Barnsley Health and Wellbeing Board

Integration and Better Care Fund 2017 - 2019

Area	Barnsley
Constituent Health and Wellbeing Boards	Barnsley
Constituent CCGs	NHS Barnsley CCG

Contents

Introduction / Foreword

Barnsley has a long history of partnership working across health and social care and is proud of its integration journey, embracing the Health Act flexibilities to develop pooled budgets, joint commissioning arrangements and integrated provider roles, ahead of many other areas.

The vision and principles of integration have become well established and imbedded into planning and delivery of service transformation programmes. In many respects integrated ways of working are now seen as 'business as usual' for delivering the right service, at the right time and in the right place. For example:

- Joint Commissioning Teams for both Children and Adult Services
- Integrated Mental Health Provision
- Integrated occupational therapy & sensory impairment provision
- Integrated Community Equipment Service
- Rightcare Barnsley
- Intermediate Care
- Neighbourhood Nursing

The Better Care Fund (BCF) Plans have played a key role in helping Barnsley with its integration journey, being delivered within the wider context of our Health and Wellbeing Strategy and Barnsley Integrated Place Based Plan (BIPBP) and enabling core health and care services to support one another and function as a united approach, to help reduce the pressures on acute services and residential care.

Barnsley is now embarking on its next step of the integration journey and developing a new accountable care partnership, bringing together commissioners and providers of health and care services in Barnsley to design and deliver integrated services for patients and deliver improved health outcomes for the Barnsley population.

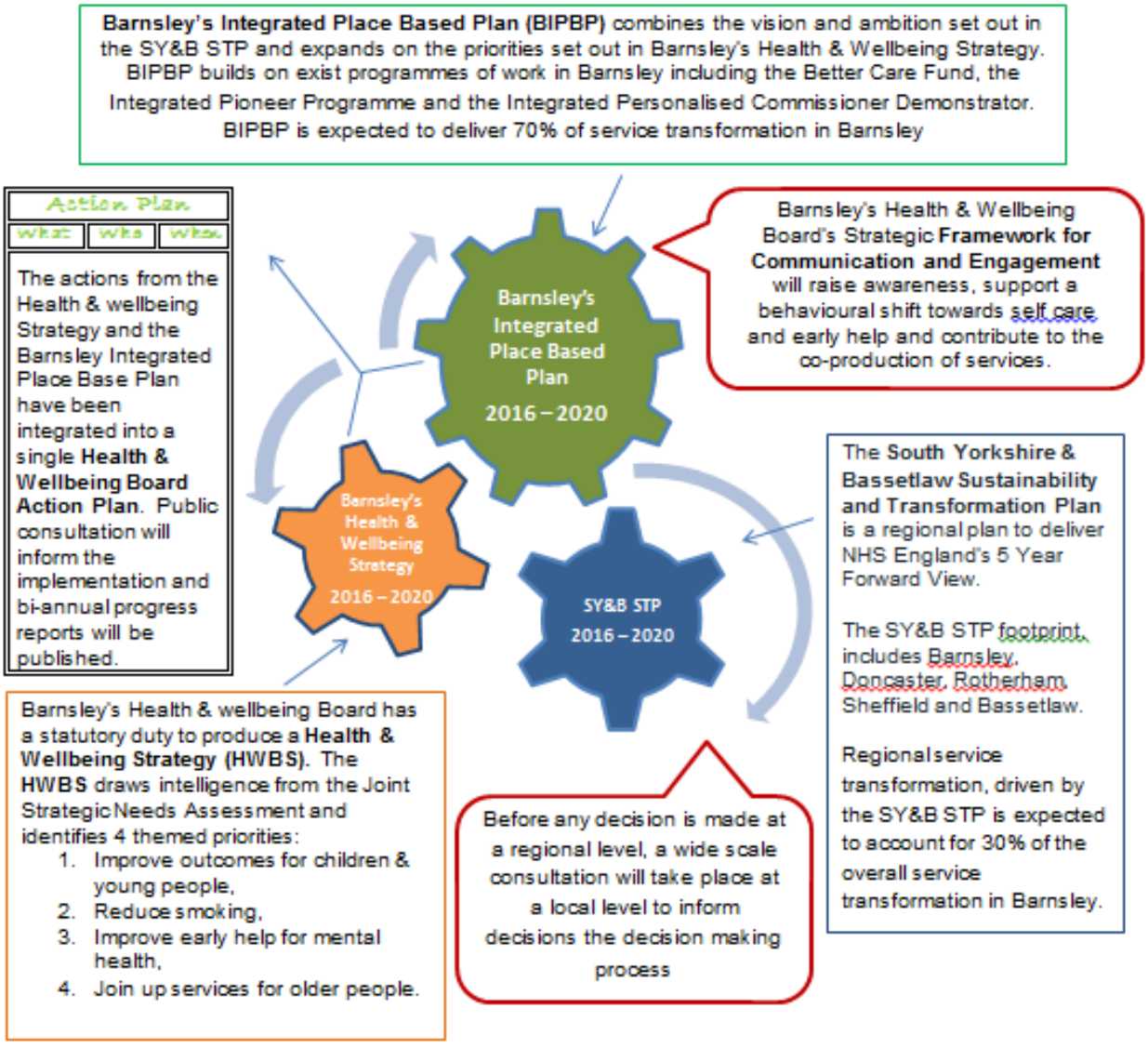
Background and context to the plan

The vision for health and wellbeing, as set out in Barnsley's Health and Wellbeing Strategy and the Integrated Place Based Plan is:

That the people of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, whoever they are and wherever they live.

Diagram 1 below illustrates the drivers of health and wellbeing service transformation in Barnsley and how we are addressing each. Collectively, these drivers and the supporting plans that we have in place will deliver the vision for integrated health and care services by 2020.

Diagram 1 shows the driver of health and wellbeing service transformation in Barnsley:



Approach to improving health & wellbeing

The key documents and the video is intended to help all those interested in the health and wellbeing of Barnsley people, to get a better understanding of the vision and strategic approach.

In summary, the strategic approach is to reduce the demand and pressure on health and care services by strengthening and embedding prevention and early help into all that we do; helping our residents to be more informed and engaged in their own and their families' health and wellbeing; and when health and care services are needed, these will be patient focused, inclusive and integrated into a single health and care plan. The role of the voluntary and community sectors as well as the role of carers is seen as a central platform, in which statutory services can build upon.

Key Documents

The key documents can be accessed by clicking on the links below:

Barnsley's Health & Wellbeing Strategy:

https://www.barnsley.gov.uk/media/4161/barnsleys-health-wellbeing-strategy-pdf-final.pdf

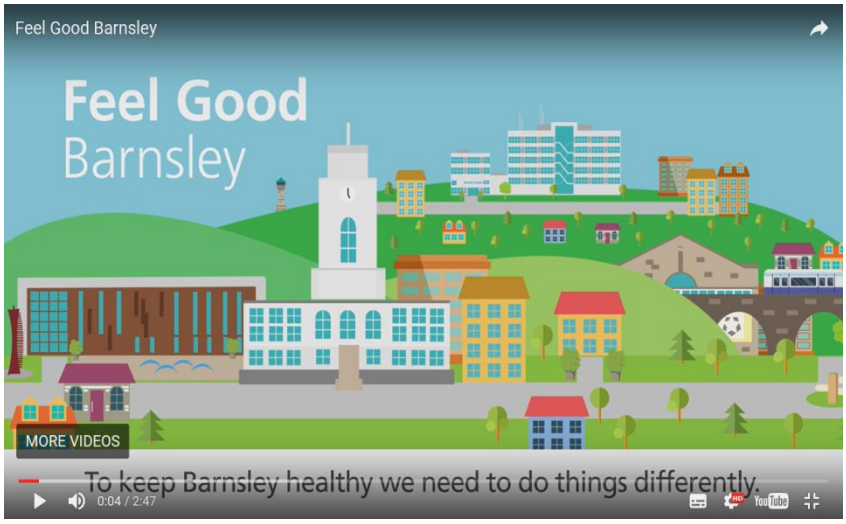
Barnsley's Integrated Place Based Plan:
https://www.barnsley.gov.uk/media/5685/barnsleyplanfinal2016.pdf

South Yorkshire & Bassetlaw STP:

https://www.barnsley.gov.uk/media/5685/barnsleyplanfinal2016.pdf

Feel Good Barnsley Video

A useful summary of the key documents and strategic approach has been produced in video format. The video can be accessed by clicking on the image below:



This approach is in line with the principles of 'inverting the triangle' as set out in our earlier Better Care Fund plans.

What is the local vision and approach for health and social care integration?

The 2017-2019 BCF Plan continues to be set within the wider context of the Health and Wellbeing Strategy, building on the previous plans and contributing to delivery of the key priorities including those included within the BIPBP, enabling us to move towards our overall vision for Health and Wellbeing. We feel that it is important that our plans are considered within this context to ensure that our efforts are co-ordinated and that our plans come together to maximise the impact that we are able to make across the whole system for the benefit of Barnsley residents.

Vision for Integrated Health & Social Care

Barnsley's Health and Wellbeing Strategy and the Barnsley Integrated Place Based Plan along with the BCF plan build upon Barnsley's integration journey to date.

Together, our strategies and plans demonstrate and details a clear consensus that integrated care in Barnsley will:

- **be co-designed and person-centred focussing on prevention and early intervention, to support independence and wellbeing.**
- **enable health, social care, housing and voluntary sector organisations, to work together, with patients, service users and carers, regardless of employer, to make the best use of the Barnsley £**
- **be delivered in or close to people's homes where appropriate and utilise community assets**
- **reduce health inequalities and ensures our vulnerable and elderly are getting the best care available.**

Barnsley's approach to integrated care also reflects the service user perspective developed by National Voices:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

In line with the vision and strategic approach set out in Barnsley's Health and Wellbeing Strategy and the Barnsley's Integrated Place Based Plan, the following have been identified as the priorities for integration in Barnsley:

- Improving services for older people
- Improving mental health and wellbeing
- Building strong and resilient communities
- Changing the way we work together (new models of care)

And the key enablers for the delivery of these integration priorities are:

- Implementation of Barnsley's Digital Roadmap.
- Robust mechanisms for communication and engagement.

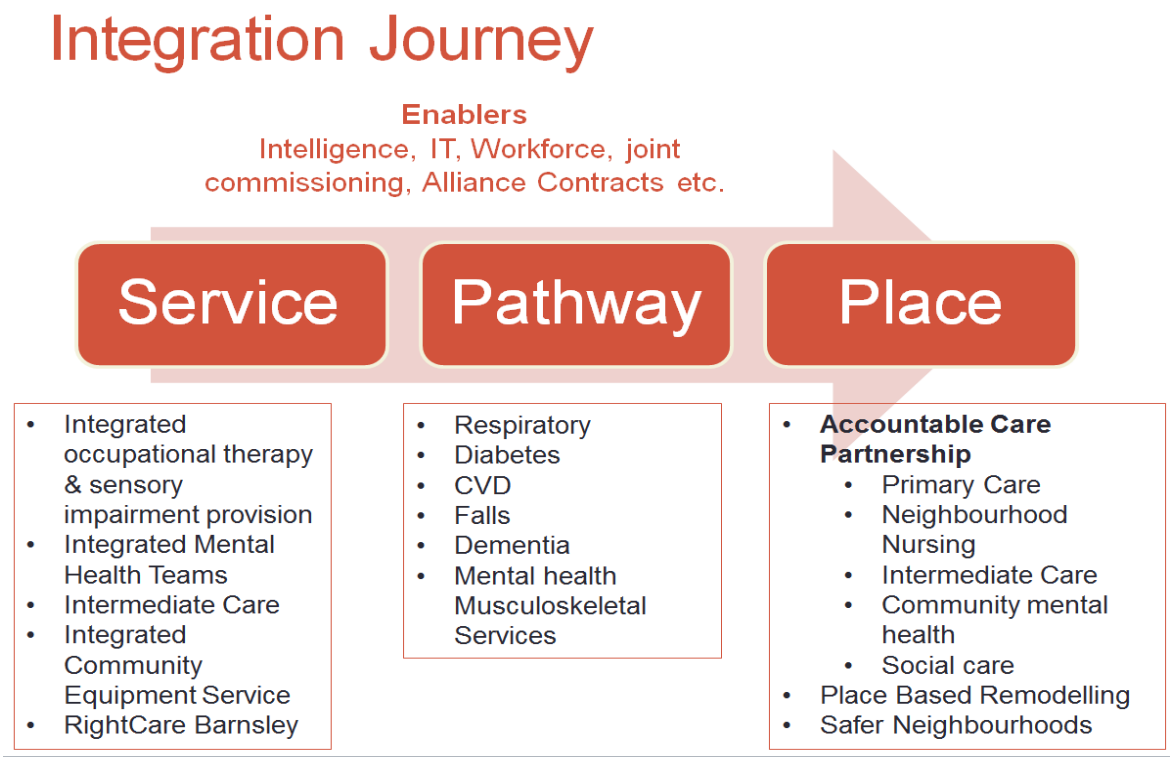
These priorities have been informed by the local Joint Strategic Needs Assessment (JSNA) and are therefore based on local evidence of where we need focus our intentions and resources.

Approach to Integrated Health & Social Care in Barnsley

The Health and Wellbeing Board continues to encourage integration by bringing together clinical, political, professional and community leaders to develop and deliver the Health & Wellbeing Strategy and the Integrated Place Based Plan. Integration is central to improving services and integration can be seen at many levels including service, pathway, process and place.

Diagram 2 below illustrates our integration journey, providing examples of key pieces of work which are taking place.

Diagram 2 – Our Integration Journey



The table below shows the range and scope of integrated services, pathways and enablers that will significantly contribute to establishing integrated services by 2020 and delivering our vision for health and wellbeing as set out in the Health and Wellbeing Strategy. The list is indicative, rather than exhaustive as many other services/initiatives can be considered as contributors / enablers for integration. It should also be noted that whilst included here because there is a clear correlation to the delivery of our BCF plan, they are not necessarily funded through the funded through the BCF/iBCF/AASCF.

Level of integration	Service/Programme/Process
Service	High Impact Change services: • Intermediate care • Hospital Discharge Team • Neighbourhood Nursing • Reablement Service
	Social Care Provision , including: • Single Point of Access • Aligned Locality Teams • Hospital based Social Work Team • Integrated Mental Health Teams • Strengthened Learning Disabilities Teams • Integrated occupational therapy & sensory impairment provision • Residential Care Team • Deprivation of Liberty Team • Brokerage Team
	Neighbourhood Nursing
	Rightcare Barnsley
	Social Prescribing
	Care Navigation
	Integrated Assistive living and technology
	Mental Health Recovery College
	Be Well Barnsley
	Universal Information and Advice (Live Well Barnsley)
	Careers Strategy and Action Plan
	Warm Homes, Healthy People Project
	Barnsley Good Gym
Pathway	Respiratory , Diabetes , CVD, Falls, Dementia Mental health & Musculoskeletal Services (including High Impact Intervention for MSK Triage)
Enablers / Process	Adult and Children's Joint Commissioning
	Local Health & Employment Integration Board
	Stabilising the Care Market
	Maintaining Care Provision
	Use of Alliance Contracts
	Local Digital Road Map (single assessment and care record)
	Map of Medicine
	Workforce - Making every contact count
	Joint strategic intelligence & Analysis
Place	Accountable Care Partnership (Commissioning & Provider integration): • Primary Care • Neighbourhood Nursing • Intermediate Care • Community mental health • Social care Multi - Agency Locality Teams
	Safer Neighbourhoods Service
	Place Based Remodelling

Until recently, our focus for integration has been on integrating services and pathway, enabled by process integration. This approach is in line with our previous BCF plans and our original Pioneer Integrated Care and Support proposals.

We have however now begun to further develop the concept of integration around place. The Health and Wellbeing Board is clear that place based integration can make a significant contribution to those longer term ambitions whilst delivering better outcomes for Barnsley people and improving the patient/service user experience.

Place Based Integration

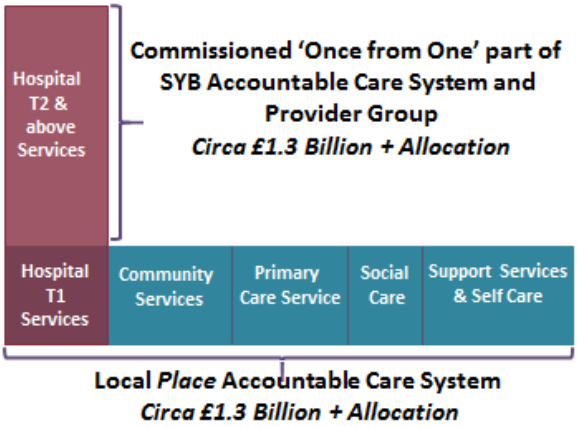
Health and care organisations across Barnsley are working together to create a new model of integrated care through an accountable care partnership. An Accountable Care Partnership Board (ACPB) was formed over 12 months ago comprising the CCG, BMBC, BHNFT, SWYFPT, Barnsley Healthcare Federation (BHF), Barnsley Hospice and Healthwatch Barnsley. The work of the ACPB is underpinned by a programme of new models of care work streams, focussed on transformation of patient pathways and alliance contracts for delivery of a range of services. In addition, Barnsley has had a joint commissioning unit in place for many years with integrated commissioning of older peoples services, mental health services, and services for people with leaning and physical disabilities.

Progress made to date includes:

- Integrated commissioning has already been in place for a number of years in Barnsley underpinned by a joint commissioning unit and an executive decision making function for children's and adult services across BCCG and BMBC, reporting to the Health and Wellbeing Board and Barnsley Clinical Commissioning Group.
- Alliance Contracts are now in place for intermediate care, neighbourhood nursing and respiratory services and Rightcare Barnsley single point of access and signed off by partners in BHNFT, SWYFT and the Barnsley Healthcare Federation
- An Accountable Care Partnership Board (ACPB) has also been in place for over twelve months bringing together commissioners and providers to explore the benefits for Barnsley people of integration of commissioning and provision at place and the potential to ultimately move to a full Barnsley Accountable Care Organisation
- SYB STP mandate to deliver a system ACS and 5 place based Accountable Care Partnerships (ACPs) is now in development
- As part of this a place based legal partnership agreement is required to be in place from April 2018 for the Barnsley ACP (in part this already exists for Barnsley through Alliance Contracts, although it is likely that partners will look to develop this further in the form of a Memorandum of Understanding)
- An Accountable Care Shadow Delivery Board has been established to deliver the Barnsley ACP and to focus on delivering integrated provision and commissioning of Tier 1 services and the Barnsley place based plan

The focus of the ACP is on delivering integrated provision and commissioning of Tier 1 services and the Barnsley place based plan as illustrated in diagram 3.

Diagram 3: Accountable Care System



Within the SYB system wide ACS, there will also be five place based accountable care partnerships (ACPs), integrating commissioning and provision. Barnsley will be a place based ACP.

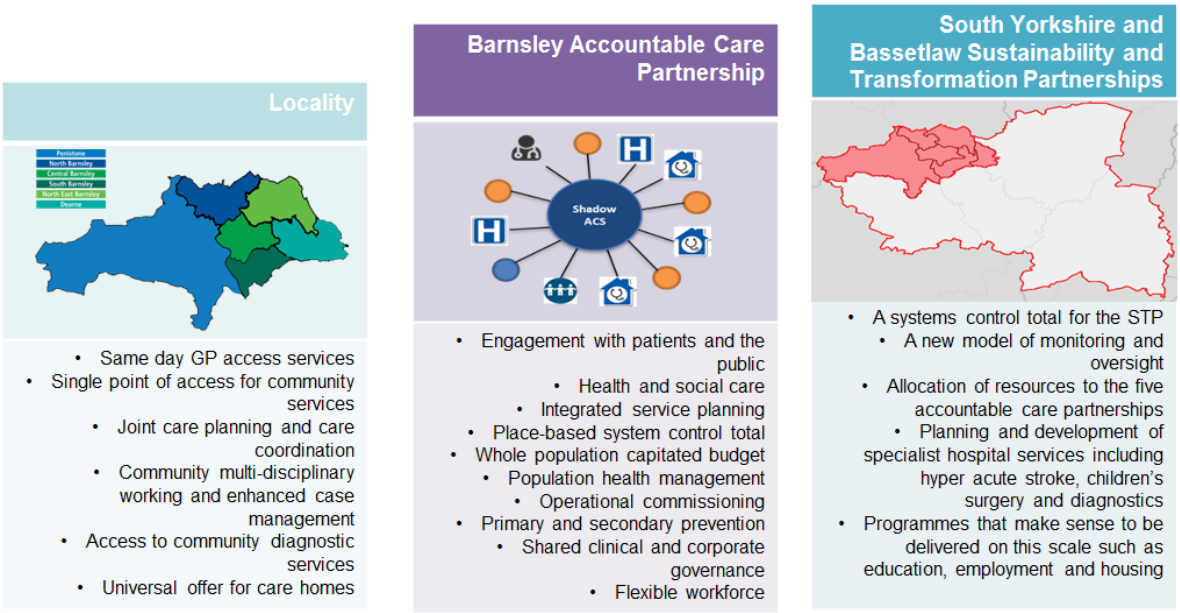
Due to the work undertaken to this point on accountable care in Barnsley, we are in a positive place to drive forward the transition from the ACPB to a shadow ACP quickly. The ACPB would like to see the shadow ACP in place from July 2017. The shadow ACP will be focused on operational delivery and currently the proposal is to name it the Accountable Care Shadow Delivery Board (ACSDB).

The role and function of the ACSDB will be to deliver integrated health and social care, as well as proposed accountability and governance structures. Initially, the four main objectives of the ACSDB will be to:

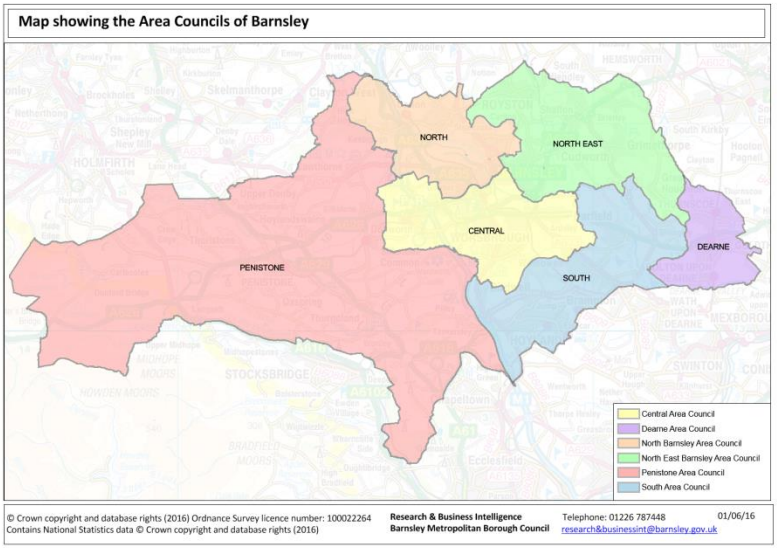
- Deliver the Barnsley Plan, in particular those elements that support delivery of the STPs priorities, including improvement in urgent and emergency care and cancer waiting times as well as progress with improving mental health services and primary care;
- Oversee the delivery of the current Alliance Agreement, acting as the Alliance Leadership Team;
- Support the transition of the ACSDB to a legally constituted ACP by 1 April 2018; and
- Deliver the Barnsley place based requirements of the STP Performance Contract.

The Accountable Care Programme in Barnsley is summarised in diagram 4 below.

Diagram 4: The Barnsley Accountable Care Programme in Summary



In designing and delivering services in Barnsley, the ACP will aim to reflect the differing needs of the communities that make up Barnsley. People and places in Barnsley differ from one area to another. In some areas of Barnsley people live the last 20 years of their lives in poor health. For this reason, the borough has been divided into 6 localities and services to support individuals are being designed around these geographies:

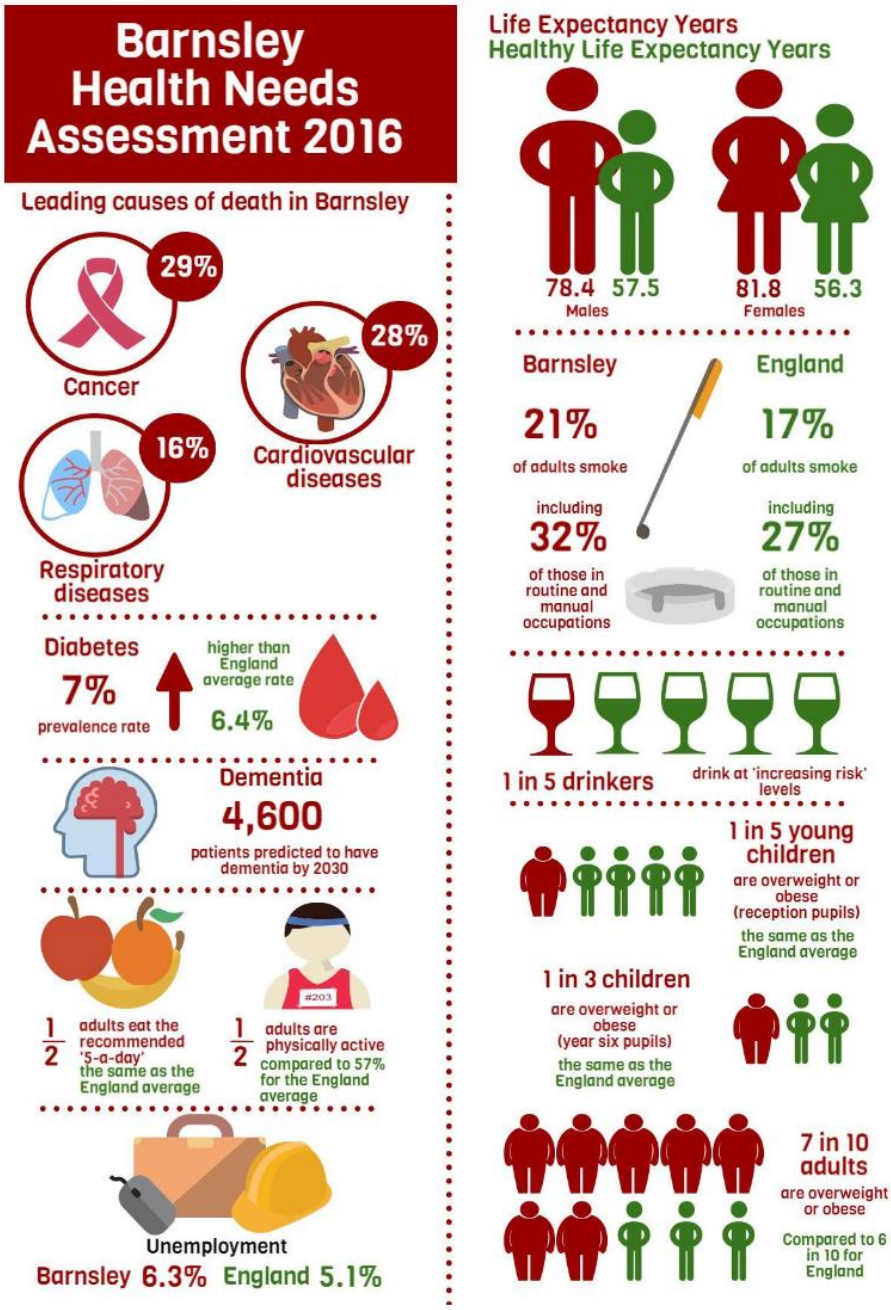


To get the right model of care for Barnsley people, we will to engage with our citizens and work together to shape an integrated service model that reflects and meets the needs of our communities.

Evidence base and local priorities to support plan for integration

All of our strategies and plans are informed by the Joint Strategic Needs Assessment to ensure we are working together to address the key challenges facing the population of the Borough. There has been considerable effort to improve health outcomes and life expectancy (particularly health life expectancy) however the 2016 JSNA identifies that Barnsley continues to face some significant challenges over the next few years and therefore the importance of focussing our plans on the key issues remains crucial.

Diagram 5: Barnsley Health Needs Assessment 2016 - Infographic



The diagram above identifies some of the key lifestyle factors such as smoking, alcohol consumption, unhealthy eating and inactive lifestyles which impact upon people's health along with wider determinants such as unemployment, poverty, deprivation and housing quality.

The health of Barnsley residents is generally poorer than the national average. There are significant health inequalities across Barnsley. This creates growing pressures on health services, social care, informal care, supported housing and other services. Some long term conditions are preventable by modifying lifestyles and behaviours and promoting healthy living. Long term conditions impact on quality of life, contribute to inequalities and become more common as people get older. As people are living longer, more of them are expected to be diagnosed with long term conditions over time.

The main health conditions are:

- Cancer
- Coronary Heart Disease
- Respiratory Disease
- Diabetes Dementia
- Poor Mental Health

Population projections based on the mid-2014 population estimates show that the number of Barnsley residents is expected to increase by 6.1% and reach approximately 247,600 by 2020 of which 20% will be aged 65 and over.

To accommodate these extra people the Local Plan (Housing Development) has proposed that an extra 14,790 dwellings are to be built across the borough between 2014 and 2033. If left, the current lack of housing options will further impact on resident's wellbeing, including poorer housing conditions, higher housing costs, more people in fuel poverty and higher levels of overcrowding.

The number of older people is expected to rise significantly and the current housing offer may not be able to cope with the demand for suitable or specialist housing to meet the needs despite the additional planned dwellings.

As a result of an ageing population, the number of people experiencing particular illnesses or conditions will also increase. Information suggests that in the next few years more Barnsley residents will:

- Suffer from Dementia
- Suffer from Depression
- Suffer a fall, particularly those aged 75 and over
- Suffer a stroke, particularly those aged 75 and over and particularly males
- Be unable to take care of themselves or move around independently
- Be living with long term illnesses
- Be living alone
- Have obesity issues

The issues and challenges identified in relation to poor health will clearly have an impact upon health services and therefore the focus of our BCF in meeting the national conditions

and delivering improvements against the key metrics will be upon delivery of activities and schemes which can mitigate the impact of some of the factors identified.

Further information on some of the other challenges and issues identified through the JSNA and other assessments is included below to provide further context. The JSNA 2016 and other related statistics and profiles can be accessed at: https://www.barnsley.gov.uk/services/our-council/research-data-and-statistics/joint-strategic-needs-assessment/

Summary of Barnsley's Profile

Population

- The population of Barnsley is approximately 239,300 and is projected to increase to 247,600 by 2020. This means that there will be more people of each age category living in Barnsley.
- The number of older people (aged +65) and those with learning disabilities and mental health issues requiring social care and support is projected to rise annually beyond 2017/18.

Deprivation

- Barnsley is ranked the 39th most deprived area in England out of 326 (where 1 is the most deprived), and 21.8% of areas in Barnsley are amongst the 10% most deprived in England. There is an interrelationship with deprivation and poor health.

Life Expectations & Healthy Life Expectancy

- There are marked differences in life expectancy and healthy life expectancy across Barnsley and therefore to make the greatest difference we need to focus our resources on the areas of greatest need.

Health

- The health of Barnsley residents is therefore generally poorer than the national average and the number of people with one or more long term conditions is expected to rise. This affects the quality of life for Barnsley residents and creates growing pressures on health services, social care, informal care, supported housing and other services.
- Dementia costs the UK economy £17 billion a year and in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year. Figures for Dementia in Barnsley for 2014/15 show that 1,904 people have a diagnosis of dementia which is a prevalence of diagnosed dementia of 0.8%. However, current estimates indicate that there could be an additional 1,057 GP patients in Barnsley with dementia who are undiagnosed, and 2030, it is predicted that 4,612 GP patients will have dementia.
- Barnsley's 2014/15 rate for the number of people known to GPs as having being diagnosed with mental health problems at 9.6% is significantly higher than the England rate of 7.3%. This represents 18,840 adults living in Barnsley who have been diagnosed with depression.
- Patients with long term conditions such as heart disease, diabetes and Chronic Obstructive Pulmonary Disease (COPD) are more likely to develop mental health problems such as depression than the general population.
- There continues to be a trend of increasing numbers of emergency admissions to hospital in Barnsley with higher levels of admission for cardiovascular disease and respiratory disease contributing to the level of admission and associated costs of admissions.

- Falls are the largest cause of emergency hospital admissions for older people and significantly impact on long term outcomes. In Barnsley the rate of emergency admissions for falls injuries in people aged over 65 years old has increased over time.

Carers

- The number of carers is difficult to estimate. The 2011 Census indicated that over 7,600 Barnsley residents were providing 50 or more hours of unpaid care each week to a friend, relative or neighbour who had a disability or health problem.

Adult Social Care

- The challenges faced by social care are well documented with councils having to manage increasing demands and costs with significantly decreasing resources.
- Increased demand as a result of a growing and ageing population, increasing prevalence of dementia and frailty, more people with complex physical and learning disabilities living longer and high level of adult mental illness.
- Increased costs as a result of pressures such as the National Living Wage, managing unfunded new burdens such as the Deprivation of Liberty Safeguards and securing the stability and financial viability of the provider market, particularly the residential and home care sectors.
- The proportion of people with multiple and complex needs and the cost of support is anticipated to rise year on year. This is particularly evident in the older people cohort where the number of high cost placements requiring 1:1 supervision to manage challenging needs is on the rise.
- The number of young adults with learning disabilities transitioning annually from children services as well as adults with complex needs living longer has resulted in spend on care / support increasing significantly in recent years.
- Current demographic projections indicate annual growth in numbers / cost of supporting people with learning disabilities of between 3% and 5% over the next 3 years.
- As a result of the Transforming Care Programme, additional cost pressures are anticipated as people with a learning disability and/or autism in specialist LD hospitals are discharged and supported by local authorities in the community.
- Without appropriate social care support people's needs are likely to escalate placing even greater strain on health services.

The Personal Social Services Adult Social Care Survey (ASCS)

- Indicates that there is a slightly higher rate of clients who are extremely or very satisfied with their care and support services compared with England as a whole, and generally clients have reported a better health and better quality of life this year than last year.
- Of the service users that tried to access information and advice about care and support, 76% found it easy or fairly easy. This is better that the national average and amongst the best performance in the region.

Health surveys

- A range of 16 recent surveys have found some common areas of feedback amongst users of health services in Barnsley:
    - Service users would like services to be more flexible and person centred, with improved communications and greater engagement and inclusion of family and friends.

- Integration between patients, carers and professionals, and between service providers and partners organisations, is seen as essential, as is access to the right service at the right time.
- Generally need more information, support and advice about local services is needed, with greater awareness of high quality services such as I-Heart Barnsley and Pharmacy First.

Housing

- The numbers of older people are expected to rise significantly and the current housing offer will be unable to cope with the demand for suitable or specialist housing to meet the needs of an additional 1,400 people aged over 64 by 2020.
- Increases in the private rented sector present challenges in ensuring people can access affordable housing that is free from health and safety hazards and which is managed responsibly.

Progress to date

As set out in our original BCF plan and carried forward into our 2016/17 plan, and in line with earlier sections of this plan, integration is seen as part of the wider transformation journey across the whole of health and social and is aligned to delivering the vision and ambitions of the Health and Wellbeing Strategy and the Barnsley Place Based Plan. More recently our developments around accountable care are also supporting our integration vision.

In considering the BCF in this context and the need to focus on the areas where there is greatest pressure in the system, the following schemes were identified in the original BCF plan and remain key to our plans in order to achieve redesigned pathways and avoid unnecessary unplanned acute hospital admissions and admissions to care homes. It is important however to emphasise that these are only part of a wider transformation and integration programme across the whole health and care system. The rationale for identification of these schemes was based upon the potential impact upon reducing emergency admissions or improving the wider system capacity to ensure that appropriate alternative care is available in the right place and at the right time.

The key schemes are those which depict the journey through the care pathway. These are:

Universal Information & Advice Strategy across all statutory agencies – Work continues to build on the tools developed such as the Live Well Barnsley website, a place where you can find information about help and support services within the borough. The site contains information and contact details about all types of services and activities that can help you look after yourself, stay independent and get involved in your community. Development of information and advice continues to move forward and this new tool which replaces the original connect for support website has been a fundamental step forward in providing access to information for those who need it.

Be Well Barnsley – Services have been in place as part of the Be Well Barnsley Service throughout 2016/17 providing support to individuals around healthy lifestyles, weight management and smoking cessation based around the principles of supported intervention, self care and behavioural change. The model of delivery has been to provide a range of

community focused preventative services/peer models which help to improve lifestyles and achieve health gain. The service has contributed to a reduction in smoking prevalence however there remain key health challenges for the population and therefore the impact of the service will be reviewed and the model refined to encourage increased up take and ensure support is meeting the needs of service users.

In addition to the Be Well Barnsley Service there has also been a specific focus on reducing smoking prevalence further with high impact actions being delivered as part of the BIPBP including developments to create a smoke free Barnsley being led by the Barnsley Tobacco Alliance. Progress to date has included all key play parks across the Borough becoming smoke free areas and the first smoke free in the town centre being established. Building on this success the next stage of the programme will be smoke free schools, launching as a pilot in 5 primary school in Autumn 2017 and being rolled out across all primary schools.

Neighbourhood Nursing – A fundamental review of Community and District Nursing Services led to the development of a new Neighbourhood Nursing Service, with the new model implemented in 2016/17. This new model is aligned to our vision for services in the community to be delivered around six localities and closely aligned to primary care. The service provides proactive case management to support people at the highest risk of admission/readmission to hospital with intensive multi-disciplinary care and care coordination within their home environment, thus supporting recovery and self-management and, avoiding hospital admissions. In addition a review of respiratory services was also completed in 2016/17 which resulted in services being redesigned to provide increased support for patients in the community as well as improved pathways within the hospital to ensure patients receive co-ordinated, specialist support. Whilst not specifically included within the BCF in 2016/17 this service compliments the Neighbourhood Nursing Service, providing specialist support for the high number of patients within Barnsley suffering from long term respiratory conditions such as COPD. In line with our vision for place based integration, both of these services are being managed within the accountable care programme as part of the alliance arrangements which are in place in Barnsley.

Right Care Barnsley – our single 'front-door' service introduced to support healthcare professions including GP's and other primary care professionals, Community Nurses, Paramedics and Emergency Department staff to identify alternative packages of care for patients at risk of an urgent hospital admission, thereby avoiding admission where this is not the most appropriate care for the individual. This service has continued to develop and expand its remit and is now providing advice and guidance to care homes to reduce the number of ambulance calls and hospital admissions for care home patients and supporting discharge processes to ensure transfers of care are managed effectively. Since being established the service has provided support resulting in up to 35% of referrals for hospital admission which would previously have resulted in an admission, being provided with an out of hospital package of care. The service are also supporting a number of initiatives that have been developed in response to the high impact interventions for managing transfers of care such as development of a trusted assessor role which is reducing delays for patients to be readmitted to long term care home placements. This service is also being managed within the accountable care programme as part of the alliance arrangements which are in place in Barnsley and during 2017/18 will become an integral component of the Intermediate Care Service.

Intermediate Care – An initial review of services resulted in a new specification being piloted throughout 2015/16 and 2016/17, testing out a model for an integrated service with an increased focus on preventing hospital admissions (as well as supporting timely discharge). Evaluation of the pilot was undertaken towards the end of 2016/17 and the findings of this have been used to develop a new model for delivery which is being implemented in 2017/18. The evaluation found that:

- Whilst the aim of the Intermediate Care Service is to rehabilitate patients following an episode of illness or injury. The majority of patients are 'stepped down' into the service from acute care. Very few are 'stepped up' from their own home.
- The model of service provision encourages multiple referrals to exit the hospital and leads to inappropriate use of services
- The acceptance and exclusion criteria into the service limits access to patients who require rehabilitation and does not reflect the patients who need extra support and care to avoid an admission or to ensure a timely discharge from an acute hospital bed. There are also patients who require a period of recuperation following an acute illness or injury before they start rehabilitation.
- The needs of patients change and change quickly. A referrer's assessment of a patients need in the acute trust can quickly change when they arrive at a 24 hour bed based facility for rehabilitation or indeed when they arrive in their own home following discharge. In addition, some patients who are referred to a rehabilitation bed end up only requiring recuperation for a short period of time and some patients who have been moved to a recuperation bed actually end up requiring rehabilitation.
- Access to reablement is perceived as a separate strand of the service which is sequential and requires another referral. It is known that patients remain within the Intermediate Care Service much longer than needed and not necessarily moved on to reablement and other services.

In response new specification has been developed and is being implemented as part of the Accountable Care alliance arrangements with providers working together to deliver a more responsive service that can meet the care needs of a wider cohort of patients including those who do not require an acute hospital bed but require extra support or require support to stay at home fit a model of care that is still classed as intermediate care.

The new service aims to enhance the current intermediate care offer by extending and enhancing the scope of the service to include access to recuperation beds for those patients who need this level of intervention with the aim of timely transition of patients between the different components of intermediate care and brokering care from other suitable services i.e. Shared Lives, Reablement (Independent Living at Home) and Support to Live at Home. The offer will also be extended to those who are able to stay at home but require enhanced support at home which goes over and above the healthcare services provided in the community (universal offer).

It is an expectation that the movement of patients between services will be seamless and timely by ensuring active case management, excellent forward planning and care brokerage. RightCare Barnsley's role will be the key going forward.

The Independent Living at Home Service, which provides reablement support has also been reviewed and re-specified to include new referral pathways to further improve, hospital discharges and assessment of longer term care packages. The primary focus for the service is to deliver against the re-ablement target. The service is being aligned to the new Intermediate Care Model to ensure improved connectivity between teams and ensure a

smoother care pathway for the patient. The service also links with the Assistive Living Technology service as well as Equipment & Adaptation and Falls services to promote independent living by creating added value across the wider frailty pathway.

Assessment & Care Management - new Operating Model - the way assessment and care management services are provided in Barnsley were fundamentally revised in April 2015 to focus more on early intervention and prevention; self-help and redirecting people to non-statutory and universal services; and short term, targeted reablement. This has enabled us to move towards the 'inverted triangle' model described in our original Better Care Fund Plan. The new operating model for adult social care has enabled more people to take control over their care and support, increased the uptake of reablement and sustained outcomes.

The model is now being further refined to align teams to the area council boundaries (in common with Neighbourhood Nursing), ensure more pro-active management of service users with complex needs and more regular review of individual care and support needs. Changes will include the creation of a team with responsibility for managing older people in residential and nursing care homes, creation of an additional locality team, increased capacity to improve monitoring of domiciliary care contracts and increased capacity for quality assurance.

These changes will help to further improve integrated working between health and social care teams to better manage individuals with complex needs in the community and avoid unnecessary hospital admissions

As the BCF is set in the context of our wider integration and transformation planes, there are also other activities and improvement projects which have taken place or are taking place which will contribute to the aims of the BCF plan. These are included in the action plan for the BIPBP and include a wide range of activities aligned to the priorities of the Health and Wellbeing Strategy and BIPBP.

Over the period of the previous BCF plans, delivering against the challenging performance targets we have set ourselves has remained a significant challenge with pressure on the both health and care services continuing to grow as the population becomes older, more people life with multiple comorbidities and long term conditions. Details of performance against the key performance measures in included within the performance metrics section.

Better Care Fund plan

Barnsley's BCF plan for 2017 -19, is an evolution of previous plans to establish integrated health and care in Barnsley. This approach enables programme continuity and provides the opportunity to go further faster on our integration journey.

Building on previous plans, the BCF plan for 2017-19 will:

- Contribute to meeting adult social care needs
- Provide resources to stabilise the local social care market in line with the ambitions of the iBCF
- Provide an improved and integrated approach to carers support

- Enable a strategic approach to DFG and improve outcomes across health, social care and housing
- Support the continued development and delivery of an out of hospital locality based services
- Support the effective management of transfers of care.

In doing so, the BCF will continue to be a significant contributor to key programmes of integration, to help deliver the wider vision for health and wellbeing and service integration in the borough.

The Better Care Fund in Barnsley is used to fund services commissioned by the NHS Barnsley Clinical Commissioning Group and Barnsley Metropolitan Council with the overall BCF plan being supported by a range of schemes which form part of the wider system wide transformation plans. The funding from the BCF remains broadly consistent in 2017/18 and 2018/19 with that of previous plans to ensure sustainability of those health and social care services and is predominantly focussed upon out of hospital NHS services and Social Care services. The level of funding has been enhanced in 2017/18 with the iBCF enabling additional areas to be supported by the BCF.

The schemes and activities included in the BCF Plan below are those which are funded by the pooled fund. There are many other initiatives and schemes being delivered individually and collectively by health a care organisations which contribute to delivery of our overall integration and transformation vision, many as part of the Barnsley Integrated Place Based Plan.

Better Care Fund Action Plan

Theme	Activity / Action	Responsible Organisation	Timescales	Expected Impact
Meeting adult social care needs	Maintaining existing care provision and other unfunded service pressures e.g. emergency duty team, adult safeguarding board, DOLS,	BMBC	Through 2017/18	Ensure care and support is available to: • meeting statutory duties • provide a quality service • improve performance in terms of delivery of timely reviews • facilitate timely discharges from hospital • ensure timely review of service user care needs • effectively support carers • reduce care home admissions • reduce other pressures on the NHS
	Expand service / management capacity to cater for the size and complexity of the service as well as to mainstream the Review Team.	BMBC	Through 2017/18	
	Contribution to care provision to cover demographic and national living wage.	BMBC	Through 2017/18 and 2018/19	
	Contribute to short term residential and respite provision (including support for carers and reablement).	BMBC	Through 2017/18 and 2018/19	
	7 Day working – social work service in the hospital	BMBC	Ongoing	
	Mental Health Community Team	BMBC	Through 2017/18 and 2018/19	
	UIA (live well Barnsley Directory)	BMBC	Through 2017/18	
	Community Bridge Building (capacity to improve access / signposting to community and universal services)	BMBC	Through 2017/18	

Stabilising the local social care market	Pay a sustainable fee to care homes	BMBC	2017/18	Maintain effective relationships and incentivise improvement in quality of care; address recruitment issues (nursing homes) and ensure a high quality, effective and sustainable independent sector.
	Strengthen contract monitoring arrangements	BMBC	2017/18	
Integrated approach to carers support	Provision of personal budgets	BMBC/CCG	2017/18	Improved support for carers in line with the Carers Strategy
	Provision of a Carers Centre	BMBC	2017/18	
Strategic approach to Equipment and Adaptations including DFG	Develop a system wide service for assistive living.	BMBC	2017/18	Ensure people have access to appropriate equipment and adaptations utilising DFG and other funding in a coordinated manner to maximise support of service users.
	Provision of Equipment and adaptations	BMBC/CCG	Through 2017/18 and 2018/19	
	Community Home Loans		2018/19	
Delivery of an Out of Hospital Service	Independent Living At Home	BMBC	Through 2017/18 and 2018/19	Improved access to reablement support to enable people to live independently at home following a period of ill health
	Mental Health Recovery College	CCG/BMBC	Through 2017/18 and 2018/19	Enable people with mental health conditions to have access to appropriate support
	Intermediate care	CCG	Through 2017/18 and 2018/19	Reduced requirement for patients to be admitted to hospital by providing appropriate care and support in community settings.
	Neighbourhood Nursing	CCG	Through 2017/18 and 2018/19	Reduced requirement for patients to be admitted to hospital by providing appropriate care and support in community settings.
	Social Prescribing	CCG	Through 2017/18 and 2018/19	Reduction in number of people accessing health services for non-health related issues, reducing social isolation and supporting people to access support services.

	Falls Service	CCG	Through 2017/18 and 2018/19	Improved support for care homes and wider community services to help identify risk and prevent falls. Increased support to patients following a fall. Reduction in hospital attendances and admissions as a result of injury caused by a fall.
Managing Transfers of Care	7 Day working – social work service in the hospital	BMBC	Through 2017/18 and 2018/19	Discharges from hospital 7 days, avoiding unnecessary delays, particularly at weekends
	Reablement / ALT / Response service – increased funding for reablement services (ILAH) to address existing demand pressures; to enhance capacity to increase usage of ALT within ASC and to cover existing response service contract pressure.	BMBC	Through 2017/18 and 2018/19	Improved access to reablement support to enable people to live independently at home following a period of ill health

National Conditions

National condition 1: jointly agreed plan

The BCF plan is a jointly agreed plan of the Health and Wellbeing Board. The Health and Wellbeing Board including the signatories to the plan approved the approach and all partners are engaged in planning processes through both the Board and the Senior Strategic Development Group which has responsibility for delivery of the Health and Wellbeing Strategy and the BCF plan.

The main acute, community and mental healthcare providers and local housing authority are members of the health and wellbeing board and have been engaged in development of all plans. The H&W Board Provider Forum are also engaged in the planning process to ensure that the wider network of providers are able to influence planning decisions and are aware of potential implications.

The proposals for the use of the iBCF were developed with involvement from the H&WB Board Senior Strategic Development Group to ensure partner contribution to the proposals and the Barnsley A&E Delivery Board to ensure account was taken of how to funding could be used to maintain levels of delayed transfers of care and support effective discharge from hospital.

The use of the IBCF grant has been agreed and approved by the Health and Wellbeing Board with all partners supporting the use of the IBCF as described in this plan to stabilise the social care market, ensure sufficient capacity to continue to provide high quality services which support service users in the context of ongoing growth in demand and continue to support timely discharge from hospital.

The iBCF will be used to cover the following headline areas (detailed expenditure plans are included within the BCF planning template):

- Care provision costs/pressures
- Stabilising the Care Market
- Reducing delayed discharges/NHS pressures
- Meeting adult social care needs

National condition 2: social care maintenance

The approach to protecting the provision of social care remains in line with our previous BCF plans and the level of funding allocated from the BCF (CCG minimum contribution to the BCF) to maintain social care provision has been increased in 2017/18 and 2018/19. In addition there is some additional growth to reflect increases in funding in relation to the disabled facilities grant and the inclusion of the iBCF.

The level of funding from the CCG minimum contribution to Social Care has been agreed to ensure the required level of uplift across 2017/18 and 2018/19. To ensure consistent level of service across the 2 years of the plan a higher proportionate uplift has been applied to 2017/18 and therefore whilst the total increase in 2018/19 appears below 1.9% of the 2017/18 level, it remains above the minimum mandated expenditure on Social Care from the CCG minimum contribution.

The level of funding allocated for Social Care from the CCG minimum contribution is £10.2m in 2017/18 and £10.4m in 2018/19

The planned spend on Social Care from the CCG minimum contribution is set out in the table below:

Area of Spend/Scheme Name	**2017/18 Expenditure**	**2018/19 Expenditure**
Long term care provision	£5,115,000	£5,298,000
Short term and respite provision	£810,000	£810,000
Mental Health Community Social Care Team	£760,000	£760,000
Other ASC provisions - DOLS, Access & Rapid Response	£679,000	£679,000
Commissioned contracts - Reablement, MH recovery college and equipment and adaptations	£2,307,000	£2,307,000
Independent sector residential beds (Intermediate Care)	£243,100	£243,100
My Best Life - Social Prescribing	£302,251	£307,394
Total	**£10,216,351**	**£10,404,494**

Within the areas set out above funding remains in place to support carers and continue to meet the duties resulting from the care and support reforms of the Care Act 2014.

The decision not to include a payment for performance risk share arrangement as part of the 2017/18 plan will ensure the level of funding available for commissioning of social care for the BCF is assured.

National condition 3: NHS commissioned out-of-hospital services

The Better Care Fund in Barnsley is predominantly based around out of hospital services in support of the strategic direction to deliver care closer to home where appropriate. NHS commissioned out of hospital services funded from the BCF continues to be above the minimum required amount.

Funding for out of hospital services is mainly to ensure the delivery and ongoing developments to intermediate care services in order to support the urgent care pathways by providing step up and step down services which avoid admission to hospital and ensure timely, well planned discharges avoiding any unnecessary delays.

In addition to Intermediate Care BCF funding is also provided for Rightcare Barnsley, Falls Services, Community Home Loans and Equipment and Adaptations. The table below provides a summary breakdown of the expenditure and the schemes being supported.

Area of Spend/Scheme Name	**2017/18 Expenditure**	**2018/19 Expenditure**
Intermediate Care Services (Including transition costs in 2017/18) including Rightcare Barnsley	£7,834,761	£7,446,455
Falls Service	£123,201	£123,324
Equipment and Adaptations	£416,044	£416,460
Community Home Loans		£552,841
Total	**£8,374,006**	**£8,539,080**

National Condition 4: Managing Transfers of Care

The level of DTOC in Barnsley remains low in comparison to neighbours and levels seen nationally however there have been some increases in the levels of DTOC during 2016/17 and therefore against this context we have set a target for 2017/18 and 2018/19 in line with national expectations and with a view to maintaining current levels over the period of this plan.

Regardless of the low levels of DTOC in Barnsley, we do acknowledge the importance of effectively managing every transfer of care in and effective manner in order to ensure that patients receive the most appropriate care from the most appropriate clinician at the right time in their journey and therefore we have used the High Impact Change Model for managing transfers of care between hospital and home to identify areas for improvement.

A sub group of the Barnsley A&E Delivery Board made up of representation from the CCG, Barnsley Hospital and South West Yorkshire Partnership Foundation Trust undertook a self-assessment against the high impact changes set out in the model to ensure a cross representation of the key organisations responsible for implementing the changes. There is however recognition of the need for other partnes to contribute and therefore the plan has been shared with and agreed by the full A&E Delivery Board membership.

Undertaking the self-assessment against the high impact change model confirmed that there is good practice across many areas.

There are also however areas where further development is required and therefore the managing transfers of care action plan attached at appendix 1 sets out where we are, the areas for improvement and timescales for delivery. The plan aims to ensure our approach, systems and processes for managing transfers of care are as effective as possible and in line with best practice.

The plan will remain fluid and will be reviewed and amended to reflect performance through the year and ensure it brings together all actions that are aimed at managing the level of delayed discharges. In addition to being reviewed as part of the governance arrangements associated with delivery of this plan, the actions included within the plan will be included within the A&E Delivery Board Improvement Plan. The A&E Delivery Board will have responsibility for ensuring delivery of the plan.

Overview of funding contributions

The funding contributions for the BCF are being used in line with the specified requirements of the policy framework and planning guidance.

Details of the specific funding streams and expenditure plans are included in the detailed BCF Planning Template.

In Summary, the CCG are contributing to the pool the specified minimum contribution. This is being used to fund out of hospital services and provide support to social care services. Within the CCG contribution to Social Care is funding to support implementation of the care act, and support for carers. These are not specified in the expenditure lines in the expenditure plan as the activities are embedded within broader activities.

Funding provided directly to the Local Authority including the Disabled Facilities Grant and IBCF is being used in line with the conditions and guidance specifically associated with these funding streams and details of the level of funding are included within the detailed BCF Planning Template.

The table below provides a summary of the level of funding included within the BCF for Care Act implementation, Carers Support, Reablement and Disabled Facilities Grant in each of the years.

Area of Spend	2017/18 Expenditure	2018/19 Expenditure
Care Act Implementation	£700,000	£700,000
Carers Support	£761,000	£761,000
Reablement	3,246,000	£3246,000
Disabled Facilities Grant	£2,544,576	£2,758,216
Improved Better Care Fund	£6,803,033	£9,395,305

Funding for Care Act Implementation, Carers Support and Reablement has been maintained at previous levels.

The Disabled Facilities Grant (DFG) provides funding (or fund works and adaptations) to help disabled and elderly people to live independently in their own homes. Means tested funding is provided to home owners or tenants to make the adaptations. The Council has recently revised its operating procedures to utilise DFG funding in a way meet the needs of disabled people in a more effective and flexible way. These changes have been incorporated into the Council's updated DFG policy - implemented from 1st April 2017. The policy now includes reference to the additional help and flexibility the Council will offer in relation to providing home adaptations for disabled people in the future and includes:

- Implementation of a fast track grant process for specific adaptations (e.g. Stairlifts, Ramps, through floor lifts and level access showers);
- Funding assistance for adaptations to Shared Lives carer properties where the application would not be eligible for Mandatory funding;
- An increase to the discretionary amount to £10k;
- Recruitment to two additional posts to increase team capacity (Project manager and case worker);
- Support for the warmer homes initiative;
- The ability to tender extensive works (e.g. extensions) for external project management

Programme Governance

The Health and Wellbeing Board is a formal committee of the local authority, established under the Health & Social Care Act 2012, and has a legal duty to produce a joint strategic needs assessment and a joint health and wellbeing strategy.

The Board brings together clinical, political, professional and community leaders and is therefore well placed to respond to these challenges. Our strength lies in working together to

increase prevention and early help, and make sure the right system of help will be there for people when they need it most.

The Health and Wellbeing Board is accountable for making the best decisions for the whole health & care system. The Board will hold steady through the inevitable periods of change ahead. It will also ensure the system has the ability to mount a robust response to unforeseen, unpredicted, and unexpected demands so that services can continue normal operations.

The BCF Plan and Fund will be managed within the governance structures of the Health and Wellbeing Board.

The BCF programme will be overseen by the Health & Wellbeing Board, via the Senior Strategic Development Group (SSDG). The SSDG brings together senior leaders from across the public sector to effectively drive forward the implementation of the priorities and objectives of the Strategy and related plans, reporting on progress and recommending any action to the Board in order to manage or mitigate any emerging risks, on an exception basis.

Development and progress of the BCF plan for 2017 -19 has been discussed on a monthly basis by partners at SSDG, including BMBC, BCCG, Berneslai Homes, and representatives for the voluntary sector and Healthwatch. Progress updates and report have also gone to the Health & Wellbeing Board.

Going forward, the BCF programme will be imbedded in to the Health & Wellbeing Board Action Plan. The BCF metrics will also form part of the Health & Wellbeing Boards Performance Dashboard and will be monitored on an annual basis. The Health & Wellbeing Board Risk register reflects the strategic ambitions of the board and in cognisant of the Health & Wellbeing Board Action Plan and Performance Dashboard.

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

The detailed governance arrangements in relation to pooled fund and related management and reporting arrangements are included within a Section 75 agreement. This 2016/17 agreement is being updated to reflect changes to the policy framework and to the Barnsley Integration and Better Care Fund Plan and this will set out the detailed management arrangements for the BCF plan including how financial risks associated with the services commissioned using the BCF will sit with the commissioning organisation and be managed as part of their financial management arrangements. There will be no payment for performance element to the BCF in 2017/18 and therefore the financial risk is limited to the commissioned services.

Assessment of Risk and Risk Management

Given the nature of the BCF in Barnsley, with the funding used to enable ongoing commissioning of health and care services, and other transformation schemes and developments which support delivery of the BCF objectives in place but funded separately in most cases from outside of the BCF, our arrangements for risk management have been agreed to ensure they are proportionate but also that any significant risks to delivery can be identified and escalated as appropriate.

The Section 75 agreement includes details of the arrangements for managing financial risk in relation to expenditure from the pooled fund and set out clear responsibilities in relation to monitoring and managing any financial risk, particularly overspends. The responsibility for managing financial risks is with the commissioning organisation for each scheme and therefore arrangements for managing risk are included within organisations financial management and budget monitoring reporting arrangements.

Each organisation has robust risk management arrangements in place with corporate risk registers identifying the most significant risk to the organisation. Where risks relate to the services which are funded from the BCF, these are managed and contained by the commissioning organisation in the first instance but where the risks may have a wider adverse impact, these are escalated through the Senior Strategic Development Group of the Health and Wellbeing Board and agreed actions recorded in the minutes.

Risks to the delivery of any of the supporting schemes are managed through the established governance arrangements in place which are in place for oversight of delivery. An example would be delivery of the new intermediate care model. The management of delivery of this scheme including management of risks would be through the alliance arrangements and the accountable care partnership board.

The Health and Wellbeing Board Risk Register contains an overall risk in relation to achieving the outcomes sought through the Better Care Fund. An extract from the Risk Register is included below.

Risk Title	Risk Consequences	Existing Control Measures	Current Score	Target Score	Risk Mitigation Action	Owner
Failure to achieve the outcomes sought through the local Better Care Fund plan	Short term impact on reducing hospital, residential and nursing care admissions, delayed discharges and improving the re-enablement of older people living independently; Long term impact on transformation of health and social care;	The BCF Plan for 2017-19 will be an evolution of the BCF plan 2016/17 to enable continutiy of programmes, and thus reduce admissions and delayed hospital discharges.	Category 3	Category 5	Final BCF guidance received in July. Work is underway to develop the narrative and complete the planning template. The narrative will include the vision for integrated care, detail local plans to integrate care by 2020, and how the money will be used to meet the 4 national conditions. Deadline for submission is 11th Sept. The BCF indicator will be incorporated into the annual performance dashboard to monitor direction of travel.	Rachel Dickinson/ Lesley Smith

National Metrics

The national metric illustrate that action in Barnsley is effective in reducing delayed transfers of care and managing admission to residential care however there remains a big challenge in relation to reducing non-elective admissions / unnecessary attendance. The targets for 2017/18 and 2018/19 for each of the national metrics is included below along with a brief rationale how the target has been set.

Non-elective admissions

The level of non-elective admissions to hospital reduced slightly in 2016/17 from the level in 2015/16 however activity remained above the target and therefore plans for 2017/18 continue to be heavily focussed upon reducing demand by providing improved health and care services in the community to avoid the need for hospital admission, whether that be as a result of an exacerbation or a fall.

The trajectories for non-elective admissions are in line with the planned levels of activity included within the CCG Operational Plan and reflected in contracts. The anticipated level of activity takes account of forecast demographic growth and the anticipated impact of a range of initiatives/service changes including the new intermediate care and neighbourhood nursing models, the ongoing development and evolution of Rightcare Barnsley, implementation of the new respiratory service, extended primary care and enhancements to primary care streaming.

	2016/17 Outturn	Total 17/18	Total 18/19
HWB Non-Elective Admission Plan* Totals	33,296	32,283	31,448

**It should be noted that the out turn figure is at a CCG level whilst the BCF targets have been adjusted to reflect the Local Authority population.*

No additional reduction in non-elective activity have been planned as part of the BCF as all services and schemes included within the BCF were taken into account in setting the CCG operational plans.

Admission to residential care homes

The level of admission to residential care was slightly lower than our target, demonstrating the success of the new operating model for social care along with improvements aimed at supporting people to live independently, with or without support in their own homes. Continuing to deliver reductions in the number of older people permanently admitted to residential care will continue to be a significant challenge as the population ages and more people require support.

Our approved target for 2017/18 is a rate of 703 admissions per 100,000, which based on the population estimate of 46,388 (65+) equating to 326 admissions in 2017/18 and 332 in 2018/19. The targets have been set in recognition of an increased level of admission (reflecting national and local trends) over recent months and including the first quarter of 2017/18, and with the aim of maintaining the level of admissions at a similar or better level than our statistical neighbours.

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	685.1	676.0	702.8	702.6
	Numerator	307	308	326	332
	Denominator	44,811	45,561	46,388	47,253

Effectiveness of re-ablement

The number of people remaining at home 91 days after a discharge to reablement services has remained in line with 2015/16 however the 2016/17 target has not been achieved. The number of people accessing reablement services was also below planned levels and therefore this has impacted upon the achievement of the target. The revised service model being implemented in 2017/18 along with improved alignment and integrated pathways with intermediate care should see increased numbers supported by the service to remain at home and live independently following a hospital admission.

The performance target agreed for 2017/18 will be a significant stretch on 2016/17 out turn which saw lower numbers than anticipated remaining at home 91 days following discharge.

The service has been through a reconfiguration in the early part of 2017/18 along with the related Intermediate Care Service and therefore in line with the new model, increased numbers of people are expected to remain at home. There is an expectation that the number of people supported by the service will also continue to grow and therefore the target has been set to deliver consistent performance over 2017/18 and 2018/19.

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	90.4%	86.0%	88.0%	88.1%
	Numerator	207	244	264	282
	Denominator	229	283	300	320

Delayed Transfers of Care

The level of delayed transfers of care remains low in Barnsley compared to peers and the national average however the number of delays has been increasing year on year and this continued to be the case in 2016/17, impacted by significant pressures over the winter period which resulted in increased delays for patients waiting to be discharged to other healthcare services such as Intermediate Care. The level of delays due to Social Care have remained extremely low in Barnsley, supported by a dedicated hospital social work team supporting discharge 7 days per week. Our challenging target to bring DTOCs back to the level of 2014/15 was not achieved in 2016/17. Work has continued to implement the actions set out in the 2016/17 DTOC action plan and we anticipate these along with service enhancements across social care and health will enable effective management of transfers of care and minimise the level of delays

Our approach to managing transfers of care is set out in the national conditions section of this plan and builds on the good processes and collaboration already in place between local partners which ensures that levels of delayed transfers of care are minimised.

The level of DTOC in Barnsley remains low in comparison to neighbours and levels seen nationally however there have been some increases in the levels of DTOC during 2016/17 and therefore against this context we have set a target for 2017/18 and 2018/19 in line with national expectations (including plans to achieve the NHS and Social Care attributable targets) and with a view to maintaining current levels over the period of this plan. Achievement of the trajectory would ensure delivery of the Health and Wellbeing Board level target by November 2017

Actual delayed transfer of care per 100,000 population (aged 18+) in 2016/17

		16-17 Actuals			
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	436.3	181.0	373.0	278.4
	Numerator (total)	834	346	713	536
	Denominator	191,169	191,169	191,169	192,523

Actual delayed transfer of care per 100,000 population (aged 18+) in 2016/17

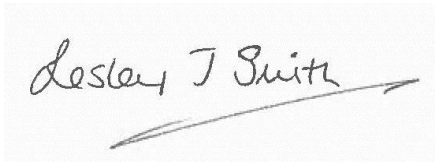
		17-18 plans				18-19 plans			
		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	286.2	291.4	291.4	283.4	291.2	291.2	291.2	291.0
	Numerator (total)	551	561	561	549	564	564	564	567
	Denominator	192,523	192,523	192,523	193,706	193,706	193,706	193,706	194,823

Approval and sign off

The Health and Wellbeing Board agreed the principles of the Integration and Better Care Fund Plan on 8 August 2017. In recognition of the deadline for submission the Board approved a recommendation to delegate the sign off of the plan for submission to the Chair of the Board and Accountable Officer of Barnsley Clinical Commissioning Group.

The final submitted plan will then be presented to the Health and Wellbeing Board on 3 October 2017. Acknowledging that at this point the feedback of the formal assurance process will not have been received, the Board will be asked to delegate the final sign off of the plan, subject to changes required as a result of the assurance process the Chair of the Board and Accountable Officer of Barnsley Clinical Commissioning Group. The final plan will then be submitted in line with the required deadline of 31 October 2018.

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Sir Stephen Houghton CBE
Position	Chair and Leader of the Council
Date	11 September 2017

Signed on behalf of the Clinical Commissioning Group	
By	Lesley Jane Smith
Position	Chief Officer
Date	11 September 2017

Appendix 1

Managing Transfers of Care Action Plan

Impact Change	Current Position	Improvement Action	Timescale	Measure of Success
1 - Early Discharge Planning	Effective discharge planning is in place for non-elective admissions with multi-disciplinary input and supported by Rightcare Barnsley. Emergency admissions have a provisional discharge date set within 48 hours	Develop arrangements for Therapy staff to be present in ED at the point of ambulance handover	November 2017	Discharge planning will have commenced as soon as patients are identified as requiring admission. Improved planning and therapy input will result in more patients going home on the planned discharge date
2 - Patient Flow	Medworxx Clinical Utilisation Review system is in place in the acute trust and used to support daily assessment of patients and provide management information to support patient flow.	Roll out the use of the Medworxx system to include intermediate care beds to enable improvement management of patient flow across the system Consider opportunities to roll out the Medworxx system to include intermediate care 'virtual beds' (patients supported in their own home)	March 2018 October 2018	Medworxx information will show a reduction in patients being identified as ready for discharge who remain in the acute and intermediate care bed base.
3 - Multi-disciplinary, multi-agency discharge teams	Assessment for Intermediate Care and Reablement is undertaken by hospital teams. Multi-disciplinary team meetings take place in hospital as part of co-ordinated discharge planning processes. Rightcare Barnsley acts as single point of contact for discharge	Identify further opportunities for multi-disciplinary working and developing alignment of assessment processes to support discharge	November 2017	Reduction in assessment processes

	support for patients requiring community service to enable them to return home. All CHC assessments are undertaken outside of hospital			
4 - Home First Discharge to Assess	Therapy assessments currently take place in hospital and capacity has not been in place in community services to undertake complex assessments in the community Recuperation beds are included within the Intermediate Care Service to enable patients requiring complex assessment to be discharged from hospital. A Trusted Assessor approach is being piloted with care homes to reduce the number care homes who carry out separate assessment of patients who are previous residents prior to the patient being discharged (currently 8 care homes)	Develop and agree a local model of discharge to assess, building best practice but reflecting local service provision Continue to work with care home providers via the care home forum to increase the number of care homes accepting hospital staff assessment	Dec 2017 Ongoing	Increase in patients discharged with support with an assessment for follow taking place outside of hospital Increase in number of care home providers signed up to the scheme
5 - Seven-day services	Health and Social Care teams are in place 7 days per week. Most care providers assess and restart care at weekends Diagnostics, pharmacy and patient transport is available 7 days per	Continue to work with domiciliary care providers to identify ways to enable more care packages to be started or restarted on a weekend	June 2018	Increase in proportion of discharges taken place on a weekend.

	week enabling patients to be discharged and care to commence outside hospital where appropriate within 24 hours			
6 - Trusted Assessor	Trusted assessor being rolled out for care homes Hospital Staff assess for Intermediate Care and Reablement services	Identify the different assessment processes in place and work with partners to develop shared assessment processes.	March 2018	
7 - Focus on Choice	Admission advice and information leaflets are available, regular conversations with patients, and relatives take place to support patient choice around discharge options. A choice protocol is in place and used across the trust along with other policies	Review information and advice to support patients to make choices about ongoing care and support Explore opportunities for voluntary sector input to discharge planning and processes to support patients	Nov 2017 March 2018	Increased patient involvement in discharge planning Early discharge for patients with complex assessment requirements.
8 - Enhancing Health in Care Homes	Coordinated Universal Service Provision for Care Homes is being rolled out to provide a comprehensive wrap around service for all patients in care homes.	Continue to roll out Coordinated Universal Service Provision for Care Homes	Ongoing	Reduction in 999 calls from care homes Reduction in A&E attendance and reduced admissions.