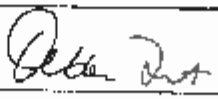
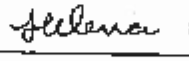
Barnet Better Care Fund Plan – 2017 -19

Local Authority	**Barnet Council**
Clinical Commissioning Groups	**NHS 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 by Health and Well-Being Board: 11th September 2017	
Date submitted: 11th September 2017	
Total agreed value of pooled budget: 2017/18 2018/19	**£30,272,581** **£32,363,041**

a) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Debbie Frost
Position	Chair
Date	11 September 2017

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Helena Hart
Date	11th September 2017

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

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 conditions

Document or information title	**Selected Links**
STP Plan	http://www.northlondonpartners.org.uk/ourplan/
HWB Strategy	https://www.barnet.gov.uk/citizen-home/public-health/Joint-Health-and-Wellbeing-Strategy-2015-2020.html
JSNA	https://www.barnet.gov.uk/citizen-home/council-and-democracy/council-and-community/maps-statistics-and-census-information/JSNA.html
Carers Strategy	https://barnet.moderngov.co.uk/documents/s29625/Appendix%20A%20Carers%20and%20Young%20Carers%20Strategy%202015-20.pdf
Joint Position Statement	http://barnet.moderngov.co.uk/documents/s41165/Appendix%201%20-%20Shared%20Position.pdf
Barnet Health and Social Care Concordat	HSCIB concordat signed.pdf Barnet Health Social Care Integrati
Health and Social Care Integration Business Case (Sept 2014)	HSCI Business Case Update Oct 014 v0.9 https://barnet.moderngov.co.uk/documents/s18828/Appendix%201%20-%20Appendix%201%20Business%20Case%20for%20Barnet%20Health%20and%20Social%20Care%20Integration%20of%20Services.pdf
Terms of Reference	JCE\CC2H ToRs https://barnet.moderngov.co.uk/documents/s41155/Appendix%201%20-%20Terms%20of%20Reference.pdf

Contents

1. Introduction

Barnet's vision for health and care is set out in our Joint Health and Wellbeing Strategy (JHWBS) and our Better Care Fund plan is built on this foundation. Our JHWBS provides a shared vision and strategic direction across partners, to:

- focus on prevention and early intervention including secondary prevention (slowing the progression of disease)
- make health and wellbeing a personal agenda by increasing individual responsibility and building resilience whilst ensuring provision for people with complex needs and/or special access needs
- joining up services so residents have a better experience
- developing greater community capacity; increasing community responsibility and opportunities for residents to design services with us
- strengthening partnerships to effect change and improvement
- putting emphasis on working holistically to reduce health inequalities in order to enhance each individual's health and wellbeing.

Our Better Care Fund plan has been based, since its inception, on this vision. Our BCF has delivered integrated services that support Barnet residents over 55 and with long term conditions to maintain and improve their health and wellbeing, through prevention, early intervention and rapid response at times of crisis. Since the inception of the BCF, we have used the fund to support residents with long term interventions to stay well through:

- Increased prevention and community based support services, provided through the voluntary sector. These follow best practice community involvement models, with substantially increased use of volunteers
- Increased and better quality support to carers, with new carers support services, specialist dementia training for carers, and support to help carers retain employment
- Extended community health and social care services to provide early intervention and rapid response for those who need it, through our Barnet Integrated Locality Team (BILT) and Rapid Response Service (RRS), which operates 7 days per week
- Enhancing hospital discharge by providing 7 day a week social work services at all acute hospital sites
- Increasing enablement care
- Improving the quality and safety of social care provision through the creation of a dedicated team to work with residential, nursing and home care providers

The Barnet Better Care Fund model has had a positive impact on outcomes for local patients and service users. It has reduced emergency care use for the users of our BILT service. It has decreased the use of residential care and significantly increased the numbers of older people supported to stay well through preventative services, up from 2000 to almost 8000 in the time period. Throughout this time, patient and user satisfaction has remained strong. However, we want to be more ambitious and develop greater integration of services that will deliver more improved outcomes for local people.

Whilst this plan is in part a continuation of the programme of work commenced in 2015/16, it has been significantly refreshed and expanded to incorporate our increased ambition, including the delivery of key initiatives from the North Central London (NCL) Sustainability and Transform plan (STP), notably the expansion of our BILT service into a wider Care Closer to Home model (CC2H); and a robust programme of work to improve performance in urgent and emergency care (UEC) against the A&E 4 hour standard and reduce Delayed Transfers of Care (DTOC). The Barnet BCF plan incorporates local action to achieve the key targets required in the BCF and the STP.

Barnet's vision for health and care integration is a long standing one – as set out in our business case for integrated care and our integrated care concordat, both of which formed part of our first BCF plan. These commitments remain current and have recently been refreshed through a joint position statement on integration agreed by the Health and Wellbeing Board[1]. This sets out the practical things we will do to further develop integrated services over the next two years.

From 2017 to 2019 our vision is to extend our integrated model of care through implementation of our Care Closer to Home model, which brings together primary care, community health, social care and voluntary and community capacity into local service networks known as CHINs. CHINs extend the current model of integrated care into truly holistic, one stop shops for people with health and care needs. Our vision is that CHINs will deliver very localised care whilst reducing variation and improving outcomes for all patients.

This BCF narrative plan, along with the financial and performance templates, sets out how we will work to implement our vision, building on experience from current BCF services and ensuring a successful transition to the Care Closer to Home vision

1.1. The Health & Social Care Needs of the Population of Barnet

- 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. The 65+ population is projected to grow by 34.5% by 2030 and the 85+ population by 66.6%.

- Dementia rates and projected growth are both higher than the London and national average[2].

- In comparative terms Barnet is a healthy borough and this is reflected in life expectancy and a wide variety of health indicators. Public Health England's (2017) Health Profile for Barnet shows that health outcomes are consistently better than those across England as a whole. The only exceptions (rates of sexually transmitted infections and tuberculosis) reflect challenges experienced across London as a region. However, our STP shows that many people are living longer but with poor health and therefore high needs from health and care services.

- Coronary Heart Disease is the number one cause of death amongst men and women. As male life expectancy continues to catch up on and converge with women it is likely that the prevalence of some long term conditions will increase in men faster than in women. It is likely that dementia will become an increasingly significant cause of death in the future.

- The total number of GP registered patients in Barnet is over 400,000. However, Barnet like other north London boroughs is in the lower quartile for GPs per 10,000 population and is above the median for GPs above the age of 55.

[1] https://barnet.moderngov.co.uk/documents/s41165/Appendix%201%20-%20Shared%20Position.pdf

[2] [1]The most recent relevant source of UK data is Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007.

- Whilst Barnet is ranked 3rd across North Central London (NCL) CCG's in terms of A&E activity usage is has the lowest rate per 1000 population.

- The rate of emergency hospital admissions due to stroke is significantly higher in Barnet than London or England.

- Barnet has the largest number of nursing home beds for older people in London and the largest number of residential care homes for older people, with a total of c. 2,800 beds. This leads to a significant net import of residents with health needs moving to Barnet from other areas.

1.2. 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 in our refreshed vision and approach. This is evident in the delivery progress to date and the milestones that have been set out to be delivered over the next two years. 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.

1.3. Key Challenges for the Plan

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.

Data Integration: Work is also progressing on the integration of records and data across agencies, providing a shared view of a patient (CIDER project) which will be used for direct care and case management in a community setting. Work is also underway at the STP level on the digital roadmap. However, as a health and care system we do not yet have a shared patient record across the NHS and social care.

Financial Constraints: The NHS and local authority face financial challenges, with all organisations delivering significant savings programmes. The CCG remains behind target funding, although have got closer to target levels in the last (2) years. [Can add specifics]

Despite these challenges, both the CCG and LBB are committed to using the Better Care Fund to improve services and outcomes for older people and those with long term conditions in line with statutory requirements and the wider policy context for health and care.

2. Progress so far

The Barnet Better Care Fund model:

Self-Management and Prevention: Over the last few years Barnet has put in place a diverse and accessible prevention "offer". The plan for 16-17 included the following initiatives:

- self-care
- community dementia support
- Ageing Well
- Later Life planning and advice
- services for falls, stroke and end of life
- equipment and adaptations
- carers support
- social prescribing

To support the 'vision' of building resilient cohesive communities, which take on more responsibility for their local area and are involved in the design and delivery of services we have established schemes that aim to build genuine partnerships with the community. Examples of services in our comprehensive prevention model include:

Community Centred Practice: Practice Health Champions: Barnet Public Health Team commissioned a pilot - Community Centred Practice - where residents through training are empowered as "Practice Health Champions". Champions use their social skills and knowledge to connect people to community resources and practical help to enable themselves, their families, friends and neighbours to live well. The Community Centred Practice (CCP) model is about working with General Practices to address social needs and to reduce reliance on both NHS and Council resources. Volunteer Practice Health Champions and GP Practices work together to deliver:

- Local projects that promote wellbeing and resilience, prevent ill health and help people who struggle to live well with long term conditions, isolation and loneliness
- Reductions in consultations in primary and secondary care and a shift in the way patients use services, moving towards social rather than medical solutions
- Reductions in GP workload pressure
- Improved staff morale.

Over 600 residents responded to a call to become Health Champions in Barnet. This shows a great willingness amongst our residents to support primary care and potential additional resource if we were able to harness this. Our intention is to build on this demonstration of interest in the further development of this model and in the expansion of our local area co-ordination service (Ageing Well, also known as Altogether Better) to a full borough-wide service, with greater targeting of those with health and social care needs.

Health Coaches: Locally we have commissioned a leading family support charity - Home Start - to deliver an innovative Health Coaches service to provide early emotional wellbeing support and practical help to families affected by mental health, domestic violence and substance misuse. As part of this service mothers who are affected by mild to moderate perinatal mental health issues are also supported. The service is delivered via home visits.

Altogether Better (Ageing Well) Programme: has catalysed community action, volunteer activities and reduced social isolation. Our Prevention and Wellbeing Team

is now developing and expanding the Ageing Well model into a full Local Area Co-ordination (LAC) model service which works borough-wide, as part of the implementation of the Council's new strengths-based operating model for adult social care.

With LAC being a long term, integrated, evidence based approach to supporting people with disabilities, mental health needs, older people and their families or carers, the service works alongside community groups and residents to:

- Build and pursue their personal vision for a good life
- Stay strong, safe and connected as contributing citizens
- Find practical, non-service solutions to problems wherever possible
- Build more welcoming, inclusive and supportive communities

The new Barnet LAC service will be integrated with Care Closer to Home Networks (CHINs) and create the link between local community groups/volunteer services and the CHIN.

The expanded dementia hub model: has been rolled out widely, offering support for adults with dementia and their carers. Those attending have access to Dementia Advisors; Dementia Cafes; community activities and day opportunities; information and advice; the Dementia Hub.

Later Life Planning services: offers information, advice and support including advice on welfare and benefits, housing or support services as well as advice and practical support on keeping healthy and active.

Additional services have been implemented to provide carers with services that are linked into both health and care schemes especially in relation to seven day working including our Ageing Well Programme which is aimed at reducing demand for adult social care services by supporting people to live independently in their communities for longer and to build support networks within local communities

Access services including primary and social care assessment: Early identification and proactively targeting of those at risk of becoming frail or unwell via utilisation of the risk tool has enabled our local providers to work in an integrated manner, evidenced through the integrated locality teams supporting patients in their own homes and the multi-disciplinary services provided to care home patients.

- Implementation of the risk tool, expanded to be used by BILT, in use across the whole of Barnet
- Development of community-based Care Space assessment hubs for ASC, co-located with the VCS – 2 covering whole of the borough, offering assessment, information and advice and trialling drop-in support.
- Memory assessment service
- Community health single point of access
- Extended hours primary care

Community based Proactive Care and Seven Day support: Intensive community based support services including rapid response and other seven day support services have supported the plan in reducing the number of non-elective attendances and admissions into an acute setting.

Funding enablers: Funding was also used for programme management, joint commissioning posts, IT development (shared care records) and the Quality in Care Homes Team.

2.1. Meeting the national conditions in 16/17

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

In 2016/17 our Better Care Fund plan was aligned to support the delivery of the programme of work under the A&E Delivery Board (including the resilience schemes).

What we did:

- Agreed a strategy for delayed transfer of mental health patients (dementia) arising from limited supply of residential beds for this cohort.
- Reviewed current voluntary sector and small contracts with both LBB and BCCG that support reductions in DToCs. The outputs of the review resulted in some services being decommissioned and new services procured.
- Developed a Discharge to Assess Model; implemented pathway 3
- Established a Care Home MDT service based upon the 'Silver Book'
- Expanded the Rapid Response service
- Established a weekly Task and Finish Group to drive forward service improvements to prevent A&E attendances and DToC; Daily reports of DToC position at all 3 RFL sites and escalated process is in place
- Continued 7 day a week on-site social work service and introduced additional Social Worker time to support discharge and MDT Assessments

With this year being well publicised as one of the most challenging times the NHS has faced in the past decade with a national picture of hospitals being unable to meet key targets Barnet, despite the planning from the Local A&E Delivery Board on the above initiatives, remains challenged. However, we have implemented robust improvement plans with monitoring taking place on a regular basis with regulators NHS England and NHS Improvement.

The A&E Delivery Board therefore has formed an improvement programme which has put in place additional initiatives to improve UEC performance for the 2017-18 period.

2.1.2. Maintaining Provision of Social Care Services

Social services funding is 'protected' through the use of a ring-fenced amount of funding which is 'passed through' from the CCG to the Local Authority. For 2016/17, this figure amounted to £6.647m.

What we did:

- Retained services such as the Care Quality Team who have a significant impact on improving the quality of the care provided by residential and nursing homes,
- Introduced the proposed carers and dementia pathways, supporting both residents and carers in community based settings
- Offered an expanded early intervention programme which included increased neighbourhood schemes via the Ageing Well programme.
- Provided sustained investment in activities to manage population pressure and ensure individuals were supported within social care and neighbourhood services.

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

Barnet has established a number of services with well-developed approaches to joint assessment and care planning.

What we did:

- Expanded the Barnet Integrated Locality Team (BILT) from West Barnet to whole population.
- Implemented a new risk profiling tool to support the early identification of patients. This is used by BILT and in each GP practice.
- Rolled out a pilot enhanced care homes scheme alongside the delivery of rolling programme of training to care homes. The targeted support was delivered by a multi-disciplinary team from both health and care.
- Adopted a case management approach inclusive of GPs.
- Implemented a single point of access for community services
- Integrated working between community health, acute sector, social care and continuing care on admission avoidance, supported early discharge and managing transfers of care.

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

We have worked collaboratively with all stakeholders to implement and deliver step changes required to support the local health economy. All providers were involved in developing the BCF plans and these were reflected in contracts. A working group of providers, including social care, was involved throughout the development and implementation of our Better Care Fund model. Work in 2016-17 is also evidenced through the wider NCL STP. Our BCF plan was developed with NHS providers, the model and targets were confirmed with them and commissioned through commissioning rounds. Providers are members of the CC2H board and we are co-designing and agreeing changes jointly with them.

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

Barnet has continued to invest in out-of-hospital services, this is evident through the expansion of the integrated locality teams (BILT) borough wide, the development of 8-8 primary care, the commissioning of rapid response, intermediate care and discharge to assess, the investment in primary care based activities to support self-management and the establishment of both carer and dementia hubs.

What we did:

- Expanded the support provided by the integrated team to the North and South of the Borough.
- Increased the cohort of risk identified patients supported in the community; with a higher number of people diverted from non-elective admissions or unplanned care through the use of a revised case management approach
- Expanded primary care activities to support self-management.
- Introduced dementia and carer hubs

2.1.6. Better Data Sharing between Health and Social Care

Locally progress has been made on data integration using NHS numbers, with all practices having migrated to the EMIS clinical data recording tool alongside having access to the risk stratification tool for identification of patients at risk of an unplanned attendance.

LBB have also implemented a new client tracking solution, MOSAICs system, which will enable the council to link care records to health records via the NHS Number which can now be saved in the MOSIACs system.

Jointly we have taken significant steps in the past year to enable integrated digital care records across different providers in Barnet. Building on the planning and scoping exercise in 2015-16, we have agreed to partner with Camden CCG to use an existing operational system – the Care Integrated Digital Record (CIDR) – so that patient records can be shared across different local care providers.

All Barnet residents will be enrolled into this programme in winter 2017 but will be given the option to opt-out.

Re-procurement of GPIT Services*:* A proportion of our BCF funding is used to develop an integrated approach for IT. The five CCGs across NCL have re-procured GPIT Support Services. Revised contract and service level agreements are currently being finalised to commence from August 2017.

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

Progress continues to be made. A stated, we currently have:

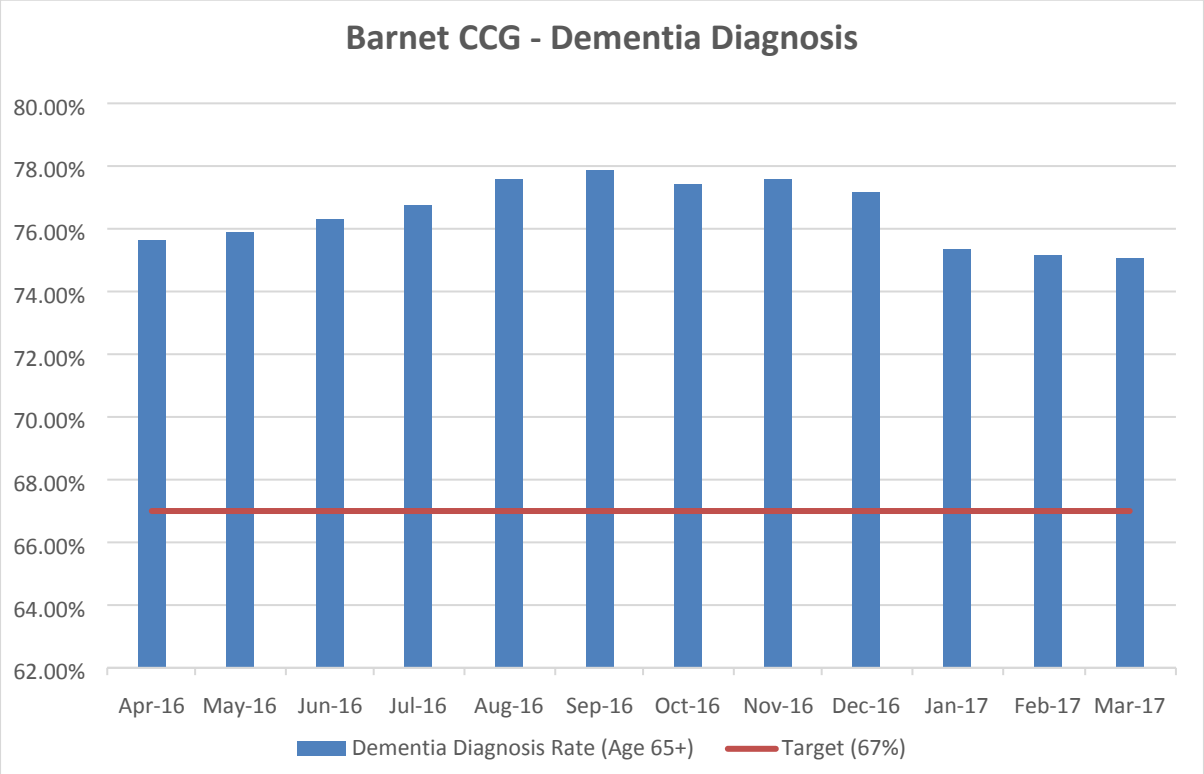
- 7 day access to community nursing, including prevention of admission
- 7 day access to 2 hour rapid response service in the community
- 7 day access to social services support, including within the acute trust
- 7 day services providing supported discharge from the acute trust
- 7 day access to equipment

We will continue to support seven days services. Key areas to further develop our provision of support include:

- 7 day access to integrated locality team
- Ability to discharge patients back to nursing/residential homes at weekends

2.1.8. Outcomes

Dementia diagnosis targets: Barnet has one of the highest dementia diagnosis rates in England; with 75.4% of the estimated number of people with dementia in Barnet diagnosed (the national target is 67%).



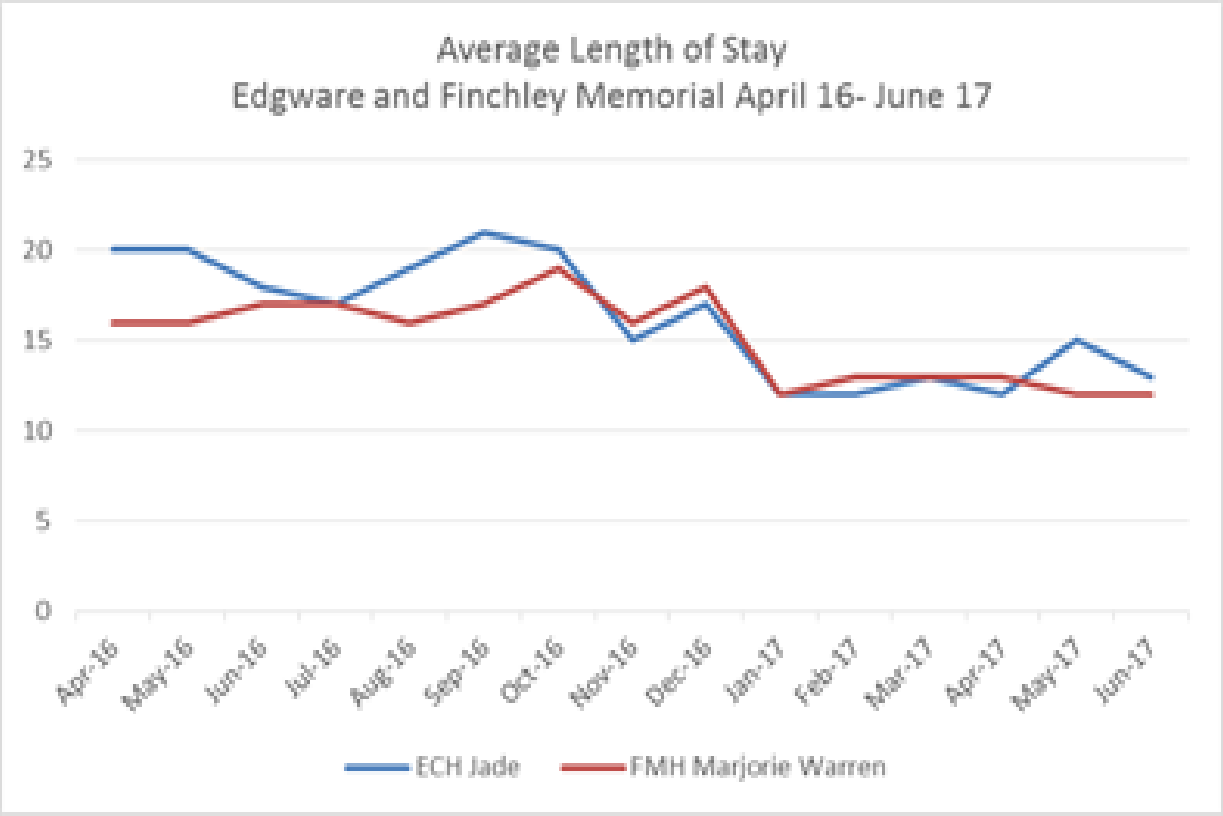
Rapid response: Those patients triaged using this service showed a 2% reduction in being re-admitted to hospital.

Discharge support: The schemes in place have helped reduce readmission to A&E and provided more acute beds for patients who most need it through their discharge support work, which has supported discharge for more than 100 patients over a five month period.

Training for care home staff (1) – Barnet CCG has provided training for care home staff to develop their confidence in assessing early signs of patients becoming unwell. This training

has been carried out by a multi-professional team including GPs. 335 staff in eight care homes have so far received training, 90% of whom have reported that they will change their clinical practice as a result.

Stroke: Joint working across the system has enabled Barnet to continue to provide an integrated offer for patients. Our early supported stroke service (ESD) has been performing well, including taking patients out of HASU so they go home quicker and saving acute expenditure.



2.2. Meeting the National Performance Metrics in 2016/17

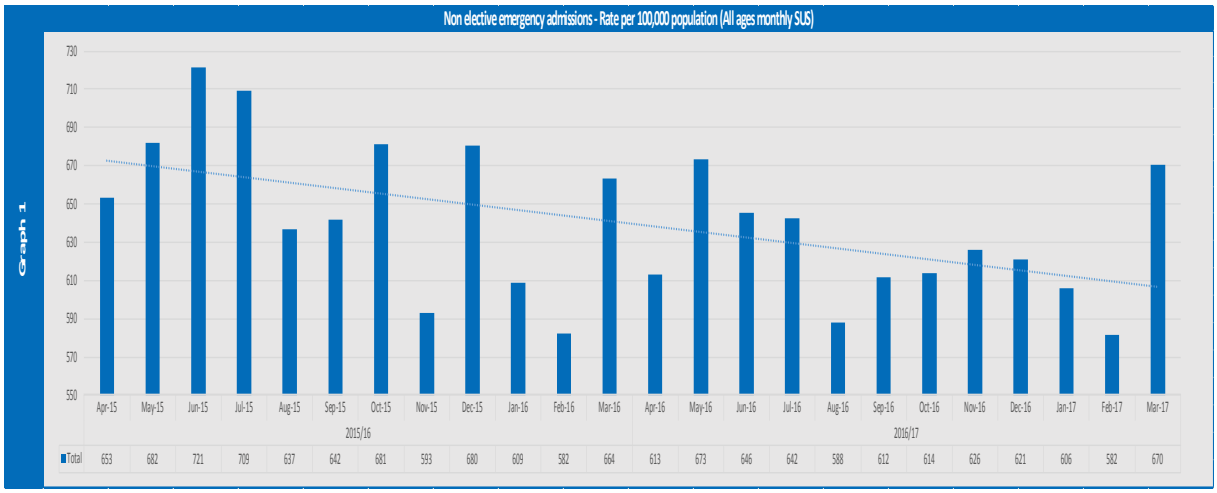
2.2.1. Non-Elective Admissions

What we did

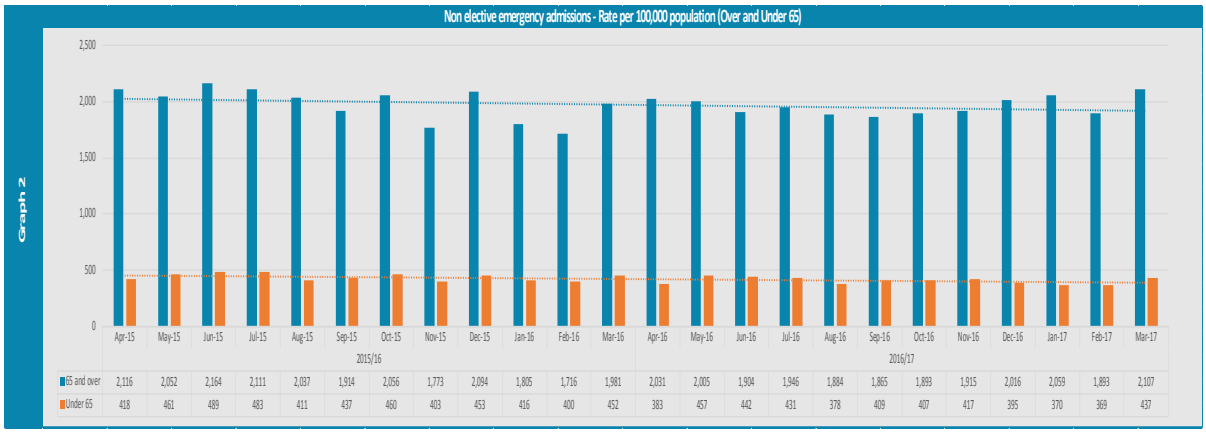
- We expanded the Integrated Locality Team remit to work with an extended cohort of individuals who are at risk of a non-elective admission including frail elderly and those with poor management of long-term conditions.
- We implemented our Dementia Pathway, including an enhanced support for carers looking after individuals with dementia as part of our integrated offer. We Enabled access to a single unified support system for older people with physical and mental health conditions.
- We worked with our community services provider and improved the stroke pathway.

Outcomes

Barnet achieved a level of reduction in its overall non-elective admissions across all ages. We saw a reduction of 4.6% in non-elective admissions per 100k, from 15/16 to 16/17

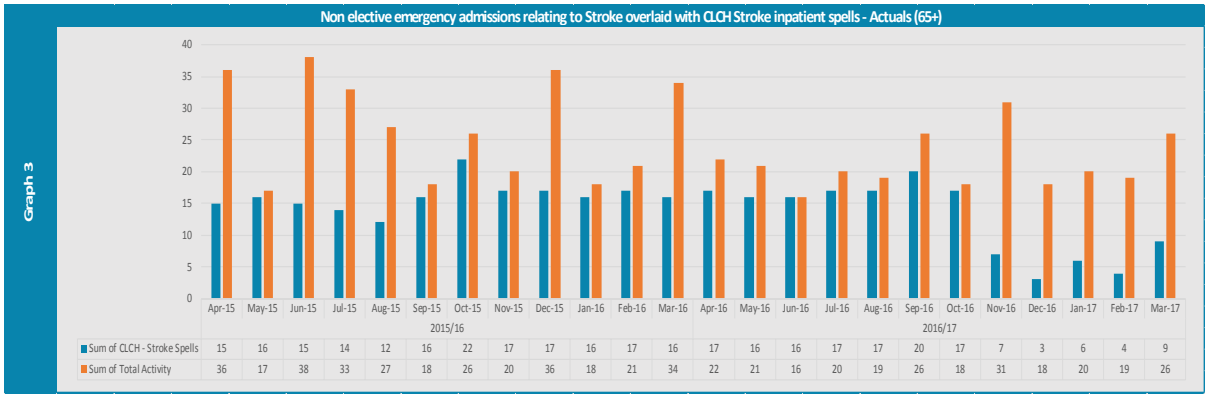


Looking at the non-elective emergency admissions rate per 100,000 population over 65 there was a reduction of 1.3% in the over 65s from 15/16 to 16/17



A review of data relating to stroke demonstrates the effectiveness of the community based support. Non-elective emergency admissions relating to stroke overlaid with CLCH stroke

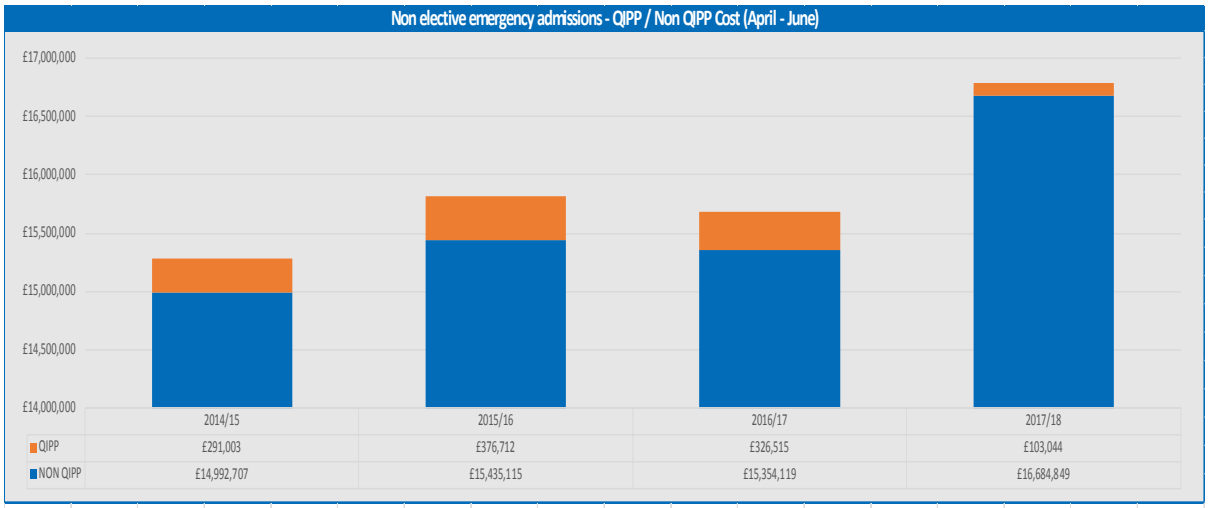
inpatient spells - Actuals (65+) shows that there has been a reduction of stroke non-elective admission by 21%.



When looking at the ambulatory sensitive conditions (ASC) non elective emergency admissions by ACS Condition - rate per 100,000 population (65+) (April - March) shows that there were reductions in the following areas when comparing 15/16 to 16/17.

- ✓ Pyelonephritis & urinary tract infection (-1%)
- ✓ Stroke (-23%)
- ✓ Atrial fibrillation and flutter (-3%)
- ✓ Diabetes (-9%)
- ✓ Cellulitis (-10%)
- ✓ TIA (-46%)
- ✓ Convulsions & epilepsy (-13%)
- ✓ Hypertension (-12%)

The graph below details the impact the schemes had on the wider **STP QIPP** schemes



There was a reduction in the level of spend for admissions relating to Non QIPP in 2016/17 against 2015/16 of -£80,996, which was a -0.5% reduction against the previous year
There was a reduction in the level of spend for admissions relating to QIPP in 2016/17 against 2015/16 of -£50,197, which was a -13.3% reduction against the previous year
There was a reduction in the level of spend for admissions in total 2016/17 against 2015/16 of -£131,193, which was a -0.8% reduction against the previous year

QIPP is generated from the STP QIPP and local QIPP has not been added in yet.

2.2.2. Permanent Admissions to Residential Care 65+

What we did:

In 2016-17 we identified the following areas for further work:

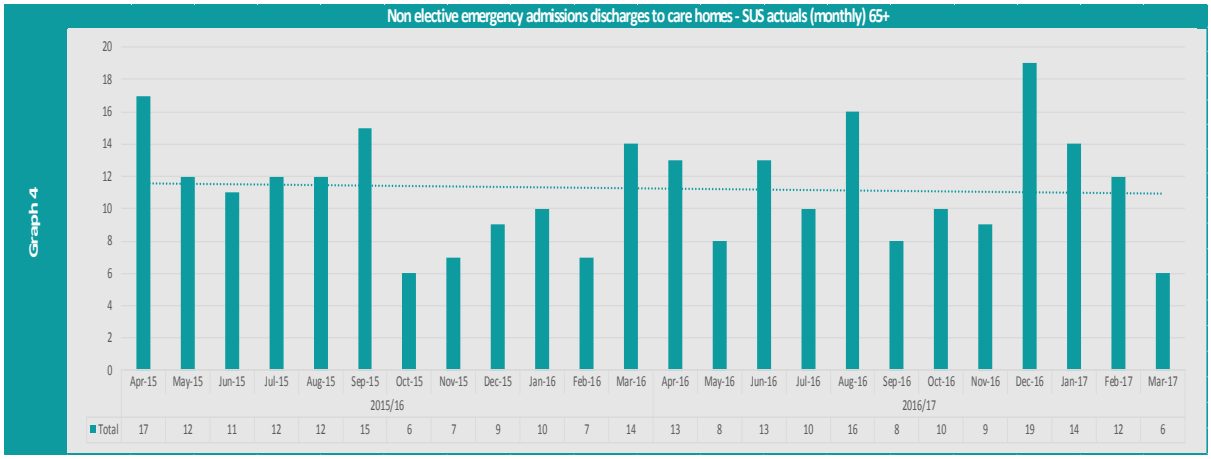
- Discharge from hospital to residential care, following elective and non-elective admissions.
- Insufficient supply of accommodation suitable for people with extra needs but not requiring residential care.
- Attitudes and expectations of health and social care professionals and families.
- Lack of access to neighbourhood support for carers and individuals at risk of a hospital admission.

We developed an Accommodation Strategy for Vulnerable People detailing 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. As a result the Council is now investing £55 million capital funding to build an additional 200 extra care housing units, including for couples, with the first new scheme due to open in June 2018.

Our Ageing Well neighbourhood programme was extended from 4 to 6 neighbourhoods and our Older People's Day Offer (Age UK) was redesigned to enable a referral pathways from the Integrated Locality Team for those individuals at risk of a hospital admission.

Outcomes:

Barnet sustained success in keeping the rate of admissions to residential care well below target for older and working age adults. For older adults new admissions are at 381.9 per 100,000, well below the target of 530.0 for year end.



2.2.3. Delayed Transfers of Care

What we did:

- We developed a joint local action plan to ensure that activity is co-ordinated and scheme impact monitored.
- We commissioned seven day services across health and social care.
- We implemented pathway 3 of the Discharge to Assess High Impact change model

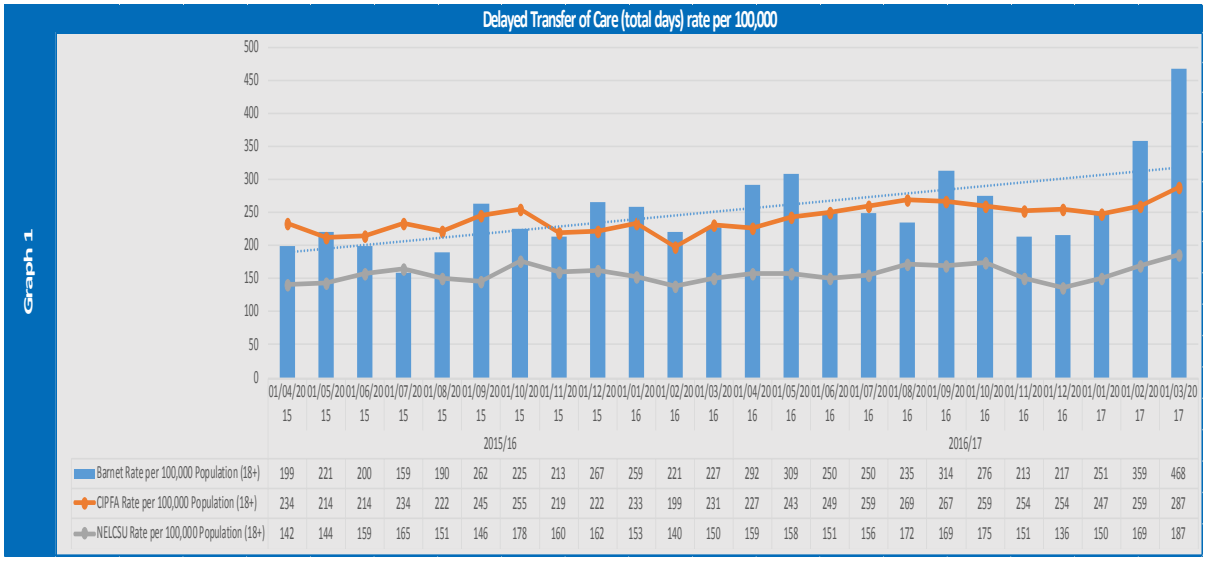
Outcomes:

Overall the HWB DTOCs target was not met, however we can see improvements from 2015/16 to 2016/17 in the NHS delay days from 12.5% to 8.9%.With the others increasing significantly.

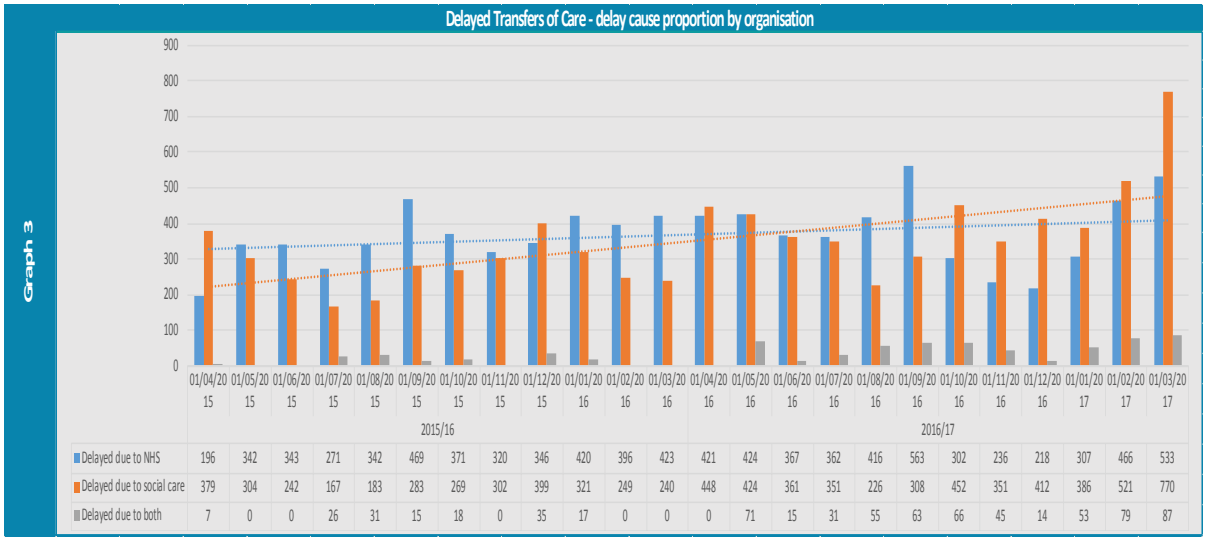
					Movements		
By Responsible	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2014/15**	**2015/16**	**2016/17**
NHS Delay Days	5,226	3,767	4,239	4,615	-27.9%	12.5%	8.9%
SocialCare Delay Days	1,975	2,523	3,338	5,010	27.7%	32.3%	50.1%
NHS And SocialCare Delay Days	-	313	149	579		-52.4%	288.6%

Analysis of DTOC in Barnet

In order to better understand the picture across Barnet, detailed analysis of the raw data in both 'snapshot' and total delayed days formats has been undertaken. Monthly figures are presented to the Joint Commissioning Executive/ Care close to home Board that presents the data in such a way to allow both trend analysis and month by month comparison.

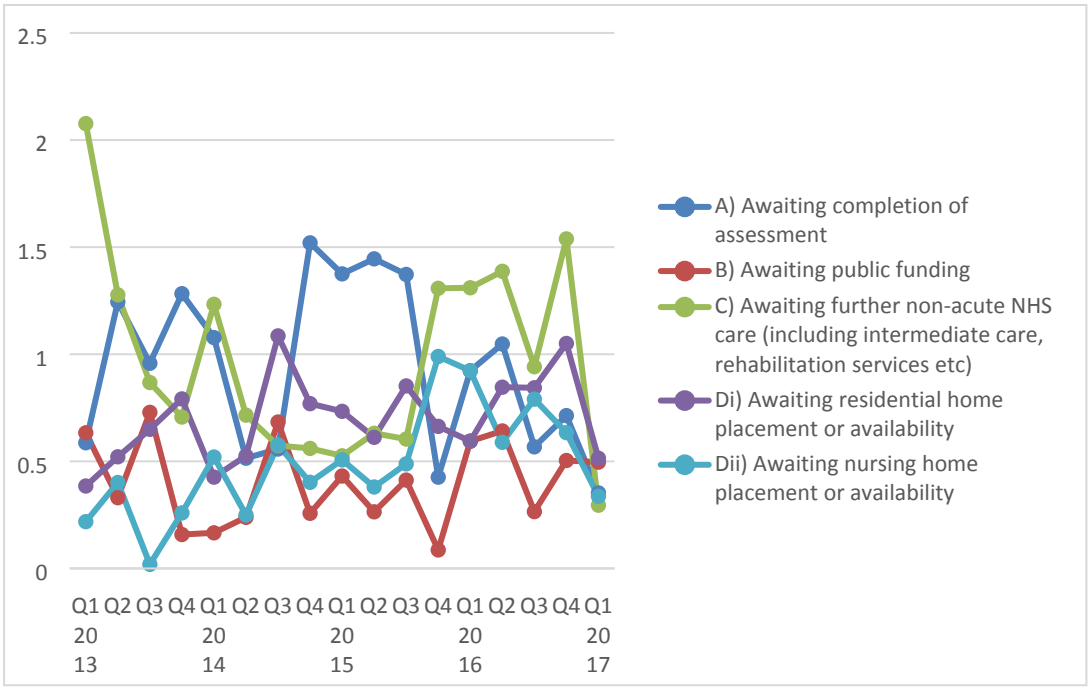


Appendix 1

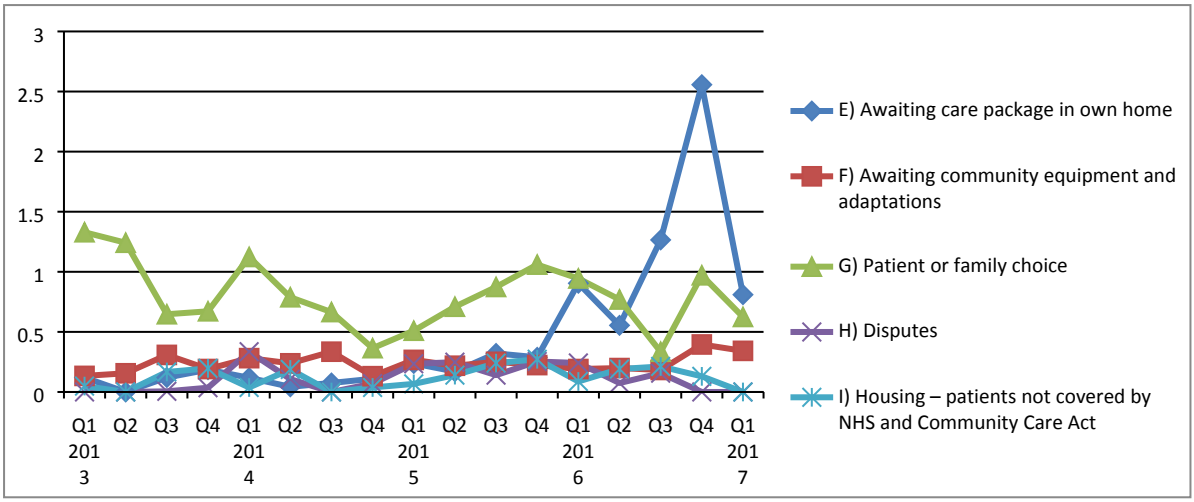


We have analysed the reasons for DTOCs and although we can see a significant increase in *awaiting care package in own home*, see graph below, the work that has been carried out through the initiatives have led to improvements in some areas

Areas of Improvement for the reasons of DTOCs for Barnet weighted by population list size.



- *Awaiting completion of assessment* has seen an improvement from 2015/16 to 2016/17. 25.9% to a reduction to -29.6%.
- *Awaiting nursing home placement or availability* 2015/16 showed an increase of 35.3% with a slight improvement to 24.2% increase.



- *Patient or family choice* 2015/16 showed an increase of 7.2% with an improvement to -4.2% reductions for 2016/17.
- *Disputes* showed an increase of 71.2% from 2014/15 to 2015/16 with a significant improvement to -46.1% reductions for 2016/17.
- Housing – patients not covered by NHS and Community Care Act, 2015/16 showed an increase of 174.1% with an improvement to -13.8% reductions from the previous year.
- A major focus for the 2017-19 plan is there for improving DTOC performance across the system. Our actions are detailed further on in this plan.

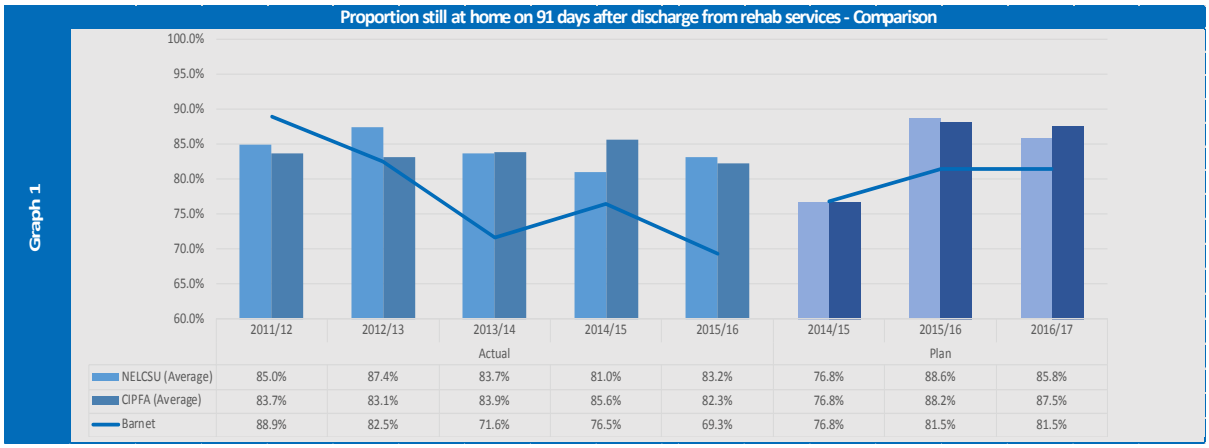
2.2.4. Reablement

What we did:

- We reviewed our enablement pathway, putting in place a new way of working as part of delivering the wider social care agenda. This included updating and promoting our enablement criteria, working closely with key partners in hospitals and the community to implement this. We have refocused the enablement intervention, so that there is an enhanced goal setting approach which has the adult at the centre.
- We have a new service provider for enablement which is co-located with the council's enablement team, which has improved joint working and reviewing of enablement
- We extended 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-imagining Mental Health we commissioned a number of services to support individuals to recovery and manage their conditions outside hospital.

Outcomes:

Reduction has been achieved from 14/15 to 16/17 from the periods of Apr – Dec for the number of readmissions of -6.6% and -1.5% respectively.



2.3. Feedback on the schemes in 16/17 that have informed the refreshed plan

We undertook a systematic review of BCF commissioned activities to assess (1) Effectiveness of activity on reducing current (and future) demand (2) cost effectiveness of interventions and (3) adherence to NICE guidelines. The learning from this was that the service model followed the evidence base for integrated care and that services were mostly meeting their intended aims. However, there is a need for:

- Significantly increased usage and throughput of the proactive care services, especially BILT and risk stratification.
- Improved linkages and pathways between the prevention services and proactive and rapid care services so that they support those most at risk of escalating care needs.
- Improve alignment across BCF commissioned services and other commissioned services targeting the same or similar group of patients/service users, including de-commissioning or remodeling services that might duplicate in the areas of crisis de-escalation/admission prevention/early discharge.

These learning points have being incorporated into the development of our Care Closer to Home Programme – the core part of this BCF plan for 2017-19.

2.4. Transition from 2016/17 to 2018 up to 2019

Our plans for 2017-2019 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] 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

(3) The Care Closer to Home Strategy and Business Case
(4) The review of services and schemes within the 2016/17 BCF plan
(5) The requirements of the "High Impact Model of Change" as well as 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.

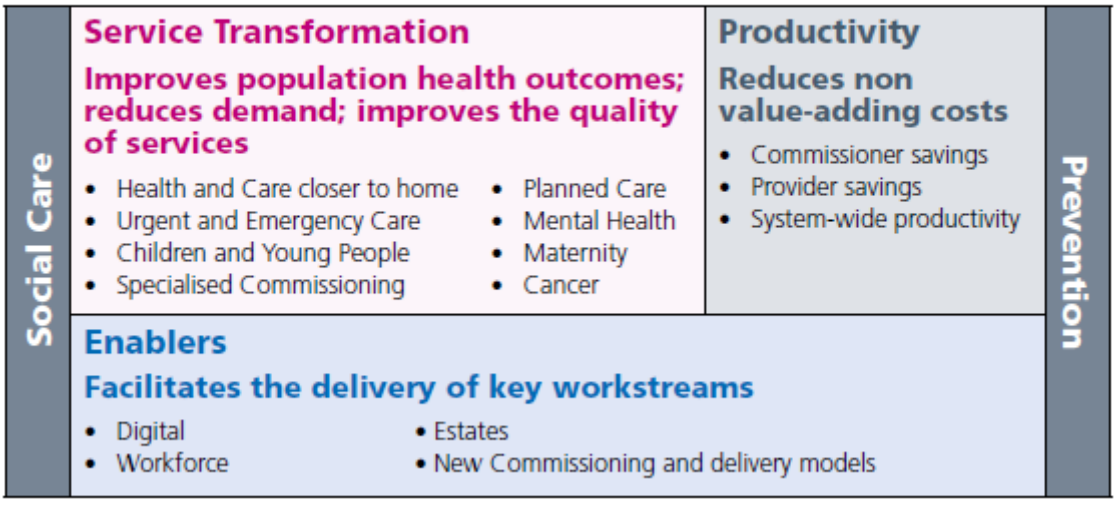
3. Vision for Health and Social Care

Just over a year ago the 21 health and social care organisations in North London came together as a partnership and developed a Sustainability and Transformation Plan (STP) for delivering services. The STP[5]., which is the culmination of joint working, seeks to address the rising demand for health and care in north central London, and the quality and financial gaps that exist at present in its provision.

The system is currently projecting a financial deficit across the NHS organisations in North London of £234m in 2016/17 and if nothing is done by 2020/21 the financial deficit in health will rise to £811m plus; plus a funding gap across North London councils on social care and public health of a further £247m. There are plans underway to reduce this financial deficit across the NHS organisations to £75m by 2020/21 however, as a system there is ongoing work to identify further opportunities for efficiencies to ensure that financially sustainable services are available.

The diagram below depicts the framework that is being implemented across North Central London (NCL).

Exhibit 1: The North London STP strategic framework



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For integrated care services in particular, the vision across North Nentral London, as part of its plan towards 2020, is to develop services that:

[5] http://www.northlondonpartners.org.uk/downloads/plans/NLPHC-STP-Strategic-Narrative-June-2017.pdf

- Provide health and care closer to home - allow people to get timely and high quality access to care when they are ill, delivered in the community where appropriate.

- Offer improved access to primary care – implementing first-wave care closer to home integrated networks
    - Help people to self-manage their condition
    - Helps understand how, when and who to access care from when their condition deteriorates.

- Provide integrated urgent care –
    - Improving and standardising access to urgent care across North London to avoid the need to attend an emergency department.
    - Support people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home
    - Provide people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence

Bearing in mind the wider financial and system constraints and ambitions our 2 year Better Care Fund plan has been refreshed to take into account the local changes that will need to be put in place to support the wider North Central London agenda.

It is strongly aligned to the CCG's Five Year Strategic Plan and Operational Plan for Patients and the Council's Five Year Plan which have a strategic vision for integration and shifting the balance of care from institutional to personal solutions.

Our plan has also taken into consideration the Council's housing strategy, which explicitly addresses the needs of older people and the Council's capital plan which includes £15m for provision of new extra care accommodation in 2017 to reduce the numbers of older people falling into residential care. The services within our plan are clearly linked to the programme of work underway via the A&E Delivery Board and the wider Urgent and Emergency Care Board.

3.1. Changes to Patient and Service user Experience and Outcomes

The vision for the next two years is to make health and care available closer to home for all, so people receive care in the best possible setting at a local level and with local accountability

Our vision is based on the local care strategy and takes into account the requirement to:

- Deliver 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.
- Implement better data sharing between health and social care, based on the NHS number.
- Establish a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional.

- Strengthen the relationships and collaboration between multiple providers; working towards the provision of integrated care by 2020.

This will be delivered through our shared approach:

- *Care closer to home*
  - Delivery of Care Closer to Home Integrated Networks (CHINs) and Quality Improvement Support Teams (QISTs)
  - Realignment and remodelling of BILT and other current BCF and community health initiatives,
  - Developing an enhanced and expanded model of multi-disciplinary working across Barnet for older people and those with long term conditions.
- *Strength based adult social care*
  - Continued expansion of the new model of social work in community hubs; including alignment and linkage with CHINs.
- *Early intervention*
  - Introduction of Local Area Co-ordination model (the progression of our current Ageing Well programme) to deliver more early intervention and build community capacity.
  - Alignment of prevention services and community participation activity with the integrated care model: information, advice, signposting, use of voluntary care sector database, volunteer matching, links to and the role of community groups.
  - Self-care and social prescribing: linking to public health and leisure services.
- *Support for specific conditions*
  - Living with and beyond cancer.
  - Stroke, dementia, end of life care.
  - Mental health: better links between employment support, wellbeing hub, the Network.
- *Redesign of partnerships*
  - Increasing the scale of the pooled budget and commissioning across BCCG and LBB.
  - Joint approach to co-production, engagement/communication and patient/user participation between LBB and BCCG.
  - Integrated commissioning of CHC and ASC care placements and packages; joint approach to care market sustainability and development.
  - Integrated care provider quality improvement function across LBB and BCCG.
  - Integration of CHC and ASC functionality.

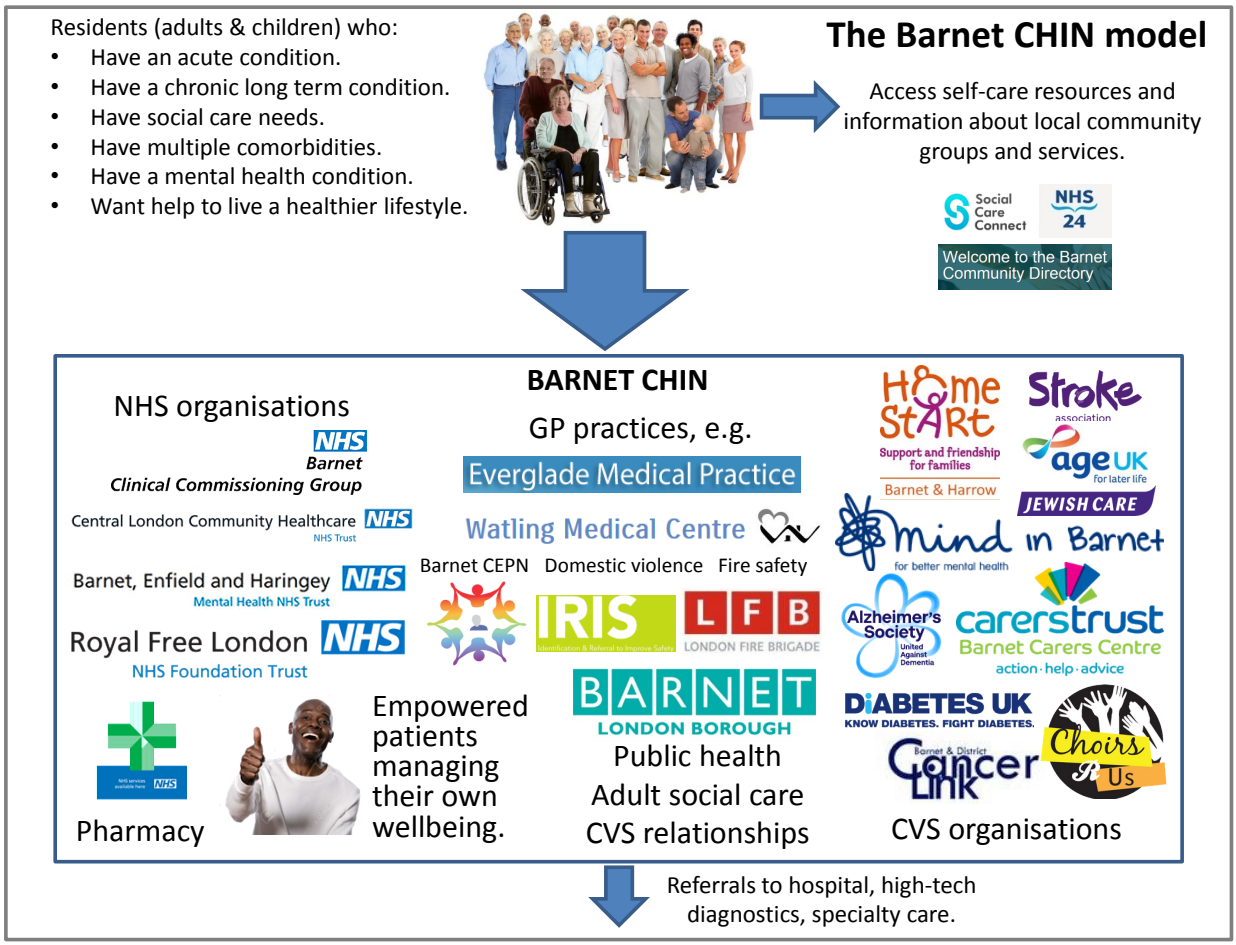
3.2. Delivering Care Closer to Home

The vision for Care Closer to Home in Barnet is that by the end of 2019:

- Everyone in Barnet can access appropriate and timely care through their local Care Closer to Home Integrated Network (CHIN).
- Barnet residents visit their local Accident & Emergency department only with genuine and urgent life-threatening emergencies.
- If a person needs to be admitted to hospital, their pathway out of hospital is mapped out at or before the time of their admission, and their discharge from hospital into the community is rapid and smooth.
- Care homes in Barnet can access multi-disciplinary support to help care home residents maintain and improve their health and wellbeing.

Each CHIN will bring primary care, secondary care, mental health care, community nursing, social care and local community and voluntary sector services together in a single local network, providing community health and well-being services that are integrated, holistic, person-centred and strengths-based to a defined local population of children and adults. Under this model, a greater proportion of services that have historically been delivered in hospitals and other specialist settings will be delivered within GP surgeries.

The diagram below sets out the long term vision for the type of services that Barnet residents will be able to access through their local CHIN:



The following principles, developed by Barnet's Joint Commissioning Executive, Care Closer to Home Programme Board, set out how organisations coming together to deliver CHINs, and the professionals who work within CHINs will work differently together.

- Partner organisations will work together with a shared purpose and pooled resources.
- Each CHIN will have a strong team ethos with a sense of a single team delivering highly personalised care in a local setting.
- There will be effective relationships between providers, residents and patients, both at an organisational level and between individuals who work together to provide services "on the ground'.
- CHINs are never "finished", they are always evolving and improving, and this improvement is driven by the staff and patients who are part of the CHINs.

Care Closer to Home Integrated Networks (CHINs) in Barnet will be local (focused on the specific needs of a small geographical community) and therefore each CHIN will be unique in terms of its clinical priorities and the combination of professionals working within the CHIN. The first CHIN, which will be launching across five GP practices in Burnt Oak in the west of the borough in autumn 2017 will focus upon:

- Managing Diabetes more effectively within the community.
- Reducing the number of children aged 0-5 presenting at A&E.
- Delivering medicines optimisation in partnership with community pharmacists.

The second and third CHINs will launch in 2018 and will cover similar areas, with additional focus on frailty and chronic disease management.

As part of Care Closer to Home, Quality Improvement Support Teams (QISTs) will be established to support CHINs. QISTs will be GP-led teams that play a central role within CHINs, providing hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients, helping to roll out best practice, clinical innovation and new technology in a systematic and consistent way.

Barnet has a diverse and accessible range of preventative services already in place. The Council has established strong engagement mechanisms with the voluntary and community sector and has mapped many of the resources in place in the borough to support delivery of a holistic, person-centred and strengths-based approach through the CHINs. Commissioned and non-commissioned preventative support will form a key part of the services offered by the CHINs, helping to keep Barnet residents healthy in ways that strengthen their connections with their communities. Patients will also be able to access support from the community and voluntary sector and universal services without seeing a GP first, often taking guidance and advice from the practice reception staff.

Governance

The Barnet Health & Wellbeing Board has agreed that the current Joint Commissioning Executive Group (JCEG) which includes representatives from the Council and the CCG, will oversee and support local implementation of STP plans in Barnet, ensuring alignment with the goals and ambitions of the Health & Wellbeing Board and the joint Health & Wellbeing Strategy. This Group will shape local delivery of STP initiatives to ensure that each initiative meets local need and works for Barnet as a local system, as well as delivering STP requirements. Barnet CHINs will be established under the umbrella of the Barnet GP Federation.

Workstreams

Barnet JCEG has developed a delivery plan for the implementation of Care Closer to Home. The programme workstreams are summarised in Appendix 1.

3.3. Funding Contributions

The BCF is now made up of three elements: the CCG minimum contribution; the Disabled Facilities Grant; and the improved BCF (IBCF).

Funding	2017/18	2018/19
Total CCG (£000s)	22,736	23,168
Minimum Spend on Social Care from CCG minimum contributions (£000s)	6,947	7,080
Out of hospital commissioning (£000s)	6,461	6,584

These figures include an uplift of 1.79% for 2017/18 and 1.9% for 2018/19, as required in national policy.

3.3.1. Care Act and Carers Breaks

An agreed Carers strategy[6] outlines the approach for supporting residents of Barnet

3.3.2. DFG

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.

3.3.3. Improved Better Care Funding

The additional funding announced in the Spring Budget 2017/18 for adult social care in Barnet amounts to:

2017-18 Additional funding for adult social care	**2018-19 Additional funding for adult social care**	**2019-20 Additional funding for adult social care**
£5,372,890	£4,092,872	£2,039,280

[6] https://barnet.moderngov.co.uk/documents/s29625/Appendix%20A%20Carers%20and%20Young%20Carers%20Strategy%202015-20.pdf

The spend for 2017/18 is as follows:

Initiative/Project	Description	Amount
Social care market stabilisation	Increasing the minimum price paid for residential and nursing placements in borough; providing inflationary uplifts to providers	£2,889,190
Supporting the NHS: **Care spend to support faster hospital discharge**	Commissioning and purchasing of additional packages of home care, telecare and enablement. Capacity to work with the market to ensure demand can be met.	£1,058,700
Social care market development	Developing the care workforce, rapid improvement work with providers, identifying opportunities to create more placements for adults with dementia and complex needs.	£580,000
Supporting the NHS	Additional social workers, occupational therapists and care brokers. Increasing capacity for responding to initial contacts, including urgent response and through Care Space hubs.	£515,000
Meeting adult social care needs	Increasing capacity for responding to initial contacts, including urgent response and through Care Space hubs.	£330,000

The table on the below shows how we have planned to use resources over the two year period.

Schemes/Projects	Area of Spend	2017/18 Expenditure (£)	2018/19 Expenditure (£)
Scheme: Personalised Support at Home			
Wellbeing Services	Social Care	£539,487	£549,737
End of Life care	Continuing Care	£1,370,369	£1,396,422
Integrated Care Planning - Review Teams	Social Care	£389,204	£396,599
Personalised Care- Safe guarding/mental health pressures	Social Care	£427,518	£435,641
Memory Assessment	Mental Health	£218,849	£223,007
Scheme: Seven Day Working and Services to Care Homes			
Seven day social care support	Social Care	£913,056	£930,404
Seven Day Community Support	Community Health	£2,257,199	£2,299,724
Single Point of Access	Community Health	£295,720	£301,339
Primary prevention -Early Intervention (inc Risk)	Primary Care	£551993	£562479
Quality in Care Home Team	Social Care	£235,135	£239,602
Seven day social care support - Acute	Acute	£130,000	£132,470
Scheme: Intermediate Care and Reablement			
Intermediate Care in the Community - Step down	Community Health	£8,838,618	£9,006,552

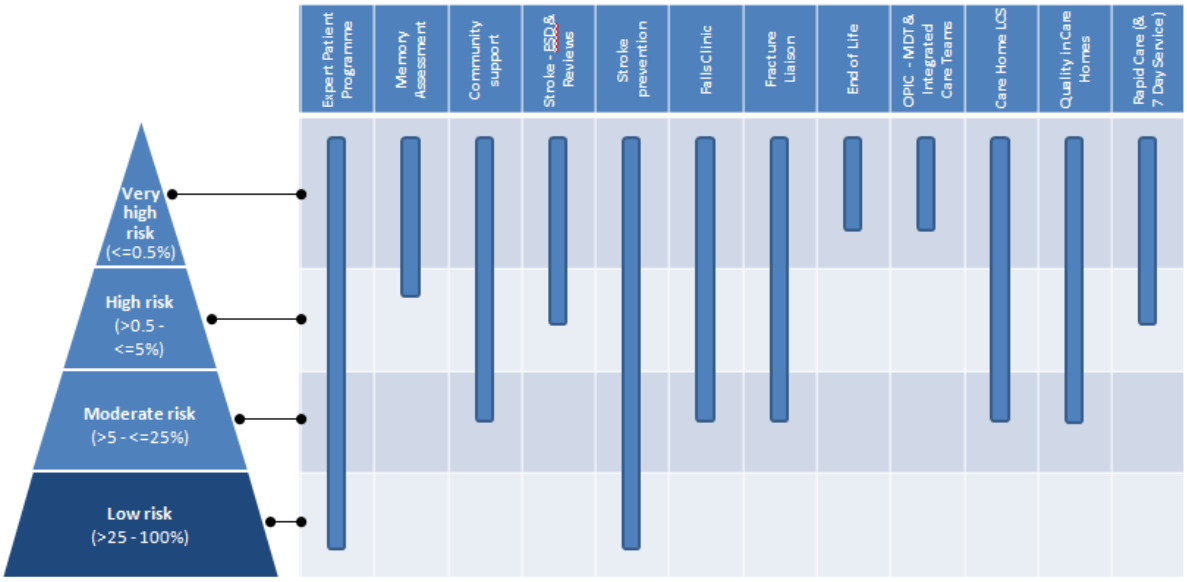
Appendix 1

Intermediate Care in the Community - Reablement/rehabilitation	Social Care	£241,393	£246,326
Fracture Liaison service	Acute	£99,079	£100,962
Scheme: Support for Patients & Carers			
DFG	Other	£2,163,540	£2,355,949*
Care Act	Other	£861,143	£877,505
Carers Support	Social Care	£305,370	£311,172
Carers Support – CCG	Social Care	£820,427	£836,016
Community Equipment	Community Health	£1,095,260	£1,116,070
Scheme: Managing Transfers of Care			
Social Care Demand Pressures	Social Care	£2,300,454	£2,344,163
IBCF (DCLG allocation straight to Local Authority)	Social Care	£5,372,890	£6,838,955
Scheme: Enabling Activity			
Enablers for integration LBB	Social Care	£775,640	£790,377
IT Interoperability	Primary Care	£70,235	£71,570
Total		**£30,272,581**	**£32,363041**

*pre-populated in BCF template – figure not confirmed through grant determination

4. Evidence base and local priorities to support plan for integration

The diagram on the below, reiterates the areas of impact on each risk category for the elements of each of the Schemes that have been in place over the last two years.



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

The review of the schemes that have made up the BCF plan deployed has shown where positive impact has been seen (reduced activity) and those that continue to represent a cost pressure, and will need to be targeted as part of the refreshed plan.

The table below depicts the activity changes in some key service areas targeted in 16/17.

Integrated Care - QIPP schemes

Sum of Activity	Column Labels				
Row Labels	2013/14	2014/15	2015/16	2016/17	Grand Total
15/16 - CHF	972	987	1002	861	3822
15/16 - COPD	328	347	291	335	1301
15/16 - Dementia	480	458	387	377	1702
15/16 - Elderly Care	112	107	103	98	420
15/16 - Falls & Fractures	688	853	703	675	2919
15/16 - Hypertension	240	235	238	259	972
15/16 - Respiratory	952	1153	995	1173	4273
15/16 - New Pool	907	1049	1066	1047	4069
Grand Total	**4679**	**5189**	**4785**	**4825**	**19478**

Weighted against list size		
% Difference		
2014/15	2015/16	2016/17
-0.3%	2.1%	-15.5%
3.9%	-15.6%	13.2%
-6.3%	-15.0%	-4.2%
-6.2%	-3.2%	-6.4%
21.8%	-17.1%	-5.5%
-3.8%	1.9%	7.0%
19.0%	-13.2%	16.0%
13.6%	2.2%	-3.4%
8.9%	-7.2%	-0.8%

Positive change can be noted with Chronic Heart Failure (CHF), Dementia, Elderly Care, falls and fractures plus the new pool which is made of additional ambulatory care activity. Areas requiring attention are Respiratory, Hypertension and COPD.

In addition to targeting specific long term conditions we will, over the next two years, monitor the comorbidities of the population as a whole to better understand and target schemes. The graphs below provide a snapshot view of the current Barnet population.

Risk Stratification *– of GP population in Barnet*

4.1. Reducing Health Inequalities

Our proposals in the Better Care Fund are informed by local needs as set out in the JSNA.

Where proposals involve a change or transformation of service delivery the project will be subject to an equalities impact assessment. These will be based on local demographic and patient data analysed by health, social care and public health partners, to ensure that health inequalities are proactively addressed and that people with protected characteristics under the Equalities Act 2010 are not disadvantaged.

5. Delivering National Conditions in 17/18 and 18/19

5.1. Jointly Agreed Plan

The Barnet BCF plan builds on the approved plans for 2016-17. As per our local governance arrangements the voluntary sector and housing have been involved in developing the initiatives that are included within the plan.

The plan has been signed off by our main acute trust, The Royal Free London; our community services provider, Central London Community Health Care (CLCH) and the Health and Wellbeing Board.

As per the approach adopted in 2016-17 it is anticipated that the continued deployment of additional resources to Social Care Activity will bring the Barnet position closer to the Relative Needs Formula for Social Care, without destabilising the existing schemes.

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 LBBs Accommodation Strategy for Vulnerable People, to secure early discharge from hospitals and reduce non-elective admissions.

5.2. NHS Contribution to social care is maintained in line with inflation

The Barnet CCG contribution to social care will be maintained in line with inflation, as set out and agreed in the BCF planning template.

The relative needs formula (RNF) allocation of £6.8M 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 funding allows Barnet to retain services such as the *Care Quality Team* whose work the care homes in Barnet has resulted in significant improvements.

With Barnet having one of the highest populations of older people in London, and high rates of dementia among the population as well as being home to large numbers of residential and nursing homes; the majority of these places being purchased by health and care systems other than Barnet, & self-funders, the Council will be:

- investing in the development of extra care, by building 200 additional extra care units over the next 5 years;
- investing the full amount of the social care precept into local social care;
- investing additional capital funding into disabled facilities grants (in addition to the central government grant funding);
- maintaining its investment into prevention services which support growing numbers of local older people;

The plans for 2017-19 build on the focus of this spend during 2016-17, as set out in section 2.1.2.

Plans for 2017-2019

- Increased investment in seven day social work to minimise admissions through A&E for older/frail cohort.
- Increased investment in delivering the high impact change models. Supporting the wider roll out of our local discharge to assess pathways.
- Sustained investment in activities to manage population pressure and ensure that individuals are supported within social care and neighbourhood services.
- Expand 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.

5.3. 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 maintenance of Dementia Hubs, the carers support services, palliative/end of live services and the locality teams.

A major component of our out-of-hospital services is the Barnet Urgent and Emergency Care Transformation Plan (see section 5.4) with an emphasis on reducing Delayed Transfers of Care.

Plans for 2017-2019

- Funding to be retained in out of hospital services
- We will review community teams including District Nursing; Barnet Integrated Locality Team; Post-Acute Care Enablement; Rapid Response; and Intermediate Care Team. The intention is to align these into a strong community nursing and therapy provision in order to keep people at home and healthy to avoid unnecessary attendances at A&E, unnecessary emergency admissions; avoid and/or delay admissions to long term care and reduce DTOCs.
- Expansion of primary care activities to support self-management via the establishment of the CHINS and QUIST.
- Rolling programme of review and assessment of BCF commissioned programmes in 17/18 to assess impact and assurance of evidence based practice.

5.4. Managing Transfers of Care

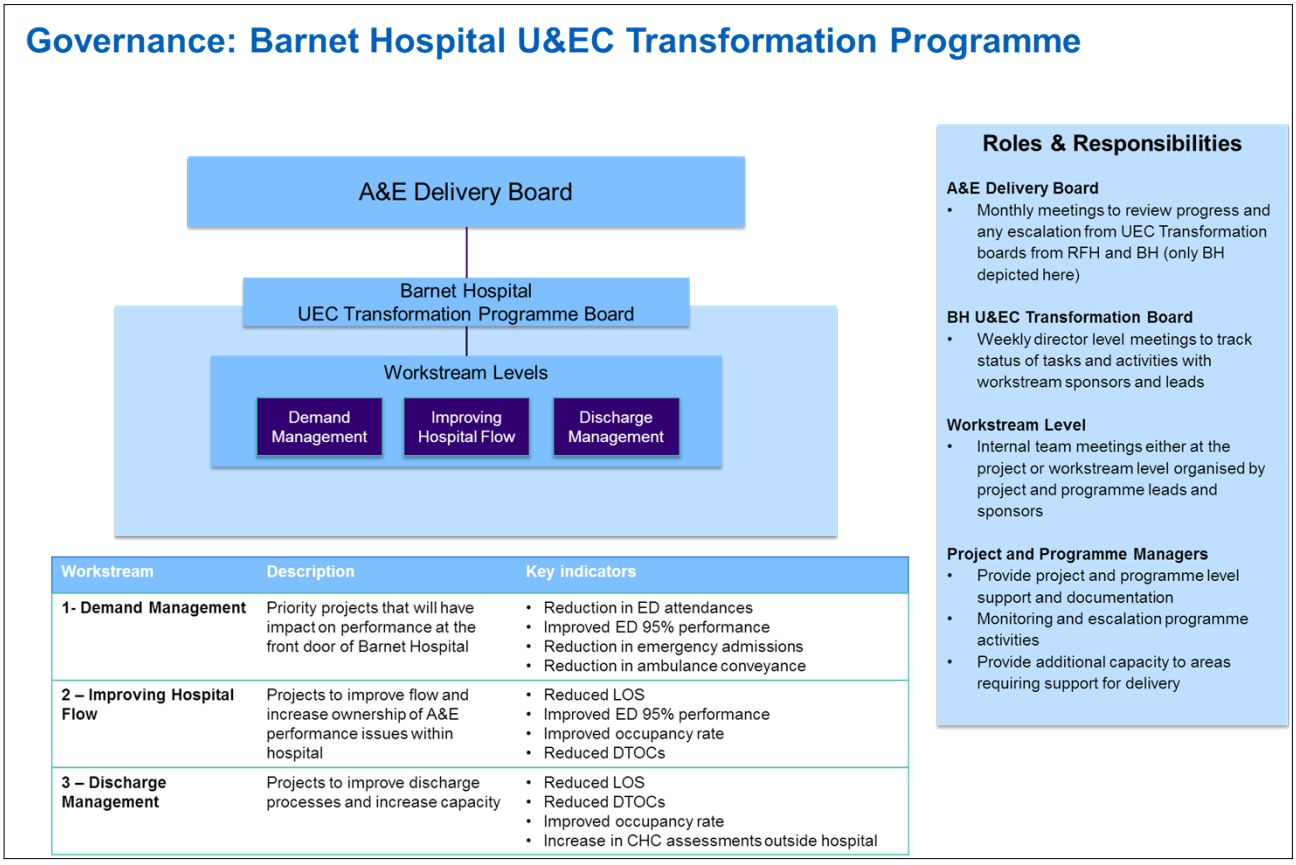
5.4.1. The Barnet Urgent & Emergency Care Transformation Plan

The priority area for Barnet's out-of-hospital services is the reduction of Delayed Transfers of Care (DToCs), particularly for Barnet Hospital. The Barnet Urgent and Emergency Care (UEC) Transformation Plan) has been developed and implemented to drive forward this work. Details are available in section 5.

The Barnet UEC Transformation Plan is governed via the weekly Barnet Hospital Urgent and Emergency Care (UEC) Transformation Board, which reports to the monthly A&E Delivery Board.

The three Discharge to Assess Pathways are key to the delivery of the Barnet UEC Transformation Plan, and work is progressing at pace to implement the pathways, including BCF investment in additional community provision to support rapid discharge.

The diagram on the **below** sets out the governance of the Barnet UEC Transformation Programme, including the three Discharge to Assess Pathways.



Workstream	Description	Key indicators
1- Demand Management	Priority projects that will have impact on performance at the front door of Barnet Hospital	• Reduction in ED attendances • Improved ED 95% performance • Reduction in emergency admissions • Reduction in ambulance conveyance
2 – Improving Hospital Flow	Projects to improve flow and increase ownership of A&E performance issues within hospital	• Reduced LOS • Improved ED 95% performance • Improved occupancy rate • Reduced DTOCs
3 – Discharge Management	Projects to improve discharge processes and increase capacity	• Reduced LOS • Reduced DTOCs • Improved occupancy rate • Increase in CHC assessments outside hospital

Barnet's approach to reducing Delayed Transfers of Care (DToCs) follows the eight high impact changes from NHS England's *High Impact Change Model*.

5.4.2. Early discharge planning:

Barnet already commission a *post-acute care enablement* (PACE) team which is responsible for supporting discharges across Enfield, Herts and Barnet. The service focusses on early supported discharge whilst under the care of the acute consultant. The team works closely with other services including Enablement, Intermediate Care, Rapid Response and voluntary sector services e.g. the jointly funded *Home from Hospital* scheme.

Barnet also commission the British Red Cross to provide a 'Home from Hospital' service, which supports vulnerable, elderly people within the community to return home following a stay in hospital. It offers a smooth transition from hospital to home with practical and emotional support for 4 to 6 weeks, to help service users regain confidence and establish independence. The type of support offered includes:

- Accompany home from hospital stay
- Emergency shopping
- Key cutting
- Moving/re-arranging furniture to support medical equipment
- Collecting prescriptions
- Benefits support
- Befriending support
- Support with accessing community services
- Support with attending outpatient appointments

The British Red Cross have recently received additional funding to support discharges in Barnet A&E and prevent admissions. They will work in partnership with Barnet hospital to provide practical and emotional support to patients and families at the A&E, and support discharges where appropriate. The service will help get people home from hospital and free up much-needed beds. They will also work with ward staff to encourage patients to get dressed and get moving as part of a campaign termed 'end PJ paralysis'. The idea behind the initiative is that by getting people moving, often reduces the length of time they need to spend in hospital.

This closely aligns with the current focus on admission avoidance and discharge support services, and the British Red Cross are in a good position to work closely with the PACE and Rapid Response teams, offering complimentary services based in the A&E setting.

Plans for 2017-2019

- Monitoring the progress of the newly introduced schemes
- Continue to identify patients who on admission are believed to potentially require complex discharge planning.
- Enabling early mobilisation of teams to support complex discharges, reducing the potential of the patient becoming a DTOC.

5.4.3. Implement Systems to Monitor Patient Flows:

Acute and Community Patient Flows: A comprehensive flow monitoring system is in place led by acute trust and reviewed daily. We have established weekly multi-agency project meetings to review key flow performance. Flow of patients is tracked via agreed A&E delivery board processes between acute and community and Intelligent conveyancing in place from London Ambulance Service (LAS).

General Practice: Barnet has deployed a risk stratification tool that enables GPs to proactively monitor patient's flows to an acute setting.

The Council have recently deployed new client monitoring system (MOSAICs) that will enable integrated tracking of service users across health and care once NHS numbers are uploaded.

The Single health resilience early warning database (SHREWD) is a real time system management database which provides a live real time view of pressure in NHS Systems. Shrewd Resilience enables front line teams and operational leaders to identify 'where' pressure is across the health system. Data is able to be captured live (or within a few hours as set) shared with providers across the health and social care economy (Acute Trusts, A&E, admissions, discharges, the LAS, Social Care, community, mental health, primary care, via a web interface and smartphone app. The system proactively alerts you to growing pressure and is accessible on smart phones and tablets.

SHREWD is managed by an independent company, transforming systems and across NCL this is within its first year of a three year contract period. It is expected that the system will be fully accessible and operational within NCL by winter 2017.

Plans for 2017-2019

- We are currently working towards implementing a shared digital platform which will enable services to access patient records.
- Ongoing review of system blockages which reduce flow of patients. Implement clear actions to mitigate these blockages when identified.

5.4.4. Implement multidisciplinary discharge teams:

We have an established integrated locality team (BILT) which works with all the GPs and in reaches into our main acute provider, liaising with the TREAT service. The team includes social care and works with high risk people with long term conditions, using risk stratification tool for identification. See also PACE, Intermediate Care and voluntary sector services referred to above.

Plans for 2017-2019

- The intention is to review and integrate more closely the various services in order to improve the patient experience, quality, flow and efficiency. This may also identify patients who did not access services who might otherwise have. Also to identify flexible options including joint budgets to support pat flow and discharge for example

5.4.5. Implementing Home First Discharge to Assess (DTA):

In August 2017 a demand and capacity modelling exercise was carried out by Royal Free London and Barnet CCG to review the current community capacity available and need for further capacity to support DTA. The exercise supported plans to open DTA at Adams Ward in Finchley Memorial and a project plan is being implemented to support the closure of the existing 17 community DTA beds to be replaced by Adams Ward to support DTA pathways 2 &3.

Further work has been done in line with the Transformation Plan and A&E Delivery Board to map Pathway Home. The first Pathway Home patient was discharged home using the drafted pathway in August with a plan to ramp up to 15 patients per week by the end of October. To support this pathway The British Red Cross has been commissioned by the CGG to provide a Home from Hospital service to Barnet residents. This service supports vulnerable, elderly people within the community to return home following a stay in hospital. It offers a smooth transition from hospital to home with practical and emotional support for 4 to 6 weeks, to help service users regain confidence and establish independence.

- We will use the modelling to commission capacity for all Barnet patients, including the 17% of patients who are at other hospital sites.
- DTA Pathway 1 Home commenced the week of 14th August 2017 and will be ramped up by 31 October to take 16 patients per week; partners across the AEDB have committed to the ramp up of this scheme to support Discharge Home with enablement for all suitable patients.
- DTA Pathways 2 and 3 will be supported by existing community beds – total of 54 beds and an additional 17 beds which will be opened at Finchley Memorial (Adams Ward) as part of the bed base for Discharge to Assess. The CCG will decommission, from February 2018, the current interim community bed model (currently commissioned from private nursing homes).
- The aim is to open 17 beds at Finchley Memorial by 1 December 2017 and will be phased into operation during December 2017 and January 2018. The criteria for these beds will include falls patients and patients with dementia. These referrals are not currently part of the D2A beds in the private sector.
- The DTA modelling also supports the target to undertake 85% of all CHC assessments outside of hospital by 31st December 2017.
- In Summary we require
    - 47 beds for Pathways 2 and 3 for patients discharged from RFL
    - 10 beds for Pathways 2 and 3 for Barnet patients discharged from other hospitals.
    - 2 beds for step up from community as part of Rapid response
    - 12 beds for stroke (already included within existing 54 bed base)

- The DTA modelling will be reviewed by 30 June 2018 – with the expectation that more patients will be discharged home with a package of support thus enabling the CCG to review and reduce the number of community beds required to support Barnet patients.

5.4.6. Seven-day services:

The following schemes are in place:

- 7 day social work service /access to Adult Social Care packages;
- intermediate care and rapid response services available 7 days per week;
- along with GP Extended Hours 8-8 service.
- The CCG has commissioned GP extended hours in line with national priorities which provides access to GP services beyond core hours 08:00-18:30 Mon – Fri. Additional GP slots are available during the weekday 18:30 – 20:00 as well as weekends which can be pre booked via patients GP practice as well as patients being able to be booked into urgent slots directly via the Integrated Urgent Care (IUC) service by calling 111.

- From an STP perspective the, CCG in collaboration with North Central London CCGs has commissioned an Integrated Urgent Care (IUC) service which is a 24/7 urgent care service that provides the public with access to both treatment and clinical advice. In addition, a new telephony routing capability was implemented via 111 *5, *6 & *7 in January 2017 and allows Health Care Professionals, LAS crew, care home staff & community nurses direct access to a GP through the 111 service. The IUC service also offers callers experiencing a mental health (MH) crisis a 'warm transfer' (i.e. where they are kept on the line until the call is connected) to a MH professional, for further telephone assessment and advice. More recently the IUC service has put in place a process to repatriate 999 low acuity C2-C4 calls to 111. All the above aims to improve flows and reduced pressures on the wider UEC system.

- MiDoS is a tool available for Health Care Professionals and enables them to search for locally commissioned health services and includes details such as bypass numbers. MiDoS takes a live feed from the main NHS Pathways Directory of services (DOS) which is used predominantly by the Integrated Urgent Care (IUC) service to refer patients to the right service based on presenting symptoms. Work is underway to expand the use of MiDOS within Barnet Health and Local Authority as well as having a patient version. It can be accessed 24 hours a day all year round.

Plans for 2017-2019

- We have plans to increase the workforce capacity through the utilisation of the iBCF. Additional social workers, occupational therapists
- Care brokers will be recruited which will enable the system to increasing capacity for responding to initial contacts, including urgent response and through our digital platform via Care Space hubs.

5.4.7. Trusted Assessors:

Nursing Home Initiative - The model being tested is:

- Trusted Assessor: a nurse to evaluate and assess clinical situation The TA will act as the liaison between the care home and hospital, keeping both informed of the patient's progress.
- Trusted coordinator: non clinical administrator supporting the clinician with care home liaison and responsible for mobilising additional volunteer workforce
- Volunteers: specifically allocated to this cohort of patients to provide companionship, comfort and familiarity. The volunteer can also help the patient out in a variety of ways including accompanying during discharge or bringing in toiletries/clothing for the patient.

Since the start of the project in May 17 there have been 210 care home resident admissions into Barnet Hospital; 104 of these came from Barnet care homes. The T.A team now provides every Barnet care home with at least one telephone update regarding their resident. 25 care homes in Barnet have now been actively visited and are fully engaged with the project. The table below details the monitoring and expected impact.

Initiative	Impact	Key Performance Indicator Influenced	Target	Validation date
• Trusted assessor model • 7 day community service • Improved patient flow • Discharge to assess	Reduction in number of DTOCs to 2.5%	• Transfer from hospital on a discharge to assess pathway takes place within 24 hours of identification as medically optimised • Number / % of DTOCs • <15% CHC assessments completed in an acute setting for pathway 3 • Increase number of patients on pathways 0 and 1 assessed at home • Increase number of patients assessed at home on pathway 2	• 2.5% DTOC x%? 75%? • 2.5% DTOC • <15% of CHC assessments • >98% • 50%?	• 31 Mar 2019
• Trusted assessor model • 7 day community services • Improved patient flow • Discharge to assess • Stroke	Improved patient flow	• Reduce % elective activity cancelled due to poor bed capacity from baseline • Patients discharged from base inpatient wards before midday • All wards implementing SAFER bundle/principles • Increase proportion of patients repatriated from HASU • days delayed on ASU waiting for rehab beds • LOS on HASU and ASU • Implement 8 high impact changes	• TBC following baseline data • 33% discharged before midday • 100% • Number of days waiting for transfer from HASU • Proportion of patients referred and accepted by a community team from a HASU and ASU • 'Established'	• 31 Mar 2019 • 31 Mar 2019 • 30 Sept 2017 • 30 Sept 2017
• Trusted assessor model • 7 day community services • Improved patient flow • Discharge to assess • Stroke	Reduction in the number of readmissions	• KPI's to cover readmission rates (review at 28 and 90 days post discharge • Improve stroke outcomes, specifically for mortality and functionality	• TBC following baseline data • Mortality at 3, 30 and 90 days after admission • Functional Independence measure?	• 31 Mar 2019
• Discharge to assess • Trusted assessor model • 7 day community service • Improved patient flow	Reduce excess bed days by 90%	• 45% reduction in excess bed days taken up by medically optimised patients • 90% reduction in excess bed days taken up by medically optimised patients	• 45% reduction • 90% reduction	• 31 Mar 2019 • 31 Mar 2020
• Stroke • Discharge to assess • Trusted assessor model • 7 day community service • Improved patient flow	Improved patient experience results	• Increase % of patients rating their inpatient episode as good on discharge home through the Friends and Family test • Improved staff survey results	• TBC following baseline survey • TBC following baseline survey	• 31 Mar 2019 • 31 Mar 2019

5.4.8. Promoting choice and self-care for patients

Working with local partners across health and social care and working within national guidelines we have reviewed and strengthened our local choice policies.

A key element is ensuring that communication is improved with patients and carers to convey the message that once a patient a medically fit for discharge we will be discharging them either to home or to an environment best suited to meet their needs. In order to improve communication and implementation of the policy we have agreed some information booklets to give to patients and carers as well as agreed a broader plan to socialise the policy across the organisation.

5.4.9. Enhancing health in care homes

The multi-disciplinary Quality in Care Homes team works with all care and nursing homes in the borough, enhanced by additional clinical/nursing input funded by CCG through CHESS scheme.

Plans for 2017-2019

- We are decommissioning the CHESS service and replacing it with a range of 'quick wins' for implementation from October 2017, including training to all care homes by the Council's Care Quality Team, with additional nursing staff leads. Training will include 'Significant Seven' and other training targeted at preventing hospital admission.
- We will develop a joint, five year Care Homes Strategy by February 2018

5.4.10. Managing Transfers of Care Milestone Plan

The milestone plans for the three workstreams of the Barnet UEC Transformation Plan are included below.

Appendix 1

Barnet UEC Transformation Plan – Workstream 1: Demand Management

Project Status	Project Key Deliverable / Output	Description of project	Responsible Director	Clinical Leads	Project Manager	Other Responsible Leads	Date to completed	
	1.1- Develop the strategy and implement the quick wins for an integrated enhanced care home support service.	Implement the quick wins for an enhanced and integrated support service for all care homes avoiding unnecessary attendances and admissions in A&E, which likely includes a rolling programme of significant 7 training. Develop the strategy to support care homes in Barnet. This will also include developing a policy and approach to support embargoed care homes.	**Catherine Searle (BCCG)**	• Jonathan Lubin	Muyi Adekoya (BCCG) Alan Brackpool (BCCG)	Jenny Goodridge (BCCG)	30 Jan 2018	• Reduce A&E attendances from care homes • Reduction of A&E admissions
	1.2-Review and make improvements to TREAT service	Review activity of service, revise specification as needed and implement changes as required to service	**Catherine Searle (BCCG)**	• Aashish Bansal	Muyi Adekoya (BCCG)	Royal Free London	31 October 2017	• Reduction of A&E admissions (QIPP)
	1.3- Improve the management of ambulance volume at Barnet site	Review demand with Herts CCGs, review what's driven numbers in Barnet and review ambulance handover process within Barnet Hospital and implement the agreed actions to improve.	**Beverley Wilding (BCCG)**	• Reg Coleman • Derek Boyle	Danny Batten (NHSE)	LAS + East of England A.S. Sally Dootson (BH)	31 October 2017	• Reduction of ambulance conveyances / bunching at BH A&E (tbc)
	1.4-Review and implement improvements to BILT	Review BILT service and deliver agreed changes to improve service (i.e. referrals, utilisation and attendance diversions)	**Catherine Searle (BCCG)**	• tbc	Manish Shah (BCCG)	Cathy Walker (CLCH)	31 October 2017	• Reduction of emergency admissions
	1.5a- Improvements to Ambulatory Care and Pathways	Increase Ambulatory care operational hours from 9 to 14 hours, renegotiate tariff for AEC pathways, develop recommendations for space in 17/18 and future plan for BH, review and prioritise the future clinical pathways to increase ambulatory care for patients.	**Beverley Wilding (BCCG)**	• Aashish Bansal • Barry Subel	Katie Quigley-Turner (BCCG)	Sally Dootson (BH)	31 October 2017	• Reduction of emergency admissions • Increase of AEC pathways • Reduction in tariff
	1.5b - Increase the use of Ambulatory care at BH	Define baseline and review and optimise 5 AEC pathways at Barnet Hospital (Abdo pain, Cardiology, Gastro, Falls, PEG complications)	**Sally Dootson (BH)**	• Reg Coleman • Derek Boyle	Dennis Carlton (BH)	Sally Dootson BH	30 April 2018	
	1.6-Review streaming (UCC) and enable redirection i.e. GPs, Pharmacies, Physio)	Review current streaming in place to increase streaming to UCC to 40—50% and develop recommendations to enable greater redirection service at the front door	**Beverley Wilding (BCCG)**	• Aashish Bansal • Barry Subel • Lead ED Consultant Barnet (tbc)	Katie Quigley-Turner (Lead)	Sally Dootson (BH- RFL)	30 Jan 2018	• Reduction of emergency admissions • Increase streaming to UCC from 20% to 40% (Jan 18), 50% (Mar 18)

Barnet UEC Transformation Plan – Workstream 2: Improving Hospital Flow

Project Status	Project Description		Responsible Director	Clinical Leads	Project Manager	Other Responsible Leads	Project End Date	Improvement Target Measure
	2.1-Safer, Faster, Better, Red and Green Days Implementation	SAFER bundle is implemented and systems to be put in place to enable escalation and actions of "red" patients.	**Julie Meddings (BH)**		Dennis Carlton (RFL - BH)	tbc	31 October 2017 (Phase 1)	• Reduction in aLOS • Reductions in DTOCs • 100% compliance of entry of red/green patients • 33% of patients discharged are before lunch
	2.2-Patient Choice Policy	Policy has been agreed and in use	**Sally Dootson (BH)**		Dennis Carlton (RFL - BH)	tbc	30 August 2017	• Reduction in aLOS • Reductions in DTOCs • Number of times patient choice policy used
	2.3-Trusted Assessor Implementation	An independent trusted assessor team is in place to support patients returning to care homes	**Sally Dootson (BH)**		Dennis Carlton (RFL - BH)	tbc	31 October 2017	• Reduction in aLOS • Local measures (TBC – SD to provide)
	2.4-Acute Bed Reconfiguration	Review and reconfigure current bed base to reduce outliers Consider options of additional capacity released by closure of chemo day unit	**Sally Dootson (BH)**	*Divisional Directors*	Dennis Carlton (RFL - BH)	tbc	tbc	• Reduction in LOS • Reduction in occupancy
	2.5– Tracker Review	Review of the tracker service provided by CLCH and develop recommendations to improve if required.	**Beverley Wilding (BCCG)**	*TBC*	tbc	tbc	tbc	• *TBC*

Appendix 1

Barnet UEC Transformation Plan – Workstream 3: Discharge Management

Project Status	Project Key Deliverable / Output	Description of project	Next Milestone (Date)	Responsible Director	Clinical Leads	Project Manager	Other Responsible Leads	Date to complete	Improvement Target Measure
	3.1- Implement Discharge to Assess Pathway 1	Implement discharge to asses pathway 1, increase enablement support provided and ensure alignment with PACE clinical pathway.	Community bed demand and capacity shared with UEC Programme Board (16 Aug 2017)	**Beverley Wilding (BCCG)**	tbc	Komal Odedra (BCCG)	John Dickinson	30 Sept 2017	• Reduce number of DTOCs • Reduction in aLoS
	3.2- Implement Discharge to Assess Pathway 2	Implement discharge to assess pathway 2 and align to decision agreed where to commission beds in community.	Community bed demand and capacity shared with UEC Programme Board (16 Aug 2017)	**Beverley Wilding (BCCG)**	tbc	Komal Odedra (BCCG)	Cathy Walker (CLCH)	tbc	• Reduce number of DTOCs • Reduction in aLoS
	3.3- Implement Discharge to Assess Pathway 3 + Improved CHC Assessments	Develop and implement discharge to assess pathway 3 aligned to Adam's ward plan. Ensure the improvements to CHC assessments are in place.	Community bed demand and capacity shared with UEC Programme Board (16 Aug 2017)	**Beverley Wilding (BCCG)**	tbc	Alan Brackpool (BCCG)	Cathy Walker (CLCH)	tbc	• Reduce number of DTOCs • 75% in Dec and 85% in March of CHC assessments completed outside hospital
	3.4-Improving referral pathways with social services			**Sally Dootson (BH)**		Sally Dootson (BH)	Matthew Kendell (LBB)	31 Oct 2017	• Reduce number of DTOCs • Reduction in aLoS

Appendix 1

6. National Metrics

The metrics in this section have taken into account performance to date and the current trajectory for the deliverables. Section 2 details the health wellbeing areas progress against the metrics set in 2016-17.

6.1. Non-Elective Admissions

Barnet CCG demand mitigations, in the form of QIPP schemes that impact on non-elective admissions (including the integrated care, seven day working and Better Care Fund schemes) are built into the CCGs Operating Plan and are reflected in in this 2 year plan.

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
7,421	7,477	7,483	7,317	7,061	7,131	7,127	6,970	29,698	28,289

As part of ensuring the outcomes of the community based schemes we have also monitored the ambulatory sensitive conditions in relation readmission performance. As the activity numbers are small there is a high percentage difference in this category, see breakdown below.

Ambulatory sensitive condition	Reduction
Pyelonephritis & urinary tract infections (UTI)	-13%
Flu & pneumonia	-26%
Chronic obstructive pulmonary disease (COPD)	-11%
Dehydration & gastroenteritis	-29%
Heart disease and heart failure	-11%
Atrial fibrillation and flutter	-57%
Stroke	-80%

Although we have considered the option of a further reduction in Non-Elective admissions, additional to those in the CCG operating plan, we will not be introducing a stretch target.

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 the 16-17 QIPP schemes in the CCG and MTFS supporting schemes in LBB and found that the integrated approaches implemented over the last two years have started to mitigate the underlying growth in non-elective admissions. We will:

- As part of mobilising our CHINS, we will be extending the cohort included in our High Risk Group – both by geography and condition to secure further reductions in the NEAs. Supporting project plans are available in Appendix 1.
- 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.

6.2. Admissions to residential and care homes

Barnet currently performs well on the metric for permanent admissions to residential care. With an ageing population and people requiring increasing levels of care, maintaining this rate will be a challenging target. Our approach to setting the residential admissions target has been to estimate that we aim to achieve a year on year reduction of 6.5% in the rate of new admissions.

	15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Annual rate	514.9	535.0	500.4	468.5
Numerator	273	290	277	265
Denominator	53,019	54,207	55,351	56,565

Key Activities:

- We will continue to 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 2017-18 we will explore opportunities to use these technologies to avoid non elective admissions for older people, those with dementia and some Long Term Conditions.
- We will also explore opportunities' to facilitate discharge as part of the work being carried out in mobilising pathway 1 discharge to assess

6.3. Delayed Transfer of Care

The Health and wellbeing board figures submitted in the main BCF financial template do not include Herts Valley, as the CCG is outside the NCL footprint. However trend analysis has confirmed that, 40% of all daily DTOCs for our main acute provider over the last few months relates to patient who are from Herts (Herts Valley and East & North Herts).

	16-17 Actuals				17-18 plans				18-19 plans			
	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Quarterly rate	851.7	799.2	707.3	1061.2	1214.3	963.1	815.7	722.9	667.8	750.2	686.1	820.1
Numerator (total)	2,531	2,375	2,102	3,202	3,664	2,906	2,461	2,214	2,045	2,297	2,101	2,545
Denominator	297,187	297,187	297,187	301,731	301,731	301,731	301,731	306,233	306,233	306,233	306,233	310,277

The forecast above relates to DTOCs for Barnet CCG, the main commissioner, over the given period.

A number of schemes across Health and Social Care are now in place to support the delivery of the reduction in DTOC, however it should be noted that the national expectations for both health and social care will be extremely challenging to deliver, given that pressures in the system are expected to rise in line with the usual seasonal fluctuations.

All Health and Social Care Partners are very committed to reducing delayed discharges and working towards the national expectations to reduce pressure in the system, however the expectations may not be achievable within the timescales.

Key Activities:

Our schemes and their associated delivery plans are based on best practice and the 8 high-level impact interventions will be overseen by the A&E Delivery Board. The programme of work includes:

- Early discharge planning: MDT meetings in place in hospital for early discharge planning including social care; daily multi-agency calls for discharge planning across the system.
- Supporting Discharge: PACE scheme in place for discharges across Enfield, Herts and Barnet which focusses on early supported discharge whilst under the care of the acute consultant. This works with Enablement, Intermediate Care, Rapid Response Service and voluntary sector- run Home from Hospital scheme commissioned by CCG/Council.
- Managing the front door: TREAT is in place to avoid admission through support from community partners and social care. 'Safer, Faster, Better' is also being implemented by the Royal Free in support of improving emergency and urgent care.

- Systems to monitor patient flow: comprehensive flow monitoring system in place led by the acute trust and reviewed daily. Weekly multi-agency project meetings to review key flow performance. Flow of Patients tracked via agreed A&E delivery board processes between acute, community and mental health services
- Intelligent conveyancing in place with London Ambulance Service (LAS) and close working with the East of England ambulance service to manage ambulance conveyances as part of arrangements for an agreed catchment area for the Trust
- Community Support: Integrated health and social care team (BILT) working with all GP practices to manage high risk people with LTCs, using a risk stratification tool for identification
- Discharge to Assess (DTA): Implementation of DTA began in November 2016. Model includes 19 DTA beds plus development of home first pathway. Bed numbers can be flexible based on demand, seasonality and type of bed. The 'Home First' model is currently being scoped with a pilot to be in place for summer 2017 to build on the existing services that are already in place.
- Seven-day services : The following schemes are in place:
- 7 day social work service /access to Adult Social Care packages; intermediate care and rapid response services available 7 days per week along with the GP Extended Hours 8-8 service
- Trusted Assessors: Trusted assessors to enable faster discharge to care homes are underway and first placements under this scheme are being made. Second initiative is a generic referral process including all paperwork agreed from the acute trust to all community rehabilitation facilities.
- Focus on choice: Legal duties in relation to choice in social care and health are maintained. A multi-agency patient choice policy has been implemented to facilitate faster discharge from acute beds.
- Enhancing health in care homes: a multi-disciplinary team in place funded by BCF which works with all care and nursing homes in the borough, enhanced by additional clinical/nursing input funded by CCG through the Care Homes Extended Support Service (CHESS) scheme.
- Mental Health DTOC action plan.

In addition to the schemes above, iBCF funding in conjunction with other BCF and resilience funding will be used to provide additional support to the wider health and care system. Funding will be used to:

All schemes are overseen and sponsors held to account by the A&E Delivery Board, and weekly progress monitored via the Urgent and Emergency Care Transformation

6.4. Effectiveness of reablement

As our actual BCF performance in 2016/17 is being provisionally reported at 72.2% (subject to validation), the 2017/18 and 2018/19 targets have been profiled to continue this upward trend.

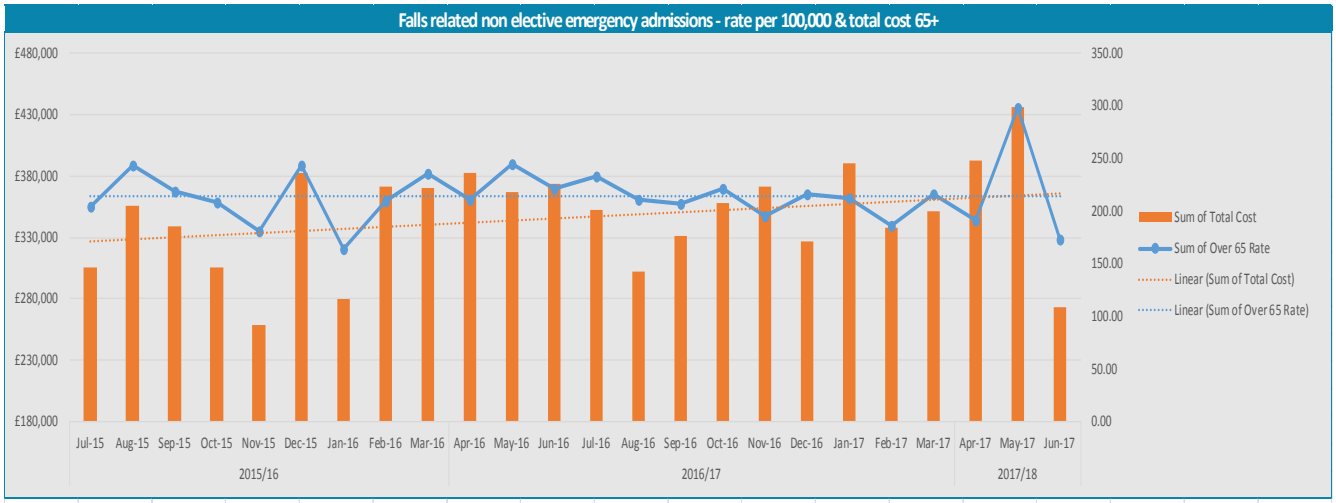
	15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Annual %	69.3%	81.5%	73.6%	75.1%
Numerator	296	330	298	304
Denominator	427	405	405	405

Key activities

- We will continue to monitor our engagement plan with key partners in community and tertiary health settings around joint working e.g. working with Intermediate Care Service; Occupational Therapists in A&E; supporting hospital discharge coordinators in making referrals.
- We will continue to promote and work closely with other preventative resources e.g. Home from Hospital and Telecare, as ways of promoting safe hospital discharges where enablement is not appropriate.
- We will monitor through our Quality Assurance activities (e.g. case audits; practice observations of staff; complaints and compliments) that a strengths based approach is used in enablement interventions which promote the person's voice, wishes and feelings and helps them use their own and local networks of support once enablement has ended.

6.5. Indicative Outcomes for Quarter 1 17-18

The graph below provides trend data on falls related non-elective admissions.



There was an improvement in performance against plan for Jun-17 of -162,353 delayed transfer of care days per 100,000 population, which was a -37.3% reduction against plan
There was an improvement in Jun-17 against Jun-16 of -100,717 DTOCS, which was a -26.9% reduction against the previous quarter

7. Barnet's Two Year Expenditure Plan, including Disabled Facilities Grant

The table below shows how we have planned to use these resources over the next two years. These decisions have been made in light of our analysis of performance, national evidence and negotiations with providers.

3. HWB Expenditure

Summary of BCF Expenditure (*)	2017/18 Expenditure	2018/19 Expenditure
Acute	£99,079	£100,962
Mental Health	£218,849	£223,007
Community Health	£10,229,599	£10,423,961
Continuing Care	£3,627,568	£3,696,146
Primary Care	£752,228	£766,520
Social Care	£14,484,115	£16,274,941
Other	£861,143	£877,505
Total	**£30,272,581**	**£32,363,042**

Summary of NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool (**)	2017/18 Expenditure	2018/19 Expenditure
Mental Health	£218,849	£223,007
Community Health	£9,134,338	£9,307,891
Continuing Care	£3,627,568	£3,696,146
Primary Care	£752,228	£766,520
Social Care	£820,427	£836,016
Other	£861,143	£877,505
Total	**£15,414,554**	**£15,707,084**
NHS Commissioned OOH Ringfence	£6,460,969	£6,583,728

Summary of BCF Expenditure from Minimum CCG Contribution (***)	2017/18 Expenditure	2018/19 Expenditure
Acute	£99,079	£100,962
Mental Health	£218,849	£223,007
Community Health	£10,229,599	£10,423,961
Continuing Care	£3,627,568	£3,696,146
Primary Care	£752,228	£766,520
Social Care	£6,947,685	£7,080,037
Other	£861,143	£877,505
Total	**£22,736,151**	**£23,168,138**

→

Additional NEA Reduction linked Contingency Fund	2017/18 Fund	2018/19 Fund
NEA metric linked contingency fund held from the ringfenced local allocation for NHS OOH spend	£0	£0

BCF Expenditure on Social Care from Minimum CCG Contribution	2016/17	2017/18	2018/19
Minimum Mandated Expenditure on Social Care from the CCG minimum		£6,793,465	£6,922,540
Planned Social Care expenditure from the CCG minimum	£6,674,000	£6,947,685	£7,080,037
Annual % Uplift Planned		**4.1%**	**1.9%**
Minimum mandated uplift % (Based on inflation)		**1.79%**	**1.90%**

Following a review of schemes in 16/17 a number of programmes will continue to be funded by the BCF and a number of new schemes and programmes will be introduced to support the delivery of the system wider projects supporting providers to implement the High Impact Change Model (HIMP) initiatives.

Our aim is to continue support the delivery of care that provides a seamless management approach to coordinating the resources required.

8. Programme Governance

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 all work together to co-produce solutions and take joint accountability for decisions and leadership on the delivery of the agreed programme of work.

- Barnet's Health and Wellbeing Board has overall responsibility for both operational and financial delivery of the Better Care Fund, totalling £30,272,581 in 2017/18 and £32,363,042 in 2018/19 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 Executive Commissioning (JCE)/ Care Closer to Home (CC2H) Board.

- From its inception the local 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 the two year period

- The JCE/CC2H board is a joint commissioning board with a membership of senior commissioners and finance directors from the CCG and LBB alongside GP clinical leads and providers. The JCE/CC2H board 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.

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

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

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

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.

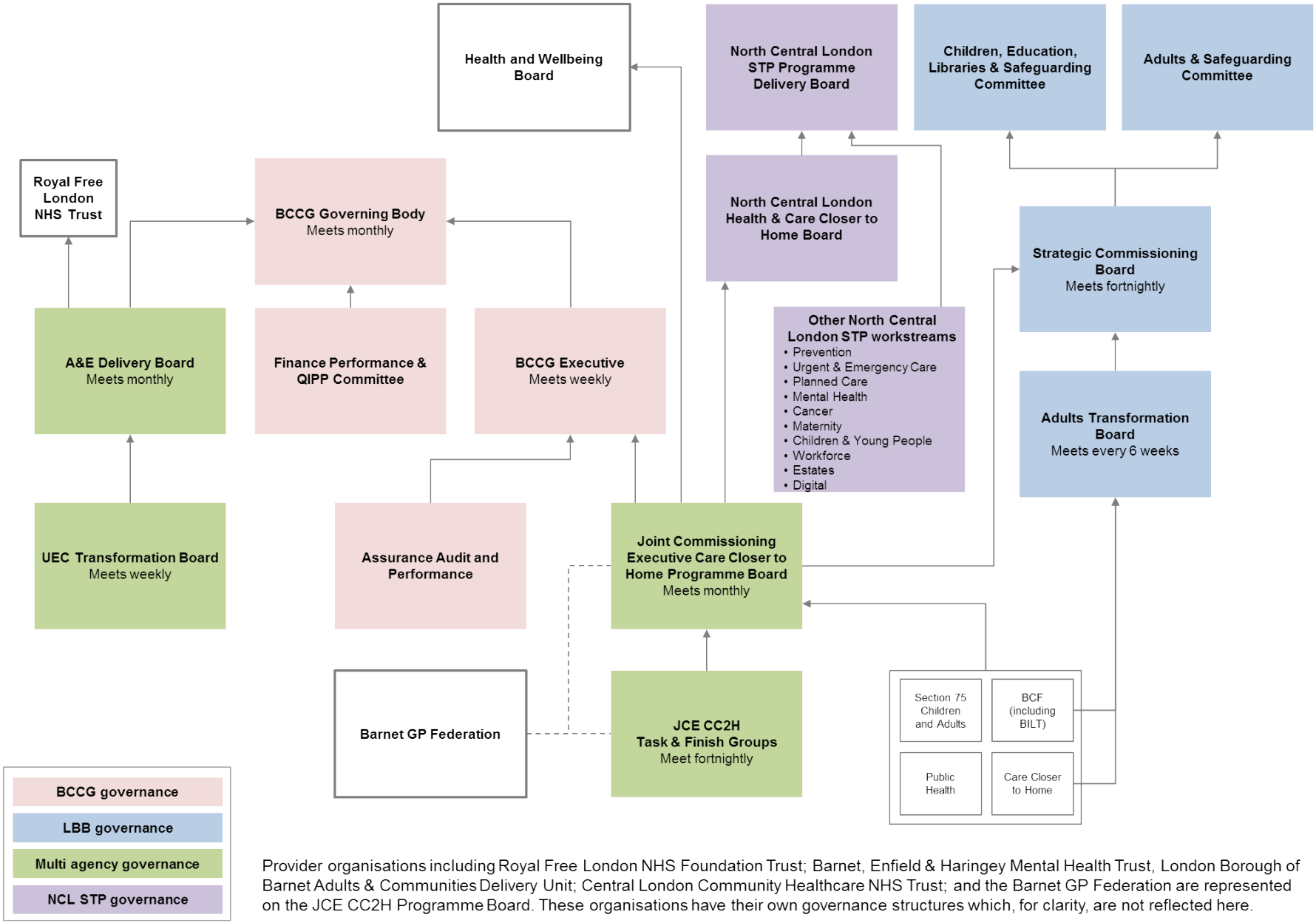
The new structure retains and builds on and extends our engagement with residents and providers (such as GPs, community nursing and secondary care) who are core members. The structure also has stronger links to broader programmes and other mechanisms of

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.

Appendix 1

GOVERNANCE ARRANGEMENTS FLOW



Provider organisations including Royal Free London NHS Foundation Trust; Barnet, Enfield & Haringey Mental Health Trust, London Borough of Barnet Adults & Communities Delivery Unit; Central London Community Healthcare NHS Trust; and the Barnet GP Federation are represented on the JCE CC2H Programme Board. These organisations have their own governance structures which, for clarity, are not reflected here.

8.2. Joint Working

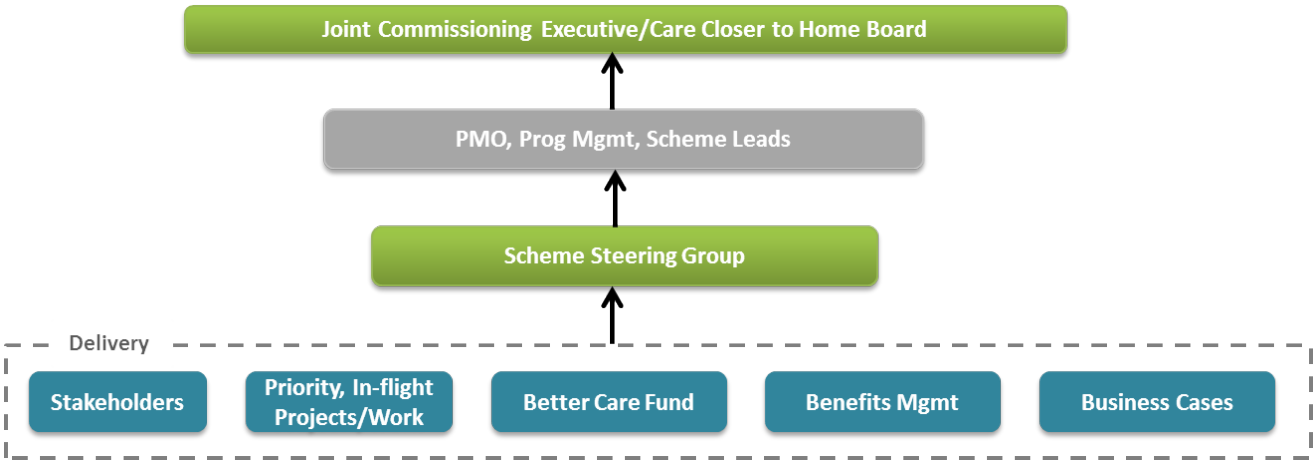
A relevant section 75 agreement is in place. Regular meetings take place at system leadership level between the Council and CCG. JCE/CC2H board provides direction and oversight to joint investments and improvement plan activity[7].

At a wider NCL and London level the nominated programme leads meet monthly to share learning.

8.3. BCF Programme Level Management Approach

Our BCF funded activities will continue to be 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 will enable the CCG and local authority to take a whole systems approach to managing down demand within the local health & social care system.

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.

[7] We can include the Terms of Reference for the JCE/CC2H Board?

Schemes: Personalised Support at Home
SRO: Assistant Director Joint Commissioning Unit

Project	Scheme Type	Area of Spend	Commissioner	2017/18 Expenditure (£)	2018/19 Expenditure (£)	Primary Outcome Measures
Wellbeing Services	15. Wellbeing centres	Social Care	Local Authority	£539,487	£549,737	Admissions to Residential Care Delayed Transfer of Care
End of Life care	10. Integrated care planning	Continuing Care	CCG	£1,370,369	£1,396,422	
Integrated Care Planning - Review Teams	10. Integrated care planning	Social Care	Local Authority	£389,204	£396,599	
Personalised Care- Safe guarding/mental health pressures	12. Personalised healthcare at home	Social Care	Local Authority	£427,518	£435,641	
Memory Assessment	12. Personalised healthcare at home	Mental Health	CCG	£218,849	£223,007	
Total				**£2,945,427**	**£3,001,406**	

Seven Day Working and Services to Care Homes
SRO: Commissioning Director

Project	Scheme Type	Area of Spend	Commissioner	2017/18 Expenditure (£)	2018/19 Expenditure (£)	Primary Outcome Measures
Seven day social care support	9. High Impact Change Model for Managing Transfer of Care	Social Care	Local Authority	£913,056	£930,404	Non elective admissions Delated Transfer of Care
Seven Day Community Support	9. High Impact Change Model for Managing Transfer of Care	Community Health	CCG	£2,257,199	£2,299,724	
Single Point of Access	2. Care navigation / coordination	Community Health	CCG	£295,720	£301,339	
Primary prevention -Early Intervention (inc Risk)	13. Primary prevention / Early Intervention	Primary Care	CCG	£551993	£562479	
Quality in Care Home Team	8. Healthcare services to Care Homes	Social Care	Local Authority	£235,135	£239,602	
Seven day social care support - Acute	9. High Impact Change Model for Managing Transfer of Care	Acute	CCG	£130,000	£132,470	
Total				**£4,383,103**	**£4,466,020**	

Intermediate Care and Reablement
SRO: Assistant Director – Urgent Care

Project	Scheme Type	Area of Spend	Commissioner	2017/18 Expenditure (£)	2018/19 Expenditure (£)	Primary Outcome Measures
Intermediate Care in the Community - Step down	11. Intermediate care services	Community Health	CCG	£8,838,618	£9,006,552	Non electives Delayed Transfer of Care
Intermediate Care in the Community - Reablement/rehabilitation	11. Intermediate care services	Social Care	CCG	£241,393	£246,326	
Fracture Liaison service	11. Intermediate care services	Acute	CCG	£99,079	£100,962	
Total				**£9,179,090**	**£9,353,840**	

Support for Patients & Carers
SRO: Assistant Director – Joint Commissioning Unit

Project	Scheme Type	Area of Spend	Commissioner	2017/18 Expenditure (£)	2018/19 Expenditure (£)	Primary Outcome Measures
DFG	4. DFG - Adaptations	Other	Local Authority	£2,163,540	£2,355,949*	Admissions to Residential Care Non elective admissions Delayed transfer of care
Care Act	3. Carers services	Other	Local Authority	£861,143	£877,505	
Carers Support	3. Carers services	Social Care	Local Authority	£305,370	£311,172	
Carers Support – CCG	3. Carers services	Social Care	CCG	£820,427	£836,016	
Community Equipment	1. Assistive Technologies	Community Health	CCG	£1,095,260	£1,116,070	
Total				**£5,245,740**	**£5,496,712**	

*pre-populated in BCF template – figure not confirmed through grant determination

Managing Transfers of Care
SRO: Assistant Director Delivery Unit

Project	Scheme Type	Area of Spend	Commissioner	2017/18 Expenditure (£)	2018/19 Expenditure (£)	Primary Outcome Measures
Social Care Demand Pressures	14. Residential placements	Social Care	Local Authority	£2,300,454	£2,344,163	Admissions to Residential Care Delayed transfer of care
IBCF (DCLG allocation straight to Local Authority)	9. High Impact Change Model for Managing Transfer of Care	Social Care	Local Authority	£5,372,890	£6,838,955	
Total				£7,673,344	£9,183,118	

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

Enabling Activity
SRO: Assistant Joint Commissioning Unit

Project	Scheme Type	Area of Spend	Commissioner	2017/18 Expenditure (£)	2018/19 Expenditure (£)	Primary Outcome Measures
Enablers for integration LBB	7. Enablers for integration	Social Care	Local Authority	£775,640	£790,377	Admissions to Residential Care Delayed transfer of care
IT Interoperability	7. Enablers for integration	Primary Care	CCG	£70,235	£71,570	
Total				**£845,875**	**£861,947**	

8.4. Measuring the Impact of the Plan

Our original plan documents the benefits realisation approach for each of the schemes that are continuing; 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 the BCF policy framework.
    b. Locally via Joint Executive/Care Closer to home Board 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.
    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 programme scheme review is an example of what took place in 16/17).

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

- Individual schemes and their impact will be reviewed by the Board as part of its work programme, through Quarters 3 and 4 of 2017-18

9. Assessment of Risk and Risk Management

The BCF refresh has involved a comprehensive review of the proposed spending plan for the two year period. JCE/CC2H have led the detailed work to review the performance of the BCF plan in over the last two years.

At a CCG level this has involved assessing the financial performance, risks and the outputs of the associated *Managing Crisis Better* QIPP, the community services supporting the delivery of the two main metrics (NEL and DTOC).

At a council level the senior team have also reviewed the deliverables in line with the medium term financial savings plan and the delivery of the metrics. Jointly, reviews of integrated schemes supporting the overall plan have also taken place.

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. Evidenced by the A&E Delivery Board Action Plan.

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[8] within the CCG and the Council.

9.1. Local Approach to Risk Sharing

The 2015/16 BCF plan established a risk and contingency process, embedded into our S75 agreement, which has operated effectively over the first two years 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 2017-19 the established BCF pooled fund risk sharing mechanisms will remain as per the 2016/17 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 continue 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).

It has also factored in the requirements for the wider resilience schemes addressing the management of delayed transfers of care across the local health economy. 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.

[8] http://www.barnetccg.nhs.uk/Downloads/Publications/Strategies/NHS-Barnet-CCG-Commissioning-intentions-plan-2017-18.pdf

9.2. 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 2017/18 and 2018/19 the legally agreed BCF pooled fund risk sharing mechanisms will remain in place as per the 2016/17 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 JCE/CC2H Group (a sub-group of the Health and Wellbeing Board - HWB) and to the HWB 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.

9.3. 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 Care System Risks				
Reduction in NEA metrics target is challenging in the context of significant local challenge and past performance	4	3	12	- Scale-up interventions that demonstrated impact in 2016-17 - Review all projects for effectiveness and impact - Regular updates to management teams - Governance arrangements to include risk and mitigation planning - Implement enhanced carers offer to reduce number of admissions for older people with dementia.
DTOC Reduction is challenging in the context of local challenge in the acute sector	4	3.5	12	- Local action plan - Targeting of population cohorts and care homes with high admissions rates - Implement key schemes e.g. High Impact change model - Sustained joint action on discharge - Strong and effective social care leadership in hospitals including 24 hour/ 7 day cover. - Clear systems in place across the sector including voluntary agencies
Deficits and overspends 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. - Ensure that risk and benefit share
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	- We will review all activities to make sure that we target resources in activities that mitigate and manage demand for ASC. - Build case for further investment in ASC services as a preventative tool for the NHS. - Use shared governance to highlight pressures (NHS and LA) and identify steps to stabilise.

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
Programme Risks				
Insufficient 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 and carers - Review lessons learnt from current cases and implement revised approach.
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. - Mitigations and contingency activity to be programmed into each cluster review.
Preventative, self-management and improved quality of care fail to translate to reduced acute, nursing and care home demand and 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 - Strong benefits tracking and performance reporting is implemented so that board can take action if needed
Front line /clinical staff leads do not deliver integrated care due to organisational and operational pressures or lack of buy-in to the proposed agenda	4	3	12	- 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. - New board delivery model includes all providers with the responsibility of holding them to account. - Providers sit on the programme board. - GP Federation are members of the programme board

10. Approval and sign off – Providers

INSERT SIGNATURE FROM RFL

CLCH Signoff of plan

-----Original Message-----
From: Cathy Walker [mailto:Cathy.Walker@clch.nhs.uk]
Sent: 11 September 2017 15:13
To: Patrick Laffey <Patrick.Laffey@clch.nhs.uk>
Cc: SEARLE, Catherine (NHS BARNET CCG) <catherine.searle1@nhs.net>; DOOTSON, Sally (ROYAL FREE LONDON NHS FOUNDATION TRUST) <sally.dootson@nhs.net>; Jayne Skippen <Jayne.Skippen@clch.nhs.uk>
Subject: Re: URGENT: Draft BCF 17-19 Plan

Thanks Patrick
I have only skimmed but am supportive in principle.

Sent from my iPad

> On 11 Sep 2017, at 14:59, Patrick Laffey <Patrick.Laffey@clch.nhs.uk> wrote:
>
> Dear Catherine
> I have reviewed the document and am pleased to see the STP and CHINs work highlighted in the introduction and the need to realign community services to deliver these later in the document. It is also positive to see the examples of CLCHs community services input to the delivery of the plans such as the reduction in length of Hospital stays and other positive whole system outcomes supporting the work so far.
> Just one query in terms of the business case for the resourcing of Barnet community Nursing – I am not sighted on the outcome of this as yet but wondered whether this ought to feature.
>
> I am covering for my manager Cathy Walker, Divisional Director of Operations today, in her absence please take this as confirmation of CLCH's support for the plan. Could you clarify who you would expect to be the CLCH formal signatory would it be Cathy or perhaps Andrew Ridley our Chief Exec.
>
> I have also copied in Jayne Skippen our Divisional Associate Director
> of Quality Regards Patrick
>
> Patrick Laffey
> Clinical Business Unit Manager - Long Term Conditions North Division
> Central London Community Healthcare

11. Appendix 1: Supporting Programme and Project Plans

11.1. Programme Monitoring Milestones

Two Year BCF Programme Plan	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BCF Quarter 1 period																					
Q1 Reporting deadline																					
IBCF Quarter 1 Reporting																					
BCF Quarter 2 Reporting period																					
Q2 Reporting deadline																					
IBCF Quarter 2 Reporting																					
BCF Quarter 3 Reporting period																					
Q3 Reporting deadline																					
IBCF Quarter 3 Reporting																					
BCF Quarter 4 Reporting period																					
IBCF Quarter 4 Reporting																					
Q4 Reporting deadline																					
A&E Delivery Board																					
Joint Commissioning Executive/ Care closer to Home Board																					
Health & Well Being Board																					

11.2. Barnet Care Closer to Home Workstream Summary/Action Plan

Workstream	Objectives	Key activities	Deliverables
Programme governance	Involve the right people in planning and decision making at the most appropriate times. Adhere to best practice for effective programme management and risk management. Manage the CC2H programme efficiently and effectively. Ensure meetings are run smoothly and efficiently. Keep a clear record of meetings and decisions. Ensure CHIN plans are aligned with Barnet's BCF plan for 2017-19.	Schedule meetings, prepare papers and agenda, take minutes and maintain actions log for: CC2H Programme Board (monthly). Chair and Chief Executives' meetings (quarterly). Develop and maintain Delivery Plan and Resource Plan. Map the governance structure around the CC2H Programme, identifying any dependencies with other critical local workstreams. Scope and initiate other workstreams as required.	Delivery Plan. Resource Plan. Meeting agendas, papers, minutes and action log. Governance map. Project Briefs for other workstreams.
CHIN governance	Establish how the different partner organisations will work together to deliver CHINs. Agree and clearly set out the responsibilities and obligations of each partner organisation.	Develop contracting framework for CHINs with BCCG. Develop contracting relationships with third party providers. Agree how to approach conflicts of interest, information governance and data sharing. Agree and sign Memorandum of Understanding between participating organisations.	Contracting framework. Memorandum of Understanding
CHIN mobilisation	Work closely with the first wave CHINs and provider organisations to prepare for the CHINs to go live. Ensure that conversations between GP practices and other provider organisations only happen once, and not separately for each CHIN. Ensure that the wider objectives of the CC2H programme, as set out in the NCL STP, are kept in mind as CHINs are rolled out. Identify the financial savings that each CHIN will deliver.	Regular meetings with the CHIN practices. Agree how to align CHIN roll out with prevention. Task & Finish group meets fortnightly to identify and then implement actions and decisions required to initiate CHINs. Identify CHIN clinical priorities – look at hospital visits and admissions by condition, age and gender.	Paper summarising the enabling role of the Barnet GP Federation in CC2H (LG). Detailed work plan of mobilisation activities. CHIN business case, identifying the clinical priorities for each CHIN and the savings that will be delivered.
Measuring outcomes	Develop a shared understand what we are trying to	Identify and gather initial baseline data for localities	Collated baseline dataset for Barnet.

Workstream	Objectives	Key activities	Deliverables
	achieve through the implementation of CHINs. Be able to measure the impact that CHINs are having on healthcare expenditure, health and wellbeing outcomes, patient/resident and staff satisfaction. Be able to identify where individual CHINs or CHINs overall are falling short of anticipated outcomes. Be able to track the financial savings that CHINs are delivering, in order to provide sufficient evidence of savings for each partner organisation that has savings targets associated with CHINs.	across Barnet, including: Financial measures Population health outcomes Activity statistics Qualitative measures Develop outcomes framework and outcome metrics (HWB, Service Performance & Quality, Financial, Qualitative) for Barnet CHINs. Create dashboard for monthly reporting of CHIN performance.	Outcomes framework, setting out the target outcomes and associated indicators. To include tracking the total £ healthcare expenditure for each CHIN population and the flows of £ through the system. Performance dashboard for monthly reporting.
Workforce, training and professional development	Deliver transformative change to the way staff work – ensure staff are not just working in the same way in a different location. Help to ensure that each CHIN has the right staff with the right skills, who have been trained appropriately. Align the CHIN workforce development with the overarching vision and work plan of Barnet CEPN.	Develop an overarching workforce strategy that articulates how staff working in and with a CHIN will work differently. Develop practice profiles: population needs (to be taken from the CHIN business case); profile of current workforce and estates profile. Identify professional competencies (skills) required by each CHIN. Provide centralised resource for the recruitment of staff to CHINS (through secondment and/or more informal joint working arrangements). Deliver centralised training and professional development for CHIN staff.	CHIN workforce strategy. Practice profiles. Workforce plans for individual CHINs – identifying the skills needed and when/how many hours per week. CHIN training materials.
Communication and engagement	Clearly communicate the objectives and benefits of Barnet's CC2H programme, to ensure successful delivery of the programme. Primary audiences: GPs and primary care staff, who will implement and operate CHINs. Other staff in the NHS, the Council and other	Develop vision/narrative for CC2H. Complete stakeholder mapping. Review opportunities for public and patient involvement. Take learnings from other CCGs' CC2H consultation and from the Reimagining Mental Health work. Identify any deliverables from the STP	Barnet CC2H vision/narrative. Stakeholder map. Communications Plan. Outputs to be identified in the Communications Plan, e.g. specific deliverables for GPs, for staff, for patients, carers, relatives and residents.

Appendix 1

Workstream	Objectives	Key activities	Deliverables
	organisations who will work in or with CHIN teams. Patients, carers, relatives and residents within the first wave CHIN.	Communications workstream that could be repurposed and reused. Develop and refine the communications Plan. Implement the Communications Plan.	
Information, advice and signposting	Improve the accessibility of information and guidance that can improve the health and wellbeing outcomes of children and adults through: Supporting people to be active members of their community and remain socially connected. Giving people the tools they need to look after themselves physically and emotionally. Empowering people to take more control over managing their own health and wellbeing. Signposting people to appropriate statutory and/or voluntary services that can help them.	Discovery – identify and map all information resources currently available to individuals, volunteers and professionals. Identify strengths and weaknesses of the current offer and develop a list of improvement opportunities. Options appraisal to prioritise the opportunities. Develop a business case for a phased approach to improvement. Implement and embed the improvements.	Project brief setting out aims, outcomes and approach to delivering the workstream. Map of all information resources currently available to individuals, volunteers and professionals. Options appraisal of improvement opportunities. Full business case for a phased approach to improvement, including funding requirements.
Local accountable care options appraisal	Develop a financial model that describes a new approach to funding, transacting, contracting services and managing risk, that can drive and embed the care model. Identify: Which existing budgets should be brought together. What organisation, partnership or alliance should hold these budgets. How risk and reward should be managed.	Develop future options for CHIN governance and contracting mechanisms, including consideration of different financial and clinical risk sharing arrangements, organisational forms and payment mechanisms. Identify the organisational behaviour change that is needed, and then identify what structures/mechanisms will incentivise this behaviour change. Co-design: closely involve GPs, providers, patients and residents in designing any new governance arrangements.	Workstream specification. Options appraisal. Co-design and engagement plan. Roadmap for moving towards a local accountable care model.

Implementation plan

The first Barnet CHIN (based around a cluster of three GP practices in Burnt Oak) is scheduled to go live in October 2017, with a further two CHINs launching before the end of the financial year. It is the intention of the Programme Board that CHINs will, over time, cover the whole population of Barnet (adults and children)

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

Appendix 1

Barnet CHIN Outline Implementation Plan

	2017								2018			
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Programme Governance												
JCE/CC2H oversight group meetings	18/05	15/06	20/07		05/09	19/10	16/11	14/12				
Chief Executive meeting (progress update; timescales; risk approach)	25/05		27/07		28/09				11/01			19/04
BCF plan submission deadline					04/09							
Develop CC2H programme plan and resource plan												
Map dependencies/links with other critical local workstreams												
Produce delivery plan, incorporating BCF plan												
CHIN governance												
Develop contracting framework for CHINs with CCG												
Develop contracting relationships with third party providers												
Agree how to approach conflicts of interest; data sharing; information governance												
Agree and sign memorandum of understanding between participating organisations												
CHIN mobilisation												
Initial meeting with first CHIN, agree objectives & savings	11/05											
Further meeting to agree data/information to support business case development by	31/05											
Regular meetings with the CHINs												
Task & Finish group meetings												
Produce a paper summarising the enabling role of Barnet GP Federation in CC2H												
First draft of business case complete for first CHIN												
Review of business case by CCG executive team												
Approval of final business case by JCEG												
1st CHIN goes live						*						
2nd CHIN goes live											**	
3rd CHIN goes live (August 2018)												
4th CHIN goes live (March 2019)												

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

Appendix 1

The following outline implementation shows the key activities and milestones to April 2018.

	2017								2018			
Measuring outcomes	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Initial information gathering, data quality and gap analysis												
Identify support available from NEL Commissioning Support Unit												
Intelligence workshop												
Review the usefulness of BCCG's risk stratification tool as a data source/tool												
Develop outcomes framework												
Develop and agree outcome metrics (HWB, Service Performance and Quality, Financial, Qualitative)												
Create dashboard for monthly reporting of CHIN performance												
Generate and circulate monthly reports to CHINs & other stakeholders												
Workforce, Training and Professional Development												
Develop practice profiles (population needs, workforce, estates)												
Agree what professional competencies (skills) are required by each CHIN												
Establish how staff within a CHIN will work differently (workforce strategy)												
Recruit (from within partner organisations) and train CHIN staff												
Communication and engagement												
Develop the vision/narrative for CC2H in Barnet												
Preliminary communication/event(s)		22/06										
Complete stakeholder mapping												
Identify workstream members and arrange meeting(s)												
Develop communication and engagement plan												
Workshop to develop and refine communication plan												
Review opportunities for public and patient involvement												
Take learnings from the implementation of Reimagining Mental Health												
Take learnings from other CCGs' CC2H consultations												
Implement communication and engagement plan												

	2017								2018			
Information, advice and signposting	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Preliminary scoping meeting												
Develop initial brief, identify workstream members and arrange meeting(s)												
Diagnostic and information gathering to identify what is out there and gaps												
Options appraisal and assessment of opportunities for patient & public involvement												
Business case development (quick win, tool, staff training, resources to maintain)												
Local accountable care options appraisal												
Develop spec for consultancy support												
CCG Exec and LBB leadership review the spec and associated budget												
Develop future options for CHIN governance and contracting												
Identify what will incentivise the behavioural change that is required												
Explore different legal forms through which clinical & financial risk could be managed												
Co-design with GPs, providers & residents												

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11.3. Mental Health – DTOC Action Plan

	Mental Health DTOC - Action Plan		
	Are all DToCs agreed by the MDT	**Yes, The patient, family and carers will be provided information about the Trusts discharge policy. The assessment and discharge process is underpinned by a MDT approach with all stakeholders focussed on recovery and discharge planning from the outset.** **The MDT will review the patient's recovery each week and work with key stakeholders and multi-professionals to discharge plan. The Patient will be considered a DToC when the individual meets the below criteria:** **a. A clinical decision has been made that patient is ready for transfer AND** **b. A multi-disciplinary team decision has been made that patient is ready for transfer AND** **c. The patient is safe to discharge/transfer.**	
	Are DToCs monitored on a daily basis via bed	**Yes, DToC's are monitored via daily borough bed management meetings at 11am and the Trust-wide Bed**	

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	management processes	**Management calls at 12 noon Monday - Friday.**	
	Do you have weekly meetings between partner organisations to validate DToCs	**Yes, DtoCs are validated at weekly borough based MDT meetings with representation from stakeholders across Health, Housing and Social Care.**	
	Is there weekly multi-agency escalation fro complex DToCs?	**Yes, during the weekly Partnership call with stakeholders a from across health, housing and social care.**	
	Do you have an <u>agreed escalation process</u> for when you do not meet your agreed DTOC trajectory?	**There is an agreed written escalation process for DToC cases not resolved within process outlined in the Discharge Policy.**	

	Please provide <u>details of your DTOC escalation process</u>?	**Escalation Level 1. Individual cases that are not actively being resolved, will be escalated between the Trust and the identified LA or CCG (Stakeholder). Escalation Level 1 will be time limited and will take place within 72 hours. The Trust borough AD will take responsibility for determining the urgency of escalation based on the presenting situation and impact on patients and Trust resources. The Trust borough based AD will liaise directly with the stakeholder AD confirming escalation to Level 1. This conversation, confirmed by email, will establish any outstanding actions required to be completed within the following 72 hour period. These actions will be designed to facilitate a safe discharge within the stated 72 hour Escalation Level 1 period. Should this fail, or the time limited period of 72 hours expire, the Trust will invoke Escalation Level 2.** **Escalation Level 2. The Executive Director of Patient Services (Trust) will contact the Director of Commissioning, or equivalent (CCG) and Director of Social Services, or equivalent, (LA). This escalation is designed to facilitate senior level brokerage, so establishing a definitive decision of liability and action. The outcome of the escalation will provide a directive for specified actions to be implemented within 72 hours, so affording a safe discharge.** **Should Escalation Level 2 not secure a safe discharge, the Trust will agree a process with both Commissioners and local authority to resolve any issues outside of this policy.**