Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**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:	**18 September 2014**
Date submitted:	**19 September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£14,286.00**
2015/16	**£20,374.00**
Total agreed value of pooled budget: 2014/15	**£14,286.00**
2015/16	**£20,374.00**

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b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Nick Balac
Position	Chair
Date	September 2014

Signed on behalf of the Council	
By	Diana Terris
Position	Chief Executive
Date	September 2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Sir Stephen Houghton CBE
Date	September 2014

c) Related documentation

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

Document or information title	Synopsis and links
Health and Wellbeing Strategy	Health and Wellbeing Strategy
Barnsley CCG Strategic Commissioning Plan	CCG Strategic Commissioning Plan
Barnsley Joint Strategic Needs Assessment	Joint Strategic Needs Assessment (JSNA)

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2) VISION FOR HEALTH AND CARE SERVICES

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

In Barnsley the Better Care Fund (BCF) is set in the context of the wider Health and Wellbeing Strategy and Vision, is aligned to the 'Stronger Barnsley Together' Programme and is seen as one strand in helping to deliver a transformation of the health and care system across the Borough. Unless considered in this context the BCF would not be able to have the impact that we would like to see across the whole system.

The Health and Wellbeing Board has a key role to play in terms of systems leadership, overseeing the delivery of the overall health and care system locally by bringing together NHS commissioners and providers, the local authority, and other partners in the wider health and care community, along with Healthwatch Barnsley as the consumer champion.

The Barnsley Health and Wellbeing Strategy 2014-19 has been developed in this context. It describes how collectively the key agencies will work better together to ensure the health and care system will deliver improved health and wellbeing outcomes for the people of Barnsley, in conjunction with a range of stakeholders from across the borough through the delivery of systems reform, quality, performance and financial metrics as defined in the:

- NHS Constitution - rights of and pledges to patients to be upheld
- Mandate for the NHS in England
- Outcomes Frameworks for the NHS, public health, and social care

The strategy sets out the strategic vision for health and wellbeing over the 5 year period to 2018/19. It describes what is being done to improve health and care outcomes for Barnsley people and how the work of the health and care system will deliver improvements against national outcomes whilst driving up quality, experience and meeting the needs and expectations of local people. In delivering the strategy the Health and Wellbeing Board will also ensure that activity is integrated with that included in NHS plans for areas such as public health, primary care and specialised health services as well as wider social care.

The Health and Wellbeing Vision for Barnsley is:

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

The Strategy is designed from a whole systems perspective focused around integrated pathways and service re-design. This will ensure the health and care system is fit for purpose and sustainable, able to meet the needs of local people and deliver the best possible outcomes for the people of Barnsley.

To deliver this vision and move to a model of health and care which will apply in five years will require some significant changes to the way that health and care services are

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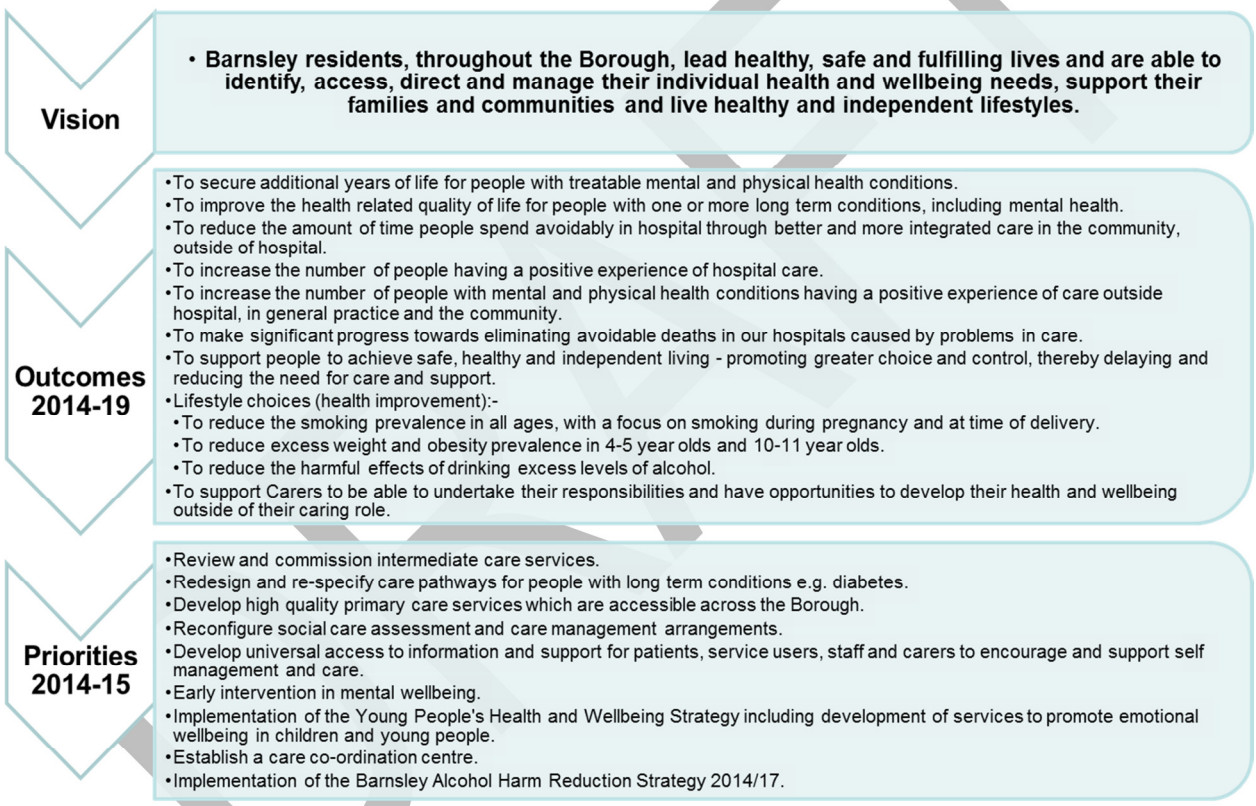
currently commissioned and delivered. Our focus will therefore be on providing care and support to the people of Barnsley with services that:

- co-ordinate around the individual – targeted to their specific needs,
- maximise independence – by providing more support at home and in the community,
- better co-ordinate information, advice and sign posting to alternative services to promote self-help and self-care,
- develop more effective prevention, re-ablement and targeted short term interventions to keep people out of the formal system for as long as possible,
- support people to manage their long term conditions and those with the greatest needs.

The diagram below sets out the H&WB vision, outcomes to 2019 and priorities over the period to 2015.



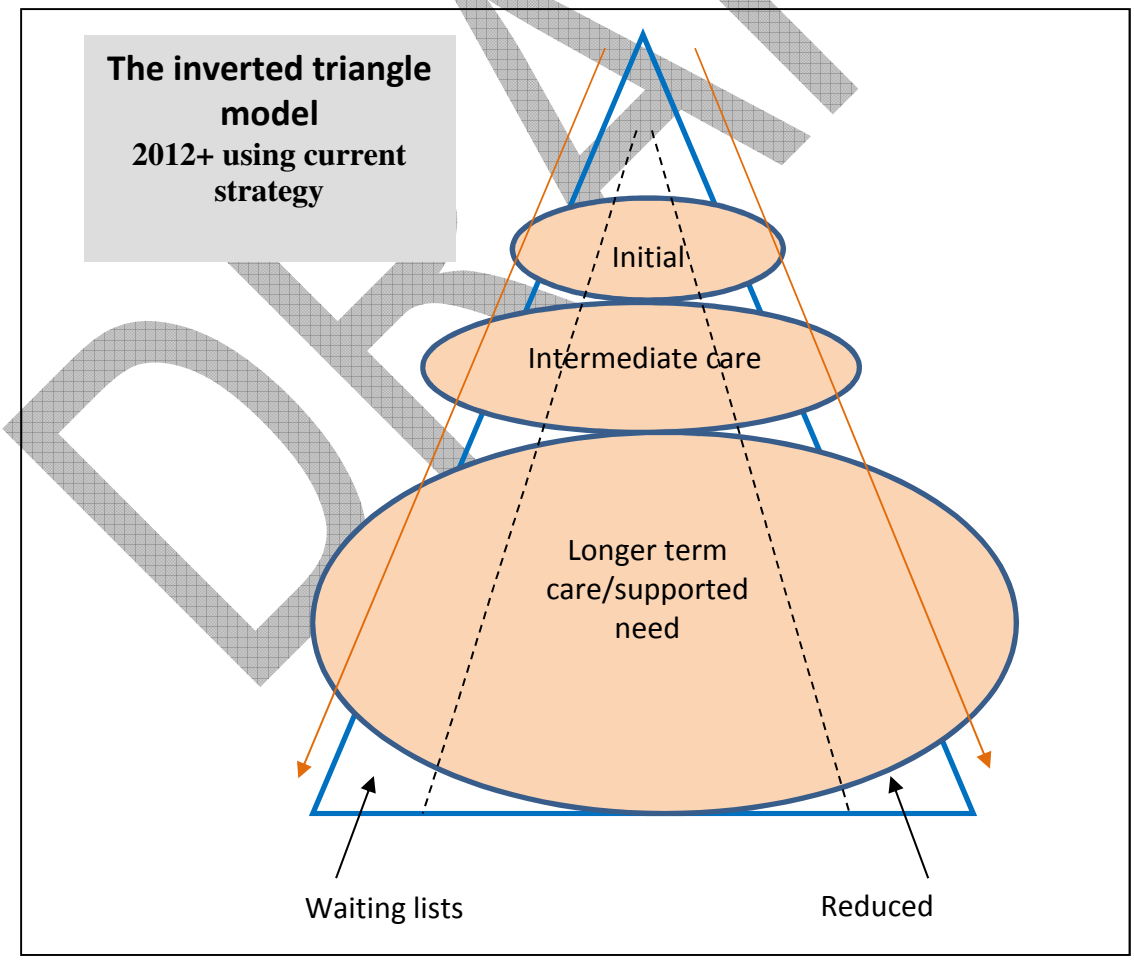
We recognise that in many cases, achieving improved health and wellbeing outcomes is a longer term ambition requiring a reorientation of current systems towards prevention and addressing the wider determinants of good health. But we are also clear that service integration can make a significant contribution to those longer term ambitions whilst delivering better outcomes for service users and a much improved patient/service user experience and we intend to use the BCF as a catalyst for change.

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, including through improved access to telecare and other equipment and adaptations which allow people to remain independent and safe. 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, i.e. 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.



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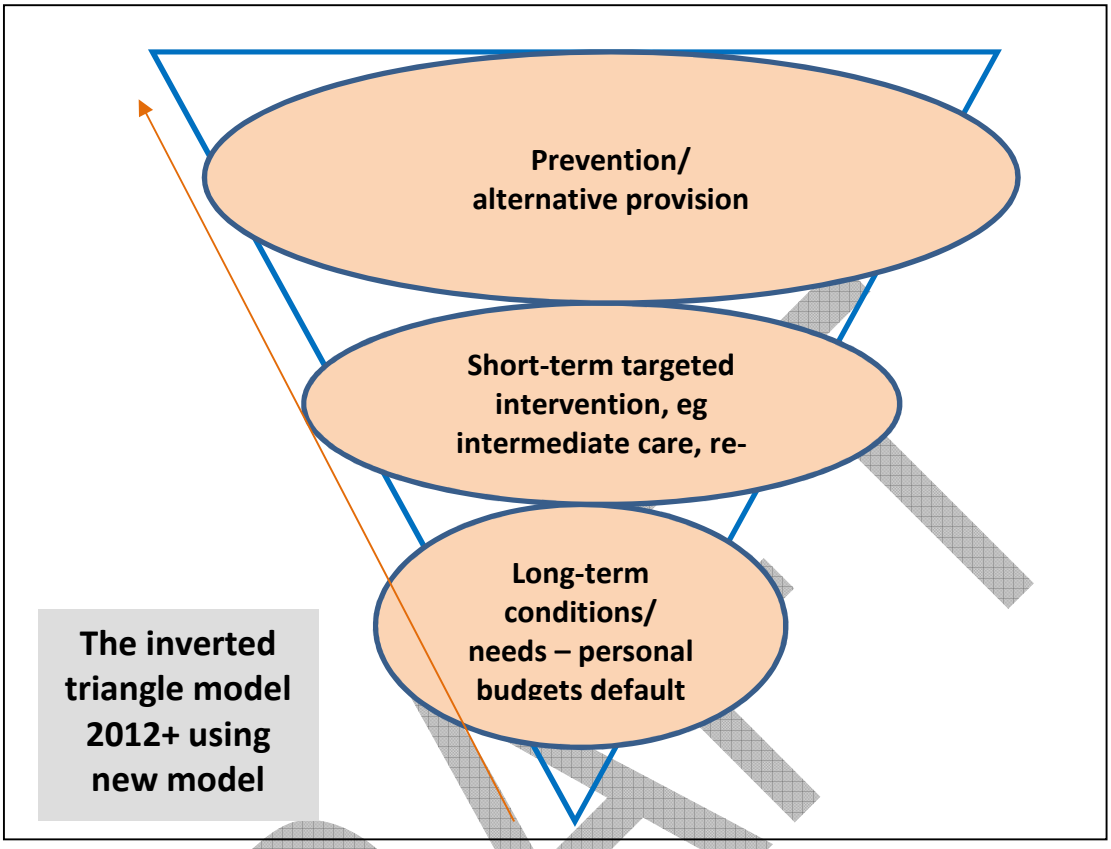
Therefore, a potential solution is to 'invert the triangle'



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

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admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

In considering the BCF in the context of our wider transformation journey we have identified the following schemes as being central to achieving our redesigned pathway and delivering the reductions in unplanned acute hospital admissions and admissions to care homes although we would again emphasise that these are only part of a wider transformation and integration programme across the whole health and care system.

- **Intermediate Care** - review and re-procurement of a single integrated service based on a revised specification with an increased focus on preventing hospital admissions (as opposed to speeding discharge), resulting in over 800 emergency admissions being avoided.
- **Right Care Barnsley** – a single 'front-door' to support medical patients aged 18 and over who are at risk of a hospital admission and those who need support to return home after discharge from an acute setting. It is anticipated that this will directly contribute to avoiding over 300 emergency admissions between 2014/15 and 2015/16
- **Virtual ward** – a proactive case management approach to supporting people at the highest risk of admission/readmission to hospital with intensive multi-disciplinary care and care coordination within their home environment, thus supporting recovery and self-management and, avoiding hospital admissions.
- **Assessment & Care Management - new Target Operating Model** - Fundamentally revising the way assessment and care management services are provided in Barnsley to focus more on early intervention and prevention; self-help and redirecting people to non-statutory and universal services; and short term, targeted reablement
- **Universal Information & Advice Strategy across all statutory agencies** – Develop integration of health and social care information into a single trusted source, increasing access to information and advice through promotion; increasing the range and type of access opportunities and improving the relevance of the content to reflect local demand
- **Integrated Personal Commissioning** – combining health and social care funding: we have submitted an expression of interest in being a trailblazer
- **Be Well Barnsley** – redesigning and re-commissioning a range of community focused preventative services/peer models which help to improve lifestyles and achieve health gain

In addition we also recognise the importance of ensuring the appropriate technological infrastructure is in place to support the required changes and the integration of services. **Our Integrated Digital Care Tech Fund 2 bid** which, if successful, will see the introduction of an information hub federating all primary health and social care systems, with the NHS Number as the primary identifier will be a key enabler of change.

The schemes and projects that are being delivered as part of the ongoing transformation of health and care, alongside those which are identified specifically in relation to the Better Care Fund will be central delivering the planned system changes.

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

The aims and objectives for integrated care are embedded within the Health and Wellbeing 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. This will see a significant shift in the medium term away from the current model which is centred around acute care.

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

Our intention through 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 and activities being delivered as part of and/or in line with the Better Care Fund will support us in delivering the changes required to meet the requirements of the act.

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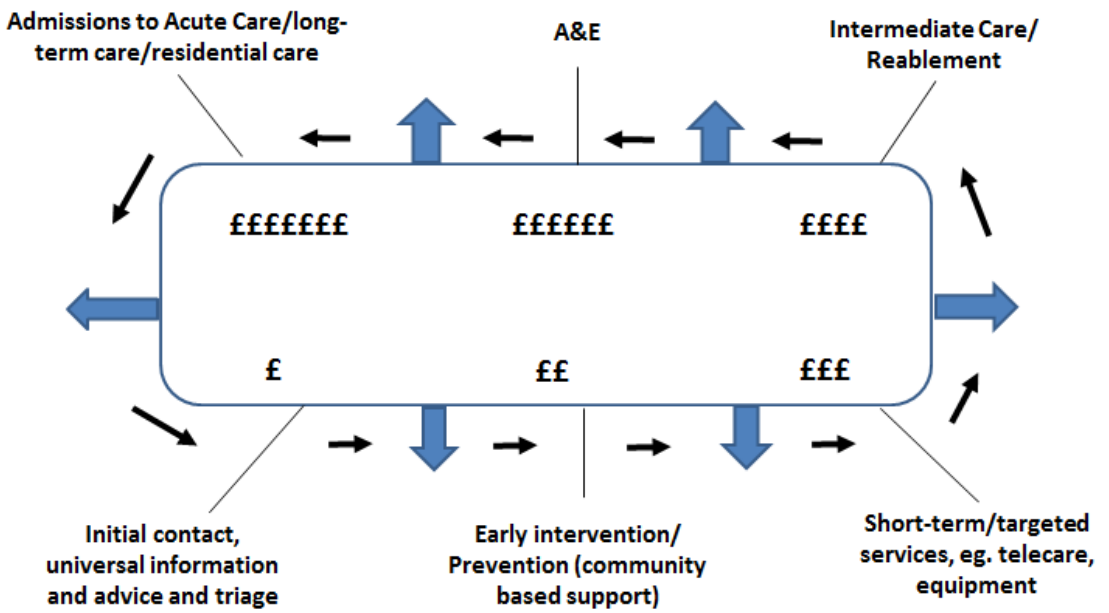
HEALTH & SOCIAL CARE SYSTEM/ PATHWAY



NB As people flow round the pathway costs increase. The strategy is therefore to increase earlier intervention/prevention and continually signpost/support people out of the statutory services

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

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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.

Whilst we recognise that the delivery of the Health and Wellbeing Strategy will be critical in changing the whole system and delivering the outcome we are aiming to achieve, the activities and schemes included within and funded through BCF have been identified as those which have a direct impact upon:

- Reducing emergency admissions to hospital
- Reducing delayed transfers of care
- 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

The BCF will also support preparation for the implementation of the Care Act e.g. promoting and providing improved universal information and advice, self-care and management, a revised and extended approach to assessment and care management.

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

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 Wellbeing 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. The Planned and Unplanned Care Programmes will contribute significantly to achieving the objectives of the BCF as they are designed to deliver the following outcomes that are intrinsic to our overall transformation journey. These are:

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

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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.

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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 support quicker 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.

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3) CASE FOR CHANGE

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

Population Needs

Barnsley faces some significant challenges over the next few years. People are living longer but with this comes an expected rise in the number of people with one or more long term conditions. This is already and will continue to place extra demands on an already stretched health and care system. Health outcomes are improving within the borough but compare relatively poorly to the rest of the country, with marked life expectancy variations within the borough itself.

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 case for change is clearly demonstrated by the challenges we face across the Health and Social Care system in Barnsley, as identified within the Joint Strategic Needs Assessment

Almost one in every four adults in Barnsley experience long-term illnesses that limit their day to day activity; higher than the national average. The prevalence of the most common long-term conditions (e.g. cardiovascular and respiratory disease, diabetes, and dementia) are higher than the national average and increasing as the population ages. The proportion of patients with more than one such condition is correspondingly high and places additional demands on the health and social care systems. The most important risk factors, such as smoking and obesity, are also more common than the national average.

There has been a trend over recent years of increasing numbers of emergency admissions to hospital in Barnsley and addressing this has been identified as part of the Health and Well-being Strategy, The CCG Strategic Commissioning Plan and is a key area of focus for the BCF. The Commissioning for Value packs (October 2013) indicated the contribution of cardiovascular and respiratory disease to the excess emergency admissions and costs in Barnsley; costs that were high, even in comparison with a group of peer areas. A continued commitment to long-term prevention (e.g. tobacco control and smoking cessation, reducing obesity) and activities with more immediate benefits (e.g. better clinical management of long-term conditions, such as heart failure and COPD) remain key components in reducing the demands for acute care as part of the wider Health and Wellbeing Strategy.

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Risk stratification

Barnsley CCG received s251 approval to undertake risk stratification during 2013/14 however there is some uncertainty around the continuing legal basis for doing this going forward and therefore the of population level risk stratification has been limited and has focused mainly on the provision of information to GP practices to facilitate compliance risk profiling and care management enhanced services in 2013/14. IN 2014/15 the GP contract incorporates a directed enhanced service (DES) requiring GP's to identify those in danger of an hospital admission using risk stratification.

To ensure that we are focusing on the areas where we can have most impact, subject to clarification of legal issues, risk stratification will be used to support the primary care sector to identify and support those people most at risk of hospital admission and a number of projects have been and continue to be supported to improve capacity within primary care to support this group of patients.

Those people with the highest level of care need or more likely those with high and moderate risk in order to be able to target those people where improved care and support closer to home can reduce the number of emergency admissions. The wider Health and Well-being Strategy focuses across the whole spectrum, ensuring those with lower levels of support needs and at low risk of hospital admission are supported appropriately to maintain independence and are able to better support themselves for longer at home. The BCF will ensure that resources are targeted in the right areas to support this approach and ensure that more patients are supported appropriately closer to home and away from a residential setting.

The Rightcare Barnsley (Care Coordination Centre) project will focus specifically on those people at risk of hospital admission, co-ordinating alternative methods of care where appropriate. The service will help GP's by supporting them to identify the most appropriate level of support and management of the cohort of patients identified through risk stratification as being at most risk.

Financial Challenges

There are also a number of financial constraints which make the current service delivery models unsustainable in the medium to long term, particularly in relation to the Local Authority financial position.

Barnsley Council has a net total budget for social care of £43.678m in 2014/15. This is a reduction of £3.748m from the 2013/14 net budget of £47.426m.

The reduction includes savings of £4.611m from:
<u>Savings</u>

- Efficiency £3.522m:
- Reconfiguration of Assessment and Care Management £0.554m
- Older People Care Package reductions through re-ablement £0.630m
- Review of Day Opportunities across all care groups £0.440m
- Review of Service User / Carer support £0.270m
- Mitigation of Demographics / maintain eligibility criteria with Health funding £0.400m
- Review of Intermediate Care Beds £0.128m

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- Other various £1.100m

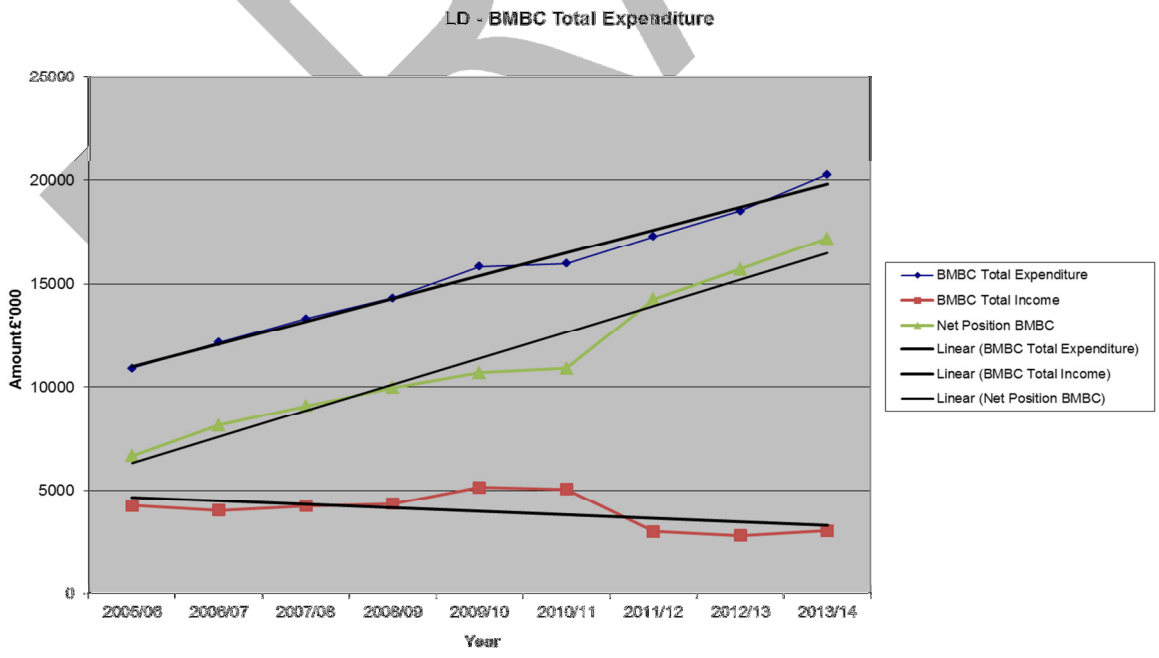
Reductions £1.089m:

- Housing related support through Supporting People £0.823m
- Reduction in Advocacy / Preventative contracts £0.266m

The social care service has delivered significant additional savings in the previous 3 years (2011/12 to 2013/14) of £12.1m from:

- Closure of In House Respite / Intermediate Care Homes £1.750m
- Closure of In-House Homecare service £1.272m
- Increased client income through fairer charging £1.000m
- Reduced housing related support through Supporting People £1.326m
- Reduced long term care budgets from re-ablement £1.000m
- Mitigate Demographics / maintain eligibility criteria with Health funding £1.500m
- Review of Assessment and Care Management £0.318m
- In House Learning Disability Day Service Rationalisation £0.360m
- Substance Misuse reductions £0.334m
- Various other £3.240m

The service has seen a significant increase in spend on Learning Disability care packages over the last few years with expenditure rising from £9.5m in 2005/06 to a forecast 2014/15 figure of £20.1m. This is a result of individuals with significant complex needs transitioning from Children to Adults on an annual basis and individuals living longer with complex needs. This is a national pressure not just something unique to Barnsley. Significant work has been undertaken which is still ongoing in relation to reviewing high cost packages of care, which to date has delivered recurrent savings of around £0.3m. This forms the largest element of annual demographic pressures across Adult Social Care as in the main demographics on other care groups are being mitigated through the actions taken to reduce spend.



Spend on Older People from 2005/06 to 2009/10 was seeing a steady year on year increase consistent with the impact of an ageing population. However actions taken to meet the Council's funding reduction targets through the closure of in-house services; the

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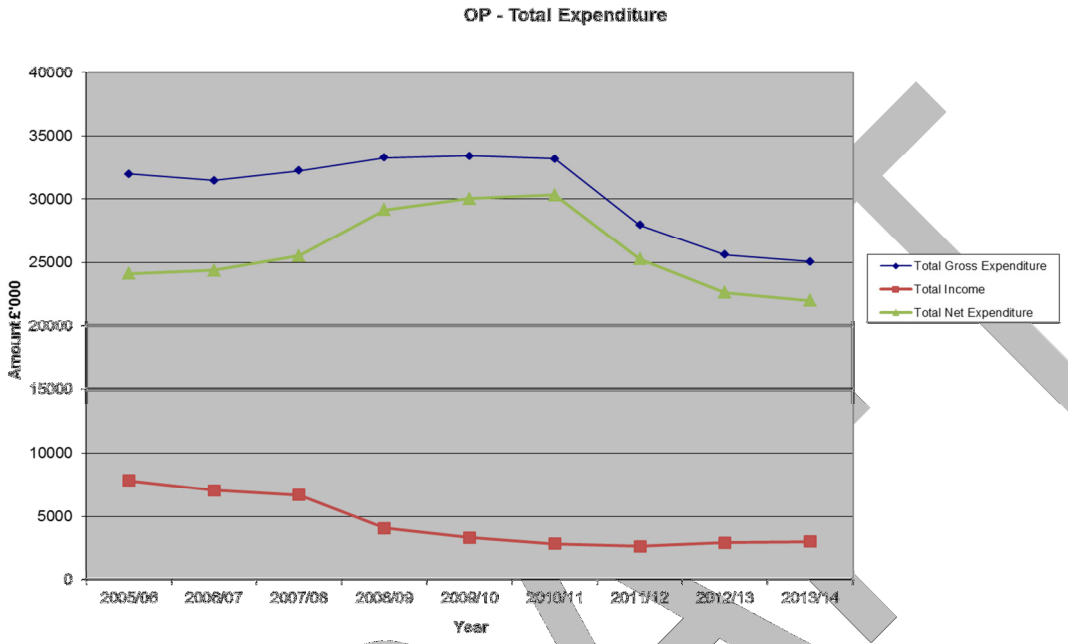
successful implementation of a re-ablement function allowing people to live independently with less or no ongoing support; and a continued focus on personalisation; have seen expenditure reduce year on year from £33.2m in 2010/11 to £24.7m in 2013/14, an overall reduction of £8.5m (25%). This position has delivered on the planned downward curve in expenditure whilst mitigating demographic pressures over that same period; however, it is likely to start to increase again now year on year from the significantly reduced baseline as a result of the ongoing impact of an ageing population.



The latest demographic profiling across social care in terms of care costs and numbers is detailed below.

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Baseline Assumption (As included in Medium Term Financial Plan)									
Activity	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Learning Disability	660	698	732	774	813	853	896	941	988
Older People	2,353	2,224	2,164	2,215	2,250	2,286	2,322	2,358	2,396
Physical Disability	221	207	202	205	206	206	207	207	208
Mental Health	na	na	na	na	na	na	na	na	na
Total Activity	**3,234**	**3,129**	**3,098**	**3,194**	**3,268**	**3,345**	**3,424**	**3,506**	**3,591**
Expenditure	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Learning Disability	15,838	17,229	18,469	20,069	21,445	22,916	24,488	26,167	27,962
Older People	19,893	19,001	19,057	18,865	19,163	19,466	19,773	20,086	20,403
Physical Disability	2,891	2,940	3,063	3,043	3,051	3,059	3,067	3,075	3,083
Mental Health	na	na	na	na	na	na	na	na	na
Total Expenditure	**38,622**	**39,170**	**40,589**	**41,977**	**43,659**	**45,441**	**47,328**	**49,328**	**51,448**
Cost Pressure					**1,682**	**1,782**	**1,887**	**2,000**	**2,120**
Cumulative					**1,682**	**3,464**	**5,351**	**7,351**	**9,471**

These projections have been included in the Councils medium term financial position as set out below.

The latest benchmark data taken from the Audit Commission value for money profiles shows that spend per head of population in Barnsley is within the lowest 20% nationally. This can be broken down over the main care groups as follows:

- Older People – In the lowest 20% spend per head of population
- Physical Disability – In the lowest 5% spend per head of population
- Learning Disability – In the lowest third spend per head of population
- Mental Health – In the highest third spend per head of population

In terms of unit cost expenditure we know Barnsley is one of the lowest fee payers nationally in relation to both Residential Care and Homecare which are the two main types of care provision.

Looking forward the Council's Medium Term Financial Strategy identifies that the Council is facing a funding gap of at least £32.3m over the financial year 2015/16 to 2016/17

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taking into account demographic pressures and assuming the current health funding remains available. This gap is expected to rise once the impact of the 2014 Budget on the 2016/17 settlement is known and further cuts will also be required for 2017/18.

The most significant impact on the Council position is the reduction in funding from the Government as part of its ongoing austerity measures which sees funding reduce by £22m (20%) from 2014/15 to 2015/16.

Of this sum £16.6m is anticipated to need delivering from HWB related spend as set out below.

Spend Area	2015/16 £m	2016/17 £m	Total £m
Adult Social Care	5.9	3.6	9.5
Children's Social Care	2.4	0.6	3.1
Public Health	2.8	1.3	4.1
Total HWB	**11.1**	**5.5**	**16.6**

4) PLAN OF ACTION

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

The Better Care Fund Plan will be delivered in Barnsley as part of the system wide transformation plans and programmes as described earlier in this document.

All projects have been developed with clear business cases and will be delivered using a programme and project management methodology. Each of the projects associated with the BCF and the wider delivery of the health and wellbeing strategy will have individual project plans against which progress can be measured.

The governance arrangements we have in place for delivering the BCF and wider transformation will ensure that progress is reviewed and monitored and that the schemes we are delivering are having the desired benefits across the system.

The headline milestones for the key projects included within the BCF plan are set out below:

Project	Headline Milestones
Rightcare Barnsley	Phase 1 Implementation – October 2014 Phased roll out of full service – Jan – July 2015 Review and Evaluation of pilot Aug – Oct 2015
Intermediate Care	Review of IC Serves – to Summer 2014 Draft Specification shared with current provider – Sept 2014 Implementation and mobilisation of pilot Oct 2014 – March 2015 Commence deliver of new specification pilot – April 2015

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Virtual Ward*	Review community nursing and community services Development of reconfiguration plan for community services Commence a phased approach to implementation
Social Care - Target Operating Model (TOM)	Service Delivery Design Phase – July – Oct 2014 Implementation/Roll out – Nov 2014 – Mar 2015 Full implementation of TOM – April 2015

* The Virtual Ward project will be informed by the initial roll out of Rightcare Barnsley and therefore the key dates are not yet fixed/

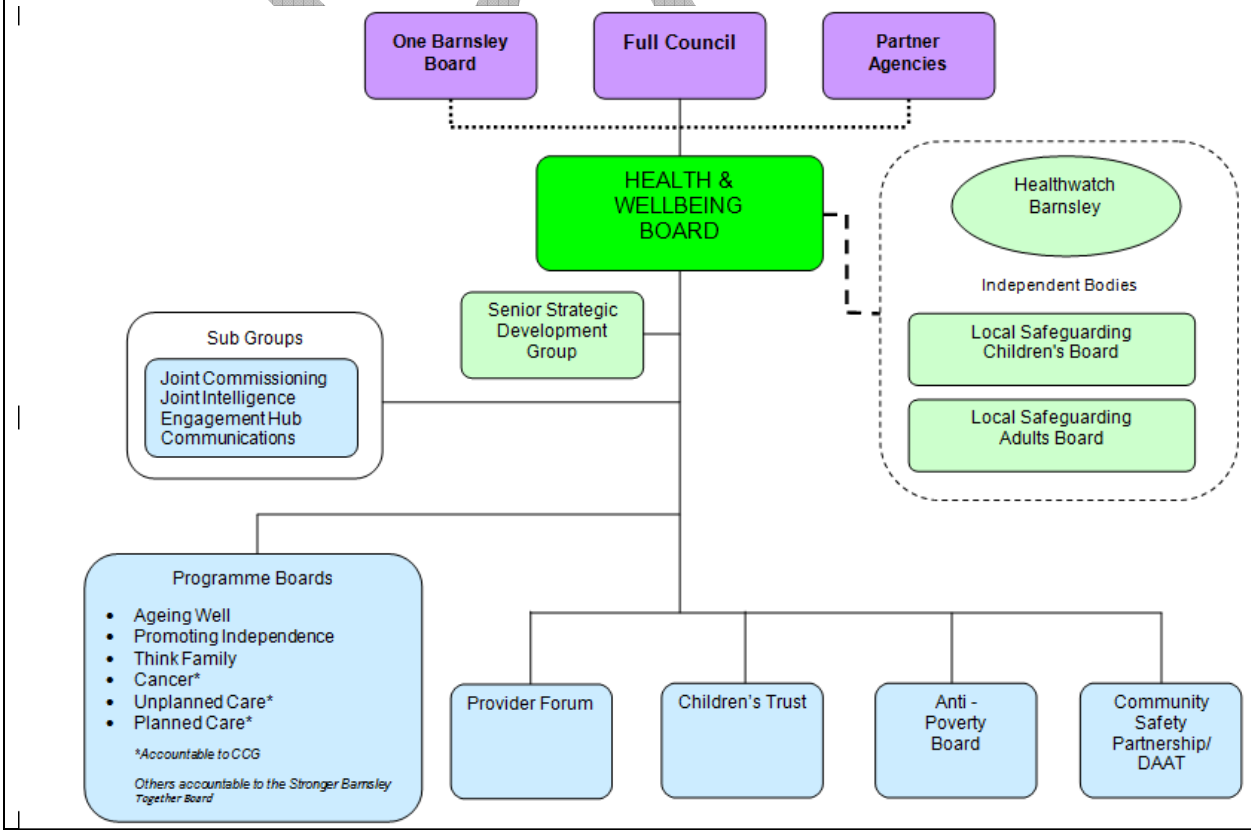
b) Please articulate the overarching governance arrangements for integrated care locally

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.

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

Health and Wellbeing Board Governance Structure



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d) **List of planned BCF schemes**

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

Ref no.	Scheme
1	Rightcare Barnsley
2	Virtual Ward
3	Intermediate Care Review
4	Frequent Callers (YAS)
5	Urgent Care Practitioners (YAS)
6	BHNFT 7 Day working
7	Personal Health Budgets
8	Be Well Barnsley
9	Care Act Implementation
10	Residential Care – Fair Fee Project
11	Social Care – Target Operating Model
12	Social Care – Funding Transfer
13	Adult Learning Disability Transformation

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Financial risk;				
Better Care Fund schemes will not succeed in reducing non-elective admissions, leading to higher costs for the CCG	3	4	12	Integrated performance reporting Reported through to HWWB and CCG Governing Body. Benefits from

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				reduced admissions are planned to be reinvested in Community Services to support transformation. A failure to deliver savings according to the planned trajectory will be off-set by a reduction in these investments.
Better Care Fund will not succeed in reducing permanent admissions to residential care, leading to higher costs for the local authority.	3	3	9	Admissions monitored on an ongoing basis, aligned to wider financial monitoring of care budgets. This will include monitoring use of alternatives to residential care. Existing budget control arrangements Include regular reporting to cabinet.
Social Care budget reductions required to balance the Councils financial position will have a negative impact across the wider health and social care system including the potential to increase activity in the acute sector.	5	4	20	Potential for elements associated with Intermediate Care to be picked up through the Intermediate Care review. Will reduce the level of available funding for intermediate care, although the proposal is seeking a financial return greater than the Council funding reduction
The Councils remaining funding gap for 2015/16 will result in actions that have a negative impact across the	3	3	9	The activity and financial position of the Council will be monitored and reported on a regular basis. The

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wider health and social care system including the potential to increase activity in the acute sector.				Council and CCG are undertaking a joint service and financial modelling project to better understand activity cost and impact across a joint health and social care system
Social Care Target Operating Model will not deliver diversions from care and reduced cost of care packages. Requires all aspects of the model to be in place.	3	3	9	Activity and costs of social care packages are monitored and reported on an ongoing basis. Detailed action plan exists for implementation of the new model and is likewise monitored in terms of progress.
Better care Fund schemes will not maintain the current low levels of delayed transfer of care, leading to higher costs for CCG and or the provider	3	1	3	Through close monitoring remedial action will be taken in the event that plans do no yield the intended consequence.
Better Care Fund schemes are delayed, resulting in delays in benefit realisation and higher costs for CCG	3	4	12	Partnership approach to scheme development. Close monitoring of intended outcomes. Close monitoring of financial and expected benefits. BCF considered in the context of wider financial position and decisions taken in this context. Mitigation will also take the form of reduced reinvestment proposals in

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				Community Services
Operational risks;				
Better Care Fund schemes will not succeed in reducing A&E attendances and emergency admissions. As a result 4 hour target will be missed and deterioration of performance against the 18 week referral to treatment target	2	4	8	The System Resilience Group will closely monitor emergency and elective performance and will agree appropriate actions. Operational Resilience and Capacity Schemes have been agreed.
Better Care Fund Schemes will increase demand for community services, resulting in higher waiting times for community care assessments	3	1	3	Integrated reporting will ensure there is performance in relation to the whole system Introduction of self-assessment portal Equally benefits realised from the shift from Acute to Community Care will reduce expenditure in Secondary Care leading to potential reinvestment in Community Services. If the shift does not occur then investment will not be required. Introduction of target operating model to reduce the number of people requiring Community care assessments.
Quality risk;				
The disruption arising from better care fund schemes reduces the quality of life for service users and patients	2	2	4	Establish integrated performance reporting to ensure we are tracking the qualitative and quantitative

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				measures (friends and family test, customer satisfaction survey's) Incentivise the right behaviour through provider contracts.

b) Contingency plan and risk sharing

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

The Better Care fund will be managed through a Section 75 agreement but expenditure will relate to currently committed service lines and therefore managed through existing contractual arrangements. In this sense accountability will rest with the contracting partner. We feel that managing the fund in this way brings financial stability and clear accountability for performance.

In line with the accountability split, the consequences of risks materialising will in the first instance rest with the accountable organisation. Therefore in respect of failure to implement a reduction in emergency admissions the risk is considered at present to rest with the CCG. Likewise the financial risk associated with failure to reduce care package costs and/or admissions and hence costs of residential care will rest with the council.

Where organisations are not able to meet and mitigate the risk this will form part of the wider Health and Social Care discussion around managing the overall position.

There is no formal contingency set aside for non-achievement, however the benefits realised through this change to service models where, for example, freed from Emergency Admission reductions would be reinvested to expand Intermediate Care and other Community Services to manage the impact of the shift. Failure to deliver the benefits will necessitate the non-investment in these services, however this is itself mitigated by the reduction in call on these services as patients remain within the Acute sector.

In addition many of the initiatives are on a pilot basis and benefit realisation will be assessed prior to longer-term funding decisions being taken. This approach provides financial flexibility and which we feel is a more effective mechanism for resource management.

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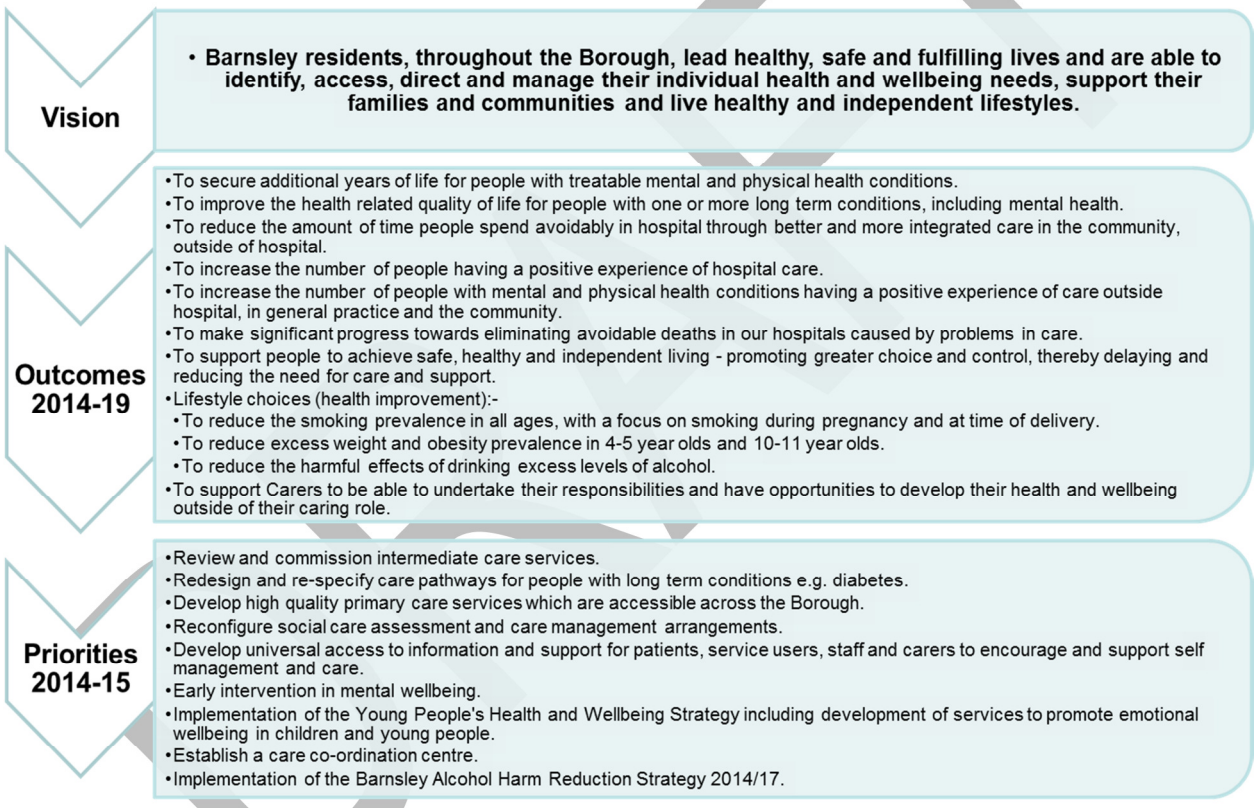
6) ALIGNMENT

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

The BCF is viewed in the Barnsley as part of a whole systems approach to health and social care integration, including our plans to implement the Care Act. The plans in our BCF submission align to a number of initiatives related to care and support and are fully aligned with the broader Health and Wellbeing Strategy and other commissioner plans in Barnsley including the Council's Corporate Plan and the CCG Strategic.

The Health and Wellbeing Board Vision and Outcomes 2014-2019 set out the strategic direction and the priorities are reflected in the plans of individual commissioners and providers.



The Programme Boards which have been established to deliver health and care transformation have a number of priorities which directly align to the achievement of the strategic vision and which will support the delivery of the BCF objectives.

The top ten priorities are:

- Review and commission intermediate care services
- Redesign and re-specify care pathways for people with long term conditions e.g. diabetes
- Develop high quality primary care services which are accessible across the borough.
- Reconfigure social care assessment and care management arrangements
- Develop universal access to information and support for patients, service users

staff and carers to encourage and support self-management and care
- Early intervention in mental well-being
- Implementation of the Young People's Health and Wellbeing Strategy including development of services to promote emotional wellbeing in children and young people
- Establishing a care coordination centre (Rightcare Barnsley)

Detailed economic modelling work is currently taking place with the support of Ernst and Young to develop a better picture of the impact of delivering the key schemes on the wider health economy. The outputs of this work will inform further development of our plans and will inform future decisions about implementation of specific interventions and service developments.

The System Resilience Group (Operational Resilience and Capacity Plan) will also see investment during 2014/15 in projects which will increase capacity across the system to ease some of the pressures currently being experienced and support the direction of travel in respect of treating people closer to home and supporting people to live more independently. The projects identified for funding to increase capacity and enable working seven days a week include:

- 7 day access to the Independent Living at Home Service (Re-ablement)
- Increased Social Work capacity including within the hospital to support discharge
- Assistive Living Technologies (Reduction in residential care admissions)
- Increased capacity in community nursing and intermediate care
- Increased capacity for mental health assessment
- Extended Therapy Services

The CCG also recognise the importance of primary care in successfully delivering system wide change and are therefore engaging in the development of proposals for co-commissioning of primary and have developed a specific programme which commenced early in 2014/15 for primary care development.

The delivery of the primary care development programme will ensure that primary care is skilled and has the capacity and infrastructure to play a key part in the transformation of health and care services.

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

Our BCF plan will be delivered as part of delivering the Barnsley CCG's 2 year operational and 5 year strategic plans. The priorities and anticipated benefits of the BCF plan align fully to the ambitions set out in the Health and Wellbeing Strategy and CCG plans and also to the council priorities as set out in the Corporate Plan.

The BCF is not viewed by the Health and Wellbeing Board or individual agencies as a standalone initiative, rather it is an integral part of our delivery plans, which taken in the round describe the changes necessary to deliver a modern model of integrated care, alongside other key system changes that are required to achieve high quality, sustainable services.

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

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

Barnsley CCG has submitted an expression of interest in the co-commissioning of primary care services with NHS England jointly with the other four CCGS within South Yorkshire and Bassetlaw (Bassetlaw, Doncaster, Rotherham and Sheffield). The expression of interest has been submitted on the basis that the current way of working neither enables system transformation nor supports the inclusion of primary care within the wider integration agenda. In taking a genuine co-commissioning approach, which builds on a strong track record of collaborative working, the potential to improve this position will be realised.

In developing the expression of interest we have developed a set of clear guiding principles to co-commissioning which reaffirm our intent to be open and transparent in how we work together and to be focused on securing health gain for our populations. The agreed principles to co commissioning are:

- We encourage provider led innovation by mobilising clinical excellence to improve standards and share best practice.
- We commit to being transparent in decisions, listening & being openly accountable to local people.
- We design governance arrangements to ensure conflict of interest is managed.
- We move money for the benefit of patients.
- We are prepared to introduce flexibilities in contractual regulation and resources.
- We intend to reduce health inequalities & variation in practice.

There are varying approaches adopted within each area to reflect our local modus operandi, however, there is a strong alignment in our strategic commissioning aims; significant similarities in our work with the Local Authorities on the Better Care Fund/ Integrated Commissioning; and consensus on the need to tackle health inequalities in a way which improves health for all citizens - all of which signal the need for a strong, vibrant primary care sector playing a key role in their communities in the delivery of new models of integrated care.

In entering into a co-commissioning arrangement we intend to have increased influence over and input into the full range of NHSE primary care responsibilities, and specifically wish to secure an early joint commissioning arrangement, pooling budgets where it is in the best interest of our patients, with NHSE to:

- develop a 'core+' contract, which complements national and local enhanced services in a more integrated way

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- seek delegated authority for patient facing DESs
- ensure a single coordinated approach to the overseeing of the primary care quality agenda, with local action and commissioning decisions taken where possible and appropriate
- develop, with other key organisations, a coherent workforce development and redesign strategy
- agree, and secure funding for high priority premises developments, entering into a risk sharing arrangement if necessary
- develop a comprehensive strategy to maximise the opportunity presented by technological advances in primary care
- establish appropriate joint governance arrangements which ensure transparency, and provide the ability for a local community to see assurance or support regarding potential conflicts of interests, whilst recognising the need for localism within each CCG area.

Adopting a genuine co-commissioning approach provides an opportunity to break down many of the barriers within the current system and will provide support the BCF objectives and ambitions by enabling a whole system approach to health and care.

Our integrated health and care commissioning will increasingly require an integrated provider response to include:

- Helping people live longer, healthier and independent lives
- A consistent offer to citizen and patient
- To have citizens and patients involved in the process of prevention and care
- To maintain a stable, publicly funded physical and mental health and wellbeing prevention and care system.

General practice will be at the centre of this approach, coordinating care for their patients, with other community services organised around practices and practice networks to create an extended and 'bigger' primary care offer. A genuine alignment of the community-based health and care budgets will assist this.

The co-commissioning of health and care services with local authorities clearly strengthens the commissioning power of each organisation. The co-commissioning of primary care offers potential to strengthen this commissioning power further.

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7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

The 'Stronger Barnsley Together' programme will seek to achieve a step change and strategic shift from the current approach to health and social care with greater focus on prevention and early intervention, enabling residents to support themselves and their families within their communities rather than being drawn into the formal system. This moving forward will allow the limited resources across a joint health and social care system to be focussed on those with greatest need and build on the success of personalisation and self-directed support.

In respect of the BCF, we define protecting adult social care in Barnsley as being about maintaining or improving the outcomes of those people who require care services. It is not necessarily about maintaining current levels of expenditure or current models of delivery.

The intention is to retain the support currently provided via the S256 grant funding, plus we are taking a range of actions to improve efficiency and reduce costs and to protect peoples access to care and support through the future operating model, review of assessment and care management, Universal Information and Advice, Rightcare Barnsley, the Intermediate Care Review and the cessation of some contracts / services, including withdrawing social care funding from some none mandatory joint services etc.

However despite all these measures being implemented to dampen demand and address demographic pressures, plus a cash reduction in expenditure there remains a significant financial gap faced by social care in 2015/16 and therefore the local health and well-being system which is likely to impact on current levels of service provision.

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

Adult Social Care has identified savings of £1.2m against the current funding gap of £9.5m resulting in a gap to find of at least £8.3m. Assuming a further £0.6m is delivered as part of the Future Council strategy for non-social care services this reduces the final gap for Adult Social Care to £7.7m

This position assumes that all the Health funding currently transferred to the Council, which from 2015/16 forms 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.

The main programme in the Better Care Fund from a Social Care perspective is a revised Social Care operating model moving the focus to early intervention and prevention; and

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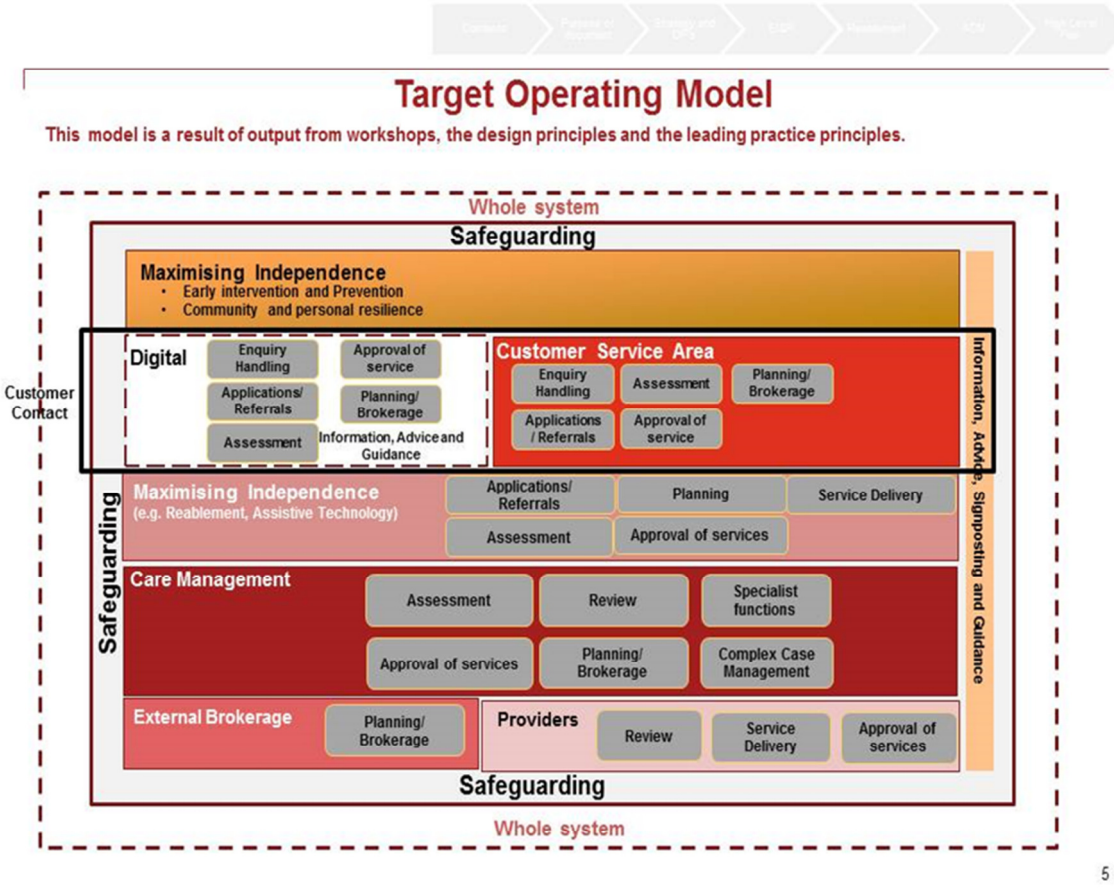
community asset building as set out in the vision for health and care services under the 'inverted triangle model. A target operating model has been established including a number of programmes which will turn this into reality as set out below, which is estimated to deliver savings of £2.4m over the two year 2015/16 – 2016/17.



This project is initially estimated to deliver savings of £1.2m in each of the two financial years 2015/16 – 2016/17 (£2.4m in total against the funding gap). The outcomes of the revised pathways and other interventions is a forecast reduction in the average cost of care in Learning Disability of 2.5% and creation of a diversion from care of older people of 5%. This impacts on the demographic model as set out in the case for change as follows:

Re-modelled Assumptions based on Transformation and Target Operating Model									
Activity	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Learning Disability	660	698	732	774	813	853	896	941	988
Older People	2,353	2,224	2,164	2,215	2,217	2,219	2,221	2,223	2,225
Physical Disability	221	207	202	205	206	206	207	207	208
Mental Health	na	na	na	na	na	na	na	na	na
Total Activity	**3,234**	**3,129**	**3,098**	**3,194**	**3,235**	**3,279**	**3,324**	**3,371**	**3,421**
Expenditure	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Learning Disability	15,838	17,229	18,469	20,069	20,546	21,034	21,533	22,045	22,568
Older People	19,893	19,001	19,057	18,865	18,883	18,900	18,918	18,935	18,953
Physical Disability	2,891	2,940	3,063	3,043	3,051	3,059	3,067	3,075	3,083
Mental Health	na	na	na	na	na	na	na	na	na
Total Expenditure	**38,622**	**39,170**	**40,589**	**41,977**	**42,479**	**42,993**	**43,518**	**44,055**	**44,604**
Cost Pressure					**502**	**513**	**525**	**537**	**549**
Cumulative					**502**	**1,016**	**1,541**	**2,078**	**2,627**

The other key Social Care scheme within the BCF plan seeks to reduce demand for Residential Care through ensuring adequate alternative services are available and people are placed accordingly, saving an estimated £0.3m. This is part of a wider project being undertaken within the Council considering the cost of care; quality of care; and appropriateness of care.

In order to meet the remaining budget reductions the Council could only realistically consider reductions in areas that the Council has no direct statutory responsibility for but which would be likely to have significant impact across the whole Health and Social Care system. Savings currently being proposed are:

- Implement revised model for the delivery method for undertaking Medication Checks £0.5m
- Cease Intermediate Care Beds (30 Beds) £0.8m
- Cease contribution to SWYPFT for Hospital At Home £0.2m
- Reduction in Mental Health contract with SWYPFT £0.5m

The impact of all these reductions is to reduce the financial gap facing social care from £7.7m to £3.3m (£2.8m in 2015/16). The Council will do what it can to manage care costs within the available funding however this remains a significant financial risk to the Council given the previous actions taken to meet funding reductions in previous years as set out in the case for change.

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As things stand the only realistic means of meeting this gap is to manage the numbers of people receiving the care they need, e.g. via managing referrals to budget, which in real terms will mean stacking cases and delaying putting packages of care in place for people; and prioritising the care packages which we are able to fund targeting those at greatest risk. It is likely this would have a significant detrimental impact in terms of the overall system with an increase in hospital admissions, and delayed discharges, all of which is against the current strategy.

In addition to the risks of this remaining financial gap there are risks that the £2m proposed savings above may also be detrimental to the wider health and social care system potentially creating a risk to the deliverability in terms of reduced admissions into the acute sector. The stopping paying for intermediate care beds will potentially impact on approximately 450 episodes of intermediate care of which approximately 180 episodes are currently step up. This could have an impact on the numbers in A&E, and potential increases in delayed discharge from hospital.

In order to protect social care in the medium to longer term a joint service planning process is being 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 considering 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 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.

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

In total £10.055m of the BCF funding will be allocated for the protection of Social Care services for:

- Intermediate Care £3.295m
- Maintaining Eligibility Criteria £4.745m
- Disabled Adaptations £1.326m
- Social Care Capital £0.690m

The funding is not allocated to one individual scheme but considered against the suite of services currently required across a joint health and social care system, whereby the funding is used in the most effective way to benefit that whole system approach. Through joint service and financial modelling the use of the funding may change as the model of health and social care changes.

A significant element is being used to maintain existing eligibility criteria for people in

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receipt of social care services in light of the significant funding reductions the Council has had to manage year on year and the demographic pressures associated with an ageing population and the significant increase year on year of people with complex learning difficulties.

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

The new duties for adult social care set out in the Care Act provide a more solid legal platform for the whole system transformation in Barnsley set out in this document. Our intention to revise and integrate the care pathway with a stronger emphasis on universal information and advice, self-care/self-management, early intervention and prevention and personalised services for those who need ongoing care, is entirely in tune with the requirements of the Care Act. Indeed we see our plans for delivering whole system transformation as the means to meeting the requirements of the Act.

Schemes set out in this plan are only part of the broader picture of whole system transformation (including plans of our main providers) but a number of BCF schemes have a clear read across to the Care Act:

- Intermediate Care Review –preventing, reducing or delaying needs (secondary and tertiary prevention)
- Personal Health Budgets – personalised care and support planning, integrated care
- Be Well Barnsley – promoting wellbeing, preventing, reducing or delaying needs (primary prevention)
- Residential care – market shaping, preventing, reducing or delaying needs
- Social Care Target Operating Model – will provide a revised structure, system and processes for Assessment and Care Management to meet many of the requirements of the Act – promoting wellbeing, preventing, reducing or delaying needs, information and advice, assessment and eligibility (including carers) care and support planning, personal budgets/direct payments, reviews, safeguarding

Within our BCF allocation we have identified £0.700m of recurrent funding to support implementation of the Act. This will be used for:

- Increased rate of carer assessments and provision of support to meet any needs arising therefrom
- Extending our Universal Information and Advice offer
- Providing access to advocacy for those who need it
- Additional capacity to undertake safeguarding investigations
- Ensuring we are able to fully meet revised national eligibility criteria
- Additional commitments arising from the care cap in year 1

An Implementation Board has been established to oversee and coordinate progress with the Act although, in the main, the work is being delivered through existing projects and structures. Dedicated project management resources have been sourced to support the effort.

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

In total £0.761m of the BCF funding will be allocated for dedicated carer specific support.

This has been considered alongside the current Carers strategy which has been jointly produced by the Council and its health partners to re-affirm a shared commitment to continue to seek out and improve the lives of carers.

The strategy includes the following key aims:

- To improve and sustain the health, emotional and economic well-being of carers.
- To help carers enjoy and improve their quality of life and achieve better satisfaction through increased choice, control and life chances.
- To provide systems and services so that Carers can stay safe, maintaining their dignity and respect and increasing their freedom from discrimination or harassment.
- To enable Carers to make a positive contribution to their local communities and to be involved in decision making in the development of policies and services.

In addition to the Councils existing support to carers the BCF funding will be specifically used for:

- Support to Carers including respite care
- Funding for Carers groups

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

The Local Authority's budget has not been affected against what was forecast in the original BCF plan

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b) 7 day services to support discharge

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

There are already many health and care services that operate on a 7 day model however in recognition of the need to extend this further if we are to provide effective, system wide services, the Health and Well-being Strategy and the CCG strategic commissioning plan have clear strategic commitments to 7 day working and 7 day 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.

Approximately £3m has been committed through the Better Care Fund in 2014/15 with further investment in 2015/16 to support the development of a whole system approach to 7 day working from primary to secondary to community and social care with a view to supporting a reduction in emergency admissions and quicker discharge from hospital where appropriate. The investment will also support us to meet the expectations set out on the 10 'Keogh' Standards to improve 7 day services.

In anticipation of this direction of travel during 2013/14, BHNFT has made progress in establishing 12/7 services including: 12/7 extended AMU Consultant cover, 12/7 extension of Imaging/Radiology services, 12/7 Pharmacy ED & AMU and 12/7 Therapy services. 7 Day Services at BHNFT is expected to; improve the discharge pathway, reduce patient mortality rates, improve patient satisfaction and maximise efficient patient flow, thereby aligning with the operational and strategic intentions of BHNFT, BCCG and NHS England. The investment in 2014/15 builds upon this by extending the funding of additional capacity.

In 2014/15, through contracting processes there is CQUIN in place which requires BHNFT to have an action plan in place to deliver the clinical standards and in 2015/16 those clinical standards which will have the greatest impact will be included within the NHS Standard Contract. In 2016/17 it is envisaged that all clinical standards will be incorporated into the NHS Standard Contract.

South West Yorkshire Partnership NHS Foundation Trust have also undertaken a review against the standards to ensure their ongoing transformation programme includes the changes required to

In addition, work is ongoing to implement 7 days working across the health and care system including within the Community and in Social Care.

The use of operational resilience funding has enabled the Barnsley System Resilience Group to support a number of initiatives which will increase capacity and enable 7 day working across the system: The schemes supported in 2014/15 which will increase capacity and enable working seven days a week include:

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- 7 day access to the Independent Living at Home Service (Re-ablement)
- Increased Social Work capacity including within the hospital to support discharge
- Assistive Living Technologies (Reduction in residential care admissions)
- Increased capacity in community nursing and intermediate care
- Increased capacity for mental health assessment
- Extended Therapy Services

In order to ensure that a whole system approach, across the health and care system, to 7 day working is established in line with national standards and local strategies, further detailed work will be taking place during 2014/15 to refine the current models and ensure best use of resources and long-term sustainability.

Engagement through the Health and Wellbeing Board will support the agenda and ensure an integrated and co-ordinated approach which focuses upon unblocking parts of the patient pathway and enabling the development of an integrated 7 day service model.

c) Data sharing

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

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.

There has already been extensive work undertaken to capture the NHS Number across the adult social care systems, with the Barnsley Council adult social care team having worked in collaboration with Liquidlogic (Adult Social Care System) between 2010 and 2012, as part of the Common Assessment Framework initiative to integrate with the Patient Demographics Service (PDS) of the NHS Spine.

The development undertaken through the common assurance process with NHS Connecting for Health enables Barnsley to match a person's NHS and social care record through the NHS number validation against the PDS on the NHS spine. Barnsley's social care workers and care practitioners are able to validate in real time, an individual's NHS Number on their social care record against their health care record.

The Jontek (Telecare) system holds 7,000 service user records with 85% currently detailing the NHS number. This has been enabled through the NHS Data Matching Service. The Independent Living at Home Service is keen to build from this foundation

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have developed a business process that ensures that the NHS Number is captured during all service establishment visits for new service users.

The CACI (Re-ablement) system holds on average 150 service user records at any one time due to the nature of this short term intervention service, which is part of a wider integrated intermediate care model. The NHS Number is captured from the new service referral forms received from social work practitioners, hospital therapists and GP Practices and entered into the system as part of the new service establishment process.

Barnsley will undertake a thorough review of the current processes which both capture and maintain the integrity of the NHS Numbers across the three primary social care systems, given the importance of this unique identifier. The deployment of Lorenzo at the hospital delivers a fully spine complaint system.

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.

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

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 deliver 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.

The Health & Wellbeing Board supported by approved match funding of £500,000 from the CCG, are sponsoring a joint application between Barnsley Hospital NHS FT and Barnsley Council Adult Care Services to the Integrated Digital Care Fund.

We recognise that one of the key assets for a sustainable integrated health and social care model is the provision of interoperable systems and workflows between services relating to patients and service users health and social care history, with clinicians having the right access to the right information at the right time.

Effective patient centred information sharing including the types of community services being received provides an environment for intelligence led decisions leading to safer more efficient interventions aimed at providing the best possible service outcomes.

Proactive and informed decision making helps support prevention and independent living, builds service capacity through alignment of resources across agencies, leading to a more efficient sustainable model of care.

The application and subsequent funding if successful is seen as one of the key enablers to delivering our BCF ambitions, aimed at reducing the number of Hospital admissions

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and facilitating earlier discharge with particular emphasis on hospital clinicians having the right access to the right information at the right time on the community care services being received by patients along with the types and history of care delivered.

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

Appropriate IG controls are in place across the health and care systems with all individual health and social care agencies operating in line with the Information Governance Toolkit.

We work closely with the Health and Social Care Information Centre, Data Services for Commissioners in collaboration with the West and South Yorkshire Commissioning Support unit to ensure that data flows are in line with Caldicott 2 and other legislative requirements and we have a number of data sharing and data processing agreements in place.

There are however still IG associated challenges in delivering integrated working especially in relation to shared data and shared systems.

Our plans to deliver interoperable health & social care systems which provide the right access to the right information at the right time will incorporate the Section 251 initiative developed nationally by NHS England as part of the Pioneer Programme for Integrated Care and Support, The initiative will……..

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

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

As part of our whole system transformation programme we will be further developing our Integrated approach to assessment and 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 an established system of risk stratification in place to identify those patients at high risk of hospital admission enabling GP's to work in a proactive and preventative way with these patients to manage their care in line with the DES.

Through the review and re-specification of intermediate care services on a pilot basis from 2015/16 there will be a single process of assessment for Intermediate Care pulling together the currently fragmented approach to assessment.

The Rightcare Barnsley project will improve co-ordination, assessment and care management by reviewing all cases and seeking to identify improvement to streamline

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the referral and assessment pathways.

A key strand of activity which will build on the key role currently played by GP's in relation to being accountable for patients and assessing their care needs is the House of Care Model which is being developed as part of the Primary Care Programme. This will begin by focusing on those people with Long Term Conditions

Care planning is a powerful way of creating an environment which helps clinicians to support self-management by patients of their own LTC. This means supporting people to understand and confidently manage the condition itself, plus also supporting them to manage the inevitable consequences of living with one or more LTCs, consequences for the way they live their lives (their roles and responsibilities) and the way they think and feel about themselves and their relationships.

At a recent Primary Care Commissioning Workshop a National Policy Lead for LTCs emphasised the "House of Care" approach of health and care professionals working in partnership, patient centred coordinated care, informed carers and good commissioning as an exemplar. He stressed the importance of personalised care plans and reported that there would be a target that from 2015 everyone with a LTC is to have a care plan. Nationally only 10-15% of patients have one now. The Year of Care model has been developed over a number of years and in diverse communities. The approach is an evidence based way of implementing collaborative care planning in a primary care setting.

There is good evidence that the care of people with LTCs can be improved, for example, personalised care planning by 2015 is a national priority and only 5 to 10% of LTC patients have a care plan and these are of variable quality. National information states patients say that they want the NHS to do more to support their own self-care. However the evidence also tells us that this is not happening. While 95% of people with diabetes, are seen annually, only 50% discuss a plan to manage their diabetes and less than 50% discuss their own goals for self-management.

It is proposed to undertake a staged implementation of the Year of Care approach to care planning for people with LTC starting with those patients that have diabetes in 2014/15. In subsequent years it is envisaged that practices will extend the Year of Care approach for all patients with a LTC.

The Year of Care (House of Care) model (YOC) is about making routine consultations between clinicians and people with LTCs truly collaborative through care planning. To ensure effective care planning can occur key things need to be in place, including health care professionals committed to partnership working, an engaged and informed patient and organisational processes that facilitate and enable care planning.

The objectives and outcomes of implementing the approach are expected to be:

- Patients with Diabetes are being diagnosed promptly, getting early treatment and this is making a real difference in Barnsley by improving quality of life, reducing hospital admissions and saving lives
- Patients are positive about having had the right amount of involvement in their care
- 95% patients have at least one annual care planning consultation
- 95% patients had the three 'traditional' components of diabetes care

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- 35% of patients with 'good' control of all three indicators
- 70% of patients having had all 9 NDA items measured in previous 15 months

The benefits will be:

- People with diabetes report improved experience of care and real changes in self-care behaviour
- Professionals report improved knowledge and skills, and greater job satisfaction
- Practices report improved effectiveness, organisation and team work
- Productivity is improved: care planning is cost neutral at practice level: there are savings for some
- Care planning takes time to embed: changes in clinical indicators across populations may be seen after two or three care planning cycles

The proposal for the Year of Care approach links to the Admission Avoidance DES being rolled out by NHS England supported by the CCG through the unplanned care programme board. Practices are reporting that the risk stratification element is quite onerous. Better care planning through the year of care model would support practices with the DES and could improve the utilisation of the Sound Doctor scheme so would be moving this initiative further forward faster and smarter.

This scheme presents an ambitious approach and will result in significant change and improvements in General Practice culture.

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

GP Risk Strat
Intermediate Care
Primary Care Strategy

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

Which Services currently have joint care plans
Where is care planning co-ordinated

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8) ENGAGEMENT

a) Patient, service user and public engagement

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

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 on the 5 Year Strategic Commissioning Plan was undertaken inviting views on the priorities for health in Barnsley. This included 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.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

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

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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.

ii) primary care providers

Our integrated health and care commissioning will increasingly require an integrated provider response to include:

- Helping people live longer, healthier and independent lives
- A consistent offer to citizen and patient
- To have citizens and patients involved in the process of prevention and care
- To maintain a stable, publicly funded physical and mental health and wellbeing prevention and care system.

General practice will be at the centre of this approach, coordinating care for their patients, with other community services organised around practices and practice networks to create an extended and 'bigger' primary care offer. A genuine alignment of the community-based health and care budgets will assist this.

Primary Care have therefore been heavily engaged and involved in the work that has taken place to develop our proposals for co-commissioning and develop the Primary Care Development Programme which will be key in supporting the system wide transformation we aspire to.

As referenced throughout the BCF plan, we do not see the BCF as a standalone initiative, it is a strand in the delivery of our wider plans and strategy in which primary care were engaged in the development through a number of events with the CCG Membership Council and Governing

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

The Local Authority as social care providers and commissioners have been engaged as part of the H&WB Board and working group.

Discussions have been held with the Health and Wellbeing Provider Forum to ensure the voluntary and community sector are aware of the BCF, and have the opportunity to contribute towards improving health outcomes and delivery of the BCF objectives around hospital admission, reducing permanent admission to residential homes, reablement and helping people to manage their long term conditions.

Healthwatch Barnsley is a full member of the local Health and Wellbeing Board and has been party to discussions throughout the development of our BCF plan as part of that role. Barnsley has a well established structure of 'Expert Partnership' partnership groups based around specific client needs (including carers) and whilst these have not been specifically part of the BCF process they are kept fully appraised of/involved in developments across the health and social care agenda.

c) Implications for acute providers

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

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

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"

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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 Practitioners
- National and local commissioning / contract standards (especially specialist commissioning)

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

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ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Rightcare Barnsley
What is the strategic objective of this scheme?
The key outcomes for the service are that: • Patients are given access to the right care, in the right setting at the right time • Patients are not kept in hospital for longer than necessary The aims of the service will be: • To facilitate the provision of the right care, at the right time, in the right setting, for the benefit of the public and patients. The Objectives are: • To identify and facilitate access to suitable alternative services, to a hospital admission, that will meet the needs of the patient • To provide a point of access to support hospital staff to discharge patients from hospital at the right time with the appropriate level of ongoing care and support
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Rightcare Barnsley service will : • Be a single unit staffed by Registered Nurses with significant clinical experience** • Have good IT systems with access to various databases and information systems in both health and social care • Be contactable by phone and other media methods - 7 days a week - hours dependent on evidence base of demand • Have detailed knowledge, referral mechanisms and algorithms to a range of community and hospital based services and can negotiate the best same day option for care **The providers will ensure that patient safety and safeguarding standards are followed and that the Nurses providing the service are competent practitioners who have the ability to manage risk by securing the appropriate service. The service will be led by a Service Manager supported by 6 x band 6 Nurse Practitioners and 1 x band 3 administrator.

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The service will be aimed be available to support medical patients aged 18 and above who are at risk of a hospital admission and medical patients requiring a package of care to be in place before being discharged from hospital

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

The service is being commissioned by Barnsley CCG on a 12 month pilot basis utilising a alliance style contract to work with the current acute and community providers in Barnsley to establish the service and evaluate the success. The pilot will inform future commissioning decisions

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Emergency admissions and subsequent re-admissions of people with chronic and complex health needs are a major cause of cost within the UK health system.

Reducing avoidable hospital admissions, re-admissions, reducing the length of stay in hospitals and improving the coordination of care are national priorities for the NHS, to help improve health outcomes for patients and to reduce health care costs.

It is estimated that by 2025 the numbers of people with long term conditions will rise to approximately 18 million.

This will have a direct impact upon the taking up of:

- Over 50% of all General Practice appointments
- 65% of all hospital out-patient appointments
- Over 70% of in-patient bed days
- 70% of the total health and social care spend in the UK

Barnsley has high levels of deprivation and although some improvements have been made in recent years, some individuals and communities continue to make high risk lifestyle choices that will impact on their future health outcomes and needs.
Barnsley still has higher than national average levels of smoking, alcohol intake and low levels of physical activity and healthy food choices, leading to: obesity, diabetes, heart disease, COPD, dementia, mental health problems and some cancers (JSNA 2013).

The proportion of Barnsley residents living with a limiting long term illness is 24.4%. This is significantly higher than England's average of 16.9%. This has a direct correlation to the increased health need in our population.

Our population continues to grow, and in particular, we have a growing elderly population. By 2021, 20% of Barnsley's population will be aged over 65 years; the elderly population is growing at a rate of 3% per year. Although life expectancy has

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improved, not all the added years to life are enjoyed in good health and we still have major issues in relation to disease prevalence and the requirement for care for people with complex health and social care needs.

In 2013, there were 7003 admissions to Barnsley Hospital NHS Foundation Trust (BHNFT) of patients with a diagnosis of the top 5 long term conditions (LTC) of: asthma, COPD, CHD, diabetes and stroke.

Not all of those admissions were as a direct result of an exacerbation of their LTC, but many were due to co-morbidity and complexity of health need issues. The cost of these admissions was £14.2 million.

Investment requirements

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

Impact of scheme

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

Feedback loop

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

Robust monitoring arrangements will be established in order that the CCG can come to a view as to the value of the investment required over a period of time. Monitoring arrangements would mean establishing data at the patient level that could then be analysed more broadly.

This as a minimum will include:

- Patient demographic and personal details
- GP
- Whether they were admitted during the previous 7 days
- Where they were referred to and the outcome of that referral
- Whether a hospital admission was averted
- Primary, secondary and subsequent diagnosis
- Pathway
- Whether they were admitted out of hours
- What alternative provision was considered and then rejected

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

Agreement of specification and contract by providers
Recruitment to the Rightcare Team
Access to patient information from a range of systems
Engagement in the new service by GP's

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Scheme ref no.
Scheme name
Virtual Ward
What is the strategic objective of this scheme?
To provide a proactive case management approach to supporting people at the highest risk of admission/re-admission to hospital with intensive multi-disciplinary care and care co-ordination within their home environment, that supports the pathway to recovery and improved self-management. **Objectives:** • To provide care closer to home for the patient • To co-ordinate care around the individual • To actively stabilise patients to be supported to be discharged from the virtual ward • To embed new approaches such as the concept of Social Capital and Social prescribing to support self-directed care and maximise independence • To re-shape community services working more closely with GPs • To drive the delivery of High Performing Teams • To improve co-terminosity across agencies and the 38 GP practices • To reduce variation and inequalities of service delivery • Facilitate faster and higher quality referrals between key organisations • To provide seamless services across a range of health, social care and community and voluntary organisations • To provide a flexible service that can respond to fluctuations in demand • To provide 24/7 access to services where required • To improve communication links across all partners • To improve interface with primary, community, secondary and social care • To use technology to maximum effect • To support independent living at home • To assist in early intervention **Outcomes:** • Improved patient health and social care outcomes • Improved productivity and efficiency in community services • Increase in numbers of patients determining their own care and support needs • Reduced duplication • Reduced health inequalities • Reduced number of GP home visits • Reduced pharmaceutical waste • Reduced transfers of care • Reduced growth in ambulance transfers • Reduced growth in attendances at Accident & Emergency • Reduced growth in unplanned hospital admissions & re-admissions • Reduced hospital length of stay • Reduced Admissions to Care Homes

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

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

This will be how we integrate, co-ordinate and deliver services and will be the starting point and mechanism of how we integrate physical health services, mental health services, memory services, health & wellbeing services, primary care, aspects of secondary care, social care and the wider community around client groups and drive the delivery of High Performing Teams, the local CQUIN in development would facilitate this approach.

Whilst it's envisaged the management of virtual wards will be hosted with Community Services, there is recognition that in order for virtual wards to be successful and deliver the desired outcomes, other local health, social care and community organisations need to be involved and be partners in the process.

This whole systems health and social care approach to virtual wards across all areas should ensure a proactive, seamless and coordinated approach to patient care, improving patient experience and improving efficiencies across local health and social care services.

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

The Virtual Wards are likely to operate using the systems, staffing and routines of a hospital ward without a physical ward building, a ward with no walls.

Patients will be selected for virtual ward admission based on the predictive risk tool score in primary care, GP clinical judgment and using the LACE tool in secondary care, those at high risk of hospital re-admission at discharge. These patients will be given intensive preventative care in the community in order to prevent an unplanned hospital admission

In the model an advanced practitioner (Care Co-ordinator) will have a dynamic case finding role and whose purpose will be to co-ordinate the holistic needs of complex patients with multiple long term chronic conditions or patients that have had multiple unplanned hospital admissions after carrying out a single assessment.

This links directly into the current 'Operating Framework for Long Term Conditions' and would give the ability to transform current complex staffing model at 'High' (Red) and give an increased flexibility to continue to transform services at the 'Medium' (Amber) and 'Low' (Green) levels of complexity. This would enable a 'Key Worker' approach at this level and would improve the business continuity of services provided to patients with complex needs in a more integrated way.

The advanced practitioner (Care Co-ordinator) will work closely with the virtual ward clerk/liaison officer who will be responsible for co-ordinating all meetings and associated

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documentation of the virtual ward e.g. minutes, action plans and up to date risk tool data. This will also involve building close working relationships with GP practices, secondary care, social care and wider community colleagues ensuring the delivery of practice based MDT meetings. This role has been replicated in other areas that have adopted and implemented virtual wards successfully. The role will be pivotal in ensuring virtual wards function efficiently as well as leading the way in embracing a community development approach to ensure success.

Each virtual ward will have the same shared governing arrangements, these include:

- Advanced practitioner (Care Co-ordinator) provides an in-reach service to GP practices, working in partnership utilising the chosen risk stratification tool to help identify high risk patients
- GPs, using their clinical judgment, can refer directly into the virtual wards.
- BHNFT using the LACE tool can refer patients into the virtual ward who may be at risk of re-admission
- The advanced practitioner visits the patient to obtain consent for information sharing and carries out the initial comprehensive single assessment
- Virtual ward rounds will be held daily, weekly, monthly as appropriate to need, these may be facilitated by tele or video conferencing
- A holistic electronic single care plan will be initiated for all patients accessing the virtual ward
- Each patient will be assigned a key worker from within the virtual ward (this is based on the needs of the patient and mutual agreement amongst the virtual ward members)
- Advanced practitioner (care co-ordinator) and the ward clerk provide the interface between the virtual ward members and GP practices, providing communication and feedback
- There will a nightly automatic update with out of hours providers, ambulance service and the local hospital with an automatic alert should patients present to these services
- There needs to be an understanding and recognition that in some cases hospital admission will be necessary
- Discharge will be facilitated and planned when the risk or need decreases and decided at the MDT meetings collectively
- All patients (where applicable) will be referred to Telehealth/care navigation service for health coaching, motivational interviewing as part of their core care plan.

The Long Term Conditions Operating Framework should provide a platform for virtual ward members when deciding on the level of intervention each patient requires. This should be used at every virtual ward meeting when discussing patients as their condition could remain stable as much as it could improve or decrease, requiring less or additional intervention respectively.

In order to sustain the input and quality improvement patients will have experienced via the virtual ward program, assurances and control measures should be established. One mechanism available is telehealth/care navigation service that would be responsible for contacting and interacting with patients post-discharge from the virtual ward. The frequency of this interaction between the patient and telehealth/care navigation service is not pre-determined and is again based on patient need utilising the Long Term

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Conditions Operating Framework.

The virtual wards will be based in the community setting and will be permanently linked to a cluster of GP practices. This way virtual ward members will form excellent working relationships with primary care colleagues. Patients are selected from participating GP practices only and will keep their existing GP practice. As highlighted above the advanced practitioner will provide the important communication and feedback, ensuring all GPs and key stakeholders are kept abreast of developments.

The evidence base

Please reference the evidence base which you have drawn on

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

Emergency admissions and subsequent re-admissions of people with chronic and complex health needs are a major cause of cost within the UK health system. Reducing avoidable hospital admissions, re-admissions, reducing the length of stay in hospitals and improving the coordination of care are national priorities for the NHS, to help improve health outcomes for patients and to reduce health care costs.

It is estimated that by 2025 the numbers of people with long term conditions will rise to approximately 18 million. This will have a direct impact upon the taking up of:

- Over 50% of all general practice appointments
- 65% of all hospital out-patient appointments
- Over 70% of in-patient bed days
- and 70% of the total health and social care spend in the UK

Barnsley has high levels of deprivation and although some improvements have been made in recent years, some individuals and communities continue to make high risk lifestyle choices that will impact on their future health outcomes and needs. We still have higher than national average levels of smoking, alcohol intake and low levels of physical activity and healthy food choices, leading to: obesity, diabetes, heart disease, COPD, dementia, mental health problems and some cancers (JSNA 2013).

The proportion of Barnsley residents living with a limiting long term illness is 24.4%. This is significantly higher than England's average of 16.9%. This has a direct correlation to the increased health need in our population.

Our population continues to grow, and in particular, we have a growing elderly population. By 2021, 20% of Barnsley's population will be aged over 65 years; the elderly population is growing at a rate of 3% per year. Although life expectancy has improved, not all the added years to life are enjoyed in good health and we still have major issues in relation to disease prevalence and the requirement for care for people with complex health and social care needs.

People with long term conditions of any nature are the most frequent users of health and social care and commonly suffer with mental health problems such as, depression, anxiety and dementia. This is also true in reverse that many people with mental health

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problems suffer from other co-morbidities of a physical health nature. As a result of these complex co-morbidities their quality of life can deteriorate rapidly and there is an increased need for multiple service input.

In 2013 there were 7003 admissions to Barnsley Hospital NHS Foundation Trust (BHNFT) of patients with a diagnosis of the top 5 long term conditions (LTC) of: asthma, COPD, CHD, diabetes and stroke.

Not all of those admissions were as a direct result of an exacerbation of their LTC, but many were due to co-morbidity and complexity of health need issues. This was at a cost of £14.2 million.

In the current virtual ward model in BHNFT, the average length of stay in a controlled group of patients who were admitted was 10.1 days. An improvement has been seen where patients have been identified by the LACE tool in secondary care and a more bespoke care package put together with community services for improved discharge. This has improved the length of stay which is now down to 8.7 days. The re-admission rate has also reduced by following this model.

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

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

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

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

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Scheme ref no.
Scheme name
Intermediate Care Review
What is the strategic objective of this scheme?
The Intermediate Care Review will lead to the development and implementation of a new specification for Intermediate Care. The aims of developing this new specification are: 1. To commission a single co-ordinated intermediate care service for the population of BMBC and BCCG. 2. To maximise the use of resources available. 3. To commission a focused service in a personalised way for individuals including culturally appropriate services. 4. To commission intermediate care as a single episode of care with access to 24 - hour beds if needed. The provider (providers) will be responsible for flow through the system based on a cost per episode model rather than multiple teams and beds being commissioned separately. 5. To commission an equitable service, 24 hours a day, 7 days a week that provides assessment, treatment and/or rehabilitation for people who need an intervention not available through other community services. 6. To commission a service which prevents inappropriate acute hospital admissions and facilitate the earliest discharge possible. 7. To commission a service which has a clear single set of quality and impact measures which can be used to understand if the service is driving up quality and having impact on the wider health and social care system. 8. To ensure that all people who meet the criteria for intermediate care receive an episode of care prior to referral for potential Continuing Health Care or Local Authority funded individual package of support or a self-funded long term care package. 9. To create a single leadership system, responsible for the delivery of intermediate care and to enable a range of providers to work together to deliver high quality outcomes for the individual using the service, people working in the services and the public purse.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Intermediate Care service will be time limited (likely to be 6 weeks) with the potential for many people to be discharged earlier. On occasion there may be benefit in working with someone for a slightly longer period of time. The lead provider will be responsible for flow in the system. The service will deliver a 24-hour episode of assessment, treatment and/or rehabilitation that addresses a recognised health need and includes the intervention of at least two

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qualified healthcare practitioners and/ or social care practitioners. There may be rare occasions when only one profession is required but this should lead to the question can the person be discharged into another part of the integrated health and social care system now?

The balance of home /bed based support will be determined by the lead provider for intermediate care services who should consider the balance /range and cost of available 24 hour beds within the locality.

The use of bed based services is likely to be for those people who initially need a level of observation, and support and continuous care at all times not available through a home based package. An episode of care may start in a bed based service and continue at home but should usually be no longer than 6 weeks in total. Bed based services should as a principle, be commissioned on a volume basis, with some flexibility retained in the resource envelop for additional capacity. As an indication only, based on the national intermediate care audit figures, we are proposing around 26 beds per 100, 000 population should be considered. For Barnsley this will mean having access to approximately 65 Intermediate Care beds.

The service will include a mixture of residential and 24-hour nursing beds with medical oversight, spread across the locality with a minimum of 4 but preferably more beds able to support people with cognitive challenges needing expert support.

The provision of 24 hour bed based services will be provided in an environment that meets CQC standards for residential and/or nursing home or community hospital care including for people with dementia if this is the most appropriate.

Other health /social care disciplines must be involved in the delivery of the service.

The provision of 24 hour home based support will be led by the most appropriate health or social care practitioner and will meet CQC standards for community and /or domiciliary care provision.

Where an element of the service is provided by an independent or voluntary sector provider the provider must be on the 'approved provider list' for the commissioning community.

The service will focus on active treatment and therapeutic intervention defined through an outcome based care plan agreed by and with the individual and/or their primary carer.

The care plan will be written in language understood by the individual and/or their primary carer.

The National Institute for Health and Clinical Excellence (NICE) have produced a number of guidelines on rehabilitation pathways for people.

The Intermediate Care service should understand these guidelines, but recognise that the pathway for different specific condition- based needs will extend beyond the scope of this episode of care.

For the purposes of this service rehabilitation is defined as 'an active, time limited

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collaboration of a person with disabilities and professionals along with other relevant people, to produce sustained reductions in the impact of the disease and disability on daily life, interventions focus on the individual, on the physical or social environment or a combination of both' (Royal College of Physicians 2010.)

Individuals will receive specific interventions overseen by a combination of skilled nursing, therapy, social services input on a 24 hour, 7 day a week basis with medical practitioner oversight as defined by the assessment and care plan.

Following admission into the service the individual's care the Multi-Disciplinary Team (MDT) will agree plan within 24 hours and a lead care practitioner identified.

The service will be measured on individual episodes of care completed and the provider (s) of service will be asked to deliver on an agreed cost/activity matrix.

Each episode of care will be individual but the service must be able to provide:

- Oversight by a senior clinician
- Nursing
- Occupational therapy
- Physiotherapy
- Social work
- Pharmacists
- Health care assistants and care workers
- Some staff working in the service should have expert knowledge to support people with mental health needs, dementia and people with learning disabilities.

As well as access to other disciplines, including the integrated community equipment service.

The overall qualified/unqualified ratio of staff should aim to be minimum of 50:50 ideally including community geriatric consultant input.

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

Locally, the health and social care commissioning community is Barnsley Clinical Commissioning Group (BCCG) and Barnsley Metropolitan Borough Council. (BMBC). NHS England commission primary and specialist services for the population. Some people commission their own care and support through personal budgets/personal health budgets or direct payments or because they fall outside of the threshold for publically funded social care.

Current Intermediate Care provision is through the SWYPFT and the private sector

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

- to support the selection and design of this scheme

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- to drive assumptions about impact and outcomes

The 2 main commissioning organisations (BCCG and BMBC) support a population of over 250,000 and are co terminus. The population of Barnsley has a higher than the UK average number of people receiving out of work benefits, teenage pregnancy rates are higher than the national average and life expectancy is lower than the national average. Over 24% of people living in the area have a lifelong limiting illness higher than the national average of 16.9%. The proportion of people over 65 living in the area will increase to nearly 48, 000 by 2020 and the number of people with a diagnosis of dementia will increase.

The Joint Strategic Needs Assessment shows that Barnsley has:

- Growing and increasingly elderly population
- Widening health inequalities across Barnsley and between Barnsley and the rest of England (life expectancy)
- High levels of deprivation
- High levels of hospitalisation
- High level of premature deaths from cancer and cardiovascular disease
- Variation in practice and performance."

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

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

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

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

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Scheme ref no.
Scheme name
YAS Frequent Callers
What is the strategic objective of this scheme?
The Frequent Callers service will help to ensure an integrated approach to patient care across the health economy. It will also reduce pressures on the emergency services by this cohort of patients; helping to improve performance for YAS Ambulance waiting times, Accident and Emergency 4 hour target, Emergency Admissions and quality indicators. The frequent caller service will contribute to the holistic approach to patient care by appropriately assessing patient needs at the point of contact and working in collaboration with other Health and Social Care providers.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Frequent Callers service is a service where the most frequent callers of the service are case managed by YAS with community providers and the emergency services; this is an award winning service (Success in Partnership Working Award; Yorkshire and Humber Health and Social Care Awards 2010) with a proven track record of improving outcomes for patients. Working on an MDT approach with the patient, their carers', emergency services, healthcare providers as well as Mental Health and Social Care services, this will help to ensure that patients are supported and receive the care that they need in settings alternative to the Emergency Department or involving the Emergency Services. The service can be rolled out into a CCG within a matter of weeks. The frequent caller service will contribute to the holistic approach to patient care by appropriately assessing patient needs at the point of contact and working in collaboration with other Health and Social Care providers. Yorkshire Ambulance Service will case manage the "Top Ten" frequent callers within Barnsley to ensure that they are appropriately supported by the local health community and to reduce calls on the emergency services; either YAS, Police or the Emergency Department. Early identification of patients who have complex care needs such as dementia, COPD, diabetes, mental illness and frail elderly will be managed more effectively; this will result in the development of active case management plans. Through liaison with local health and social care providers the service will support the delivery of appropriate care and will facilitate an improved patient experience by ensuring patients have agreed care plans.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

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The Service will be commissioned by the CCG and delivered by Yorkshire Ambulance Service who will case manage the highest users of the 999 or 111 service or those identified as frequent calls by the emergency services. The Service will work on an MDT approach with the patient, their carer's, emergency services, healthcare providers as well as Mental Health and Social Care services to help to ensure that patients are supported and receive the care that they need in settings alternative to the Emergency Department or involving the Emergency Services.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Frequent callers account for a significant volume of work for the 999 and 111 services; some 111 patients call daily or, in a small number of cases up to 50-70 times in a month. This equated to over 18,000 calls for 111 across the region for 2013/14 for a limited cohort of patients. This is similar for the 999 service where 200 patients across the region make 1,000 calls a month for an ambulance and onward conveyance to the Emergency Department. Frequent Calls, while a small group of patients, have a significant impact on the Emergency Services. Frequent Callers are also a cohort of patients that needs the care and support of the local health community. The potential gap is the identification and case management of these patients.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£60,000 2014/15, £100,000 (to be agreed) 2015/16
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
From modelling to date, the proposal will reduce pressures on the emergency pathway, but will also reduce emergency activity (999 & 111 calls, ED Attendances and Emergency Admissions). This will help improved YAS waiting times performance and the Accident and Emergency 4 hour waiting time target and performance indicators.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Assessment of the impact the service has on the number of contacts by those patients identified as the most frequent callers. This data will be collected and reported by YAS The System Resilience Group will have oversight of this service to ensure it is delivering the intended benefits

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What are the key success factors for implementation of this scheme?
Identification of the frequent callers through the call management systems Expertise in case management to understand alternatives to ambulance attendance and transport to hospital Engagement of other providers and the individuals in the process

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Scheme ref no.
Scheme name
Urgent Care Practitioners
What is the strategic objective of this scheme?
This service will contribute to: • Treatment of more patients at home – particularly those with long term conditions, • Avoidance of attendance at ED through appropriate non-conveyance and direct access admission, • Reduction in admissions, tests, and other associated secondary care costs, • Management of direct referrals from nursing homes, with high non-conveyance rates, • Management of fallers including assessment/treatment/arrangement of transport if needed, • Keeping palliative care patients at home, • Increased patient satisfaction.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
YAS Urgent Care Practitioners (UCPs) are advanced paramedics or nurses with extended patient assessment and treatment skills that will attend non-emergency incidents instead of an ambulance, or alternatively take over from ambulances crews if appropriate. Patients seen by UCPs can either be "seen and treated" on the spot or be referred onwards to appropriate health care services, thus freeing up an ambulance to respond to more critical calls and preventing patients attending the Emergency Department when alternative appropriate services are available. This will help to improve both YAS and ED Performance targets and quality indicators. YAS is proposing to pilot this service in a number of CCGs in 2014/15; with the aim of evaluating the pilot and developing a substantive service from 2015/16 onwards.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The Service will be commissioned by the CCG and delivered by Yorkshire Ambulance Service The intention is to work with commissioners to identify the potential application of the model within the local context and available patient pathways, recognising that these could vary in different urban and rural settings. A collaborative approach will be adopted to co-develop an Advanced Paramedic service based on a core YAS model, which is fully integrated with the wider health system.
The evidence base

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Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

YAS responses are increasing by 2-3% a year across the region with 15,000 to 50,000 per year across a CCG. 75% of these patients will be taken to an Emergency Department and, of these, 49-55% will be admitted *(Source: NHS Comparators-2012/13).*

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

£200,000 to £300,000

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

The benefits from implementing the UCP scheme across the health care community for patient, the local health community and YAS are:

- The patient is seen and treated effectively by the most appropriate service; improving patient outcomes and experience.
- Patients are appropriately and safely treated away from the Emergency Department; relieving pressure both in ED and also on the number of Emergency Admissions.
- The CCG is commissioning a safe, improved quality service that reduces costs across the health economy as a whole.
- For YAS this allows activity growth to be managed in a more costs effective way and reduces pressure on ambulance resources.
- For YAS staff it will produce clear career and professional development opportunities.

This proposal will support the strategic objectives of both CCGs and the Yorkshire Ambulance Service.

It is anticipated that the use of Urgent Care Practitioners, by freeing up ambulance crews, will improve on YAS response targets.

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

Review and evaluation of the scheme through the System Resilience Group

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

Establishment of Urgent Care Practitioner Team in Barnsley

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Scheme ref no.
Scheme name
7 Day working
What is the strategic objective of this scheme?
To improve access and ensure excellent clinical care for the population of Barnsley over seven days a week;
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The purpose of this scheme is to ensure the identification and development of a co-ordinated and joined up approach to 7 day working across health and social care to supporting a reduction in emergency admissions and quicker discharge from hospital. In December 2013, Sir Bruce Keogh set out expectations based on 10 Keogh Standards for Trusts, to improve 7 Day Services. Trusts will be assessed by the CQC for compliance and also incentivised via CCG NHS provider contracts such as CQUIN goals. In anticipation of this direction of travel during 2013/14, BHNFT has made progress in establishing 12/7 services including:12/7 extended AMU Consultant cover, 12/7 extension of Imaging/Radiology services, 12/7 Pharmacy ED & AMU and 12/7 Therapy services. 7 Day Services at BHNFT is expected to; improve the discharge pathway, reduce patient mortality rates, improve patient satisfaction and maximise efficient patient flow, thereby aligning with the operational and strategic intentions of BHNFT, BCCG and NHS England. Barnsley intends to adopt a whole system approach to 7 day working from primary to secondary to community and social care. Executive level engagement by BHNFT and BCCG with the Health and Wellbeing Board will support the agenda in unblocking parts of the patient pathway to allow us to move to an integrated seven day services model. To that end a number of further schemes are being developed by SWYPFT, BMBC and GP providers to support 7 day working.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
BHNFT is committed to working with the Health and Wellbeing Board, Working Together Programme, our lead Commissioner and our health, social care and ambulance provider partners in order to provide excellent care for the patients of Barnsley and District. Each week there is an operational meeting chaired by the Chief Operating Officer of BHNFT that includes membership of all other providers which include social services, therapies, SWYFT, Rapid Response Team and attendees from ED, Medicine, Case Management, Pharmacy and Therapies. All issues relating to discharge of patients and services are addressed and discussed on a weekly basis with clear actions to ensure the patients are directed in an efficient manner to their next provider of care. This working in partnership

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has allowed recognition of each stage of the patient journey and fostered an understanding of each provider's capacity and capability to manage the demands created by the acute trust.

The evidence base

Please reference the evidence base which you have drawn on

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

- The national 10 Keogh Standards
- 'Everyone Counts: Planning for patients' NHS England 2014
- 'NHS Services- open seven days a week- every day counts' (NHS IQ 2013)
- "Making best use of the better care Fund", Kings Fund 2014

Investment requirements

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

Impact of scheme

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

High level benefits are expected to be;

- achievement of the 10 Keogh Standards;
- reduced HSMR;
- reduced emergency admissions;
- achievement of the 4 hour target;
- reduced length of stay;
- improved patient care;
- safer prescribing, dispensing and administration of medicines;
- improved patient satisfaction survey;
- increased weekend discharges;
- improved timeliness of senior review;
- reduced readmissions and the associated savings;
- reduced unnecessary diagnostic requests;
- increased reputation; and
- optimum patient flow.

Feedback loop

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

7 day service delivery will be monitored via the patient flow action plan which is overseen by the system resilience group.

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

- Agreement and funding of the schemes
- Implementation
- Benefits delivery

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- Ensuring sustainability
- Partnership working

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Scheme ref no.
Scheme name
Personal Health Budgets
What is the strategic objective of this scheme?
The Personal Health Budgets (PHB) project forms part of a portfolio of strategic programmes designed to transform health and social care across Barnsley. Barnsley CCG working in collaboration with the Local Authority has set up this project to give people more choice and control over resources enabling them to purchase their own care and support, this includes the development of PHBs and Direct Payments (DP) and Integrated Individual Budgets to jointly support health and social care needs. The project will develop strategies, systems and processes to deliver personal health budgets as part of a range of options available to support more personalised health and social care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To work across the Health and Social Care organisations in Barnsley to develop a new, sustainable approach to delivering personalised care and support based on maximizing inclusion, self-reliance and resilience and drawing on the strength of all of our community. The Project will achieve this by focusing on, and improving, all aspects of health, social care and wellbeing services: • Introducing Personal Health Budgets for key conditions. • Introducing Integrated Individual Budgets to jointly support health and social care needs • Continuing to develop universal access to information and support The project will be underpinned by adopting integrated ways of working that support the service user, their families and carers to take more responsibility for their own health and social care in terms of staying healthy, independent and in accessing the right care in the right place at the right time. This project is available for people eligible for NHS Continuing Health Care (CHC) funding initially, however this will expand from April 2015 to include people with Long Term Conditions and/or Mental Health Needs in line with Government role out.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The project is commissioner-led, but is a collaborative endeavour, involving all key health and social care stakeholders in Barnsley. Primarily Barnsley Clinical Commissioning Group (BCCG) and Barnsley Metropolitan Borough Council (BMBC), however it is accepted and expected that other partner stakeholders are involved including West, South Yorkshire and Bassetlaw Commissioning Support Unit, Barnsley Hospital NHS Foundation Trust and South West Yorkshire Partnership Trust .

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The evidence base

Please reference the evidence base which you have drawn on

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

In November 2012, the Secretary of State for Health announced that CCGs must have systems in place to respond to people in receipt of NHS Continuing Healthcare who will have a "right to ask" for a personal health budget including direct payments by April 2014,. This was followed in October 2013 when it was announced that CCG's needed to be in a position to respond to a "right to have" request by people in receipt of NHS CHC by October 2014 and be able to respond to people who have "a right to request" a personal health budget for their long term health conditions and/or Mental Health needs by March 2015.

Evidence and support has been gathered from the following to support this project:

Personal Health Budgets: first steps, 2009 (Department of Health)
Personal Health Budgets and NHS continuing care, Discussion Paper, Department of Health 2012
The NHS Next Stage Review Final Report for High Quality Care for All, Professor the Lord Darzi of Denham KBE 2008
Direct Payments for Health Care, NHS England 2014
The NHS Mandate 2013
Putting People First 2010

Ongoing support from the NHS PHB Yorkshire and Humber Network along with inclusion within the NHS PHB learning network

Investment requirements

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

Impact of scheme

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

Feedback loop

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

Annual patient survey conducted to detail personal outcomes including analysis of contact with health services prior to and post utilising this approach
Financial review of funding including analysis of current spend against future spend

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

That people with key conditions who choose to take more choice and control over resources are able to do so, enabling them to purchase their own care and support which includes the use of Personal Health Budgets or Direct Payments.

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Scheme ref no.
Scheme name
Be Well Barnsley Building Community Capacity to deliver Health and Well Being
What is the strategic objective of this scheme?
To improve health and wellbeing across Barnsley, in particular in more disadvantaged communities and among people at risk of needing more intensive services
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Service We are re-designing and then re-commissioning services which help to improve lifestyles and achieve health gain. This includes • Services to help people stop smoking, achieve healthy weight, eat better food and increase physical activity**.** • The service will link to the provision of low level mental health and alcohol support and to advice and information services. • It will be inclusive and provide support to help people with learning and physical disabilities undertake exercise and other support alongside their local communities. • Another key feature is providing a level of preventive service for people who may otherwise escalate into Social Care. This will include creating local networks to combat loneliness and social isolation, and offering some more specific support for example in areas such as Falls Prevention. • As we recognise that much poor health is caused or exacerbated by wider determinants of health we will be linking the service to those services which support income maximisation, employment and skills and housing. **The model** The model of will be one aimed at: • Promoting prevention, independence and personal control through a Personalisation approach. • Delivering advice and behaviour change through digital media as well as face to face • Providing the optimum level of support to each customer, moving away from some of the more 'sheep dip' approaches of the past. • Creating a 'triage' capacity linked to the Council's Customer Services Operation which will mean we can offer a wider range of signposting, help people knit together support and also optimise staff capacity and training. • Providing all appropriate staff with motivational training using the Making Every Contact Count (MECC) approach and training face to face staff in Motivational

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Interviewing.

Our planned model of service is for a 'Managed Network' which will consist of some specially commissioned services and others which are part of the Universal Offer. We will also link with other existing commissioned services such as the Physical Activity Care Pathway (for people with Long Term Conditions) and the IAPT Psychological Support Services and other Mental Health provision.

The commissioned service will include support workers, who will either provide direct support to individuals and families or support and signpost people to make their own arrangements.

The service will work at three levels

- With individuals
- With Families
- With Communities (both geographical and communities of interest)

Customer and Patient Cohorts

In this highly personalised model we will be describing our service users as customers and will be helping them make choices that meet their needs.
The main cohorts of people we will be targeting are:

- People who need to stop/reduce smoking/alcohol or their weight
- People who need to take more physical exercise
- People who need support to help make healthy choices for themselves and their families in areas such as money management, cooking, eating and exercise
- People with low level mental health needs who would benefit from preventive services

The delivery chain

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

Commissioners

The lead commissioner is BMBC with the Public Health and Communities Directorates collaborating to embed new approaches to Public Health within Area Councils and Local Communities.
Some of the elements of service are funded by Barnsley CCG, such as the NRT elements of Stop Smoking Services and the Physical Activity Care Pathway.
At this stage the main providers are PSS and SWPFT. However, we are almost at the end of the contract cycle and will soon be consulting on new models of delivery.

Future Provider Model

While not wanting to pre-empt the outcome of a tender process, our vision is for a network of provision which achieves the following:

- Creates and adds to local social capital by supporting local groups to deliver services
- Makes increasing use of volunteers, peer mentors and experts by experience and a reducing level of paid staff over time
- Supporting Volunteers to move into paid employment or training in other settings.
- Has clear routes for access into the service and for transfer out so that there is throughput and wider coverage

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- Supports the development of sustainable activity in local communities
- Contributes to wider aims and initiatives, for example, making best use of our parks and green spaces, increasing growing, cooking and eating of fresh food, reduced carbon emissions by encouraging walking to school and work etc.
- Networks between a range of other services to help people develop a menu of support which is personal to their needs.

The supply chain therefore will be a combination of formal services, commissioned community based interventions and wider and better use of universal services and volunteers.

The evidence base

Please reference the evidence base which you have drawn on

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

We have looked at a range of evidence, including national evaluations and local feedback from individuals and focus groups about how they wish to be supported:

Formal Evidence has included:

- Evaluations of Health Trainer Programmes
- Evaluations of Schemes to reduce Social Isolation and Loneliness
- NICE Guidance on Falls, IAPT and Exercise Pathways
- LGA reports and recommendations on Loneliness
- NESTA Cities of Service Programme on Growing and Eating

Consultation has included

- Customer Feedback from Health Trainer Programmes and Change for Life
- Consultation via Area Councils on key local needs and priorities
- Focus Groups with LGBT, Deaf, Mental Health and Physical Disability Reference Groups
- Discussions with The Gypsy and Traveller Community

Needs Analysis includes

- JSNA which shows Barnsley to have made some progress in improving life expectancy but a significant and persistent challenge in terms of the numbers of people with Long Term Conditions and Limiting Illnesses.
- JSNA and DWP data on levels of absence from work due to mental ill health
- High numbers of ESA Claimants and % of out of work benefits paid to people who have long term health needs
- Increased numbers of Children and adults measured as obese.
- Low % of men and women talking recommended levels of exercise per week.
- High numbers of smokers
- High rates of hospital admissions for alcohol related problems

Clearly our current health and wellbeing services are struggling to achieve behavioural changes so we feel we need to try new approaches to engaging the community in tackling its own health.

These sources give us confidence that our new model and design principles will attain higher levels of compliance and health improvement as we are working on a more personalised approach, will ensure all staff are trained in appropriate techniques and will do more to match staff to customers to ensure rapport and insight.

We also feel that by commissioning some services from local CVS and Social Enterprise Groups we will achieve a ‘double bottom line’ of improving health and wellbeing while creating greater social and community capital.

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

This service is being funded by the Public Health Grant with some CCG elements embedded. It does not require new money. It is included in these templates as a way of illustrating to the reader the wider range of innovative and integrated work underway in Barnsley and the context in which we are building upstream preventative capacity as well as dealing with the immediate pressures of urgent care and emergency admissions.

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

We will be measuring a number of Public Health Outcomes:

- Smoking Cessation
- Increased Physical Activity
- Weight Management
- Alcohol usage

In addition we will measure individual and community reported benefits re:

- Social Isolation and Loneliness
- Increased levels of volunteering
- Start-up of social and micro enterprises
- Use of community assets such as libraries, church halls and parks and green spaces

Wider Health Measures

- People with personal health plans supported by local community services
- Number of Health Mentors and Experts by experience recruited and trained.

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

As the new service is scoped and specified, we will build in an evaluation methodology which will be built on the highly regarded Barnsley Evaluation Tool for the DH Pioneer Programme.
We will incorporate a combination of PH Outcome Framework Measures with qualitative measurement of personal and social capital.

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

- Market supported to develop and deliver new models
- All partners being prepared to collaborate to deliver a new person centred rather than organisation centred model of service.
- Ability to retain staff with Health Trainer, Motivational Interviewing and Personalisation skills in the local system during period of re-design.

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Scheme ref no.
Scheme name
Care Act Implementation
What is the strategic objective of this scheme?
Undertake all actions required associated with the implementation of the Care Act in line with national standards and guidance.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Create greater incentives for employment for disabled adults in residential care Put Carers on a par with users for Assessment Introduce a new duty to provide support for carers Link LA information portals to national portal Advice and support to access and plan care, including rights to advocacy Provider quality profiles Implement statutory safeguarding adult's boards Set a national minimum eligibility Ensure Councils provide continuity of care for people moving into their areas until reassessment Clarify responsibility for assessment and provision of social care in prisons Disregard of armed forces GIPs from financial assessment Training social care staff in the new legal framework Savings from staff time and reduced complaints and litigation
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Impact will be across numerous service areas and providers
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Evidence driven from national guidance
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Funding allocated per estimated costs of provided by DH £700,000
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

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Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Impact per the expectations of the Care Act
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
A cross agency Care Act implementation group has been established. Progress will be monitored and reported through that group.
What are the key success factors for implementation of this scheme?
Full implementation of the requirements of the Care Act

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Scheme ref no.
Scheme name
Residential Care – Fair Fee Project
What is the strategic objective of this scheme?
To minimise future costs for supported care home placements through agreement of a fair fee linked to better use of community based alternatives.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Working with providers of residential care to understand the cost of providing care in the Borough, develop an understanding of the current market position, and to agree a fair fee structure for the next 5 years based on this information. In understanding the market, develop an understanding of routes into residential care and consider if with appropriate alternative options, the number of people in residential care could be reduced leading to people living more independent lives and reducing the costs of long term care. Build in the outcomes of a review of extra care housing to consider the impact effective use of this could have on supporting alternatives to residential care. Consider the output of the work commissioned to undertake a Vulnerable and Older People's housing needs assessment. Take a more strategic commissioning role in relation to the residential care market, the likely number of beds required moving forward, the cost and quality, aligned to maintaining independence for people for as long as possible. Consideration of self-funders and potential impact if capital runs out. Consideration as to the impact of the Care Act.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Residential Care placements for eligible individuals are determined through the local authority assessment processes. The Council commissioning function seeks to shape the market however in Barnsley this is largely driven by individual providers with a current over supply of places and new providers still coming into the market. Providers were engaged with limited success at the start of the project and are expected

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to be involved at the end, where the outcomes of the work will be shared with them.

The evidence base

Please reference the evidence base which you have drawn on

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

The evidence chain is being developed as part of the various projects which will be used in making strategic decisions in terms of the commissioning of residential care.

It is expected the key outputs will include:

- Understanding of demand for residential care over the next 5 years
- The impact of alternative support options and impact these might have on the number of residential care beds required
- The cost of alternative support options compared to the cost of a residential care bed
- The impact on the wider health and social care system of keeping people out of residential care where appropriate

Investment requirements

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

The Council has commissioned the various projects as follows:

- Fair Fee Project £85,000
- Extra Care Housing Review – utilised existing internal resources
- Housing Needs Assessment £60,000

Impact of scheme

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

Overall it is currently anticipated the impact of the various aspects of the project will deliver a reduction in residential care beds per the BCF target reduction of 38 beds, which at an average net unit cost of £13,100 per annum offset by an average cost of community support of £4,300 would deliver total savings of £0.3m.

However it is likely the reductions will have to be net of:

- Increase in support provided to Extra Care Housing schemes; and
- Potential uplift in the weekly fee payable to residential care homes.

This would require diversion beyond the initially identified target of 38 beds.

Initial case audit of a sample of 58 individuals suggested:

- 28 were appropriately placed in residential care
- 29 could have been considered for alternative support (16 into appropriate extra care)
- 1 case was unclear

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Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Detailed monitoring will be undertaken in relation to the numbers of individuals supported in residential care and other alternative provision alongside the costs associated with each type of support measured against the current baseline position.
What are the key success factors for implementation of this scheme?
More people supported to live independently. Reduced costs of long term care. Improved processes, leading to improved decision making around the needs of individuals.

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Scheme ref no.
Scheme name
Social Care Target Operating Model
What is the strategic objective of this scheme?
To work closely with partners to provide better support at home and earlier treatment and interventions in the community to prevent people needing emergency care in hospital or care homes. Requires move from individuals being passive recipients to a more active role of responsibility and greater engagement with their communities.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To develop a future operating model with the following key characteristics: • A focus on early intervention and prevention, self-help and redirecting people to non-statutory services • A community engagement model providing low level support, with universal information and advice • Short term targeted interventions to prevent long term support • Statutory sector services for more complex long term conditions • Financial savings and improved customer experience The output of the work to date has identified a revised target operating model with a revised pathway across the whole system with 3 key areas for review: • Assessment and Care Management / Customer Services • Maximising Independence (Early Intervention and Prevention / Community and Personal Resilience) • Maximising Independence (Reablement / Assistive Technology) Cutting across the whole system is improved information, advice, signposting and guidance. The assessment and Care Management element of the project has already delivered a cost reduction of £1m and the project is now required to deliver a revised way of working that enables the function to be delivered effectively within a significantly reduced resource envelope. Key changes required are: • Reducing avoidable contacts through digital services • Enabling and supporting people to self-serve • Shifting activity to third parties • Improving processes and standardising the way work is carried out • Delivering a number of these processes in a shared environment with deeper

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capabilities
- Focusing and aligning expertise and skills with functions – lower cost
- Better productivity through enhanced training and supervision
- Better scheduling of work and use of resources
- Maximising independence solutions are widely available for new and existing contacts – based on needs
- Streamlining and accelerating access to Maximising Independence solutions – reducing the need for unnecessary assessments
- Proportionate gathering of information

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

The overall revised operating model will require embedding across the joint Health and Social system with all key stakeholders understanding and following the expectations of the revised pathway, referring individuals into the correct element of the pathway at the most appropriate time.

The key aspects of the revised assessment and care management model will involve the Council in terms of the current Assessment and Care Management Staff and the Councils Customer Service programme.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A significant amount of work has been undertaken in the first phase of the review which identified and modelled the benefits to be gained. Detailed reports are available to support the direction of travel and gains to be realised.

Additional work is still required to progress the work around the wider aspects of the Target Operating Model particularly around Maximising Independence and developing community assets and resilience. It is difficult at this stage to understand the financial and operational impacts of these aspects of the model without further work being undertaken.

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

The Council invested £150,000 in the phase 1 work which is now complete and have committed a further £250,000 to the detailed design and implementation stage of the project. This is largely focussed on delivering the Assessment and Care Management aspects of the project. In addition to this significant staff time has been committed to being involved in the associated workshops and working groups.

Additional investment is also to be made in developing the wider aspects of the project around maximising independence. These are in the process of being considered.

Impact of scheme

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Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The Assessment and Care Management function has already been reduced by £1m in 2014/15, as part of the Council's required savings targets, in anticipation of the project being successfully delivered. The wider financial benefits arising from the wider aspects of the Target Operating Model will be linked to reducing the need for long term care aligned to the development of Preventative / early intervention services and greater community resilience / development of community assets. These are very much the principles of the Council 'Inverting the Triangle' model which seeks to just meet any unmet needs of individuals who have gone through all the aspects of the revised pathway. It is anticipated that these benefits may be more about mitigating future demand rather than delivering cash releasing savings from the current system. Current estimates are that this will deliver a financial return of £1.2m in 2015/16 and a further return of £1.2m in 2016/17, reducing the balance of demographic pressures from £3.4m over 2 years to £1m over 2 years.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Detailed modelling will be undertaken in terms of key assumptions around changes in activity and unit costs arriving at an assumed efficiency sum that might be deliverable. Ongoing monitoring will be undertaken against those key assumptions to measure that actual impact against the forecast impact.
What are the key success factors for implementation of this scheme?
Individuals flowing through the system per the revised expected flows Staff across the system operating per the revised agreed processes Increased take up of Maximising Independence related support More individuals supported within their communities Reduced numbers in receipt of long term Council funded support

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Scheme ref no.
Scheme name
Social Care Funding Transfer
What is the strategic objective of this scheme?
Maintenance of the existing Social Care transfer monies to continue to deliver for the wider benefit of health and social care as reported through the current Section 256 agreement.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The transfer monies include: • NHS England (S256) £5.676m • Carers Funding (CCG) £0.761m • Re-ablement Funding £2.363m • Disabled Facilities Grant £1.326m • Social Care Capital Funding £0.690m It is expected that these funds will continue to be used for the benefit of health and social care aligned to 'Stronger Barnsley Together' consistent with the principles as set out in the Better Care Fund submission. The funding is not allocated to one individual scheme but considered against the suite of services currently required across a joint health and social care system, whereby the funding is used in the most effective way to benefit that whole system approach. Through joint service and financial modelling the use of the funding may change as the model of health and social care changes. A significant element is being used to maintain existing eligibility criteria for people in receipt of social care services in light of the significant funding reductions the Council has had to manage year on year and the demographic pressures associated with an ageing population and the significant increase year on year of people with complex learning difficulties. The 'Stronger Barnsley Together' programme will seek to achieve a step change and strategic shift from the current approach to health and social care with greater focus on prevention and early intervention, enabling residents to support themselves and their families within their communities rather than being drawn into the formal system. This moving forward will allow the limited resources across a joint health and social care system to be focussed on those with greatest need and build on the success of personalisation and self-directed support.

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To support the integration principle Barnsley has aligned budgets across health and social care whereby consideration is given to the cost of services and funding across the whole system rather than looking at the individual organisations. It is on this principle that the use of the funding has been considered and agreed.

This principle will continue through the medium term financial planning period to consider the changing landscape and requirements associated with health and social care over the next few years aligned to the significant financial challenges both organisations will face over that same period. To this end a joint medium term financial plan is being developed and agreed through the Health and Wellbeing Board, aligned to the Better Care Fund and all the associated plans.

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

The monies are currently used across a whole range of providers.

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

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

The evidence base is driven from how the funding is currently used, the impact of that funding and more importantly the impacts of removing that funding from those areas.

Detailed joint service and financial modelling will inform any medium to longer term changes required in how the funding is used.

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

The total funding of £10.126m will be used for:

- Re-ablement
- Independent Living at Home (Assistive Technologies)
- Other Intermediate Care Services
- Hospital Social Work
- Maintaining eligibility criteria (Including managing demographic pressures)
- Carers Breaks - Short Term Residential (Respite)
- Funding for Carers Groups
- Provision of adaptations for disabled people
- Capital investment needs associated with the revised Target Operating Model and a shift to greater prevention and early intervention along with other interventions that improve individuals potential prior to receiving an ongoing package of care

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

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headline metrics below
This funding is effectively funding what would be considered core functions and hence the impact to the system is largely maintaining and supporting the whole system. The impact would be adverse were this funding to be removed from the area's currently supported unless done so in a planned and managed way of the back of evidence based modelling.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Outcomes will be measured through the existing performance management frameworks.
What are the key success factors for implementation of this scheme?
Effective use of funding across a joint health and social care system whereby outcomes are maximised and costs contained within an overall available funding envelope.

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Scheme ref no.
Scheme name
Adult Learning Disability Transformation phase 1 & 2 – Constraining future demographic pressures through rigorous Social Work and Commissioning and Contracting practice
What is the strategic objective of this scheme?
• Local services wherever possible • Fostering maximum independence for individuals through progressive enablement and promoting choice • Supporting people to live in the least intensive environment that can meet their needs.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Phase 1 of the project ran from October 2012 to January 2014. This involved undertaking in-depth independent reviews of high cost individual residential and nursing placements. The reviews involved: • a fundamental re-assessment of individuals' needs and aspirations • using the Care Funding Calculator to understand the relationship between needs and costs • discussing and challenging providers over costs and renegotiating contracts to reflect the outcome of the reassessment. Results of phase one Overall • 49 cases have been reviewed so far, of these 26 are local authority funded, 18 are health funded, and five are joint funded between health and social care. • 18 negotiations have been completed and savings achieved. • 17 people are now in active case management and on track to progress to lower intensity support. • One person has a new package competitively procured resulting in improved quality of life at 37 percent reduced costs compared to original placement cost. Phase two: applying the progression model to people in supported living services While supported living generally can allow more independence than residential settings, some people will not be realising their full potential. For instance, some have tenancies in accommodation linked to high levels of support that they no longer need. Around 150 people are in supported living services.

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Phase two of the project, which started in January 2014, involves in-depth assessment and review, and progression-focused case management. It will also involve a wider range of person-centred living options with an emphasis on enablement. Service specifications are being drafted with pen pictures of the types of need services will have to meet, which includes behaviour that challenges.

There will be challenges in this process, such as achieving a balance between personal choice and efficiencies and economy of scale, and finding sensitive ways of changing some people's service in response to assessed need.

To support an increase in personalised supported living, Barnsley has identified the need for greater specialist crisis support in the community, such as support workers spending intensive time with individuals to prevent crisis hospital admission. This is being considered with some other South West Yorkshire authorities in relation to a change to the specification of the commissioned service and by the local provider South West Yorkshire Partnership Foundation Trust as part of their Learning Disability Transformation Programme.

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

The revised working practices will require embedding across the joint Health and Social system for people with a learning disability including service providers and family/informal carers. The key elements focus on ensuring that the right amount of support is provided at the right cost in an individual and personalised way.

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

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

The project work in Barnsley has been cited as evidence of good practice in the recent report from the Winterbourne View Joint Investment Programme.

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

The Council and CCG invested in the phase 1 and 2 of the work. This was originally focussed on delivering the wider recommendations arising from the Winterbourne View report and has encompassed ensuring detailed assessments are translated into care plans and specification which ensure best value for money. Investment has also been made in contract monitoring and compliance In addition to this significant staff time has been committed to being involved in the associated workshops and working groups.

Nationally and locally it is recognised that the demographic changes presented by people with a learning disability present a significant challenge to the health and social care system.

Impact of scheme

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Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
People with learning Disability are achieving better outcomes at reduced cost. The savings for the Clinical Commissioning Group (CCG) and the council from the project at August 2014 were £637,000 which represents a 12 percent saving on the placement budget. This was achieved by negotiations with providers to amend care packages based on the in-depth reviews such as reducing one to one support, or from tackling simple over-funding. Further savings are expected when the 17 individuals move to lower intensity support. Initial PCT and council non recurrent
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Robust monitoring of care plans including challenging outcomes and developing a culture of progression. The project team continue to oversee and monitor the progress of the project. Ongoing monitoring is undertaken to measure financial savings.
What are the key success factors for implementation of this scheme?
Phase one of the project has resulted in many important lessons, including: • A project team approach is seen as necessary to provide a consistent focus on approach and outcomes. • Bringing commissioning and contracting support to the front line means care and costs are considered together. • The project found no correlation between cost and quality in services; • Commissioners need a good understanding of provider costs and how these link to care. Using the care funding calculator facilitates challenge. • Specialist social work and case management expertise is needed to support individuals, families and providers to implement change.

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ANNEX 2 – Provider commentary

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

Name of Health & Wellbeing Board	Barnsley Health and Wellbeing Board
Name of Provider organisation	Barnsley Hospital NHS Foundation Trust
Name of Provider CEO	Diane Wake
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	31065
	2014/15 Plan	31325
	2015/16 Plan	32242
	14/15 Change compared to 13/14 outturn	0.84%
	15/16 Change compared to planned 14/15 outturn	2.9%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	152
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1328

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust is fully engaged and has contributed to the model put forward. We fully sign up to the theoretical construct of the plan and will continue to work with our partners to deliver it.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Non-elective activity is still increasing. Whilst we are confident that the initiatives outlined will produce many benefits it is not clear and evidenced that they will reduce admissions to the outlined level.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	See risk section.