Integrated Personal Commissioning programme – application form

Please send to england.ipc@nhs.net by Friday 7 November 2014

1. Partners: Which organisations have agreed to join the programme?

Voluntary sector organisations including user-led organisations
DIAL Barnsley
Clinical Commissioning Group
Barnsley Clinical Commissioning Group
Local authority
Barnsley Metropolitan Borough Council

2. Sign-off: Who has confirmed support for this application?

Please ask each person to provide their name, job title and organisation, and **to sum up in no more than 50 words** why they support this application. Signatures are not required.

ESSENTIAL: We will only shortlist your application if it has the support of the people listed in this section.
Lead voluntary sector organisation chief executive
Sharon Brown Chief Executive DIAL Barnsley We support this application because it is committed to the principles of co-production and person-centered planning, recognising the importance of self-management to deliver better outcomes. It will also improve the customer journey for people who have both health and social care needs, increase social capital and nurture reciprocity
CCG chief officer
Lesley Smith Interim Chief Officer Barnsley CCG The CCG support this application as it contributes to the Health and Wellbeing Vision for people of Barnsley, recognising the importance of self-management and co-production to deliver better outcomes. It will further support Health and Social Care organisations to build on the personalised care work putting the individual at the centre and in control of their care needs.
Director of adult social services
Martin Farran Executive Director Adults and Communities Barnsley MBC Giving individuals more choice and control over how their needs are met will build on the work within the Pioneer programme; bringing health and social care together whilst promoting self-management, enabling them to retain their independence for longer and achieve better outcomes for people.
Health and Well-Being Board chair
Sir Stephen Houghton Health and Wellbeing Board Chair and Council Leader Barnsley MBC This is aligned to the outcomes of the Health and Wellbeing Board, building on the

work already underway to explore new funding models and delivery of Personal Health Budgets, allowing people to help shape care that is meaningful to them and also effective use of resources.

DESIRABLE: Please confirm who else supports your application and why. It is up to you to decide who needs to be included; suggestions are listed below.

- User-led organisation Chief Executive DIAL Barnsley – DIAL promotes the belief that service users themselves are the 'experts' in understanding their own needs and are the best people to manage their care.
- CCG Finance Officer – Is supportive of the need to change how services are delivered and made available to people, believing that the learning from this application will support future work.
- Healthwatch Chief Executive – Believe in equality, diversity and inclusivity by supporting people who access health and social services to self manage.
- Clinical Lead, In-patient and Community Health Services – Believes that this approach will promote a seamless pathway with greater integration of care across health and social care services.

3. Aims and priorities

Why do you want to join the Integrated Personal Commissioning programme?

The outcomes within the IPC programme clearly align with the ongoing work that both the CCG, MBC and other local partner organisations are doing relating to Personalising Health and Social Care, through the Promoting Independence Programme within the Health and Wellbeing Board.

Barnsley is a Pioneer site for integration which the IPC programme will build upon, generating learning across all organisations that will be used to further develop integration and promotion of self-management.

There is local evidence that personalised care works, BMBC have been successful in establishing Personalised Budgets for social care with 2630 people having a Personal Budget to direct their care, 23% of these choose to receive a direct payment to meet their social care needs.

It is reported through the local work on Social Care Personalisation that Personalised Budgets deliver better outcomes for Barnsley people, with fewer complaints; and no one in receipt of a Personal Social Care Budget requesting to return to a traditional model of care.

Both BCCG and BMBC believe that a significant outcome of taking part in the IPC programme will be the creation of a more joined up patient/client journey with less bureaucracy.

It is collectively understood that organisations achieve little in isolation and risk duplication of resources. The work required within the IPC programme will have a positive effect when addressing the anticipated challenges of increased demand and reduction in available finances.

The provision of Personalised Health Budgets and Integrated Individual Budgets for people with complex needs or who are frequent users of services are considered, along with other activity as a way to achieve the outcomes within the Better Care Fund.

What do you hope to achieve?
A reduction in demand on acute care, by supporting people to keep well using self-management and crisis prevention. An increase in people self managing their conditions and remaining out of health care provision for longer, by supporting them to design their own support around their needs. An increased focus on self-care, promoting Universal Information and Advice and sign posting at an early stage. An increase in the number of people who choose to direct their own care and support to meet their health and social care needs providing a better quality of care and a more positive experience. Learning within a supported environment by utilising the support of both the IPC programme and also other organisations taking part; assisting with the delivery of identified local priorities and promoting increased scale and pace. Learning from the IPC programme, both what went well and what could have been done better, will be transferred across other priority areas including those within Long Term Conditions and Mental Health as supported by the Health and Wellbeing Board. Whole system transformation utilising the learning from the identified cohort. Culture change within health care commissioning and provision, leading to improved outcomes for people.
How does this fit with local priorities for the NHS and local government including the joint health and wellbeing strategy?
The Health and Wellbeing Board have a jointly agreed vision - 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 Health and Wellbeing Board have developed a series of principles to shape and underpin its intentions of co-producing a safe and sustainable health care system, the IPC programme will contribute to these principles which are; Shared responsibility - enabling partnership working with local people, across the public, private voluntary and community sectors. Promotes independence – investing in prevention and early intervention using a person and family centered approach. High quality and value for money – integrating health and social care, offering choice and control, improving the experience and delivering better outcomes. Transparent and accountable – giving the people of Barnsley the opportunity to shape how services are designed and delivered, aligning and where possible pooling of resources to deliver high quality services based on individual needs. It is recognised that achieving improved health and wellbeing outcomes is a longer

term ambition requiring a reorientation of current systems, that taking part in the IPC programme will support organisations to achieve.

4. People who will benefit (see prospectus for examples): Which groups will take part and why; how many people do you expect will benefit?

What is already in place?

People who receive support to manage their Diabetes will be the chosen cohort, with a focus on people who have most contact with acute services, those with complex difficult to manage Diabetes and other clinical conditions.

The decision to use people with complex Diabetes was taken as this links in with the future work relating to the Planned Care programme that sits under the Health & Wellbeing Board, there are a number of activities that relate to self-management and taking more control of how needs are met, such as the Pathway review for people with Diabetes which will include the use of Personalised Care Plans, Social Care Prescribing and the Year of Care which has a focus on the following -

- Improving care for people with long-term conditions.
- Putting people with LTCs in the driving seat of their care and supporting them to self-manage their condition.

Using the elements within the House of Care for collaborative care planning to create an engaged informed patient with healthcare professionals committed to partnership working.

The local community health provider organisation are tasked with supporting the work through the planned care programme and agree that the additional work around blending funding to become more creative to meet the needs of the most complex individuals within this cohort would produce results that would be able to be transferred across other cohorts.

There is a local user lead Advisory Group which through conversations with the community health provider organisation who help facilitate this, would be interested to work within the IPC programme.

The CCG profile identifies that -

The prevalence of Diabetes within Barnsley is 6.8% of the population compared to 5.9% in other similar CCGs, this equates to 13,692 people aged 17 and above.

People with Diabetes in Barnsley are 46.4% more likely to have a myocardial infarction, 33.8% more likely to have a stroke and 75.3% more likely to have a hospital admission relating to heart failure than the general population of Barnsley.

Data shows that spending on prescriptions to treat Diabetes cost more per adult (£290.24 per year a total of £4 million for Barnsley CCG) compared to other areas in England.

Research shows that the prevalence of Diabetes is higher in areas experiencing deprivation.

Further detailed analysis will be completed to establish the number of people within the chosen cohort and to establish the level of social care funding that is accessed by these people.

It is acknowledged that in order to achieve a body of evidence and learning for future work there needs to be a reasonable number of people within the cohort without the number being so large that it is unachievable.

What will be different within 2 years (by March 2017)?

A reduction in demand on acute care, including hospital admissions, by supporting people to keep well using self-management and crisis prevention.

People who are experts in their own care will be supported to identify, access, direct and self-manage their health and social care needs, research shows that poor management of health conditions leads to increased contact with acute services.

There will be an increase in people who receive a Personalised Integrated Care Plan, including the integration of Health and Social Care budgets.

People will be reporting improved outcomes relating to the management of their condition, and quality of life.

Utilising the priorities of the Planned Care Programme Board relating to the review of the Diabetes Care Pathway there will be a clearly defined pathway, with a coordinated approach across Health and Social Care for people who wish to direct and manage their own care needs.

There will be improved integration between specific health providers for people with more complex cases or more than one clinical condition.

People who self-manage their condition will be supported to share their experiences with others using peer support groups, initially facilitated by health and social care organisations.

There will be a greater choice and range of support for people to choose, promoting an increase in the quality of support available through indirect competition.

What are you proposing to do to achieve this?

Data indicates that in 2013/14 there were 5470 admissions into the acute hospital, 227 of these admissions were as a direct result of Diabetes, with the remaining 5,243 recorded as having Diabetes along with a secondary Clinical need that either occurred as a result of their Diabetes or compounded their Diabetes.

Further detailed analysis will be completed to establish the number of people within the chosen cohort and to establish the level of social care funding that is accessed by this cohort of people; this will be done utilising the data that the CCG, BMC, the Acute Trust and the local community health provider hold, it is acknowledged that accurate data is the key to the success of this project.

Using the data available we will identify the people with the most complex Diabetes, those with additional Clinical conditions and those who are identified as frequent users of acute services, these people will be the target population within the cohort.

Dependent on the number of people within the cohort the multi agency group will then decide whether to open this work out to another Long Term Condition client group such as people with Chronic Obstructive Pulmonary Disease, the choice of which Long Term Condition Group will be determined following further analysis of activity and funding

streams and in line with other priorities.

Working in partnership with Social Care we will analyse this group to identify which of this group also have social care needs.

The cohort group will be purposefully selected.

We will coordinate the data across the finance departments of both organisations to identify the funding attached to these individuals and develop a funding model using health and social care funding for this group.

We will utilise the Equality Impact Assessments in place for Personal Health Budgets and Personal Social Care Budgets to ensure we do not negatively affect the protected characteristics.

There will be a multi agency development group convened to lead on the IPC programme which will include all key partners from CCG, MBC, the Acute trust, community health providers and the voluntary sector which will set the Terms of Reference for the work required and develop an action plan using a project management approach, this will report to the Promoting Independence board in the first instance.

Barnsley MBC is working with the CCG to support Personal Health Budgets; this includes the provision of support planning and personalisation support service. This will enhance and streamline the joined up approach between both Health and Social Care funding streams, creating true integration of budgets, embedding person centred approaches within the planning process, reduce burocracy, and create a seamless service for people.

5. Financial model: How will you develop a financial model which enables NHS and social care money to be brought together?

What is already in place?
We have a clearly identified budget that is currently used to meet the needs of people with Diabetes. We have a clearly identified budget that is currently used to meet the needs of people with Social Care needs. There is currently a resource allocation model within social care that is being adopted in the implementation of Personal Health Budgets and work is ongoing to refine this to determine Personal Health Budget allocations. The continued joint partnership approach that the CCG and the Social Care follow will assist in working together effectively to allow the funding streams to be brought together. This has been proven to be effective through the implementation of Personal Health Budgets as the Local Authority now delivers the Personal Health Budgets payments and Monitoring service. The Local authority also commissions Continuing Healthcare care packages working alongside healthcare professional to ensure that the needs of individual are met, this again demonstrates the effective partnership in place between organsiations. The Partnership between Barnsley MBC and CCG works effectively and reports through to the Promoting Independence Programme Board. This provides the strategic direction and governance required between organisations. There is a joint commissioning team currently in place and this will continue to deliver

the commissioning intentions of both organisations.
What will be different within 2 years (by March 2017)?
There will be a range of options available to individuals by March 2017, including direct payments; direct payments managed by an agent, third party supported managed accounts, Individual Service Funds, User Controlled Trusts, Notional (Virtual) budgets. Market Development with providers of services is evident to ensure sustainability of services, a move away from block contracts and the introduction of personalised services being commissioned, ensuring that choice and control is given to individuals. People who have a primary need of complex Diabetes in association with additional needs will be able to access the totality of the funding available to meet their holistic needs, this will include social care funding if accessed. There will be a joint approach to assessment and resource allocation approval taking into account the total needs of an individual in relation to social care and health care, this will include people who have more than one Long Term health condition. Processes will be strengthened to allow the pooling of resources. Care pathways will be individualised and costed to ensure efficient use of resources.
What are you proposing to do to achieve this?
There are integrated programme arrangements in place across health & social care to drive our improvement priorities within which integrated commissioning developments will sit so interdependencies can be managed effectively using a risk managed approach. Activity data will be analysed within block contracts currently in place for this cohort and a joint funding model will be developed taking into account the funding resources available. Data will be analysed to determine those with a secondary Long Term Condition need which will be included within their integrated budget to ensure that there is a coordinated approach to the self-management and direction of their care. Information will be gathered as part of the analysis to determine future commissioning arrangements and to ensure that the market is developed to meet any potential change in services required to meet the needs of individuals. This analysis will also assist in the development of commissioning services on an individual basis rather than through a block contract. Develop a joint approach to ensure that all those eligible for an IPC are identified; this will be achieved through analysis of data and review of budgets. Review and strengthen the current processes in place supporting Personal Health Budgets and Social Care Budgets and ensure cohesion between services. Use the funding model to identify gaps in provision and opportunities for development. Care pathways will be analysed and funding will be allocated appropriately to each element of the pathway.

The continued testing of models developed in the early stages will identify changes required and any potential risks that will need to be managed through the project.

It is acknowledged that this is a key activity which would require support from NHS England IPC team to help develop examples of funding models.

Barnsley MBC is working with the CCG to support Personal Health Budgets; this includes the provision of support planning and personalisation support service. This will enhance and streamline the joined up approach between both Health and Social Care funding streams, creating true integration of budgets, embedding person centered approaches within the planning process, reduce bureaucracy, and create a seamless service for people.

6. Person-centred approaches: What support will be offered to people in your cohort?

What is already in place?

Barnsley MBC currently provide a Self Directed Support Service for the delivery of Personal Health Budgets for people with Continuing Health Care needs.

Personalised Care training is available for both health and social care staff, provided by social care.

There is an established pathway for Personal Health Budgets.

A Universal Information and Advice offer has been developed (including a digital offer) ensuring easy access to coordinated information, advice and services. This supports increasing personal resilience and empowers individuals by offering greater choice and control.

Healthwatch is well established in Barnsley and currently work with health and social care to promote a personalised approach to meeting needs.

DIAL the local User Lead Organisation is well established and is instrumental in the support to health and social care to promote a personalised approach to meeting people's needs.

Policies and Procedures for Personal Health Budgets and Personal Social Care budgets have been Equality Impact Assessed and do not negatively impact on the protected characteristics.

What will be different within 2 years (by March 2017)?

People who are experts in their own care will be supported to identify, access, direct and self-manage their health and social care needs, research shows that poor management of health conditions leads to increased contact with acute services.

There will be an increase in people who receive a Personalised Integrated Care Plan, including the integration of Health and Social Care budgets.

People will be reporting improved outcomes relating to the management of their condition and quality of life.

Utilising the priorities of the Planned Care Programme Board relating to the review of the Diabetes Care Pathway there will be a clearly defined pathway, with a coordinated approach across Health and Social Care for people who wish to direct and manage

their own care needs.

There will be improved integration between specific health providers for people with more complex cases or more than one clinical condition.

There will be a joint approach to assessment and resource allocation approval, taking into account the total needs of an individual in relation to social and health care, this will include people who have more than one Long Term Health condition.

Processes will be strengthened to allow the pooling of resources.

There will be a range of options available to individuals to help them self-manage their care to whatever degree they feel comfortable with including direct payments; direct payments managed by an agent, third party supported managed accounts, Individual Service Funds, User Controlled Trusts, Notional (Virtual) budgets.

Connect to Support/Connect to Barnsley website will include details of services available to help support people to self-manage.

There will be an availability of evidence to show that this approach works, which will be utilised to promote integration of health and social care budgets within other cohorts.

This evidence will also support the cultural changes required when considering funding services differently within the NHS.

What are you proposing to do to achieve this?

The establishment of a dedicated Brokerage service within Social Care that will have personal centered values and approaches at the center, and work across a range of funding streams supporting integration of budgets and a seamless customer focused approach.

Universal Information, Advice and signposting will be promoted across health and social care in conjunction with the Universal Information and Advice offer.

The Connect to Support/Connect to Barnsley website will be utilised to provide details of services available to help people self-manage their health and social care needs.

There will be a multi agency development group convened to lead on the IPC programme which will include all key partners from CCG, MBC, the Acute trust, community health providers and the voluntary sector which will set the Terms of Reference for the work required and develop an action plan using a project management approach, this will report to the Promoting Independence board in the first instance.

Support from partners within the third sector including user lead organisations and Healthwatch to identify the Personalisation learning outcomes for both users and providers of services.

The priorities within the Planned Care Programme Board relating to Diabetes care will be incorporated into the personalised model with the identified cohort; this includes the review of the Diabetes Care Pathway taking into account the need to incorporate Social Care Prescribing and Personalised Care Planning.

Information will be gathered as part of the analysis to determine future commissioning arrangements and to ensure that the market is developed to meet any potential change in services required to meet the needs of individuals. This analysis will also assist in the development of commissioning services on an individual basis rather than through a block contract.

Develop a joint approach to ensure that all those eligible for an IPC are identified; this will be achieved through analysis of data and review of budgets.

Workforce development will form a key aspect to changing the culture of both health and social care staff, there will be an expectation that all staff within the key organisations will undertake training on person centered values and approaches, embedding this in culture change.

7. Personal budgets: What will be the scale and pace for rollout of personal budgets for people with health needs, and how will funding be made available?

What is already in place?

There is an established pathway for Personal Health Budgets.

There is a Self Directed Support Service to support both Personal Budgets in health and social care.

Enhancing the quality of life for people with Long Term Conditions is included within the CCG Commissioning Plan, specifically the provision of person centered integrated care for people through improvements in primary care and putting people in charge and having ownership of their care through personalised care plans and budgets.

There is local evidence that personalised care works, BMBC have been successful in establishing Personalised Budgets for social care with 2630 people having a Personal Budget to direct their care, however local evidence demonstrates that this was a slow process which although now delivers outcomes was slow and labor intensive to begin with.

Uptakes of personal budgets in social care are reported to the Health and Wellbeing Board via the Promoting Independence Programme.

What will be different within 2 years (by March 2017)?

Integrated personal budgets will be available to all people within the cohort leading to an increase in the number of people managing their own care.

People who are experts in their own care will be supported to identify, access, direct and self-manage their health and social care needs.

It is recognised that achieving improved health and wellbeing outcomes is a longer term ambition requiring a reorientation of current systems, that taking part in the IPC programme will support organisations to achieve.

Utilising the priorities of the Planned Care Programme Board relating to the review of the Diabetes Care Pathway there will be a clearly defined pathway, with a coordinated approach across Health and Social Care for people who wish to direct and manage their own care needs.

There will be clear data on the uptake of integrated budgets which will be used to support the ongoing work required relating to integration of personalised budgets across other cohorts/groups of people with Long Term Health Conditions and or Mental Health in line with the Government directives.

What are you proposing to do to achieve this?
There will be a multi agency development group convened to lead on the IPC programme which will include all key partners from CCG, MBC, the Acute trust, community health providers and the voluntary sector which will set the Terms of Reference for the work required and develop an action plan using a project management approach, this will report to the Promoting Independence board in the first instance. There are integrated programme arrangements in place across health & social care to drive our improvement priorities within which integrated commissioning developments will sit so interdependencies can be managed effectively using a risk managed approach. Develop a joint approach to ensure that all those eligible for an IPC are identified; this will be achieved through analysis of data and review of budgets. Activity data will be analysed within block contracts currently in place for this cohort and a joint funding model will be developed taking into account the funding resources available. Data will be analysed to determine those with a secondary Long Term Condition need which will be included within their integrated budget to ensure that there is a coordinated approach to the self-management and direction of their care. Information will be gathered as part of the analysis to determine future commissioning plans to assist in the development of commissioning services on an individual basis rather than through a block contract.

8. Leadership and partnership: How will you get key people on board and build capacity in the voluntary and community sector?

What is already in place?
There is an established Governance structure for all health and social care priorities within the Health and Wellbeing Board. The Health and Wellbeing Board comprises of public, private and voluntary sector organisations, this board includes the main local health providers and is responsible for the implementation of the Better Care Fund activity. The need to progress Integrated Commissioning is identified within the Promoting Independence Programme Board. There are integrated programme arrangements in place across health & social care to drive our improvement priorities Enhancing the quality of life for people with Long Term Conditions is included within the CCG Commissioning Plan, specifically the provision of person centered integrated care for people through improvements in primary care and putting people in charge and having ownership of their care through personalised care plans and budgets. The review of the Diabetes care pathway is identified within the Planned Care

Programme Board.

The Planned Care and Promoting Independence Programme Board report to both the Health and Wellbeing Board and also the CCG Governing Body.

DIAL the local User Lead Organisation promotes the belief that service users themselves are the 'experts' in understanding their own needs and are the best people to manage their care.

DIAL is well established and is instrumental in the support to health and social care to promote a personalised approach to meeting people's needs.

Healthwatch Barnsley works closely with community and voluntary sector organisations both on behalf of individuals but also as a conduit for views of the local people.

National reporting arrangements for Personal Health Budgets and Personal Budgets are well established and are utilised to benchmark against.

There is a community Diabetes support group however due to lack of involvement from local members this is not as successful as it could be, this does however provide details of people who may be willing to support the IPC work with regards to peer support.

The Partnership between the Local Authority and the CCG works effectively and reports through to the Promoting Independence Programme Board. This provides the strategic direction and governance required between organisations.

There is a joint commissioning team currently in place and this will continue to deliver the commissioning intentions of both organisations.

Barnsley already has an existing Voluntary & Community Sector infrastructure in place and an active Barnsley Community & Voluntary Network supported through Community & Voluntary Sector. In addition to this there is a new governance framework to support devolution in Barnsley which comprises of 6 Area Councils and 21 Ward Alliances.

Area Councils commission services against community priorities with the ward Alliances having a minimum of 6 community representatives. This is further complemented with a growing body of neighborhood networks and the CCG jointly fund the Innovation fund which focuses on sustainable projects from communities.

The council is also one of 8 places working with Nesta to develop volunteering based on an American model (Cities of service).

Equality forums are developing and our expert partnerships are currently reviewing their roles in the light of the Health & Wellbeing Board.

There is increasing community leadership and community led planning.

What will be different within 2 years (by March 2017)?

It is recognised that achieving improved health and wellbeing outcomes is a longer term ambition requiring a reorientation of current systems, that taking part in the IPC programme will support organisations to achieve.

There will be a new target operating model for Social Care and we should see elements of that model being delivered by the Voluntary and Community Sector or through social enterprises. The support to the Voluntary and Community Sector will be strengthened.

Community leadership and community led planning will continue to support the work to establish resilient communities that are able to support each other.

Engagement activities and peer support, along with skills development arrangements will be better connected.

Market Development with providers of services will be evident to ensure sustainability of services, with a move away from block contracts and the introduction of personalised services being commissioned, ensuring that choice and control is given to individuals.

There will be an availability of evidence to show that this approach works, which will be utilised to promote integration of health and social care budgets within other cohorts.

This evidence will also support the cultural changes required when considering funding services differently within the NHS.

What are you proposing to do to achieve this?

There will be a multi agency development group convened to lead on the IPC programme which will include all key partners from CCG, MBC, the Acute trust, community health providers and the voluntary sector which will set the Terms of Reference for the work required and develop an action plan using a project management approach, this will report to the Promoting Independence board in the first instance.

There are integrated programme arrangements in place across health & social care to drive our improvement priorities within which integrated commissioning developments will sit so interdependencies can be managed effectively using a risk managed approach.

Link into current provider forums and utilise the Connect to Support/Connect to Barnsley website.

Use the Making it Real “I” statements and PHB Markers of Progress to establish a baseline to monitor performance along with the reporting requirements from NHS England.

Develop a peer network group for this cohort to provide support, linking into the PHB peer networks.

The priorities within the Planned Care Programme Board relating to Diabetes care will be incorporated into the personalised model with the identified cohort; this includes the review of the Diabetes Care Pathway taking into account the need to incorporate Social Care Prescribing and Personalised Care Planning – House of Care.

Barnsley Councils strategy has a priority project – (Community Offer) which is being shaped with the aim of having a published vision by January 2015. The project will advance a ‘relationship deal’ in the borough based on resilient communities with the council occupying the spaces that only it can fill.

Capacity within communities will be further developed within the Council’s strategic plan.

9. Co-production and culture change: How will you change attitudes throughout the system, and ensure that people and families lead the new approach?

What is already in place?
Personal Budgets and Personal Health Budgets are established within social care and the Personal Health Budget target group – Continuing Health Care. DIAL the local user lead organisation already support service changes through coproduction. There is local evidence that personalised care works, BMBC have been successful in establishing Personalised Budgets for social care with 2630 people having a Personal Budget to direct their care, 23% of these choose to receive a direct payment to meet their social care needs. It is reported through the local work on Social Care Personalisation that Personalised Budgets deliver better outcomes for Barnsley people, with fewer complaints; with no one in receipt of a Personal Social Care Budget requesting to return to a traditional model of care. Both BCCG and BMBC believe that a significant outcome of taking part in the IPC programme will be the creation of a more joined up pathway with less bureaucracy. Social Care has already experienced significant culture change in relation to personal budgets. Social Care Personal budgets have a well established service user group to ensure coproduction. Barnsley Personal Assistant finder is now live for social care Personal Budgets. There is a joint commissioning team currently in place and this will continue to deliver the commissioning intentions of both organisations. Personalised Care training is available for both health and social care staff, provided by social care. A Universal Information and Advice offer has been developed (including a digital offer) ensuring easy access to coordinated information, advice and services. This supports increasing personal resilience and empowers individuals by offering greater choice and control.
What will be different within 2 years (by March 2017)?
There will be a joint approach to assessment and resource allocation approval taking into account the total needs of an individual in relation to social care and health care, this will include people who have more than one Long Term health condition. People who are experts in their own care will be supported to identify, access, direct and self-manage their health and social care needs, research shows that poor management of health conditions leads to increased contact with acute services. The beginnings of whole system transformation utilising the learning from the identified cohort. Culture change within health care commissioning and provision, leading to improved

outcomes for people.

It is recognised that achieving improved health and wellbeing outcomes is a longer term ambition requiring a reorientation of current systems, that taking part in the IPC programme will support organisations to achieve.

What are you proposing to do to achieve this?

There are integrated programme arrangements in place across health & social care to drive our improvement priorities within which integrated commissioning developments will sit so interdependencies can be managed effectively using a risk managed approach.

Utilise the social care learning relating to changing the culture, this includes using the social care personalisation user group to help change views and provide evidence of positive outcomes.

Extend Barnsley Personal Assistant finder to people wanting an Integrated Personalised budget to meet their health and social care needs.

Incorporate Integrated Personalised care and support into the workforce development plans for health and social care staff.

Build on the work of the brokerage team to support new approaches to supporting people to direct their own support.

Information will be gathered as part of the analysis to determine future commissioning arrangements and to ensure that the market is developed to meet any potential change in services required to meet the needs of individuals. This analysis will also assist in the development of commissioning services on an individual basis rather than through a block contract.

Connect to Support/Connect to Barnsley website will include details of services available to help support people to self-manage.

There will be an availability of evidence to show that this approach works, which will be utilised to promote integration of health and social care budgets within other cohorts.

This evidence will also support the cultural changes required when considering funding services differently within the NHS.

The Connect to Support/Connect to Barnsley website will be utilised to provide details of services available to help people self-manage their health and social care needs.

Support from partners within the third sector including user lead organisations and Healthwatch to identify the Personalisation learning outcomes for both people who use and providers of services.

Develop a joint approach to ensure that all those eligible for an IPC are identified; this will be achieved through analysis of data and review of budgets.

Analysis of the uptake of integrated budgets will help identify the people who are either not engaging with the process or choosing to opt out; conversations can then be planned with these groups to establish why they choose not to engage.

10. Managing risk: How will make sure that progress is not held up by unforeseen problems?

What is already in place?
There are 2 levels of risk that could affect the delivery of this work, firstly the strategic risks to the programme such as failure to change the culture of organisations and secondly the operational risks relating to the delivery of the programme, such as safeguarding issues. There are integrated programme arrangements in place across health & social care to drive improvement priorities within which integrated commissioning developments sit. There is potential to destabilise the market through the work needed to reorganise care pathways and packages into individual packages. There is the potential for financial implications, which would be evident when trying to take funding out of established and block contracted services to fund people's individual packages. Each programme within the Health and Wellbeing Board has a clearly populated Risk Management matrix, which highlights the potential risks and any mitigating actions relating to the programme activity, these are reviewed by the programme leads. There is a Data sharing protocol between health and social care which is utilised for people accessing Personal Health Budgets. There are robust and tested financial management processes within the current financial frameworks in both health and social care. The continued testing of models developed within Personal Health Budgets for people with Continuing Health Care will identify changes required and any potential risks that will need to be managed through the project. There is a personalisation risk management policy which details the requirement There is a Risk Enablement process which is used for both Personal Health Budgets and Personal Budgets.
What will be different within 2 years (by March 2017)?
People who choose to direct their own support will not be at any greater risk than those who do not. Information shared between organisations will be done so without risk of breaching Data protection regulations. The continued testing of models developed in the early stages will identify changes required and any potential risks that will need to be managed through the project. The provider market will not become destabilised as a result of people changing the services they want. Whilst there is a move away from block contracts and the introduction of personalised services being commissioned, ensuring that choice and control is given to individuals provider services will be supported to change how they support people without the risk to the market.

There will be a wider range of options available to promote choice and self management, these options will remain safe and outcome focused.
What are you proposing to do to achieve this?
There are integrated programme arrangements in place across health & social care to drive our improvement priorities within which integrated commissioning developments will sit so interdependencies can be managed effectively using a risk managed approach Carry out a risk assessment for the identified cohort, detailing both the strategic risks and operational risks to all concerned. Ensure all strategic risks are included on the programme boards risk matrix for consideration by the Health and Wellbeing Board. Any financial risks that are identified as a result of the new approach will be included within the Medium Term Financial Strategy and mitigating actions sought. With regards to operational risks, promote positive risk taking through the use of the Risk Enablement Panel if needed. With regards to operational risks, incorporate positive risk taking into the workforce development plans for health and social care staff. The continued joint partnership approach that the CCG and MBC follow will assist in working together effectively to allow the funding streams to be brought together in a risk managed way. This has been proven to be effective through the implementation of Personal Health Budgets as the Local Authority now delivers the Personal Health Budgets payments and audit/monitoring service. The continued testing of models developed in the early stages will identify changes required and any potential risks that will need to be managed through the project.

11. Capacity and resources: What people and other resources will you put in place to deliver Integrated Personal Commissioning?

What is already in place?
A dedicated Personal Health Budget lead within Barnsley CCG with experience in Personal Social Care budgets, who has been identified as the lead officer to progress integration of health and social care, this lead has direct reporting into the Promoting Independence Board to support the CCG to develop and change services. A dedicated Personalisation lead within Barnsley MBC who manages the Self Directed Support and has been identified as the lead officer to progress integration of health and social care. The finance lead within the CCG has previous in depth experience of Personalised Social Care, this includes the processes required to individualise packages of care rather than use block contracts. Barnsley MBC currently provide a Self Directed Support Service for the delivery of Personal Health Budgets for people with Continuing Health Care needs, this includes support planning/brokerage, payment function and audit/monitoring of direct payments.

The continued joint partnership approach that the CCG and MBC follow will assist in being able to work together effectively to allow the funding streams to be brought together. This has been proven to be effective through the implementation of Personal Health Budgets as Social care now delivers the Personal Health Budgets payments and Monitoring service. Social care also commission Continuing Healthcare care packages working alongside healthcare professional to ensure that the needs of individual are met; this again demonstrates the effective partnership in place between organsiations.

There is a joint commissioning team currently in place that will continue to deliver the Commissioning Intentions for both health and social care.

Personalised Care training is available for both health and social care staff, provided by social care.

Workforce development staff that are expert in support plan training are available through the Social Care Workforce Development Service.

A Universal Information and Advice offer has been developed ensuring easy access to coordinated information, advice and services. This supports increasing personal resilience and empowers individuals by offering greater choice and control.

Connect to Support/Connect to Barnsley is in place and available to help people to obtain support to meet their social care needs.

Information Governance leads are established and available to support the requirements of the programme.

What will be different within 2 years (by March 2017)?

Utilising the priorities of the Planned Care Programme Board relating to the review of the Diabetes Care Pathway there will be a clearly defined pathway, with a coordinated approach across Health and Social Care for people who wish to direct and manage their own care needs.

It is recognised that achieving improved health and wellbeing outcomes is a longer term ambition requiring a reorientation of current systems, that taking part in the IPC programme will support organisations to achieve.

Commissioning arrangements will focus on individualized commissioning agreements rather than block contracts.

There will be a dedicated Brokerage service across health and social care, which will be available for all people within the cohort and subsequent cohorts.

Training relating to support planning and helping people to manage their own support will be available.

The establishment of a dedicated Brokerage service within Social Care which will work across a range of funding streams supporting integration of budgets across health and social care, providing a seamless customer focused approach.

What are you proposing to do to achieve this?

Information will be gathered as part of the analysis to determine future commissioning arrangements and to ensure that the market is developed to meet any potential change in services required to meet the needs of individuals. This analysis will also assist in the development of commissioning services on an individual basis rather than through a block contract.

Identify the requirement for additional financial and contracting expertise with organisations; raise this as a future financial requirement within the programme boards.

The establishment of a dedicated Brokerage service within Social Care working across a range of funding streams supporting integration of budgets and a seamless customer focused approach.

Universal Information, Advice and signposting will be promoted across health and social care in conjunction with the Universal Information and Advice offer.

The Connect to Support/Connect to Barnsley website will be utilised to provide details of services available to help people self-manage their health and social care needs.

Support from partners within the third sector including user lead organisations and Healthwatch to identify the Personalisation learning outcomes for both people who use and providers of services

The priorities within the Planned Care Programme Board relating to Diabetes care will be incorporated into the personalised model with the identified cohort; this includes the review of the Diabetes Care Pathway taking into account the need to incorporate Social Care Prescribing and Personalised Care Planning.

Utilise the support available from NHS England; this will include the requirement for expert advice relating to breaking down and re-costing care pathways and if needed relax national rules and regulations to support the integration of health and social care.

12. Learning from results: How will you share your learning and ensure robust evaluation [1]?

What is already in place?
National reporting arrangements for Personal Health Budgets and Personal Budgets are well established, adhered to and are utilised locally to benchmark progress against. Uptakes of personal budgets in social care are reported to the Health and Wellbeing Board via the Promoting Independence Programme. It is recognised that achieving improved health and wellbeing outcomes is a longer term ambition requiring a reorientation of current systems, that taking part in the IPC programme will support organisations to achieve. The Partnership between the Local Authority and the CCG works effectively and reports through to the Promoting Independence Programme Board. This provides the strategic direction and governance required between organisations. There is a social care Personal Budget User Satisfaction Survey in use locally. There is an agreement to contribute to the POET survey. Healthwatch and DIAL the user lead organisation work with people on both a collective and individual basis to gather their experiences and support them to feed this into

organisations to effect positive change.

Social care have developed a Personalisation DVD for use to promote the positive outcomes for people who manage their own support.

What will be different within 2 years (by March 2017)?

There will be an availability of evidence to show that this approach works, which will be utilised to promote integration of health and social care budgets within other cohorts.

This evidence will also support the cultural changes required when considering funding services differently within the NHS.

Learning within a supported environment by utilising the support of both the IPC programme and also other organisations taking part; assisting with the delivery of identified local priorities and promoting increased scale and pace.

Learning from the IPC programme, both what went well and what could have been done better, will be transferred across other priority areas including those within Long Term Conditions and Mental Health as supported by the Health and Wellbeing Board.

Whole system transformation utilising the learning from the identified cohort.

Culture change within health care commissioning and provision, leading to improved outcomes for people.

There will be clear data on the uptake of integrated budgets that will be used to support the ongoing work required relating to integration of personalised budgets across other cohorts/groups of people with Long Term Health Conditions and or Mental Health in line with the Government directives.

What are you proposing to do to achieve this?

There will be a multi agency development group convened to lead on the IPC programme which will include all key partners from CCG, MBC, the Acute trust, community health providers and the voluntary sector which will set the Terms of Reference for the work required and develop an action plan which will include how learning is shared, this will report to the Promoting Independence board in the first instance.

There are integrated programme arrangements in place across health & social care to drive our improvement priorities within which integrated commissioning developments will sit so interdependencies can be managed effectively using a risk managed approach.

Identify with NHS England the need for proportionate evaluation, to ensure resources are focusing on how to achieve outcomes rather than focusing on gathering information.

A programme of performance reporting will be developed to report into the Health and Wellbeing Board, this will be in line with the current requirements for national evaluations such as the Personal Health Budgets Markers of Progress.

Take part in national evaluation requirements as directed.

Establish activity requirements nationally set. Contribute to future promotional material across the local organisations to ensure that positive stories are available. Utilise the social care Personal Budget User satisfaction survey and incorporate the findings from this into future requirements. Utilise and actively seek feedback via Healthwatch and DIAL with regards to people who manage their own support

13. Main contact person

We will send all correspondence to the person named below.

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Notes

[1] We are currently developing plans for a national evaluation of the programme; more information will be available in due course. All sites taking part in the programme will be expected to take part in the national evaluation.