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Barnsley Health and Wellbeing Board

Stronger Barnsley Together

Pioneers in integrated care and support

Expression of Interest (EOI)

Barnsley Clinical Commissioning Group

NHS Foundation Trust

STRONGER BARNSLEY TOGETHER - PIONEERS IN INTEGRATED CARE AND SUPPORT - EXPRESSION OF INTEREST (EOI)

Sponsored by Barnsley's Health and Wellbeing Board (See Appendix 1)

The vision

Stronger Barnsley Together – pioneering for better outcomes and sustainable costs

We are... ... focusing on better information, advice and guidance, using new technology and signposting to alternative services... scaling up preventative services, providing early help, re-ablement and more self-management of long term conditions... using an asset-based approach to individuals and families in need, supporting them to manage their own health and care... developing community capacity rather than encouraging dependency... developing a new relationship with our citizens and communities based on co-production and reciprocity... aligning resources and programmes across agencies ... creating integrated pathways and flexible, user-centred services... reducing costs and personalising budgets.

Integrated care and support in Barnsley - why?

Barnsley has developed a strong track record of partnering with children, families and communities across the borough and partnerships across organisations. Because of this, we know we can work together, making the most of our shared assets, to make Barnsley stronger.

There are real challenges ahead. The current changes across health and social care represent the most significant since the inception of the welfare state. The scale of the impact in Barnsley is enormous and includes:

- the need to reduce engrained inequalities impacting on life chances, health and wellbeing
- the need to regenerate the local economy, increase community resilience and tackle family poverty, exacerbated by the recent benefit system changes, which is estimated to reduce Barnsley's individual, family and community income by £93m[1]
- demographic changes, including growth in older people and the ageing population, plus the numbers of younger people/adults with complex health and social care needs
- cuts to public funding, pressure to change health services and social care delivery, and the impact on workforce development
- adoption of new technologies.

Quite simply, isolated structural change, transactional changes, 'salami slicing' and single agency efficiency plans will no longer work. Doing more of the same is not affordable and will not work; doing less of the same will not meet need; **doing differently - in a way that delivers whole system transformation across the Health and Wellbeing Partnership is the only sustainable way forward in Barnsley.**

So what are we doing about it?

We are determined to use the strength of our partnerships, and the resources for which we are responsible, to deliver better outcomes for individuals, children and families, carers and communities. This will involve building on our strengths – and what we have accomplished so far – and applying a range of f**ast track enablers** to increase the pace of service integration necessary to meet these challenges. The aim is to **dismantle barriers to create clear integrated pathways** towards co-ordinated services and care. We are committed to driving these changes forward because we believe it is the right course of action, but gaining pioneer status will elevate the profile of the challenge, reinforcing the scale and pace need to achieve our ambition for a whole system transformation to deliver real benefits for the people of Barnsley.

The 2013-2016 Joint Strategic Needs Assessment (JSNA), structured around whole lifetime planning and the Health and Wellbeing Strategy, set out clear priorities for action and improvement in Barnsley, including cancer, CVD, COPD, alcohol misuse, children's health and the ageing population. These are being progressed through a range of initiatives, many of which are already starting to bear fruit. These initiatives will be crucial for Barnsley to inform and support the integrated transformation programme, which will be based on three building blocks:

- **strength in partnership and governance**
- **innovation in practice**
- **whole systems transformation - 'inverting the triangle'**

Pioneer status - so why Barnsley? - Barnsley's building blocks

The three building blocks, when taken together, are unique to Barnsley and will form the platform for success as a health and care integration pioneer:

1 Strength in partnership and governance

- A flourishing Health and Wellbeing Board with strong and dynamic relationships with all statutory partners, including Barnsley Council (BMBC), the Clinical Commissioning Group (CCG), Acute Trust, Community Trust, Police, and Healthwatch
- Integrated health and social care services across Adults' and Children's Services, with integrated or aligned budgets across key services.
- A revitalised Children's Trust and Safeguarding Board currently driving the post-Ofsted Improvement Plan overseen by Barnsley's Improvement Board.
- An integrated Public Health Service, which seamlessly transferred to the council in April and provides significant strategic influence.
- Good commissioner/provider relationships, developing 'intelligent commissioning' and collaboration, providing quality community health and acute NHS services.
- A fully operational Healthwatch with a history of commitment to service users and carer engagement.
- Co-terminosity across agencies and the 38 CCG GP practices.
- Good community and voluntary sector involvement across health and social care agendas, including, for example Turning Point, Voluntary Action Barnsley (CVS), community sector.
- Evidenced-based success in delivering community partnerships work, for example The Dearne Approach - a locality based citizenship, engagement and community budgeting model, promoting a radical approach to co-production set to be rolled out across Barnsley.
- Development of a new political governance model involving communities in commissioning to meet local priorities via Area Councils and Ward Alliances, with devolved budgets, and ongoing work to include other key partners.
- Section 75 NHS Act (2006) agreement between NHS Barnsley Clinical Commissioning Group (CCG) and Barnsley Council (BMBC), to underpin the joint commissioning of services and support to individuals.
- Integrated/shared governance, for example in Children and Adult Services, including joint management protocols and partnership agreements (particularly BMBC and South West Yorkshire Partnership Foundation Trust (SWYPFT).
- Working together in shared spaces, for example integrated anti-social behaviour teams with police and council staff co-located, the LIFT buildings and wellbeing centres in advanced learning centres, embedding strategic level information sharing protocols, including, for example, the UK's first NHS and social care record integration, thereby removing barriers at the frontline.
- the Barnsley Challenge Board, bringing together headteachers and other education and skills leaders, including academy principals, to lead the improvement agenda relating to achievement and attainment standards for children and young people.

2 Innovation in practice

Alongside the **strength in partnerships,** a range of **practice innovations** have been seeded, many of which are already delivering improved experiences and/or outcomes for adults, children and families, and communities. Some have already been highlighted as regional and national exemplars.

Telehealthcare (See fast track enabler 1)	A single integrated telehealthcare centre operates on a major scale across Barnsley, 24 hours a day, 7 days a week, 365 days a year, and monitors telecare alerts, home safety and personal security systems, enabling people to live at home independently. Care navigators from SWYPFT operate collaboratively with telehealthcare, encouraging self-directed care. *(See page 7 for further details)*
Personalised budgets (fast track enabler theme)	Barnsley is part of the Personalised Health Budget (PHB) pilot programme which gives NHS England authorisation to pay direct payments for continuing health care funding and renal transport, potentially involving over 160 people. It is a collaborative plan across the CCG and council, building upon 'People in Control' and using the expertise of the Personalisation Operational Board. There are currently 20 people directing their own support to meet their continuing health care needs via a direct payment and a further 19 people directing their own support to meet their continuing health care needs using the local authority to do this on their behalf. These people and their experiences will inform and shape the PHB programme in the future. Next steps include a whole system training agenda incorporating

local citizens and users as a priority. A robust evaluation of the systematic changes is being undertaken. Barnsley also contributed to the POET (Personal Budget Outcomes and Evaluation Tool) survey. Personalised budgets are also being taken forward in conjunction with **whole lifetime planning**, using the Marmot 'lifecourse' concept of personalised planning for the whole person for the whole of their life, including points of transition, putting empowerment of the individual at the centre.

Right to Control Trailblazer (connects to personalised budgets)

Right to Control is a rights-based approach to support and services for disabled people. It brings together a wide range of cross-government funding streams, including Access to Work, Adult Social Care, Disabled Facilities Grants (DFGs), the Independent Living Fund (ILF), Supporting People and Work Choice, with a view to streamlining the customer experience across these funding streams. Disabled people, eligible for the Right to Control, are also offered greater choice and control over the support they receive to go about their daily lives, as well as the option to take a direct payment and arrange their own support.

Stronger Families and Troubled Families (see fast track enabler 2)

Stronger Families is Barnsley's innovative multi-agency integrated approach to working with children and families, with the aim of early intervention, to prevent families from needing more intrusive and costly interventions. *(See page 8 for further details)*

This is complemented by the Troubled Families programme where Barnsley is targeting 645 families to support the aims, objectives and outcomes of the National Troubled Families agenda, now being extended for a further five years. Good progress is being made as a result of concerted and co-ordinated efforts across the Children's Trust and Health and Wellbeing Partnerships, based on a **whole family approach**. On a payment by results basis, Barnsley aims to draw around £2m in the next three years. A key theme is to deliver cost efficiencies through streamlining whole family interventions.

The Dearne approach (see fast track enabler 3)

An approach developed in partnership with Turning Point, based on their 'Connected Care' model of engagement. This is an Innovative model of community led commissioning involving communities in the design and delivery of neighbourhood services. This is shifting the balance of power and changing the way that commissioners do business with the community. There is a focus on building capacity, promoting community enterprise and volunteering and developing community budgeting to match local need. *(See pages 8/9 for further details)*

Home Truths

Here, the significance of the relationships between GPs and social care staff in driving demand for social care has been researched. The aim is to improve the functional relationship to manage demand. Work includes progressing pre and early diagnosis of dementia which complements Barnsley's Dementia Friendly status. The broad focus is early intervention and crisis response; signposting, optimising emergency unplanned care and end of life care. Home Truths is one of only six such initiatives in the UK. The work is being used to shape opportunities for whole systems transformation.

Connect to Barnsley and Connect to Support

Launched in June 2013, this is a website that brings together a wide range of local services, support and advice, enabling people to access information and advice in one place; look at what support is available to live independently; see how local health and social care services can help; read about what services are available where they live; and find out who to contact for further advice and support. Connect to Support enables people to browse online and purchase local health and social care services and products. People can make independent arrangements and find details of local community and voluntary groups and activities.

Customer Services Organisation transformation

This is a refreshed customer relationship manager system which, over time, will provide a single view of customer interactions and self-service capabilities at reduced costs. There will be a greater move towards web, SMS, mobile apps and social media supported by a telephone call centre and major web development. There will be capability to examine geodemographics and work across organisational boundaries.

Excellence in training and development

Barnsley Council has a high performing training and development function to support workforce and organisational development across the council, NHS and independent sector providers, currently trading on a sub-regional basis.

Integrated Youth Strategy

A new Integrated Youth Strategy brings together the resources of Youth Services (including youth clubs, Youth Offending Team, Targeted IAG (formerly Connexions), Positive Activities Team, Participation and Inclusion Team. This will enable the co-ordination and targeting of resources according to needs, delivered through integrated pathways, wherever possible on a locality basis. Alternative delivery models, including co-production with communities and voluntary sector involvement, are being explored.

Evidence-based practice, focusing help on the disproportionately vulnerable	Family Nurse Partnership, Having a Baby Programme, Multi Systemic Therapies, Improving Access to Psychological Therapies, Incredible Years and Strengthening Families parenting programmes, and Breaking the Cycle for Substance Misusing Parents are all examples of multi-agency, multi-funded interventions designed to offer evidence-based support at the earliest opportunity to improve outcomes and promote independence and self-management in future. These programmes have high levels of success in Barnsley substantiated through evidenced based evaluation.

3 Whole system transformation - 'inverting the triangle'

To address the challenge set out in the Health and Wellbeing Strategy, we have initiated a new approach known locally as **'Inverting the Triangle'.** *(See Appendix 2)* This will see a step change and a cultural and strategic shift from the current approach, with a greater focus on prevention and early intervention, enabling individuals to support themselves and their families, within their communities, rather than being drawn into the formal system. This will require a change in relationship to one which sees a shift from passive recipient of services to active agent, facilitated by a move away from an overly professionalised model to a community and citizenship model, where all parts of the community have a role to play and are encouraged to do so.

The **Inverting the Triangle** approach and principles have been agreed by the Health and Wellbeing Board and have the full support of partners. They also chime with the evolving neighbourhood governance model around Area Councils and Ward Alliances by helping local people identify and address local needs, promoting greater involvement and ownership through co-production, reciprocity and citizenship.

So what next? - the plan for whole systems integration and transformation

In summary...

Using our **strength in partnership** and governance, our **innovation in practice** and our strategy to **invert the triangle**, our proposal is to fundamentally shift the focus from health and care agency interventions, to more holistic engagement and citizenship; at individual, family and community level. The provision of information, advice and signposting is key, alongside access to flexible and integrated service pathways which support people to maintain control and enable self-management wherever possible. Based on an asset, not a deficit model to create social value, we are confident that this will bring about the change required across Barnsley communities based on **engagement and behaviour change**.

We have a strong track record of making things happen, exemplified by developments such as the new Area Governance arrangements, Dearne Approach and the engagement of Turning Point, Stronger Families, Personal Budgets, People in Control, Right to Control Trailblazer and Telehealthcare.

Pioneering: a three pronged approach

Our pioneering transformation model is therefore straightforward. Our approach is based on three prongs:

firstly ... inverting the triangle

We wish to take this existing initiative further forward with increased pace and earlier delivery of benefits. Specifically, we will be applying a whole systems integrated approach to drive transformation through inverting the triangle to deliver the following success measures:

- a focus on prevention, early intervention and early help, directing people to local, non-statutory sector services
- a community engagement model promoting mental and emotional wellbeing, providing low level social support
- person, family, and community-centred services premised on an asset-based model, optimising people's independence, health and wellbeing through self-help and self-direction.
- exploring the benefits of working with volunteers, championing community health improvement on a peer-to - peer basis, for example the 'Altogether Better' initiative.
- financial efficiency and sustainable costs.
- short-term targeted interventions plus supporting those with stable long-term conditions to self-manage.
- universal information and advice, and the promotion of lifestyle changes.

secondly ... joining the dots, joining the programmes

Key to success will be the creation of **a joint transformation programme** across the partnership so the benefits and added value of each programme can be maximised and improved outcomes can be enabled. A selection of these is highlighted as **innovation in practice** by improved outcomes. The various programmes will be defined as either:

- single agency activity
- activity for collaboration
- joint activity

There will be increased transparency and programmes will be subject to quality conversations and co-ordinated planning and delivery across the partnership to maximise outcomes:

- securing co-ordinated and integrated pathways and care services based on lifetime planning, including for those who need intervention and targeted services, for example people with long-term conditions and/or high intensity needs.
- accessible and responsive 24/7 services.
- using technology to maximum effect.
- single points of access and access to triage services.

The joint programme approach will be supported by a joint programme office, already agreed by the Health and Wellbeing Board.

Joining the dots: exploring opportunities now...

A transformation workshop has already been set for September 2013 for all Barnsley Health and Wellbeing Board partners to share and assemble a co-ordinated transformation programme. Major transformation requirements will be assessed and opportunities will be identified to work together in a new approach so that all contributions can be maximised to deliver shared outcomes. For example, looking at older people's services, end of life care, and integrated pathways across health and social care for children and young people.

A practical example may be the A&E four hour wait target, where we will be looking at whole systems change beyond BHNFT hospital organisation. This may include learning from the Home Truths work with GPs to unlock resources; learning from SWYPFT ICAT initiative care services; including Troubled Families and Stronger Families activity looking at accelerating prevention, and Drug and Alcohol Services considering how to offset crisis resulting in A&E attendance. Opportunities to enable communities to adopt behaviour changes in decision making about what constitutes the need to attend A&E will be explored further. Examples include looking at Public Health promotion work; Fire Services Home Safety awareness campaigns; and work with police on peak time prevention, including night time demand. Volunteers in A&E could be trained to provide advice and support.

In this way, partnership actions will deliver multiple benefits and impact on key outcomes. A push on greater use of assistive technology, including Telehealthcare and the Connect to Barnsley portal, will further support communities to be more self-sustaining.

Joining the dots: promoting community-based services....

We will be looking at increasing the capacity of community-based services to deliver care closer to people's homes and provide genuine alternatives to hospital-based care. This will help, for example, people with long-term conditions and ambulatory care sensitive conditions, who currently have to regularly attend hospital appointments in out-patient clinics as part of their monitoring and management.

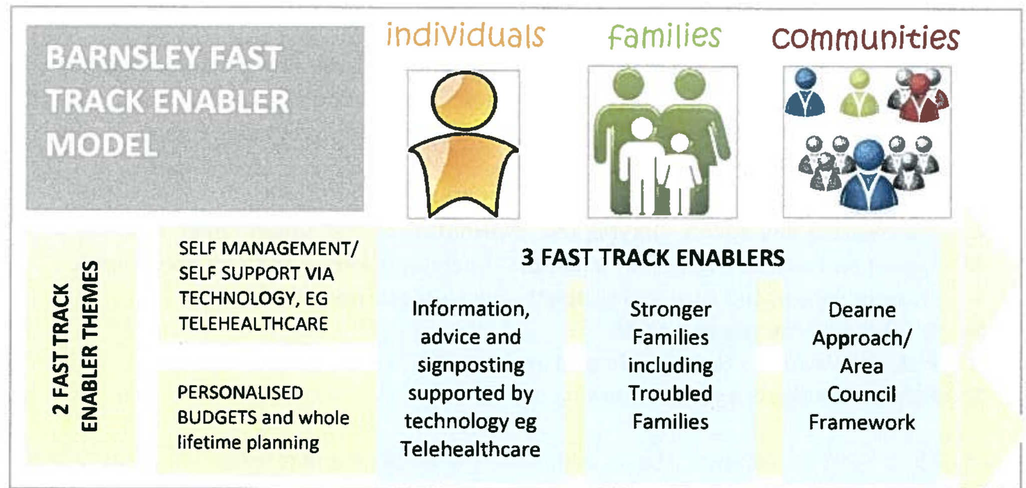
We are aiming to create a 24/7 integrated care system that can responds to escalating need as and when it arises. Current models of service delivery in primary, secondary, community health and social care will work together to adapt to meet this agenda. Provider partners, including BHNFT and SWYPFT, will be working collaboratively across the whole system to shift capacity into community-based solutions.

We will be promoting a rehabilitative approach to enable people to regain and maintain their optimal levels of health, independence and wellbeing, preventing the escalation of a crisis in people's health and care needs, thereby breaking the cycle of unnecessary dependence on health and social care services.

thirdly... fast track enablers

Using the principles of **inverting the triangle,** and looking across the whole range of **innovations in practice,** forming the **new joint programme,** we will identify key catalysts for change at three levels:

- **individual**
- **family**
- **community**



The catalysts, with scope for special impact at each level, have been designated as **fast track enablers** so that progress continues to be rapid, scalable and radical, resulting in sustained behavioural changes, based on developing models of peer support.

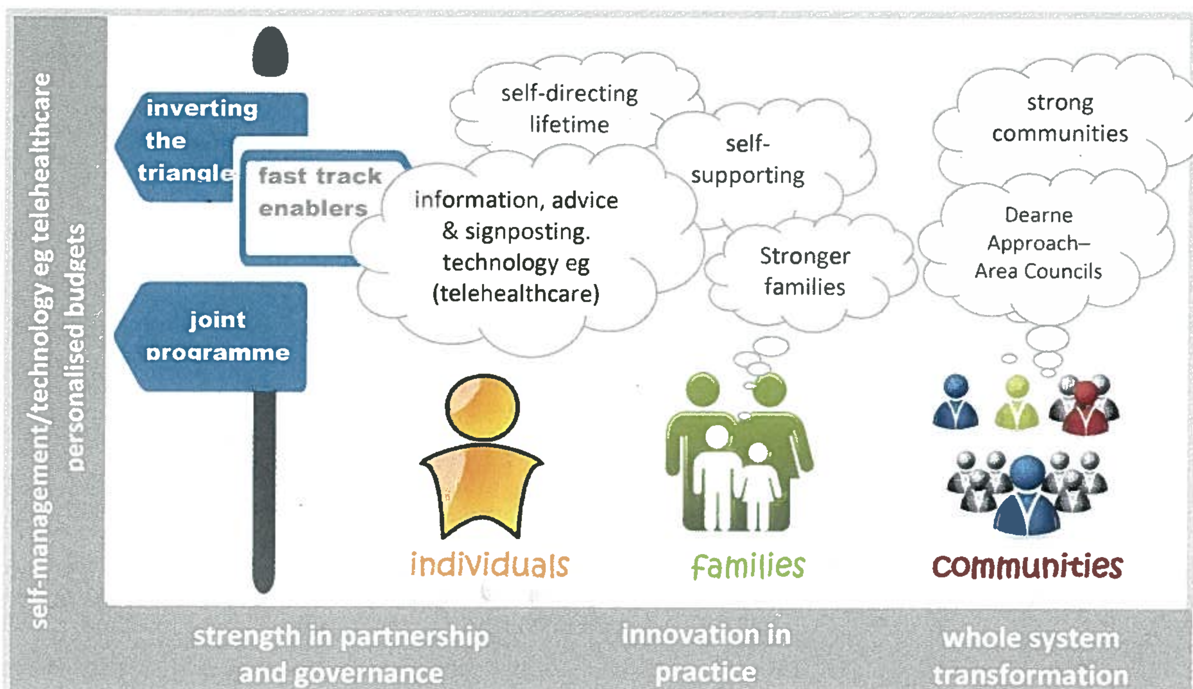
Individual level... our aim is to **prioritise information, advice and signposting to drive self-directed care, assisted by technology, including telehealthcare** as the fast track enabler, alongside **personalised budgets**. To ensure we drive the 'National Voices' agenda, we will also focus on person-centred and **whole lifetime planning.**

Family level... our priority will be to support families to be self-managing and self-supporting, avoiding crisis and the need for statutory interventions in a whole family approach. To achieve this, the fast track enabler will be the **Stronger Families** work focusing on areas such as supporting **emotional/mental wellbeing** to promote enablement and the concept of self-management, thereby inverting the triangle. The **Troubled Families** programme will also be key.

Community level... we aim to engage and empower community behaviour changes so that communities can be more self-sustaining, agreeing and targeting the use of resources and co-producing or independently providing solutions and support. At this level, the fast track enablers will be the **Dearne Approach** and the new **Area Council Framework.**

All levels... our emphasis will be on two cross-cutting **fast track enablers... self-management,** supported **through technology such as Telehealthcare,** and enabling **personalised budgets**.

Stronger Barnsley Together – pioneers in integrated care and support



Achieving outcomes

We intend to measure the success of our transformation programme according to the Barnsley 'I Statements' set out in our Health and Wellbeing Strategy. These are based on the narrative developed by 'National Voices' in association with 'Making it Real' (adopted by the Health and Wellbeing Board Strategy) which was tested and agreed through local citizen consultation.

- **Information and advice - having the information I need, when I need it.**
- **Action and supportive communication - keeping friends and family and place.**
- **Flexible, integrated care and support - my support, my own way.**
- **Workforce - my support staff.**
- **Risk enablement - feeling safe and in control.**
- **Personal budgets and self -funding my money.**

As well as the 'I Statements' above, which include children and families, there are specific considerations to take into account based upon consultation centred around the established children's outcomes framework as highlighted in Barnsley Children's Prospectus 2013.

Fast track enabler 1 - innovation in practice – technology: telehealthcare

A whole system approach to the design, development and deployment of Telehealthcare services will make a significant contribution to the successful implementation of the new Inverting the Triangle care model as the inputs, outputs and outcomes are closely aligned. The technologies are predominantly aimed at the, soon to be, 60,000 people in Barnsley with long term conditions who contribute nationally to 70% of all NHS spend. The majority are over the age of 65, with the requirement for holistic health and social care service provision, supported through the delivery of Telehealthcare services in Barnsley. Conditions include dementia, falls, COPD, heart failure and diabetes.

Telehealthcare outputs/outcomes include self-care, independence, choice and control, and quality of life for service users which help to optimise the use of other services such as hospitals, GPs, ambulance, community health care and social services, to help manage growth in service demand due to an ageing population at a time of diminishing financial resource.

The technologies enable people to live independently and safely in their own home for longer, at the centre of their care, with services delivered more closely to the community, supporting the shift from hospital care. People in receipt of the technologies are less likely to require as many hospital visits, or community nursing inputs, less intervention from GPs, and generally have a greater understanding of their health conditions, which supports positive behavioural change, particularly in respect of Telehealth.

Early intervention, through communication media such as Connect to Barnsley, is vital in preventing or delaying the need for people to require more expensive health or social care service provision, at the same time as improving people's quality of life as a result of independent living. The technologies are not targeted exclusively at older people; they are currently benefiting 150 people with learning disabilities and are increasingly being used by children and families and people with mental or physical disabilities.

Unique to Barnsley...

- We are one of only a small number of organisations across the UK that are working collaboratively in the delivery of Telehealthcare (Telehealth and Telecare) with an integrated approach to service provision between health and social care. Telecare is fully integrated across the HART Re-ablement Pathway to maximise the potential for independent living and reduce the costs associated with long-term care as part of the preventative agenda.
- We have developed an award winning 'falls collaborative' between NHS, Yorkshire Ambulance Service and the local authority (Independent Living at Home Service) with Telecare at the centre.
- District nurses plug and play carelines from the boots of their cars if they feel a patient may require further support. Care Navigators (SWYPFT) and Telehealthcare Wellbeing Assistants (BMBC) work alongside one another in the delivery of Telehealthcare Services clinical/non-clinical skill mix.
- We are developing a UK Centre of Excellence in collaboration with Bosch, initially for the provision of Telecare Services and working on a telehealthcare awareness training programme as we scale up the service.

Fast track enabler 2 - innovation in practice – families – Stronger Families

In 2012, a Stronger Families Team (SFT) was set up in the north east area of the borough to trial a multi-agency, integrated approach to help families avoid the need for intrusive and more costly interventions. The aim of the team was to bring services together to develop the early help offer in social care, (Munro Review 2011), aspects of the national Health Visitor Improvement Plan, with reference to partnership working and the emerging Troubled Families agenda. Barnsley's SFT model, which goes further than the Hackney model highlighted in the Munro Review, brings together social workers, child psychologists, health visiting, school nursing and voluntary services, as well CAMHS, to intervene with families on a locality basis. Integrated Targeted Youth have also been part of the test team.

The emphasis is on the importance of intervening early when additional needs are identified for a child or young person to achieve positive outcomes. The aim is also to identify the key services and interventions rather than risk duplication to help prevent families becoming confused about who and how support is being offered. The team in the north east of Barnsley has developed an integrated approach to responding to domestic violence incidents reported to the police that do not require intervention by children's social care.

This model will be rolled out across the borough during July 2013 through the establishment of four SFTs. In addition, Addaction, a key voluntary sector partner, has developed a whole family-based intervention to be rolled through the SFTs to support behavioural change in families where substance misuse is identified as a significant issue. Discussions are underway to confirm how Education Welfare Service and Integrated Youth Service will link into the four teams.

From the health services' perspective, SFTs will have integrated arrangements with an advanced health visitor, school nurse and CAMHS therapist. A family nurse (FNP) will also be linked to each of the four teams. These key professionals will work with their colleagues in the core team, including social workers and family support workers, and across the locality to support integrated working via the identification of vulnerable families and co-ordination of appropriate services at the right level and the right time. SFTs will provide smoother access to services and support for families via GPs and schools, both sectors having expressed concerns about access to early support services. The team will help embed the use of a new Continuum of Assessment.

One key aim of the SFTs is to deliver at the Universal Partnership Plus level of the Health Visiting Implementation Plan, where the advanced health visitor will work closely with colleagues from Children's Social Care, CAMHS, children's centres and voluntary agencies particularly 'Pathways' (a third sector domestic violence service) and other local voluntary agencies such as the Romero Project.

SFTs will be enabling access to Webster-Stratton or 'Triple P' parenting courses. In the north east pilot, by working alongside CAMHS, the SF health visitor has been able to support colleagues in ensuring that more appropriate referrals reach CAMHS. The health visitor role has been and will continue to be instrumental in setting up new relationships with local GPs. Public Health services are actively supporting the SF development as it takes forward direct work with individual families with a strong focus on health promotion topics such as breast-feeding, children's eating, exercise and work with young people in schools around pregnancy and parenthood. Public Health services are providing evaluation resources to help track and measure progress in the tricky area of preventative strategy impact.

The Troubled Families (TF) programme is integral to the Stronger Families (SF) work and there is tight collaboration to maximise outcomes. (See page 3 for further details of the TF programme) An element of the TF programme work relates to tackling data flows and performance management systems, the benefits of which can be applied to the SF initiative as it develops.

Over and above the SF and TF programmes, the Early Years services, including children's centres, will be driving forward the health, wellbeing and skills agenda, supporting children, parents and families. Schools and colleges will continue to pursue the improvement of attainment and achievement of children and young people, and they are playing an instrumental role in engaging and supporting families through the commissioning and delivery of a range of family support services.

Fast Track Enabler 3 - Community - Innovation in Practice – The Dearne Approach

Following work during 2010-2011 to develop a Local Integrated Services (LIS) approach in Thurnscoe, a proposed plan and way forward was agreed to establish Trust Thurnscoe/Connected Care initiative as a pilot for a new way of working for the council and partners at a neighbourhood level. At its most basic level, the LIS approach pulls together citizens from a neighbourhood, local elected members and representatives from statutory, voluntary and community sector partner organisations who provide services in the area to research local needs, plus co-design and develop services to meet the needs of local people within existing (and in the current climate, declining) budgets. Fully developed, the LIS approach offers the opportunity to develop a full model of community-led commissioning of services which could be provided by a wide range of potential providers, including specifically designed consortia, social enterprises or by the community itself.

Essentially it is about identifying the needs of individuals and communities and delivering outcomes to meet these needs. The anticipated benefits of a LIS approach include:

- improved outcomes from streamlined core programmes, eliminating smaller, often time and resource intensive, activities.
- helping to empower communities and build community capacity, reducing the dependency on the public sector.
- allowing resources to be targeted and prioritised to meet local community needs.
- encouraging innovation and enterprise among public sector employees.
- enabling better use and targeting of resources across agencies and sectors, increasing value for money.
- reduced costs throughout the system while enhancing frontline service delivery outcomes.

Above all, the approach and way of working represents a fundamentally different way of commissioning and delivering services, working with and alongside the community. This is a cultural change in terms of how services are delivered and how partners work together.

The Dearne Approach is bringing to life **Whole Place community budgeting** at local level incorporating LIS principles. Learning so far is confirming that the **role of elected members is of vital importance**. Recruitment and deployment of local community researchers has been very effective as a model for community engagement. It has enabled the 'reach' of the research to be extended to groups and individuals that traditional research methods may not have reached. We have also noted the importance of good quality research findings to inform local priorities. Baseline costing methodology has been developed and is ready to use on service areas identified through community research. This is an exciting development which is being subjected to formal evaluation with a view to rollout as achievements are evidenced. In summary, it involves:

- an approach developed in partnership with Turning Point based on their 'Connected Care' model of engagement.
- innovative model of community-led commissioning involving communities in the design and delivery of services.
- shifting the balance of power – changing the way that commissioners do business with the community.
- designing and delivering integrated neighbourhood services.

Evaluation, programme management and workforce development

External support/challenge

The EOI has attracted the support of Turning Point and University of Leeds, plus National Voices, as external partners/advisors who are interested in supporting the approach we are adopting and being involved in the wider transformation work ahead. We are open to challenge and keen to share learning across the system supported by our external partners. We aim to do this through a range of methods including direct engagement, networking, using online technology and partnership events.

Barnsley has a strong track record of engagement with national development programmes. For example, we were part of the early implementers network for Health and Wellbeing Boards and we recently concluded a Local Government Association Development Programme in readiness for the Health and Wellbeing Board taking on its statutory responsibilities in April 2013. Barnsley, therefore, welcomes the opportunity to discuss further opportunities for tailored support from national partners in respect of this pioneer programme, which may include, for example, areas such as workforce development. At this stage, we anticipate that areas for freedoms and flexibilities potential may include proposals to adjust the way that the success of health and care organisations are measured to reflect the impact of inverting the triangle.

Finance, performance and metrics

Though we have already carefully considered a range of performance measures relevant to the achievement of the outcomes (*see Appendix 3*), metrics for the transformation plan will be established, with support from the University of Leeds, who have agreed to provide independent evidence based evaluation. This will incorporate measurement against national outcomes frameworks. We also wish to involve our local communities. For these reasons, we wish to co-design the metrics as part of the pioneering programme. This will include tracking of systems change and the achievement of outcomes for individuals, communities and families, with the University of Leeds Business School providing independent evaluation.

Cost benefit analysis will also be undertaken and financial modelling will be a key part of the evidence based evaluation to build a sustainable finance plan. We will look to track a cohort of high intensity service users, likely to have long term conditions. The intention is to monitor cost movements, checking for cost shunting, to identify the impact of the strategy, the joint programmes and the community capacity building. We will be looking for opportunities to ascribe the savings to the actual intervention source/programme creating the impact. We are also looking at the 'Family Cost Calculator' in the Troubled Families programme to evidence the savings and other areas including the Adult Learning Disability Review Care Calculator. As well as this work, Barnsley Public Health will be undertaking evaluation work to measure the success of Stronger Families. The Dearne Approach initiative is also progressing through evidence based evaluation. All of these will be drawn together through the joint programme office.

Future plans... other enablers

We have plans to drive changes in systems, processes and frameworks in 'back office' functions and our remit will extend to exploring innovation in estates provision, access, ICT, finance and performance management systems and systems intelligence. For example our JSNA data is increasingly joined up, with scope to integrate/align intelligence and research functions. These enablers will be progressed through our pioneer proposal.

Predictive risk stratification tools and techniques will be used to provide clear information on need.

Programme management, workforce and organisational development

Barnsley Health and Wellbeing Partnership has already agreed a **joint programme office** to deliver the pioneering programme. **Robust programme management** principles will be applied, including the development and implementation of a **risk management plan** to account for identified risks and the range of mitigation strategies required to secure success. Resources have been aligned and plans to underpin the transformation include an **integrated workforce and organisational development** plan which will incorporate a commitment to **communication** and cross-agency **staff engagement**. We recognise the cultural shift needed, not only with Barnsley people, families and communities, but with our staff. Workforce planning for change across the partnership will be key to the success of the programme and will help to drive organisational development.

And finally ...

We believe that Barnsley has all of the necessary characteristics to deliver a successful integrated health and care pioneer programme and that we are able to meet the specified expectations. Together, we will deliver our transformation programme across three phases:

- **Phase 1 2013/14** - already underway as described.
- **Phase 2 2014/16** - to achieve medium term objectives including evidence based evaluation of cost savings, embedding of personalised budgets and results delivery on fast track enablers. Alignment of joint programmes and delivering key impacts including improved self-direction and independence at individual family and community level and better all round service experience.
- **Phase 3 2016/18** - achievement of whole systems transformation - better outcomes and sustainable costs.

Glossary

A&E	Accident and Emergency
Barnsley Healthwatch	Local consumer champion for health and social care
BHNFT	Barnsley Hospital NHS Foundation Trust
BMBC	Barnsley Metropolitan Borough Council
CAF	Common Assessment Framework
CAHMS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardio Vascular Disease
CVS	Council for Voluntary Services
DFG	Disabled Facilities Grant
FNP	Family Nurse Partnership
GP	General Practitioner
HART	Home Assessment Re-ablement Team
IAG	Information, Advice and Guidance
ICAT	Intermediate Care Assessment Team
ICT	Information, Communication, Technology
ILF	Independent Living Fund
JSNA	Joint Strategic Needs Assessment
LIFT	Local Improvement Finance Trust Imitative
LIS	local Integrated Services
PHB	Personal Health Budget
POET	Personal Budget Outcomes and Evaluation Tool
SFT	Stronger Families Team
SMS	Messaging Service
SWYPFT	South West Yorkshire Partnership Foundation Trust
TF	Troubled Families
YAS	Yorkshire Ambulance Service

Footnote

1 *Sheffield Hallam University, 'Hitting the Poorest Places Hardest: the local and regional impact of welfare reform' 2013*

Appendix 1

Expression of interest sponsors: Barnsley Health and Wellbeing Board

Leader of the Council (Chair) - Councillor Sir Stephen Houghton CBE

Cabinet Member for Adults and Communities – Councillor Jenny Platts

Cabinet Member for Children, Young People and Families – Councillor Tim Cheetham

Cabinet Member for Public Health – Councillor Chris Lamb

Chief Executive of Barnsley Council - Diana Terris

The Council's Executive Director of Adults and Communities - Martin Farran

The Council's Executive Director of Children, Young People and Families - Rachel Dickinson

Barnsley's Director of Public Health - Sharon Stoltz (currently Acting Director)

Chair of NHS Barnsley Clinical Commissioning Group - Dr Nick Balac, (Vice Chair)

The Chief Operating Officer of NHS Barnsley Clinical Commission Group - Mark Wilkinson

The Chairman of Barnsley Hospital NHS Foundation Trust – Steve Wragg

The Chief Executive of Barnsley Hospital NHS Foundation Trust - (currently being appointed)

The Chief Executive of South West Yorkshire Partnership Foundation Trust - Steven Michael

A representative of the NHS Commissioning Board - David Black (Medical Director, NHS Local Area Team, South Yorkshire and Bassetlaw)

Barnsley Healthwatch - Chris Green and Margaret Baker

Barnsley's District Commander, South Yorkshire Police - Chief Superintendent Andy Brooke

Appendix 2

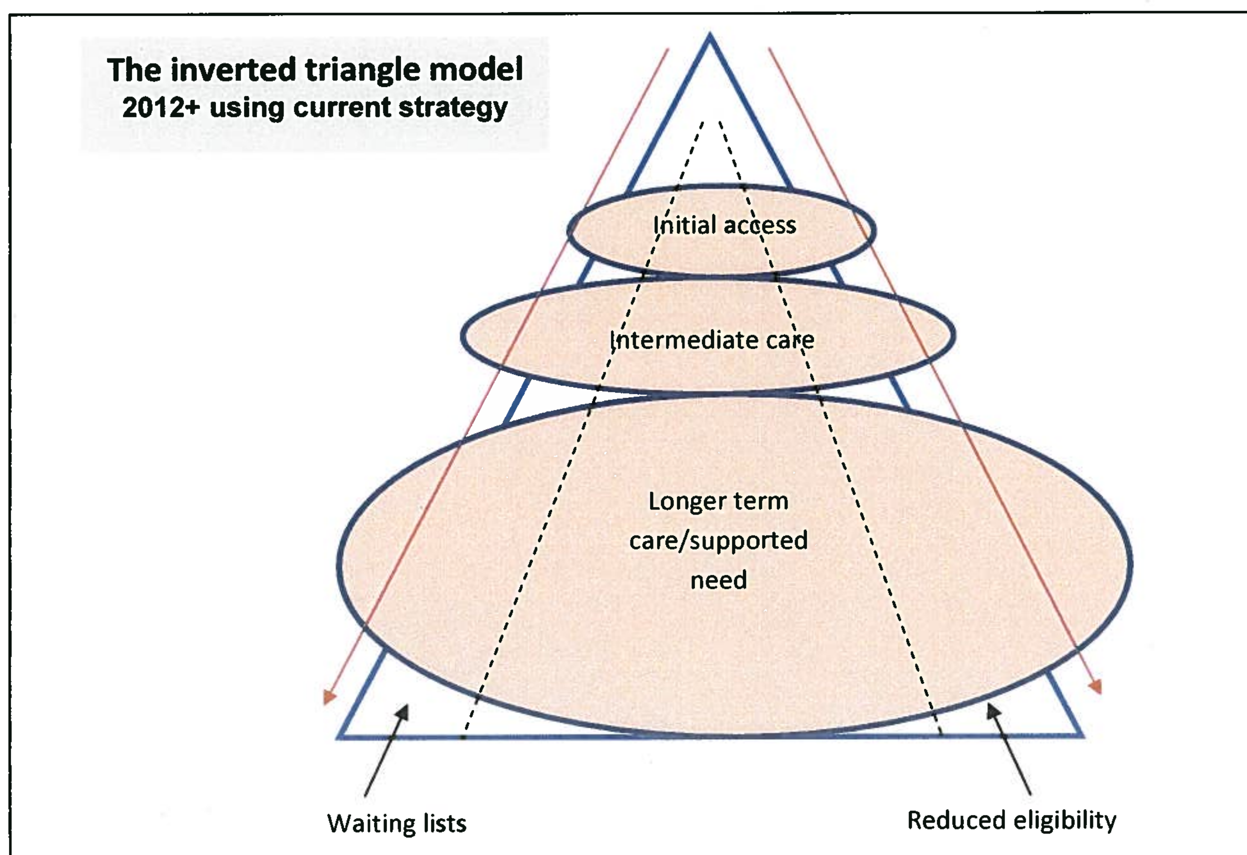
Inverting the triangle – a health and social care system for the 21st century

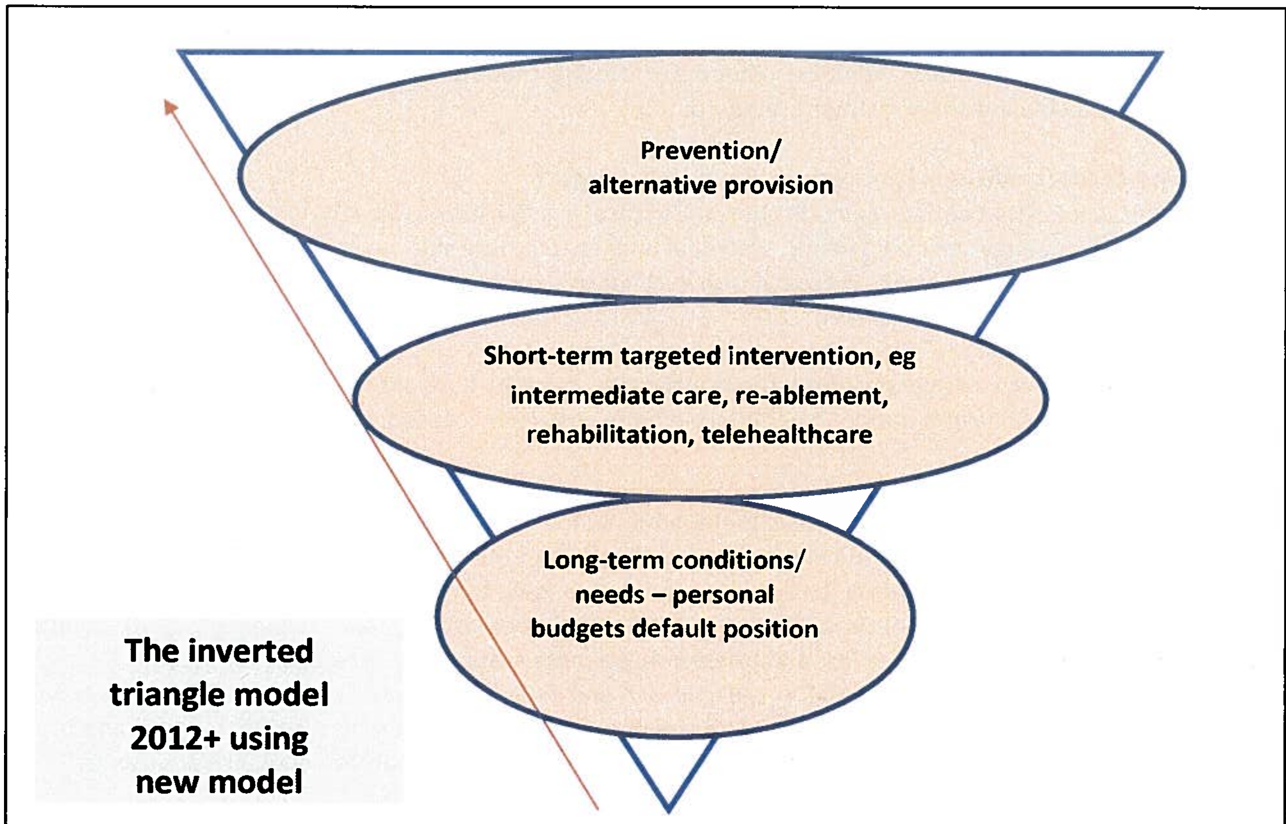
Today's narrative around the challenge across the public sector and the need for reform is a familiar one:

We need to scale up preventative services . . . . pool resources across agencies . . . . need an asset-based approach to people in need supporting them to manage their own health and care . . . . we need to develop community capacity rather than state paternalism and dependency . . . . we need to develop a new relationship with our communities and citizens based on co-production and reciprocity . . . . we need integrated pathways and a range of flexible customer focussed provision . . . . we need to focus on better informing and sign-posting to alternative and preventative services, early intervention and re-ablement.

While the growth in the numbers of older people, who are also living longer, plus younger people with significant health and social care support is something to celebrate, it represents a significant challenge as the current model and level of service provision will not be able to cope. Add to this the additional reduction in resources due to national austerity measures, and it is clear that efficiencies and technological improvements alone will not balance the equation. Status quo is simply not an option. Equally, the impact of not facing up to the situation means we will systematically struggle and eventually fail to meet critical needs without a major injection of additional resources that simply do not exist.

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





The proposal is to move away from the traditional approach based on eligibility and reactive ill health provision and systems/services based around the legislative framework, ie 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

Fundamentally we have got to systematically manage the 'front end' of how people enter the health and social care system and how their needs are met. We need to shift resources from those in greatest need to provide a better service for the majority:

Tier 1 – Universal information and advice, lifestyle changes, early intervention/prevention, triaging
A much greater emphasis on providing co-ordinated and connected information and advice. NB – although some agencies have a one-stop shop, different agencies have their own, therefore, for the customer, it is not one stop. Most of these services are not mandatory and therefore have a tendency to be the first that are reduced when there are budget problems

Tier 2 – Short-term/target interventions
For example health coaching supporting people to adapt their life style; telehealthcare supporting people to manage their own health and social care needs should be the default option of what is offered to people whose needs are not met at tier 1

Tier 3 – Re-ablement/intermediate care
Specialist and specific targeted services which support people to regain their skills to maintain independent living. A key emphasis upon time limited interventions, managing expectations that the service support them to achieve agreed outcomes and then refers them on to tiers 1 and 2. Locally we can evidence that over 50% of people who receive these services go on to need no further on going provision and the majority of the others require less service than would otherwise have been provided. NB we need to review the model to

both ensure we maximise efficacy and utilise resources, including that available via the independent section, which can often provide inward investment required.

Tier 4 – Long-term conditions that require on-going support

Building on the success that already exists in adult social care, ie in Barnsley over 80% have a personal budget to support them to manage their own needs. Personal Budgets promote self- management, which needs to be the default position across health and social care in children's and adults services for all those who need support to manage a long-term condition.

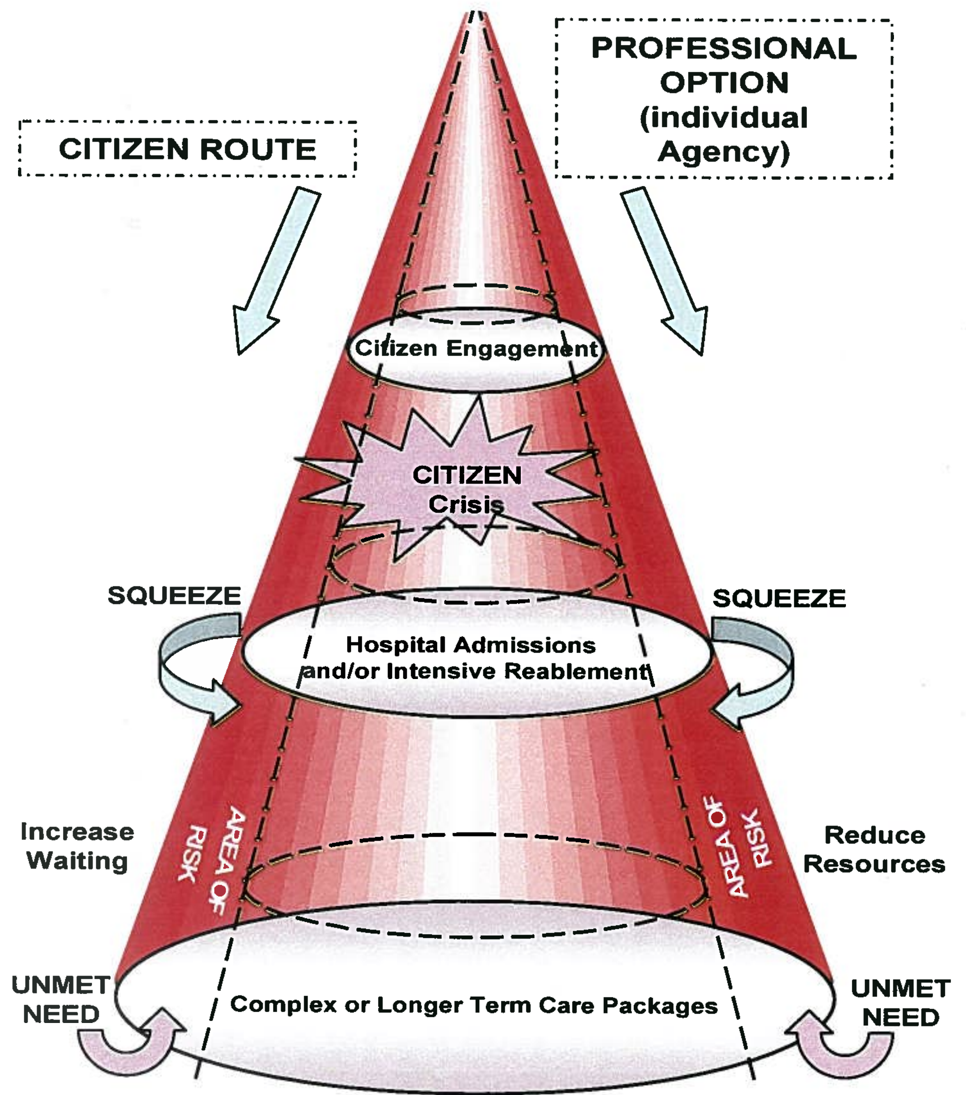
The above model heralds a radical shift from the traditional approach. It means moving away from eligibility criteria and the 'professional gift' model, to embrace a more customer-focused, citizenship and community empowerment approach.

NB – The move from a 'professional' led assessment model to the four key questions will mean services are better tailored and targeted to meet individuals' needs, plus deliver the outcomes they want. Combined with this, evidence from Personal Budgets is that people are creative, tend to be less risk adverse, and ask for less than we would have provided. Therefore, not only will this model potentially provide services to more people, with better outcomes, it will also cost less and, therefore, be more sustainable. However, an equally important factor is the need to change the 'social contract' and expectations, not just by greater emphasis on self-management, but also via an expectation of reciprocity. Asking those receiving support to contribute to their community, forges links and a relationship, but also changing the nature of the relationship, ie. as an active contributor, not just a passive recipient.

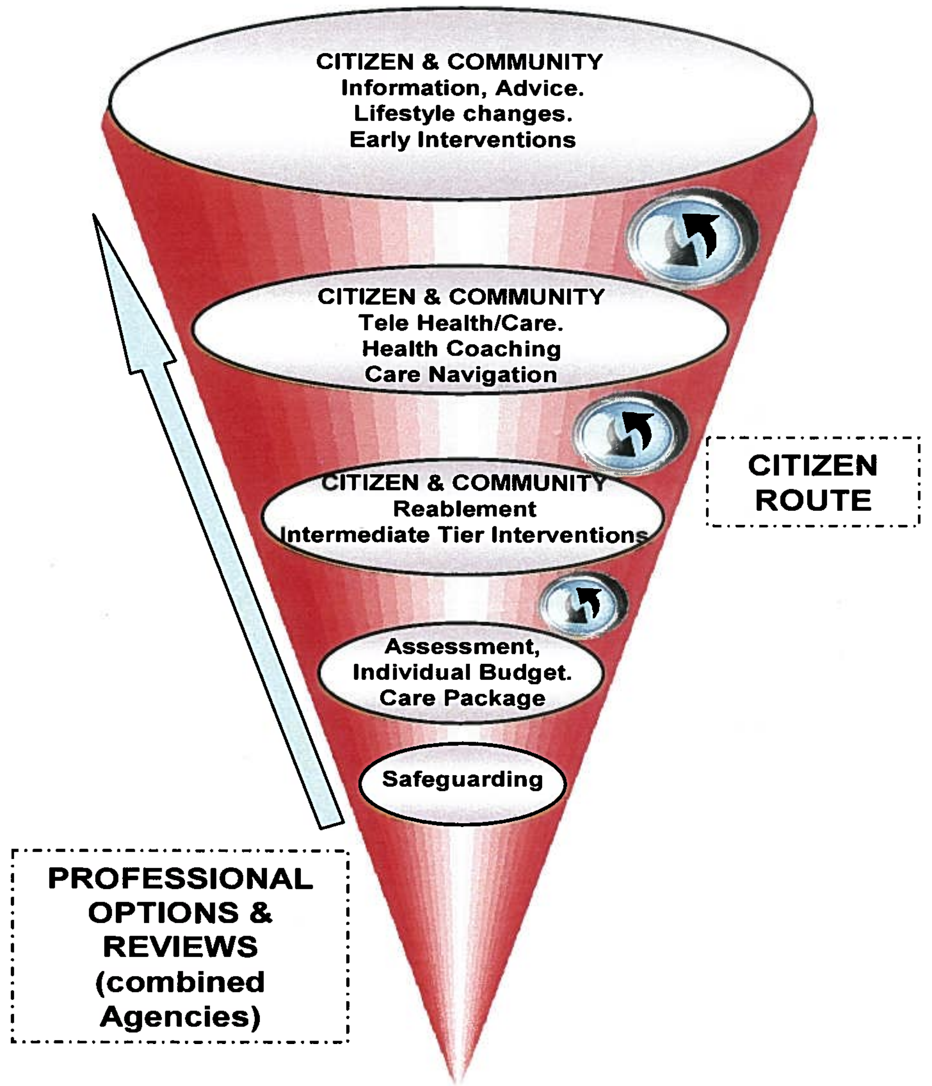
It requires a truly 'whole system' change, as small single agency approaches have historically had relatively little impact.

The above model is applicable across health and social care, Children's and Adults Services, and arguably could be adapted to have a much broader application. The question is can we afford not to change.

The inverted triangle model



2012+ using Current Strategy



2012+ using New Model

Appendix 3

Measuring success - a starting point

Safeguarding

- Reduction in the number of new child protection plans in area
- Reduction in the number of re-referrals to Safeguarding Team
- Reduction in the number of Looked After Children from the locality
- Reduction in Domestic Violence Referrals to the Police
- Reduction in contact-ins into children's social care which do not progress to referral and allocation

Health

- Number of teenage pregnancies per 1000
- Substance misuse parent/young people
- Adult mental health figures (to be negotiated)/CAMHS referrals
- Weight measures at 5 and 11 - improved obesity levels
- Adult Life expectancy
- Reduced smoking prevalence in under 15s
- Reduced hospital admissions for under 18s
- Improving access to services for GPs and their patients
- Reduced hospital admissions for older people

Education

- Number of pupil with attendance rates below 85% primary and secondary
- Number of NEETS (not in education, employment or training) at 16 and then at 18
- Quality return on the kind of activity young people are moving onto post 16 and post 18

Positive contribution

- Volunteering post 14
- Participation in local government – Participants in Youth Council Elections/Turn-out for local and national elections/Numbers attending local Boards
- Reduction in Anti-Social Behaviour Orders
- Reduction in number of Acceptable Behaviour Contracts
- Reduction in the number of first time entrants to the youth justice system

Earning a good Living

- Increase in the number of families with at least 1 person working
- Decrease in the number of under 16 year olds living in poverty
- Impact on adult literacy – need base-line data
- Young people with appropriate qualification/training at 16+ and at 18+

Specific measures

- Number of Common Assessments/Family Assessments (CAFS) in the area to increase
- Number of CAFs with a clear and active plan to increase
- Number of CAFS closed with a positive outcome to increase
- Number of families engaging with Pathways to increase (Voluntary sector provider supporting victims and perpetrators of domestic violence)
- Reduction in the number of families where immunisations & vaccinations are not up-to date
- Strengths and difficulties questionnaires show improvement in 75% of cases
- Abbreviated Parenting Scale shows improvement in 75% of cases
- Cases are closed with outcomes achieved in 75% of cases
- Service Users are reporting an increase in their levels of functioning on the scaling rates