Barnsley Better Care Fund 2019/20

Strategic Narrative

A – Person Centred Outcomes (1500 words)

The 2019/20 BCF Plan builds on previous plans and continues to be set within the wider context of the Health and Wellbeing Strategy, contributing to delivery of the key priorities and 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.

The vision and principles of integration have become well established and 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.

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.

Together, our strategies and plans demonstrate and detail 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.

All of the services/schemes funded from the BCF, working alongside other local health and care services will support us in our journey towards achieving our vision. In 2019/20, two new schemes have been included, both of which will help people to maintain their independence within their own home. These are:

Extra Care – Introduction of a 24 hour care model within extra care schemes to improve the accommodation and support offer to older people, contributing to the reduction in long term admissions to residential care homes and avoiding unnecessary hospital attendances and admissions.

Warm Homes Hospital Discharge Service – Providing support to vulnerable people who are unlikely to be eligible for social care and do not require reablement to help facilitate hospital discharges and reduce likelihood of readmission by linking into low level support in the community. The service also provides advice and support to access warm homes discounts, change energy suppliers, access heating and insulation schemes and support to apply for aids, adaptations and equipment for within their home.

Emphasis on prevention, self-care and early help is evident across all our strategic plans and as such is now an established way of working across health & wellbeing services.

The development of our Neighbourhood Services model is designed to integrate care around the patient at a local level, utilising population health management approaches and helping us to focus on prevention, support people to manage their long term conditions and taking a personalised approach to care planning and the delivery of care and support.

Alongside this, BMBC Area Councils have established relationships with local communities and the voluntary and community sector and have a clear role in the prevention and self-care agenda. Area Councils take an asset based approach building on what is strong, not what is wrong and solutions to problems are co-produced. Examples of wellbeing services include:

- Healthy Holidays
- Social Isolation
- Warm Homes
- Advice services
- Sloppy Slippers
- Memory Café
- Dementia Friendly Area
- Foster Care campaign
- Chairobics
- Luncheon Clubs and Tea Dances
- Community First Aid
- Period Poverty
- Community Orchard
- Healthy Eating
- Community Gardens/Allotments and Incredible Edible projects

We are working with partners across the ICS to deliver the NHS Long Term Plan objectives, rolling out the NHS personalised care model and:

- supporting everyone to stay well, building on community capacity through continued development and expansion of our Social Prescribing Service, 'My Best Life', linked into our emerging PCN offer.
- supporting people with LTC's to build knowledge, confidence and skills to live well with their health conditions by continuing to utilise patient activation and increasing the use of personalised care and support plans and shared decision making tools across health and care services.

- Building on the success of direct payments for social care, in which Barnsley is one of the best performers nationally, empowering people with complex needs by providing personal health budgets, giving people greater choice and control over how their care is planned, managed and delivered.

Together all partners across Barnsley have agreed a shared outcome framework, focussed on addressing equality and health inequality issues across the Borough, identifying the priorities and outcomes that we aim to improve for local people and providing a mechanism for monitoring whether we are delivering the expected improvements. This framework is set around 5 domains with 12 agreed outcomes and a number of supporting indicators.

Overarching
- Improve health and wellbeing
- Reduce health inequalities by ensuring improvement is fastest for those with greatest needs

Lifestyle and wider determinants
- People are supported to lead healthy and productive lifestyles and are protected from illness
- Wider determinants of people's health and wellbeing are prioritised

Resilience and emotional wellbeing
- People feel emotionally well and resilient
- People with poor mental health are better supported in the community

High quality coordinated care
- People receive services rated as high quality
- There are fewer unplanned hospital admissions and people spend less time is hospital
- People coming to an end of their lives receive services which are responsive to their needs and preferences

Improving quality of life
- People with long-term health and care needs and their carers have a better quality of life
- People can manage their own health and maintain independence, wherever possible
- People have a positive experience of work and education

The development of neighbourhood models will ensure that locally, services are tailored to the needs of individuals and communities and areas of high deprivation and poorer health outcomes experience the most rapid improvements to health and wellbeing. We do however recognise that we cannot achieve integrated care and new models of care without considering the workforce requirements and looking at opportunities to address the future workforce challenges across Barnsley partner organisations and working collaboratively in different ways to deliver future models of care. Workforce development is core to this work and delivery of key national strategies such as the NHS 10 year plan and the Primary Care Contract.
An out of hospital workforce strategy will be developed and overseen by the Integrated Care Partnership.

Another key enabler of integration and person centred care will be the delivery of a shared care record, taking forward the record sharing that has traditionally been available through the NHS summary care record and enhanced in Barnsley through the medical interoperability gateway. The identification and delivery of person centred outcomes forms a central pillar of the development of single assessment processes and a shared care record for Barnsley with the aim being to reduce the number of times that people are asked the same questions and ensure that health and care professionals have ready access to information at the right time and in the right place.

Patients will also be empowered to be active participants in their own care through the adoption of person held records (PHRs) with secure access to key elements of the care record including problems/diagnoses, medication/allergies and key information on community-based support.

We also continue to recognise the important role of carers in supporting the delivery of person centred and personalised care. The Barnsley Carers Strategy highlights the importance of recognising the value of carers both in terms of the support they need themselves to optimise their quality of life and to continue to be effective in their caring role, but also because carers support the most vulnerable to remain healthy and independent and prevent people from needing or using more costly interventions. Central to the strategy is the need to ensure there is a co-ordinated whole system approach to Carer support in Barnsley, which builds on and adds value to existing partner resources. To achieve this, a key recommendation was to commission a new integrated all Carers Service.
The Carers Service was commissioned in August 2018 to provide information, advice and support to improve the mental, physical, emotional and economic well-being of carers, so they can continue in their caring role, look after their own health and wellbeing and have a life of their own in terms of opportunities for work, training, education, leisure and social interaction. The service also has a preventative focus to ensure that carers are able to access appropriate information and support as early as possible to help them improve their health and wellbeing, and to prevent any problems they may be facing from getting worse or reaching a crisis point. The service also carries out low level assessments for one-off payments to carers to help sustain caring roles.

B – HWB Level (800words)

The joint commissioning arrangements outlined in the BCF plan 17-19 remain in place. The Health and Wellbeing Board is currently exploring a joint place based commissioning model, bring together Elected Members and GP to shape the commissioning landscape in Barnsley. In the first instance, joint commissioning decisions will be made in regards of a specific section 75 pooled fund for prevention, focussed on early help, prevention and self-care. Joint Commissioning is also supported by the alliance arrangements we have in place for integrated services and the Integrated Care Partnership Group

The Accountable Care Partnership Board, established in 2016 has now become the Integrated Care Partnership Group (ICPG) and is supported by an Integrated Care Delivery Group (ICDG). On behalf of the Health & Wellbeing Board, the ICPG is now the driver for strategic developments for integrated care with the aim of having integrated services by 2020 and addressing health inequalities across Barnsley.

Most recently the focus for the ICPG has been on 'Place Based Integration' and specifically the development of our 'Neighbourhood Approach' to integrate services and bring care closer to home.

The aim is to create an integrated joined up health and care system where the people of Barnsley don't see organisational boundaries. Instead, they experience continuity of care and see familiar faces that are clearly connected to each other regardless of where they are seen. Patients and their families will be supported and empowered by what feels like "one team", each delivering their part without duplication.

The creation of a simpler, integrated health and care system would support a shift in focus on treating patients with health problems to supporting the community to remain healthy in the first instance – improving population health and well-being and addressing inequalities, particularly life expectancy and healthy life expectancy.

Health and care services in Barnsley will offer holistic care and support providing parity of esteem which is fundamental to our approach to integrated health and care services.

Health and care staff will have strengths based care and support planning conversations that seek to address a whole person's life including co-morbidities and other risk factors, rather than just assessing a narrow set of needs.

The model will maximise choice and control and make positive changes in people's lives, in terms of wellbeing, resilience, independence and connections to others.

The introduction of Primary Care Networks in the NHS Long Term Plan has firmly established primary care as central to our Neighbourhood Approach. Barnsley has the largest PCN nationally with the model having a single PCN with 6 Neighbourhood Networks. This model will achieve the benefits of scale where appropriate whilst having the flexibility to shape and delivery services tailored to local need. The PCN will unite primary care and NHS community services, and embed these services within the wider Neighbourhood Teams to focus on improving population health, improving health outcomes and reducing health inequalities.

This will build upon work which has already been taking place to pilot the introduction of Integrated Wellbeing Teams bringing together Primary Care, Neighbourhood Nursing, Adult Social Care, Family Centres, Berneslai Homes, Safer Neighbourhood Services, Social Prescribing and the Community and Voluntary sector.

In Barnsley, to ensure that our PCN and neighbourhood networks and Area Councils have the best opportunity to make a positive impact upon the health and wellbeing of

their populations and reducing health inequalities across the borough, we have been working together to develop a neighbourhood model of service delivery that aligns to the six area geographies in Barnsley. There are three complimentary programmes of work focused on neighbourhood development –
1 – Neighbourhood networks (Primary Care)
2 – New community health services (Core Neighbourhood Teams)
3 – Neighbourhood Integrated Wellbeing Teams

The ICPG in Barnsley have agreed a number of design principles for integrated care which will inform the development of the neighbourhood service model. There are:

- Mutuality
- Population Focussed
- Shared Values and Governance
- Care Closer to Home
- Staying Well
- Use of resources

The Neighbourhood service model will bring together a wide range of community services (including Neighbourhood Nursing, therapy services, end of life, memory assessment, falls and intermediate care) to work with Social Care and the Voluntary Sector alongside the Primary Care Network, in neighbourhoods to deliver the integrated service model.

These community services will support the delivery of new models of care and will work closely with the Acute Hospital to ensure only people who require care in a hospital setting are admitted to hospital and those who are admitted have effective discharge planning and are able to return home in a timely manner with the support they require. This work will support the further embedding of the 8 changes of the HICM, enabling us to continue to see one of the lowest rates of delayed transfers across the country.

(i) Your approach to integration with wider services (e.g. Housing) 800 words

The Health and Wellbeing Board, Senior Strategic Development Group and Integrated Care Partnership Groups in Barnsley have representation from across the Local Authority (People, Communities and Public Health), the CCG, local CVS, Berneslai Homes, Health care Providers and South Yorkshire Police ensuring our approach to both improving health and wellbeing and integration take account of the whole range of wider services that can contribute to improved health and wellbeing. Through these arrangements, all local partners have been involved in the development of the BCF plan for 2019/20. Engagement of the Health and Wellbeing Board, the role of the Integrated Partnership in developing strategies and plans for integration and our governance processes ensure that all our plans including the BCF are aligned and jointly agreed.

The BCF is fully aligned with wider strategies including the Barnsley Housing Strategy 2014-2033. The Housing Strategy includes a specific objective to support people to live independently by improving the range of options for supported housing and providing more choice and options to help vulnerable and older people live independently in their own homes. Ambitions include ensuring extra care provision is fully integrated into the wider health and care pathways and that there is access to aids and adaptations across all tenures. The BCF in 2019/20 continues to support these ambitions through the aids and adaptations and community home loans services and the investment in 2019/20 of £480k to provide 24/7 onsite care provision in 2 extra care housing schemes.

DFG Policy is aligned to the ambitions of the H&WB Strategy and BCF and aims to support people to live independently within their own home and to return home. The DFG policy and use of the DFG funding has been agreed by the Local Authority as the housing authority in Barnsley.

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 DFG policy identifies 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. Stair lifts, 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

The policy also allows for aids and adaptions to be undertaken for people who are supporting people with their care needs as part of the shared lives programme, helping people to receive care and support in a home based setting rather than in hospital.

In 2018, a review of the assisted living services was undertaken. This has resulted in the bringing together of a range of services to enhance the offer for prevention and early help and improve access and customer satisfaction. The review considered a range of services including:

- Minor adaptations.
- Disabled Facilities Grant Administration.
- Assisted Living Technology Service.
- Alarm response service.
- Handy person & advisory service (Stayput).

- Professional Assessment (Equipment, Adaptations & Sensory Team (EASI))
- Community Equipment Store.

The transformed assisted living model now sits alongside a range of other initiatives as part of Barnsley's co-ordinated approach to deliver commissioned preventative services and those provided by different stakeholder organisations. The Service will positively impact on the health, wellbeing and life expectancy of the people of Barnsley and also address inequalities across the Borough through its aim to support and enable people to remain safe and well in their own home (through improved self-care) for as long as possible.

A number of the services and schemes funded through the BCF and aligned to the specific funding for DFG related services, including Community Home Loans, Equipment and Adaptations and Occupational Therapy aim to ensure that people are able to quickly access the support they need to maintain their independence.

C – System Level Alignment (1500 words)

The South Yorkshire and Bassetlaw Integrated Care System (ICS) is the local approach to delivering the NHS Long Term Plan and sets out a vision of a better NHS, the steps we should take to get us there, and how everyone involved needs to work together. 25 health and care partners from across the region are involved in the ICS, along with Healthwatch and voluntary sector organisations.

The ambition of the ICS is to enable everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and to live longer. The plan is to invest in, reshape and strengthen primary and community services so that we can provide the support people in our communities need to be as mentally and physically well as possible. Mental health will be integral to our ambitions around improving population wellbeing.

Through our involvement and engagement within the SYB Integrated Care System we are involved in all of the key work streams and working together to support the delivery of the ambitions for SY&B.

The SYB STP in 2016 pledged to give people more options for care while joining it up for them in their neighbourhood, helping them to stay healthy, tackling health inequalities, improving quality, access and outcomes of care, reduce workforce pressures and introduce new technologies. There was also a specific focus on cancer, mental health and primary care, and the two key enablers of workforce and digital technology.

Within Barnsley, our Place Based Plan 2016-2020 was based on the local delivery of the SYB Sustainability and Transformation Plan priorities as well as the local priorities and outcomes for Barnsley, including improving population health.

As members of the SYB ICS (H&WB Board, Local Authority, CCG, Providers – all members), Barnsley stakeholders have been able to contribute to the development of the emerging ICS response to the NHS Long Term Plan – The ICS Strategic Plan and ensure that system and place plans are aligned and complimentary.

The emerging ICS Strategic Plan builds on the successes and learning from delivery of the STP and starts with tackling health inequalities. Healthy life expectancy is lower in South Yorkshire and Bassetlaw compared to the national average. There are high levels of the common causes of disability and death, including high rates of smoking, obesity, physical inactivity and hospital admissions due to alcohol. Much of this burden of illness can be prevented or delayed. Our focus will be on cutting smoking, reducing obesity, limiting alcohol-related A&E admissions and lowering air pollution. Reflecting the emphasis of the NHS Long Term Plan on the need to develop new care models to support integration and to provide enhanced health care in care homes to improve quality of life of residents, he plan will also include the aims for delivering new models of care including out of hospital care which links back into local areas through the newly created Primary Care Networks (PCNs) in South Yorkshire and Bassetlaw. Our vision and model of Integrated Neighbourhood Teams are fully aligned with the wider SYB plans.

The Health and Wellbeing Strategy 2016-2020 is currently being reviewed with a new Strategy being developed to ensure continued focus on improving the health and wellbeing of Barnsley residents. The new Health and Wellbeing Strategy will enable us to link system priorities to local place priorities and reflect these in local plans for transformation and integration.

The Better Care Fund Plan sits within this wider context, being one component of the overall strategy for health and wellbeing and integration. The BCF Plans are consistent with the aims of the NHS Long Term Plan and will play 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.

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 services which form part of the wider integration plans being taken forward by the Integrated Care Partnership. The funding from the BCF remains broadly consistent in 2019/20 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 2019/20 to reflect growth in the contribution to Social Care and the inclusion of winter pressures funding within the BCF alongside the iBCF. This has enabled 2 new schemes to be introduced in 2019/20 as described earlier.

The strategic governance arrangements for the Better Care Fund remain the same as over the last 2 years with oversight being provided the Health and Wellbeing Board and the BCF being managed within the governance structures of the Health and Wellbeing Board. The section 75 agreement remains in place (to be updated for 2019/20 to reflect changes to planned expenditure)and sets 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.

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.

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.

In terms of delivery of our overall model for integrated care, the Integrated Care Partnership Group, on behalf of the Health and Wellbeing Board, is the driver for strategic developments for integrated care and through the Delivery Group will oversee the delivery of our neighbourhood service model for integrated care by 2020.

Since the publication of the Barnsley BCF Plan for 2017/19 we have delivered a wide range of changes and made a number of significant achievements including:

- Increased social work capacity and ensured supply and capacity in the domiciliary and residential care markets through effective use of the IBCF
- Enhanced 7 day working in social care to support discharge planning and ensure access to appropriate packages of care following an hospital admission.
- Introduced a new carers support service
- Implemented community respiratory and diabetes pathways to support people to manage their conditions and avoid avoidable admission to hospital.
- Introduced a new primary care streaming service adjacent to ED and a Home Visiting Service to ensure patients are seen in a timely manner.
- Agreed plans for the wider integration of out of hospital health and care services to provide a neighbourhood approach linked to primary care.
- Established our Primary Care Network model with one network underpinned by 6 neighbourhood networks.
- Continued to invest in new roles linked to primary care including clinical pharmacists and social prescribing link workers.

- Delivered improvements and embedded changes from the High Impact Change Model for Managing Transfers of Care ensuring that our excellent performance in managing patient flow and ensuring patients are able to be discharged from hospital in a timely manner is maintained and delayed transfers of care and the exception rather than the norm. Specific examples include:
- Therapy staff working with ED to support assessment and discharge planning.
- MDT discharge planning.
- Introduction of systems to improve patient flow linked to roll out of Red2Green
- Bringing together hospital discharge, social care and community teams to deliver an MDT approach to discharge planning and using this approach to reduce the number of patients with long lengths of stay.
- Extending the trusted assessor model used for CHC, reablement and other community services to care homes.
- Introduced home first, supported by therapy and community services
- Continued to roll out support for care homes including the deployment of digital technology to enable the Rightcare Barnsley Team to support care homes in the management of patients and avoidable ambulance call outs and hospital attendances.
- Rolling out the red bag scheme to all care homes.