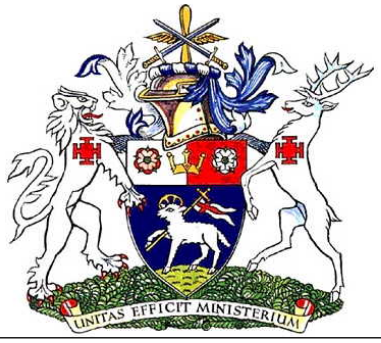	**Adults Safeguarding Committee** **7th March 2016**
Title	**Implementation of Better Care Fund: Development of Integrated Locality Teams**
Report of	Commissioning Director – Adults and Health
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	No
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Summary

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

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

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

Recommendations

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

1. WHY THIS REPORT IS NEEDED

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

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

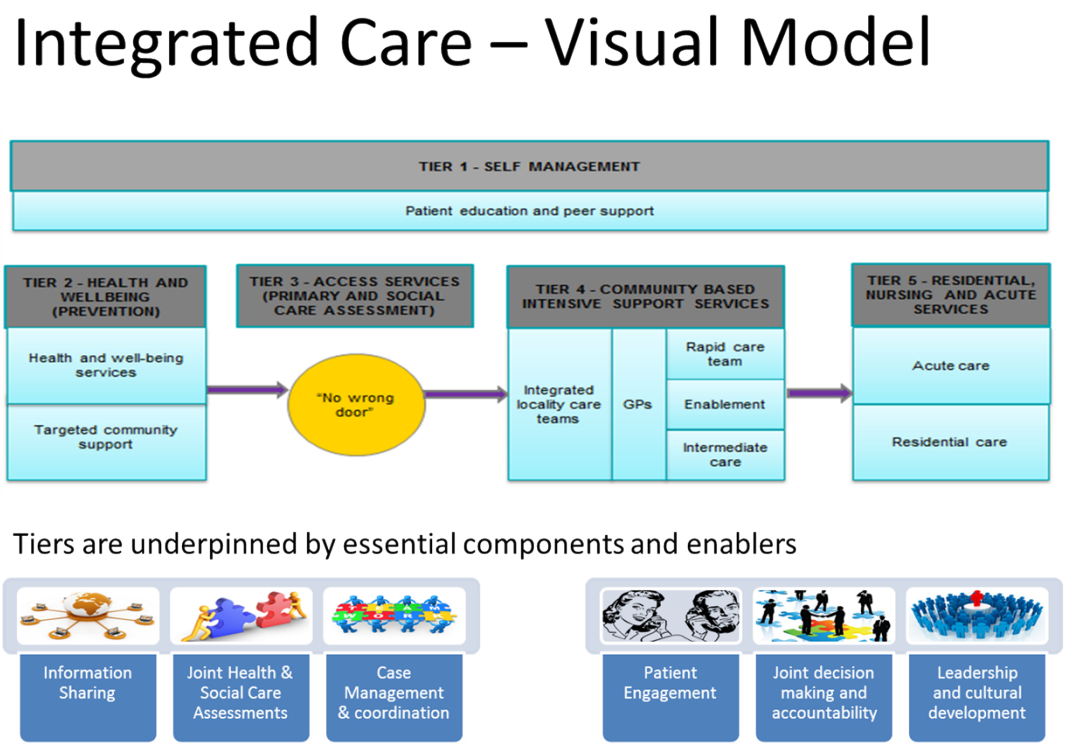
1.3. Phase Two involved piloting a co-located integrated locality team in the west of the Borough. The Team includes social care, mental health and community health staff and is based in a GP practice. The team started working with patients referred from seven GP practices and has been extended to all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

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

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

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

1.6. Barnet Integrated Locality Team



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

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

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

- Community Point of Access: Receives and manages referrals for adult community health services, ensuring urgent and non-urgent referrals and requests are pro-actively managed to enable rapid co-ordinated care and effective planned care.

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

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

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

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

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

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

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

1.7. Phase Three

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

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

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

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

d. Reduction in carer breakdown, measured by carer satisfaction and stability
e. Increase in the ability of residents to manage their own care and utilise services more effectively as set out in anticipatory care plans.

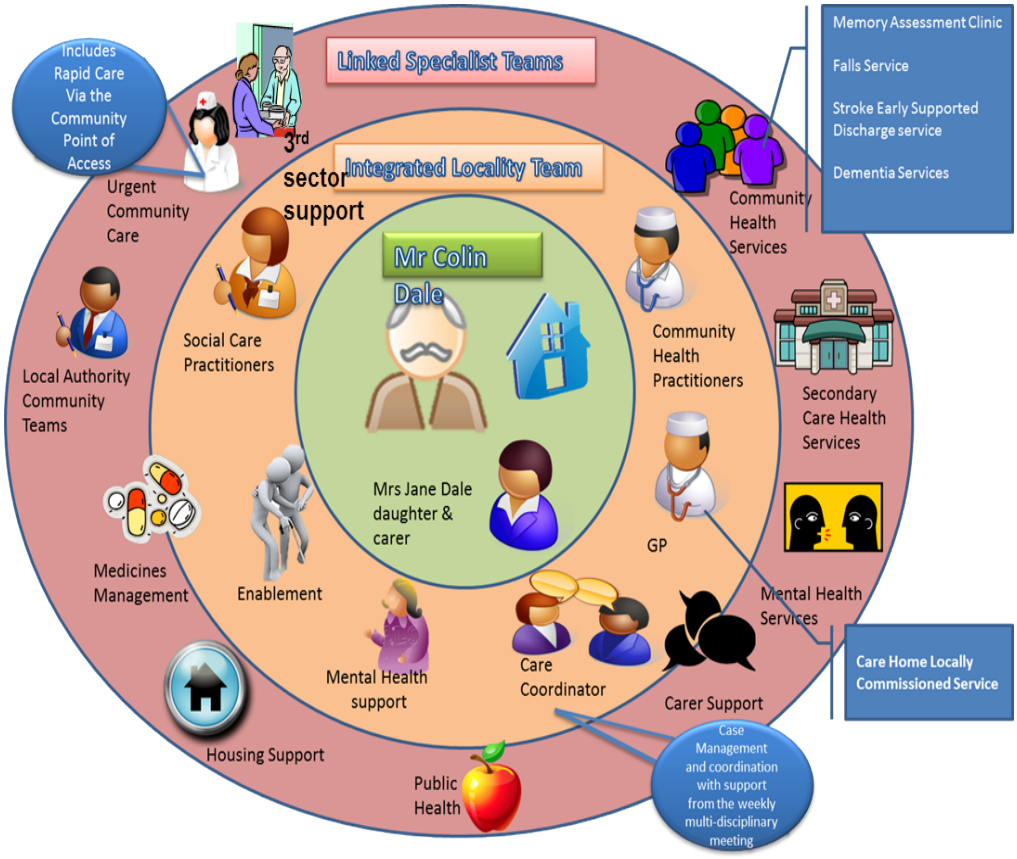
f. CCG Quality, Innovation, Productivity plan (QIPP) and Council MTFS savings against integrated care in 2016/17 and beyond to be realised

g. Improved service user/patient experience throughout the system

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

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

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



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

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

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

1.8. Benefits of this approach

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

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

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

1.8.4. Risk based working reduces demand and enhances experience

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

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

1.9. **Service Funding**

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

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

2. REASONS FOR RECOMMENDATIONS

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

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

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1. Not applicable.

4. POST DECISION IMPLEMENTATION

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

5. IMPLICATIONS OF DECISION

5.1. Corporate Priorities and Performance

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

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

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

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

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

£24.4m.

5.3. **Social Value**

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

5.4. **Legal and Constitutional References**

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

- Promoting the best possible Adult Social Care services.

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

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

5.5. **Risk Management**

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

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

5.6. **Equalities and Diversity**

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

a) eliminate unlawful discrimination, harassment, victimisation;

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

c) foster good relations between these groups.

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

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

5.7. **Consultation and Engagement**

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

5.8 **Insight**

5.8.1 Not relevant to this decision.

6. BACKGROUND PAPERS

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

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