Barnet Better Care Fund Plan – 2016/17

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:	**12 May 2016**
Date submitted:	**3 May 2016**
Total agreed value of pooled budget: 2016/17	**£24,324,521**
2016/17	

a) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Debbie Frost
Position	Chair
Date	28.4.16

Signed on behalf of the Council	
By	Andrew Travers
Position	Chief Executive
Date	28.4.16

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Helena Hart
Date	28.4.2016.

b) 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	
Barnet Council Priority & Spending Review	
Barnet CCG Operational Plan	
Barnet Joint Strategic Needs Assessment	Others available upon request
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)	

a) 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.

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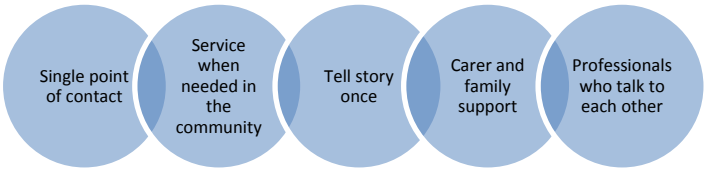
Contents

1. Our Vision for Health and Social Care Integration

1.1. Our Vision

In 2015-2016 we submitted a plan[1] for our use of Better Care Fund resources. In 2016-2017 we intend to continue to work to the vision set out in this plan.

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.



Our vision was built upon fundamental strategic drivers such as our local Health and Wellbeing Strategy, all of which still continue to be fundamental to our integration plans from 2016/17 onwards.

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 as well as their carers.
- Listens and acts upon the view of residents and providers to make continued improvement to services.
- 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.

[1] Better Care Fund Plan 2015 - 16 - https://barnet.moderngov.co.uk/documents/s20674/Appendix%201%20Final%20BCF%20Plan%20Part%201%20v1.1%2014%20Jan%202015.pdf

Our Barnet Health & Social Care Integration Business Plan[2] sets out the details of how this will be achieved.

1.2. Transition from 2015/16 to 2016/17 BCF

Our plans for 2016-2017 are informed by the:

(1) Refreshed Barnet Joint Strategic Needs Assessment (JSNA[3]), as agreed by the Health and Wellbeing Board in September 2015

(2) Joint Health & Wellbeing Strategy (2015 – 2020[4]), adopted by the Health and Wellbeing Board in November 2015

(3) The evaluation of the Barnet Integrated Locality Team (BILT) pilot programme, completed in September 2015 from this we found the need to engage with GPs in a more systematic way and clearly identified opportunities to extend the cohort we were working with

(4) Findings of the CSU deep dives completed in 2015-2016 for the following areas: admissions to residential care from hospital, non-elective admissions to hospital, and falls related injuries. Our learning from these enquiries included the need to embed local voluntary sector provision within pathways, the need to refresh our commissioning specifications in light of updated NICE guidance and the identification of the importance of carers in preventing A+E admissions and admission to residential care

(5) A review of the 'trigger points' for entry to the adult social care system and the factors associated with individuals moving to higher levels of dependency once they are within the system. We identified an opportunity to redesign our accommodation offer to reduce the number of people who are delayed in hospital because their accommodation is unsuitable and the importance of helping individuals manage their conditions including work with those receiving an early dementia diagnosis.

Together these will provide a joint framework for commissioning services that respond to local population need in ways that will minimise, wherever possible, unplanned admissions to hospitals and residential care. In 2016-2017 we will make a number of changes to our BCF programme to reflect our learning from 2015-2016. This will include an expansion of our integrated locality teams, increased emphasis on services to carers and targeting of our early intervention and prevention offer at those at greatest risk of increased dependency.

In 2016-2017 we will undertake a systematic review of BCF commissioned activities to assess (1) Effectiveness of activity on reducing current (and future) demand (2) cost

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[2] https://barnet.moderngov.co.uk/documents/s18033/Business%20Case%20for%20Barnet%20Health%20and%20Social%20Care%20-%20Integration%20of%20Services.pdf

[3] JSNA - https://www.barnet.gov.uk/citizen-home/council-and-democracy/council-and-community/maps-statistics-and-census-information/JSNA.html

[4] JHWB Strategy - https://barnet.gov.uk/citizen-home/public-health/Joint-Health-and-Wellbeing-Strategy-2015-2020.html

effectiveness of interventions and (3) adherence to NICE guidelines. Where it is appropriate we will use the outcome of these reviews to redesign our BCF services for 2017-2018 and to inform our conversations with providers.

We recognise that the development of the local Sustainability and Transformation Plan for North Central London will result in us revisiting our integrated care plans in 2016-2017 but for the purposes of this submission we have referenced new and emerging NCL work-strands where these will have an impact on the achievement of the BCF national conditions.

1.3. The Impact of Policy and Planning Developments

Since commencing with the delivery of the Better Care Plan the policy landscape for health and care has continued to evolve at pace and is complex. Locally, we have reflected on the impact of the current policies on our local vision and approach. This is evident in the delivery progress to date and the milestones that have been set out in our 2016/17 plan. We have also considered how related local developments (The Strategic commissioning framework for primary care, Digital road map, system resilience planning etc.) link into this Better Care Plan.

1.4. Key Challenges for the Plan in 2016-17

We understand the significant health and social care challenges we face. The latest JSNA[5] states that Barnet is the largest Borough in London and is continuing to grow rapidly with large areas of regeneration especially in the West of the Borough. The population of Barnet is, like most of the UK, ageing with the proportion of people aged over 65 forecast to grow up to three times as fast as the overall Barnet population.

Barnet has one of the largest numbers of care homes in Greater London (79 residential and 23 nursing homes: CQC June 2015), leading to a significant net import of residents with health needs moving to Barnet from other areas.

Locally primary care faces operational, clinical and financial challenges – not least a challenge with recruitment to GP vacancies, primary care estate, increased patient demand and regional contract reviews which are all putting pressure on the local system.

Financial Constraints:

As previously stated in the 2015/16 plan, given the financial position of the Barnet health economy, significant emphasis will still be applied to delivery of targets related to reducing non-elective emergency admissions for the cohorts identified within the plan alongside supporting the required improvements in relation to delayed transfers of care as well as a reduction in residential placements.

Data Integration:

[5] JSNA summary https://www.barnet.gov.uk/citizen-home/council-and-democracy/council-and-community/maps-statistics-and-census-information/JSNA.htm

Locally, progress has been made on data integration using NHS numbers, with all practices having migrated over to using EMIS clinical data recording tool alongside having access the a risk stratification tool for identification of patients at risk of an unplanned attendance. LBB have also start the process of moving towards utilising the recently procured MOSAICs system (NHS numbers can be stored). However, further work is required on the integration of records and data across agencies for direct care and case management in a community setting; which will be further developed under the CCGs IMT programme board.

Across the local health and care economy it is acknowledged that there is a need to embrace the goals of the new national information framework which supports the effective delivery of technology enabled personalised and seamless care.

Despite these challenges both the CCG and LBB are jointly committed to using identified schemes within the Better Care fund to support the development of services for older people in line with national strategies and statutory requirements (The Care Act (2014); The NHS Outcomes Framework 2015/16, Department of Health (2014); A Vision for Adult Social Care: Capable Communities and Active Citizens (2010); Putting People First (2007); Care Services Efficiency Delivery (2011) and the NHS Five Year Forward View (2014)).

1.5. Aims of the Barnet's 2016-17 Plan

For 2016-2017 the overall BCF pot has increased by a £797,000 uplift to core the CCG allocation, £17,059 additional CCG funding and £100,000 increase in DFG funding.

	2015-2016 £000s	2016-2017 £000s
Total BCF Allocation	£23,412	£24,307
DFGs Allocation (not included in CCG BCF Allocation)	£1,872	£1,971
CCG Allocation	£21,540	£22,336
Change %	n/a	£797 = 3.4%

This now translates to:

	Gross Contribution
Total Local Authority Contribution	**£1,971,131**
Total Minimum CCG Contribution	**£22,336,331**
Total Additional CCG Contribution	**£17,059**
Total BCF pooled budget for 2016-17	**£24,324,521**

The aims of the Barnet BCF plan have been refreshed in light of the strategic policy context and the work to develop our vision and ambition post March 2016.

The table below shows how we have planned to use these resources in 2016-2017. These decisions have been made in light of our analysis of performance, national evidence and negotiations on additionally with providers. It should be noted that no providers will receive any uplift against 2015-2016 allocations.

Scheme	Area of Spend	Amount 2015/16	Amount 2016/17
Theme: Seven Working			
7 day social Work	Social Care	£100,000	£100,000
Adult Social Care - sustaining 7 day working	Social Care		£797,000 (New)
Intermediate Care in the Community	Continuing Care	£340,522	£340,522
Rapid Response	Community Health	£1,014,618	£1,014,618
Single Point of Access	Community Health	£290,520	£290,520
Social Care Demand Pressures	Social Care	£2,260,000	£2,260,000
Theme: Assistive Technologies			
Community Equipment	Community Health	£1,076,000	£1,076,000
Theme: Improving healthcare services to care homes			
Primary care commissioned service	Primary Care	£400,000	£400,000
Quality in Care Home Team	Social Care	£231,000	£231,000
Children's Commissioning	Social Care	£100,000	£100,000
Theme: Integrated Care Teams			
Integrated Care Locality Team	Community Health	£862,366	£862,366
JCU funding for Heads of Service	Social Care	£200,000	£200,000
Primary care commissioned service	Primary Care	£270,000	£270,000
Shared Care Records	Social Care	£262,000	£262,000
Social care integrated practice	Community Health	New	£151,360
Supporting delivery of BCF Plan	Social Care	£200,000	£200,000
Transitions	Social Care	£100,000	£100,000
Integrated Locality Team – LBB	Social Care	£131,000	£131,000
Theme: Intermediate Care Services			
Intermediate Care in the Community	Community Health	£8,488,189	£8,488,189
Stroke support services	Community Health	£195,000	£195,000
Fracture Liaison Service	Acute	£97,337	£97,337
Theme: Personalised Support / Care at Home			
Ageing Well	Social Care	£350,000	£350,000
End of Life care	Continuing Care	£1,364,609	£1,364,609

IT Interoperability	Primary Care	£69,000	£69,000
Safeguarding	Social Care	£120,000	£120,000
Memory Assessment	Mental Health	£215,000	£215,000
Mental Health Pressures	Social Care	£300,000	£300,000
Dementia	Social Care	£180,000	£180,000
Theme: Reablement Services			
DFG	Other	£1,870,000	£1,970,000
Enablement	Social Care	£200,000	£200,000
Stroke Support Services	Social Care	£37,000	£37,000
Theme: Support for carers			
Care Act	Other	£846,000	£846,000
Carers Support	Social Care	£300,000	£300,000
Carers Support – CCG	Social Care	£806,000	£806,000

For 2016/17, the deployment of additional resources to Social Care Activity brings the Barnet position closer to the Relative Needs Formula for Social Care, without destabilising the existing schemes. Beyond the protection of social care and DFGs, most of the remaining budget remains committed to the NHS commissioned community health services.

The Barnet Health & Social Care economy is facing significant financial challenges. Demand is increasing and budgets are under severe pressure. The Health and Social Care workforce is challenged in terms of both recruitment and skills to respond to this demand. It is clear that in 2016-2017 Barnet, alongside its North Central London colleagues will need to accelerate its work to create new models of integration that reduce and mitigate demands on the health and social care economy.

2. LOCAL CASE FOR CHANGE

2.1. Context on the Case for Change

The Case for change in Barnet is still based on the five underlying factors set out in the original business case (page 16).

Recent National publications in respect of care for older people convey the challenges faced across the United Kingdom. These challenges in a nutshell encompass huge increases in spend that are set to continue to rise if not addressed with a continuing evidenced decrease in the quality of the care delivered.

This is the position in Barnet as spend on unplanned admissions has increased significantly and identified as an outlier within the 'Right Care – Better Value Data Packs' published in January 2016. https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/lond-2016

Nationally the Five Year Forward View challenges providers to look to new models of care, creating accountable care systems (ACS) where commissioners and providers come together to determine priorities and assess need together.

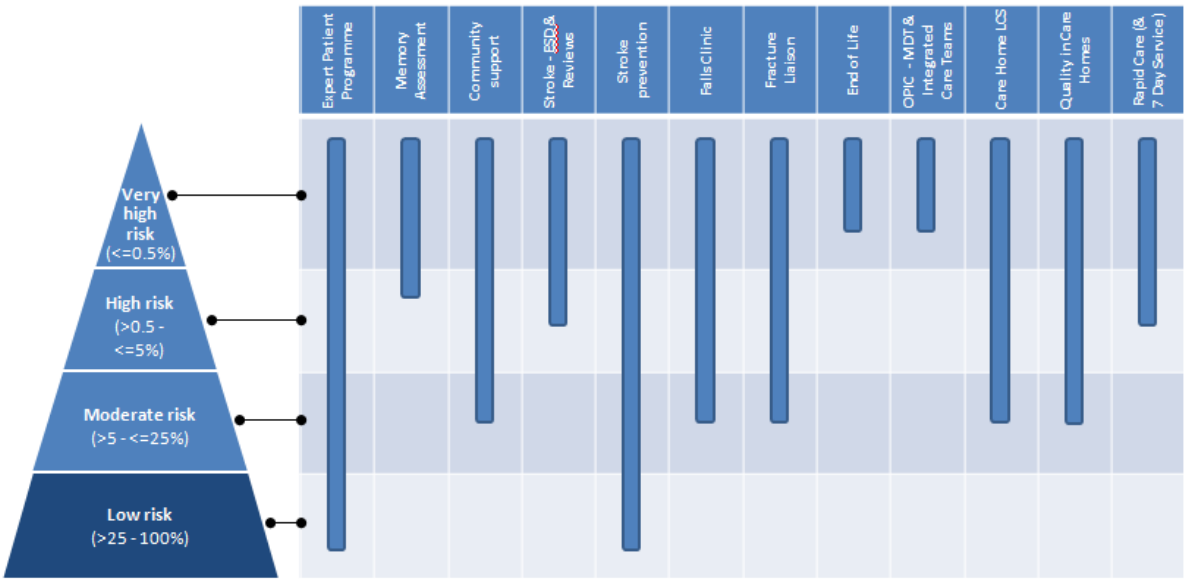
In 2016-2017 we expect to continue to target joint performance improvement activity at the outcomes identified in the 2015-2016 Better Care Fund Plan:

- Delayed Transfers of Care
- Self-Directed Support
- Non Elective Admissions
- Permanent Admissions to Residential Care 65 Years+
- Effectiveness of Reablement
- Patient Satisfaction.

We will continue to review and adapt the programme to ensure that BCF funds are deployed in ways that secure reductions in the use of unplanned high-cost health and care services.

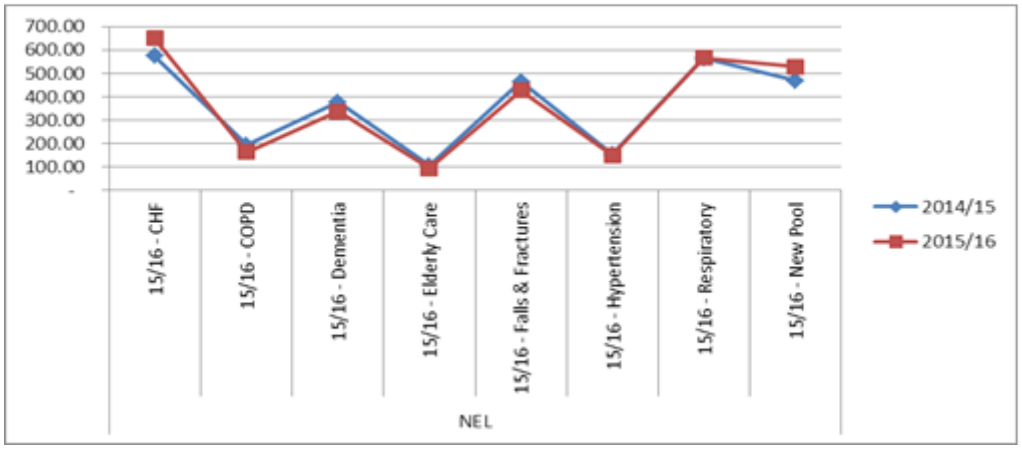
2.2. An evidence base supporting the case for change

The diagram on the next page, reiterates the impact on each risk category for the elements of each of the Schemes taken forward in 2015/16.



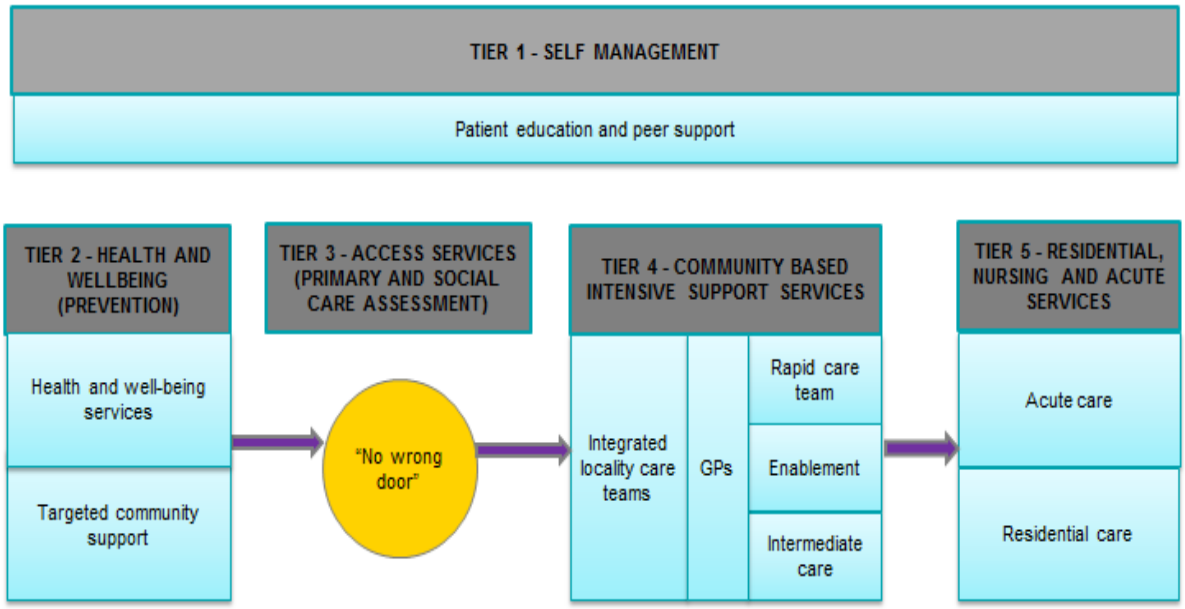
Risk Stratification *– classifications targeted by elements of schemes of work*

The first year of implementing the programmes within the Better Care Fund has demonstrated where a positive impact has been seen in (reduced activity) and those that continue to represent a cost pressure and hence will need to be targeted in the 16/17 plan. The table below is an excerpt that depicts the activity changes in some of the key service areas targeted in 15/16 *managing crisis better* QIPP scheme.



Positive change can be noted with COPD, Dementia, falls and fractures. Areas requiring attention are Chronic Heart Failure, Respiratory, and New Pool which comprises of the additional services (to address gaps in current provision) that will be in place through the implementation of a Barnet wide integrated locality team, closer integrated links between the TREAT and PACE services and the additional work that will be implemented under the Dementia Strategy, the Care Home Strategy and the work underway to support our local delayed transfer of care processes. The tables in the following pages provides a snap shot of the deliverables attained in the 2015/16 schemes.

2.3. Progress achieved by the 2015/16 Schemes



The Barnet BCF Plan is based around the 5 Tier model of care, with each identified scheme targeting the key deliverables outlined within the model care under each tier.

The five tier model delivery is managed and governed effectively within the local integration programme. The contributions and outputs from the schemes are connected effectively to the wider Barnet LBB and CCG governance structures, where applicable via the Joint Commissioning Executive Group.

Scheme ref no: 1 – Funded from PH Grant not BCF Pool
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.
Overview of the scheme
Enables 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 is organised by people with existing long-term conditions, and who are therefore sensitive towards individual issues and needs. In addition, trainers have the ability to signpost the patient to other local support services such as long-term conditions Mentors. Structured patient education programmes based on specific long-term conditions have also been introduced alongside the generic Expert Patient Programme. The content and structure of these courses is determined by a systematic review of needs evidence and service piloting results. Thel focus is on one or more of the following long-term conditions: diabetes, CHD, pain management, respiratory conditions, dementia or depression.
Impact of scheme
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. **T**he 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. Diagnostic work in 2015-2016 has revealed that specific support for people to manage conditions was required through structured education, health champions, social prescribing and Making Every Contact Count. Joint planning with Health Education England, NHS Providers, Barnet CCG, Public Health and Adult Social Care through the Ageing Well Programme has resulted in a number of schemes being commissioned to deliver these activities. A joint Mental Health Enablement and Ageing Well borough wide social prescribing scheme was also launched.

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.

Overview of the scheme

The scheme comprises of the following services, full descriptions of service provision is available in the BCF plan 2015/16 on page 62.

01 Dementia Services:

1. **Memory assessment service** - re-design of the existing memory service to create a discrete fully functioning memory service.
2. Development of a **community support offer for people with dementia and their carers**. To include dementia hub.

02 Stroke Services:

1. **Early stroke discharge** -increase the provision of specialist intermediate care / rehabilitation for stroke in the patient's.
2. **Stroke reviews** - to establish a formal stroke review service
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.

03 Falls Service:

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.
2. **Fracture Liaison Service** - identify people at risk of further falls or fractures in acute settings, providing comprehensive assessment and specific treatment recommendations.
3. **Falls co-ordinator** - support the development of an integrated falls system in across Barnet

04 Palliative / End of Life Care:

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.
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.

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 was completed as there is an overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3.

Area	Service	2015/16 Target	Performance to date
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.*	*Across the pathway the falls service has seen a reduction in 2015/16 especially in hip trauma and sprain strain, this has led to a cost reduction on the previous year of £163k.*
Care homes/ Delayed transfers of care	Dementia	22% reduction in admissions to care homes based on the "Department of Health (2009) "Living well with dementia: A National Dementia Strategy". Reduction in excess bed days by 272 over BCF period in line with current projections in our local Business Case.	Across the pathway it data shows a movement in the case mix alongside an overall reduction in activity of 30, this has led to savings of £300k in 2015/16
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.	

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.

Overview of the scheme

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, the service 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. 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

MDT comprising health and social care professionals, mental health support and end of life support and voluntary sector input. Team support adults in the community, in partnership with local GPs, who are living with multi-morbidity and complex long-term conditions.

04 Risk Stratification Tool (RST)

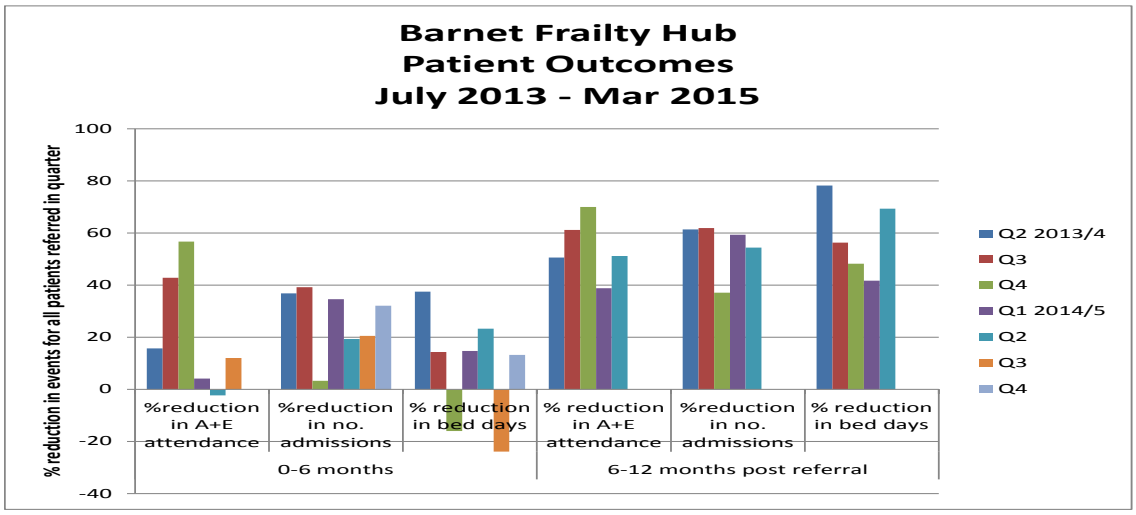
A software based risk stratification tool is being used to identify frail and elderly patients at risk of future unplanned hospital attendance or deterioration in health.

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.

Impact of scheme

There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3



The above graph shows the percentage reduction in adverse clinical outcomes (A+E, admission, emergency bed days) in the six month period after referral to the Frailty MDT and for the period 6-12months after. It breaks the changes down to each quarter.

The data for 0-6 months is from July 2013 to March 2015 (follow up to Sept 2015) and for the one year follow up July 2013 to end Sept 2014 (follow up to Sept 2015).

Columns above the zero line reflect improvement.

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 or social care crisis.

Overview of the scheme

The inter-linkage between the two services provides 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. 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.

Impact of scheme

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

Area	2015/16 Target	Performance to date
Non-elective admissions/Reablement	Reduction of hospital activity in the most at risk cohort identified from risk stratification. Assumptions for delivery of 486 (155 & 331) over BCF period.	Across the pathway data demonstrates that there has been an alteration in case mix with a reduction in cases of urinary tract infections with complications. Alongside this an overall activity reduction has led to savings of £39k. COPD – Has a reduction in activity that driven by a reduction in chronic obstructive pulmonary disease by 39, this has led to an efficiency of £146k. Hypertension – £60k efficiency has been driven by a change to the case mix in 2015/16 as activity has seen a marginal reduction.

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.

Overview of the scheme

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
	Protecting social care	Local Authority	3,080,000	3,080,000
	Care Act Implementation	Local Authority		846,000
Scheme 4b. Enablers (administrative)	BCF Plan delivery	Local Authority	200,000	200,000
	DFG & Adult social care capital grant	Local Authority		1,872,000

Impact of scheme

In 2015-2016 we delivered 268 adaptions to people's homes to help them stay at home longer. We introduced an extended carers' offer to help residents with a dementia diagnosis manage their condition. We have seen a reduction in the numbers of older people having first contact with adult social care through an unplanned admission with an increase in the number of older people making contact through our universal neighbourhood offer.

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

3. Barnet 2016/17 Plan

3.1. Working towards achieving Our Strategic Goals

Our Better Care Plan is strongly aligned to the Barnet CCG Operational Plan for Patients, 2016/17and the current Five Year Strategic Plan of the Clinical Commissioning Group. The Council's Five Year Plan has a strategic vision for integration and shifting the balance of care from institutional to personal solutions.

There is a housing strategy which explicitly addresses the needs of older people and the Council's capital plan includes £15m for the provision of new extra care accommodation in 2017 to reduce the numbers of older people falling into residential care.

The development of the NCL Sustainability and Transformation Plan has also been a key influence in our Better Care Plan and wider ambitions for integrating health and social care. Our expansion programme for extra care housing provision and the development of more step up/step down in the community will facilitate timely discharge from hospital.

3.2. Feedback on the schemes in 15/16 that have informed the refreshed plan

- ✓ Findings from engagement with service users on introducing community based locality teams and the multi-disciplinary meetings across health and social care have been used to inform the future options and solutions.
- ✓ Findings from the engagement with service users undertaken during the evaluation of the pilot Barnet integrated locality team schemes
- ✓ The CSU deep dives completed in 2015-2016 for the following areas: admissions to residential care from hospital, non-elective admissions to hospital, and falls related injuries
- ✓ The independent review on non-electives by CHKS

Other Reference Sources of Data and Analysis that underpin our BCF plan

- NHSE Benchmarking data (e.g. readmissions within 30 days)
- LAS Conveyances Reports
- System Resilience data
- Risk Stratification data from Primary Care
- LA Benchmarking: e.g. on permanent admissions to residential care
- Adult Social Care Performance Reports and Dashboards
- Regional and National BCF analysis from the Central team

3.3. BCF Metrics supporting the refreshed plan

3.3.1. Non-Elective Admissions

Performance Overview 2014-2016:

- The baseline activity for 2014 non-elective admissions was 30,055;
- The 2015 plan was 29,419 admission, a 2% reduction on 2014 admissions;
- Actual non-elective admissions in 2015 was 30,241, although it should be noted that activity is estimated for several contributing CCGs (Brent, Harrow and Westminster CCGs, contributing to 3.3% of the HWB population) due to data availability;
- Actual admissions in 2015 were 2.8% higher than plan and 0.8% higher than in 2014.

Trajectory for 2016-2017:

- The 2016/17 target is based on 2015/16 month 9 forecast outturn non-elective admissions from SUS SEM data.
- Local output of national Indicative Activity Hospital Modelling (IHAM) growth (2.5%) is then applied to the 2015/16 baseline for Barnet CCGs element of the non-elective activity.
- Barnet CCG demand mitigations in the form of QIPP schemes that impact on non-elective admissions (including the integrated care and Better Care Fund schemes) are built into the CCGs Operating Plan and are reflected in the 2016/17 plans. The demand mitigations reduced the planned growth to 1.8% over 2015/16 forecast outturn.

Non Elective Admissions

	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Quarterly rate	7530	7234	7747	7581

Context and Key Activities:

The demands on the acute care system are the local health and care economy's greatest risk to sustainability.

We have reviewed the impact of QIPP schemes and found that they have started to mitigate the underlying growth in non-elective admissions. In 2016-2017 we will be extending the cohort included in our High Risk Group – both by geography and condition to secure further reductions in the NEAs.

We have recently completely a review of our falls services and identified improvements to the services to reduce the numbers of over 85s admitted falling a fall. In 2016-2017 we will ensure that we implement the whole of the NICE recommended pathway.

The extended Integrated Locality Team will work with an extended cohort of individuals who are at risk of a non-elective admission including frail elderly and those with poor management of long-term conditions. The Dementia Pathway, including an enhanced support for carers looking after individuals with dementia, will form part of the Integrated offer. This will ensure that there is a single unified support system for older people with physical and mental health conditions.

Building on the integrated approach to housing solutions developed in partnership with Barnet's regeneration company (Re) and our housing provider Barnet Homes will deliver measurable health and wellbeing benefits. In 2016-2017 we intend to review our DFG, community equipment and enablement pathway to identify where further changes are needed. In 2015-2017 we delivered 238 DFGs to help keep individuals at home and to minimise the need for residential care. In November 2017 LBB will open a further extra 50 care units for individuals with complex needs (including dementia) to help them remain safely at home

3.3.2. Permanent Admissions to Residential Care 65+

Performance Overview 2014-2016:

- The baseline for 2014/15 was 467.83 admissions per 100,000 population. The 2015/16 target aimed to achieve a 15% reduction on this baseline and was set at 399.0 admissions per 100,000 population.
- These rates were calculated on the pre-SALT definition of residential admissions which excludes a number of cases from the measure (for example, full cost payers and property disregard cases).
- Performance in the first three quarters of 2015/16 is as set out in the table below. The rate of admissions remained below the interim target levels despite the last quarter reflecting a winter peak and may see an increase in the rate.

Quarter	Admissions per 100,000
Q1	**91.1**
Q2	**155.1**
Q3	**292.77**

Trajectory for 2016-2017:

- The 2016/17 target has been baselined and set using the new SALT definition of residential admissions.
- 2016/17 interim targets have been set to adjust for the winter peak.
- The trajectory for Q3 and Q4 is provisional because of the introduction of a new case management system for Adult Social Care may have an impact on the numbers and will require review once the impact of new methods of data capture is known. The quarterly targets are set as below:

Quarter	Admissions per 100,000
Q1	**120**
Q2	**240**
Q3	**360**
Q4	**530**

Target Rationale:

- The target is set at 530 admissions per 100,000.
- This aims to maintain the 15% reduction in admissions set as the target for 2015/16, baselined and calculated using the new SALT definition for residential admissions.

Context and Key Activities:

LB Barnet has a higher rate of permanent admissions to residential care 65+ than other London Boroughs and in 2015-2016 we have undertaken work to identify the reasons for this. The following areas for further work have been identified:

- Discharge from hospital to residential care, following elective and non-elective admissions.
- Limited supply of accommodation suitable for people with extra needs but not requiring residential care.
- Attitudes and expectations of health and social care professionals and families.
- Lack of access to neighbourhood support for carers and individuals at risk of a hospital admission.
- The London Borough of Barnet has more residential and nursing beds than any other London Borough.

In 2016-2017 we will publish an Accommodation Strategy for Vulnerable People. This strategy provides the rational for a rapid increase in extra care units, new models of step up/step down provision and an integrated approach to DFGs, enablement and community equipment.

We will also work through the Local Medical Committee and the, HEE facilitated, NHS staff peer learning sets to increase knowledge of new types of accommodation. Opportunities to further develop the use of assistive and digital technology has already been highlighted as part of our DTOC plans but in 2016-2017 we will explore opportunities to use these technologies to avoid non elective admissions for older people, those with dementia and some Long Term Conditions.

In 2016-2017 the Ageing Well neighbourhood programme will be extended from 4 to 6 neighbourhoods and our Older People's Day Offer (Age UK) will be redesigned to enable a referral pathway from the Integrated Locality Team for those individuals at risk of a hospital admission.

As part of the Joint System Resilience work we will continue to identify and address system issues that result in individuals being admitted for electives not being discharged home. Our joint work to reduce non-elective admissions will also help to reduce the numbers discharged to residential care.

3.3.3. Delayed Transfer of Care

Performance Overview 2015-2016

Delayed Transfer of Care 2015-2016 Performance

	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Quarterly rate	620.6	611.7	705.2	693.4
Numerator	1,813	1,787	2,060	2,058
Denominator	292,125	292,125	292,125	296,808

Trajectory 2016-2017

	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Quarterly rate	598.6	590.0	680.2	669.3
Numerator	1,777	1,751	2,019	2,017
Denominator	296,808	296,808	296,808	301,320

Context and Key Activities

Improving DTOC performance relies on the range of recently commissioned activities continuing to maintain their impact, and continuing to commission the eight high impact changes outlined in self-assessment tool recently published by the Department of Health. We have developed a joint local action plan to ensure that activity is co-ordinated and impact monitored.

Adult Social Care performance on DTOC is better than the London level of performance and we recognise that it is important to maintain those activities (such a 24/7 social work, mental health support and a social work presence in A&E) that have helped to secure this level of performance.

Following the acquisition of Barnet and Chase Farm Hospitals NHS Trust (BCF) by the Royal Free London NHS Foundation Trust (RFL) on the 1 July 2014, there was a requirement to transform services to build on the benefits of each legacy organisation and to build this into the broader scope across the enlarged organisation. Discharge forms one of the 8 pillars within Improving Hospital Flow programme and an integrated discharge team is a key enabler to effective Discharge Planning and management.

A review of the discharge needs across the Royal Free London Trust took place, looking at the factors which influence the level of complexity associated with the planning of patient discharge including:

- Baseline pre-admission care needs / level of independence of the patient
- Current individual care needs and likelihood for improvement towards baseline
- Immediate care needs required in order to facilitate discharge
- Support network in place at normal place of residence including family, friends or formal carers
- Physical environment that the patient needs in order to facilitate a safe discharge from hospital

These factors result in an individual patient falling into one of three broad categories, which will have defined discharge support:

- Routine discharges managed at ward level by the ward teams
- Patients with on-going needs would be supported by the site based flow team
- Care needs requiring specialist input would be supported by the discharge navigator team

3.3.4. Reablement

Performance Overview 2014-2016:

- Reablement data is reported one year in arrears. The table below shows the figures reported in the years 2014-2016.
- Barnet's performance was consistently above 83% from 2010/11 to 2012/13, exceeding the national average.
- There was a sudden drop in performance in 2013/14. This was primarily due to data quality issues.
- Performance climbed again in 2014/15 but did not reach the in-year target of 81.5%.
- A dedicated project is underway to resolve the data quality issues associated with this measure and improve the accuracy of the return. Barnet will report under these arrangements in 2016/17 for the first time.

Year	2012/13	2013/14	2014/15
Barnet %	83.2	71.9	**77.1**
NSN average %	84.2	85.1	**86.6**
England average %	**81.4**	**81.9**	**82.1**

Trajectory for 2016-2017:

- This is an annual measure with no in-year trajectory

Target Rationale:

- Barnet has a target to reach the top quartile of comparator boroughs by 2020.
- The 2015/16 target was set to increase performance to 81.5%, which would take Barnet above the national average. This was not met (as shown in the 2014/15 data above).

- The target for 2016/17 aims to increase performance to the level intended in 2015/16 and return Barnet to performance which exceeds the national average.

Context and Key Activities:

- In 2015-2016 we reviewed our enablement services to ensure that they are better targeted at those individual where needs could be stabilised or reduced. There is on-going work to ensure that the service is appropriate used and targeted at those individuals where cost benefit will be realised (no increase in needs for 32 weeks). In 2016-2017 we will review our enablement pathway.
- A review of those readmitted to hospital was undertaken with hospital social work teams. This review identified that readmission to hospital is increased for individuals with complex community service and reablement packages at discharge. In 2016-2017 we will extend the scope of our integrated locality team (including MDT) to support those individuals identified as at risk of readmission or escalation of social care needs following discharge.
- As part of the development of our two local mental health programmes: re-imaging mental health (CCG lead) and Mental Health Enablement (LB Barnet lead) we will commission a number of services to support individuals to recovery and manage their conditions outside hospital. These will include employment support, new accommodation models and primary care support. We expect to see the impact of this new mental health enablement offer in 2016-2017 on enablement outcomes and delayed transfers of care.
- Stroke and dementia services have been commissioned to provide appropriate reablement support to this cohort. The further development of our stroke review service will happen in 2016-2017.

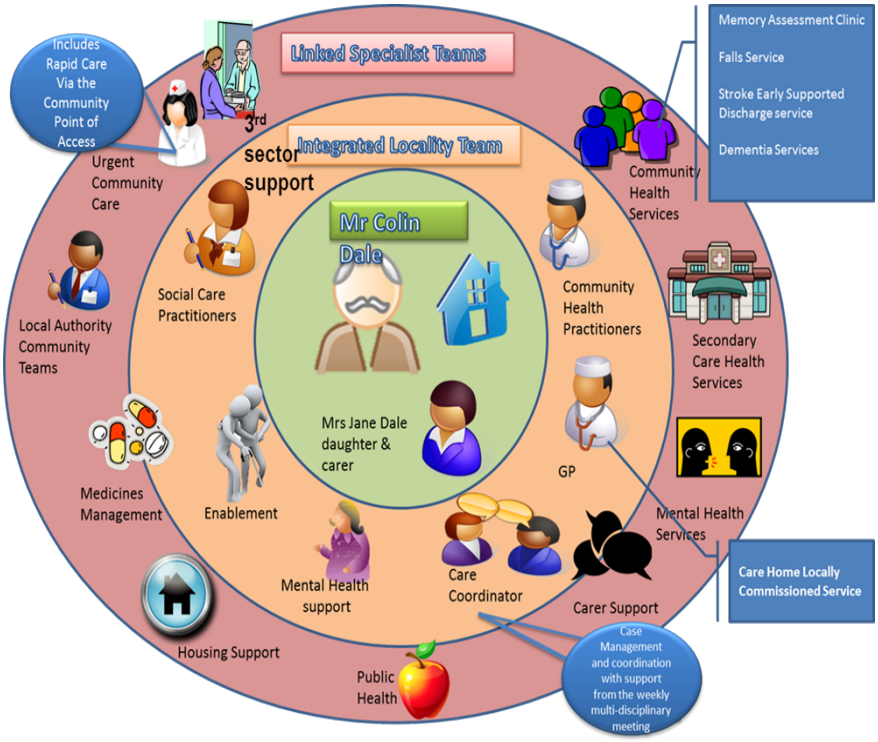
3.4. Disabled Facilities Grants

As a London Borough, the disbursement of DFGs forms part of the overall approach to prevention and early intervention to ensure people can remain at home and in their communities. DFGs will be used, in conjunction with the Council's Accommodation Strategy for Vulnerable People, to secure early discharge from hospitals and reduce non-elective admissions.

3.5. Details on 16/17 Schemes

Locally we will be rolling over key schemes from the 15/16 plan; see pages Annex 1 of the 15-16 plans (page 56).

Our aim is to continue support the delivery of care that provides a seamless management approach to coordinating the resources required. The diagram below depicts the integrated approach to supporting patients/service users and carers.



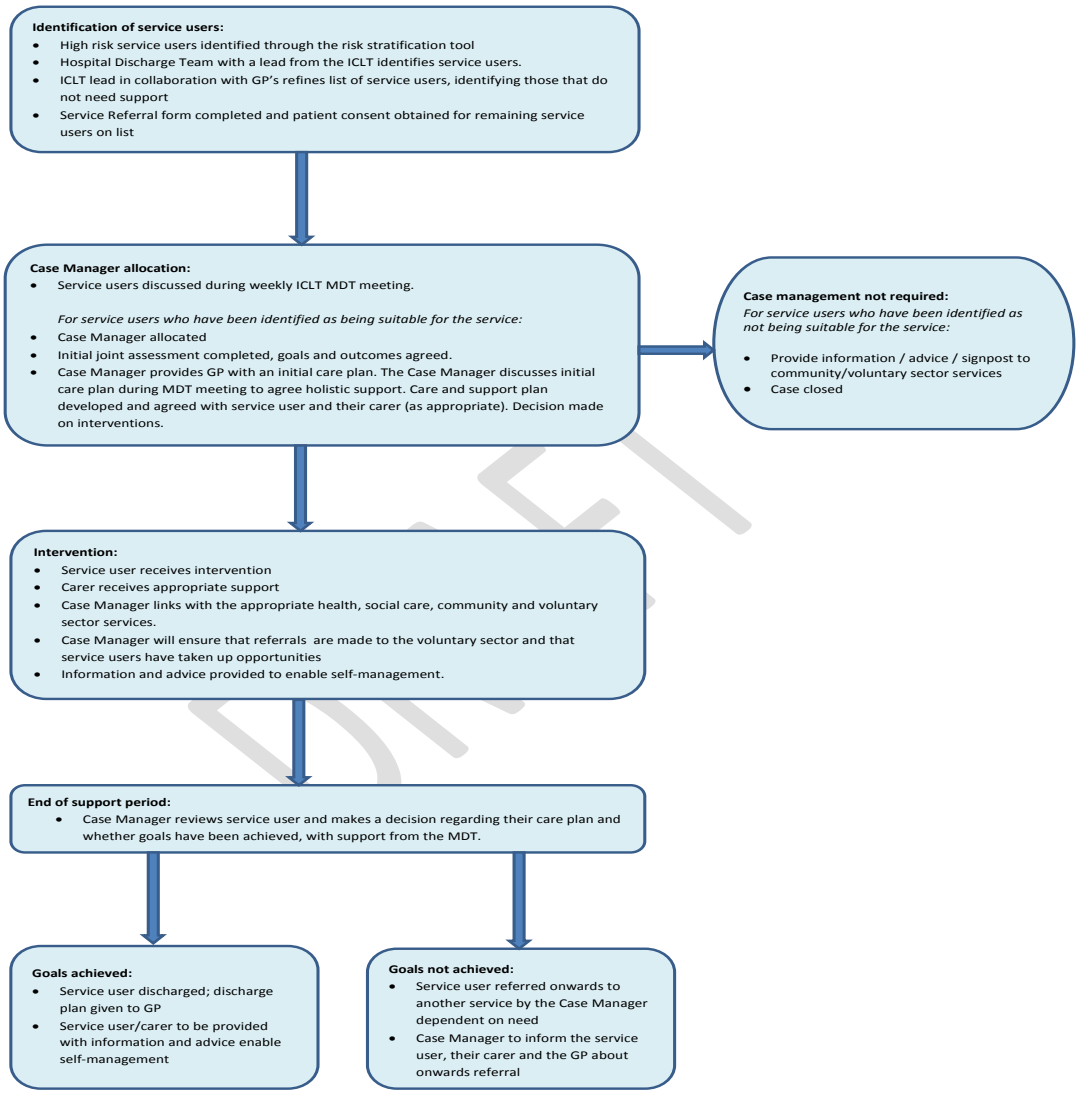
As per the 5-Tier model diagram in section 2.3 the rolled over schemes include:

- **Scheme 1: Self-Management and Health and Wellbeing Services:** 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.

3.5.1. Integrated Teams in the Community

An extended model of integrated care is being rolled out widely across Barnet in 16/17. The model of care is based on co-production and collaboration across the local health economy, the outputs of the pilot ILT in the West of the borough and based on key principles including the national evidence for care to be integrated so that better, more person-centred care can be provided for the growing number of older people with social care needs and multiple long-term conditions is well documented and is now established as NICE Guidance Older people with social care needs and multiple long-term conditions (NG22).

The proportion of the local population that will receive case management is derived from the Risk Stratification Tool and who are identified as being at the highest risk of hospital admission (i.e level 3 patients). 1971 patients have been identified at level 3. As the expanded Barnet Intergrated Locality Team (BILT) mobilises over the forthcoming months it is expected the service will start seeing complex patients with 3 or more long term conditions from quarter 2 onwards. The cohort will be reviewed in quarter 3.

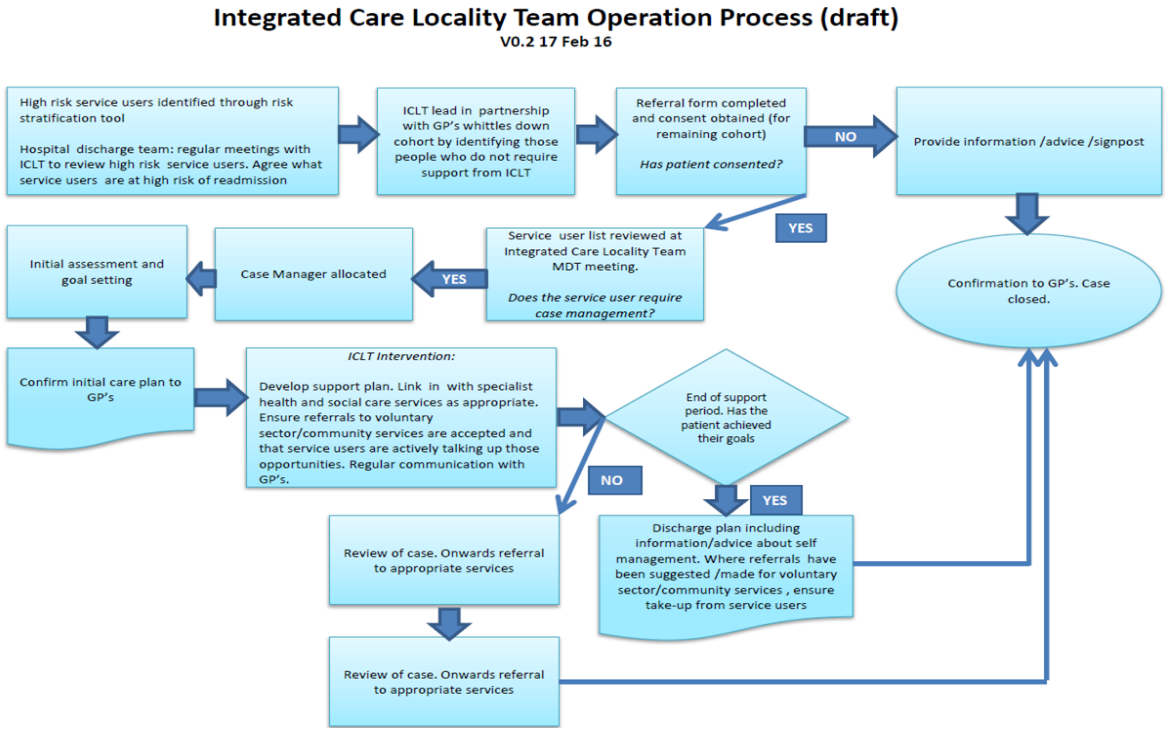


The aim of BILT is to deliver appropriate care to older people in the community. This should reduce avoidable hospital admissions, reduce use of unplanned care, deliver high quality community services for people who have been identified as in need of preventative care and reduce duplication across health and social care services. This includes:

- Partnership working with social care, health services, the voluntary sector and community services
- Providing coordinated care and case management through the appropriate pathways, linking acute, primary care, social care services, voluntary sector and community services
- A co-ordinated care plan with an agreed lead professional and care co-ordinator
- Using risk stratification and clinical/professional judgement to identify those who are at high risk of unplanned hospital admissions and/or residential or nursing care homes
- Promoting and embedding a culture of integrated working among the team to deliver the service
- Identifying and providing early interventions as appropriate, preventing avoidable A&E attendance and unplanned admissions to hospital by providing a 'joined-up' service to people with complex health and social care conditions and supporting people who require end of life care
- Working closely with service users, carers, GP's, health and social care professionals and community/voluntary services to ensure care is managed at home as the place of choice
- Promoting self-care planning and self-care management through provision of information and advice, thereby supporting service users and their carers to make informed choices and take control of their health and wellbeing
- Increased use of the Directory of Services and signposting via 111 and, once in place, the citizen portal, which will be available on the London Borough of Barnet website.

The overarching philosophy around the development of the integrated locality team service is a risk stratification approach linked to GP practices so that admission to secondary care and/or residential or nursing care homes should be the last resort for any service user where it is clinically appropriate and that supported discharge home from acute care should be achieved as quickly and efficiently as possible.

The service's ultimate objective is to promote and maximise independence by enabling people to continue to live safely at home as long as they are able to or wish to do so.



Key areas within the service model:

- **Multidisciplinary approach:** provide an integrated, multidisciplinary service that can provide users with a coordinated assessment and intervention

- **Integrated and coordinated services:** integrate all elements required by the service user and work to ensure interventions are delivered efficiently and effectively across the main service delivery areas minimising duplication of paperwork and personnel

- **Whole system focus:** work closely with multiple agencies in the wider health and social care system. This will include but not be limited to, primary care, social care, carer agencies, acute hospitals and third sector in identification and management of people who are at higher risk of hospital admission and/or have complex needs. Provide a point of access to agencies and through joint assessment. Provide effective triage and navigation of service users to the most appropriate pathway.

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

High level Milestones	Who	Date
Specification and costs to be agreed by JCEG	JCEG	25 April
Business Case, specification, Equalities Impact Assessment and Quality Impact Assessment approved by: **QUIPP** **FPQ**	 QUIPP FPQ	 May May

Develop, agree and sign of Information Sharing Agreement and Memorandum of Understanding	Project Manager	May - July
Contract negotiation with CLCH	Head of JCU	April - May
Develop and agree Performance Framework	Project Manager/Provider	May - June
Reconfigure existing BILT, MDT and CNS to align with new service specification	Provider	May - June
Communication activities with GP's, service users/carers, staff, service user groups	Project Manager	May - July
Extended service go live	Provider	4 July 2016

3.5.2. Developing the Workforce

The table below shows that there is a total workforce of 10,200 people across Adult Social Care in Barnet. Almost 90% of the workforce is in the private sector which is greater than the national average of approximately 78%.

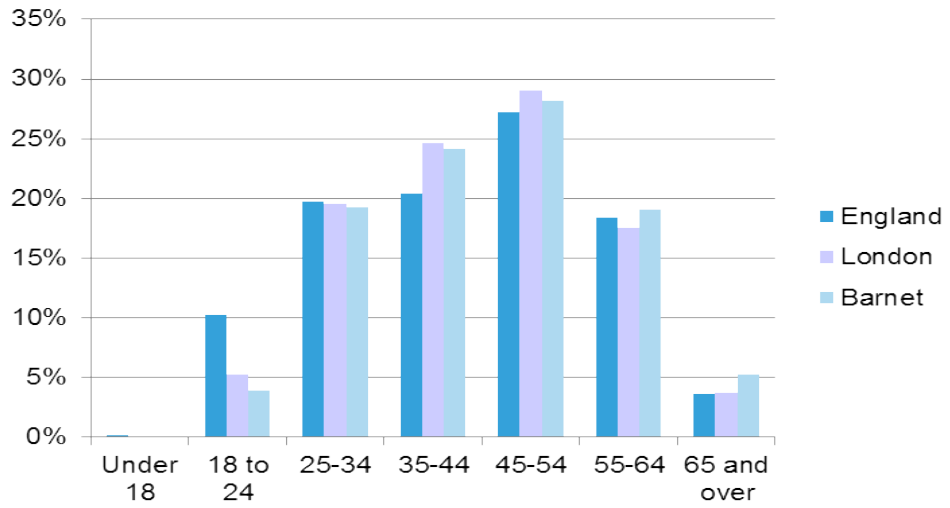
Sector	Jobs	
	Number	Percentage
Independent	9,000	88%
Statutory local authority	300	3%
Jobs for / direct payments recipients	900	9%
Total**	10,200	

Barnet Adult Health and Social Care Workforce. (SfC – NMDS Adult Social Care, 2013)

Barnet experiences a higher than average turnover of adult social care staff. A National Minimum Data Set (2013) for Adult Social Care indicates that turnover rates in Barnet have been:

- 18% across the sector as a whole
- 43% for Registered Nurses (31 leavers)
- **22% for Care Workers (248 leavers)**
- 9% for Senior Care Workers (14 leavers)
- 7% for Senior Management (less than 5 leavers)

The adult social care workforce in Barnet is also generally older than the average across London and England which has implications for sustainability depicted in the chart on the next page. This along with a high turnover of staff means that Barnet will need to recruit significant numbers of staff to the sector to maintain services (Skills for Health, 2015).



The age of the current adult social care workforce in Barnet (Skills for Health, 2015)

The Table below shows that the majority of the Barnet's adult social care workforce (35%) has no qualification.

Qualification	England	London	Barnet
Entry or Level 1	1%	0%	0%
Level 2	23%	19%	30%
Level 3	16%	15%	12%
Level 4	14%	16%	18%
Other (social care)	8%	9%	2%
Any other qualification	4%	4%	3%
No qualification held	35%	36%	35%

Qualifications of Barnet's Adult Social care workforce Skills for Health, 2015

Training and Development

In Barnet there are a number of training initiatives both being planned and delivered through various providers. Health Education North Central and East London- Community Education Provider Network (CEPN) that are targeting the priorities identified within the Care Home Pilot (2013) including:

1. Improved multi-agency working between care homes, health, social care and other organisations.

2. Improving the quality and consistency of clinical care around:
   - pressure sores,
   - medicines management
   - the deteriorating patient
   - dementia

- End of life care.

The 2015/16 Locality Funding Investment Plan for the Barnet Community Education Provider Network has included a number the initiatives that provide training for those providing care to care homes; care home staff; GP's and community nursing staff and carers (Table below).

Local Education Training Board Priority	**Method delivered**
Long Term Conditions Complex needs	Case studies (theoretical or real) discussed in multidisciplinary groups addressing the complexity of managing these cases
End of Life (EoL)	In particular education about EoL care outside of cancer diagnosis; in particular focusing on supporting people dying of heart failure to do so at home if they so wish. Collaboration with North London Hospice Education team providing co-facilitation
Improve integration	Multi-professional engagement in groups (facilitated by CEPN faculty members)
Patient empowerment/ preventative health	Session/s on empowerment. Involvement patient representation to explain how they manage to improve their own health outcomes by taking control of their own health
Mental Health Training	Two to three sessions led by Primary Care Academy (education arm of BEH Mental Health Trust) addressing management of medically unexplained symptoms (MUS) and long term mental health conditions – areas identified as learning needs of Barnet health workforce and in keeping with ~Barnet CCG commissioning intentions.
Public Health perspective	Working with public health colleagues to ensure attendees aware of the bigger population picture and not just individual patient need.
NHS Values and Behaviours	Faculty development embedding these values and behaviours in facilitators and role modelling to groups
Supporting 5-Year Forward View new models of care	Breaking down barriers between primary and acute care and Integrating physical, mental and social care (especially to support management LTC) by learning together and considering complex cases which demand integrated working practice.
Engaging communities	Involving voluntary groups in the CLGs thus creating stronger partnerships.

The 2015/16 Locality Funding Investment Plan for the Barnet Community Education Provider Network

One of the projects proposed is aimed at increasing the number of apprenticeships in the Barnet healthcare economy working in Bands 1-4. Working with CITE (Communities into Training and Employment) the aim would be to recruit new personnel and provide a training scheme crossing the traditional barriers between primary, secondary and community care providing experience in GP surgeries, care homes, in hospital setting and in the community. This will increase not only capacity in the care system but the skills and flexibility of the workforce including within local care homes.

The Cavendish Review recommended that there should be common introductory training for health and social care workers who have direct contact with patients. As of 1 April 2015, it

became mandatory for all employees in Barnet to complete the Care Certificate within 12 weeks of employment.

The Health Care Support Worker Academy aims to support Health Care Support Workers currently employed in Barnet to gain their Care Certificates by signposting them to appropriate resources that already exist (e.g. LMC programme) and also by providing educational opportunities to attain the competency areas which are harder to cover. The aim is to work with partner organisations including CLCH and the Royal Free London NHS Foundation Trust. This work will be supported by Barnet CCG's Workforce Lead Nurse and London Borough of Barnet's' Integrated Quality in Care Homes (IQICH) Team and the Nurses Forum.

Integrated Working Staff Development Programme 2016-2017 Key Activities

Activity	Timescales	Leadership
Every Contact Counts up-skill over 300 members of the frontline workforce (such as housing officers, customer service advisors) to be able to communicate wellbeing messages to our residents, at risk of non-elective admissions	- April – June 2016: train the trainer devised and development sessions scheduled. - April, July and September 2016 cohorts recruited for training - October – November 2016 – evaluation and review. Modification of training materials - December 2016 and February 2017 2nd round cohort recruited.	LBB Public Health
The Community Centred Practice (CCP) programme, working with selected GP practices across the borough, will integrate volunteers and the voluntary and community sector with primary care provision.	- April to June 2016: GP recruitment - June to Sept 2016: volunteers recruited and matched - Sept 2016 to Jan 2017 Training and Review - February 2017: Review and Progression.	LBB Public Health
Develop strengths based practice across social care	Integrated Locality Teams: Integrated Development Sessions scheduled for Sept 2016 and Jan 2017	CLCH – Integrated Locality Team Provider LBB Adult Social Care

Activity	Timescales	Leadership
and NHS integrated teams.	- Adult Social Care Workforce – strengths based practice learning sets established. April to July 2016 - Mental Health 'trailblazer' multi-discipline learning sets established – March 2016 – May 2016	Barnet CCG
Integrated Case Management - staff co-design (MDT and Integrated Locality Team)	Reflective learning sessions – journey so far and improvement opportunities. Sept 2016 and January 2016.	Barnet CCG

4. National Conditions

4.1. Agreement on a local action plan to reduce delayed transfers of care

Local context and performance

In accordance with National Guidance the Clinical Commissioning Group and the Local Authority works in partnership with system partners to prevent delayed transfers of care. The System Resilience Group meets monthly and receives performance reports to monitor overall performance across all three of the Royal free Hospital sites (Hampstead, Barnet and Chase Farm). Members of the System resilience Group include system resilience leads from Enfield, Haringey and Camden and Hertfordshire.

A capacity and escalation plan is also operational across all CCGs, and during times of anticipated additional pressure and increased demand daily telephone conference calls take place to assist to assist with discharges that are more complex to ensure maximum performance.

Context for joint working

System resilience leads have regular contact and meet with operational leads from the Royal Free Hospital, CLCH and the Local Authority. A system resilience Task and Finish Action Group meets every Tuesday to review and monitor progress and agree actions that are recorded within a jointly agreed Action Plan.

Our third sector partners: the Red Cross and Age UK provide Home from Hospital and Enablement services as part of the discharge pathway for our older frail patients. North London Hospice and Marie Curie are linked into the pathway for end of life and palliative care.

A weekly MDT meeting takes place every Tuesday between multi-providers including LAS, Mental Health, Acute, Community Services provider, palliative care and with pharmacy input.

The Action plan is updated and circulated weekly to all partners with overall progress of initiatives monitored each month at the SRG Meetings

Challenges for 2015-2016

- The lack of complex Neurology Rehabilitation Beds
- High numbers of admissions from Care Homes that block capacity which could have been avoided
- Recruitment difficulties across health and social care
- Industrial Action resulting in compromised capacity
- Ambulances being conveyed to London from EAST into the RFL sites
- Admissions of patients into Barnet from across the borders of Hertfordshire
- The need for additional NWB rehabilitation capacity
- Demand for Packages of Care to enable quicker discharge
- The need for a co-ordinated discharge to assess model, system and process

Changes from 15/16

- New requirement for 2016-2017
- In 2015-2016 providers and commissioners have worked together to create a joint local system resilience plan.
- This plan is aligned to Barnet's BCF objectives.
- The most recent version of this plan is attached as appendix A.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Align Better Care Fund and System Resilience programmes.
- Review Resilience Programme funding and consider for pooling within BCF.
- Agree strategy for delayed transfer of mental health patients (dementia) arising from limited supply of residential beds for this cohort.
- Review current Voluntary Sector and Small contracts with both LBB and BCCG that support reductions in DToCs
- Review and develop a Discharge to Assess Model
- Establish a Care Home MDT service based upon the 'Silver Book'
- Implementing additional OOH Capacity
- Expanding the Rapid Response service in times of surge
- Establish a weekly Task and Finish Group that drives service improvements to prevent A&E attendances and DToC
- Daily reports of DToC position at all 3 RFL sites and escalated action where appropriate
- Continue 7 day a week on side social work service and introduction of additional Social Worker time to support discharge and MDT Assessments
- Procurement of a new Risk Stratification Tool that identifies those at risk and those using NHS and Social Care services more frequently than expected

4.2. Maintaining Provision of Social Care Services

Barnet Council has set a five year Financial Strategy (MTFS) to 2020 agreed by full Council in March 2016. The Council has agreed a balanced (breakeven) budget for this five year period. The Adult Social Care budget is balanced (breakeven) throughout this period.

In 2016-2017 the total Council general revenue budget will be £278m and spend on Adult Social Care (ASC) is £86,336,349 (33% of the total Council budget). In 2016-2017 Adult Social Care savings are £3.4m - this represents 21% of the total Council savings and reflects the Council's commitment to protect services to the vulnerable by applying a lower savings target to ASC than to other areas.

Demographic funding of £1.8M has been applied to the adult social care budget for 16/17 and demography has been modelled into the 5 year financial strategy. Inflationary pressures are addressed through central inflation funds, which are applied to each area of the Council based on actual inflationary impact from contracts and therefore ASC will receive sufficient inflation funding to cover actual inflation demands. National Living wage implications are being factored into inflationary funding. An assessment of the impact of the NLW has been

undertaken and requests for fee uplifts are being managed through a standardised process with other Councils in the West London Alliance.

The RNF allocation of £6.7M has been applied for the protection of adult social care in the Better Care Fund, along with the nationally mandated amount for Care Act 2014 new burdens (£833K). The social care precept has also been applied in Barnet and is adding a further £2.7M of adult social care protected funding. Prevention spend on the Adult Social Care Budget is £2.85m. Prevention services are also provided through the public health budget.

Changes from 15/16

- Increased investment in Adult Social Care Commissioned Services – the BCF allocation is now in-line with the Relative Needs Formula amount for LB Barnet £6.71m
- Increased emphasis on managing out the key triggers for entry to high cost acute and residential settings.
- Review of entry points to residential care from hospital settings and development of an action plan to address.
- Renewed focus on supporting carers and reducing risk of break-down of care.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Renewed emphasis and recognition of the role of social care services in preventing unplanned hospital admissions and mitigating length of hospital stay.
- Increased investment in carers' services – to reduce risk of non-elective admissions and admission to residential care.
- New carers and dementia pathway to reduce risk of break-down of care & to support individuals to manage their condition.
- Expanded offer of early intervention services for older people – expanding from four neighbourhoods to include two additional neighbourhoods – through our expansion of the Ageing Well Programme.
- Increased investment in seven day social work to minimise admissions through A&E for older/frail cohort.
- Sustained investment in activities to manage population pressure and ensure that individuals are supported within social care and neighbourhood services.
- Expanded role for Adult Social Care within the Integrated Locality team located within the community services provider.
- Continuation of joint work to manage delayed transfers of care.

4.3. Joint approach to assessments and care planning/accountable professional for Care Management

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

- Use of risk stratification in primary care to identify those most at risk of admission to ensure that they are actively case managed.
- 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.
- 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 expansion of the 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 led by the MDT. It has fed directly from risk stratification undertaken manually by GPs.

With implementation of the risk stratification tool and the planned expansion of the Integrated Locality Team, 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 on-going 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 on-going 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 on-going 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 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.
- Outlining how often patients should have their care plan re-evaluated and hence could move within the framework.

Changes from 15/16

- Expanded and redesigned integrated service offer will single point of assessment.
- Population cohort expanded to include patients identified as having the highest risk via the risk stratification tool. This will include those identified at risk of readmission at transfer of care
- Community Services provider (CLCH) as lead provider.
- Multi-disciplinary team and care navigators integrated into single service.
- Planned development of the transition to palliative care pathway for some clients.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Barnet Integrated Locality Team expanded from West Barnet to whole population.
- Additional support to GPs to use risk profiling tool.
- Expansion of ‘at risk’ cohort to those with LTC/ co-morbidities
- Revision to Risk Assessment Tool to include risk factors for entry to adult social care services.
- Case management approach.
- Revised dementia pathway – including support for carers and increased use of third sector community support programmes.

4.4. Agreement on the consequential impact of the changes on the providers

Approval of the BCF plan by all partners, including agreeing the impact on providers and how the services funded through the BCF are contractualised, is an essential part of the governance associated with the Barnet Integration Programme.

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 parties.

There are a range of plans, schemes and projects where service providers are active participants in collaboratively designing, implementing and managing services with commissioners which as a collective take into consideration the changes that will take place across the local health economy over the next few years.

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.

GP's are fully involved in the development of our 5 tier integrated care model with a number providing input and challenge as the programme progresses.

The wider GP network has been engaged through presentations at locality meetings and through discussions with the LPC.

We recognise that extensive engagement is essential to implement integrated care and are in the processes of developing a primary care strategy.

Social care providers 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.

The on-going 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.

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.

Acute providers:

Our main acute provider is now Royal Free NHS Foundation Trust working through 2 key sites in Hampstead and Barnet.

The on-going 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.

<u>Changes from 15/16</u>

- There will be no change in approach to 2016/17 blocks.
- Consequential impacts were managed through in 2015-2016 – approach will remain consistent for 2016-2017

<u>Plan for 2016-2017 – Additions to 2015-2016 Programme</u>

- Non-elective activity for 2016/17 is currently planned as 2015/16 forecast outturn plus 3% growth plus the impact of commissioner integrated care and diabetes & endocrinology QIPP schemes.
- The programme of work set out in the Better Care Fund comprises of schemes that are expected to have an increased impact on service provision over the next two years. Clearly defined service specific key performance indicators (KPI's) are in place to support the initial review of the performance and wider healthy economy impact during 2016/17.
- Barnet will work with the North Central London (NCL) and West London Alliance collaborative to develop a consistent approach to residential and nursing home prices and a joint approach to addressing gaps in provision.

4.5. Agreement to invest in NHS commissioned out-of-hospital services

The detailed spending plan submitted in the NHSE Submission template demonstrates the breadth of the Barnet BCF plan in investing in NHS commissioned services out of hospital. This includes not only NHS community services and social care services but a range of prevention services included in the Ageing Well programme, the mobilisation of Dementia Hubs, the carers support services, palliative/end of live services and the locality teams.

Changes from 15/16

- Reviewed and revised current schemes to identify opportunities to increase scale or to target as those mostly likely to enter the health and social care system through A&E, be re-admitted following discharge and/or have a delayed transfer of care.
- Procurement of risk assessment tool, additional support to GPs and expanded integrated locality team will be rolled out in 2016-2017.
- Barnet wide integrated service mobilised to provide out of hospital support
- Resilience funding in place to provide seamless approach for discharging and managing patients in the community

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Funding to be retained in out of hospital services
- BILT evaluation, deep dives and reviews have been used to reshape offer to ensure further reduction of non-elective admissions.
- Expansion of at risk cohort identified for BILT services- with a higher number of people diverted from non-elective admissions or unplanned care through the use of a revised case management approach
- Expansion of primary care activities to support self-management.
  Rolling programme of review and assessment of BCF commissioned programmes to assess impact and assurance of evidence based practice.

4.6. Better Data Sharing between Health and Social Care

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 in 2016 and will result in the recording of the NHS Number for all social care clients from this point forwards.

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

In addition Barnet CCG is looking to work collaboratively with all care providers within the local health economy by encouraging the sharing of patient records with the view to improve care and enable patients to be seen in a variety of settings, with the benefit of care professionals accessing care record from the various provider (where possible) at the point of care. The sharing of care records would include sharing between secondary, community, social care providers and primary care GP Federation(s) leveraging on existing clinical systems and the agreed interoperability platforms to allow patient care records to flow between the various clinical systems.

Changes from 15/16

- North Central London confirmed as digital road map footprint.
- Digital maturity self-assessments are in the process of being completed for providers locally
- This provides us with a baseline (provider) position on the use of digital technology to operate paper-free at the point of care.
- Continue to build on interoperability between primary care, community care and secondary care.
- Interoperability between social care and NHS care records was delayed as LBB commissioned and implemented a new care record system.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Implementation of MOSAIC system for adult social care clients in April 2016 will enable the electronic care record for Adult Social Care Clients to record the associated NHS number for linkages across to health services accessed by adult social care clients.
- North Central London (NCL) CCGs are working together on a digital roadmap.
- Plan for implementation of the road map to be developed across 2016/17.

4.6.1. Approach to communication with local people on use of their data set out

We are committed to providing local people with as much information as possible about how data is shared about them in accordance with the Data Protection Act and where appropriate services will seek patient consent before any onward referrals to other services.

An example of how this was managed in 2015/16 is depicted below.

Information on how initiatives will provide appropriate governance is also evidenced by the information Sharing Agreement has been put in place for the Barnet Integrated Locality Team (BILT) which clearly sets out a requirement to gain patient consent before a referral is accepted.

The BILT patient leaflet articulates how information will be shared, the need for patient consent and reassurance that people do not have to provide consent and this will not affect any care they require regular health and care services. Patient consent is a prerequisite for any referrals to BILT.

BILT will be expanded over the forthcoming months and we plan to write to all GP practices to inform them of our approach to identify patients for the service and an accompanying letter seeking patient consent will also be provided, which will set out a request to gain patient consent, why information needs to be shared and the option for people not to provide consent if they are not happy to do so.

Information Sharing Engaging with the Public

- We are committed to providing local people with as much information as possible about how data is shared about them in accordance with the Data Protection Act and where appropriate services will seek patient consent before any onward referrals to other services. For example an Information Sharing Agreement has been put in place for the Barnet Integrated Locality Team (BILT) which clearly sets out a requirement to gain pain consent before a referral is accepted. The BILT patient leaflet articulates how information will be shared, the need for patient consent and reassurance that people do not have to provide consent and this will not affect any care they require regular health and care services. Patient consent is a prerequisite for any referrals to BILT.

- BILT will be expanded over the forthcoming months and we plan to write to all GP practices to inform them of our approach to identify patients for the service and an accompanying letter seeking patient consent will also be provided, which will set out a request to gain patient consent, why information needs to be shared and the option for people not to provide consent if they are not happy to do so.

- See Attachment section for an example of the information provided to patients who access the BILT service

4.7. Plans to support seven day services across Health and Social Care

There is a national requirement to deliver against a set of 10 clinical standards for seven day services (7DS)[6] which NHS organisations are expected to meet by 2017. The standards include delivery of 7DS improvements within acute settings including diagnostic availability, and delivery of improvements in 7DS across other system wide settings such as primary, community mental health, and social care.

These developments aim to improve clinical outcomes and patient experience, reduce the risk of morbidity and mortality, and provide consistent NHS services across seven days. Specifically the following outcomes are intended to be delivered as a result of implementing the 10 standards:

- Reduced admissions
- Reduced variation in:
- Length of stay by day of week
    - Mortality by day of week
    - Re-admittance by day of week (variation 1.8% between highest and lowest number across 7 days from Q2 2016)
    - Access to diagnostics (achievement of clinical standards 2, 5, 6 & 8)

- Reduced delays in clinical decision making
- Reduction in decompensation especially for the elderly
- Reduced risk especially for longer lengths of stay e.g. falls, HAI rate.

Local Progress

Locally we recognise that discharge from hospital is a process not an isolated event and that it should involve the development and implementation of a plan to transfer an individual from hospital to home or an appropriate setting.

The System Resilience Group has a number of initiatives that are progressing alongside Urgent Care Projects, QIPP Projects and MH Concordat and Planned Care initiatives. These have been mapped together with interdependencies of all projects identified so that they all concentrate on three priorities:

- Keeping people out of hospital when they can be better cared for in the community.
- Patient journey during hospital stay.
- Discharging people home with support that prevents a readmission and reduces the need for Residential or Nursing Care.

Initiatives

Initiative	Objective
Tracker Nurses in place across the three main provider sites	• Facilitate early discharge of patients from acute hospital • Reduce length of stay in acute hospital.
2 hour Rapid Response Service in the	Reduction in A&E attendance.

[6] http://www.nhsiq.nhs.uk/media/2638611/clinical_standards.pdf

Community	Reduction in non-elective admissions
Home from Hospital Service will provide older patients living in the London Borough of Barnet support and practical help, enabling a smooth transition back home from hospital following discharge; or to	prevent A&E attendance/ hospital admission

Changes from 15/16

- Revised programme of work with care homes
- New approach to service delivery via the out of hours 111 service (procurement led by Enfield CCG)
- Early intervention and prevention programme embedded in the BCF programme will expand to a further two wards.
- Targeted early intervention and prevention working with cohorts at risk of unplanned admissions to hospital and residential care.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- In 2016-2017 the Barnet BCF programme will include:
- Integrated Locality Team to support patients/carers/service in the community enabling the reduction of non-elective admissions and unplanned care for ‘at risk’ cohort
- Utilisation of an expanded rapid response service model with increased staffing and longer opening hours, supporting patients and carers in the community. The service will respond to referrals within two hours and reduces the requirement for unplanned attendances in an acute setting
- An expanded prevention and early intervention programme to divert individuals from secondary care and high dependency social care services.
- Continued investment in community services that provide seven day services to individuals
- Introduction of a care home pilot supporting identified top referring homes (unscheduled attendances/ LAS non conveyances). Team will provide clinical training advice and support to improve the management of patients who are most at risk of an emergency admission, based on best practice in the silver book.
- Further development of our joint DTOC plan and alignment of key activities (care homes, home from hospital, reablement) with BCF programme.
- Joint work to address availability of accommodation for dementia cohort at risk of delayed transfer of care.
- Developing a discharge to assess model.

High Level Action Plan

Activity	Timescales	Leadership
Review of 2015-2016 7 Day Working Programme	May – July 2016	Joint Executive Commissioning Group
Programme development and expansion proposals developed	July- Oct 2016	CCG BCF Lead
De-commissioning/ Re-commissioning programme Agreed	Oct 2016	Joint Executive Commissioning Group
Staff consultation and engagement	July to Oct 2016	CCG and LBB BCF Leads
Provider negotiations	Oct to Jan 2016	CCG and LBB BCF Leads
Revised service implemented	April 2017	

5. Risk Management in 16/17

The BCF refresh has involved a comprehensive review of the proposed spending plan for 2016/17. JCEG have led the detailed work to review the performance of the BCF plan in 2015/16. At a CCG level this has involved assessing the financial performance, risks and the outputs of the associated *Managing Crisis Better* QIPP. At a Council level the senior team have also reviewed the deliverables in line with the medium term financial savings plan.

As part of managing the resilience across the system, partners have considered the overall pressures within the BCF spending plan, the level of investment needed to meet the BCF metrics and national conditions.

These discussions have taken place in the context of wider financial pressures affecting all partners in the health and care system, plus the need to balance priorities within a complex planning environment and a health and care economy which continues to face significant sustainability risks linked the over use of acute care. Evidenced by the engagement exercises around establishing the local commissioning intentions[7] within the CCG and the Council.

5.1. Local Approach to Risk Sharing

The potential risks associated with the Barnet BCF plan are based on:

> Cost of non-electives: The cost of non-delivery of the reduction in non-elective activity anticipated through the Better Care Fund in 16/17 is £560k. This cost is derived from the data used in our "managing crisis better" QIPP scheme, as outlined in the 15/16 BCF Plan. More data is below.

The 2015/16 BCF plan established a risk and contingency process, embedded into our S75 agreement, which operated effectively in the first year of the pooled fund. This mechanism is in addition to existing risk mechanisms that currently exist in the health and care economy for expenditure that sits outside of the BCF pooled fund services. Our approach is to draw on contingency held centrally, should it be needed, as this represents the most efficient mechanism for commissioners. For 2016/17 the established BCF pooled fund risk sharing mechanisms will remain as per the 2015/16 arrangements, with contingency being drawn from organisational contingency funds.

In developing our approach, we have fully considered the complexities in the health and care economy in relation to patient flows and the success of our targeted schemes to reduce non-elective activity for the cohorts targeted in our Better Care Fund plan (the success of these is set out in the section below – data behind rationale). The acute hospital sites contained within our Better Care Fund plan admit patients from a large number of other London boroughs and counties outside London in the east of England region and our approach to risk sharing and contingency has fully considered the impact of these flows.

[7] http://www.barnetccg.nhs.uk/Downloads/Publications/Strategies/NHS-Barnet-CCG-Commissioning-intentions-plan-2016-17.pdf

5.2. Rational Supporting Local Approach

The rational is based on the cost of non-electives using SUS PbR activity data based on the requirements identified in the “managing crisis better” QIPP scheme.

In 15/16 this QUIPP scheme delivered a reduction in activity for the conditions targeted through the designated enablers in the BCF plan. Each enabler was targeted at specific HRGs to reduce activity. HRGs were grouped into a ‘master condition’ for monitoring purposes. These schemes achieved a reduction in activity in15/16.

Master Condition	2014/15	2015/16
15/16 - COPD	331	281
15/16 - Dementia	645	578
15/16 - Elderly Care	183	161
15/16 - Falls & Fracture	797	730
15/16 - Respiratory	980	972
Total	**2936**	**2722**
15/16 - New Pool	802	905

The 16/17 “managing crisis better” QIPP scheme builds on the achievements of 15/16, with an increase in the HRGs being monitored. Evidence from 15/16 shows that the enablers in position are being effective at the targeted HRGs and that the ‘new pool’ master conditions (activity increase in 15/16), will see a reduction due to the active enablers.

Master Condition	Target Activity Baseline 2015/16	Target Activity reduction	Total QIPP 2016/2017
16/17 - COPD	281	27	64,827
16/17 - Dementia	578	62	254,301
16/17 - Elderly Care	161	11	27,310
16/17 -Falls & Fractures	730	53	126,420
16/17 - New Pool	905	34	78,621
16/17 - Respiratory	972	3	8,178
Grand Total	**3,627**	**190**	**559,657**

5.3. Mitigation Approach

The Barnet Better Care Fund Plan is governed by a Section 75 agreement between Barnet Council and NHS Barnet CCG. This agreement sets out the detailed arrangements for the BCF pooled fund, including risk sharing, risk management, and escalation routes. For 2016/17 the legally agreed BCF pooled fund risk sharing mechanisms will remain in place as per the 2015/16 arrangements.

The mechanism recognises that the initial level of risk sharing is at an individual organisation or project/programme level, utilising established contingencies, which are in existence outside of the core BCF pool to mitigate risks in the first instance. Expenditure on Protecting Social Care Services, Disabled Facilities Grants, Social Care Capital and Care Act Implementation is explicitly assumed to remain within the allocation and thus deemed to be expenditure that is not risk shared.

Should risks exceed those that can be managed at a project/programme level, an escalation route to the Joint Commissioning Executive (a sub-group of the Health and Wellbeing Board - HWBB) and to the HWBB itself is in place. The committee will consider various options to mitigate any risk. These include an appraisal of actions that can be implemented to contain expenditure, use of wider organisational contingency funds, under spends from other project/programmes from the BCF pool and how any risk or overspend will be apportioned.

Appropriate Commissioning and Contracting Mechanisms also exist and are built into provider contracts to manage and minimise the impact of any variation to the system. Moreover, the main focus of the schemes in the plan is geared towards management of the target group of service users/patients in a community setting through admissions avoidance and reducing delayed transfers of care. The implementation of these schemes will be done in a planned and managed to way to allow flexibility to transfer resource should there be slippage within the schemes.

5.4. BCF Risk Log

The table in this section details the most important risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government. Details of the mitigating steps that will be taken are also provided.

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
Health and Social Care System Risks				
Reduction in non-elective admissions target is undeliverable in the context of significant local challenge and past performance	4	4	16	Scale-up interventions that demonstrated impact in 2015-2016 on non-electives Review all projects for effectiveness and impact

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
DTOC Reduction is undeliverable in the context of local challenge in the acute sector	4	3.5	14	Local action plan Targeting of population cohorts and care homes with high admissions rates Sustained joint action on discharge
An underlying deficit in the health economy impacts on service delivery and/or investment	4	4	16	Systematic review of all investments to ensure that resources follow investments with high ROI/ CBA.
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	In 2016-2016 we will review all activities to make sure that we target resources in activities that mitigate and manage
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
Implementation of day seven hospital and primary care services delayed	3	3	9	Impact and timescales to be regularly reviewed through joint governance
Programme Risks				
Lack of nursing/residential placements for complex mental health cases (dementia) increases risk of delayed discharges	4	4	16	Working with neighbouring trusts and LAs to increase supply of places. Review lessons learnt from current cases and implement revised approach

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
Milestones are missed due to the complexity and scale of change/ review programme	3.5	3	10.5	Structured programme management with senior commissioner leadership established for 2016-2017.
The baseline data used to inform projected performance improvements are incorrect and thus the	4	3	12	Validation of assumptions and savings target with respective finance
performance and financial targets are unrealistic/unachievable	4	3	12	Define any detailed mapping and consolidation of opportunities and costs to validate plans. Develop strong patient and service user
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
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 expanded integrated care model to allow for greater understanding of the wider impact across the health economy Co-design and transitional planning with providers is in place Ongoing review of impact through regular provider lead

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
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	2	3	6	Engagement of social work and clinical staff in co-design and assessment reviews Front line/ clinical staff engagement and input in developing integrated care model and plans Communications strategy with staff across the system Maintain formal and informal networks where providers and commissioners can design solutions.

6. Governance Arrangements

6.1. Health and Wellbeing Board Oversight and Sign Off of Plan

Barnet has a well-established and effective programme governance structure, which is designed to ensure that there is transparency on decision making, momentum in the delivery of the agreed schemes and utilisation of a co-production approach for ensuring wider engagement in shaping and mobilisation integration on the changed protocols and pathways. Providers, commissioners and Public Health work together to co-produce solutions and take joint accountability for decisions and leadership on the delivery.

Barnet's Health and Wellbeing Board has overall responsibility for both operational and financial delivery of the Better Care Fund, totalling £24,324,521 and will maintain oversight of the outcomes. The Health and Wellbeing Board has delegated the day to day delivery and oversight of the integration programme to the Joint Commissioning Executive Group (JCEG).

From 2015-16 BCF funding has been underpinned by a Section 75 pooled budget arrangement jointly governed by the LA and CCG under an existing overarching arrangement. This will continue for 2016/17.

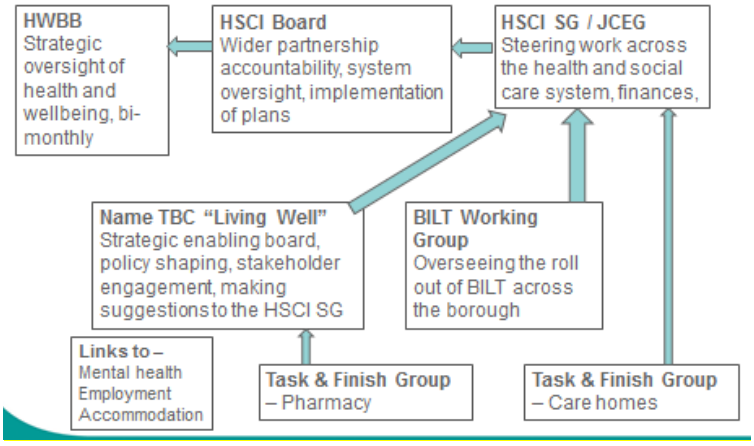
The final plan will be signed off by the Health and Wellbeing Board and shared with the Council and CCG's Governing Body.

The JCEG is a joint commissioning group with a membership of senior commissioners and finance directors from the CCG and Council. The JCEG oversees and reviews all aspects of joint NHS and local authority commissioning economy and has the responsible for overseeing the performance of the delivery of the BCF Schemes and will report to the Health and Wellbeing Board. The Health and Wellbeing Board has also approved a scheme of delegation for the Pooled Budget and Section 75 agreements.

In addition the CCG and the Council through existing, robust governance mechanisms will ensure there is appropriate oversight and decision making.

6.2. Health and Social Care Integration – Provider/Commissioner Governance

In 2015-2016 we refreshed the governance of the Health & Social Care Integration Programme to ensure that we have a structure that can deliver our ambitions with clear accountability and engagement with appropriate stakeholders, led by the Barnet Health and Wellbeing Board. The revised structure ensures that prevention and early intervention activities are under a single governance structure. The programme is led by the chief operating officer of NHS Barnet CCG and the Director of Adult Social Services (DASS) at London Borough of Barnet, with support from the Director of Public Health.



Governance Arrangements Flow

The new structure retains, builds on and extends our engagement with residents and providers (such as secondary care, pharmacy) who are core members of our (name still to be finalised) "Living Well", HSCI Board and BILT working group. The structure also has stronger links to broader programmes and other mechanisms of engagement with service users such as the CCG's Public and Patient Engagement Committee and Adult Social Care Service User engagement structures.

The Operational Groups that support the delivery of the programmes meet monthly and comprise senior operational managers from the relevant partner organisations. These groups coordinate the day to day delivery of the individual projects and services within the approved spending plan, produces the Integration Executive's finance and performance analysis reporting on a monthly basis, ensuring the delivery of the individual milestones within projects and the programme as a whole, assesses and addresses policy developments at an operational level, ensures matrix working and resourcing across organisational boundaries within individual projects, and directs the engagement plan between the integration programme and the structure and governance arrangements of all partner organisations as well as the communications and engagement plan with wider stakeholders, including the public.

The functions, duties, and delegation in terms of decision making are reflected in the terms of reference for the groups operating at the respective tiers of the programme governance structure diagram, with terms of reference updated and refreshed at least annually. Sample Terms of References for the working groups are provided.

6.3. Joint Working

A relevant section 75 agreement is in place. Regular meetings take place at system leadership level between the Council and CCG. A Joint Commissioning Executive Group provides direction and oversight to joint investments and improvement plan activity.

In the 2016-2017 Better Care submission we have committed to undertake a systematic review of BCF commissioned activities to assess:

- Effectiveness of activity on reducing current (and future) demand;
- Cost effectiveness of interventions; and

- Adherence to NICE/ best practice guidelines.

6.4. Key Activities 2016-2017

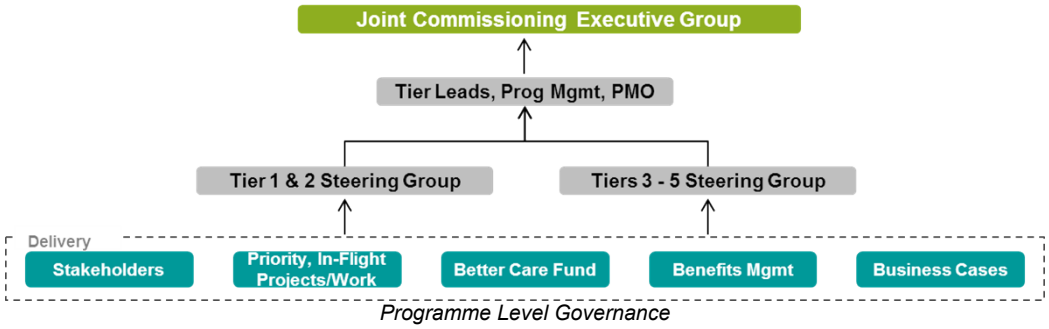
Over quarter 1 of 2016/17 London Borough of Barnet and Barnet CCG will identify and agree further KPI's to enable assessment of the impact of the Better Care Fund in enhancing the outcomes and experiences of Barnet residents;

- Individual schemes and their impact will be reviewed by the Joint Commissioning Executive Group as part of its work programme, through Quarters 1 and 2 of 2016/17
- The application of funding will be evaluated in Quarter 3 of 2016/17 to inform planning for 2017/18

BCF Programme Level Management Approach 2016-2017

In 2016/17 our BCF funded activities are clustered into thematic groups with each of the themes being overseen by a strategic (senior) commissioner from either the CCG or local authority. Each of the thematic clusters will include activities commissioned by the CCG and local authority. This approach should enable the CCG and local authority to take a whole systems approach to managing down demand within the local health & social care system. In light of the significant overlap between the community equipment s75 agreement and the system resilience programme it is proposed that these are included with the scope of the project/BCF spend reviews.

The structure for managing the oversight of the various schemes is depicted below and links back to our 5 Tier model in the original plan



Programme Level Governance

The charts on the next few pages provide the suggested clustering of BCF areas of spend/ projects and proposals on strategic commissioning lead responsible for overseeing delivery.

Seven Day Working and Services to Care Homes
Strategic Commissioner: Commissioning Director Adults & Health LBB Planned Expenditure £5,433,660

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
7 day social work	Social Care	Local Authority	£100,000	Non elective admissions Delated Transfer of Care
Adult Social Care - sustaining 7 day working	Social Care	Local Authority	£797,000	
Intermediate Care in the Community	Continuing Care	CCG	£340,522	
Rapid Response	Community Health	CCG	£1,014,618	
Single Point of Access	Community Health	CCG	£290,520	
Social Care Demand Pressures	Social Care	Local Authority	£2,260,000	
Primary care commissioned service	Primary Care	CCG	£400,000	
Quality in Care Home Team	Social Care	Local Authority	£231,000	

It is proposed that the system resilience programme is included in this block for review

Personalised Support at Home
Strategic Commissioner: Director of Operations and Delivery BCCG Planned Expenditure £2,598,609

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
Ageing Well	Social Care	Local Authority	£350,000	Admissions to Residential Care Delayed Transfer of Care
End of Life care	Continuing Care	CCG	£1,364,609	
IT Interoperability	Primary Care	CCG	£69,000	
Safeguarding	Social Care	Local Authority	£120,000	
Memory Assessment	Mental Health	CCG	£215,000	
Mental Health Pressures	Social Care	Local Authority	£300,000	
Dementia	Social Care	Local Authority	£180,000	

Intermediate Care
Strategic Commissioner Head of Joint Commissioning Unit BCCG Planned Expenditure £8,780,526

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
Intermediate Care in the Community	Community Health	CCG	£8,488,189	Non electives Delayed Transfer of Care
Stroke support services	Community Health	CCG	£195,000	
Fracture Liaison service	Acute	CCG	£97,337	

Reablement and Support for Carers
Strategic Commissioner: Adults Wellbeing Being Strategic Lead LBB Planned Expenditure £5,235,000

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
DFG	Other	Local Authority	£1,970,000	Admissions to Residential Care Non elective admissions Delayed transfer of care
Enablement	Social Care	CCG	£200,000	
Stroke support services	Social Care	Local Authority	£37,000	
Care Act	Other	Local Authority	£846,000	
Carers Support	Social Care	Local Authority	£300,000	
Carers Support – CCG	Social Care	CCG	£806,000	
Community Equipment	Community Health	CCG	£1,076,000	

It is proposed that the LBB Community Equipment element is included within this block for the purposes of the review.

Enabling Activity
Strategic Commissioners: Adults Wellbeing Being Strategic Lead LBB and Head of Joint Commissioning Unit BCCG
Planned Expenditure £2,276,726

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
Children's Commissioning	Social Care	Local Authority	£100,000	Self-management Satisfaction with services Admissions to Residential Care Non electives
Integrated Care Locality Team	Community Health	CCG	£862,366	
JCU funding for Heads of Service	Social Care	Local Authority	£200,000	
Primary care commissioned service	Primary Care	CCG	£270,000	
Shared Care Records	Social Care	Local Authority	£262,000	
Social care integrated practice	Community Health	Local Authority	£151,360	
Supporting delivery of BCF Plan	Social Care	Local Authority	£200,000	
Transitions	Social Care	Local Authority	£100,000	
Integrated Locality Team - LBB	Social Care	CCG	£131,000	

6.5. Measuring the Impact of the Plan

The 15/16 plan documents the benefits realisation approach for each of the schemes; these have been rolled forward and adapted to reflect the changes in the deliverables (where appropriate).

The impact of the plan will also be measured:

1. Quarterly,:
    a. Using a national template into NHS England. This measures the delivery of each local plan in relation to the *BCF national conditions* and *BCF national metrics* as detailed by definitions provided in Annex A and B of the BCF policy framework 2016/17.
    b. Locally via JCEG who have oversight of the BCF section 75.
    c. Locally to Health and Wellbeing Board.

2. Monthly:
    a. Locally via the Programme performance dashboard providing performance summary across the whole programme/metrics (example at Appendix 16).
    b. Locally via individual project/theme level governance boards, with monthly operational oversight by the BCF operational group. Allowing for much more in-depth discussion on specific milestones, trajectories and KPIs at project level.

3. Via specific evaluation activity e.g. clinical audits, independent evaluations (the BILT review is an example of how this was carried out in 15/16).

This plan is signed on the understanding and agreement by both parties that:

- Over quarter 1 of 2016/17 London Borough of Barnet and Barnet CCG will identify and agree further KPI's to enable assessment of the impact of the Better Care Fund in enhancing the outcomes and experiences of Barnet residents;

- Individual schemes and their impact will be reviewed by the Joint Commissioning Executive Group as part of its work programme, through Quarters 1 and 2 of 2016/17

- The application of funding will be evaluated in Quarter 3 of 2016/17 to inform planning for 2017/18

6.6. Programme Milestones

HSCI High Level Plan 2016-2017	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Programme Planning	Draft programme 25th April		19th June									
Programme Milestone plan	Agreed 25th April											
Develop Performance framework	Agreed 25th April											
S75 in place (revised)				31st July								
Review of previous year performance		19th May										
Data sharing approach		31st May										
Stakeholder engagement re future strategy post 2016/17		5th May										
Review Personalised Support at Home Programme			Review start		Review completed 16th August							
Recommendations Personalised Support at Home Programme					Draft 31/08							
Board sign off - Personalised Support at Home commissioning						25-Sep						

Commissioning and Decommissioning Programme Agreed (JCEG)							10/10/2016					
Prevention Review			Project initiation		Final Report			Committee Sign Off				
Prevention Review Communication events						Provider workshop						
Prevention activity - decommissioning and commissioning agreed					Inclusion in final report							
Revised Health Champion - Roll Out		Initial Recruitment			Phase 2 recruitment		Phase 3 Recruitment					
Health champions Stg1 GP and residents engagement					Review		Revised programme					
Health champions stg2 - procurement					Commissioning review	Market Engagement &Testing	Tender					
Implement Extended Ageing Well Model				Review meeting 10th July			Review & Recommendations for next stage 31st October 2016					

Develop extended social prescribing				Review meeting 10th July								
Visbuzz roll out		All sites identified 24th May										
Evaluation of Making Every Contact Count E-module roll out										Phase 1 Testing		Phase 2 Testing
Enablement and Support for Carers Review				Project Initiation			Project Report 24/10					
Recommendations Enablement and Support for Carers programme							Recommendations Report					

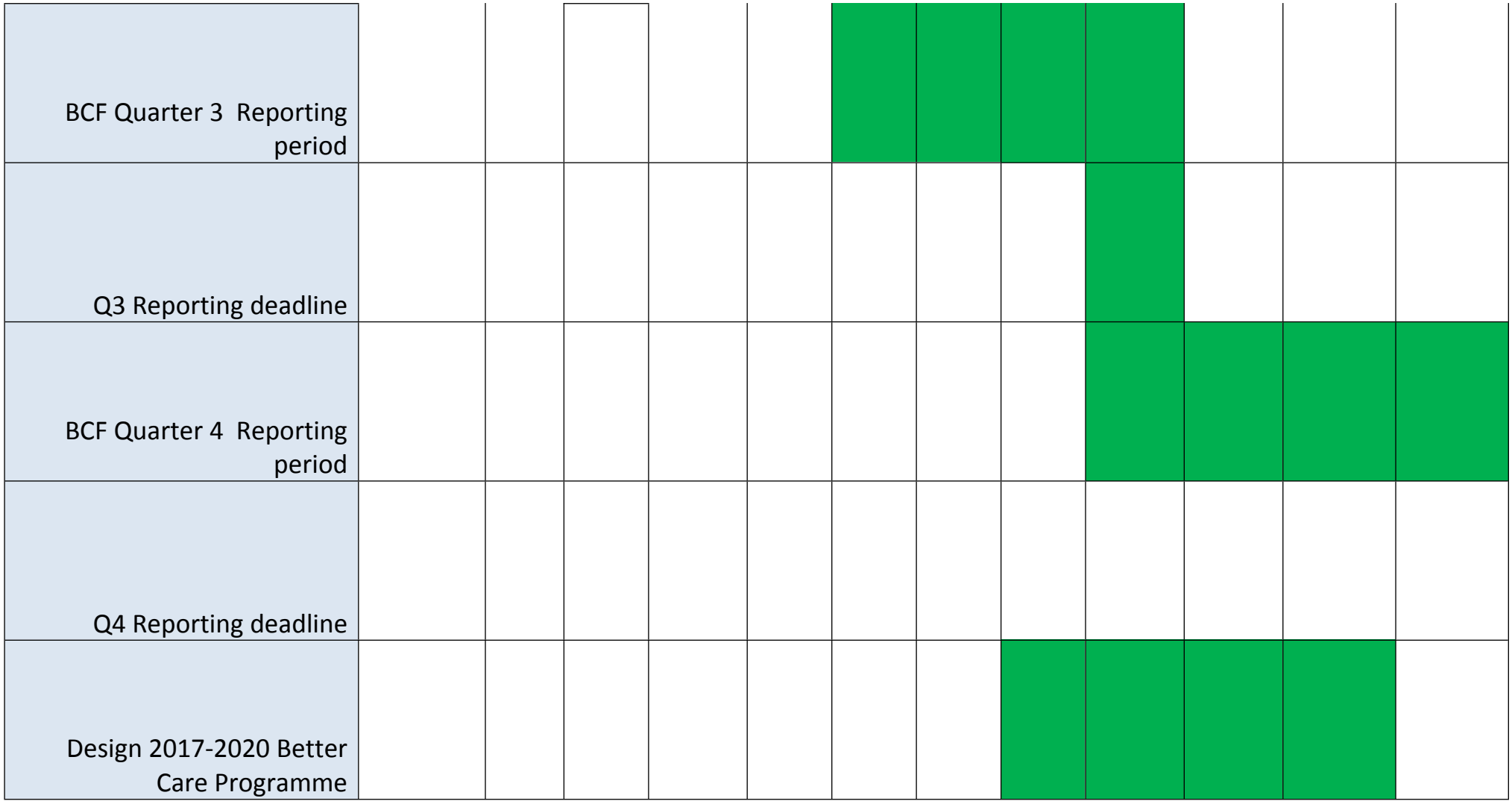
Enablement and Support for Carers Commissioning and Decommissioning Programme Agreed (JCEG)								19th Recommendations Report					
Board sign off - Reformed Enablement and Support for Carers Commissions													
Extended BILT Evaluation										Commissioned		Reported 16/02	
BILT Data tracking	Risk tool matching scheme agreed												
7 day working and Care Home Programme Review				Project Initiation			Project Report 24/10						
Recommendations 7 day working and care home programme							Recommendations Report 24/10						

Commissioning and Decommissioning Programme Agreed (JCEG)							Draft report 24/10	Final Report 19/11				
Board sign off - Reformed Seven day working and Care Homes Commissions			Project initiation			Project Report Date TBC						
Intermediate Care Programme Review						Recommendations Report TBC						
Recommendations Intermediate Care programme							Final Report					
Commissioning and Decommissioning Programme Agreed (JCEG)									12/12/2016			

Board sign off - Intermediate Care Commissions												
Integrated Locality Teams Evaluation Report												Final Report
Palliative Care Pathway Review						Project Initiation						
Palliative Care recommissioning agreed (JCEG)							Recommendations 24/10					
Board sign off - Intermediate Care Commissions								Final report 19/11				
Digital Road Map Design (NCL)		Provider self-assessments		NCL Plan agreed								

Recommendations - Digital Road Map NCL					Phase 1 Activity	Phase 2 Activity	Phase 3 Activity					
NHS number incorporation into ASC Records	MOSAIC Implemented	NHS Number flagged										
Revised client tracking using NHS number		Collection Development										
Review of revised risk assessment tool			Project initiation	Project Report								
Explore further integration of care records provider and social care				Stakeholder workshops	Recommendations report 31/08							

recommendations for further integration of care records					Draft report 31/08	Final report 30/09							
BCF Quarter 1 period													
Q1 Reporting deadline													
BCF Quarter 2 Reporting period													
Q2 Reporting deadline													


BCF Quarter 3 Reporting period
Q3 Reporting deadline
BCF Quarter 4 Reporting period
Q4 Reporting deadline
Design 2017-2020 Better Care Programme

Commissioning Decisions 2017-2020 Programme (following review programme)												
HSCI Board		7th										
Health & Well Being Board		12th		21st								
HSCI Steering Group			3th									
Joint Commissioning Executive Group	25th		20th									

7. Engagement Activities

Both Clinical Commissioning Group (BCCG) and London borough of Barnet (LBB) have well established mechanisms for provider engagement. Regular provider forums take place across commissioners and client groups. Open days bring together providers to discuss emerging trends in the population, strategic and financial issues, and commissioning intentions.

In adult social care, regular Provider Forums take place. Large events bring together providers across the borough, while more specific activity takes place focussed on client groups (such as older people), services (such as home care), and sectors (including targeted voluntary sector engagement, for example). Forums are followed up with other regular communication; including newsletters, further information, and consultation. Open communication is maintained throughout as a key part of the commissioning cycle. One-to-one leadership sessions with the acute providers and key providers in the area also take place.

The content of our Better Care Fund (BCF) has been discussed with providers, users, clinicians and carers as an integral part of our strategic planning processes. The starting point for all discussions has been our jointly-agreed JSNA and the priorities and plans agreed by the Health and Wellbeing Board (HWBB). Through co-producing these documents, and basing our planning on evidence and feedback, we have worked hard to establish our engagement on the basis of partnership working over many months. In this context we have had many engagement events, including with GP leads and service providers. We recognise BCF as a significant opportunity to accelerate our progress in delivering our existing ambitions and plans, including our established programmes to improve services for older people.

We have engaged through a number of different forums:

Work stream	Type of engagement	Details	Number of patients	When	Outcome
Development of Barnet Integrated Locality Teams	Patient input into developing the service	Patients who accessed the service where asked to complete a questionnaire on the service they received. What worked well, areas of improvement	All patients who have accessed the service	Ongoing	Outputs have been used to develop the service currently being commissioned from a lead provider
	GP	Workshops held with West locality GP's that participated	GP	Bi-monthly	Feedback from GP's used to make

A&E and DToC Plan of Action following weekly T&F Group Meetings

Work stream	Type of engagement	Details	Number of patients	When	Outcome
	engagement	in the pilot Attendance at GP locality meetings	practices N/A	Various locality meetings throughout the year	continuous improvements to pilot Raising awareness of the service
	Voluntary sector engagement	Workshops held with Healthwatch and voluntary sector providers	N/A	Various throughout the year	Feedback from the voluntary sector used to to strengthen links between BILT and voluntary sector services
	Engagement with community groups	Presentation at LBB Communities Together Network	N/A	March 2016	Links established with a few community groups
Delivering the Dementia Manifesto					
Learning Disabilities Partnership Board	Engagement with PWLD and stakeholders (vol sec, carers, providers)	Workshops, presentations and discussions on Transforming Care for PWLD and Autism	Representation at LDPB varies usually between 4 – 6 PWLD	Regular meetings during 2015/16 - @ 2 – 3 months	• Comments on proposals included in responses to consultations • PWLD informed and aware of changes to service models
Health Development Group	Engagement with PWLD and	PWLD are represented on the group which contributes to the development of health	1 - 2	Meetings during 2015/16 - @	• Identifying issues and concerns • Developing health objectives/outcomes

A&E and DToC Plan of Action following weekly T&F Group Meetings

Work stream	Type of engagement	Details	Number of patients	When	Outcome
	stakeholders (vol sec, carers, providers and clinical staff from community LD service)	objectives and priorities for service development		2 – 3 months	• Developing proposals for service development (business cases)
Autism Steering Group	Engagement with people with Autism and stakeholders (vol sec, carers, providers)	People with Autism and carers are represented on the steering group and some task/project groups	2	The steering group met twice in 2015/16	• Contributing to Autism work and oversight of strategy • Identifying priority issues and activity required to address
Patient Care & Treatment Reviews (CTRS)	Individual reviews of patient care and treatment (in assessment and treatment / hospitals)	NHSE requirement for CTRs within 10 days of admission and community CTRs for those e at risk of admission	15 or advocates where patients do not have capacity	N/A	• Comprehensive review of care and treatment including input form external experts (clinical and by experience) • Recommendations and action plan for each individual • Themes identified across providers
Reimagining Mental Health	Breakfast Club meetings	An event which brings together all co-design groups (see below) plus members of the community, public and third sector to discuss and celebrate the progress of Re-Imagining Mental Health	40+	Six-weekly	• Members of community are engaged about the RMH programme / services. • Open space to discuss thoughts and ideas.

A&E and DToC Plan of Action following weekly T&F Group Meetings

Work stream	Type of engagement	Details	Number of patients	When	Outcome
		Programme. (RMH)			
	Co-design Groups	A professionally mixed group (voluntary, Council, NHS and people with lived experience) that will focus on different agendas and subject matters for the Re-Imagining Health Programme i.e children & YP, MH training	2-3	Every 1 – 2 months	• All those involved are actively contributing to the re-imagining health programme • The groups help identify priority issues which need to be addressed and also offer possible solutions.
Visbuzz	Engagement with potential champions and users of the service	Promotion at events and groups to engage residents who could become Visbuzz users, champions or refer friends/neighbours to the service. Including – Barnet Senior Assembly event, Dementia Club for people with dementia and their carers, Barnet Elderly Asian Group, Sheltered Housing residents	180	One off	• Identified 12 Visbuzz Champions • 5 referrals to Visbuzz
Ageing Well	Developing branding	Design workshop to develop branding for Ageing Well	15	One off	• Input into name of strategic board and prevention work • Feedback on developing a brand for Ageing Well workstream
Partnership Boards	Engagement	5 x Partnership Board (carers; PSI; mental health; LD; older adults) that bring together	~ 50	Quarterly plus 2 seminars a	• Input into strategy and service development • Feedback on user experience

A&E and DToC Plan of Action following weekly T&F Group Meetings

Work stream	Type of engagement	Details	Number of patients	When	Outcome
		service users, carers, voluntary and community sector providers and commissioners		year	
Ageing Well	Engagement	review into data sharing in health and social care	12	One off	• To contribute to the National Data Guardian's review of standards of data security for patients' confidential data
Ageing Well	Engagement	4 x Locality Summits that brings together service users, carers, voluntary and community sector providers and local businesses	20-30 per meeting	Quarterly	• Input into strategy and service development • Development of new primary and secondary preventative activities and groups

Meetings with all key providers to secure agreement on any consequential impact of the 2016/17 BCF Plan have taken place across March 2016.

8. Appendix One: Supporting Documents:

8.1. DTOC- TASK AND FINISH GROUP ACTION PLAN

Avoidance of Attendance and Unplanned Admissions and

(Formerly Delayed Transfer of Care)

Action Plan – Update 22th March 2016

Dial in: 0844 4 737373 PIN 60 89 26

	Action	Description	Progress	Clinical Lead	Lead	Timescale
1	**Care Homes**	A Care Home Team Model that supports people living in Care Homes, specialist advice and access to Consultant support and joint training with LLB.	• Top 10 homes –identified information shared • Draft service speciation shared for comment • Model of care 3 PAs- RFH responded 02/02 requesting fuller discussion on the future model. CLCH responded 02/02. • COO requested further conversations to be undertaken at SRG 10/2 to identify ways in which support can be provided to the care home that does not create risks. Agenda item action plan • Draft Specification with Model	**JL** **JL**	**MJ/DM** **MJ/DM** **FG**	Completed Completed Completed

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			Staffing and Support went to Executive Team 2 February. Agreed in principle subject to Clinical Cabinet 28 Feb. Signed off by Clinical Cabinet on 28 Feb. • Mobilisation / Implementation group meeting being held on 25 Feb. Engaging all partners and IT, Estates, Performance, Communications etc. • KS comments emailed to DM for consideration • FG comments to specification emailed for consideration • Develop a Contract variation for RFL • Pharmacy has been mobilised against service specification • Create an operate – operational policy • Communication Plan • Frequent Flyers to be identified by RFL: two sub groups in existence o Elderly – Penny Wiseman	**BS** **JL** **JL**	**BD/DM** **MJ/DM** **MJ/DM** **MJ**	Completed Completed Version 2 Future meetings fortnightly on a Thursday to accommodate Clinical Lead In development in line with mobilisation timescales 8 March

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			○ Frequent attenders FG to obtain membership, TOR and understanding of reporting / connectivity with SRG/care homes projects	**JL** **JL**	**CD** **SC**	On-going evaluation at end of March CV completed and sent for sign off
			• Set up Stakeholder/project team group meeting to finalise draft • Create programme mobilisation plan	**JL**	**FG**	Part of mobilisation planning
			Programme Interdependencies with procurement of Risk Stratification Tool	**JL**	**MJ/ KS**	KS and FG have met and agreeing SoP and phased recruitment process
			Project Board established initial meeting held Full membership and ToR to be confirmed	**JL**	**MJ/DM**	FG Chasing data to be shared at stakeholder group meeting TBC On-going
			Learning to be shared from CHAT Team operational in Enfield	**JL**	**FG**	Meeting Fortnightly. SRG representation / links being made to progress agree actions across tehe system

	Action	Description	Progress	Clinical Lead	Lead	Timescale
					MJ	Risk stratification tool out to OJEU Bids expected end of Jan 2016
					GT	On-going
					GT	Monthly meetings being arranged
					MJ/MA	

	Action	Description	Progress	Clinical Lead	Lead	Timescale
					JB/MJ	
		OOH care home support Jan-March	• Top 10 Care homes Agreed linked to 1 above • applied learning from HCCG model • Agreed referral process • Service spec in draft • outcome measures/ performance near agreement • operational Policy • Meetings with Care Homes • Start date 22 February	**BS**	**BSH**	Completed Completed Completed Completed Completed Completed Completed

	Action	Description	Progress	Clinical Lead	Lead	Timescale
2	**Additional GP Slots / increased capacity in Primary Care**	Delivering additional bookable appointments during the weekend	In place and operational since 11 December. More capacity being considered in late afternoon/evening and weekends :- • GPs to be based in acute site(s) or nearest practice GP • Review St Thomas model • Slots to be directly bookable from ED • Find space at RFL sites for GPs to work from RFL or local GP surgeries to provide • EMIS training for RFL staff • Obtained GP Federation support • SRG support gained in principle • Review Enfield model – JB sending details • Internal meeting to develop the model and service specification and understand links with other services being confirmed by Primary Care Lead. Meeting held 25/2 Actions agreed: • Obtain A&E hourly data to support decision making and inform peak times cover is required	**BS** **BS** **BS**	**BW** **BW/BD** **BW** **BD** **BW** **KF** **BW** **BD** **BW**	Mobilised and operational from 11 December. TBC Awaiting contact details TBC TBC TBC Completed Completed – explore to models 22/02 SRG requested meeting to

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			• Email networks to establish availability and capacity identify Monday 4.00 – early afternoon as an immediate requirement • Obtain standard operating procedures / pathways criteria from Lambeth, Camden and Enfield • Obtain learning from St Thomas • Facilitate discussion with Camden federation • Establish clinical reference group to review pathway • Internal discussion to review finance budget / governance sign off • Further discussion with federations regarding model • Barndoc to provide update of KPIs		**KF** **BW/FG** **KF/BW**	discuss model and how it will operate to include BSH/BW/RW/ KS with existing provider Date of meeting March 15th In principle agreed with Network now working through the detail suggested times 5 – 9pm. But to be confirmed

	Action	Description	Progress	Clinical Lead	Lead	Timescale
					BW **TBC** **BS/BW** **BS/BW** **BHS**	 Agreed in principle by federation / network 15 March End of March
3	**A&E – MH Liaison**	24 hour response and support	In Place • Issues in Jan exception report identified Re: MH assessments delays. FG to pick internally to be shared with MH Leads • MH Leads to attend weekly meetings • specification included in 16/17 contract • The Service specification to be slightly amended to also include the team's	CB	**FG/RD/ PA** **JC /DD**	Completed

	Action	Description	Progress	Clinical Lead	Lead	Timescale

			input into bed meetings and discharge planning to assist with preventing Dtoc
			• Meeting being arranged by MH Leads to negotiate recurrent service specification and movement into BEHMHT Baseline.
			  • Engagement Sally Duson at RFL
			  • Business Plan next year (16/17) to be reviewed separate line for CAMH (Transformation Plan)
			  • Julia Chappell is lead
					AJ/DM
					
					PA/ JC/KD
						Meeting taking place on 22 March then engagement with RFL lead

	Action	Description	Progress	Clinical Lead	Lead	Timescale
4	**Review capacity** **NWB and Rehab and Enablement**	Create additional step down bed capacity within the within Care Homes. Targeted at NWB patients and those needing extended rehabilitation	10 Beds commissioned from Care Homes against a Access Protocols for NWB and Rehab and Enablement (Attached) 2 at Magnolia care home with nursing – 2 referrals 2 at Elmstead care home with nursing – dementia 3 at Apthorpe –- residential 3 at Dellfield Court – residential Pathway and protocol needs to be the same as for NWB and Rehab and enablement Merging protocols Send LF copy of protocol developed for step down for review and comments / changes Ensure timely assessments and accurate EDD's are in place as part of the patient journey to ensure they are returning home ASAP Meetings taken place between CCG and LBB and CLCH and CCG draft pathways in place		**AB** **AB/LF/KS**	COMPLETED -Mobilised and operational. Protocols in place for all step down capacity with weekly monitoring of admissions and through put. Completed Completed

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			Financial envelope agreed for step down beds. Review being undertaken on spend against allocated funds and forecast outturn Documentation and Governance arrangements in draft to be signed off		**AB** **AB**	Completed Completed Operational completed
		Develop step down support / NWB in community in patients home	Financial envelop agreed Recruitment being mobilised Contract variation to be linked to Rapid Response		**BD/DM** **KS** **DM/AM**	Completed Completed Completed CV being developed to extend for 2 months to link with D2A and longer term resilience

	Action	Description	Progress	Clinical Lead	Lead	Timescale
		Enablement service commissioned from Housing 21 do not take NWB)	System understanding of capacity need including BCF allocations and existing contracts to ensure appropriate resourcing Review specification of Housing 21 to include NWB in criteria LBB re procurement of Housing 21 / Enablement. Currently published on OJEU. Linked to BCF and Integration Requested review of additional capacity opportunities with LBB – BCCG LBB explored no additional capacity explored Requested review of all patients to ensure they meet criteria		**DM** **KS/LF** **LF** **LF**	Pathway and inclusion of Housing 21 to be part of the pathway / protocol 13 Feb Both protocols shared with LBB and CLCH Review of current contract with LBB as currently out to Tender Referral criteria and clients using service to be reviewed to ensure appropriate capacity. Meeting in diary with Contract lead LBB Currently on-going Expected response 22 March

	Action	Description	Progress	Clinical Lead	Lead	Timescale
		Work with HVCCG to review rehab capacity /process	Ongoing Commissioner to commissioner dialog to ensure continuous flow. SRG requested a meeting to discuss wider Resilence patient flows. Draft agenda agreed 15/02 Requested information on 17 HVCCG patients within 09/03 teleconference identified awaiting response from RFL		**BD/DM** **FG/BD**	Completed Now linked to System wide capacity and escalation plan now operational Date of meeting with draft agenda circulated for availability and meeting date secured On-going review during assurance of Easter and times of SURGE
5	**Create a time limited budget and process to enable patients to go home and unblock delays**	Ability to create bespoke care packages in the community that complement existing capacity at pace	Agreed budget allocated Develop with Budget holder a process for authorisation and sign off This will be logged and reviewed and changes made to current arrangements / contracts if delays are caused through poor response from existing capacity / services Use bed meetings to identify 'one off requirement' Assess call on the budget and gaps in services to inform future changes to		**AB with BD and DM**	Completed Funding identified completed Ongoing Review – call on budget being logged to understand reasons for use

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			contracts or commissioning of new support Approval process revised Requested expenditure against plan		**AB**	By End of March
	Review MFP including opportunities for discharge to **Assess – ideally in peoples own homes**	Explore Discharge to Assess opportunities and potential outcomes Develop Pathways and Capacity	Regular reporting being established -Need-weekly numbers, sites/ward, PACE discharge to assess Teleconference held 22 Jan SRG requested a meeting to agree Discharge to Assess actions and principles members to include LBB, RFL, CLCH, CCGs. LF to review data and revert to group 16/02. Data received by LBB assessing impact of 180 patients. How many PACE likely to need long term care. Reduced capacity within LBB Admin has delayed	**BS**	**AB** **LF**	RFL undertaking regular awaiting results PACE discharge to assess meeting to taken place. A wider Discharge to assess meeting arranged for 2/3 10.30 – 11.30 Patient assessment numbers meeting between FG/LF by 22 March

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			review due to training requirements Linked to Step Down and NWB. Also reviewing the DST with CHC colleagues to ensure that the checklist is undertaken in a timely manner to ensure Fast Track patients are dealt with as a priority. DST Meeting held on 2 March. Paper of proposed model to be submitted to SRG Fast Tracks are always prioritised, and following local agreement full assessments from Royal Free sites are prioritised. Additional Band 6 capacity being recruited to deal with growth in demand CHC Deep dive identified delays, action plan in place. Submission of CHAT Tool submitted 22 Jan Approved by COO in process of Finance and HR sign off Issue raised that DNs no longer undertaking DSTs	**BS**	**DM/BD** **AB / NP**	D2A Model to be agreed based upon South Warwickshire Best Practice example from Monitor Further meeting arranged to align Model to Barnet System **Completed** NP escalating through contract lead and Director – may be escalated to SRG

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			Meeting held on the 9th March agreed principle of Discharge to assess with members in attendance. Paper circulated and agreed in principle by SRG for wider discussion and approval		**AB/NP** **AB / NP** **BD/DM /FG/ KS**	Awaiting review meeting in April Paper circulated for comment 5th March service draft specification to be developed for discussion at wider stakeholder meeting
		Review MFP(medically optimised)numbers at Barnet and Barnet & chase	Establish expected numbers ongoing Review process/ definition/utilisation. Received by CCG shared with FG.	**BS**	**AB/FG** **AP**	On going Barnet site undertaken by AB 10/02 now on-going daily and discussed at RFL bed meetings Additional support from SRG to be provided at Hampstead site

	Action	Description	Progress	Clinical Lead	Lead	Timescale
		Review Discharge Management / Teams at each hospital site	Review internal MDT operational processes. Meeting of staff to walk through the pathway, assess patient flow and agree improvements to	**BS**	**FG/KS** **DM/SM**	Internal review completed. 2 hour session being planned to audit existing practice and ensure co-ordinated approach and best practice. Now pending action as part of Discharge to Assess. TBC
7	**PACE and Treat and Enablement Capacity**	Develop service specifications against services that can be monitored and assessed for sustainability	Specification's in draft CV in draft KPIs received Finalisation of specification Stakeholder meeting FG to review Pace specification Service specification to go to Clinical Cabinet	**BS**	**BD/DM /FG/KS**	Completed specification agreeing baselines Clinical cabinet mtg. 24 March
8	**Bring together data and information of all frequent users of NHS services across Acute**	Recognised that frequent users of services are known to many agencies. Need a system wide integrated planning response	Developing the information and sharing arrangements across agencies • Procurement Pack published on		**BD/DM**	Ongoing. Project Manager started at CCG 4 Jan this has now been identified as on oh his prioritises. Currently scoping existing information and

	Action	Description	Progress	Clinical Lead	Lead	Timescale
	Hospital, GPs, LAS, BEHMHT, and CLCH.		OJEU 20 Jan • Draft Project Brief for Frequent User Project prior to procurement of Tool by End of Jan • Data shared with LLB • To share with system leaders at MDT meeting before end of February • FG to chase information from RFL		**GT**	agreeing project brief and outcome measures. Moderation phase early March Completion TBC Now also being reviewed as part of 1 CHT
9	**Neuro Rehabilitation**	There is a lack of capacity of complex Neuro Rehabilitation Beds. Look to lowering the threshold	Linked to NWB and a wider re-design programme just being scoped across Barnet and Camden Clinical meeting across 2 CCGs – 5 Feb Project Support and Project Management to be agreed at meeting Progress to a re-design project / Business Case for Neurological Model of conditions	**SB/DF**	**DM/AB**	OBC – 9 March –approved Project Board to meet in April

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			including Rehab OBC going to QIPP 9 march – approved		**DM**	Workshop to build model April
10	**Communication Plan across all initiatives**	Communication Plan	Communication plan approved at Jan SRG Information / leaflets being developed and circulated Engagement across all initiatives through Leads across SRG Members Budget being identified High number of LAS conveyances being explored alongside availability of diagnostic tests at the weekend and Eve New CCG communications Mananger been appointed- to attend T&F ad hoc/as required. Revised communication plan to be completed for April SRG across all SRG schemes	**BS**	**SC** **AP/JG**	Ongoing Handover completed Meeting to take place – revised Plan April SRG

A&E and DToC Plan of Action following weekly T&F Group Meetings

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			Review of local standby coms requested for times of surge particularly between WIC and ED's which support national coms			09/03 for social media Update on progress meeting with SRG lead and Comms Lead TBC for March
11	**Production of CCG Operational Plan**	To work with ABa to ensure alignment with SRG initiatives`	A B attended meeting and will provide updates on progress as plans emerge		**ABa**	Second submission of the Operational Plan submitted to Unify2 on 2 March Midday as required. Next submission April 11
12	**Diagnostics extension at WIC**	Review need and opportunities to extend existing WIC diagnostic requirements	Discussion with CLCH/ RFH to identify opportunity to extend current working practice at FMH	**BS**	**FJ/BD**	Update 8/03 FG chased
13	**DToC Submission**	Submission required by NHSE on 19 February	Submission coordinated and signed off – submitted 19 Feb. Awaiting feedback	**BS**	**BD**	Completed
14	**Jnr Dr Submission**	Assurance during 8/9 March	Submission being made and signed off 2 March	**BS**	**BD/DM**	by CoP – 2 March- completed

	Action	Description	Progress	Clinical Lead	Lead	Timescale
15	**Easter Assurance**	Assurance for Easter submission being made on 7 March	Currently being completed. To be Co-ordinated by SURGE prior to submission on 7 March	**BS**	**BD/DM**	By CoP 7 March- completed
	Escalation Capacity and Access	Template of available capacity across all CCGs and Local Authorities	In draft and circulated to SRG members for comment with additional information identified as required as it gets utilised and becomes operational.	3	Escalation Capacity and Access	COMPLETE Template of available capacity across all CCGs and Local Authorities
	Enhanced Rapid Response	Additional Capacity to prevent A&E and unplanned admissions	In place since November 7 days PW.	4	Enhanced Rapid Response	COMPLETE Additional Capacity to prevent A&E and unplanned admissions
	Establish a Task and Finish Group to explore 'What we can do differently@	An action focus group of system representatives to agree urgent solutions to preventing delayed discharges	In place Attendees • Buz Dodd • Diane Meddick • Fran Gertler • Karen Spooner • Marsha Jones • Aji Michael • Kirstie Haines • Liam Furlong • Beverley Wilding • Rebecca Thornley	BS	BD/DM	COMPLETE NLBP Weekly Tuesday 10.00.am meeting Membership extended to include LBB, MH as well as RFL and CLCH No formal ToR objective to expedite initiatives and schemes and take immediate actions

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			• Alan Brackpool • Paula Arnell • Rodney D'Costa • Bob Ryan T&F Group to replace Urgent Care Operational Group agreed at SRG. SRG will be the monitoring Group of progress			within the system. Replacing UCOG decision 12 Jan at UCOG Meeting / SRG Completed and ongoing weekly

Name	Abbreviation	Organisation
Dr Debbie Frost	DF	Barnet CCG
Dr Barry Subel	BS	Barnet CCG
Dr Jonathan Lubin	JL	Barnet CCG
Dr Charlotte Benjamin	CB	Barnet CCG
Colin Daff	CD	Barnet CCG
Buz Dodd	BD	Barnet CCG
Diane Meddick	DM	Barnet CCG
Bhavini Shah	BSH	Barnet CCG
Marsha Jones	MJ	Barnet CCG (Darzi Fellow)
Aji Michael	AJ	Barnet CCG
Beverley Wilding	BW	Barnet CCG
Alan Brackpool	AB	Barnet CCG
Paula Arnell	PA	Barnet CCG
Samantha Campbell		Barnet CCG
Rodney D'Costa	RDC	Barnet CCG/LBB
Rebecca Thornley	RT	Barnet CCG
Garrett Turbett	GT	Barnet CCG

Aji Michael	AM	Barnet CCG
Sharon McFarlane	SM	Barnet CCG
Kirstie Haines	KH	London Borough Barnet(LBB)
Liam Furlong	LF	London Borough Barnet (LBB)
Karen Spooner	KS	Central London Community Hospital (CLCH)
Fran Gertler	FG	Royal Free Hospital (RFL)
Fiona Jackson	FJ	Royal Free Hospital (RFL)
Alex Pinches	AP	Royal free Hospital (RFL)

8.2. Examples of Information Sharing Arrangements and Approach to Patient Consent

8.2.1. MOU between providers

Provided on request

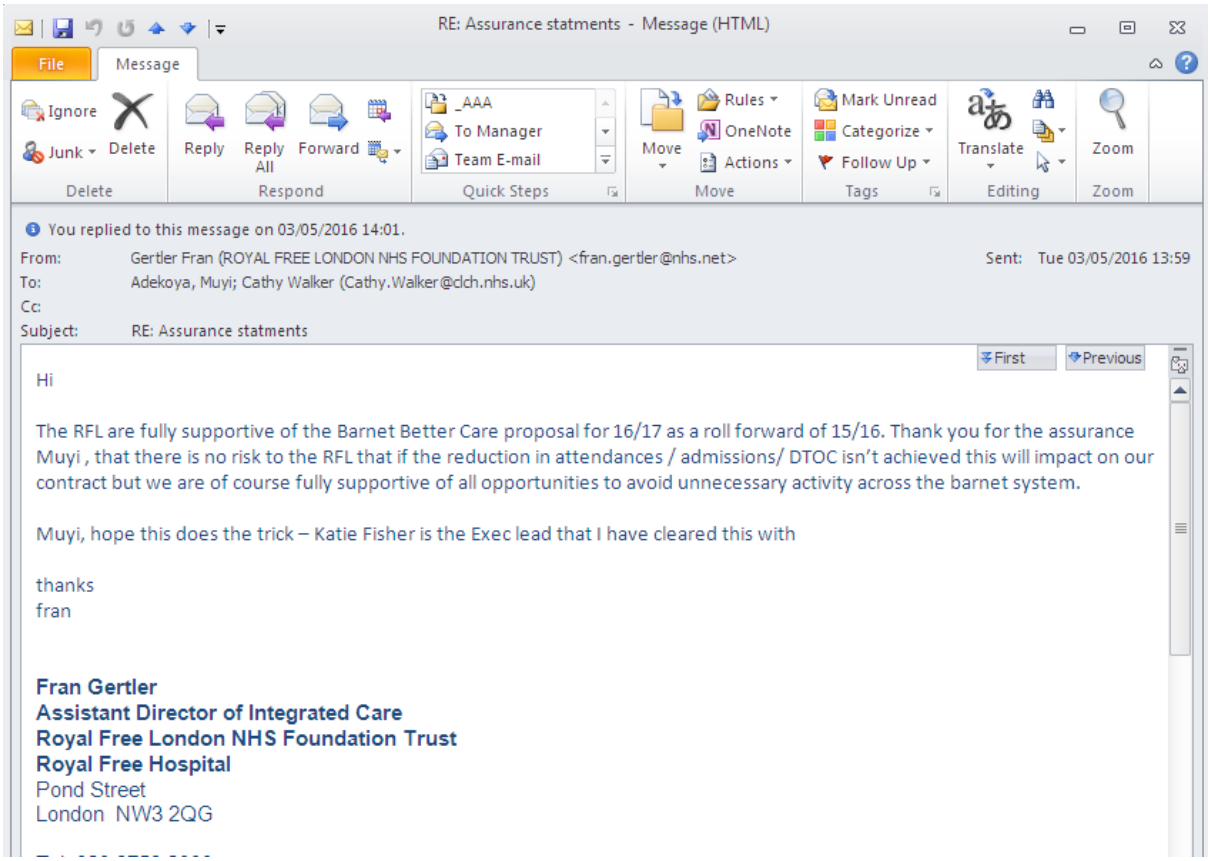
8.2.2. Information provided for patients

Provided on request

8.2.3. Operational Flows for managing patient consent

Provided on request

Assurances from Provider



RE: Assurance statments - Message (HTML)

File | Message

Ignore | Junk | Delete | Reply | Reply All | Forward | Delete | Respond | _AAA | To Manager | Team E-mail | Quick Steps | Move | Rules | OneNote | Actions | Move | Mark Unread | Categorize | Follow Up | Tags | Translate | Editing | Zoom | Zoom

You replied to this message on 03/05/2016 14:01.

From: Gertler Fran (ROYAL FREE LONDON NHS FOUNDATION TRUST) <fran.gertler@nhs.net>
Sent: Tue 03/05/2016 13:59
To: Adekoya, Muyi; Cathy Walker (Cathy.Walker@clch.nhs.uk)
Cc:
Subject: RE: Assurance statments

First | Previous

Hi

The RFL are fully supportive of the Barnet Better Care proposal for 16/17 as a roll forward of 15/16. Thank you for the assurance Muyi , that there is no risk to the RFL that if the reduction in attendances / admissions/ DTOC isn't achieved this will impact on our contract but we are of course fully supportive of all opportunities to avoid unnecessary activity across the barnet system.

Muyi, hope this does the trick – Katie Fisher is the Exec lead that I have cleared this with

thanks
fran

Fran Gertler
Assistant Director of Integrated Care
Royal Free London NHS Foundation Trust
Royal Free Hospital
Pond Street
London NW3 2QG

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	CLCH
Name of Provider CEO	Cathy Walker Divisional Director
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

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?**	yes
2.	**If you answered 'no' to Q2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	yes