Barnet Health and Social Care Economy

Integration of Health and Social Care Services

Outline Business Case - March 2014

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Approvals

By signing this document, the signatories below are confirming that they have fully reviewed the Outline Business Case for the Integrated Health and Social Care project and confirm their acceptance of the completed document.

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DOCUMENT CONTROL

Version History

Version	Date	Author(s)	Summary of Changes
1	13.12.13	Joint Team	Overview of content further developed
2	17.12.13	Joint Team	Updated commercial case
3	20.12.13	Joint Team	Final draft for internal (EY) review
4	23.12.13	Joint Team	Updated following internal QA review
5	08.01.14	Joint Team	Updated to incorporate SG and DG comments
6	21.02.14	Joint Team	Final submitted draft
7	06.03.14	Joint Team	Revised Final draft

Contents

1. Executive Summary

London Borough of Barnet (LBB) and Barnet Clinical Commissioning Group (BCCG) have committed to a shared vision to integrate Health and Social Care services for frail older people and those over 55 with long term conditions. Progress has already been made in Health and Social Care through the integration of Learning Disability and Mental Health Teams as well as establishing a joint commissioning function. However, it is recognised that there is a need for further system wide change to transform the way services are planned and delivered, to ensure future sustainability and improved outcomes for residents of Barnet.

This Outline Business Case (OBC) summarises the outcome of a programme of work jointly undertaken by LBB and BCCG between 10th September and the end of February 2014 to progress that vision towards developing a target operating model. The programme is aligned to the wider transformation portfolio of programmes in Barnet and provides a Blueprint to drives future service delivery. This model developed is integral to the plans for the 'Better Care Fund' and underpins the priorities for investment identified.

The purpose of the OBC is to:

- Enable the respective commissioning organisations to make an informed decision on progressing the integration project towards implementation.
- Provide analysis of how to most effectively spend the collective Health and Social Care resources to improve outcomes for the local population, taking account of funding and demographic challenges
- Inform the 'Better Care Funding, ' submission in February 2014.
- Outline proposals for the operating arrangements and commercial model to deliver the change in the future

Scope of the OBC:

The scope of the OBC is to translate the existing vision for integration and current delivery projects into a shared model for services. This includes a review of current integrated working arrangements and assessing how best to move towards a target operating model for integrated provision of services for:

- *Frail and Elderly:* aged 65+
- *Long Term Conditions:* people aged 55 – 65 with long term conditions.
- People living with Dementia
- End of Life Care (considered within scope but has been defined for the purposed of this work as a service rather than a condition).

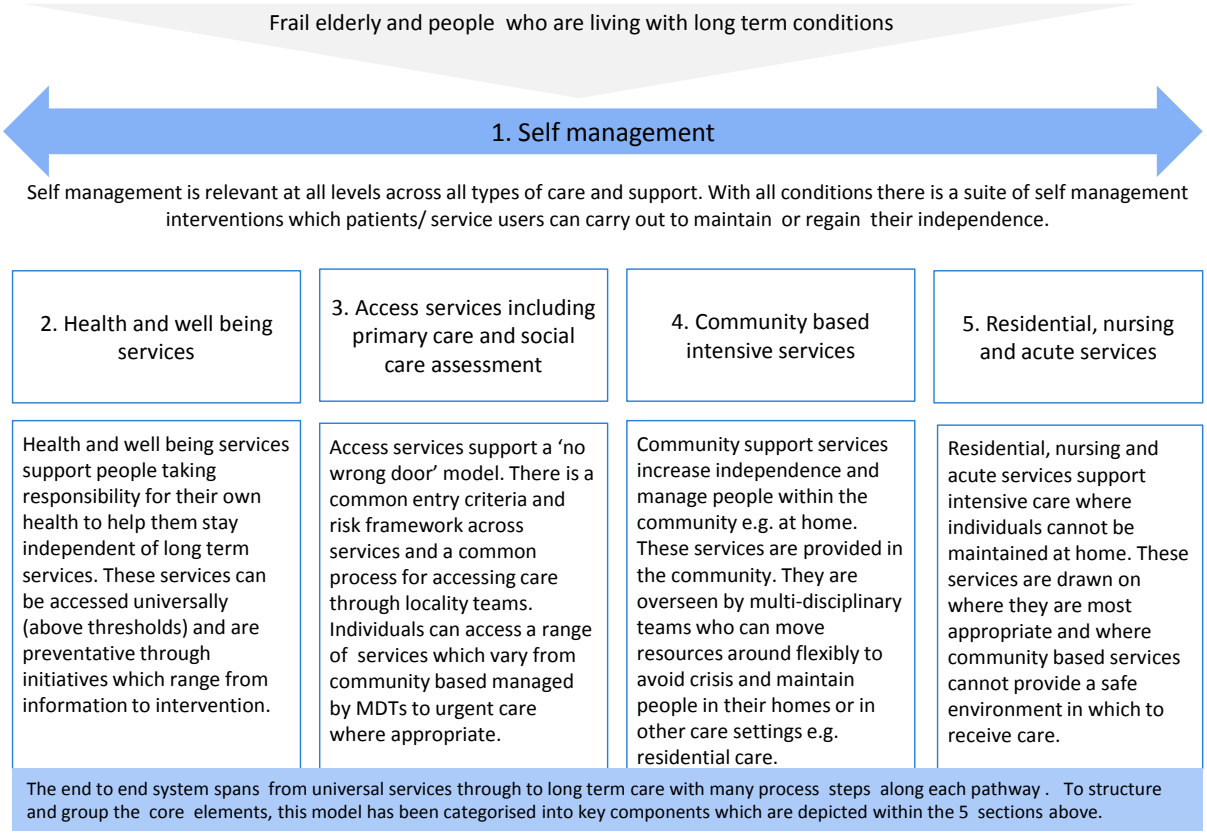
The total value of core services in the scope of the programme is £77.6m, of which 46% is LBB spend and 54% is BCCG spend.

Summary of the operating arrangements

The operating model proposed focuses on:

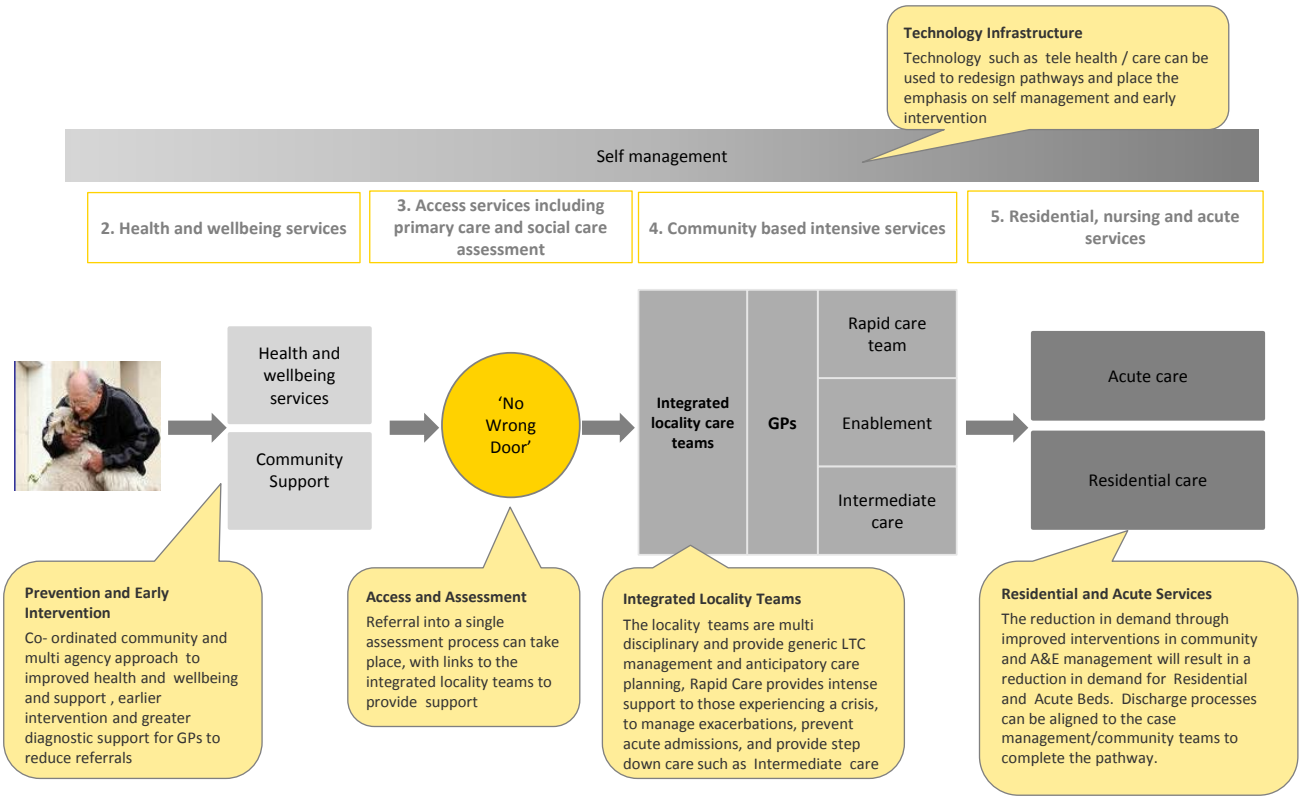
- Better coordination (across the wider health and social care community) and;
- Investment in prevention and self-management as the key to maximising wellbeing and independence.
- improving quality of life, outcomes
- Reducing on the demand for services particularly in residential and acute care.
- Integrate the approach to access, assessment and delivery responses through a single system.

Integrated Locality Teams are at the heart of the model with risk stratification, improved anticipatory care, rapid care and effective care navigation as central components. The five tier model is predicted on making the best use of the assets of communities and individuals to maximise quality of life and maintain independence.



The model outlines the ambition, and articulates the scale and pace required to meet the needs of the changing population of Barnet. It also builds on 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 diagram below represents the journey for Mr Dale through a co-ordinated care system and how this improves his outcomes. The key enables and components of services are also described

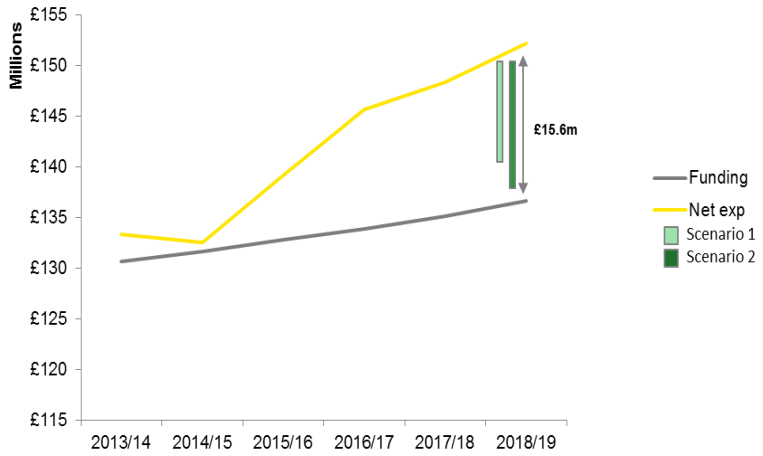


Financial case for integration

The majority of the cost savings will be delivered through targeted integration projects, where relevant services (referred to as 'core' services) can be jointly commissioned based on commonalities or as part of an integrated care pathway. The financial modelling has considered what level of reduction is needed in these services to bring the system back into financial balance and to release sufficient funds to invest in levels 1-4 of the conceptual model.

The scenarios modelled are reductions in acute and placement activity of 2% (Scenario 1) and 3% (Scenario 2) per annum for the five year period, based on feedback from the Steering Group as to what level of activity shift would be achievable over this timescale.

The graph below shows the two scenarios modelled against the projected budget. Both scenarios will balance the budget over a five year period, but a 3% shift in activity per annum provides a greater pool for investment over the life of the programme, and is hence the desired scenario. Although this will be challenging to achieve, the return on investment from increasing community support and health and wellbeing initiatives make it possible. It is also a requirement of the Better Care Fund to enact this shift in activity, and will provide a portion of the investment needed for schemes, such as a new integrated care model, that are outlined within Barnet's BCF submission.



Evidence to support the assertion that increased investment in community and preventative services can reduce acute activity can be found in the Appendices section of this report.

Evidence for activity shift:

- Promoting self-management – the North West London Integrated Care pilot saw a 25% reduction in bed days and 45% reduction in admissions as a result of improved disease management of those with LTCs
- DH evidence indicates that intelligent patient programmes can decrease A&E attendance by 16% and outpatient visits by 10%
- Integrated locality teams, formed as part of the North West London integrated care pilot, led to a reduction in non-elective admissions of 6.6%
- Proactive case management, using risk modelling, reduced A&E attendance amongst those being managed by 40% in Oxfordshire
- Rapid response triaging gave net savings of £3.6m per annum in Bristol
- Integrated geriatrician service in East Lothian avoided acute admission for 77% of patients referred in the first six months

In light if the timing if the 'Better Care Fund' submission, LBB and BCCG were keen to undertake an analysis of how best to make use of the joint resources available and investment priorities.
The options considered are based on the required changes in services focus on a multi-disciplinary system that builds upon the existing improvements being made in provision of advice and information, and to implement prevention and targeted intervention through the introduction of:

- Proactive care based on risk stratification to identify residents on the cusp of acute, hospital or residential care.
- Focused care planning and care navigation.
- Development of integrated Locality Teams and the Multi-Disciplinary case conferences approach.

In order to drive this forward, the key priorities for identified are:

1. Investment in the development of the Locality Model
2. Increase investment in prevention services
3. Meeting the anticipated increase in demand as a result of the 'Care Bill'

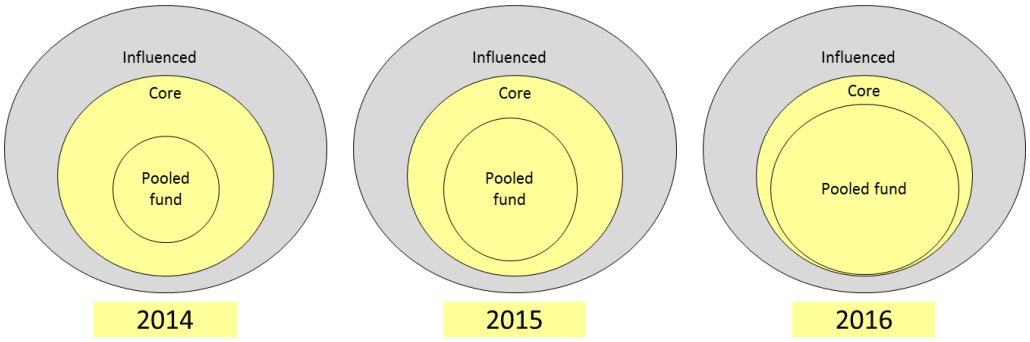
Commercial arrangements

This business case does not give a recommendation for a specific contracting mechanism. Structural integration would be a complex, challenging process to achieve within the current provider landscape. However, a level of integration has been achieved for learning disability services in Barnet, with a pooled budget arrangement and an integrated care team.

It was recognised that locally, the 'lead provider' in some instances may be a management function for a bundle of services as opposed to being the main delivery mechanism for services. Equally across the five levels of the model there may be a number of lead providers for different service packages and an alliance may need to be formed between these for pathway coordination focused on the individual.

In terms of the pooled funding arrangement, the concept of core and influenced services were described in Section 6. It is expected that, in line with the staged approach to implementation, the pooled budget amount for the core fund would begin with the priority areas for the Better Care Fund, submitted in Feb 2014. However to ensure benefits were jointly realised some alignment of core and influences budgets would be required with clear performance metrics monitored by the collective governance.

As the service model and commercial approach develops further the pooled budget would expand incrementally as more services come on stream.



Next steps

There is a consensus across key stakeholders that it may be appropriate to approach integrated provision for the population cohort in a staged process.

1. Design and build the operating arrangements
2. Market test appropriate 'segments' of the model
3. Enter a dialogue with providers to identify the appropriate contracting approach.

This would enable commissioners to work hand in hand with providers to build the new operating arrangements and ensure a smooth, safe transition to the new ways of working. This process should be supported by the development of a joint programme plan and robust programme governance arrangements.

2. Introduction

The London Borough of Barnet (LBB) and Barnet Clinical Commissioning Group (BCCG) have developed a shared 'model' approach to delivering integrated care across Barnet. A clear strategic vision for Barnet is driving integrated working going forward and a range of initiatives aimed at delivering the vision on the ground. Some progress on integrated working has been made and there are a number of spearhead initiatives and projects, notably the Older Persons Integrated Care pilot. However, whilst there are local examples of good practice, some services remain disjointed with organisations and practitioners, working independently of each other presenting a leadership challenge in managing a fragmented system.

This outline business case will support LBB and BCCG in developing the business case and is integral to the 'Better Care Fund' plans. It aims to bring together partners to co-design a service model to help address some of the challenges in terms of:

- Improving outcomes
- Reducing funding
- Structural financial deficits
- Increasing demand
- High customer expectations regarding experience
- Organisational and commercial reconfigurations across the Council and NHS commissioning and provider landscape
- The anticipated impact of the Care Bill.

This outline business case aims to address the critical question for BCCG and LBB of:

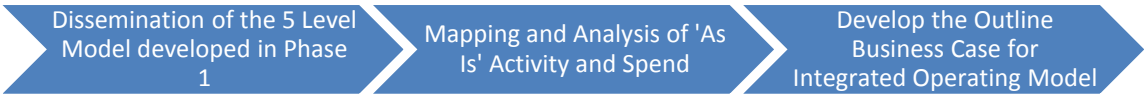
'How do we achieve better health and wellbeing outcomes and improve user experience for the frail, older population in Barnet in a financially sustainable way?'

The purpose of this outline business case is to answer the above question. It achieves this by considering:

- The outcomes for Mr Colin Dale and the vision for Integrated Care in Barnet that will deliver these
- The model of care to deliver the outcomes and vision
- A profile of the financial envelope in scope and the impact of future funding and demographic challenges on this amount
- A range of financial scenarios to achieve a shift of cost and activity and the priorities for early investment based on expected ROI
- Understanding of the commercial options available to the council and a sense of direction on an innovative, pragmatic approach with regard to the local context
- A test of the model against an agreed standard to provide a recommendation to the Steering Group and Health and Wellbeing Board
- A description of the expected governance arrangements and principles, key implementation considerations and next steps to take the work forward.

Approach to delivery:

Phase two of the project to develop and outline business case consisted of 3 key stages:



This has included:

Stakeholder engagement – This has had 3 functions:

1. Project governance and steer – The steering group and finance and HWWB resources committee have validated the outcomes, model and other elements of direction of travel described in this case
2. Co design – To develop the detailed model that will deliver the outcomes for Mr Colin Dale and the vision for integrated care
3. Informal Consultation – This has been to test a variety of ideas addressed in the case at forums such as the residents' consultation facilitated by 'HealthWatch' and the Older Peoples Partnership Board.

Financial Modelling – This has included:

- Data gathering
- Baselining of the As –Is, current spend across the five tier model
- Developing funding portfolio scenarios
- Developing investment shift scenarios
- Developing activity shift scenarios
- Identifying investment priority areas
- Financial case consolidation

Model assessment – Testing the model against the agreed standards

Implementation planning – Identifying the risks, constraints implementation and governance considerations.

Further details on the stakeholder engagement can be found in the Appendix 8 of this report.

3. Strategic Case for Change - Why Integration? Why now?

London Borough of Barnet (LBB) and Barnet Clinical Commissioning Group (BCCG) recognise that there is significant potential for integrated working to deliver better outcomes, an improved patient experience and address some of the future funding challenges. The availability of funding to invest early in some activities over the next two years means that the mechanism to deliver integration merits the development of a jointly sponsored outline business case.

Recognising a significant element of the pressure in the system is as a result of demand from some specific user groups, the scope of this programme includes all LBB and BCCG budgeted expenditure on the following groups of people:

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

Barnet has made some progress on integrated working which provides an excellent platform for further development. Some examples of this include:

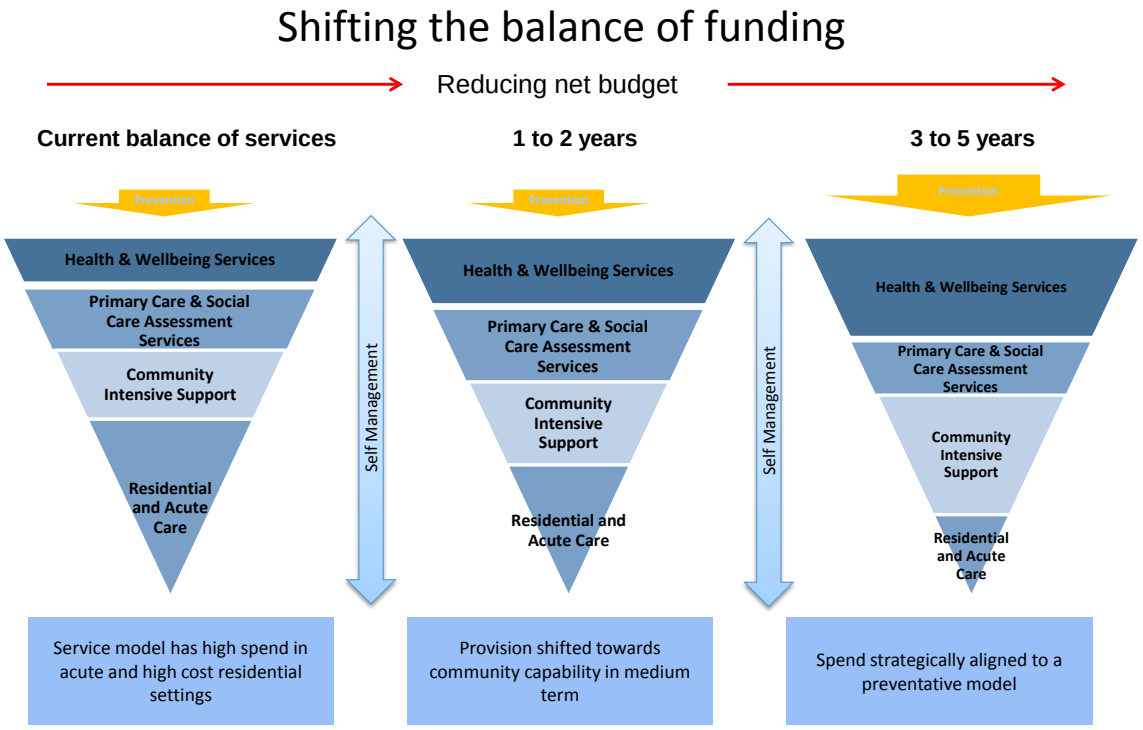
- Development of an integrated strategic vision supported by a multi-agency partnership
- An integrated commissioning team
- Social care Multi-disciplinary teams, co terminus with GP localities
- An integrated care pilot for older people
- Care homes pilot
- Falls project
- Dementia services

However there are significant challenges in the current system that need to be addressed through a more fundamental change to ways of working:

- A need to deliver a system that is more person focused, improving the experience of using care
- A greater focus on wellness – the current system is still heavily weighted towards reactive care
- The prevention and self-management elements of current service are identified as underdeveloped in Phase 1
- Demographic pressures and policy drivers, notably the Care Bill which will increase demand on social care services
- Both the BCCG and Adult Social Care face significant financial challenges
- Acute services are facing significant financial and demand pressures – the CCG invests approximately 10% more budget in acute service that the best performers and less that average in community based services (Recovery plan May 2013). Individual organisations productivity savings alone will not suffice.

Further information on progress to date can be found in the Phase 1 Model, the 'As Is' baseline of services and in the design group outputs, all contained in the Appendices section of this report.

The available Better Care Fund (BCF) funding provides an opportunity to invest in a more holistic integrated model and begin the process of whole system reconfiguration. The progress to date and acknowledgement of current challenge that need to be urgently addressed provide the optimal local condition to progress integration to the next stage. The strategic case for change is about improving outcomes and delivering a better user experience in a more financially sustainable way. Barnet will achieve this by moving to a model that invests more funding in lower level and preventative support, shifting the balance of care over time out of hospital and longer term residential care.



4. Vision for integrated care

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

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

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

The vision and key design principles from Mr Dale's perspective is outlined below:

"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."

Key Design Principles:

1. My primary contact will always take responsibility for making sure my care is coordinated and I am kept informed along with my family.
2. I will feel like I am dealing with one care organisation, and only have to tell my story once, rather than to multiple health clinicians
3. I will be able to get the right care and treatment quickly without having to deal with lot of people
4. I will receive care provided by well-trained teams, at home or at a place that is convenient for me

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

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

Mr Colin Dale and his carer will:

- Be supported to have a high quality of life and increase his self -care skills
- Have support focused on 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 models such as expert patient/carer groups to support self-management e.g. taking medicines properly
    - Be able to easily access up to date information from one place about what support is available.

2. **There is a 'no wrong door 'principle to accessing 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 their skills, increases quality of life and prevents deterioration.**

    Mr Dale will

    - Understand what is happening, what his and his carer's choices are and be fully supported to stay at home
    - 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 and 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 to ensure a seamless transition through the system including from community service to hospital when required.

3. **Intensive community based support is readily accessible and reacts quickly to need**

    Mr Dale will

    - Understand his and his carer's choices 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 response service which 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, 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
    - 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
    - When the time comes, be able to experience a dignified death in the place of his choice.

In addition to the outcomes for Mr Dale and other residents of Barnet as described above, the following sets out **what success looks like for the workforce, commissioners and providers.**

For the Workforce	▸ Ability to focus on delivering support to citizens ▸ Providing greater and more flexible career opportunities and ability for up skilling/ skills transfer between professionals as care moves within the system ▸ Fewer barriers to effective decision making ▸ Focus on culture change, empowering staff to take ownership of delivering high quality services ▸ Developing a stable workforce ▸ Better understanding of each other's roles and skills and their role in delivering the model ▸ Supported to develop multi-disciplinary team work skills ▸ Effective systems for information sharing and recording
For Commissioners	▸ Established protocols and pathways to ensure clear governance arrangements are in place ▸ A system that is accountable to users and has been designed with their involvement ▸ Joint investment in early identification, prevention and early intervention to prevent escalation of needs ▸ Financial risk sharing arrangement to ensure value for money ▸ Transparent performance and financial framework supported by joint governance to ensure robust management of quality and costs ▸ Development of strong working relationships between community services, acute services and Primary Care through implementation of Integrated Case Management ▸ High quality and safe services
For Providers	▸ Critical mass of services to enable flexible use of resources ▸ Opportunity to invest due to greater financial certainty and delivery flexibility ▸ Increasing productivity and accelerating improvements in service quality through working with all stakeholders to redesign services. ▸ Provision of safe, high quality services ▸ Reducing waste in the system through eliminating the amount of duplication ▸ Making better use of community assets due to flexibility and removal of organisational boundaries ▸ More integrated back-office and support function to provide seamless support and enable efficiencies ▸ Simplified contracting arrangements and more focus on effective delivery

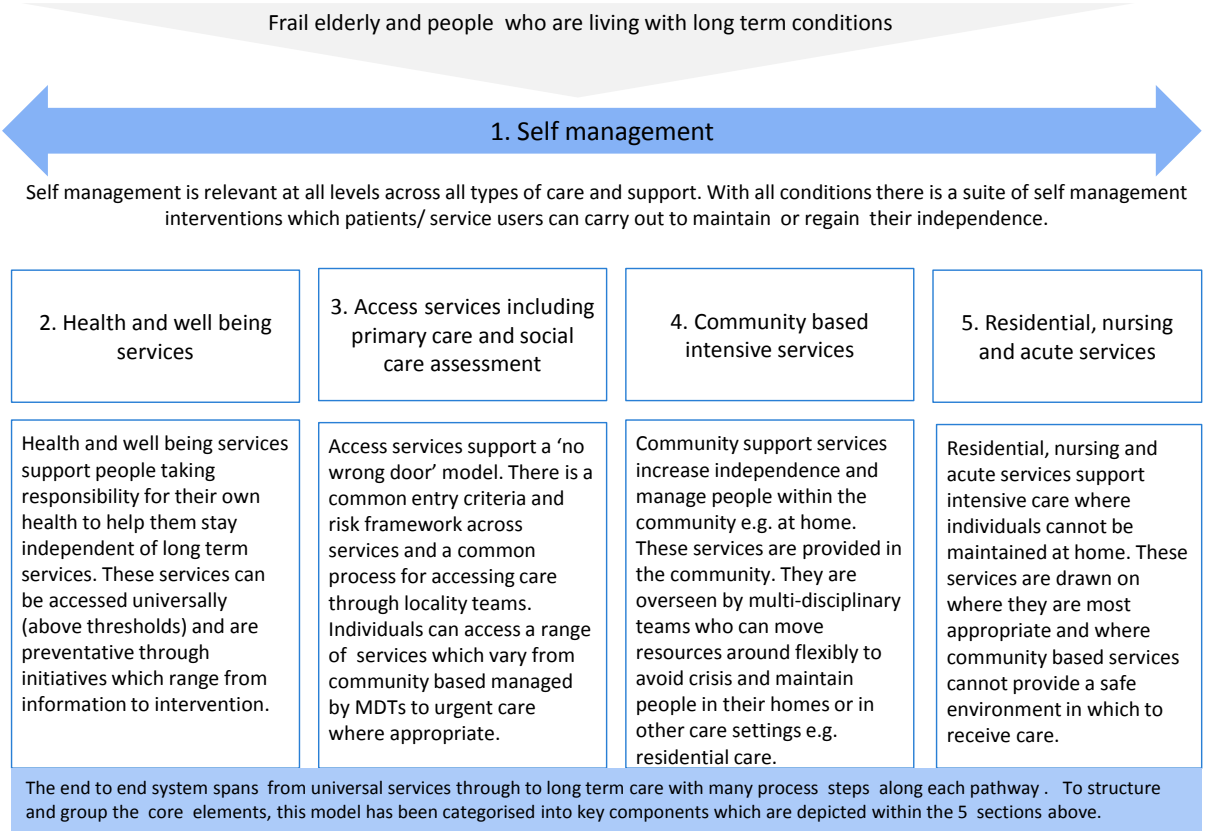
5. Operating Arrangements for Barnet's Integrated Care System

The following section outlines the operating arrangements for the new delivery model by component correlating with the 5 tier model. However, it is recognised that for different elements of the service e.g. Health and Wellbeing, the offer and response will also have an impact on other parts of the population and pathways. It is anticipated that the model will be subject to continuous improvement in the course of implementation.

Through a series of stakeholder engagement workshops and research a number of themes have emerged that will drive the service specification for integrated care based on the 5 tier model as illustrated below:

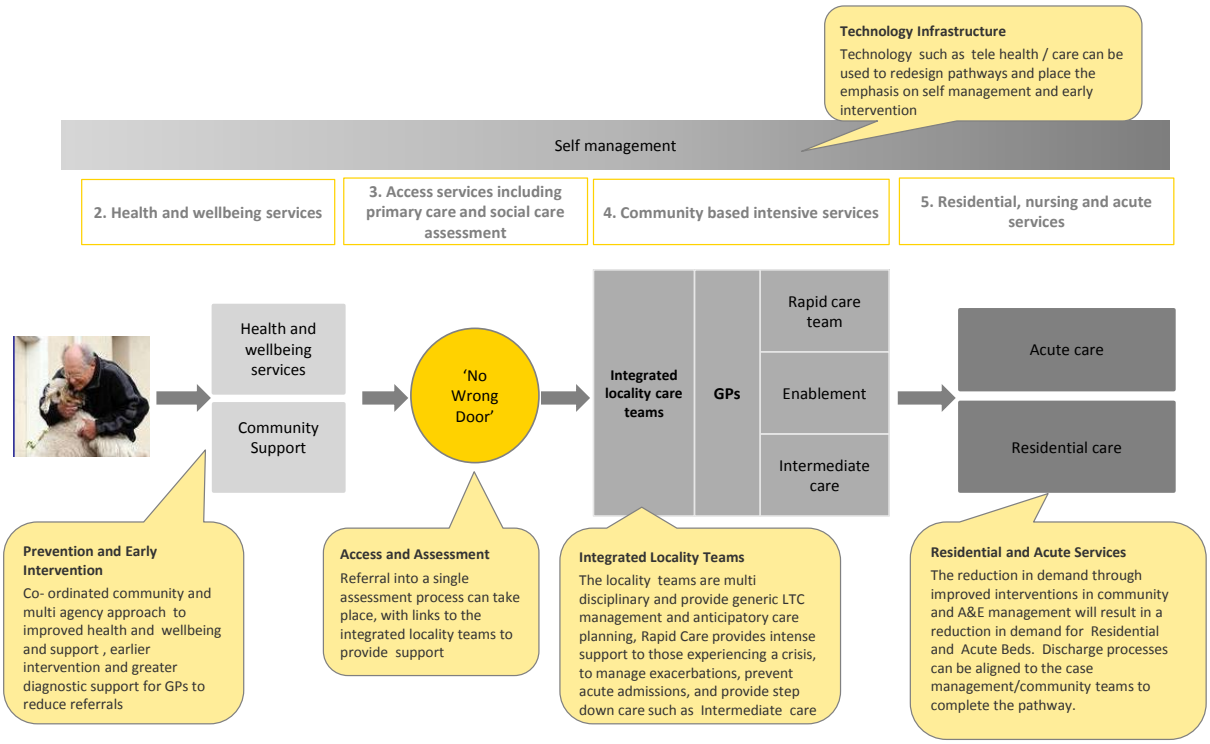
Health and social care Integration in Barnet

The five tier model is predicted on making the best use of the assets of communities and individuals to maximise quality of life and maintain independence.



The model outlines the ambition, and articulates the scale and pace required to meet the needs of the changing population of Barnet. It also builds on 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 journey for Mr Dale through a co-ordinated care system and how this improves his outcomes.

The Model of integrated care in Barnet



The key components of the integrated service are as follows:

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

1. Developing greater self–management

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

A particular focus for Barnet to consider is how best to invest and improve on self- management and Health and Wellbeing as areas that are currently under developed in the area. In this tier of the model the focus is on "self-managed ailments" through to "long term conditions."

Self- management cuts across all tiers of the model and there are clear overlaps and dependencies with prevention and earlier intervention. The aim is always to promote and maintain independence which applies as much to supporting people to return home from a period in residential or acute care as it does to community based services.

Current direction/ development in this area

The focus for self-management and prevention activities in this model should be on 3 key priority areas in recognition that there needs to be a staged approach to whole system change. Other priorities are likely to come on stream as the model develops and integration of self care and health well-being is broadened.

The proposed priorities are **diabetes management** (drawing on the NCL project evidence), **early identification and management of dementia** and **falls prevention**. This reflects the need to test assumptions about the scale of implementation across a wide range of providers and the public, the reach and impact of initiatives / interventions and return on investment where there is currently a limited evidence base. There is good evidence that programmes that support people to manage diabetes (using the DESMOND education programme) will have a positive impact. Other areas that this layer should explore over the course of the development of this model (on top of the two other priority areas of fall prevention and early identification of dementia) include cardiac and stroke rehabilitation, pain management, respiratory conditions, and depression (based on feedback gathered from Barnet CCG/ evidence from the JSNA).

The Design Group considered that a population based, coordinated approach to support the self-management and targeted prevention agenda was required. This could be achieved through a consortium approach involving, people who use services and their carers, community groups, voluntary sector and health and social care agencies based on the principle that the patient is expert in their own condition. This approach would include introducing measures to incentivise the behavioural and cultural changes required e. g through contracts or specific outcomes based goal setting. NB. Consideration needs to be given to the most appropriate structure for Barnet to integrate the existing prevention and care navigation roles into one joint system

The 'Year of Care' model states that the following are necessary for a patient to be informed and engaged: awareness of processes and options; being supported emotionally and psychologically; access to their own records; goal setting; being sent test results prior to consultations; and

structured education / information. This tier of the model will consider these principles in the design of each intervention.

The key components of the model to deliver increased self-management can be summarised as follows:

- Patient education and awareness raising on how to manage conditions, e.g. generic and specific expert patient programmes/ disease specific education programmes such as DESMOND/DAPHNE
- Development of a community based motivational coaching offer to encourage and assist behaviour change
- Expanding the self-management offer to at risk groups. Developing specialist strategies aligned to specific population needs e.g. diabetes, falls prevention, dementia awareness
- Development of an enhanced risk stratification tool to search GP registers and identify individuals at risk. This will improve anticipatory care planning
- Enhancing the professional knowledge about prevention, 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
- Strengthening the role of community pharmacy and other professionals/agencies to deliver the self-management offer
- Increasing the use of technology to support self-care in the community such as telecare and telehealth.
- Providing a range of enhanced support to carers including carer education programmes that focus on training carers to know what to spot in terms of patient symptoms / trigger points and how to escalate these issues.
- Development of tailored interventions which substantially increase the ability of carers to care, thereby supporting people to remain in their own homes rather than go into residential or acute care
- Development of housing options and Disabled Facilities Grants to enable people to plan ahead
- Development of the accessible psychological support provided in the community, including increased investment in CBT and IAPT capacity.
- Evidence-based schemes run through pharmacies, such as the Minor Ailment Scheme/ Healthy Living Pharmacy.

How will this be delivered?

A multi-agency group of social workers, staff from the voluntary sector and public health, patients, GPs, nurses, pharmacists, users and carers and members of the core prevention team should come together to make use of pooled resources and develop a shared self-management strategic plan and self-care pathway.

Education and awareness raising about how best to manage conditions, e.g. expert patient programmes (EPP). The beginners (generic) EPP programme should be rolled out widely to support people to manage their long-term conditions. This programme will help to up-skill people and improve their health literacy so that they become more confident about looking after their own health. The prevention coordination approach would link into the Expert Patient's Programme (EPP) run by patients who will also be able to signpost people into other local support networks. Disease specific patient education programmes should also be rolled out widely. An example would be

rolling out diabetes management programmes e. g DESMOND which has been demonstrated to have a significant impact.
Long-term condition champions and community coaches could be identified and developed in the community, building on the model being taken forward in Harrow. Barnet already has a successful community coaches programme that focuses on early intervention activities with children and young people. If this model was replicated to support older adults within this model, these champions/ coaches would focus on motivating people with long-term conditions to make positive lifestyle choices and support them in the community to manage their own care

Enhancing the professional knowledge about prevention, self-management tools and what is available in order to reduce dependency on GPs and divert to more self-management routes. Investment will focus on working collaboratively with primary care health professionals to change the current culture of dependence on the GP as the first point of call; empowering patients to be more confident to look after themselves and access community services such as pharmacies as places of support and increasing the use of assistive technology. GPs and other primary care professionals need to receive training on how to promote self-care. This training should seek to encourage GPs to think differently about when they prescribe unnecessarily for minor ailments, and to better understand what can be offered over the counter that might work in place of a prescription. Health professionals should be supported in a coordinated way to give the same messages, for example, about antibiotics. Linked to this, increasing the use of 'medicines use reviews' in pharmacies will ensure that GP's use of prescriptions for this cohort is operating effectively. Focus should also extend to other staff working within GP practices to ensure that practice nurses, health care assistants and receptionists are informed and feel confident to implement the required change of approach. This also applies to social care teams to ensure consistency of advice across the system. Community Pharmacy engagement will be required to bring them into the network in a more structured manner to assure delivery.

Mainstreaming the use of technology to support self-care in the community: Mainstreaming the use of assistive technologies, community equipment and aids and adaptations supported by increased investment in this area will be central to improving the self-management offer in Barnet. Coordinated promotion of remote monitoring of conditions such as asthma and hypertension should be considered. Assistive technology if promoted and rolled-out at scale and pace within the model could also support medicines adherence and smoking cessation.

The national work on enhancing **the role of the community pharmacy** to support people manage their own conditions is also relevant:

- The Minor Ailment Scheme currently being piloted in Barnet where patients are given a passport to support them in self-managing their minor ailment without needing to visit the GP, could be rolled out pan-London, under direction from NHS England in 2014.
- Stakeholders working together to develop self-management could consider opportunities to develop and tailor the "Healthy Living Pharmacy" (HLP) approach, based on an in-depth understanding of the implementation of the programme across the country. Evidence of the HLP success in other areas would be required, however, before considering this model.

TIER 1 - Key investment priorities in this tier, focusing on 3 priority areas of diabetes, dementia and falls to test the end to end integrated model from population to targeted prevention to self - management to treatment / support interventions:

- *Education and awareness raising programmes about how best to manage conditions, notably the generic EPP programme and diabetes management education*
- *Development of a coordinated prevention approach and associated long term condition champions.*
- *Enhanced use of assistive technology to support people manage their own conditions*
- *Investment in professional training on how to promote self-care to patients*

2. Promoting Health and building the capacity of individuals and communities

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 focus on preventing the onset of ill health, and improving people's social well-being. This layer includes activities within the community that build up older people's personal and physical resilience, develop and maintain their social networks, increase their skills and employment opportunities, encourage healthy lifestyles and lend support to both families and friends who provide informal care and carers who provide either formal or informal care.
It will support increased community capacity to build resilience through close working with volunteer support networks, local community organisations that offer assistance, and non-traditional sources of health and wellbeing support such as workplaces and local businesses.

This tier covers:

- the core preventative services delivered by the Public Health team such as initiatives to e.g. increasing physical activity and healthy eating, offering Health Checks, and ensuring that older people do not experience excess cold in their homes;
- the Council and the CCG's "universal offer" to older people through the preventative services they commission through the voluntary sector;
- The Council's carer support services.

As mentioned in Tier 1, the Design Group considered that a population based, coordinated approach to support the self-management and targeted prevention agenda was required.

Current direction/ developments relevant to this tier

The key components of the model are as follows:

- Developing a central message that "wellbeing is everyone's business" across the Borough. This should highlight the importance of promoting wellbeing in leisure provision, workplaces, housing, environmental planning etc., and will involve local teams working together more closely to tackle the wider determinants of health.

- 'Making every contact count' – through targeted work with GPs and a range of professions/agencies to raised their awareness of the catalogue of services available to help ensure that they refer their patients to appropriate social support services and networks.
- Lifestyle support and targeted interventions commissioned by the Public Health team, and developed in partnership with the voluntary, community and commercial sectors, to help older people make positive lifestyle choices that impact on their health and well-being, and prevent/ delay the onset or progression of ill health (i.e. the promotion of physical activity in older people, promotion of healthy eating and weight management, alcohol awareness and education, and smoking cessation services)
- Implementation of the Ageing Well Programme, including greater investment in volunteering to support people in the community, the promotion of healthy lifestyle choices for older people, building up community resilience through TimeBanks, focusing on thermal efficiency for older people, and reducing social isolation. This will be delivered closely alongside the Council and NHS's universal prevention offer to Barnet's older population
- Market development and strategic partnership building in the voluntary and commercial sectors to support development and delivery of targeted interventions seeking to improve the health and wellbeing of the older population and their carers in Barnet
- An accessible centralised information, advice and signposting service covering the whole range of services available to increase prevention and self-care among the entire cohort group
- Development of a comprehensive support offer for Carers in the Borough which applies to all tiers of the model.

How will this be delivered?

Building the capacity of communities. One of the key objectives of the capacity building in this tier of the model is to ensure there is stronger infrastructure in place to promote health and wellbeing across Barnet's communities. This aims to unite different commercial, public and voluntary organisations in partnership, make best use of existing community assets whilst also considering back-office efficiencies that could be made across the sector. There should be consideration given as to whether to build on Barnet Council's innovation bank and social care innovation grants run over the last two years. Capacity building will involve strengthening the links between volunteering and the enhanced Ageing Well programme (see below), alongside the Community Infrastructure Organisation, as well as investing in and building the volunteer base to support delivery of the Council, NHS, public health, and voluntary sector prevention and wellbeing offer.

Developing an accessible centralised information, advice and signposting service, including:

- Identifying individuals within local communities who can signpost people into services and motivate them to engage with their communities, training them and expanding the expert base available to do help people to live independently building on Barnet's Ageing Well programme and Community Coaches scheme
- Supporting signposting to services in this tier, a standardised menu of wellbeing service options should be developed, signed up to by professionals, which can be accessed by the older person via collaborative care planning with service providers. A similar menu of service options should be designed for carers.
- Developing a single authoritative source of information and advice so that there is one place that brings together: information about existing service provision that prevents ill health and loss of independence; information about the funding streams for these services; information about the people within the integrated care model and the services they are using over time; research, evidence and evaluation of good practice.

- This will be supported by the development of Trusted Information Access Points in the community in High Street locations (using libraries, community pharmacies, supermarkets, Leisure centres, Housing offices,) that provide information on how to keep well and independent in the Borough. These access points will also offer training to the cohort groups about using ICT to stay connected to others and to access information. They could be referred to as "wellbeing kiosks", and could be enhanced prevention tools such a blood pressures monitors.

TIER 2 - Key priority areas for investment, recognising that the model for the Health and Wellbeing tier is underdeveloped and the priorities for development in tier 2 are interdependent with those set out in tier 1:

- *Investment in health promotion and targeted prevention activities*
- *Continued investment in the Ageing Well programme*
- *Investment into the development of volunteers*
- *Strategic partnership building with the voluntary, community and commercial sectors to support the design and delivery of health and wellbeing services in the Borough*
- *Implementation of information and advice services within the community*

In future, consideration could be given to the creation of **"Well-Being Plus" sessions**, that bring agencies together in community spaces to provide a host of wellbeing services, including information and advice, that can result in the development of "information prescriptions"; health checks; environmental health; falls prevention; self-management techniques; GP and community nurse outreach; befriending services; support and networking opportunities for carers; attendance by Care Navigators from the MDT; practical support services; attendance by Healthwatch as the main "consumer champion" in the Borough. Before decision is taken as to whether to proceed with this type of model, work should be completed to understand the evidence base, ensure the creation of these sessions will not result in duplication of other activities, and also ensure that resources are deployed as efficiently as possible to fund them.

3. A ' No Wrong Door' approach to accessing the right support

What will this achieve?

The vision for this tier of the model is to ensure that there is a single common access process, assessment and urgent care response capability. Service users, patients and carers should be able to access multi-disciplinary triage as part of a single access process operating across multiple locations. There should be a common risk assessment framework which links to universal access points. This also ensures that anyone being directed to support services is directed to the appropriate resource according to need hence making best use of professional time and input. Therefore, knowledge needs to be disseminated across the system about how the model can support individuals and their carers.

Current direction/ developments relevant to this tier include:

Community Point of Access: The Barnet Community Point of Access Model is planned as a central hub for in-scope adult (55+) referrals, appointments and queries for community health and reablement. Referrals will be accepted, logged and triaged into two streams, urgent and routine.

Urgent referrals will be sent directly to the Rapid Care service for clinical triage and a clinical decision will be taken to determine the correct pathway and course of action. Routine referrals will be clinically triaged and be sent to the locality (including LTC) or specialist teams to determine clinical needs. This will build over time to incorporate other elements such as voluntary services which link with overall model e.g. Home from Hospital services.
The current 'front door' for London Borough of Barnet (Social Care Direct) will continue as an access point for a wider range of social care services and where necessary, will refer on to the Locality Teams to provide assessment and care planning.

Risk Stratification: Central to this will be embedding the Risk Stratification Tool as part of the Older People's Integrated Care project. This is aimed at identifying frail elderly people at risk of needing more intensive support care; and to develop a proactive and anticipatory care plan that will enable people to stay out of hospital and residential care longer and continue living independently.

Older People Integrated Care Locality Teams: To introduce three locality teams to incorporate community nursing care navigators, social care, intermediate care, mental health, generic LTC nurses and end of life care. These support people at home and in care homes, and offer a range of services as part of agreed pathways to meet the needs of people registered with GP practices within the locality. Care navigators will represent the foundation of a planned approach to the care of the elderly and frail population by ensuring a coordinated response following risk stratification.
In order to support a Locality team the Multi-Disciplinary Team meeting approach (comprising expert support for older people with complex issues) has been established (see Tier 4) so that higher risk individuals, identified through risk stratification and managed by care navigators can be referred for detailed review and input from the wider group of health professionals.

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. This is a key enabler for the wider integration agenda and was a key issue raised during the phase 2 stakeholder engagement.

Key components of the model in tier 3 are:

- 'No wrong door' principle to improving access
- Community point of access development
- Risk Stratification
- Development of Integrated Locality Teams as one system to plan and deliver care closer to home.
- Provide carers with support to help them cope with patient needs and manage care at home.
- Building stronger links between GPs, Community and Acute care and Locality Teams.
- ICT architecture development which supports information sharing, e.g. single shared record

How will this be delivered?

Risk Stratification: This ensures people in the system have a clear and consistent view of those individuals with complex needs or at risk of becoming unwell. It allows for development of care plans and supportive approaches, with clear links to escalation routes, to prevent deterioration and

to trigger rapid care when needed. It also helps to ensure standards remain consistently high and patients, partners and staff know who to call in different situations. This includes;

- Use of risk stratification tool
- Effective multi-disciplinary triage at a locality level to divert patients /users to the most appropriate service.
- Support from a robust and comprehensive Rapid Care service.
- Developing a shared risk assessment and set of shared escalation protocols to ensure a common understanding and consistency across the Health and Social Care system.
- Identify individuals at risk in accordance with an agreed framework using GP registers and/or risk stratification tools. This could include long term conditions, mental health issues and isolation measures. This would help the Multi-Disciplinary Teams use the intelligence to develop a set of targeted services and understand where and how to direct them.

Developing Integrated Locality Teams: Key features of the model include:

- Co-location which facilitates closer communication and informal contact, leading to greater mutual understanding and learning across professional boundaries.
- Named professionals providing co-ordinated continuity of care.
- Development of the 'trusted assessor' role across professionals and agencies with an agreed process and framework
- Ensuring rapid access to services are accessible and robust to prevent admission, facilitate discharge or manage escalation/or potential escalation of needs in the community 7 days per week
- Establishing relationships with GP practices for proactive management of cases and improving anticipatory care systems.
- Provision of integrated social, clinical and therapeutic interventions.
- Signposting to services where lower level needs are identified.
- Supporting people to move back to primary care/self-management when a crisis is over
- Supporting carers, families and helping people to maintain their social networks

Build stronger links between GPs, Community and Acute care and Locality Teams through:

- Integration of the GP role into the multi-disciplinary approach which could be achieved through joint regular meetings with the locality team.
- Developing the links between community, primary and acute nursing to enhance and develop an integrated approach to assessment and management of patients in the community to ensure consistency of approach.
- Links to the voluntary and community sector to support self-management

Further develop the ICT architecture which supports both information sharing and integrated processes including shared records and assessment tools

TIER 3 - Key Priorities for Investment

- *Shared Risk Stratification Approach.*
- *Integrated Locality Teams*
- *Greater integration of GP's, Primary, Acute and Community nursing with Social Care.*

4. Investing In Community Intensive Support

What will be achieved?

Community intensive support services increase independence and promote the management of people with acute and complex needs within their community. A weekly MDT meeting will provide a more intensive approach to managing complex cases by planning care across multiple providers. This will link to Integrated Locality Teams, particularly care navigators, to ensure that they can move resources around flexibly to avoid crises and maintain people in their homes or in other care settings within the community, 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.

Current direction/ developments relevant to this tier include:

Multi- Disciplinary Team Meetings: This approach, comprising expert support for older people with complex issues, will allow the higher risk individuals, identified through risk stratification or other mechanisms. 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 support across health, social care and voluntary sectors, with a focus on care-planning will be the key to success. Current arrangements will be reviewed over time to ensure that the MDT team meetings approach fits within the locality team model and remains coherent in supporting clinical need. The care navigators will support the implementation of actions within the care plans. **Rapid Care service**: the existing service is currently expanding to increase capacity and clinical capability to manage more complex care. This includes developing a community based ambulatory assessment, diagnostic and treatment approach to prevent A&E admission. 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.

Key components of the model include:

- Multi-disciplinary team meetings that can vary support provided to individuals quickly, supporting them to stay in their own home. Rapid Care
- Enablement, Intermediate and Respite Care.
- Development of enabling technology such as tele health and telecare
- Supporting carers in their role.

How will this be delivered?

Multi-Disciplinary Team Meetings: The Multi-Disciplinary meeting approach for more complex needs where there is a need to involve more specialist support or treatment. It feeds from risk stratification, locality based Integrated Teams and others to implement and manage a care plan approach delivered by partners and co-ordinated by the care navigators. They can vary support provided to individuals quickly to support people to stay in their own home

The care plan will be defined to meet patient need. It will incorporate a follow-up approach and when applicable, a clear discharge pathway to specialist services, primary care, social care or third sector. This will enable the locality integrated teams to maintain demand and capacity; and enable

patients to remain with their GP as lead accountable professional while retaining support from then locality teams.
The output from the meeting does not replace other formal health and social care provision and would not become an on-going source of assessment and support but may see an individual and their family/carer, identified as high risk, once to four times a year. The meeting will involve a range of practitioners including a geriatrician (acute and mental health), GP, social work, integrated locality team and others (e.g. falls specialist).

Key components of the model assuming this is progressed as one integrated system:

Named professionals to assure delivery of the community intensive support
- Develop and/or deliver care in accordance with the patients single care plan
- Engage pro-actively and collaboratively with GP practices for management of cases and ongoing care
- Effective clinical input into integrated multi-disciplinary teams including targeted communication of service capabilities to key decision makers, e.g. hospital based clinicians.
- Agreed pathways and protocols with secondary care and others.

Rapid Care services provide intense support to those experiencing a crisis including: Rapid access to support to prevent hospital admission, facilitate discharge or manage escalation, or potential escalation of needs in the community. Following an urgent event where ongoing and short term support, appropriate support will be put in place. This could include using telecare or telehealth, it could be accessing some of the community groups or voluntary sector services available in the local area. In some cases, it may require some more intensive support like home care or a residential care home. People may need to start thinking about end of life care.

In addition to the Rapid Care service, the Design Group suggested that new initiatives could be developed to offer greater levels of support to those in crisis. These would ensure people are supported and maintained at home for as long as possible and avoid admissions. These might include:

- A coordinated night sitting service as part of the rapid care offer or a coordinated care package to reduce admissions to residential and acute care.
- 'Trial at home' - having support or care outside of hospital, including an enhanced enablement package and contingency planning that is clearly articulated before the person returns to the home.

Enablement, Intermediate and Respite Care, Extra Care Housing and Adaptations

- Enablement programmes will continue to support people at home for as long as possible. Targeted specialist services for specific needs - e.g. intermediate care, COPD Service, Heart Failure, falls, stroke, dementia and telecare / telehealth.
- Provision of home adaptations, Disabled Facilities Grants to support people to remain at home
- Ensuring supply of appropriate housing to enable people to remain in the community including extra care and support services
- Establish the clear principle that people are discharged back to where they were prior to admission unless there are exceptional circumstances
- Social care respite to be available for people with complex needs and to support their carers.
- Education of acute sector professionals about community options and the role of social care in assessing for these

- Rehab/intermediate care in the home

Integrated services will use a single Integrated Case Management approach to access community services, specialist pathways or to identify the right low level interventions in a planned, coordinated way.

Development of enabling technology : The Integrated locality teams use shared systems, e.g. joint assessments, case conferences, etc. to work together. Barnet has been developing ICT solutions to enable integrated care to be delivered to patients, including:

- Integrated patient care planning – to support joint planning and can be, shared and monitored collectively.
- Patient records sharing – practitioners from multiple settings are able to view patient information.

TIER 4 - Key priorities for investment:

- *Development of the Locality Integrated Teams and MDT approach into one integrated system*
- *Expansion of the Rapid Care offer to include short term crisis care at home and 'trials' to facilitate more effective rehabilitation.*
- *Development of enablement options at earlier stages in service user, patient pathways*

5. Reducing the demand for hospital based, residential and nursing home care

What will this achieve?

Residential and non-acute bed hospital care will sit within the integrated model. Acute hospital care sits outside this model. 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. In total, these homes provide 3,068 beds for a range of older people and younger people with disabilities. The council funds 1147 (37%) places within a wide variety of homes and 187 (6%) are funded through Continuing Health Care. Projections show that the number of residential placements within Barnet will increase by around 30% to over 2,800 placements by 2020. This means that the pressure on care homes within the borough is set to increase for the foreseeable future. There is also a higher than average number of people referred by GP's to acute care.

The focus of this 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.

Current direction/ developments 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
- Development of extra care housing

The key components of the model for residential and acute care:

- Invest in more step up and step down intermediate care with access via rapid care teams to reduce the need for or length of stay in hospital. It is recognised that use of step up and step down needs to be carefully managed to reduce unnecessary dependency on social care
- Develop clearer protocols so that residential care staff are clear about when to manage and /or escalate concerns.
- Implement widespread up-skilling of care home staff to reduce the need to admit to hospital and address the current high rate of admission
- 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
- Ensure London Ambulance Service alternative pathways link to care homes

How will this be delivered?

Hospital non-acute beds: The key components of the model for acute services include:

- Use of ambulatory care pathways in community and hospital settings, 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 at 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.
- Clear linkages between the PACE and TREAT teams within acute settings and the integrated locality teams to support early discharge with care
- 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, replace use of A&E.
- Development and use of alternative pathways for London Ambulance Service calls

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.

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

TIER 5 - Key priorities for investment:

The focus of this tier of the model over time will be the disinvestment / decommissioning of acute beds and residential services as a result of more effective demand reduction and management. In addition to the existing investment in improving quality in care homes, the priorities for this programme will include:

- *Better discharge planning to ensure services are in place to support step down.*
- *Use of hospital networks to provide improved access to centres of excellence.*
- *Partnership with acute providers to optimise use of specialist resources and facilities.*
- *Development of clear, joint referral and escalation protocols.*
- *Up skilling of care home staff, including enhancing medical skills to reduce referrals to acute services.*

How will we know that the 5 tiered integrated model is working?

The following is a suggested set of indicators that could be developed with stakeholders in the Implementation Planning phase as a basis for the programme's KPIs.

The level of reported Social care-related quality of life of frail elderly people
The proportion of frail elderly people who use services and their carers who find it easy to find and understand information about the support available
The proportion of frail elderly and those with LTCs people and their carers who reported they had as much social contact as they would like
Health related reported quality of life for people over 55 with LTCs
Carer reported quality of life
The proportion of frail older people and those over 55 with LTCs feeling supported to manage their condition
The proportion of frail older people who report having told their story once using a single point of access to the support or care they needed
The proportion of frail older people and those with LTCs who report having control over the services they receive
The proportion of carers who report they have been included or consulted in discussions about the person they care for
The proportion of frail older people and those with LTCs who use services and feel safe /say those services have made them feel safe and secure
Years of life lost from causes considered amenable to healthcare / life expectancy at 75
Number of permanent admissions to residential and nursing care homes, per 1000 population
The number of older people and people with LTCs consulting their GPs for minor ailments
The proportion of stroke patients reporting an improvement in activity / lifestyle
The proportion of older people who were still at home 91 days after discharge from hospital into enablement/rehabilitation services
Number of A&E attendances of frail elderly people
in the number of emergency admissions of frail older people for acute conditions that should not usually require hospital admission
Number of bed days associated with emergency admissions
Number of emergency readmissions within 30 days of discharge from hospital
Reported satisfaction in the quality of care experienced by residents in care homes
Bereaved carers' views of the quality of care in last three months of life

The model has also drawn from examples of other UK and international innovative practice as set out in the Appendices section of this report.

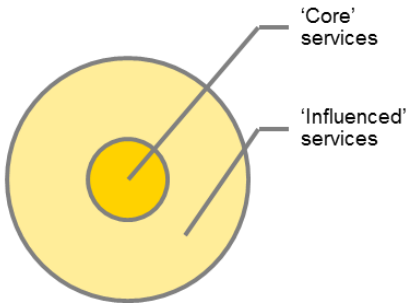
What difference will the new model make to Mr Dale and other residents of Barnet?

Mr Colin Dale is 82 , lives at home on his own and has diabetes	Mr Dale accesses lunch clubs provided at his local community centre. As a result of a health awareness campaign, he consulted his GP and was diagnosed as diabetic. He now manages his condition effectively through a programme of self medication and has become increasingly careful about his diet. Previously, he would have been less aware of his symptoms which may have resulted in him requiring acute medical care.
Ms Nazia Asmar is 61. She had a stroke six months ago but has made a quick recovery to return home	Ms Asmar has a single care plan and was supported by her care coordinator to ensure she had the necessary supports to rapidly return home from hospital following a trial. She has been provided with aids and adaptation in her home which mean that she can move around safely and remain independent. Previously, she would have received separate social care and health assessments and dealt with different professionals in the planning of her care. She is also likely to have required on going support in her home.
Mrs Amy Cheung is 75, she has dementia and diabetes and lives on her own. Amy has a fall in her home and uses her telecare alarm to call for help	Mrs Cheung would have previously been admitted to hospital because the services that responded would have been unable to cope with a person with dementia. The triage system in the new model ensure the right person, with the right skills can do an assessment and organise the urgent provision needed. Some support is provided to get Mrs Cheung well again after her fall and an assessment is done on the house to see if things need to change to prevent this happening again. This means she has been able to be treated in her own home and avoid experiencing unnecessary and potentially stressful hospital admission
Mr Joe Cohen is 85 and lives in a care home. He gets dizzy quite often and has been admitted to hospital a few times due to dehydration	Mr Cohen has lived in a care home for about six months, he is in and out of hospital as a result of health difficulties. In the new model there will be much more regular health checks provided into care home to ensure that people are on appropriate medicine, getting the right nutrition and hydration and are comfortable moving around their environment without falling over. The service will also work with care home staff to develop protocols for treatment of ill health, getting the right information for medics to review and have an agreed plan with the individual and family for end of life care.

6. Financial and Investment Case

Current financial context

The services scope of the programme covers all services that are provided to the frail elderly and those over 55 suffering from one or more long term conditions. Some services will be fully integrated and others reflect the areas of spend that the programme needs to influence as illustrated below.



The definition of the core services to be integrated is all services that are provided in the community, as well as non-acute bed based care services for the in scope groups. These services will be redesigned as part of integration, and there are likely to be a conscious investment decision. For example, this grouping could include residential care, community healthcare, homecare, and all preventative and self-management services.

The total value of core services in the scope of the programme is £77.6m, of which 46% is LBB spend and 54% is BCCG spend – refer to table below for additional detail.

The 'influenced' services around the outside are services that are not intended to be redesigned, but which may see a movement in activity (and hence cost) as a result of the programme. It is expected that the savings would be predominantly realised from reduced activity in these services as a result of the programme. Services in this grouping are all acute services, and inpatient mental health services.

The total value of services that will be influenced by the programme is £55.8m, of which 1% is LBB spend and 99% is BCCG spend.

The table below shows the resources in scope for this programme (split by 'core' and 'influenced' services and as a combined total). The total resource envelope is £133m, of which over 61% is spent on acute and residential care services, with less than 3% being spent on self-management and health and wellbeing services. This shows that resource in the system not sufficiently weighted towards preventative services.

	Level 1	Level 2	Level 3	Level 4	Level 5	Total
Core - LBB	£100,000	£3,401,471	£3,744,002	£14,394,221	£14,132,946	£35,772,640
Core - BCCG	£272,000	£27,237	£502,500	£28,888,927	£12,440,000	£42,130,664
Influenced - LBB	£0	£0	£0	£344,401	£0	£344,401

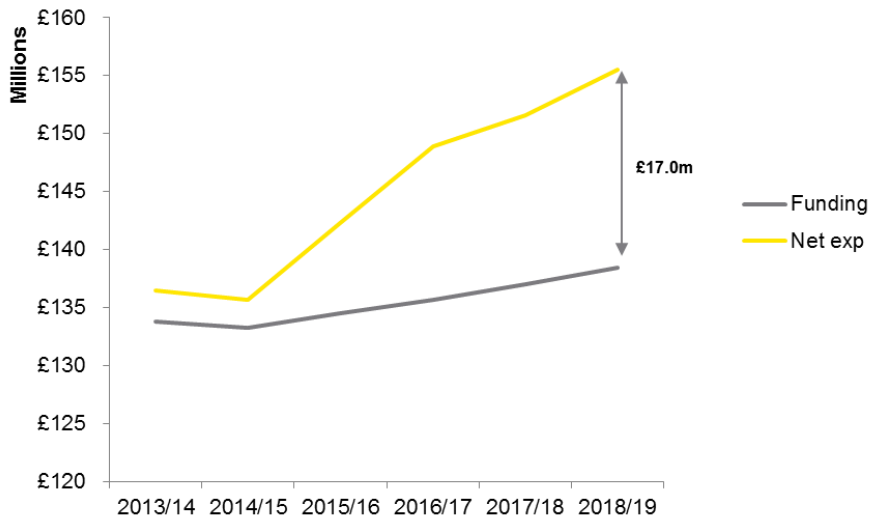
Influenced - BCCG	£0	£0	£0	£63,538	£58,205,929	£58,269,467
Total	**£372,000**	**£3,428,708**	**£4,246,502**	**£43,691,087**	**£84,778,875**	**£136,517,172**
%	0.27%	2.51%	3.11%	32.00%	62.10%	

The data underpinning this table has been validated with stakeholders from LBB and BCCG, at a working session of the Steering Group in December 2013.

What is the current financial gap?
The following table and graph show the combined effect of the reduction in funding and projected increase in expenditure, to illustrate the possible financial gap if no action is taken until 2018/19:

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

Further detail of income and expenditure projections can be found in Appendix 5



The assumptions applied to the base case are listed below. The data used in devising the resource and cost projections in the above table have been taken from LBB's MTFP and BCCG's financial plan submission in February 2014.

Financial:

- BCCG's revenue resource limit (RRL) has been assumed to increase by between 2.98-4.44%, as indicated in the financial plan submission. Note that the RRL increase of 4.44% in 2015/16 is due to a one-off transfer of funding from NHS England to BCCG for the Better Care Fund. RRL has been pro-rated to the services in scope

- Acute costs have been assumed to decrease by 2.42% in 2014/15, followed by subsequent annual increases of between 0.86%-2.69%. This is per the financial plan submission
- Community services costs have been assumed to increase annually, by between 2.01%-14.44%, as indicated in the financial plan submission
- Mental health service costs have been assumed to increase by between 2.01%-3.96% in each year apart from 2015/16, when a decrease of 0.68% is forecast
- CHC provision and assessment costs are assumed to remain almost constant in 2014/15 and 2015/16, followed by increases of between 2.61%-2.74%
- LBB funding is assumed to reduce by 10% in 2014/15 and 2015/16, and 7% thereafter. Further expenditure reduction assumptions have been taken from LBB's MTP
- Changes in expenditure at a service grouping level (e.g. acute) have been assumed to apply equally across all services in scope

Demographics:

- People aged 55+ with a long term condition and the frail elderly account for a large proportion of A&E admissions and are main users of acute and residential care services
- Datasets from POPPI used to indicate future increase of approximately 2.5% per annum across the cohort of individuals in the scope of this programme

Savings plans/QIPP

- The table reflects the impact of any existing QIPP and savings plans from 2014/15 onward, because the assumptions used above are taken from BCCG's summary financial plan, which factors in QIPP effects on an annual basis. This includes the following QIPP programmes:

Scheme	2014/15	2015/16
Acute Productivity- First to Follow Up Metrics	£1,112,000	£0
Acute Productivity C2C Metrics	£538,000	£639,000
Acute Productivity - Day Case to OP Shift	£628,000	£412,000
Medicines Optimisation (Prescribing)	£500,000	£500,000
Frail and Elderly (Including A&E Short Stay)	£1,504,000	£550,000
Pathway Redesign (including Ambulatory Care)	£423,000	£690,000
Out- Patients attendances- Referral Management First	£1,470,000	£280,000
Demand Management	£2,585,000	£813,000

- Partners will need to assess the impact of the resource shifts outlined in this document against savings required by QIPP, as well as the activity shift that is required in the BCF. In addition, the QIPP and BCF requirements will affect services that are outside the scope of this business case
- The 2013/14 gap reflects the relevant proportion of the CCG's budget deficit that is being met from the 2% headroom

What are the agreed scenarios to reduce costs?

Approach

The scenario modelling approach is intended to provide a high level view of the scale of ambition and change required to achieve sustainability. The majority of the cost savings will be delivered through targeted integration projects, where relevant services (referred to as 'core' services) can be jointly commissioned based on commonalities or as part of an integrated care pathway. Once the current spend is fully understood, the model will be able to show benefit opportunities by shifting activity and costs away from acute services into either preventative services or the community.

The financial modelling has considered what level of reduction is needed in these services to bring the system back into financial balance and to release sufficient funds to invest in levels 1-4 of the conceptual model.

The scenarios modelled are reductions in acute and placement activity of 2 and 3% per annum for the five year period, based on feedback from the Steering Group as to what level of activity shift would be achievable over this timescale.

The scenarios

Scenario 1
Cost and savings profile of services within reducing funding applying a 2% reduction per annum

Scenario modelled

- Reduced residential placements and acute activity (including outpatients, non-elective, A&E and elective) by 2% per annum for five years

Impact on resource shift

- The 2% per annum reduction reduces the gap, although it does not provide a surplus for reinvestment during the five year period

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

Scenario 2

Cost and savings profile of services within reducing funding applying a 3% reduction per annum

Scenario modelled

- Reduced residential placements and acute activity (including outpatients, non-elective, A&E and elective) by 3% per annum for five years

Impact on resource shift

- The 3% per annum reduction reduces the gap faster than a 2% reduction in acute and placement activity

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

The benefits from this shift in activity will be shared by both organisations (refer to the Commercial Case for further detail as to how this arrangement may work). In particular, since LBB would not be starting with an initial deficit, and the shift in activity would produce benefits in year 1 of £0.5m across both organisations, there would be the opportunity to invest in preventative services. LBB has set aside £310k of funding in 2014/15 for preventative services, comprising of £60k for Ageing Well projects, and £250k for enhanced self-management services.

Additionally, LBB will need to shift resource away from placements in order to meet the financial requirements of the Care Bill, which are estimated to be £5-10m per annum for the cohort in scope. Given the cost reduction modelled through scenario 2, it is likely that LBB would need to find an additional £2-8m per annum in order to manage their financial pressures resulting from the Care Bill.

The activity shift as presented will provide some of the investment in schemes highlighted in Barnet's BCF submission. The total benefit from the 3% per annum activity shift outlined above in 2014/15 and 2015/16 is £5.8m, which can be used to provide investment towards initiatives that are outlined in the BCF. These include:

- New integrated care model – investment of £2.8m in 2015/16
- Multi-disciplinary case planning and care navigation - £0.8m in 2015/16
- Rapid care - £0.9m in 2015/16
- Service redesign for falls, stroke, dementia and palliative care – £3.0m in 2015/16

There are additional schemes (such as £10.3m for specialist community long term conditions services) noted in the BCF, and investment in these could be derived from extending the 3% per annum shift in acute activity beyond the services within the scope of this programme, to encompass all acute services.

Investment priorities

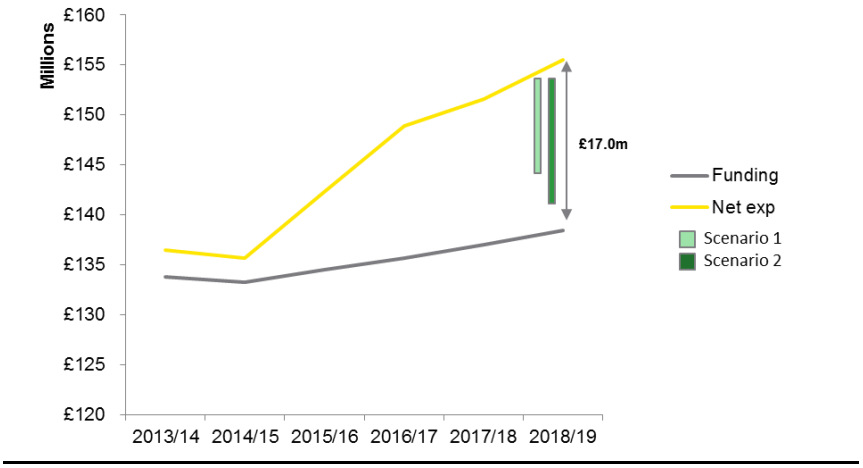
- Creation of locality based prevention teams including healthcare co-ordinators to support the self-management and wellbeing agenda. These teams will engage with the cohort in preventing illness and maintaining wellbeing through a healthy lifestyle, and will use social support to prevent escalation
- Design and implementation of a risk stratification framework that uses GPs' registers
- Development of an information about the range of services available and integrated model
- Integration of GPs and other health professionals into community-based multi-disciplinary teams
- A rapid response team, delivered through a single point of access. The team will triage, and deliver appropriate responses to contacts. The rapid response team would also work in step-up and step-down intermediate care facilities

- Residential healthcare service – this would be a GP led service supporting care homes across Barnet, delivering more proactive care and up-skilling care home staff to have better health input.

The examples above align to the Better Care Fund application as they support delivery of:

- Protecting social care services – developing ways of joining up care will help to ensure that those who need support are still able to access it, despite the substantial financial pressures
- Seven day services to support discharge – the investment in integrated multi-disciplinary teams should include the provision of additional social care in hospitals to support discharge, as this has been shown to reduce delayed discharge statistics
- Single joint assessments and accountable lead professionals – this can be achieved through the investment in the integrated network of multi-disciplinary teams
- Savings through reduced acute activity

Conclusion



The graph above shows the two scenarios modelled against the projected budget. Both scenarios will balance the budget over a five year period, but a 3% shift in activity per annum provides a greater pool for investment over the life of the programme, and is hence the desired scenario. Although this will be challenging to achieve, the return on investment from increasing community support and health and wellbeing initiatives make it possible. It is also a requirement of the Better Care Fund to enact this shift in activity, and will provide a portion of the investment needed for schemes, such as a new integrated care model, that are outlined within Barnet's BCF submission.

Evidence to support the assertion that increased investment in community and preventative services can reduce acute activity can be found in the Appendices section of this report.

Evidence for activity shift:

- Promoting self-management – the North West London Integrated Care pilot saw a 25% reduction in bed days and 45% reduction in admissions as a result of improved disease management of those with LTCs
- DH evidence indicates that intelligent patient programmes can decrease A&E attendance by 16% and outpatient visits by 10%
- Integrated locality teams, formed as part of the North West London integrated care pilot, led to a reduction in non-elective admissions of 6.6%
- Proactive case management, using risk modelling, reduced A&E attendance amongst those being managed by 40% in Oxfordshire
- Rapid response triaging gave net savings of £3.6m per annum in Bristol
- Integrated geriatrician service in East Lothian avoided acute admission for 77% of patients referred in the first six months

7. Commercial Options Appraisal

The current provider landscape for services in scope

London Borough of Barnet (LBB):
Directly provided:

- Assessment and care planning
- Commissioning function
- Occupational therapists
- Social workers
- Public health team

Externally commissioned:

- Public health services, including smoking cessation, health checks, ageing well and Winter Well, are commissioned from a number of different public and third sector partners
- Health and Wellbeing Services: Mixture of 3rd sector providers
- Homecare: Cost and volume contract with three providers (corresponding to the three localities, co- terminus with the CCG).
- Enablement: Block contract provided by Housing 21 (flexible deployment of hours).
- Residential care: A single block contract is in place for historic in house provision (reducing over next 10 years)
- Spot purchased residential and nursing care, extra care and supported living
- Social care front door services – Customer Services hub for information, advice and initial assessments are provided by Capita
- Back office support functions (HR, Finance, Procurement, Estates) are provided by Capita
- Disabled Facilities Grants are administered through a joint venture company owned by Capita and LBB.

BCCG:

- Community health services: Block contract with Central London Community Healthcare NHS Trust (wider foot print than Barnet CCG)
- Mental health: Block contract with Barnet, Enfield and Haringey NHS Trust. Small amount of services are also purchased from Camden & Islington NHSFT and Central and North West London NHSFT
- Acute services: Predominant provider in Barnet is Barnet & Chase Farm Hospitals NHS Trust, with an activity based PbR contract. Some services also provided by Royal Free Hospitals NHSFT

Other:

- Primary care and specialist services are currently commissioned by NHS England
- Back office commissioning support functions are provided by NHS North and East London CSU

Joint commissioning:

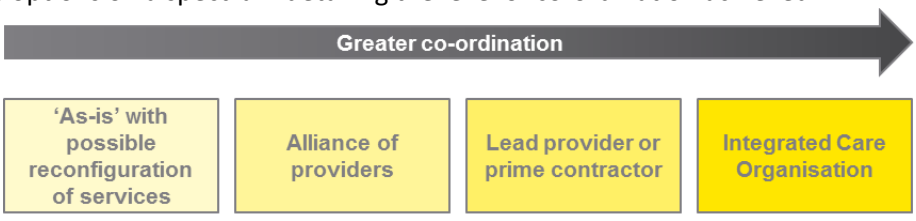
There are s256 and s75 joint funding arrangements in place. These cover a wide range of services, including Outreach Barnet, handyperson services, the rapid response team, CELs, integrated provision for mental health and dementia, LD services, and frail elderly services.

Current challenges:

- Care provision across the current economy is fragmented, which leads to inefficiency in processes and multiple hand-offs
- LBB has a higher proportion of residential care home placements than the surrounding boroughs. This is equivalent to an additional 30 funded placements relative to comparable boroughs
- Recruitment into social care roles in residential and nursing care homes is challenging, and payment of the London Living Wage would lead to additional costs to social care of approximately £11m in Barnet
- Acute spending in the borough is the highest in London. Some identified contributing factors in this are a high number of referrals from GPs and Care Homes and relative underinvestment and therefore a lack of viable community alternatives to acute care. This is also reflected in the spend on excess non-elective bed days
- Barnet and Chase Farm NHST not viable in the current health economy, and is in the process of being acquired by the Royal Free London NHSFT. This is likely to lead to significant changes to the way in which acute services are delivered in Barnet over the next three to five years
- Re-commissioning of Dementia services currently to ensure sustainable, safe delivery of future services
- Re-commissioning timeframe for Community Health Services – significant changes to the contract would require a 12 month notice period
- The current contracting arrangements with providers do not encourage the generation of savings across the system, risk sharing, or integrated care. Payment by results places a greater focus on the use of specialist services (with a higher tariff) and may detract from investment in the preventative and community aspects of the system that stakeholders wish to promote. Similarly, the use of block contracts for community and mental health services may not incentivise productivity or savings across the system

A: What could a new contracting model look like?

Four potential options for a new contracting model are outlined below, and the diagram below shows these options on a spectrum detailing the level of co-ordination achieved.



Option 1: Continue 'as-is' with possible service reconfiguration

- Commissioners and providers remain as separate statutory bodies (landscape remain largely unchanged)
- This option gives providers such as Barnet & Chase Farm the opportunity to complete restructuring programmes and potentially reconfigure services
- This approach avoids additional transformation costs, which may be desired by some stakeholders given their financial pressures
- Pursuing a tactical approach such as this will not deliver the savings that the system will be required to deliver in order to meet the financial challenges faced by LBB and BCCG.

Option 2: Commission from an 'alliance' of providers

- A formal partnership agreement is set up between providers, possibly underpinned by a Section 75 agreement for pooled funding from LBB and BCCG
- The partnership agreement would encourage the alignment of finance, performance and governance arrangements
- Providers would be collectively accountable for delivery against an agreed performance framework – this could be based on the outcomes framework detailed in this business case, as well as the work undertaken by NCL on value based commissioning
- A 'pre-alliance' contract could be signed with providers to give a phased approach to integration, with portion of provider income being based on the performance framework. This approach is being used by Central Manchester CCG, and may facilitate engagement with providers such as Barnet & Chase Farm, who are undergoing transformation of their own.

Option 3: Commission groups of services from a lead provider

- Services are commissioned from a principal provider, who subcontracts where necessary to deliver the services required
- The lead provider chosen could be a genuine lead provider (an organisation that will provide the majority of the services in the contract, and subcontract where it needs to) or a prime contractor, who manages the system and subcontracts all or the majority of the provision
- Different lead providers could be selected for different groupings of services (e.g. linked to tiers).
- The lead provider model is an innovative model for integrated care for people over 65 years old, and the use of different lead providers, bringing knowledge of different levels of care, could help to devise a unique model of care in Barnet.
- Key considerations for commissioning governance and funding (pooled and aligned budgets) to ensure the statutory responsibilities and of both organisations are addressed and the benefits of the investment model are realised by both organisations. Equally the interface between this model and the existing provider landscape will need to be mapped.

Option 4: Integrated Care Organisation

- Structural approach to integration, where health and social care provision is merged into one organisation. This approach would require significant structural change in Barnet
- This would be underpinned by a joint funding arrangement from LBB and BCCG
- This approach is being undertaken in Torbay and South Devon, although the local acute provider's takeover of the community health and social care provider has been delayed due to competition regulations

- This approach could lead to a more co-ordinated approach to care, with fewer hand-offs (dependent on the pathways and care models), a simpler contracting mechanism for commissioners, and the ability to impose requirements for continuous improvements and innovation within the organisation
- An integrated care organisation would also have the critical mass required to flexibly manage demand, and there would be the opportunity for providers to benefit from back-office efficiencies
- The structural change required may take focus away from the requirement to shift investment from acute services to community and preventative services, reducing the potential benefits available
- Providers may not wish to sacrifice their independence, and LBB and BCCG wish to remain structurally independent

Summary

This business case does not give a recommendation for a specific contracting mechanism. Structural integration would be a complex, challenging process to achieve within the current provider landscape. However, a level of integration has been achieved for learning disability services in Barnet, with a pooled budget arrangement and an integrated care team. This is viewed as a successful arrangement by key stakeholders in this programme, and provides evidence that the two organisations can work together to create integrated solutions for discrete population groups. However, based on the local provider landscape, and discussions with commissioners from LBB and BCCG, a hybrid of Options 2 and 3 would be viable and reduce the transition costs associated with option 4. The next stage of the programme should consider the options in more detail.
It was recognised that locally, the 'lead provider' as defined in option 3 in some instances may be a management function for a bundle of services as opposed to being the main delivery mechanism for services. Equally across the five levels of the model there may be a number of lead providers for different service packages and an alliance may need to be formed between these for pathway coordination focused on the individual.

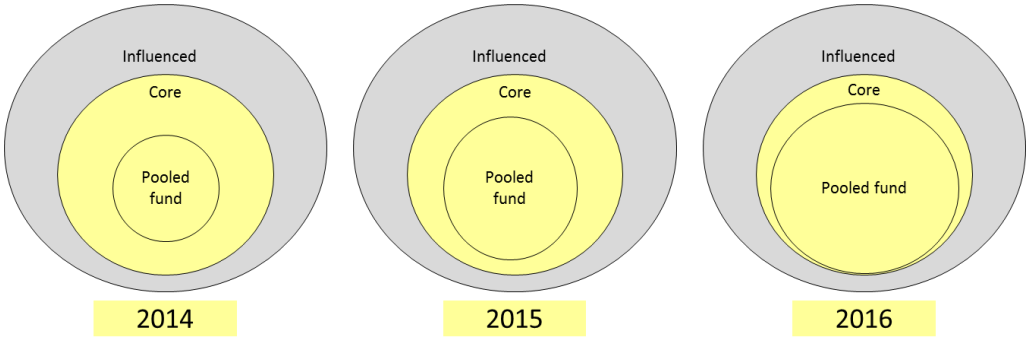
There is a consensus across key stakeholders that it may be appropriate to approach integrated provision for the population cohort in a staged process.

- Design and build the operating arrangements
- Market test appropriate 'segments' of the model
- Enter a dialogue with providers to identify the appropriate contracting approach.

This would enable commissioners to work hand in hand with providers to build the new operating arrangements and ensure a smooth, safe transition to the new ways of working

In terms of the pooled funding arrangement, the concept of core and influenced services were described in Section 6. It is expected that, in line with the staged approach to implementation, the pooled budget amount for the core fund would begin with the priority areas for the Better Care Fund, submitted in Feb 2014. However to ensure benefits were jointly realised some alignment of core and influences budgets would be required with clear performance metrics monitored by the collective governance.

As the service model and commercial approach develops further the pooled budget would expand incrementally as more services come on stream.

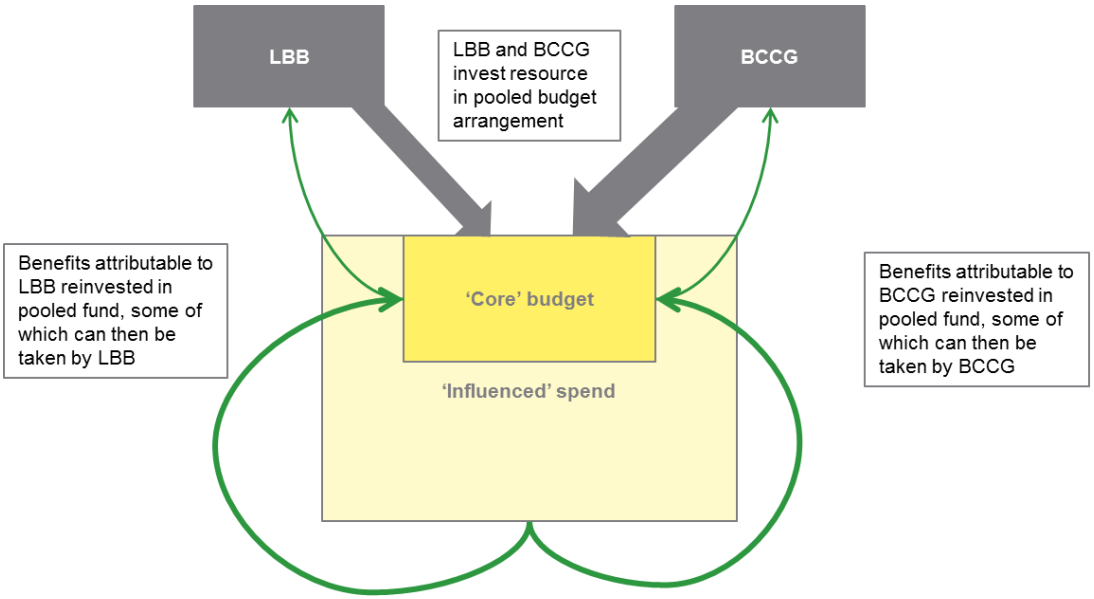


Further details of each of the contracting mechanisms set out above, with potential benefits, risks and case studies, can be found in the Appendices section of this report.

B: How can the organisations incentivise risk sharing?

The CCG is constrained by the projected budget deficit of £20.9m for 2013/14, and the need to take action to reduce this. This pressure may also constrain the level of resource that the CCG is able to commit to any joint funding pot, and any benefits derived by the CCG are likely to be used to reduce the deficit initially, rather than being reinvested in the system to produce further benefits. From LBB's perspective, the impact of the Care Bill could lead to significant financial pressures. This could put pressure on funding in the core and pooled budgets. Both organisations may wish to cap their exposure to the other's financial risk.

The significant budget pressures facing both LBB and BCCG require that the chosen contracting model allows for a portion of the benefits of integration to be 'cashed' by each organisation against their respective financial challenges. The diagram below illustrates how such a reward mechanism may work:



Going forward the proportional risk/reward sharing arrangement would need to be configured jointly between the CCG and LBB. This arrangement would govern the level of benefits that are:

- Retained in the pooled budget and reinvested in additional services
- Contribute to reducing the individual organisations financial deficit/ funding cuts

- Make provisions for the individuals organisations risk exposure (for example the Care Bill or the changes to allocation for CCGs (for example reallocation of money as a result of 'specialist' commissioning activity to the local area NHS teams)

This could be done in the following ways:

- A 50/50 split of the reduction in the influenced services
- In proportion to funds invested in the 'pooled' budget
- In proportion to funds invested in the core budget
- In proportion to the target investment (recognising and incentivising the increasing level of spending on low level prevention, self-management and social care community support)
- In proportion to the agreed size of the financial challenge facing the two organisations

C: What payment mechanisms might be used in the contracting model?

In order to deliver the savings required of the programme, a set of alternative financial mechanisms should be devised and agreed with partners. The current incentivisation mechanisms that are in place are primarily block contracting for community services, budget management for in house provision and PbR for acute activity. Although these mechanisms are simple, and understood by stakeholders, neither of these mechanisms provides an incentive to move activity away from acute and residential care, and improve outcomes for patients and service users. In order to incentivise the required shift in activity, an alternative payment mechanism should be used. Two examples of alternative payment mechanisms, that link to outcomes, are described below.

Single payment for a full cycle of care

- Single payment for all the provision in a defined cycle of care
- Transfers the financial risk of delivering agreed services from commissioners to providers
- Includes mandatory outcome based reporting, to incentivise an improvement in outcomes and engineer the desired shift in activity
- More complex than the mechanisms currently in use, since a full cycle of care could last for a number of years
- It may be challenging for providers to adapt to the outcomes based reporting required
- Potentially developed using the outputs from NCL Value Based Commissioning project
- Southwark and Lambeth ICO is working with the National Commissioning Board to develop a single payment of care methodology for people with long term conditions

Outcomes based capitation

- Combines fixed payments per patient or service user with performance incentives based around the outcomes framework
- Transfers the financial risk of delivering agreed services from commissioners to providers
- Encourages providers to work together to achieve outcomes and would therefore be well suited to an alliance of providers
- Providers such as Barnet & Chase Farm, and Barnet, Enfield and Haringey, may resist as they are experiencing financial pressures of their own, and hence may not have the resource to develop a complex mechanism such as this
- The mechanism is being piloted by Oxfordshire CCG for frail elderly services, with estimated benefits of 2-3% per annum on a budget of £215m

Both mechanisms provide an opportunity to transfer some of the financial risk of delivering agreed services across the range of delivery levels from commissioners to providers. Both of these methods may be challenging to sell to providers, who are experiencing financial pressures of their own (particularly Barnet & Chase Farm, and Barnet, Enfield and Haringey NHS Trusts), but the investment model proposed above would allow for significant re-investment of benefits in the system, which giving further opportunity to reduce costs for all parties and bring financial stability longer term.

Summary: A final decision on a preferred payment mechanism needs to be made in conjunction with the decision on the chosen contracting model, as different payment mechanisms are suited to different contracting models. However, the two options outlined move away from payment based on activity towards payment based on outcomes, and this will be a key enabler in moving activity away from costly acute and residential care. This direction of travel is aligned to the current proposals being considered in the NCL Value Based Commissioning programme that can be used in designing the payment mechanism.

8. Conclusions and Next Steps

In addition to ensuring the commissioning model meets the person centred design criteria (for Mr Colin Dale and other residents) developed in Phase 1, the following sets out a range of standards against which this outline business case has been tested. **The Project Steering Group agreed that the most important standards are cost quality and cost with equal weighting.**

1. Quality	Comments
Does the model improve the quality of services and commissioning for outcomes?	▸ A more flexible, multi skilled workforce, with access to specialist support where required will ensure individual get the right care at the right time. ▸ The focus on prevention and early identification should support the improvement of health outcomes for individuals. ▸ The contracting mechanism once decided will have quality linked KPIs incentives built into drive standards of care provision up. ▸ The larger scope of services will also allow the provider more ability to innovate and invest in new technologies and approaches. ▸ The implementation of a 24/7 service will reduce variations in care and working with individuals to identify their outcomes and meet the more holistically will improve perceived quality as well as delivery quality

2. Cost	Comments
Does the model or option allow lower costs for commissioners?	▸ The service and commercial model demonstrate the ability to realise significant financial benefits in terms of reducing duplication, acute activity and ensuring appropriate use of more intensive community services. ▸ The commercial options provide clear accountability for financial management and reporting however, the detailed contract management arrangement will need to be developed through the implementation process.

3. Governance and Flexibility	Comments
Does the model satisfy democratic accountability and is future proofed?	▸ The model ensures clear accountability for clinical and social care standards and safeguarding. ▸ All integrated services will establish treatment protocols to be approved by clinical leads. ▸ The governance, contract monitoring arrangement and performance of the organisation should clearly demonstrate clinical and social care accountability for performance indicators, service standards and safeguarding

4. Acceptability to Stakeholders	Comments
How well does the new model satisfy stakeholder requirements/views?	▸ The model provides holistic support to service users and patients across the spectrum of care needs reducing referrals and supporting seamless care. ▸ The design of the model has been informed by stakeholder engagement ▸ The development of the commercial option and detailed specification will be carried out in collaboration with providers.

The full range of standards agreed by the Steering Group is set out in the Appendices section of this report and the agreed final model will be evaluated against these in more detail in the next phase of the programme**.**

This outline business case provides detail of the operational model and financial and commercial case for integration in Barnet but does not make a recommendation for a specific contracting mechanism.

Structural integration would be a complex and challenging process to achieve within the current provider landscape. A level of integration has already been achieved for learning disability services in Barnet, with a pooled budget arrangement which provides evidence that LBB and BCCG can work together to create integrated solutions for discrete population groups.

However, based on the local provider landscape, and discussions with commissioners from LBB and BCCG, a hybrid of Options 2 and 3 would be viable and reduce the transition costs associated with option 4. It was recognised that locally, the 'lead provider' as defined in option 3 in some instances may be a management function for a bundle of services as opposed to being the main delivery mechanism for services. Equally across the five tiers of the model there may be a number of lead providers for different service packages and an alliance may need to be formed between these for pathway coordination focused on the individual.

The next stage of the programme should consider the options in more detail. The level of resources required to take the work forward should not be underestimated. To finalise the direction of travel for Barnet in terms of the commercial and operational model to implementation, a focused programme of work is required. Expertise in programme management, PMO, specification design, procurement, contract management, stakeholder engagement, finance, legal, IT, pathway redesign, clinical standards, and equality impact assessments will be required to support the transition.

Next Steps

There is a consensus across key stakeholders that it may be appropriate to approach integrated provision for the population cohort in a staged process as follows.

1. Design and build the operating arrangements in more detail in coproduction with stakeholders
2. Market test appropriate 'segments' of the model
3. Enter a dialogue with providers to identify the appropriate contracting approach and market test.

Supporting this is a requirement to develop a more detailed programme activity and resource plan.

Following approval by the organisations prospective governing bodies, the development of a specification that would allow the commissioners to select a lead partner is required. Immediate next steps are outlined below.