BARNSLEY
Metropolitan Borough Council

Public Document Pack

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 5 April 2016
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

AGENDA

1 Declarations of Pecuniary and Non-Pecuniary Interests

2 Minutes of the Board Meeting held on 2 February, 2016 (HWB.05.04.2016/2) *(Pages 3 - 6)*

3 Minutes from the Children and Young People's Trust Executive Group held on 5 February, 2016 (HWB.05.04.2016/3) *(Pages 7 - 16)*

4 Minutes from the Barnsley Community Safety Partnership held on 25 February, 2016 (HWB.05.04.2016/4) *(Pages 17 - 26)*

5 Minutes from the Stronger Communities Partnership held on 16 February, 2016 (HWB.05.04.2016/5) *(Pages 27 - 30)*

For Decision/Discussion

6 Health and Wellbeing Strategy Development Update (HWB.05.04.2016/6) *(Pages 31 - 36)*

7 Better Care Fund - Update (HWB.05.04.2016/7) *(Pages 37 - 42)*

8 Development of the Sustainability and Transformation Plan (HWB.05.04.2016/8) *(Pages 43 - 80)*

9 Transforming Care Barnsley's Adult Learning Disability Work Programme (HWB.05.04.2016/9) *(Pages 81 - 146)*

10 BMBC Housing Strategy (HWB.05.04.2016/10) *(To Follow)*

To: Chair and Members of Health and Wellbeing Board:-

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Councillor Jim Andrews BEM, Deputy Leader
Councillor Margaret Bruff, Cabinet Spokesperson - People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson - Communities
Diana Terris, Chief Executive
Rachel Dickinson, Executive Director People
Wendy Lowder, Interim Executive Director Communities
Julia Burrows, Director Public Health
Nick Balac, NHS Barnsley Clinical Commissioning Group
Lesley Smith, NHS Barnsley Clinical Commissioning Group
Tim Innes, South Yorkshire Police
Emma Wilson, NHS England Area Team
Adrian England, HealthWatch Barnsley
Steven Michael OBE, South West Yorkshire Partnership NHS Foundation Trust
Richard Jenkins, Barnsley Hospital NHS Foundation Trust

Please contact Peter Mirfin on 01226 773147 or email governance@barnsley.gov.uk

Thursday, 24 March 2016

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MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 2 February 2016
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

MINUTES

Present

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Councillor Jim Andrews BEM, Deputy Leader
Councillor Jenny Platts, Cabinet Spokesperson - Communities
Julia Burrows, Director Public Health
Nick Balac, NHS Barnsley Clinical Commissioning Group
Lesley Smith, NHS Barnsley Clinical Commissioning Group
Tim Innes, South Yorkshire Police
Emma Wilson, NHS England Area Team
Adrian England, HealthWatch Barnsley
Sean Rayner, South West Yorkshire Partnership NHS Foundation Trust
Richard Jenkins, Barnsley Hospital NHS Foundation Trust

In attendance – Councillors Cherryholme and Miller

32 Declarations of Pecuniary and Non-Pecuniary Interests

Cllr Platts declared a non-pecuniary interest in minute numbers 38 and 43 in her capacity as a Member of Barnsley Hospital NHS Foundation Trust Governing Body, insofar as the discussion referred to the Trust.

33 Minutes of the Board Meeting held on 8th December, 2015 (HWB.02.02.2016/2)

The meeting considered the minutes of the previous meeting held on 8th December, 2015.

RESOLVED that the minutes be approved as a true and correct record.

34 Minutes from the Children and Young People's Trust Executive Group held on 18th December, 2015 (HWB.02.02.2016/3)

The meeting considered the minutes from the Children and Young People's Trust Executive Group held on 18th December, 2015.

RESOLVED that the minutes be received.

35 Minutes from the Barnsley Community Safety Partnership held on 11th November, 2015 (HWB.02.02.2016/4)

The meeting considered the minutes from the Community Safety Partnership held on 11th November, 2015.

RESOLVED that the minutes be received.

36 Minutes from the Provider Forum held on 9th December, 2015 (HWB.02.02.2016/5)

The meeting considered the minutes from the Provider Forum meeting held on 9th December, 2015.

RESOLVED that the minutes be received.

37 Minutes from the Stronger Communities Partnership held on 9th November, 2015 (HWB.02.02.2016/6)

The meeting considered the minutes from the Anti-Poverty Board held on 9th November.

RESOLVED that the minutes be received.

38 Better Care Fund - Plan for 2016/17 (HWB.02.02.2016/7)

The item was introduced by Lesley Smith, Chief Officer Barnsley CCG. Members heard how NHS England is required to ringfence £3.519 billion within its allocation to CCGs to establish the BCF in 2016/17. The remainder of the £3.9 billion fund being made up of the £394 million Disabled Facilities Grant paid direct to local authorities. In Barnsley the total value of the fund in 2016/17 is expected to be a similar level to 2015/16.

The meeting noted that the performance element of the BCF had been removed for 2016/7. Beyond 2016/7, the spending review had emphasised the ambitions for the full integration of health and social care by 2020. The meeting discussed the work required within and between agencies to progress this.

It was noted that the detailed planning guidance had yet to be published but it was suggested that planning ought to start imminently, with SSDG leading the work, supported by a task and finish group of relevant officers.

RESOLVED:-
(i) that the policy framework for 2016/17 and related requirements be noted;
(ii) that SSDG be tasked to draft the BCF plan for 2016/17;
(iii) that authority be given to the Chair and Vice Chair to agree the first draft of the BCF plan for 2016/17 for submission, following consultation with SSDG;
(iv) that the Board receives a final draft of the BCF plan for 2016/17 at its meeting on 5th April, 2016, prior to final submission on 11th April, 2016.

39 Anti Poverty Action Plan (HWB.02.02.2016/8)

The item was introduced by Councillor Platts, drawing attention of the meeting to the worsening of Barnsley's relative position in the revised Index of Multiple Deprivation. The committee discussed the role that the Anti-Poverty Action Plan had to play in redressing this.

Members commented on the need to incorporate performance targets against each of the performance measures and acknowledged that work continued to populate

this. The meeting noted the correlation between poverty and poor mental health and that measures to deal with had not been included in the Action Plan.

The meeting noted the emphasis within SWYPFT to focus on improving the employment prospects of people with mental health issues. It was acknowledged that mental health needed to be a cross cutting theme in all strategies partners developed, and the meeting noted the emphasis to be placed in the Community Safety and Stronger Communities Strategies in this respect.

Noted were the specific arrangements in place for mental health under the Crisis Care Concordat.

RESOLVED that:-
(i) the Anti-Poverty Action Plan be approved subject to further work to develop performance targets for each of the measures;
(ii) the connection between poverty and mental health be noted and the work to focus on mental health in the development of strategies and plans be welcomed.

40 Sport and Active Lifestyle Strategy (HWB.02.02.2016/9)

The item was introduced by the Adam Norris, Senior Health Improvement Officer. Members heard how the action plan had been developed following the recently approved Sport and Active Lifestyle Strategy. It focused on increasing physical activity in the Borough over the next three years.

Members noted that the levels of physical activity in the borough were actually reducing against an already low base, presenting a particular challenge to stabilise levels before progress could be made.

The action plan identified work to analyse key factors that prevented people being more active so that targeted interventions could be developed.

RESOLVED that the content of the action plan be noted.

41 Update on Multispecialty Community Providers (HWB.02.02.2016.10)

The item was introduced by Lesley Smith, Chief Officer at NHS Barnsley CCG, and an update given on the development of the Multi-Specialty Community Provider (MCP) model.

RESOLVED that the report be noted.

42 Health and Wellbeing Strategy development - update (Oral report)

The item was introduced by Richard Lynch, Head of Service Commissioning, Governance & Partnerships who gave an update on the progress made in reviewing and refreshing of the Health and Wellbeing Strategy.

It was noted that work was in hand for a workshop of SSDG members to come together on 26th February, 2016 to consider priorities in reviewing the strategy. It was hoped to establish more focused outcomes, and to work with partners about how the data available can be used to track performance.

Members commented on the need to consider those areas where joint working under the Board could make a difference.

RESOLVED that the report be noted.

43 Barnsley Health and Social Care System Financial and Economic Modelling (HWB.02.02.2016/12)

Neil Lester, Deputy Chief Finance Officer at NHS Barnsley Clinical Commissioning Group gave a presentation on the financial and economic modelling work that had been undertaken to identify the key challenges being faced by each agency to 2020/21.

The presentation highlighted key assumptions for each agency and the extent to which the assumptions could be relied upon. Partners noted the significant financial challenge faced over the next five years, and the system wide transformation required to meet this challenge.

RESOLVED:- that the Financial and Economic Model be used to support the development of system-wide planning and modeling of impacts as the move is made towards a more fully integrated model of health and social care.

44 NHS Planning Guidance 2016/17 – 2020/21

Members of the Board noted the link circulated, highlighting the recently published NHS planning guidance 2016/17 – 2020/21.

RESOLVED that the information be received.

Chair

Minutes of the Children and Young People's Trust Executive Group Meeting held on 5 February 2016

Present

Core Members

Rachel Dickinson (Chair)	BMBC, Executive Director: People
Bob Dyson	Independent Chair of the Barnsley Safeguarding Children Board
Margaret Libreri	BMBC, Service Director for Education, Early Start and Prevention
Mel John-Ross	BMBC, Service Director of Children's Social Care and Safeguarding
Brigid Reid	Barnsley CCG, Chief Nurse
Gerry Foster-Wilson	Executive Headteacher, Representing the Barnsley Association of Headteachers of Primary, Special and Nursery Schools
Sean Rayner	SWYPFT District Director Barnsley/ Wakefield
Amanda Glew	BMBC Organisation Development Manager
Cllr Margaret Bruff	Cabinet Member: People (Safeguarding)
Nigel Middlehurst	Voluntary Action Barnsley, External Services Manager
Dave Whitaker	Executive Headteacher, Representative of Secondary Headteachers
Dr Clare Bannon	Barnsley GPs Local Medical Committee

Deputy Members

Angela Kelly	BMBC, Targeted Youth Support Operations Manager (for Barnsley Youth Council – youth voice)
Deborah Mahmood	South Yorkshire Police, Head of crime (for Chief Supt. Tim Innes)
Diane Wall	Barnsley College Safeguarding Team Leader (for Jenny Miccoli)
Diane Lee	BMBC Head of Public Health (for Penny Greenwood)
Keith Dodd	BMBC Communities Business Manager (for Wendy Lowder)
Sue Gibson	Barnsley Hospital NHS Foundation Trust, Head of Midwifery/ Nursing (for Heather McNair)

Advisers

Julie Green	BMBC, Strategic Lead, Procurement and Partnerships

In attendance

Anne Smith	BHNFT, Public Health Midwife (for item 5)
Carrianne Stones	Healthwatch Barnsley Manager (for item 6)
Victoria Schofield	BMBC Head of Children in Care (for item 8)
Julie Dickinson	BMBC Safeguarding & Quality Assurance Project Officer (for item 14)
Denise Brown	BMBC, Governance, Partnerships and Projects Officer

			Action
1.	**Apologies:**		
	Richard Lynch	BMBC, Head of Commissioning, Governance and Partnerships	
	Tim Innes	South Yorkshire Police Chief Superintendent (Barnsley Commander)	
	Penny Greenwood	BMBC, Head of Public Health, Health protection	
	Emma White	BMBC Public Health	
	Jenny Miccoli	Barnsley College, Vice Principal Teaching, Learning and Student Support	

		Action
	Anna Turner — BMBC, School Models and Governor Development Manager Wendy Lowder — BMBC, Service Director for Stronger, Safer and Healthier Communities	
2.	Identification of confidential reports and declarations of any conflict of interest Reports to be treated as confidential are: • Item 11 – Tackling child poverty and improving family life strategic priority report. • Item 15 – Continuous service improvement plan No conflicts of interest were declared.	
3.	Minutes of the Trust Executive Group meeting held on 18 December 2015 The minutes of the meeting were approved as an accurate record.	
3.1	Action log/ matters arising Actions arising from 6 November 2015: • Minute 5. Effective engagement with schools. A meeting has been arranged for Margaret and Monica to discuss the possibility of putting together a traded package to fund a Safeguarding lead post for schools. • Minute 6(i). A notice had been included in e-bulletin 309, circulated on 5 February 2016, reiterating that 'where schools want to refer children to CAMHS the most appropriate route to refer is through their school nurse, rather than directing via parents making requests to GPs.' A list of school nurses and linked schools had been attached to the bulletin. • Minute 6(iii). Rachel had asked Tom Smith to follow up the action to arrange a light touch learning event to consider the issues raised during a discussion re. improving education, achievement and employability. • Minute 13.1(i). It was confirmed that PCSO representation on the Behaviour Attendance Group has been arranged. • Minute 13.1(iv). Following the TEG meeting, an Education Welfare officer had confirmed that schools are always contacted following a truancy sweep, and either the school or an Education Welfare Officer contacts the parents, who are given an information leaflet on the importance of school attendance. Contacts with school and parents are all recorded. Actions arising from 18 December 2015: • Minute 5. Noted that Kaye Mann had made contact with colleagues to arrange attendance at the secondary school Headteachers meeting re. the RUDifferent social norms programme outcomes. • Minute 9.1. Confirmed that partners had attended the Officer Group re. the continuous service improvement plan.	
4.	Barnsley Safeguarding Children Board Meeting held on 29 January 2016 – highlights (Bob Dyson) The following items discussed at the BSCB meeting were highlighted: • Ray Powell, the BMBCs Prevent Coordinator, had attended the meeting with two colleagues from SY Police. It was agreed that Bob would arrange for the briefing to be circulated to TEG members. • A briefing paper which sets out the changes to the process and practice of Children's Social Care Screening and Assessment had been supported by	Bob

		Action
	the BSC Board, and is on the TEG agenda. There continues to be concern regarding the high level of contacts into social care. • The Children's Sexual Exploitation (CSE) Strategy had been approved by the BSC Board. • Concern was raised that the recent Department for Education's (DfE) elective home education guidelines for Local Authorities means that there are no real checks and safeguards in place for children educated at home. It was agreed that a letter would be sent to the DfE to highlight these concerns, and copied to the Chief HMI and Regional Ofsted lead.	Mel/ Bob
5.	Stillbirths in Barnsley (Sue Gibson and Anne Smith) The reason behind the low rates of stillbirths in Barnsley had been queried at previous TEG meetings, and the attached presentation was given to review the trends of intrauterine foetal death (IUFD) and stillbirths in Barnsley Hospital. The following points were highlighted: • The UK ranks 33rd of 35 high income countries for its stillbirth rates • It is a national maternity priority to reduce the numbers of stillbirths/ IUFDs • Declining rates of IUFD in Barnsley was noted over the last five years, more than halving the rate of IUFDs from 4.68% in 2010 to 2.15% in 2014 • For more than 50% of the women it was their first pregnancy • Most common presentation was reduced foetal movements, and intrauterine growth restriction (IUGR) • The greatest risk factors include: smoking, which was identified as the most common modifiable risk factor; medical disorders; and intrauterine growth restriction (IUGR)(babies not developing as they should) • Nearly 40% of the women had a body mass index (BMI) of between 25.0 and 29.9; and nearly 35% had a BMI of between 18.5 and 24.9 • Placental insufficiency was the cause of death in 44% of cases • Barnsley is classed as outstanding with 100% compliance in the 'stillbirth care bundle' which includes four elements: reducing smoking in pregnancy; detecting foetal growth restriction; raising awareness of reduced foetal movement; improving effective foetal monitoring during labour The following questions were raised/ comments noted: • Rachel queried what factors had caused the IUFD rates to decline, and it is felt that the work to reduce smoking in pregnancy, and the implementation of individualised growth charts to improve detection rates of babies not growing sufficiently, which both started in 2011/12, had started to make a difference. • It is important that the developing Family Centres are aware of the risks of smoking during pregnancy, and Keith was tasked with making the Communities Directorate aware of this, to be taken into account when making future commissioning decisions. • More needs to be done to encourage pregnant women with high BMI rates to lose weight. • Young women using substances or drinking heavily are on a high risk pathway of care and the fact that they are not losing their babies is a positive endorsement of the care that they receive. • Anne expressed concern that the 'smoking cessation' service, which had managed to reduce the percentage of women smoking during pregnancy down to 17%, had been decommissioned. Rachel undertook to relay that concern to commissioners.	Keith Rachel

		Action
	It was agreed that the key messages from the presentation would be sent to Nina Sleight.	Denise
6.	<u>Work of Healthwatch</u> (Carrianne Stones) Carrianne credited Healthwatch champions for providing the slides for the attached presentation. The presentation highlighted the following: • A quarterly Healthwatch Bulletin is produced by young people for the 750 members, which includes health and social care related information. It also provides feedback to members regarding how their views are being used to make a difference. • A Health Booklet is currently being produced to highlight: emotional health and wellbeing; sexual health; drugs and alcohol; school nursing system and healthy eating. A health survey was designed which 365 young people completed and the relevant information was included in the booklet. Healthwatch Barnsley was awarded £300 from Berneslai Homes for a project to promote healthy eating amongst young people in Barnsley. A page dedicated to healthy eating has been included in the Health Booklet, including details of relevant services available for young people. It is hoped that the booklet will be available from April 2016. • Healthwatch was approached by the Patient Experience Support Officer from Barnsley Hospital for views on a flyer designed to gain complaints and compliments from young people. Following consultation, feedback forms were submitted. The final draft of the flyers will be shared with young people so that they can see the impact of their feedback. The following comments were noted: • Brigid emphasised how valuable the contribution of Healthwatch had been, particularly in relation to the work of CAMHS. • Bob suggested working more closely with Healthwatch in future in relation to safeguarding issues and it was agreed that Bob would ask the BSC Board Manager, Nigel Leeder, to contact Carrianne Stones regarding this. • It was noted that Healthwatch is not currently engaged with primary schools, and it was agreed that Gerry and Carrianne would meet to discuss how this could be achieved. • Young people are informed of the positive impact that their contribution is making via the bulletin, and through Healthwatch representatives who go into schools on a regular basis. **It was agreed that:** • TEG agendas will be sent to Carrianne in future who will determine whether there are any agenda items which Healthwatch could contribute to, or comment on in order to ensure that the Children's Trust is sufficiently connected to Healthwatch in future. • The draft Children and Young People's Plan 2016-19 would be sent to Carrianne for comment by Healthwatch. Rachel congratulated Healthwatch on the excellent achievements over the years.	Bob Gerry/ Carrianne Denise Denise

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<u>Developing a model of early help for families</u> (Margaret Libreri)
The attached presentation provided an update on the work taking place around early help for families including: transformation to family centres, and the outcome of the early help peer review. It was noted that information regarding impact on outcomes was not available at this stage. It is important to get integrated working and workforce development right.
The presentation highlighted the following:

A Stronger Communities Partnership has been established which has oversight of the early help agenda, and there is an early help steering group for children.
From 1 April 2016 there will be a single point of referral into services.
A range of services focused on the family and young people will be offered through Family Centres.
The emphasis will be on targeted services, but there will still be a universal element in terms of access, i.e. won’t have to be referred.
Need is being targeted through prevention and early intervention; working in a whole family way from pre-birth to 25 years; building on family strengths and developing family resilience and aspiration.
How data is used, and information shared, is critical to ensure we are delivering the right services and programmes based on evidence of outcomes.
Family star and teen/youth star are very effective in measuring outcomes and understanding the difference that early help is making.
Everyone needs to take ownership of early help, and not see it as something to be passed on to another service. For early help to be successful all partners, and the children’s workforce, need to have the ability to signpost referrals appropriately. It is important to achieve permeable routes to the right help.
Partners need to be willing to take a coordinated approach. Key areas of work with partners include: workforce development; understanding the vision for early help and the outcomes that it can have an impact on; and integrating systems and processes as much as possible.
It is important to work with partners to ensure good systems and processes are in place for gathering data and providing feedback regarding what is working well, or not working well.

During the discussion the following points were noted:

It is concerning that the number of early help assessments being completed has decreased, and is the lowest it has been for years.
Early help is an ‘invest to save’ initiative. Getting early help right will prevent problems from escalating and avoid longer and more expensive interventions.
It is vital that the workforce are developed to strengthen core skills including: good leadership and management; an understanding of multi-agency working; an ability to be professionally curious; identify needs as early as possible across the spectrum of outcomes; offer the right service at the right time; consider the needs of the whole family; be tenacious and provide respectful challenge when necessary; strive for continuous improvement; demonstrate improved performance.
The challenge is to ensure that everyone sees early help as their responsibility, and leaders need to ensure that front line practitioners understand this. It is not about referring an identified problem on to another service, but rather joining efforts to achieve good outcomes for a

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	young person or family. It is important to emphasise that even seemingly simple interventions will help to secure good outcomes. • There needs to be more discussion between agencies about the child's needs, and services trying to achieve the same outcomes need to be integrated. **The Trust Executive Group agreed to:** • Endorse the direction of travel, including a single point of access. • Enforce the message that early help is everyone's responsibility. • Ask the Early Help Steering Group to: - Collect good examples of early help in action. It was suggested that short, two line sentences, of examples of early help in action would be helpful. - Consider short video clips with stories that people can relate to that illustrate a successful experience of early help; to capture what early help looks like at different stages and how it can ultimately manage the demand for high level services. - Join up early help efforts for children and families. • Receive a progress report at the TEG meeting on 29 April 2016. • Consider a celebration event in six months' time to recognise the work that has taken place; test those areas that we would expect early help to have had an impact on, such as Fair Access Panel and referrals into CAMHS; and capture any learning where earlier intervention would have been helpful. Margaret informed the meeting that a Head of Early Help Strategy is being recruited to in the Communities Directorate. This role will be critical in progressing strategic developments, partnership engagement and communication. Rachel asked that the Early Help Steering Group be thanked for their work.	Members Margaret Libreri Margaret Margaret Margaret
8.	<u>Contacts into Social Care</u> (Vicky Schofield) The briefing paper re. Children's Social Care screening and assessment sets out the recent changes to practice and assessment, focusing on the current timeliness, volume and quality of social work assessments; and social work practice in relation to referrals to the service, including recording of information. The following points were highlighted: • Performance reporting in Barnsley indicated a consistent increase in social care referrals, which resulted in fewer assessments being completed within timescales. It was also noted that only 30% of assessments resulted in an ongoing intervention to Children's Social Care. • A number of issues were identified where current practice could be improved upon. In future, social workers will be required to apply their professional judgement and only record contacts which constitute a welfare concern for a child. Contacts into the service which are requests for information; to provide information about low level concerns or to seek advice or guidance about available services, are not recorded in the same way. This will enabled the service to focus on those children who are most at risk. • Operational guidance has been provided for screening staff. The Screening Team provides the first point of contact for all enquiries to Children's Social Care in Barnsley.	

		Action
	• The proposed Multi-Agency Referral Audit (MARA) Group will provide a consistent and regular overview of agency practice at the point of referral to Children's Social Care. The Safeguarding Children Board has given their support for this approach. • Terms of reference for the MARA Group will be considered at the next Performance and Quality Assurance (PAQA) group meeting. • It was acknowledged that this is not a risk free strategy, and is heavily dependent on good management oversight, social work skill and expertise. • On Wednesday afternoons there will be an open door session with the screening team which people are invited to attend. This provides an opportunity for practitioners to talk to social workers about individual cases. The team can be contacted via e-mail or on their usual contact number. The following comments were noted: • At the Safeguarding Children Board meeting a discussion was held regarding the duty of those people who are initiating contacts into social care to keep their own records. • It was noted that some Local Authorities record phone calls, and it was suggested that this be considered as it provides the opportunity to listen to the calls, and use the recordings for training purposes. • Written referrals will need to be routinely audited by managers. • An audit trail is crucial and there needs to be assurance that other agencies are auditing contacts in the same way. **The Trust Executive Group agreed to:** • Endorse the approach with appropriate auditing through PAQA. • Receive an update to TEG alongside a report to the BSCB.	Vicky/ Mel
9.	Local Area Special Educational Needs Ofsted Inspection (Margaret Libreri) Margaret handed out the attached paper at the meeting which provides an update on progress in relation to compliance with SEN reforms and the Children and Families Act, and in preparation for the Ofsted inspection, including: meeting the duty to identify disabled children and those with special educational needs; joint working across agencies, services and institutions; education health and care plans. Work is taking place with early years' settings and schools to assess and meet children's needs according to the SEN code of practice. Consideration has also been given to the systems in place and identifying areas where they are not working effectively. **It was agreed that** the self-assessment would be brought to the TEG meeting on 29 April for consideration, and that a representative of the Barnsley Parents and Carers Forum would be invited to attend. This will be the main agenda item to collectively consider the key areas of focus.	Margaret
10.	Children and Young People's Plan 2016-19 (Julie Green) The following update on finalising the CYP Plan was provided: • Julie thanked everyone who had submitted comments and amendments. • A meeting has been arranged with young people from Barnsley College regarding designing the graphics for the CYP Plan.	

		Action
	• The current version of the plan has been sent to the Youth Council to be shared with young people. **It was agreed that:** • The CYP Plan would be sent to the Barnsley Parents and Carers Forum and Healthwatch for comment. • The amended version of the CYP Plan would be circulated to members. There is still time to make final comments, but hopefully there will be no major changes at this stage. • At the next meeting a discussion will be held regarding the process for monitoring the CYP Plan and for challenging progress to ensure that the desired outcomes are achieved. Rachel asked Julie to let her know if any difficulties are encountered with finalising the plan.	Denise Denise Julie
11.	Strategic Priority: Tackling child poverty and improving family life - confidential (Andrea Hoyland) The report provided an update on progress towards meeting targets against key indicators in the CYP Plan relating to tackling child poverty and improving family life. It was noted that following the Council restructure in 2015 the child poverty element of this theme sits in the Healthier Communities service area of the Communities Directorate. The Anti-Poverty Delivery Group is a multi-agency, cross sector partnership group which sits under the newly established Stronger Communities Partnership, and is one of three delivery groups. The Anti-Poverty Action Plan 2015-18 details activity for the first of the next three years under four key challenge areas: • To increase early take up of financial advice and support for skills and employability, to help people to make the most of the money they have and improve their potential income. • To reduce child poverty, to help parents give their children the best start in life. • Ensure that strategies and plans are 'poverty proof'. • To evaluate joint impact, and to determine whether or not the expected results are being achieved. Dan Jarvis, MP for Barnsley Central, has drafted a Child Poverty report to highlight child poverty and is committed to working with the Anti-Poverty Delivery Group to reduce the levels of child poverty in Barnsley and across the country. The current version of the Anti-Poverty Action Plan is scheduled to go to Cabinet on 10 February 2016 for approval. The following comments were noted: • There is a detailed needs assessment for anti-poverty that underpins the strategy and action plan which is kept up-to-date by BMBC Business Intelligence • Information had been shared with local MPs. • Dan Jarvis will be kept informed of progress.	

		Action
12.	Performance: escalated items from theme leads No other performance issues or risks were highlighted.	
13.	Local Transformation Action Plan (Brigid Reid) The Local Transformation Action Plan is on both the CCG and BMBC websites. The following points were noted: • Patrick Otway has been asked to develop a 'plan on a page'. • Key aspects of the transformation plan are: the work already taking place with schools, and access to therapeutic support. • The Terms of Reference for the 'Future in Mind' Implementation Group will be considered at the next ECG meeting. • An update is due to be provided to the TEG meeting in April, and the Action Plan is going to Scrutiny in May 2016. • A lot of work has gone into developing the plan, and the contribution of Nette Carder, interim BDU Director for SWYPFT, was acknowledged. It was noted that Carol Harris will be starting as the BDU Director from March 2016. • This is a good piece of work, and tracking progress to deliver the plan is a top priority to ensure that it has the required impact on outcomes.	
14.	Joint TEG/BSCB Risk Register (Mel John-Ross) The risk register had been discussed at the last joint TEG/BSCB meeting in October 2015. In terms of the BSCB the risk register is fully completed, however, there is further work in terms of scoring key risks that are particularly relevant to the CYP Trust. Margaret Libreri pointed out that a risk needs to be included regarding maintaining a rigorous performance management framework. Members were asked to let Rachel know if there are any risks missing. **It was agreed that** Rachel and Mel would meet to consider the risk register before it comes back to the TEG.	Members Rachel/ Mel
15.	Continuous service improvement plan (Mel John-Ross/ Julie Dickinson) – confidential It was noted that there were no particular concerns and no actions were flagged 'red'. A joint development day had been held to update specific plans owned by the BSCB, and they will continue to be updated. It was agreed that owners of the Early Help Action Plan would be invited to attend the next TEG meeting to provide an update on progress.	Margaret
16.	Issues for escalation to other Boards • Health and Wellbeing Board: early help; work of Healthwatch; reduction in stillbirths. • Barnsley Safeguarding Children Board: No issues for escalation.	Nina/ Margaret/ Sue Gibson

		Action
17.	Proposed agenda items for the next meeting on 17 March 2016 It was agreed that the key priorities for the next meeting are: • Early Help Action Plan • Local Transformation Action Plan • A process for taking the CYP Plan forward and a system for delivering it	
18.	Any other business Opportunity for secondary schools in England that do not currently have an established counselling provision to receive a high quality professional counselling service at no cost to the school for two years Brigid had forwarded an e-mail which it was agreed would be circulated following this meeting. 'Following recent government guidance recommending the availability of counselling in every school (1), the University of Roehampton, along with colleagues at the Metanoia Institute and Universities across the UK, are currently planning to conduct a study of school-based counselling as a means of reducing psychological distress in pupils: The ETHOS trial, funded by ESRC. We are looking to recruit approximately 18 secondary schools that do not currently have an established counselling provision to participate in the study. Eligible schools will receive a high quality professional counselling service at no cost to the school for two years. Those interested in finding out more about becoming a participating school should contact Peter Pearce at peter.pearce@metanoia.ac.uk (1) www.gov.uk/government/uploads/system/uploads/attachment_data/file/416326/Counselling_in_schools_-240315.pdf	Denise
19.	Attachments • Item 5 – IUFD and stillbirths in Barnsley Hospital – review of trends • Item 6 – Work of Healthwatch Barnsley • Item 7 – Developing a model of early help for families • Item 9 – Progress in relation to the Children and Families Act, and readiness for the Ofsted inspection	

Dates of future TEG meetings:

Date	Time	Venue
17 March (Thursday)	14.00 – 17.00	Westgate Plaza Boardroom, Level 3, Room 3
29 April (Friday)	9.30 – 12.30	Westgate Plaza Boardroom, Level 3, Room 3
17 June (Friday)	13.30 – 16.30	Westgate Plaza Boardroom, Level 3, Room 3
*4 August (Thursday)	09.00 – 12.00	Westgate Plaza Boardroom, Level 3, Room 3
6 October (Thursday)	09.00 – 12.00	Westgate Plaza Boardroom, Level 3, Room 3
24 November (Thursday)	14.00 – 17.00	Westgate Plaza Boardroom, Level 3, Room 3

Barnsley Community Safety Partnership
Executive Group meeting

BARNSLEY COMMUNITY SAFETY PARTNERSHIP
EXECUTIVE COMMITTEE MEETING MINUTES

Thursday 25th February, 2016
1.30pm to 3.30pm

Westgate, Plaza, Level 3, Boardroom

Present:
Wendy Lowder, Barnsley MBC (Chair) Tim Innes SYP Paul Brannan, Barnsley MBC Gill Blake, SYP Melanie Fitzpatrick, Barnsley MBC Darren Asquith, Berneslai Homes Linda Mayhew, South Yorkshire Criminal Justice Board John Hallows, Barnsley Neighbourhood Watch Liaison Group Carrie Abbott, BMBC/Public Health Councillor Jenny Platts, Barnsley MBC Tony Dailide, BMBC Mark Lidster, South Yorkshire Fire Service Max Lanfranchi, National Probation Service Deb Mahmood, SYP Shelley Hemsley, SYP Jayne Hellowell, Barnsley MBC Dorne Kanarek, Barnsley MBC Ben Finley, Barnsley MBC Julie Oxley, Neighbourhood Resolution Project Mel John-Ross, Barnsley MBC Jackie Hardy – SYP Lorna Naylor, Barnsley MBC (Minutes)

Introduction - Chair
The Chair welcomed everyone to the meeting and introductions were made.

DRAFT

1. Apologies

Apologies were received from Jan Hannant, Jade Frances-Rose, Cheryl Winn and Dave Fullen.

2. Minutes of Previous Meeting –11th November 2015

The minutes of the meeting of 11th November 2015 were agreed as a true record.

Action Schedule as at 11th November 2015

2.1 The Hate & Harassment Partnership Terms of Reference are currently being reviewed to incorporate the wider remit of community cohesion and will be submitted to CSP Board meeting for ratification in May 2016.

4.1 Unauthorised / Illegal Encampment Protocol – A decision is required in relation to the re-opening of the emergency stopping site Grange Lane site. Paul Brannan/Wendy Lowder to progress through the Council's Cabinet approval process.

5.2 JSIA – A summary of the key findings of the 2015/16 JSIA will be incorporated into the Partnership Plan 2016 – 2019.

6.2 Hate and Harassment Partnership Funding – Paul Brannan to advise Wendy Lowder of which agencies have responded so that a reminder e-mail can be circulated to partner agencies.

All other actions on the schedule were discharged or covered on the agenda.

3. DHR Process and Governance Arrangements

Jayne Hellowell presented the updated process for requesting a Domestic Homicide Review (DHR). The chair of any future reviews will be Bob Dyson, Chair of the Executive Group. Currently there are 2 reviews being undertaken, the outcome from these reviews will be presented to the CSP in due course.

Any follow up actions from a DHR will be taken forward by a DHR/MARAC steering group who will report to the Domestic Abuse and Sexual Violence Partnership. The purpose of the group will be to provide the opportunity for leads from key organisations to meet to discuss issues and developments relating to MARAC referrals and share any lessons learnt from domestic homicide reviews.

Tony Dailide informed the group that it is proposed that in future the Safeguarding Adult Reviews will follow the same format as DHRs.

The 3 statutory partners, Barnsley MBC, SY Police, and the CCG have been asked to fund the costs of the independent chair to carry out a DHR. This amounts to approximately £10,000 per review.

Jayne Hellowell and Melanie Palin were thanked for their work on this piece of work.

Action : The CSP ratified the new procedures and approved the implementation of the DHR/MARAC Steering Group.

4. Domestic Abuse & Sexual Violence Strategic Review

Jayne Hellowell informed the meeting that the Domestic Abuse & Sexual Violence Strategic review will take place over the next 3 months, funded by Barnsley MBC. The review is to examine as systematically as possible what the relative harms and needs are for individuals and families suffering domestic abuse and sexual violence in Barnsley, and to make evidence-based decisions on how needs might be effectively met within the resources available.

A project initiation document has been presented to the Domestic Abuse and Sexual Violence Partnership Board setting out the key aims of the project.

The Strategic Review and business case will be completed in spring 2016, following this, the services will tendered during 2016/17 with a start date of April 2017.

Members are asked to note that the review is running parallel to the review of the homeless support services and substance misuse services. The review will acknowledge the need to look across services particularly where clients present with multiple and complex needs.

Action : Members to note the Domestic Abuse and Sexual Violence Strategic Review and that a further report summarising the findings and recommendations will be brought to the CSP at a later date.

5. Restorative Justice Presentation – Julie Oxley, NR Co-ordinator

Julie Oxley gave a presentation of the Neighbourhood Resolution(NR) Project. The presentation highlighted that:-

- NR uses a multi partnership approach.
- Regular briefings are completed with partners.
- An Executive Steering Committee has been established to oversee the work of NR.
- A lone working process is operating to allow greater flexibility for both Facilitators volunteering and clients.
- Referrals are made to partner organisations, providing additional support for our communities and protecting vulnerable people.

So far the project has achieved:-

- A reduction in repeat calls from clients who have been referred to NR.
- Effective information sharing to protect vulnerable clients and to reduce duplication in delivery of services.
- Approved Accredited Training provider status by the Restorative Justice Council for the restorative justice (RJ) approaches training given to Facilitators.

Future opportunities for the Project are to:-

- Continue to support the SY RJ Hub completing victim initiated work for victims of criminal proceedings in Barnsley.
- Extend the delivery of the Accredited Training programme to other areas (Sheffield have already requested the training from Barnsley).
- Work towards achieving quality marks to recognise our work with volunteers and the voluntary sector in Barnsley.

- Recognise and celebrate the valuable contributions and dedication of volunteers at a volunteer celebration event planned for 10th March 2016. Partners and local organisations will be invited to the event.

Julie was thanked for the presentation and her work on the Neighbourhood Resolution Project. Linda Mayhew commended the work of the project.

Action: Members to note the work of the Neighbourhood Resolution Project.

6. Strategy and Performance Group (S&PG) Highlight Report

Mel Fitzpatrick presented the highlight report of the Strategy and Performance Group detailing the exceptions from Quarter 3 2015/16. It was recommended that the CSP Board members:

- Endorse the recommendations of the report; and,
- Task the S&PG to oversee the quarter 3 performance remedial actions and bring highlight reports to back to the CSP Board.

Reducing Re-offending Sub Group

An escalation was received querying whether the Re-offending Sub-Group should remain a local sub-group or be folded into the regional Reducing Re-offending Steering Group. The Board requested an options paper be drafted by the sub-group for consideration at the next S&PG with recommendations being reported to the CSP Board in May 2016.

Linda Mayhew informed the meeting that there is a Re-offending Strategy being developed at a county level and that this needs to link with the local CSP arrangements. The strategy will be going to consultation in March 2016.

Jackie Hardy is reviewing offender management on behalf of SYP. It was agreed that Dorne Kanarek and Paul Brannan meet with Jackie as part of the offender management Review.

Hate and Harassment Sub Group

Deb Mahmood reported that there has been a reduction in the number of hate crime/incident reports received and that this is in line with the regional trend. A training package is currently being rolled by the SYP the Hate Crime Co-ordinator to various services and businesses to raise awareness of how to spot and report hate and harassment.

The CSP Board agreed the proposed remedial actions. Mel John-Ross advised that she would also make a request to the Alliance Board to help encourage reporting within schools and amongst young people, and the use of language line if necessary.

An escalation was received from the sub-group in relation to 2016/17 funding for future communication activities. It was requested that all agencies consider making a contribution towards 2016-17 communication activities. Wendy Lowder agreed to circulate a reminder e-mail.

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Drug and Alcohol

It was noted that there is a 12 month data lag with the Local Alcohol Profile for England (LAPE) and that the next release is due May 2016. The latest published data shows an increase in the number of females recorded with an alcohol related hospital admission. It was acknowledged that this data is based upon a robust national statistical model which includes alcohol specific conditions plus those where alcohol is casually implicated. This trend does however correlate with the upward trend of female referrals for alcohol misuse to treatment services.

It was noted that the number of successful treatment completions by criminal justice clients as at the latest data position (November 2016) in relation to opiates, non-opiates and alcohol is below the target set for 2015/16. Recently, the Criminal Justice Report has introduced regional and national comparative indicators. On review of this, Barnsley is exceeding regional averages.

Carrie Abbot supported the performance highlights and advised that work is ongoing with public health to review set targets and trajectories locally which would feed into the review of the CSP Plan and performance framework.

The CSP Board agreed the proposed remedial actions.

There were no specific escalations received from the Drug and Alcohol Action Board.

Domestic Abuse and Sexual Violence Partnership

The number of reported domestic abuse incidents and crime have reduced in the 12 months rolling period to December 2015. This trend is replicated across the SYP force area.

Shelly Hemsley/Tim Innes informed the meeting that an in-depth analysis is taking place with regards to the national issue of under-reporting of domestic abuse incidents. SYP are currently undertaking consultative work with victims to review satisfaction levels and a report with the summative findings and recommendations will be submitted to the next CSP Board in May 2016.

Jayne Hellowell will report back to DASVP to ensure these findings feed into the work being undertaken by the sub-group.

There were no specific escalations received from the Domestic Abuse and Sexual Violence Partnership.

Tactical Tasking & Co-ordination

The number of reported ASB incidents have increased when compared to the 12 month year-to-date position. Criminal damage and arson incidents have also increased however, this is the lowest increase in the force area.

There has been an increase with regards to accidental dwelling fires. Mark Lidster made a request that all agencies help with identifying vulnerable people within the Borough, so that the Fire Service can undertake Home Safety checks. Mark circulated a leaflet 'Keep Safe and Well' for distribution. John Hallows offered support on behalf of Neighbourhood Watch. John to liaise with Mark.

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The Terms of Reference for the Tactical Tasking and Co-ordination Sub Group have been updated to include the role and remit of South Yorkshire Fire and Rescue. Mel Fitzpatrick to circulate for comments.

Action: Ben Finley/CRC to meet to discuss an options paper for consideration by the next CSP Board in relation the local governance arrangements for re-offending.

Action: Dorne Kanarek/Paul Brannan to meet with Jackie Hardy to discuss the review being undertaken by SYP in relation to offender management.

Action: Wendy Lowder to circulate an e-mail to Board members to request consideration be given to funding communication activities in relation to Hate and Harassment projects in 2016/17.

Action: Mel John-Ross to request the Alliance Board encourage the reporting of Hate and Harassment incidents.

Action: SYP are currently undertaking consultative work with domestic abuse victims to review satisfaction levels and a report with the summative findings and recommendations to be submitted to the next CSP Board in May 2016.

Action: Mel Fitzpatrick to circulate the revised Terms of Reference of the Tactical Tasking and Co-ordination Sub Group and Board members to provide comments within a 1 week timeframe.

7. Refreshed Partnership Plan

Following the CSP visioning conference, the final report from Bluelight Consultancy has now been received.

The Partnership Plan for 2016-2019 will be drafted to take into account the key findings from the conference. Mel Fitzpatrick/Gill Blake will contact priority leads to discuss the next steps with a view to having a draft Plan sent out for consultation by the end of March 2016. The finalised plan will be presented to the May CSP Board meeting.

Action : All members to note the timescales for refreshing the Partnership Plan.

8. Crime Performance Overview

Deb Mahmood gave an overview of crime performance. Barnsley District overall is performing well at present. Key points highlighted:

- Increase in Child Sexual Exploitation (CSE) reports since January;
- Slight increase in vehicle crime;
- Slight increase in violence against the person;
- Increase in ASB especially Kendray, Goldthorpe, Elsecar and within the town centre.

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Tim Innes added to the above stating that Barnsley still has the lowest crime rates within the County and at present are able to manage/deal with the number of incidents. Tim praised the partnership working in place in Barnsley and advised that he has encouraged other areas to learn from Barnsley's approach.

Mel John-Ross added the increase in CSE reports may be due to training / awareness raising taking place by BSARCS.

9. Any other business

Paul Brannan informed the meeting that Barnsley has obtained the first injunction against a particular traveller family preventing them returning to Carlton Industrial Estate for 2 years.

Dorne Kanarek suggested having a design team for the Neighbourhood Hub and asked for names of people who wished to be involved. Suggestions were :-

Dorne Kanarek (BMBC) (Chair)
Jackie Hardy (SYP)
Paul Brannan (BMBC)
Darren Asquith/Dave Fullen (Berneslai Homes)
Jayne Hellowell (BMBC)
Vulnerable Adults Team
SY Fire Service

Wendy Lowder suggested a presentation should be given at the next CSP Board meeting in May on the outline structure of the Neighbourhood Hub.

Action: Dorne Kanarek to arrange a Neighbourhood Design Team meeting and prepare a presentation to the next CSP Board meeting.

12. Date and Time of Next Meeting

The next meeting will be held on **Wednesday 11th May, at 10:00 to 12:00 in Barnsley Town Hall.**

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Barnsley Community Safety Partnership
Executive Group meeting

Action schedule from minutes (25th February 2015)

1	**Domestic Abuse and Sexual Violence Strategic Review**
1.1	**Member's note that the Domestic Abuse and Sexual Violence Strategic Review is taking place and that a further report be brought to the CSP at a later date.**
2	**Actions Brought Forward from November CSP Board**
2.1	**The Hate & Harassment Partnership Terms of Reference are currently being reviewed to incorporate the wider remit of community cohesion and to be submitted to CSP Board meeting for ratification in May 2016.**
2.2	**Unauthorised/Illegal Encampment Protocol – A decision is required in relation to the re-opening of the emergency stopping site Grange Lane site. Paul Brannan/Wendy Lowder to progress through the Council's Cabinet approval process.**
2.3	**JSIA – A summary of the key findings of the 2015/16 JSIA to be incorporated into the Partnership Plan 2016 – 2019.**
3	**Strategy and Performance Group Highlight Report**
3.1	**Ben Finley/CRC to meet to discuss an options paper for consideration by the next CSP Board in relation the local governance arrangements for re-offending.**
3.2	**Dorne Kanarek/Paul Brannan to meet with Jackie Hardy to discuss the review being undertaken by SYP in relation to offender management.**
3.3	**Wendy Lowder to circulate an e-mail to Board members to request consideration be given to funding communication activities in relation to Hate and Harassment projects.**
3.4	**Mel John-Ross to request the Alliance Board encourage the reporting of Hate and Harassment incidents.**
3.5	**SYP are currently undertaking consultative work with domestic abuse victims to review satisfaction levels and a report with the summative findings and recommendations to be submitted to the next CSP Board in May 2016.**
3.6	**Mel Fitzpatrick to circulate the revised Terms of Reference of the Tactical Tasking and Co-ordination Sub Group and Board members to provide comments within a 1 week timeframe.**
4.	**Refreshed Partnership Plan**
4.1	**Members to note the timescales for refreshing the Partnership Plan.**

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5	**Any other business**
5.1	**Dorne Kanareck to arrange a meeting to discuss the design of the Neighbourhood Hub and prepare a presentation for the next meeting of the CSP.**

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BARNSLEY METROPOLITAN BOROUGH COUNCIL
COMMUNITIES DIRECTORATE

STRONGER COMMUNITIES PARTNERSHIP
TUESDAY, 16TH FEBRUARY, 2016

Attendees:-
Councillor C Lamb, BMBC (Chair)
Councillor J Platts, BMBC
Jake Lodge, Student (Observer)
Wendy Lowder, BMBC
Keith Dodd, BMBC
Jacqui Bradley, BMBC – Minute Taker
Joe Micheli, BMBC
Margaret Libreri, BMBC
Tony Dailide, BMBC
Carrie Abbott, BMBC
Lisa Wilkins, BMBC/CCG
Darren Asquith, Berneslai Homes
Marie Hoyle, Practice Manager, Kakoty Practice
Nigel Middlehurst, VAB
Adrian England, Healthwatch
Phil Parkes, SYHA
Chris Middleton, CCG

Apologies:-
Philip Spurr, BMBC
Helen Jaggar, Berneslai Homes
Dave Fullen, Berneslai Homes
Jade Rose, CCG
Vicky Peverelle, CCG
Sean Rayner, SWYPFT

MINUTES

1 Welcome and Introductions

2 Minutes of Last meeting – Action Log

Attendance list amendments - Councillor Platts asked for her name to be added to the list. Marie Hoyle confirmed that she is the Practice Manager at the Kakoty Practice

Item 4 - following a query from Adrian England, Keith Dodd confirmed that the Terms of Reference referred to in this section relate to the Resilient & Healthy Communities Group. The Terms of Reference for the Partnership are still in draft and will be discussed later.

Deputies – Members were asked to ensure they nominate a deputy to attend meetings on their behalf. Keith Dodd circulated the current membership list and asked everyone to let him have their named deputies by email.
Action – All

Health & Resilience Group – Joe Micheli reported that the group will be meeting next week. Diane Lee has taken over as chair of the group from Phil Hollingsworth.

Early Help (Children) - Margaret Libreri confirmed that the findings from the peer review have now been included in the action plan. Membership of the steering group has also increased.

Early Help (Adults) - Tony Dailide reported that work is progressing. Diane Lee will now chair both the Early Help (Adults) and Resilient and Healthy Communities Delivery Group meetings.

Outcomes Framework – the proposed meeting in January didn't take place. Now that the delivery groups have been established, Keith Dodd proposed that this item be discussed in more detail at the next meeting in May. This was agreed.

Councillor Platts reported that the anti-poverty delivery plan has now been approved by Cabinet. The Delivery Group met yesterday to discuss performance outcomes. There are some gaps and these will be closely monitored to avoid further slippage.

3 Terms of Reference

Adrian England queried the section about confidentiality and stated that many of the Partnership's members could have a conflict of interest with the agenda items being discussed.

It was agreed that this section be re-worded and Councillor Lamb asked for a standing item to be included at the beginning of the agenda for any Declarations of Interest.

Keith Dodd agreed to update the Terms of Reference and circulate a revised draft by email for comments. He also asked colleagues to resend any earlier comments previously sent to Dan Carver so that they can be incorporated.

Actions – Keith Dodd

4 Review of Voluntary Sector Presentation

Joe Micheli and Nigel Middlehurst gave a presentation on the findings of the review undertaken by Rocket Science.

Questions:-

Following a query from Councillor Platts about the proposal in the review document that a different methodology be utilised to allocate resources to Area Councils - Joe Micheli confirmed that we knew that a very simple allocation methodology was used when the Area Arrangements were established however we did feel that a more developed approach was required based on deprivation / other domains. This needed further consideration.

Lisa Wilkins asked about Public Health support to the Area Councils and Borough wide schemes. Wendy Lowder confirmed that Public Health link names had been provided to the Area Council Chairs and Area Managers.

Lisa also asked if the CCG have had any input into the review. Jamie Wike from CCG was involved in the review.

Wendy Lowder commented that the review document should refer to the public sector not just BMBC and the slides amended to reflect this.

That the review report should also be tabled at the CCG management team meeting.

Action : Joe Micheli

Marie Hoyle asked about the low number of applications and how can organisations apply for funding. Wendy Lowder confirmed that VAB can advise on how to obtain external funding.

Nigel Middleton reported that there has been an increase in bids from small organisations.

Councillor Lamb confirmed that we need to maximise the funding opportunities.

Councillor Platts referred to a presentation to the anti-poverty delivery group and confirmed that information on how to apply for funding is available, it needs to be published more.

Clarity required on how much of the information from Research and Intelligence was readily available to the Voluntary and Community Sector

Action : Joe Micheli to query with Liz Pitt. Challenge exclusions if required and escalate to SCP if required.

5 Outcomes Framework

Keith Dodd reported that this is currently being drafted and will circulate the latest version for comments.

It was agreed that the next meeting focus on priorities and outcomes.

6 High Level Project Plan

Adrian England asked if the draft Children & Young People's Plan could be circulated to Partnership members for comments. This was agreed.

Action – Margaret Libreri

7 Date and Time of Next Meeting

Tuesday, 24th May, 2016 at 1.30 pm

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REPORT TO THE HEALTH AND WELLBEING BOARD

05 APRIL 2016

UPDATE ON THE DEVELOPMENT OF THE HEALTH AND WELLBEING STRATEGY 2016 -2019

Report Sponsor:	Rachel Dickinson Executive Director, People
Report Author:	Richard Lynch Head of Service Commissioning, Governance & Partnerships, People
Date of Report:	5th April 2016

1. Purpose of Report

1.1 To update members on the progress of development of the revised Health & Wellbeing Strategy and related documents, with proposed timescales for completion.

2. Recommendations

2.1Health & Wellbeing Board members are asked to:-

- Note the progress to date and receive an update regarding proposed timescales for consultation and completion of the revised strategy.
- Approve and note timescales for the draft Annual Report (2015/16) to the Board to coincide with the timescales for performance, and the subsequent schedule for the development and implementation of a revised partnership communication plan.

3. Introduction/ Background

3.1 The current strategy expires this year (2016) and HWB Members are asked to consider the process and timescales for developing a revised strategy. The draft strategy will be presented for consideration by the Board at its meeting on 7th June 2016.

3.2 The revised strategy will frame the ambition of the Health & Wellbeing Board to align the efforts of partners to achieve a number of key strategic aims designed to drive the improvement of health and wellbeing outcomes in Barnsley.

3.3 Underpinning the revised strategy is an approach to gather and report intelligence that will allow members to lead and direct change across systems. Work is underway to identify those areas of data and intelligence that will be of most benefit to members in developing understanding of the local health and wellbeing picture.

3.4 To date, we have taken the key messages emerging from the Health & Wellbeing Board development day and consulted with key partners, including Senior Strategic Development Group. We are therefore proposing to frame the strategy in accordance with five key outcomes:

- Children start life healthy and stay healthy
- People live longer, healthier lives
- Health inequalities are reduced
- People live in strong and resilient families and communities
- People have improved mental health and wellbeing

3.4 A review of the working of Health & Wellbeing Boards in neighbouring and comparator authorities suggests some good practice emerging in the focus of health and wellbeing strategies. The outcomes framework proposed considers health and wellbeing (as distinct from health & social care only) in its broadest sense. The strategy however, will seek to focus the aligned efforts of partners on those areas which can achieve cross-system impact.

3.5 A proposed work programme for the Board will be developed alongside the revised strategy to allow members to consider how best we can drive change, monitor progress against our ambitions, celebrate areas of achievement and respectfully challenge where required.

3.6 In addition, it is recommended that the draft Annual Report 2015-16 be presented to the Board in October, to coincide with the timescales for the reporting on intelligence and performance.

3.7 A refreshed Communication Plan will also be presented to the Board for consideration in October.

3.8 A summary project plan is attached to inform members of key milestones and reporting timescales.

4. Financial Implications

4.1 None at this stage.

5. Consultation with stakeholders

5.1 Per attached plan

6. Appendices

6.1 Appendix 1 Project Plan

Officer: Richard Lynch **Contact: 01226 773672** **Date: 22nd March 2016**

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Barnsley Health & Wellbeing Board Strategy Refresh: 'Live' Action Plan
Date: 22nd March 2016

	22.02.	29.02.	07.03	14.03	21.03	28.03	04.04	11.04	18.04	25.04	02.05	09.05	16.05	23.05	30.05	06.06	13.06	20.06	27.06	04.07	11.07	18.07	25.07	01.08	08.08	15.08	22.08	29.08	05.09	12.09	19.09	26.09	Oct-16	Nov-16	Dec-16
Preparation																																			
Internal Audit Action Plan Agreed																																			
Agree Strategic Outcome Areas																																			
Map current priorities/other strategies to outcomes																																			
Meet with Robin Douglas (tbc)																																			
Review strategies from other areas																																			
H&WBB Priorities (cross reference with STP)																																			
Agree joint strategic priorities at SSDG									18th																										
Agree delivery principles									18th																										
Framework (cross reference with STP)																																			
Develop strategy structure and content sections																																			
Agree strategy structure and content sections with SSDG									18th																										
Populate content sections (with reference to consultation feedback)																																			
Consultation (Purdah - 30th March - 6th May)																																			
Meet with Elaine Equeall																																			
Meet with Healthwatch																																			
Identify exisiting groups for consultation																																			
Agree consultation method (survey / focus group ??)																																			
Develop consultation resources																																			
Undertake consultation																																			
Review consultation outcomes																																			
Reflect consultation outcomes in draft strategy																																			
Intelligence & Performance																																			
Review measures and performance to date																																			
Identify sucesses and areas for improvement																																			
Assess effectiveness of the measures (driving/capturing improvements)																																			
Review & Refresh JSNA																																			
Agree future performance indicators at SSDG (inc. data source & dashboard)																														12th					
Submission of performance dashboard to H&WBB for sign off																																	4th		
Governance: Sign off of the Stratergy																																			
Submission of draft strategy to SSDG													17th																						
Submission of draft strategy to H&WBB																7th																			
All partners to secure the relevant sign off for the startegy by their Boards																																			
Leader to clarify role of Cabinet in helping to develop the strategy (tbc)																																			
Submission of draft strategy to Full Cabinet																																29th			
Area Councils to consider the impact of the strategy																																			
Overview & Scrutiny (tbc)																																			
City Regions (tbc)																																			
Governance: H&WBB & SSDG Operating Protocols																																			
Review and revise the TofR for the SSDG (inc. membership, attendance, interests, info/data sharing)													17th																						
Review and revise the TofR for the H&WBB (inc. membership, attendance, interests, info/data sharing)																7th																			
Implement an action log for SSDG									18th																										
Implement an action log for H&WBB							5th																												
Submission of Memorandum of Agreement to SSDG																														12th					
Submission of Memorandum of Agreement to H&WBB																																	4th		
Review standard agenda items for SSDG (interests, action log, performace, risk reg etc)																		20th																	
Development of SSDG & H&WBB work plan																														12th					
Develop a risk log (linking to BCF risk log)	21st																	20th															4th		
Submission of draft Annual Report to SSDG													17th																						
Submission of draft Annual Report to H&WBB																7th														12th					
																																	4th		
Communications																																			
Review & refresh the H&WBB Communication Plan											5th																			12th			4th		
Update & keep live the Councils Webpage for the H&WBB																																			

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REPORT TO THE HEALTH AND WELLBEING BOARD

5 April 2015

Better Care Fund Update – Quarter 3 2015/16 Reporting and Planning for 2016/17

Report Sponsor: Lesley Smith/Rachel Dickinson
Report Author: Jamie Wike
Received by SSDG: Date
Date of Report: 22 March 2016

1. Purpose of Report

1.1 To provide the Board with an update on progress against the Key Performance Indicators (KPIs) contained within the Better Care Fund, as reported to NHS England on 26 February 2016
1.2 To provide an overview of the financial position in relation to the Better Care Fund (BCF)
1.3 To provide an update on the planning requirements and the proposed approach to developing the BCF Plan for 2016/17

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Note the contents of the report including the proposed approach and timescales for developing the BCF plan for 2016/17 and agree that the final plan be signed off by the Chair and Vice Chair of the Board to ensure national submission deadlines can be met. .

3. Introduction/ Background

3.1 The Better Care Fund 2015/16

3.2 The Better Care Fund (BCF) was established from 1 April 2015, in line with NHS England and Local Government Association directions.

3.2 The aim of the BCF is to support transformation and integration of Health and Social Care in line with the Health and Wellbeing Strategy for Barnsley.

3.3 The total value of the fund in 2015/16 is £20,374k. £2,016k of this is provided from grants made directly to the Local Authority for Disabilities Facilities and

Social Care Adaptations. The remaining £18,358k is provided from the CCG baseline allocation.

3.4 In 2015/16, the Barnsley Health and Wellbeing Board (H&WB) developed and submitted a plan for usage of BCF resources, which set out KPIs and planned schemes and initiatives aimed at delivering against these.

3.5 The only KPI which has a financial impact is that related to reducing emergency admissions. The plan submitted by Barnsley H&WB included a trajectory to reduce emergency activity by 2.9% over the periods Quarter 4 2014/15 (reporting period 1) to Quarter 3 2015/16 (reporting period 4). Failure to achieve this reduction results in a Payment for Performance element to be withheld from the fund and retained by the CCG in order to off-set increasing emergency admissions costs. The total value of the payment for performance fund is £1,976k.

3.6 In line with the agreed Section 75 agreement with the Local Authority, the financial impact of failure to achieve the payment for performance element is to be shared equally between the CCG and the Local Authority. The financial implications for both parties are set out in section 4 below.

3.7 <u>The Better Care Fund 2016/17</u>

3.8 Following confirmation during late 2015 that the BCF would continue into 2016/17, the Department of Health and Department for Communities and Local Government published the '2016/17 Better Care Fund' Policy Framework.

3.9 The report presented to the board on 2 February 2016 provided an overview of this policy framework and included details of proposed changes including the introduction of two new national conditions and the removal of the mandatory requirement for a payment for performance framework based upon delivery of the target to reduce emergency admissions. The two new national standards are:

- Investment in NHS Commissioned out-of-hospital services
- Agreement of a local action plan to reduce delayed transfers of care (DTOC) and improve patient flow

3.10 The Board approved the proposed approach to BCF planning on 2 February 2016, recognising the anticipated short timescales likely to be included in the detailed guidance.

3.11 The Better Care Fund 2016/17 planning guidance was published on 24 February 2016 and confirmed the detailed requirements and submission timescales. The requirements are in line with the policy framework as described in the report to the Board in February.

3.12 Alongside the guidance, the Better Care Fund allocations were also published. As anticipated the total minimum requirement for the fund is at a similar level to 2015/16. The total value of the fund in 2016/17 will be £20,594k (£20,374k in

2015/16). £2,331k of this is provided from grants made directly to the Local Authority for Disabilities Facilities and the remaining £18,358k is provided from the CCG baseline allocation.

4. 2015/16 Better Care Fund Performance

4.1 Payment for Performance (P4P) related to Emergency (Non-Elective) Admissions

4.2 The current performance levels against the target reductions within the BCF plan are set out below:

- Period 1 (Quarter 4 2014/15) – 1.5% increase (114 against target reduction of 128)
- Period 2 (Quarter 1 2015/16) – 5% increase (387 against target reduction of 58)
- Period 3 (Quarter 2 2015/16) – 8.8% increase (661 against a target reduction of 353)
- Period 4 (Quarter 3 2015/16) – 1.65% increase (129 against a target reduction of 353)

4.3 This means that the BCF target to reduce emergency admissions has not been met, with activity continuing to increase in each quarter of the reporting period. As set out below, the level of emergency admissions over the period has been 1,291 higher than the baseline period and 2,183 above the target:

Target reduction periods 1-4	892
Actual over-performance against baseline (Q1-3)	1,291
Total reduction required in period 4	**2,183**

4.4 In financial terms, the value withheld over the reporting period totals £1976k. In line with the Section 75 agreement, the CCG has paid BMBC £988k less into the pool and will manage the risk related to the £988k applicable to the CCG internally.

4.5 Reducing the number of emergency admissions is a key objective for the wider health and care economy and therefore there is a continued focus on ensuring a sustained effort to reduce the number of admissions into hospital and also to improve the flow of patients through the hospital and support timely discharge by commissioning appropriate out of hospital services.

4.6 Other Key Performance Indicators

4.7 Reduction in the number of permanent residential and nursing home admissions (65yrs & over). Latest performance is below the BCF plan with lower numbers of permanent admissions - **achieving**

4.8 Increase the number of people who are still at home 91 days after discharge from hospital who access reablement services. Latest performance indicates that more people remain at home 91 days after discharge than the BCF plan – achieving

4.9 Maintaining the number of delayed transfers of care. Performance in Barnsley is good with low numbers of delayed discharges and therefore the plan was to maintain the levels seen in 2013/14. The latest performance shows that the average number of delayed discharges per month has increased during 2015/16 and therefore the planned level of delayed discharges may not be achieved – **not achieving**

4.10 Reduce the proportion of people reporting a poor experience of General Practice. The 2014/15 results show an improvement from 7.3 to 6.4 (average number of negative responses per 100 patients) between 13/14 and 14/15. The BCF target was based upon the 2012/13 baseline of 5.3 and the aim was to reduce the numbers reporting a poor experience of GP services. The 2013/14 results show that performance deteriorated with the number increasing above the baseline to 7.3 creating a bigger challenge in respect of achieving the BCF target. There has however been significant investment in primary care and this has been supplemented by the Prime Ministers challenge fund to improve access to primary care which reflect the improvement between 2013/14 and 2014/15, the first year of the BCF - **not achieving but improving based upon the latest reported position to March 2015.**

4.11 Increasing the proportion of people who feel they are supported to manage their long term condition. The GP survey results show that performance has reduced from the baseline position of 67.7% to 66.5% and is therefore below the target of 70%. Activity in 2015/16, particularly in primary care to support people with long term conditions is anticipated to lead to improved performance against this measure and delivery of the agreed target of 70% by the end of the 2015/16 financial year, based on the survey reporting period to March 2016 does remain possible – **not achieving**.

5. 2016/17 Better Care Fund Planning

5.1 Following the publication of the Better Care Fund Policy Framework in January 2016, more detailed planning guidance was published on 24 February 2016. This guidance was published later than expected and therefore the timescales for submission were adjusted to take account of this. The table below shows the anticipated submission deadlines as set out in the paper to the Board in February against the revised deadlines for submission of the BCF Plan.

Original expected deadline	Deadlines in final planning guidance
8 Feb 2016 – First Draft*	2 March 2016 – First Draft*
11 April 2016 – Final BCF Plan	21 March2016 – Second Draft*
	25 April 2016 – Final BCF Plan
* The draft submissions do not require full plans and are based on the submission of a planning template confirming the funding and proposed performance measures. The final BCF plan due to be submitted on 25th April will require a full narrative plan.	

5.2 Based upon the expected timescales and anticipation that the guidance would be published in early January 2016, and recognising even then that the likely timescales would be tight, it was agreed that the BMBC Executive Director, People and the Chief Officer of NHS Barnsley CCG sign off the draft plan on behalf of SSDG and the Health and Wellbeing Board with the final plan then being submitted to the Health and Wellbeing Board on 5 April 2016 for approval.

5.3 The sign off and submission of the draft planning return template on 2 March and 21 March 2016 has been done in line with the agreed proposal however the delay in the publication of the guidance to 24 February 2016 and the need to engage all stakeholders in the development plan means that the final plan will not be complete and ready for sign off until mid-April 2016, after the Board meeting in April and before the next meeting in June. It is therefore proposed that the final plan be circulated to all Board members and that the Chair and Vice Chair of the Board approve the BCF Plan on behalf of the Board.

5.4 It is proposed that BCF Plan for 2016/17 will roll forward, as appropriate, the plan from 2015/16 and be updated to reflect the new national conditions and the removal of the payment for performance element of the fund. Taking this approach will allow the BCF to continue whilst the broader approach to transformation and integration is considered, developed and included as part of the refresh of the Health and Wellbeing Strategy and the development of other associated plans such as the Sustainable Transformation Plan for Health and Care across South Yorkshire and Bassetlaw and the Barnsley Integrated Transformation Plan.

6. Conclusions

6.1 The Board are asked to note the contents of the report in relation to the 2015/16 BCF plan and performance and to agree with the proposals for the BCF in 2016/17, including rolling forward the plan from 2015/16 and that the Chair and Vice Chair of the Board sign off the final plan to enable submission by the deadline of 25 April 2016.

Officer: Jamie Wike **Contact:** 01226 433702 **Date:** 22/03/16

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REPORT TO THE HEALTH AND WELLBEING BOARD

5 APRIL2016

SUSTAINABILITY AND TRANSFORMATION PLAN

Report Sponsor: Lesley Smith
Report Author: Jade Rose
Received by SSDG:
Date of Report: 15 March 2016

1. Purpose of Report

1.1 To provide H&WBB members with an overview of the Sustainability and Transformation Plan
1.2 To provide H&WBB members with a proposed way forward for developing a single, integrated transformation plan for Barnsley

2. Recommendations

2.1Health and Wellbeing Board members are asked to:-

- Note the information contained in this report
- Actively support and engage in the development of the regional STP
- Support the development of a single integrated transformation plan across Barnsley

3. Introduction/ Background

3.1 As part of the 2016/17 NHS planning guidance (https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf) CCGs have been asked to develop a Sustainability and Transformation Plan (STP). The STP is expected to set out how the local system will holistically deliver the triple aim – better health, transformed quality of care delivery and sustainable finances. The plan is expected to cover the period between October 2016 and March 2021 and will be formally assessed following submission in June 2016.

Some of the key points within the document are;

- Planning by individual institutions will be increasingly supplemented with planning by place for local populations
- The STP is intended to be a truly place based plan

- It will also become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards
- The most compelling and credible STPs will secure the earliest funding from April 2017 onwards.

4. STP Footprint

STPs will be delivered by local health and care systems or 'footprints': organisations that are working together to deliver transformation and sustainability. Footprints are local geographic areas where people and organisations have agreed to work together to develop robust plans to transform the way that health and care is planned and delivered for their populations over the next five years. The STPs are a means to help deliver the Five Year Forward View vision of better health and wellbeing; improved quality of care and stronger NHS finance and efficiency by 2020/21.

There are 44 footprints which collectively cover the whole of England but range in size and population. Barnsley is part of the South Yorkshire and Bassetlaw footprint with a total population of 1.5 million.

5. STP Requirements and Milestones

The high level milestones for development and submission of the regional STP are;

Submission date	Activity	Status
28th January	Transformation footprint submission	Complete
2nd March	Submit STP narrative	Complete
15th April	Checkpoint submission	
30th June	Submit full STP	
July	Assessment of plans by NHS England	

To deliver the regional STP, a regional STP Task and Finish Group is meeting on a fortnightly basis with regional events planned to include partners from across the region. There is also a clear expectation that work will be undertaken in local areas to ensure that local partners are engaged in the development of the STP at a regional and local level.

On the 15th March 2016, STP development guidance was issued by NHS England; 'Developing Sustainability and Transformation Plans'. This recent guidance sets out the 10 big questions that the STP is expected to address across the footprint;

1) How are you going to prevent ill health and moderate demand for healthcare?
2) How are you engaging patients, communities and NHS staff?
3) How will you support, invest in and improve general practice?
4) How will you implement new care models that address local challenges?
5) How will you achieve and maintain performance against core standards?

6) How will you achieve our 2020 ambitions on key clinical priorities?
7) How will you improve quality and safety?
8) How will you deploy technology to accelerate change?
9) How will you develop the workforce you need to deliver?
10) How will you achieve and maintain financial balance?

This guidance also sets out the expected template for submission.

The 'Developing the Five Year Forward View: Sustainability and Transformation Plans – Stakeholder Briefing Pack' was also recently released which is attached for additional information.

6. Developing the STP in Barnsley

To support the development of a regional STP, it is necessary that the 3 gaps are considered across Barnsley. The three gaps are;

1) Health and Wellbeing gap
2) Quality and Outcomes gap
3) Finance and Efficiency gap

A small sub group of the SSDG has been set up to focus on how these gaps are being addressed by work taking place across Barnsley.

A mapping exercise of all transformation work across BHNFT, SWYPFT, BCCG, BMBC ASC, BMBC Communities, BMBC Public Health and South Yorkshire Fire and Rescue has been carried out and this was shared at a recent SSDG workshop focused on the development of the Barnsley contribution to the STP.

During the SSDG workshop a number of key actions were agreed;

- Work would be undertaken by all partners to support the development of the regional STP recognising the challenging timescales involved
- There was a need to develop a single integrated transformation plan for Barnsley
- There needed to be an initial focus on 4 key priority areas. These were agreed as;
    - Urgent Care and Complex Patients
    - Adult Social Care
    - Early Help and Prevention
    - Primary and Community Care Workforce Capacity

7. Proposed Plan for an Integrated Transformation Plan for Barnsley

At the SSDG STP workshop on the 26th February, it was proposed that a single integrated transformation plan is developed for the 4 priority areas noted above.

It is proposed that this will be taken forward by a sub group of SSDG working across the system and that this dovetails with both the development of the regional STP and the Health and Wellbeing Strategy refresh. It is proposed that a logic model is completed for each of these Priority Areas. The Logic Model is a single page template that works on the premise of defining the outcomes you want to see for the priority area and identifying what needs to happen to deliver the outcomes.

Recognising that this is a system wide transformation plan, there will need to be agreement and sign up to this process and plan from all parties across the system. It is expected that the planning process and draft plans will be shared with all parties and that SSDG will have oversight of the development of the integrated transformation plan.

8. Conclusion/ Next Steps

8.1 In conclusion, the Health and Wellbeing Board is asked to;

- Note the content of this report.
- Support the development of a regional STP
- Support the development of a single integrated transformation plan for Barnsley

9. Appendices

9.1 Appendix 1 – Developing Sustainability and Transformation Plans
9.2 Appendix 2 – Developing the Five Year Forward View: Sustainability and Transformation Plans – Stakeholder Briefing Pack'

Officer: Jade Rose **Contact: jade.rose2@nhs.net** **Date: 23/04/2016**

NHS

Preparing for 15 April and beyond

March 15 2016

STPs are an opportunity to develop a local route map to an improved, more sustainable, health and care system

44 STP footprints have been agreed

- Each will be convened by a local leader, backed by national bodies
- Footprints are not statutory boundaries – they are vehicles for collaboration
- Planning will still need take place at different levels - subsidiarity is a key principle

A good STP focuses on the big questions and early action

- Get going on some early actions rather than waiting for the plan to be complete
- As ‘umbrella’ plans, STPs can be a way of making sense of competing priorities
- Think about populations, not institutions or organisational form
- Spend time on identifying the practical opportunities and solutions, not endlessly debating the scale of the challenge

It won’t be easy

- There will be technical challenges, e.g.
  - Cross-footprint flows and boundaries
  - Incentives that pull in different directions
- Non-technical challenges, e.g.
  - Building meaningful relationships
  - Freeing people to focus on the long-term
  - Moving quickly, whilst ensuring buy-in

This is an opportunity to build or strengthen relationships

- Across health, social care and local government – but also with patients, communities, staff and the voluntary sector
- STPs aren’t all about writing the plan: building energy, relationships and collaborative leadership is even more important
- Trust and ownership is crucial for implementation

Overview of the process

1 *Collective leadership agreed*

2 *15th April checkpoint*
Set out early thinking

3 *30 June submission*
Full Plan submitted to national bodies

Develop local leadership and collaboration

Establish common purpose

Define early vision and priorities

Take early action, get runs on the board

Identify and quantify opportunities and develop plan

Ongoing planning, implementation and learning

Build the leadership → Develop the vision and take early action → Continued implementation

Engagement of staff and communities at every stage

The April 15th checkpoint: Summary

NHS

Each STP area is asked to make a submission by 15 April focusing on the following **two questions**:

a. What leadership, decision-making processes and supporting resources you have put in place to make progress?

b. What are the major areas of focus and big decisions you will need to make *as a system* to drive transformation?

A short template to fill in and submit to england.fiveyearview@nhs.net is provided in the annex.

Different areas will be starting from different places

- Many areas will have already undertaken considerable amounts of work. Where this is the case, you should of course build on this work – we are not asking areas to redo what they've already done, although there may be gaps to fill.
- National and regional teams will offer greater support to those areas which are just starting out.
    - Page 8 sets out in more detail what to expect by when.
    - Regional teams will contact each area to discuss what support would be helpful.

The April 15th checkpoint: agreeing areas of focus for your STP

A full STP will need to be underpinned by

- an understanding of your current major local challenges against the ‘3 gaps’ (health and wellbeing, care and quality, and finance and efficiency);
- how those challenges are expected to evolve over the next 5 years in a ‘do nothing scenario‘;
- emerging hypotheses for what is driving the gaps and therefore the action needed.

National priorities and local challenges

- The STP process is intended above all to be a process for partners across a footprint to work together to identify, agree and address significant challenges. **It is not a checklist exercise.**
- In order to support this effort, and drawing on commitments from the mandate to NHS England and the shared planning guidance, on the following pages we have set out 10 key areas where we know we need to make progress across the health and care system.
- Reflecting on these 10 areas, for the April submission we would expect footprints to be identifying key local priorities for transformation through the remainder of the STP process.

10 big questions – what are your priorities? (1/2)

NHS

Given your local circumstances, where do you need to focus in order to allow you to deliver the priorities for the health and care system by 2020/21?

1 **How are you going to prevent ill health and moderate demand for healthcare?** Including:
- A reduction in childhood obesity
- Enrolling people at risk in the Diabetes Prevention Programme
- Do more to tackle smoking, alcohol and physical inactivity
- A reduction in avoidable admissions

2 **How are you engaging patients, communities and NHS staff?** Including:
- A step-change in patient activation and self-care
- Expansion of integrated personal health budgets and choice – particularly in maternity, end-of-life and elective care
- Improve the health of NHS employees and reduce sickness rates

3 **How will you support, invest in and improve general practice?** Including:
- Improve the resilience of general practice, retaining more GPs and recruiting additional primary care staff
- Invest in primary care in line with national allocations and the forthcoming GP 'Roadmap' package
- Support primary care redesign, workload management, improved access, more shared working across practices

4 **How will you implement new care models that address local challenges?** Including:
- Integrated 111/out-of-hours services available everywhere with a single point of contact
- A simplified UEC system with fewer, less confusing points of entry
- New whole population models of care
- Hospitals networks, groups or franchises to share expertise and reduce avoidable variations in cost and quality of care
- health and social care integration with a reduction in delayed transfers of care
- A reduction in emergency admission and inpatient bed-day rates

5 **How will you achieve and maintain performance against core standards?** Including:
- A&E and ambulance waits; referral-to-treatment times

10 big questions – what are your priorities? (2/2)

NHS

Given your local circumstances, where do you need to focus in order to allow you to deliver the priorities for the health and care system by 2020/21?

6 **How will you achieve our 2020 ambitions on key clinical priorities?** Including:
- Achieve at least 75% one-year survival rate (all cancers) and diagnose 95% of cancer patients within 4 weeks
- Implement two new mental heath waiting time standards and close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and deliver your element of the national taskforces on mental health, cancer and maternity
- Improving maternity services and reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries
- Maintain a minimum of two-thirds diagnosis rate for people with dementia

7 **How will you improve quality and safety?** Including:
- Full roll-out of the four priority seven day hospital services clinical standards for emergency patient admissions
- Achieving a significant reduction in avoidable deaths
- Ensuring most providers are rated outstanding or good– and none are in special measures
- Improved antimicrobial prescribing and resistance rates

8 **How will you deploy technology to accelerate change?** Including:
- Full interoperability by 2020 and paper-free at the point of use
- Every patient has access to digital health records that they can share with their families, carers and clinical teams
- Offering all GP patients e-consultations and other digital services

9 **How will you develop the workforce you need to deliver?** Including:
- Plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values
- Integrated multidisciplinary teams to underpin new care models
- New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice

10 **How will you achieve and maintain financial balance?** Including:
- A local financial sustainability plan
- Credible plans for moderating activity growth by c.1% pa
- Improved provider efficiency of at least 2% p.a. including through delivery of Carter Review recommendations

Support for STP areas

Over the next period, we will co-produce and share further support to help develop STPs. We would encourage you to start progressing the work now, and refine in the light of this support:

Support	Description	By when
Library of resources	• Consolidated resource pack with links to care and quality standards, priorities and policy commitments for 2020 /21 and health and wellbeing indicators to enable Footprints to agree local ambitions to close gaps	• March
Finance and efficiency support	• Financial model/template for footprints to capture the impact of their plans to close the gaps for submission in June	• April/May
STP footprint–specific data packs	• Bespoke data packs for each STP area providing a baseline against key indicators from the CCG Improvement & Assessment framework; key finance and operational performance indicators including CQC ratings, national health and wellbeing indicators and other relevant data	• April
Exemplar plan	• Potential early co- development of a full plan with a leading area to help inform what 'good' looks like	• April
"How to" guides for specific priorities & master-classes	• Concise guides on, e.g. how to implement the cancer taskforce, along with regional roadshows or master-classes	• April-May
Development days	• One-day events with footprint leadership teams across a region to network, share progress and challenges with peers and CEOs of ALBs	• 27 April: North • 3 May: London • 4 May: South • 5 May: Mid/East
Leadership support	• Provision of external support and challenge from independent figures for those STP areas that request it	• From April

Key contacts

- If you require any support, please contact your relevant ALB Regional Director.
- For general enquiries and submitting your template, please email england.fiveyearview@nhs.net, copying in your Regional Director.

NHS

Annex: Template for the 15 April checkpoint

Please use the following slides for your submission, and remove the earlier slides to keep the pack concise (max 10 slides).

Purpose of this template

NHS

This annex presents a simple template, with five sections, that collectively seek to capture:

- The leadership, decision-making and supporting resources you have put in place to progress your STP
- The major areas of focus and big decisions you will need to make as a system to drive transformation

We understand this is an early checkpoint – we don't expect finalised or comprehensive answers at this stage

- Your thinking in some areas will naturally be more advanced than others
- Early hypotheses or potential directions of travel that have not yet been fully signed up to are still helpful
- Please be concise, keeping to 10 slides in total
- The completed template needs to be sent to england.fiveyearview@nhs.net by 5pm on 15 April.

e filled out template will form the basis for discussions at regional development days late April/early May

The development days will provide an opportunity for:

- footprints to test out hypotheses and early thinking and exchange lessons learned; and
- national bodies to understand how STP areas are working together, their early thinking on top priorities and emerging vision, and for local areas to communicate issues and barriers that require national support or action

Please fill in key information details below
Name of footprint and no: **Region:** **Nominated lead of the footprint including organisation/function:** **Contact details (email and phone):** **Organisations within footprints:**

Section 1: Leadership, governance & engagement

NHS

Please discuss progress you have made (and any challenges) in the following areas:

- **Collaborative leadership and decision-making.** Please describe what arrangements you have put in place and how they will facilitate rapid progress and meaningful system leadership rather than just individual institutions. Please also give details of how the nominated lead will be supported at a working level e.g. has a programme director been appointed.
- **An inclusive process.** Describe how you are and will be involving patients and the wider community in the development of your STP and—more importantly—in its execution.
- **Local government involvement.** What are the partnership arrangements between local government, NHS commissioners and NHS providers (and others)? How does this fit with existing arrangements such as Health and Wellbeing Boards? If your STP footprint covers organisations under a proposed health devolution footprint how do you propose to manage this if the areas are not coterminous?
- **Engaging clinicians and NHS staff.** Please discuss the role both hospital and community based clinicians and staff will play in shaping and delivering the future NHS in your area.

Section 2a: Improving the health of people in your area

NHS

Please see slide 6 for potential areas of focus for improving health and wellbeing

As you develop your full STP, what are your emerging hypotheses for improving the health of people in your footprint?

These may include:

- Your initial thinking about how to radically upgrade prevention over the next five years.
- The role patients and communities have in mobilising healthier behaviours – and how will you give them greater control.
- How your system will work with local government to deliver prevention and public health improvements.
- Your proposals for improving the health and wellbeing offer the NHS makes to staff in your area and how you will engage other employers, working with local government, on this agenda.

Section 2b: Improving care and quality of services

NHS

Please see slides 6 & 7 for potential areas of focus for improving care and quality

As you develop your full STP, what are your emerging hypotheses for improving care and quality across your footprint?

These may include:

- The need to invest and support transformation in general practice, with a focus on workforce.
- Ambitions for achieving and maintaining core standards and improving quality and safety.
- Actions you will take on key clinical priorities including cancer, mental health, maternity, learning disabilities and dementia.
- How will you use RightCare to eliminate variation and waste across the health and care economy at pace?
- Developing and implementing new care models at scale to achieve your local ambitions, for example: a simplified and integrated urgent and emergency care system; whole population health models; hospital groups, networks or franchises; health and social care integration
- The role of key enablers, especially workforce and technology, to make the above happen.

It's important that proposed solutions and priorities are linked back to your local challenges

- **This is an opportunity to address areas where footprint partners may previously struggled to make progress on difficult issues**

Section 2c: Improving productivity and closing the local financial gap

NHS

Please discuss your emerging thinking in the following areas.

Please set out your current assessment of your footprint's major efficiency and finance challenges, your understanding of the key drivers of those challenges, and the major areas of focus in your STP that will help to address them.

This may include:

- The extent to which your prevention and care model improvement plans will deliver reductions in anticipated levels of demand
- How care and quality and new care model plans will improve provider productivity, both through technical or operational efficiencies but also better resource allocation decisions
- The other big decisions you need to take as a system to return to aggregate balance and longer-term sustainability.

Please note that we do not expect detailed financial modelling at this stage, although you will need this for the final June submission. We will be providing more information soon about support available to develop this.

Instead, we suggest you focus on the big decisions or opportunities you need to take as a system to close the projected financial gap in your area.

Section 3: Your emerging priorities

NHS

Please discuss your emerging thinking on what the key priorities are to take forward in your STP, and why:

- **Describe your main areas of focus,** to address (a) the priorities set out for the NHS in the Five Year Forward View, the mandate and the shared planning guidance, and (b) your own particular local challenges as set out in section 2
- Any **big decisions** you will need to make *as a system* to drive transformation

Section 4: Support you would like

NHS

Please discuss your emerging thinking in the following areas:

- Areas where you would like **regional or national support** as you develop your plans.
- **National barriers** or actions you think need to be taken in support of your STP.
- Areas where you could share **good practice** or where you would like to access expertise or best practice from other footprints.
- Any other **key risks** that may affect your ability to develop and/or implement a good STP.

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NHS

Delivering the Five Year Forward View: Sustainability and Transformation Plans (STPs)

Stakeholder briefing pack

March 2016

Five Year Forward View

#futureNHS

Contents

1. Background: The Five Year Forward View - *Delivering change and closing the gaps in quality of care, health and wellbeing, and NHS finance and efficiency.*

2. Delivering the Five Year Forward View: STPs

3. How the footprints were formed

4. How STPs will be managed locally

5. Summary of footprints

6. Footprint maps – national and regional

7. Key questions

8. Timetable

9. Contact details

Background: The Five Year Forward View

- The **NHS Five Year Forward View**, published in October 2014, considers the progress made in improving health and care services in recent years and the challenges that we face leading up to 2020/21. These challenges include:

  - the **quality of care** that people receive can be variable
  - **preventable illness** is common
  - growing demands on the NHS means that local health and care organisations are facing **financial pressure**
  - the **needs and expectations of the public are changing**. New treatments options are emerging, and we rightly expect **better care closer to home**.

There is broad agreement that in order to create a better future for the NHS, all those with a stake in health and care must **make changes to how we live, how we access care, and how care is delivered**.

- This doesn't mean doing less for patients or reducing the quality of care provided. It means **more preventative care**; finding **new ways to meet people's needs**; and identifying ways to **do things more efficiently**.

- For the NHS to meet the needs of future patients in a sustainable way, we need to **close the gaps in health, finance and quality of care** between where we are now and where we need to be in 2020/21.

Delivering the Forward View: STPs

NHS

- The **NHS Shared Planning Guidance**, published in December 2015, asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View (5YFV).

- **Sustainability and Transformation Plans (STPs)** will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term.

- STPs are not an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there.

- **STPs will delivered by local health and care systems or 'footprints': organisations working together to deliver transformation and sustainability.** The footprints used will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs, with shared links and dependencies. For example, neighbouring STP areas will need to work together when planning specialised or ambulance services or working with multiple local government authorities and, for areas within a proposed devolution footprint that cross STP boundaries, further discussion will be required in working through the implications. Other issues will be best planned at Clinical Commissioning Group (CCG) level.

How the footprints were formed

NHS

- Footprints are local geographic areas where people and organisations have agreed to work together to develop robust plans to transform the way that health and care is planned and delivered in for their populations over the next five years. The STPs are a means to help deliver the Five Year Forward View vision of better health and wellbeing; improved quality of care, and stronger NHS finance and efficiency by 2020/21.

- The majority of footprints were agreed by local health and care organisations as submitted. In one or two areas, further conversations were required to ensure planned footprints were fit for purpose. In developing the footprints, the following issues were taken into account:

1. **Geography -** including patient flow, travels links and how people use services
2. **Scale -** the ability to generate solutions which will deliver sustainable, transformed health and care which is clinically and financially sound
3. **Fit with footprints of existing change programmes and relationships**, such as Vanguards, Success Regime sites and Devolution areas
4. **The degree of existing and future challenges** across the footprint
5. **Leadership and capacity** to drive change

- Approaches have – quite rightly – varied across the country to take account of local circumstances. What works in London will not be right for Cumbria.

How the footprints will be managed locally

NHS

- Each footprint has been asked to set out **governance arrangements** for agreeing and implementing their STP.

- This should include the **nomination of a named person** who will be responsible for overseeing and coordinating the STP process locally: a senior and credible leader who can command the trust and confidence of the local health and care system, such as a CCG Accountable Officer, a provider Chief Executive, a Local Authority Chief Executive or senior clinician.

- The system leaders will be **responsible for convening and chairing system-wide meetings**, facilitating the **open and honest conversations** that will be necessary to secure sign up to a **shared vision** and plan. They will be part of an emerging national cadre of system leaders whose collective efforts will help transform health and care over the next few years.

- It is therefore vital that each system leader is able to command both local and national support. Although the particular skills needed will vary depending upon the challenges in each footprint, as system leaders they will be expected to **build support across their footprint**, whilst providing the leadership necessary to cut through long standing and difficult issues, helping to identify and deliver innovative solutions.

Summary of footprints

- There are **44** footprints, which collectively cover the whole of England.
- The footprints range in size and population – from around 300,000 to 2.8 million people.*
- There is no single right answer and the footprints will vary according to local circumstances.

NHS region	Total number of STP footprints	Average number of CCGs per footprint	Average footprint population (million)
England	44	4.8	1.2
North	9	7.4	1.7
Midlands and East	17	3.6	1.0
London	5	6.4	1.7
South	13	3.8	1.1

Footnotes:
- One CCG (Cumbria) is split across two footprints.
- ONS 2014 population estimates used.

National map of footprints

STP no	Footprint Name	Footprint Population (million)
1	Northumberland, Tyne and Wear	1.4
2	West, North and East Cumbria	0.3
3	Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	1.3
4	Lancashire and South Cumbria	1.6
5	West Yorkshire	2.5
6	Coast, Humber and Vale	1.4
7	Greater Manchester	2.8
8	Cheshire and Merseyside	2.4
9	South Yorkshire and Bassetlaw	1.5
10	Staffordshire	1.1
11	Shropshire and Telford and Wrekin	0.5
12	Derbyshire	1.0
13	Lincolnshire	0.7
14	Nottinghamshire	1.0
15	Leicester, Leicestershire and Rutland	1.0
16	The Black Country	1.3
[illegible]	Birmingham and Solihull	1.1
[illegible]	Coventry and Warwickshire	0.9
[illegible]	Herefordshire and Worcestershire	0.8
[illegible]	Northamptonshire	0.7
[illegible]	Cambridgeshire and Peterborough	0.9
[illegible]	Norfolk and Waveney	1.0
23	Suffolk and North East Essex	0.9
24	Milton Keynes, Bedfordshire and Luton	0.9
25	Hertfordshire and West Essex	1.4
26	Mid and South Essex	1.2
27	North West London	2.0
28	North Central London	1.4
29	North East London	1.9
30	South East London	1.7
31	South West London	1.5
32	Kent & Medway	1.8
33	Sussex and East Surrey	1.8
34	Frimley Health	0.7
35	Surrey Heartlands	0.8
36	Cornwall and the Isles of Scilly	0.5
37	Devon	1.2
38	Somerset	0.5
39	Bristol, North Somerset, South Gloucestershire	0.9
40	Bath, Swindon and Wiltshire	0.9
41	Dorset	0.8
42	Hampshire and the Isle of Wight	1.8
43	Gloucestershire	0.6
44	Buckinghamshire, Oxfordshire and Berkshire West	1.7
	Total	54.3

NHS

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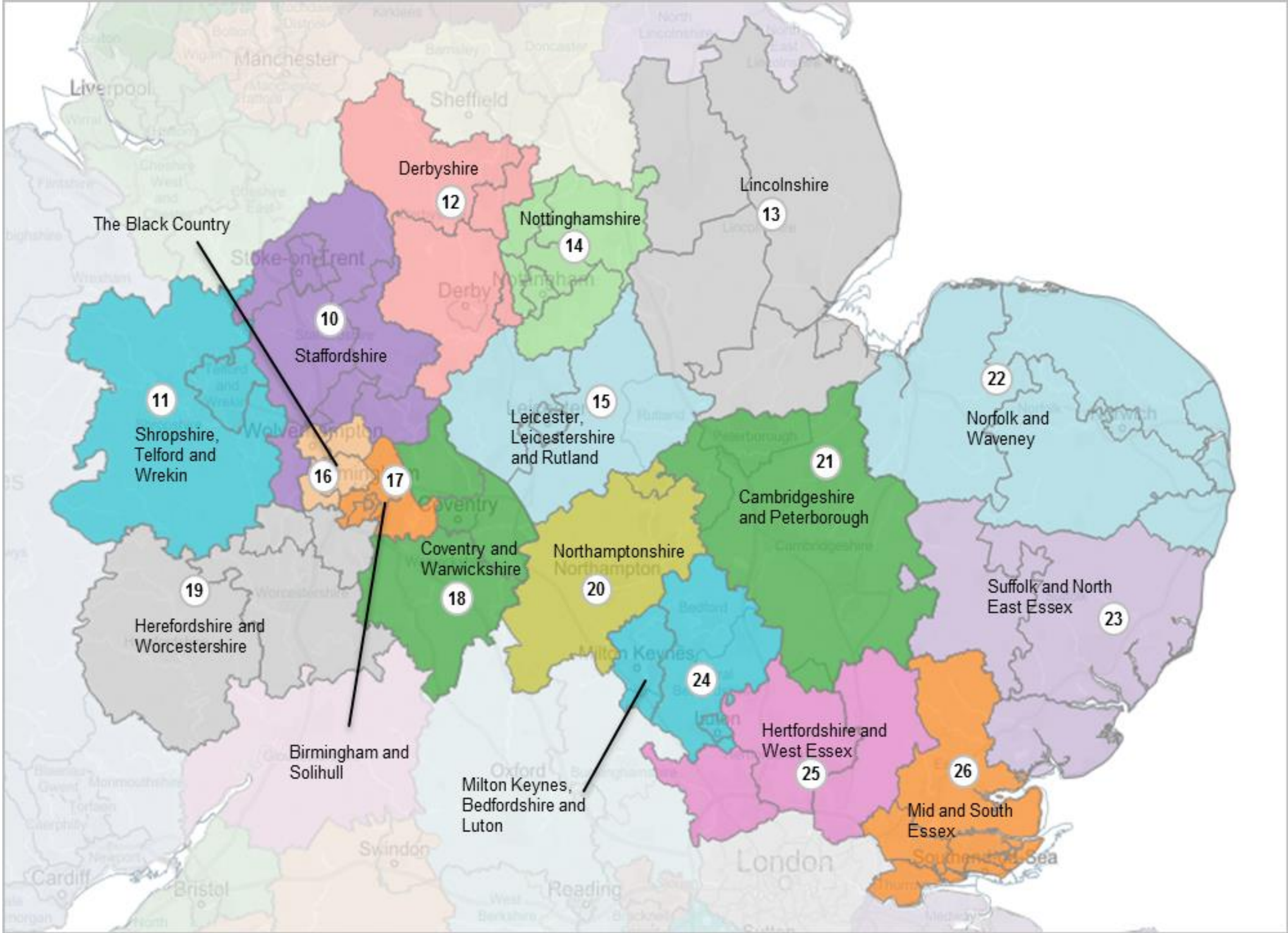
North region - map

Midlands and East region - map



South region – map

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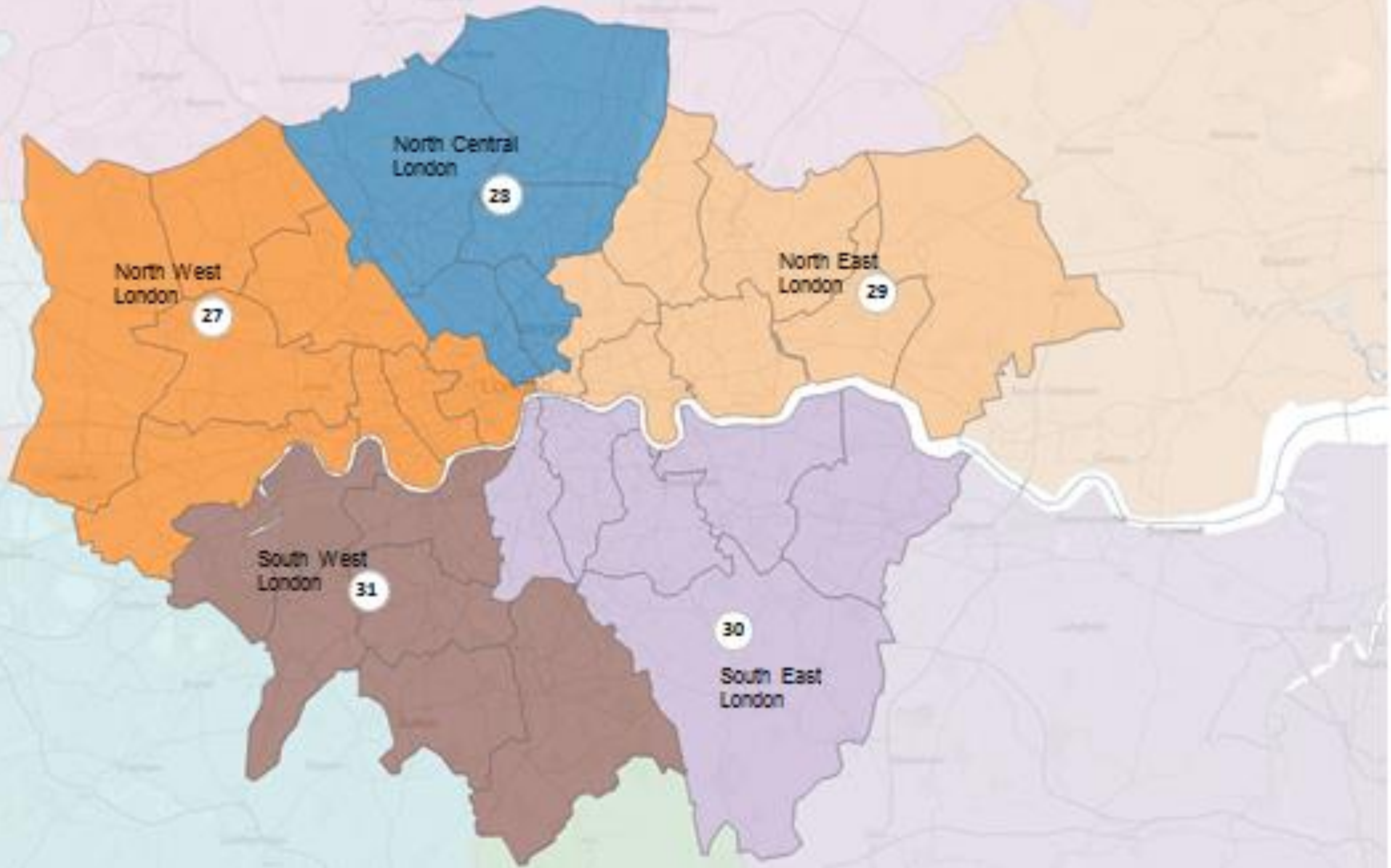
London region – map



Key questions (1)

NHS

How did you agree the footprints?

The NHS Shared Planning Guidance asked each area to develop a proposed STP footprint by January 29 2016, engaging with local authorities and other partners on what this should look like. The footprints were reviewed by the national bodies with regard to geography (including patient flow), scale, fit with footprints of existing change programmes, financial sustainability, and leadership capacity. There were one or two areas where further clarification was sought and following further conversations locally, changes were agreed.

Will the footprints replace other local NHS governance structures?

No – the local, statutory architecture for health and care remains, as do the existing accountabilities for CEOs and AOs. This is about ensuring that organisations are able to work together at scale and across communities to plan for the needs of their population, and ultimately deliver the Five Year Forward View – closing the gaps in quality, health and NHS finances by 2020/21. Organisations are still accountable for their individual organisational plans, which should form part of the first year of their footprint's STP.

How do STP footprints fit with other health and care footprints?

The boundaries used for STPs will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs, with shared links and dependencies. For example, neighbouring STP areas will need to work together when planning specialised or ambulance services or working with multiple local government authorities and, for areas within a proposed devolution footprint that cross STP boundaries, further discussion will be required in working through the implications. Other issues will be best planned at Clinical Commissioning Group (CCG) level.

Key questions (2)

NHS

How will other partners be involved?

STPs will need to be developed with and based upon the needs of local patients and communities and command the support of clinicians, staff and wider partners such as Local Authorities. We simply cannot transform health and health care without the active engagement of the clinicians and staff who actually deliver it, nor can we develop care integrated around the needs of patients and users without understanding what our communities want and without our partners in Local Government. That is why we are asking for robust local plans for genuine engagement as part of the STP process. Where relevant, areas should build on existing engagement through Health and Wellbeing Boards and other existing local arrangements. Nationally, we have established an Oversight Group to provide advice and challenge to the NHS CEO Five Year Forward View Board to help us develop this process.

What does success look like?

If we get this right, together we will engage patients, staff and communities from the start, allowing us to develop services that reflect the needs of patients and improve outcomes by 2020/21, closing all three gaps. We will mobilise energy and enthusiasm around place-based systems of health and care, develop the ownership, relationships and governance necessary to deliver, providing a coherent platform for future investment from the Sustainability and Transformation Fund.

This will require a different type of planning process – one that releases energy and ambition and builds greater trust ownership. It will require the NHS at both local and national level to work in partnership across organisational boundaries and sectors, and will require changes not just in process, but in culture and behaviour. This will not happen overnight, but we will work with local and national partners to provide challenge and support.

Next steps:

NHS

What	When
Publication of agreed footprints, plus further support for STP footprints on how to analyse their local gaps in quality, health and finance	March 2016
Work with footprints on gap analysis	Throughout March 2016
Footprints to make a short submission to national bodies setting out: 1. Governance arrangements (including lead) 2. Emerging priorities for action	15 April 2016
Regional development days for footprint leads	Late April/Early May 2016
Each footprint to submit their STP to the national bodies	30 June 2016
Series of regional conversations between national bodies and footprints	Throughout July 2016

Contacts

We will be contacting partners, stakeholders, people and communities to discuss STP engagement opportunities shortly.

For general enquiries, please contact your relevant Regional Director or england.fiveyearview@nhs.net

REPORT TO THE HEALTH AND WELL BEING BOARD

Date 5th April 2016

Title: Transforming Care
Barnsley's Adult Learning Disability Work Programme

Report Sponsor: Rachel Dickinson
Report Author: Sharon Graham
Received by H&WBB Board: 5/4/2016
Date of Report: 21/03/2016

1. Purpose of Report

To provide the Health and Well-being Board with an overview of the national Transforming Care agenda, the development of the Barnsley, Wakefield, Calderdale and Kirklees Transforming Care Partnership and how this fits with local plans to improve services for people with a learning disability.

To request sign off by the Health and Well-being Board of the Transforming Care Plan and proposed governance arrangements.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to:-

- Note the fundamental work being undertaken to improve care, support and life time outcomes for people with a learning disability in Barnsley
- Note the requirements of NHS England to transform care for those people in in-patient settings or 'at risk of admission' due to periods of mental illness and/or complex, challenging behaviour
- Agree the content of the Transforming Care Plan attached as Appendix A
- Agree the proposed governance arrangements for the delivery of the Transforming Care Plan through the regional Transforming Care Partnership and the Adult Joint Commissioning Group

3. Background

3.1. Transforming Care – Building the Right Support

3.1.1 In 2015 the Department of Health published Building the Right Support, a plan to ensure delivery of the Transforming Care vision of hospitals not being homes for people with a learning disability and to put in place the type of community support required to help get people out of hospital, reduce admissions and minimise the length of stay when hospital is required.

3.1.2 Building the Right Support placed a requirement on commissioners to work collaboratively across regions to deliver fundamental and whole system change

over a 3 year period through the development and delivery of a Transforming Care Plan.

3.1.3 In line with current commissioning arrangements for community learning disability services with South West Yorkshire Partnership Foundation Trust (SWYPFT), Barnsley has established a partnership with Wakefield, Calderdale, and Kirklees.

3.1.4 The partnership consists of representatives from all of the 4 areas including CCG, NHSE and LA Commissioners. As required by NHSE the partnership has one Senior Responsible Officer, the SRO for Barnsley's partnership is the Chief Finance Officer for Kirklees and Greater Huddersfield based on current in patient numbers.

3.1.5 Barnsley's partnership grouping places us in the upper third of bed usage overall however Barnsley's position as an individual CCG area place us just outside of national requirements to commission no more than 15 beds per 1million population. There are currently 6 Barnsley patients in hospital, 3 are identified as 'long stay' 2 are recent admissions and 1 is currently on a discharge pathway from an acute mental health ward.

3.1.6 Transforming Care Partnership's (TCP's) were required to submit the first draft of their Transforming Care Plan to NHS England on the 8th of February. Feedback was given and second drafts were submitted on the 24th of February. Our current plan has been signed off as 'met with support'. This means that the plan is detailed enough to commence delivery on the 1st of April subject to engagement with support sessions around key areas up to this date.

3.1.7 The plan is based on whole system budgets being aligned or pooled. There is an expectation that redesigned systems can be funded within existing resources however transitional funding support of £30 million match funding, plus £15 million capital funding will be made available by NHSE to support implementation plans.

3.1.8 The focus of the plan is on those in hospital and those at risk of admission and need to align with other priorities: Local transformation of Children and Young Peoples' Health and Wellbeing; MH Crisis Care Concordat; Personal health Budgets and integrated personal commissioning; Autism Act statutory guidance; SEND reforms – Education, Health and Care plans.

4. Key Issues and Interdependencies

4.1.1. The national requirement supports the local desire to develop health and social care services for people with a learning disability and those on the autistic spectrum based on the following:

- Clear outcome focussed pathways

- Developed according to specific needs of individuals
- Develop and maximise independence
- Achieve better outcomes and an improved quality of life
- Offer value for money.
- Support people to remain independent for as long as possible
- Support people in their own homes or another community setting, particularly in times of crisis stopping people being admitted unnecessarily to secure hospital beds
- Develop appropriate community services including accommodation to support people stepping down from secure settings or being re-patriated from out of borough placements

The successful delivery of Transforming Care creates a fundamental interdependency between 5 key areas of work being delivered locally, these are summarised below and full details can be found in Appendix B.

4.1.2. **Self Assessment Framework** - annual self assessment to drive local improvements across the health and social care sector. This will ultimately result in people with a learning disability having improved life outcomes and requiring less support from statutory services.

4.1.3. **High Cost Placement Review (LD transformation project phase one)** – ensuring those people in long term accommodation are receiving the right support at the right price and that opportunities for progression to less intensive support settings are maximised.

4.1.4. **Accommodation and Support Project (LD transformation project phase two)** – ensuring that people have choice and control over where they live, who they live with and the support they get to live as independently as possible. This includes developing the market to support those people with complex needs and/or challenging behaviour who otherwise would be at risk of spending long periods of time in institutional care.

4.1.5. **Transforming Care** - placing a requirement on Commissioners to commission appropriate support within the local community to step people down from hospital placements and prevent unnecessary admissions through good crisis response services.

4.1.6. **Transformation Programme** - re-commissioning specialist health services for people with a learning disability to address gaps in intensive and crisis support which results in some individuals being admitted unnecessarily into hospital provision, supporting those people stepping down from locked accommodation to maintain their place within the community and to support those people in out of area placements to be re-patriated.

5. Conclusion

5.1.1 The scope of Barnsley's current programme of work to improve services for people with a learning disability is much wider than the Transforming Care agenda and focusses on the wider population not just those in in-patient

settings. However each workstream contributes to the delivery of Transforming Care and as such will contribute to the delivery of the expected outcomes.

6. Governance and Reporting Arrangements:

6.1.1 There is a requirement for each Transforming Care Plan to have an agreed governance arrangement. A Partnership Board has been formed regionally to oversee delivery of the plan and each local area will determine their own governance process.

6.1.2 The Adult Joint Commissioning Group (AJCG) agreed on 23 February 2016 to oversee the local delivery plan and undertake the role of governing body for the Transforming Care Plan.

6.1.3 The plan is additionally being submitted to the Health and Well-being Board for sign off with a report to be submitted annually describing overall delivery against the plan.

6.1.4 A highlight report will be completed and submitted to the AJCG bi-monthly in relation to the Transforming Care Plan.

6.1.5 The Lead Commissioner will additionally produce a local delivery plan against key workstreams in the plan with update reports to be submitted to the AJCG quarterly as a minimum.

7. Consultation with Stakeholders:

7.1.1 There is a requirement for all Transforming Care Plans to include comprehensive details around how partnerships will consult with stakeholders. A copy of the draft communication and engagement plan is attached as Appendix C.

7.1.2 Service Users and Carers from Barnsley will be invited to contribute to developments through the regional plan.

7.1.3 Additionally Barnsley commissioners will continue to engage with Service Users and Carers around local service developments through the commissioning cycle including co-production of service specifications, involvement in procurement and service reviews.

8. Appendices:

Appendix A – Barnsley/Wakefield/Calderdale and Kirklees Transforming Care Plan

CKWB Plan Draft v5.docx

Appendix B – Barnsley's Learning Disability Work Programme

TC Appendix B.docx

Appendix C – CKWB Transforming Care – Communication and Engagement Plan

TCP LD Engagement Equality and Commun

9. Background Papers:

Building the Right Support – National Plan

Building the right support - national pla

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Contact: 01226 775831 sharongraham@barnsley.gov.uk

Date: 21st March 2016

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NHS
Greater Huddersfield
Clinical Commissioning Group

Calderdale, Wakefield, Kirklees and Barnsley (CKWB)

Transforming Care Partnership Plan

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1. Executive Summary

The Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership has been formed to collaboratively develop a programme that will transform our community infrastructures and reshape services for people with a learning disability and autism. The plan will be framed around Building the Right Support and the National Service Model October 2015 and it will be developed to ensure the needs of the five cohorts below are included as well as the wider population when transforming services.

- A mental health problem, such as severe anxiety, depression or a psychotic illness which may result in them displaying behaviours that challenge
- Self-injurious or aggressive behaviour, not related to severe mental ill-health, some of whom will have a specific neurodevelopmental syndrome with often complex life-long health needs and where there may be an increase likelihood of behaviour that challenges
- 'Risky' behaviour which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour) and which could lead to contact with the criminal justice system
- Lower level health or social care needs and disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system
- A mental health condition or whose behaviour challenges who have been in inpatient care for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed

The CKWB region was rated as the 6th highest for CCG commissioned inpatient beds in July 2015 and although work has been ongoing and the number has reduced, we are still well over the national planning assumptions for inpatient beds. For NHS England commissioned beds, the region was mid table, but following several discharges since July 2015, the numbers are now within the national planning assumptions.

Each area within the partnership had already developed programmes locally to transform services, but it has been acknowledged that the partnership will prove invaluable to harness the collective knowledge and experience to further build on progress already made and to use our resources more effectively and efficiently to gain more momentum in the delivery of new models of care and support for the most complex people.

The key aims for our plan will be:

- **Reduction of inpatient beds, delivering a 60% reduction across the partnership by 2019**

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- **Developing better/new/broader range of specialist community services that are flexible and responsive to manage crisis better and prevent admission**
- **Developing capable communities to enable people to live in their own homes**
- **Developing a better understanding of our local populations with complex needs and how best to support them in a crisis**
- **Ensure people with a learning disability and autism have the opportunity to live meaningful and fulfilled lives**

2. Mobilise communities

2.1 Governance and stakeholder arrangements

2.1.2 Governance arrangements for this transformation programme

There are strong partnerships in place across the CKWB region and these have enabled many of the key partners to be brought together and engage in the development of this plan. NHS and Local Authority commissioners and a wide range of other stakeholders are committed to developing and delivering the new models of care and support for people with learning disabilities with complex needs. This will be achieved working closely with all key partners and people with learning disabilities, their families and advocates and will be provided through more detailed co-produced plans.

The CKWB Transforming Care Partnership Board has been established to oversee the development and delivery of the transformation programme across the region. This Board has endorsed the draft plan and during the next two months the final draft will be completed and formal endorsement will be sought from Health and Wellbeing Boards within the region. Partners represented at the CKWB Transforming Care Board include:

- Kirklees Council
- Calderdale Council
- Wakefield Council
- Barnsley Metropolitan Borough Council
- Calderdale Clinical Commissioning Group
- Greater Huddersfield Commissioning Group
- North Kirklees Clinical Commissioning Group
- Wakefield Clinical Commissioning Group
- Barnsley Clinical Commissioning Group
- Specialist Commissioning Services
- Learning Disability Partnership Boards

Representation is from senior leaders from each organisation who have the authority or lead role to deliver the transformation programme.

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2.1.2 Internal Governance

Transforming Care Plan

Each CCG will also feed the TCP plan into their respective quality and safety groups to ensure the clinical governance is met; these will also go to their Governing Bodies for information.

Local Plans

Each area has currently got its own governance structure for reporting their local plans; these joint groups (listed below) will also be used to feed the TCP plan progress.

Calderdale – Joint Transforming Care Steering Group
Barnsley – Adult Joint Commissioning Group
Wakefield – Connecting Care Executive
Kirklees – Integrated Commissioning Executive

The terms of reference for the Board and further details regarding programme governance are embedded below.

CKWB Board TOR Draft v5.doc

Health and Wellbeing Boards – Dates of next meeting for sign off

Kirklees Health and Wellbeing Board – 31st March 2016
Calderdale Health and Wellbeing Board – 17th March 2016
Wakefield Health and Wellbeing Board – 24th March 2016
Barnsley Health and Wellbeing Board – 5th April 2016

2.1.3 Describe stakeholder engagement arrangements

There have been multiple engagement events across the partnership around learning disability services and although the key stakeholders that have been identified above are actively working on the development of the transformation plan, it is recognised that much wider and targeted engagement needs to happen to develop a fully co-produced transformation plan and one of the key work-streams will be to develop a detailed communications and engagement strategy ensuring input from other stakeholders including:

- People with Learning Disabilities, Carers and their Families, all ages including those with lived experience of secure services
- Patient Reference Groups – Kinfo
- NHS service providers including
    - Primary Care
    - Community Services

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  - Acute Care
  - Specialist learning disability service providers
- Voluntary and Community Sector
- Public Health
- Criminal Justice System
- Private Providers
- Health Education England

2.1.4 Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

There have been numerous engagement events across the four areas in the TCP over the last three years which have focused on building better services in the community, including enhanced community team pathways with 24/7 coverage, accommodation, provider frameworks for community provision and crisis services. South West Yorkshire Partnership Foundation Trust has also delivered several engagement events around their transformation for LD community and inpatient services that covered the TCP region.

2.2 Engagement with Children and Young People

There has been lots of engagement across the TCP following on from the Future in Mind Report with children, young people and their families and carers. The feedback from this engagement has helped develop a 5 year strategy to improve access to services, developing new and innovative ways to meet mental health and learning disability needs whilst building up resilience in children, young people and their families in their schools and wider communities to improve outcomes.

Significant consultation and engagement has also taken place with children, young people and their families specifically in relation to services for ASD / ADHD and LD. The purpose of the consultation was to develop a new pathway for accessing services and improve engagement, and develop a more integrated delivery model for these services. A transformation group has been working together for two years, including practitioners and parent reps, developing and consulting on the pathway and changes to the services. There have been numerous engagement events with children, young people and their families and carers which has further helped shape the proposals, and update on progress to date. This work is continuing currently

Following engagement, recovery plans have been developed for the ASD / ADHD pathway which are being redesigned to reduce waits, and increase capacity for undertaking assessments. The referral process has also been reviewed in line with the local transformation plan. This includes referrals direct from universal and early help services to improve information and develop a more multi-disciplinary offer. The pathway development also includes a non-clinical offer with the Educational

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Psychology team within the Local Authorities SEND service undertaking assessments.

The SEND Service have worked with the Community Paediatric service to develop an early intervention offer, and package of support for ASD / ADHD / LD which aligns with the new pathway being developed, and fits in the recommendations in the transformation plan.

The developments for LD and ASD align with the transformation to develop an early response and support for children and young people, and will support a reduction in in-patient services and minimise the impact of pre-admission CTR (care and treatment review).

The consultation undertaken for Future in Mind is listed below.

- Education and Schools partnership group
- Third Sector partner engagement
- Listen to ME(ntal Health)
- Young Healthwatch Mental Health Forum
- Risk-taking Behaviours
- School Counselling Support
- New Technologies / Social Media
- Support for LGBT young people (Lesbian, Gay, Bisexual and Transgender)
- Emotional support for younger people
- Transition in to adult services
- Access to services through the hubs
- CAMHS Friends and Family Questionnaires
- Perinatal Mental Health user survey

The common themes from engagement whether that be from the learning disability transformation programmes, the care closer to home programmes or the future in mind transformation are the same, people want to be empowered and to have more control. This plan is about enabling people to be more resilient, providing them with the skills and tools and developing a robust community infrastructure that will be flexible and able to deliver high quality services as and when people need them.

2.3 Feedback from Engagement Events

- Easy access to services and information that is easy to understand
- Care closer to home, but do not want homes turned into hospitals
- Bespoke housing- right housing/environment for the individual
- Personalisation needs to include people with challenging behaviours
- Families should be recognised as being part of the workforce, could support be provided in the family home whilst Mum and Dad take a break elsewhere?

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- Training does not just have to happen in a ‘room’. Sometimes it’s about sharing information and good ways of doing things
- Using people’s communication plans and person centred plans helps us understand what they want. It helps us make sure the Mental Capacity Act is being used affectively
- We need to get the voice of families in the JSNA
- We need to make sure people who are away from home get access to advocacy
- We need to make sure that people are not isolated. People need those who love them in their lives and support should be given to visit family and friends
- We need to invest in prevention to prevent families breaking down
- Having access to the internet
- Accessible leisure activities e.g. swimming, football, drama group and other groups are important to our wellbeing and support to be able to do these
- LD champions who work in general hospitals to ensure the nursing staff understand our needs
- Keep our Activity centre, and have more groups.
- Reasonable adjustments should be included within all health and social care contracts
- Very important to have efficient caring help. Priorities for carers; plenty of help and more facilities for good respite care
- Supporting people who use services is critical to maintaining their care / wellbeing
- Independent support such as advocacy is highly valued by users and carers
- People also find support in other ways such as community groups, voluntary organisations, friends and social groups
- Social connections and a sense of belonging is important to wellbeing and coping
- Staff can be caring and compassionate, basing their care around the person’s needs as much as they can in the restrictions that they work in
- Hospital / bed based care does work for some people; it is often very much like a house or flat not like a ward – it is home for some people and should be recognised
- Visits to doctors are helped if the doctor or nurse knows the individual and their history and has time to listen carefully, it is important that if referring to hospital the right information is passed on
- Local register needs to include all people with challenging behaviour
- Still too many people in high cost placements out of district
- Access to Mental Health Services is sometimes difficult
- Barriers to accessing universal services within the community
- Short breaks tend to be building based

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- Too much investment in specialist services and high cost placements without understanding the quality of these placements
- Not all GP practices offer health checks
- Lack of hydrotherapy services – time limited/cost
- Landlord / housing issues – not responding to repairs quickly, chasing up responses from housing
- Withdrawal of service bus and general bus services reducing
- The negative impression of hospitals that have been given since winterbourne, and other hospital scandals
- More supported work placements/job opportunities - We do not want to just walk round shopping centres all day
- Speech and Language Therapy and support in school, needs resourcing
- There needs to be raised awareness at all levels of learning disability and autism
- More communication is needed with the people who use services, their families and carers. This needs to be ongoing genuine consultation resulting in recommendations that are acted upon and resourced
- We need more learning disability and autism champions – on the Clinical Commissioning Group Board, in general practice, at the council and other providers of health and care services
- Not getting diagnosed early enough - underlying conditions or co-morbidities not being addressed in a holistic way
- Confusion of where to go for services/help and understanding what is available - no single point of access
- Transitions are problematic (children's services to adults, hospitals to community, from one provider or funder to another)
- Too much focus on risk and not enough thought given to independence
- Lack of understanding of MHA / Consent, some people noted that Sections are being used or managed inappropriately
- Not enough independent / advocacy support to help explain and challenge restrictions / out of area decisions that take the person far away from family
- Professional workloads / processes are not well designed to meet needs for this group – e.g. GP appointments too short, LD Community teams have too broad a remit, support workers are isolated/ low wage based, specialist providers are few
- Care plans are often not complete or up to date or well followed; reviews are often infrequent or not robust; health action plans in primary care not being used
- There is a lack of networking across the system to wrap care around people – reports of arguments between agencies and refusals to accept cases e.g. Autism

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- When communications are poor, people with learning disabilities feel they are not listened to and not understood – their views are not taken into account and changes in care are being made 'to them'
- Professionals noted the lack of integration in systems, partnerships and funding leading to delayed decisions, particularly in relation to judicial requirements: 'people are getting stuck in the system'

2.4 Describe the Health and Care Economy covered by the plan

There are various providers including NHS providers, private sector and the voluntary sector that are providing services across the region and most are under single commissioner contracts, either block, frameworks or spot purchased. There is a mix across the TCP where some joint commissioning between local authorities and CCGs and pooled budgets are in place but not with all. The partnership is committed to further exploring ways of joint commissioning, pooled budgets and alternative ways of commissioning to support the delivery of the transformation plan.

The current model of provision albeit slightly different in each area is generally the 'traditional' model that is dependent on care home provision and 24/7 supported living services. It is recognised there is a need to develop new bespoke models of provision to be able to care and support people with learning disabilities and/or autism with behaviour that challenges.

The arrangements below are for **all ages** including children and young people

2.5 Current Commissioning Arrangements

Clinical Commissioning Groups – A range of local commissioning arrangements exist across each area but are not all consistent across the partnership:

- Personal health budgets are offered to enable personal choice and flexibility, this allows people to purchase their own support Block contracts are in place for community services from SWYPFT
- Block contracts are in place for some A&T beds and some are purchased on a spot purchase basis
- Spot contracts are in place for all inpatient rehabilitation beds
- Block and spot contracts are in place for respite services and day care services
- A mixture of Frameworks, spot and block contracts are in place for residential/nursing placements

Local Authorities – A range of local commissioning arrangements exist within each authority, but are not all consistent across the partnership:

- All local authorities offer personal budgets, enabling individual to choose a managed budget, a direct payment or a mixture of the two. A range of support

services are offered to people who chose a direct payment to help them identify and secure the support they need and to help manage the direct payment. In most authorities such options are supported by approved provider lists or a system for accrediting providers. Many of these are now featuring joint care and health budget elements.

- Regarding provision of supported living services, accommodation and day care, most authorities have a Framework Agreements or Approved Provider mechanism in place covering provisions for different levels or types of need.
- Provision of highly specialised services or tailored individual packages may involve traditional tenders outside of those arrangements if they do not fall under the supported living framework agreement.
- The community support and supported living framework agreement, offers 3 levels of funding for specialist social care funded services, that enables individual bespoke packages of social care provision to be commissioned.
- For respite provisions, authorities use a mixture of block and spot purchase contracts within traditional building based services and also provide personalised respite provisions via direct payments that focus on individual outcomes.
- Residential care is usually on a block or spot-contract basis, but mainly spot as personalisation has meant a shift in commissioning block residential care

NHS England Specialised Commissioning – Services such as Child and Adolescent Mental Health services (CAMHs) and Adults are commissioned for patients from England. These services meet the four factors for specialised services as described in the prescribed services manual. (NHSCB 2013).The services are commissioned and contracted for using the NHS standard contract. Services are contracted on a block basis with an all-inclusive price. Currency for payment is usually by occupied bed day for impatient services and by activity for community services. CQUIN schemes are in place for all services and monthly contract monitoring meetings are held to manage performance against the contract.

2.6 Provider geography, natural alignments and collaborative arrangements

The partnership is committed to further exploring ways of joint commissioning, pooled budgets and alternative ways of commissioning to support the delivery of the transformation plan and there is one key area where this is already happening.

South West Yorkshire Partnership Foundation Trust currently provides the specialist community service and some of the assessment and treatment beds across the TCP. The partnership is already working on a joint service specification for the community services including the new enhanced community service and discussions

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are taking place for most of the CCGs to commission the inpatient assessment and treatment beds.

It is recognised there are benefits from further joint working with providers and this will be incorporated within the overall plan for further scoping to identify key areas where changes can be made at provider level. Especially where care providers are present across all four partner regions.

2.7 System and market engagement

There are several provider forums across the partnership, which bring a range of social care, health care, private and voluntary sector providers together to share best practice, work in partnership to address key issues and challenges, make clear local priorities/need and give clear strategic messages on market development. This needs to be further developed to bring this together across the partnership and mechanisms put in place to ensure a strong collaborative approach to deliver the system wide changes.

2.8 Geographical boundaries and organisational considerations

There is a natural grouping across our TCP as we all commission from the same partnership trust for specialist learning disability services. However there are considerations to be taken into account when further developing the plan including:

- Local variation in the need for market transformation
- Geography and deprivation
- Extremes of inpatient numbers
- Determining ordinary residence
  - Our TCP has 36 secure beds and this can be an issue when stepping people down due to ordinary residence rules
- People from out of area currently in our transformation area or people from our transformation area placed 'out of area'
  - Our TCP is a net importer for residential placements and London is one of the main areas who export into our area
  - Our TCP is an exporter for college placements are there are not enough locally
  - Prison population high in Wakefield
- Commissioning of specialised services
- Different pathways
- Transition from children to adult services
- Data and information sharing across transformation region
- Contracts
- Vanguards and Integrated Care Pilots

One of the key actions on our route map is to undertake an in-depth review of our current baseline considering all the above factors.

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3. Understanding the status quo

3.1

Baseline estimates - LD				
Age Band	**2015**	**2020**	**2025**	**2030**
18-24	2788	2586	2541	2781
25-34	3839	3994	3977	3772
35-44	3757	3709	3960	4122
45-54	4157	4042	3638	3608
55-64	3289	3634	3901	3774
65-74	2637	2823	2829	3152
75-84	1374	1575	1942	1571
85 and over	498	590	729	914
Total	**22339**	**22953**	**23517**	**23694**

Information has been gathered from various sources and analysed to provide a baseline assessment of needs and services. This has included the Learning Disability Self-Assessment Framework, Joint Strategic Needs Assessment's, Joint Health & Wellbeing Strategies, Transforming Care Data, Projecting Adult Needs & Service Information System, Projecting Older People Population Information System, Future in Mind Strategy and internal databases.

3.1.1 Population and Demographics

Area	Total population	Adult population	LD/Autism Population	LD/Autism known to services
North Kirklees/Greater Hudds	423,000	335,826	7,912	1,530
Calderdale	203,000	169,798	3,827	672
Wakefield	332,000	287,379	6,180	1,374
Barnsley	231,200	199,749	4,420	1,106
Total	**1,189,200**	**992,752**	**22,339**	**4,682**

3.1.2 Analysis of inpatient usage by people from Transforming Care Partnership

The national plan 'Building the Right Support' published on 30th October 2015 sets out a planning assumption that each TCP will reduce reliance on inpatient care, and where they are currently above this level, will plan to reach an inpatient rate within the range 20-25 inpatients per million population for NHS England commissioned services and 10-15 inpatients per million for CCG commissioned services by March 2019. The CKWB partnership has a population of approx. £1.2 million and is basing the plans on the following

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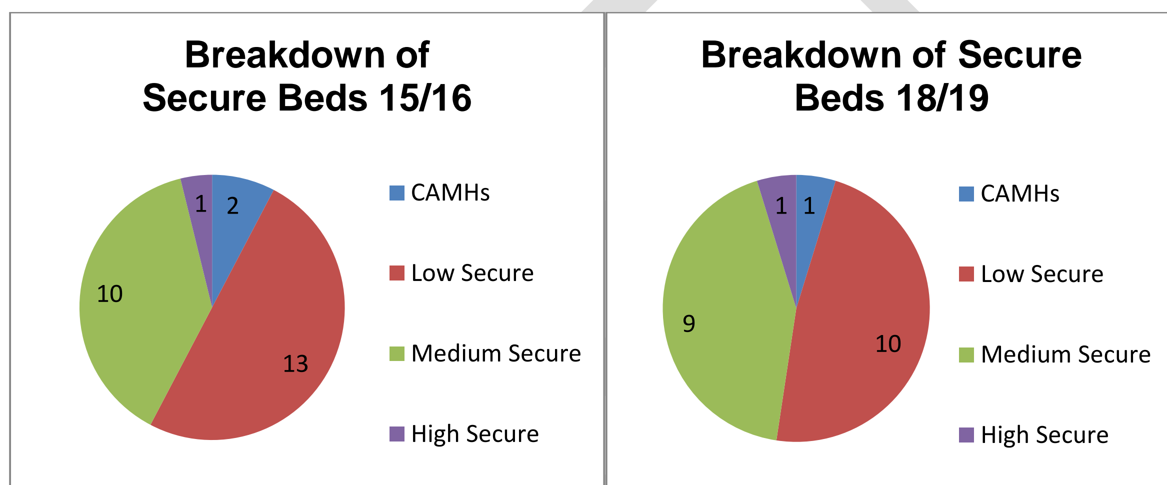
NHS England commissioned - 30 inpatient beds

CCG Commissioned - 18 inpatient beds

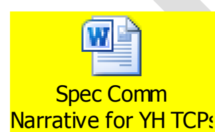
3.2 NHS England Commissioned Services

There are currently 26 people in secure services and the breakdown of type of bed is shown below. This number is already within the 20-25 planning assumption range, however work is ongoing to reduce these numbers and it is forecast that this will be 21 in 18/19 which will be lower than the planning assumptions.

Secure Beds	Actual 15/16	Forecast 18/19
Adults	24	20
Children	2	1
Total	26	21



Attached is NHS Specialised Commissioning narrative to support this plan



3.3 Clinical Commissioning Group Commissioned Services

There are currently 38 people in inpatient beds, this is more than double the national planning assumption level, however by the end of year 1 this will have reduced by 45% and by the end of year 2 we will have achieved better than the levels suggested of 18 inpatient beds across the partnership. It is worth noting that although the numbers are quite high for year 0, there as only been 4 people out of the 38 that have been in longer than five years. See below table for forecast in reduction of beds over the next three years.

3.3.1 Numbers and Projections for CCG Commissioned Inpatient Beds

Year	Year 0 (2015/16)	Year 1 (2016/17)				Year 2 (2017/18)				Year 3 (2018/19)			
Period	31/03/16	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CCG Inpatient Beds	38	31	28	26	21	16	16	16	15	14	14	14	14

3.3.2 Annual spend of inpatient beds commissioned by the CCG's and NHS England Specialist Services

	Annual cost (£) 2015/16	Annual cost (£) 2016/17	Annual cost (£) 2017/18	Annual cost (£) 2018/19
CCG commissioned patients	£6,365,346	£4,529,910	£2,844,699	£2,532,525
NHS England Specialised Commissioned patients	£5,980,476	£5,370,223	£5,004,406	£4,760,305
Total	**£12,345,822**	**£9,900,133**	**£7,849,105**	**£7,292,830**
Cumulative Reduction in spend		**£2,445,689**	**£4,496,717**	**£5,052,992**

The current spend is in excess of £12m and the planned reduction of spend in inpatient beds is over £5m with the largest reduction coming from CCG commissioned beds which will be used to reinvest into community provision.

3.4 Describe the current system Current Services and Provision

3.4.1 Learning Disability Community Teams

All 5 CCGs commission their local specialist learning disability service from South West Yorkshire Foundation Partnership Trust at an annual cost of approx. £7.7m. In some of the areas Social Workers and Community Nurses work together as part of the integrated Community Teams for Learning Disabilities (CTLDs) which is managed by the Local Authorities, but this is not consistent across the TCP as some have moved away from this approach.

3.4.2 Assessment and Treatment Units

SWYPFT provide assessment and treatment beds across two units. Fox View has 4 beds and is in Kirklees and Horizon is an 8 bedded unit and is in Wakefield. Assessment and Treatment beds are currently block commissioned by three of the CCGs and these services include a number of therapies including psychology. Of the other two CCGs, one commissions a block bed from another trust and the other CCG commissions from the private sector on a spot purchase.

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3.4.3 Inpatient Rehabilitation

All inpatient rehabilitation beds are spot purchased by all CCGs from private providers who all offer a similar service.

These placements are mainly out of area of the TCP, see table below showing current position.

Provider	Total of Beds either commission or used	No of beds in TCP area	No of beds out of TCP area
Priory Group	5	5	0
Cambian Healthcare	15	2	13
Lighthouse Group	5	0	5
Other Provider	4	2	2
Turning Point	1	0	1
St Georges Healthcare	2	0	2
Total	**32**	**9**	**23**

3.4.4 Respite and Short Break Services

Across the TCP there are different respite services and short break services commissioned by both health and social care including joint commissioned services. Demand continues to grow for these services.

A recent trend since the introduction of personal budgets has seen a steady increase in the number of people taking a direct payment as an alternative to traditional, building-based short break services. A direct payment/PHB can be used to create an individually designed person centred short break, possibly visiting a place of interest, friends or extended family, staying in ordinary accommodation with a personal assistant or paid carer. This more personalised creative approach still gives carers a break from caring but also enables the cared for person to have a new life experience.

We expect to see continued demand for short breaks services grow, but expect more people to take up direct payments/PHB to purchase an individually designed short break. We also expect individuals to join together personal budgets to collectively purchase short break services with friends.

3.4.5 Residential/Care Home

Learning disability care home provision for individuals with challenging behaviour and complex health needs represent a significant cost pressure within the overall care home provision expenditure. The TCP all commission care home provision via spot purchasing arrangements to promote user choice. The local authorities all work

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in partnership with its independent sector market and has developed 'fair rates for care' where the Council is statutorily required to implement 'usual rates' in an attempt to balance local market conditions, the strategic aim to promote and support independence, organisational pressures and to provide reasonable levels of stability and sustainability within the local care home market. The Council has an approach of working with providers to raise standards of care through its contract monitoring and annual review processes and provider forum mechanisms. Each area within the TCP has an accommodation strategy in place which clearly states the intentions to reduce the use of care home provision and develop supported living.

3.4.6 Supported living

There are various levels of supported living across the regions and this is one of the largest provision currently commissioned by all areas.

Intensive care and support provided on a 24 hour- 7 days a week basis (where the Council typically commissions both the care and support service plus the accommodation)

Support and enablement services for people with lower levels of need who have their own living arrangements in place (e.g. living with parents etc.).

3.4.7 Support and Enablement/Care at Home

There are many packages of support offered in a person's home across the area, this is also significant spend for all areas.

3.4.8 Day Care

There are several day care facilities commissioned by both local authorities and CCGs across the TCP, these range from dealing with low to high complex people with a learning disability.

3.4.9 Other services commissioned include the following

- Shared Lives
- Advocacy Services
- Transport Services
- Housing Related Support
- Information and Advice Support

Current spend on LD Services

Provision	Annual cost to CCG(s) in 15/16 (£)	Annual cost to local govt in 15/16 (£)	Total
Community Teams	£7,646,832	£3,242,000	£10,888,832

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Other Community teams	£62,002	£0	£62,002
Day Care Facilities	£1,601,353	£9,704,025	£11,305,378
Domiciliary/Home Care	£3,486,537	£1,252,310	£4,738,847
Educational Establishment	£525,562	£0	£525,562
Care Home	£16,639,562	£26,606,000	£43,245,562
Respite Services	£954,182	£1,107,621	£2,061,803
Shared Lives	£137,952	£1,067,000	£1,204,952
Supported Living	£2,827,027	£31,303,183	£34,130,210
Short Breaks Service	£0	£570,000	£570,000
Housing Support	£0	£0	£0
College Transport	£0	£221,860	£221,860
Support/Advice Services	£28,500	£651,500	£680,000
Other Costs requires further breakdown	£9,801,216	£18,810,000	£28,611,216
Total	**£43,710,725**	**£94,535,499**	**£138,246,224**

3.5 How does the current system perform against current national outcomes?

3.5.1 Inpatient Bed Commissioned v National Planning Assumptions

When Building the Right Support was published, the CKWB partnership was ranked 6th in the country for the highest number of inpatient beds commissioned by the CCG by population. Since this data was taken based on July 2015, we have already reduced our inpatient beds by 6, with a further 7 by the end of quarter 1 in 16/17. The current position of secure beds commissioned is already aligned to the upper planning assumption.

3.5.2 Adult Social Care Outcomes

The two key measurements which relate to people with a learning disability on the Adult Social Care Outcomes Framework (ASCOF) are shown below. The performance for the CKWB Partnership for both outcomes, are equal to or greater than the England average, and both outcomes are greater than the average for Yorkshire and Humber region.

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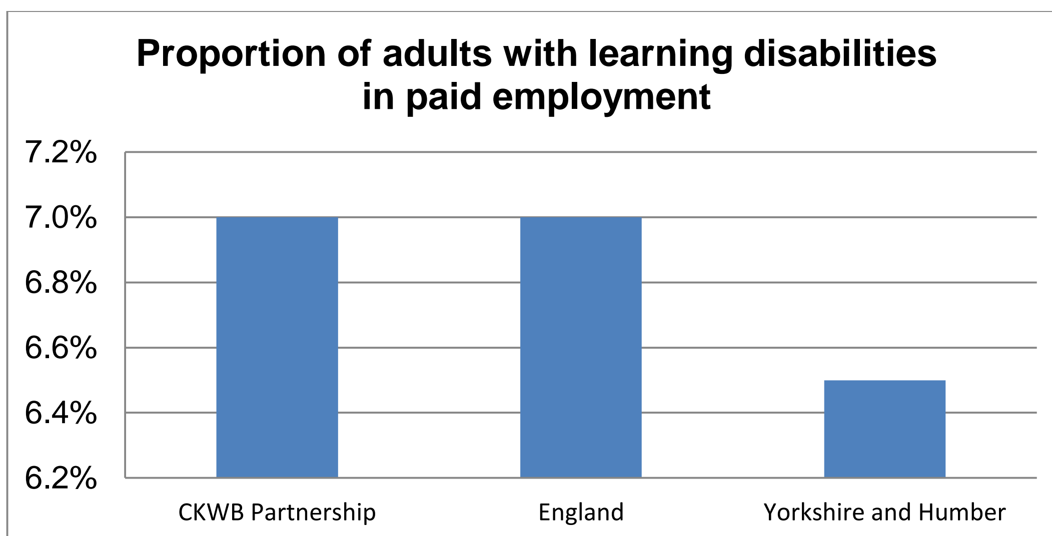

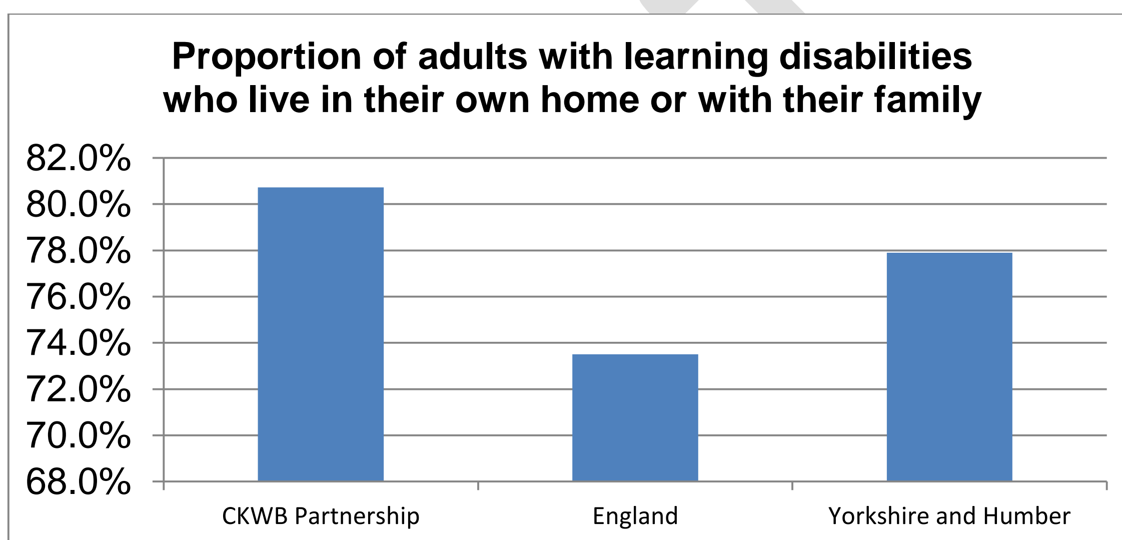

3.5.3 What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

Each of the partner areas has a range of accommodation provision through, in house, independent and voluntary sector provision locally. Wakefield for example has over 60 supported living establishments for individuals and up to 12 people living together and Calderdale has a 12 bed short stay, emergency and respite provision. This estate is reviewed locally on an ongoing basis for its quality, usage and relevance to the overall need of the LD population.

There will be a full consolidated review of the estates for all areas included in the TCP and a full update will be provided in the next plan.

3.6 What is the case for change?

3.6.1 Challenges within the current care model

- Lack of specialist enhanced or crisis support teams over 7 days per week that support parents and care providers in the individual's home

- No step up ‘safe places’ for people to go when a crisis occurs, the default is an inpatient bed
- Lack of a preventative approach to people in crisis and clarity about action/support needed.
- Lack of support/training for carers to manage family members with complex needs behaviours that challenge
- Lack of understand of numbers ‘at Risk’ potential to need crisis support to prevent admission
- Not enough robust specialist respite provision
- Lack of highly skilled providers across the area to manage challenging people in a community setting
- Availability of specialist designed suitable premises for people with behaviours that challenge/autism
- Lack of positive risk taking across the board
- Lack of partnership working in the wider community to assist in safe discharge of people with history of offending behaviours
- Lack of good information systems and sharing data, forward planning
- A lack of robust outcome measures (possibly a knock-on effect from poor information systems) means that progress had been hard to measure and is a key element that needs to change
- The length of time required to develop sustainable community-based alternatives to admission. Particularly housing, architectural based solutions
- A lack of systems/capability to identify people at risk of poor outcomes/ potential admission
- Commissioning for specialised services is done on a system wide basis rather than sub regional basis.
- We have no control over admissions directed by the courts.
- The need to change the culture across the board/re-shape the current market provision, by giving clear messages
- The health and social care system faces unprecedented funding pressures and significant future challenges. More focus on individual outcomes and value for money
- Although direct payments are well established, there is still a lot of work to fully roll out and implement personal health budgets further

3.6.2 How can the current model of care be improved?

Due to the challenges within the current system, we must transform to increase the efficiency and quality of our local services which requires new thinking and radical changes across the system. Our services need to be organised and aligned to deliver high quality and evidenced based care. We need to ensure we have the right people delivering the right service in the right setting at the right time. We need to develop a clear understanding of the type and volume of specialist service required now and in the future.

- Person centred planning ensuring choice and control is the key to all service provision and planning

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- Promotion of personalised budgets to provide more control to people, better planning and co-production
- Together with our partners we need to make sure the needs of people with learning disabilities are fully met with timely and appropriate care that is planned, proactive and coordinated and evidenced based
- Systematic early identification and intervention and detailed complex needs prevention planning
- Effective Prevention from a young age, especially as young people prepare for adulthood, addressing or reducing the impact of challenging behaviours Helping people to stay out of trouble and supporting people who enter the Criminal Justice System
- Development of and retention of a consistently highly skilled, confident and value driven workforce
- Create and support capable communities ensuring families and carers are trained and supported utilising organisations such as Kinfo to deliver specific training around learning disabilities
- Clear and concise service specifications to ensure providers are clear of their roles and responsibilities and better contract monitoring , with a focus on developing outcome specifications
- Clear criteria around the threshold for admission into an inpatient bed
- Further development of the CTR process to improve the process from pre-admission to discharge along the pathway
- Standardised performance measures for all providers to allow regular reporting of performance and activity
- Agree a set of minimum outcome measures to allow benchmarking and tracking of performance, (NDTi Community Inclusion Web, Triangle - Outcome Star)

4. Develop your vision for the future

4.1 Vision, strategy and outcomes

Our vision is to radically change the parts of the system that are not working well and become an area of best practice in which each locality is able to meet the needs of its complex needs population locally in all but the most complex cases. We will do this by building upon what we know works well and identifying gaps in service and areas for improvement. We will then invest in a model of care and support that meets the needs of the LD population now and in the future. It is worth noting that we are already doing well at managing people in their own homes and exceed the national average by 7% and we will build on this to ensure the five cohorts can also be managed in their own homes. We will work collaboratively and innovatively to look at the way we commission and deliver future care and services. We will ensure that the change is system wide and encompasses the cultural shift that is required to succeed.

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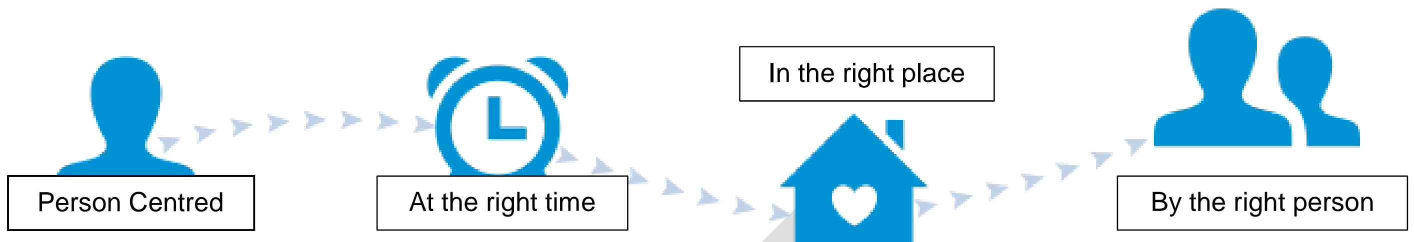
The core strategy will be to develop capable communities, a highly skilled workforce and more quality accommodation options across the pathway, with a clear focus on personalised care at the right time in the right place by the right person. It will be aligned to our care closer to home strategy which encompasses the wider determinants of health and social care, enabling people to be independent, living in their own homes and communities with access to all services when required.



4.1.1 Describe your aspirations for 2018/19

The partnership will work together to achieve positive outcomes for people with a learning disability, ensuring they have the same choices and control to have a meaningful and fulfilling life. We will support individuals to use mainstream services and participate in their local communities whenever possible and when problems arise, people will be supported by specialist services and facilities to prevent crisis, and if a crisis situation does occur it will be managed well.

As a result of the changes covered in this plan we will ensure:

- Good quality learning disability services delivered by highly skilled staff will have an approach based on strong community support services, planned around people in the environment that they are in, focussing on person-centred care, and looking at each individual's needs and where appropriate the family needs. This approach should be applied to all, including people with very complex needs.
- People with a learning disability and/or autism, including people with complex and challenging behaviour will sometimes have physical or mental health problems and will be supported to access mainstream health services whenever possible that will make reasonable adjustments to the provision of their care.
- More people with learning disability and/or autism will be supported to live in the community / in their own at home and when people display challenging behaviours, the appropriate support will ensure that they will be kept safe within their communities wherever possible
- We will become centres for excellence in supporting people with learning disabilities and/or autism in the community. We will develop and apply best practice and evidence based interventions to ensure we facilitate the most successful outcomes for people.

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- We will ensure that population data is kept up to date and use this to better understand the needs of our population ensuring flexible and intelligent commissioning practices that make the right services available and at the right time.
- All generic health and social care services will be encouraged to extend the range and provision Learning Disability / Autism champions to improve the care experience.
- There should be provision for those people who have low level needs, who may not currently meet the criteria for services, through appropriately accessible local prevention and wellbeing services.
- We will build community capacity to encourage co-production based choice and control. Where they need more specialist support, including specialist support arising from complex and challenging behaviour they will have access to skilled support staff and where necessary the support of specialist professionals to assist assessment and help plan more effective support.
- The service will be committed to achieving the outcomes of ‘rights, inclusion, independence and choice’, and to ensuring that it ‘sticks with’ individuals in spite of the difficulties experienced in meeting their needs.
- Services should ensure that those with learning disabilities and their carer’s are able to access the right level of information, advice and advocacy support.
- Carers should be provided with support in accordance with the national Carers Strategy and the Care Act, and services should ensure that appropriate attention is given to meeting the needs of older carers and people with learning disabilities and/or autism who are carers themselves.
- A named single point of contact who will lead on co-ordinating all professionals involved in support the individual

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4.2 How will we know if we have succeeded?

There are a number of different tools and frameworks that are being used or developed to measure outcomes and the TCP will be including this as a key action within the plan to review what is available and align this to the overall outcomes that this plan is working towards.

When all the national measurements have been published from NHS England, we will identify any gaps that we feel needs to be captured from an outcomes perspective to ensure we are not duplicating work by using many different methods. This is about streamlining the process to implement a framework that everyone can use across the system that is easy to use, whilst providing meaningful information.

4.2.1 Improved quality of care

- I get the right treatment and medication to keep me well

- I am cared for by people who are well supported
- I get the additional support I need in the most appropriate setting
- I get good quality general healthcare
- I have regular care reviews to assess if I should be moving on
- I am involved in decisions about my care

4.2.2 Improved quality of life

- I am safe
- I am supported to live safely and take an activity part within the local community
- I have a choice about living near to my family and friends
- I am protected from avoidable harm, but also have my own freedom to take risks
- I am treated with compassion, dignity and respect
- I am supported to make choices in my daily life
- I am helped to keep in touch with my family and friends

4.2.3 Reduced reliance on inpatient services

- Reduction in inpatient services
- Reduction in secure inpatient beds
- Reduced length of stay
- Delayed discharges will be minimised

4.3 How will improvement against each of these domains be measured?

Our SMART objectives are:

4.3.1 Improved quality of care

- Quality review of care plans via contract monitoring
- Use of quality initiatives such as 'quality checkers' using the experience of people who use services.
- Service user / Carer feedback
- Increased % of people with health checks and health action plans
- Increased uptake of screening and immunisation
- Improved management of long term conditions e.g. diabetes
- Improvement in health lifestyle indicators e.g. smoking, BMI etc.
- Reduced A&E attendances
- Reduced avoidable emergency admissions

4.3.2 Improved quality of life

- Reduction in avoidable and premature deaths
- Reduction of unplanned respite
- Reduction of placement breakdowns
- Number and % of people in their own homes

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- Number and % of people in settled and secure accommodation of their choice
- Number and % of adults in employment

4.3.3 Reduced reliance on inpatient services

- Reduction in inpatient services by 50%
- Reduction in secure inpatient beds by 10% bringing the number lower than then national expectation
- Reduced length of stay
- Delayed discharges will be minimised
- Any hospital stays will be closer to the individual's home and support networks

5. Implementation planning

5.1 Proposed service changes

5.1.1 Overview of your new model of care

The proposed model will be based on the principles described in the national service model and will be developed across the life span taking into consideration the changing needs and requirements of people with learning disabilities.

5.2 Key themes for implementing the Transformation Programme:

- Choice and control at the heart of all service provision and planning
- Systematic Early Identification and Intervention
- Planned, proactive and coordinated care in the community
- Effective Prevention and Management of Crisis
- Helping people to stay out of trouble and supporting people who enter the Criminal Justice System
- A Consistently Highly skilled, confident and value driven workforce
- Equitable service provision and high quality evidence based care in the

5.3 What existing services will change or operate in a different way

5.3.1 Community Service Model – Enhanced Pathway

Across the TCP we are working jointly with SWYPFT to develop a more robust community service including an enhanced pathway in line with the national service model. A new service specification has been designed and is currently under review with all organisations for sign off. This service specification encompasses the principles within the national service model and the aims and objectives are below:

- Ensure people with a learning disability are included as equal citizens, with equal rights of access to equally effective treatment enabling a purposeful and fulfilling life

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- Provide a robust Care coordination framework (CPA) with an underpinning principle to provide a single integrated health and social care process to deliver continuity of care
- Implement Person-Centred Practice and individual service design including the following principles:
    - Prevention and early intervention
    - A whole systems life course approach
    - Family carer and stakeholder partnerships
    - Behaviour that challenges is reduced by better meeting needs and increasing quality of life support for communication
    - Physical health support
    - Mental health support
    - Function based holistic assessment
    - Support for additional needs
    - Positive behavioural support
    - Safeguarding and advocacy
    - Specialist local services
    - Workforce development
    - Monitoring quality
- Ensure care and support is proactive, planned and coordinated and the individuals and families have more choice and control over what this looks like
- Ensure better and quicker identification and treatment of mental health problems within the learning disability or autism community
- Ensure that any hospital admission needed is as short as possible, part of the integrated pathway and in a local generic mental health or specialist inpatient service
- Ensure individuals are resettled in the community with a highly personalised health, care and housing package put in place through careful planning with the individual, their family and independent advocate
- Ensure personal health budgets are promoted and offered where appropriate and the required support to be provided to individuals and their families to manage this
- Development and implementation of a risk register to ensure early intervention and to prevent unnecessary admissions

5.4 What new services we will commission

5.4.1 Crisis response capacity

A key element of the new service spec is that community teams should be ensuring that patients identified as 'at risk' have the necessary care plans, relapse prevention and contingencies in place so that crisis occur as rarely as possible. We will also build on current work to know who is at risk within the community and manage this group more successfully, there are current discussions about including the

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maintenance of the risk register as a CQUIN in the 16/17 contract with SWYPFT to ensure a consistent approach across the region.

However, even best managed plans cannot avoid all crisis situations. The first point of contact for developing crisis should be the CLDT who will work though the care and contingency plan to try and avoid escalation and to de-escalate the situation. However if a full crisis occurs in an unforeseen way or when the CLDT is not available it is essential that services can respond to their needs with appropriate and effective advice and support 24 hours a day, 7 days a week. This service will be delivered by an intensive support team. As well as improving service accessibility and responsiveness this will positively impact on the number of out-of-hours admissions to in-patient units. It would be consistent with current commissioning guidance to develop this service through investment in the existing mental health crisis response service with the caveat that it is also suitable for people with learning disability and/or autism who experience behavioural crises. Linkage to services such as appropriate short break facilities and to the out of hours management system for local learning disability residential/supported living services could provide some flexible options to lessen immediate pressures and provide 'holding solutions' until the day-time services can resume responsibility. Where the person in crisis is in the 'core group' they should have in place a well thought out contingency plan, which should assist the effective management of the situation.

Community services across the partnership generally operate on a traditional working day pattern, Monday to Friday 9.00-5.00. Outside these hours Social Services Emergency Duty Teams provide the principle crisis response. Those caring for somebody with a learning disability or autism often describe the challenges posed are when individuals get up preparing to leave for a day centre or in the early evening once they have returned to the family home. Services need to be flexible enough to offer some support during these periods. Each person identified as 'at significant risk' in receipt of care should have a crisis plan, accessible to the individual and their carers outlining what actions they can take and who to contact.

The focus of all crisis responses should be:

- Providing specialist support in the most familiar setting, their own home, family home, care home via providing specialist advice and additional support to the people who know the person best
- Provide support in a specialist "'safe, calming therapeutic unit' that enables the contingency plan to be implemented in a safe environment, ensuring whenever possible the least restrictive intervention is used and the individual returns home on a night whenever possible
- As above but with the addition of short term overnight stay.

5.4.2 Respite Care and Short Breaks

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It is recognised by health and care commissioners that respite care and short breaks are an important part of the current provision available to users and carers. This provision can help to avoid the need for admissions to bed based care or the escalation of difficulties that could lead to care breakdown.

Whilst it is accepted that it will be carried forward into the new model, there is also an opportunity to refresh the approach and leverage any new benefits that integrated working will bring. At the most basic level, respite can mean different things not only to different people using services but also to different commissioners. This plan recognises that respite may not be fully maximised at present because it will inevitably be bounded by where it is commissioned from and by whom.

In particular the focus on personalisation will enable personal budgets as well as direct payments to be used for care that is designed and controlled by the users and carers – which will mean that respite provision can be more responsive, more innovative and fit with the individual's interpretation of what respite means to them and works for them.

Opportunities for short breaks tailored to individual needs are available to every family supporting a person whose behaviour presents a challenge at home. Providing carers with a break when they are under pressure will prevent crises developing and help to prevent placements from breaking down.

5.4.3 An Effective Response to Challenging Behaviour

Learning disability services should give priority to people with complex needs and challenging behaviour. They are the people with the greatest need for services and marked improvements can be achieved by the provision of quality services. The adoption of a challenging behaviour policy by all providers will underpin this and ensure that there is a consistent response across all services. It should commit staff to maintain input and contact with service users to resolve problems.

The group of people whose behaviour is complex and presents a serious challenge to services should be identified, and logged on the "At Risk Register" and the services that are assessed as necessary to meet their needs developed through a person centred planning process. The plans should be clear about environmental risk factors, triggers, warning signs and contingency arrangements and ensure that back-up resources can be made available to sustain arrangements through difficult periods, and that services are put in place to support this.

The new service specification for SWYPFT includes the need for access to specialist staff that have the appropriate skills and knowledge about complex and challenging behaviour that can provide specific support to individuals, their carers and families, providing specialist assessment, supporting development of proactive support plans giving advice and information and provide training.

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Further modelling is required whilst the Programme is in implementation and cohorts are migrating to optimised care options, so that we can test and refine our assumptions on capacity and demand and match these with the quantity of staff and caseloads in the model.

The CLDT should have an adequate workforce with appropriately accredited training to equip them with the specialist knowledge and skills required to work with people with learning disabilities who have complex challenging behaviour. All staff working with people with learning disabilities should receive appropriate training in relation to challenging behaviour commensurate with their role.

Services should use a competency framework to oversee staff training and competency based on Skills for Care Guidance for Employers (2013). A Positive Behaviour service will need to be embedded within and alongside other services by establishing working protocols that are communicated and agreed with relevant stakeholders. Ensuring effective links with other key services are created by amenable working practices and appropriate formal arrangements.

5.4.4 Specialist Providers

This will be a key area the partnership will be working together on in the market development work stream. There is a need for providers to support people with very complex needs and it is recognised that a regional framework will be beneficial for economies of scale. As mentioned existing frameworks are in place for learning disability provision and these frameworks could be used as a basis to extend into a more specialist and bespoke service across the partnership.

5.4.5 Safe Place Accommodation

At times people with learning disabilities may need access to short term residential care to provide a safe environment. This service should include access to day facilities as well as overnight accommodation and should only be utilised in the short term with the expectation that it would be no longer than 4-6 weeks before moving back into their own community setting or returning home. This facility would be used to support individuals that live in the community and are either approaching a crisis or have reached crisis and require a safe environment where the enhanced community team can work with the person undertaking assessment and treatment to prevent admission to an inpatient facility.

5.4.6 Bespoke Homes in the Community

It is acknowledged that some people (the most complex and challenging) stepping down from inpatient settings will require more bespoke person centred homes designed to the individual needs to live in that will keep them safe and they will be supported by personalised packages of care that will be flexible according to their needs. Whenever possible these bespoke individual homes will provide long term

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assured tenancies whilst balancing the need to ensure active engagement with ongoing therapeutic care and support. It is expected that there may need to be a period of relatively intensive support, together with focused rehabilitation work to successfully manage their transition. These homes will be smaller developments in community settings and the key to their success will be co-produced planning with people with a learning disability and their families, providers and other stakeholders. It is also really important that when identifying people who would like to live in these homes, they are matched appropriately to the other people that will be living in the development.

Please note the above is not a group home, they are individual homes with their own front doors and gardens, where people will have personalised packages to support them to live independently. I think there has been a misinterpretation of this on the assurance framework as it refers to group homes.

Calderdale has already developed a number of houses able to support up to 4 people with similar needs in the community and this has facilitated the return to area of a number of people, learning will be shared from this across the partnership.

Within Kirklees we currently have a property that we are considering for the development of four to six individual homes which would cater more towards the five cohorts of people identified in ‘Building the Right Support’ and we are in discussions with providers regarding the delivery of care. This is something that as a partnership we have discussed and will be reviewing our current cohort of people in an inpatient bed to ensure we have the right mix of people in these homes. We have also got some potential funding from the sale of two properties with the release of the legal charge and are currently developing a PID to submit to NHS England for approval to reinvest into this service.

5.4.7 Supported Living Services

There are many supported living services across the partnership and a review of these will be undertaken to identify if some of these can be redesigned to meet the needs of the five cohorts that this plan refers to. We will work with providers to identify what the gaps are in terms of training and building viability to see if any existing services can be adapted or whether we need to look at building new provision to meet the needs of people with more intensive needs and forensic backgrounds.

5.4.8 Positive Behavioural Support

Across health and social care, statutory and the independent sector the workforce plan will specify the use of the Positive Behavioural Support Competency Framework That will underpin the development of a Positive Behavioural Support Hub. This will be a coordinated, planned network for the development and delivery of accredited training and bring together local expertise to develop full range of training,

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supervision and coaching for front line staff including personal assistants, their supervisors, managers and families. We will be discussing with local universities and Health Education England on how this can be scoped and delivered.

5.4.9 Personalisation

In keeping with the national personalisation agenda, we will work to increase the numbers of people on self - directed forms of care and support. In support of the roll out of personalisation, commissioning and contracting arrangements have already been evaluated and amended with the specific purpose of encouraging and enabling providers to offer choice and flexibility only to those seeking control over support, but to all individuals in receipt of services, including self-funders. This has been supported by a dramatic reduction in block or cost and volume contracts, with a continued migration to framework and spot contracting arrangements.

The table below shows the numbers of people receiving a direct payment or personal health budget and whilst the numbers look quite high, it only reflects 16% of the overall LD population known to services. The expertise of local authorities on direct payments is being utilised for further roll out of personal health budgets across health and this will be another key action within the plan to further analyse the position and identify how we can work collaboratively to further roll out personalisation across the TCP.

People receiving personal health budgets/Direct payments	**Number**	**Value**
Personal Health Budgets	61	£ 2,642,734
Direct Payments	711	£ 11,598,285
Total	**772**	**£ 14,241,019**

Local offers are currently being developed in each areas for PHBs and the partnership will take the opportunity to review the viability of extending these across the region and it will consider how and what can be done as part of the overall plan together. Our plan is to offer individuals and families ongoing support to identify a personalised solution via taking control of a direct payment and the responsibilities within that. Some of the areas that will be included will be:

- Individual service funds/pooled funds to enable people with a learning disability to work closely with providers and user led organisation to co-produce a personalised plan – it is felt that these could be a good option for the five cohorts identified
- We will also work with the voluntary sector such as Mencap to utilise their expertise and support for the further development and implementation of PHB's focussing on the five cohorts identified
- We will develop the local market place to ensure quality, creative and flexible services and support available including specialist support for people with

more challenging behaviours. This should lead to increased local choices for individuals and increase take up of such budgets.

- Commissioning and contracting arrangements will be evaluated and amended with the specific purpose of encouraging and enabling providers to offer choice and flexibility not only to those individuals seeking absolute control over the support provided but to all individuals in receipt of services. This anticipated outcome will be a reduction in block or cost and volume contracts and a continued migration to framework and spot contracting arrangements.

5.5 How will people be fully supported to make the transition from children's services to adult services?

Young people with behaviour that is complex and challenges should be the subject of focused attention and support and recorded in EHC plans. The arrangements will specify that no young person be placed in a distant residential school or other distant placements when their needs can be met effectively nearer to home. Commissioners will ensure that the necessary work is undertaken to build the capacity and confidence of local communities to support young people with more complex needs.

Effective transition support is based on person-centred planning and partnership working and place young people's needs and aspirations at the centre of the transition process. This will help the processes of consolidating identity, achieving independence, establishing adult relationships and finding meaningful occupation. Transition planning should start at the age of 14 years and adult services should become increasingly involved from this age and remain involved during a planned and coordinated handover.

Transition planning will start at a very early age with raising people's hopes and aspirations, we have a statutory duty to start formal planning from 14 years of age (Year 9) for those with an Education Health and Care plan in place or transitional assessment. Preparing for adulthood must focus on:

- Higher education and/or employment – this includes exploring different employment options, such as support for becoming self-employed and help from supported employment agencies
- Independent living – this means young people having choice, control and freedom over their lives and the support they have, their accommodation and living arrangements, including supported living
- Participating in society, including having friends and supportive relationships, and participating in, and contributing to, the local community
- Being as healthy as possible in adult life (SEN Code of Practice 2014 – page 122)

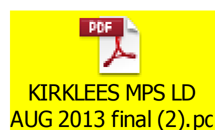
Draft protocols have been developed to ensure all parties understand each other roles and the statutory duties placed upon them. For the most complex young people this is and will always be a challenge. Having a clear preparing for adulthood multi-agency protocol and pathway in place will help make the transition a more positive experience.

In Kirklees they are developing an All Age Disability approach which will bring together key disabled children services and adult learning disability services into one single lifelong planning approach, this is a key theme that will be reviewed across the TCP as part of the early intervention and prevention work stream.

5.6 How will you commission services differently?

There will be an increased focus on outcomes when commissioning services, notably around the quality of care and support, and the quality of life enjoyed by those with a learning disability and/or autism, and their family and carers. The outcomes measures will also encourage care settings to be in the community and away from inpatient services unless they are appropriate.

Local commissioners have a commitment to work with the independent and third sector to ensure there is a vibrant and high quality market to support the needs of people with complex needs. One way this is achieved is via the production of Market Position Statements, they are aimed at care providers giving them clear messages regarding need and strategic market priorities. Attached is Kirklees as an example of how this is being approach, but each area has their own and we will work on developing a market position statement across the TCP.



A significant amount of work has already taken place developing a framework for complex community care for learning disabilities in some of the areas within the TCP and this will be reviewed to look at extending across the partnership for health and social care to ensure economical consistency and sustainability of the provider market.

Greater understanding of the children's and autism population will mean commissioning arrangements may need to change. Market development activities will be required where providers do not currently provide the capability required.

Market position statements will be key in signalling new and changed commissioning intentions to the market, and commissioners are likely to need to follow this up by working with the market closely to encourage and support these commissioning intentions being addressed.

The increase in complexity of needs and also the increased use of personal budgets and personal health budgets means that small niche providers are likely to be required to address some of the accommodation requirements. Therefore commissioning mechanisms, as well as market development activities, are likely to need to encourage a much smaller type of provider. There may also be a need to encourage social enterprises as a good way to deliver services. This will require additional market development effort to ensure suitable social enterprises are developed that can take on such services. Collaborative commissioning will be considered wherever appropriate and this will be one of the key discussions when further work has been done around new services that will be commissioned.

Resettlement of long term hospital people

There are currently 12 people who have been in hospital longer than five years, split into the following

CCG Commissioned 4

NHS England Commissioned 8

It is recognised that these people may find it difficult to resettle back into a community setting and the TCP will use progression modelling to ensure this is done successfully.

The Care and Treatment reviews will ensure a clear and co-produced pathway and personalised and flexible packages will be available to ensure the transition is appropriate to meet the individual's needs. Personal health budgets will be offered whenever appropriate as the default choice for procuring a package to support the individual.

The funding of these packages in 16/17 have been included in the transformation funding following confirmation that the dowries will not be transferred with the person. It is anticipated that future dowries will transfer down once NHS England specialist Commissioning have decommissioned beds. However this has been included on the TCP risk register.

5.7 How does this transformation plan fit with other plans and models to form a collective system response?

- This plan is being developed based on local strategies and in line with national guidance. We will ensure that has the plan is further developed the following plans and guidance are all aligned to ensure we meet the

requirements of these. Local Transformation Plans for Children and Young People's Health and Wellbeing
- Local action plans under the Mental Health Crisis Concordat
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)
- Work to implement the Autism Act 2009 and recently refreshed statutory guidance
- The roll out of education, health and care plans as part of the SEND agenda

6. Delivery

6.1 What are the programmes of change/work streams needed to implement this plan?

The key work streams including themes have been agreed by the board as follows. The identified leads are including in the terms of reference embedded in the document. These are subject to change following the engagement event with stakeholders:

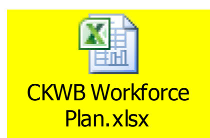
- **Early intervention and prevention**
  - Develop excellent Case Management/Care and Treatment Reviews processes
  - Risk Register
  - Children's Transformation Plan including Transition
  - All age approach
  - Develop better links with Youth offending and probation services
- **Data Sharing and Intelligence**
  - Further information gathering on current baseline
  - Review of current systems/databases
  - Develop an agreed quality and standards framework
- **Finance and Contracting**
  - In-depth analysis at how current monies are spent
  - Mapping exercise
  - Personal health budgets/Direct payment
  - Co Commissioning
  - Framework agreements
- **Market Development including estates**
  - Looking at people's needs and what services we currently have. CKWB market position statement
  - Aim to develop new services, support choice and control and helping people into work or activities
  - Develop more housing and social care options
  - Reducing the reliance on care homes
  - Developing a better community LD/Autism team

- **Workforce Development and Training**
    - Develop a suitable workforce
    - Improving training staff across lots of different services
    - Training and supporting carers
    - Rolling out Positive Behavioural Support
- **Communications and Engagement**
    - See plan attached in section 6.4

6.2 Workforce Development Plan:

Each area within the partnership currently has its own initiatives within workforce development around overall quality of support, specific training requirements such as MCA and Safeguarding, provider engagement to assess current and future workforce needs, as well as management and leadership support. Local authorities have a responsibility to ensure and an adequately trained workforce is available to meet the social care need and each area is meeting that requirement. Support for learning disabilities provision forms part of this overall workforce development.

As a TCP we will review the current work happening in workforce development and identify the gaps relating to this plan. It has been discussed that we may build on the existing workforce development strategies and ensure representation is appropriate from a Transforming Care perspective, rather than creating another work stream to deliver this. However the principles will be followed on the attached workforce development plan below.



It is recognised that in order to deliver the outcomes required through transforming care, the learning disabilities workforce needs to have a range of the right skills, capability and capacity to deliver personalised and high quality support. Services along the spectrum from secure down to universal and community need appropriate skills to be able to support and intervene effectively, and importantly know how to access higher levels of support if required. So someone who works in a job centre, for example, who is trying to support an individual with autism may have a basic awareness of the condition but may need to ask a CTLD nurse or other professional for advice if the level of skill required exceeds their knowledge. Likewise a supported living provider for learning disabilities would have skills to deliver the designated care plans of the individuals within their service but may need to draw upon psychological support from a clinical professional if an aspect of behaviour was causing concern at the time.

By achieving this, the TCP will not only be able to deliver appropriate support but achieve effective use of resources. Positive Behavioural Support training is

specifically mentioned in the Building the Right Support (Oct 2015) documentation as best practice for people with LD/Autism and who display behaviour that challenges and the partnership needs to respond to this in particular. However, a model of up skilling community services will enable more people to remain as independent as possible and in effect 'raise the bar' to which community services can safely operate.

Under pinning this is the principle that people with learning disabilities and autism can learn, develop and become more independent, hence a new requirement; that of progression planning, innovative service design and improved commissioning skills will also be required.

As a result the priority is to develop a comprehensive workforce strategy including individual local and TCP wide requirements. Adequate resourcing will need to be identified to not only deliver the work stream but also keep existing staff through professional development and recognition both financially and personally that the role they do is valued (the NMDS-SC states that there is a 22.8% turnover rate within Y&H region). This will also include the key roles of care management, integrated working and collaborative commissioning.

Internal financial constraints through austerity measures within the LA and external cost risks through examples such as the living wage need to be incorporated into the workforce plan as direct staffing costs are the largest percentage of spend across both health and social care.

6.3 Estates Plan

Where there are gaps identified then the TCP will develop provision collectively or where there is a commissioning case for change. What is acknowledged across the partnership is a need for a flexible accommodation options and work has and will continue to be carried out working with providers of support and accommodation to enhance the range of accommodation provision.

As a partnership we have agreed that estates will be a key theme that sits under the market development work stream.

6.4 Engagement Plan

A draft plan is embedded below.

6.5 Key Enablers to success

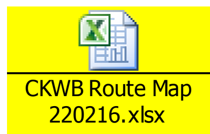
Shared Vision – It is essential that all organisations within the partnership have the same vision to change the system and deliver better services for people with a learning disability and autism.

Commitment – There needs to be the appetite to deliver from each organisation and this needs to be supported from the top to ensure it is deemed a priority for the people involved.

Public Support – Engagement is a key factor to ensure the public fully support the principles of the transforming care plan across our partnership

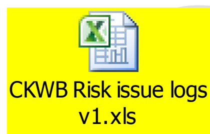
Funding – To be able to deliver better services in the community, there will be a requirement to pump prime and there will be times where organisations are double funding whilst the transformation is ongoing. There are already huge constraints across health and social care with funding cuts, so it is essential that agreed funds are made available and match funded to succeed.

What are the key milestones – including milestones for when particular services will open/close?



What are the risks, assumptions, issues and dependencies?

6.6 Key Risks



6.7 Key Dependencies

There are other partner agencies that need to be more involved in discussions and they will be included within the stakeholder engagement plan:

Criminal Justice System - we recognise that they will need to be involved in the transfer of people being placed in the community. Need to be aware that there will be some people living in the community that may need additional support and resource.

Primary Care as there will be individuals being supported in the community accessing mainstream services. Raise awareness of the individuals and their circumstances. They may need more intensive support and care management.

Police so that we raise awareness of the individuals living in the community and provide additional education to the workforce. Police could potential be involved in MDT discussions. In Kirklees we have worked with West Yorkshire police to roll out

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National Mencap Stand by Me Police Promise, one element has been to link PCSO with local care service provision. This is an area that we will look at sharing across the TCP.

Council Services to raise awareness with them that include housing, employment services and leisure providers to ensure people are supported to access services.

6.8 External policies / External changes

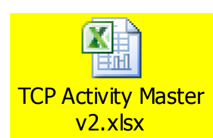
The shift of responsibilities from NHS England to CCGs needs to be understood and factored into commissioning arrangements. NHS England and all CCGs are represented within the governance structures for the programme of work.

What risk mitigations do you have in place?

Please see the risk register in section 6.6

7. Finances

Please refer to appendix 1 for the finance and activity tracker



Estimated costs to deliver the programme

Cost	Costing assumptions	Funding	TCP Funding	Matched Funding
Programme Manager	This plan requires a full time experienced programme manager to enable the plan go be delivered in a timely manner	£210,000	£105,000	£105,000
Project Support	The programme manager will require full time project support to deliver the plan	£75,000	£37,500	£37,500
Case Managers x 2	To facilitate the discharge of people currently in CCG commissioned inpatient beds, two dedicated case manager will be	£266,658	£133,329	£133,329

	required			
Communications and Engagement	A budget has been calculated in the comms and engagement plan, albeit this is not yet fully scoped	£122,000	£61,000	£61,000
PBS Training	The extent of this training is so significant the TCP will require dedicated funding to enable this to be successful Estimate	£100,000	£50,000	£50,000
Double funding of packages	This is an estimate as full mapping has not yet been undertaken, it is assumed no dowries will be passed down in 16/17	£750,000	£375,000	£375,000
Total		**£1,523,658**	**£761,829**	**£761,829**

With regards to capital monies, this requires a full audit of current estates across the region to identify if we can reinvest in these assets or whether we need to build new provision across the partnership. This work will be one of the key deliverables and will also require input from funding organisations, providers and architects and although discussions are already taking place in individual areas.

DRAFT

1. Barnsley's Learning Disability Programme – Key Workstreams

1.1. Learning Disability Health and Social Care Self Assessment Framework (SAF)

1.1.1. The 2014 Self Assessment Framework was formally signed off in January 2015 and was reported to Health and Wellbeing Board in April 2015.

1.1.2. An action plan is in place to address areas for improvement and this is delivered by the Learning Disability Health Group, which reports into the Adult Joint Commissioning Group, who will oversee progress on behalf of the Health and Wellbeing Board.

1.1.3. There was no requirement to complete a self assessment in 2015. Data was gathered from IHAL and ASCOF returns and shared with Commissioners for local evaluation. NHS England are currently revising the self assessment to align with the Transforming Care agenda.

1.1.4. Based on the 2014 results and current action plan the Learning Disability Health Group prioritised the following key areas for improvement in 2015/16:

- Increasing the number of people with a learning disability receiving a health check.
- Increasing the number of people with a learning disability who have a health action plan.
- Contract Compliance and Quality Assurance.
- Effective joint working.
- Supporting people with a learning disability into and in employment.

1.2. Assuring Transformation

1.2.1. The Transforming Care agenda puts a focus on local Commissioners to ensure there are clear discharge plans in place for any person with a learning disability receiving care or treatment in a hospital operated by either an NHS or independent sector provider.

1.2.2. Commissioners were required to develop a local register of all patients who met the criteria for Transforming Care (any individual with a diagnosis of learning disability and/or on the Autistic Spectrum in in-patient care). This was reported to NHS England to form a National Register.

1.2.3. Barnsley currently has 6 patients who meet the criteria for inclusion on the national 'register' receiving inpatient care as part of NHS England monitoring arrangements. There are a further 10 patients in secure provision.

1.2.4. From Autumn 2014 Commissioner led Care and Treatment Reviews have been undertaken for all existing patients. These involve a planned multi disciplinary and patient centred review of the placement and rationale with a

strong focus on developing plans for a pathway to discharge and future care provision.

1.2.5. During 2015 the monitoring requirements have progressively increased. Commissioners are currently required to complete weekly admission and discharge trackers and a fortnightly comprehensive update to NHS England, they are also required to update via the Health and Social Care Information Centre website on a monthly basis. All new patients, including those with a Learning Disability and/or those on the Autistic Spectrum that are admitted into general acute mental health inpatient beds, are to be reported, and this has significantly increased the numbers. Local Commissioners are also required to attend Care and Treatment Reviews of those in secure care, led by Secure Commissioning.

1.2.6. From July 2015 a new Care and Treatment Review (CTR) pathway has been implemented nationally. This includes the requirement to complete a Care and Treatment Review prior to a hospital admission or where this is not possible, conduct a 'blue light' meeting within two weeks of admission. It also includes the right for any party to request a Care and Treatment Review within six months of admission and a requirement to complete a Care and Treatment Review annually for all patients. Commissioners are also now required to create a 'at risk of admission' register to ensure good plans are in place for those people who may be at risk of admission to in patient care due to mental illness of challenging behaviours.

1.2.7. The leadership of the Care and Treatment review process by Commissioners locally has required a great deal of Commissioner capacity to deliver, however positive outcome for patients are being achieved with much better coordinated decision making about how to minimise time spent in hospital and innovative approaches of services working together effectively in the best interest of patients beginning to be evidenced.

1.3. **High Cost Placement Review (Transformation Phase 1)**

1.3.1. In 2012 in partnership with Social Care and Health colleagues Commissioners began a review of all individuals in high cost residential placements to ensure people were receiving the right support, in the right place at the right time and that the cost of placements evidenced good value for money.

1.3.2. The initial phase of the high cost placement review has now concluded with 52 cases reviewed and negotiations with Providers completed. Overall savings of £630,000 per year across Health and Social Care funded packages have been achieved, 14% of this saving was for CCG funded packages, 8% for Social care funded packages.

1.3.3. The second phase of this project overlaps the Accommodation and Support Project described below, creating pathways for those individuals where progression opportunities were identified at phase 1 of the review process.

1.3.4. In addition to financial savings the project has achieved:

- people with a learning disability are being supported to progress towards getting the least intensive support needed to meet their needs which promotes greater independence and also maximises cost effectiveness in the system
- assurance of the quality and best value of individual placements
- assurance that individual packages are based on robust assessment and are appropriate in scale and type of service to meet individual need
- an understanding of the stratification of the population of Barnsley under review – this understanding will inform commissioning and service re-design plans
- local case management and commissioning staff have developed knowledge regarding the systematic use of fair funding methodology and re-negotiation skills
- the operational staff culture is changing to more aspirational, enabling and proactive approaches

1.4. Accommodation and Support Project (Transformation Phase 2)

1.4.1. The focus at Phase two is on people with Learning Disability in Supported Living services, of which there are around 150. As with phase one, the re-assessment of needs has demonstrated that some people are receiving more support than they need. The project has also found that the current supported living provision does not have the flexibility of accommodation and support to meet the needs of a wider range of people with Learning Disability and particularly those with more complex needs and challenging behaviour.

1.4.2. Overall, the current pattern of service provision for people with learning disability does not have enough differentiation to meet the full range of presenting needs. This reflects national learning, most notably through the Transforming Care agenda, that people with learning disability and complex needs and challenging behaviour are too often ending up in hospital and then staying in hospital for a long time due to a lack of good alternative services.

1.4.3. Plans to deliver a new model of community based services for people with Learning Disability are now being progressed following recent approval at cabinet.

1.5. Community Services Transformation

1.5.1. In addition to new models of community services a changed approach is also required from our NHS specialist Learning Disability Services.

1.5.2. SWYPFT provides specialist Learning Disability Services in Barnsley and they have been working closely with Barnsley Commissioners on the agenda and to redesign their own services in line with new requirements.

1.5.3. Barnsley needs services that are more responsive and able to support people with Learning Disability in their own environments, recognising early signs, instead of escalating issues leading to admission to hospital.

1.5.4. If people do need to be admitted to hospital, the environment needs to be appropriate and safe.

1.5.5. A multi disciplinary approach is needed to work together effectively to support people with Learning Disability to be discharged to appropriate levels of support to meet their needs and to maintain their health and wellbeing in community settings.

1.5.6. (Case Study) There has been a recent example of excellent responsive and collaborative working that has resulted in a young patient with significant needs being successfully returned to Barnsley, to be cared for in the Psychiatric Intensive Care Unit with additional support from the Learning Disability Service and involving previous know care staff and family members.

Transforming Care Programme (TCP)
Services for People with a Learning Disability

Communication, engagement and equality Strategy

GHCCG
February 2016
Draft v1

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1. Introduction

This strategy sets out the communications, engagement and equality activity required to engage with service users, carers, families and key stakeholders on services currently provided for people with a learning disability across Calderdale, Kirklees, Wakefield and Barnsley (CKWB).

This strategy sets out a partnership approach to communicate and engage with service users, carers, families and key stakeholders who will be directly affected by any transformation to current services. The strategy includes:

- Background to the transformation
- The aim of the strategy
- The legal requirements we will follow
- What we already know
- Our approach to communication, engagement and equality
- The high level resources required
- A high level timeline of activity

2. Background

The Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership has been formed to collaboratively develop a programme that will transform our community infrastructures and reshape services for people with a learning disability and autism.

The transformation plan will be framed around 'Building the Right Support' and the 'National Service Model' October 2015 for transforming services. The service areas requiring transformation will include:

- Mental health services
- Services that support specific neurodevelopmental syndrome
- The criminal justice system
- Lower level health or social care services
- Inpatient care

Each local area (CKWB) within the partnership had already developed individual programmes to transform services. The partnership will share collective knowledge and experience to further build on progress already made. The key aims for the plan will be:

- Reduction of inpatient beds, delivering a 60% reduction across the partnership by 2019
- Developing better/new/broader range of specialist community services that are flexible and responsive to manage crisis better and prevent admission
- Developing capable communities to enable people to live in their own homes
- Developing a better understanding of our local populations with complex needs and how best to support them in a crisis
- Ensure people with a learning disability and autism have the opportunity to live meaningful and fulfilled lives

3. The aim of the strategy

The aim of the strategy is to ensure that all service users, carers, families and key stakeholders are involved in the development and consideration of any plans to transform the future of learning disability services across the four local areas (CKWB). This includes gathering any information to support the completion of an equality impact assessment.

The objectives are:

- To ensure we work within our legal obligations, as the CCG are the lead organisation it will require the programme to be compliant with NHS legislation
- To develop an annual action plan which will ensure the strategy is delivered
- To collectively utilise any existing intelligence, resources and approaches to deliver the communication, engagement and equality activity required
- To map all key stakeholders across CKWB and ensure a plan is in place to involve people at each stage of the commissioning cycle
- To ensure we have targeted the right audiences and it includes representation from protected groups
- To ensure we inform and communicate people at the right time and in the right way using methods and approaches that are suitable for the target audience
- To demonstrate that we have listened to service users, carers, families and key stakeholders and can evidence how they have helped to shape future services. To provide a report of findings on all activity
- To use the engagement findings to support the development of any equality impact assessment
- Deliver formal consultation as and when required with the legislative requirements if there are any changes to the way services are currently provided or delivered

4. Legislation

Under current legislation CCGs are the accountable organisations for all engagement and consultation activity. The legislation that the CCGs must abide by is set out below:

4.1 Health and Social Care Act 2012

It makes provision for CCGs to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners, and it also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution – and to promote awareness of the NHS Constitution.

Specifically, CCGs must involve and consult patients and the public:

- in their planning of commissioning arrangements
- in the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
- In decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees on any proposals for a

substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

4.2 The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, which are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity', and c) foster good relations. GHCCG has developed an Equality and Diversity Strategy which details their approach. To evidence 'due regard' as required by the Equality Act 2010 where a decision is being made about a potential change to a service an equality impact assessment (EQIA) will be completed.

4.3 The NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains a number of patient rights which are a legal entitlement protected by law. One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- The development and consideration of proposals for changes in the way those services are provided, and
- In the decisions to be made affecting the operation of those services.

5. What people have already told us

There have been numerous engagement events across the four areas in the TCP over the last three years. South West Yorkshire Partnership Foundation Trust has also delivered several engagement events around their transformation for LD community and inpatient services that covered the TCP region.

There has also been lots of engagement across the TCP following on from the Future in Mind Report with children, young people and their families and carers. The feedback from this engagement has helped develop a 5 year strategy.

The common themes from engagement from the learning disability transformation programmes, the care closer to home programmes and the future in mind transformation are similar. The findings are set out below:

- Easy access to services and information that is easy to understand
- Care closer to home, but do not want homes turned into hospitals
- Bespoke housing- right housing/environment for the individual.
- Personalisation needs to include people with challenging behaviours.
- Families should be recognised as being part of the workforce, could support be provided in the family home whilst Mum and Dad take a break elsewhere?
- Training does not just have to happen in a 'room'. Sometimes it's about sharing information and good ways of doing things.

- Using people’s communication plans and person centred plans helps us understand what they want. It helps us make sure the Mental Capacity Act is being used affectively.
- We need to get the voice of families in the JSNA.
- We need to make sure people who are away from home get access to advocacy.
- We need to make sure that people are not isolated. People need those who love them in their lives and support should be given to visit family and friends
- We need to invest in prevention to prevent families breaking down.
- Having access to the internet.
- Accessible leisure activities e.g. swimming, football, drama group and other groups are important to our wellbeing and support to be able to do these
- LD champions who work in general hospitals to ensure the nursing staff understand our needs.
- Keep our Activity centre, and have more groups.
- Reasonable adjustments should be included within all health and social care contracts.
- Very important to have efficient caring help. Priorities for carers; plenty of help and more facilities for good respite care.
- Supporting people who use services is critical to maintaining their care / wellbeing
- Independent support such as advocacy is highly valued by users and carers
- People also find support in other ways such as community groups, voluntary organisations, friends and social groups
- Social connections and a sense of belonging is important to wellbeing and coping
- Staff can be caring and compassionate, basing their care around the person’s needs as much as they can in the restrictions that they work in
- Hospital / bed based care does work for some people; it is often very much like a house or flat not like a ward – it is home for some people and should be recognised
- Visits to doctors are helped if the doctor or nurse knows the individual and their history and has time to listen carefully, it is important that if referring to hospital the right information is passed on.
- Local register needs to include all people with challenging behaviour.
- Still too many people in high cost placements out of district.
- Access to Mental Health Services is sometimes difficult.
- Barriers to accessing universal services within the community.
- Short breaks tend to be building based.
- Too much investment in specialist services and high cost placements without understanding the quality of these placements.
- Not all GP practices offer health checks.
- Lack of hydrotherapy services – time limited/cost.
- Landlord/housing issues – not responding to repairs quickly, chasing up responses from housing.
- Withdrawal of service bus and general bus services reducing.
- The negative impression of hospitals that have been given since winterbourne, and other hospital scandals .
- More supported work placements/job opportunities - We do not want to just walk round shopping centres all day.
- Speech and Language Therapy and support in school, needs resourcing.

- There needs to be raised awareness at all levels of learning disability and autism.
- More communication is needed with the people who use services, their families and carers. This needs to be ongoing genuine consultation resulting in recommendations that are acted upon and resourced.
- We need more learning disability and autism champions – on the Clinical Commissioning Group Board, in general practice, at the council and other providers of health and care services.
- Not getting diagnosed early enough- underlying conditions or co-morbidities not being addressed in a holistic way
- Confusion of where to go for services/help and understanding what is available - no single point of access
- Transitions are problematic (children's services to adults, hospitals to community, from one provider or funder to another)
- Too much focus on risk and not enough thought given to independence
- Lack of understanding of MHA / Consent, some people noted that Sections are being used or managed inappropriately
- Not enough independent / advocacy support to help explain and challenge restrictions / out of area decisions that take the person far away from family
- Professional workloads / processes are not well designed to meet needs for this group – e.g. GP appointments too short, LD Community teams have too broad a remit, support workers are isolated/ low wage based, specialist providers are few
- Care plans are often not complete or up to date or well followed; reviews are often infrequent or not robust; health action plans in primary care not being used
- There is a lack of networking across the system to wrap care around people – reports of arguments between agencies and refusals to accept cases e.g. Autism
- When communications are poor, people with learning disabilities feel they are not listened to and not understood – their views are not taken into account and changes in care are being made 'to them'
- Professionals noted the lack of integration in systems, partnerships and funding leading to delayed decisions, particularly in relation to judicial requirements: "people are getting stuck in the system"

6. Approach to communications, engagement and equality

6.1 Communication and Engagement with key stakeholders

Partner organisations involved in the delivery of the transformation plans will be engaged at a Transforming Care Board, this board will be led by Greater Huddersfield CCG. Those organisations represented at the CKWB Transforming Care Board include:

- Kirklees Council
- Calderdale Council
- Wakefield Council
- Barnsley Metropolitan Borough Council
- Calderdale Clinical Commissioning Group
- Greater Huddersfield Commissioning Group

- North Kirklees Clinical Commissioning Group
- Wakefield Clinical Commissioning Group
- Barnsley Clinical Commissioning Group
- Specialist Commissioning Services

Representation will be from senior leaders from each organisation who have the authority to deliver the transformation programme. This means that they will also take the lead on any required communication, engagement and equality by:

- To agree jointly the resources required for communications, engagement and equality and develop and agree a joint strategy and delivery plan
- Supporting the delivery of communication, engagement and equality across CKWB with existing staff in their own organisations as part of a working group

Broader stakeholders will be engaged at various stages of the programme. These stakeholders include:

- People with Learning Disabilities, Carers and their Families, all ages
- Patient Reference Groups – Kinfo
- MPs and Councillors
- NHS service providers including
  - Primary care
  - Community Services
  - Acute Care
  - specialist learning disability service providers
- Voluntary and Community Sector
- Public Health
- Criminal Justice System,
- Private Providers
- Health Education England
- Health and Wellbeing boards
- Healthwatch
- Overview and Scrutiny Committee (OSC)
- Inclusion North

6.2 Using what we already know

All existing intelligence that has already been gathered from service users, carers, families and key stakeholders over the last two years from CKWB will be collectively reviewed. This would include:

- Pals and complaints data
- Patient Opinion and NHS Choices postings
- Friends and family test
- Any previous engagement activity

This information will be used to develop an overview of the things people want to see as part of a transformation programme. A number of key themes have already been identified in section 4, these themes will support the development of an initial plan for transforming services.

6.3 Our approach to communication and engagement

In order to gather views on the draft plan to transform services across CKWB it is our intention to deliver a CKWB wide ‘My Health Day’.

‘My Health Day’ was an annual engagement event already set up to engage all stakeholders across CKW. These events were held in a central location and service users, carers, families and key stakeholders attended the event to engage people. The events were very well attended and received excellent feedback.

The events will be revived and renamed, they will also be held in the same venue which is central to CKWB and all stakeholders will be invited to attend. Barnsley stakeholders will be new to this arrangement and we will ensure we gather feedback at the end of the first event to ensure they are suitable.

The events will be run at the same time in the same venue each year on an annual basis. The aim of each event is set out below:

- **April 2016 - Event 1:** The aim of the first event will be to map and engage key stakeholders on the draft transformation plans. Participants will be encouraged to provide feedback on the plans and identify how they would like to be involved. This will include the completion of a stakeholder mapping exercise. Principles for engagement will be agreed and added to the strategy.

- **April 2017 - Event 2:** The aim of the second event will be to provide an update on the progress of the plans. Participants will be asked to evaluate any progress and provide further feedback. More opportunities for involvement will be communicated.

- **April 2018 - Event 3:** The aim of the third event will be to communicate the transformation of services, provide opportunities for any feedback and final evaluation. Success can be celebrated and ongoing engagement of key stakeholders could be a key theme.

6.4 Training service users to deliver engagement

Calderdale CCG currently has 8 people with a learning disability who are trained to deliver engagement. The training package is delivered by the Engagement Champions programme which is a joint CCG and voluntary sector initiative.

The ‘Engagement Champions’ project recruits individuals from voluntary organisations and trains them as a volunteer. The volunteer is trained to understand the importance of involvement and how as a champion they can help others to have a voice. The training is specifically adapted in an easy read format using pictures and images and each participant has to attend three training sessions to qualify as a champion. The champion receives a certificate and is registered as an ‘approved provider’, providers are paid in recognition of their skill. The champion has to attend an annual training refresh to maintain their approved provider status.

The volunteers, trained as ‘champions’, help to design approaches to engaging other service users, families and carers. As part of the approach to engagement it is recommended that this model is rolled out across CKWB. The role of the ‘Champions’ will be to:

- Involve themselves in a joint working group for communications, engagement and equality
- Help to co-design the delivery plan for the communications, engagement and equality strategy

- Identify the content for each of the annual 'My Health Day' events and identify appropriate methods of engagement

6.5 Annual delivery plan for communications, engagement and equality

An annual delivery plan for communications, engagement and equality will be developed. The plans will reflect the timelines and delivery set out in 3 year transformation plan. The annual 'My Health Day' will support the development of this plan and ensure:

- Any plans for communications, engagement and equality are shared and communicated to all stakeholders at the beginning of each year. This will ensure people are aware of the service areas and can help shape the plans
- Methods and approaches for effective communication and engagement will be discussed at the 'My Health Day' to ensure the process for involvement is right for the target audience
- Recruitment to any working groups can take place as an annual event ensuring everyone has an opportunity to be involved.

The plans will suggest a number of methods for involving people and will include:

- Co-production
- Interviews and case studies
- Surveys
- Workshops
- Face to face conversations and interviews
- Measuring service user/carer experience

The plans for communication will include a joint programme approach for communications which will include:

Stakeholder management

- Social media
- Publicity and campaigns
- Individual communications to support any engagement
- Communications to support 'My Health Day'

The annual delivery plans for communication, engagement and equality will be signed off by the Transforming Care Board each year.

7. Equality

An EQIA will be prepared for any of the affected services. This will require consideration of protected groups access, experience and outcomes through evaluation of engagement and experience data and evidence of the user profiles and any research available.

This will be gathered from patient information and other local health and social care information. Information collected as part of any engagement will be included. Research other proxy data will be utilised to give a profile of each local area.

All engagement activity will be equality monitored (see appendix 1). The engagement information gathered will be used to assess whether we have engaged a representative sample of the relevant community and to establish whether there are any trends in opinion and feedback.

Once analysed all the data will be used to develop the EQIA and consideration given to the potential impact of any change to the commissioning of services which could have an differential impact on any protected groups. Where this is identified consideration will be given to any mitigation of the potential impact.

The completed EQIA will be used to support the relevant decision making body to be assured that they have given due consideration to any potential impacts on protected groups.

8. High level timeline for communications, engagement and equality

What	When by
Develop a strategy for communications, engagement and equality	March 2016
Develop a draft delivery plan for communications, engagement and equality	March 2016
Event 1: 'My Health Day'	April 2016
Deliver the communications, engagement and equality plan (2016/17)	May 2016 onwards
Set up 'Engagement Champions' training programme	July 2016 onwards
Develop a draft delivery plan for communications, engagement and equality	March 2017
Event 2:'My Health Day'	April 2017
Deliver the communications, engagement and equality plan (2017/18)	May 2017
Engagement Champions training refresh	July 2017 onwards
Develop a draft delivery plan for communications, engagement and equality	March 2018
Event 3: 'My Health Day'	April 2018
Deliver the communications, engagement and equality plan (2018/19)	May 2018
Engagement Champions training refresh	July 2018 onwards

9. High level budget for communications, engagement and equality

Communications, engagement and equality budget	
Item	**Estimated cost (3 year**

	period)
Communications, engagement and equality lead (CKWB) (3 years)	**TBC**
My Health Day – 3 annual events	**£12,000**
Engagement champions training programme and management over a 3 year period	**£20,000**
Annual non pay budget to deliver communications and engagement – 10k per annum	**£30,000**
Interpreter and support costs – 5k per annum	**£15,000**
Consultation budget – not included	**Cost per consultation**
TOTAL	**TBC**

10. Governance

Kelly to add

Appendix 1 – Equality monitoring form

Equality Data Collection Form

In order to ensure that we provide the best services for all of our communities, and to ensure that we do not knowingly discriminate against any section of our community, it is important for us to gather the following information. No personal information will be released when reporting statistical data and all information will be protected and stored securely in line with data protection rules.

This information will be kept confidential and you do not have to answer all of these questions, but we would be very grateful if you would.

Please tell us the first part of your postcode ________ (i.e. HD2) O **Prefer not to say**

Gender - What sex are you?

O Female O Male O **Prefer not to say**

Transgender - Is your gender identity different to the sex you were assumed to be at birth?

O Yes O No O **Prefer not to say**

What is your age?

O Under 16 O 16-25 O 26-35 O 36-45 O 46-55 O 56-65
O 66-75 O 76-85 O 86+

O **Prefer not to say**

What is your ethnic group?

Asian or Asian British

O Indian
O Pakistani
O Chinese
O Other Asian background

Black African/Caribbean or Black British

O African
O Caribbean
O Other Black/ African/ Caribbean background

Mixed/ multiple ethnic groups

O Black Caribbean and White
O Black African and White
O Asian and White
O Other mixed/multiple ethnic group

White

O British - English/Scottish/Welsh /Northern Irish
O Irish
O Gypsy/Traveller
O Other white background

Other

O Arab
O Other ethnic group

O **Prefer not to say**

Please state any other ethnic group here..

Do you consider yourself to be disabled?
The Equality Act 2010 states that a person has a disability if:
'a person has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on that their ability to carry out normal day-to-day activities'

O Yes (detail below) O No O **Prefer not to say**

If yes, please tick impairment below (Tick all that apply).

O	Physical or mobility	O	Visual	O	Learning disability
O	Mental Health condition	O	Hearing	O	Long-standing illness or health condition e.g. cancer, diabetes, HIV
O	Other (please state)			O	**Prefer not to say**

What is your sexual orientation? (Please tick)

O Bisexual (both sexes) O Lesbian (same sex) O Gay man (same sex) O Heterosexual (opposite sex)
O Other O **Prefer not to say**

Do you consider yourself to belong to any religion?
O Yes (please tick below) O No O **Prefer not to say**

O Christianity (including Catholic, Protestant or any Christian denomination) O Judaism O Buddhism O Hinduism
O Sikhism O Islam

Carer
Do you provide care for someone, such as family, friends, neighbours or others who are ill, disabled or who need support because they are older?

O Yes O No O **Prefer not to say**

Thank you for taking the time to complete this form.