Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Barnsley Metropolitan Borough Council**
Clinical Commissioning Groups	**NHS Barnsley Clinical Commissioning Group**
Boundary Differences	**There are no boundary differences**
Date agreed at Health and Well-Being Board:	
Date submitted:	
Minimum required value of ITF pooled budget: 2014/15	**£14,286,000.00**
2015/16	**£20,374,000.00**
Total agreed value of pooled budget: 2014/15	**£14,286,000.00**
2015/16	**£20,374,000.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Barnsley Clinical Commissioning Group
By	Dr Nick Balac
Position	Chair
Date	<date>

Signed on behalf of the Council	Barnsley Metropolitan Borough Council
By	Diana Terris
Position	Chief Executive
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Councillor Sir Stephen Houghton CBE
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This plan has been developed as an integral part of the Health and Wellbeing Board's development of a whole system approach, with a revised single Health and Wellbeing Strategy across all agencies, with a focus on a joint 'Pioneer' transformation of pathways, supported by aligning resources available across health and social care (medium term financial strategy) plus the development of the NHS Barnsley Clinical Commissioning Group Strategic 5 year Commissioning Plan for health and care in Barnsley and the operational 2 year plan.

Commissioners and providers have been involved in the development of this plan at a strategic and operational level through the Health and Wellbeing Board and the Better Care Fund Working Group.

The Better Care Fund Working Group is made up of representatives from the Barnsley CCG, Barnsley MBC and the 2 main providers of health care in the Borough, Barnsley Hospital NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust.

The plan is a joint expression of how, together through the Health and Wellbeing Board, the Health and Social Care Community intend to use the Better Care Fund to support our already ambitious plans for Integrated Care and Support in Barnsley as set out in our Pioneer Plan, Stronger Barnsley Together, contributing to the overall health and wellbeing vision for the Borough.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

There are a wide range of patient, service user and public engagement activities undertaken through the year by commissioners and providers to seek feedback on patient experience and to inform commissioner and provider plans.

The BCF Plan has been developed taking account of the plans already in place and the feedback from engagement activity that has been undertaken to inform these plans.

The CCG and Local Authority have commenced a broad whole system transformation as set out in the Pioneer Programme, Stronger Barnsley Together which is sponsored by the Health and Wellbeing Board and its partner agencies. Linked to this, a period of engagement is underway on the 5 Year Commissioning Strategy inviting views on the priorities for health in Barnsley. This includes holding a number of consultation events, supported by Healthwatch Barnsley during the planning period and up to March 2014. The BCF plans are seen as one component of delivering the system wide vision for health and care in Barnsley and therefore the engagement activity and more importantly the outcomes from it, will be used to develop and finalise the proposals for the use of the BCF and the BCF Plan.

We are seeking to use this, alongside the development of the Stronger Barnsley Together Pioneer Programme as an opportunity to review and refresh the Health and Wellbeing Strategy which will also be subject to engagement activity, including a formal three month consultation and therefore this will provide a further opportunity for patient, service user and public input to the BCF.

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

Document or information title	Synopsis and links
Stronger Barnsley Together – Pioneers in Integrated Support, Expression of Interest	Contains details of the pioneer programme including details around approach and direction

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The 2010 Index of Multiple Deprivation (IMD) identified Barnsley as being the 47th most deprived place in England and the 27th most deprived place for employment. Our JSNA reveals poor (although improving) health amongst the population in comparison to the rest of England together with marked variation in life expectancy across the Borough. Death rates from the 3 main killers – cardiovascular disease (heart disease and stroke), cancer and respiratory disease have fallen over the last 10 years but still remain significantly higher than the England average. Cancer, particularly lung cancer, is the main cause of premature death.

The Joint Health and Wellbeing Strategy 2013-2016 for Barnsley was published last year. The strategy sets out a vision for Barnsley:

> *"Barnsley residents, throughout the Borough, lead healthy, safe and fulfilling lives, able to identify, direct and manage their individual health and wellbeing needs, support their families and communities and live healthy and independent lifestyles"*

To achieve the vision for Barnsley, a series of outcomes have been developed for the residents and communities of the Borough:

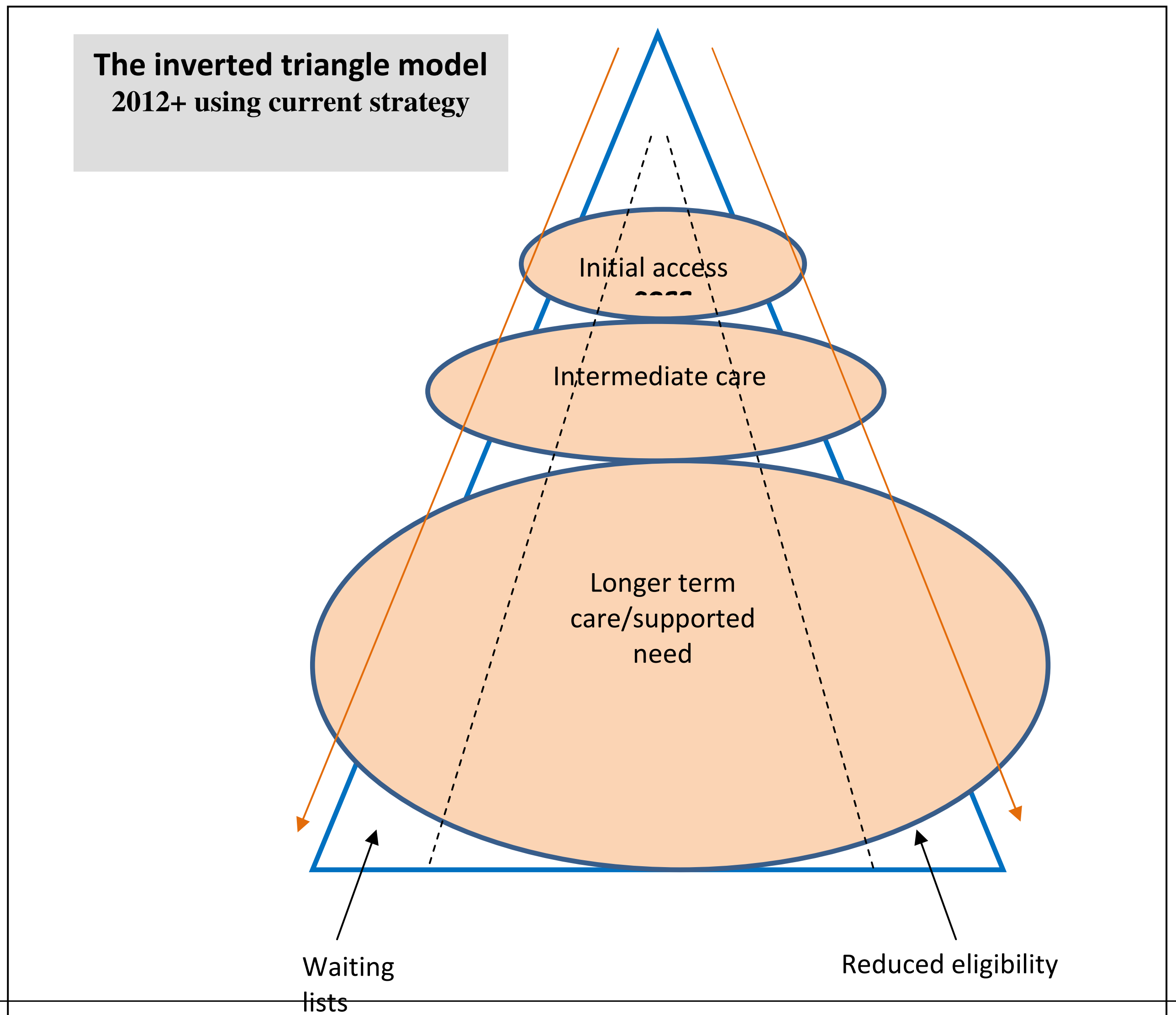
- Every child has the best start in life, able to fulfil their potential, achieve their ambitions and play their fullest role in society, thereby breaking the link between early disadvantage and poor outcomes throughout life
- Health inequalities within the Borough are reduced so that all residents have the best possible quality of life, with the gap against the national average reducing
- Older people achieve healthy, independent living – adding years to life and life to years
- Residents have greater choice and control over their health and wellbeing, are able to manage their own needs and direct their own support, (particularly those with long term conditions)

We recognise that in many cases, achieving improved health and wellbeing outcomes is a longer term ambition requiring a reorientation of current systems towards prevention and addressing the wider determinants of good health. But we are also clear that service integration can make a significant contribution to those longer term ambitions whilst delivering better outcomes for service users and a much improved patient/service user experience. We see this being most effectively achieved by completely redesigning the patient/service user pathway by placing particular emphasis on providing better information, advice and sign posting to alternative services to promote self-help, self-management of long term conditions as a critical enabler of future sustainability and

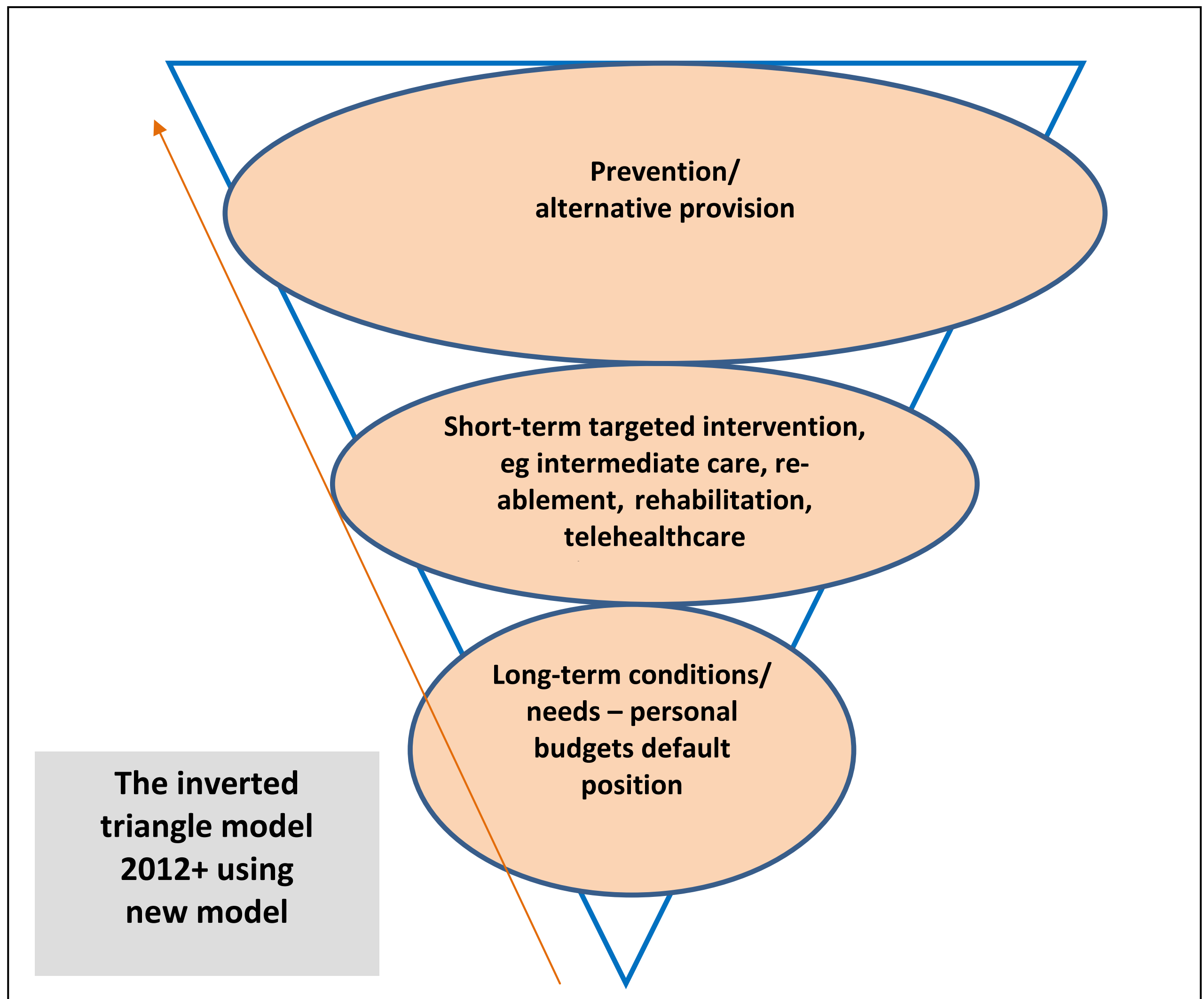
developing more effective prevention, re-ablement and targeted time limited interventions – all combining to reduce dependence on institutional/bed based provision and ensure more effective management of long-term conditions.

Our approach is therefore one of pathway integration and redesign rather than structural integration. We have set out in our Pioneer Integrated Care and Support proposal that we are seeking to fundamentally shift the focus from statutory health and care agency interventions, to more holistic engagement and a citizenship approach at individual, family and community level. The provision of information, advice and signposting, is key alongside access to flexible and integrated service pathways which support people to maintain control and enable self-management wherever possible. Based on an asset, not a deficit model to create social value, we are confident that this will bring about the change required across Barnsley communities based on engagement and behaviour change, both in professionals and those in receipt of services.

The current model as depicted below is largely based on a traditional model of rationing via eligibility criteria, ie Use of Fair Access to Care Criteria, FACS, in social care. As demands inevitably increase and budgets reduce, the response will lead to ever tightening eligibility criteria (as already experienced nationally) plus waiting lists growing, with less people receiving support services. As already stated, culminating in an unsustainable system struggling to provide only for those with the highest level of need.



Therefore, a potential solution is to ‘invert the triangle’



The proposal is to move away from the traditional approach based on eligibility and reactive ill health provision and systems/services based around the legislative framework, i.e. community care assessments etc. and simply ask four key questions:

- What do you need to stay safe
- What do you need to stay connected to your community
- What do you need to stay out of statutory sector services
- What can you offer to support your community

Our aim is to build on this and to use the Better Care Fund to help us to provide care and support to the people of Barnsley, in their homes and in their communities, with services that:

- **co-ordinate around individuals**, targeted to their specific needs;

- **maximise independence** by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing;

- **prevent ill health,** reducing levels of CVD, respiratory conditions and mental health

- **improve outcomes**, reducing premature mortality and reducing morbidity;

- **improve the experience of care**, with the right services available in the right place at the right time;

- **through proactive and joined up case management**, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

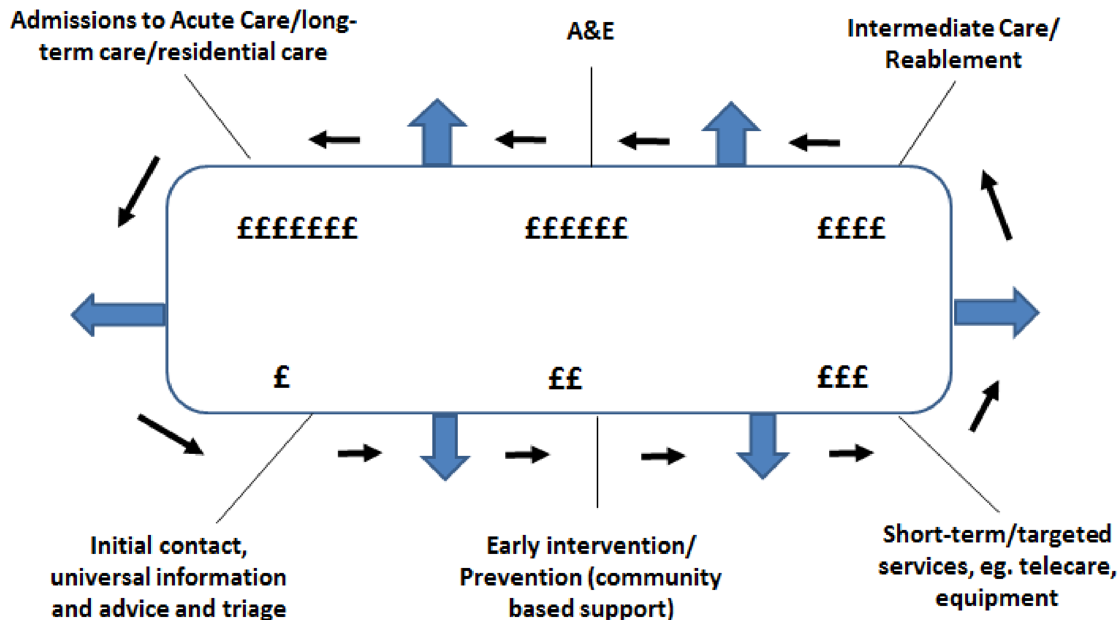
The aims and objectives for integrated care are embedded within the Health and Wellbeing Board Strategy and CCG 5 year Strategic Commissioning Plan and reflect the principles set out in our Pioneer Integrated Care and Support Programme as described above. The BCF will play a key role in delivering activities set out in the Commissioning Strategy that will integrate care and support so that care pathways are based around individual.

The aim is to deliver integrated care that is co-ordinated around the individual, provided in the most appropriate place, in a timely manner and with funding flowing where it is needed to improve outcomes for patients in the context of their family and community.

The health and social care system/pathway diagram below demonstrates the flow of patients around the care pathway, highlighting that cost increase the further around the system that service users and patients flow.

Our intention the the delivery of the Health and Wellbeing Strategy and the utilisation of the Better Care Fund will be to focus on supporting people and providing appropriate access to information, advice and support to ultimately delay and reduce the need for health and social care support and treatment further around the pathway.

Some of the Better Care Fund will be used to help us prepare for the implementation of the Care Bill.



The key objectives of the BCF will be to deliver against the areas identified in the national conditions for the fund and also to deliver improved performance against the key performance indicators which the fund and integration of services will impact upon.

The activities provided through the BCF will therefore have a focus upon

- Providing joint assessments across health and care ensuring that, where funding is used for integrated packages of care, there will be an appropriate accountable lead professional.
- Protecting vulnerable adults by ensuring those people who are in need of care and support are able to access that support in a way that best suits their needs and requirements.
- Establishing stronger and more co-ordinated 7 day working across the sector including to reduce the levels of emergency admissions and to support timely discharge from Hospital, either to home or to an alternative, appropriate setting.
- Data sharing between agencies to facilitate a joined up approach to care planning and delivery. Sharing of information should also lead to longer term efficiencies and reductions in duplication releasing vital funds to further improve health services and support integration which further supports health and care workers to deliver improved quality of care to patients and service users. The NHS number will continue to be used as the unique identifier. NB Barnsley has already established a N3 connection to support data sharing and the use of the NHS number.

In support of delivering against those areas identified in the national conditions, as set

out above, we will also focus on the provision of information, advice and sign posting to support and promote self-management and self-care by enabling people to make better informed decisions in managing their own health and social care needs.

Activities and schemes included within and funded through BCF will be those which have a direct impact upon:

- Reducing delayed transfers of care
- Reducing emergency admissions to hospital
- Improving the effectiveness of re-ablement and rehabilitation services
- Reducing inappropriate admissions of older people (65+) in to residential and nursing care
- Patient and service user experience and the use of patient experience information to improve services
- Proportion of people feeling supported to manage their (long term) conditions

We expect this to deliver:

- Easier access to information and advice to help people make the right choices for them about their care and support across the whole system for both service users/patients and staff to navigate services.

- Reduced reliance on traditional, statutory services, sign posting people to alternative services

- Fewer admissions to care homes and for shorter duration towards the end of life

- Improved 'welfare' support, particularly those who are isolated, lonely and or have poor mental well being

- Care and support needs met locally wherever possible with an enhanced choice of support options

- An increased level of self-care and people managing their own care and support needs

- Fewer admissions to hospital and less time spent in hospital for patients who need to be admitted

- More cost effective use of resources

- More appropriate use of clinicians' / professionals time so that they can concentrate on issues for which they are trained and skilled

- An opening up of the provider base and therefore an increase in the range of services offered, leading to a more holistic package of care

- Support preparation for the implementation of the Care Bill e.g. promoting and providing improved universal information and advice, self-care and management, a revised and extended approach to assessment and care management.

c) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The main mechanism for the delivery of change and transformation within the health and care system is through the Programme Board Structures which are in place under the Health and Well-being Board to support the Stronger Barnsley Together (Pioneer Programme) and within the CCG to support deliver of the priorities identified within the BCCG strategic commissioning plan.

Programme Board Structure

There are 6 joint programme boards under the auspices of the Health and Wellbeing Board. Three sit within the Stronger Barnsley Together Programme and these are; Ageing Well, Promoting Independence and Think Family. These 3 programme boards will also be the mechanism for delivering a number of the priorities as set of in the BCCG strategic commissioning plan.

Three further programme boards Cancer, Planned Care and Unplanned Care are more focused on clinical delivery and are health led but designed to deliver the following outcomes that are intrinsic to our overall transformation journey. These are:

Cancer

- Improved cancer mortality rates for the Barnsley community
- Reduced variation in screening uptake across the Borough
- Improved symptom awareness
- Increase in life expectancy
- Reduced health inequalities

Planned Care

- Reduced CVD mortality rate
- Improved primary prevention of CVD
- Reduced practice variation in chronic disease management
- Increased numbers of patients completing cardiac rehabilitation schemes
- Increased symptom awareness
- Reduced inappropriate elective admissions
- Reduced first inappropriate outpatient attendances
- Reduced outpatient follow up rates
- Increased quality and provision of primary care diagnostics and monitoring
- Increased use of clinical pathways
- Care closer to home

Unplanned Care

- Reduced emergency admissions and readmissions to hospital
- Reduced A&E attendances
- Reduced non-elective admission rates
- The A&E operational 4 hour standard achieved and maintained
- Joined up working between primary, community and secondary care providers
- Improved patient experience and patient safety

Outside of the programme board structure but integral to delivery of the Health and Wellbeing Strategy and the ambitions for the better care fund, there are also detailed organisational plans in place, including transformation plans for Barnsley Hospital NHS Foundation Trust and South West Yorkshire Partnership Foundation Trust.

Each of the Programme Boards includes multi agency representation across both commissioner and provider organisations enabling improved joint working and helping to ensure that commissioner and provider improvement and transformation plans are aligned.

The Programme Boards will deliver a range of projects and initiatives which, although not exclusively, will support the aims of the BCF and we would specifically expect these to deliver the following improvements over the next few years:

- A much improved, enhanced and integrated information and advice service to allow people, including those who self-fund, to manage their own care and support needs and to connect them to sources of support available within their local communities

- Greater community capacity, community enterprise and volunteering to provide locally based initiatives to support older and vulnerable people with low level support needs. This will be linked with our revised area governance arrangements which are based on an Innovative model of community led commissioning involving communities in the design and delivery of neighbourhood services

- A stronger focus on the individual in the context of the family through the ‘Think Family’ programme board which in the longer term will contribute to resilience, personalisation and independence throughout life.
- Enhanced provision of low level wellbeing services provided in primary care and other community settings which address the needs of those in 'social crisis' but who not necessarily have a treatable mental illness. This would include things to support recovery, build personal resilience, reduce social isolation and provide meaningful activity

- Improved information, signposting and triage across the system and particularly at Accident and Emergency to ensure alternatives are known, considered and accessed where appropriate including respite/temporary admissions to a care home, telecare/telehealth, rehabilitation and re-ablement.

- Development of primary care services to improve access to primary care, provide a stronger focus on prevention of ill-health, delivery new integrated ways of working and develop the market of primary care providers.

- An asset based approach to assessment and care management which builds on people's strengths and the support available to them through friends, family and community, rather than what they cannot do.
- An expanded and fully integrated suite of intermediate tier services, focused on preventing admission to hospital as well as speeding discharge, to include primary care interfaces; virtual ward, re-ablement services including telecare and the voluntary sector
- Improved access to, and take-up of, telehealth and telecare provision
- Improved diagnosis and range of support available for people with dementia, plus development of plans to be a dementia friendly community.
- Improved coordination and targeting of preventative work specific to conditions such as Cardiovascular Disease, high blood pressure, respiratory, drug and alcohol misuse, and mental health by coordinating commissioning across the health and social care economy of programmes such as NHS Health Checks and the Wellness Service.

There will also be a range of other activities and improvement which will contribute to the aims of the BCF plan however at this point these will be delivered outside of the BCF. A good example of this may be Public Health led health improvement programmes.

A number of public health services commissioned by BMBC make an important contribution to the wider aims of the Better Care Fund through a focus on prevention and encouraging residents to make healthier lifestyle choices that will help to maintain their health and independence for longer. Further work will be undertaken during 2014/15 to develop integrated care pathways that include a much stronger focus on the prevention of ill-health as well as supporting self-management and independence for those with existing conditions. This will allow for Public Health resources to be aligned to the Better Care Fund in future years as part of an integrated approach to promoting 'wellness' in Barnsley. Also the development of a ‘foodladder’ as part of the anti-poverty strategy – ranging from the development of a truly targeted Local Welfare Assistance Scheme supporting people in financial crisis, to guidance and support to food banks, and moving people on the ‘Community Supermarkets’ to initially support access to food, but also to provide wrap around range of inputs to move people on, for example, into employment or training.

Another area of work which will over time support the long term goals of the BCF is that being taken forward by the Children and Young People’s Trust to develop an early intervention approach which includes addressing health inequalities, family support and the delivery of Barnsley's strategy for children and young people with special educational needs, disabilities and complex health needs (known as 'One Path, One Door') and the SEND agenda. The emphasis is on strengthening families, personalisation and resilience and therefore should reduce future reliance on health and care services.

The initial priorities for the BCF, utilising the pooled funding will be:

- Intermediate Care – Review the full range of Intermediate tier services to ensure that that the full range of Intermediate Care Services meet the needs of the population and able to effectively support people to avoid admission to nursing

and residential care, reduce hospital admissions where possible and for those who need hospital care, support early discharge as appropriate.

- Seven day working - Identifying and developing a co-ordinated and joined up approach to 7 day working across health and care to support the reduction in emergency admissions and discharge from hospital.
- Integrated Technology and improved data sharing – Developing proposals to improve data sharing and join up IT systems to support integrated working. This is a key element and enabler to the Health and Wellbeing Strategy and details of our approach are included within this Strategy document
- Development of integration of Social Care Services into Primary Care to improve accessibility of services, deliver new integrated ways of working and improve outcomes for patients.

The delivery of the Health and Wellbeing Strategy and CCG Strategic Commissioning plan will see a wide range of other programmes of work which sit outside of the Better Care Fund but ultimately when all taken together will support the delivery of the Health and Wellbeing Vision for Barnsley and more specifically the aims of the Better Care Fund.

We also intend to utilise the Better Care Fund to assist us to meet the additional statutory responsibilities brought about by the Care Bill, e.g. providing support for carers, promoting and supporting general wellbeing, assessments of people who fund their own care, etc.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The implementation of the Better care Fund Plan will have implications across the whole health and care environment as care becomes more integrated and an increased emphasis on prevention changes the patterns of where and how care and support is provided. It will be important to create a culture change across the system to ensure any developments become embedded and the anticipated benefits are achieved.

In terms of specific impacts upon the acute sector, the push to reduce emergency activity by around 15% will reduce the number of people using acute services/A&E and the number of emergency admissions, plus an anticipated reduction in overall funding – to be reinvested in community provision aimed at achieving the ambitions of the Health and Wellbeing Strategy.

There is no intention to reduce any funding for acute MH services although as part of the intention to reengineer the health and social care pathway for all service users we intend to improve access to Personal Budgets/Personal Health Budgets and put additional

resources into low level mental wellbeing services which may of themselves provide a 'step-down' influence"

A review of the Intermediate Care services will likely provide a new model which will give greater emphasis to preventing avoidable admissions to Hospital or long term nursing/residential care and further support earlier discharge from hospital.

It will be important to assess the impact upon the acute sector as changes are made to care pathways to ensure that the new models of delivery do have the anticipated impact e.g. reduction in emergency admissions. To support this schemes delivered through the BCF may need to be 'pump primed' to support establishment of the new services prior to the transition from acute care. It may also be necessary to allow a lead in time to enable the development of new services and or new job roles such as Nurse Practitioners.

Changes to the patient mix, 7 day working and reducing the number of non-elective admissions, unless managed effectively could affect the sustainability of the hospital. To maintain sustainability there are a number of considerations including

- Critical mass – numbers of consultants required to sustain local specialist services i.e. Stroke, Cardiology – solutions may come from Technological Solutions i.e. telemedicine
- Cost and ability to establish 7 day services (workforce issues)
- Lead time to develop alternative professionals – i.e. Nurse PR actioners
- National and local commissioning / contract standards (especially specialist commissioning)

Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The Better Care Fund will be overseen by the Governance of the Health and Wellbeing Board in Barnsley. The Health and Wellbeing Board provides the system wide leadership to the Stronger Barnsley Together Programme and are in the process of developing a joint medium term financial plan.

The BCF will be an integral part of this process and programmes of work will be overseen by the established joint programme board structure and fed via agency specific reporting lines to embed within business practices. Business cases will be formulated and ratified via this governance structure and assessed against the overall direction of travel being engineered in Barnsley.

3) NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services

The Council is currently forecasting a funding gap of £28m over the two years 2015/16 - 2016/17 and is seeking to balance this funding deficit from 2015/16. On the basis that Social Care is the largest spend area within the Council it is expected that a significant element of this funding gap will fall to those services. In addition to this the service faces annual demographic pressures from children transitioning into Adults within the Learning Disability service. Collectively it is estimated that the impact of this will create a funding gap in 2015/16 for Adult Social Care of up to £10m (which grows to £14m when demographic pressures are included).

This position assumes that all the Health funding currently transferred to the Council, which from 2015/16 will form part of the BCF, continues at its current level. Were this not to be the case the funding gap for Social Care would be greater. As such, the BCF will support a whole system wide approach in terms of the resources across health and social care, including protecting the level of social care provision as appropriate to prevent a negative impact on health services. NB – It is anticipated, that assuming corporate initiatives deliver efficiency savings that there will be a minimum additional funding gap of approximately £6m that the Health and Wellbeing Board will need to underwrite pending the strategy delivering the pathway redesign and associated cost reductions.

Please explain how local social care services will be protected within your plans

In order to protect Social Care services a joint service planning process will be undertaken through the Health and Wellbeing Board to consider the overall available funding across a joint Health and Social Care system, taking into account the available BCF, and consider where the overall resources should be spent and on what services in order to achieve the best outcomes whilst meeting the needs of service users and patients across a joint single Health and Social Care system.

This may involve a change in current service provision and/or investment in existing Social Care related services, in order to prevent people getting to a point of crisis where they require more formal interventions, in particular, admission to hospital or long term residential care.(hospital admission / residential care etc).

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

The Health and Well-being Strategy and the CCG strategic commissioning plan set out our strategic commitment to 7 day working and 7 days services to support discharge.

Resources have been identified and set aside as part of planning processes and 7 day working has been established across the health and social care system. Examples of where we have extended services over a 7 day period include:

Developments in the Acute Medical Unit including additional consultant cover and extended opening for the chaired area.
Provision of 24/7 diagnostic support for X-ray and CT, and Therapy support for AMU and the Emergency Department.
Provision of ED Patient Support Assistants (24/7) and Patient Flow Assistants (12/7)
Establishment of a Frail Elderly Team (12/7)
Extension of social work provision to cover 7 days per week
Extension of re-ablement services to 7 days per week.

Further detailed work will be taking place during 2014/15 to refine the current model and ensure best use of resources and long-term sustainability, notably as part of our redesign of both assessment and care management and intermediate care. In advance of completing these reviews we have already broadened access criteria to some services to create a universal offer aimed at reducing admissions and speeding discharge

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS number is used as the primary identifier in correspondence across health and care services. NHS organisations have always used the NHS number as the primary identify and this is now extended to enable social care to access and use the NHS number.

Barnsley achieved the UK's first NHS and social care record integration and is now able to match in real-time an individual's NHS and social care record through NHS number validation against the Personal Demographics Service (PDS) on the national Spine. Part of the Department of Health Common Assessment Framework (CAF) programme, this initiative sits at the core of Barnsley's aim to provide seamless health and social care delivery, improving people's outcomes and independence through better control and governance.

Using the NHS number allows staff to ensure that they are talking about the same person across health and social care and critically prevents duplication or inaccuracy across care records. Moving forward, this will enable relevant information and assessment data to be shared electronically with the individual's consent, in order to achieve a greater level of seamless care.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

There is a commitment to sharing systems or ensuring they talk to each other at the highest level across the health system in Barnsley. There is already an N3 connection to enable sharing and use of the NHS number and work is ongoing to develop an IT strategy which will support the integration of systems and sharing of information between primary and secondary care and the Local Authority and also allow easier access for patients and service users to their health and care records

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Appropriate IG controls are in place across the health and care systems.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

As part of our whole system transformation programme we will be further developing our Integrated approach to assessment on care planning, targeting our resources at people with medium and emerging risk of hospital admission and providing interventions to slow progress to more intensive levels of need. We have so far established: Accountable GP for over 75's £5 per head of funding for over 75's Personalised Care Plans for People with LTC's Risk Stratification for people with LTC's

4) RISKS

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

Risk	Risk rating	Mitigating Actions
Managing need to shift out of hospital care with impact on BHNFT financial viability and potential for consequent changes	High	• Commissioners Working Together • Providers Working Together
Lack of agreed savings plans to achieve known savings targets for the local authority in 15/16, and potential impact on health and care system	High	• Whole system and financial modelling of emerging plans
Different organisational priorities/commitment to whole system working	Medium	• Health and Wellbeing Board Organisational Development
Impact of Social Care Bill increasing the number of people requiring state funded support	Low	• Financial modelling

Better Care Fund - Finance Summary

Finance - Summary

##

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Barnsley Metropolitan Borough Council	Y	£ 2,016	£ 2,016	£ 2,016
Barnsley Clinical Commissioning Group	Y	£ 6,594	£ 18,358	£ 18,358
NHS England	Y	£ 5,676		
BCF Total		£ 14,286	£ 20,374	£ 20,374

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Better Care Fund - Outcomes and Metrics

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	691.0	N/A	600.0
	Numerator	289		251
	Denominator	41820		41280
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	82.70	N/A	89.00
	Numerator	163		175
	Denominator	197		197
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	56.0	56.0	56.0
	Numerator	103	103	103
	Denominator	2	2	2
		(State time period and select no. of months) 19	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	531.0	528.0	525.0
	Numerator	3185	3168	3150
	Denominator	6	6	6
		(State time period and select no. of months) 6	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*			N/A	
		(State time period and select no. of months) 1		*(State time period and select no. of months)* 1
Local measure *Proportion of people who feel supported to manage their long term conditions*	*Metric Value*	71.5		73.0
	Numerator			
	Denominator			
		(State time period and select no. of months) 1	*(State time period and select no. of months)* 1	*(State time period and select no. of months)* 1