Barnet Better Care Fund

Draft Submission. Version 4.3

Local Authority	Barnet Council
Clinical Commissioning Group	NHS Barnet
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 to be agreed at Health & WellBeing Board	23.01.14
Date Submitted	08.01.14

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	
	2015/16	

Authorisation and Sign Off	
Signed on behalf of the Clinical Commissioning Group	NHS Barnet CCG
By	John Morton
Position	Chief Operating Officer
date	23-Jan-14
Signed on behalf of the Local Authority	London Borough of Barnet
By	tbc
Position	
date	
Signed on behalf of the Health & Wellbeing Board	
By Chair of the HWB:	Councillor Helena Hart
Position	Lead Member - Health and Chair of HWB
date	23-Jan-14

Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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

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

For key schemes already underway, such as the Older People's Integrated Care project and Rapid Response, service providers are active participants within established frameworks to work collaboratively to design, implement and manage services with commissioners. This occurs through a variety of mechanisms such as operational co-production, steering group memberships and front-line delivery.

Service provider involvement in the Integrated Health & Social Care Model has been achieved through participation in the 'as-is' mapping of current provision and spend, development of a target operating model, and by involvement in a series of design workshops which focussed on opportunities and operational deliverables. This has brought realism to the plan and shared ownership through a commitment to improve care for the people of Barnet. This will continue with providers being engaged in validating and developing the plans for implementation as we move forwards. The development of the Integrated Health and Social Care Model has been formally supported by providers as key members of the HSCIB.

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

Patient, service user and public engagement

Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it

Patients and service user views are integral to the Vision for Integrated Care in Barnet and will serve as a benchmark to measure our success in delivering plans that truly impact on areas that are important to our residents. The formation of the **Joint Commissioning Unit** offers real opportunity to build further on this by enabling a shared platform for bringing together health and social care perspectives and resources.

Engagement continues both in relation to the plan itself and, more locally on an ongoing basis with respect to individual service areas, for example, dementia. Our track record highlights initiatives such as our Ageing Well project which has been developed from the ground up with local people, in response to needs identified by the community. We also regularly draw on experiences and feedback gained at CCG public engagement events and in broader project-based consultation exercises such as Guiding Wisdom for Older People.

Through workshops with Older Adults Partnership Board members, Healthwatch facilitated forums, interviews and surveys, the Integrated Health & Social Care Model has been built taking into account the calls from local residents to increase co-ordinated care to enable them to live better for longer. The co-chair of the Older Adults Partnership Board is also a member of the design group.

Further under-pinning this and developing further the work of National Voices, Barnet is participating in a value-based outcomes commissioning programme with other CCGs in North Central London. With patient and service user participation from the outset, this will equip commissioners to change the way in which they do business to achieve patient-centred goals.

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

Moving forward, we will use the existing Older Adults Partnership Board framework as the key patient and public representative group with involvement from service users, carers, Healthwatch and voluntary sector. In addition, we will continue to utilise other opportunities such as the CCG public engagement mechanisms and Barnet Older People's Assembly, to ensure that patient and user perspective is reflected in all our programmes as they develop.

Related documents

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	
Barnet Health and Social Care Concordat	Available on request
Barnet Integrated Health and Social Care Model 2013	
Barnet Health & Well-Being Strategy	
Barnet Council Corporate Plan	
Barnet CCG Integrated Strategic and Operational Plan (ISOP)	
Barnet CCG Recovery Plan	
Health and Social Care Integration Board Terms of Reference	
Health and Social Care Integration Board Programme Governance	
Barnet, Enfield & Haringey Clinical Strategy	
Older People Integrated Care business case	
OBC for shared care records, rapid care and SPA, winter pressures plan if needed	

VISION AND SCHEMES

Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19. - What changes will have been delivered in the pattern and configuration of services over the next five years? What difference will this make to patient and service user outcomes?

Background and Context

The £3.8bn Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.

The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. The Better Care Fund is intended to provide an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability.

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work already underway in Barnet.

A principal challenge for Barnet is managing the aspirations of the BCF against a backdrop of a financially challenged CCG and a local authority under the financial constraints applying to local government, and with the emerging additional costs of the Care Bill. Local demographic and infrastructure changes, including re-configuration of acute services and a high number of residential and nursing homes create additional pressures which must be addressed.

The Vision

The Vision for Health and Social Care services in Barnet centres one **Mr. Colin Dale** who represents a typical user of health and social care services in Barnet. He is an 82 year old gentleman living in Oakleigh. He has multiple needs and medical conditions and is receiving a range of services and support from health, social care and the voluntary sector. He has been admitted to hospital twice in the last year and on both occasions his family have felt that the system has not worked very well together and that the responsibility for his overall care and support is not properly co-ordinated and they find it difficult to know who is responsible for what. Mr. Dale's wife died 10 years ago and he lives alone with his dog, Sally. His daughter, Louise and her family live in East Finchley.

What do Mr. Dale and his family want for him when he needs help?

- A single point of contact
- Quick and responsive services
- To tell their story once
- Professionals and services that talk to each other.

The **concordat Vision** agreed by all parties of the Health and Social Care Integration Board states:

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

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

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

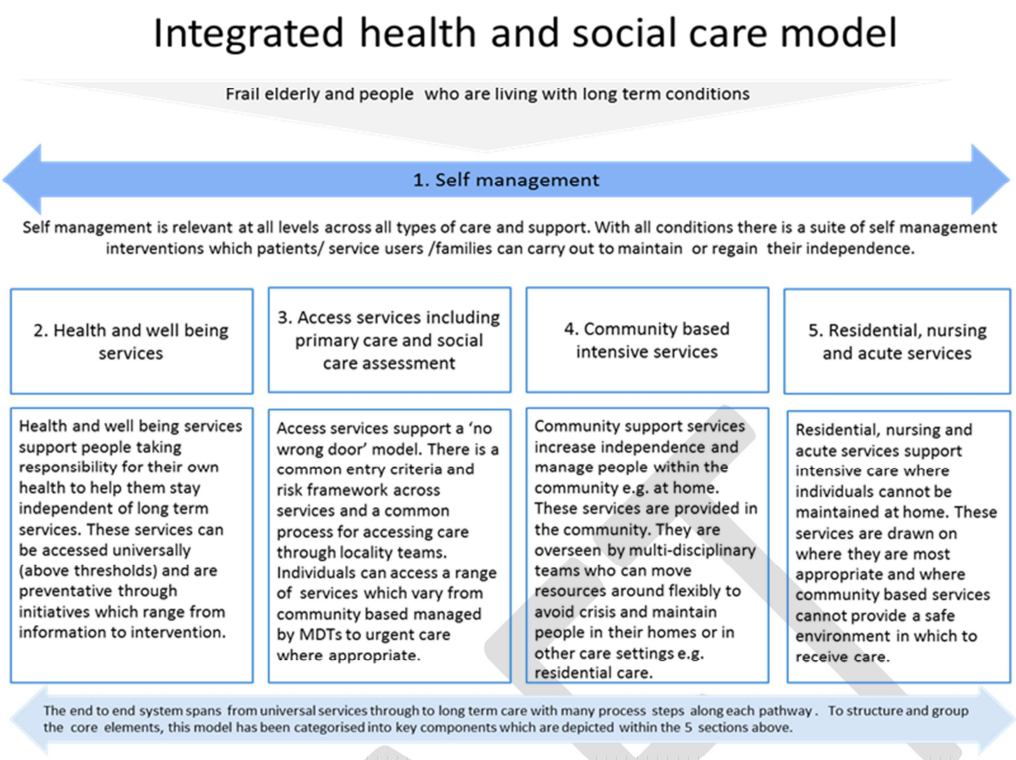
    - **Keeping Well** – A strong belief in 'prevention is better than cure' including a focus on supporting people to adopt healthy lifestyles to prevent avoidable disease and illness.

    - **Keeping Independent** – This aims to ensure that when extra support and treatment is needed, it is delivered in a way which enables people to get back up on their feet as soon as possible supported by health and social care services working together.

- Both the **Barnet Council Corporate Plan** and the **Barnet CCG Integrated and Strategic and Operational Plan** echo these themes through outcome-based commitments to work with partners and residents to :

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

Recent work to develop a **Barnet Health and Social Care Integration model** has strengthened this further with the Vision for Services pictorially represented below. It consolidates existing work being undertaken and provides a clear direction of priorities and delivery for the future. This turns the Vision into a tangible reality for delivery via a 5 tiered model of care with future-proofing to meet short and longer term health and social care strategic plans including those to deliver integrated care at scale and pace. It advocates a consequential shift of activity and costs from reliance on acute care and care home placements towards prevention and self-management.



In **3-5 years time** we will have developed a fully integrated health and social care system for the frail and elderly population through implementation of a whole systems approach that:

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

In addition, we will have fully explored the opportunities arising from the Better Care Fund from extension of the scope beyond the current target group – for example into services for residents with learning disabilities.

Integration Aims & Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the integration transformation fund will secure improved outcomes in health and care in your area. Suggested points to cover:
• What are the aims and objectives of your integrated system?
• How will you measure these aims and objectives?
• What measures of health gain will you apply to your population?

The overall aims and objectives for Integrated Care can be extracted from the Health & Social Care concordat.

We will work together tirelessly to deliver the Barnet vision of integrated care so that Mr. Dale and others like him enjoy better and easier access to services.

This will ensure that:

• People in Barnet will feel like they are dealing with one care organisation
• They will have access to accurate information which will enable them to make informed choices and take responsibility for their health and wellbeing
• They will be able to get the right care and treatment quickly without having to deal with lots of people
• Personal information will only have to be provided once and will be shared securely with other organisations involved in the person's care
• Care will be provided safely by well-trained teams, at home or at a place that is convenient for them
• Someone will always take responsibility for making sure care is coordinated and the person being cared for, their family and carers, are kept informed
• People will be supported to be as independent of public services as possible through a local care system that encompasses prevention, self-care and supportive communities

These are challenging ambitions – and rightly so – as they represent the right thing to do for Mr. Dale. We also recognise that there needs to be significant change to current service provision to enable these ambitions to be realised. This journey has started and from 2014-15 we will see:

- Increased activity from the newly formed Joint Commissioning Unit in exploring potential and taking forward joint commissioning and procurement projects
- Our community providers expanding existing services and introducing new models of care focussed on case management and care at home
- Implementation of a community point of access for health and social care services
- Expansion of 7 day services
- Targeted work with care homes to address demand arising from our local position of net importer of residents to over 100 establishments
- Further integration of emergency and planned activity in hospitals with community care to support discharge and avoid admission, actioned in collaboration with the new Clinical Commissioning Programmes at the CCG
- GPs collaborating into networks for provision of more localised services targeted at their populations

Measuring success against the aims and objectives will be key in understanding the impact of Health and Social Care Integration programmes both from organisational perspectives, but more importantly to assess whether change makes things better for Mr Dale. An over-

arching set of outcome measures have been drawn from the Health and Social Care Integration Model utilising the value-based outcomes approach and existing targets within the current Health & Social Care outcome frameworks.

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

1. **People and their families are supported to manage their own health and wellbeing wherever they can and for as long as possible:**

   Mr Colin Dale will:
   - Be supported to have a high quality of life and increase his self -care skills
   - Have support focused to his assets and interests, building on these to stay well and independent for as long as possible
   - Have access to information and education on healthy living and staying well including:
     - Access to prevention services
     - Access to national and local self–help and support models such as expert patient/carer groups and *Breathe Easy* to support self-managemen
   - Be able to easily access up to date information from one place about what support is available

2. **There is no wrong door principle to access advice and support. Primary care and social care assessment will identify early and proactively target those at risk of becoming frail or unwell. When necessary a support package focused around the individual will be put in place that optimises his skills, increases quality of life and prevents deterioration.**

   Mr Dale will
   - Understand what is happening, what his choices are and be fully supported to stay at home or in a home based setting
   - Be able to work with staff to involve his carers and/or a wider family network to ensure they understand what is happening, what the choices are and be involved in decision making as appropriate
   - Only have to tell his / his carer(s) story once due to a single assessment process
   - Receives the right kind of support at the right time from skilled professionals
   - Have a care navigator who ensures seamless transitions through the system including from community service to hospital when required

3. **Intensive community based intensive are readily accessible and react quickly to need**

   Mr Dale will
   - Understand what is happening, what his choices are and is fully supported to stay in control as far as possible (as will his carers and/ or family)
   - Be able to access advice and support through one number
   - Have single care plan and review for his support
   - Have access to a multi skilled rapid care service who can provide appropriate and timely support to prevent things getting worse and help regain independence
   - Have access to service that can help him have a better experience of hospital discharge when returning home or to a home based setting, with a focus on regaining health, wellbeing and independence
   - Be able to access appropriate specialist resources and services where required

4. Ensuring quality long term care is provided in the most appropriate setting by a workforce with the right skills

Mr Dale will

- Have access to a range of alternatives to residential care such as accessible housing or extra care housing and support to provide suitable alternatives to residential care
- Be supported, with his family and/or carer where appropriate to continue to build self-management skills and regain independence as far as possible
- Be treated with respect and dignity
- Have access to people with the right skills at the right time to ensure his health and wellbeing is maintained or improved
- Experiences seamless continuity of care across primary care, community care and the hospital
- Be able to experience a dignified death in the place of his choice

Description of Planned Changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:
1. The key success factors including an outline of processes, end points and time frames for delivery
2. How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The London Borough of Barnet (LBB) and Barnet CCG have been working on proposals to underpin the BCF for the last six months and have engaged widely with members, boards and providers, as well as patients and service users. We have jointly engaged external support to develop a new model of care **(Health and Social Care Integration model)** which forms the foundation for the delivery of this transformation.

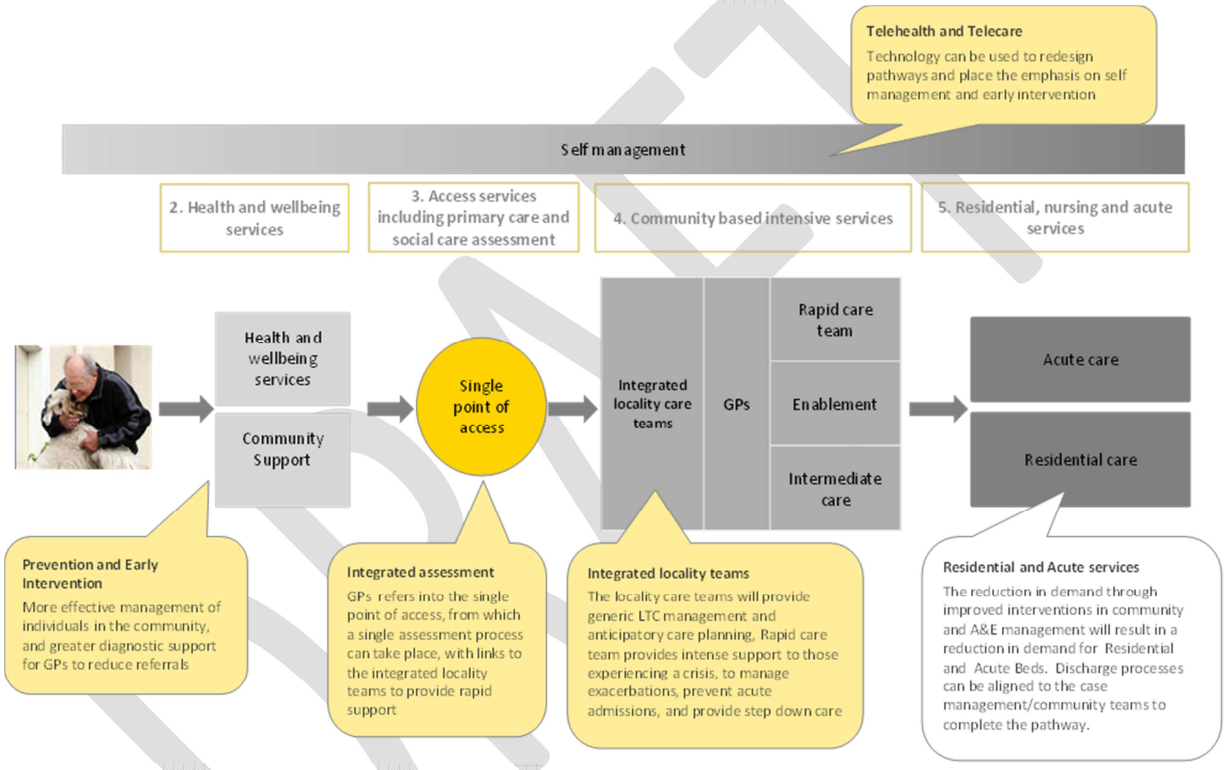
The BCF proposals are built on transforming services through integrated care to improve outcomes for the people of Barnet, while releasing savings through efficiency and effectiveness. The recognition that much of the BCF funding will come with services already provided is going to provide particular challenge to delivery in the local setting.

While good progress has been made on the two spearhead projects (Older People's Integrated Care and Quality in Care Homes projects) we would recognise this has been limited in scope and has at times been challenging as partnership working has developed. Our approach moving forwards will be to drive integrated health and social care delivery into a higher gear, focussing entirely on commissioning of the BCF services. This work is already underway with the projects developed during 13/14 and is currently extending to encompass rapid care services, single point of access, shared care records and locality based integrated care teams.

The **Joint Commissioning Unit (JCU),** with strong senior management leads from both organisations, formed in August 2013 and will be the central hub for delivery of much of the BCF work plan. The Unit operates in accordance with a programme management approach with over-arching governance from the Health & Social Care Integration Board (HSCIB) and

integrated Project Management Office support. These provide the framework to ensure that priority is given to projects which align with Health & Social Care strategy while giving assurance that projects deliver on time, in full and are of an appropriate quality.

The Health and Social Care Integration model builds on the progress to date and provides a framework for investment and delivery of integrated care over the next 3-5 years. It outlines the ambition, and articulates the scale and pace required to meet the needs of the changing population of Barnet. It also builds on our successful experiences in winter planning, especially in 13-14, which embedded the commitment to 7 day working for health and social care. Core to the model is a focus on prevention, single point of access, risk stratification and appropriate care at the right time through locality based integrated care teams and rapid care provision. Correlating with the 5 tiered model, the pictorial representation below illustrates the new journey for Mr Dale through a co-ordinated care system and how this improves his outcomes.



The key components of the integrated service can be consolidated as follows:

Developing greater self-management (Tier 1)

What will this achieve?

Enhanced personalisation of health and social care through:

- Promoting and enabling independence through self-management
- Promoting the co-design and production of services with service users, patients and carers

How will this be delivered?

- Patient education and awareness raising on how to manage conditions, e.g. expert patient programmes
- Development of an enhanced risk stratification approach to search GP registers and identify

individuals at risk

- Prevention coordinators to support the self-management / targeted prevention agenda. The coordinators would be locality based and linked to the GP surgeries as a way of raising the profile of the whole range of services available to increase self-management
- Expanding the self-management offer to at risk groups. Developing specialist strategies aligned to specific population needs e.g. stroke, dementia awareness
- Enhancing professional knowledge about prevention and self-management tools and what is available in order to reduce dependency on GPs and diverting people to more self-management routes. This is closely linked to the offer described in tier 2, the development of a catalogue and an education programme for professionals to highlight the range support available
- Increasing the use of technology to support self-care in the community such as telecare and telehealth

Promoting Health and Wellbeing initiatives and building the capacity of individuals and communities to reduce demand (Tier2)

What will this achieve?

This tier focuses on promoting the population's health and wellbeing and equity of access to support and enable people to stay healthy and lead active lives. It requires coordinated support activities that reduce the barriers experienced by people and improves their social well-being. These include activities that build up and grow personal and physical resilience, develop and maintain social networks, increase skills and employment opportunities, encourage healthy lifestyles and support from families and friends who provide care.

It will support increased community capacity to build resilience including self-help initiatives, volunteer support networks, local community organisations that offer assistance and non-traditional support. This also covers preventative services.

How will this be delivered?

- Accessible centralised information and signposting about the whole range of services available to increase prevention and self- management (as described above in the 'self-management 'section above)
- Market development in the voluntary sector
- Implementation of an enhanced Ageing Well Programme

Improving access via a 'No Wrong Door' approach (Tier 3)

What will this achieve?

The vision for this tier is to ensure that there is 'no wrong door' for frail older people and those with long term conditions. There is a single common access process linked to urgent care response capability. Service users, patients and carers can access multi-disciplinary triage as part of a single access process operating across multiple locations. There is a common assessment framework which links to universal access points.

How will this be delivered?

The 'in flight' and planned business cases relevant to this tier include:

Community point of access: this will be a central hub for adult referrals, appointments and queries. Accepting referrals for patients and services within the target group, they will be triaged into two streams - urgent and routine. Urgent referrals will be sent directly to the Older Peoples Assessment

Unit (Rapid Care Service) for clinical triage and clinical decision making to ensure a timely response from the correct pathway. Routine referrals will be clinically triaged and be sent to the locality (including LTC) or specialist teams for assessment or management. Over time, social care services and voluntary sector services will be built into this model to reduce the need for different arrangements for other health and social care providers.

Risk Stratification: Build upon the existing model for risk stratification to identify frail elderly at risk of needing care; and to develop a proactive and anticipatory care plan that will enable people to stay out of hospital longer and continue living independently.

Locality Based Integrated Care teams: Introduce 3 locality teams to incorporate community nursing, care navigators, social care, intermediate care, IAPT and generic LTC nurses. These will offer a range of services as part of agreed pathways to meet the needs of people registered with GP practices within the locality. With GPs, they will manage the interface between early diagnosis with LTC and episodes of related ill-health by providing the pivotal point of contact and ensuring that patients are supported to manage their care. This will be provided through delivery of lower level support, access to prevention and voluntary sector services, or anticipatory care planning. Roles will be distributed according to the patient need drawing on the skills and competencies within the team. In essence, they will provide '*the glue'* between the patient, the GP and community intensive support by enabling seamless transitions between periods of well-being to illness with a continued focus on the patient.

Shared care record: The business case is for an information repository providing a single holistic view of an individual's health and social care that will be accessible 24/7 from any location, wherever staff are working. By collating information from different organisations' systems, this will enable everyone (staff and patient/service user alike) to have a single shared view and will also prevent service users from having to provide information multiple times to different practitioners.

Key components of the model in tier 3 are:

- Risk Stratification
- 'No wrong door' principle which will be delivered though a single point of access
- Development of Integrated Locality Teams linked to primary care and Rapid Care.
- Single assessment process and 'trusted assessor' approach
- Building stronger links between GPs, Community and Acute nursing and Locality Teams.
- ICT architecture which supports information sharing, e.g. single shared record

Investing in community intensive support (Tier 4)

What will be achieved?

Community intensive support services increase independence and promote the management of people within their community. A weekly MDT will provide a more intensive approach to managing complex cases by planning care across multiple providers. This will link to Integrated Locality Teams, particularly care navigators, to ensure that they can move resources around flexibly to avoid crises and maintain people in their homes or in other care settings within the community, e.g. residential care. This will be under-pinned by a rapid care service that will provide intensive home-based packages of care to support people in periods of exacerbation or ill-health.

The 'In flight' and planned business cases that relate to this tier include:

Multi-Disciplinary Team Meetings: A weekly meeting that will allow higher risk individuals, identified through risk stratification or other methods, to be referred for detailed review and input from the wider group of health professionals. Ongoing care will be co-ordinated by the care navigators. The target

group is people with short term health and social care conditions, long-term and /or complex conditions, or at the end of life. The planned co-ordination of care across health, social and voluntary care sectors, with a focus on self-care, education, early detection and intervention and the use of telecare will be the key to success.

Rapid Care service: the business case is to expand the existing The Older Peoples Assessment Unit (OPAU) by increasing clinical capacity and developing a community based ambulatory assessment, diagnostic and treatment service to prevent A&E admission is being implemented. This is to bring together the existing teams, rapid response, COPD, heart failure, diabetes, PACE, falls, and ESD stroke teams. Development will focus on 4 clinical pathways: Exacerbation management, long term condition complications, deterioration leading to an immediate need for palliation, and ambulatory assessment, diagnostics and treatment. This is a key development in strengthening the tier 4 services needed to reduce tier 5 activity.

How will this be delivered?

Key components of the model include:

- Multi-disciplinary teams to review and assess complex patients at risk of admission to introduce care plans and link to services to keep them at home
- Rapid Care who can provide intensive support to individuals quickly when needed, as an alternative to hospital care
- Development of Enablement, Intermediate and Respite Care.
- Development of enabling technology.

Reducing the demand for hospital based, residential and nursing home care (Tier 5)

What will this achieve?

Reducing the demand for residential and acute care is a primary focus as Barnet has a significantly high level of bed based care. Care home supply in the Borough is one of the largest in Greater London. Within Barnet, there are 95 residential and 23 nursing homes registered with the Care Quality Commission. There is also a higher than average number of people referred by GP's to acute care.

The focus of the Integrated Model is therefore balanced towards tiers 1 – 4 to reduce demand for residential and acute care. However, there will still be a requirement for these services in circumstances where community care and support is not a viable option.

The 'In flight' and planned business cases relevant to this tier include:

- The significant progress made across Health and Social Care in addressing this through:
    - My Home Life
    - Care homes pilot
    - Quality in Care Homes Team
    - PACE and TREAT

How will this be delivered?

Hospital non-acute beds:

The key components of the model for acute services include:

- Use of ambulatory care pathways, to prevent admissions.
- Creating a robust interface between consultants and the integrated health and social care

services to facilitate step sideways and step down to more appropriate care closer to home.
- Better joint discharge planning with social care input to ensure services are in place to support step down and reduce out of hours discharges.
- Use of hospital networks to provide improved access to centres of excellence and other specialist skills.
- Partnership with acute providers to optimise use of specialist resources and facilities.
- Development of clear referral protocols to optimise productivity of elective care and outpatient clinics and other aspects of acute care.

Residential Care:
The recent 'My Home Life' report identified a key theme in feedback from care home managers[1] as poor co-ordination between health professionals and care homes with regard to discharge of residents, inappropriate placements within homes and lack of understanding of the role of care homes. Focus needs to be on ensuring that admissions to residential care are appropriate, better inter professional coordination and efficiency of discharge planning.

The key components of the model for residential care**:**
- Invest in more step up and step down intermediate care with access via rapid care teams.
- Develop clearer protocols so that residential care staff are clear about when to escalate concerns.
- Implement widespread up-skilling of care home staff, particularly in medical skills to reduce the need to admit to hospital.
- Target quality improvement work in care homes and expanding the quality in care homes team.
- Develop a robust set of quality measures above and beyond what can be assessed by CQC, including a KPI on hospital attendances that do not result in admissions.
- Develop a 'care homes scorecard' also based on locally agreed quality measures.
- Improve the GP offer to care homes and strengthen their and community nursing presence via use of contracts.
- Ensure out of hours GPs are linked into the care home service model, but with an initial focus on getting the "in hours" service right and extending to 7 day cover
- Link the MDT in with PACE/ TREAT and rapid response models.

GPs are pivotal to the delivery of the plan as they are the centre for organising and co-ordinating people's care. We will work with NHS England to deliver the new arrangements under the **General Medical Services contract** for 14-15 to further strengthen the role of primary care in the provision of more personal care for older people and those with complex health needs. New contractual developments to focus on a named, accountable GP for people aged 75 and over, flexibilities in delivering out-of-hours services and a new enhanced service to reduce unplanned admissions will offer opportunities to link directly with the plan and focus on integrating services locally. These will be considered in the context of 7 day provision linking with our out of hours provider.

In line with the **Barnet CCG Primary Care Strategy,** we have invested in IT infrastructure for GPs and on increased working with Community Pharmacy. Our GPs have begun to develop networks and we will invest in initiatives to address demand management issues and to support the management of more complex care in Primary Care.

We recognise that the changes will require a phased and managed approach working with partners. An overview of the anticipated timeline is:

[1] London Validation Report, My Home Life (November 2012)

Jan – Mar 14

- Continue with planned programme projects such as older peoples integrated care and rapid care
- Validate Health and Social Care Integration model and complete full business case to inform BCF investment for 15-16 including development of locality based integrated care teams
- Work with partners to co-design detailed operational delivery models including phasing of delivery
- Establishment investment profile from other parties, e.g. public health, into the Health and Social Care model to influence delivery of the BCF
- on an North Central London level continue with the value-based outcome work to further inform commissioning and contracting options

April – March 2015

- Complete detailed planning including milestones and specifications for implementation of early phase plans including testing models and sharing learning
- Establish benefits tracking mechanism to effectively monitor delivery of outcomes
- Establish and monitor financial flows
- Establish a mechanism to capture user views to effectively feed in use perspective to inform progress and continued improvement
- Develop later phase plans

From April 2015

- Use preparation from planning to implement and deliver plans through 15-16 with fully agreed BCF investment
- Fully functioning benefits tracking and financial monitoring model to monitor progress and outcomes

Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Our two primary providers of acute hospital services are Barnet and Chase Farm NHS Trust and Royal Free NHS Foundation Trust. Extensive re-configuration of local infrastructure and service provision is currently underway. As outlined in the **Barnet, Enfield & Haringey Clinical Strategy**, changes of Chase Farm hospital site have resulted in shifts in demand and activity. Barnet Hospital has its own financial challenges and a proposed acquisition by the Royal Free is being taken forward. Partnership working in relation to implementation of

these plans has resulted in solid working relationships which have allowed us to test elements of the BCF plan particularly over the winter period of 13-14.

The Barnet Integrated Strategic and Operational Plan and Recovery Plan 2013 set out the challenges related to the local spend on acute hospital services. We spend about £43M more than other London Boroughs for the same population and, recognising the issue, are already taking steps to address this through an extensive service re-design and QIPP programme. In this context we have a very strong focus on:

- Transformational change of the health system through provision of integrated care for patients with complex needs as defined in the BCF plan. Through proactive identification, care planning and integrated management of care for patients with complex needs we will seek to avert crises, thus reducing the unplanned use of acute care;

- Reduction in elective acute care through robust management of referrals, and redesign of care pathways to provide upstream early intervention, a greater range of care in a primary care setting, and community based alternatives to acute care.

The business case for the ongoing Older Peoples Integrated Care (Frail Elderly) programme outlines potential reductions in attendances at A&E, emergency admissions, and length of stay. It is recognised that this will increase over the lifetime of the project with financial modelling in the initial years being conservative, with greater savings once fully embedded. Overall savings for 2014/15 are estimated to £639,377 and £904,165 in 2015/16.

Throughout this work stakeholders, including acute providers, have been kept informed of the CCG's commissioning issues through regular provider events to engage them in the work of the CCG, Clinical Commissioning Programmes and through Clinical Quality and Risk meetings with provider Trusts. We have worked hard to establish a partnership approach to local service delivery to ensure that we maintain quality and work collaboratively in implementation.

The Barnet Integrated Health and Social Care model provides greater ambition in terms of movement of costs and services away from acute and residential care through the provision of a framework for future delivery at scale and pace. It recognises both the NHS costs and the associated cost to social care of admissions to care home directly to the acute setting. Modelling in the outline business case makes assumptions on relative percentage shifts in activity over 3 years with re-investment in prevention, self-management and community based intensive services. . Further validation by the CCG and LBB is planned for January 2014, including testing assumptions on quantification of shift with providers. As part of the design groups, acute providers have been integral to shaping the model by influencing where service improvements would benefit patients and where efficiencies could be achieved.

Given the financial position of the Barnet health economy, significant emphasis will be applied to delivery of these targets through a shared plan with providers. Non-delivery must be seen in the context of an anticipated funding gap in Health and Social Care, and will manifest as multiple organisations running in deficit and reduced services. Further discussions will ensue with regard to commissioning options to support the plan, to include how we maintain stability in our provider landscape and risk share across the system.

Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Strong Governance exists in Barnet across both Health and Adult Social Care. This includes the Health & Wellbeing Board (HWB) and its Finance sub-group; and the Health & Social Care Integration Board (HSCIB). Underpinning this is a shared Programme Management Office (PMO) and a Joint Commissioning Unit (JCU) comprising staff from both Barnet CCG and Council (Adults & Communities). While this is currently working well, there is a recognition that this will need to be re-aligned over the next few months to manage the changes associated with the BCF pooled budget.

The **Barnet Health & Social Care Concordat** articulates a clear vision and strategy for integrated care and this was agreed by all partners at the HWB. The Concordat itself was designed by partner members of the HSCIB.

We have regular meetings between our council cabinet member responsible for health and our CCG chair, together with regular meetings involving the senior management teams of Barnet CCG and Council (Adults & Communities). Our transformational plans and programmes are formally discussed and approved at local borough governance levels within the local authority and CCG.

The following embedded files refer to the relevant Terms of Reference for the governance framework operating in Barnet.

HWBB Final Terms of Reference.docx

Paper 2 Health Social Care Integratic

HSCIB Programme Governance vFinal.d

NATIONAL CONDITIONS

Protecting social care services

Please outline your agreed local definition of protecting social care services.

In Barnet, protecting social care services means delivering on the Health and Well-Being targets of Keeping Well and Keeping Independent, making sure that those in need receive timely and effective support, whilst managing increased demand and financial pressures. The BCF, as agreed by all partners, provides the platform for future investment and planning for health and social care with a central priority on outcomes for our people. Our commitment to the Barnet Health and Social care Integration Model clearly demonstrates that the BCF will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

Please explain how local social care services will be protected within your plans.

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

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

7-day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)
Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

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

With a recognition that although have made significant progress, we need to enhance further the scope and reach of services already in place, we have taken the opportunity in recent months to test a number of initiatives for 7 day provision with additional funding available via winter pressures and Barnet, Enfield & Haringey clinical strategy. Using the evaluation of effectiveness of these initiatives, we will develop a forward plan to provide a consistent 7 day offer which can flex according to demand.

A range of current and planned services support this namely:

- Our district nursing and intermediate care services currently operate over 24 hours on a small scale. This will be extended into locality based integrated care teams with additional capacity for overnight coverage for ongoing care where necessary, including the use of night sitters where necessary
- We have recently increased the access hours of the community based rapid response team to accept referrals 7 days per week from GPs, out of hours services, care homes and acute teams providing intensive support for up to 120 hours
- Tracker nurses working within acute trusts are currently working 7 days per week identifying those who could be transferred home and supporting discharge
- Supported assessment, triage and discharge arrangements within local acute trusts including Urgent Care Centre (UCC), ambulatory care pathways, PACE, TREAT and RAID have recently been implemented and are all planned to offer 7 day provision from Jan 2014
- A work in progress is the development of protocols between services to support smooth transition and optimal care for patients to move home quickly, for example between rapid response and the UCC
- From Jan 2014, social work teams will be available 7 days per week within A&E departments to support care planning for transfer home and to understand and assess demand and impact for future plans
- Systems have been re-aligned to ensure that care packages can be accessed from our main providers throughout the weekend to initiate new packages of care and for changes to existing.
- Barnet is operating a managed system for Delayed Transfers of Care throughout the winter period, involving all providers. This is proving successful in facilitating, unblocking reasons for delay and allowing for transfer throughout the 7 days period
- A number of initiatives have been implemented within the acute trusts that impact of 7 day staffing particularly to support discharge. Examples include occupational therapy and access to pharmacy. These will require evaluation for future planning.
- By April 2014, we will have implemented the Barnet community point of access which will provide effective and safe referral point to facilitate discharge over 7 days
- Our out of hours GP cover is provided by Barndoc. Further work is required to strategically link and strengthen pathways between both Barndoc and primary care in general to ensure that appropriate services are in use over 7 days
- Early work is also underway to implement alternative care pathways with London Ambulance Service to facilitate avoided admissions

To support the above a clear communication strategy will be developed to give an over-arching view of the services available and to stream-line referrals and transitions across interfaces.

Data-sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Most NHS acute and community health providers already currently use the NHS number extensively as the primary identifier for patients. This will also be strengthened in primary care with requirements under the new arrangements for the GMS contract for 14-15.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

*Adult social services is in the process of adopting this. For example a **Shared Care Records** project is already underway, as agreed by the HSCIB, which will use the NHS number as the primary identifier for service users.*

Please confirm that you are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to using systems based upon Open Application Programming Interface and Open Standards.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements , professional clinical practise and in particular requirements set out in Caldicott2.

Barnet Council / CCG operate within an established Information Governance framework, including compliance with the IG Toolkit requirements and the seven principles in Caldicott 2. The contract documents used by Barnet CCG to commission clinical services conform to the NHS standard contract requirements for Information Governance and Information Governance Toolkit Requirement 132. Barnet CCG as a commissioner and to the extent that it operates as a data controller is committed to maintaining strict IG controls including mandatory IG training for all staff, and has a comprehensive IG Policy, Framework, IG Strategy and other related policies. Information Governance arrangements and the IG Framework conform to the IG Toolkit requirements in Version 11 of the IG Toolkit, including clinical information assurance as set out in requirement 420 and the requirements for data sharing and limiting use of Personal Confidential Data in accordance with Caldicott 2.

Joint-assessments and accountable lead professional

Please confirm 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.
Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional

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.

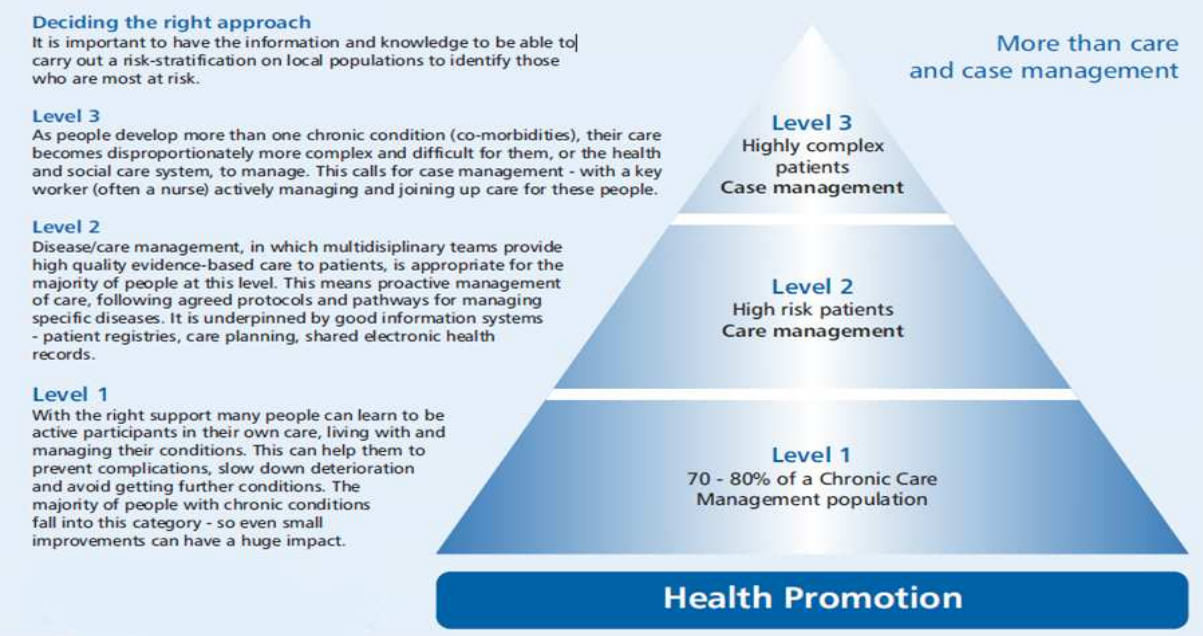
Key elements include:

- Use of risk stratification in primary care to identify those most at risk of admission to ensure that they are actively case managed. This calls upon practice intelligence and third-party data regarding utilisation of other services e.g. accident and emergency
- 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 which supports GPs with risk stratification and provides the care co-ordination role following MDT assessment.
- Planned changes to the GP contract for 14-15 whereby enhanced services are being introduced that aims to improve services for patients with complex health and care needs, who may be at high risk of unplanned admission to hospital. In particular, to case manage vulnerable patients (both those with physical and mental health conditions) proactively through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator
- Planned introduction of locality based integrated care teams incorporating health and social care with anticipated streamlining of care according to patient need rather than referral point. This will also bring into play a generic long term condition approach which will enable early identification and care planning for future management of exacerbations

This programme of work sits within the older people integrated care project and, as such has an existing agreed format for assessment, allocating lead professional, planning care and monitoring success measures of interventions. This will develop further within this programme to ensure that as services grow that assessments remain fit for purpose and allocate responsibilities appropriately.

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

The most accurate method of identifying individuals at risk of a non-elective admission is through predictive models that use statistical algorithms to predict an individual's level of future risk. These individuals are at the highest risk of a non-elective admission (that is the top 5% of the risk pyramid) as reflected in Level 3 of the Kaiser Permanente's Pyramid



Kaiser Permanente's Pyramid

As part of the Older Peoples Integrated Care project a Risk Stratification tool has been procured and plans were in place for it to be utilised on a minimum cohort of 50,000 people, targeting those residents within the frail and elderly group to:

- Identify frail and elderly patients at risk of future A&E attendances and unplanned admissions
- Screen for the most important conditions including, but not limited to, long term conditions affecting frail and elderly people
- To provide GPs with a robust approach in understanding the variation in risk of future A&E attendances and hospital admissions across their local population
- To provide robust reports which allow practices to identify patients for review for case management interventions and multi-disciplinary team case conferences.

Although recent national information governance issues have hindered progress with the usefulness of the automated United Health HealthNumerics-RISC® tool we have identified a local work-around solution linked to the NHS England DES for GPs. In 13-14 a minimum of 2% of GP registered patients will be risk profiled using information available to primary care including: the RISC tool, the Urgent Care Dashboard and local practice searches, for example those identified as frequent attenders in Primary Care. To embed a holistic approach across a range of physical and mental health issues we have maintained a wide target group (within the frail and elderly cohort) to include patients already on or requiring initiation on pathways of care across a range of clinical areas such as end of life or palliative care, dementia, chronic disease, mental health and learning disabilities. It is anticipated that between 0.5% and 1% of the patients identified through this process may benefit from more active case management, and will have a joint care plan put in place.

Our approach moving forwards will include:

- Agreeing an approach for risk stratification for future years to further increase the number of residents who are identified through this method to prevent avoidable admission and better care

- fully implementing and integrating the guidance on joint assessments and accountable lead professional currently awaited from NHS England as part of the GMS contract changes for 14-15

- To further embed the framework for stratifying Barnet patients according to the four risk levels (as below), that will determine prioritisation of care planning and, where relevant, screening for the most important conditions affecting elderly people.

	Requires Action Plan?	Frequency of review	Access to Rapid Response	Active Management
Highest Risk	Yes – Plan may include points to be picked up by community, social or specialist services.	Monthly	Yes	Yes
High Risk	Yes – Plan may include points to be picked up by community, social	Quarterly	Yes	No
Medium Risk	Yes – May include another GP review within a defined follow up period, navigation services may improve coordination of interventions	Quarterly	Yes	No
Low risk	Not required. Patient may benefit from information via navigation services	Annual	Yes	No

OUTCOMES AND METRICS

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

n/a

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	492.96	N/A	
	Numerator	243		
	Denominator	49294		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	83.10%	N/A	
	Numerator	331		
	Denominator	398		
		(Oct 2012 - Dec 2012)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month, attributable to social care and both)	*Metric Value*	1.8		
	Numerator	5		
	Denominator	274,300		
		(April 2012 - March 2013)	(April - Dec 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - Sept 2014)	(October 2014 - March 2015)
Patient experience Patient experience (Adult Inpatient Survey 2012 - overall experience Q68, measure on a score of 0 - 10, 10 being best performance)		Barnet and Chase Farm = 7.7 Royal Free = 7.7	N/A	
		(Sept 12 - Jan 13)		*(insert time period)*
Service user experience Adult Social Care survey - overall satisfaction, those that replied extremely, very or quite		87%	N/A	
		Feb-13		*(insert time period)*
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

FINANCE

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority			£1,872,000	
CCG		£6,634,000	£21,540,000	
BCF Total		**£6,634,000**	**£23,412,000**	

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

Finance schemes summary. for draft 4.

KEY RISKS

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

Risk	Risk Rating	Mitigating Actions
1. Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector	High	• An impact assessment will be required for the Health and Social Care Integration model to allow for greater understanding of the wider impact across the Barnet health economy • Ongoing stakeholder engagement including co-design and transitional planning
2. Baseline data supporting our plan relies on current assumptions. If they are incorrect it means that our financial and performance targets for 2015/16 onwards are unachievable.	High	• Validation of modelling in Health and Social Care Integration model extending into opportunities and costs for operational delivery • Continued monitoring of assumption base-lines to identify trends early
3. Organisational and operational pressures will restrict the ability of the local workforce to deliver the plans in accordance with the requirements.	High	• Embed the work of the joint commissioning unit with the programme to deliver projects • Work with providers to co-design and seek shared opportunities for delivery • If necessary invest in pump-prime activity to drive the plan at an early stage • Consider alternative commissioning options
4. Planned improvements in the quality of care and in preventative services will not result in the expected reductions in acute and nursing / care home activity, impacting the overall funding available to support core services and future schemes.	High	• Preventative work plans to be founded in a robust evidence base to maximise probability of success • Widespread stakeholder engagement to embed communication messages and hence increase uptake • Continued monitoring of outcomes to assure delivery with governance arrangements to enable service adjustments as required
5. The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	High	A Care Bill Work Programme involving Officers from across the Council and including Lead Member representation has been established to evaluate the financial and non-financial impact of the Care Bill and related mitigating actions. The Council will also be participating in an LGA/ADASS sponsored survey in January 2014. This utilises a model developed by Surrey County Council to help assess the current and expected costs of implementing the Care Bill in particular the cap on people's care costs and the universal offer of deferred payment agreements from April 2015 and April 2016 respectively.