Barnsley Health and Wellbeing Board

Better Care Fund 2016/17 – Headline Narrative

The 2016/17 Better Care Fund (BCF) in Barnsley is a continuation of the plans from 2014/15 and 2015/16 reflecting the original principles that the BCF is part of the wider system wide transformation. This narrative is therefore intended to be read alongside the current BCF plan and provide an update on developments and the plans to meet the additional conditions of the BCF introduced for 2016/17.

Overall planning for 2016/17 is taking account of the changing landscape and ensuring the alignment to developing the Sustainable Transformation Plan (STP) for South Yorkshire and Bassetlaw and the Barnsley Integrated Transformation Plan which will underpin delivery of the wider STP.

The original Better Care Fund Plans for Barnsley were signed off by the Health and Wellbeing Board and the plan to retain the current plans as outlined above have been agreed by the Health and Wellbeing Board along with the updates included in this narrative ensuring ongoing support and sign up to delivery of the plan in the context of the wider planning arrangements by all partners.

The Vision for Health and Care Services in Barnsley

In Barnsley the Better Care Fund (BCF) is set in the context of the wider Health and Wellbeing Strategy and Vision 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 Barnsley Health and Wellbeing Strategy 2014-19 was developed in this context and describes how collectively the key agencies are working better together to ensure the health and care system is delivering improved health and wellbeing outcomes for the people of Barnsley.

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.

Whilst the Health and Wellbeing Strategy remains current, it is being reviewed and refreshed as part of the 2016/17 planning arrangements and will be published alongside the STP and Integrated Transformation Plan for Barnsley.

The current 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 ongoing review of the Health and Wellbeing Strategy has resulted in a proposal to refine the overall vision. The revised vision is still to be agreed however the current proposal sets out the vision as:

"People take control of their health & wellbeing, (able to access integrated services) and enjoy happy healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live"

The focus of the revised strategy will be for communities, the public sector and other organisation's to work together to ensure:

- Children start live healthy and stay healthy
- People live longer, healthier lives
- People live in strong and resilient communities
- People have improved mental health and wellbeing
- Health Inequalities are reduced

The strategy will be underpinned by clear shared principles based around strong partnership working (with local people and communities), building on our strengths, reducing duplication and increasing efficiency and focussing on making a difference. The strategy will also describe how we will deliver system wide objectives to upgrade prevention, embed a culture of integrated care, ensure system resilience and accelerate the implementation of key system enablers to support transformation.

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 and the recently published Public Health Strategy 2016-2018 set out the approach to addressing the local public health priorities in Barnsley.

We are however 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.

Our approach therefore continues to be one of pathway integration and redesign rather than necessarily structural integration in line with our original Pioneer Integrated Care and Support proposals 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 Evidence Base

The evidence base for the Barnsley BCF plan is set out in sections 1 and 3 of the original BCF plan particularly in relation to the population needs and the financial challenges faced across the health and care economy. Further work has taken place to understand the population needs and financial challenges building on the JSNA and other data sources and this has fed into planning processes for 2016/17 and informing our plans however many of the challenges remain consistent. This is particularly the case in relation to longer term health needs of the Borough and health inequalities.

Life expectancy is a clear example, whilst overall life expectancy has been increasing slightly over recent years with the gap between Barnsley and the national average 1.3 years for men and 1.5 years for women, the health life expectancy for both men and women has actually reduced over the last 5 years. Healthy life expectancy for men is 56.3 years compared to the national average of 63.3 years (7 years less) and for women it is 56.2 years compared to 63.9 years (7.7 years less). There is also a marked difference within the borough with life expectancy still significantly lower in the most deprived communities.

Key health factors contributing to the gap in life expectancy remain consistent with circulatory disease, cancer and respiratory diseases being among the main contributors to the gap in life expectancy.

The need to address the health inequalities and improve health outcomes is clear in our overall approach to planning, with a clear focus on prevention and embedded in the revised aims of the Health and Wellbeing Strategy.

Over the period of the original BCF plans (2014/2016) the number of emergency admissions to into hospital and numbers overall accessing urgent care have continued to increase and therefore, alongside prevention, we will continue to focus on delivery of the schemes which are intended to reduce pressures on the urgent care system, ensure people have access to the right care at the right time and in the right place and supporting people to live independently in their own homes.

Many of the schemes identified in our better care fund plans remain ongoing developments with evaluation planned during 2016/17 to inform future developments. There have however been some successes already during 2015/16 with one example being the introduction of Rightcare Barnsley (care co-ordination centre) to support health care professionals including GP's to identify alternative packages of care for patients at risk of an urgent hospital admission, thereby avoiding admission where this is not the most appropriate care for the individual. This has seen up to 35% of referrals for hospital admission being provided with an out of hospital package of care.

As there are no new schemes included in the BCF for 2016/17 and work is taking place to pull all transformation and integration into the integrated transformation plan for Barnsley there are currently no significant risks identified with delivery of the plan in 2016/17.

A Co-ordinated and Integrated Plan

Governance Arrangements

Section 6 of the original BCF plan set out how the BCF aligns with other plans and how our planning process ensure the alignment between organisational plans, the BCF and the H&WB Strategy.

The strategic governance arrangements for the Better Care Fund remain the same as over the last 2 years with oversight being provided by the SSDG and responsibility for the plan ultimately sitting with the Health and Wellbeing Board. The section 75 agreement which will be updated to reflect changes in 2016/17 sets out the detailed management arrangements for the BCF plan. There have however been some changes to the supporting governance infrastructure particularly the programme board structures described in section 2c of the original BCF plan.

There were originally six programme boards which operated under the auspices of the Health and Wellbeing Board. Three sat within the 'Stronger Barnsley Together' Programme and the other three were more focussed on clinical delivery and transformation and were health led Boards focussed in delivering the transformation plans and priorities set out in the CCG strategic commissioning plan. The work of all the programme boards contributed to delivery of the BCF Plan and the wider Health and Wellbeing Strategy.

A review of the programme board structures and the 'Stronger Barnsley Together' Programme was undertaken in 2015 resulting in the programme boards being disbanded. A Clinical Transformation Board (CTB) was established and first met in June 2015, providing a simpler structure with strong clinical leadership and for the delivery of health and care led transformation. The CTB is a CCG Board however it is also attended by senior representatives from BMBC (Director of Public Health and Director of People) and the Medical Directors of Barnsley Hospital NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust as the main providers of Acute, Community and Mental Health Services for Barnsley residents.

The key functions of the Clinical Transformation Board are:

- Service transformation
- Pathway redesign
- Commissioning for improved outcomes
- Quality improvement through service redesign
- Reducing health inequalities and prevention
- Providing clinical leadership to integrated commissioning and service transformation
- Evaluation of transformation programmes, ensuring benefits realisation and informing future years commissioning.

More recently, building on the work which has been undertaken to develop stronger and more resilient communities, a new partnership Board has been established which will oversee much of the work previously linked to the Stronger Barnsley Together Programme. The multi-agency Stronger Communities Partnership brings together responsible authorities, statutory and voluntary services, and local people to provide system-wide leadership to the community and early help offer. The Stronger Communities Partnership acts as the executive body for activity being delivered across: Early Help; Anti-poverty; and Strong, resilient & healthy communities.

The Stronger Communities Partnership membership consists of the following agencies:

- Barnsley Metropolitan Borough Council
- The Health and Wellbeing Board - Provider Forum
- South Yorkshire Police
- Berneslai Homes
- NHS Barnsley Clinical Commissioning Group
- Voluntary Action Barnsley
- Health Watch
- Barnsley Healthcare Federation
- South West Yorkshire Partnership Foundation Trust

The partnership's priorities will be progressed through three Delivery Groups:

- Resilient and Healthy Communities - key themes will include volunteering and social action, behaviour change, Be well Barnsley, activity focussed on stronger resilient communities, area councils (evaluation), market development (Provider dimension), Social Value Toolkit, current view of VCS.
- Early Help and Prevention - having a focus on early help for adults, children and families. The complexity of existing arrangements has promoted a twin track approach to the Early Help aspect of the work; ensuring that the more progressed activity associated with children and families can continue while the emerging activity associated with communities and a universal offer can be developed effectively. Key themes will include Think Family, Troubled Families, Supporting People, Substance Misuse, Housing Advice, Domestic Violence, Offenders.
- Anti-Poverty - aligned to the revised anti-poverty delivery plan.

Both the Clinical Transformation Board and the Stronger Communities Partnership will provide updates into the SSDG and to the Health and Wellbeing Board with these including as appropriate updates on schemes which relate to the BCF Plan

There are also other governance structures in place where activities associated with the BCF plan are discussed and agreed, for example the System Resilience Group where action is agreed to ensure resilience across the health and care system. This includes specific activity to reduce pressures on urgent care through the development and delivery of a sustainable system action plan aimed at reducing the numbers accessing urgent care, supporting patient flow through and ensuring timely discharge from care. This plan will link to the DTOC improvement plan and also support the delivery of the planned levels of non-elective hospital admissions included in the CCG and H&W Board plans.

As set out in the introductory paragraph, the BCF planning process and plan is also being aligned to other key plans including the STP, Integrated Transformation Plan and the new Health and Wellbeing Strategy.

The final Better Care Fund Plan 2016/17 will be approved by the Health and Wellbeing Board.

National Conditions

Approach to risk sharing and contingency

In 2015/16 there was a formal risk share arrangement in place between the CCG and the Council based around the planned level of reductions to non-elective admissions to hospital. The purpose of the risk share was to offset the potential financial risk of continuing to fund non-elective admissions should the levels not reduce in line with the BCF plan. In 2015/16 the level of non-elective admissions continued to increase and therefore £1.9m was retained by the CCG in line with the national guidance and the section 75 and risk sharing agreement.

For 2016/17 it has been agreed that whilst every effort will still be made to reduce emergency admissions there will not be a risk share or contingency fund in place as part of the BCF.

The BCF schemes such as Rightcare Barnsley, Intermediate Care and Urgent Care Practitioners which are designed to prevent hospital admission have been taken into account as part of the CCG operational planning however whist these schemes can individually be seen to be delivering benefits they do appear to be avoiding admissions but not reducing the overall admissions as the underlying trends, increasing in people with complex needs and the ageing population are all contributing to higher numbers coming into healthcare services.

Other schemes such as ‘Be Well Barnsley’ are longer term and will not begin to have a positive impact for a number of years and therefore planned growth in non-elective admissions has been included within the CCG operational plan and financial plans.

In line with current arrangements to risk associated with any overspend against the services commissioned through the BCF will remain with the Commissioner.

Joint agreement of plans and engagement

The BCF plan is a jointly agreed plan of the Health and Wellbeing Board. The approach to planning and engagement is included within the original BCF submission and plans for 2016/17 have been agreed in line with this.

The main acute, community and mental healthcare providers and local housing authority are members of the health and wellbeing board and have been engaged in development of all

plans. The H&W Board Provider Forum are also engaged in the planning process to ensure that the wider network of providers are able to influence planning decisions and are aware of potential implications.

As the plan for 2016/17 is a continuation of the original plan the implication for providers is not expected to change and resources are in place to deliver each of the ongoing schemes.

As part of the wider planning and the development of the Barnsley Integrated Transformation Plan which will support the SY&B Sustainability and Transformation Plan, there will be a specific work stream focussed upon ensuring the that the workforce is in place to support the new ways of working and to develop plans for supporting the current workforce to adapt and change.

Maintaining the provision of Social Care

The approach to protecting the provision of social care remains in line with the current BCF plan and the level of funding allocated from the BCF to maintain social care provision is in line with in 2015/16, with some growth to reflect increases in funding in relation to the disabled facilities grant.

Funding also remains in place to support cares and continue to meet the duties resulting from the care and support reforms of the Care Act 2014. Details of this are included within the BCF planning Template.

7 Day Services

The approach to seven day services continues to be in line with the current BCF with the services highlighted in the plan moving towards 7 day provision and meeting the Keogh standards where these relate to acute care.

The specific funding identified to support 7 day services within the Better Care Fund is in line with the agreement in 2014/15 and 2015/16 to support the Acute Trust in moving towards achievement of the Keogh Standards. This funding was always anticipated to be required over a number of years to support transition and ensure the hospital have the required resources to deliver contracted activity until the national tariff payment system covers the cost of 7 day delivery and therefore is continuing in line with agreed plans.

Delivery of the Keogh standards included in contract arrangements with providers is being monitored by the CCG Clinical Quality Board.

7 day social work to support discharge from hospital is also in place (part of SRG plans – CCG funding) with additional capacity deployed to enable timely assessment and access to care packages for patients leaving hospital with continuing social care needs. A review of the impact of this scheme is being undertaken in early 2016/17 to identify the impact of the additional capacity and inform a decision of any required service changes and continued investment through 2016/17.

Better Data Sharing

Data sharing is recognised as an important element of integrating and transforming services in Barnsley. The current BCF sets out the arrangements in place and the governance arrangements to support this.

A key development in 2015/16 has been the introduction of the Medical Interoperability Gateway (MIG) across primary care enabling primary care providers to view (share) GP medical records. This has enabled the IHEART Barnsley Service, which is providing increased primary care capacity and is supported by the Prime Ministers Challenge Fund, to deliver a wide range of GP services from 2 hubs in Barnsley with full access to read patient records and ensure appropriate account can be taken of these when seeing and treating patients. In 2016/17 there are plans to consider the roll out of the MIG to other providers as part of the IT strategy and the implementation of the emerging digital roadmap.

The Digital Roadmap and associated plans is currently being developed alongside the STP and Barnsley Integrated Transformation Plan to ensure IT and Information are effective enables to transformation and integration of services. A key strand of this work will include better access to and sharing of data to improve care planning and delivery.

A joint approach to assessments and care planning

The approach to assessment and care planning continues to be in line with the current BCF. There has been increased focus on care planning through the implementation of the Year of Care approach in primary care and the implementation of Rightcare Barnsley has also supported improvements to care planning through the brokerage service offered to health care professionals which ensures patients have access to the right care at the right time and in the right place – out of hospital where it is safe and appropriate..

Out of Hospital Services

The Better Care Fund in Barnsley is predominantly based around out of hospital services in support of the strategic direction to deliver care closer to home where appropriate. NHS commissioned out of hospital services funded from the BCF is in excess of the previous Payment for Performance element of the fund and is included to ensure continued delivery of intermediate care services to support the urgent care pathways by providing step up and step down services which avoid admission to hospital and ensure timely, well planned discharges avoiding any unnecessary delays.

The review of Intermediate Care which was included within the original BCF resulted in the development of a revised service model which has been implemented as a pilot during 2015/16 and will continue into 2016/17 to enable a full evaluation of the impact and to identify if and how intermediate care services should be commissioned in future. The pilot is currently planned to run until September 2016, with evaluation ongoing during this period and this will be followed by a decision on future commissioning. During 2016/17 the level of funding for Intermediate Care Services has therefore being maintained.

Delayed Transfers of Care

The level of DTOC in Barnsley remains low in comparison to neighbours and levels seen nationally however there have been some increases in the levels of DTOC during 2015/16 and therefore we have set a target for 2016/17 which looks to reduce levels of DTOC back towards the average level in 2014/15. The shared DTOC action plan which is included at appendix 1 sets out the activities which have been agreed to reduce the DTOC level in line with the target.

In developing the plan we have reviewed best practice tools and resources including the High Impact Change Model for managing transfers of care and included actions as appropriate in response to the 8 identified changes. This plan will remain fluid and will be reviewed and amended to reflect performance through the year and ensure it brings together all actions that are aimed at reducing the level of delayed discharges including those identified by the System Resilience Group and included within the Sustainable System Action Plan for Urgent and Emergency Care, those actions and initiatives included in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan and those which are included in the Barnsley Integrated Transformation Plan is in development and will be in place and included in the final BCF plan for 2016 and monitored alongside delivery of the plan by SSDG. There is also a role to play for the Barnsley SRG and therefore the SRG will also be inputting to and contributing to the delivery of the DTOC plan.

National Metrics

The approach to developing the targets for the national metrics is set out in the comments section of the BCF planning return template. The approach is consistent with previously and based on delivering continuous improvement where possible but recognising the current position and challenges faced in 2015/16 and expected in 2016/17.

In relation to non-elective admissions, no additional level of reduction in included in the BCF plan as the level set out in the CCG operational planning template is reflective of recent trends and all expected changes as a result of service changes, transformation and policy changes. This includes the impact of services funded through the BCF as well as other initiatives as part of the wider system transformation plans. The level of activity included within plans is included within financial plans and contracts and will therefore be proactively monitored and managed as part of BCF performance reporting as well as through the CCG contract management and reporting processes.

The target relating to the long term support needs of older people by admission to residential and nursing care homes has been agreed at a rate of 675 admissions per 100,000, which based on the population estimates would equate to 308 admissions during the year. This appears to reflect a slight increase in planned admissions from 2015/16 however this is to reflect changes to the calculation following discussions across the region to ensure consistency in applying the definitions of Adult Social Care Outcome Framework measures. Historically where a person comes out of residential or nursing care within a set time period these have not been counted as permanent admissions. The figures will now include all cases where there is an ‘intention to admit permanently’ and therefore, based on current

rates this would mean an increase of around 5% so the 16/17 target is in effect set to maintain current rates.

There has been a change in focus locally around reablement aimed at assessing the outcomes at the end of reablement rather than just focussing on the 91 day measure as there are many reasons why someone may not remain at home after 91 days. There does however continue to be a desire to help people to maintain their independence at home and therefore a target has been set which aims to continue to improve the proportion of people still at home after 91 days.

The rationale for the target for delayed transfers of care is set out in the section above with the target being to reduce the level of DTOC back towards the levels in 2014/15.

The local measures included in the BCF reflect local plans and targets included as part of operational plans and are retained to ensure a continued focus upon these areas particularly given that initial targets have not yet been achieved.

Barnsley Better Care Fund Delayed Transfers of Care (DTOC) Action Plan 2016/17

Introduction

The Barnsley the Better Care Fund (BCF) Plan 2016/17 is set in the context of the wider Health and Wellbeing Strategy and Vision 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.

Overall planning for 2016/17 is taking account of the changing landscape and ensuring the alignment to developing the Sustainable Transformation Plan (STP) for South Yorkshire and Bassetlaw and the Barnsley Integrated Transformation Plan which will underpin delivery of the wider STP.

The DTOC action plan has been developed in the same context, recognising that the work to deliver the STP and the Urgent and Emergency Care Network Plan will have an impact upon patient flows and patterns of activity across the system, the DTOC plan builds upon the good work already taking place and the improvements which have been made to services during the last few years.

The level of DTOC in Barnsley remains low in comparison to neighbours and levels seen nationally across both NHS and Social Care. The BCF schemes such as the introduction of Rightcare Barnsley, the new target operating model in social care alongside some of the additional capacity which has been supported through the System Resilience Group such as increased social care assessment capacity over 7 days, enhanced intermediate care bed capacity and increased therapy support have helped to maintain this positive performance. There have however been increases in the levels of DTOC during 2015/16 and therefore the DTOC action plan aims to deliver some additional improvements which will reduce the number of delays during 2016/17.

In the context of the recent trends of increasing numbers of attendances at A&E and increases in the number of non elective admissions to hospital, we have set an ambitious target for 2016/17 which looks to reduce levels of DTOC back towards the average level in 2014/15. This will be challenging however we believe that patients should not be in hospital any longer than they need to be and that it is important for the patient to be receiving the right care in the right place and to return to there home with the right support in place as soon as possible.

In developing the plan we have reviewed best practice tools and resources including the High Impact Change Model for managing transfers of care and aligned planned actions as appropriate against the 8 identified high impact changes. The plan will remain fluid and will be reviewed and amended to reflect performance through the year and ensure it is aligned with the other complimentary activity being undertaken by the System Resilience Group to develop a Sustainable System plan for Urgent and Emergency Care as well as the emerging priorities and actions included in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan and those which are included in the Barnsley Integrated Transformation Plan.

The DTOC action plan will be monitored alongside delivery of the overall BCF plan by Senior Strategic Development Group of the Health and Wellbeing Board and progress will also be reported to the System Resilience Group.

DTOC Action Plan 2016/17

Theme	Activity/Actions	By When	Responsibility / Lead Organisation	Expected Impact	RAG	Comments / Progress Updates
Early Discharge Planning	Review of current discharge planning processes (discharge pathway) and revision to establish processes which support joint planning for discharge at the point of admission to both acute care and community services	July 16	BHNFT/ SWYPFT	Increased understanding of demand and capacity Improved communication between organisations and teams		
	Review Social Care 'discharge' assessment processes to ensure input as early as possible to discharge planning	July 16	BMBC	Earlier input to discharge planning Timely establishment/ re-establishment of packages of care		
Systems to monitor patient flow	Continuation of daily situation reporting across the system and SitRep calls	Ongoing	BCCG/BHNFT / SWYPFT / BMBC / YAS	Daily understanding of capacity, expected demand, pressures, delays. Ability to respond quickly to emerging pressures		
	Implementation of Medworx Clinical Utilisation Review system Phase 1 Acute Phase 2 Community Beds	Phase 1 Sept 2016 Phase 2 TBC	BCCG/BHNFT /SWYPFT	Clear understanding of patient acuity and level of care required Better understanding of patient flow issues Earlier intervention to maintain flow		

Multi Disciplinary Working	Continue to enhance the role of Rightcare to support discharge.	Dec 2016	BCCG/BHNFT /SWYPFT	Phase 3 of the service is to provide a single point of referral to discharge support services for the hospital wards and departments for patients who require community services in order for them to return home, following a hospital presentation or admission and the development of management plans for those identified at risk of readmission.		
Home first/Discharge to Assess	Access to 'spot purchase' respite and recuperation beds in the community	Ongoing	BCCG	Timely discharge of patients with ongoing support needs to enable assessment and choice for patients regarding long term care		
	Build on review of discharge planning and processes to establish Discharge to Assess model	Mar 2016	BHNFT/ SWYPFT / BMBC	Reduced admissions to care homes People are able to return home earlier with support		
Seven Day Service	Review impact of additional social care capacity to support 7 day assessment and agree approach	May 2016	BCCG/ BMBC	Increased weekend discharges Timely patient flow and discharge 7 days		
	Consider the model and access arrangements to domiciliary care provision particularly at weekends as part of re-procurement	Sept 2016	BMBC	Improved timeliness of access to domiciliary care packages Increased flexibility of care packages to meet patient needs.		

Trusted Assessor	Establish a 'Trusted Assessor' function for patients returning to Care Homes	Sept 2016	BMBC/BCCG	Reduction in delays for discharges of patients returning to care homes		
Focus on Choice	Develop support services with voluntary sector providers with a presence in Hospital to provide advice and ongoing input to support discharge	Sept 2016	BHNFT/BCCG	Improved support to patients returning home Improved patient understanding of choices and options for ongoing care		
Enhancing Health in Care Homes	Community Nursing Review to ensure community health and care teams work care homes and support patients in care homes	March 2017	BCCG	Reduced unnecessary admissions and improved hospital discharge		
	Intermediate Care specification to ensure access to high quality community beds in care homes for reablement and rehabilitation	Oct 2016	BCCG	Reduction in delayed discharges for patients awaiting reablement support Reduction in variation in quality of care in different settings.		

Organisations:
BCCG – Barnsley Clinical Commissioning Group
BHNFT – Barnsley Hospital NHS Foundation Trust
BMBC – Barnsley Metropolitan Borough Council
SWYPFT – South West Yorkshire Partnership NHS Foundation Trust
YAS – Yorkshire Ambulance Service