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

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014 (final submission no later than 12 noon 9th January 2015). Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

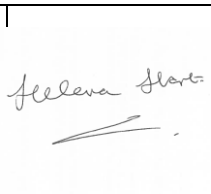
a) Summary of Plan

Local Authority	**Barnet Council**
Clinical Commissioning Groups	**Barnet Clinical Commissioning Group**
Boundary Differences	**Coterminous, however, the GP-registered population includes patients who reside in another LA's area. Barnet's integrated care model includes these patients.**
Date agreed at Health and Well-Being Board:	**18.09.2014**
Date submitted:	**19.09.2014 & 09.01.2015**
Minimum required value of BCF pooled budget: 2014/15	**£6,634,000**
2015/16	**£23,412,000**
Total agreed value of pooled budget: 2014/15	**£6,634,000**
2015/16	**£23,412,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Debbie Frost
Position	Chair
Date	09.01.2015

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

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

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Selected Links
Barnet Health and Social Care Concordat Barnet Integrated Health and Social Care Model 2013 Barnet Health and Well-Being Strategy Barnet Council Corporate Plan 2013 Barnet Council Priority & Spending Review 2014 Barnet CCG 2 Year Operational and 5 Year Strategic Plan Barnet Joint Strategic Needs Assessment (JSNA) 2011 - 2015 Health and Social Care Integration Board Terms of Reference Health and Social Care Integration Board Programme Governance Barnet, Enfield & Haringey Clinical Strategy Health and Social Care Integration Business Base (Sept 2014)	 HSCIB concordat signed.pdf  Barnet Health Social Care Integrati  Barnet Health Social Care Integrati  Barnet Health & Social Care Program  HSCI Business Case Update Oct 014 v0.9 Others available upon request

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20.

The Vision for integrated care in Barnet is articulated in the Health and Social Care Integration Concordat and states:

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

In **3 to 5 years' time,** we will have developed a fully integrated health and social care system for the frail and elderly population through implementation of our model so that it:

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

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

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

- Specific health trends: While many people in Barnet experience good health, some issues remain significant obstacles. This includes cancers where although mortality associated with cancers remains relatively low, an improved take-up of screening could ensure earlier identification and treatment. This increases the likelihood of survival and decreases the need for more radical treatment. Death rates for chronic obstructive pulmonary disease (COPD) and cardiovascular disease (CVD) are falling; however we recognise that early identification of undiagnosed COPD remains a priority, as does smoking cessation to prevent CVD. Also of significance is the "obesity epidemic". Almost 25,000 residents of Barnet aged over 18 years are obese. While this represents a lower prevalence than the national average (15.4% versus 24.5%), it is still a significant number, especially considering that those who are obese are at greater risk of premature death and a number of health complications including diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases and infertility and respiratory disorders.
- **Improving independence:** With increased demand pressures from a growing population and reduced financial resources, it will be essential that we enable more people to take personal responsibly for their own health and wellbeing through particularly through prevention schemes.

Our **Barnet Health and Well-Being Strategy** 2012 to 2015 (October 2012) centres on reducing such health inequalities by focusing on how more people can 'Keep Well' and 'Keep Independent':

- **Keeping Well:** focus on supporting people to adopt healthy lifestyles to prevent avoidable disease and illness.
- **Keeping Independent:** when extra support and treatment is needed, it is delivered in a way which enables people to get back up on their feet quickly, supported by health and social care services working together.

The strategy recognises that we can only achieve this through a partnership between residents and public services.

The views of patients, service users and carers are integral to the vision for integrated care in Barnet, with extensive involvement of a wide range of individuals and organisations including Healthwatch Barnet, Older Adults Partnership Board, Age UK (Barnet) and the Alzheimer's Society. The role of public and patient engagement is outlined in more detail in Section 8a below.

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

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

Diagram 1 – Barnet Vision for Colin Dale

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

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

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

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

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

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

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

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

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

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

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

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

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

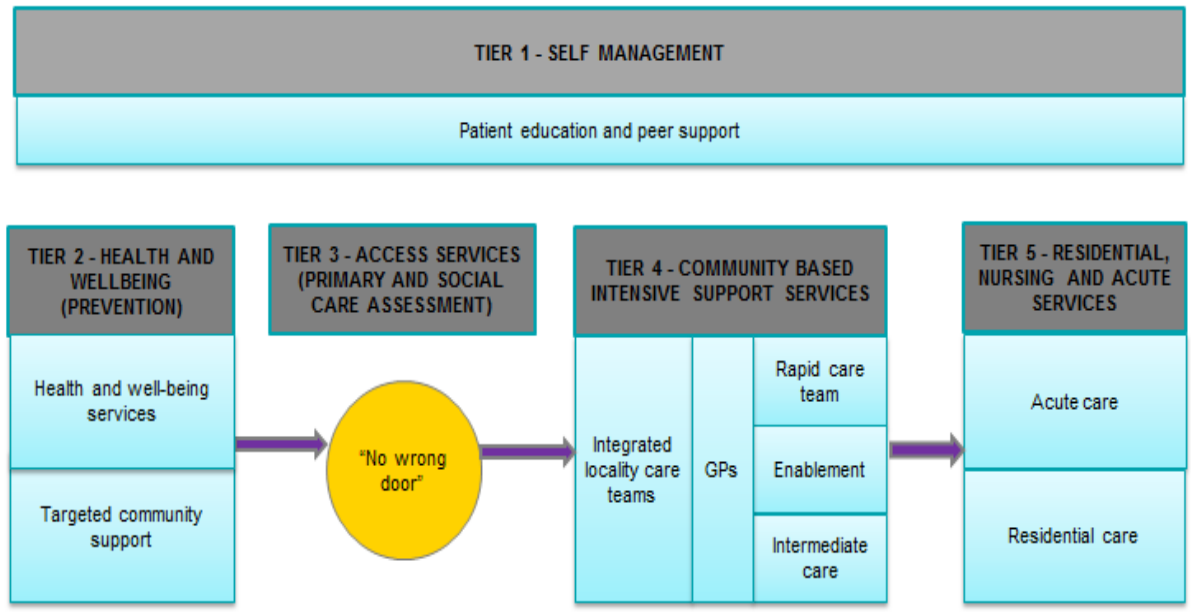


Diagram 2 – Overview of the Barnet Integrated Care Model

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

The integrated care model consists of five tiers of integrated health and social care services, all designed with the aim of providing people with the right care, in the right place, at the right time, through a significant expansion of care in community settings and championing of prevention and self-management. Our schemes of work for BCF therefore comprise:

- **Scheme 1: Self-Management and Health and Wellbeing Services (Tier 1):** This reflects Tier 1, i.e. people and their families are supported to manage their own health and wellbeing wherever they can and for as long as possible.
- **Scheme 2: Access services including primary and social care assessment:** identify early and proactively target those at risk of becoming frail or unwell. When necessary a support package focused around the individual will be put in place that optimises Mr Dale's skills, increases his quality of life and prevents deterioration.
- **Scheme 3: Community based intensive services (Tiers 3 and 4):** Intensive community based support services are readily accessible and react quickly to need.
- **Scheme 4:** Enablers: supports the delivery of the three schemes above and consists of a range of successful operational services, including planning for later life (a team of advisors that help people prepare for their old age), shared digital care records (to enable all professionals and teams to work together to

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

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

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

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

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

Our BCF schemes of work will significantly contribute to improved patient, service user and carer experience, better quality outcomes and financial benefits through identified service efficiencies and productivity. The BCF translates these top level outcomes into measurable whole system targets with agreed, shared accountability across all of our providers and commissioning organisations.

Table 1 below shows to which core target or outcome each scheme contributes:

Scheme	Scheme description	Benefits					
		NEL	Residential & Nursing Adm	Reablement Effectiveness	DTOC	Patient Satisfaction	Self Dir. Support
1	Expert Patient Programme	✓				✓	✓
2a	Long-term conditions (dementia, stroke, falls, pall. care)	✓	✓		✓	✓	
2b	Older People Integrated Care (OPIC)	✓	✓	✓		✓	✓
2c	Care Homes	✓				✓	
3a	Rapid Care	✓		✓	✓	✓	
4	Enablers					✓	✓

Table 1 – Overview of Scheme Contributions to BCF Benefits and Outcomes

Table 2 overleaf details our current and target performance against the set baseline for each of those quantifiable targets and measures:

	Current Level	Target Next Year	Benchmark (ONS Peer Group)	Comment
Non-elective admissions	29,094 80 per 1,000 population	28,073 3.5% reduction	64 per 1,000 population	• Barnet is already in the top quartile on non-elective admissions performance • Improvement from reducing GP variation and increased use of risk stratification
Care homes	487	405	410.9 (for current level and based on LBB comparator group)	• Aim for top quartile performance
At home after 91 days	71.9%	81.5%	85%	• Move from bottom quartile to second
Delayed transfer of care	7 per 100,000 population	6 per 100,000 population	6 per 100,000 population	• Move from second quartile to top quartile
Patient experience	0.87	0.92	0.869 (based on CIPFA comparator group; data is currently restricted and is owned by the NHS Information Centre)	• The metric is based on the Annual Social Care User Survey (2013/14), Question 1: Overall how satisfied or dissatisfied are you with the support or services you have received from social services in the last 12 months?
Self Directed Support	1 (2,701 people)	1 (2,718 people)		The metric is from the adult social care outcomes framework, long term support indicator. Percentage of people with self-directed support, expressed as a percentage of all eligible social care service users.

Table 2 – Current and Target Performance for BCF Benefits and Outcomes

Improved Outcomes

Better patient and carer experience:

- The provision of a local, high quality service that targets those most at need. In addition, it will enable people to remain at home, where essential care can be delivered and monitored.
- Reduction of duplication in assessment and provision of care through use of an integrated locality team approach to case management.
- "No wrong door" for frail, older people and those with long-term conditions.

- Increase in the number of people who have early interventions and proactive care to manage their health and wellbeing.

Improved older adult outcomes (health and social care):

- Ensuring quality long-term care is provided in the most appropriate setting by a workforce with the right skills.
- Pro-active care to ensure that long-term conditions do not deteriorate, leading to reductions in the need for acute or long-term residential care, and reducing the demand for repeat interventions and crisis services such as emergency departments.
- Increased use of health and social care preventative programmes that maintain people's health and wellbeing, and improved practice in use of medication leading to a reduction in unplanned and emergency admissions to hospital and A&E.

Lower cost, better productivity - achieved through the ability to improve future resource planning and needs by way of:

- Utilising risk stratification to manage the care of those individuals most at risk of an escalation in their health and social care needs.
- Utilising a joint approach to care will ensure a better customer journey and led to better management of resources providing the services.
- Increased information and signposting to ensure preventative services are fully utilized.
- Supporting people to stay living at home for as long as possible and enabling them to take more responsibility for their own health and wellbeing, which in turn will help reduce or delay the rising admissions to residential care.

c) What changes will have been delivered in the pattern and configuration of services over the next five years and how will BCF funded work contribute to this?

There will be significant changes to the delivery of services over the next 5 years.

Section 2a above outlines the five tiers that form the foundations of our integrated care model. Transforming services through integrated care will ensure that we are improving outcomes for patients and service users, gaining the best value for money in services and are maximising opportunities arising from joint commissioning. This section outlines the operating arrangements for each of the tiers of the integrated care model.

Diagram 3 below illustrates our approach for how the design and structure of services will evolve significantly to reflect each tier of our integrated care model:

Diagram 3 – Evolution of Services for Mr Colin Dale

The diagram shows four of the five tiers, namely 1) Self-Management, 2) Prevention (i.e. Health and Wellbeing), 3) (A single point of) Access to Assessment and Care Planning and 4) Community Based Intensive Support Services. Tier 5 is not shown in this diagram because it shows the key changes we aim to make through our integrated care vision. We aim to reduce demand for tier 5 services through the support we provide in tiers 1-4. The following paragraphs describe each tier.

Tier 1: Self-Management – Shifting the focus of health and social care delivery away from formal care and institutions and developing the individual's resilience to seek their own solutions and manage circumstances:

- All individuals with a recognised long-term condition (such as diabetes or heart disease) will be offered self-management education, training and support.
- Up-skilling people and improving their health literacy so that they are more confident about looking after their own health.
- Access to support from a long-term condition Mentor or Health Champion, or access to online support forums tools.
- Development of Healthy Living Pharmacies, to review medication, access community based preventive services and to work with a health champion to adopt healthier behaviours.
- Training for health and social care professionals to enable them to support and empower people to manage their long-term conditions independently.

Tier 2: Health and wellbeing – Preventing the onset of ill health and improving people's social well-being:

- Targeted primary and secondary prevention to reduce health inequalities.
- Encouraging healthy lifestyles and lending support to families, friends and carers who provide informal care.
- Strong Information and Advice offer, with branding and in a format that will make these services publically recognisable, readily available, understandable and easy to access. Increased use of social media, mobile and internet technology to support delivery.
- Early contact made with people identified as at risk of needing Tier 3 and 4 services, to link with advice and support to help keep them well. Examples include the Falls Clinic, Dementia Hub, Dementia Cafes, Dementia Advisors, Day Care and Stroke Support Services.
- Health education package for carers, which supports safe caring, promoted by GPs, LBB, carer's services and hospitals. Dedicated carer's centres.
- Implementation of the Ageing Well Programme (user, carer and community led prevention and social inclusion activities), including greater investment in volunteering to support people in the community.
- GP network led Wellbeing service piloting community navigation to health, social care and voluntary sector services.
- Evidence base of what works at a system and individual level will be developed to inform future commissioning.

Tier 3: Access services – Primary and social care assessment for people with a long-term condition, aimed at preventing emergency and unnecessary admissions:

- **Identification of at risk Older Adults through risk stratification:** population profiling; predictive modelling of high-risk patients; disease profiling to enable early identification and navigation to the appropriate prevention services.
- **Community Point of Access:** single point of access to provide advice and support for older adults and those with long-term conditions, signposting them quickly and efficiently to the correct services and provide a timely and direct referral route to existing community health services.
- **Shared Care Record:** An information repository providing a single, holistic view of an individual's health and social care needs that will be accessible 24/7 from any location and wherever staff are working. This is a key system enabler.

Tier 4: Intensive Community Support – Services to increase independence and provide health and care support to manage people in the community e.g. at home.

- **Care Co-ordination and Case Management:** Delivered through Integrated Locality Teams in partnership with GPs (including social care, mental health and community healthcare), to support and manage care from self-management through periods of crisis, into end of life pathways where necessary. They will review and assess complex patients living with multi-morbidity and long-term conditions at risk of admission to introduce care plans and link to services to keep them at home. Building from an initial framework of a team based with each of the 3 localities, they will move resources around

flexibly to avoid crises and maintain people in their homes or in other care settings.

- **Weekly Multi-disciplinary Team (MDT) meetings** will provide a more intensive and coordinated approach to managing the most complex cases by planning individualised care packages across multiple providers.
- **Care Navigators** supporting these groups with implementation and delivery of care plans through care co-ordination and signposting.
- **Rapid Care service** that will provide intensive home-based packages of care to support people in periods of exacerbation or ill-health.
- **Enablement services,** working closely and effectively with facilitated discharge to provide holistic care packages seamlessly with other care providers.

Tier 5: Reduce demand for residential, nursing and acute services.

Residential, nursing home and hospital inpatient services support intensive care where individuals cannot live happily, healthily and independently at home. The aim is for these services to be accessed only when other community based services available cannot provide the correct level of care or an appropriate environment for the patient or service user.

The focus of our integrated care model is to shift activity to Tiers 1 – 4 and to reduce demand for acute hospital and residential care (Tier 5). Within Tier 5, we are developing several initiatives to reduce demand for acute hospital care, including reducing the risk of people in nursing or residential care being admitted to hospital.

Both acute hospital sites serving Barnet operate admission prevention services (TREAT) and early supported discharge schemes (PACE). 7 day a week social worker services operate in both hospital sites.

Our leadership and thinking and working with stakeholders are integrated across aligned activities. The Chair of BCCG also chairs our local System Resilience Group (SRG) to set and implement plans across the whole health and social care system to manage patient flow and demand and capacity management driven by winter pressure and other identified risks to public health. In December 2014 we hosted an A & E Summit to bring together all major stakeholders for urgent care in Barnet to agree how we can work better for patients to reduce admissions and help them leave hospital and return home faster. This included social workers, BCCG, the London Ambulance Service (LAS) and the Royal Free NHS Foundation Trust.

In Scheme 2 we have a dedicated set of initiatives which target care homes, working with locally commissioned services to improve staff skills and quality of care in care homes. Our aim is to support the care homes themselves to appropriately respond to patients requiring intensive support, preventing hospital admission with the deployment of additional support from the integrated care model. Dedicated GP support has been enhanced, for example with fortnightly ward rounds and six monthly holistic reviews and post-admission and medication reviews (over and above the services commissioned under GP GMS and PMS contracts). We have a dedicated improvement team for Care and Nursing Homes (IQICH, recognised for its good practice in the Skills for Care Accolade awards). All this work is further improving the relationship between the care home and GP, increasing levels of proactive and preventative care given to anticipate

potential issues and prevent crisis and avoidable emergency admissions. We are also supporting people's preference of place of death through advanced end of life care planning, with a Barnet GP acting as dedicated 'End of Life Champion'. The scheme is providing education and training to care home staff and managers to empower them to improve the quality of care and build networks between care homes to facilitate shared learning and best practice.

Scheme 4 (Enablers) includes improvements to hospice services, to provide a more appropriate environment than acute hospital for people if their health deteriorates and they require palliative care.

Tables 3 and 4 overleaf list the schemes of work for each Tier for the next two years. They show the total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below) and their contribution to reducing non-elective admissions. The savings are based on a £2,004 average unit cost per admission, as used in our Business Case for Integration (included in Section 1c above) and our financial model in Part 2 (spreadsheet) of our Plan.

The estimated reduction in non-elective admissions (NEL) in Tables 3 and 4 reflects the figures in Tab 4, HWB Benefits Plan of Part 2 of this submission, covering two full years (eight quarters) from 1 April 2014 to 31 March 2016.

More details of each Scheme are included in Annex 1. This includes the:

- Impact of schemes on reducing nursing and residential care home admissions, improving the effectiveness of reablement and reducing delayed transfers of care.
- Evidence base and assumptions used to analyse the costs and benefits and their specific contribution to our target benefit and outcome measures detailed in Part 2 of this submission.

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention					
		a. Expert Patient Programme & long-term condition Mentors	*35,000 (Not BCF pool)*	n/a	23	46,092	3.62
3, 4	2	Assessment & Care Planning					
		a. Long-term conditions	267,357	4.03	15	30,060	2.36
		b. Older People Integrated Care	1,057,451	15.94	155	310,620	24.41
		c. Care Home – LCS	231,000	3.49	29	58,116	4.57
4	3	Community Intensive Support					
		a. Rapid Care	636,171	9.59	413	827,652	65.04
		b. 7 Day Social Work & Enablement	300,000	4.52			
All	4	Enablers					
		a. Services	862,021	12.99			
		b. Administrative	3,280,000	49.44			
		Total:	**6,634,000 (BCF Pool)**	**100**	**635**	**1,272,540**	**100**

Table 3 – Cost and Impact of Schemes on NEL Admissions April 2014 – March 2015

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention a. Expert Patient Programme & long-term condition Mentors	*87,120 (Not BCF pool)*	n/a	119	238,476	11.66
3, 4	2	Assessment & Care Planning a. Long-term conditions	2,722,921	11.63	110	220,440	10.77
		b. Older People Integrated Care	1,292,026	5.53	331	663,324	32.42
		c. Care Home – LCS	1,146,000	4.89	10	20,040	0.98
4	3	Community Intensive Support a. Rapid Care	1,316,464	5.62	451	903,804	44.17
		b. 7 Day Social Work & Enablement	300,000	1.28			
All	4	Enablers a. Services	10,636,589	45.43			
		b. Administrative	5,998,000	25.62			
		Total:	**23,412,000 (BCF Pool)**	**100**	**1,021**	**2,046,084**	**100**

Table 4 – Cost and Impact of Schemes on NEL Admissions April 2015 – March 2016

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The delivery of our BCF plan will occur in the context of a challenging health and social care environment:

- Barnet Clinical Commissioning Group (BCCG) has an inherited debt of £34.1m. The Revenue Resource Limits (RRL) in place for 2014/15 and 2015/16 continue to disadvantage BCCG by providing funding below the 'fair share' target. Significant ongoing QIPP challenges will continue for BCCG in to the foreseeable future.
- The Barnet Council (LBB) Priorities and Spending Review (PSR) forecast a gap in the Council's finances of £72m between 2016 and 2020. It has identified a package of options for LBB to save money and raise revenue, with a potential to provide a financial benefit of approximately £51m. Adults & Communities share of the PSR package of savings is £12.6m. This includes proposals for improving organisational efficiency, reducing demand and promoting independence and service re-design.
- In addition to the £72m gap, the Council must meet the challenge of providing the new statutory duties of the Care Act, including for the 32,000 informal carers across Barnet.
- Significant change in the landscape for the provision of hospital services as a result of strategic change and re-configuration.
- Barnet has more than 100 care homes, with the highest number of residential care beds in London, leading to a significant net import of residents with health needs moving here from other areas.

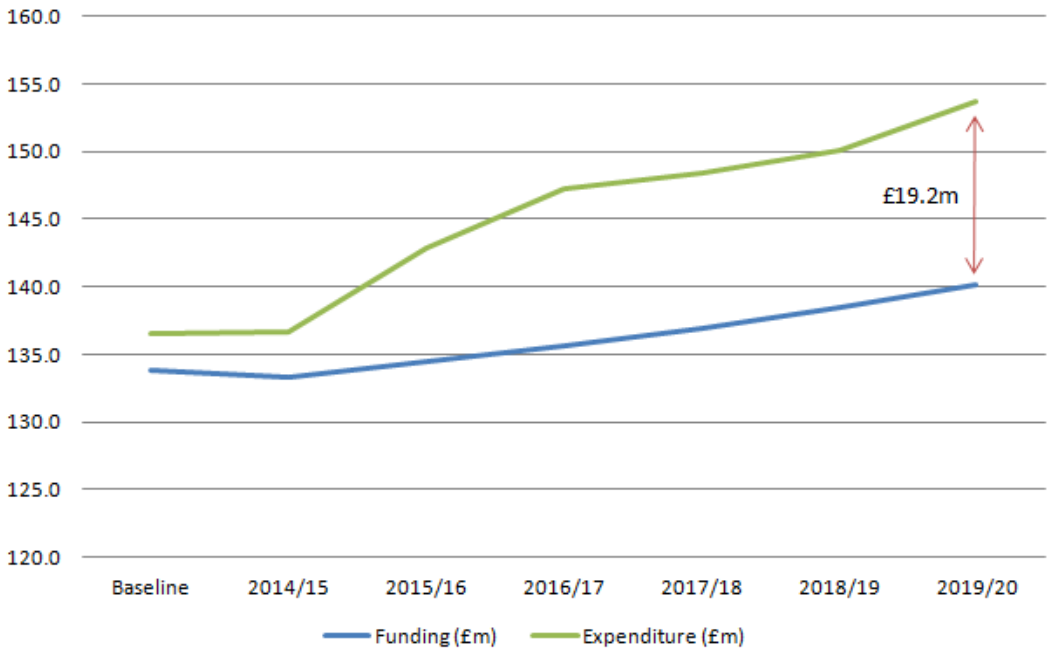
Our case for change centres on five issues:

1. **A challenging financial environment with significant uncertainty**
2. **An ageing population with a growing burden of disease**
3. **High levels of variation in primary care**
4. **Outcomes which are not as good as we aspire to**
5. **Insufficient spend on areas that support integrated care**

We have undertaken a **financial analysis of the affordability and deliverability of our integrated care model** to address the critical question for the Barnet economy of how we can achieve better health and wellbeing outcomes and improve user experience for the frail, older population in Barnet in a financially sustainable way.

Our Business Case for integrating health and social care services includes our BCF Plan and shows that the combined effect of likely reduced funding and our forecast increases in expenditure may create a significant financial gap over the next six years **if we do not change our current care model**. Based on the scope of services at the time of developing the business case, our baseline for the first year of the business case modelling period (2013/14) was a budget of £133.8m with a forecast expenditure of £136.5m. This leaves a funding gap of £2.7m. Diagram 4 below illustrates our analysis of

the costs involved, which give us an indicative view of the possible longer term forecast funding gap relevant to older people (in scope) from 2014 to 2020. **This demonstrates the need for change to our model of care.**



Data source: LBB & BCCG Business Case for Integration of Services September 2014.

Diagram 4 – Graph of Forecast Funding Gap for Services 2014 – 2020

Our strategy for embedding integrated care will enable us to implement ambitious change in the scale and scope of services to close any potential funding gap. Our BCF plan is our first significant step to embed fully integrated care for the whole health and social care system in Barnet.

We have taken a conservative approach to financial modelling, which provides a solid baseline on which to expand initiatives and increase the scope of future projects. This will enable us to identify and realise additional benefits going forward and to factor in the impact of other local or national changes that will influence our model for integration, e.g. the Care Act.

There has also been significant change in the local provider landscape following implementation of the Barnet, Enfield & Haringey Clinical Strategy. This has created shifts in capacity and demand throughout the local system that continues to have knock-on impacts. Some implications are clearly visible and are being managed e.g. demand pressures on community beds, whilst others continue to emerge. Until the local health economy settles down following this change it will be difficult to gain a true understanding of the new baseline for Barnet. Similarly, the recent acquisition of **Barnet & Chase Farm hospital by the Royal Free NHS Foundation Trust** has changed operational practice and subsequent service demand models. The impact of this is only just starting to be manifested in the system but is likely to impact over the next 12 months and beyond.

The population cohort most likely to represent a pressure on the system is growing. The population of Barnet is expected to increase by nearly 5% over the next 5 years (an increase of 17,308), **with disproportionate growth in both the young and old cohorts**. The effects of an ageing population will become most acute, with the over-65 population forecast to grow by 10.4% over the next 5 years and 24% over the next decade, placing increased pressure on social services and health budgets.

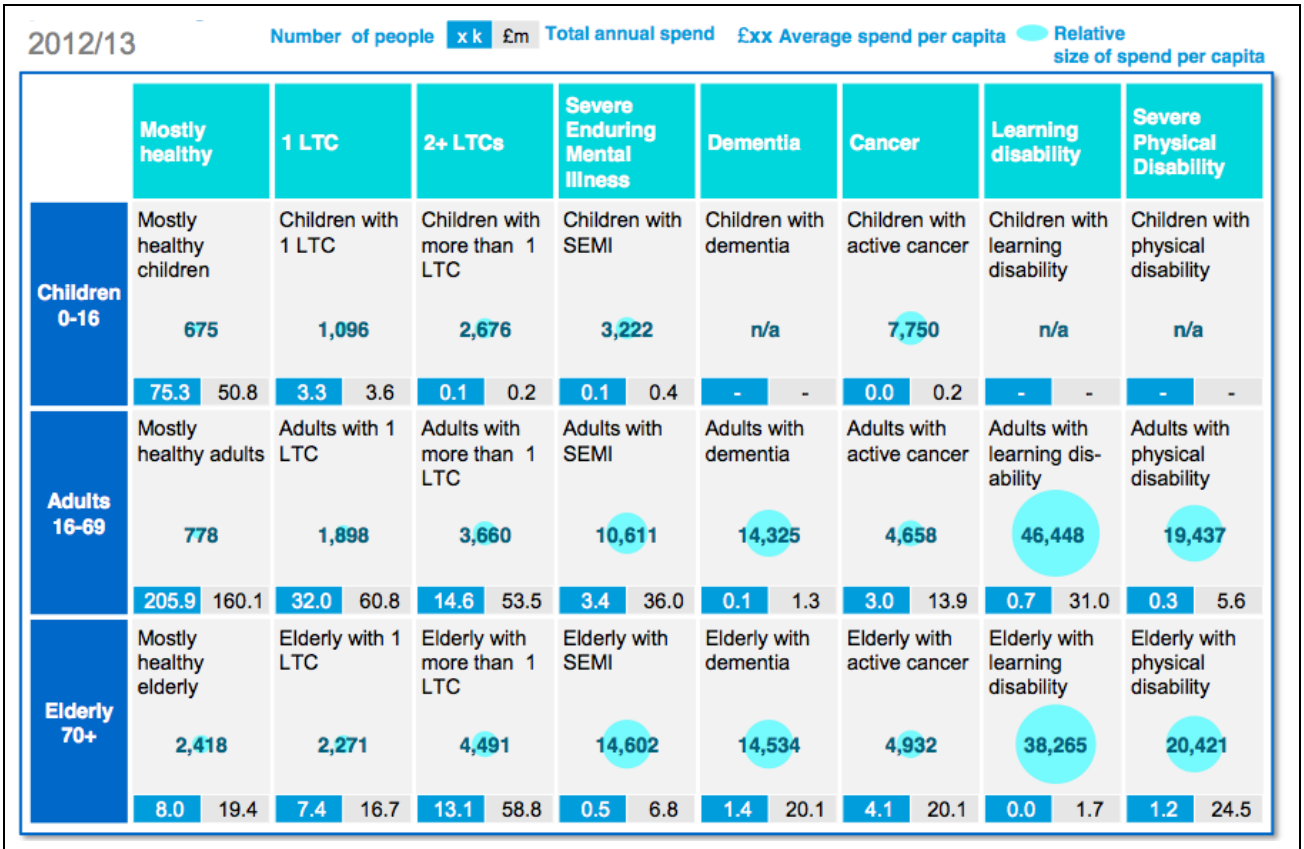
Barnet will have one of the largest increases in elderly residents out of all the London boroughs over the next five to ten years. There are currently 52,000 people in Barnet over the age of 65, and this will increase to 59,800 by 2020. We also have more than 100 care homes in the borough, disproportionately high compared to other London boroughs. Barnet's Health and Wellbeing Strategy 2012 to 2015 (October 2012) sets out our ambition to make Barnet '*a place in which all people can age well*'. The challenge is to make this a reality in the context of such rising demand and need for rising health and social care among older people, and ongoing and resulting financial pressures facing the NHS and Council.

Table 5 overleaf shows that segmentation of the Barnet population identifies that £95.5m per annum is spent on 21,900 people aged 70 or over with one or more long-term conditions or dementia. In addition £114.3m is spent on 46,600 adults with one or more long-term conditions. There are today more than 1,600 people over 65 with long-term conditions or physical frailty receiving community based care services in their home through Adult Social Care.

These figures form a natural starting point for identifying and defining specific cohorts of people in our community around which we are developing the integrated care model.

Our approach for determining the scope of the first schemes of work detailed in Annex 1 was to refine these cohorts as our target users for the services, using risk stratification. This gave us a specific view of the number and profile of those most at risk of an unplanned admission to hospital.

This approach confirmed the three main cohorts for the Plan as detailed below. Section 7d[i] sets out in more detail our approach to risk stratification and how it might evolve in line with future opportunities for detailed, parallel segmentation of the population to identify the need for new services.



	Mostly healthy	1 LTC	2+ LTCs	Severe Enduring Mental Illness	Dementia	Cancer	Learning disability	Severe Physical Disability
Children 0-16	Mostly healthy children 675 75.3 50.8	Children with 1 LTC 1,096 3.3 3.6	Children with more than 1 LTC 2,676 0.1 0.2	Children with SEMI 3,222 0.1 0.4	Children with dementia n/a - -	Children with active cancer 7,750 0.0 0.2	Children with learning disability n/a - -	Children with physical disability n/a - -
Adults 16-69	Mostly healthy adults 778 205.9 160.1	Adults with 1 LTC 1,898 32.0 60.8	Adults with more than 1 LTC 3,660 14.6 53.5	Adults with SEMI 10,611 3.4 36.0	Adults with dementia 14,325 0.1 1.3	Adults with active cancer 4,658 3.0 13.9	Adults with learning dis-ability 46,448 0.7 31.0	Adults with physical disability 19,437 0.3 5.6
Elderly 70+	Mostly healthy elderly 2,418 8.0 19.4	Elderly with 1 LTC 2,271 7.4 16.7	Elderly with more than 1 LTC 4,491 13.1 58.8	Elderly with SEMI 14,602 0.5 6.8	Elderly with dementia 14,534 1.4 20.1	Elderly with active cancer 4,932 4.1 20.1	Elderly with learning disability 38,265 0.0 1.7	Elderly with physical disability 20,421 1.2 24.5

Source: McKinsey Integrated Care Model

Table 5 – Population Segmentation For Barnet Population 2012 – 2013

Closing current variations in primary care and improving performance represents a significant opportunity for Barnet. Benchmarking shows that Barnet currently performs poorly against peers in terms of experience of and access to primary care:

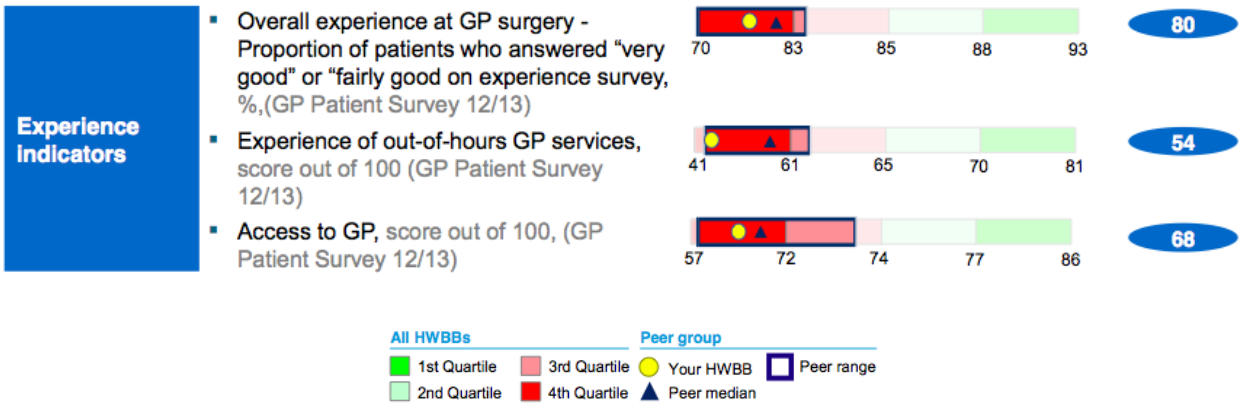


Table 6 – Access to and Experience of Primary Care: Barnet Performance Relative to Other Local Areas 2012 – 2013

In addition there is a **wide variation across the borough's GP practices in terms of non-elective admissions performance** as can be seen below. Closing these gaps represents a strong opportunity to meet challenging NEL reduction targets:

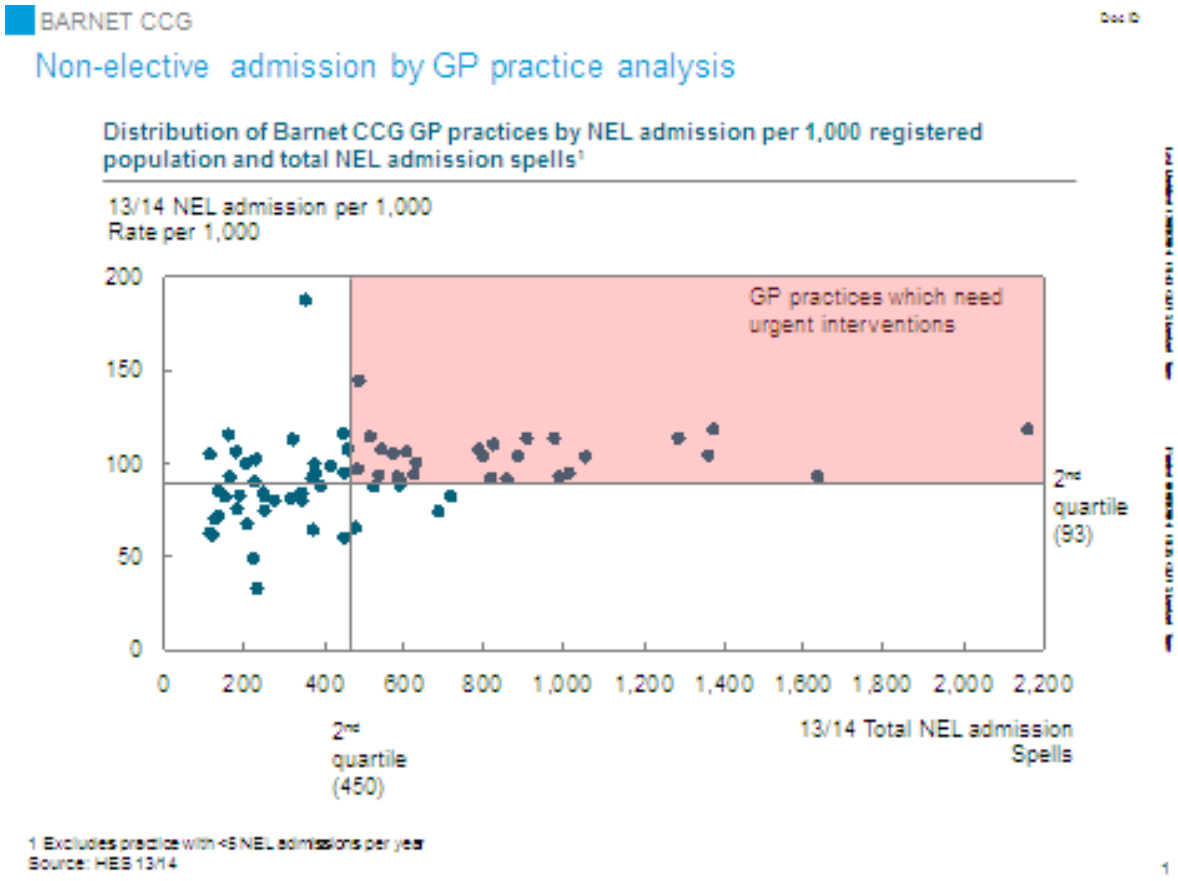


Diagram 5 – BCCG NEL Admissions By GP Practice 2013 – 2014

There are further opportunities to improve BCF metrics and to improve outcomes.

Barnet has made progress in reducing non-elective admissions over recent years with a 2.2% decrease between 2009/10 and 2013/14. This has been reinforced in the BCF Health and Wellbeing Board (HWB) Fact Pack and baseline data. It states that "Barnet performs significantly better than peers and most of England on non-elective admission rates and that activity growth is significantly better than peers and top quartile for England as a whole".

Table 7 – Barnet NEL Admission Rate per 1,000 Population 2013 – 2014

While this is encouraging, it should be noted that the reduction is not consistent and reflects unusual trends in provider activity for specific periods in 2013/14. We therefore need to be cautious in our assumptions on how this reduction can be sustained and increased going forward.

When considering benchmarking and target setting, it can be noted that the BCF HWB Fact Pack identified a limited opportunity for reducing non-elective admissions for Barnet compared to ONS and peer group data, which put Barnet non-elective activity in the top decile (all HWB). However, international scientific evidence and case examples for fully

operational best-practice integrated care suggests that full delivery of the four key components of integrated care outlined in Table 8 below could impact as a reduction of up to 37% in hospitalisations. Taking into account population growth and current performance, it is suggested that this represents a potential opportunity for Barnet of a **10 - 19% reduction in non-elective admissions over 3 to 5 years**.

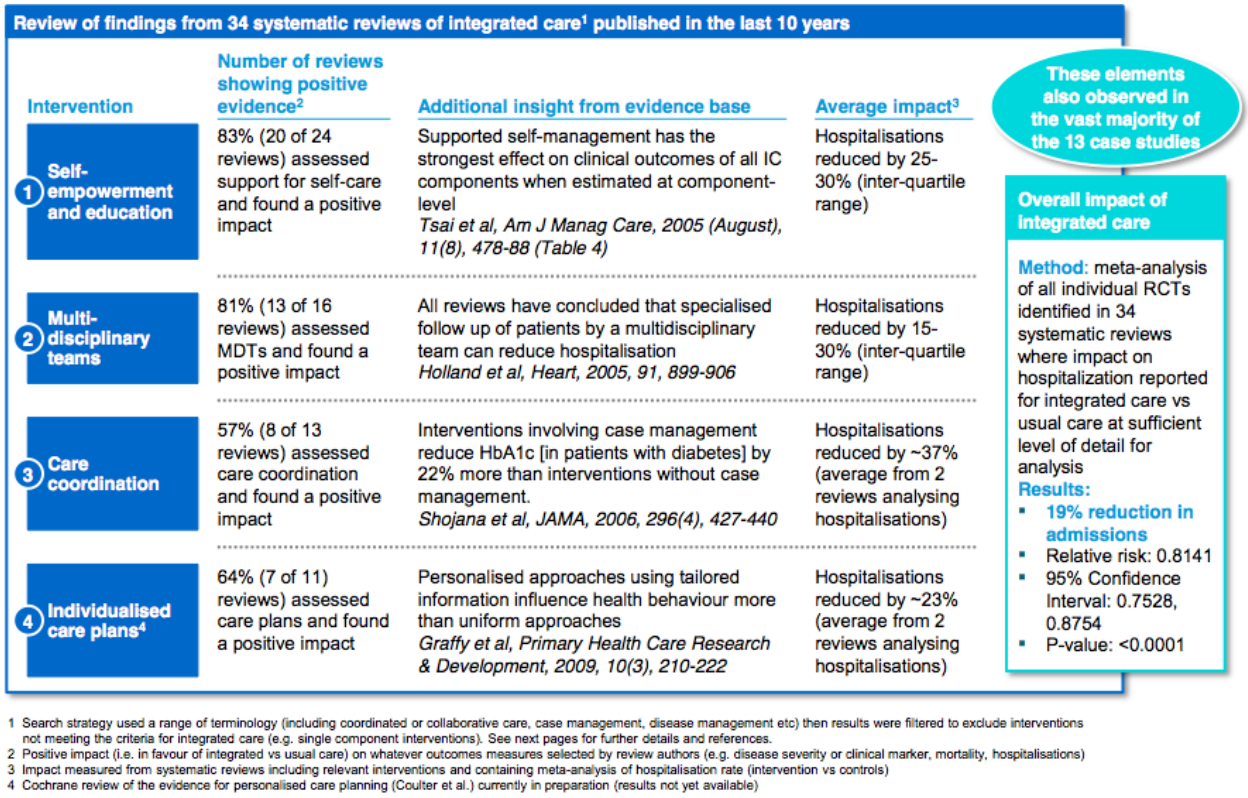


Table 8 – Review of Best Practice Integrated Care Systems 2004 - 2014

Compared to peers Barnet has the scope to improve **delayed transfers of care** to move into the top quartile (all HWB); and to increase the proportion of elderly people aged 65 or over who were still at home 91 days after discharge from hospital into **rehabilitation** or **reablement** services:

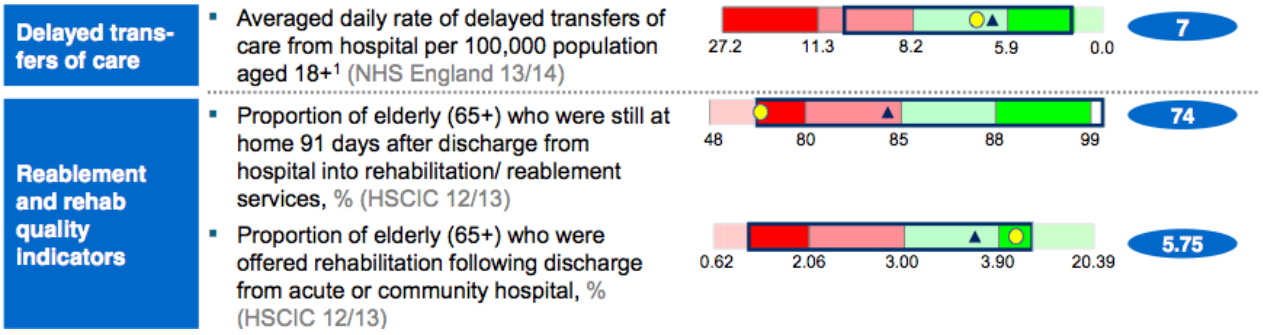


Table 9 – Barnet DTOC and Reablement Performance 2012 - 2014

It is recognised locally that the resource in the current system is not sufficiently weighted towards key services to achieve this. Of the total £133m resource envelope over 61% is

spent on acute and residential care services. Less than 3% is currently spent on self-management and health and wellbeing services, with the remainder spent in the other two tiers.

The BCF provides an opportunity to target investment in a more holistic, integrated model and accelerate the process of whole system reconfiguration.

Barnet will address the challenges set out in this case for change by moving to an integrated care model, investing in lower level, preventative and community based support, through shifting the balance of care and activity over time from hospital and longer term residential care. It will focus on the following groups of people:

1. **Frail elderly people:** people aged 65 or over who suffer from at least three of the 19 recognised Ambulatory Care Sensitive (ACS) conditions.
2. **People with long-term conditions**: those aged 55 to 65 with one or more long-term conditions.
3. People living with **Dementia**.

The target for the BCF pay for performance element is set at 3.5% (equivalent to 1,021 less non-elective admissions) in 2015 to 16. This supports a longer term plan to deliver a continued downward trend in non-elective admissions at a controlled and sustainable pace as indicated in the 5 year strategic plans.

There remains a focus on initiatives that are designed to support people to remain as independent as possible, for as long as possible; meeting statutory social care needs whilst still delivering the efficiencies required by LBB. This includes a requirement to ensure that more people can stay in their own homes with the support of enablement services and a reduction in their need for statutory care services.

Our Health and Social Care Integration (HSCI) Programme will continue as planned and through the extensive capacity and demand modelling we will re-assess how we can deliver fully on this trajectory. We also understand that there is still work to do particularly in relation to improving the patient experience to primary care and access to a GP that will directly impact on successful delivery of the Programme.

We have planned our BCF to deliver the model within limited financial resources. Given the funding allocations of BCCG and LBB, there may a requirement for additional investment into Barnet to deliver the maximum benefit from the model identified.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

A phased approach is being taken to service development over the next 5 years. The core services are those that we will be re-designing for integration, investing and re-allocating resources as necessary. These include residential care, community healthcare, homecare, and self-management or preventative services.

The accelerated programme of work will create efficiencies and financial benefits for health and social care through a reduction in non-elective admissions and length of stay for the frail and elderly population. It will achieve a step change in care delivery over a period of 2 to 5 years, leading to fewer crises, and more planned care for the frail elderly, encompassing a number of services now designated under the BCF scheme of work.

The key milestones are outlined below:

Tiers	Progress to date	2014/15	2015/16
Overall	Full Business Case approved and further validated in the context of separate modelling to support BCCG QIPP and the payment for performance element of the BCF. BCCG has analysed in detail its current and planned spend on non-elective admissions. Development of the programme of work and PMO function Governance arrangements in place	Develop Business Case to support integrated care model and strategic approach to future commissioning /contracting for approval Co-design detailed operational delivery models including phasing of delivery, funding streams, future capacity and workforce requirements. Determine outcome measures and regular monitoring mechanism with assurance Test current governance arrangements for BCF particularly in relation to agreement and monitoring of risks and benefits Agree shared PMO arrangements to support delivery programme Develop a communications strategy, including a mechanism to capture user views to effectively feed in user perspective to inform progress and continued improvement.	Test outputs of current service delivery and scope further plans Fully functional benefits tracking and financial monitoring model in place Implement communications strategy Establish and monitor financial flows to and from the pooled budget including those contributed from parties outside health and social care Develop feedback mechanism to interested parties to promote success and share learning.
1	Expert Patient Programmes planned for Autumn 2014 Telehealth pilot underway as part of Rapid Care Project Engagement with range of stakeholders including voluntary sector in development of tier specification	Deliver project plans in line with tier specifications: priority focus on self-management, e.g. defined roles of health champions and long-term condition Mentors; and healthy living pharmacy Design and deliver carers support programmes Design and implement structured education offer Pilot programmes for Telecare and Telehealth	Deliver project plans in line with tier specifications: priority focus on self-management Mainstream programmes for Telecare and Telehealth if appropriate
2	Ageing Well project operational in 3 areas	Implement early phase plan: Ageing Well	Develop an evaluation model to support development of a local

	Clear links established between HSCI/BCF Programme and public health Carers service re-design being taken forward in the context of the BCF	Design Health education package for carers Design preventative services and develop the market/ strategic partnerships in voluntary and commercial sectors to deliver. Link into Public Health team initiatives (e.g. NHS Healthchecks, healthy eating and physical activity promotions, smoking cessation) Link into "universal offer" to older people through preventative services Link into LBB carer support services	evidence base to support future commissioning Unified branding for prevention tier Use learning from care pathways re-design for Stroke, Dementia and Falls to scope, design and extend wider Tier 2 – 4 end-to-end services, in line with work programme.
3	Community Point of Access (CPA) opened April 2014 Risk Stratification Tool live in all GP Practices.	Phased roll out of Community Point of Access. Embed use of the risk stratification model as the default method for design and delivery of services for targeted cohorts, in stages by level of risk. Develop early phase plan: Shared Care Record (Business Case to be signed off)	Develop a single assessment process, using findings from the Risk Stratification Tool and other projects. Incorporate service re-design projects: dementia and end of life pathways. Implementation of the Shared Care Record
4	Integrated locality Teams trail-blazer team mobilised in August 2014 The Care Navigation Service (CNS) and Multi-Disciplinary Team (MDTs) case conferences started in July 2013. Expanded Rapid Care service in August 2013, now available 7a.m to 10p.m 7 days a week	Implement and monitor early phase plan: Rapid Care Finalise the design and delivery model of borough wide Integrated Locality Teams. Extend the scale and operations of Multi Disciplinary Teams, including assessment of higher risk individuals and planned co-ordination of care. Implement Care Homes LIS for GPs and monitor outcomes.	Rapid Care pathway development linked to PACE. TREAT and other front door services in acute settings. Embed Integrated Locality Team model expanding across service areas as required Explore role of existing Older Peoples Assessment Unit (OPAU) to offer increased clinical capacity and expertise. Develop Enablement, Intermediate and Respite Care offer to meet need.

Table 10 – Milestones for Integrating Health and Social Care Services in Barnet

Interdependencies and existing programme alignment:

- Establishment of aligned budgets for BCCG, LBB and other parties, e.g. public health, into our integrated care model to influence delivery of the BCF.
- At a North Central London (NCL) CCG level, the establishment of Integrated Provider Units (IPUs) and value based commissioning.
- Integration with new and re-designed LBB systems and services designed to meet the requirements of the Care Act, including LBB first point of contact and assessment services, information and advice offer, enablement services and new, upgraded case management and other ICT systems.
- Link into further development of 'Integrated Quality in Care Homes' team to improve standards of care and co-ordination between health professionals and care homes, especially with regard to discharge of residents, inappropriate placements within homes and lack of understanding of the role of care homes.

b) Please articulate the overarching governance arrangements for integrated care locally

Diagram 6 below illustrates the governance and board structure for the Health and Social Care Integration (HSCI) Programme.

Initial governance arrangements were put in place in April 2013. This included gateway review and approval processes for projects and work, project and programme reporting, roles and responsibilities, the Programme Management Office (PMO), risk, change and issue management processes, information governance (IG) and terms of reference.

Governance structures have been regularly reviewed as the programme has evolved and this will continue as required. The current governance and board structure is below.

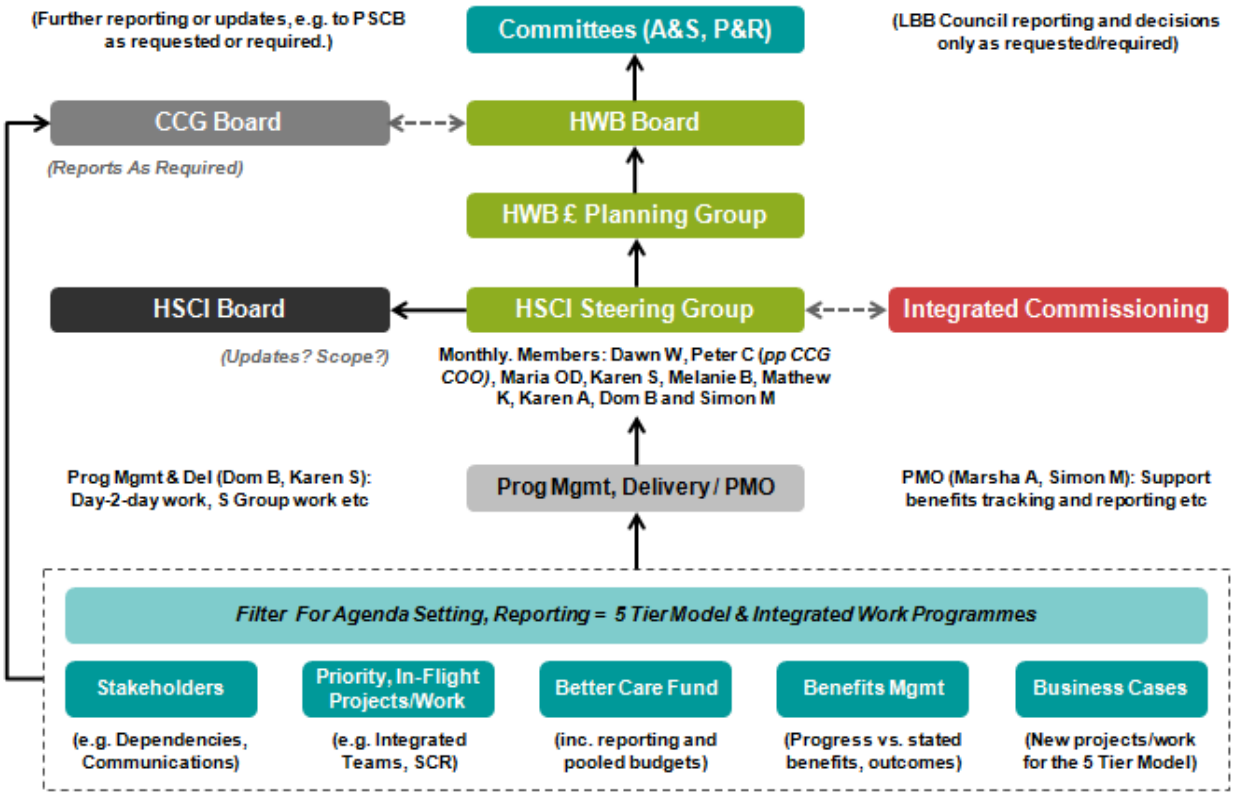


Diagram 6 – Barnet HSCI/BCF Governance Arrangements 2014

The LBB Director of Adults & Communities and BCCG Chief Operating Officer act as joint sponsors for BCF. The LBB Assistant Director of Adults & Communities and BCCG Director of Integrated Commissioning act as joint Programme Directors and Project or Tier Sponsors.

Each tier has a dedicated lead and subject matter expert. Each project has a project manager and prioritised work plan, aligned to Programme aims and objectives and agreed benefits and outcomes. Tier leads work in partnership to define strategies for delivering end-to-end services.

All Programme and project work uses approved programme and project management methodologies. Work is grouped and delivered in tranches based on priority (e.g. by its

contribution to desired benefits or outcomes and how achievable the work is against other competing demands for resources).

We will deliver and manage work and define, validate and track the realisation of desired benefits using our programme, project and benefits management methodologies and tools.

This will enable an objective and independent scrutiny and assurance of work done, with scheduled reporting and reviews to monitor outputs and to retain tight management and financial control of Programme spend and delivery.

Proposed new projects must have a viable Business Case that clearly states the strategic fit to the BCF, and financial and non-financial benefits of putting in place the changes described.

The Programme Board (Steering Group) will consider the Business Case and approve or reject it against agreed evaluation criteria, e.g. whether it meets the vision, aims and objectives of the 5 tier model, meets one of the six core BCF target benefits and outcomes, improves on the quality of services and commissioning for outcomes, or meets commercial criteria such as lower costs (i.e. reduced duplication or acute activity). If accepted the Programme will deliver the project, tracking progress and outputs against similar quality assurance criteria.

The Health and Wellbeing Board (HWB) Finance Group, a formal sub-committee of our HWB, is responsible for setting and controlling expenditure for budgets for Better Care Fund and for wider work to integrate care services, e.g. with Public Health to deliver services for Tier 1 of our integrated care model. The HWB Finance Group also monitors progress in delivering BCF services and tracking benefits realisation against these budgets, reporting back to HWB accordingly.

LBB and BCCG already have a Section 75 Agreement for integrated care in place. This started in August 2013, for an initial three year period. The agreement will be extended beyond this date by both parties to support the long-term delivery of BCF and integrated care services.

Our S75 Agreement states the aims of both parties and our statutory responsibilities for integrated care. It also contains baseline arrangements for creating and managing pooled budgets, including the role and responsibilities of the nominated Lead Party and annual accounting, auditing and reporting cycles.

We have already aligned our Section 256 and some social care and community contract budgets to design and deliver the integrated services described in this BCF plan, e.g. Integrated Locality Care Teams and Rapid Response and stroke support services.

We are now working to formalise these arrangements under a pooled budget as required for BCF. We have set up a Working Group, containing executive or lead representatives from our finance, governance and legal functions to develop and implement the pooled budget, e.g. scope and level of contributions and how this is reviewed and increased over time, risk and reward share arrangements (see Section 5b below) and operational requirements, e.g. the timing of and information required for accounting and reporting cycles.

We have already agreed a number of core principles. For example, the pool will start with the £23.4m BCF fund and increase over time to include core LBB and BCCG budgets for relevant care services. Until these budgets are transferred into the pool, we will manage them on an open book basis. The Pool will be reviewed every year in September, to define the pooled budget for the following financial year.

Work is ongoing with meetings set through December and early January, to finalise the draft arrangements as a Schedule to the S75 Agreement. This includes confirming the Lead Party and testing scenarios for annual contributions to the Pool and tolerances for managing risk and reward sharing (see Section 5b below).

Final approval of the detailed principles and arrangements for the Pool will be an agenda item for HWB, BCCG and LBB Adults & Safeguarding Committee (A&SC) meetings scheduled from January to March 2015. This is in line with advice from NHS England to sign the pooled budget and risk and reward share arrangements once our BCF Plan is approved. Our intention is to implement the pooled budget from April 2015 subject to the BCF plan receiving full approval.

A copy of our latest work plan for establishing the Pool is below.

HSCI BCF Pooled Budget Work Plan MS

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

A programme approach is in place to support planning and delivery of the Health and Social Care Integration (HSCI) Programme and BCF Schemes of work. The figure below illustrates the current and proposed scope:

Projects comprise a defined change (output) for one or more tiers, e.g. the Shared Care Record to implement a new IT system for sharing information about the care people receive, or a suite of defined changes by theme or condition, e.g. Stroke, to deliver end-to-end integrated services.

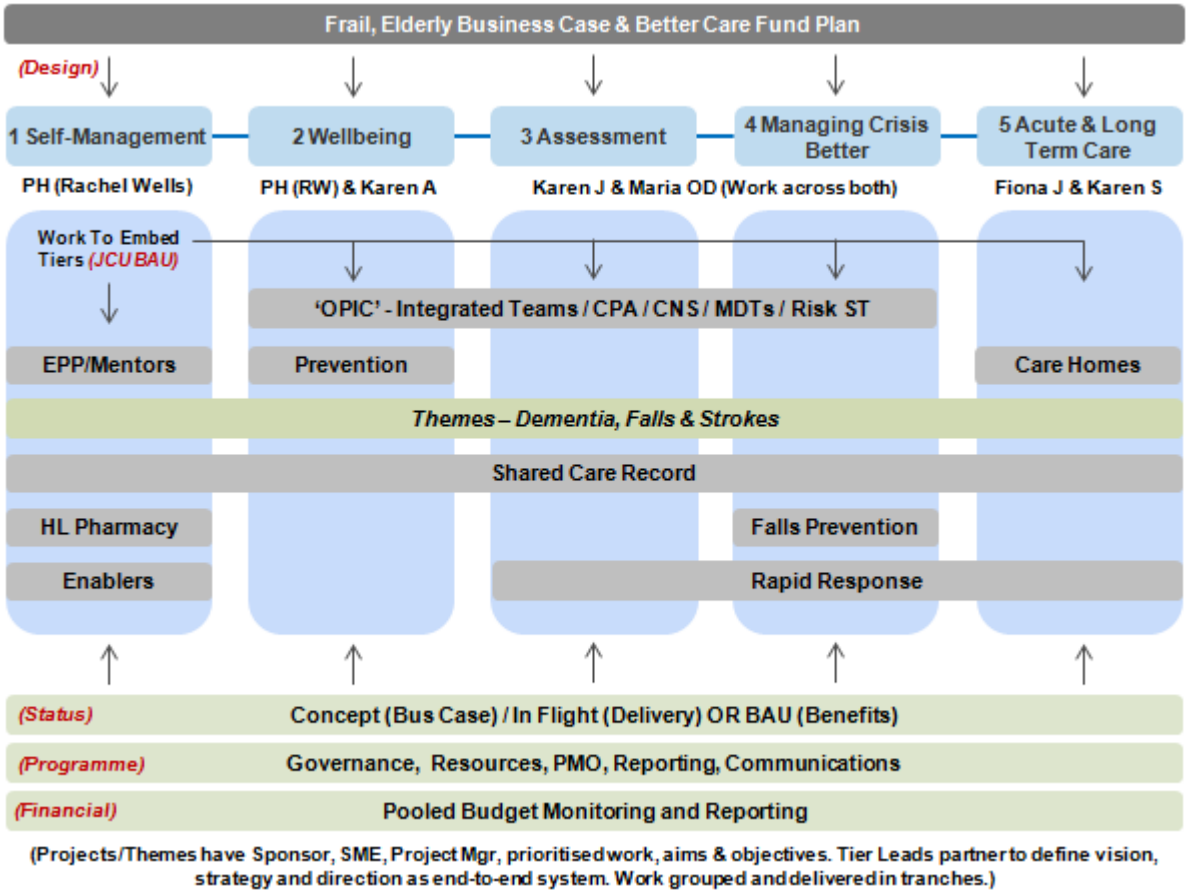


Diagram 7 – Barnet HSCI/BCF Programme Scope and Structure 2014

A Programme Management Office (PMO) will coordinate and manage Programme work and operations. This will include governance, administration, project/work delivery and reporting, benefits realisation, documentation, information control and communications and engagement with stakeholders. Governance will complement wider arrangements in place as appropriate, e.g. where decision making is to be escalated to or made directly by HWB.

As indicated above the HSCI Steering Group oversees operational implementation of the BCF. It meets monthly and has terms of reference set to flex meet the emerging needs of this BCF plan. Members include BCCG and LBB director level roles, Joint Commissioning staff, tier leads, finance and PMO.

A key role of this group will be to monitor delivery including early identification of risks and issues. If plans go off track, project leads will be expected to work with the PMO to assess the scale of any problem and to develop a remedial plan, where necessary, to re-align service delivery. If the project requires a revised approach this will be managed via a formal change request agreed with the PMO and the operational group. Direct linkages with the over-arching governance structure through senior management will facilitate this mechanism as required.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Tier 1 & 2. Self-management and prevention a. Expert Patient Programme & Long-Term Condition Mentors
2	Tier 3 & 4. Assessment & Care Planning a. Long-term conditions (dementia, stroke, falls and palliative care) b. Older People Integrated Care (OPIC) c. Care Homes
3	Tier 4. Community Intensive Support a. Rapid Care b. Seven Day Working
4	Enablers a. Service enablers b. Administrative enablers

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
3.5% reduction in non-elective admissions target is undeliverable in the context of significant local challenge and past performance	4	4	16	• Routine monitoring of activity shifts and remedial action as required • Continued analysis of interdependencies to fully understand impact and consequences • Regular updates to management teams • Governance arrangements to include risk and benefits share
Shifting resources to fund new joint interventions and schemes could de-stabilise current service providers and create financial and operational pressures.	2	2	4	• Impact assessment of integrated care model to allow for greater understanding of the wider impact across the health economy • Ongoing stakeholder engagement including co-design and transitional planning with providers • Ongoing review of impact
The recent acquisition of Barnet and Chase Farm hospital by Royal Free and subsequent change in the NHS provider landscape could impact the implementation of BCF services	2	3	6	• Provider engagement • Robust commissioning plans with contingency arrangements
Front line /clinical staff leads do not deliver integrated care due to organisational and operational pressures or lack of buy-in to the proposed agenda	4	3	12	• Increased focus on workforce development and organisational development with all providers • Front line/ clinical staff engagement and input in developing integrated care model and plans • Communications strategy with staff across the system • Incentivise provider to develop workforce models
The capacity within commissioning and provider organisations to deliver changes is limited and prevents progress	3	3	9	• Develop the Business Case to include resource to deliver the BCF plan. This could include BCCG and LBB initialisation resources to support delivery and implementation of schemes/work streams.
The baseline data used to inform financial model is incorrect and thus the performance and financial targets are unrealistic/unachievable	4	3	12	• Validation of assumptions and savings target with respective finance departments • Close monitoring and contingency planning • Define any detailed mapping and consolidation of opportunities and costs

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
				to validate plans. • Develop strong patient and service user engagement plans to ensure current information so as to flex and tailor plans to meet needs
Preventative, self-management and improved quality of care fail to translate to reduced acute, nursing and care home expenditure, impacting the level of funding available in future years	5	2	10	• Assumptions are modelled on the best available evidence of impact, including metrics from other areas and support from the National Collaborative • Use 2014/15 to test and refine assumptions with a focus on developing more financially robust Business Cases.
The local authority's financial position is challenging and significant savings from all service areas are needed to deliver cost savings and realise benefits within the planned timeline	4	3	12	• Managed and phased approach to spend and save model • Robust governance in place to support risk and benefits share • Clear identification and monitoring of saving opportunities • BCF could be the catalyst to savings in other areas of LBB spending, i.e. Adult Social Care.
The Care Act will increase costs from April 2015 and again from April 2016 resulting in increased cost pressures to local authorities and CCGs	4	4	16	• Undertake an initial impact assessment with a view to refining assumptions. • Explore and develop opportunities and benefits arising from the introduction of this legislation that may help to offset negative financial consequences. • Define the impact of the Care Act and the potential pressures on LBB and BCCG budgets as a result. • Ensure appropriate utilisation of allocated funds within BCF to meet need
An underlying deficit in the health economy impacts on service delivery and/or investment	4	4	16	• Develop a managed and phased approach to spend and save model • Ensure robust governance is in place to support risk and benefits share
Social care is not adequately protected due to increased pressure impacting the delivery of services	4	3	12	• Work with partners on developing plan for protection of services
Resources cannot be shifted from the acute sector due to members of the public presenting themselves to A&E directly or requiring emergency admissions (through pressures in other parts of the health economy) resulting in no overall shift in numbers	4	4	16	• Engage with colleagues in adjust HWB to determine their strategic changes and how it will impact Barnet • Discussions with key stakeholders including acute sector, social care community care, etc. to explore linkages and why shift is not taking place • Invest in re-educating public on use of acute sector. • Public communications strategy,

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
				including targeting primary care settings
Population characteristics and demographics adversely impact on deliverability of the model (e.g. population growth and continued net importation of over 75s into care homes from other areas)	3	3	9	• Focus on high impact project to target populations • Factor growth into planning assumptions and monitor trends
Differing discharge arrangements between Barnet and surrounding Trusts means patients receive and inconsistent service	2	2	4	• Stakeholder engagement with surrounding Trusts and GP networks • Consider working with neighbouring trusts to develop common discharge plans in line with borough specifications • MDT to monitor eligibility for services and ensure appropriate referrals
Acceptability of 7 day services impacting on integrated care model	2	2	4	• Stakeholder engagement on 7 day working • Cross system sharing of good practice

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Given the financial position of the Barnet health economy, significant emphasis will be applied to delivery of targets related to reducing in non-elective emergency admissions. Non-delivery must be seen in the context of an anticipated funding gap in Health and Social Care and will manifest itself as cost pressures within organisations and potential reduced services.

Section 4b above details our plans for establishing a pooled budget to manage the funds allocated for BCF and the corresponding risk and reward share arrangements to deal with the issues.

The amount of BCF pooled funding at risk is £2,054,100. This equates to 3.5% reduction in non-elective admissions and has been calculated with the support of informatics and finance using agreed methodologies. It builds on existing BCCG QIPP plans, particularly related to Integrated Care and Ambulatory care and reflects a 2 year plan (2014 - 16) with increasing ambition for 15 - 16. It also builds on our Business Case for Integration included here in Section 1c above. We have recently modelled 2015 – 16 following the recognised Newham/Tower Hamlets methodology.

Tables 11 and 12 overleaf list our BCF schemes that directly support achievement of this target for the next two years. They include the total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget and their contribution to the target. The savings are based on a £2,004 average unit cost per admission used in our Business Case for Integration (included in Section 1c above) and our financial model in Part 2 (spreadsheet) of our Plan.

The estimated reduction in non-elective admissions (NEL) in Tables 11 and 12 reflects the figures in Tab 4, HWB Benefits Plan of Part 2 of this submission, covering two full years (eight quarters) from 1 April 2014 to 31 March 2016. More details of each Scheme are included in Annex 1. This includes the:

- Impact of schemes on reducing nursing and residential care home admissions, improving reablement effectiveness and reducing delayed transfers of care.
- Evidence base and assumptions used to analyse the costs and benefits and their specific contribution to our target benefit and outcome measures detailed in Part 2 of this submission.

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention a. Expert Patient Programme & long-term condition Mentors	*35,000 (Not BCF pool)*	n/a	23	46,092	3.62
3, 4	2	Assessment & Care Planning a. Long-term conditions	267,357	4.03	15	30,060	2.36
		b. Older People Integrated Care	1,057,451	15.94	155	310,620	24.41
		c. Care Home – LCS	231,000	3.49	29	58,116	4.57
4	3	Community Intensive Support a. Rapid Care	636,171	9.59	413	827,652	65.04
		b. 7 Day Social Work & Enablement	300,000	4.52			
All	4	Enablers a. Services	862,021	12.99			
		b. Administrative	3,280,000	49.44			
		Total:	**6,634,000 (BCF Pool)**	**100**	**635**	**1,272,540**	**100**

Table 11 – Cost and Impact of Schemes on NEL Admissions April 2014 – March 2015

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention a. Expert Patient Programme & long-term condition Mentors	*87,120 (Not BCF pool)*	n/a	119	238,476	11.66
3, 4	2	Assessment & Care Planning a. Long-term conditions	2,722,921	11.63	110	220,440	10.77
		b. Older People Integrated Care	1,292,026	5.53	331	663,324	32.42
		c. Care Home – LCS	1,146,000	4.89	10	20,040	0.98
4	3	Community Intensive Support a. Rapid Care	1,316,464	5.62	451	903,804	44.17
		b. 7 Day Social Work & Enablement	300,000	1.28			
All	4	Enablers a. Services	10,636,589	45.43			
		b. Administrative	5,998,000	25.62			
		Total:	**23,412,000 (BCF Pool)**	**100**	**1,021**	**2,046,084**	**100**

Table 12 – Cost and Impact of Schemes on NEL Admissions April 2015 – March 2016

Part of the ongoing strategic approach to establishing the BCF pooled budget will be to ensure sustainability in the key services that will deliver the target for NEL that we require. This will involve continual monitoring and review of all services being funded under these arrangements linked to robust commissioning decisions based on evidence.

Outline priority investments are already agreed for 2015/16 and mobilisation plans will reflect availability of funding. This is supported by demand and capacity modelling in the Full Business Case. The risk of not-achieving targets will be mitigated where possible through contractual arrangements and we will work closely with providers to deliver in line with expectations. Where appropriate, contingencies to mitigate any at risk BCF funding (arising from non- or below target achievement of the NEL target) will be identified from the pool itself or other organisational funds. This could include the use of pooled budget under spend, other reserves or re-prioritisation of forward spend. BCCG and LBB corporate risk registers already reflect the risks, aims, and scope of the BCF.

Section 4b above describes our approach and work plan for our HWB and HWB Finance Group to establish a pooled budget to manage all the funds allocated for BCF and the corresponding risk and reward sharing arrangements.

Our work to finalise the pooled budget includes developing detailed arrangements for the proportion of contributions as a basis for sharing risk and reward and mechanisms to deal with:

- The impact on the Pool as a result of receiving only part of the 'at risk' funding of £2,054,000 for reducing non-elective admissions and how to offset any loss in funding, e.g. through establishing contingency funds, increasing contributions or adjusting the scope and benefits of the Pool accordingly.
- Varying the level and proportion of contributions each year, depending on policy direction, any changes to income and our agreed priorities for the future development and delivery of integrated care against Pool performance and benefits realised.
- Potential overspend and under spend of budgets and how future contributions or the level of risk and reward taken on by each Party is adjusted to reflect this and return the Pool to the level required to deliver the benefits identified.

Our Section 75 Agreement provides baseline arrangements for decision making and the risk share approach for the Pool. We will develop more detailed arrangements for HWB, BCCG and LBB Council approval for the end of March 2015 as described in Section 4b above.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

BCF is integral the delivery of our integrated care model. It consolidates existing work being undertaken and provides a clear direction of priorities and delivery for the future. The Better Care Fund is also aligned to the following initiatives and is a critical element of both BCCG and LBB longer term strategic plans (CCG 2 and 5 year plan; LBB Medium Term Financial Strategy 2015/16 and Priorities and Spending Review (PSR) 2016 - 2020:

Initiative	Dependency
Clinical service re-design particularly in relation to urgent care and long-term conditions pathways	• An enabler to shifting settings of care and improving integration between care settings
Changes to social care statutory responsibilities and service delivery. For example, increased Care Act duties and the re-modelling of the 'first contact for social care of LBB to increase the capacity to manage demand	• Demand manage new statutory responsibilities of LBB • Impact on BCF metrics and spend • New flow of users resulting in change of legislation
System-wide operations resilience planning and delivery	• Impact on non-elective activity • Manage seasonal demand and surges in line with BCF strategy • Cross-system stakeholder understand of issues and solutions
Acute service reconfiguration particularly the continuing implications of the Barnet, Enfield & Haringey Clinical Strategy and the recent acquisition of Barnet & Chase Farm Hospital by the Royal Free NHS Trust	• Impact on non-elective activity • New flow of patients resulting in shifts in capacity and demand throughout the local system • Other implications such as demand pressures on community beds
Refresh of the Joint Strategic Needs Assessment	• Identification of new demand for services in future and alignment of our plans to meet this need
Value based commissioning approach	• Identification and exploration of alternative contracting models
HSCI Full Business Case	• Critical enablers for demand and capacity modelling for delivery and future investment • Corporate sponsorship of HSCI/BCF Programme of work

The dependencies and alignment of these related initiatives will be managed through HWB and the HSCI Board and the governance arrangements described in Section 4.

Local interest in the BCF is high and as plans develop in related areas consideration will be given to how best to strategically link where necessary. This is anticipated over the next few months in relation to user engagement/ voluntary sector services and telecare. Additional work is required to align plans with Housing strategy.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Our BCF vision for delivering integrated care aligns fully with **BCCG 2 year operating plans and 5 year strategic plans**. They are built around the same **vision** for services with over-arching values and a set of **strategic goals**:

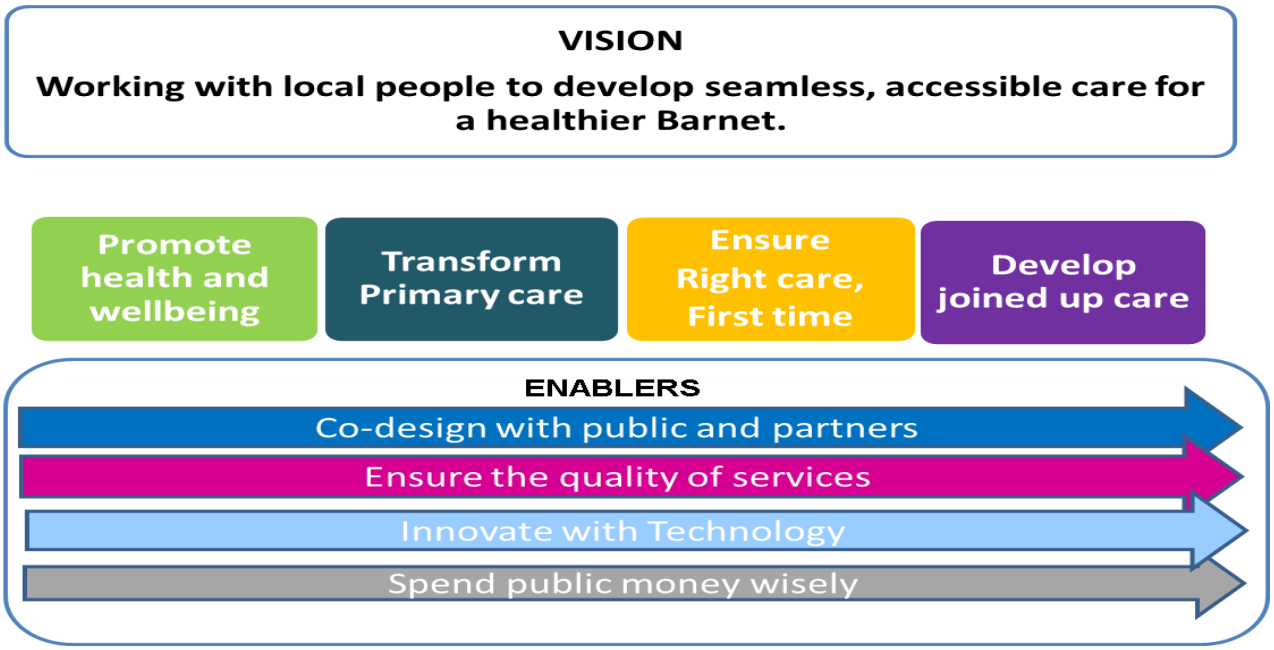


Diagram 8 – BCCG Vision for Barnet and Better Care Fund

These strategic goals set the direction of travel for BCCG whilst providing a framework, which is flexible enough to encompass new local and national priorities. They also focus on the organisational development that needs to take place to engage our stakeholders, strengthen our governance and financial management to deliver our challenging agenda. Our delivery of BCF lies in the 'Joined Up Care' Strategic Transformation Programme and encompasses a key set of priorities for 2015/16 focussed on:

- Implementation of our 5 tier integrated care model by maximising our existing resources including the Better Care Fund.
- Roll out of Multi-disciplinary teams across Primary Care.
- Roll out of Risk Stratification Tool to support Primary Care.
- Partnership working with Voluntary and Community based organisations.
- Improve care in the community for over 75 with complex needs.

The Barnet Council Local Vision is set out in its Business Planning framework for 2015/16 to 2019/20 (LBB Policy & Resources Committee, 02/12/14), specifically the LBB Corporate Plan and the Adults & Safeguarding Committee (A&SC) Commissioning Plan 2015 – 2020 which encompasses our Better Care Fund plan.

The LBB Corporate Plan contains 3 core principles – Fairness, Responsibility and Opportunity – all of which are embedded in the A&SC Commissioning Plan. This outlines how LBB will manage the key changes required by the Care Act and BCF at a time of rising demand, increased expectations and shrinking resources. The commissioning intentions support the overall vision of the Council that:

"All adults will be given the opportunity to live well, age well and stay well. This means that all adults will feel safe and be safe in their environment. Financial constraints should not hinder the delivery of good outcomes for all but to achieve this Barnet's community will need to continue to play an important part, creating responsive and responsible neighbourhoods and communities in which vulnerable adults can live well and with personal autonomy, meeting principles of fairness through a targeting of resources on those that need it most. In order to support our growing and ageing population we will need a stronger focus on prevention and early intervention with a reshaped specialist care offer for those that need it".

The proposals for implementing the 5 tier integrated care model align with the Local Vision of both BCCG and LBB. Both demonstrate a commitment to work in partnership on:

- **Alternative ways to deliver services in partnership with residents and other organisations** – for example, integrating care and health services where this delivers the best outcomes; and stronger integration with customer services and public health to help people better self-manage and plan to age well.
- **Implementing the Care Act** – for example, improved advice and advocacy and information services with a greater availability of helpful information to support ageing well.
- **Going further with personalisation by developing creative approaches to meeting care needs** – for example a shift from specialist segregated services to community settings; support to remain at home for longer and greater use of direct payments and personalised health budgets.
- **Focus on efficiency, effectiveness and impact** – for example, through the integration of services explore alternative delivery models for health and adult social care to maximise BCCG and LBB's chance of mitigating the impacts of rising demand, increasing expectations and shrinking resources.

The BCF plan is crucial in supporting the delivery of the long-term strategic, operating and financial plans for the health and social care economy through the re-design of core services to develop a sustainable local care model.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

As a member of the North Central London (NCL) CCG group, BCCG has submitted an expression of interest for primary co-commissioning to NHS England. After NHS England confirmed receipt the NCL CCG group met the NHSE NCL Area team Assistant Head of Primary Care and are pursuing further development of the plan.

The plans for the development of primary care complement the BCF plan by:

- Recognising and supporting the critical link with general practice in delivering integrated care, designing and delivering services around patients and service users.
- Enhancing the ability to commission integrated services along whole pathways, supporting in particular Tiers 3 and 4.
- Providing a platform for innovation, improvement and investment in primary care, particularly in the development of GP networks.
- Focussing on improving prevention of illness and the prevention of morbidity (or delay in onset) in clients with long-term conditions, through improving the level and range of preventative interventions within health and social care, and improving support for self-management by clients will be delivered in primary care settings.
- Developing and supporting services that deliver on the BCF metrics such as the specific local service specification for GP practices to support improved care within care homes.
- Feeding in programmes of work linked to delivery of the London Primary Care Strategic Commissioning Framework (formerly the London GP Development Standards) relating to delivering within primary care: accessible care – better access to routine and urgent care from primary care professionals, at a time convenient and with a professional of choice; coordinated care – greater continuity of care between NHS and social care services, named clinicians, and more time with patients who need it; Proactive care – more health prevention by working in partnerships with other health and social care service providers to reduce morbidity, premature mortality, health inequalities.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) **Protecting social care services**
i) Please outline your agreed local definition of protecting adult social care services (not spending)

In Barnet, protecting social care services means:

- Maintaining current FACs eligibility of substantial and critical for adult social care, and enabling the authority to meet new national eligibility criteria from April 2015.
- Ensuring that additional demand for Social Care Services which supports the delivery of the integrated care model and which delivers whole system benefits and savings will be funded.

It is recognised that the priorities for spending against the BCF are likely to be greater than the available BCF funds. LBB and BCCG agree to plan and review on an annual basis the allocation of the BCF to these priorities.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care.

The BCF includes identified funds to support the implementation of new statutory requirements contained within the Care Act. The Barnet BCF allocation includes specific funding to cover aspects of the increased demand relating to new eligibility regulations and new duties in relation to safeguarding, wellbeing, prevention and carers. Whilst this funding will not cover all the demands arising from the Act, it will be used as part of our local work to ensure that we are prepared for the implementation of the Act in April 2015.

There is a clear synergy between better access, improved care planning and community support for frail older people contained within our BCF integrated care model and the enhanced duties on local authorities in relation to supporting people to plan how to meet their care needs early on through enhanced advice, information and prevention. Barnet has a Care Act preparation programme in place and the dependencies between this and the BCF plan are being scoped.

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

- Strategic direction for BCF to take into account existing and future commissioning plans of BCCG and LBB and to have due regard to the Joint Strategic Needs Assessment (JSNA).
- An agreed shared governance framework for spend and management of the BCF with membership from health and social care. To include an approval process for services with appropriate input from relevant parties. Oversight and governance provide by HWB.

- Services delivered through a jointly owned integrated care model with emphasis on maintaining people with health and social care needs in the community. Modelling to measure impact upon and reflect changes in demand to social care services e.g. enablement with a view to maintaining or increasing where necessary.
- Maintaining and developing services for carers.
- Maintaining current FACs eligibility of substantial and critical, and through meeting needs of national eligibility criteria from April 2015.
- Where possible move to joint commissioning of services via an agreed framework e.g. care home beds, enablement.
- Working with LBB and providers to manage demand to ensure optimal usage of social care service provision.
- Embed social care services within integrated delivery models to flex operational efficiencies and build services with greatest impact on people utilising the most appropriate care choice. Example would be delivery of enablement services through locality based integrated care teams.
- Ensuring that additional demands for social care attributable to increased out of hospital healthcare are considered for funding as part of the pooled budgets.
- By ensuring that personalisation and self-directed support continue in integrated arrangements through selecting this as our local performance indicator.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total set aside for the protection of social care is £4,141,357.

In addition we have identified a further £846,000 which represents Barnet's proportion of the £135m for the implementation of the new Care Act duties.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Barnet has a clear and mutually agreed definition on what constitutes "protecting adult social care services". It is recognised that the priorities for spending against the BCF are likely to be greater than the available BCF funds, in the context of on-going austerity in the public sector and demographic change. However, to date the plans delivered and the work between health and social care support this approach.

Barnet has a Care Act Implementation Project Board which oversees work relating to the national and local requirements and to assess the impact of the Care Act reforms on Adult Social Care services in Barnet. The implementation of our 5 tier integrated care model will underpin LBB's ability to fulfil its statutory responsibilities, in particular in relation to prevention, assessment, care planning and carers.

The work of the Project Board is focused on seven work streams, each with a dedicated lead manager and implementation plan, as follows:

1. **Demand Analysis and Modelling:** delivering a picture of what the total impact of the Care Act on LBB's finance and resources will be;
2. **Prevention, Information and Advice:** refreshing and updating prevention, information and advice initiatives and catalogues;
3. **Carers:** ensuring that LBB carer's services comply with Care Act regulations;
4. **First Contact, Eligibility, Assessment and Support Planning:** ensuring readiness for national eligibility criteria, developing and implementing new approaches to assessment and support planning, ensuring sufficient capacity and effective risk mitigation arising from the likely increased take up of assessment due to the funding reforms and creating a first contact service that is able to manage demand efficiently and effectively and enable costs to be reduced;
5. **Finance:** delivering a universal deferred payment offering and making any necessary changes to charging and debt collection processes.
6. **Marketplace:** updating existing and developing new policies and processes related to market shaping and provider failure;
7. **Communications, Workforce Development and Governance:** developing and delivering internal and external communications related to the Care Act, delivering a comprehensive workforce development plan and staff training to prepare the social care workforce and co-ordinating public consultation and corporate decision making

v) Please specify the level of resource that will be dedicated to carer-specific support

The level of resource associated with carer-specific support in the BCF is:

Carers breaks	£846,000
Carers services (S256)	£300,000
Total	£1,146,000

Our integrated care model includes other elements of carer support in addition to the above funding. For example, the dementia cafes and the dementia advisor provide support to carers. However, for the purposes of this section, only funding that provides **support to carers alone** has been included in the table.

Carers are critically important in Barnet. The borough has over 32,000 carers with over 6000 providing over 50 hours of care a week. This is the second highest number of carers in the London region. As part of the modelling work for Care Act Implementation (see Section 7a[iv]) Barnet has estimated that the financial cost for carrying out additional carers assessments (including the cost of related support) would cost a projected £962k - £1.44m, against a backdrop of a financial challenge for BCCG and LBB.

Our priorities for carers are:

- Early recognition and support for carers
- Information and advice offer for carers
- Supporting carers to fulfil their employment potential
- Carers as expert partners in care

We are developing a suite of performance and monitoring tools and reports to improve our infrastructure, capacity to track contracts and performance activity in Adult Social Care and key partners relating specifically to carers. This will help us deliver improved insight and analysis about what works best, highlight risks, and inform how we optimise allocation of our BCF resources going forward.

We have reviewed our Carers Strategy Partnership Board arrangements strengthening the carer's voice in service development and commissioning, and we plan to further strengthen the role of health here working closely with the Joint Commissioning Unit.

All of the above work is coordinated through a project dedicated to Carers as part of the Care Act Implementation Project Board (see Section 7a[iv]). It highlights dependencies too, which include HSCI and Family Services (Children and Families Act requirements around young carers and transition).

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Overall the impact has not changed significantly compared to original submission (the Barnet BCF allocation includes approximately £1.206m to cover some aspects of the increased demand relating to new eligibility regulations and new duties in relation to safeguarding, wellbeing, prevention and carers).

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

We have already made reasonable progress to establish 7 day working in Barnet but we recognise the need to enhance further the scope and reach of services already in place.

We have engaged with a variety of stakeholders to get agreement and commitment to seven day service delivery particularly during the design phase of our integrated care model through:

- Co-design working sessions for integrated care in 2013/14. These sessions included patients, LBB, GPs and Acute and Community Service providers as outlined in Section 8.
- NCL wide sessions to share development plans, ideas and best practice

We are working towards implementing the national standards for 7 day services in urgent and emergency care within the next three years. Our intention is to develop a programme across three years to embed seven day services into core contracts for services and the intention is for all of the clinical standards to be incorporated into the national quality requirements section of the NHS Standard Contract for Barnet's provider services.

High level delivery plan associated with the move to 7 day services:

Priority action	**Milestone**
Acute services	
Extension of hours of tracker nurse provision to support identification of those who could be discharged	Nov 13
Supported assessment, triage and discharge arrangements within local acute trusts including Urgent Care Centre (UCC), ambulatory care pathways, PACE, TREAT and RAID to extend over 7 days.	Ongoing
Operational resilience plans agreed to test some 7 day delivery. Outputs to be evaluated to inform future planning. Examples include occupational therapy and access to pharmacy.	Awaiting plan sign off
Undertake action in service development and improvement plan identifies 7 day working to assess current position and develop forward plan for delivery for national seven day standards	2014/15 onwards
Community & Primary Care services	
Extension of 7 day provision of core community services to 7 days – district nursing, intermediate care and Rapid Care. To include night sitting where required	Nov 13
Links established between services above and current providers of seven day services (e.g. out of hours GPs and London Ambulance Service (LAS))	May 14
Barnet Community Point of Access is operational providing an effective and safe referral point to facilitate access to rapid response/nursing teams over 7 days.	April 14

Refresh of current alternative care pathways with LAS to facilitate avoided admissions.	Ongoing
Social Care	
Social work and Occupational Therapy teams operational 7 days per week within A&E departments at both main Acute hospitals to support care planning for transfer home	Jan 14
Access to new and amended packages of care throughout the weekend	Jan 14
Other	
Ongoing managed system for Delayed Transfers of Care involving all providers facilitating and unblocking reasons for delay and allowing for transfer throughout the 7 days period.	Ongoing
A communication strategy with over-arching view of the services available and to stream-line referrals and transitions across interfaces.	tbc

Table 13 – Barnet Milestones for the Roll Out of 7 Day Working

Collectively, this delivery plan will result in:

- A consistency of service delivery over 7 days that will even out pressure points and lead to reduced non-elective admissions including at weekends
- More integrated approach to individual care with clear pathways from assessment to care planning and delivery
- Increased discharges over the weekend with confidence of appropriate support

The key risk associated with delivery of 7 day services will be implementation of the clinical standards for 7 day services by acute providers, acceptability amongst staff and population demographics related to acuity.

c) **Data sharing**

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Locally we recognise the importance of joint working across all health and social care services. The NHS Number will be used as the primary identifier for integrated case management, data exchange and care reviews. It is already used as the unique identifier for most NHS organisations across Barnet.

Social Care includes the NHS Number with some client records; however, this is not currently required for all client information. Adult Social Care is in the process of procuring a new case management system, which will be implemented by April 2015 and will result in the recording of the NHS Number for all social care clients from this point forwards.

To further support this integrated care, we are implementing the Barnet Shared Care Record. This project, which has been agreed and approved by HWB and overseen by the Health and Social Care Steering Group will be a key enabler for sharing information between care providers:

- The Barnet Shared Care Record Project will first implement the service in 2015.
- It will not replace local systems, but will provide a single view of an individual's care by combining information from all the care providers in the Barnet area.
- It will use the NHS Number as the unique identifier to combine data about individuals and data submitted to the Shared Care Record must use it this way.
- Initial data providers have been identified as those that will already have the NHS Number included in their records (e.g. GP Records, Community Health).
- Change in business processes will reinforce the use of the NHS Number as the primary method for identifying individuals alongside the roll out of the Shared Care Record in early 2015.

Following initial roll out of the service, the project will work to increase the data in the Shared Care Record and to improve the process of sharing. The project plan outlines an approach to work with these care organisations during 2015/16 to where the NHS Number is not currently in use to undertake the preparatory work required to move to routine use of the NHS number as the primary identifier in the process of information sharing.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The use of Open Standards and Open APIs is a principle that is adopted and built in to the procurement of any new system (e.g. the recent Adult Social Care procurement of a new case management system includes the requirement to use Open APIs and Open Standards (e.g. ITK) both in the mechanisms used to connect to local systems and the method for interfacing with external systems).

Requirements also include the adoption of common formats for information/data (e.g. CDA). From a technical perspective a system that securely uses Open Standards and/or Interfaces will be prioritised over an identical system that does not.

Where existing systems are required to be enhanced or changed specifications always include the use of Open Standards and non-bespoke development whenever possible. Where new development is required (e.g. new messaging interfaces) LBB will always seek to publish these and have them approved.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

LBB / BCCG operate within an established information governance (IG) framework, including compliance with IG Toolkit requirements and the seven principles in Caldicott 2.

The contract documents used by BCCG to commission clinical services conform to the NHS standard contract requirements for IG and IG Toolkit Requirement 132.

BCCG as a commissioner and to the extent that it operates as a data controller is committed to maintaining strict IG controls including mandatory IG training for all staff, and has a comprehensive IG Policy, Framework, IG Strategy and other related policies.

IG arrangements and the IG Framework conform to IG Toolkit requirements in Version 11 of the Toolkit, including clinical information assurance as set out in requirement 420 and the requirements for data sharing and limiting use of Personal Confidential Data in accordance with Caldicott 2.

In addition to maintaining a current PSN Code of Connection, LBB is working towards compliance with the latest NHS IGT V12 which will be completed by the start of 2015. All new projects / business process changes complete an IG Impact Assessment prior to initial approval and activity is routinely reported to Information Management and Governance Groups.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

For the target cohorts of people listed in Section 3, risk stratification has given us a specific view of the proportion, number, profile and characteristics of those people most at risk of unplanned admissions to hospital.

This approach has identified 1,975 adults in the highest risk cohort and 17,463 adults in the next. The data also indicates that PbR costs associated with people in classification levels 2 and 3 are £85m, representing approximately 52.4% of total spend.

The latest view of the level of risk for the BCCG population is as follows:

Risk Level	Population Percentile	Number of Patients	Risk Ratio Range	Ave Risk Ratio	Average In Patient Admission (planned same day care)	Average Unplanned In Patient Admission	Average Unplanned Chronic In Patient Admission
3	0% to 0.5%	1,975	25.925- 40.226	32.230	11.51	3.99	2.77
2	> 0.5% to 5%	17,463	4.785- 25.914	10.216	2.03	0.77	0.36
1	> 5% to 25%	77,463	0.783- 7.785	1.806	0.34	0.09	0.02
0	> 25% to 100%	297,226	0.05- 0.783	0.304	0.08	0.01	0.00
Total Population		394,127		1.198	0.274	0.105	0.044

Table 14 – Risk Classifications for the Barnet Population December 2014

This underpins the scope of services offered in Tiers 3 and 4 which in turn is the basis for partnering with GPs to proactively engage with these people to offer the services.

Approach

BCCG uses a recognised risk stratification tool and in August 2014 we completed an accelerated programme to implement the tool in GP practices and train practices to use it. All GP Practices now have and use the tool to identify patients at risk of a future unplanned hospitalisation within the next 12 months due to chronic conditions. It predicts future health risk based on recent patient activity using predictive models. The following data sets are used to determine the relative risk of patients within a given population:

- Primary Care (GP Registry, GP Medication and GP Activity Data) and
- Secondary Care (SUS PbR/SEM datasets including in-patient, out-patient and A&E activities)

The data links to the Kaiser Long-term Conditions triangle by classifying patients into 3 levels and then assigns the RISC level of a patient following a scoring process:

Total Population Level	RISC % Range	RISC % of total population	LTC Triangle population (top 26% of total PCT Population)	LTC Triangle % of total population
3	0% to 1/2%	1/2%	5%	1.3%
2	>1/2% to 5%	4-1/2%	15%	3.9%
1	>5% to 25%	20%	80%	20.8%
0	>25% to 100%	75%	Not Included in LTC Triangle	74%

Table 15 – Barnet Risk Stratification Tool Classifications

The following diagram shows which elements for the Schemes described in Section 2 above are designed for and impact on each risk category (grouping):

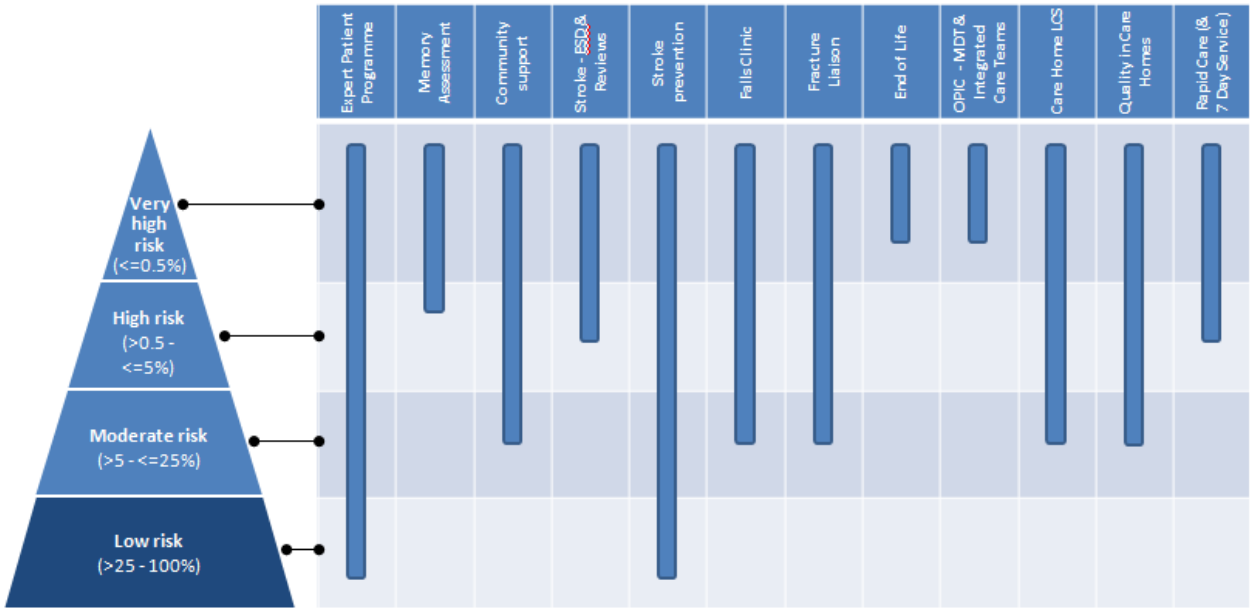
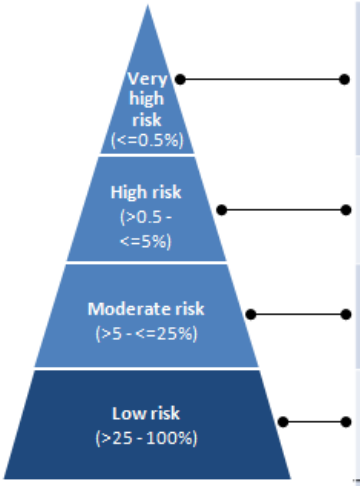


Diagram 9 – Risk Classifications Targeted By BCF Scheme Elements

For the population cohorts (by risk level) listed above the following table details the costs of the schemes and their impact on reducing non-elective admissions for each initiative:



Pop (All)	Pop (65+)	NEL Adm (65+)	Cost (£m)
1,975	1,617	4,045	21.75
17,463	13,718	3,292	42.58
77,463	36,010	104	11.05
297,226	745	0	8.60
394,127	**52,090**	**7,441**	**83.98**

Scheme	Cost (£m) *	NEL Adm Impact	% NEL Target
2b 2c 3a	2.34 1.37 1.95	9 4 87	0.54 0.24 5.25
2a 2b 2c 3a	2.99 2.34 1.37 1.95	23 88 35 779	1.39 5.32 2.11 47.04
1 2a 2b	0.19 2.99 2.34	112 100 389	6.76 6.04 23.50
1	0.19	30	1.81
n/a	**8.84 ****	**1,654**	**100**

Total:

* Total cost of project over two years, shown for reference purposes only. Schemes 3b, 4 do not contribute direct benefits in reduced admissions and so are not included.
** Total cost of individual schemes 1, 2a to c and 3a, not the total of the individual costs listed.

Diagram 10 – Cost and Impact of BCF Scheme Elements for Barnet by Risk Level

Our approach to using risk stratification to implement this first tranche of our integrated care model will include:

- Supporting GP practices to use the tool regularly to inform care planning and case management in line with the GP Admissions avoidance DES from NHS England as part of the GMS contract for 2014/15.
- Embedding use of the tool as a partnership approach with the Integrated Locality Teams to put in place a framework for integrated joint assessments and the role of the accountable lead professional.
- To link risk stratification to current service provision, and where necessary, re-align to target those patients identified through the risk stratification model to maximise clinical and financial impact.
- Agreeing an approach for risk stratification in future to ensure continuity.

Over the longer-term, we will work with all stakeholders to assess opportunities to move to commissioning of services through risk stratification or detailed segmentation of the population. We expect our BCF plans to evolve as implementation continues and we are able to measure the impact of changes made.

At the same time the technology and breadth, depth of data used in risk stratification will continue to evolve, increasing the value of the insights provided.

As a result risk stratification may be better utilised for niche cohorts or the planning and the delivery of individual scheme elements, working together with parallel segmentation techniques. Or segmentation may emerge as the best approach for Barnet overall.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

A number of existing and planned models will ensure that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Key elements include:

- Use of risk stratification in primary care (as above) to identify those most at risk of admission to ensure that they are actively case managed.
- A weekly multi-disciplinary team meeting that provides a formal setting for multidisciplinary assessment and health and social care planning for very complex high risk patients who require specialist input. This accepts referrals from multiple sources including primary, secondary and social care and results in collective ownership of a planned care approach.
- A care navigation service that provides a care co-ordination role following MDT assessment.
- Admissions avoidance DES as per GP contracts for 2014/15 where new responsibilities for the management of complex health and care needs for those who may be at high risk of unplanned admission to hospital have been introduced. In particular, to case manage vulnerable patients (both those with physical and mental health conditions) proactively through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator.
- Planned introduction of Integrated Locality Teams incorporating health and social care with anticipated streamlining of care according to patient need rather than referral point. This will also bring into play a generic long-term condition approach which will enable early identification and care planning for future management of exacerbations.
- An enhanced GP service focussed on care homes to provide a much more holistic management approach to supporting homes to reduce admissions.

Barnet has an agreed format for assessment, allocating lead professional, planning care and monitoring success measures of interventions. To date this has been a paper-based approach operated on a small scale led by the MDT. It has fed directly from risk stratification that was, until recently, being undertaken manually by GP.

With the roll-out of the risk stratification tool and the introduction of the Integrated Locality Team trailblazer during the summer of 2014 we have an increased ability to target those most at risk of admission and so see a shift in approach and activity.

A key principle of using the bottom-up build operational model is to provide the freedom and the permission for partners, including GP practices, to work together to develop and agree a robust framework for joint assessment and care planning.

To remove potential barriers to success we have focussed the work around the needs of the patient and, in particular, are advocating an outcomes based approach to make the benefits tangible to those delivering care. We have also created an environment that supports innovation and ownership of the model with the commissioner only providing

high level outlines of requirements to allow for innovation and advocating a hands off commissioner position to allow for problem solving and planning by the teams themselves. Development of a risk and issues log will identify clearly the possible barriers to implementation of the model on a longer term or wider basis that can then be addressed as part of ongoing implementation. It is intended that this work taken forward will include:

- Working directly with GP practices to assess risk stratification data together to determine how best to prioritise the numbers of people who need care planning and case management to address those most at need and high climbers (those with a significant change in risk score over a short period of time).
- Agreeing an ongoing outcomes-based mechanism to allocating of accountable lead professional across a range of providers and clinicians. This is envisaged as the single contact point for the patient and other professionals in relation to the ongoing care plan for an individual. They may not be fully responsible for the delivery of all care to that patient but will have an overview of what the care plan encompasses, what next steps may be required for the patients and can support timely decision making.
- Developing a fit for purpose joint assessment framework that can be utilised and is accepted across the system.
- Developing and introducing a standard care plan.
- Assessing and evaluating the inter-dependency between the team and the Admissions Avoidance DES to ensure that GPs are supported in being accountable for co-ordinating patient centred care.
- Identify any gaps in service, including evaluating whether current systems accommodate to the needs of those with dementia and mental health problems adequately.
- Active consideration and challenge to crossing boundaries of care to reduce the numbers of people working directly with the patients and to explore possible opportunities and efficiencies.
- Evaluating the need for keeping a ‘watching brief’ approach for a proportion of the population.
- Outlining how often patients should have their care plan re-evaluated and hence could move within the framework.

Utilisation of an exemplar framework as overleaf may be beneficial.

	Requires Care Plan?	Joint assessment	Active Management & accountable lead professional (ALP)
Very High Risk	Yes – Plan may include action points to be picked up by community, social or specialist services.	Yes for some.	Yes for some. ALP agreed as part of assessment and care planning. May be allocated via MDT approach across GP, community services, social or specialist services
High Risk	Possibly – particularly for 'high climbers' with identified significant change in risk score	Possibly high climbers	Possibly high climbers. ALP – generally GP with some managed under MDT
Medium Risk	Not generally	No	No ALP - GP
Low risk	Not required. Patient may benefit from information via navigation services	No	No ALP - GP

Table 16 – Cost and Impact of BCF Scheme Elements for Barnet by Risk Level

The pilot team will work with 7 GP practices in one locality. This will be followed by a planned roll out across the area over the next year.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

From July 2013 to July 2014 233 people were managed via the MDT and all had a jointly agreed care plan. These figures are expected to increase as detailed above.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

A range of individuals and organisations have been involved in developing the constituent services within the BCF plan, and the over-arching plan itself, making patient and service user views integral to the Vision for Integrated Care in Barnet.

The patient engagement and service user groups we approached to shape our vision were **Healthwatch Barnet, Barnet Older Adults Partnership Board** (a resident and service user engagement group)**, Barnet Older Adults Assembly** (a large user and carer forum), **Age UK (Barnet), Alzheimer's Society** and others.

We also drew on experiences and feedback gained at **Council** and **BCCG public engagement** events and in broader project-based consultation exercises such as **Guiding Wisdom for Older People**.

Our care model incorporates universal preventative and self-management services, such as the **Barnet Ageing Well** project. This initiative was developed in response to needs identified by the community.

The **integrated care model** was developed from feedback from local residents. Ongoing involvement and oversight by the co-chair of the Older Adults Partnership Board keep the strategy grounded and progressive.

We have not only used requirements feedback from engagement groups to inform strategy but also used groups to test the practical implementation of that model. Workshops were held with Older Adults Partnership Board members, Older Adults Assembly meetings and public forums. These were facilitated by Healthwatch, and enriched with interviews and surveys.

Feedback from patients and service users was key in helping us develop our vision in particular:

- Meeting the changing needs of the people.
- Allowing for greater choice on where and how care is provided.
- Promoting individual health and wellbeing to be managed by that person.
- Listening to and acting upon the views of residents and providers to improve patient experience and care.

Further under-pinning this, and picking up the work of National Voices, BCCG is participating in a **value-based outcomes commissioning programme** with other NCL CCGs. Patient and service users have been involved from the outset through multi-disciplinary workshops to develop an agreed outcomes hierarchy and as part of expert reference groups to test and validate the findings. The continuing work with Camden CCG, focussing on frail and elderly populations, will equip health commissioners to change the way in which they do business to achieve patient-centred goals.

Continued patient, service user, carer and public engagement are essential to bring momentum to the implementation of the **integrated care model.** Moving forward, we will continue to use the existing **Older Adults Partnership Board** framework as the key patient and public representative group with involvement from service users, carers, Healthwatch and the voluntary sector. We will develop an engagement strategy with this forum at the core that will allow us to ensure in-depth engagement, and involvement in planning and monitoring, from residents as we implement the model. This will include:

- Tier specific workshops.
- Engagement with experience panel or reference groups, the Barnet Seniors' Assembly, a group of over 150 older local residents supported by LBB.
- Engagement with other partnership boards, e.g. carers.
- Membership of relevant steering groups.
- Links with other organisations communications strategies e.g. BCCG and Age UK.
- Engagement with voluntary sector and existing services (e.g. Neighbourhood model) to engage hard to reach communities.
- Co-production approaches to new specifications.

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

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Key NHS partners include **Royal Free NHS Foundation Trust** (following the recent merger with Barnet & Chase Farm NHS Trust), **Barnet, Enfield and Haringey Mental Health Trust**, our community health services provider, **Central London Community Healthcare NHS Trust**, hospices and **London Ambulance Service**.

Our BCF plan has its foundations in the **Barnet Health and Social Care Concordat** – a clearly articulated vision for integrated care agreed by all partners.

The concordat was co-designed by the partner members of the **Health and Social Care Integration Board (HSCIB)**. It provides the over-arching strategy for delivery endorsed fully by service provider recognition and support. The integrated care model has been formally supported by providers as above as key members of the HSCIB and is embedded within organisational plans.

The plan brings together work in progress in individual organisations (health, social care and voluntary sector), joint work being undertaken through the work programme of the HSCIB and emerging priorities as identified in a newly developed 5 tier integrated care model co-produced with partners.

For key schemes already underway, such as Older People Integrated Care and Rapid Care, service providers are active participants in existing frameworks and work collaboratively to design, implement and manage services with commissioners. This occurs through a variety of mechanisms such as operational co-production, steering group memberships and front-line delivery. We have taken this further with development of locality based integrated care teams (July 2014) through a bottom-up build approach via a shared trail-blazer team.

Service provider involvement in the integrated care model has been achieved through participation in the 'as-is' mapping of current provision and spend, development of a target operating model, and by involvement in a series of design workshops which focussed on opportunities and operational deliverables. This has brought realism to the plan and shared ownership through a commitment to improve care for the people of Barnet. This continues with providers being actively involved in developing the plans for implementation including acting as tier sponsors in relevant areas. A key development has been the establishment of the bi-weekly Barnet Integrated Care Strategy steering group. This is co-chaired by the sponsors for tiers 3 and 4 and encompasses projects being delivered in tiers 3 to 5. It provides the forum to influence operational delivery and explore the implications of the BCF, in detail, beyond the high level principles and financial models that are embedded within existing operational plans.

Our **Clinical Commissioning Programme for Integrated Care** gives us a joint forum for commissioners and providers. This will be further aligned to form a core part of the service provider engagement vehicle moving forwards. With HSCIB running alongside, our plan embeds service provider engagement at both operational and strategic levels.

ii) Primary care providers

The primary care infrastructure in Barnet includes 67 GP practices, our out-of-hours provider Barndoc and 77 community pharmacies. GP practices are structured in localities with designated BCCG Board member and management leads. In additional to practices operating individually we are seeing an increasing shift towards network development resulting in increased service delivery on this basis. This will be explored further in terms of a future delivery model.

GPs were involved in the development of our 5 tier integrated care model with a number providing input and challenge to the OBC process. These included BCCG Board member GPs and others with a specific interest in older adults. We also value the support of GP clinical leads to provide expertise and clinical advice in relation to service re-design and operational plans.

The wider GP network has been engaged through presentations at locality meetings and through discussions with the LPC. There is an ongoing programme of communications and engagement underway with events targeting the Integrated Locality Teams and the introduction of the Care Homes Locally Commissioned Service. GP leads have been identified for key services to ensure that their views are integral to operational standards and fit for purpose.

We recognise that extensive engagement is essential to implement integrated care and will develop a primary care facing plan on a broader basis over the next few months.

iii) Social care and providers from the voluntary and community sector

Current plans have been jointly developed with anticipated delivery largely expected through Joint Commissioning.

Strong working partnerships exist between commissioners and provider side teams within LBB (e.g. social work) with sponsorship of key projects and with an established co-production approach. This is now most visibly seen within the bottom-up build Integrated Locality team where a number of staff are central to leading the change management process. In terms of service re-design they are active stakeholders in informing direction of travel and providing feedback on suitability.

The ongoing work has also supported a facilitative approach to building key stakeholder partnerships across the system, particularly between social care and community services, and collectively we are now working collaboratively to understand respective organisational perspectives, concerns and issues. By fostering joint ownership of the model and centring the work on the needs of Barnet patients and service users we aim to adopt a shared approach to innovation and problem solving.

Other key partners have been in included in developing integrated health and social care services, such as Housing 21, other care agencies, Barnet Homes, and various voluntary sector providers (Healthwatch Barnet, Age UK and the Alzheimer's Society and British red Cross). There is very much a growing interest in this area from partners and we are harnessing the energy, enthusiasm and skill by inclusion in steering groups and experts by experience panels as appropriate.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Our main acute provider is now Royal Free NHS Foundation Trust working through 2 key sites in Hampstead and Barnet. Extensive re-configuration of local infrastructure and service provision has recently be completed with changes to the Chase Farm hospital site, as outlined in the Barnet, Enfield & Haringey Clinical Strategy, and the acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free Hospital. This has resulted in shifts in demand and activity through 2013/14 which will impact for this year and beyond.

The ongoing financial position of BCCG is well known by acute partners including a recognition that extensive service re-design and a robust QIPP programme is required to deliver a stable system in financial balance. Therefore we have a very strong focus on:

- Transformational change of the health system by providing integrated care for patients with complex needs as defined in this plan. With proactive identification, care planning and integrated management of care for such patients we will seek

to avert crises, thus reducing the unplanned use of acute care;
- Reducing elective acute care through the robust management of referrals and the re-design of care pathways to provide upstream early intervention, a greater range of care in primary care settings and community based alternative care.

Relationships with providers of acute services are proactive and constructive and they actively demonstrate support for our over-arching strategy behind BCF and its aims.

The current BCCG QIPP plans for Integrated Care (2014/16) represented savings of approximately £3.1m as outlined in contract negotiations and agreed plans. The revised BCF guidance (July 2014) requires greater ambition in terms of movement of costs and services away from acute, primarily in the form of emergency admissions, and hence the savings methodology and projections for the second year of this plan have been scaled up. It has also used information from the 'Appropriate Place of Care Audit' and the modelling associated with the full Business Case to understand the numbers of non-elective patients who are receiving care in an inappropriate location, and the capacity and demand limits of current provision.

Revised savings equate to 1,021 less non-elective admissions in 2015 to 16 with a relative estimated impact on the acute sector as outlined in Table 17 below. This reflects the 3.5% ambition in line with the BCF but should be noted as being a significant challenge in light of the wider financial, demographic and environmental issues in Barnet. The numbers below are based on a different costing model to above (as derived from BCF guidance) and simply represent indicative workings that require further validation.

	Estimated Activity Reduction 15/16	**Estimated impact at £2,004 (amended to reflect local cost with MFF)**
Royal Free (Barnet site)	656	1,314,626
Royal Free (Hampstead site)	307	616,230
Other	62	123,244
Total	**1,021**	**2,054,100**

Table 17 – Estimated Impact of BCF Plan on Acute Service Providers 2015 to 2016

With current BCCG contractual arrangements funding will follow the patient, therefore any additional acute activity resulting from non-delivery of the target will be reimbursed in accordance with agreed tariffs. This will mitigate the risk somewhat for providers although it is recognised that deviation from plan could create operational issues. Current systems will continue in terms of demand management and urgent planning and these will directly support reductions in emergency admissions and capacity and surge management.

ANNEX 1 – Detailed Scheme Descriptions

Scheme ref no.
1a.
Scheme name
Expert Patient Programme
Scheme description
Pilot scheme and roll out of generic and disease-specific Expert Patient Programmes – organised by individuals who have existing long-term conditions.
What is the strategic objective of this scheme?
The objectives of this scheme are to: • Empower patients to self-care and manage their condition. • Optimise individual patient's health status. • Increase knowledge, understanding of long-term conditions and lifestyle/behavioural influences. • Improve the patient's experience, and • Mitigate for unnecessary A&E attendances and unplanned hospital admissions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme will enable community social care professionals (health and primary care) to refer older people who have just been diagnosed with a long-term condition, into the Expert Patient Programme. The scheme will be organised by people with existing long-term conditions, and who are therefore sensitive towards individual issues and needs. In addition, these trainers will have the ability to signpost the patient to other local support services such as long-term conditions Mentors. The primary objectives of the projects in this tier are to up-skill people and improve health literacy. This will make individuals with long-term conditions more confident about looking after their health. Structured patient education programmes based on specific long-term conditions will also be introduced alongside the generic Expert Patient Programme. The content and structure of these courses will be determined by a systematic review of needs evidence and service piloting results. The outcome of this analysis will highlight which course subjects will have the biggest impact on particular cohorts within Barnet. It is envisioned that the disease specific pilots will focus on one or more of the following long-term conditions: diabetes, CHD, pain management, respiratory conditions, dementia or depression. The generic and disease specific programmes will be launched (staggered) as follows: • Pilot of generic programme: January 2015 • Pilot of disease specific programme: April 2015 Evaluation of the various pilots will help to determine an optimum programme for Barnet's residents. The generic programme, the disease-specific programme, or a combination of both will be rolled out to up to 5% of the eligible population of older people with long-term conditions should the pilots prove to be successful (currently 1,975 older people with long-term conditions).
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Project lead: Steve Buck/Lisa Jacob Project plan in place to deliver phase 1 from January 2015. This will be provided by **SM:UK** and will be delivered through 3 cohorts of 16 people each based in community venues in each of the 3 localities.

Phase 1 is being sponsored by Public Health and commissioned in partnership. The initial programme is partly funded on the basis of a successful BCCG bid last year and identified Public Health sitting alongside the core BCF pool. Costs will therefore be excluded from the part 2 submission.

Plans for April 2015 are in development and we are currently exploring links with existing structured education programmes in Barnet. Current plans make provision for roll out to 240 people in 2014/15.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

Research into the success of expert patient programmes has produced mixed results. For example, a number of papers have suggested that further analysis and a review of comparator schemes is necessary before the full effectiveness of such programmes can be gauged. However, despite some criticism, there exists a general consensus that these programmes reduce both costs and service utilisation e.g. GP's.

Background paper on the Expert Patient Programme for NICE Expert Testimony (A. Rogers) – This expert paper reviews the effectiveness of this Expert Patient Programme launched by the Department of Health in 2001. Although the results are very mixed, it is reported that there was a moderate increase in self-efficacy amongst the patients who joined the programme. In addition, overnight hospital stays reduced across the target cohort, and there was an overall reduction in service utilisation. These factors are likely to offset the costs of intervention, making the programme a cost effective alternative to usual care for long-term conditions. To summarise, the paper states that any expert patient programme should be able to meet a wide range of needs for patients with long-term conditions, rather than focusing on one course.

In addition, the HWB Fund Fact Pack highlights the importance of self-empowerment and education to a successful integrated care system. Significantly, the average impact of support for self care was estimated at 25 - 30% reduction in hospitalisation (impact measured from systematic reviews).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment – the costs of the projects for 2014-15 are estimated at £122,120. However this currently sits outside the proposed main BCF pooled budget and so is not included in Part 2 of this submission.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

The evidence base suggests that savings of between £452 (DoH) and £987 (SM:UK) can be expected per person with respect to reduced admissions. Using these assumptions the impact is estimated at 142 (23 + 119) reduced non-elective admissions over the BCF period as indicated above.

Key assumptions in the financial model:

- Estimated cost of an emergency admission is £2,004 based on local calculations
- Roll out of programme to 5% of population aged over 65 with long-term conditions over 5 years. Cohort size for 2015-16 is 240 people
- Benefit based on £987 saving per person risk adjusted to reflect:
    - 95% attendance rate - based on national data and local knowledge of Barnet residents
    - Time lag in benefit gain

To ensure the Expert Patient Programme is fulfilling its primary objectives, we have planned for an evaluation of the first cohort. This will assess local impact/programme outcomes and will be measured against key success criteria and performance indicators. It is intended that the results of this review will inform future commissioning. As a result we may need to re-plan the level and timing for realising the

benefits identified in this plan
Assumed Benefit Map – Expert Patient Programme:

Benefits Map 1 - Expert Patient Progra

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use "Benefit Cards", an important control document containing all the information for all agreed benefits for each scheme, which enables us to monitor and measure the delivery of scheme outcomes and benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- Clear programme of structure education linked to benefits
- Structured education supported by relationships between primary care, specialists, carers and patients
- Professional development and support from long-term conditions specialists.
- Acceptability and utilisation of programme by population

Scheme ref no.
2a.
Scheme name
Long-term Health Conditions (dementia, stroke, falls and palliative care)
Scheme description
Increase the scale of services to support people with long-term conditions.
What is the strategic objective of this scheme?
The objectives of this pilot scheme are to: • Improve clinical outcomes across the cohort of individuals with the specific long-term conditions identified. • Invest in community and other services to provide better care for patients with long-term conditions, keeping them out of hospital and creating financial benefits. • Reduce the number of emergency admissions for people with long-term conditions. • Provide patients with services closer to home. • Facilitate advanced care planning to support end of life care in the patients preferred place of death.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme forms part of Tier 3 and 4 (assessment and care planning) and represents a family of services targeted at long-term conditions – primarily dementia, stroke and falls. It also encompasses end of life care with the recognition that this needs to fit seamlessly into pathways for the management of long-term conditions. **<u>01 Dementia Services</u>**: Two key service developments are being taken forward in relation to dementia at this stage. 1. **Memory assessment service** - re-design of the existing memory service to create a discrete fully functioning memory service to meet the Memory Service National Accreditation Programme (MSNAP) and National Dementia Strategy standards. 2. Development of a **community support offer for people with dementia and their carers**. To include dementia hub with resource centre, dementia advisors and dementia cafes. Dementia Friendly Communities Project. **<u>02 Stroke Services:</u>** Suite of three services to focus on prevention of stroke, and improved outcomes post-stroke through early supported discharge (with appropriate rehabilitation at home) and robust review. 1. **Early stroke discharge** -increase the provision of specialist intermediate care / rehabilitation for stroke in the patient's home by increasing early supported discharge capacity, reducing the length of stay in hospital and acute activity and freeing up resources. 2. **Stroke reviews** - to establish a formal stroke review service: every stroke survivor in Barnet to receive a 6 month review using the GM-SAT tool to prevent further strokes which will result in better outcomes for patients. 3. **Stroke prevention** - to support an increase in the recorded prevalence of Atrial Fibrillation in primary care, and treat them with anticoagulation across the sector using the GRASP AF tool. This is a preventative measure that will reduce the number of people having a stroke and avoiding admissions etc.

03 Falls Service:

The Falls Service will focus on preventing falls in the community by indentifying susceptible patients and facilitating education, exercise and fall recovery. Furthermore, it will work with/offer treatment from the multi-disciplinary teams to ensure a holistic approach to preventing further falls.

1. **Falls Clinic** – re-configured clinic modelled to best practice standards focussing on therapy led interventions (with medical support) to provide a seamless patient-centred, integrated and comprehensive service. Targeted to those who have fallen or those at risk of falling. To act as a the central hub for a co-ordinated falls offer in Barnet linked to primary care, falls co-ordinator and fracture liaison service. To establish clear pathways into ongoing voluntary sector strength and balance classes.
2. **Fracture Liaison Service** - aims to identify people who may be at risk of further falls or fractures in acute settings, providing comprehensive assessment and specific treatment recommendations.
3. **Falls co-ordinator** - To support the development of an integrated falls system in across Barnet and promote this across the whole health and social care economy linking voluntary sector, health and social care sector falls prevention initiatives

04 Palliative / End of Life Care:

Service re-design is currently underway in relation to end of life care through a comprehensive mapping exercise and review of the current pathway in partnership with multiple stakeholders. The over-arching aim would be to update the pathway to reflect a more integrated approach with clear pathways into and out of other supporting pathways including those managing long-term conditions. Focus will be retained on quality of care, advanced care planning and preferred place of death. The two key in-scope services in relation to the Better Care Fund are:

1. **Home based palliative care service** providing a key link between district nursing and hospice / acute service to support patients and carers in the last few weeks of life. The service offers additional resource at this time, tailored to identified needs, aimed specifically to enable people to die at home if this is their preferred choice.
2. **Palliative care provided through hospices**. This includes access to in-patient beds, out-patients consultant and nurse-led clinics, home visits and counselling/bereavement services.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All projects noted are within the work plan for the Joint commissioning unit and hence have nominated service commissioners and project plans.

Service area	Commissioning lead	Provider	Progress
Dementia – Memory assessment service	Caroline Chant	**Barnet. Enfield & Haringey MHT**	Operational to new spec from May 2014
Dementia - community support service	Caroline Chant	**Alzheimer's Society**	Operational. Re-procurement planned
Stroke – Early Stroke Discharge	Caroline Chant	**Central London Community Health**	Operational to new spec from April 2014
Stroke – Reviews	Caroline Chant	**Central London Community Health/ Stroke Association**	Operational since Summer 2013. Ramping up activity
Stroke – Prevention	Caroline Chant	**Primary Care**	Ongoing

	Falls – Falls clinic	Ette Chiwaka	**Central London Community Health/ Age UK (Barnet)**	New service expected Dec 2014
	Falls – Fracture Liaison Service	Ette Chiwaka	**Royal Free NHS Trust**	Operational since July 2013
	Falls – Falls Co-ordinator	Ette Chiwaka	**London Borough of Barnet**	Recruitment completed October 2014
	Home-based palliative care	Ette Chiwaka	**Central London Community Health/ North London Hospice**	Ongoing
	Palliative Care	Ette Chiwaka	**North London Hospice/ Marie Curie Hospice**	Ongoing

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

Despite the many positives that come from growing older, there is also a higher risk of deteriorating health, reduced wellbeing and lack of independence. At present, there is estimated to be 23,355 people aged 65 or over in Barnet with a limiting, long-term illness.

01 Dementia service – The elderly cohort is expected to increase by more than 20% over the next ten years. The chances of developing dementia are significantly increased in old age. Barnet will experience an increase in the volume of dementia cases reported, because the life expectancy of its residents is continually increasing. In 2012, Barnet had a higher population of adults with dementia than any other London Borough (the 2012 percentage was also significantly higher than national averages). In 2014, there was estimated to be 4,000 people living in Barnet with dementia. This number is rapidly increasing (1.5 times faster than other London locations) making this a key challenge for health and social care.

02 Stroke service - There are approximately 400 strokes per year in Barnet with an estimated health cost of £5,743 per patient (2011-12). In 2013 we identified that although mortality rates is good compared to England and London averages, hospital admission rates were significantly higher than the national average and in addition Barnet patients were significantly more likely to be readmitted to hospital within 28 days of discharge. Evidence suggests that an appropriately resourced Early Supported Discharge service provided to a selective group of stroke patients can reduce long-term dependency and institutional care (Langhorne, P. 2005; 2007) as well as being cost effective (Beech et al 1999). Alignment with the National Stroke Strategy would also require all stroke survivors and their carers to receive regular reviews of their health and social care needs.

In relation to stroke prevention the Barnet Joint Strategic Needs Assessment (JSNA) states that "unless we take steps 16% more people will suffer from strokes by 2020". This links to a growing and ageing population. In Barnet there were 4,168 cases of AF on QOF registers in Barnet (2010/11), this gives Barnet an AF prevalence of 1.1% (370,335-total list size). The national average is 1.43% and hence identifies an opportunity to close the gap. Evidence suggests that optimal management of AF in the population could reduce overall risk of stroke by 10%i.

03 Falls service - Falls and the related injuries are amongst the most common medical problems experienced by older adults. Around 30% of over 65s living at home experience at least one fall a year,

rising to 50% of adults over 80, who are living at home, or in residential care. The burden of falls is equally felt in both the acute and social care setting as it involves LAS, A&E, primary care, urgent care providers, community services, local authority and third sector. Barnet identified a growing trend in falls related admissions; with an FY 11/12 spend of £3.3m, an increase in of 10.5% since FY 09/10. This is illustrated in the table below, which shows the spend on falls related activity by age group and provider in Barnet ,2011/12:

	Fractured neck of femur		Other codes related to Falls		Total	
Age Band	**No of Patients**	**Cost**	**No of Patients**	**Cost**	**No of Patients**	**Cost**
65-69	8	£46,621	62	£144,273	70	£187,894
70-74	15	£114,902	57	£126,242	72	£244,143
75-120	203	£1,333,940	757	£1,543,352	960	£2,877,292
Total	**226**	**£1,462,463**	**876**	**£1,816,867**	**1102**	**£3,309,330**

Due to the preventable nature of falls, it is felt that this is an area where cost savings can be made by ensuring that there is a focus on preventing and managing falls, as well as having a seamless pathway that can deliver appropriate care to our population closer to their homes.

04 Palliative / End of Life Care - In Barnet the current expected death rate is 486 per 100,000 (JSNA); with a higher rates in the older population. In 2011 non-cancer related deaths accounted for over 70% of deaths in Barnet.

The End of Life profile published in 2014 and recent work with stakeholders has highlighted a number of areas for development in Barnet namely:

- Preferred place of death. Most deaths in Barnet occurred in hospitals 1285 (54%) and only 434 (18%) occurred in the home with an additional 18% in care homes. This falls far below the aspirational levels of patients which indicate that 63% want to die at home.
- Care homes. Although the rate of deaths in care homes in Barnet is lower than England Average there is still room for improvement towards the England Lowest rate.
- Cost of admission. Evidence suggests that the estimated average cost of an admission is £2,506 and approximately 15% of admissions ending in death have a stay of more than 21 days. More importantly, they are likely to be poor care experiences for the person, and their relatives and carers. Expert opinion suggests that such long stays are often the result of gaps in services and an inability to discharge.
- Traditionally palliative care services have been oriented towards cancer care. As indicated above 70% of deaths are non-cancer related and hence could be linked to long-term conditions such as respiratory and neurological disorders and dementia.

Noting these themes, our BCF schemes recognise the importance of end of life care particularly in terms of embedding it within integrated care pathways both for a planned response (with advanced care planning) and to react quickly to sudden changes in medical status. Through 2015-16 our re-design of care pathways will continue to develop an integrated approach linked to GPs, Integrated Locality Teams, Rapid Response and carers support.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment – Outlined in the tables below. Breakdown:

- Dementia services are £395,632.
- Stroke Service is £487,868
- Falls services is £539,691
- Palliative Care services is £1,300,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Savings estimate based on reduced non-elective admissions, reduced admissions to care homes and delayed transfers of care over the BCF period. This is based on:

Non-elective admissions	Falls	Estimated relative impacts of 10%, 25% and 35% related to reduced admissions for falls and fractured neck of femur over the next 3 years. This is supported by evidence from other areas of the country and NICE. Based on the reach of the combined falls clinic and fracture liaison service at 984 people per annum. Phasing adjusted to reflect planned timelines for roll out of schemes.
Care homes	Dementia	22% reduction in admissions to care homes based on the "Department of Health (2009) "Living well with dementia: A National Dementia Strategy". Benefits model based on 780 new diagnoses of dementia per year within the memory assessment service. Time lag noted and hence benefits risk adjusted for 15-16.
Delayed transfers of care	Dementia	Reduction in excess bed days by 272 over BCF period in line with current projections in our local Business Case. Assumptions falling from *Counting the cost report* (2009) and DEMHOS study data that indicate that 25-35% of patients with dementia admitted with 4 specific medical problems; and evidence suggests that if this duration were to be reduced by seven days per patient, the total national savings would be almost £117m per year. This target represents a 50% reduction in excess bed days from the 2012 baseline for patients with dementia in first 10 diagnosis codes on admission.
Delayed transfers of care	Stroke	Reduction in excess bed days by 272 over BCF period in line with current projections in our local Business Case. Expected benefits to be achieved through targeting of services towards active management of length of stay at the HASU and ASU in line with PbR tariffs and trim points. Initial local evidence suggests an average reduction in excess bed days of 1 – 2 days per stroke patient utilising ESD with planned 35% increase in capacity people supported to go home straight from HASU and additional reduction in excess bed days in ASU. Evidence based on successful projects in Berkshire and Camden (REDS) and supported by the London Stroke network.

Other key assumptions from the financial model with respect to long-term conditions services:

- Estimated cost of an emergency admission is £2,004 based on local calculations
- No direct benefits from Dementia support services, Stroke review, Falls co-ordinator or Palliative

Care services at this stage to eliminate overlap.

- Optimism bias applied to service lines to accommodate for potential overlaps, time lag in benefits realisation or to account for interventions where there would not have resulted in the desired impact

Non-financial benefits are included in the embedded benefits map:

Benefits map LTC.docx

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use Benefit Cards, an important control document containing all the information for agreed benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
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		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.
- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- Improved long-term conditions management for in-scope services.
- Increase in preferred place of death.
- Interdependencies between service elements and other schemes (self-care) need to operate appropriately to deliver full benefits.
- Professional development and support from specialists in long-term conditions is important.

Scheme ref no.
2b
Scheme name
Older People Integrated Care (OPIC)
Scheme description
OPIC is the combined view of a number of different existing projects/services: Multi Disciplinary Team Case Conference (MDT), Care Navigation Service (CNS), Barnet, Community Point of Access (CPA), Risk Stratification Tool (RST), Barnet Integrated Locality Team. All focus on the delivery of assessment, care planning and co-ordination.
What is the strategic objective of this scheme?
The over-arching objectives of the services above are to: • Ensure that the right people receive proactive case management in a cost effective manner. • Allow care providers to focus case management on individuals that will benefit most. • Avoid duplication e.g. multiple assessments, by providing co-ordinated care. • Provide a Community Point of Access for referrals to community health services enabling clear and responsive communications between HCPs across all sectors. • Prevent unnecessary A&E attendances and unplanned hospital admissions. • Optimise individual patient's health status through case managed healthcare. • Optimise individual patient's community support through case management as well as access to social care. • Prevent or delay elderly admissions to long-term care and packages of care. • Empower patients to self-care and manage their condition. • Improve the patient's experience.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
01 Multi Disciplinary Team Case Conference (MDT) The MDT conference brings together health and social care professionals into a weekly case conference to assess and agree a care plan for the individual needs of frail and elderly patients identified as at highest risk of hospital attendance or significant deterioration in health. This is targeted at the most complex cases where standard measures have been unsuccessful or a particular risk is identified. **02** Care Navigation Service (CNS) The Care Navigation is the interface between the MDT, the Integrated Locality Team (ILT) and the patient. They improve the health, wellbeing and independence of frail and elderly patients through the provision of case management, care co-ordination and signposting. Target cohort generally originates from the MDT or the ILT. Over time the team will become an integral part of the ILT. **03** Barnet Integrated Locality Team Currently being piloted as a trail- blazer team, this is an MDT comprising health and social care professionals, mental health support and end of life support and voluntary sector input. The teams will come together into a single unit to develop a joint assessment and care planning approach that links directly with users and carers. They will support adults in the community, in partnership with local GPs, who are living with multi-morbidity and complex long-term conditions. This is based on the successful models based in Greenwich and other areas. **04** Risk Stratification Tool (RST) A software based risk stratification tool is being used to identify frail and elderly patients at risk of future unplanned hospital attendance or deterioration in health.

05 Barnet Community Point of Access (CPA)

The Barnet Community Point of Access acts as a central point to receive and manage referrals for adult community health services, ensuring urgent and non-urgent referrals and requests are pro-actively managed to enable rapid co-ordinated care and effective planned care. Urgent calls are identified quickly and services deployed to prevent admissions and to support longer term care.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All projects noted are within the work plan for the Joint commissioning unit and hence have nominated service commissioners and project plans.

Service area	Commissioning lead	Provider	Progress
MDT	Muyi Adekoya	**Primary Care, Royal Free NHS Trust, Central London Community Health, London Borough of Barnet, North London Hospice, BCCG, Barnet, Enfield & Haringey Mental Health Trust, London Ambulance Service**	Operational since July 2013
CNS	Muyi Adekoya	**Central London Community Health**	Operational since May 2013
ILT	Muyi Adekoya	**Phase 1 - Primary Care, Community Health, Barnet, Enfield & Haringey Mental Health Trust & London Borough of Barnet. Phase 2 – planned Royal Free NHS Trust, North London Hospice,**	Trail blazer team live – August 2014
Risk stratification	Muyi Adekoya	**United Health**	Accelerated deployment July/Aug 2014
Community Point of Access	Muyi Adekoya	**Central London Community Health**	Operational since April 2014

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

A systematic review of integrated care (IC) report findings (over the last 10 years) as outlined in the HWB Fact Pack showed that of the 16 services that had assessed support for MDTs, 81% found that interventions had a positive impact on their IC Programme. In addition, all reviews concluded that

specialised follow ups by a multidisciplinary team reduces hospitalisations. The average impact of an MDT was a 15-30% reduction in hospitalisation (impact measured across systematic reviews).

57% (8 out of 13) of those who assessed care coordination said that it was an important component of integrated care. An average taken from two reviews showed that care coordination reduced hospitalisations by 37%.

64% (7 out 11) of those who assessed care plans found a positive impact. An average from 2 reviews suggested that hospitalisations were reduced by 23%.

This evidence is also backed up by feedback and benchmarked activity from areas such as Tower Hamlets, Torbay and Liverpool which have seen significant reductions in acute activity.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment: Outlined in table below. Current indicative breakdown:

- MDT is £112.592
- Care navigation is £497,366
- ILT is £262,020
- Risk stratification tool is £121,983
- Community Point of Access is £298,065

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Savings estimate based on reduced non-elective admissions, reduced admissions to care homes and delayed transfers of care over the BCF period. This is based on:

Non-elective admissions	Benefits model based on evidence supporting reduction of hospital activity in the most at risk cohort identified from risk stratification. This is estimated at 30% reduction of costs across the system targeted to proportion of the target cohort (1992 people) subject to case management, personalised care plans and/or multi-disciplinary teams. This is in line with the scientific evidence and case examples contained in Barnet BCF Fact Pack which highlighted systematic reviews *(Holland et al, Heart 2005; Shojani et al, JAMA 2006; Graffy et al, Primary Health care Research & Dev, 2009)* of such services resulted in reductions of 15-37%. There is also broad support in recent UK based Integrate Care Programmes (Tower Hamlets, Torbay) with an emerging evidence base for quantified benefits. Local evaluation of pilot scheme in September 2015 has identified similar outputs to systematic reviews in relation to non-elective admissions (24% reduction). As this is an emerging service model expected to grow through 15-16, benefits will be subject to monitoring and further evaluation as the scheme progresses Assumptions for delivery of 486 (155 & 331) over BCF period.
Care homes	Although there is a limited amount of national evidence to suggest that Integrated care services will delay or reduce the need for permanent care home admissions (e.g. Cost of Dementia Care report by Health Foundation states that 18% fewer people could need residential care after two years with care management to coordinate health and social care); further work is required in Barnet to quantify such benefit particularly in the context of the high number of beds in the system (approx. 2800). This is particularly relevant in the context of implementation of Care Act responsibilities and cross-over with services such as Carers and enablement. A local evidence base has been derived from the evaluation of our pilot OPIC scheme (small scale demonstration of no additional costs to social care from projects and potential to

	reduce demand) and analysis and modelling of current enablement services (efficiency gains identified through demand management for more intensive services such as Homecare, residential and nursing care, acute care – estimates suggest 15-20% reduction). This is further supported by a successful ongoing programme of work within LBB to ensure that care home placements are offered appropriately within the support offer (5% reduction in placements in 13-14). On this basis, a target of 12 fewer permanent admissions to care homes has been set for 14-16 and 15-16. This will be monitored and re-validated in year.
Effectiveness of rehab/reablement	Target to increase people who leave enablement/rehab with no home care or increase to current package by 23 (11 & 12) through BCF period based on local analysis and modelling of current enablement provision and local service improvement initiatives. As above, efficiency gains of 15-20% expected through demand management for more intensive services such as Homecare, residential and nursing care, acute care. Access to enablement service has been secured for the ILT team to ensure clear pathways in and out and to support ease of referral. Substantial evidence base as outlined in Developing Intermediate Care, Kings Fund 2009 and Halfway Home, DH 2009.

Other key assumptions from the financial model with respect to OPIC:

- Estimated cost of an emergency admission is £2,004 based on local calculations.
- No direct benefits from Community Point of Access and Risk Stratification Tool included.
- Optimism bias applied to service lines to accommodate for potential overlaps, time lag in benefits realisation or to account for interventions where there would not have resulted in the desired impact.
- Approach will subject to continued evaluation through 15-16 and will flex to accommodate planned changes to service structure in line with the development of ILT and to revise benefits accordingly.

Benefits Map – OPIC:

Benefits Map 3 - OPIC (Annex 3).docx

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use Benefit Cards, an important control document containing all the information for agreed benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL	
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0	
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0	
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0	
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
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		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- Fully integrated OPIC service with seamless transition between elements.
- Interdependencies with other services in terms of benefits.
- Primary care engagement in care co-ordination and MDT role.

Scheme ref no.

2c

Scheme name

Care Homes – Locally Commissioned Service (LCS)

Scheme description

To improve the quality and level of care provided in care homes throughout the borough.

What is the strategic objective of this scheme?

The objectives of the scheme include:

- To improve the **quality of care** in homes.
- To improve the relationship between the care home and the GP.
- To commission a more holistic medical offer to care homes through a distinct service from GPs to include a fortnightly ward round, six monthly holistic reviews and post-admission reviews and medication reviews (over and above the service commissioned under current GP GMS and PMS contracts).
- To increase the level of **proactive and preventative care** given in care homes, anticipating when issues may arise and preventing crisis. Particularly in relation to **preventing avoidable emergency admissions**.
- To support people's preference of place of death through advanced care planning.
- To provide education and training to care home staff and managers to empower them to improve quality of care.
- To establish networks between care home to facilitate shared learning and best practice.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

There are 2 components to this scheme as outlined below:

1. **Care Homes Locally Commissioned Service** - Many GP practices provide care to people within care homes; however, it is acknowledged that this group have higher needs than the general population. Therefore, a locally agreed service has been commissioned by Barnet CCG, in addition to the essential and specialised services within the GMS/PMS contract.

   The service includes all care homes, including homes for elderly people and people with learning disabilities or multiple disabilities. The expected input from GPs is:

   a. Increased proactive GP input into care homes.
   b. Introduction of weekly GP ward rounds (with care home nurses as appropriate) in particular focussing on new admissions to the home and patients who have been recently discharged from hospital, ensuring that a medical review is carried out and a care plan is in place.
   c. Introduction of a 6 monthly holistic review of all patients under the care of the GP.
   d. Support the home with planning and delivery of end of life care, meeting the gold standards for such care, and
   e. Closer working with the home to promote high standards of clinical care within the home.

2. **Quality in Care Homes Team** – Commissioned via LBB, this dedicated resource supports the 105 care homes in Barnet in terms of benchmarking of core standards and providing support to improve quality. Key focus is on improving leadership in care homes by empowering management to take ownership of quality issues and to adopt alternative ways of problem solving and preventative strategies to improve standards. An integrated training programme ensures that all managers have appropriate core skills and knowledge.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Service area	Commissioning lead	Provider	Progress
Care Homes LCS	Emma Hay (BCCG)	**Barnet GPs**	Operational since September 2014
Quality in Care Homes Team	Karen Jackson (LBB)	**London Borough of Barnet**	Operational since early 2013

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

The care market in Barnet is dominated by residential care; there are **104 nursing and residential homes for elderly care and 45 care homes** that cover mental health, learning disability and multiple disabilities. In total, these homes provide approximately **2800 - 3,051 beds** for a range of older people and those with mental health issues or learning disabilities.

Many GP practices (44 in Barnet) provide care to people within care homes, however, it is acknowledged that this group have higher needs than the general population and therefore, a service is required in addition to the essential and specialised services within the GMS/PMS contract. The Care Quality Commission published a review of health care in care homes and identified that support provided by GPs was an area for improvement (CQC 2012).

The Care Home Pilot - 2013

The recent 'care home pilot' in 2013, worked with 5 care homes, with the main objective of focusing on improving outcomes for Care/ Nursing Home residents within Barnet. The pilot focused on the implementation of changes to the way in which health and social care practitioners work within care homes. A key recommendation was for a consistent approach to daily management of medical input to care homes (in particular where support is provided by more than one GP practice) and the introduction of a weekly minimum half day round per care home.

The data

Data analysis of admissions into hospital from care homes conducted for 2012/13 revealed that, emergency admissions increased by 5% compared to the previous year (2011/12), costing an additional 27% on the back of more expensive mix of HRGs and unfavourable adjustments to the national tariff which totalled £6,618,774 (A&E and emergency admissions). Of the 2,328 people in care homes (2012/13), there were 1,394 A&E admissions with an average of 2 attendances at A&E for those with at least 1 attendance at A&E per year. In addition, the total cost of secondary care usage (A&E, outpatient, follow up, procedures) in 2012/13 amounted to £7,104,408.31 for patients with an NHS number who were living in care homes[1].

Due to changes in data access, a similar analysis has not been available in 2013/14, although data revealed that over a 10 month period (April 2013-January 2014) there were 554 inpatient admissions of the 3,051 residents in care homes costing a total of £1,830,414.

[1] Report produced by Barnet PCT, Informatics team

Care Home Staff

The Quality in Care Homes team mandate is broadly based on the eight themes within the ***My Home Life's*** vision of best practice underpinned by an evidence base developed by more than 60 academic researchers from Universities across the UK. The themes are grouped into three different areas:

- Those best practices which seek to personalise and individualise in homes – tailoring care to each individual.
- Those which are concerned with what needs to be done to help resident, relatives and staff navigate their way through the journey of care.
- Those concerned with the issues of leadership and management required to transform care into best practice.

Initial scoping in 2012 identified workforce as the first priority in Barnet to address particular needs in terms of lack of appropriately skilled staff to fill vacant posts within care homes and high turnover rates. Evidence suggested that critical factors contributing to this were a dis-empowered workforce, low wages and lack of career path.

A report from John Rowntree Foundation found that the approach did promote quality of life in care homes through:

- Positive relationships in care homes that enable staff to listen to older people, gain insights into individual needs and facilitate greater voice, choice and control.
- Care home managers playing a pivotal role in promoting relationships between older people, staff and relatives.
- Care home providers and statutory agencies considering how their attitudes, practices and policies can create pressure and unnecessary paperwork which ultimately reduce the capacity of care homes to respond to the needs of older people, and
- A reduction in the use of negative stereotypes of care homes that can impact on the confidence of staff and managers.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment: Outlined in table below. Current indicative breakdown:

- Care Homes LCS is £915,000
- IQICH team is £231,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Benefits will manifest primarily from these schemes in terms of reduced accident and emergency attendances and admissions avoidance; and it is assumed that will accrue from December 2014 onwards.

Activity assumptions are based on a 2% reduction in acute costs (A&E, admissions and outpatients) in the target cohort of people for care homes. This is extrapolated to a target of 39 fewer non-elective admissions over the BCF period which represents a very prudent target taking into account significant optimism bias to account for overlap with other services, particularly OPIC and Rapid Care; and those homes/GP practices that do not participate. The scheme will be available for all GP practices and hence has an estimated target cohort of 2328 people.

Evidence to support assumptions is available from projects such as work undertaken in Cornwall and Scilly Isles (Improving quality of dementia care, HSJ Oct 2012) that found that training care home staff:

- Reduced falls and injuries.
- Reduced hospital admissions by 50%.

And the Integrating Care and Supporting Care Homes project (BGS Oct 2012) that showed significant reduction in non-elective admission spend.

Key assumptions from the financial model with respect to care homes:

- Estimated cost of an emergency admission is £2,004 based on local calculations
- Other benefits have been identified outside the BCF plan framework, primarily A&E attendances and outpatients appointments
- Quality in Care Homes Team is primarily a quality driven initiative with some non-quantifiable benefits within the BCF framework.

Benefits Map – Care Home Locally Commissioned Service

Benefits Map 5 - LCS (Annex 5).docx

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use Benefit Cards, an important control document containing all the information for agreed benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
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		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- GP engagement and delivery of scheme.
- Buy in from care homes and change in practice in terms of managing a higher proportion of care in the home environment.
- Delivery of key performance indicators.
- Reduced turnover of staff in care homes.

Scheme ref no.

3 (a & b)

Scheme name

Rapid Care and Seven Day Working

Scheme description

The Rapid Care service works to deliver an immediate response to a health crisis. The duties they perform include:

- Arranging appropriate services
- Assessing for delivering nursing care as required e.g. provision of IV antibiotics,
- Access to social work and enablement services as required.

What is the strategic objective of this scheme?

The objectives of this scheme are to put in place the following services:

- Extended hours service that provides full rapid assessment of health and social care need.
- Ambulatory Assessment Diagnostic and Treatment Service.
- Telehealth pilot in care homes.
- 7 day availability of social work assessment and enablement.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The inter-linkage between two services that provide an urgent but co-ordinated approach to an unplanned episode of ill-health or crisis.

1. **Rapid Care -** The primary aims of the Rapid Care expansion are to reduce unnecessary hospital admissions, better manage acute complications, and support end of life care so that people can remain in their own homes as long as possible. This will be achieved by providing urgent care for older people/people with long-term conditions and improving crisis response/support services. In addition, the expanded service will also work to improve frail and elderly access to quality acute health care community intervention.

   Key service deliverables:
   a. Triaged response via Community Point of Access.
   b. 2 hour response time.
   c. 7 day service.
   d. Use of skill mix including emergency nurse practitioners.
   e. Consultant cover.

   Target groups are all over 65s at risk of admission. Operational delivery is targeted towards those conditions that we have identified as high volume e.g. pneumonia, urinary tract infection and heart failure.

2. **7 Day Social Work & Enablement** – Supporting the Rapid Care service is 7 day access to social work assessment in the acute hospital setting and enablement services. This ensures that patients who attend A&E but could be adequately treated at home with other services can be assessed quickly and supported to return home with an appropriate package of care (health and/or social care). The team facilitates discharge home with transport, access to equipment and ongoing services. Enablement and home care packages can be established over 7 days.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

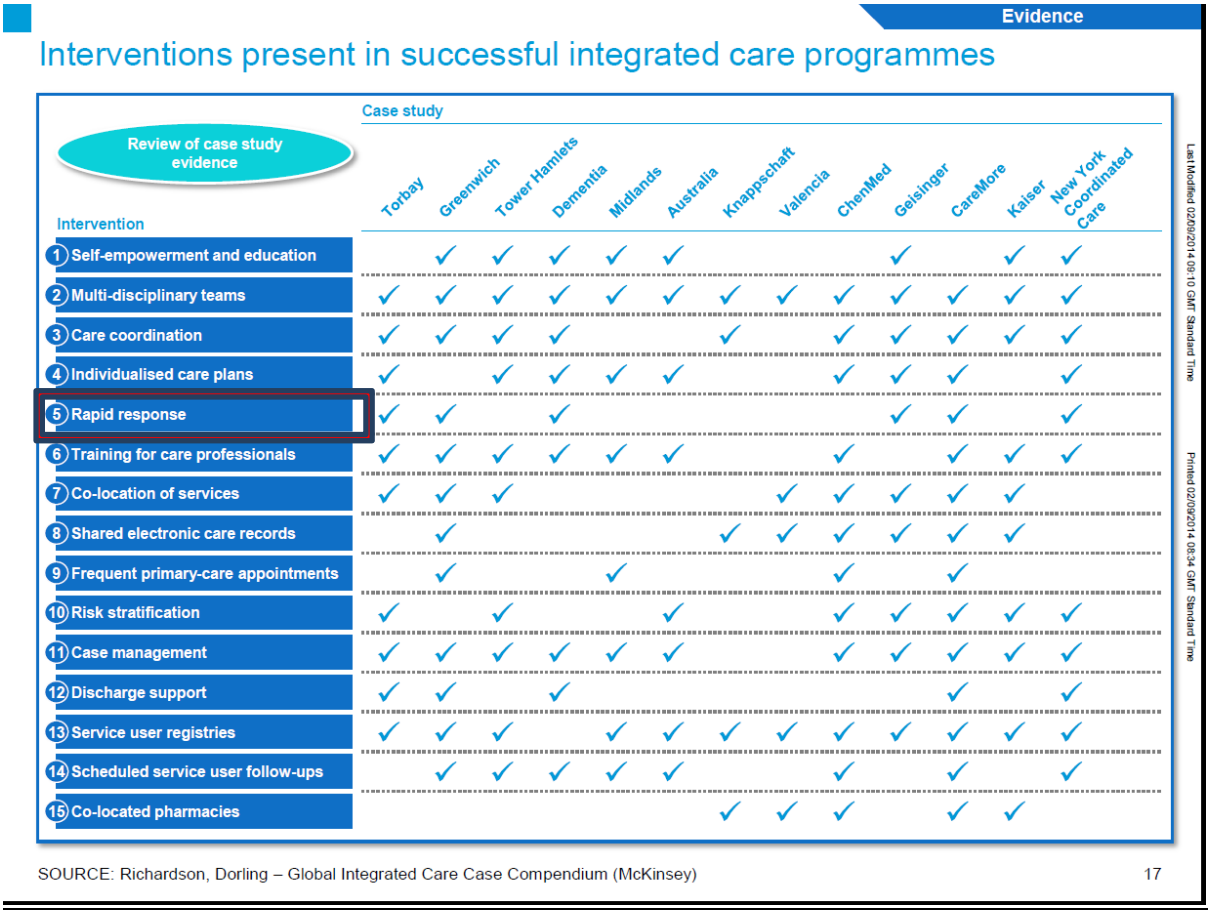
Service area	Commissioning lead	Provider	Progress
Rapid Care	Muyi Adekoya	**Central London Community Health**	Significant planned expansion occurred between October 2013 and April 2014.
7 Day Social work & Enablement	Liam Furlong/ Ette Chiwaka	**London Borough of Barnet/ Housing 21**	Ongoing

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

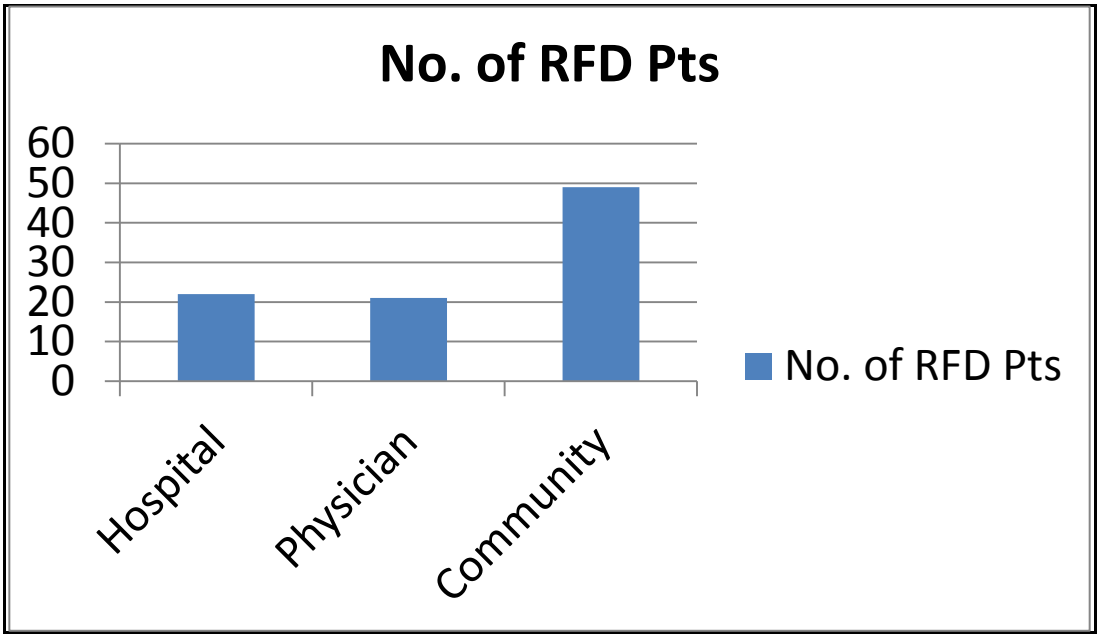
Rapid response is identified as key intervention present in successful integrated care programmes:



Evidence from Kings Fund – *Avoiding Hospital Admissions – What does the research evidence say?* Showed that for selected patients avoiding admissions by providing appropriate care at home gave similar outcomes at lower cost.

The evidence from Purdy S (2010) also suggests that hospital admissions can be reduced through active management of ambulatory care-sensitive conditions (ASC). Five conditions account for half of all ASC admissions, of which three disproportionately affect older people (urinary tract infection/pyelonephritis, pneumonia and chronic obstructive pulmonary disease (COPD))

BCCG also commissioned an Appropriate Place of Care audit in July 2014 at both local acute hospitals and across community beds. This identified that of the 431 Barnet patients that were in the beds at the time of the audit 30% were either not considered as meeting the appropriate criteria for admission or did not meet the criteria for continued stay. As seen by the snapshot below, of those that were 'ready for discharge' a significant reason for delayed discharge was a wait for social care packages or care home beds (defined as community in the graph).Evidence also suggested that admissions were occurring over the weekend as a result of staff being unable to discharge pending social care assessments and placements. To address this, social work teams have been deployed in A&E departments at weekends and both home care and enablement services have been adjusted to accept new referrals.



Similarly, analysis of urgent care activity in 12/13 and 13/14 identified surge activity related to A&E attendances and non-elective admission on Sundays and Mondays indicating a bottle-neck in service delivery during this period identifying a need to implement consistent 7 days services including those to assess for and initiate social care packages. This led to the implementation of the 7 day social work service and variation of enablement contracts to support 7 day referrals.

Local evidence suggests that the model of care is working. The 7 day service has been in place for several months and is monitored as part of a BCCG QIPP scheme. Current estimates for savings in 14-15, as a result of Rapid Care and to a lesser extent OPIC, will be £771k-£1,2m.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment: Outlined in table below. Current indicative breakdown:

- Rapid Care is £1,314,215.
- 7 day social work & enablement is £300,000.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed

including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below).
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Benefits will manifest primarily in terms of admissions avoidance and effectiveness of rehab/reablement.

The model assumes an avoided admission with respect to 40% of the current referral capacity into Rapid Care using an optimism bias to account for those who were treated but were not acute enough for admission, inappropriate service users and the overlap with other services including falls. This is quantified as 864 (413 & 451) fewer admissions. In line with the evidence base above services are targeted to specified conditions and are available 7 days per week. Local impact for the service (and to a lesser extent OPIC) suggests that estimates for savings in 14-15 will be £771k-£1,2m.

It will also contribute to the reablement target as Rapid Care and 7 day capacity link very robustly with PACE and TREAT teams operating in the acute hospitals and intermediate care. Prudent target to increase people who leave enablement/rehab with no home care or increase to current package by 20 (10 per year) based on local analysis and modelling of current enablement provision and local service improvement initiatives. As above, efficiency gains of 15-20% expected through demand management for more intensive services such as Homecare, residential and nursing care, acute care. Access to enablement service is integrated within Rapid Care and is accessible from A&E to support ease of referral. Substantial evidence base as outlined in Developing Intermediate Care, Kings Fund 2009 and Halfway Home, DH 2009. Further work will continue to establish more robust targets through 2015-16.

Key assumptions from the financial model with respect to Rapid Care:

- Estimated cost of an emergency admission is £2,004 based on local calculations.
- Current commissioned capacity supports 180-200 referrals per month. Baseline modelling has been undertaken at 120 per month to prevent overlap.

Benefits Map – Rapid Care:

Benefits Map 4 - Rapid Care (Annex 4)

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use Benefit Cards, an important control document containing all the information for agreed benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL	
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0	
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0	
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0	
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- Stakeholders buy in to support referrals particularly primary care.
- User acceptability of model of care.
- Interdependencies with other services such as PACE and TREAT.

Scheme ref no.
4 (a & b)
Scheme name
Enablers – service and administrative
Scheme description
A suite of services or projects intrinsically linked to BCF pool as key enablers.
What is the strategic objective of this scheme?
The over-arching objectives of the scheme are to: • Secure ongoing delivery of key service lines associated with BCF tiers 1 and 2 that are not currently subject to service re-design or linked to benefits realisation processes. • Secure on-going delivery of critical underpinning projects for the integrated care model. • Deliver critical enablers to support delivery of projects within and alongside the BCF 5 tier care model. • Allow monitoring and management of the total BCF pool in conjunction with benefits/metrics e.g. unplanned hospital admissions, reduced care home admissions. • Provide framework to increase the size and scope of BCF pool over time.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The table below outlines the key elements of the enablers.

Scheme	Service line	Provider type	15-16 (£)	15-16 (£)
Scheme 4a. Enablers (services)	Carers services	Charity/Voluntary Sector	300,000	300,000
	Later life planners	Charity/Voluntary Sector	150,000	150,000
	Ageing Well	Local Authority	150,000	150,000
	Shared Care Records	Local Authority	262,021	262,021
	Community Equipment	Private Sector		1,169,761
	Other Community Services	NHS Community Provider		6,965,100
	Carers Breaks & additional enablement funds	BCCG		1,641,926
Scheme 4b. Enablers (administrative)	Protecting social care	Local Authority	3,080,000	3,080,000
	BCF Plan delivery	Local Authority	200,000	200,000
	Care Act Implementation	Local Authority		846,000
	DFG & Adult social care capital grant	Local Authority		1,872,000

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Enablers are largely managed as business as usual services rather than on a project management basis. They feed into the core business of both BCCG and LBB in the context of managing the day to day delivery of the integrated care model, measuring benefits and ensuring supporting infrastructure is in place.

In line with the programme management approach, as the commissioning intentions/status of services change they will move into the 'active' commissioning cycle and will be project managed as required.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

- Elements included link to over-arching strategic aims for BCF and hence align to planned or possible future service re-design e.g. community services / enablement.
- Elements noted to align to key priority cohorts to be targeted within integration programme (carers) or underpinning infrastructure (Shared Care Record).
- A number of services are those that are currently funded from existing budgets aligned to the BCF that require ongoing funding e.g. Section 256.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment: Outlined in tables below

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Although extensive financial modelling to support implementation of the 5 tier model has been completed, the projects listed in this section have not been included as they are not currently designated to contribute to the BCF metrics.

Over time the constituent elements of this scheme will be subject to change either through dis-investment and/or movement of funds into or out of the pooled budget; or through the natural progression of commissioning intentions and service re-design. As an example, Community Equipment is currently a designated budget within this scheme as a 'business as usual service line'; if it becomes a 'live project' the process will include analysis and outlining key benefits expected from any service improvements.

April 2014 to March 2015:

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1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

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1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Enablers support the other schemes. This scheme consists of a range of operational services that underpin the delivery of the integrated care model either as key infrastructure or as community support. Enabler projects or services include planning for later life, shared digital care records and other community services. Although the enablers in this scheme do not directly deliver the target improvements in the 6 core BCF metrics, each is measured against its own suite of performance indicators, such as numbers of carers assessments per year.

Where such indirect benefits are measurable across the whole integrated care model we will validate and track their realisation through benefits management tools and techniques if appropriate. We will define the best approach for each benefit, balancing the likelihood of establishing measurable links between them and project/service outputs against their complex nature and the information required for Benefit Cards as detailed above or alternative methods.

Where relevant we will define any indirect financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. We will agree a project work plan with them.

This will include milestones for achieving benefits, timescales for reviewing progress to determine if work is on schedule and regular impact assessments. Project/service teams will prioritise work accordingly. The work plan will also include details of any handover and further work to embed activities and continue to realise benefits long-term.

We will also embed the funding for enabler services in our Pooled Budget arrangements to ensure regular monitoring horizon scanning for future opportunities for benefits within these service lines. All this will enable the right people to take the appropriate action to facilitate realising these benefits and remove blockages to delivery.

What are the key success factors for implementation of this scheme?

- Ongoing delivery of enabling services.
- Interdependencies with other services identified in terms of benefits.
- BCCG and LBB understanding/engagement in enablers.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Barnet
Name of Provider organisation	Royal Free NHS Foundation Trust
Name of Provider CEO	David Sloman, however report is signed off by Kim Fleming (Director of Planning)
Signature (electronic or typed)	Kim Fleming

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	29135
	2014/15 Plan	29502
	2015/16 Plan	30002
	14/15 Change compared to 13/14 outturn	+367(+1.2%)
	15/16 Change compared to planned 14/15 outturn	+500 (+1.6%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	134
	How many non-elective admissions is the BCF planned to prevent in 15-16?	891

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We are aware of BCCG plans and have been engaged in Better Care Fund discussions. We are committed to working with BCCG both now and in the future on this plan, however we are not in a position to sign off these activity reductions as we need to understand how the individual schemes of work explicitly link to the reductions planned.
2.	**If you answered 'no' to Q2 above, please explain why you do not agree with the projected impact?**	As above
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	As above

[i] *Commissioning for Stroke Prevention in Primary Care -The Role of Atrial Fibrillation June 2009*
http://www.improvement.nhs.uk/heart/Portals/0/documents2009/AF_Commissioning_Guide_v2.pdf