

Barnsley Plan

November 2016



Barnsley Plan

Version and distribution:

Version	Date	Board	Comments
V5	6/12/16	Barnsley Health and Wellbeing Board	
V5	6/12/16	Overview and Scrutiny Committee	
V5	8/12/16	Barnsley CCG Governing Body	

#BetterBarnsley

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Foreword

WHAT IS THE BARNSLEY PLAN?

The Barnsley Plan has been developed through partnership across the public sector and voluntary community sector organisations.

It draws on inputs through the engagement and design of our health and care services as well the priorities set out in key documents including the Barnsley Health and Wellbeing Strategy, the Five Year Forward View, GP Forward View, Mental Health Forward View, Facing the Future and National Cancer Strategy.

The development of the plan has been overseen and driven via the Barnsley Senior Strategic Development Group and is one part of the delivery model for the Health and Wellbeing Strategy for Barnsley.



Vision and Principles

OUR VISION FOR BARNSELEY:

That 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.

The principles that will guide us:

Focus on inefficiencies and outcomes

We know that we need to do things differently and we need to be more radical in favour of prevention.

Inspire and empower

We know that we cannot do this alone or in isolation. We must engage as many people as possible to make the greatest difference.

Connect, collaborate & co-produce

We know that the solutions will involve working together with the public, patients, carers and our partners and communities. We will broaden our reach to those who we have not connected to in the past.

Go further, faster

We know that time and resources are precious and therefore we must target our resources and prioritise those actions that will take us further, faster.



Our System

Barnsley is a metropolitan borough in South Yorkshire. We have a strong track record for working in partnership across well established networks.

Collectively we spend approximately £480 million on health and care across a population of approximately 239,000.

Barnsley has consistently lagged behind the England average for health and social care outcomes. We know that Barnsley has not delivered its potential to reduce the substantial gap in healthy life expectancy. There is a marked variation in life expectancy across the borough and average life expectancy in Barnsley is lower than the national average. The percentage of adults diagnosed with depression is higher in Barnsley at 15.8% than the national average of 11.7%. The proportion of Barnsley residents living with a limiting long term illness is 24.4%. This is significantly higher than the national average of 16.9%.

We know that a high proportion of current illness in the borough is either preventable or 'delay-able' and the financial benefit of reducing this matches the moral imperative to do so.

We also know why; because no one organisation has it in its power to deliver this, it requires whole system solutions where every member understands their role. We also know that to fully address this challenge we need behaviour change in our local population as well as different responses from organisations.

This plan, under the umbrella of a multi agency Senior Strategic Development Group, sets out to address these challenges. By developing our partnerships at the most advanced level and by working with national partners and regulators, as well as communities, patients and carers, we will ensure we deliver real change and close the gaps that we have previously been unable to fully address.





Barnsley Strengths

Co-terminus borough-wide council and clinical commissioning group meaning that services can be more easily commissioned

Track record of strong partnership approach across the system and with our communities

One combined mental health and community trust

Successfully bid for Prime Minister's Challenge Fund to improve access to GP services

GP federation working on behalf of the majority of GP practices as providers to facilitate changes in approach at practice

One acute hospital trust

Joint commissioning for adult & children's services

Integrated Care Pioneer Site and Integrated Personalised Commissioning Demonstrator Site

TRAVELERS

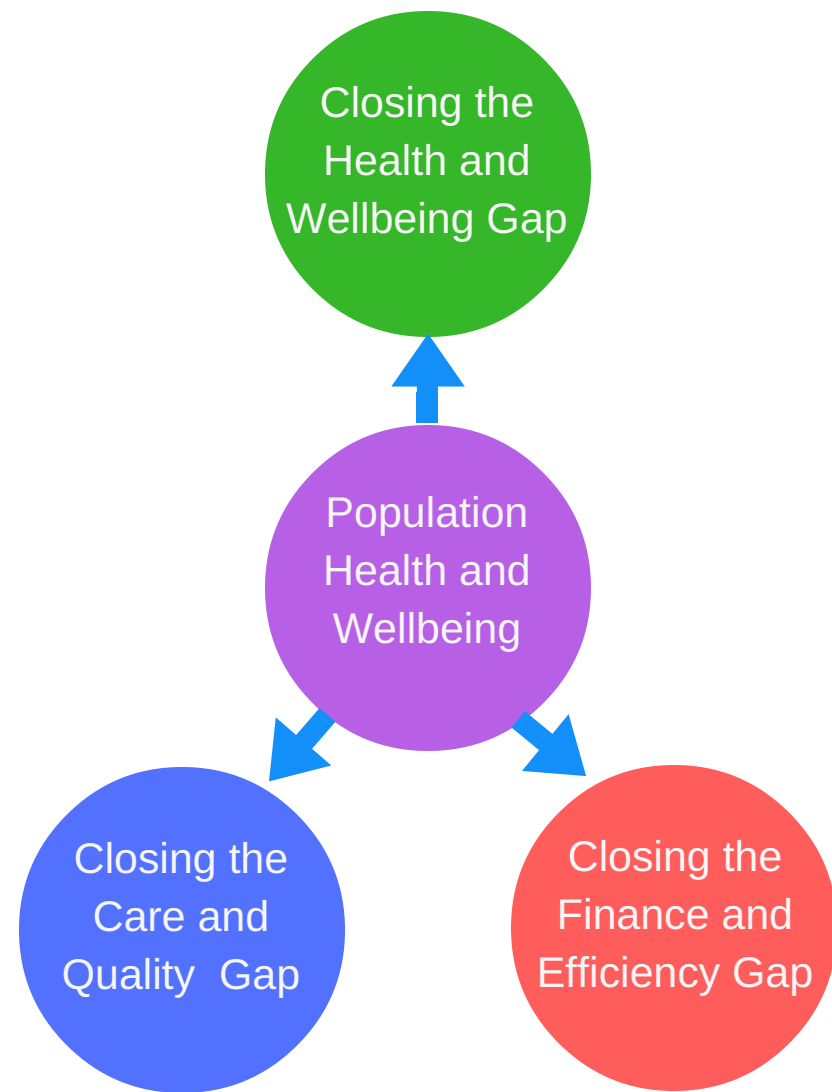
UTERS

WORKERS

The Case for Change

HEALTH AND WELLBEING SYSTEM CHALLENGE

In Barnsley there are three key challenges to improving population health and wellbeing and to providing high quality sustainable services to our population. This plan needs to address each of these three areas. We will specifically set out what each of these challenges mean.



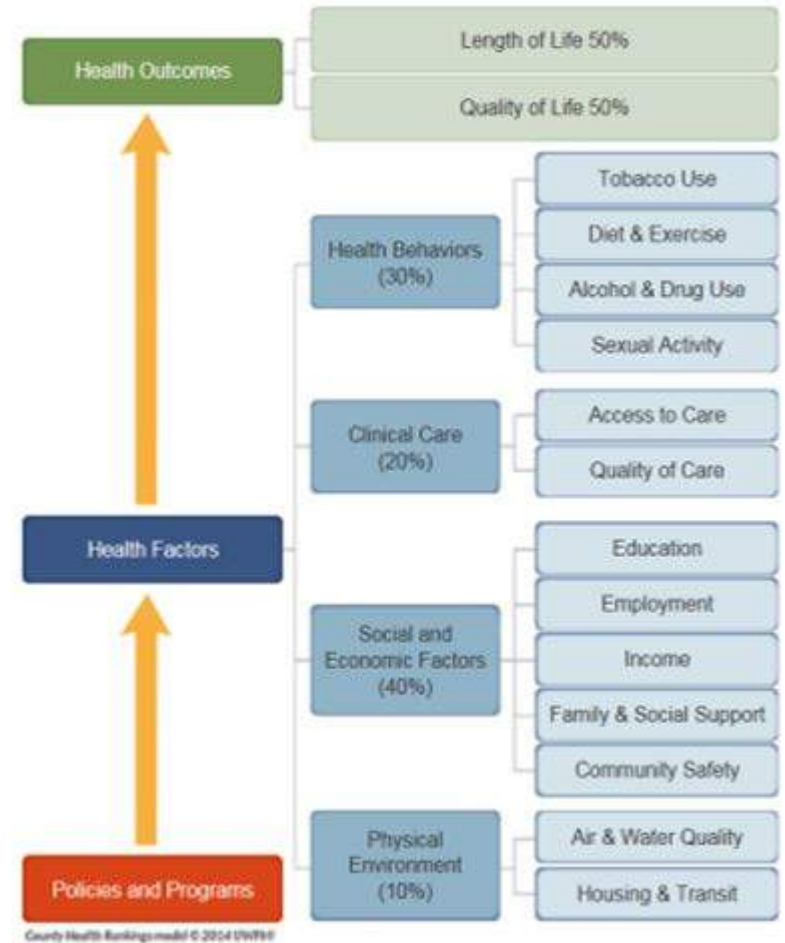
Scale of the challenge

The scale of the challenge health and care services currently face mean that we need a significant step change in the scale and pace that we transform our services and importantly the way we work in order that we are able to provide affordable and sustainable services.

This means planning for the future through a radical upgrade in prevention streamlining and aligning services that work independently of organisation boundaries and tackling the broader determinants of health and wellbeing.

Securing behaviour change across the population is also key if we are to succeed in our aims to improve health outcomes for the residents of Barnsley.

This is a significant task and carries a large agenda. The NHS Five Year Forward View reinforces this approach and provides us with an opportunity to genuinely transform the way we work.



Health and Wellbeing Gap

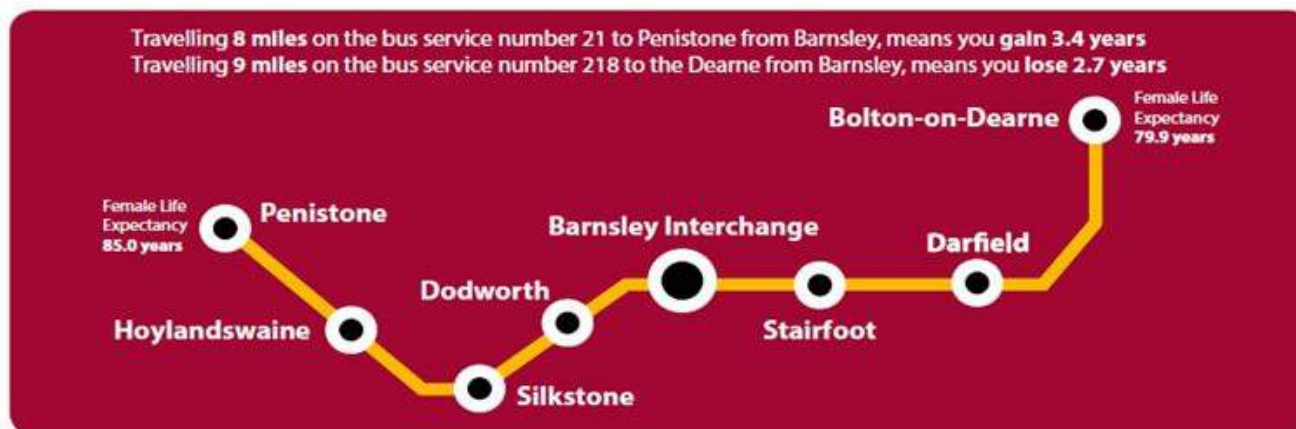
We have high levels of deprivation, poor lifestyles, too many people dying prematurely and from preventable diseases. We also have:

- Lower levels of life expectancy than the national average
- A reduction in healthy life expectancy for both men and women
- Marked inequalities between Barnsley and England and also across Barnsley
- High than expected incidence of long term conditions and resultant admission rates
- High levels of smoking prevalence, obesity and alcohol related hospital admissions
- In 2015, Barnsley ranked the 39th most deprived Borough out of 326 local authorities

Barnsley has significantly worse levels with regard to a range of childhood factors that affect health including:

- Children living in poverty
- School readiness and pupil absence
- Under 16 and under 18 conception

Female life expectancy changes across Barnsley (as at 2013)



Care and Quality Gap

The ageing population, increasing complexity of need and increasing patient expectations are combining to put the health and social care system under unprecedented pressure. Technical advances in treatment have also added to the demand.

Care needs to be more integrated. There are currently too many barriers in how care is provided – between primary care, community health services and hospitals, between physical and mental health and between health and social care, between professional, patient and carer.

In social care there are increasing demands but 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. There have been several years of funding restrictions to social care budgets. Social care spending is protected where possible at the cost of other services but the ability to do this is running out.

After a long period of sustained delivery there is now an increasing pressure to meet referral to treatment targets. We also have:

- High volumes of some procedures of limited clinical priority
- High rates of emergency readmissions within 14 days
- High rates of emergency admissions related to ambulatory care sensitive conditions
- High volumes of out of area mental health placements

Finance Gap

Across South Yorkshire and Bassetlaw we currently invest £3.9 billion on health and social care for the 1.5 million population.

After taking into account the resources that are likely to be available and the likely demand for health and social care services over the next four years, we estimate that there will be a financial shortfall of £571 million by 2020/21. The health service gap is £474 million while £107 million relates to social care and public health.

On a pro rata basis, current modelling indicates the equivalent finance and efficiency gap across Barnsley health and social care is approximately £90 million by 2020/21. It is expected that by working differently we will deliver this through:

- Transforming secondary care through productivity improvements of 2%
- Managing activity related demand by a 2% reduction



Our Approach

THE BARNSLEY WAY

The plan supports the delivery of the Barnsley Health and Wellbeing Strategy. Whilst there is a history of partnership working in Barnsley, often programmes, projects and initiatives have been planned and delivered in silos. In order to realise the full benefit and see real improvement in population health and wellbeing outcomes as well as services that give our public the best value for every pound they spend on health and care, we must align our priorities and work together.

We also need to work more effectively in partnership with local people and communities so that people can play their part in taking responsibility for health and well-being. Improving our Barnsley's health and wellbeing must be done in partnership. The Barnsley Plan work will bring together partners to listen and take action in order to achieve our ambitious priorities. The Barnsley Plan describes our shared vision, objectives and future models of care.



What we need to achieve:

Improved health & wellbeing:

Health and wellbeing is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment.

These 'broader determinants of health' are more important than health care services in ensuring a healthy population, and therefore this is where the Board will focus its efforts.

Reduced health inequalities:

There are marked inequalities in health which exist between Barnsley and England as a whole and within Barnsley itself, which is not acceptable.

A gap also exists between people with severe mental illness, learning disabilities and autism, and the general population. Our approach will therefore be to target our resources to achieve equality of outcomes for all.

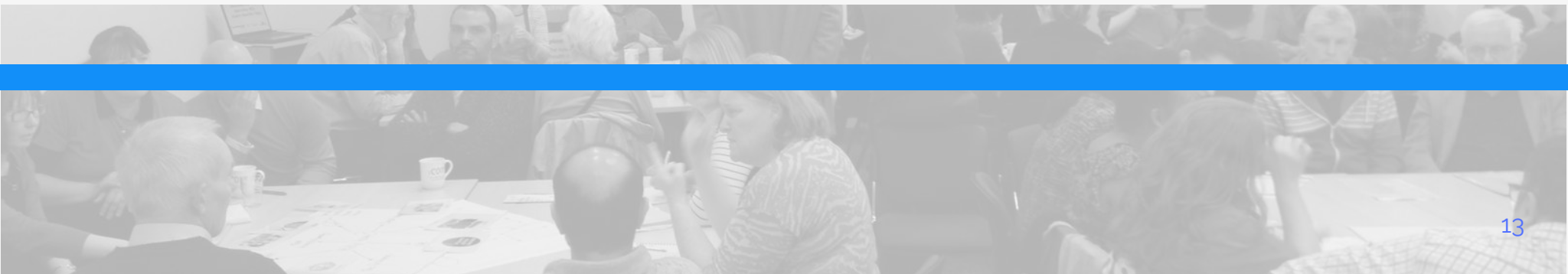


What this will mean for individuals:

- Children start life healthy and stay healthy
- People live happy, healthier and longer lives
- People have improved mental health and wellbeing
- People live in strong and resilient families and communities
- People contribute to a strong and prosperous economy

HOW WILL THE SYSTEM NEED TO CHANGE?

- By strengthening and broadening partnership working to make the health & care system stronger and more responsive
- By creating joined up approaches that make sense to us all by putting public, patients and carers at the heart of what we do



South Yorkshire & Bassetlaw (SYB) Sustainability & Transformation Plan Priority Areas (STP)

Across SYB, a number of transformational and cross cutting work streams have been identified as shown in the table below. These are all work streams where there is a clear benefit in working across a larger foot print but where there are also local plans being implemented.

Transformational Work Streams

Maternity &
Children's

Mental Health &
Learning Disabilities

Urgent &
Emergency Care

Elective Care &
Diagnosis

Cancer

SYB Cross Cutting Work Streams

Workforce

Digital/IT

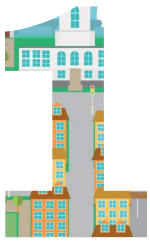
Carter*, procurement and shared services

Finance

Economic Development, Public sector Reform and the City Region

Across Barnsley there is a significant amount of transformation work taking place which will support these South Yorkshire and Bassetlaw transformation work streams. This is detailed in the following slides.

*Refers to the Lord Carter review of 'Productivity in Hospitals' 2016.



Maternity & Children's Services (SYB)

What is the challenge?

- Meeting new standards for maternity care
- Not all children have the best start in life, with high rates of preventable health problems arising
- Rising demand and high use of acute services

What are we going to do?

- Improve personalisation and choice in maternity services
- Reduce the rate of smoking in pregnancy
- Increase the rate of breast feeding
- Connect primary and community services more closely and support families to manage common childhood conditions in the community
- Support an increase in levels of physical activity, working with families and schools
- Improve oral health in children
- Implement a perinatal and maternal mental health strategy
- Support all children, young people and families to make healthy lifestyle choices
- Tackle child poverty and improve family life

What are the benefits?

- Women will have maternity services that are safer, more personalised, kinder, professional and more family friendly; every woman will have access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.
- A reduction in preventable health problems
- Improved access to care close to home
- Reduced infant mortality and morbidity rates
- Improved pre-, peri- and post-natal mental health provision
- Reduction in childhood hospital admissions for dental extractions



Mental health & learning disabilities (SYB)

What is the challenge?

- Approximately 25% of the population experiences some kind of mental health problem in any one year
- People with severe mental illness can lose 20 years of life
- Co-morbid mental health problems raise total health care costs by at least 45% for each person with an additional long term conditions
- These challenges are compounded by a stigma that exists around mental health and learning disabilities and the lack of parity of esteem with physical health services
- Transforming Care Challenge for people with a learning disability

What are we going to do?

- Focus on early intervention and crisis care
- Review of day opportunities for people with a learning disability
- Implementation of the all age Mental Health & Wellbeing Strategy, incl. enhanced crisis care, early interventions for people with psychosis, development of hospital liaison services, focus on improving the physical health of people with a serious mental illness
- Implementation of suicide action plan
- Implement integrated personalised commissioning to join up health & social care needs and give people greater say in how they are supported
- Implement Local Transformation Plan for Children and Young People's Mental Health & Emotional Well Being
- Implement a multi-agency public sector hub with South Yorkshire Police & partners
- Deliver large scale mental health awareness work force development across all agencies

What are the benefits?

- Barnsley residents wellbeing and mental health is improved
- Residents with mental illness will receive high quality, response care with a focus on early intervention and recovery and will be better supported to look after their physical health.
- Reduction in mental health related A&E attendances and hospital admissions
- Parity of esteem is delivered
- Equity of access to services for mental health that is similar to those for physical health
- Years lost to life for people with severe mental illness are reduced
- People with learning disabilities are supported to live in the community reducing the need for hospital admissions and long stay placements
- Reduced length of stay for people with learning disabilities



Urgent & emergency care (SYB)

What is the challenge?

- Increasing complexity and acuity of patients and a high volume of A&E Adult Attendances and non-elective adult inpatient admissions
- Data analysis suggests that up to 30% of attendances could be managed in an alternative setting
- Workforce challenges and capacity issues resulting in quality issues, failure to meet NHS Constitutional standards
- Financial sustainability – difficulty in meeting current demand with the current resources

What are we going to do?

- Support the development of RightCare Barnsley
- Increase access to primary care through I HEART Barnsley
- Intermediate Care Review
- Community Nursing Review
- Implementation of integrated clinical pathways for respiratory services

What are the benefits?

- Lower demand enabling improved quality
- Greater cost effectiveness
- Improved patient access and reduced variation in delivery
- Increased support for self care which will enable long term management, improved health and wellbeing and reduce the burden on healthcare services
- Reduction in unnecessary hospital admission and readmission
- Reduction in A&E attendances
- Increased early supported discharge



Elective care (SYB)

What is the challenge?

- Across the system there is increased demand in both elective and diagnostic care across clinical pathways
- There is a need to align elective and urgent care work to ensure that quality is not impeded due to inter dependencies

What are we going to do?

- Develop integrated clinical pathways for diabetes, respiratory disease, and musculoskeletal diseases.
- Implement Map of Medicine
- Develop consultant advice and guidance to GPs
- Continue to enhance direct access to diagnostics and the clinical interpretation and management advice on reports
- Implement Social Prescribing
- Improve oral health in children

What are the benefits?

- Reduce the growth in demand on elective services
- Decrease number of admissions for dental extractions
- Decrease number of new outpatient appointments
- Higher proportion of outpatient clinics held closer to home
- More sustainable delivery of referral to treatment performance
- Improved patient experience and outcomes
- Improved support for self care and within pathways freeing capacity and reduce avoidable spend



Cancer (SYB)

What is the challenge?

- An ageing population and a rise in lifestyle related risk factors mean that cancer incidence is increasing
- Improvements in cancer survival rates mean that more people are living with and beyond cancer

What are we going to do?

- Radical upgrade in prevention though delivery of the tobacco control strategy
- Work with primary care to increase early diagnosis of cancer
- Increase screening uptake
- Develop shared care pathways across primary and secondary care
- Develop a primary care training programme
- Revitalise the Cancer Care Review Process
- Maximise opportunity to further develop the Survivorship Programme (Living with and Beyond Cancer)
- Implement the End of Life Strategy

What are the benefits?

- Greater ability to address the primary and secondary causes of cancer
- Earlier diagnosis and intervention to achieve a shift in the stage at which a cancer is diagnosed
- Ensure care is delivered in the most appropriate setting
- Improved quality of care and patient experience
- Improved personalisation and choice
- Reduce duplication and drive integration of services
- Greater uptake of choice at the end of someone's life

Barnsley Priority Areas

In addition to the SYB work stream, we recognise that there are a number of priority areas where we can come together as a local system to deliver a greater collective benefit for Barnsley people. These are:

- **Healthy life expectancy**
- **Building stronger communities and being in control of my wellbeing**
- **Improving mental health and wellbeing**
- **Improving support for older people**
- **Changing the way we work together (new models of care)**





Improving healthy life expectancy (Barnsley)

What are we going to do?

- Through Smoke Free Barnsley, work collaboratively to reduce adult smoking prevalence by at least 1% year on year from 24.4% to at least 18% by 2019
- Establish an Alcohol Alliance and a comprehensive programme which creates a culture where sensible drinking is the norm
- Heart of Barnsley – CVD & diabetes - decrease the prevalence, morbidity and mortality from cardiovascular disease (CVD) and diabetes, through a programme of healthy public policies and lifestyle services/interventions, along with enhancement clinical management of CVD risk factors and secondary prevention in primary care and secondary care; implementation of the National Diabetes Prevention Programme.
- Strengthen the relationship between housing and health to enable people to have better living conditions

What are the benefits?

- Healthier population
- Reduction in long term conditions associated with smoking
- Reduction in long term conditions associated with alcohol consumption
- Reduction in alcohol related admissions to hospital
- Improved quality of care
- Greater ability to address the primary and secondary causes of cancer
- Increase in healthy life expectancy
- Reduction in alcohol related harm e.g.. domestic violence, criminal assault, antisocial behaviour
- Reduction in alcohol and smoking related: primary care attendances, A&E attendances, admissions to hospital
- Improved quality of care for patients with CVD and diabetes, leading to increased quality of life, decrease in primary care, A&E and hospital admissions



Strengthening relationships with communities and individuals (Barnsley)

What are we going to do?

- Harness the renewable energy represented by patients and communities, maximising the potential health gains from social action and volunteering and maximise the potential of community assets and social capital to support residents to maintain their independence and social participation
- Develop a system wide volunteering strategy
- Develop new impact volunteering to support demand management eg in reach work to hospitals
- Support individuals and communities to improve their health literacy
- Improve access to universal information and advice
- Implement social prescribing
- Map peer support networks, identify gaps and build new networks where required
- Drawing on the strength of local communities, pilot a place based health and wellbeing (including community safety and employment) approach in one locality
- Develop and implement a systematic approach to personalised self management and self care across Barnsley
- Strengthen local voice by securing and responding to feedback about service design and delivery

What are the benefits?

- Strong communities are essential to good health and wellbeing and building individual resilience and independence
- Improved quality of care
- Improved physical, emotional and mental wellbeing
- Improved access to the right service or support
- People will feel enabled to take control of their health
- More residents will get the information and advice that they need to resolve or self-manage a wide range of problems early before they escalate
- Social prescribing will help to link patients with non-medical sources of support within the community
- Patients and carers to be more active participants in their care, supported to understand their choices, truly share decision making, reach self-identified goals and adopt more healthy behaviours. enabling them to live the life they want to their best ability.
- People will understand the system and know what to do and where to go if things change or go wrong. They will be better able to plan ahead and stay in control in emergencies. Patients will have systems in place to get help at an early stage to avoid a crisis
- Decrease demand for primary care, specialist mental health services and social care services



Improving mental health & wellbeing (Barnsley)

What are we going to do?

- Establish a Mental Health Alliance
- Focus on the early recognition of mental ill health and the prevention of escalation of need.
- Implement the Local Transformation Plan for Children and Young People's Mental Health & Emotional Well Being
- Deliver the Mental Health Crisis Care Concordat
- Expand Improving Access to Psychological Therapies (IAPT) services and enhanced psychological support for people with long term conditions
- Develop shared care pathways across primary and secondary care
- Deliver large scale mental health awareness work force development across all agencies
- Implement a work place health charter across the public sector and other local businesses.
- Enhanced support for people with mental illness to stay in and get into work
- Develop personal health budgets for people with mental health problems
- Implement a multi-agency public sector hub with South Yorkshire Police and partners

What are the benefits?

- Barnsley residents wellbeing and mental health is improved
- Reduction in the gap in life expectancy between people with severe mental illness, learning disabilities and autism and the general population
- Children and adults will receive earlier help, diagnosis and treatment of mental health problems in the most appropriate setting and at the earliest possible time to prevent escalation.
- Increased support available to prevent a crisis occurring and also when a crisis occurs
- Improved co-ordination of interventions for physical and mental health for people with multiple vulnerabilities
- People with long term illnesses and disabilities will have improved psychological health and be better able to cope with their physical health problems



Improving support for older people (Barnsley)

What are we going to do?

- Develop more cohesive ways of working across older people's services to enable an improvement in the coordination of service developments to improve the quality of care for older people.
- Develop integrated care pathways for the prevention and management of falls and osteoporosis that is clinically and cost efficient and has sufficient capacity to have a population impact
- Further develop services for people with dementia in order to deliver an integrated pathway for dementia ensuring high quality care throughout the pathway that reflects the priorities within the Prime Minister's Challenge on Dementia 2020.
- Consider the options for further integration of equipment and adaptation provision across Barnsley
- Early help - strengthen low level supports such as services that support people who are socially isolated
- Integrate our approach to telehealth and telecare
- Redesign homecare support
- Key worker role for Police Community Support Officers

What are the benefits?

- Holistic services for older people and quality of life for older people
- Increased independent living
- Reduction in unnecessary emergency admissions and readmissions
- Increased support for carers and reduction in carer breakdown
- Reduction in avoidable:
 - A&E attendances
 - Emergency hospital admissions
 - Hospital readmissions
- Prevention or delay in need for domiciliary care packages
- Prevention of avoidable care home admissions
- Ensure care is delivered in the most appropriate setting
- Reduce duplication and drive integration of services
- Equipment availability is appropriately delaying or reducing the need for support
- More cost efficient equipment provision
- Mobilise faster timely discharge



Changing the way we work together (New Models of Care)

What are we going to do?

- Explore the development of an Accountable Care Organisation in Barnsley
- Develop integrated locality based health and wellbeing teams
- Implement the GP Forward View to strengthen primary care
- Create a single Barnsley health and care digital record

What are the benefits?

- Holistic services for all
- Joined up, integrated care
- Increased access to primary care
- Improvements brought about through increased digitisation of information that can be accessed by different parts of the health and care service
- Reduction in unnecessary emergency admissions and readmissions
- Ensure care is delivered in the most appropriate setting
- Reduce duplication and drive integration of services



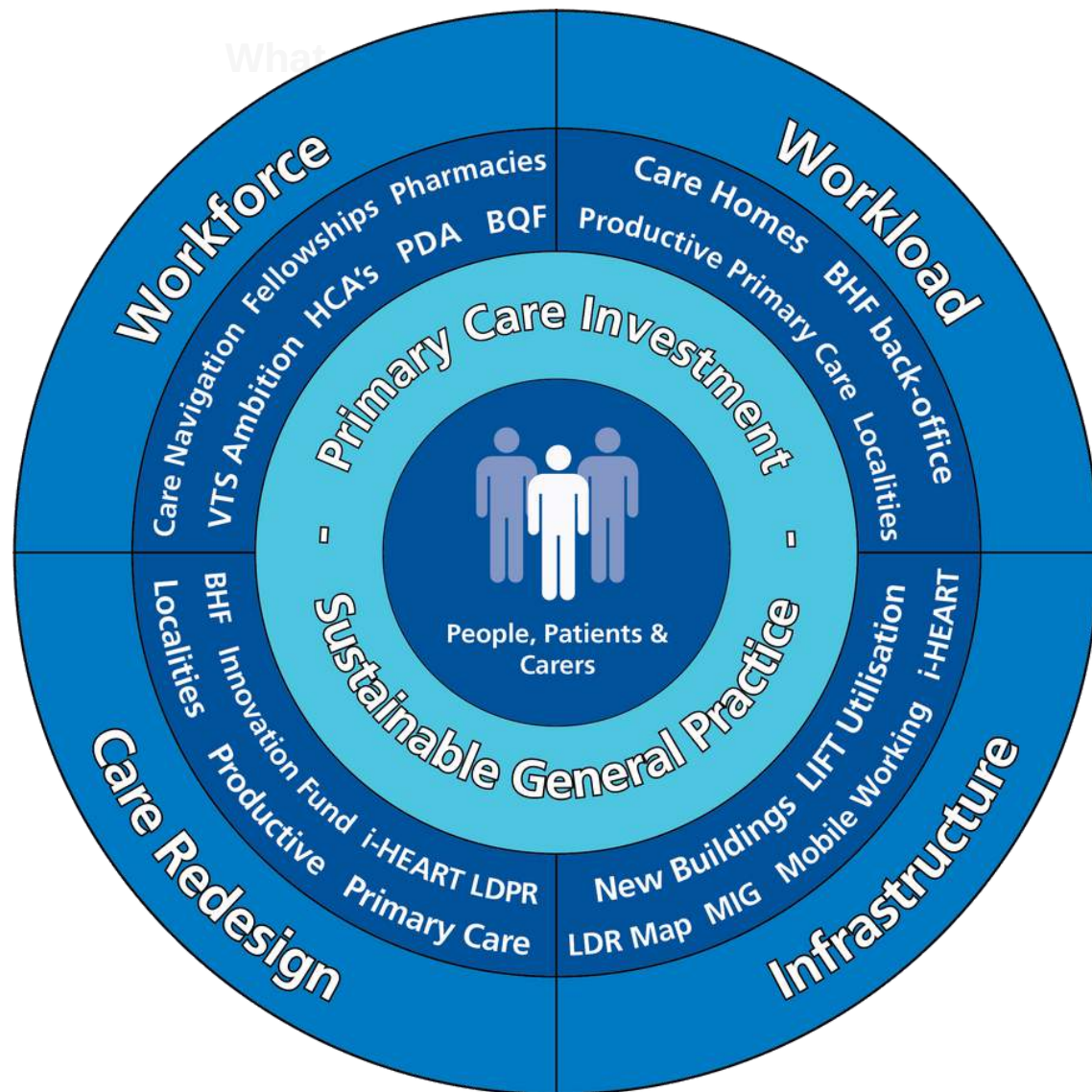
Changing the way we work together - Strengthening Primary Care

What are we going to do?

Strengthening Primary Care across Barnsley is fundamental in delivery of the Barnsley priority areas.

Our vision is a future in which the current model of primary care is allowed to deliver its full potential. It is for an integrated wider primary and community care offer, which is comprehensive and serving the full range of needs found in the community.

This diagram identifies the work streams that will be delivered to support this in Barnsley.





Changing the way we work together - Accountable Care Organisation Development

What are the benefits?

- Barnsley CCG has an ambitious strategy to integrate the delivery of health and care for the people of Barnsley. This ambition is supported by our commissioning partners in Barnsley Metropolitan Borough Council and our provider partners in BHNFT and SWYPFT and by the Barnsley Healthcare Federation.
- Our vision for the future of health and care in Barnsley is to create a simpler, more joined up health and care system; one where the people of Barnsley don't see organisational boundaries. Instead, they experience continuity of care; they see familiar faces that are clearly connected to each other regardless of where patients are seen; be that in hospital, in the community or at home. They won't experience gaps in care; they are not isolated but supported and empowered by what feels like "one team", each delivering their part without duplication.
- Our goal is to dismantle boundaries at the point of delivery of care, to create a Barnsley where patient interests come first and resources are focused on improving health outcomes in areas of the borough where inequalities are greatest.

Digital Road Map

Deliver our 'Digital Road Map' to improve services

We recognise that our IT systems are a barrier to people working together, communication between health and care teams needs to improve and we need to take a holistic view of the patient and see them as a whole.

We have therefore developed a 'Digital Road Map' to transform our approaches, develop systems that 'talk' to each other and deliver a better experience for patients and service users.



Digital Road Map



Our vision in Barnsley is to:

- Increase technology enabled care to support people to stay in their homes for longer and help them maintain their independence and wellbeing.
- Transform the way in which we engage with citizens; empowering them to maintain their own health and wellbeing through digital solutions
- Transform the way in which health and care providers, our voluntary and charitable sector organisations engage with patients and their communities
- Accelerate mechanisms that promote record sharing and support access to data for those working within health and care services
- Enable clinicians to provide the best care in all settings by the use of mobile technology.

We will:

- Implement our Local Digital Roadmap
- Work collaboratively to support the development of interoperable IT solutions to enable appropriate record sharing
- Fully roll out the Medical Interoperability Gateway (MIG) to allow appropriate access to primary care records
- Support the development of mobile working for clinical staff across Barnsley
- Deliver the national ambition to be 'Paper Free at the Point of Care' by 2020

Engagement

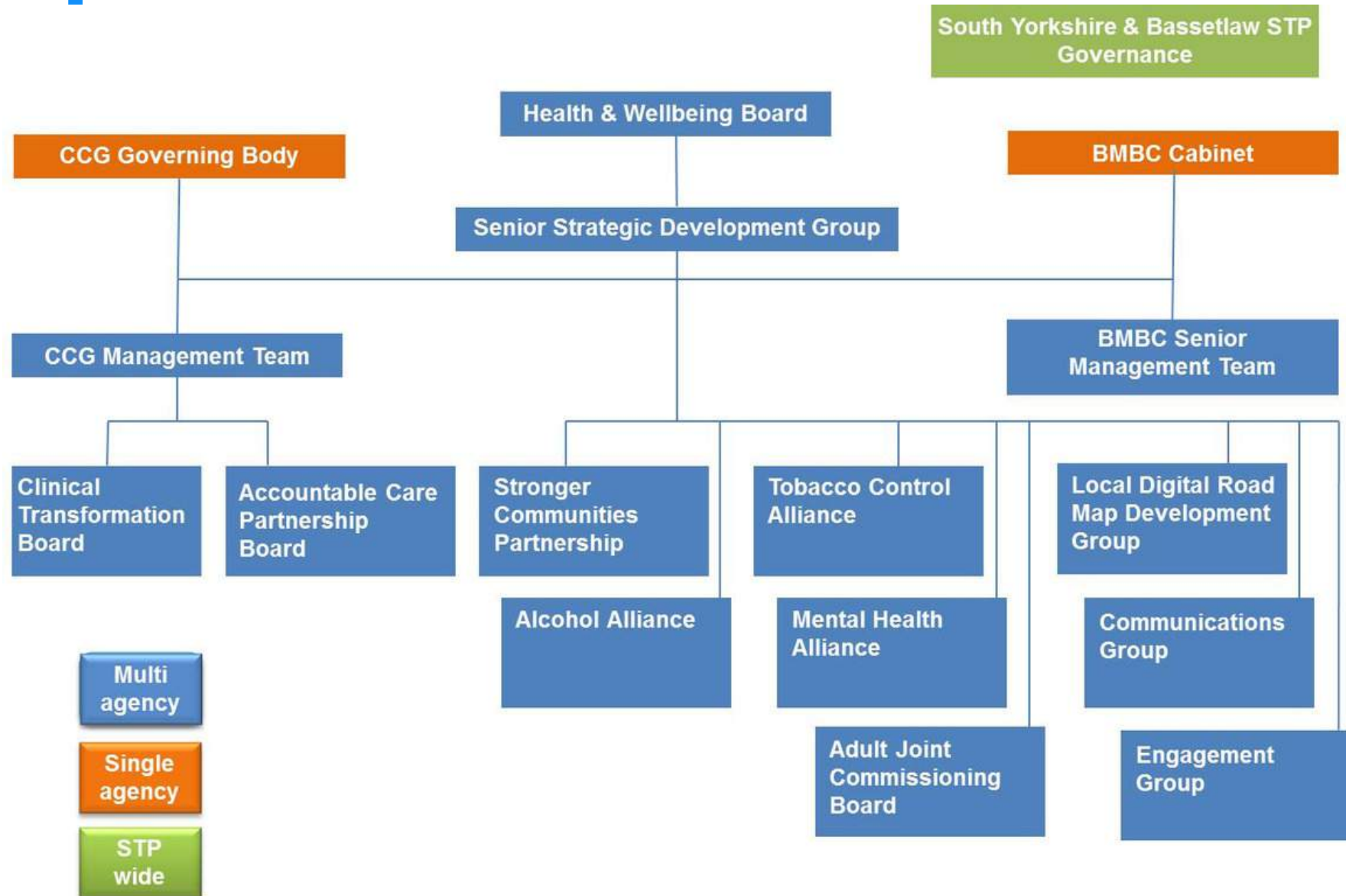
Having a strategic framework for communication will allow partners to make greater use of networks, target specific issues and share information through a mixture of channels. This approach will also enable us to pull resource and networks across organisations to allow better joined up working and less duplication.

Partners are committed to putting the voice of Barnsley people at the heart of decisions. In Barnsley we have a strong tradition of service user, carer, patient and community involvement through groups such as Carers and Friends Group, Learning Disabilities Forum, Older Peoples Forum, Patient Forums, Equality Forums, Healthwatch Barnsley and our Ward Alliances. These and other forums play a key role in bringing together people's experience of health and social care in Barnsley to influence and shape local services:

- We intend to develop and build upon the mechanisms to hear the voice of local communities use the community voice to assess our progress against our priorities.
- We are proud to have such an extensive reach in to local communities, where we can have ongoing conversations about what is and what isn't working, and how together we can improve outcomes for our people. Openness and transparency will help bring about continuous improvement.
- We need to engage with communities about behaviour change and personal responsibility effectively.
- This information can then be used by the Area Councils, individuals and voluntary and community groups to achieve creative solutions to improve and shape the health and wellbeing of their communities.
- We intend to develop the mechanisms to hear the voice of our communities and use the community voice to assess our progress against our priorities and co-produce service change with communities, patients and carers.



Governance delivery & implementation



What will be different for Barnsley people?

It's 2015

Mrs Brown is 75 and lives alone at home in Barnsley. She doesn't know many people. She has had high blood pressure and early onset dementia for some time. She is losing her eyesight and is becoming increasingly unsteady on her feet.

Mrs Brown receives some care from the council, and a few services from the local NHS which help to give her some independence. These include some home care and telecare from the council. She also sees the specialist nurses at the memory assessment service, the outpatients department for her vision and the district nurse is currently visiting daily to treat an injury from a fall. She has been to hospital three times in the past two months because of a fall or her conditions meaning an ambulance had to be called.

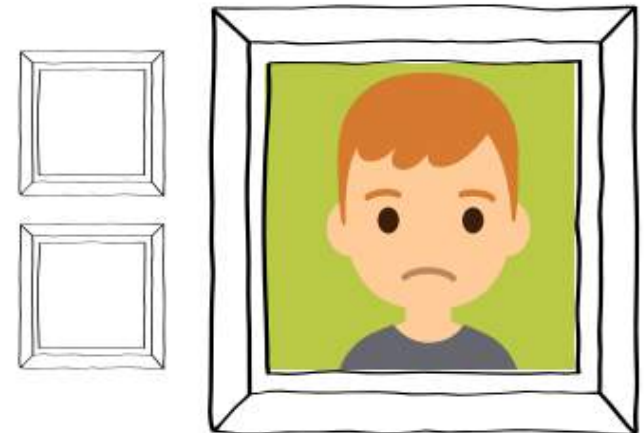
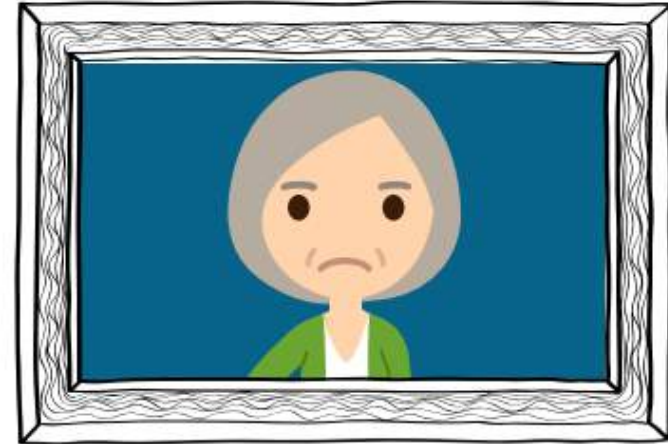
She has had to have a number of assessments, is often referred on from the people she has told her story to, has to do a lot of travelling to different services which are changed at the last minute.

Jack, Mrs Brown's son, who lives on the next street cares for Mrs Brown for about 20 hours per week. He is struggling to pay his bills as he is unable to work and the carers' benefit does not cover these outgoings. He may have to give up caring and try to go back to work. Consequently Jack is suffering with anxiety and mild depression.

Mrs Brown is worried that she will have to go into a home if Jack is unable to continue caring and her health and wellbeing deteriorates further.

This is an expensive situation for two reasons:

- Duplication of resources
- The likelihood that Mrs Brown's situation will escalate and lead to more intensive, more expensive care.



It's 2020

Mrs Brown is now 80. She is still at home despite her fears. Following a discussion with Mrs Brown and Jack, Mrs Brown was given an integrated personal budget to help her manage her health and care needs. As part of this, a single integrated care plan was developed jointly with Mrs Brown and her son Jack. Her care plan involves planned integrated health and care services, the use of assistive technology and the support from local neighbours and the local VCS. For the services Mrs Brown has chosen to buy with her personal budget, there is consistent information about quality that has been provided from regulator's report that helps them make informed choices about who provides the care.

Having a single integrated care plan is a much more cost effective approach as resources are planned more effectively across the system, leading to less emergency visits, and avoiding the need for Mrs Brown to go into a care home.

This has taken some pressure off Jack who is now able to find time to do some training to help him when he is ready to go back to work. Because the system has been integrated and devolved, it is now much clearer how the system works and patients and carers are partners in making decisions. As a result Jack wants to be a part of helping design future services. He has agreed to join a sub group of the Health and Wellbeing Board to help design e-health services for the future so individuals can remain in control of their own health and wellbeing.

Staff in the local health and care economy work together in local multi-disciplinary teams. This helps them to respond more readily to Mrs Brown's needs without having to have multiple appointments and assessments every time something happens. Staff focus on working proactively with Mrs Brown to help her manage her conditions better and therefore avoid a hospital visit due to escalation. Staff have also had training in the use of mobile technology. They can now share and access information to provide the best care for their patients.

