a clear advantage in this respect, because it is wholly under the control of the Council. Changes would be more difficult to implement under other ADMs, because the Council (which, as it cannot delegate its statutory duties, would retain responsibility for implementing any changes) would be asking a separate organisation to make any necessary changes.

This does not necessarily rule out any of the ADM options. The research carried out by the project has identified examples of PSMs and NHS shared services responding to national policy, such as implementing new requirements from the Care Act 2014. However, a partnership outside the public sector could reduce the Council's future options around delivering health and social care integration because a NHS organisation may be unwilling to delegate services to a private sector organisation. Nonetheless under any of the ADM options that involve a partner organisation, the Council will need to think carefully about how it builds in the necessary flexibility to amend contracts to reflect any future changes in central government policy.

[10] Based upon the findings from informal market engagement, it is highly likely that the prime contractor in any partnership outside the public sector would be a private sector company.

Could this option generate savings and/or additional income?

It should be recognised that, at this stage in the evaluation process, the financial and commercial assessment can only be an educated estimate, based on a series of assumptions about the services and the market. Modelling has been carried out at a level that is appropriate to enable a comparison of the different options' ability, relative to each other, to generate efficiency savings and additional income. It is not intended that the modelling should provide the greater level of certainty that one would expect with a detailed business plan.

The following table provides a high level summary of the outcomes of the financial modelling.

ADM financial model

Assumed value of in-scope services, 2017/18	14,603,108

Saving opportunity	Risk	Reformed in-house service	NHS shared service	Partnership outside the public sector	The Barnet Group	Public service mutual
Review Social Care Direct provision and delivery with close integration with professional social work teams	Low	Initial analysis shows this option is likely to achieve 86% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 85% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 74% of the £1.96m savings target as providers are likely to guarantee savings equivalent to 10% of the value of in-scope services.	Initial analysis shows this option is likely to achieve 82% of the £1.96m savings target.	Initial analysis shows this option is likely to slightly exceed the £1.96m savings target.
Reduce employee-related costs through productivity improvements, efficiencies, reviewing skills mix	Low					
Management overhead savings	Low					
Review support functions within Delivery Unit	Medium					
Efficiencies in contracts with health	Medium					
Passenger transport saving	Medium					
Enablement service	High					
Additional income from trading and other sources	High					

	Reformed in-house service	NHS shared service	Partnership outside the public sector	The Barnet Group	Public service mutual
Total savings	**1,677,660**	**1,662,833**	**1,460,000**	**1,611,186**	**2,105,898**
Revised budget	**12,925,448**	**12,940,275**	**13,143,108**	**12,991,922**	**12,497,210**
Level of confidence in delivering and facilitating wider MTFS savings target (£13.1m)	85%	85%	85%	85%	95%
Therefore level of MTFS savings delivered from 2017/18 onwards	**11,141,035**	**11,141,035**	**11,141,035**	**11,141,035**	**12,451,745**
Total benefit to the Council	**12,818,695**	**12,803,868**	**12,601,035**	**12,752,221**	**14,557,643**
Rank	2	3	5	4	1

Delivering the ADM savings target

The ASC ADM project has a savings target of £1.96m between 2017/18 - 2019/20. All references to “the savings period” in this section refer to this three year period.

Reformed in-house service

Under this option, savings would be generated through a reduction in employee-related costs and some reduction in management overheads. The staffing savings would be realised through actions to review the skills mix of staff, increase staff productivity, review support services and improve the overall efficiency of the service.

The Council’s strategic partnership with Cambridge Education enables efficiencies to be realised by providing school transport. ASC transport is having initial conversations about providing the brokerage through a single service. This initiative is still under development so a conservative estimate has been made that a saving could be achieved over the savings period.

The proposed new operating model emphasises the crucial role that Social Care Direct (SCD) has to play in providing information and advice, and signposting people to relevant services outside of the Council. Given the importance of SCD in the new operating model, under a reformed in-house service the SCD team would be reviewed and integrated with the teams that deliver professional social work. The senior management team of the Delivery Unit estimates this integration could realise efficiency savings.

A shared service with one or more NHS partners

Most of the savings under this option would be generated through economies of scale and procurement savings on supplies and equipment.

It is assumed that one of the partners in a shared service would be a NHS Foundation Trust. This would allow the shared service to trade services with the private sector and/or with individual citizens[11]. The service could explore a range of different trading opportunities such as retailing and hiring out daily living aids and equipment; or offering telecare services for self-funders. The service could offer its expertise in areas such as health and social analytics and care home quality monitoring to other organisations. Therefore achievable net income is included in the savings period.

Further income is also assumed under this option as best practice research suggests under a pooled social care and health budget there would be increased investment in ASC from the NHS as a more cost-effective alternative to NHS in-patient services.

11 Councils may only trade with the private sector or with individual citizens through a separate company. NHS Foundation Trusts are autonomous bodies and are therefore able to trade in their own right.

Employee-related cost savings are assumed over the savings period. However these savings are lower than the savings assumed under the reformed in-house service because increasing the efficiency of the service will be more difficult under a shared service, as the service will be much larger and more operationally complex than the current in-house service. However, in the longer term it should be possible to realise more significant savings.

The assumed saving on management overheads is assumed to be higher under a shared service than under a reformed in-house service. The rationale is that two services brought together would only need one senior management team and this could deliver an increased reduction in management overheads.

A shared service would realise the same savings from ASC transport efficiencies and from integrating the SCD service as the reformed in-house service.

A partnership outside the public sector

Initial market testing intelligence has indicated that in this context a private sector partner could realise efficiency savings equivalent to 10% of the in-scope services. For the purposes of modelling, the total value of the in-scope services is assumed to be equal to the projected budget for employee-related costs and transport costs in 2017/18 (£14.6m). This gives an assumed total saving of £1.46m over the savings period.

Local Authority Trading Company (The Barnet Group)

In the following respects the assumptions for this option are the same as those for the reformed in-house service: reviewing support roles; management overhead savings; savings on transport; and efficiencies from closer integration of the SCD team with professional social workers.

As a LATC, The Barnet Group is able to trade and therefore this option would also benefit from the freedom to generate a profit from trading services with the private sector and/or with individual citizens. It is assumed that The Barnet Group would have higher levels of commercial expertise than a NHS shared service and therefore its assumed level of net trading income over the savings period is higher than the NHS shared service option.

Savings through reducing employee-related costs are assumed to be lower under this option than under a reformed in-house service. As delivery of statutory ASC functions would be a new service area for The Barnet Group, it would take some time to establish the service fully before beginning to implement changes to improve the productivity and efficiency of the service. Therefore it is assumed that The Barnet Group could deliver savings in relation to employee-related costs over the savings period but these would be lower than savings under a reformed in-house service.

Public service mutual organisation

As an organisation independent from the Council, a PSM could have a much more streamlined organisational structure, with faster decision-making processes and reduced bureaucracy. This would mean it could introduce changes to improve the efficiency of the service more quickly than would be possible under an in-house service. Therefore it is assumed that a PSM could deliver employee-related cost savings.

The assumed saving on management overheads applied to the in-house option has been increased under a PSM because research into comparable PSMs suggests a PSM could be implemented with a very flat management structure, and this would deliver a significant reduction in management overheads.

Like a LATC and a shared service, a PSM could generate trading income. Higher net income over the savings period has been assumed for a PSM because as an independent organisation it would have greater control over how it spends its trading surplus. The incentive for staff to generate income through trading would be higher because they could see a direct link between the PSM's trading activities and the money it has available to invest in service improvement. Best practice research also suggests the sense of ownership that staff have from holding a financial "stake" in a PSM encourages a much more entrepreneurial culture.

The Delivery Unit proposes to reform the enablement service, with a greater emphasis upon occupational therapy, and staff development to increase skills around behaviour change and use of equipment and preventative services. The Delivery Unit's senior management team estimates these reforms could realise efficiency savings over the savings period.

The PSM would also benefit from some procurement savings on supplies and equipment, though to a much lesser extent than a shared service.

It is also assumed that a PSM could realise the same savings from ASC transport efficiencies and integrating the SCD service as the reformed in-house service.

Supporting the wider savings target

The Adults and Safeguarding Committee has an overall savings target of £18.5m between 2016/17 and 2019/20. The Committee's savings proposals[12] assume total savings of £3.4m in 2016/17, and a saving of £1.96m to be delivered directly by the ADM project in the period 2017/18 to 2019/20 (as outlined in the section above). This leaves a saving of £13.1m between 2017/18 and 2019/20 that the ADM needs to enable and support by reducing need for Council-funded services.

[12] Approved by the Council's Policy and Resources Committee on 16 December 2015. http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=692&MId=8349&Ver=4

The level of confidence in meeting this £13.1m savings target has been set at 95% if the service is delivered through a PSM organisation. This confidence rating reflects the high level of alignment between the aims of the proposed new operating model and the key features of a PSM. The confidence rating for the other options has been set lower, at 85%, as these options are not so well aligned with the operating model.

Has this option been tested by other Councils?

Local authorities have only been able to delegate certain statutory ASC functions, such as assessment of need, since the implementation of the Care Act in April 2015. Therefore the market for providing these services outside Councils is still emerging. There are few examples of the full range of statutory adult social work being delivered through ADMs. It is important to recognise that implementing any ADM (other than a reformed in-house service) in these areas would mean following a path that, so far, has been taken by very few other Councils.

Although the Council has experience of delivering services through all of the ADM options, some have not been used before for such a large service area, or for services that carry such inherent risk and complexity.

ASC is an essential service that supports vulnerable people. Any failure of the service to look after people and keep them safe could have devastating consequences. The current service is not robust, with an overspend forecast in this financial year and significant savings targets in future years, which are reliant on the reduction of need for statutory care for their achievement. In this context it would not be responsible to select an ADM that has never been tested as a way to deliver statutory social care functions.

The in-house service delivery model is in use by the majority of local authorities and is well tested for the delivery of statutory ASC functions. The other ADM options have been tested to a lesser extent:

- There are two examples of PSMs successfully delivering the full range of statutory ASC functions: Focus in North East Lincolnshire and People2People in Shropshire.
- There are also examples of NHS shared services delivering the full range of statutory ASC functions, including Torbay Council, Staffordshire County Council, SEQOL (Swindon) and Sirona (Bath and North East Somerset).
- Although there are a number of LATCs which provide social care provider services such as home care and day services, there are no examples of a LATC delivering the full range of statutory ASC functions on behalf of a Council. The closest example identified is Optalis in Wokingham, which

carries out some initial assessments as part of a wider offer of care and support services.

- There are also no examples of a provider outside of the public sector delivering the full range of statutory ASC functions on behalf of a Council, although some providers have experience of providing some of the services within the ADM scope but across a number of different contracts.

Across those options that are untested or less tested, the Council needs to consider whether the potential benefits those options present are sufficient to justify the Council accepting the risks associated with pioneering a new approach.

Options appraisal summary

	Is there market appetite for this option?	Could this option carry out statutory social care functions?	Could this option deliver cultural and process change?	Could this option generate savings and/or additional income?	Has this option been tested by other Councils?
Public service mutual organisation	✓	✓	HIGH	HIGH	✓
NHS shared service	✓	✓	HIGH	MEDIUM	✓
Reformed in-house service	✓	✓	MEDIUM	MEDIUM	✓
LATC (The Barnet Group)	✓	✓	LOW	MEDIUM	✗
JV with partner outside the public sector	✓	✓	LOW	LOW	✗

Conclusion

The following options will not be investigated further:

- A JV with a partner outside the public sector. This is the worst performing option judged against both the ability to generate savings and the extent to which it can support the required process and cultural change. In this context there are not sufficient benefits to justify the potential risk of delegating such a wide range of statutory ASC functions to an untested provider market.

- Delegating the services to The Barnet Group. Although The Barnet Group has a track record as a social care provider organisation, its experience lies in providing social care services, rather than delivering statutory ASC functions of assessment, care and support planning, statutory review, safeguarding, Mental Capacity Act 2005 and Mental Health Act 1983 (amended 2007) Functions, such as Deprivation of Liberty Safeguards. Insufficient synergies have been identified between The Barnet Group and the in-scope ASC services to warrant combining the services. There is also a significant potential conflict of interest arising from Your Choice Barnet's role as a major local provider of learning disability services, sheltered housing and, in the future, extra care sheltered housing. It would be very difficult for The Barnet Group to ensure sufficient separation between the role of assessing social care need and the role of providing social care services to meet those needs. This option also has a less strong financial case than the other three options.

The following options will be taken forward to a detailed options appraisal:

1. **Public service mutual (PSM) organisation**. This option appears to be the most effective way to deliver the required level of cultural and process change at a rapid pace. It also has the strongest financial business case: based upon the preliminary financial modelling, a PSM organisation is the only option that could deliver the project's savings target of £1.96m by 2019/20.

2. **NHS shared service.** The potential benefits arising from integration of health and social care are highly significant. New legal structures for shared services (such as Accountable Care Organisations) are emerging that could increase the attractiveness of this option to the Council. This option has a strong financial case, delivered primarily through efficiencies in contracts with health.

3. **A reformed in-house service**, delivered by the Council's Adults and Communities Delivery Unit, in partnership with Capita. This option could deliver the desired cultural and process change, albeit more slowly than could be achieved through other ADMs. This option also has a strong financial case, mostly delivered through a reduction in employee-related costs, realised through reviewing the skills mix of staff, improving staff productivity and increasing the overall efficiency of the service.

7. Next steps

The next stage of this project will be delivered through three workstreams:

1. Producing a further business case that develops each of the three shortlisted options in greater detail, describing how the service would operate; what resources would be required for implementation; timescales for implementation; and how and when savings would be realised.
2. Continuing the work already initiated to prepare for the proposed new operating model through culture and process change (as described in the project methodology on p24).
3. Public consultation on how the new operating model should be implemented and on the proposed shortlist of ADM options.

Based upon the findings from these three workstreams, a preferred ADM will be recommended to the Adults and Safeguarding Committee in September 2016.

	2016						
	Mar	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Adults and Safeguarding Committee: consideration of outline business case							
Produce the further business case							
Prepare the new operating model							
Public consultation (12 weeks)							
Adults and Safeguarding Committee: consideration of further business case							

Workstream summary: producing a further business case

Activity	**Product**
Workstream management, including • Co-ordinating workstream activities. • Procuring and managing any external consultancy support required. • Writing the further business case.	• Business case. • Committee paper. • Project management documentation: project plan, risk register, stakeholder communications plan etc.
Carry out research to explore the different ways through which innovative new technology solutions could be implemented.	• Summary of findings that informs the business case.

Activity	Product
Continue to develop the reformed in-house service option.	• Outline implementation plan setting out resources required and how the current service will change.
Identify the actions that need to be carried out and decisions taken to set up and establish a PSM. Estimate the implementation costs and timescales.	• Outline implementation plan setting out resources required for implementation; recommending a governance and legal structure and outlining how the service could grow income over time.
Explore the tax implications (particularly VAT) of creating a new corporate entity separate from the Council.	• Specialist advice on tax implications, and recommendations on the best route to take, including estimated tax liability under new corporate entity.
Engage with local NHS providers to identify potential partners and explore possible implementation priorities and timescales.	• Summary of which potential partners have expressed an interest, and with what terms and caveats.
Model financial costs and benefits of each of the three options, including projected set-up and procurement costs, and net savings projections both for the short term (2017/18 – 2019/20) and the medium-to-long term.	• Detailed financial model setting out costs and benefits of each option.

Workstream summary: preparing for the new operating model

Activity	Product
Workstream management, including • Co-ordinating workstream activities. • Procuring and managing any external consultancy support required. • Ensuring the workstream aligns with the Council's wider ASC transformation programme.	• Project management documentation: project plan, risk register, stakeholder communications plan etc.
Translate the operating model into a detailed set of operational changes and outcomes.	• Summary of the operating model that can be shared with service users, carers, residents and staff.

Activity	Product
Design and facilitate a co-design process, involving service users, carers, residents and staff in the development of the new operating model.	• Specifications for each element of the operating model, describing what changes need to be made, what barriers need to be overcome and the ways in which the service will look and feel different when the operating model has been implemented successfully.
Run staff consultation on the service restructure proposed as part of the new Mental Health Community Model[13] (implementation of these proposals to be integrated with this workstream).	• Consultation documentation • Staff communications.
Implement the changes identified through the co-design process. Monitor and measure the impact of the changes and use this evidence to continually review and refine the changes. (This will become a business-as-usual approach.)	• Baseline data (before changes are implemented). • Data collected and analysed.

Workstream summary: public consultation

Activity	Product
Write the public consultation document.	• Consultation document setting out proposals and consultation questions.
Facilitate consultation event(s) to hear the views of a range of service users, carers and residents.	• Invitations using a range of appropriate channels that reflect the diversity of service users. • Consultation event materials, also reflecting the diversity of service users.
Write up the findings from the public and staff consultations.	• Consultation findings summary document.

[13] See item 8, approved by the Adults and Safeguarding Committee on 16 September 2015: http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=698&MId=8360&Ver=4

Project budget

The following project costs are anticipated for April 2016 – September 2016:

Workstream	Costs (exclusive of VAT)
Producing the full business case	• Project management. **c.£70,000.** • External consultancy/professional advisory services to support the workstream activities. **c.£27,000.** • This assumes the project manager will lead the development of the business case, with significant input from Council teams.
Developing the new operating model	• Project management. **c.£70,000.** • External consultancy services to support the workstream activities. **c.£20,000.** • This assumes the Adults and Communities Delivery Unit will lead the development and implementation of the new operating model.
Public consultation	• Additional resource to support Council officers preparing and delivering the public and staff consultations. **c.£10,000.**
Total	**c.£197,000**

Timescales for ADM implementation

The following timescales are anticipated for implementation of each of the ADM options (assuming a recommended option is approved by the Adults and Safeguarding Committee in September 2016):

- **Reformed in-house service:** implementation of the transformation programme (as described in Appendix B) would take approximately 18 months to complete.
- **PSM:** timescales depend upon the implementation approach. For example:
    - In Shropshire, P2P was created with a team of eight staff, voluntarily seconded from the Council, serving only Shrewsbury. P2P's scope expanded over a two year period, growing to 66 staff by the end of the first year and 120 by the end of the second year. Under this approach a PSM could be established in as little as three months and begin operating in December 2016.
    - In North East Lincolnshire, Focus began its operations at full scale. The business case for a PSM was approved in July 2012 and Focus launched 10 months later, running in "shadow form" as part of the

Council for a further 5 months. Under these timescales, a PSM could be established in shadow form by June 2017; launching as a fully independent company in November 2017.

- **NHS shared service:** timescales depend on the shared service model adopted. A Section 75 Agreement with transfer of staff employment could be implemented in approximately 12 months. An ACO model would take longer, as this is a new form of NHS organisation. The Barking & Dagenham, Havering and Redbridge Accountable Care Organisation pilot will plan and assess the pilot over a period of 6-9 months, followed by phased implementation over three years.

All of these assumptions will be tested and explored in greater detail as part of the development of the full business case.

The new ADM needs to start delivering savings from the financial year 2017/18. Therefore under each of the options a phased approach to savings realisation would be required, under which some savings can be realised while implementation of the ADM is still in progress.

Indicative implementation milestones for the shortlisted ADM options

	Sep 2016	Dec 2016 (+3 months)	March 2017 (+6 months)	Sep 2017 (+12 months)	March 2018 (+18 months)	Sep 2018 (+2 years)	Sep 2019 (+3 years)
Transformation under a reformed in-house service			*Transformation programme -------------- (underway now) continues --------------*				
Public Service Mutual: rapid mobilisation		● *Launch (limited scope)*		*----- Extension of scope -----*			
Public Service Mutual: standard mobilisation			● *Launch (shadow form)*	● *Launch (independent)*			
NHS shared service through Section 75				● *Launch*			
NHS shared service through ACO				*---------------------------------Phased implementation ---------------------------------*			

Appendix A: Stakeholder engagement events

Date	Event title	Stakeholder group	# attendees
11 August 2015	Alternative delivery models – your chance to help shape early on	Adults and Communities Delivery Unit staff	12
12 August 2015 (2 sessions)	Adult Social Care Services Workshop	People who use ASC services and their carers; representatives from local CVS groups and service providers[14].	19
29 September 2015	Follow-up meeting from Adult Social Care Services Workshop	Staff from Richmond Fellowship (a mental health charity and service provider).	5
7 October 2015	Follow-up meeting from Adult Social Care Services Workshop	Staff from the Barnet Centre for Independent Living.	4
13 October 2015	Follow-up meeting from Adult Social Care Services Workshop	Members of Barnet Seniors' Assembly.	12
15 October 2015	Follow-up meeting from Adult Social Care Services Workshop	Staff and members of the Stroke Association (Barnet).	16
27 October 2015	Follow-up meeting from Adult Social Care Services Workshop	Members of Barnet Learning Disability Parliament.	15
3, 4, 5 November (4 sessions)	Alternative delivery model sessions	Adults and Communities Delivery Unit staff.	c.12 at each session
1 December 2015 (2 sessions)	ADM Staff Engagement Sessions	Adults and Communities Delivery Unit staff.	c.25 at each session
9 December 2015	Adult Social Care Services Workshop	People who use ASC services and their carers.	18
10 December 2015	Adult Social Care Services Workshop	Local CVS groups and service providers[15].	11

[14] Representatives from Advocacy in Barnet, Barnet Asian Elders, Barnet Carers Centre, Barnet Centre for Independent Living (People's Choice team), Barnet Seniors' Assembly, Chinese Mental Health Association, Healthwatch Barnet, One Housing Group, Richmond Fellowship, Stroke Association.

[15] Representatives from Advocacy in Barnet, Barnet Asian Elders, Barnet Carers Centre, Barnet Centre for Independent Living, Barnet Mencap, Barnet Seniors' Assembly, Healthwatch Barnet, Kisharon, Mind in Barnet, Richmond Fellowship, Stroke Association.

Appendix B: In-house service transformation programme

Under a reformed in-house service the in-scope services would continue to be delivered by the Council's Adults and Communities Delivery Unit, in partnership with Capita, which provides back office services[16] to the Delivery Unit under the Council's corporate CSG contract.

To deliver the operating model, the following would be required:

More efficient working practices.
The introduction of community hubs instead of home visits to provide assessments and reviews in community locations, and to provide information and advice to help people access support within their communities.

A new case management system is being implemented that will make practitioners' administration and case recording significantly more efficient. This will be enhanced with new mobile devices such as tablet computers that allow for easier working around the borough and can cut down on travel time and duplicate recording.

The new system will be an enabler for changes to performance management. The service will need to adopt a data and insight-driven approach to performance improvement and user and carer outcomes

Front line staff will continue to be part of the Better Care Fund integrated teams as they are rolled out across Barnet.

Opportunities to get greater value from the support services currently provided by CSG will be explored.

Culture change and workforce development.
A continuous improvement culture needs to be developed with positive and proactive practice around risk and decision making, and where staff feel comfortable in giving residents choice and control to take risks. Work will continue to help change the type of conversation held with residents so that not everything has to lead to a full statutory assessment of Care Act eligible needs but rather work is focused on achieving the outcomes users and carers want, and ensuring record keeping is proportionate.

Priorities for workforce development will include embedding an asset-based and solutions-focused approach among all front line practitioners; personal accountability; dealing with difficult conversations and situations; risk assessment and management; and effective mental capacity and safeguarding practice. An ongoing programme of work to improve and assure practice quality will be required.

[16] Finance, ICT, Procurement, Insight, Customer Services, HR, Estates and Health and Safety.

The asset-based approach will be applied to practitioners' work with residents and also to non-customer focused work, to improve problem solving and grow personal accountability.

There will be skill mix changes in operational teams with 17 registered social worker posts being replaced with Assessment and Enablement Officer posts[17]. The service will need to extend its skill mix and productivity improvements further to deliver the agreed service model. It will also need to work on developing the peer support, advice and community/volunteer involvement required to deliver the service model.

Service development.
Work is ongoing to enhance the telecare services provided and in particular to grow the offer to support residential and supported living placements.

The new model for mental health social work is being implemented to grow a social model with emphasis on recovery and community inclusion. This includes a real focus on employment and housing.

Continued implementation of the carers' strategy will include launch of a new service in early 2016 for individuals with dementia and their carers. This will be delivered in-house and support carers to prepare for their caring role.

Improvements are being scoped to the online ASC offer, to increase provision of digital access to services. This will include improving the information and advice provided; providing online self-assessment and editable support plans; utilising the benefits of the new case management system to allow self-service; and creating an online marketplace/management tool for people who receive Direct Payments.

The approach to prevention and initial access to social care will be enhanced. This will include provision of better and broader information and advice; widening the online information available on Social Care Connect; and avoiding contact at crisis point.

The brokerage service will be developed to enhance the Delivery Unit's ability to find creative forms of provision and ensure that the right balance of high quality – good value for money is achieved in making placements.

The enablement model will grow, with particular focus on increasing employment opportunities; growth and promotion of telecare; and service development of the Network model for mental health.

[17] Approved by the Council's General Functions Committee on 18 February 2016.
http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=174&MId=8584&Ver=4

Implementing this approach

Implementing this remit will be challenging and will require resource. Much of this will need to come from the business-as-usual structure, with a need to include:

- Coaching for operational managers, with a focus on culture change, motivation and accountability.
- Facilitation of action learning sets and reflective practice sessions.
- Change management capacity including National Graduate Development Programme (NGDP) graduates and other temporary resource.
- Experimentation with new roles, such as community facilitators to prototype different preventative models.
- Back-fill capacity to free up practitioners to develop new ways of working and facilitate co-production.
- Training on topics including asset-based approach, feedback, delegation, challenging conversations and use of community resources.
- Use of the Delivery Unit’s in-house policy and improvement team.
- Freeing up management time to focus on delivery of this agenda.

Appendix C: NHS shared service implementation options

Historically, shared services across health and ASC have been implemented in a number of different ways. For example:

- In 2005, Torbay Council delegated its ASC functions to Torbay Primary Care Trust (PCT), under Section 31 of the Health Act 1999, which introduced powers for Primary Care Trusts to exercise various local authority functions and for local authorities to exercise various Primary Care Trust functions. Under this agreement Torbay PCT became Torbay Care Trust and held responsibility for commissioning and providing integrated health and social care services to people in Torbay. As part of the changes associated with the Health and Social Care Act 2012, responsibility for commissioning ASC services was transferred back to Torbay Council in April 2012 (responsibility for delivery of ASC services remained with the Care Trust). The Care Trust was renamed Torbay & Southern Devon Health and Care NHS Trust.

- In October 2015, Torbay & Southern Devon Health and Care NHS Trust merged with South Devon Healthcare NHS Foundation Trust (which ran Torbay Hospital) to form Torbay & South Devon NHS Foundation Trust, the first example of an Integrated Care Organisation in England, providing both acute and community healthcare and ASC services.

- In 2011, Swindon Borough Council and Swindon Primary Care Trust created SEQOL, a single organisation to co-deliver health and social care services in Swindon. SEQOL was created as an employee-owned Community Interest Company (CIC).

- In 2012, responsibility for ASC in Staffordshire was transferred from Staffordshire County Council to Staffordshire and Stoke on Trent Partnership NHS Trust under a Section 75 Agreement[18], with pooled budgets hosted by the NHS Trust. This partnership created the largest integrated health and social care provider in the UK, responsible for community healthcare and ASC across a population of 1.1 million people.

The NHS Five Year Forward View[19] set out a vision for the "next generation" of health and social care integration, in which services are integrated around the person and networks of care, cutting across organisations, are developed. For example:

- In Northumberland, local NHS organisations have joined with Northumberland County Council, local GPs, mental health services and the ambulance service

[18] Section 75 of the National Health Service Act 2006 allows various innovative forms of joint working between NHS organisations and local authorities.

[19] Published on 23 October 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

to create a single Accountable Care Organisation (ACO) by 2017. The ACO will be responsible for delivering population-level health and social care outcomes, and will take on the risks around planning and funding services for the population.

- In December 2015 it was announced that the London Boroughs of Barking & Dagenham, Redbridge and Havering would run a pilot to develop an ACO across the three boroughs. Potentially, the new organisation would manage urgent and emergency care, other elements of hospital care, primary and community health services, social care and preventive services.
- In Greater Manchester, 10 local authorities, 12 clinical commissioning groups and 14 NHS partners will take control of the region's £6bn health and social care budget from April 2016. Ultimately the new mayor of the conurbation will assume control over how budgets are allocated for public health, social care, GP services, mental health and acute and community care.

Other innovative delivery models are likely to emerge following the announcement in the Government's Spending Review of November 2015 that each part of the country will be required to develop plans for the integration of health and social care services by 2017, to be implemented by 2020.

Appendix D: Findings from informal market engagement

Conversations and meetings were held with a sample of 11 potential partners and suppliers to test the extent to which these organisations have the appetite and capability to work with the Council to develop and operate the ADM. It was made clear to the organisations taking part in this exercise that it did not constitute any commitment by the Council to undertake any procurement exercise in the future. The exercise included no element of supplier selection or evaluation, and no parties were prejudiced by any response or failure to respond to the invitation. The exercise did not constitute a call for competition to procure anything, and the Council is not bound by any proposals or solutions offered as a result.

The key findings from informal market engagement are:

- **Market appetite:** there is a limited market for these services – there are only a small number of credible organisations who would be interested and able to lead a bid for an opportunity of this scope and scale. Whilst an OJEU procurement notice may identify more organisations that may be interested it remains likely that a procurement would quite soon distil down to a small number of prime contractors with a larger number of subcontractors supporting them. It could be a risk for the Council to go down the route of outsourcing to one lead provider, so innovative approaches such as using lots to develop a “best of breed” model may be a more favourable option.

- **Market maturity:** as the above suggests there is not a mature market for this scope of services. Of the 11 organisations interviewed none have a single contract that covers the full scope that the Council is considering, although some cover elements of the scope across a number of different contracts. Externalising this service would therefore be relatively pioneering. This leads to some risks as the solutions and benefits are unproven, and it is still unclear how the market will respond. However, there are also potential benefits – a provider may be prepared to invest to gain early market share and it may be possible for the Council to agree favourable terms.

- **Potential benefits:** only two organisations were willing to estimate the level of financial benefits - around 20% savings on the 2015/16 budgets, however these were only very rough estimates. These responses suggest that there is potential for savings to be made. However the organisations could not provide evidence of the financial benefit at this stage, which supports the thought that the market may be immature. The ways of delivering financial and citizen benefits were seen as being more prevention work, demand management, efficiency, technology, local market development and more personalised care.

- **Shaping a future contract:** most of the organisations felt that a contractual relationship of between five and seven years would allow up-front investment

return and the time to implement longer term changes. Having sufficient control and including demand management areas was seen as key if outcomes-based targets and risk/reward were required. Effective integration with health was also seen as an important element by most organisations.

- **Engagement with a procurement process:** most of the organisations (10 of the 11 interviewed) said they would probably engage to some degree with a procurement if only to find out more, but with several seeing themselves as being part of a consortium to meet the full requirement rather than leading a bid. This highlights the need for an innovative procurement process that will allow consortia to form, or that will enable the scope to be divided into lots. Although consortia based approaches can bring the advantages of “best of breed” solutions, they can also be fragile – they often involve organisations who have not worked together before and so they may experience problems in establishing effective relationships.

These findings highlight that it may be a risk for the Council to enter such a new and fragile market. Should this option be taken forward, it would be necessary to design an approach that encourages multi-organisation solutions. This would help to obtain the best market response and most effective solutions.

Appendix E: Summary of The Barnet Group's proposal

The Barnet Group was set up by the Council as a Local Authority Trading Company (LATC) in 2012. The Barnet Group is the parent company to two subsidiary companies:

- Barnet Homes, which manages the borough's 15,000 council homes on behalf of the Council and also works to prevent homelessness and allocates homes to social housing applicants.
- Your Choice Barnet (YCB), an ASC company that provides care and support services to adults with learning and physical disabilities.

Under procurement case law (known as the Teckal exemption), the Council can contract with The Barnet Group without going through a competitive procurement exercise. A key requirement for meeting the Teckal test is that the Council exercises decisive influence over The Barnet Group's strategic and significant decisions and that The Barnet Group's trade with customers other than the Council is limited to less than 20% of its total turnover.

Two meetings were held with The Barnet Group to explore its appetite and capability to deliver the in-scope services. The Barnet Group already has a strong working partnership with the Council, and connections with local partner organisations.

The Barnet Group's proposed ADM would focus on prevention and early intervention, providing short-term support to enable people to remain independent, whilst providing appropriate ongoing support for those who need it.

The Barnet Group has indicated that it would set up another subsidiary company through which to deliver the in-scope services, and that the management of this service would be separate from the management of Your Choice Barnet. The ADM would have its own Board. Both Directors would report into The Barnet Group's Chief Executive. In this scenario, extremely robust processes would be required to manage and monitor the risk of conflict between care brokerage (one of the in-scope services) and YCB services.

The Barnet Group's view is that it could deliver savings through:

- Reducing expenditure on Council-funded packages of care and support, by increasing prevention and short term services to enable people to remain in their own homes.
- Exploring peer-to-peer training as a way to spread good practice and encourage practitioners to identify alternatives to traditional Council-funded care and support.
- Employing new employees through The Barnet Group's employment vehicle, TBG Flex.

- Changing the skill mix of front line staffing, with increased numbers of Assessment Officers.
- Streamlining processes, including the development of automated processes.
- Extending the use of telecare equipment and IT software.

Based upon its experience of taking over the management of YCB and Housing Options services, The Barnet Group recommends a phased approach to transition over a two-to-three year period, in order to minimise risks to service delivery while delivering efficiency improvements.

Appendix F: Public service mutual (PSM) research

Features of a PSM

- It delivers public services.
- Any profits it generates are re-invested in the service.
- It is independent of the Council, has a high degree of control over its future, can innovate, grow rapidly and generate additional income.
- It can have a number of different ownership structures, for example:
    - 100% owned by the PSM staff.
    - Jointly owned by the PSM staff and the local community.
    - Jointly owned by the PSM staff and the Council.
- Its strategic direction is set by a management board, the membership of which reflects the PSM's ownership structure.

The PSM could take a number of different legal forms. In recent years the most popular form for these types of organisation has been a Community Interest Company (CIC), but other forms such as limited companies or community benefit societies have also been used. Under some legal forms, the PSM could be a charity or have charitable status.

Choice of legal form depends upon the strategic and operational priorities of the PSM. For example: preferred governance arrangements; the extent to which it wants to trade; the extent to which it wants to fundraise and apply for charitable grants; and the importance of "locking in" the PSM's assets for the benefit of the community.

Findings from research into PSM organisations

Focus in North East Lincolnshire was the only one of the Department of Health's Social Work Practices with Adults pilot sites that took responsibility for all professional social work (except mental health services) at its inception. ASC services moved from the local authority to a NHS care trust in 2011, and professional social work was then delegated to Focus in 2013.

Barnet's project team researched Focus and then spent a day with Focus' senior leadership team in September 2015. They heard that the service has streamlined its day-to-day activities by removing non-statutory Council processes and procedures. Decisions can be made much more quickly. Staff feel they have greater freedom to be creative in the way they work and this shows in higher levels of staff engagement and reduced sickness absence rates, from approximately 8-9% to 2-3%.

Focus is a staff mutual organisation, which means it is owned by its employees. All permanent members of staff can pay £1 to buy a share in the organisation, and 92% of employees have taken up this opportunity. Employees also make up a majority on

Focus' management board. Staff feel strongly that Focus is "their" organisation and they are very proactive in working to develop the service further and ensure its ongoing success. Since becoming a PSM there has also been a shift from staff being quite "institutionalised" and focused upon the internal workings of the service, to staff being much more outward-looking and building stronger relationships within the wider local community.

In 2014 Focus formed two subsidiary companies: Focus Solutions, which provides ICT systems and consultancy support to local authorities, and Focus Independent Professionals, which offers social work staffing solutions. These companies are still in the early stages of development but over time they are expected to generate profit that can be re-invested into the service.

Focus noted that it would be easy to underestimate how much work is involved in establishing a new organisation. Actions such as setting up a bank account, registering to pay VAT, appointing accountants and obtaining insurance can all be complex and time-consuming, particularly so when the new organisation is not a conventional, straightforward business operation. It is also important to consider carefully how much strategic ASC expertise needs to remain within the Council.

In November 2015 the project team also visited People2People (P2P) in Shropshire. P2P was created because although many improvements were being made to the Council's ASC services, those improvements were not being implemented effectively. The ASC senior management team thought there could be much more improvement, more quickly, if the service was delivered outside of the Council.

P2P rented accommodation outside of a Council building, in order to make a clear statement to staff and people using the service that it was not part of the Council. Staff got the new accommodation ready themselves. At first it was a shock to staff that the Council wasn't going to sweep in and get everything ready for them, but this sent a powerful signal to the public and staff about P2P's independence from the Council, and started to create a strong sense of ownership and pride amongst the staff in "their" service. Like Focus, P2P is a staff-owned mutual organisation.

P2P believes the PSM model will be successful if staff really want it to happen. There has been some staff attrition since P2P was established, as some staff who did not support the model left, but this means that those staff who remain really understand and believe in what P2P stands for.

Initially some local community and voluntary sector groups were suspicious of P2P and some saw it as an attempt by the Council to encroach on "their" territory. However, these groups now see P2P as "one of us" and are keen to collaborate with P2P and work together on joint initiatives and funding bids.

Across both P2P and Focus there was acknowledgement that the barriers to change in an in-house service were almost always cultural and behavioural. Staff had got into the habit of saying “the Council wouldn’t let us do that”. When the Council was no longer running the service, staff felt they had greater power to innovate and make improvements.

Service development opportunities that could be explored under a PSM

- Reforming the enablement service, with a home carer workforce development plan to increase skills around behaviour changes and use of equipment and preventative services. Over time this service could expand into the delivery of intermediate care services on behalf of the CCG.
- Exploring opportunities to trade in services such as staff training and development, telecare, recruitment and support of personal assistants, health and social care analytics, and retailing adaptations, equipment and electronic aids.
- Co-production of services with staff and service users, and developing a recruitment strategy to increase the proportion of the workforce with lived experience of social care services.
- Developing an in-house volunteering programme and partnering with CVS organisations to develop new ways of delivering services.

Appendix G: Equalities

Equalities impact of the proposed new operating model

An initial equalities impact assessment (EIA) of the proposed new operating model was completed in October 2015 and included as part of the strategic outline case presented to the Adults and Safeguarding Committee on 12 November 2015[20]. The EIA showed "impact unknown" for staff and "no impact anticipated" for residents and service users. This EIA was reviewed by the lead officer in February 2016 and no requirement to update it was identified. The EIA for the proposed new operating model will be reviewed again following public consultation on the proposed new operating model.

The profile of the protected characteristics of ASC service users and Adults and Communities Delivery Unit has not changed materially since its publication in the strategic outline case in November 2015.

Equalities impact of the shortlisted ADM options

The ADM options have been evaluated on the basis of the extent to which they fulfil the options appraisal criteria agreed by the project board, as described in section 6. The options of outsourcing/JV with a partner outside the public sector and delegation of services to The Barnet Group will not be considered further because they were the weakest options when judged against these criteria. The potential equalities impact of these options has therefore not been considered.

The three shortlisted options are unlikely to have an equalities impact upon ASC service users because all three options are structures through which the proposed new operating model would be delivered. However, not enough is yet known about how the ADM options would be implemented to say for certain that the choice of ADM will not have an equalities impact upon service users. Therefore the potential impact on service users will be reviewed prior to submission of the further business case in September 2016.

The ADM options will affect Adults and Communities Delivery Unit employees, with reference to which organisation employs them and potentially their terms and conditions of employment and their job roles. However, not enough is yet known about the ADM options to be able to say what the equalities impact would be under each option; which staff would be affected and in what ways they would be affected. Therefore the potential impact on employees will also be reviewed when the three shortlisted options have been developed in greater detail as part of the development of the further business case.

[20] See Appendix C: Equalities.
http://barnet.moderngov.co.uk/documents/s27172/Appendix%20A%20Strategic%20outline%20case%20for%20a%20future%20operating%20model%20for%20adult%20social%20care.pdf

Appendix H: Health and Safety

An initial assessment of Health and Safety risks associated with the proposals has been carried out. This has identified that there are no additional Health and Safety risks beyond those normally associated with the delivery of these services and which are managed through the established Health and Safety policies and procedures. An assessment of the possible Health and Safety risks associated with the community hubs pilot has been carried out separately by the hubs pilot project team.

In the event of a third party or separate organisation being established, there will need to be due consideration of Health and Safety matters in the commissioning process.

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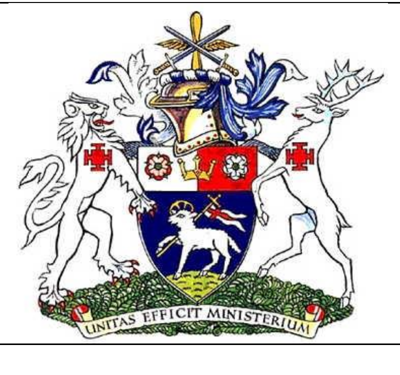
AGENDA ITEM 10



Adults and Safeguarding Committee

7 March 2016

Title	**The Independent Living Fund Transfer: Update Report**
Report of	Jon Dickinson, Assistant Director, Adults and Communities
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	
Officer Contact Details	Gary Johnson, Customer Finance Manager 020 8359 2289 gary.johnson@barnet.gov.uk

Summary

A report was presented to the Adults and Safeguarding Committee on 23 April 2015 about the closure and management of the Independent Living Fund transfer. At this meeting the Committee requested a follow up report regarding the outcome of care reviews after the transfer.

Since the last report, social care practitioners have undertaken a review of care needs of those individuals whose Independent Living Fund was transferred to the Council. These reviews focused on meeting care needs in accordance with the Care Act 2014. Following these reviews, individuals now have a single personal budget from social care that incorporates all elements needed to meet their eligible needs.

Recommendation

1. That the Adults and Safeguarding Committee note the contents of this report.

1. WHY THIS REPORT IS NEEDED

1.1 Legislative Background

The Independent Living Fund was established in 1988 to provide for discretionary cash payments to meet the needs of people with high care needs. These payments were administered by the Department for Work and Pensions. The Government closed the Independent Living Fund with effect from 30 June 2015. Responsibility for meeting care needs was transferred to councils along with funding with effect from 1 July 2015.

1.2 The transfer of the Independent Living Fund in Barnet

1.2.1 At the time of the transfer, information provided by the Independent Living Fund showed that there were 90 people living in the borough of Barnet who were receiving payment from them. The total gross value of Independent Living Fund payments received by people living in Barnet was circa £1.8m over a full financial year. The net value of these payments was circa £1.6m (after deducting client contributions). In addition to Independent Living Fund Payments the majority of recipients had been assessed as eligible for a social care personal budget, collectively worth £1.8m a year.

1.2.2 Prior to the transfer both the Department of Health and Independent Living Fund provided guidance to all councils on how the transfer should be managed.

1.2.3 Before the transfer, the Council consulted all recipients of Independent Living Fund payments on a number of proposals to manage the transfer. The consultation focused on three main areas; care assessments; financial assessments; and a transitional protection scheme to enable people to plan their future care arrangements after the transfer. These proposals formed the basis of the recommendations which were approved by the Adults and Safeguarding Committee.

1.2.4 At its meeting on 23 April 2015, the Adults and Safeguarding Committee approved the following:

- That the care needs of former Independent Living Fund recipients be assessed in accordance with Barnet Council's care eligibility criteria for adults with care needs as set out in the Care Act 2014 and associated statutory guidance.
- That the financial contributions towards care are assessed in accordance with Barnet Council's Fairer Contributions Policy. Independent Living Fund transferees would be assessed in accordance with the Council policy on assessing contributions towards community based services.
- That a six month transitional protection scheme be in place for transferees who may have a change in the amount they receive as a personal budget to meet care needs following a care needs assessment by a social care worker.

1.3 The management of the transfer in Barnet

1.3.1 All Independent Living Fund recipients were contacted by the Council before the formal transfer to the local authority. They were provided with information about how the transfer would be managed, the payment process, the care and financial review process, and where they could obtain independent advice.

1.3.2 The localised transfer of the Independent Living Fund in Barnet was managed within the Adults and Communities delivery unit. A team of social care practitioners were responsible for contacting people to undertake a review of care needs. Where appropriate, carers and advocates were contacted as part of the review process. The customer finance team was responsible for assessing contributions and the processing of payments.

1.3.3 Care reviews focussed on assessing eligible care needs to understand how individuals had arranged their support with funding from both the Independent Living Fund and social care. Where necessary, a multi-disciplinary approach was adopted to maximise the social care outcomes. For example, social care practitioners offered referrals to the Barnet Centre for Independent Living peer brokerage service who assisted people with planning better, alternative ways of providing support to meet outcomes.

1.3.4 It was identified that 83 of the 90 people who transferred needed to be reviewed in accordance with the policy for managing the transfer in Barnet. For the remaining seven cases, reviews were not undertaken for reasons outlined in the table below.

Table 1: Independent Living Fund transferees:

	Number
Independent Living Fund transferees requiring a review	83
Moved out of the borough	1
Deceased	3
Residential care needs	1
Receive continuing health care funding	2
Total	**90**

1.3.5 **The outcome of care reviews following the transfer**

1.3.6 The conditions for receiving payments from the Independent Living Fund were different from the national social care eligibility criteria for councils. Personal budgets were reviewed to ensure that care needs and support plans were in accordance with statutory guidance issued under the Care Act 2014. Social care workers undertook a planned schedule of care reviews to re-assess care needs.

1.3.7 During these care assessments alternative ways of providing care were discussed which delivered better outcomes for individuals. Where appropriate, this has included supporting people to use telecare and other forms of technology to promote greater independence and less dependency on carers. For example, using online shopping rather than paying a carer to do shopping.

1.3.8 Of the 83 individuals requiring a review, 78 have had their reviews completed and five are currently in the process of being reviewed.

1.3.9 Personal budgets were revised following these reviews and where appropriate adjustments made to the level of personal budget. From the 78 people whose care needs were reviewed there were:

- 51 people whose overall personal budget remained the same;
- 26 people whose personal budget has been reduced;
- 1 person whose personal budget was increased after the care review (increased by £9,600 pa).

1.3.10 Changes in the level of funding paid through a personal budget were mainly due to the differences in the eligibility criteria and types of care that can be paid for by the Independent Living Fund and the Council.

1.3.11 Following a reassessment the overall reduction in personal budget needed to meet care needs was £197,000 per year.

Table 2: Breakdown of changes in personal budgets following a care review

Percentage decrease	Number	Average value of personal budget per person	Average reduction
0-10	8	£944.03	£64.43
10-20	9	£698.08	£103.58
20-30	5	£742.11	£193.18
30-40	1	£492.82	£171.04
40-50	2	£558.14	£258.89
50+	1	£1297.00	£681.11

1.3.12 This includes examples of personal budgets being reduced where care funding provided by the Independent Living Fund did not meet the Council's eligibility criteria. For example, a service user receiving payments from the Independent Living Fund to meet night time care needs which no longer existed.

1.3.13 Under the transitional protection scheme any reduction in a personal budget would not come into effect until six months after the person being notified. The purpose in transitional protection was to give people sufficient time to make adjustments to their care arrangements.

1.3.14 The Independent Living Fund assessed contributions towards the costs of care differently from councils. After the transfer all recipients were financially assessed in accordance with Barnet Council's Fairer Contributions Policy. Following a financial assessment the overall average contribution per person was reduced from £65.00 to £40.50 per week. This represents an overall reduction of £115,000 per year in contributions.

2. REASONS FOR RECOMMENDATIONS

2.1 The Adults and Safeguarding Committee is recommended to note the contents of this report further to its request for an update at its meeting on 23 April 2015.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Following the Committee meeting, the Adults and Communities delivery unit will continue to complete the last of the reviews. Individuals will transition to new personal budgets and support plans as the transitional period comes to an end.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The transfer of Independent Living Fund supported the delivery of the following 2015/20 Corporate Plan priority outcomes:

The Council, working with local, regional and national partners will strive to ensure that Barnet is the place:

- of opportunity, where people can further their quality of life
- where people are helped to help themselves
- where responsibility is shared fairly
- where services are delivered efficiently to get value for money for the taxpayer.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 The Independent Living Fund function and associated funding provided by the Department for Work and Pensions was transferred to the Council from 1 July 2015. The amount that was transferred for 2015/16 was £1,165,778 (balance of funding from 1 July 2015 to 31 March 2016 - the equivalent of £1,554,371 full year effect). The Department for Local Government and Communities is

currently consulting on the future funding arrangements and their consultation document refers to the Council receiving funding of:

	2016/17	2017/18	2018/19	2019/20
Amount	£1,476,044	£1,427,439	£1,382,360	£1,340,371

5.3 Social Value

5.3.1 Not applicable in the context of this report.

5.4 Legal and Constitutional References

5.4.1 Under the Care Act 2014 there is a requirement to assess care needs in accordance with a national eligibility threshold. The Department of Health also set statutory guidance which all councils in England are required to follow.

5.4.2 Sections 23.26 to 23.40 of the statutory guidance set the framework within which the transfer of the Independent Living Fund had to be managed. When managing the transfer the Council followed the statutory guidance.

5.4.3 The responsibilities of the Adults and Safeguarding Committee are contained within the Council's Constitution - Section 15 Responsibility for Functions (Annex A). Specific responsibilities for those powers, duties and functions of the Council in relation to Adults and Communities including the following specific functions:

- Promoting the best possible Adult Social Care services.
- Work with partners on the Health and Well-Being Board to ensure that social care interventions are effectively and seamlessly joined up with public health and healthcare, and promote the Health and Well-Being Strategy and its associated sub strategies.
- Ensuring that the Council's safeguarding responsibilities are taken into account.

5.5 Risk Management

5.5.1 The Independent Living Fund transfer was managed by an operational team within the Adults and Communities delivery unit. Social care practitioners in the locality and learning disability teams had responsibility for ensuring that people continued to receive the level of care funding necessary to meet their assessed care needs. The financial impact was monitored operationally by the customer finance team within the Adults and Communities delivery unit. The strategic financial risks associated with the transfer were monitored by Customer and Support Group Finance.

5.6 Equalities and Diversity

5.6.1 On 1 October 2012, new provision in the Equality Act 2010 came into force banning age discrimination in health and social care. This is in line with the duties incumbent on all public bodies through s149 of the Equality Act 2010 to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

5.6.2 Adults and Communities works within London Borough of Barnet's policy framework for equalities. Adults and Communities offers services to users within this framework, and undertakes relevant action to ensure social care is accessible to groups with different equalities characteristics; for example producing easy read information for people with learning disabilities and offering interpreters for service users.

5.6.3 Age discrimination should be considered broadly: younger people may perceive that older people receive more favourable treatment from services as well as older people perceiving that they are less favourably treated. The perception does not mean that all age groups should therefore be offered identical support or services. However, it does require the local authority to have a transparent and fair rationale for different approaches or support offered to different age groups, which target need, just as it already does for current positive action in place, such as providing interpreters.

5.6.4 There is a general risk applicable to all local authorities, which may face an increased level of potential legal challenge from individual users or groups, who challenge on the grounds that the council has failed to pay due regard to equalities under the Public Sector Equality Duty. Nationally there have been legal challenges based on equalities legislation: for example the 2011 challenge to Birmingham City Council on its proposed change to its adult social care eligibility criteria.

5.6.5 The mainstreaming of care and financial assessments for Independent Living Fund service users ensured that transferees were treated in the same way as other people with assessed care needs.

5.6.6 An Equalities Impact Assessment was undertaken on the transfer of the Independent Living Fund.

5.7 Consultation and Engagement

5.7.1 Not applicable to this report. The proposals on the management of the transfer were subject to a separate public consultation and approved by the Adults and Safeguarding Committee on 23 April 2015.

5.8 **Insight**

5.8.1 Insight data is not applicable in the context of this report.

6. BACKGROUND PAPERS

6.1 The Care Act 2014 at:
http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

6.2 The Care Act 2014: statutory guidance for implementation at:
https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

6.3 Funding local authorities to support former Independent Living Fund recipients (consultation):
https://www.gov.uk/government/consultations/former-independent-living-fund-recipient-grant

6.4 The Independent Living Fund Transfer, Adults and Safeguarding Committee, Thursday 23rd April 2015
http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=698&MId=7934&Ver=4

6.5 Adults and Safeguarding Committee meeting, 25 April 2015, minute 8 “the Independent Living Fund Transfer”.
http://barnet.moderngov.co.uk/documents/g7934/Printed%20minutes%2023rd-Apr-2015%2019.00%20Adults%20and%20Safeguarding%20Committee.pdf?T=1

	Adults Safeguarding Committee **7th March 2016**
Title	**Implementation of Better Care Fund: Development of Integrated Locality Teams**
Report of	Commissioning Director – Adults and Health
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	No
Officer Contact Details	Muyi Adekoya: Acting Head of Service, Joint Commissioning Unit Email: Muyi.Adekoya@barnetccg.nhs.uk

Summary

The strategy to achieve an integrated health and care system is set out in the Health and Social Care Integration Business Case agreed by the Council in November 2014, which in turn formed the basis for the Better Care Fund Plan 2014-2016 approved by NHSE in January 2015.

The objective of the Barnet Better Care Fund plan is to develop systems of care that improve outcomes for Barnet residents, whilst managing growing financial pressures. This requires collaboration between providers within the local health economy to manage the common resources available to them.

This report sets out how local integrated teams are being developed for older people and people with long term conditions in Barnet.

Recommendations
1. That the Committee note the progress to date in implementing integrated care. **2. That the Committee note the approach to mobilising integrated locality teams in Barnet.**

1. WHY THIS REPORT IS NEEDED

1.1. The strategy to achieve an integrated health and care system is set out in the Health and Social Care Integration Business Case agreed by the Council in November 2014, which in turn formed the basis for the Better Care Fund (BCF) Plan 2014-2016 approved by NHSE in January 2015.

1.2. Phase One of the integrated care programme saw the introduction of Care Navigators, a Barnet wide multi-disciplinary team meeting (MDT, run once a week), a risk stratification tool (RST) and a Rapid Care Team (RC). Care Navigators are individual workers who support service users/patients to access the care and support they need. MDTs are care planning conferences involving primary and secondary care clinicians, social care and mental health staff, who plan and review complex care plans for this group of users/patients who are at high risk due to their health conditions. The RST is an IT system which identifies individuals who are at high risk of a health crisis from GP care records. The RC team operates seven days a week from 7a.m. to 10p.m, staffed by community health staff, and provides a care response within two hours of referral by a GP. The aim of Phase One has been to improve outcomes for residents by providing care coordination with proactive case management, care planning, navigation and sign-posting of people at very high risk and high risk of admission.

1.3. Phase Two involved piloting a co-located integrated locality team in the west of the Borough. The Team includes social care, mental health and community health staff and is based in a GP practice. The team started working with patients referred from seven GP practices and has been extended to all 20 practices in the west of the borough. The team provides intensive support to people with complex needs who are experiencing significant problems and who are at high risk of hospital admission or breakdown of home based care arrangements.

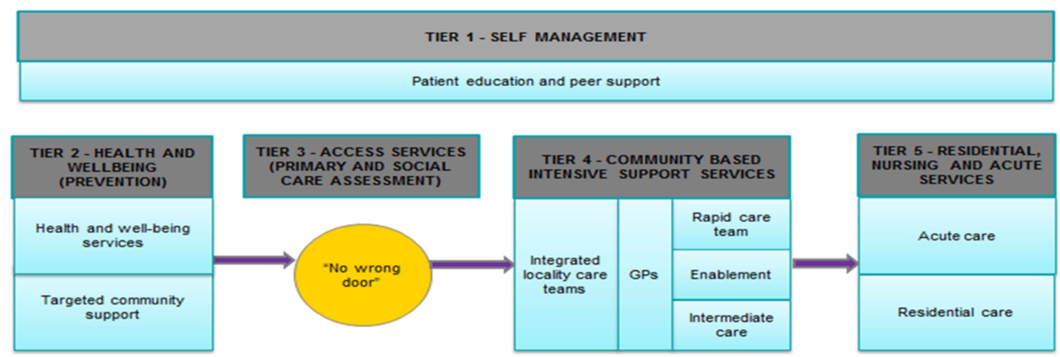
1.4. The next stage of the programme is to refine the team model based on feedback from patients/ service users and carers, from staff and outcomes to date. There is a strong support for the changes made to the care system to date and a desire to move towards full integration of the required services. This work will be set out in the Barnet Better Care fund plan for 2016/17, which will be submitted to NHS England in early 2016.

1.5. This work is governed by the Health and Wellbeing Board. Programme management is through the Health and Social Care Integration Board (HSCI) which includes the Council, CCG and NHS and social care providers. The next phase of the programme of work which will bring together the services established in phases one and two together to create a fully integrated care system. Work is also to be done to build primary care capacity for frail and

elderly populations and to improve health care support to Barnet Care Homes.

1.6. Barnet Integrated Locality Team

Integrated Care – Visual Model



Tiers are underpinned by essential components and enablers

- Our local model for managing care in Barnet is shown in the model above; and referenced in the Health and Wellbeing strategy 2015-2020.

- Rapid Care: Provides intensive, home-based packages of care to support people in periods of exacerbation or ill-health.

- Weekly Multi –Disciplinary Team Meeting (MDT): The Barnet MDT (Multi-disciplinary Team) continues to bring together all services who work with frail and elderly Barnet residents to provide expertise and care planning for those people who have the most complex needs.

- Community Point of Access: Receives and manages 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.

- Care Navigation Service: enables access to local services including social care assessments, and advice on use of personal budgets.

- Integrated Locality Team: The pilot of the integrated locality team, which has been testing models of integration, in the west of the Borough has demonstrated the effectiveness of providing community

based care in collaboration with GP practices; it has also highlighted the need for further integration with other parts of the system and is one of the key enablers for supporting the delivery of the non-elective targets set out in the Better Care Fund.

1.6.1. A phased approach was used to mobilise the above services targeted at the 65+ age group with three or more long term conditions. This approach has meant that each service has been commissioned in its own right; enabling the HSCI programme board to monitor the effectiveness of each new addition, ensuring that the activity is clearly identified and utilised.

1.6.2. Performance data confirms that the above services are delivering against the targets and outcomes set for the population in scope. However, it should be noted that the wider set of targets for the Better Care Fund cover the whole of the borough and it is important that the roll out of the integrated team model continues. The targets are: reduction in emergency admissions; reduction in delayed transfers of care; patients staying at home three months after a hospital admission; self-directed support; service user satisfaction.

1.6.3. The pilot team has been evaluated by Barnet's Public Health team. The results of the evaluation indicate that there is a strong case for change to expand the integrated team model across the borough and that the team works well with its service users, with good satisfaction levels. To improve the model as it is rolled out, we need to ensure that the RS tool is used consistently by all GP practices and evaluation needs to be built into the day to day work of the teams.

1.6.4. From next year, the commissioning intention is that the different components of the integrated care model are brought into a single service with a phased roll out across the borough ('Phase Three'). The Service will provide a specific focus on collaborative case finding and care planning, deliver joint assessment and care navigation across the system, and provide enhanced specialist interventions for high risk residents (for those registered with a Barnet GP) by embedding the specialist MDT approach into every day practice. The Service will incorporate health and social care and link in with the voluntary sector. It is envisaged that some BCF pump priming will be required for one year, after which funding for the service will be mainstreamed. Funding for the service will be specified in the 16/17 BCF Plan.

1.7. Phase Three

1.7.1. The expansion of the model will enable the following to be achieved:

a. Using the risk tool and social care risk indicators, the top cohort of high risk service users will be profiled, screened and segmented to inform interventions.

b. Collaborative care planning will reduce unplanned care and crisis care demand and ultimately lead to reduced admissions (both Acute and Residential) in the cohort.

c. Prevention interventions and services will be used more effectively and whilst demand here will increase, this will in turn reduce high cost intensive support.

d. Reduction in carer breakdown, measured by carer satisfaction and stability

e. Increase in the ability of residents to manage their own care and utilise services more effectively as set out in anticipatory care plans.

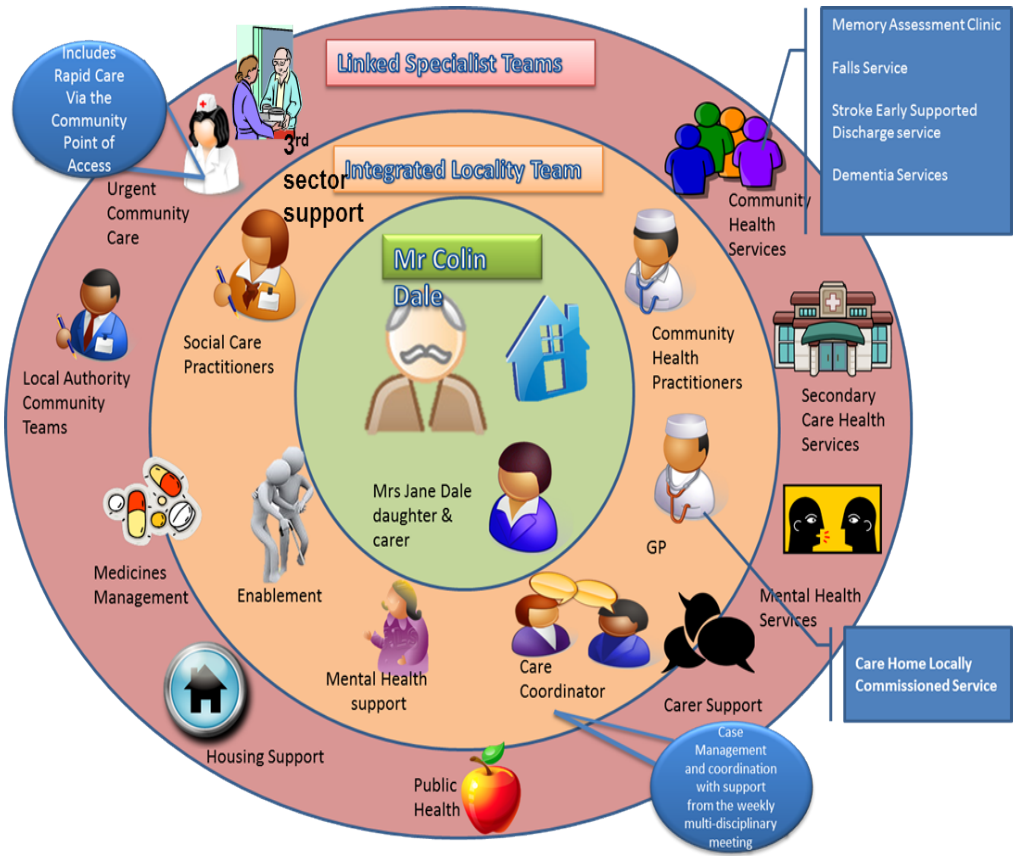
f. CCG Quality, Innovation, Productivity plan (QIPP) and Council MTFS savings against integrated care in 2016/17 and beyond to be realised

g. Improved service user/patient experience throughout the system

h. Provider evidence for required changes to commissioning intentions and operational models for 2017 and beyond.

i. Contribute to social care and health demand management by the use of prevention and early intervention.

1.7.2. The model is still focused around health and social care delivering early interventions, signposting and the management of older adults by enabling more alternatives to hospital admission or care home placements, delivering care closer to home through a pathway of care using a systematic approach, as depicted on the next page.



1.7.3. The aim of this comprehensive model will be to reduce demand of unplanned care and through planned and managed interventions improve the ability of service users to manage their own care. Reducing unplanned care will lead to a reduction in crisis care and non-elective admissions, which in turn reduces or delays admissions to residential or nursing care homes.

1.7.4. The service will provide a whole system approach to early intervention and enable a good oversight, communication and understanding of individuals with higher risk profiles. There will be a significant emphasis on self-management, building up patient and carer knowledge and self-management skills.

1.7.5. A multi-disciplinary case management approach will be in place to coordinate interventions in conjunction with specialist community and social care services.

1.8. Benefits of this approach

1.8.1. An effective operational model to case management, plan and review of patients across the tiers will be specified and commissioned.

1.8.2. The service will utilise a risk profiling tool to manage the identified cohort and track them through the local health and social care economy.

1.8.3. The approach provides the delivery of an enabling service which will support the implementation of a practice dedicated to catering for care homes residents.

1.8.4. Risk based working reduces demand and enhances experience

1.8.5. It will continue to support the delivery of the Better Care Fund conditions and targets as outlined below

National Condition	Deliver a joint approach to assessment and care planning. The output is joint assessment framework in Barnet.
Reduction in Non-Elective Admissions	Enable the delivery of a reduction in non-elective admissions (NELs) through actively implementing crisis care plans/anticipatory care plan. This will be measured by the reduction in the risk score of service users who have had a service and their use of unplanned care.
Use of risk stratification	100% of local residents who have been identified as in need of preventative care have had their needs examined and have been offered a care plan where appropriate.

1.9. **Service Funding**

1.9.1. Within the Better Care Fund budget 2015-16 integrated care is currently agreed in the following service lines. As the service is expanded across the borough, commissioners will be working with providers to provide services through mainstream funding.

Service	Service component	Funding source	Provider	£'000
Older People Integrated Care - MDT	Mental Health	BCF	NHS Mental Health Provider	45
Older People Integrated Care - MDT	Acute	BCF	NHS Acute Provider	45
Older People Integrated Care - MDT	Charity/Voluntary Sector	BCF	Charity/Voluntary Sector	23
Care navigators	Community Health	BCF	NHS Community Provider	497
Integrated locality team pilot	Community Health	BCF	NHS Community Provider	131
Integrated locality team pilot	Social Care	Local Authority	Local Authority	131
Risk stratification tool	IT	CCG	CCG	122

2. REASONS FOR RECOMMENDATIONS

2.1. This report provides details on the pilot of the integrated locality team and proposals to expand the model across Barnet.

2.2. The proposed model is a key enabler supporting the delivery of the Better Care Fund targets.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1. Not applicable.

4. POST DECISION IMPLEMENTATION

4.1. The Health and Wellbeing Board has the responsibility to report to NHS England on progress against the Better Care Fund targets.

5. IMPLICATIONS OF DECISION

5.1. Corporate Priorities and Performance

5.1.1. Integration of Health and Social Care remains a key priority in the Barnet Health and Wellbeing Strategy 2016 to 2020 and will continue to deliver London Borough of Barnet Commissioning Intentions and Barnet CCG 5 year Strategic Plans.

5.2. Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1. From April 2015, the Department of Health (DH) required councils and Clinical Commissioning Groups (CCGs) to pool their budgets allocated for the delivery of the schemes of work in the Better Care Fund (BCF) Plan. This would enable the Council, the CCG and the Health and Wellbeing Board (HWBB) to determine investment and realise the target benefits and outcomes identified.

5.2.2. The HWB Finance Group, a sub group of the HWB acts as the pooled fund management executive, through the officers and group members with the requisite delegated authority, and monitors progress in delivering the target benefits and outcomes in the BCF Plan and Business Case, including oversight of work and spend.

5.2.3. The HWB has responsibility for agreeing the use of the BCF funds. Proposals are reported to the HWB by the HWB Finance Group for agreement. The BCF allocation for Barnet is set by central government and for 2015-16 is £23.4m. The BCF comprises £6.6m of funding formerly referred to as Section 256 funding, with the remainder comprising pre-existing CCG funding. The bulk of this funding is used to cover the costs of the CCG's contract with the Barnet community health provider. Other elements are used as pump priming funding for the specific initiatives described in the report, along with funding for the protection of social care and Care Act implementation. BCF allocations for 2016-17 have recently been published; the new allocation has increased to

£24.4m.

5.3. **Social Value**

5.3.1. There are currently no proposed procurements and therefore no Social Value considerations relevant to the decision. The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4. **Legal and Constitutional References**

5.4.1. The responsibilities of the Adults and Safeguarding Committee are contained within the Council's Constitution - Section 15 Responsibility for Functions (Annex A). Specific responsibilities for those powers, duties and functions of the Council in relation to Adults and Communities including the following specific functions:

- Promoting the best possible Adult Social Care services.

5.4.2. Adults and Safeguarding Committee is responsible for the following:

- Working with partners on the Health and Well-Being Board to ensure that social care interventions are effectively and seamlessly joined up with public health and healthcare, and promote the Health and Well-Being Strategy and its associated sub strategies.
- Ensuring that the Council's safeguarding responsibilities is taken into account.

5.5. **Risk Management**

5.5.1. A full risk log for the programme is maintained by staff managing the programme and is regularly reviewed by the programme board.

5.5.2. A Section 75 Agreement for Integrated Care between BCCG and LBB, Section 75 of the NHS Act 2006 (pooled budgets arrangements) is in place.

5.6. **Equalities and Diversity**

5.6.1. Section 149 of the Equality Act 2010 sets out the public sector equality duty which obliges the Council to have due regard to the need to:

a) eliminate unlawful discrimination, harassment, victimisation;

b) advance equality of opportunity between those covered by the Equality Act and those not covered, e.g. between disabled and non- disabled people; and

c) foster good relations between these groups.

5.6.2. By section 149(2) of the Equality Act 2010, the duty also applies to 'a person, who is not a public authority but who exercises public functions and therefore must, in the exercise of those functions, have due regard to the general equality duty'. This means that the council will need to have regard to their general equality duty.

5.6.3. Considerations of equality are reflected in the programme plan and in day to day business with particular attention to older adults and those with disabilities.

5.7. **Consultation and Engagement**

5.7.1. Consultation and engagement takes place through the HSCI Board and HSCI Steering Group, and the structures that work below the Board with residents and stakeholders to enable services to develop in a responsive way with coproduction as a core principle. Feedback from Service users is regularly reflected in performance reports.

5.8 **Insight**

5.8.1 Not relevant to this decision.

6. BACKGROUND PAPERS

6.1. Health and Social Care Integration business case
http://barnet.moderngov.co.uk/documents/s17691/Appendix%203-%20HSCI%20Draft%20Business%20Case%20for%20publication.pdf

6.2. Barnet Better Care Fund plan 2014-16 (Attached)

Updated July 2014 (Plan Submitted 15/09/14 & 09/01/15)

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 (final submission no later than 12 noon 9th January 2015). 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 & 09.01.2015**
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	09.01.2015

Signed on behalf of the Council	
By	Andrew Travers
Position	Chief Executive
Date	09.01.2015

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Helena Hart
Date	09.01.2015

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	Selected Links
Barnet Health and Social Care Concordat Barnet Integrated Health and Social Care Model 2013 Barnet Health and Well-Being Strategy Barnet Council Corporate Plan 2013 Barnet Council Priority & Spending Review 2014 Barnet CCG 2 Year Operational and 5 Year Strategic Plan Barnet Joint Strategic Needs Assessment (JSNA) 2011 - 2015 Health and Social Care Integration Board Terms of Reference Health and Social Care Integration Board Programme Governance Barnet, Enfield & Haringey Clinical Strategy Health and Social Care Integration Business Base (Sept 2014)	HSCIB concordat signed.pdf Barnet Health Social Care Integrati Barnet Health Social Care Integrati Barnet Health & Social Care Program HSCI Business Case Update Oct 014 v0.9 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 and 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 to 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 effective preventative and self-management approaches which support their own health and wellbeing.
- Creates a sustainable health and social care environment, which enables organisations to work productively 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 to services.

Our plans are informed by the **Barnet Joint Strategic Needs Assessment** (JSNA) 2011 to 2015 (July 2011). This provides a framework for informed **commissioning and the prioritisation of need and demand management based upon on local evidence.** We will focus on tackling the areas of inequality and highest impact, which include:

- An increasing ageing population, with growing numbers of people with long-term conditions as a result of an above average growth rate (5.5%) in the elderly population: 3,250 more residents aged over 65 (+7.4%) and 783 more aged over 85 (+11.3%). In addition to the other, more traditional, health risks associated with old age, long-term conditions such as dementia are a particular issue that we expect to become more prevalent as people live into old age. For example, prevalence rates for dementia as calculated by the London School of Economics and King's College for the Alzheimer's Society predict that dementia will affect 8% of people aged 65 years and over in Barnet and 24% of people aged over 85 years. Whilst the number of people in Barnet aged over 65 with dementia in 2010 was estimated to be 3,778, this is predicted to rise to 4,744 by 2020. This is an increase of 26% over 10 years, compared to only 17% across London.

- Specific health trends: While many people in Barnet experience good health, some issues remain significant obstacles. This includes cancers where although mortality associated with cancers remains relatively low, an improved take-up of screening could ensure earlier identification and treatment. This increases the likelihood of survival and decreases the need for more radical treatment. Death rates for chronic obstructive pulmonary disease (COPD) and cardiovascular disease (CVD) are falling; however we recognise that early identification of undiagnosed COPD remains a priority, as does smoking cessation to prevent CVD. Also of significance is the "obesity epidemic". Almost 25,000 residents of Barnet aged over 18 years are obese. While this represents a lower prevalence than the national average (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 a number of health complications including diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases and infertility and respiratory disorders.
- **Improving independence:** With increased demand pressures from a growing population and reduced financial resources, it will be essential that we enable more people to take personal responsibly for their own health and wellbeing through particularly through prevention schemes.

Our **Barnet Health and Well-Being Strategy** 2012 to 2015 (October 2012) centres on reducing such 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 that we can only achieve this through a partnership between residents and public services.

The views of patients, service users and carers 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. The role of public and patient engagement is outlined in more detail in Section 8a below.

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

- A single point of contact for all their care needs
- Quick and responsive services
- Professionals and care services that talk to each other **and**
- For Mr Dale to only need to tell his story once (Diagram 1)

Diagram 1 – Barnet Vision for Colin Dale

We have a shared 'model' approach to delivering integrated care across Barnet and we have made significant progress so far. For example, both the Care Navigation Service (CNS - a team that supports the delivery of integrated care plans for people with frailty and long term conditions) and Multi-Disciplinary Team (MDTs - to plan and manage the delivery of the most complex care including GPs, acute consultants, social care, specialist mental health, community health) case conferences started in July 2013. We launched the Rapid Response service in August 2013 and the Community Point of Access (CPA) in April 2014. The Risk Stratification Tool (IT based case finding tool) is now in use in all GP Practices and our Integrated Locality Team pilot (a fully integrated, co-located team of community health and social care professionals, linked to 7 GP practices) became operational in August 2014. Our Care Homes Locally Commissioned Service, operational since September 2014, is improving the quality and level of care provided in care homes throughout Barnet. This scheme is enhancing relationships between GPs and care homes, offering a more holistic medical to care homes for more proactive and preventative care to anticipate when issues may arise and to prevent crisis and avoidable emergency admissions. Distinct services from GPs include fortnightly ward rounds, six monthly reviews and post-admission and medication reviews over and above services commissioned through current GP GMS and PMS contracts.

All these new services are beginning to demonstrate improved outcomes for frail elderly people and those with long-term conditions, alongside returning financial benefits.

As the number of frail elderly people requiring health and social care support increases, it is essential that they are offered services that help them to remain independent and live healthily in their own homes for as long as possible. They need timely access to crisis response services to prevent unplanned hospital admissions and dedicated support to recover quickly from illness and prevent future deterioration.

Current health and care services in Barnet do not always fulfil these objectives and as result there is an over-reliance on hospital services and residential care. There are local examples of good practice, especially in our new services described above, but some health and social care services for frail elderly people are still delivered separately from

individual teams. This can result in a disjointed response or service which fails to meet the health and social care needs of individuals holistically.

For Mr Colin Date, this means that in the current system, he receives separate assessments and has to tell his story a number of times. In an average month (without an emergency visit) he may see approximately 10 different professionals from across health and social care, each of whom delivers a specific but isolated task. The number of visits typically increases during and after each exacerbation in one of his conditions. Although Mr Dale and his family recognise that each intervention helps, they often find themselves spending a lot of time waiting for someone to come and deliver the different elements of his care.

Each intervention adds some value to Mr Dale's life, but because the interventions are not integrated to focus on the person and their long-term needs, each intervention does not link with the next to multiply value. The lack of a strong "chain" of support to help maintain health, wellbeing and independence means that the value added by the individual interventions evaporates over time.

In our current system, we find that people sometimes have to re-tell their story to each care or health service provider that they use. They sometimes don't get the support they need because the different services don't share relevant information. Older people can be discharged from hospital to homes not wholly suitable to their needs, so they deteriorate or fall and return to A&E. Health or care workers sometimes make home visits at times that do not fit in with the needs of the person receiving care. Finally, some patients may face longer waits in hospital before being discharged, because hospital and social care staff are unable to coordinate next steps.

We realise that although we have made progress with our integrated care services, there remains much to do to improve services across the whole system in Barnet. Our work to date has focused on developing intensive support and admission avoidance services which address pressures on acute hospital services. The benefits realised so far reflect this, starting to show a reduction in unplanned emergency admissions to hospital and an increase in people enabled to remain independent and well at home.

We now need to maximise the benefits of our new service model, ensuring that all people in Barnet who could benefit, are supported with fully integrated care, thereby achieving better health outcomes for people and increased financial benefits for the health and social care system. We need to do more work to understand the long-term impact of integrated care services on adult social care. We need to ensure that our proposed model will deliver benefits to ensure sustainable, local adult social care services.

Another priority is to increase self-management and prevention in our integrated care model, providing access to an appropriate range of information, services, care and long term self-management solutions for all who could benefit. This should reduce stress, isolation and possible person and/or carer breakdown, thereby reducing demand on health and social care services and ensuring services can provide the right level of care at the right time across the whole system in Barnet.

The London Borough of Barnet (LBB) and Barnet Clinical Commissioning Group (BCCG) have worked for many months on our jointly agreed integrated care model.

The Better Care Fund (BCF) plan has its foundations in the **Barnet Health and Social Care Concordat** (included in Section 1c above). Our Concordant is a clearly articulated vision for integrated care co-designed and agreed by all parties of the **Barnet Health and Social Care Integration Board (HSCIB)**.This integrated care model is the foundation of our future transformation:

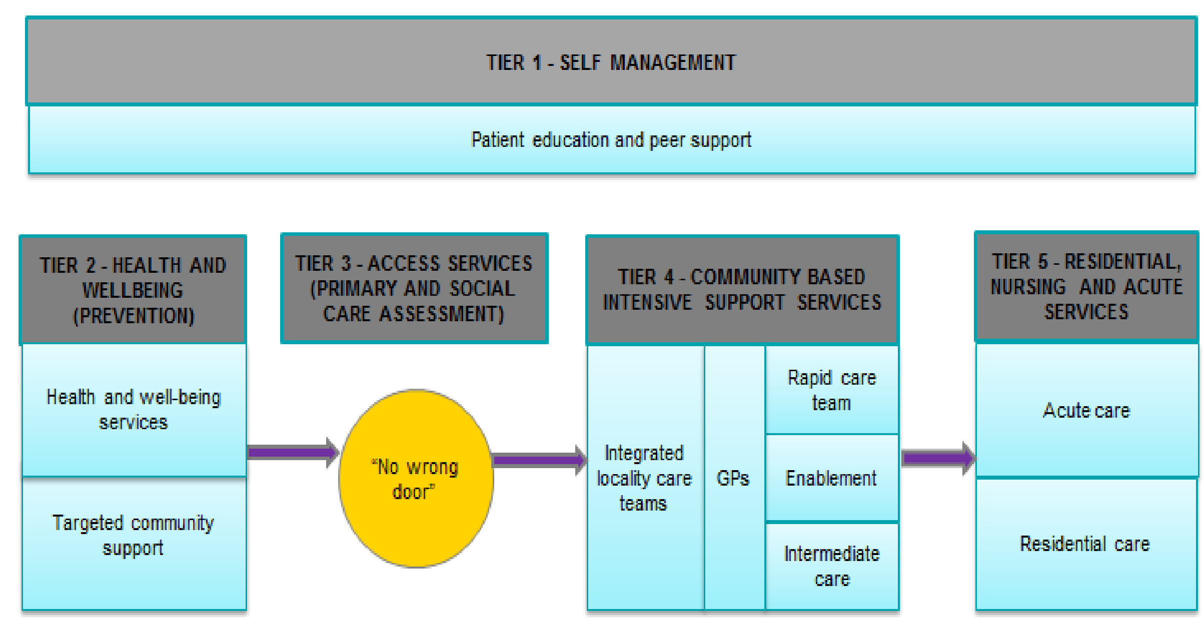


Diagram 2 – Overview of the Barnet Integrated Care Model

The BCF will be an important enabler for us to implement our vision at scale and pace.

The integrated care model consists of five tiers of integrated health and social care services, all designed with 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 of work for BCF therefore comprise:

- **Scheme 1: Self-Management and Health and Wellbeing Services (Tier 1):** This reflects Tier 1, i.e. people and their families are supported to manage their own health and wellbeing wherever they can and for as long as possible.
- **Scheme 2: Access services including primary 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 Mr Dale's skills, increases his quality of life and prevents deterioration.
- **Scheme 3: Community based intensive services (Tiers 3 and 4):** Intensive community based support services are readily accessible and react quickly to need.
- **Scheme 4:** Enablers: supports the delivery of the three schemes above and consists of a range of successful operational services, including planning for later life (a team of advisors that help people prepare for their old age), shared digital care records (to enable all professionals and teams to work together to

deliver care and support to Mr Dale) and other community health services. These services do not directly deliver the 6 core BCF targets but support their achievement through other indirect benefits and underpin the delivery of the different tiers in our integrated care model.

We realise that implementing our vision for the BCF will be challenging, especially in the context of the required 3.5% reduction in non-elective emergency admissions (NEL) and both a Clinical Commissioning Group and Local Authority facing severe financial challenges, including the financial pressures associated with the implementation of the Care Act in social care.

Local demographic and infrastructure challenges, including re-configuration of acute services and a relatively high number of residential and nursing homes create local pressures for Barnet, which must be addressed. There is also the local recognition that much of the BCF funding will come with services already provided.

However, we believe this plan is a significant, proactive step towards dealing with these challenges successfully. Our BCF plan is aligned to the NHS BCCG Draft Delivery Plan, presented to the BCCG Board on 28 August 2014 and remains part of the overall aim to manage demand pressures and improve long-term sustainability.

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

Our BCF schemes of work will significantly contribute to improved patient, service user and carer experience, better quality outcomes and financial benefits through identified service efficiencies and productivity. The BCF translates these top level outcomes into measurable whole system targets with agreed, shared accountability across all of our providers and commissioning organisations.

Table 1 below shows to which core target or outcome each scheme contributes:

Scheme	Scheme description	Benefits					
		NEL	Residential & Nursing Adm	Reablement Effectiveness	DTOC	Patient Satisfaction	Self Dir. Support
1	Expert Patient Programme	✓				✓	✓
2a	Long-term conditions (dementia, stroke, falls, pall. care)	✓	✓		✓	✓	
2b	Older People Integrated Care (OPIC)	✓	✓	✓		✓	✓
2c	Care Homes	✓				✓	
3a	Rapid Care	✓		✓	✓	✓	
4	Enablers					✓	✓

Table 1 – Overview of Scheme Contributions to BCF Benefits and Outcomes

Table 2 overleaf details our current and target performance against the set baseline for each of those quantifiable targets and measures:

	Current Level	Target Next Year	Benchmark (ONS Peer Group)	Comment
Non-elective admissions	29,094 80 per 1,000 population	28,073 3.5% reduction	64 per 1,000 population	• Barnet is already in the top quartile on non-elective admissions performance • Improvement from reducing GP variation and increased use of risk stratification
Care homes	487	405	410.9 (for current level and based on LBB 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 100,000 population	6 per 100,000 population	6 per 100,000 population	• Move from second quartile to top quartile
Patient experience	0.87	0.92	0.869 (based on CIPFA comparator group; data is currently restricted and is owned by the NHS Information Centre)	• The metric is based on the Annual Social Care User Survey (2013/14), Question 1: Overall how satisfied or dissatisfied are you with the support or services you have received from social services in the last 12 months?
Self Directed Support	1 (2,701 people)	1 (2,718 people)		The metric is from the adult social care outcomes framework, long term support indicator. Percentage of people with self-directed support, expressed as a percentage of all eligible social care service users.

Table 2 – Current and Target Performance for BCF Benefits and Outcomes

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 of care 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 that 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.

Section 2a above outlines the five tiers that form the foundations of our integrated care model. 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.

Diagram 3 below illustrates our approach for how the design and structure of services will evolve significantly to reflect each tier of our integrated care model:

Diagram 3 – Evolution of Services for Mr Colin Dale

The diagram shows four of the five tiers, namely 1) Self-Management, 2) Prevention (i.e. Health and Wellbeing), 3) (A single point of) Access to Assessment and Care Planning and 4) Community Based Intensive Support Services. Tier 5 is not shown in this diagram because it shows the key changes we aim to make through our integrated care vision. We aim to reduce demand for tier 5 services through the support we provide in tiers 1-4. The following paragraphs describe each tier.

Tier 1: Self-Management – Shifting the focus of health and social care delivery away from formal care and institutions and developing the individual's resilience to seek their own solutions and manage circumstances:

- All individuals with a recognised long-term condition (such as diabetes or heart disease) will be offered self-management education, training and 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 enable them to support and empower people to manage their long-term conditions independently.

Tier 2: Health and wellbeing – Preventing the onset of ill health and improving people's social well-being:

- Targeted primary and secondary prevention to reduce health inequalities.
- Encouraging healthy lifestyles and lending support to families, friends and carers who provide informal care.
- Strong Information and Advice offer, with branding and in a format that will make these services 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.
- Health education package for carers, which supports safe caring, promoted by GPs, LBB, carer's services and hospitals. Dedicated carer's centres.
- Implementation of the Ageing Well Programme (user, carer and community led prevention and social inclusion activities), including greater investment in volunteering to support people in the community.
- GP network led Wellbeing service piloting community navigation to health, social care and voluntary sector services.
- Evidence base of what works at a system and individual level will be developed to inform future commissioning.

Tier 3: Access services – Primary and social care assessment for people with a long-term condition, aimed at preventing emergency and unnecessary admissions:

- **Identification of at risk Older Adults through risk stratification:** 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 point of access to provide advice and support for older adults and those with long-term conditions, signposting them quickly and efficiently to the correct services and provide a timely and 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 needs that will be accessible 24/7 from any location and wherever staff are working. This is a key system enabler.

Tier 4: Intensive Community Support – Services to increase independence and provide health and care support to manage people in the community e.g. at home.

- **Care Co-ordination and Case Management:** Delivered through Integrated Locality Teams in partnership with GPs (including social care, mental health and community healthcare), 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 crises and maintain people in their homes or in other care settings.

- **Weekly Multi-disciplinary Team (MDT) meetings** will provide a more intensive and coordinated approach to managing the most complex cases by planning individualised care packages 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 closely and 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 home and hospital inpatient services support intensive care where individuals cannot live happily, healthily and independently at home. The aim is for these services to be accessed only when other community based services available cannot provide the correct level of care or an appropriate environment for the patient or service user.

The focus of our integrated care model is to shift activity to Tiers 1 – 4 and to reduce demand for acute hospital and residential care (Tier 5). Within Tier 5, we are developing several initiatives to reduce demand for acute hospital care, including reducing the risk of people in nursing or residential care being admitted to hospital.

Both acute hospital sites serving Barnet operate admission prevention services (TREAT) and early supported discharge schemes (PACE). 7 day a week social worker services operate in both hospital sites.

Our leadership and thinking and working with stakeholders are integrated across aligned activities. The Chair of BCCG also chairs our local System Resilience Group (SRG) to set and implement plans across the whole health and social care system to manage patient flow and demand and capacity management driven by winter pressure and other identified risks to public health. In December 2014 we hosted an A & E Summit to bring together all major stakeholders for urgent care in Barnet to agree how we can work better for patients to reduce admissions and help them leave hospital and return home faster. This included social workers, BCCG, the London Ambulance Service (LAS) and the Royal Free NHS Foundation Trust.

In Scheme 2 we have a dedicated set of initiatives which target care homes, working with locally commissioned services to improve staff skills and quality of care in care homes. Our aim is to support the care homes themselves to appropriately respond to patients requiring intensive support, preventing hospital admission with the deployment of additional support from the integrated care model. Dedicated GP support has been enhanced, for example with fortnightly ward rounds and six monthly holistic reviews and post-admission and medication reviews (over and above the services commissioned under GP GMS and PMS contracts). We have a dedicated improvement team for Care and Nursing Homes (IQICH, recognised for its good practice in the Skills for Care Accolade awards). All this work is further improving the relationship between the care home and GP, increasing levels of proactive and preventative care given to anticipate

potential issues and prevent crisis and avoidable emergency admissions. We are also supporting people's preference of place of death through advanced end of life care planning, with a Barnet GP acting as dedicated 'End of Life Champion'. The scheme is providing education and training to care home staff and managers to empower them to improve the quality of care and build networks between care homes to facilitate shared learning and best practice.

Scheme 4 (Enablers) includes improvements to hospice services, to provide a more appropriate environment than acute hospital for people if their health deteriorates and they require palliative care.

Tables 3 and 4 overleaf list the schemes of work for each Tier for the next two years. They show the total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below) and their contribution to reducing non-elective admissions. The savings are based on a £2,004 average unit cost per admission, as used in our Business Case for Integration (included in Section 1c above) and our financial model in Part 2 (spreadsheet) of our Plan.

The estimated reduction in non-elective admissions (NEL) in Tables 3 and 4 reflects the figures in Tab 4, HWB Benefits Plan of Part 2 of this submission, covering two full years (eight quarters) from 1 April 2014 to 31 March 2016.

More details of each Scheme are included in Annex 1. This includes the:

- Impact of schemes on reducing nursing and residential care home admissions, improving the effectiveness of reablement and reducing delayed transfers of care.
- Evidence base and assumptions used to analyse the costs and benefits and their specific contribution to our target benefit and outcome measures detailed in Part 2 of this submission.

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention					
		a. Expert Patient Programme & long-term condition Mentors	*35,000 (Not BCF pool)*	n/a	23	46,092	3.62
3, 4	2	Assessment & Care Planning					
		a. Long-term conditions	267,357	4.03	15	30,060	2.36
		b. Older People Integrated Care	1,057,451	15.94	155	310,620	24.41
		c. Care Home – LCS	231,000	3.49	29	58,116	4.57
4	3	Community Intensive Support					
		a. Rapid Care	636,171	9.59	413	827,652	65.04
		b. 7 Day Social Work & Enablement	300,000	4.52			
All	4	Enablers					
		a. Services	862,021	12.99			
		b. Administrative	3,280,000	49.44			
		Total:	**6,634,000 (BCF Pool)**	**100**	**635**	**1,272,540**	**100**

Table 3 – Cost and Impact of Schemes on NEL Admissions April 2014 – March 2015

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention					
		a. Expert Patient Programme & long-term condition Mentors	*87,120 (Not BCF pool)*	n/a	119	238,476	11.66
3, 4	2	Assessment & Care Planning					
		a. Long-term conditions	2,722,921	11.63	110	220,440	10.77
		b. Older People Integrated Care	1,292,026	5.53	331	663,324	32.42
		c. Care Home – LCS	1,146,000	4.89	10	20,040	0.98
4	3	Community Intensive Support					
		a. Rapid Care	1,316,464	5.62	451	903,804	44.17
		b. 7 Day Social Work & Enablement	300,000	1.28			
All	4	Enablers					
		a. Services	10,636,589	45.43			
		b. Administrative	5,998,000	25.62			
		Total:	**23,412,000 (BCF Pool)**	**100**	**1,021**	**2,046,084**	**100**

Table 4 – Cost and Impact of Schemes on NEL Admissions April 2015 – March 2016

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.

The delivery of our BCF plan will occur in the context of a challenging health and social care environment:

- Barnet Clinical Commissioning Group (BCCG) has an inherited debt of £34.1m. The Revenue Resource Limits (RRL) in place for 2014/15 and 2015/16 continue to disadvantage BCCG by providing funding below the 'fair share' target. Significant ongoing QIPP challenges will continue for BCCG in to the foreseeable future.
- The Barnet Council (LBB) Priorities and Spending Review (PSR) forecast a gap in the Council's finances of £72m between 2016 and 2020. It has identified a package of options for LBB to save money and raise revenue, with a potential to provide a financial benefit of approximately £51m. Adults & Communities share of the PSR package of savings is £12.6m. This includes proposals for improving organisational efficiency, reducing demand and promoting independence and service re-design.
- In addition to the £72m gap, the Council must meet the challenge of providing the new statutory duties of the Care Act, including for the 32,000 informal carers across Barnet.
- Significant change in the landscape for the provision of hospital services as a result of strategic change and re-configuration.
- Barnet has more than 100 care homes, with the highest number of residential care beds in London, leading to a significant net import of residents with health needs moving here from other areas.

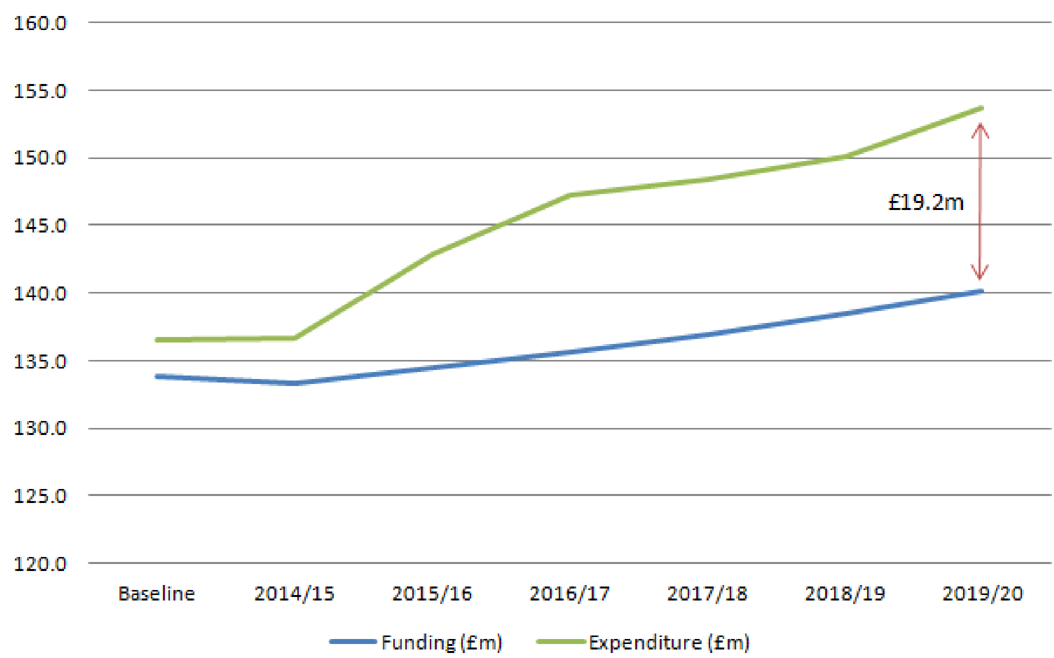
Our case for change centres on five issues:

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. **Insufficient spend on areas that support integrated care**

We have undertaken a **financial analysis of the affordability and deliverability of our integrated care 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.

Our Business Case for integrating health and social care services includes our BCF Plan and shows that the combined effect of likely reduced funding and our forecast increases in expenditure may create a significant financial gap over the next six years **if we do not change our current care model**. Based on the scope of services at the time of developing the business case, our baseline for the first year of the business case modelling period (2013/14) was a budget of £133.8m with a forecast expenditure of £136.5m. This leaves a funding gap of £2.7m. Diagram 4 below illustrates our analysis of

the costs involved, which give us an indicative view of the possible longer term forecast funding gap relevant to older people (in scope) from 2014 to 2020. **This demonstrates the need for change to our model of care.**



Data source: LBB & BCCG Business Case for Integration of Services September 2014.

Diagram 4 – Graph of Forecast Funding Gap for Services 2014 – 2020

Our strategy for embedding integrated care will enable us to implement ambitious change in the scale and scope of services to close any potential funding gap. Our BCF plan is our first significant step to embed fully integrated care for the whole health and social care system in Barnet.

We have taken a conservative approach to financial modelling, which provides a solid baseline on which to expand initiatives and increase the scope of future projects. This will enable us to identify and realise additional benefits going forward and to factor in the impact of other local or national changes that will influence our model for integration, e.g. the Care Act.

There has also been significant change in the local provider landscape following 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, whilst others continue to emerge. Until the local health economy settles down following this change 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 NHS Foundation Trust** has changed operational practice and subsequent service 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 growing. The population of Barnet 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.

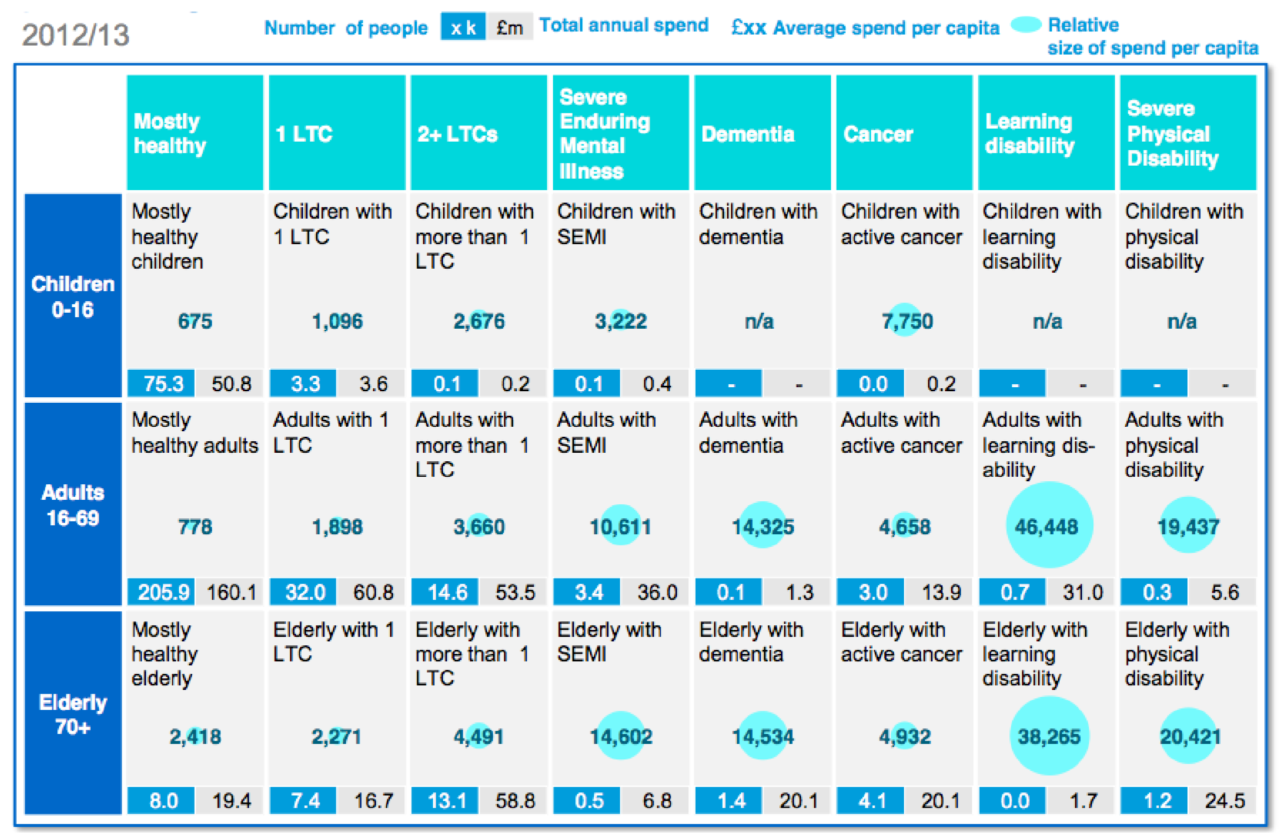
Barnet will have one of the largest increases in elderly residents out of all the London boroughs over the next five to ten years. There are currently 52,000 people in Barnet over the age of 65, and this will increase to 59,800 by 2020. We also have more than 100 care homes in the borough, disproportionately high compared to other London boroughs. Barnet's Health and Wellbeing Strategy 2012 to 2015 (October 2012) sets out our 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 such rising demand and need for rising health and social care among older people, and ongoing and resulting financial pressures facing the NHS and Council.

Table 5 overleaf shows that segmentation of the Barnet population identifies that £95.5m per annum is spent on 21,900 people aged 70 or over with one or more long-term conditions or dementia. In addition £114.3m is spent on 46,600 adults with one or more long-term conditions. There are today more than 1,600 people over 65 with long-term conditions or physical frailty receiving community based care services in their home through Adult Social Care.

These figures form a natural starting point for identifying and defining specific cohorts of people in our community around which we are developing the integrated care model.

Our approach for determining the scope of the first schemes of work detailed in Annex 1 was to refine these cohorts as our target users for the services, using risk stratification. This gave us a specific view of the number and profile of those most at risk of an unplanned admission to hospital.

This approach confirmed the three main cohorts for the Plan as detailed below. Section 7d[i] sets out in more detail our approach to risk stratification and how it might evolve in line with future opportunities for detailed, parallel segmentation of the population to identify the need for new services.



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

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

Source: McKinsey Integrated Care Model

Table 5 – Population Segmentation For Barnet Population 2012 – 2013

Closing current variations 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:

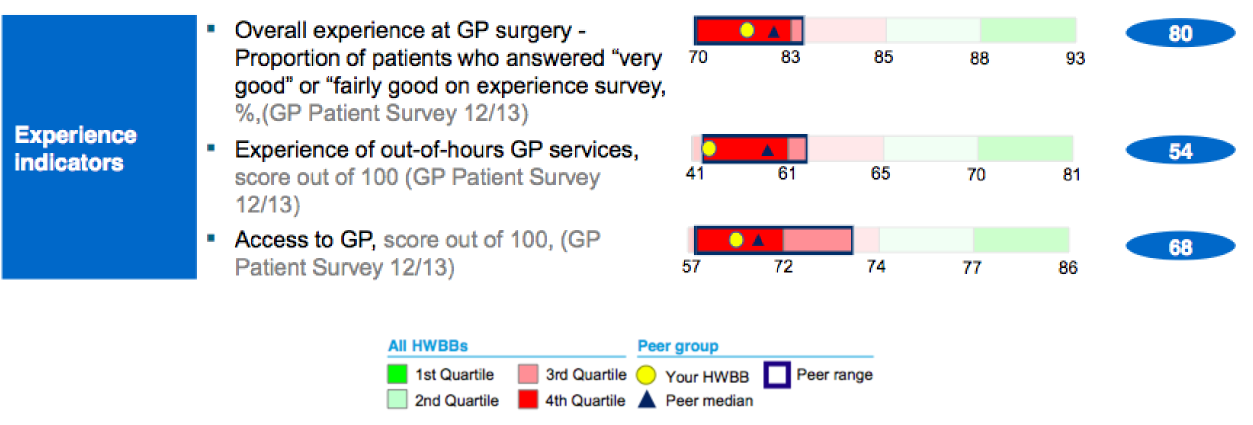


Table 6 – Access to and Experience of Primary Care: Barnet Performance Relative to Other Local Areas 2012 – 2013

In addition there is a **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 NEL reduction targets:

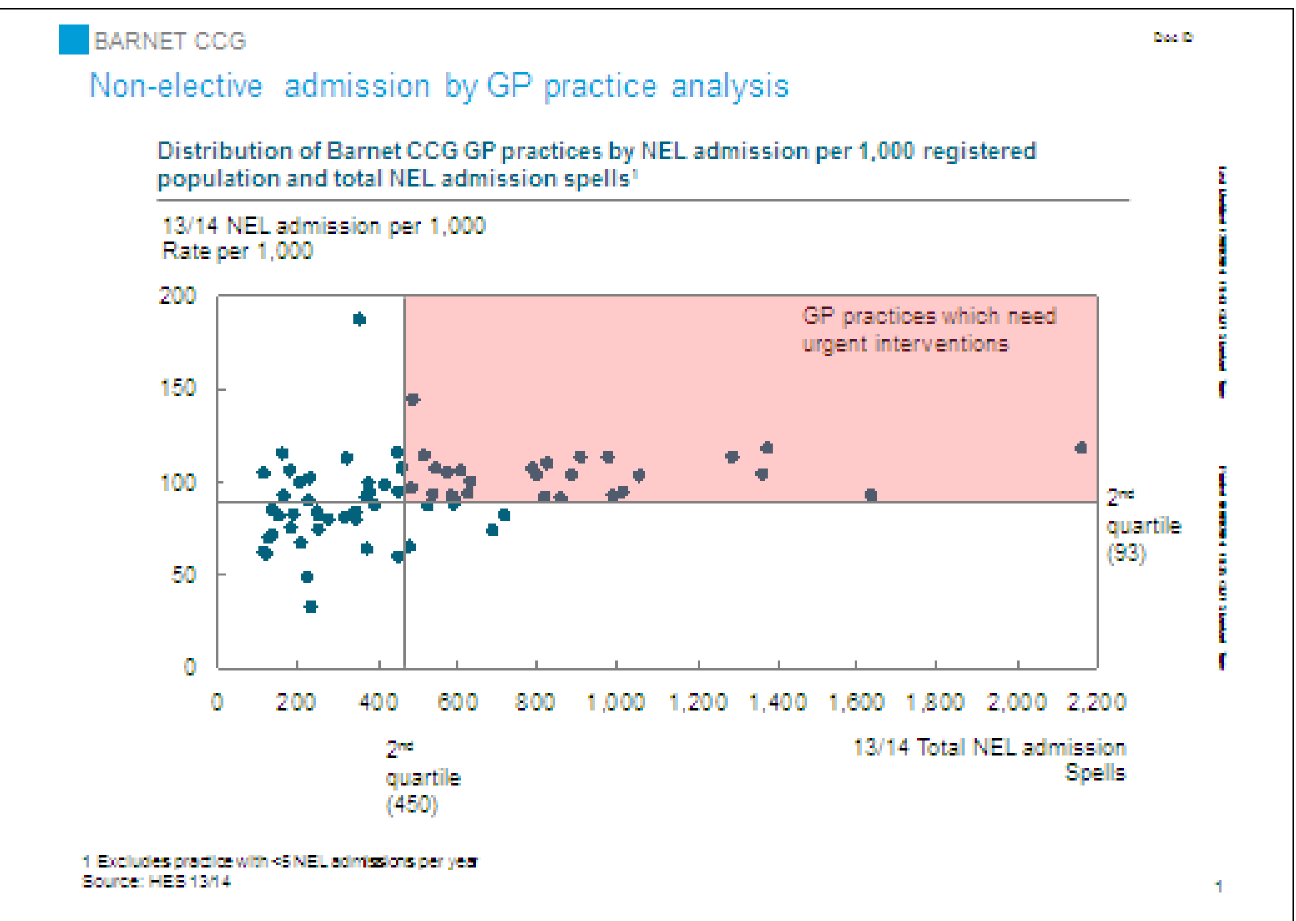


Diagram 5 – BCCG NEL Admissions By GP Practice 2013 – 2014

There are further opportunities to improve BCF metrics and to improve outcomes.

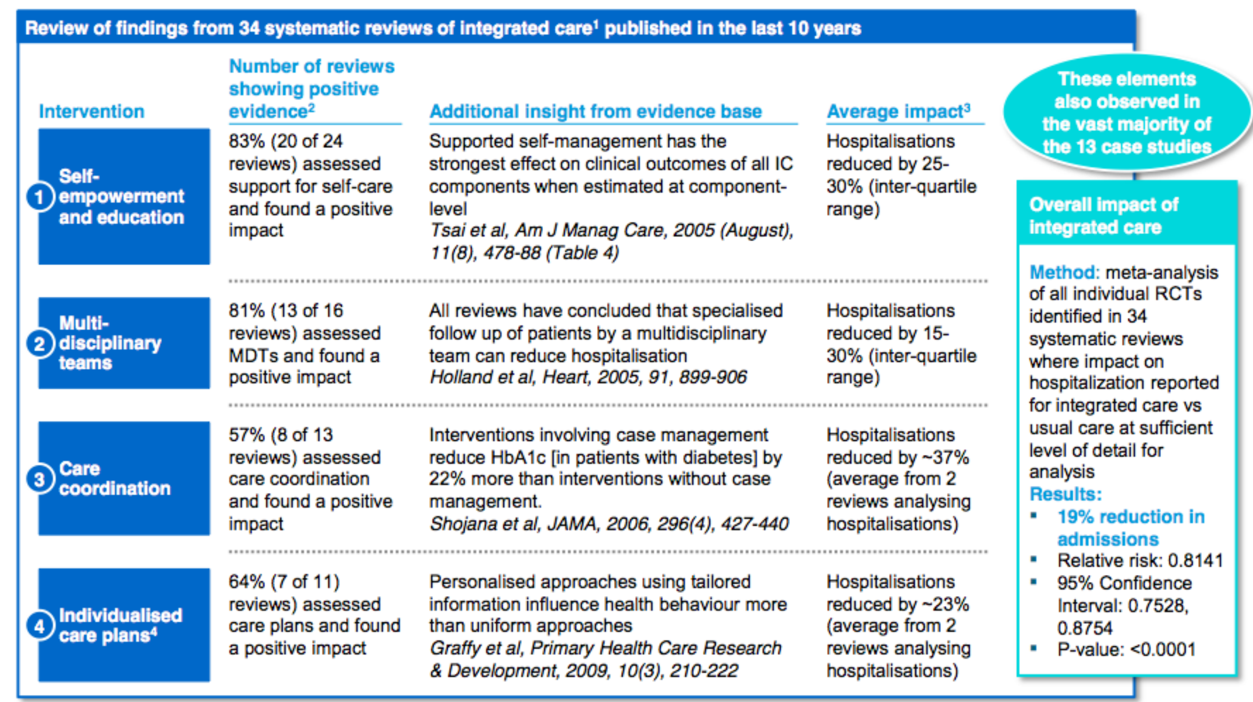
Barnet has made progress in reducing non-elective admissions over recent years with a 2.2% decrease between 2009/10 and 2013/14. This has been reinforced in the BCF Health and Wellbeing Board (HWB) Fact Pack and baseline data. It states that "Barnet performs significantly better than peers and most of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

Table 7 – Barnet NEL Admission Rate per 1,000 Population 2013 – 2014

While this is encouraging, it should be noted that the reduction is not consistent and reflects unusual trends in provider activity for specific periods in 2013/14. We therefore need to be cautious in our assumptions on how this reduction can be sustained and increased going forward.

When considering benchmarking and target setting, it can be noted that the BCF HWB Fact Pack identified a limited opportunity for reducing non-elective admissions for Barnet compared to ONS and peer group data, which put Barnet non-elective activity in the top decile (all HWB). However, international scientific evidence and case examples for fully

operational best-practice integrated care suggests that full delivery of the four key components of integrated care outlined in Table 8 below could impact as a reduction of up to 37% in hospitalisations. Taking into account population 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 to 5 years**.



Review of findings from 34 systematic reviews of integrated care[1] published in the last 10 years

Intervention	Number of reviews showing positive evidence[2]	Additional insight from evidence base	Average impact[3]
1 Self-empowerment and education	83% (20 of 24 reviews) assessed support for self-care and found a positive impact	Supported self-management has the strongest effect on clinical outcomes of all IC components when estimated at component-level *Tsai et al, Am J Manag Care, 2005 (August), 11(8), 478-88 (Table 4)*	Hospitalisations reduced by 25-30% (inter-quartile range)
2 Multi-disciplinary teams	81% (13 of 16 reviews) assessed MDTs and found a positive impact	All reviews have concluded that specialised follow up of patients by a multidisciplinary team can reduce hospitalisation *Holland et al, Heart, 2005, 91, 899-906*	Hospitalisations reduced by 15-30% (inter-quartile range)
3 Care coordination	57% (8 of 13 reviews) assessed care coordination and found a positive impact	Interventions involving case management reduce HbA1c [in patients with diabetes] by 22% more than interventions without case management. *Shojana et al, JAMA, 2006, 296(4), 427-440*	Hospitalisations reduced by ~37% (average from 2 reviews analysing hospitalisations)
4 Individualised care plans[4]	64% (7 of 11) reviews) assessed care plans and found a positive impact	Personalised approaches using tailored information influence health behaviour more than uniform approaches *Graffy et al, Primary Health Care Research & Development, 2009, 10(3), 210-222*	Hospitalisations reduced by ~23% (average from 2 reviews analysing hospitalisations)

These elements also observed in the vast majority of the 13 case studies

Overall impact of integrated care

Method: meta-analysis of all individual RCTs identified in 34 systematic reviews where impact on hospitalization reported for integrated care vs usual care at sufficient level of detail for analysis

Results:
- 19% reduction in admissions
- Relative risk: 0.8141
- 95% Confidence Interval: 0.7528, 0.8754
- P-value: <0.0001

1 Search strategy used a range of terminology (including coordinated or collaborative care, case management, disease management etc) then results were filtered to exclude interventions not meeting the criteria for integrated care (e.g. single component interventions). See next pages for further details and references.
2 Positive impact (i.e. in favour of integrated vs usual care) on whatever outcomes measures selected by review authors (e.g. disease severity or clinical marker, mortality, hospitalisations)
3 Impact measured from systematic reviews including relevant interventions and containing meta-analysis of hospitalisation rate (intervention vs controls)
4 Cochrane review of the evidence for personalised care planning (Coulter et al.) currently in preparation (results not yet available)

Table 8 – Review of Best Practice Integrated Care Systems 2004 - 2014

Compared to peers Barnet has the scope to improve **delayed transfers of care** to move into the top quartile (all HWB); and to increase the proportion of elderly people aged 65 or over who were still at home 91 days after discharge from hospital into **rehabilitation** or **reablement** services:

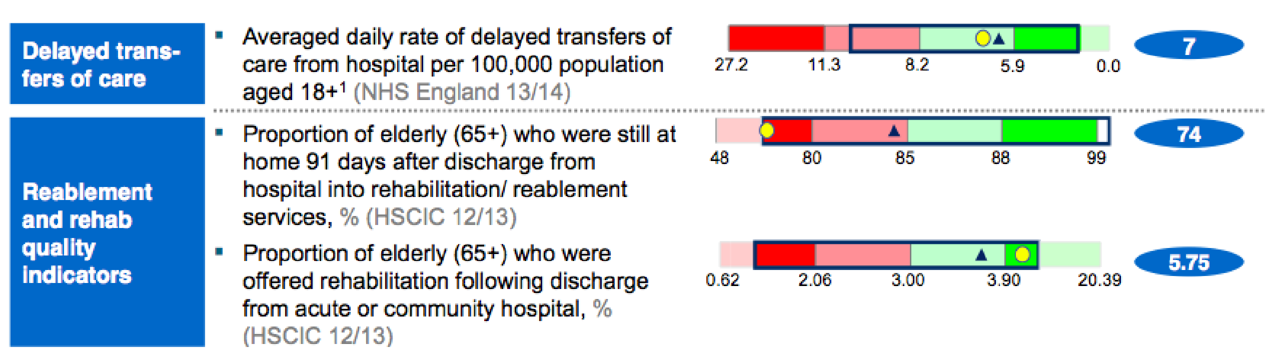


Table 9 – Barnet DTOC and Reablement Performance 2012 - 2014

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 spent 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, preventative and community based 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:** people aged 65 or over who suffer from at least three of the 19 recognised Ambulatory Care Sensitive (ACS) conditions.
2. **People with long-term conditions**: those aged 55 to 65 with one or more long-term conditions.
3. People living with **Dementia**.

The target for the BCF pay for performance element is set at 3.5% (equivalent to 1,021 less non-elective admissions) in 2015 to 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 initiatives that are designed to support people to remain as independent as possible, for as long as possible; meeting statutory social care needs whilst still delivering the efficiencies required by LBB. This includes a requirement to ensure that more people can stay in their own homes with the support of enablement services and a reduction in their need for statutory care services.

Our Health and Social Care Integration (HSCI) 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 Programme.

We have planned our BCF to deliver the model within limited financial resources. Given the funding allocations of BCCG and LBB, 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 years. The core services are those that we will be re-designing 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 to 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 BCCG QIPP and the payment for performance element of the BCF. BCCG has analysed in detail its current and planned spend on non-elective admissions. Development of the programme of work and PMO function Governance arrangements in place	Develop Business Case to support integrated care model and strategic approach to future commissioning /contracting for approval Co-design detailed operational delivery models including phasing of delivery, funding streams, future capacity and workforce requirements. Determine outcome measures and regular monitoring mechanism with assurance Test current governance arrangements for BCF particularly in relation to agreement and monitoring of risks and benefits Agree shared PMO arrangements to support delivery programme Develop a communications strategy, including a mechanism to capture user views to effectively feed in user perspective to inform progress and continued improvement.	Test outputs of current service delivery and scope further plans Fully functional benefits tracking and financial monitoring model in place Implement communications strategy Establish and monitor financial flows to and from the pooled budget including those contributed from parties outside health and social care Develop feedback mechanism to interested parties to promote success and share learning.
1	Expert Patient Programmes planned for Autumn 2014 Telehealth pilot underway as part of Rapid Care Project 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 Design and deliver carers support programmes Design and implement structured education offer Pilot programmes for Telecare and Telehealth	Deliver project plans in line with tier specifications: priority focus on self-management Mainstream programmes for Telecare and Telehealth if appropriate
2	Ageing Well project operational in 3 areas	Implement early phase plan: Ageing Well	Develop an evaluation model to support development of a local

	Clear links established between HSCI/BCF Programme and public health Carers service re-design being taken forward in the context of the BCF	Design Health education package for carers Design preventative services and develop the market/ strategic partnerships in voluntary and commercial sectors to deliver. Link into Public Health team initiatives (e.g. NHS Healthchecks, healthy eating and physical activity promotions, smoking cessation) Link into “universal offer” to older people through preventative services Link into LBB carer support services	evidence base to support future commissioning Unified branding for prevention tier 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 Risk Stratification Tool live in all GP Practices.	Phased roll out of Community Point of Access. 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. 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. Incorporate service re-design projects: dementia and end of life pathways. Implementation of the Shared Care Record
4	Integrated locality Teams trail-blazer team mobilised in August 2014 The Care Navigation Service (CNS) and Multi-Disciplinary Team (MDTs) case conferences started in July 2013. Expanded Rapid Care service in August 2013, now available 7a.m to 10p.m 7 days a week	Implement and monitor early phase plan: Rapid Care Finalise the design and delivery model of borough wide Integrated Locality Teams. Extend the scale and operations of Multi Disciplinary Teams, including assessment of higher risk individuals and planned co-ordination of care. 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. Embed Integrated Locality Team model expanding across service areas as required Explore role of existing Older Peoples Assessment Unit (OPAU) to offer increased clinical capacity and expertise. Develop Enablement, Intermediate and Respite Care offer to meet need.

Table 10 – Milestones for Integrating Health and Social Care Services in Barnet

Interdependencies and existing programme alignment:

- Establishment of aligned budgets for BCCG, LBB and other parties, e.g. public health, into our integrated care model to influence delivery of the BCF.
- At a North Central London (NCL) CCG level, the establishment of Integrated Provider Units (IPUs) and value based commissioning.
- Integration with new and re-designed LBB systems and services designed to meet the requirements of the Care Act, including LBB first point of contact and assessment services, information and advice offer, enablement services and new, upgraded case management and other ICT systems.
- Link into further development of ‘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

Diagram 6 below illustrates the governance and board structure for the Health and Social Care Integration (HSCI) Programme.

Initial governance arrangements were 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, information governance (IG) and terms of reference.

Governance structures have been regularly reviewed as the programme has evolved and this will continue as required. The current governance and board structure is below.

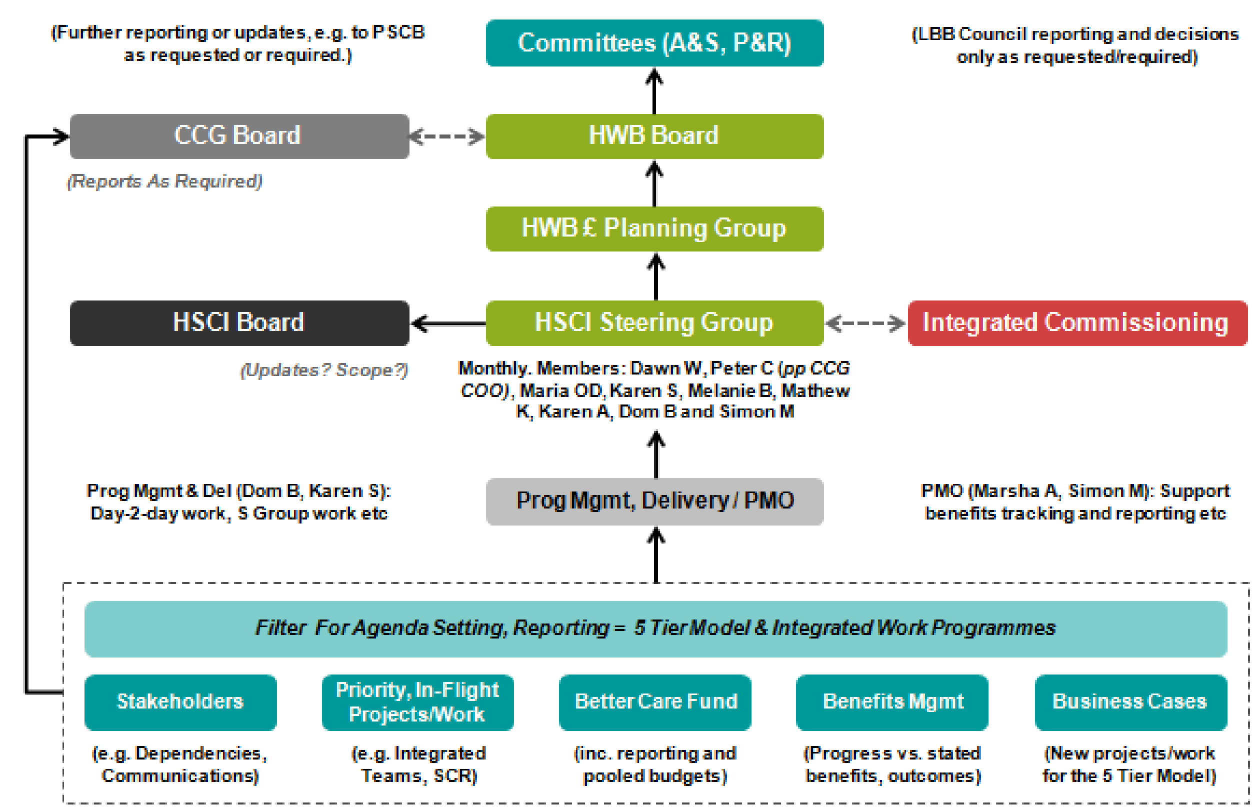


Diagram 6 – Barnet HSCI/BCF Governance Arrangements 2014

The LBB Director of Adults & Communities and BCCG Chief Operating Officer act as joint sponsors for BCF. The LBB Assistant Director of Adults & Communities and BCCG Director of Integrated Commissioning act as joint Programme Directors and Project or Tier Sponsors.

Each tier has a dedicated lead and subject matter expert. Each project has a project manager and prioritised work plan, aligned to Programme aims and objectives and agreed benefits and outcomes. Tier leads work in partnership to define strategies for delivering end-to-end services.

All Programme and project work uses approved programme and project management methodologies. Work is 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 and benefits management methodologies and 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 (Steering 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.

The Health and Wellbeing Board (HWB) Finance Group, a formal sub-committee of our HWB, is responsible for setting and controlling expenditure for budgets for Better Care Fund and for wider work to integrate care services, e.g. with Public Health to deliver services for Tier 1 of our integrated care model. The HWB Finance Group also monitors progress in delivering BCF services and tracking benefits realisation against these budgets, reporting back to HWB accordingly.

LBB and BCCG already have a Section 75 Agreement for integrated care in place. This started in August 2013, for an initial three year period. The agreement will be extended beyond this date by both parties to support the long-term delivery of BCF and integrated care services.

Our S75 Agreement states the aims of both parties and our statutory responsibilities for integrated care. It also contains baseline arrangements for creating and managing pooled budgets, including the role and responsibilities of the nominated Lead Party and annual accounting, auditing and reporting cycles.

We have already aligned our Section 256 and some social care and community contract budgets to design and deliver the integrated services described in this BCF plan, e.g. Integrated Locality Care Teams and Rapid Response and stroke support services.

We are now working to formalise these arrangements under a pooled budget as required for BCF. We have set up a Working Group, containing executive or lead representatives from our finance, governance and legal functions to develop and implement the pooled budget, e.g. scope and level of contributions and how this is reviewed and increased over time, risk and reward share arrangements (see Section 5b below) and operational requirements, e.g. the timing of and information required for accounting and reporting cycles.

We have already agreed a number of core principles. For example, the pool will start with the £23.4m BCF fund and increase over time to include core LBB and BCCG budgets for relevant care services. Until these budgets are transferred into the pool, we will manage them on an open book basis. The Pool will be reviewed every year in September, to define the pooled budget for the following financial year.

Work is ongoing with meetings set through December and early January, to finalise the draft arrangements as a Schedule to the S75 Agreement. This includes confirming the Lead Party and testing scenarios for annual contributions to the Pool and tolerances for managing risk and reward sharing (see Section 5b below).

Final approval of the detailed principles and arrangements for the Pool will be an agenda item for HWB, BCCG and LBB Adults & Safeguarding Committee (A&SC) meetings scheduled from January to March 2015. This is in line with advice from NHS England to sign the pooled budget and risk and reward share arrangements once our BCF Plan is approved. Our intention is to implement the pooled budget from April 2015 subject to the BCF plan receiving full approval.

A copy of our latest work plan for establishing the Pool is below.

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 Health and Social Care Integration (HSCI) Programme and BCF Schemes of work. The figure below illustrates the current and proposed scope:

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.

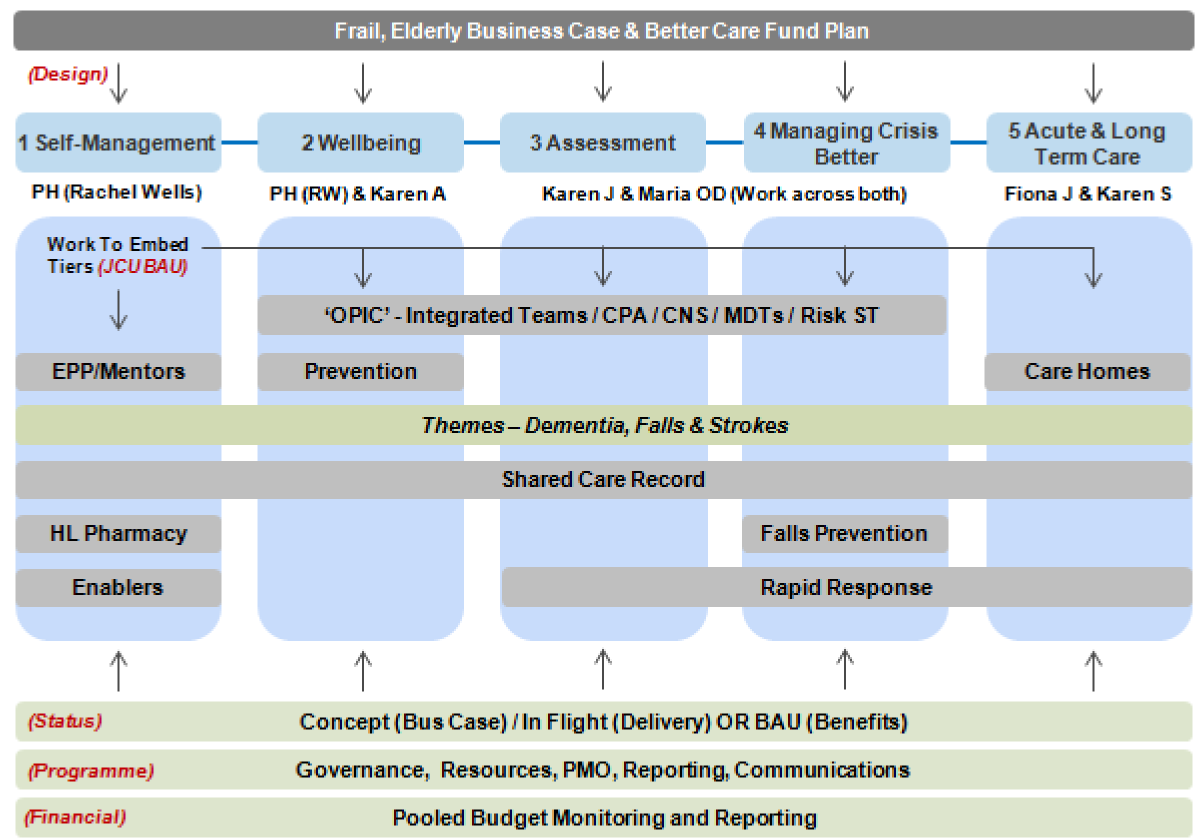


Diagram 7 – Barnet HSCI/BCF Programme Scope and Structure 2014

A Programme Management Office (PMO) will coordinate and manage Programme work and operations. This will include governance, administration, project/work delivery and reporting, benefits realisation, documentation, 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 HWB.

As indicated above the HSCI Steering Group oversees operational implementation of the BCF. It meets monthly and has terms of reference set to flex meet the emerging needs of this BCF plan. Members include BCCG and LBB director level roles, 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 a. Expert Patient Programme & Long-Term Condition Mentors
2	Tier 3 & 4. Assessment & Care Planning a. Long-term conditions (dementia, stroke, falls and palliative care) b. Older People Integrated Care (OPIC) c. Care Homes
3	Tier 4. Community Intensive Support a. Rapid Care b. Seven Day Working
4	Enablers a. Service enablers b. Administrative 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)	Prob (1 - 5)	Rating (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 • Continued analysis of interdependencies to fully understand impact and consequences • Regular updates to management teams • 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 integrated care model to allow for greater understanding of the wider impact across the health economy • Ongoing stakeholder engagement including co-design and transitional planning with providers • Ongoing review of impact
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 • 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 • Front line/ clinical staff engagement and input in developing integrated care model and plans • Communications strategy with staff across the system • 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 BCCG and LBB initialisation resources to support delivery and implementation of schemes/work streams.
The baseline data used to inform financial model is incorrect and thus the performance and financial targets are unrealistic/unachievable	4	3	12	• Validation of assumptions and savings target with respective finance departments • Close monitoring and contingency planning • Define any detailed mapping and consolidation of opportunities and costs

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
				to validate plans. • 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 • 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 • Robust governance in place to support risk and benefits share • Clear identification and monitoring of saving opportunities • BCF could be the catalyst to savings in other areas of LBB spending, i.e. Adult Social Care.
The Care Act will increase costs from April 2015 and again from April 2016 resulting in increased cost pressures to local authorities and CCGs	4	4	16	• Undertake an initial impact assessment with a view to refining assumptions. • Explore and develop opportunities and benefits arising from the introduction of this legislation that may help to offset negative financial consequences. • Define the impact of the Care Act and the potential pressures on LBB and BCCG budgets as a result. • 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 • 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 HWB to determine their strategic changes and how it will impact Barnet • Discussions with key stakeholders including acute sector, social care community care, etc. to explore linkages and why shift is not taking place • Invest in re-educating public on use of acute sector. • Public communications strategy,

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
				including targeting primary care settings
Population characteristics and demographics adversely impact on deliverability of the model (e.g. population growth and continued net importation of over 75s into care homes from other areas)	3	3	9	• Focus on high impact project to target populations • 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 • Consider working with neighbouring trusts to develop common discharge plans in line with borough specifications • MDT to monitor eligibility for services and ensure appropriate referrals
Acceptability of 7 day services impacting on integrated care model	2	2	4	• Stakeholder engagement on 7 day working • 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 reducing in non-elective 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.

Section 4b above details our plans for establishing a pooled budget to manage the funds allocated for BCF and the corresponding risk and reward share arrangements to deal with the issues.

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 on existing BCCG QIPP plans, particularly related to Integrated Care and Ambulatory care and reflects a 2 year plan (2014 - 16) with increasing ambition for 15 - 16. It also builds on our Business Case for Integration included here in Section 1c above. We have recently modelled 2015 – 16 following the recognised Newham/Tower Hamlets methodology.

Tables 11 and 12 overleaf list our BCF schemes that directly support achievement of this target for the next two years. They include the total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget and their contribution to the target. The savings are based on a £2,004 average unit cost per admission used in our Business Case for Integration (included in Section 1c above) and our financial model in Part 2 (spreadsheet) of our Plan.

The estimated reduction in non-elective admissions (NEL) in Tables 11 and 12 reflects the figures in Tab 4, HWB Benefits Plan of Part 2 of this submission, covering two full years (eight quarters) from 1 April 2014 to 31 March 2016. More details of each Scheme are included in Annex 1. This includes the:

- Impact of schemes on reducing nursing and residential care home admissions, improving reablement effectiveness and reducing delayed transfers of care.
- Evidence base and assumptions used to analyse the costs and benefits and their specific contribution to our target benefit and outcome measures detailed in Part 2 of this submission.

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention					
		a. Expert Patient Programme & long-term condition Mentors	*35,000 (Not BCF pool)*	n/a	23	46,092	3.62
3, 4	2	Assessment & Care Planning					
		a. Long-term conditions	267,357	4.03	15	30,060	2.36
		b. Older People Integrated Care	1,057,451	15.94	155	310,620	24.41
		c. Care Home – LCS	231,000	3.49	29	58,116	4.57
4	3	Community Intensive Support					
		a. Rapid Care	636,171	9.59	413	827,652	65.04
		b. 7 Day Social Work & Enablement	300,000	4.52			
All	4	Enablers					
		a. Services	862,021	12.99			
		b. Administrative	3,280,000	49.44			
		Total:	**6,634,000 (BCF Pool)**	**100**	**635**	**1,272,540**	**100**

Table 11 – Cost and Impact of Schemes on NEL Admissions April 2014 – March 2015

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention					
		a. Expert Patient Programme & long-term condition Mentors	*87,120 (Not BCF pool)*	n/a	119	238,476	11.66
3, 4	2	Assessment & Care Planning					
		a. Long-term conditions	2,722,921	11.63	110	220,440	10.77
		b. Older People Integrated Care	1,292,026	5.53	331	663,324	32.42
		c. Care Home – LCS	1,146,000	4.89	10	20,040	0.98
4	3	Community Intensive Support					
		a. Rapid Care	1,316,464	5.62	451	903,804	44.17
		b. 7 Day Social Work & Enablement	300,000	1.28			
All	4	Enablers					
		a. Services	10,636,589	45.43			
		b. Administrative	5,998,000	25.62			
		Total:	**23,412,000 (BCF Pool)**	**100**	**1,021**	**2,046,084**	**100**

Table 12 – Cost and Impact of Schemes on NEL Admissions April 2015 – March 2016

Part of the ongoing strategic approach to establishing the BCF pooled budget will be to ensure sustainability in the key services that will deliver the target for NEL 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 are already agreed for 2015/16 and mobilisation plans will reflect availability of funding. This is supported by demand and capacity modelling in the Full Business Case. The risk of not-achieving targets will be mitigated where possible through contractual arrangements and we will work closely with providers to deliver in line with expectations. Where appropriate, contingencies to mitigate any at risk BCF funding (arising from non- or below target achievement of the NEL target) will be identified from the pool itself or other organisational funds. This could include the use of pooled budget under spend, other reserves or re-prioritisation of forward spend. BCCG and LBB corporate risk registers already reflect the risks, aims, and scope of the BCF.

Section 4b above describes our approach and work plan for our HWB and HWB Finance Group to establish a pooled budget to manage all the funds allocated for BCF and the corresponding risk and reward sharing arrangements.

Our work to finalise the pooled budget includes developing detailed arrangements for the proportion of contributions as a basis for sharing risk and reward and mechanisms to deal with:

- The impact on the Pool as a result of receiving only part of the 'at risk' funding of £2,054,000 for reducing non-elective admissions and how to offset any loss in funding, e.g. through establishing contingency funds, increasing contributions or adjusting the scope and benefits of the Pool accordingly.
- Varying the level and proportion of contributions each year, depending on policy direction, any changes to income and our agreed priorities for the future development and delivery of integrated care against Pool performance and benefits realised.
- Potential overspend and under spend of budgets and how future contributions or the level of risk and reward taken on by each Party is adjusted to reflect this and return the Pool to the level required to deliver the benefits identified.

Our Section 75 Agreement provides baseline arrangements for decision making and the risk share approach for the Pool. We will develop more detailed arrangements for HWB, BCCG and LBB Council approval for the end of March 2015 as described in Section 4b above.

6) ALIGNMENT

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

BCF is integral the delivery of our integrated care 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 BCCG and LBB longer term strategic plans (CCG 2 and 5 year plan; LBB Medium Term Financial Strategy 2015/16 and Priorities and Spending Review (PSR) 2016 - 2020:

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 LBB • Impact on BCF metrics and spend • New flow of users resulting in change of legislation
System-wide operations resilience planning and delivery	• Impact on non-elective activity • Manage seasonal demand and surges in line with BCF strategy • 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 • New flow of patients resulting in shifts in capacity and demand throughout the local system • 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 • Corporate sponsorship of HSCI/BCF Programme of work

The dependencies and alignment of these related initiatives will be managed through HWB and the HSCI Board and the governance arrangements 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

Our BCF vision for delivering integrated care aligns fully with **BCCG 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**:

VISION

Working with local people to develop seamless, accessible care for a healthier Barnet.

Promote health and wellbeing

Transform Primary care

Ensure Right care, First time

Develop joined up care

ENABLERS

Co-design with public and partners

Ensure the quality of services

Innovate with Technology

Spend public money wisely

Diagram 8 – BCCG Vision for Barnet and Better Care Fund

These strategic goals set the direction of travel for BCCG 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. Our delivery of BCF lies in the 'Joined Up Care' Strategic Transformation Programme and encompasses a key set of priorities for 2015/16 focussed on:

- Implementation of our 5 tier integrated care model by maximising our existing resources including the Better Care Fund.
- Roll out of Multi-disciplinary teams across Primary Care.
- Roll out of Risk Stratification Tool to support Primary Care.
- Partnership working with Voluntary and Community based organisations.
- Improve care in the community for over 75 with complex needs.

The Barnet Council Local Vision is set out in its Business Planning framework for 2015/16 to 2019/20 (LBB Policy & Resources Committee, 02/12/14), specifically the LBB Corporate Plan and the Adults & Safeguarding Committee (A&SC) Commissioning Plan 2015 – 2020 which encompasses our Better Care Fund plan.

The LBB Corporate Plan contains 3 core principles – Fairness, Responsibility and Opportunity – all of which are embedded in the A&SC Commissioning Plan. This outlines how LBB will manage the key changes required by the Care Act and BCF at a time of rising demand, increased expectations and shrinking resources. The commissioning intentions support the overall vision of the Council that:

"All adults will be given the opportunity to live well, age well and stay well. This means that all adults will feel safe and be safe in their environment. Financial constraints should not hinder the delivery of good outcomes for all but to achieve this Barnet's community will need to continue to play an important part, creating responsive and responsible neighbourhoods and communities in which vulnerable adults can live well and with personal autonomy, meeting principles of fairness through a targeting of resources on those that need it most. In order to support our growing and ageing population we will need a stronger focus on prevention and early intervention with a reshaped specialist care offer for those that need it".

The proposals for implementing the 5 tier integrated care model align with the Local Vision of both BCCG and LBB. Both demonstrate a commitment to work in partnership on:

- **Alternative ways to deliver services in partnership with residents and other organisations** – for example, integrating care and health services where this delivers the best outcomes; and stronger integration with customer services and public health to help people better self-manage and plan to age well.
- **Implementing the Care Act** – for example, improved advice and advocacy and information services with a greater availability of helpful information to support ageing well.
- **Going further with personalisation by developing creative approaches to meeting care needs** – for example a shift from specialist segregated services to community settings; support to remain at home for longer and greater use of direct payments and personalised health budgets.
- **Focus on efficiency, effectiveness and impact** – for example, through the integration of services explore alternative delivery models for health and adult social care to maximise BCCG and LBB's chance of mitigating the impacts of rising demand, increasing expectations and shrinking resources.

The BCF plan is crucial in supporting the delivery of the long-term strategic, operating and financial plans for the health and social care economy through the re-design of core services to develop a sustainable local care model.

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.

As a member of the North Central London (NCL) CCG group, BCCG has submitted an expression of interest for primary co-commissioning to NHS England. After NHS England confirmed receipt the NCL CCG group met 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 programmes of work linked to delivery of the London Primary Care Strategic Commissioning Framework (formerly 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. LBB and BCCG 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:

- Strategic direction for BCF to take into account existing and future commissioning plans of BCCG and LBB 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 HWB.

- 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 LBB 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 attributable 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 a further £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 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 5 tier integrated care model will underpin LBB'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 seven work streams, each with a dedicated lead manager and implementation plan, as follows:

1. **Demand Analysis and Modelling:** delivering a picture of what the total impact of the Care Act on LBB's finance and resources will be;
2. **Prevention, Information and Advice:** refreshing and updating prevention, information and advice initiatives and catalogues;
3. **Carers:** ensuring that LBB carer's services comply with Care Act regulations;
4. **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;
5. **Finance:** delivering a universal deferred payment offering and making any necessary changes to charging and debt collection processes.
6. **Marketplace:** updating existing and developing new policies and processes related to market shaping and provider failure;
7. **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

The level of resource associated with carer-specific support in the BCF is:

Carers breaks	£846,000
Carers services (S256)	£300,000
Total	£1,146,000

Our integrated care model includes other elements of carer support in addition to the above funding. For example, the dementia cafes and the dementia advisor provide support to carers. However, for the purposes of this section, only funding that provides **support to carers alone** has been included in the table.

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 (see Section 7a[iv]) 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 BCCG and LBB.

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 coordinated through a project dedicated to Carers as part of the Care Act Implementation Project Board (see Section 7a[iv]). It highlights dependencies too, which include HSCI 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

We have already made reasonable progress to establish 7 day working in Barnet but 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 our integrated care model through:

- Co-design working sessions for integrated care in 2013/14. These sessions included patients, LBB, GPs and Acute and Community Service providers as outlined in Section 8.
- NCL wide sessions to share development plans, ideas and best practice

We are working towards implementing the national standards for 7 day services in urgent and emergency care within the 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 required	Nov 13
Links established between services above and current providers of seven day services (e.g. out of hours GPs and London Ambulance Service (LAS))	May 14
Barnet Community Point of Access is operational providing an effective and safe referral point to facilitate access to rapid response/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

Table 13 – Barnet Milestones for the Roll Out of 7 Day Working

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 HWB and overseen by the Health and Social Care Steering Group will be a key enabler for sharing information between care providers:

- The Barnet Shared Care Record Project will first implement the service in 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.
- It will use the NHS Number as the unique identifier to combine data about individuals and data submitted to the Shared Care Record must use it this way.
- 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 and/or 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 / BCCG operate within an established information governance (IG) framework, including compliance with IG Toolkit requirements and the seven principles in Caldicott 2.

The contract documents used by BCCG to commission clinical services conform to the NHS standard contract requirements for IG and IG Toolkit Requirement 132.

BCCG 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.

IG arrangements and the IG Framework conform to IG Toolkit requirements in Version 11 of the 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

For the target cohorts of people listed in Section 3, risk stratification has given us a specific view of the proportion, number, profile and characteristics of those people most at risk of unplanned admissions to hospital.

This approach has identified 1,975 adults in the highest risk cohort and 17,463 adults in the next. The data also indicates that PbR costs associated with people in classification levels 2 and 3 are £85m, representing approximately 52.4% of total spend.

The latest view of the level of risk for the BCCG population is as follows:

Risk Level	Population Percentile	Number of Patients	Risk Ratio Range	Ave Risk Ratio	Average In Patient Admission (planned same day care)	Average Unplanned In Patient Admission	Average Unplanned Chronic In Patient Admission
3	0% to 0.5%	1,975	25.925- 40.226	32.230	11.51	3.99	2.77
2	> 0.5% to 5%	17,463	4.785- 25.914	10.216	2.03	0.77	0.36
1	> 5% to 25%	77,463	0.783- 7.785	1.806	0.34	0.09	0.02
0	> 25% to 100%	297,226	0.05- 0.783	0.304	0.08	0.01	0.00
Total Population		394,127		1.198	0.274	0.105	0.044

Table 14 – Risk Classifications for the Barnet Population December 2014

This underpins the scope of services offered in Tiers 3 and 4 which in turn is the basis for partnering with GPs to proactively engage with these people to offer the services.

Approach

BCCG uses a recognised risk stratification tool and in August 2014 we completed an accelerated programme to implement the tool in GP practices and train practices to use it. All GP Practices now have and use the tool to identify 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%

Table 15 – Barnet Risk Stratification Tool Classifications

The following diagram shows which elements for the Schemes described in Section 2 above are designed for and impact on each risk category (grouping):

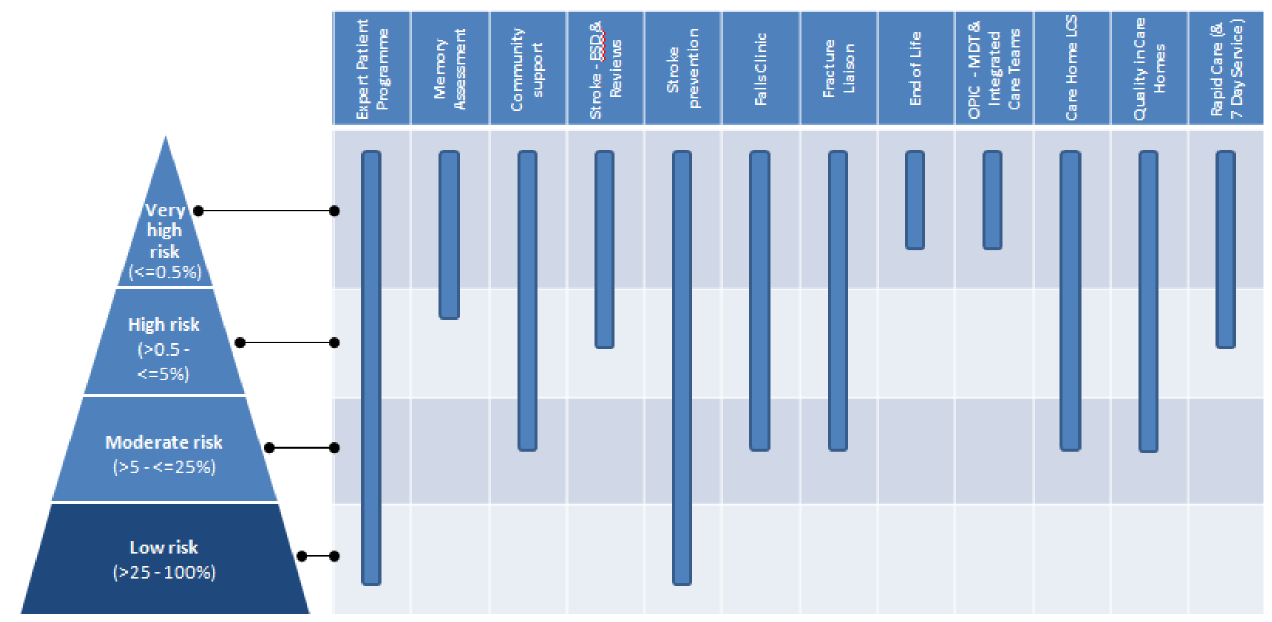
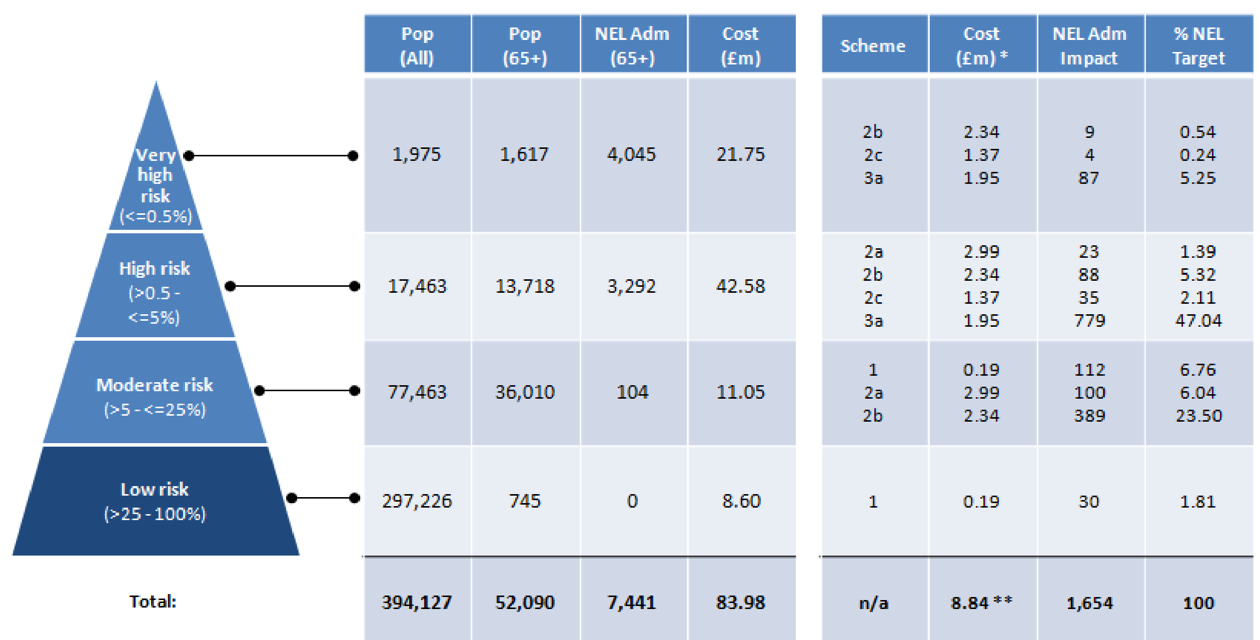


Diagram 9 – Risk Classifications Targeted By BCF Scheme Elements

For the population cohorts (by risk level) listed above the following table details the costs of the schemes and their impact on reducing non-elective admissions for each initiative:



Risk level	Pop (All)	Pop (65+)	NEL Adm (65+)	Cost (£m)	Scheme	Cost (£m) *	NEL Adm Impact	% NEL Target
Very high risk (<=0.5%)	1,975	1,617	4,045	21.75	2b 2c 3a	2.34 1.37 1.95	9 4 87	0.54 0.24 5.25
High risk (>0.5 - <=5%)	17,463	13,718	3,292	42.58	2a 2b 2c 3a	2.99 2.34 1.37 1.95	23 88 35 779	1.39 5.32 2.11 47.04
Moderate risk (>5 - <=25%)	77,463	36,010	104	11.05	1 2a 2b	0.19 2.99 2.34	112 100 389	6.76 6.04 23.50
Low risk (>25 - 100%)	297,226	745	0	8.60	1	0.19	30	1.81
Total:	**394,127**	**52,090**	**7,441**	**83.98**	**n/a**	**8.84 ****	**1,654**	**100**

* Total cost of project over two years, shown for reference purposes only. Schemes 3b, 4 do not contribute direct benefits in reduced admissions and so are not included.
** Total cost of individual schemes 1, 2a to c and 3a, not the total of the individual costs listed.

Diagram 10 – Cost and Impact of BCF Scheme Elements for Barnet by Risk Level

Our approach to using risk stratification to implement this first tranche of our integrated care model 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.
- Embedding use of the tool as a partnership approach with the Integrated Locality Teams to put in place a framework for integrated 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 in future to ensure continuity.

Over the longer-term, we will work with all stakeholders to assess opportunities to move to commissioning of services through risk stratification or detailed segmentation of the population. We expect our BCF plans to evolve as implementation continues and we are able to measure the impact of changes made.

At the same time the technology and breadth, depth of data used in risk stratification will continue to evolve, increasing the value of the insights provided.

As a result risk stratification may be better utilised for niche cohorts or the planning and the delivery of individual scheme elements, working together with parallel segmentation techniques. Or segmentation may emerge as the best approach for Barnet overall.

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 contracts 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 have an increased ability to target those most at risk of admission and so see a shift in approach and activity.

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 assess risk stratification data together to determine how best to prioritise the numbers of people who need 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 keeping 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 overleaf may be beneficial.

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

Table 16 – Cost and Impact of BCF Scheme Elements for Barnet by Risk Level

The pilot team will work with 7 GP practices in one locality. 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

From July 2013 to July 2014 233 people were managed via the MDT and all had a jointly agreed care plan. These figures are expected to increase as detailed 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)**, Barnet Older Adults Assembly** (a large user and carer forum), **Age UK (Barnet), Alzheimer's Society** and others.

We also drew on experiences and feedback gained at **Council** and **BCCG 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 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, BCCG is participating in a **value-based outcomes commissioning programme** with other NCL CCGs. 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 are essential to bring momentum to the implementation of the **integrated 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, e.g. carers.
- Membership of relevant steering groups.
- Links with other organisations communications strategies e.g. BCCG 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 BCCG public board meetings and through an elected member scrutiny exercise at LBB 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 and Haringey Mental Health Trust**, our community health services provider, **Central London Community Healthcare NHS Trust**, hospices and **London Ambulance Service**.

Our BCF plan has its foundations in the **Barnet Health and Social Care Concordat** – a clearly articulated vision for integrated care agreed by all partners.

The concordat was co-designed by the partner members of the **Health and Social Care Integration Board (HSCIB)**. It provides the over-arching strategy for delivery endorsed fully by service provider recognition and support. The integrated 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 5 tier integrated care model co-produced with partners.

For key schemes already underway, such as Older People Integrated Care and Rapid Care, service providers are active participants in existing frameworks and 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. We have taken this further with development of locality based integrated care teams (July 2014) through a bottom-up build approach via a shared trail-blazer team.

Service provider involvement in the integrated 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 to 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.

Our **Clinical Commissioning Programme for Integrated Care** gives us a joint forum for commissioners and providers. This will be further aligned to form a core part of the service provider engagement vehicle moving forwards. With HSCIB 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 BCCG 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 our 5 tier integrated care model with a number providing input and challenge to the OBC process. These included BCCG 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 Locally Commissioned 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 on 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 developing integrated health and social care services, such as Housing 21, other care agencies, Barnet Homes, and various voluntary sector providers (Healthwatch Barnet, Age UK and the Alzheimer's 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 BCCG 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. Therefore we have a very strong focus on:

- Transformational change of the health system by providing integrated care for patients with complex needs as defined in this plan. With proactive identification, care planning and integrated management of care for such patients we will seek

to avert crises, thus reducing the unplanned use of acute care;
- Reducing elective acute care through the robust management of referrals and the re-design of care pathways to provide upstream early intervention, a greater range of care in primary care settings and community based alternative care.

Relationships with providers of acute services are proactive and constructive and they actively demonstrate support for our over-arching strategy behind BCF and its aims.

The current BCCG 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 1,021 less non-elective admissions in 2015 to 16 with a relative estimated impact on the acute sector as outlined in Table 17 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 numbers below are based on a different costing model to above (as derived from BCF guidance) and simply represent indicative workings that require further validation.

	Estimated Activity Reduction 15/16	Estimated impact at £2,004 (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	**1,021**	**2,054,100**

Table 17 – Estimated Impact of BCF Plan on Acute Service Providers 2015 to 2016

With current BCCG contractual arrangements funding will follow the patient, therefore 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 create operational issues. 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 Descriptions

Scheme ref no.
1a.
Scheme name
Expert Patient Programme
Scheme description
Pilot scheme and roll out of generic and disease-specific Expert Patient Programmes – organised by individuals who have existing long-term conditions.
What is the strategic objective of this scheme?
The objectives of this scheme are to: • Empower patients to self-care and manage their condition. • Optimise individual patient's health status. • Increase knowledge, understanding of long-term conditions and lifestyle/behavioural influences. • Improve the patient's experience, and • Mitigate for unnecessary A&E attendances and unplanned hospital admissions.
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 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 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 such as long-term conditions Mentors. The primary objectives of the projects in this tier are to up-skill people and improve health literacy. This will make individuals with long-term conditions more confident about looking after their health. Structured patient education programmes based on specific long-term conditions will also be introduced alongside the generic Expert Patient 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. The generic and disease specific programmes will be launched (staggered) as follows: • Pilot of generic programme: January 2015 • Pilot of disease specific programme: April 2015 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 1,975 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: Steve Buck/Lisa Jacob Project plan in place to deliver phase 1 from January 2015. This will be provided by **SM:UK** and will be delivered through 3 cohorts of 16 people each based in community venues in each of the 3 localities.

Phase 1 is being sponsored by Public Health and commissioned in partnership. The initial programme is partly funded on the basis of a successful BCCG bid last year and identified Public Health sitting alongside the core BCF pool. Costs will therefore be excluded from the part 2 submission.

Plans for April 2015 are in development and we are currently exploring links with existing structured education programmes in Barnet. Current plans make provision for roll out to 240 people in 2014/15.

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 expert patient programmes 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 such programmes can be gauged. However, despite some criticism, there exists a general consensus that these programmes reduce both costs and service utilisation e.g. GP's.

Background paper on the Expert Patient Programme for NICE Expert Testimony (A. Rogers) – This expert paper reviews the effectiveness of this Expert Patient Programme 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 target cohort, and there was an overall reduction in service utilisation. These factors are likely to offset the costs of intervention, making the programme a cost effective alternative to usual care for long-term conditions. To summarise, the paper states that any expert patient programme should be able to meet a wide range of needs for patients with long-term conditions, 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

Investment – the costs of the projects for 2014-15 are estimated at £122,120. However this currently sits outside the proposed main BCF pooled budget and so is not included in Part 2 of this submission.

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

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

The evidence base suggests that savings of between £452 (DoH) and £987 (SM:UK) can be expected per person with respect to reduced admissions. Using these assumptions the impact is estimated at 142 (23 + 119) reduced non-elective admissions over the BCF period as indicated above.

Key assumptions in the financial model:

- Estimated cost of an emergency admission is £2,004 based on local calculations
- Roll out of programme to 5% of population aged over 65 with long-term conditions over 5 years. Cohort size for 2015-16 is 240 people
- Benefit based on £987 saving per person risk adjusted to reflect:
    - 95% attendance rate - based on national data and local knowledge of Barnet residents
    - Time lag in benefit gain

To ensure the Expert Patient Programme 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 and performance indicators. It is intended that the results of this review will inform future commissioning. As a result we may need to re-plan the level and timing for realising the

benefits identified in this 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?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use "Benefit Cards", an important control document containing all the information for all agreed benefits for each scheme, which enables us to monitor and measure the delivery of scheme outcomes and benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work 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/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

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

- Clear programme of structure education linked to benefits
- Structured education supported by relationships between primary care, specialists, carers and patients
- Professional development and support from long-term conditions specialists.
- Acceptability and utilisation of programme by population

Scheme ref no.
2a.
Scheme name
Long-term Health Conditions (dementia, stroke, falls and palliative care)
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 benefits. • Reduce the number of emergency admissions for people with long-term conditions. • Provide patients with services closer to home. • Facilitate advanced care planning to support end of life care in the patients preferred place of death.
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 4 (assessment and care planning) and represents a family of services targeted at long-term conditions – primarily dementia, stroke and falls. It also encompasses end of life care with the recognition that this needs to fit seamlessly into pathways for the management of long-term conditions. **<u>01 Dementia Services</u>**: 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. **<u>02 Stroke Services:</u>** 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-centred, 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 in acute settings, 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

04 Palliative / End of Life Care:
Service re-design is currently underway in relation to end of life care through a comprehensive mapping exercise and review of the current pathway in partnership with multiple stakeholders. The over-arching aim would be to update the pathway to reflect a more integrated approach with clear pathways into and out of other supporting pathways including those managing long-term conditions. Focus will be retained on quality of care, advanced care planning and preferred place of death. The two key in-scope services in relation to the Better Care Fund are:

1. **Home based palliative care service** providing a key link between district nursing and hospice / acute service to support patients and carers in the last few weeks of life. The service offers additional resource at this time, tailored to identified needs, aimed specifically to enable people to die at home if this is their preferred choice.
2. **Palliative care provided through hospices**. This includes access to in-patient beds, out-patients consultant and nurse-led clinics, home visits and counselling/bereavement services.

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

All projects noted are within the work plan 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	**London Borough of Barnet**	Recruitment completed October 2014
Home-based palliative care	Ette Chiwaka	**Central London Community Health/ North London Hospice**	Ongoing
Palliative Care	Ette Chiwaka	**North London Hospice/ Marie Curie Hospice**	Ongoing

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 Joint Strategic Needs Assessment (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.

03 Falls service - Falls and the related injuries are amongst the most common medical problems experienced by older adults. Around 30% of over 65s 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 in the table below, which shows the 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.

04 Palliative / End of Life Care - In Barnet the current expected death rate is 486 per 100,000 (JSNA); with a higher rates in the older population. In 2011 non-cancer related deaths accounted for over 70% of deaths in Barnet.

The End of Life profile published in 2014 and recent work with stakeholders has highlighted a number of areas for development in Barnet namely:

- Preferred place of death. Most deaths in Barnet occurred in hospitals 1285 (54%) and only 434 (18%) occurred in the home with an additional 18% in care homes. This falls far below the aspirational levels of patients which indicate that 63% want to die at home.
- Care homes. Although the rate of deaths in care homes in Barnet is lower than England Average there is still room for improvement towards the England Lowest rate.
- Cost of admission. Evidence suggests that the estimated average cost of an admission is £2,506 and approximately 15% of admissions ending in death have a stay of more than 21 days. More importantly, they are likely to be poor care experiences for the person, and their relatives and carers. Expert opinion suggests that such long stays are often the result of gaps in services and an inability to discharge.
- Traditionally palliative care services have been oriented towards cancer care. As indicated above 70% of deaths are non-cancer related and hence could be linked to long-term conditions such as respiratory and neurological disorders and dementia.

Noting these themes, our BCF schemes recognise the importance of end of life care particularly in terms of embedding it within integrated care pathways both for a planned response (with advanced care planning) and to react quickly to sudden changes in medical status. Through 2015-16 our re-design of care pathways will continue to develop an integrated approach linked to GPs, Integrated Locality Teams, Rapid Response and carers support.

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

Investment – Outlined in the tables below. Breakdown:

- Dementia services are £395,632.
- Stroke Service is £487,868
- Falls services is £539,691
- Palliative Care services is £1,300,000

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

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
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2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Savings estimate based on reduced non-elective admissions, reduced admissions to care homes and delayed transfers of care over the BCF period. This is based on:

Non-elective admissions	Falls	Estimated relative impacts of 10%, 25% and 35% related to reduced admissions for falls and fractured neck of femur over the next 3 years. This is supported by evidence from other areas of the country and NICE. Based on the reach of the combined falls clinic and fracture liaison service at 984 people per annum. Phasing adjusted to reflect planned timelines for roll out of schemes.
Care homes	Dementia	22% reduction in admissions to care homes based on the "Department of Health (2009) "Living well with dementia: A National Dementia Strategy". Benefits model based on 780 new diagnoses of dementia per year within the memory assessment service. Time lag noted and hence benefits risk adjusted for 15-16.
Delayed transfers of care	Dementia	Reduction in excess bed days by 272 over BCF period in line with current projections in our local Business Case. Assumptions falling from *Counting the cost report* (2009) and DEMHOS study data that indicate that 25-35% of patients with dementia admitted with 4 specific medical problems; and evidence suggests that if this duration were to be reduced by seven days per patient, the total national savings would be almost £117m per year. This target represents a 50% reduction in excess bed days from the 2012 baseline for patients with dementia in first 10 diagnosis codes on admission.
Delayed transfers of care	Stroke	Reduction in excess bed days by 272 over BCF period in line with current projections in our local Business Case. Expected benefits to be achieved through targeting of services towards active management of length of stay at the HASU and ASU in line with PbR tariffs and trim points. Initial local evidence suggests an average reduction in excess bed days of 1 – 2 days per stroke patient utilising ESD with planned 35% increase in capacity people supported to go home straight from HASU and additional reduction in excess bed days in ASU. Evidence based on successful projects in Berkshire and Camden (REDS) and supported by the London Stroke network.

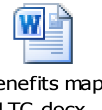
Other key assumptions from the financial model with respect to long-term conditions services:

- Estimated cost of an emergency admission is £2,004 based on local calculations
- No direct benefits from Dementia support services, Stroke review, Falls co-ordinator or Palliative

Care services at this stage to eliminate overlap.

- Optimism bias applied to service lines to accommodate for potential overlaps, time lag in benefits realisation or to account for interventions where there would not have resulted in the desired impact

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?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

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

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL	
As is position	**Baseline position** *(current baslined budget - to the nearest £1,000)*														£0	
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0	
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0	
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
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		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work 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/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

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

- Improved long-term conditions management for in-scope services.
- Increase in preferred place of death.
- Interdependencies between service elements and other schemes (self-care) need to operate appropriately to deliver full benefits.
- Professional development and support from specialists in long-term conditions is important.

Scheme ref no.
2b
Scheme name
Older People Integrated Care (OPIC)
Scheme description
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: • Ensure that the right people receive proactive case management in a cost effective manner. • Allow care providers to focus case management on individuals that will benefit most. • Avoid duplication e.g. multiple assessments, by providing co-ordinated care. • Provide a Community Point of Access for referrals to community health services enabling clear and responsive communications between HCPs across all sectors. • Prevent unnecessary A&E attendances and unplanned hospital admissions. • Optimise individual patient's health status through case managed healthcare. • Optimise individual patient's community support through case management as well as access to social care. • Prevent or delay elderly admissions to long-term care and packages of care. • Empower patients to self-care and manage their condition. • Improve the patient's experience.
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?
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 Integrated Locality Team (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 identify 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 work plan for the Joint commissioning unit and hence have nominated service commissioners and project plans.

Service area	Commissioning lead	Provider	Progress
MDT	Muyi Adekoya	**Primary Care, Royal Free NHS Trust, Central London Community Health, London Borough of Barnet, North London Hospice, BCCG, Barnet, Enfield & Haringey Mental Health Trust, London Ambulance Service**	Operational since July 2013
CNS	Muyi Adekoya	**Central London Community Health**	Operational since May 2013
ILT	Muyi Adekoya	**Phase 1 - Primary Care, Community Health, Barnet, Enfield & Haringey Mental Health Trust & London Borough of Barnet. Phase 2 – planned Royal Free NHS Trust, North London Hospice,**	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 MDTs, 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

Investment: Outlined in table below. Current indicative breakdown:

- MDT is £112.592
- Care navigation is £497,366
- ILT is £262,020
- Risk stratification tool is £121,983
- Community Point of Access is £298,065

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

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Savings estimate based on reduced non-elective admissions, reduced admissions to care homes and delayed transfers of care over the BCF period. This is based on:

Non-elective admissions	Benefits model based on evidence supporting reduction of hospital activity in the most at risk cohort identified from risk stratification. This is estimated at 30% reduction of costs across the system targeted to proportion of the target cohort (1992 people) subject to case management, personalised care plans and/or multi-disciplinary teams. This is in line with the scientific evidence and case examples contained in Barnet BCF Fact Pack which highlighted systematic reviews *(Holland et al, Heart 2005; Shojani et al, JAMA 2006; Graffy et al, Primary Health care Research & Dev, 2009)* of such services resulted in reductions of 15-37%. There is also broad support in recent UK based Integrate Care Programmes (Tower Hamlets, Torbay) with an emerging evidence base for quantified benefits. Local evaluation of pilot scheme in September 2015 has identified similar outputs to systematic reviews in relation to non-elective admissions (24% reduction). As this is an emerging service model expected to grow through 15-16, benefits will be subject to monitoring and further evaluation as the scheme progresses Assumptions for delivery of 486 (155 & 331) over BCF period.
Care homes	Although there is a limited amount of national evidence to suggest that Integrated care services will delay or reduce the need for permanent care home admissions (e.g. Cost of Dementia Care report by Health Foundation states that 18% fewer people could need residential care after two years with care management to coordinate health and social care); further work is required in Barnet to quantify such benefit particularly in the context of the high number of beds in the system (approx. 2800). This is particularly relevant in the context of implementation of Care Act responsibilities and cross-over with services such as Carers and enablement. A local evidence base has been derived from the evaluation of our pilot OPIC scheme (small scale demonstration of no additional costs to social care from projects and potential to

	reduce demand) and analysis and modelling of current enablement services (efficiency gains identified through demand management for more intensive services such as Homecare, residential and nursing care, acute care – estimates suggest 15-20% reduction). This is further supported by a successful ongoing programme of work within LBB to ensure that care home placements are offered appropriately within the support offer (5% reduction in placements in 13-14). On this basis, a target of 12 fewer permanent admissions to care homes has been set for 14-16 and 15-16. This will be monitored and re-validated in year.
Effectiveness of rehab/reablement	Target to increase people who leave enablement/rehab with no home care or increase to current package by 23 (11 & 12) through BCF period based on local analysis and modelling of current enablement provision and local service improvement initiatives. As above, efficiency gains of 15-20% expected through demand management for more intensive services such as Homecare, residential and nursing care, acute care. Access to enablement service has been secured for the ILT team to ensure clear pathways in and out and to support ease of referral. Substantial evidence base as outlined in Developing Intermediate Care, Kings Fund 2009 and Halfway Home, DH 2009.

Other key assumptions from the financial model with respect to OPIC:

- Estimated cost of an emergency admission is £2,004 based on local calculations.
- No direct benefits from Community Point of Access and Risk Stratification Tool included.
- Optimism bias applied to service lines to accommodate for potential overlaps, time lag in benefits realisation or to account for interventions where there would not have resulted in the desired impact.
- Approach will subject to continued evaluation through 15-16 and will flex to accommodate planned changes to service structure in line with the development of ILT and to revise benefits accordingly.

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?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

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

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	**Baseline position** *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	**Forecast financial saving (£000s)**	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	**Financial savings realised (£000s)**	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work 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/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

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 Homes – Locally Commissioned Service (LCS)
Scheme description
To improve the quality and level of care provided in care homes throughout the borough.
What is the strategic objective of this scheme?
The objectives of the scheme include: • To improve the **quality of care** in homes. • To improve the relationship between the care home and the GP. • To commission a more holistic medical offer to care homes through a distinct service from GPs to include a fortnightly ward round, six monthly holistic reviews and 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. Particularly in relation to **preventing avoidable emergency admissions**. • To support people's preference of place of death through advanced care planning. • To provide education and training to care home staff and managers to empower them to improve quality of care. • To establish networks between care home to facilitate shared learning and best practice.
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?
There are 2 components to this scheme as outlined below: 1. **Care Homes Locally Commissioned Service** - 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: a. Increased proactive GP input into care homes. b. 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. c. Introduction of a 6 monthly holistic review of all patients under the care of the GP. d. Support the home with planning and delivery of end of life care, meeting the gold standards for such care, and e. Closer working with the home to promote high standards of clinical care within the home. 2. **Quality in Care Homes Team** – Commissioned via LBB, this dedicated resource supports the 105 care homes in Barnet in terms of benchmarking of core standards and providing support to improve quality. Key focus is on improving leadership in care homes by empowering management to take ownership of quality issues and to adopt alternative ways of problem solving and preventative strategies to improve standards. An integrated training programme ensures that all managers have appropriate core skills and knowledge.

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

Service area	Commissioning lead	Provider	Progress
Care Homes LCS	Emma Hay (BCCG)	**Barnet GPs**	Operational since September 2014
Quality in Care Homes Team	Karen Jackson (LBB)	**London Borough of Barnet**	Operational since early 2013

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 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 disabilities. In total, these homes provide approximately **2800 - 3,051 beds** for a range of older people and those with mental health issues or learning disabilities.

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 Care Quality Commission published a review of health care in care homes and identified that support provided by GPs was an area for improvement (CQC 2012).

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.

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.

[1] Report produced by Barnet PCT, Informatics team

Care Home Staff

The Quality in Care Homes team mandate is broadly based on the eight themes within the ***My Home Life's*** vision of best practice underpinned by an evidence base developed by more than 60 academic researchers from Universities across the UK. The themes are grouped into three different areas:

- Those best practices which seek to personalise and individualise in homes – tailoring care to each individual.
- Those which are concerned with what needs to be done to help resident, relatives and staff navigate their way through the journey of care.
- Those concerned with the issues of leadership and management required to transform care into best practice.

Initial scoping in 2012 identified workforce as the first priority in Barnet to address particular needs in terms of lack of appropriately skilled staff to fill vacant posts within care homes and high turnover rates. Evidence suggested that critical factors contributing to this were a dis-empowered workforce, low wages and lack of career path.

A report from John Rowntree Foundation found that the approach did promote quality of life in care homes through:

- Positive relationships in care homes that enable staff to listen to older people, gain insights into individual needs and facilitate greater voice, choice and control.
- Care home managers playing a pivotal role in promoting relationships between older people, staff and relatives.
- Care home providers and statutory agencies considering how their attitudes, practices and policies can create pressure and unnecessary paperwork which ultimately reduce the capacity of care homes to respond to the needs of older people, and
- A reduction in the use of negative stereotypes of care homes that can impact on the confidence of staff and managers.

Investment requirements

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

Investment: Outlined in table below. Current indicative breakdown:

- Care Homes LCS is £915,000
- IQICH team is £231,000

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

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Benefits will manifest primarily from these schemes in terms of reduced accident and emergency attendances and admissions avoidance; and it is assumed that will accrue from December 2014 onwards.

Activity assumptions are based on a 2% reduction in acute costs (A&E, admissions and outpatients) in the target cohort of people for care homes. This is extrapolated to a target of 39 fewer non-elective admissions over the BCF period which represents a very prudent target taking into account significant optimism bias to account for overlap with other services, particularly OPIC and Rapid Care; and those homes/GP practices that do not participate. The scheme will be available for all GP practices and hence has an estimated target cohort of 2328 people.

Evidence to support assumptions is available from projects such as work undertaken in Cornwall and Scilly Isles (Improving quality of dementia care, HSJ Oct 2012) that found that training care home staff:

- Reduced falls and injuries.
- Reduced hospital admissions by 50%.

And the Integrating Care and Supporting Care Homes project (BGS Oct 2012) that showed significant reduction in non-elective admission spend.

Key assumptions from the financial model with respect to care homes:

- Estimated cost of an emergency admission is £2,004 based on local calculations
- Other benefits have been identified outside the BCF plan framework, primarily A&E attendances and outpatients appointments
- Quality in Care Homes Team is primarily a quality driven initiative with some non-quantifiable benefits within the BCF framework.

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?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

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

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL	
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0	
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0	
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0	
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work 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/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

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.
- Delivery of key performance indicators.
- Reduced turnover of staff in care homes.

Scheme ref no.
3 (a & b)
Scheme name
Rapid Care and Seven Day Working
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, • Access to social work and enablement services as required.
What is the strategic objective of this scheme?
The objectives of this scheme are to put in place the following services: • 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. • 7 day availability of social work assessment and enablement.
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 inter-linkage between two services that provide an urgent but co-ordinated approach to an unplanned episode of ill-health or crisis. 1. **Rapid Care -** 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 long-term conditions 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: a. Triaged response via Community Point of Access. b. 2 hour response time. c. 7 day service. d. Use of skill mix including emergency nurse practitioners. e. 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. 2. **7 Day Social Work & Enablement** – Supporting the Rapid Care service is 7 day access to social work assessment in the acute hospital setting and enablement services. This ensures that patients who attend A&E but could be adequately treated at home with other services can be assessed quickly and supported to return home with an appropriate package of care (health and/or social care). The team facilitates discharge home with transport, access to equipment and ongoing services. Enablement and home care packages can be established over 7 days.

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

Service area	Commissioning lead	Provider	Progress
Rapid Care	Muyi Adekoya	**Central London Community Health**	Significant planned expansion occurred between October 2013 and April 2014.
7 Day Social work & Enablement	Liam Furlong/ Ette Chiwaka	**London Borough of Barnet/ Housing 21**	Ongoing

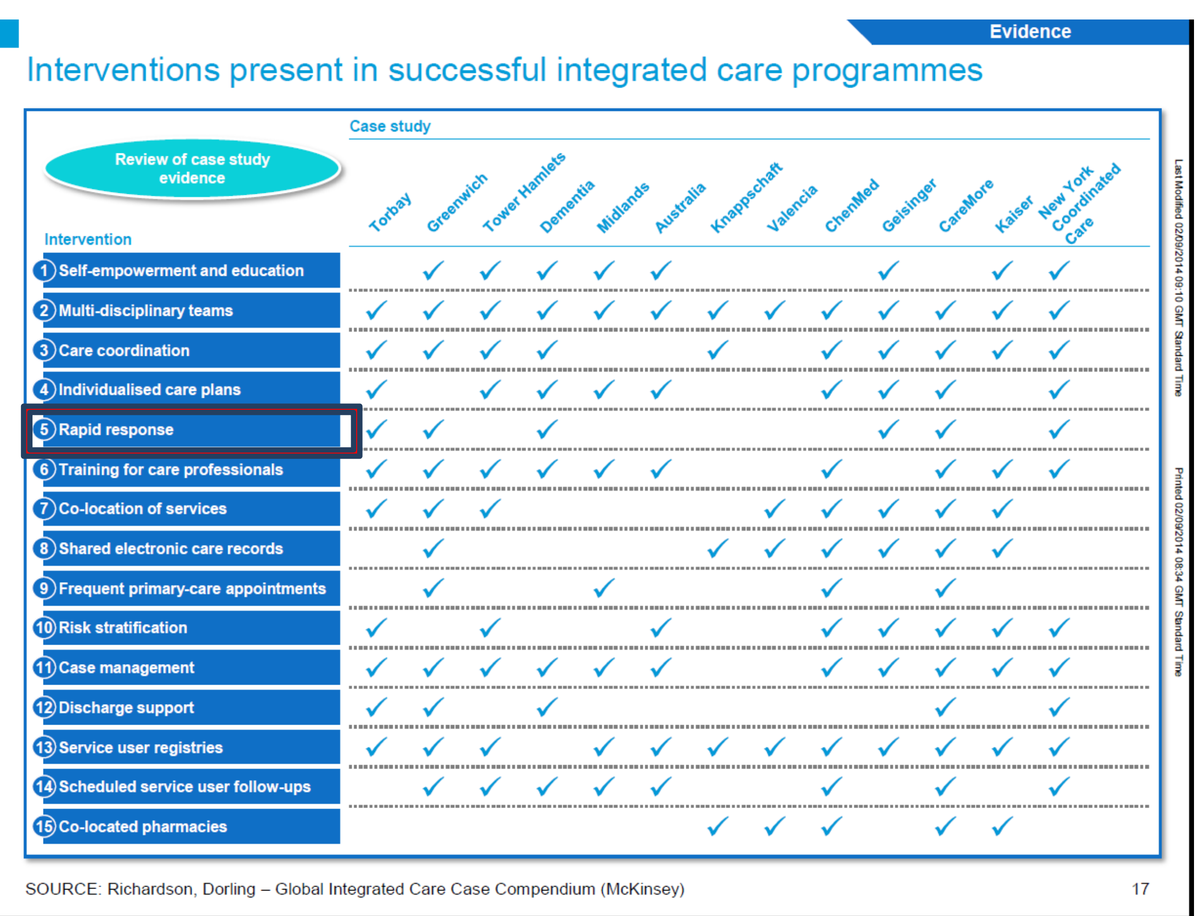
The evidence base

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?

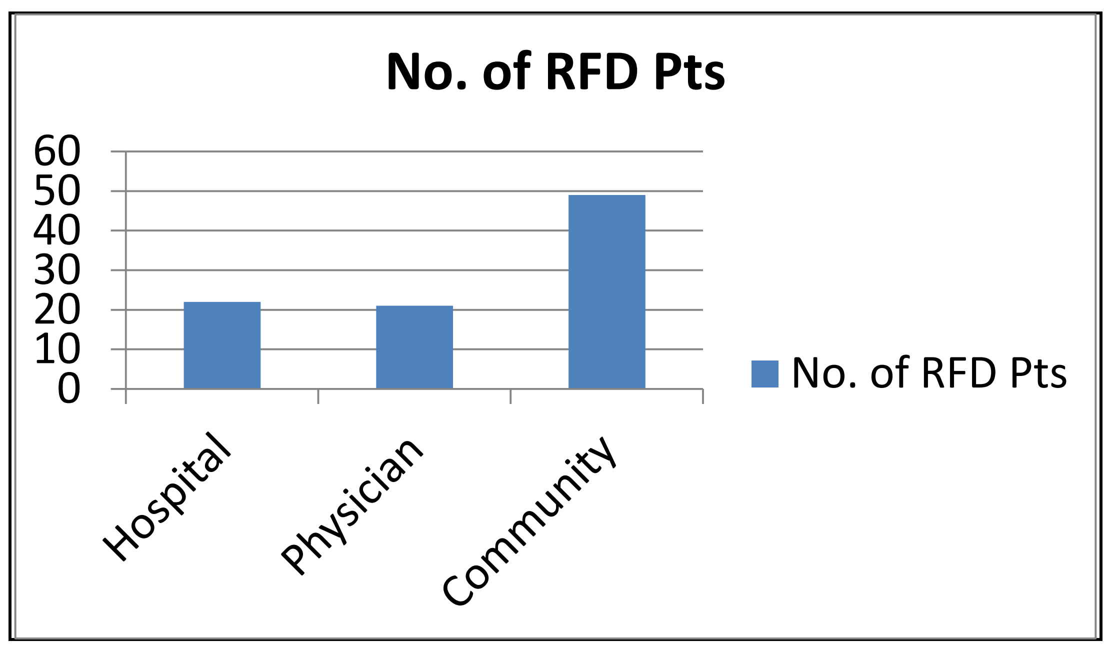
Rapid response is identified as key intervention present in successful integrated care programmes:



Evidence from Kings Fund – *Avoiding Hospital Admissions – What does the research evidence say?* Showed that for selected patients avoiding admissions by providing appropriate care at home gave similar outcomes at lower cost.

The evidence from Purdy S (2010) 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))

BCCG also commissioned an Appropriate Place of Care audit in July 2014 at both local acute hospitals and across community beds. This identified that of the 431 Barnet patients that were in the beds at the time of the audit 30% were either not considered as meeting the appropriate criteria for admission or did not meet the criteria for continued stay. As seen by the snapshot below, of those that were 'ready for discharge' a significant reason for delayed discharge was a wait for social care packages or care home beds (defined as community in the graph).Evidence also suggested that admissions were occurring over the weekend as a result of staff being unable to discharge pending social care assessments and placements. To address this, social work teams have been deployed in A&E departments at weekends and both home care and enablement services have been adjusted to accept new referrals.



Similarly, analysis of urgent care activity in 12/13 and 13/14 identified surge activity related to A&E attendances and non-elective admission on Sundays and Mondays indicating a bottle-neck in service delivery during this period identifying a need to implement consistent 7 days services including those to assess for and initiate social care packages. This led to the implementation of the 7 day social work service and variation of enablement contracts to support 7 day referrals.

Local evidence suggests that the model of care is working. The 7 day service has been in place for several months and is monitored as part of a BCCG QIPP scheme. Current estimates for savings in 14-15, as a result of Rapid Care and to a lesser extent OPIC, will be £771k-£1,2m.

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

Investment: Outlined in table below. Current indicative breakdown:

- Rapid Care is £1,314,215.
- 7 day social work & enablement is £300,000.

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

Extensive financial modelling to support implementation of the 5 tier model has been completed

including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below).
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Benefits will manifest primarily in terms of admissions avoidance and effectiveness of rehab/reablement.

The model assumes an avoided admission with respect to 40% of the current referral capacity into Rapid Care using an optimism bias to account for those who were treated but were not acute enough for admission, inappropriate service users and the overlap with other services including falls. This is quantified as 864 (413 & 451) fewer admissions. In line with the evidence base above services are targeted to specified conditions and are available 7 days per week. Local impact for the service (and to a lesser extent OPIC) suggests that estimates for savings in 14-15 will be £771k-£1,2m.

It will also contribute to the reablement target as Rapid Care and 7 day capacity link very robustly with PACE and TREAT teams operating in the acute hospitals and intermediate care. Prudent target to increase people who leave enablement/rehab with no home care or increase to current package by 20 (10 per year) based on local analysis and modelling of current enablement provision and local service improvement initiatives. As above, efficiency gains of 15-20% expected through demand management for more intensive services such as Homecare, residential and nursing care, acute care. Access to enablement service is integrated within Rapid Care and is accessible from A&E to support ease of referral. Substantial evidence base as outlined in Developing Intermediate Care, Kings Fund 2009 and Halfway Home, DH 2009. Further work will continue to establish more robust targets through 2015-16.

Key assumptions from the financial model with respect to Rapid Care:

- Estimated cost of an emergency admission is £2,004 based on local calculations.
- Current commissioned capacity supports 180-200 referrals per month. Baseline modelling has been undertaken at 120 per month to prevent overlap.

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?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

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

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	**Baseline position** *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	**Forecast financial saving (£000s)**	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	**Financial savings realised (£000s)**	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
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		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work 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/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

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

- Stakeholders buy in to support referrals particularly primary care.
- User acceptability of model of care.
- Interdependencies with other services such as PACE and TREAT.

Scheme ref no.
4 (a & b)
Scheme name
Enablers – service and administrative
Scheme description
A suite of services or projects intrinsically linked to BCF pool as key enablers.
What is the strategic objective of this scheme?

The over-arching objectives of the scheme are to:

- Secure ongoing delivery of key service lines associated with BCF tiers 1 and 2 that are not currently subject to service re-design or linked to benefits realisation processes.
- Secure on-going delivery of critical underpinning projects for the integrated care model.
- Deliver critical enablers to support delivery of projects within and alongside the BCF 5 tier care model.
- Allow monitoring and management of the total BCF pool in conjunction with benefits/metrics e.g. unplanned hospital admissions, reduced care home admissions.
- Provide framework to increase the size and scope of BCF pool over time.

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 table below outlines the key elements of the enablers.

Scheme	Service line	Provider type	15-16 (£)	15-16 (£)
Scheme 4a. Enablers (services)	Carers services	Charity/Voluntary Sector	300,000	300,000
	Later life planners	Charity/Voluntary Sector	150,000	150,000
	Ageing Well	Local Authority	150,000	150,000
	Shared Care Records	Local Authority	262,021	262,021
	Community Equipment	Private Sector		1,169,761
	Other Community Services	NHS Community Provider		6,965,100
	Carers Breaks & additional enablement funds	BCCG		1,641,926
Scheme 4b. Enablers (administrative)	Protecting social care	Local Authority	3,080,000	3,080,000
	BCF Plan delivery	Local Authority	200,000	200,000
	Care Act Implementation	Local Authority		846,000
	DFG & Adult social care capital grant	Local Authority		1,872,000

The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Enablers are largely managed as business as usual services rather than on a project management basis. They feed into the core business of both BCCG and LBB in the context of managing the day to day delivery of the integrated care model, measuring benefits and ensuring supporting infrastructure is in place. In line with the programme management approach, as the commissioning intentions/status of services change they will move into the 'active' commissioning cycle and will be project managed as required.
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? • Elements included link to over-arching strategic aims for BCF and hence align to planned or possible future service re-design e.g. community services / enablement. • Elements noted to align to key priority cohorts to be targeted within integration programme (carers) or underpinning infrastructure (Shared Care Record). • A number of services are those that are currently funded from existing budgets aligned to the BCF that require ongoing funding e.g. Section 256.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Investment: Outlined in tables below
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
Although extensive financial modelling to support implementation of the 5 tier model has been completed, the projects listed in this section have not been included as they are not currently designated to contribute to the BCF metrics. Over time the constituent elements of this scheme will be subject to change either through dis-investment and/or movement of funds into or out of the pooled budget; or through the natural progression of commissioning intentions and service re-design. As an example, Community Equipment is currently a designated budget within this scheme as a 'business as usual service line'; if it becomes a 'live project' the process will include analysis and outlining key benefits expected from any service improvements. April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

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?

Enablers support the other schemes. This scheme consists of a range of operational services that underpin the delivery of the integrated care model either as key infrastructure or as community support. Enabler projects or services include planning for later life, shared digital care records and other community services. Although the enablers in this scheme do not directly deliver the target improvements in the 6 core BCF metrics, each is measured against its own suite of performance indicators, such as numbers of carers assessments per year.

Where such indirect benefits are measurable across the whole integrated care model we will validate and track their realisation through benefits management tools and techniques if appropriate. We will define the best approach for each benefit, balancing the likelihood of establishing measurable links between them and project/service outputs against their complex nature and the information required for Benefit Cards as detailed above or alternative methods.

Where relevant we will define any indirect financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. We will agree a project work plan with them.

This will include milestones for achieving benefits, timescales for reviewing progress to determine if work is on schedule and regular impact assessments. Project/service teams will prioritise work accordingly. The work plan will also include details of any handover and further work to embed activities and continue to realise benefits long-term. We will also embed the funding for enabler services in our Pooled Budget arrangements to ensure regular monitoring horizon scanning for future opportunities for benefits within these service lines. All this will enable the right people to take the appropriate action to facilitate realising these benefits and remove blockages to delivery.
What are the key success factors for implementation of this scheme?
• Ongoing delivery of enabling services. • Interdependencies with other services identified in terms of benefits. • BCCG and LBB understanding/engagement in enablers.

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 BCCG plans and have been engaged in Better Care Fund discussions. We are committed to working with BCCG 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 of work explicitly link to the reductions planned.
2.	**If you answered 'no' to Q2 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

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

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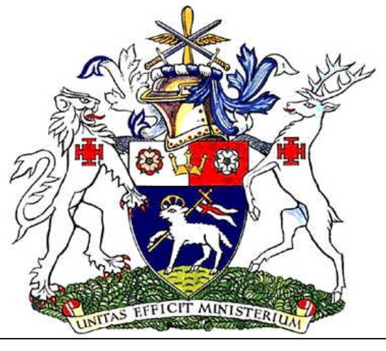
AGENDA ITEM 12

	**Adults & Safeguarding Committee** **7 March 2016**
Title	**Adults & Safeguarding Committee Work Programme**
Report of	Dawn Wakeling – Commissioning Director, Adults and Health
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A – Committee Forward Work Programme
Officer Contact Details	Ola Dejo-Ojomo – Governance Officer - 020 8359 6326 Email: ola.dejo-ojomo@barnet.gov.uk

Summary

The Committee is requested to consider and comment on the items included in the 2015/16 work programme

Recommendations

1. **That the Committee consider and comment on the items included in the 2015/16 work programme.**

1. WHY THIS REPORT IS NEEDED

1.1 The Adults & Safeguarding Committee Work Programme 2015/16 indicates forthcoming items of business.

1.2 The work programme of this Committee is intended to be a responsive tool, which will be updated on a rolling basis following each meeting, for the inclusion of areas which may arise through the course of the year.

1.3 The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

2. REASONS FOR RECOMMENDATIONS

2.1 This recommendation allows members of the Committee to consider future reports on the work programme.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 There are no specific recommendations in the report. The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

4. POST DECISION IMPLEMENTATION

4.1 Any alterations made by the Committee to its Work Programme will be published on the Council's website.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**
5.1.1 The Committee Work Programme is in accordance with the Council's strategic objectives and priorities as stated in the Corporate Plan 2015-20.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**
5.2.1 None in the context of this report.

5.3 **Social Value**
5.3.1 N/A.

5.4 **Legal and Constitutional References**
5.4.1 The Terms of Reference of the Policy and Resources Committee is included in the Constitution, Responsibility for Functions, Annex A.

5.5 **Risk Management**
5.5.1 None in the context of this report.

5.6 **Equalities and Diversity**
5.6.1 None in the context of this report.

5.7 **Consultation and Engagement**

5.8 **Insight**
5.8.1 N/A

6. BACKGROUND PAPERS

6.1 None.

London Borough of Barnet Adults and Safeguarding Committee Forward Work Programme March 2016 - June 2016

Contact: Ola Dejo-Ojomo 020 8359 6326 anita.vukomanovic@barnet.gov.uk

Title of Report	**Overview of decision**	**Report Of** *(officer)*	**Issue Type (Non key/Key/Urgent)**
7 March 2016			
Report on Adult Social Care Alternative Delivery Model project Outline Business Case	Committee to receive a report on Adult Social Care Alternative Delivery Model project Outline Business Case.	Commissioning Director (Adults and Health)	**Non-key**
Contract Extension : Mental Health Day Opportunities Service	Committee to consider extending the Mental Health Day Opportunities Service.	Commissioning Director (Adults and Health)	**Key**
Implementation of Better Care Fund: Development of Integrated Locality Teams	Implementation of Better Care Fund: development of integrated locality teams.	Commissioning Director (Adults and Health)	**Non-key**
Independent Living Fund transfer	A briefing to members on the outcome of care reviews for those clients whose care funding transferred to Barnet Council following the closure of the Impendent Living fund on 30 June 2015. At the Adults and Safeguarding Committee on 23 April 2015, there was an item on the transfer and members requested a further report on the management of the transfer, particularly care reviews.	Assistant Director Adult Social Care	**Non-key**

Subject	Decision requested	Report Of	Contributing Officer(s)
Updated Commissioning Plan	Committee to receive and updated Commissioning Plan.	Commissioning Director (Adults and Health)	**Key**
Items to be allocated			
Commissioning Strategy for Supported Living	Committee to receive a commissioning strategy for supported living.	Commissioning Director (Adults and Health)	**Key**
Home care commissioning - outcomes based approach	Committee to receive a report on home care commissioning - outcomes based approach.	Commissioning Director (Adults and Health)	**Non-key**
Implementing the Care Act: Adult Social Care and Support Contributions Policy	Committee to receive a report on implementing the Care Act: Adult Social Care and Support Contributions Policy	Commissioning Director (Adults and Health)	**Key**
Implementing the Care Act: Cap on Care Costs Policy	Committee to receive a report on implementing the Care Act: Cap on Care Costs Policy.	Commissioning Director (Adults and Health)	**Key**
Implementing the Care Act: Appeals Policy	Committee to receive a report on implementing the Care Act: Appeals Policy.	Commissioning Director (Adults and Health)	**Key**

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