Public Document Pack

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 8 August 2017
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 6th June, 2017 (HWB.08.08.2017/2) *(Pages 3 - 6)*

3 Minutes from the Children and Young People's Trust Executive Group held on 9th June, 2017 (HWB.08.08.2017/3) *(Pages 7 - 14)*

4 Minutes from the Safer Barnsley Partnership held on 28th June, 2017 (HWB.08.08.2017/4) *(Pages 15 - 24)*

5 Minutes from the Provider Forum held on 14th June, 2017 (HWB.08.08.2017/5) *(Pages 25 - 30)*

6 Minutes from the South Yorkshire and Bassetlaw STP Collaborative Partnership Board held on 12th May and 9th June, 2017 (HWB.08.08.2017/6) *(Pages 31 - 54)*

For Decision/Discussion

7 Public Questions (HWB.08.08.2017/7)

8 Feel Good Barnsley Video (HWB.08.08.2017/8)

9 Health and Wellbeing Board Action Plan Highlight Report (HWB.08.08.2017/9) *(Pages 55 - 58)*

10 Better Care Fund: Guidance & Principles (HWB.08.08.2017/10) *(Pages 59 - 140)*

11 Carers' Strategy (HWB.08.08.2017/11) *(Pages 141 - 152)*

12 Healthwatch Annual Report (HWB.08.08.2017/12) *(Pages 153 - 188)*

Items for information

13 Pharmaceutical Needs Assessment (PNA) 2018-2020 (HWB.08.08.2017/13) *(Pages 189 - 190)*

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

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Dr Nick Balac, Chair, NHS Barnsley Clinical Commissioning Group (Vice Chair)
Councillor Jim Andrews BEM, Deputy Leader

Councillor Margaret Bruff, Cabinet Spokesperson – People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson – Communities
Rachel Dickinson, Executive Director People
Wendy Lowder, Executive Director Communities
Julia Burrows, Director of Public Health
Lesley Smith, Chief Officer, NHS Barnsley Clinical Commissioning Group
Scott Green, Chief Superintendent, South Yorkshire Police
Emma Wilson, NHS England Area Team
Adrian England, HealthWatch Barnsley
Dr Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust
Rob Webster, Chief Executive, SWYPFT
Helen Jaggar, Chief Executive Berneslai Homes

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

Monday, 31 July 2017

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 6 June 2017
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 Margaret Bruff, Cabinet Spokesperson - People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson - Communities
Rachel Dickinson, Executive Director People
Wendy Lowder, Executive Director Communities
Julia Burrows, Director Public Health
Dr Nick Balac, Chair, NHS Barnsley Clinical Commissioning Group
Adrian England, HealthWatch Barnsley
Helen Jaggar, Chief Executive, Berneslai Homes
Sean Rayner, District Director, South West Yorkshire Partnership NHS Foundation Trust
Dr Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust

1 Declarations of Pecuniary and Non-Pecuniary Interests

There were no declarations of pecuniary or non-pecuniary interest.

2 Minutes of the Board Meeting held on 4th April, 2017 (HWB.06.06.2017/2)

The meeting considered the minutes of the previous meeting held on 4th April, 2017.

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

3 Minutes from the Children and Young People's Trust Executive Group held on 3rd March, and 28th April, 2017 (HWB.06.06.2017/3)

The meeting considered the minutes from the Children and Young People's Trust Executive Group held on 3rd March and 28th April, 2017. The meeting noted in particular work to better connect the Youth Council to the Trust, in order to explain its work, and preparations being made for an Ofsted inspection of Special Educational Needs and Disabilities, especially with regard to care planning. The meeting also noted work for young people to give feedback to the South Yorkshire Passenger Transport Executive regarding a range of transport issues, particularly accessibility, affordability and issues of personal safety, and that this work was progressing well. The progress in taking forward action plans to promote a smoke free generation, particularly to achieve better connection with schools to this activity, and work to re-design the 0-19 service was also considered by the Executive Group meeting.

RESOLVED that the minutes be received.

4 Minutes from the Safer Barnsley Partnership held on 27th March, 2017 (HWB.06.06.2017/4)

The meeting considered the minutes from the Safer Barnsley Partnership meeting held on 27th March, 2017. The meeting noted progress in joining up the Council and South Yorkshire Police in the Safer Neighbourhoods Service, aligned to the Area Councils, and its focus on an early help approach to supporting people in our communities. The meeting also noted the re-commissioning of the Domestic Abuse and Sexual Violence Service, Multiple Needs Service for Young People and Adults, and the Substance Misuse Service, all of which will be delivered by local companies.

RESOLVED that the minutes be received.

5 Minutes of the South Yorkshire and Bassetlaw STP Collaborative Partnership Board held on 17th March, and 7th April, 2017 (HWB.06.06.2017/5)

The meeting considered the minutes from the South Yorkshire and Bassetlaw Sustainability and Transformation Plan Collaborative Partnership Board meetings held on 17th March and 7th April, 2017. The meeting noted the importance of the Memorandum of Understanding in making progress on the Sustainability and Transformation Plan. Whilst the principle that service users should be no worse off, in terms of the quality of outcomes, as the broad context for the transformation process was understood, there was a need to consider how this played out in detailed proposals in terms of the ability of the Council to support this. Whilst the need for some specialist treatment to be undertaken regionally or sub-regionally was acknowledged, it also seemed likely that some aspects of the care pathway could be provided locally/in the community and the overall impact on service users would be a key consideration in making a judgement about the better integration of services.

RESOLVED that the minutes be received.

6 Public Questions at the Health and Wellbeing Board - Procedural Arrangements (HWB.06.06.2017/6)

Further to the agreement in principle given at the meeting on 4th April, 2017, the meeting received a report on proposed procedural arrangements for the public to ask questions at the Health and Wellbeing Board meetings. The meeting noted that the Chair would have discretion to limit the number of questions asked at each meeting to a reasonable number, if a large number of questions were received, or to allow questions to be asked in real cases of urgency where the proposed deadlines could not be met.

RESOLVED:-

(i) that the proposed arrangements for the public to ask questions at the Health and Wellbeing Board, as set out in the appendix to the report, be approved for implementation from the next meeting, subject to placing a time limit of 15 minutes on the time taken for questions, at the Chair's discretion;

(ii) that the arrangements be reviewed after six months operation and annually thereafter; and

(iii) that the Council's Cabinet be requested to approve the procedures and amend the Board's Terms of Reference accordingly.

7 Local Plan - Video (HWB.06.06.2017/7)

This item was deferred.

8 Carers Strategy - Presentation (HWB.06.06.2017/8)

This item was deferred.

9 Proposed use of additional Adult Social Care funding (2017-20) (HWB.06.06.2017/9)

The meeting received a report on proposals for the use of the additional adult social care funding allocated to the Borough for the period 2017-20. The report summarised in paragraph 4.2 the areas towards which funding would be prioritised, with detailed proposals set out in Appendix 2, in compliance with the Government's conditions on the use of the funding. The meeting noted the intention to address issues associated with adult social care but also to support the interface between health and social care. The proposals had been the subject of discussions with partners and agreement at SSDG.

The meeting noted the specific condition that the funding should support improved performance at the health and social care interface, and that Barnsley performed well already in this area. If the proposals go some way to accelerating the discharge process still further this would be welcomed. The meeting noted the inclusion of proposals to create a more sustainable care market, which would be accessed by providers through normal routine business.

RESOLVED:-

(i) that the proposed use of additional non-recurrent adult social care funding for the period 2017-20, summarised in paragraph 4.2 and detailed in Appendices 1 and 2 of the report, be approved; and

(ii) that the progress made as a result of this funding form part of the Board's periodic consideration of the Better Care Fund performance report.

10 End Of Life Care letter (HWBB.06.06.2017/10)

Further to discussion at the Board meeting in January 2017 and the forwarding of a report on the current provision in Barnsley for palliative and end of life care to the Minister for Community Health and Care, the meeting received a letter from the Minister acknowledging receipt of the report and noting how impressed the Minister was with the work being done locally on this matter.

RESOLVED that the letter be received and the Board place on record its thanks to the staff and volunteers involved in providing this service in Barnsley.

Chair

This page is intentionally left blank

Children and Young People's Trust Executive Group Meeting
9 June 2017, from 09.30 – 12.30
Westgate Plaza Boardroom, Level 3, Room 3

Present

Core Members:

Brigid Reid (Chair)	Barnsley CCG, Chief Nurse
Cllr Tim Cheetham	Cabinet Member: People (Achieving Potential)
Gerry Foster-Wilson	Executive Headteacher representing Primary Schools
Mel John-Ross	BMBC, Service Director of Children's Social Care & Safeguarding
Margaret Libreri	BMBC, Service Director for Education, Early Start & Prevention
Alicia Marcroft	BMBC Head of Public Health, Children and Young People
Dave Ramsay	South West Yorkshire Partnership Foundation Trust (SWYPFT) Deputy Director of Operations

Deputy Members:

Adrian England	Barnsley Governors Association (for Margaret Gostelow)
Karen Markham	Barnsley College Director of Teaching & Learning (for Phil Briscoe)
Nik Dodsworth	South Yorkshire Police (for Scott Green)
Nick Bowen	Horizon CC Principal representing Secondary Schools

Advisor:

Richard Lynch	BMBC Head of Commissioning, Governance and Partnerships

In Attendance:

Amy Booth	BMBC, Health and Wellbeing Officer (shadowing Alicia Marcroft)
Kathryn Wilkinson	Management Support Officer, Minute Taker

		Action
1.	Apologies The following apologies were noted: Rachel Dickinson – BMBC, Executive Director: People Bob Dyson – Barnsley Safeguarding Children Board Independent Chair Teresa Gibson – Healthwatch Barnsley Manager Anna Turner – BMBC School Models and Governor Development Manager Wendy Lowder – BMBC Executive Director Communities Paul Hussey – Interim Service Director, Stronger, Safer and Healthier Communities Margaret Gostelow – Barnsley Governors Association Chair Dr Jamie McInnes – Barnsley Local Medical Committee GP representative Phil Briscoe – Barnsley College Vice Principal Quality and Student Experience Scott Green – South Yorkshire Police Chief Superintendent Dave Whitaker – Executive Headteacher representing Secondary Schools	

		Action
2.	<u>Feedback from the front line</u> At this point in the meeting colleagues were given an opportunity to share examples of good practice or challenges on the front line. Gerry raised the issue of SEN pupils attending mainstream schools and the challenges that poses for schools regarding staffing resources as children with SEN either require 1:1 staffing or 2:1 staffing. Margaret stated that there are cost pressures around this and a report highlighting these issues is going to the next meeting of the Schools Forum. This could also be escalated to the SEND Strategy Group. Margaret will also pick this up with Sue Day (Interim Manager, Assessment and Review Team). It was noted that Barnsley received a Gold Award for young people's involvement following the work on national takeover day. Young people have attended a Cabinet meeting and the Safeguarding Children Board.	**ML**
3.	<u>Identification of confidential reports and declarations of any conflict of interest</u> It was noted that items 5, 6, 10 and 12 of the minutes are to be treated as confidential. There were no conflicts of interest declared.	
4.	<u>Minutes of the Trust Executive Group meeting held on 28 April 2017</u> The minutes of the previous meeting were agreed as an accurate record, subject to the following amendments: <u>Item 9 – Draft BSCB Minutes of 24 March 2017 highlights</u> – Rachel reminded members that this important piece of work had been a response to David Cameron's call to action – after discussion it was agreed to delete *had been a response to David Cameron's call to action as that referred to the growth in Registered Health Visitors which pre dated the changes in the Public Health grant and subsequent work on 0-19 lead by BMBC which Rachel was referring to.* <u>TEG Work Programme Review</u> Brigid queried the point about adding a further column to the document – this to be considered later in the meeting.	
4.1	<u>Action log / matters arising</u> The following updates were noted: <u>Actions from previous meeting</u> Item 2.1 – Meeting with the Youth Council and Item 2.2 – CYP Plan amendments – these two points to be merged together to become one action. Richard stated that regarding follow up from the Youth Council, he is waiting for members to feed back the young people's comments. Pending receipt of feedback, work to be undertaken on the design of the CYP Plan. <u>Actions from 28 April 2017</u> Item 2 – Integrated Front Door, Worsbrough – Mel to take this forward. Item 13 – Healthy Weight Alliance (NCMP) – a meeting has been arranged to discuss. This action can now be closed.	**RL** **RL** **MJ-R**

		Action
For discussion		
5.	Keeping Children and Young People Safe (Mel John-Ross)	
5.1	• **Managing risk for children in care placed outside the Borough** Mel outlined that this report went to the Overview and Scrutiny Committee on 2 May 2017 and highlighted the following points: o One of the corporate indicators is that children should be placed in local authority care within 20 miles of their home address. 84.9% of children in Barnsley are placed within 20 miles of their home address. The aspirational figure is 92%, which has not been met, however Barnsley has achieved better than the national figure, which is 74%. Placing children within the borough helps to promote their identity and also their family relationships. Research shows that children perform better if these links are sustained and if they are placed locally that helps to meet their needs. o The report outlines the reasons why children are sometimes placed outside Barnsley. Barnsley has a relatively stable group of children in care with low numbers due to good permanence planning. Children perform well if they have placement stability. More foster placements are needed in Barnsley and a recruitment campaign has recently been carried out to try and attract more foster carers. More foster placements are required particularly to care for children on a long term basis and to care for teenagers. o The report contains figures of children placed more than 20 miles away from their family. o Section 3 shows educational, health and police support for children in care. Mel outlined the future challenges and priorities, which are around securing the right place for children. There is a placement sufficiency strategy in place and a Board that oversees the work, which is achieving the right outcome for children. Brigid reported that a sharing the learning event had been held for Designated Nurses across South Yorkshire. Gerry asked what interface is there between foster carers and Social Care to find out what would help them in caring for children in their care. Mel responded that they had learned more after being part of the South Yorkshire Empower and Protect Programme when they recruited foster carers specifically to care for young people at risk of CSE. During the second year of the programme it was around caring for vulnerable adolescents. Foster carers have a fear and anxiety around being left with young people presenting with challenging and risky behaviour. The department treats foster carers as professionals and ensures they have a team around them supporting them and the children in their placement. The team needs professional advice from CAMHS and there is a need to ensure that foster carers do not feel alone and that they are provided with professional supervision. Foster carers all have their own social worker and they have the opportunity to access training and support and have a clear progression route.	

		Action
	Regarding the recruitment of foster carers, Mel to use the report that went to ECG around this and share it with TEG members. It was noted that some foster carers leave Barnsley Local Authority and go to private fostering agencies. Richard stated that Barnsley performs well to avoid the need for children to go into residential care. 20-25 Barnsley children are placed in residential care, which equates to about 8% of the CiC population. It was acknowledged that residential care is sometimes needed for children in care in order to achieve best outcomes. Mel stated that people want to see real foster carers and real young people and a video has been made with young people showing how their lives have changed due to being in foster care. The placement sufficiency strategy and action plan deals with retention of foster carers as well as recruitment. In the recent Yorkshire and Humber ACDS self assessment placement sufficiency was one of the top focuses. It was asked if Overview and Scrutiny made any comments about the report at the meeting. Mel responded that the feedback was that there had been a robust discussion and challenge by members. Corporate Parenting Panel will oversee the work contained in this report. David stated that there is a cohort of young people in out of borough placements where there might be the potential for them to fall through the net regarding health issues. Brigid responded that progress has been made regarding provision and charging for Health Assessments and Reviews but that there remains a challenge, particularly around access to NHS therapeutic services. • **Ofsted Common Inspection Framework for CSC** o Mel reported that this report has already been to the Safeguarding Children Board so some members of TEG will already have seen it. In June 2016, Ofsted launched a major consultation with stakeholders on its proposals for the future inspection of local authority children's services and children's social care settings. These proposals were aimed at establishing the following: - A set of principles to underpin social care inspections and which, firstly, focus on the issues which matter most to the lives of vulnerable children and, secondly, ensure consistency in Ofsted's expectations of providers. - A new more proportionate approach to the inspection of local authority children's services, following conclusion of the current single inspection framework. - A new common inspection framework for children's social care settings, which would include independent fostering agencies. The report outlines a summary of proposals for the future inspection of Local Authority children's services. From January 2018 there will no longer be an assessment of the effectiveness of LSCBs. The Local Authority has a multi agency officer group that will lead the preparation for the inspection.	**MJ-R**

		Action
	• **JTAIs of Child Protection Provision** (for information) This guidance is to assist inspectors from Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMI Probation) when they conduct a joint targeted area inspection (JTAI) that includes a deep dive investigation of the response to children who are/or have been neglected. Mel stated that they had looked at CSE cases, children living with domestic abuse and children living with neglect and the teams have prepared for all those areas. Neglect is a real issue in Barnsley and for children subject to child protection plans the highest category is neglect. The Performance Audit and Quality Assurance Sub Committee (PAQA), which is a sub-committee of Barnsley Safeguarding Children Board has undertaken an audit of neglect cases. An audit was carried out on 10 cases of children who have been on child protection plans longer than two years and those who have been on repeat plans. Social care has completed a single agency audit of neglect cases. It was suggested that a partner be invited in to look at our auditing so we have external challenge. Mel drew colleagues' attention to the section of the Barnsley Safeguarding Children Board minutes dated 26 May 2017 which sets out the summary of the discussion around this at the Safeguarding Board.	
6.	<u>Neglect Strategy</u> (Mel John-Ross) Mel outlined that the Neglect Strategy is a partnership strategy and is not a Barnsley MBC document. This Strategy will be launched during Safeguarding Week, which is the week commencing 3 July 2017. It was noted that it has been agreed that a sub committee of the Safeguarding Board would be set up to look at neglect. Further work to be highlighted through the sub committee acting on the identity of neglect cases and the levels of response. It was asked about children who are living in poverty but they may not be identified as living in poverty and how is that information passed on to social care so that something can be done following the neglect pathway. Mel responded that children who live in poverty are not always neglected and support for them would be around our early help offer. We need to ensure all agencies know the pathway to early help. Where a child is being abused or harmed, we are raising awareness among all professionals and partners around pathways and who to contact to escalate those concerns. Social care is involved where a child is suspected of being harmed or abused and their needs are neglected which results in significant harm to them. The signposting of where people can go if they suspect neglect could be embedded in the strategy.	
7.	<u>Results of the peer challenge on children missing education</u> - presentation (Margaret Libreri) Margaret delivered a presentation on the results of the peer review on children missing education.	

		Action
	It was agreed that a narrative is needed that shows the inter relation between TEG and the Alliance and what could TEG assist the Alliance with and vice versa and what can we as a partnership do to support the work that is happening. It was asked if TEG could see the work programme from the Alliance at the next TEG meeting. ML responded that the Alliance is accountable to TEG so we should bring reports from the Alliance to be presented to TEG. It was agreed that TEG needs more information around the work that the Alliance is involved with. It was asked if exclusion figures are higher in Barnsley than the national average. Margaret responded that permanent exclusions have gone up slightly but from a very low base so are not a significant problem. Fixed term exclusions in secondary are the highest regionally. Margaret stated that some schools are good at engaging and participating in initiatives and consequently have done well, whereas some schools do not engage with the support that is offered to them. It was highlighted that there is an issue around transition from primary to secondary school. It was agreed that as part of the action plan we consider transition and particularly around vulnerable children.	**ML**
8.	Information Sharing baseline position (Sara Hydon) A draft briefing note was presented to the meeting, outlining the information governance arrangements and system interoperability between the Council and Health. It was agreed that there is further work to do around the ethos of information sharing and discussions need to take place with colleagues about enacting the information sharing agreement.	
9.	Stronger Communities Partnership Position Statement – for information	
Standard agenda items		
10.	Continuous Service Improvement Plan – confidential (Julie Govan) - Members comments Brigid stated that it would be useful to focus on four areas which are: 1. Early Help 2. Neglect 3. Missing 4. Fostering • Early Help is green. The self assessment that went to BSCB was discussed. Governance arrangements around Early Help assessment need to be strengthened. • Neglect - Julie stated that there is evidence of improvement but it has to shown as amber until it is signed off. It is a progress document as well as a monitoring document.	

		Action
	• Missing - Mel stated that there is a multi agency panel, which includes key partners and oversees our most vulnerable young people. Mel stated that she is taking the report on missing children from Barnsley to Corporate Parenting Panel. PAQA is undertaking an audit on our return to care interview. • Fostering - the judgement of amber would fit but there is still further work to do. Julie highlighted a number of areas where there had been a change and asked if members were happy for the plan to be approved. • Front Door overall progress has gone from amber to green. • Planning has an action which has moved to red as the number of children on a child protection plan over two years has increased. • CAMHS has an action which has moved to red as the baseline regarding average waiting time from referral to treatment has not been received. • PLO overall progress has moved to red. Mel explained that it refers to the national process around when preparations are made to go into public law care proceedings regarding a child and this is an action from when Ofsted carried out an inspection in 2014. It had been tackled by producing data to track our performance as care proceedings should be completed within 26 weeks so that children are not languishing before the court. It is about timely permanency. Barnsley's performance has dropped against the 26 weeks timescale. However, for some of the cases there might be a good reason for this. There needs to be information available to be able to track timely permanency. • Voice of the child and Care 4 Us. A challenge has been raised regarding the absence of a clear process with Care 4 Us Council and therefore should it be amber? Margaret and Mel have looked at the capacity of targeted youth support and social care providing support to Care 4 US meetings. The post of family support worker to support the Care 4 Us meetings is to be recruited to so that there is the right support for the Care 4 Us council and the meetings are coordinated and managed. It was agreed to move to amber. • For the next meeting it to be decided which areas we should be considering. It was asked if the dates of the Officer Group could be shared with TEG members and for them to also attend Officer Groups. The dates of the meetings of the officer Groups are held on a Thursday 8:30-10:30am at Gateway Plaza as follows: 27 July 2017 7 September 201 5 October 2017 9 November 2017 14 December 2017	

		Action
11.	TEG work programme review (Richard Lynch) The work programme is reviewed at every meeting. The way it is structured is in response to the priorities set out in the Children and Young People's Plan. It was noted that the three key areas for improvements should be lifted and stand above or link to the key actions to make it clearer. As the group likes to revisit individual items, we need to determine how we make it more aligned or dynamic. Richard to circulate a draft before the next meeting.	**RL**
12.	BSCB Minutes of 26 May 2017 (confidential) (For information)	

Proposed main agenda items for the next meeting on 21 July 2017

- BSCB Annual Report (Bob Dyson)
- BSCB Minutes of 14 July 2017 – Highlights (Bob Dyson)
- Improving staff skills to deliver quality services (Amanda Glew) – 45 minutes
- Looked After Children Sufficiency Strategy/ Foster Carer Placements (Richard Lynch/ Jon Banwell)
- Continuous Service Improvement Plan
- TEG Work Programme

Dates of future meetings in 2017	Time	Venue
21 July (Friday)	09.30 – 12.30	Westgate Plaza Level 3, Room 3
28 September	14.00 – 17.00	Westgate Plaza Level 3, Room 3
13 November	13.30 – 16.30	Westgate Plaza Level 3, Room 3

SAFER BARNSLEY PARTNERSHIP
EXECUTIVE BOARD MEETING MINUTES

Wednesday, 28 June 2017
13:30 – 15:30
Silver Suite, Barnsley Police Station, Churchfields

Present:
Scott Green, Chief Superintendent: South Yorkshire Police (Chair) Wendy Lowder, Executive Director Communities: Barnsley Council Paul Brannan, Head of Service, Safer Barnsley: Barnsley Council Jane Wood, Head of Social Care & Health: Barnsley Council Jayne Hellowell, Head of Commissioning: Barnsley Council Carrie Abbott, Service Director Public Health: Barnsley Council Cheryl Wynn, Partnerships & Projects Officer: Office Police & Crime Commissioner Ben Finley, Youth Justice Service Manager: Barnsley Council Cllr Dave Griffin: Barnsley Council Tony Griffiths, Housing Management Group Manager: Berneslai Homes Phil Hollingsworth, Head of Stronger Communities: Barnsley Council Steve Fletcher, District Commander: SY Fire & Rescue John Hallows, Chair: Barnsley Neighbourhood Watch Liaison Grp Cllr Jenny Platts: Barnsley Council In attendance : Sharon Pitt, Business Support Office:, Barnsley Council (Minutes) Mel Fitzpatrick, Strategic Governance & Partnership Manager: Barnsley Council

1. Apologies & Introductions
The Chair welcomed everyone to the meeting and introductions were made. Scott Green confirmed he would chair the meeting and that he and Wendy Lowder would alternate the chairing of the Executive Board meetings going forward. Apologies were received from: Rhona Bywater – SYJS Damian Henderson & Kelly Jenkins – South Yorkshire Fire & Rescue Delphine Waring, Sarah Poolman & Mark James – South Yorkshire Police Ann Powell – National Probation Service Mel John-Ross – Barnsley Council Lennie Sahota – Barnsley Council (Jane Wood to attend) Dave Fullen – Berneslai Homes (Tony Griffiths to attend) Lesley Smith – Barnsley CCG Linda Mayhew – Criminal Justice Board

The Chair offered his formal congratulations to Phil Hollingsworth who would be taking up the position as Service Director - Safer, Stronger & Healthier Communities for Barnsley Council from 10 July 2017. In addition, he advised the meeting that Superintendent Sarah Poolman and DCI Delphine Waring had also recently taken up new appointments with South Yorkshire Police Barnsley District.

2. Minutes of Previous Meeting

The minutes of the meeting held on 27 March 2017 were agreed as a true record.

Action Schedule

Action 1.1 – Accommodation Providers & Looked After Children

Ben Finley confirmed that looked after children and links with accommodation providers falls within the remit of social care reporting to the Safeguarding Board. The number of looked after children placed in Barnsley by other Local Authorities was discussed. Ben Finley agreed to facilitate discussions with neighbouring authorities and accommodation providers to review the protocol in place for out of authority placements. Ben Finley agreed to provide a briefing note at the next Safer Barnsley Partnership Board meeting. Wendy Lowder requested that the briefing note include an outline of in-authority placements into Barnsley analysed by placing Local Authorities along with an overview of any demand created on Safer Neighbourhood Service resources.

Action: Ben Finley to provide a briefing note at the next meeting to include an overview of in-authority placements into Barnsley, demand on Safer Neighbourhood Services and a progress update of developments with accommodation providers and neighbouring authorities outlining agreed protocols for out-of-authority placements.

Action 1.2 - Partnership Information Sharing Protocol

Mel Fitzpatrick confirmed this had been circulated to all Board members, with a reminder, and requested that members return signatures in line with the given timescales. The Chair emphasised the importance of all partners signing up to the protocol as set out in the Crime and Disorder Act. Jayne Hellowell confirmed that a suite of supporting information sharing agreements are being developed and that sign-up to the over-arching information sharing protocol by partners is a crucial part of this process. The Chair asked that where sign-off is not received by any partner agencies, that this be escalated to the Co-Chairs of the Safer Barnsley Partnership.

Action: If sign-off of the Information Sharing Protocol is not received by any partner agency in line with given timescales, Mel Fitzpatrick to escalate to the Co-Chairs of Safer Barnsley Partnership.

Action 2.1 - South Yorkshire Fire & Rescue Integrated Risk Management Plan

Steve Fletcher confirmed that the South Yorkshire Fire & Rescue Integrated Risk Management Plan has now been implemented and that a new fire station is planned on the existing site on Broadway which will offer shared services. The Chair welcomed this as a great opportunity and any interested partners should contact Jayne Hellowell with suggestions on services which could be offered in the new premises. Jayne Hellowell to co-ordinate responses and bring back to

the next Board meeting.

Action: Jayne Hellowell to co-ordinate responses regarding proposals in relation to providing shared and co-located services at the new fire station.

Action 3.1 – Night Time Self-Assessment

It was noted that the assessment been rescheduled for September and the results will be scheduled for a future Board meeting.

Action: Mel Fitzpatrick to schedule an update from the Night Time Self-Assessment for a future meeting.

Action 4.1 - CSE / Safeguarding Update Report

Item deferred. Item to be re-scheduled for next Board meeting.

Action: Mel Fitzpatrick to schedule CSE/Safeguarding update for next Board meeting.

Action 5.1 - CRC Progress Update

Item deferred. Item to be re-scheduled for next Board meeting.

Action: Mel Fitzpatrick to schedule CRC progress update for next Board meeting.

Action 6.1 - Charlie Taylor Review of Youth Justice

Item deferred. Item to be re-scheduled for next Board meeting.

Action: Mel Fitzpatrick to schedule Charlie Taylor Review of Youth Justice update for next Board meeting.

Action 7.1 – Safer Barnsley Governance Update

Governance to be discussed as part of the agenda – item discharged.

Action 8.1 - Safer Neighbourhood Service Update

Paul Brannan advised that he had held an initial meeting with CRC regarding proposals to align specific resources with the Safer Neighbourhood Service. Wendy Lowder requested that a further meeting be held to agree a way forward in terms of aligning CRC resources with the Safer Neighbourhood Service.

Action: Paul Brannan to meet with CRC to agree a way forward in terms of aligning CRC resources with the Safer Neighbourhood Service.

Action 9.1 - Commissioned Services update

Action not progressed. Jayne Hellowell to action and circulate a briefing note in relation to the new service commissions.

Action: Jayne Hellowell to circulate briefing note in relation to the new service commissions.

Action 10.1 – Referral Route to South Yorkshire Fire and Rescue

Steve Fletcher confirmed that a refresh of how information is shared between Health and the South Yorkshire Fire and Rescue will be circulated. Jayne Hellowell reported that a meeting is to be held to carry out a whole system review to facilitate clearer pathways.

Action: Steve Fletcher to circulate information sharing process between South Yorkshire Fire and Rescue and Health.

Action 10.2 – Extension of Board Membership to SWYPFT

Mel Fitzpatrick confirmed that an invite had been extended to Sean Rayner as the District Director for SWYPFT and that a response was awaited.

Action: Mel Fitzpatrick to contact Sean Rayner to confirm the representative from SWYPFT.

Action 10.3 – Safer Barnsley Agenda – June 2017

Mel Fitzpatrick confirmed that the Safer Barnsley Partnership Board agenda had been revised to focus on performance and delivery. Item discharged.

3. Strategic Planning Approach Presentation

Mel Fitzpatrick provided an overview of the Safer Barnsley approach to strategic planning on behalf of the Strategy & Performance Group. The presentation gave an outline of the strategic planning approach, the Partnership Plan and key priorities (2016-2020) along with current governance structures.

Scott Green highlighted that in terms of governance; the Safer Barnsley Partnership is a statutory partnership as set out in the Crime and Disorder Act 1998 and although locally the Safer Barnsley Partnership feeds into the Health and Wellbeing Board, there are no statutory reporting requirements placed on Community Safety Partnerships in relation to Health and Wellbeing Boards.

Scott Green re-emphasised that in line with the current governance arrangements, the Safer Barnsley Partnership should focus on strategic issues and proposed that the current Strategy and Performance Group be subsequently renamed the Performance and Delivery Group with the Terms of Reference amended to reflect tactical overview of the Safer Barnsley Partnership Delivery Groups. This was endorsed by members of the Board.

Scott Green confirmed that the Safer Barnsley Partnership will task the Performance and Delivery Group to oversee the effective delivery against the identified priorities ensuring a risk-based approach and focusing on the areas which collectively, the partnership can achieve the greatest impact supporting individuals, families and communities to achieve the best possible outcomes.

Scott Green advised that the Safer Barnsley Partnership needs to be cited on the strategic risks associated with the delivery of the Safer Barnsley priorities and that the next Board should consider the strategic risk register.

Action: Mel Fitzpatrick to review the Strategy & Performance Group Terms of Reference to reflect the name change and remit and submit to the next Performance and Delivery Group for consideration. These will then be presented for ratification to the Safer Barnsley Partnership.

Action: Mel Fitzpatrick to review the Safer Barnsley strategic risk register and agenda for the next Safer Barnsley Partnership.

4. Protecting Vulnerable People Priority Presentation / Check & Challenge

Jayne Hellowell gave a presentation on behalf of the Protecting Vulnerable People Delivery Group. The presentation gave an overview of the Delivery Group governance, delivery plan and the key actions to drive forward the identified priorities, the performance picture linked to the recently developed performance framework and key challenges and solutions.

Jayne Hellowell outlined that significant progress had been made with the re-commissioning of services supporting vulnerable people and that the group would continue to have a campaign-based approach particularly in relation to raising awareness of domestic abuse. Jayne Hellowell outlined the revised governance arrangements in relation to MARAC and advised that all Chairs had received refresher training.

Steve Fletcher asked for further clarity in relation to the governance arrangements of the Safe and Well Scheme stating that currently this is owned by the Early Help Adults Group under the Stronger Communities Partnership and the Protecting Vulnerable People Delivery Group. Wendy Lowder advised that this would be addressed as part of a proposed governance review in relation to the Stronger Communities Partnership.

Wendy Lowder thanked Jayne Hellowell and the Delivery Group for the valuable work undertaken to reshape commissioned services. It was emphasised that campaigns should be undertaken routinely and the changes made to MARAC governance and accountability were welcomed.

Tony Griffiths stated that the Delivery Plan was comprehensive and welcomed that the plan reflects the need to address domestic abuse across all risk levels.

Paul Brannan added that connectivity across the Delivery Groups and priorities will be vitally important in order to collectively address cross-cutting issues such as town centre conduct. Wendy Lowder stated that cross-cutting issues will be considered by the Performance and Delivery Group.

Scott Green thanked Jayne Hellowell for the presentation and the work of the Delivery Group. Scott Green requested that the performance framework for the Protecting Vulnerable People priority be reviewed and further refined particularly at a tactical level.

Action: Phil Hollingsworth to provide an update to the next Safer Barnsley Partnership in relation to the proposed Stronger Communities Partnership governance review and the links to the Safer Barnsley Partnership.

Action: Jayne Hellowell & Jakki Hardy to further review and refine the Protecting Vulnerable People performance framework and submit to the Performance and Delivery Group for ratification.

5. Community Tolerance & Respect Priority Presentation / Check & Challenge

Paul Brannan gave a presentation on behalf of the Promoting Community Tolerance and Respect Delivery Group. The presentation gave an overview of the Delivery Group governance, delivery plan and the key actions to drive forward the identified priorities, the performance picture linked to the recently developed performance framework and key challenges and solutions.

Paul Brannan outlined that significant progress has been made with the further development of the Channel Panel which reports to the Silver Prevent Partnership. A Prevent training programme has been implemented which supports development of skills and knowledge across all sectors.

Wendy Lowder thanked Paul for his presentation and thanked the Delivery Group for their work in relation to Prevent. It was highlighted the next regional Prevent meeting will be held in Barnsley. Wendy Lowder stressed the importance of encouraging representation from a broad range of stakeholders across the region in order to facilitate joint working and the sharing of best practice.

A discussion was held in relation to hate crimes and incidents and national standards for recording. Scott Green stated that a large proportion of hate crimes were usually recorded with the primary contributing factors being either vulnerability or ethnicity. Scott Green confirmed that the force lead for hate crime is Sarah Poolman.

Scott Green thanked Paul Brannan for the presentation and the work of the Delivery Group and requested that the performance framework for the Community Tolerance and Respect priority be reviewed and further refined particularly at a tactical level.

Action: Paul Brannan & Jakki Hardy to further review and refine the Community Tolerance and Respect performance framework and submit to the Performance and Delivery Group for ratification.

6. Tackling Crime & ASB Priority Presentation / Check & Challenge

Ben Finley gave a presentation on behalf of the Tackling Crime & ASB Delivery Group. The presentation gave an overview of the Delivery Group governance, delivery plan and the key actions to drive forward the identified priorities, the performance picture linked to the recently developed performance framework and key challenges and solutions.

Ben Finley outlined that the revised governance arrangements in relation to Crime and ASB were developing and that work was underway to further embed and align early help approaches. Ben highlighted that there had been changes in the joint Priority Lead Officer with DCI Delphine Waring taking up with position over recent weeks.

Steve Fletcher requested that the Fire Service be represented on the Delivery Group. John Hallows also asked if he could be added to the group on behalf of the Barnsley Neighbourhood Watch Group. Ben Finley confirmed he would amend the membership.

Both Wendy Lowder and Scott Green thanked Ben Finley for the presentation and the work of the Delivery Group. Scott Green requested that given the recent changes to Priority Lead Officer, that the delivery plan and performance framework for the Crime and ASB priority be reviewed to ensure full alignment with the Safer Barnsley strategic priorities.

Action: Ben Finley and Delphine Waring to further review and refine the Tackling Crime & ASB delivery plan and performance framework and submit to the Performance and Delivery Group for ratification.

Action: Ben Finley to add Steve Fletcher (SYFR) and John Hallows (BNWLG) as members of the Crime and ASB Delivery Group.

7. Any Other Business

Scott Green informed the meeting that an Organised Crime Partnership Board will be established locally and will be chaired by Delphine Waring. Meetings will be held quarterly and a number of attendees of the Safer Barnsley Partnership Board will be invited.

Wendy Lowder requested that the Board representative from the CCG be clarified.

Action: Mel Fitzpatrick to clarify the Safer Barnsley Board representative with the CCG.

Scott Green thanked everyone for their input and thanked Mel Fitzpatrick for her work in supporting the development of the Safer Barnsley Partnership.

8. Date and Time of Next Meeting

The next meeting will be held on Thursday, 14 September 2017, 13:30 – 15:30
Silver Suite, Barnsley Police Station, Churchfields

Action schedule from minutes (28 June 2017)

1	**Action schedule 27 March 2017**
1.1	Ben Finley to provide a briefing note at the next meeting to include an overview of in-authority placements into Barnsley, demand on Safer Neighbourhood Services and a progress update of developments with accommodation providers and neighbouring authorities outlining agreed protocols for out-of-authority placements.
1.2	If sign-off of the Information Sharing Protocol is not received by any partner agency in line with given timescales, Mel Fitzpatrick to escalate to the Co-Chairs of Safer Barnsley Partnership.
1.3	Jayne Hellowell to co-ordinate responses regarding proposals in relation to providing shared and co-located services at the new fire station.
1.4	Mel Fitzpatrick to schedule an update from the Night Time Self-Assessment for a future meeting.
1.5	Mel Fitzpatrick to schedule CSE/Safeguarding update for next Board meeting.
1.6	Mel Fitzpatrick to schedule CRC progress update for next Board meeting.
1.7	Mel Fitzpatrick to schedule Charlie Taylor Review of Youth Justice update for next Board meeting.
1.8	Paul Brannan to meet with CRC to agree a forward in terms of aligning CRC resources with the Safer Neighbourhood Service.
1.9	Jayne Hellowell to circulate briefing note in relation to the new service commissions.
1.10	Steve Fletcher to circulate information sharing process between South Yorkshire Fire and Rescue and Health.
1.11	Mel Fitzpatrick to contact Sean Rayner to confirm the representative from SWYPFT.
2.	**Strategic Planning Approach Presentation**
2.1	Mel Fitzpatrick to review the Strategy & Performance Group Terms of Reference to reflect the name change and remit and submit to the next Performance and Delivery Group for consideration. These will then be presented for ratification to the Safer Barnsley Partnership.
2.2	Mel Fitzpatrick to review the Safer Barnsley strategic risk register and agenda for the next Safer Barnsley Partnership.
3	**Protecting Vulnerable People Priority Presentation/Check & Challenge**
3.1	Phil Hollingsworth to provide an update to the next Safer Barnsley Partnership in relation to the proposed Stronger Communities Partnership governance review and the links to the Safer Barnsley Partnership.

3.2	Jayne Hellowell & Jakki Hardy to further review and refine the Protecting Vulnerable People performance framework and submit to the Performance and Delivery Group for ratification.
4 4.1	**Promoting Community Tolerance & Respect Priority Presentation/Check & Challenge** Paul Brannan & Jakki Hardy to further review and refine the Community Tolerance and Respect performance framework and submit to the Performance and Delivery Group for ratification.
5. 5.1 5.2	**<u>Tackling Crime & ASB Priority Presentation / Check & Challenge</u>** Ben Finley and Delphine Waring to further review and refine the Tackling Crime & ASB delivery plan and performance framework and submit to the Performance and Delivery Group for ratification. Ben Finley to add Steve Fletcher (SYFR) and John Hallows (BNWLG) as members of the Crime and ASB Delivery Group.
6. 6.1	**<u>Any Other Business</u>** Mel Fitzpatrick to clarify the Safer Barnsley Board representative with the CCG.

This page is intentionally left blank

Health and Well Being Provider Forum

Minutes of the meeting held on Wednesday 14 June 2017

Present

Helen Jaggar	Berneslai Homes (Chair)
Pauline Kimentas	Age UK
Andrew Pearce	Caremark
Cindy Mitchell	SYHA
Richard Walker	TLC Homecare
Nicola Lang	SWYPFT
Jo Clark	CAB
Anne Simmons	Alzheimers Society
Kevan Riggett-Barrett	BPL
Sam Goulding	IDAS
Jamie Wike	NHS Barnsley CCG
Sean Rayner	SWYPFT
Phil Parkes	SYHA
Rachel Neale	VAB
Keith Dodd	BMBC (Item 9)

	ACTION
Item 1 – Apologies Apologies were received from Tim Wilson, BPL; Tyler Moore, Centrepoint; Stephen Gallagher, Barnsley Futures; Carolyn Ellis, VAB; Cath Bedford, NHS; Teresa Gibson, VAB; Richard Walker, TLC Homecare	
Item 2 – Minutes of meeting held These were agreed as an accurate record. **Item 2.1- Matters arising** Newly commissioned providers – an invitation had been extended to join the forum and all new providers had expressed a desire to attend future meetings. Dementia Friend Sessions – AS reported a reminder e mail had been circulated to providers asking that any Dementia Friends Champion record Dementia Friends Information sessions on the website to ensure records are up to date. A reminder will now be sent every 12 months to ensure the database is up to date. HJ said that as dementia is one of the priorities of the Health and Wellbeing Board it would be useful to discuss the work that providers are doing in relation to this at a future meeting. As work is currently being done on producing a Barnsley Joint Dementia Action Plan HJ agreed to circulate to this to the forum for any comments.	**HJ**
Item 3 – Health and Wellbeing Board An update was provided on the key points from the meeting held on 6th June attended by HJ/SR. • Feedback received from the Children and Young People's Trust Executive Group. Focus was on the impact of a smoke free	

generation and seeking young peoples' views on transport within the borough. • Starting to look at delivery of 0 – 19 years services which fall within the LA's remit. • Safer Barnsley Partnership Board – advised of new commissioning providers. Paper tabled on the new Safer Neighbourhood Services. Council's Community Safety Team and Police coming together in co-located services. Central hub at Churchfields in the town centre with 4 area hubs to be based at Royston, Goldthorpe, Kendray and the town centre. Focus will be on dealing with families who have multiple and complex needs. As part of the new commissioning providers who deal with domestic abuse and mental health will be part of the process. • Raised how the public ask questions at Board. The lead officer from the various partnerships attending extract a specific item from their minutes to share into Board. As the forum has representation HJ said providers may wish to reflect on one key message from the minutes that could be shared at future Board meetings. • Paper tabled on adult social care funding as Barnsley received an additional one off sum of £11 m. over the next 3 years. The paper identified and the Board approved how the additional resources would be invested. HJ outlined the main areas of spend and asked if the forum had any comments on the allocation of the funding. The forum raised the following comments which HJ agreed to feedback, in particular to SSDG. – Concern expressed on allocation of only £700,000 (6% of total available) to recruit and retain staff across entire social care sector in Barnsley when considered against the level of investment of £800,000 over the 3 year period to increase the Council's management and infrastructure. . Felt that 6% of the allocation was unlikely to impact on enhancing the quality and sustainability of providers' businesses. – Felt there would have been some reference to the domiciliary care market rather than just nursing home beds. – Requested understanding of the Carers Centre model which fell under Communities. – As only £4.3 m. of the £11 m. spend has been detailed in Appendix 2, requested detail on how remaining spend will be allocated. • Any further comments to be forward to HJ.	**HJ** **All**
<u>Item 4 – Stronger Communities Partnership</u> PP reported that no further Partnership Board had been held since the previous meeting of the forum. However a dedicated workshop had been held on 23 May 2017 on the Early Help Strategy 2007 – 20200. This was attended by members of the Health and Wellbeing Board,	

BMBC, CCG, third sector providers and facilitated by Jayne Hellowell, Head of Commissioning, BMBC. Key points from the Workshop were noted: Initially summary of key achievements of the groups sitting underneath the Partnership were given and noted as: <u>Anti Poverty Steering Group</u> – second community shop opened in Athersley with growing project on adjacent land. 50 all electric properties fitted with gas supplies from Better Homes Energy Fund, Council wide fuel poverty training has been done to support and address signs of poverty. <u>Early Help Steering Group</u> – input into community nursing offer, South Yorkshire Fire and Rescue Safe and Well, Families Centres have now increased number of early help assessments therefore giving better outcomes for children and families. Shared promotional video for early help which is about to be launched. PP agreed to circulate to providers when available. The workshop then posed 3 questions. These and the key responses were noted as: Q.1 What were the future priorities around early help? Information sharing – noted that W. Lowder looking at BMBC systems and how they interact and then will look to tie into this. Providers raised the role of the third sector in delivery of this agenda and how they could contribute. Felt that a number of organisations could contribute that are quite peripheral. Organisations that have a contract to deliver specific pathways are more embedded into this agenda. Raised that there was no service user representation therefore further input from community needed to understand impact of the services they receive. Q2. How will we know if we've got there? Need to consider how you hear the customer voice and measure intervention – all in attendance struggled on how you record that people are happier and more confident to be more independent. Felt that outcomes from STAR and 5 ways to wellbeing were ways of measuring outcomes. Q3. How will we deliver? Felt that this was in relation to the governance structures and there was little progress in this respect therefore PP said that any ideas would be welcomed. PP requested providers to reflect on the above and forward directly to him any methods that are currently used to measure outcomes or provide feedback if any of the referenced ways e.g. 5 ways to wellbeing are being utilised.	**PP** **All** **All**
Item 5 – Social Prescribing – My Best Life – Update PP provided an update. Steering Group membership was noted as representation from CCG, BMBC, Berneslai Homes, GP's, Area Council and third sector however the group is still forming. Richard Walker is the forum's representative. The management base is located at Westmeads, Royston. Community bases within GP surgeries and which mirror the community nursing patches are located in the north, north east, south, central, Penistone	

and Dearne. The scheme was launched on the 1st April 2017. From 1/4/17 to 31/5/17, 124 referrals have been made and to date this has totalled 170. The target for referrals in the first year being 600. 90 onward referrals have been made. The majority of initial referrals have been 60 years+, retired, with a split of 63% female, 37% male. PP said the Steering Group were keen to have representation from the third sector to ensure awareness of organisations' capacity to manage onward referrals with existing resources. Early indications were that this is not an issue however PP requested that providers feedback directly to him should there be an indication contrary to this so this can be used as an evidence base to commissioners and funders. One of the challenges faced by the Steering Group would be how to show the impact a referral has had on an individual. HJ felt it would be interesting over the next 6 months to note whether referrals were predominantly from people living in their own homes as the data has not yet been analysed. Providers again raised the capacity to widen the referral route after the first 12 months. PP said discussions with various people would need to commence once the scheme had been in operation for 12 months. KRB raised if BPL were being used for onward referrals to highlight the benefits of exercise. PP said that referrals were made to any organisation where an individual's circumstances could benefit. KRB stated that BPL were looking to revitalise over the next year a GP referral system that had previously achieved good results. AS raised which organisations were used for referrals in respect of dementia specific customers as to date no contact had been made with the Alzheimers Society. PP said links were in place and a referral had been made to BIAD. Agreed PP request Natalie Dunn, Team Leader to contact KRB and AS direct. PP agreed to provide a further update at the forum's December meeting.	**All** **PP** **PP**
Item 5 – Barnsley Place Based Plan The forum received a presentation from J. Wike, CCG the main focus being to provide an update on the outcomes from the recent engagement and community conversations held on the Plan between February and April 2017. The responses and headline findings were discussed. The forum felt that when the CCG/hospital undertook any future consultation it would be beneficial to consider their engagement methods to ensure service user voices were heard as some response figures were quite stark. JW stated that some organisations had been more proactive in this than others and this may be indicative in the responses. The forum raised that only 6 people, mainly from the third sector had attended the focus group and felt that information with regard to this may not have been widely disseminated. J. Wike said that a summary report from the findings has now been published and circulated for individual organisations to consider with their governing body. For Barnsley the governing body will identify specific areas for review and this will be subject to further detailed engagement. He felt this was an area that providers could be involved in. In April new NHS guides were published on how the CCG should engage on service change and this has been taken into consideration.	

Information was also provided in respect of the review taking place on sustaining hospital services which will take place over the next 12 months. This will look at how hospitals can improve working together to deliver better services and felt this could a future discussion topic for the forum. The Accountable Care Partnership Board will also be looking at Accountable Care Plans and establishing at STP level how this is operated.	
Item 6 – Future Agenda Items Oral Health and Smoke Free Generation presentations to be given at meeting on 13/9/17. Suicide Prevention (to be tabled at future meeting) Social Prescribing Update to be provided on 13/12/17 - PP.	
Item 7 – Any Other Business **i. Age Friendly Barnsley** – PK tabled a paper outlining the purpose of the Age Friendly Conference to be held at Priory Campus on 6/10/17. This is to showcase best practice already ongoing in Barnsley and to look at what is needed to make Barnsley a more age friendly place. Providers were asked if they wished to be involved in the planning/day or forward any examples of good practice to the contacts detailed within the paper.	**All**
Item 8 – Date of next meeting – 13 September 2017 at Berneslai Homes Board Room, Gateway Plaza.	
Item 9 – Early Help Adults Workshop K. Dodd, BMBC gave a presentation on the Universal Information and Advice Project and the focus on digital and promoting self reliance. The forum discussed their role in respect of Live Well Barnsley and what they were doing to shift service to self serve. Details of how providers can get established on Live Well Barnsley are detailed in the leaflet below which is self explanatory or contact can be made with Claire Beecroft at: ClaireBeecroft@barnsley.gov.uk Live Well Barnsley – A5 4pp Flyer.pdf	

This page is intentionally left blank

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

12 May 2017, The Birch/Elm Room, Oak House, Rotherham

Decision Summary

Minute reference	Item	Action
41/17	**Minutes of the previous meeting held 7 April 2017** The following amendment was required at 39/17, Bassetlaw paragraph, 2nd line, Barnsley should be altered to read Bassetlaw.	**JA**
43/17	**National Update** **SYB Memorandum Of Understanding** a) That Will Cleary-Gray would collate all feedback and comments regarding the draft and bring revised MOU to the next Collaborative Partnership Board Meeting on 9th June. b) That members should forward any further feedback to Will Cleary-Gray.	**WC-G** **ALL**
44/17	**Finance update** **Stroke Business Case** • A short note to members will be circulated that identifies the process that was used concerning the submission of the three capital bids e.g. how they got from the list to being submitted to the Department of Health in the timescales involved. The following additional comments were made by members: • It is important that the revised figures regarding the Stroke blueprint and analysis are shared with stakeholders to inform understanding of potential changes and impact.	**JC** **JC**
46/17	**Update on Programme Activity:** **a. Workforce** Members noted the connection with the Workforce Framework paper previously presented to the Collaborative Partnership Board and Tim Gilpin and Peter Hall would support a discussion at a future Collaborative Partnership Board Meeting.	**TG/PH**
47/17	**b. Proposed Joint Infrastructure and the DWP Initiative** Kevan Taylor informed members there would be a presentation and proposal regarding the DWP initiative at the next Collaborative	**KT**

	Partnership Board meeting in June.	
49/17	**d. Cancer** The Chair advised members that the Cancer Alliance Board agreed a shared inter provider transfer (IPT) policy at the May Cancer Alliance Board meeting and has advised the Collaborative Partnership Board at this meeting that the policy had been signed off and was ready to be sent out to partners. After discussion members agreed that the Clinical Reference Group would finalise any outstanding clinical issues within 6 weeks, which will need to be agreed to ensure we are able to successfully operationalise the policy.	**CRG** **CPB**
51/17	**Findings from conversations with the public and staff on the SYB STP** • all future Board reports will be circulated as a single PDF as well as the combined 'Master All' document. Helen Stevens added that her work stream will be looking at a SYB STP website, branding and narrative and a report will be brought to the next Collaborative Partnership Board meeting.	**JA** **HS**
55/17	**Update on Organisational Development** The Collaborative Partnership Board agreed: • 4/5 senior people should be nominated as enablers from each 'place' on the Board. • Social Kinetic will circulate a questionnaire for Board members and those nominated as enablers to complete, this will be 'live' for 2 weeks. • Social Kinetic will then analyse the data received back from the questionnaires. • A wider team event should be arranged e.g. a one day workshop, 10am to 4pm for approximately 80-100 people should be arranged for the whole Collaborative Partnership Board and Team to attend.	**ALL** **Social Kinetic** **Social Kinetic** **Social Kinetic**

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of 12 May 2017,
The Birch & Elm Room, Rotherham

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash	South Yorkshire and Bassetlaw STP	STP Lead/Chair & CEO, Sheffield Teaching Hospitals NHS F T		✓	
Adrian Berry	South West Yorkshire Partnership NHS FT	Deputy Chief Executive		✓	Rob Webster CEO
Adrian England	Healthwatch Barnsley	Chair	✓		
Ainsley Macdonnell,	Nottinghamshire County Council	Service Director		✓	Anthony May CEO
Alison Knowles	Locality Director North of England,	NHS England	✓		
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher	✓		
Catherine Burn	Voluntary Action Representative			✓	
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer	✓		
Chris Holt	The Rotherham NHS Foundation Trust		✓		Louise Barnett
Des Breen	Working Together Partnership Vanguard	Medical Director	✓		
Greg Fell	Sheffield City Council	Director of Public Health	✓		John Mothersole CEO
Frances Cunning	Public Health England	Deputy Director of Health and Wellbeing	✓		
Helen Stevens	South Yorkshire and Bassetlaw STP	Assc. Director of Comms & Engagement	✓		
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Interim Accountable Officer	✓		
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer,	✓		
Jane Anthony	South Yorkshire and Bassetlaw STP	Corp Admin, Exec PA, Business Mgr	✓		
Janette Watkins	Working Together Partnership Vanguard	Director	✓		
Janet Wheatley	Voluntary Action Rotherham	Chief Executive	✓		
Jeremy Cook	South Yorkshire and Bassetlaw STP	Interim Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive	✓		First Hour
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Julia Burrows	Barnsley Council	Director of Public Health	✓		

Julia Newton	Sheffield Clinical Commissioning Group	Chief Finance Officer	□	✓	
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive	✓		
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive	✓		
Lesley Smith	NHS Barnsley Clinical Commissioning Group	Accountable Officer	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive		✓	
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer		✓	
Matt Powels	NHS Sheffield Clinical Commissioning Group	Director of Commissioning	✓		Maddy Ruff
Matthew Groom	NHS England Specialised Commissioning	Assistant Director		✓	
Matthew Sandford	Yorkshire Ambulance Service NHS Trust	Associate Director of Planning & Dev	✓		
Mike Curtis	Health Education England	Local Director	✓		
Neil Taylor	Bassetlaw District Council	Chief Executive	✓		
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Chief Operating Executive	✓		
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Interim Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS F T	Chief Executive	✓		
Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Acting Chief Executive	✓		
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive	✓		
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health	✓		
Sean Raynor	South West Yorkshire Partnership NHS FT	District Service Director, Barnsley and Wakefield	✓		Adrian Berry
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive	✓		
Steve Shore	Healthwatch Doncaster	Chair		✓	
Will Cleary-Gray	South Yorkshire and Bassetlaw STP	Sustainability & Transformation Director	✓		

Minute reference	Item	Action
40/17	**Welcome and introductions** The Chair welcomed members and noted apologies for absence.	
41/17	**Minutes of the previous meeting held 7 April 2017** The following amendment was required at 39/17, Bassetlaw	**JA**

	paragraph, 2nd line, Barnsley should be altered to read Bassetlaw. Subject to the above amendment the minutes of the meeting were accepted as a true and accurate record and would be published.	
42/17	**Matters arising** All matters arising would be picked up as part of the agenda.	
43/17	**National Update** **South Yorkshire and Bassetlaw Memorandum Of Understanding** Will Cleary-Gray updated members on the progress of the Memorandum of Understanding (MoU). The MoU is not a legal contract, nor does it serve to replace the legal framework or responsibilities of our statutory organisations. It is an agreement that sets out the framework within which our partner organisations will come together to establish how we will develop as an Accountable Care System. A draft was shared with Collaborative Partnership Board members attending the South Yorkshire and Bassetlaw Sustainability and Transformation Partnership (SYB STP) timeout on 28 April 2017. Feedback from the timeout was incorporated into the draft MoU and those present at that meeting agreed the revised document should be shared with statutory organisations. The draft was circulated with an accompanying letter from Sir Andrew Cash in which he outlined the context of the MoU, the document being a first draft and requested their feedback which would be incorporated into the document. The draft MoU has also been shared with NHS Improvement and NHS England and with the Five Year Forward View Team. Will Cleary-Gray will collate all further feedback and comments regarding the draft and bring a revised MoU to the next Collaborative Partnership Board meeting on 9th June 2017. The following comments were made by members: • A sentence should be added to the document regarding stakeholders because as provider groups start to develop and emerge they will also be part of the stakeholder agreement and as such should be invited as and when they develop. • This is a helpful and very well written document, this is a social movement of working together. • 'Parties to' and 'partners in' is a useful way to make a distinction between the various stakeholders and how they may wish to be reflected in the MOU. • Clarify 'partners' and 'parties': 'partners' provide support for the direction of travel, 'parties' are organisations that will be signing the MoU. • Yorkshire Ambulance Service is a Trust therefore the word 'Foundation' should be removed when referring to this service. • In the glossary it may be helpful to have an explanation of both 'horizontal' and 'vertical' parties. Will Cleary-Gray agreed to incorporate the above comments into the draft.	**ALL** **WC-G** **WC-G**

	The Chair urged members to forward any further feedback direct the Will Cleary-Gray. The Collaborative Partnership Board noted the Memorandum of Understanding.	**ALL**
44/17	**Finance update** Indicative Budget 2017-18 Jeremy Cook presented his finance report to the meeting drawing attention to the following issues: **Capital** Capital bids had been submitted to the Department of Health under very tight deadlines. STP had submitted 3 bids but as yet has not received any feedback on them from the Department of Health. **STP Budget 17/18** Jeremy Cook added the STP budget for 2017-18 had not yet been worked up as notification of funding from NHS England and NHS Improvement. The Chair advised members she would update them from a national meeting held in London on 2nd May 2017 that both she and Will Cleary-Gray attended. **Financial modeling** Jeremy Cook advised members that a simplified version of the financial plan was being developed. The Finance Steering Group meeting on 23rd May 2017 will receive a presentation regarding the progress. **Hyper acute stroke services business case** Jeremy Cook informed members that there is a difference between the blueprint and analysis figures in terms of the way forward for the hyper acute stroke services business case. Will Cleary-Gray advised members that the team has been working through the revised flows with Yorkshire Ambulance Service to establish clarity. The reviewed flows would be shared with stakeholders. Jeremy responded to comments from members as follows: • There was some urgency around the capital bids as the submission deadline was tight. In future it is expected that such urgent items are channelled through the new Executive Sub Group. The Executive Steering Group is not formed at the moment and Terms of Reference are being taken to the Financial Oversight Committee today and the Executive Steering Group on Tuesday, 16th May and will circulated thereafter. • A short note to members will be circulated that identifies the process that was used concerning the submission of the three capital bids e.g. how they got from the list to being submitted to the Department of Health in the timescales involved.	**JC**

	The following additional comments were made by members: • We must ensure we are aware of the national parameters of bids and their criteria so we can adapt our cases to fit. • It is important that the revised figures regarding the Stroke blueprint and analysis are shared with stakeholders to inform understanding of potential changes and impact. The Chair thanked Jeremy Cook for the information provided.	**JC**
45/17	**Summary update to the Collaborative Partnership Board** The Chair gave members an update on recent national discussions. The Chair and Will Cleary-Gray attended the STP National meeting with Chairs and CE's present from the other 8 STP systems on 2nd May 2017. The Chair informed members that discussion had taken regarding: • Working with the Centre, • Understanding support offer from the Centre including transformational funding, • Understanding how the 9 Accountable Care Systems (ACS) will work together and share information as an emerging ACS. The Chair conveyed the following key items that she took away from the meeting: • The timeline for developing a Memorandum of Understanding which was ending in June. • The national priorities. • The focus on delivery and transformation. The Chair added that she was awaiting the outcomes from the national ACS meeting which would provide detail and clarity regarding the above discussions and areas where we work with the Centre and other emerging ACS. Will Cleary-Gray presented the remaining summary report updates to the Collaborative Partnership Board. The Collaborative Partnership Board received the report and welcomed the updates provided from each of the STP work streams that they would use to inform local discussions.	
46/17	**Update on Programme Activity:** **a. Workforce** The Chair welcomed Linda Crofts, Head of Learning & Development, Sheffield Teaching Hospitals to the meeting. Linda Crofts was also supporting the STP workforce work-stream. Linda Crofts added that it is important to acknowledge that developing the workforce is an opportunity as well as a challenge to achieving successful transformational change. Linda Crofts informed members she was here today to talk through work developing the Excellence Centre and to seek the support of colleagues in the Partnership. At the moment the Excellence Centre is looking to strengthen their Employer Forum.	

	Linda Crofts gave her presentation to Board members. Linda Crofts responded to comments from members as follows: • We should recognise our unregistered workforce is vital to transformational change • We have a good infrastructure in South Yorkshire, we need to bring together the Excellence Centre and Faculty for Advanced Practice. • South Yorkshire has developed good partnerships regarding the development of its workforce, it needs to build on the successes and relationships it already has. Such partnerships are not as well developed in other areas and it would be detrimental to the collaborations already built up if we were to replicate the model to include other areas. Members made the following additional comments • We should understand the resources we have in our different organisations and note that we could work better if we are better connected. • We should ensure there is no duplication i.e. we should change our mindset and create a culture of coming together, noting the potential to focus on learning and development and pool our resources. • Healthcare systems need to understand different skill sets are required outside hospitals. We need to bridge the skill gap to ensure staff are developed and able to respond to take care of people outside of hospitals. • If trained well, some staff bands can potentially free up higher grades so they are able to undertake additional training when required. • We must factor in a consistent approach across South Yorkshire in order that sectors and roles within it are not destabilized. • Social care is keeping people out of hospital. 'Place' relates to 60% of what is going on in STP and therefore we should start discussions with social care teams and their representatives. Collaborative Partnership Board members thanked Linda Crofts for attending this meeting and for her presentation. Members noted the connection with the Workforce Framework paper previously presented to the Collaborative Partnership Board and Tim Gilpin and Peter Hall would support a discussion at a future Collaborative Partnership Board Meeting.	**TG/PH/BC**
47/17	**b. Proposed Department of Work and Pensions (DWP) initiative** Kevan Taylor informed members there would be a presentation and proposal regarding the DWP initiative at the next Collaborative Partnership Board meeting in June.	**KT**
48/17	**c. Urgent Care** The Chair welcomed Rachel Gillott, Programme Director Urgent and Emergency Care, SYB STP to the meeting. Rachel Gillott gave her presentation to Board members.	

	Members were informed that Urgent Care is a big area of work and what this work area is still looking at is identifying two or three major items they want to progress.	
49/17	**d. Cancer** The Chair highlighted that the draft Memorandum of Understanding articulates a move towards a new performance management framework for Cancer. One which will require a clear Inter Provider Trust policy to support the safe and timely transfer of patients between providers: *"We will work to deliver the 62 day referral to treatment standard at system level as a single measure across our provider organisations. This will create capacity to focus not only on the headline target but also enable us to focus on measures which hold the greatest significance to people affected by cancer such as quality of life, whilst also working to improve inter provider transfers within 38 days"*. The Chair added the challenges for this work area being: • 62 days target from referral to treatment - there are clear time pressures in terms of expectation of the achievement of 62 day performance, with a significant national focus. The explicit timeframes within which 62 day performance must be met include 70% of provider organisations must meet the target by July with 100% of provider organisations and Cancer Alliances by September 2017. • A 38 day transfer protocol • What constitutes transfer? • As part of current conversations it is expected that providers will be expected to sign up to a local IPT policy as a requirement to access the Sustainability element of the STF. • We are also aware that any Cancer Transformation funding will also be released based on progress towards recovery of 62 day performance as an SYB&ND system. There has been a significant amount of work, over 18 months to the shared IPT policy. This has been a hugely challenging process in which we have asked organisations and individuals to shift focus from local organisational performance towards a 'new world' acceptance of collective responsibility for shared performance in line with the future aspirations of the Cancer Alliance and STP. Reporting the 62 days as a whole system takes away any focus on grey areas that damage relationships and allows us to get the pathway right for patients. In considering the work to date, the current national focus and the emerging MOU, the Cancer Alliance board agreed the shared Inter provider transfer (IPT) policy at the May Cancer Alliance Board meeting and require the support of the Collaborative Partnership Board to progress. Members responded with the following comments: • Bearing in mind governance protocol the policy should go back to the Clinical Reference Group (CRG) to sign off before us. • We could sign up to the overall policy, dotting the i's and crossing the t's is down to implementation and at the CRG. • The policy needs any issues resolved before we sign it off e.g. exactly what defines a referral. If it can't be resolved by the CRG within a specific time then it should go externally to be	

	resolved and then come back here for signing off in 6 weeks time. The Chair advised members that the Cancer Alliance Board agreed a shared inter provider transfer (IPT) policy at the May Cancer Alliance Board meeting and has advised the Collaborative Partnership Board at this meeting that the policy had been signed off and was ready to be sent out to partners. After discussion members agreed that the Clinical Reference Group would finalise any outstanding clinical issues within 6 weeks, which will need to be agreed to ensure we are able to successfully operationalise the policy.	**CRG** **CPB**
50/17	**e. Mental Health & Learning Disabilities** Unfortunately, due to constraints on time Kathryn Singh and Jackie Pederson were unable to give their presentation. However, they suggested that members read the section of Paper D which provided up-to-date information.	
51/17	**Findings from conversations with the public and staff on the SYB STP** Helen Stevens presented her report to the Collaborative Partnership Board. The report consisted of 3 elements: • an overarching report, • a summary report of community responses about the South Yorkshire and Bassetlaw Sustainability and Transformation Plan(SYB STP), • an analytical report on the current views of the SYB STP. Helen Stevens reported that there had been good engagement in this process and took this opportunity to thank Healthwatch and the voluntary sector for their assistance which has helped to inform this report. Helen Stevens agreed that: • the information contained in this report can now go into the public domain, • all future Board reports will be circulated as a single PDF as well as the combined 'Master All' document. Helen Stevens added that her work stream will be looking at a SYB STP website, branding and narrative and a report will be brought to the next Collaborative Partnership Board meeting. The Collaborative Partnership Board noted this report.	**JA** **HS**
52/17	**Independent Review of Hospital Services** Unfortunately, due to constraints upon time this item was not discussed and members were referred to the written update.	
53/17	**Review of Commissioning** Unfortunately, due to constraints upon time this item was not discussed.	
54/17	**Hyper Acute Stroke Services and Children's Services** Unfortunately, due to constraints upon time this item was not discussed, however, there was a comprehensive report circulated on this subject.	

55/17	**Update on Organisational Development** The Chair welcomed Grace Doherty and Claire Cater from Social Kinetic to the meeting. Grace Doherty and Claire Cater gave their presentation to the meeting. The presentation summarised the work embarked upon so far with Social Kinetic. The next phase for Social Kinetic would be to focus on human factors and they outlined the next phase of their programme for Board members consideration. The Collaborative Partnership Board agreed: • 4/5 senior people should be nominated as enablers from each 'place' on the Board. • Social Kinetic will circulate a questionnaire for Board members and those nominated as enablers to complete, this will be 'live' for 2 weeks. • Social Kinetic will then analyse the data received back from the questionnaires. • A wider team event should be arranged e.g. a one day workshop, 10am to 4pm for approximately 80-100 people should be arranged for the whole Collaborative Partnership Board and Team to attend. The Chair and Collaborative Board members thank Social Kinetic for their presentation and their attendance at this meeting.	**ALL** **Social Kinetic** **Social Kinetic** **Social Kinetic**
56/17	**Any Other Business** There was no other business brought before the meeting.	
57/17	**Date and Time of Next Meeting** The next meeting will take place on 9 June 2017 at 9.30am to 11.30am.	

This page is intentionally left blank

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

9 June 2017

The Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU

Decision Summary

Minute reference	Item	Action
59/17	**Minutes of the previous meeting held 12 May 2017** The following amendment was required at 49/17 (delete last two paragraphs and insert: The Chair advised members that the Cancer Alliance Board agreed a shared inter provider transfer (IPT) policy at the May Cancer Alliance Board meeting and has advised the Collaborative Partnership Board at this meeting that the policy had been signed off and was ready to be sent out to partners. After discussion members agreed that the Clinical Reference Group would finalise any outstanding clinical issues within 6 weeks, which will need to be agreed to ensure we are able to successfully operationalise the policy. Add Richard Jenkins to the list of those present.	 **JA** **JA**
61/17	**National Update** Members agreed that SYB STP should continue to progress our plans and work together as an ACS.	 **ALL**
62/17	**SYB MOU** **South Yorkshire and Bassetlaw Memorandum Of Understanding** Will Cleary-Gray agreed to circulate a revised draft next week when all comments had been received. In order that members had another opportunity to review the draft SYB MOU following changes members agreed that the turnaround of the document should be within 48 hours of it being circulated. To enable the final draft to be circulated to local governance by Friday, 23rd June 2017.	 **WC-G** **WC-G**
63/17	**Finance Update** Will Cleary-Gray requested members to provide any written comments they may have regarding the finance update direct to Jeremy Cook and he would duly respond and address them.	 **ALL**

64/17	**Development of a Single Accountability Framework** After discussion, members endorsed: • the establishment of a short-life working group to draw up the framework, with representatives drawn from the STP executive, STP cancer, urgent and emergency care and mental health programme plus one place, NHS England and NHS Improvement (local and national) • Alison Knowles to Chair the group with support from Andrew Morgan and their respective teams. Greg Fell and Richard Jenkins volunteered their help to Alison Knowles regarding the Single Accountability Framework.	**AK** **AK & AM** **GF & RJ**
65/17	**Summary update to the Collaborative Partnership Board** • Sharon Kemp from RMBC has had a conversation with Will Cleary-Gray about having a regular item on the Collaborative Partnership Board agenda for discussion and feedback that reflects the full breadth of Local Authority and partners' work. Sharon Kemp will be bringing back a proposal for members' consideration on how this might look. Lesley Smith added that as part of the National Accountable Care System Development programme there are currently 3 ACSs participating in the Population Health Management which is a huge theme and has lots of different elements. Lesley Smith stated a small team may be required to engage in this on behalf of SYB STP and requested members to flag up with her who they feel should be approached to be in the team.	**SK** **LS**
66/17	**Health Inequalities** The presentations accompanying the report will be circulated after this meeting. The Chair noted that a pocket of work relating to the stratification of health care to enable aspirations to be delivered was required and we should work through this as a system. Therefore, we should schedule in scorecard discussions and invest time for this subject.	**JA** **WC-G**
67/17	**SCR/STP Health Led IPS Employment Service** The Chair confirmed he will be happy to meet with Kevan Taylor and the combined authorities will have direct discussions regarding this initiative.	**KT**

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of 9 June 2017,
The Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw STP	STP Lead/Chair and CEO, Sheffield Teaching Hospitals NHS F T	✓		
Adrian Berry	South West Yorkshire Partnership NHS FT	Deputy Chief Executive	✓		Rob Webster CEO
Adrian England	Healthwatch Barnsley	Chair		✓	
Ainsley Macdonnell,	Nottinghamshire County Council	Service Director	✓		Anthony May CEO
Alison Knowles	Locality Director North of England,	NHS England	✓		
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher	✓		
Brian Hughes	NHS Sheffield Clinical Commissioning Group	Director of Commissioning	✓		Maddy Ruff
Catherine Burn	Voluntary Action Representative		✓		
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer	✓		
Des Breen	Working Together Partnership Vanguard	Medical Director	✓		
Greg Fell	Sheffield City Council	Director of Public Health	✓		John Mothersole CEO
Frances Cunning	Public Health England	Deputy Director of Health and Wellbeing	✓		
Helen Stevens	South Yorkshire and Bassetlaw STP	Assc. Director of Comms & Engagement	✓		
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Interim Accountable Officer	✓		
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer,	✓		
Jane Anthony	South Yorkshire and Bassetlaw STP	Corp Admin, Exec PA, Business Mgr	✓		
Janette Watkins	Working Together Partnership Vanguard	Director	✓		
Jeremy Cook	South Yorkshire and Bassetlaw STP	Interim Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive		✓	
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Julia Burrows	Barnsley Council	Director of Public Health	✓		
Julia Newton	Sheffield Clinical	Chief Finance Officer		✓	

	Commissioning Group				
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive		✓	
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive	✓		
Lesley Smith	NHS Barnsley Clinical Commissioning Group	Deputy STP Accountable Officer	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive	✓		
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer		✓	
Matthew Groom	NHS England Specialised Commissioning	Assistant Director		✓	
Mike Curtis	Health Education England	Local Director	✓		
Neil Taylor	Bassetlaw District Council	Chief Executive		✓	
Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		✓	
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Chief Operating Executive	✓		
Richard Henderson				✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Interim Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS F T	Chief Executive	✓		
Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Acting Chief Executive	✓		
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		✓	
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health	✓		
Sean Raynor	South West Yorkshire Partnership NHS FT	District Service Director, Barnsley and Wakefield	✓		Adrian Berry
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive		✓	
Steve Shore	Healthwatch Doncaster	Chair	✓		
Will Cleary-Gray	South Yorkshire and Bassetlaw STP	Sustainability & Transformation Director	✓		

Minute reference	Item	Action
58/17	**Welcome and introductions** The Chair welcomed members and noted apologies for absence. The Chair reminded members that the Collaborative Partnership Board meeting is for Chief Executives or Accountable Officers to attend in person as representatives of their respective organisations. As SYB STP moves forward, its governance will be increased to	

	ensure accountability and Chief Executives and Accountable Officers will be expected to attend rather than sending a deputy.	
59/17	**Minutes of the previous meeting held 12 May 2017** The following amendment was required at 49/17 (delete last two paragraphs and insert: The Chair advised members that the Cancer Alliance Board agreed a shared inter provider transfer (IPT) policy at the May Cancer Alliance Board meeting and has advised the Collaborative Partnership Board at this meeting that the policy had been signed off and was ready to be sent out to partners. After discussion members agreed that the Clinical Reference Group would finalise any outstanding clinical issues within 6 weeks, which will need to be agreed to ensure we are able to successfully operationalise the policy. Add Richard Jenkins to the list of those present. Subject to the above amendments the minutes of the meeting were accepted as a true and accurate record and would be published.	**JA** **JA**
60/17	**Matters arising** All matters arising would be picked up as part of the agenda.	
61/17	**National Update** The Chair noted the position emerging from the national election this morning. The Chair added that there would likely be a clear message for STPs coming out of the annual conference next week. At a local level he felt that partners were in a strong position to continue with plans. Members made the following comments: • Within the current political climate there are numerous scenarios that could emerge. It is right that we carry on as planned. • Partners needed to consider risk over the next period. • Doing nothing is not an option and therefore we should continue our direction of travel. • The vision of agencies working together in a coherent way cannot be disputed. Members agreed that SYB STP should continue to progress our plans and work together as an Accountable Care System (ACS). The Chair added we believe that with careful design we can plan our way ahead for communities and patients in a sustainable way.	**ALL**
62/17	**SYB MOU** **South Yorkshire and Bassetlaw Memorandum Of Understanding** Will Cleary-Gray updated members on the progress of the Memorandum of Understanding (MoU). The revised SYB MoU document was not circulated due to comments still coming in from local Boards, Governing Bodies and Councils and with feedback still awaited from one or two partners.	

	Will Cleary-Gray added that the document has been shared with the Centre and regions and has been received positively. Members were reminded a package of support to take forward the STP ambitions would follow signing of the MOU. The Chair added that there was a helpful minute from last month's meeting where Will Cleary-Gray stated 'The MoU is not a legal contract, nor does it serve to replace the legal framework or responsibilities of our statutory organisations. It is an agreement that sets out the framework within which our partner organisations will come together to establish how we will develop as an Accountable Care System.'. Will Cleary-Gray agreed to circulate a revised draft next week when all comments had been received. In order that members had another opportunity to review the draft SYB MOU following changes members agreed that the turnaround of the document should be within 48 hours of it being circulated. To enable the final draft to be circulated to local governance by Friday, 23rd June 2017. Therefore, if any member observed that their feedback was not addressed they had the opportunity to flag this up. The Collaborative Partnership Board noted the Memorandum of Understanding.	**WC-G** **WC-G**
63/17	**Finance update** The finance update was considered. Will Cleary-Gray requested members to provide any written comments they may have regarding the finance update direct to Jeremy Cook and he would duly respond and address them.	**ALL**
64/17	**Development of a Single Accountability Framework** Alison Knowles, Locality Director, NHS England presented the paper which set out how South Yorkshire & Bassetlaw could work with the regional and national teams in NHS England and NHS Improvement to shape a new regulatory relationship and establish a Single Accountable Framework. Alison Knowles highlighted the proposed ways of working and the outline structure for the Single Accountability Framework that was identified in the paper. Members were also informed that the MOU commits to having such a framework in shadow form from October 2017 and this would require agreement from the Collaborative Partnership Board in September 2017. Alison Knowles invited comments and welcomed volunteers to join the working group. Alison Knowles responded to members comments as follows: • Care Quality Commission (CQC) is not involved at the moment but we need them to be drawn into this as they are aligned nationally. • There are national teams progressing this work and we are able to help shape national thinking.	

	• Aiming to be innovative regarding clinical engagement, looking to engage clinicians and also patients into this framework. Members made the additional comments: • The scorecard core targets for all England should blend with local targets. • Wider consideration should be given to the targets (e.g. not just hospitals). • We have an opportunity to be innovative and organise our architecture to change and not just use our existing frameworks. • Recognise we are responsible for our own organisations and that there is scope to support each other. • The system should have ownership of any health differentials, there should be no health inequalities across the system. After discussion, members endorsed: • the proposed way forward, • the establishment of a short-life working group to draw up the framework, with representatives drawn from the STP executive, STP cancer, urgent and emergency care and mental health programme plus one place, NHS England and NHS Improvement (local and national) • Alison Knowles to Chair the group with support from Andrew Morgan and their respective teams. Greg Fell and Richard Jenkins volunteered their help to Alison Knowles regarding the Single Accountability Framework. The Chair thanked Alison Knowles and looked forward to the Single Accountability Framework coming back to a future Collaborative Partnership Board meeting.	**AK** **AK & AM** **GF & RJ**
65/17	**Summary update to the Collaborative Partnership Board** Lesley Smith informed members that the identified Accountable Care Systems have been asked to get involved at a national level in establishing a set of priorities. As a result of this request SYB STP is leading on a number of areas e.g. urgent care and primary care. As a result SYB STP will get access to additional support regarding oversight and assurance. Will Cleary-Gray updated members as follows: • Sharon Kemp from RMBC has had a conversation with Will Cleary-Gray about having a regular item on the Collaborative Partnership Board agenda for discussion and feedback that reflects the full breadth of Local Authority and partners' work. Sharon Kemp will be bringing back a proposal for members' consideration on how this might look. • NHS England is aligning staff to aid delivery in key areas. SYB STP has received additional support from NHS England regarding finance and engagement. The programme is looking to gain additional support in other areas e.g. for the single accountable framework, planning and programme	**SK**

management. Alignment of staff is taking place at pace and this is very helpful to SYB STP.

- NHS England has given full assurance on Children's Non Specialised Surgery and Anaethesia and this project will progress to Joint Committee of Clinical Commissioning Groups (JCCC) at the end of June for endorsement. The Hyper Acute Stroke (HASU) and needs more work and therefore will not proceed to JCCC in June. Our challenge is to work through in a mature way to find a solution. Will Cleary-Gray added that the earliest a decision on HASU could be reached in early autumn.

- Due to pre-election period guidance the work for the Hospital Services Review (HSR) has been delayed. However this can now be progressed and some key appointments have been made to support this work:

    - Chris Welsh has been appointed as the independent review director and clinical lead.

    - Sir Jonathan Michael is engaged to provide peer support to Chris Welsh and review team.

    - Alexandra Norrish is engaged as the Programme Director and will phasing in work in June and full time in August.

    - SYB STP is about to appointment a consultancy to support the work.

- All elements of the Hospital Services Review will be in place shortly.

Helen Stevens informed members that communications for the HSR review is in hand. She is working on the HSR Communications Plan which is just one element of the STP. Helen Stevens reminded colleagues of the importance of the work happening in local communities and that all communications would reflect the whole picture.

The Chair added that the HSR launch will be in 4-6 weeks' time and we will utilise this time to ensure everything is clear and is in place.

The Chair invited Louise Barnett to give members a verbal update of the Urgent and Emergency Care Workstream.

Her update items included:

- performance and the STP agenda;
- a prevention stream being in place to help people stay healthy at home;
- mapping what is happening in the system;
- a show and tell to better understand 'place';
- Crystallising the workstream to ensure there is no duplication;
- A recent workstream visit to the 111 and 999 service and discussion regarding the 111 contract.

The Chair thanked Louise Barnett for her update.

	The Chair invited Richard Jenkins and Idris Griffiths to give members a verbal update of the Elective and Diagnostic Services. Richard Jenkins and Idris Griffiths update items included: • The existing Radiology and Pathology outpatients and looking at organisations and their different approaches across the patch. This is an opportunity to share best practice and in June organisations will come together at an event to communicate strategies and technologies regarding delivery. The event is scheduled for 30th June at the New York Stadium in Rotherham and will include patients and the public. • Another area the group is looking at is endoscopy. • The workstream will be reviewing the NHS England Elective Care Delivery Plan. The Chair thanked Richard Jenkins and Idris Griffiths for their update. Lesley Smith added that as part of the National Accountable Care System Development programme there are currently 3 ACSs participating in the Population Health Management which is a huge theme and has lots of different elements. Lesley Smith stated a small team may be required to engage in this on behalf of SYB STP and requested members to flag up with her who they feel should be approached to be in the team. The Collaborative Partnership Board received the report and welcomed the written and verbal updates provided from each of the STP workstreams and they would use these to inform local discussions.	**ALL**
66/17	**Health Inequalities** The Chair welcomed Greg Fell, Sheffield City Council Director of Public Health to give his report on Health Inequalities to the meeting. Greg Fell informed members that the report was written with co-authors Ian Cameron and Steve Pintus. The paper summarised the output of a DPH/PHE sponsored workshop on health inequalities and the role of STP in addressing this. Greg Fell picked out the three key points from the workshop being: • Health inequalities are not a public health issue, they are a system issue. • We must have real genuine prioritisation of primary care. • Agree and enact a principle of a disproportionate offer and resourcing. The presentations accompanying the report will be circulated after this meeting. Gregg Fell added: • If we continue as we have always done we will not make much progress to address health inequalities.	**JA**

	• GP funding is fairly equal in £ per head but this formula does not reflect need. • There are social complexities to consider. • There is evidence that health inequalities can be addressed through primary care. The Chair noted that a pocket of work relating to the stratification of health care to enable aspirations to be delivered was required and we should work through this as a system. Therefore, we should schedule in discussions and invest time for this subject. Collaborative Partnership Board members thanked Greg Fell for attending this meeting and presenting this report.	**WC-G**
67/17	**SCR/STP Health Led IPS Employment Service** Kevan Taylor informed the Collaborative Partnership Board that Sheffield City Region (SCR) Health-Led Employment Trial and Collaborative Health Partnership is a potential significant investment to obtain jobs. Employment is one of the key determinants of health. Part of this subject is how we form relationships with ourselves and with Local Authorities. The Chair welcomed Andrea Fitzgerald, Senior Programme Manager Employment, Sheffield City Region , and Fiona Goudie, Clinical Director - Strategic Partnerships Sheffield Health & Social Care NHS Foundation Trust to the meeting to give their presentation on this subject. At this point that the meeting had a short 10 minute recess due to the building being evacuated for an unexpected fire drill. The meeting resumed and Andrea Fitzgerald and Fiona Goudie continued their presentation. Kevan Taylor informed the Collaborative Partnership Board that the project is using Sheffield CCG infrastructure regarding procurement. Additional support is required from GP practices and he will obtain this outside this meeting. The Chair confirmed he will be happy to meet with Kevan Taylor and the combined authorities will have direct discussions regarding this initiative. Helen Stevens offered her help and assistance to Andrea Fitzgerald and Fiona Goudie regarding the communications mechanism into this programme. The Chair thanked Andrea Fitzgerald and Fiona Goudie for attendance and presentation at this meeting.	**KT**
68/17	**Any Other Business** There was no other business brought before the meeting.	

69/17	**Date and Time of Next Meeting** The next meeting will take place on 14th July 2017 at 9.30am to 11.30am.	

This page is intentionally left blank

REPORT TO THE HEALTH AND WELLBEING BOARD

8th August 2017

Health & Wellbeing Board Action Plan Highlight Report

Report Sponsor: Rachel Dickinson
Report Author: Karen Sadler
Received by SSDG: 26th July 2017
Date of Report: 31st July 2017

1. Purpose of Report

1.1 To highlight progress against the Health & Wellbeing Board Action Plan

2. Recommendations

2.1Health and Wellbeing Board members are asked to:-

- Note the progress being made to deliver the Health & Wellbeing Strategy and Barnsley's Integrated Place Based Plan.
- Share the highlights that have been drawn from the health & Wellbeing Board Action Plan Progress Update.

3. Introduction/ Background

3.1 The ambition and direction set out in Barnsley's Health & Wellbeing Strategy (2016 -2020), together with the commitment and actions from Barnsley's Integrated Place Based Plan, have been translated into a high level action plan – known as the Health & Wellbeing Board Action Plan.

3.2 The Health & Wellbeing Board Action Plan includes over 50 programmes of work and is delivered by the following partnerships/boards:

- Barnsley's Children and Young People Trust Executive Commissioning Group
- Adult Joint Commissioning Group
- Tobacco Control Alliance
- Strategic Alcohol Harm Reduction Group / Alcohol Alliance
- Strategic Mental Health Groups / Mental Health Alliance
- More and Better Jobs Taskforce
- Stronger Communities Partnership, and sub groups:
    - Customer Strategy Implementation Board

    - Anti-Poverty Delivery Group
    - Early Help Delivery Group
- Barnsley Clinical Commissioning Group
- Barnsley Accountable Care Partnership

3.3 The Health & Wellbeing Board Action Plan is monitored bi-annual by the Senior Strategic Development Group (SSDG). At present all actions in the Health & Wellbeing Board Action Plan are RAG rated as Green or Amber, with no programmes marked as Red.

3.4 There is an opportunity for the delivery partnerships/boards to highlight risk to delivery within the reporting framework. At present, no significant risks have been highlighted.

3.5 The attached highlight report (appendix 1) provides a summary of progress being made against the priorities outlined in the Health & Wellbeing Strategy /Barnsley's Integrated Place Based Plan.

4. Conclusion/ Next Steps

4.1 Good progress is being made in delivering the Health & Wellbeing Board Action Plan. This demonstrates that the system is moving more towards prevention and early help, addressing inequalities and developing place based integrated services.

5. Appendices

5.1 Appendix 1: Health & Wellbeing Board Action Plan Highlight Report.

Officer: Karen Sadler **Contact:** karensadler@barnsley.gov.uk **Date:**31st July 17

Health & Wellbeing Board Action Plan Highlight Report

August 2017

Supporting all children, young people and families to make healthy choices	**Daily Mile** To increase physical activity, at least 27 schools are delivering the Daily Mile. 12 more schools are preparing to introduce it next year.	**Fluoride Varnish** Rates of fluoride application are up to 67% from 59% in 2014. Barnsley is 4th in the country for the highest % of applications.	**Smoke Free Zones** All play parks across the borough and the town centre zone are now smoke free	**Training for Midwives** A new video for Midwives to cover issues such as risks of smoking in pregnancy.
Improving early help for mental health	**Training for Businesses** Mental Health First Aid training for business through the workplace health charter	**Training for staff** Relevant frontline staff are also being training in perinatal mental health	**Secondary Schools** The 4:Thought programme provides early brief and solution focused interventions young people.	**Mental Health and employment** Work is underway to develop a local programme to help people with mental health into employment.
Improving services for older people	**Back on your feet** Helping front-line staff to provide a first line of treatment following a fall.	**Berneslai Homes** spend approximately £2 million per annum to reduce falls in social housing.	**Dementia Champions** Numbers are increasing within GP practices and Pharmacists. **Dementia Friends** training is available to business in the borough	**Support for Dementia Carers** More people are accessing the web based support - www.dementiacarer.net
Changing the way we work together	**BREATHE** The integrated respiratory service for Barnsley is underway.	**Community Midwives** Maternity care has improved with the roll out of community hubs. 89% of women now see 3 midwives or less.	**Food Access Network** Bringing together people providing food to people on low income. A joined up approach.	**Workplace Wellbeing Charter** 23 work places have registered and 5 have achieved charter status. ASOS is the first company nationally to achieve excellence status in 8 areas of the charter.
Building strong and resilient communities	**Live Well Barnsley** The local online directory service is being developed with details of more and more community services and groups be added. https://www.livewellbarnsley.co.uk/	**My Best life** The Social Prescribing service helps people with health needs to connect to activities in their community to improve wellbeing. People are referred to the service GPs. GP buy-in so far is good.	**Carers Strategy** Has been co-produced with service users & carers. Work is now underway to develop the action plan.	**Community Involvement** BMBC have won a Local Government Chronicle Award for their work in developing the Barnsley Deal.

Case Studies from My Best Life

Jenifer

Following the loss of her husband Jenifer* had suffered with mental health and emotional turmoil, leading to unemployment, large debts, food and fuel poverty and social isolation. Struggling to cope and having no self-esteem, Jenifer felt like she had nothing to live for and had tried to take her own life several times. This was not only hard on Jenifer but also on her family. Jenifer was referred to My Best Life Service by her GP.

Jane*, the Advisor from My Best Life spent time listening to Jenifer and finding out that the life she had lead before her husband die was full of love, friendship, joy and fulfilment. Slowly, but surely Jenifer began to have hope once again and felt able to re-build her life. Jane helped Jenifer to clear the debt from her utility account, accessed food from food banks, put in a claim for additional benefits until she is well enough to go back to work, and consider volunteering opportunities, to build up her confidence. Jenifer is now in a much better place mentally and is going for a daily walk and making it to a few coffee mornings to interacting with other people. This is the start of Jenifer's journey and she is looking forward to life's little pleasures such as taking her granddaughter to the park.

Jane spent approximately 8 hours with Jenifer.

Alice

Alice* had only recently move to Penistone when she had an operation on her knee, limiting her ability to get out and about and her ability to work. Alice was going through a divorce and was concerned about managing her finances. Suffering from social isolation, Alice became lonely and depressed and was therefore referred to My Best Life Service by her GP.

Emma*, the Advisor from My Best Life worked with Alice to empower her to take action meet her goals and ambitions, and signed posted Alice to other local services that could help.

Alice joined Penistone Job Club and has applied for part-time opportunities as well as taking a volunteering opportunity helping with the community gardens. Alice is looking to join a local sewing class and has attended a coffee morning in the village. To help her get out and about more, and to see her friends and family, Alice has bought herself a car
Alice is being supported by both DIAL and StepChange, to take charge of her finances and she hopes to soon find employment.

*All names have been changed to protect identity.

REPORT TO THE HEALTH AND WELLBEING BOARD

8 August 2017

Better Care Fund: Guidance & Principles

Report Sponsor:	Lesley Smith/Rachel Dickinson
Report Author:	Jamie Wike/Lennie Sahota
Received by SSDG:	
Date of Report:	20 July 2017

1. Purpose of Report

1.1 To provide the Board with an overview of the 2017-2019 'Integration and Better Care Fund' planning requirements and timescales, and provide an update on the local planning processes and proposed principles in developing the Barnsley Better Care Fund Plan.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Note the contents of the report including the Integration and Better Care Fund Planning requirements and agree that due to the submission deadline and requirement for Board sign off of the plan that the final plan is circulated to members of the board for comment with sign off of the plan for submission being delegated to the Chair of the Board and Accountable Officer of Barnsley Clinical Commissioning Group.

3. Introduction/ Background

3.1 <u>The Better Care Fund 2017/19</u>

3.2 Following the publication of the NHS Operational Planning Guidance and Contracting Guidance 2017/19 in September 2016 which signalled that the BCF would continue into 2017/18, with the requirement for Health and Wellbeing Boards to submit two year Better Care Fund Plans covering the period 2017/18 and 2018/19, there have been a number of delays in publication of the guidance. The Department of Health and Department for Communities and Local Government published the '2017-19 Integration and Better Care Fund' Policy Framework in March 2017, however the final detailed planning guidance and requirements was only published on 4 July 2017.

3.3 The BCF policy framework and guidance confirms the intention for the Better Care Fund (BCF) to provide the mechanism for joint health and social care

planning and commissioning, bringing together ring fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and for the first time, funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF).

3.4 The key changes to the policy framework from 2016/17 include:

- A requirement for plans to be developed for the two-year period 2017-19 rather than a single year and;
- The number of national conditions which local areas will need to meet through the planning process has been reduced to four.

3.5 The four national conditions require:

- That a BCF plan, including at least the minimum contribution to the pooled fund, must be signed off by the Health and Wellbeing Board, and the constituent Local Authorities and CCG's
- A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
- That a specific proportion of the area's allocation is invested in NHS-commissioned out of hospital services;
- All areas to implement the High Impact Change Model for Managing Transfers of Care to support system-wide improvements in transfers of care.

3.6 The reduction in national conditions is intended streamline the assurance processes and focus the conditionality of the BCF, however the guidance emphasizes that this should not diminish the importance of the issues that were previously subject to conditions. Plans are therefore required to describe how local areas will continue to improve and build on improvements made to:

- Develop delivery of seven day services across health and social care;
- Improve data sharing between health and social care; and
- Ensure a joint approach to assessment and care planning.

3.7 In addition and in line with the conditions of the additional funding for social care announced in the March budget, the plan will need to demonstrate this funding is being used for the purposes of:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- Stabilising the local social care provider market.

3.8 In summary, the planning guidance requires local areas to develop a joint spending plan that meets the national conditions. In developing the BCF plans there will be a requirement to agree, through the Health and Wellbeing Board:

1. A jointly agreed narrative plan including details of how the national conditions are being addressed; how the BCF plans will contribute to local plans for integrating health and social care; and
2. A completed planning template, demonstrating:
   - Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
   - A scheme-level spending plan demonstrating how the fund will be spent; and
   - Quarterly plan figures for the national performance metrics.

3.9 The national metrics associated with the BCF will continue as in 2016/17. A planned performance trajectory will be required for each of the 4 metrics which include:

- Non-elective admissions to hospital
- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care.

3.10 Following finalisation and submission, plans will be subject to a regional assurance process which will initially see plans either; approved, approved with conditions or not approved.

3.11 The timetable for submission and approval is set out in the table below:

Milestone	Date
Publication of Policy Framework	31 March 2017
Publication of planning requirements and templates	4 July 2017
First Quarterly monitoring returns on use of the IBCF funding from Local Authorities*	21 July 2017
Areas to confirm draft DToC metrics*	21 July 2017
BCF Planning submission from local Health and Wellbeing Board areas	11 September 2017
Regional Assurance processes	12-25 September 2017
Regional Moderation	w/c 25 September 2017
Approval letters issued giving formal permission to spend	6 October 2017

Escalation panels for plans rated as not approved	w/c 10 October 2017
Deadline for areas with plans rated approved with conditions to submit updated plans	31 October 2017
All section 75 agreements to be signed and in place	30 November 2017

* The first monitoring return for the IBCF and the draft DToC metric trajectory have been submitted in line with the milestone date.

4. 2017-19 Better Care Fund Plan

4.1 For 2016/17 the Better Care Fund plan was a roll forward of the 2015/16 plan to enable the work around the BCF to continue whilst the broader transformation and integration plans were being considered as part of the development of Sustainability and Transformation Plans and Local Place Based Plans.

4.2 During 2016/17 the Health and Wellbeing Board approved a new Health and Wellbeing Strategy and Place Based Plan setting out the local plans to improve health and wellbeing within Barnsley. On this basis the proposed approach to developing the BCF Plan for 2017-19 is to set the plan in the context of delivery of the overall Health and Wellbeing Strategy and Plan and use this is as the foundation for setting out our vision for integration of Health and Care services.

4.3 To bring the focus further towards the integration agenda, it is also proposed that the plan for 2017-19 should emphasize the current arrangements which are already in place for joint commissioning of health and care services and the emerging development of an Accountable Care Partnership in Barnsley.

4.4 The Senior Strategic Development Group will have oversight of the development of the plan ensuring input from and engagement of all partners during the planning process and to support partner sign off and buy in to the final plan.

4.5 Due to the late publication of the guidance and the timescales and milestones set out in the planning requirements it has not been possible to present a draft plan to this meeting and the next Health and Wellbeing Board would not be until after the submission deadline. There is however a requirement for the plan submitted on 11 September to be signed off by the Health and Wellbeing Board and therefore it is proposed that the final draft plan be circulated to members of the Board and signed off on behalf of the Board by the Chair and by the Chief Officer of the CCG.

5. Conclusions

6.1 The Board are asked to note the contents of the report along with the Integration and Better Care Fund Planning requirements and agree that due to the submission deadline and requirement for Board sign off of the plan that the final plan is circulated to members of the board for comment with sign off of the

plan for submission being delegated to the Chair of the Board and Accountable Officer of Barnsley Clinical Commissioning Group.

6. Financial Implications

6.1 The required level of funding for the BCF in Barnsley has increased in 2017/18 and 2018/19, mainly to take account of the fact that the IBCF funding paid directly to local government is required to be included in the pool. The table below provides details of the contributions into the BCF pooled fund.

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution exc iBCF	£2,544,576	£2,758,216
Total iBCF Contribution	£6,803,033	£9,395,305
Total Minimum CCG Contribution	£18,590,357	£18,943,574
Total BCF pooled budget	**£27,937,966**	**£31,097,096**

6.2 It should be noted that, with the exception of the IBCF funding, the other funding included within the pooled fund is not new funding and therefore in developing the plan, recognition needs to be given to ensuring continuation of commissioned services and meeting other conditions for use which also applies to the funding including use of the Disabled Facilities Grant, funding to support implementation of the Care Act and providing dedicated carer specific support.

6.3 The use of the additional funding included as part of the IBCF has already been agreed by the Health and Wellbeing Board at its meeting on 6 June 2017 and therefore the details of this will be included within the final plan.

7. Consultation with stakeholders

7.1 In developing the BCF Plan 2017-19 for Barnsley all key partners will be engaged to ensure appropriate input to development and agreement of the plan. As described in section 4, the plan will build upon current place based plans and organisational plans and therefore will take account of the consultation activity and feedback gathered in the development of these plans.

8. Appendices

8.1 Appendix 1 – 2017-19 Integration and Better Care Fund Policy Framework
8.2 Appendix 2 – Integration and Better Care Fund planning requirements for 2017-19

Officer: Jamie Wike **Contact:** 01226 433702 **Date:** 20/07/17

This page is intentionally left blank

Department of Health

Department for Communities and Local Government

2017-19 Integration and Better Care Fund

Policy Framework

March 2017

Title: Integration and Better Care Fund Policy Framework 2017-19
Author: Social Care, Ageing and Disability / Integration, Local Devolution and Policy Improvement / 11120
Document Purpose: Policy
Publication date: 03/17
Target audience: This document is intended for use by those responsible for delivering the Better Care Fund at a local level (such as clinical commissioning groups, local authorities and health and wellbeing boards) and NHS England.
Contact details: Integration, Local Devolution and Policy Improvement Unit Richmond House Whitehall London SW1A 2NS Bettercarefund@dh.gsi.gov.uk

Published to gov.uk, in PDF format only.

www.gov.uk/dh

2017-19 Integration and Better Care Fund

Policy Framework

Prepared by the Department of Health and the Department for Communities and Local Government

Contents

Executive Summary

Why Integrate?

People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of available resources.

How is Integration being done?

There is no single way to integrate health and care. Some areas are looking to scale-up existing initiatives such as the New Care Models programme and the Integration Pioneers. Others are using local devolution or Sustainability and Transformation Plans as the impetus for their integration efforts.

One part of the solution – the Better Care Fund

The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. This policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically. Details of the financial breakdown are below:

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)*	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

*Combined amounts announced at Spending Review 2015 and Spring Budget 2017

Many areas choose to pool more than is required. For 2017-19, there are four national conditions, rather than the previous eight:

1. **Plans to be jointly agreed**
2. **NHS contribution to adult social care is maintained in line with inflation**
3. **Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care**

4. **Managing Transfers of Care** (a new condition to ensure people's care transfers smoothly between services and settings).

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: **Delayed transfers of care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.**

Going beyond the Better Care Fund through Graduation

The Better Care Fund is intended to encourage further integration and 90% of areas say it has already had a positive impact on integration locally. For the most integrated areas, there will be benefits in graduating from the Fund to reduce the reporting and oversight to which they are subjected. We are planning to test the graduation process with a small number of advanced areas (6 to 10) in a 'first wave', in order to develop our criteria for graduation for all areas. We are therefore inviting 'Expressions of Interest' from areas that think they are exemplars of integration, by 28th April 2017.

Agreeing a local vision of integration

As part of Better Care Fund planning, we are asking areas to set out how they are going to achieve further integration by 2020. We would encourage areas to align their approach to health and care integration with Sustainability and Transformation Plan geographies, where appropriate. This may be an exact match (e.g. Greater Manchester) or it may be smaller units within Sustainability and Transformation Plans. The focus may also be on commissioning integration (e.g. North East Lincolnshire) or through Accountable Care Systems or Organisations that bring together provision (e.g. Northumberland). What matters is that there is locally agreed clarity on the approach and the geographical footprint which will be the focus for integration.

Measuring progress on integration

To help areas understand whether they are meeting our integration ambition, we are seeking to rapidly develop integration metrics for assessing progress, particularly at the interface where health and social care interact. These will combine outcome metrics, user experience and process measures. Following the development of the metrics and an assessment of local areas, we will ask the Care Quality Commission to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care.

Need more detail?

Further information on everything here can be found in the full Integration and Better Care Fund Policy Framework 2017-19.

Introduction

This document sets out the story of integration of health, social care and other public services. It provides an overview of related policy initiatives and legislation. It includes the policy framework for the implementation of the statutory Better Care Fund (BCF) in 2017-19, which was first announced in the Government's Spending Review of 2013 and established in the Care Act 2014. And it sets out our proposals for going beyond the BCF towards further integration by 2020. Whilst there will now be no separate process for integration plans, we will provide a set of resources, integration models and indicators for integration to help local areas towards our shared goal of person-centred, coordinated care.

This Policy Framework has been developed by the Department of Health (DH), Department for Communities and Local Government (DCLG), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and NHS England.

The case for integrated health and care services

Today, people are living much longer, often with highly complex needs and multiple conditions. These needs require ongoing management from both health and care services, which combine both the medical and social models of care. As our population ages and the financial pressures on the health and care system increase, we need to be better at providing proactive, preventative care in community settings, so that people can be supported to live at home for longer and avoid the need for commissioned health and care services.

More joined up and sustainable services help improve the health and care of local populations and may make more efficient use of available resources (i.e. by reducing avoidable hospital admissions, facilitating timely discharge, and improving people's experiences of care). Integration needs to reflect the different strengths that the NHS and social care bring to an integrated response, including the role of social services of promoting and supporting independence, inclusion and rights as far as possible, invigorating wider community services and supporting informal carers.

People want services to work together to provide them with person-centred coordinated care. National Voices set out a narrative for person-centred care, which sums up what we are working to achieve: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."[1] This translates into positive interactions with health and care services, and better experiences for individuals as illustrated by Figure 1.

[1] http://www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care

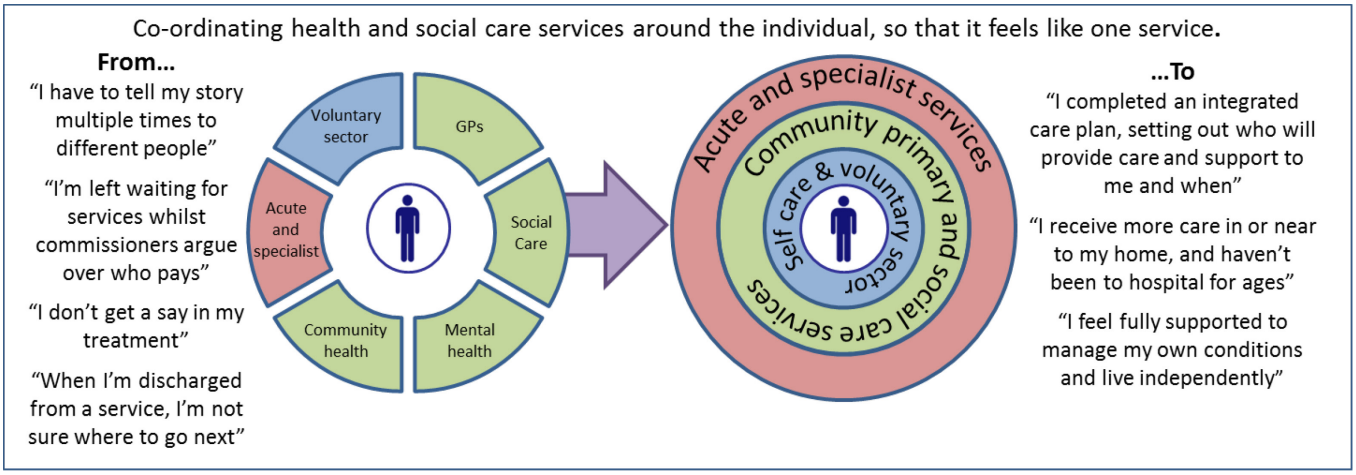


Figure 1: Co-ordinating health and care services around the individual

1. Integration to date

Integration is not a new goal and there have been initiatives over a number of years (see Figure 2).

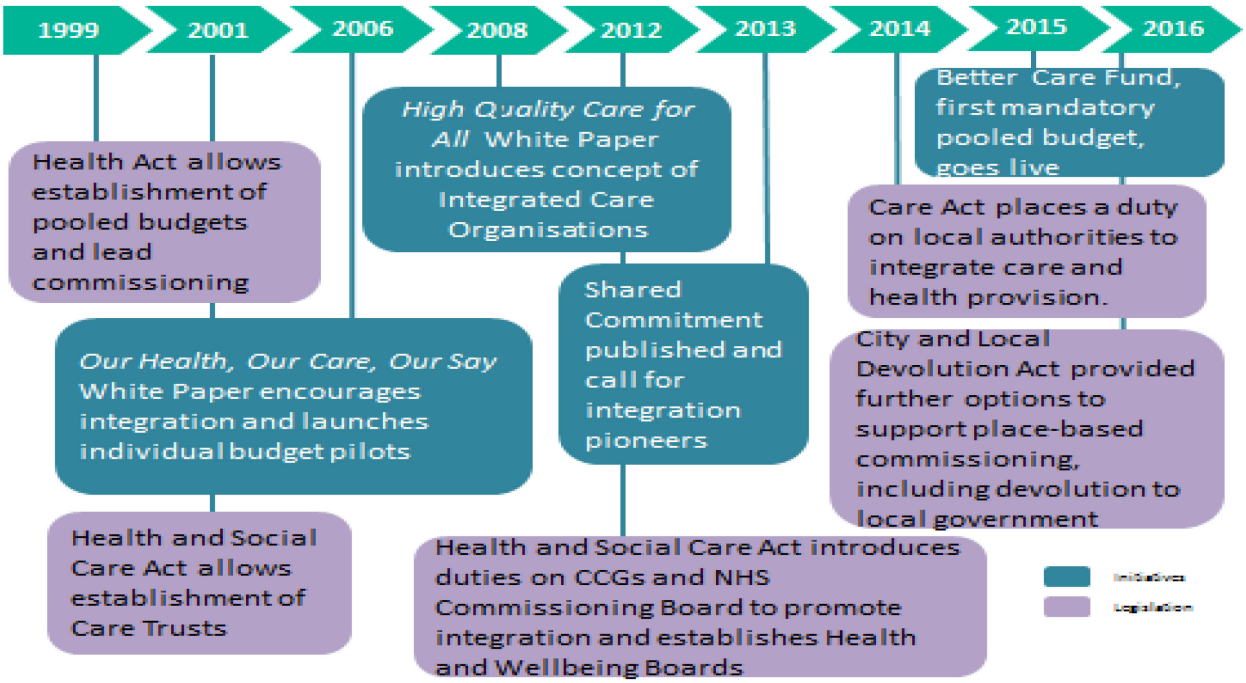


Figure 2: Key integration initiatives and enabling legislation

The Coalition Government and partners set out collective intentions on integration in Integrated Care and Support: Our Shared Commitment in 2013.[2] This showed how local areas can use existing structures such as **Health and Wellbeing Boards** to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

This collaboration with 12 national partners was backed by a call for areas wanting to lead the way to apply to become an 'Integrated Care Pioneer'. We identified excellent examples of joined-up care happening in different ways up and down the country and the **Integrated Care Pioneers Programme** was launched to learn from the most innovative areas and to encourage change from the bottom up. The second annual report[3] of the Pioneers summarises some of the recent learning and experiences, and the Pioneers' resource centre[4] contains a collection of tools, information and useful links.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf
[3] https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf
[4] https://www.england.nhs.uk/pioneers/resource-centre/

More recently, the LGA, ADASS, NHS Confederation and NHS Clinical Commissioners have developed a shared vision document, Stepping up to the place[5] for a fully integrated system based on existing evidence. This framework describes the essential characteristics of an integrated system to improve the health and wellbeing of local populations, and paves the way for integration to happen faster and to go further, so that integrated, preventative, person-centred care becomes the norm.

There is also a growing recognition of the important contribution of housing to integration. A national Memorandum of Understanding to Support Joint Action on Improving Health through the Home[6] has been signed by a spectrum of organisations including: DH, DCLG, NHS England, ADASS and the LGA, along with members of the wider housing sector. The proposals set out in the Housing White Paper – Fixing our Broken Housing Market[7] – also underline the Government's commitment to do more to provide the homes we need for all in our society, including older people and those with care and support needs.

[5] http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Stepping%20up%20to%20the%20place_Br1413_WEB.pdf
[6] https://www.adass.org.uk/media/3957/health-and-housing-mou-final-dec-14.pdf
[7] https://www.gov.uk/government/collections/housing-white-paper

2. Integration now and the wider policy context

Just as progress has already been made on integration, there are a number of current initiatives across the health and care system that contribute towards this goal.

Announced in June 2013, the **Better Care Fund (BCF)** brings together health and social care budgets to support more person-centred, coordinated care. In the first two years of the BCF, the total amount pooled has been £5.3bn in 2015-16 and £5.8bn in 2016-17.

The BCF offers a good opportunity to have shared conversations, and to consider issues from different perspectives, particularly how BCF plans can support the delivery of wider objectives and strategies around health and social care. In particular, every health and care system in England has produced a **Sustainability and Transformation Plan (STP),** providing the system-level framework within which organisations in local health and care economies can plan effectively and deliver a sustainable, transformed and integrated health and care service. Local areas should ensure the financial planning and overall direction of travel within BCF plans and the local STP(s) are fully aligned.

The **vanguards**, which are part of NHS England's new care models programme[8], have clear plans for managing demand more effectively across the local health and care system and reducing costs, at the same time as improving outcomes for patients and users. The vanguards programme has published two frameworks that cover population-based integrated models – the **Multi-speciality Community Providers (MCPs) and the Primary and Acute Care Systems (PACs)**.[9] Many of these two types of vanguards include social care as well as pursuing integration within health services. All areas are encouraged to take action against the core elements described in the models where these support local objectives around the integration of health and care services. Scaling up of PACS and MCPs in a small number of STP areas will create Accountable Care Organisations, with further details in the Next Steps on the NHS Five Year Forward View.

Local devolution deals can add impetus to all of these initiatives, offering local areas the opportunity to go beyond the integration of health and social care and drawing in other local government services such as housing, planning, skills, justice, and transport. This provides opportunities for local areas to further tailor public services around individual needs and also to tackle the wider determinants of health. Figure 3 shows how multiple integration initiatives interact, for example, within Greater Manchester.

[8] https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf
[9] https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf and https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf

Greater Manchester is a **devolution** area, and there is a single **Sustainability and Transformation Plan** for the entire geography.

GM has a joint commissioning board at GM level – 12 CCGs and 10 LAs (+NHS England)

Within Greater Manchester there are a number of areas that are **new care models**: Wigan; Salford; Stockport; Tameside and Glossop.

In Greater Manchester, there are ten local authority areas, each have a **Better Care Fund** plan:

- Tameside
- Stockport
- Manchester
- Trafford
- Wigan
- Bolton
- Bury
- Rochdale
- Oldham
- Salford

Figure 3 – Integration initiatives in Greater Manchester

There is a growing evidence base on the contribution that **housing** can make to good health and wellbeing. At a system level, poor housing costs the NHS at least £1.4bn per annum. And there are also costs to local government and social care. On an individual level, suitable housing can help people remain healthier, happier and independent for longer, and support them to perform the activities of daily living that are important to them – washing and dressing, preparing meals, staying in contact with friends and family.

The increase in funding for the **Disabled Facilities Grant (DFG)** – and the decision to move it into the BCF in 2015-16 – is recognised as an important step in the right direction. Further action to support people into more suitable accommodation, and to adapt existing stock, is also to be welcomed.

The Department of Health is also currently working with NHS England, Local Government and others to improve the support available to informal **carers**. Supporting informal carers also supports those they care for: improving outcomes for both parties, enabling people to live independently in the community for longer and reducing impact on commissioned services. All areas are therefore encouraged to consider how BCF plans can improve the support for carers. In doing so, they may wish to make use of *'An Integrated Approach to Identifying and Assessing Carer Health & Wellbeing'*[10], an NHS England resource that promotes and supports joint working between adult social care services, NHS commissioners and providers, and voluntary organisations.

Within an area, a number of initiatives can also contribute towards overall system integration. These are not sufficient to full integration of health and social care, but can offer important contributions to key cohorts of patients and service users. For example:

[10] https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf

- Some local areas are also taking action on **'Integrated Personal Commissioning'** (IPC), whereby individuals experience holistic, personalised care and support planning, and an option for them to commission their own care using a personal budget or direct payment arrangements that combine funding from health, social care and education. IPC is being progressed by nine demonstrator areas (covering 20 CCGs and 12 local authorities) that are leading the way in developing a practical operating framework to enable wider replication, with a further 10 early adopters set to join the programme by March 2017.[11]

  NHS England expects that IPC will become a mainstream model of care for around 5 per cent of the population, enabling the expansion of personal health budgets and integrated personal budgets at scale. IPC is expected to be operational in 50% of STP footprints by 2019. Some Demonstrator sites (i.e. Luton and Stockton on Tees) are incorporating their work on IPC into BCF plans, using personal health budgets and integrated personal budgets to create more stable, coordinated care at home and in the community for high risk groups. Other parts of the country are also encouraged to consider this approach.

- Learning from the six **Enhanced Health in Care Homes** (EHCH) vanguard sites suggests that action to provide joined up primary, community and secondary health and social care to residents of care and nursing homes, as well as those living in the wider community, can have significant benefits. These include transforming the quality of care, reducing costs and activity levels, and supporting relationship-building at local level. Some parts of the country (i.e. East and North Hertfordshire and others) are already building in work around EHCH into their BCF plans and other parts of the country are encouraged to do the same. For more details, please see the 'Enhanced Health in Care Homes Framework'.[12]

[11] https://www.england.nhs.uk/commissioning/ipc/sites
[12] https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

3. Integration now and the Better Care Fund 2017-19

This Policy Framework for the Better Care Fund (BCF) covers two financial years (2017-19) to align with NHS planning timetables and to give areas the opportunity to plan more strategically. In 2017-18, the BCF will be increased to a mandated minimum of £5.128 billion and £5.617 billion in 2018-19.[13] The local flexibility to pool more than the mandatory amount will remain. Further details of the financial breakdown are set out in Table 1 below.

The main change to the Framework from last year is inclusion of significant amounts of local authority social care grant funding. Some of this was announced at the 2015 Spending Review, with an additional £2 billion over three years announced at Spring Budget 2017. There will be grant conditions on this new money to ensure it has the expected impact at the care front line.

In developing this framework, we have listened to feedback from local areas about the need to further streamline the processes around planning, assurance and performance reporting. There is also a halving of the number of national conditions that areas are required to meet through their BCF plans - reduced from eight to four. We have also set out more clearly, the requirements around the social care national condition.

The national conditions that areas will need to meet in their plans for 2017-18 and 2018-19 are: **plans to be jointly agreed; NHS contribution to adult social care is maintained in line with inflation; agreement to invest in NHS commissioned out of hospital services; and managing transfers of care**. The detailed requirements for each condition are set out in **Annex A**.

The removal of some national conditions from 2016-17 does not reflect a downgrading of the importance of these policies and we expect them to underpin local BCF plans. For example, all areas should be working to embed 7-day services across the health and care system. Shared information, interoperable IT and joint care assessments are critical enablers to deliver integrated services - therefore, we expect every area to continue taking action to build on the progress made in the last two years. In **Annex B** we have set out what you can do to keep up the momentum.

Statutory and Financial Basis of the Better Care Fund

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding.

[13] These are indicative figures only.

Better Care Fund in 2017-18

The Mandate to NHS England for 2017-18 requires NHS England to ring-fence £3.582 billion within its overall allocation to Clinical Commissioning Groups to establish the BCF in 2017-18. The Mandate was published on 20th March 2017.[14]

The remainder of the £5.128bn BCF in 2017-18 will be made up of the £431m Disabled Facilities Grant (DFG) and £1.115bn new grant allocation to local authorities to fund adult social care, as announced in the 2015 Spending Review and Spring Budget 2017. Both grants are paid directly from the Government to local authorities.

As in the previous two years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) also remains in the NHS allocation.

Better Care Fund in 2018-19

The Mandate to NHS England for 2017-18 also denotes an indicative ring-fence of £3.65bn from allocations to Clinical Commissioning Groups for the establishment of the BCF in 2018-19. The actual amount will be confirmed via the Mandate for 2018-19, which will be published in winter 2017-18.

The remainder of the £5.617bn BCF in 2018-19 will be made up of the £468m DFG and an indicative amount of £1.499bn new grant allocation to local authorities to fund adult social care, both of which will be paid directly from the Government to local authorities.

As in 2017-18, funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) remains in the NHS contribution.

Table 1: BCF funding contributions in 2017-19

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

[14] https://www.gov.uk/government/publications/nhs-mandate-2017-to-2018

Conditions of access to the Better Care Fund

The amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations (as discussed earlier, these are £3.582bn in 17-18, and an indicative amount of £3.65bn in 18-19). These powers do not apply to the amounts paid directly from Government to local authorities.

For the DFG, the conditions of usage are set out in a Grant Determination Letter, due to be issued by DCLG in April. This references the statutory duty on local housing authorities to provide adaptations to those disabled people who qualify, and sets out other relevant conditions.

For the new grant allocation to local authorities to fund adult social care, the conditions of usage will also be set out in a Grant Determination Letter. This will also be issued by DCLG in April, though a draft version of the conditions has been shared in March, for information.

National Conditions for 2017-19

In 2017-19, NHS England will require that BCF plans demonstrate how the area will meet the following national conditions:

- **Plans to be jointly agreed;**
- **NHS contribution to adult social care is maintained in line with inflation;**
- **Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and**
- **Managing Transfers of Care**

The refreshed definitions of these national conditions are set out at **Annex A.**

NHS England will also set the following requirements, which local areas will need to meet to access the CCG elements of the funding:

- A requirement that the BCF is transferred into one or more pooled funds established under section 75 of the NHS Act 2006; and
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s).

Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except, as mentioned above, for those amounts paid directly to local government. The Act makes provision

at section 223GA(7) for the mandate to NHS England to include a requirement that NHS England consult Ministers before exercising these powers. The 2017-18 Mandate to NHS England confirms that NHS England will be required to consult the Department of Health and the Department for Communities and Local Government before using these powers.

Disabled Facilities Grant

In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans; as set out in the DFG Grant Determination Letter due to be issued by DCLG in April 2017.

New grant for adult social care (announced in the 2015 Spending Review and Spring Budget 2017 as 'Improved Better Care Fund' (iBCF) funding)

The Government's Spending Review in 2015 announced new money for the BCF of £105m for 2017-18, £825m for 2018-19 and £1.5bn for 2019-20. The Spring Budget 2017 subsequently increased this to £1.115bn for 2017-18, £1.499bn for 2018-19 and £1.837bn for 2019-20. The Government will require that this additional Improved Better Care Fund (iBCF) funding for adult social care in 2017-19 will be pooled into the local BCF. This funding does not replace, and must not be offset against the NHS minimum contribution to adult social care.

The new iBCF grant will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government. The Government will attach a set of conditions to the Section 31 grant, to ensure it is included in the BCF at local level and will be spent on adult social care. The final conditions will be issued in April. However, a draft has been shared with areas in March. The draft conditions of use of the Grant can be summarised as:

1. Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

2. A recipient local authority must:

    a) pool the grant funding into the local BCF, unless an area has written Ministerial exemption;

    b) work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

c) provide quarterly reports as required by the Secretary of State.

3. The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

In terms of the wider context, the funding is also intended to support councils to continue to focus on core services, including to help cover the costs of the National Living Wage, which is expected to benefit up to 900,000 care workers. This includes maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services, such as those which support best practice in managing transfers of care.

Local authorities will be required to confirm that spending of the BCF money provided at Spending Review 2015 and Spring Budget 2017 will be additional to prior plans for social care spending, via a Section 151 Officer letter.

The assurance and approval of local Better Care Fund plans

As in 2016-17, plans will be developed locally in each Health and Wellbeing Board area by the relevant local authority and Clinical Commissioning Group(s). Plans will be assured and moderated regionally in line with the operational planning assurance process set out in the Integration and Better Care Fund Planning Requirements, published by NHS England and the Local Government Association.

Recommendations for approval of overall BCF plans will be made following moderation of regional assurance outcomes by NHS England and local government. Plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once NHS England and the Integration Partnership Board have agreed that the conditions attached to that funding have been met.

Local authorities are legally obliged to comply with grant conditions. The NHS Act 2006 (as amended by the Care Act 2014) allows NHS England to direct the use of the CCG elements of the fund where an area fails to meet one (or more) of the BCF conditions. This includes the requirement to develop an approved plan. If a local plan cannot be agreed or other National Conditions are not met, any proposal to direct use of the CCG elements of the Fund will be discussed with the Integration Partnership Board.

National performance metrics

As in 2015-16 and 2016-17, local areas are asked to agree and report metrics in the following four areas:

- Delayed transfers of care;
- Non-elective admissions (General and Acute);
- Admissions to residential and care homes; and
- Effectiveness of reablement

The detailed definitions of these metrics will be set out in the Integration and Better Care Fund Planning Requirements.

We are no longer requiring the national collection of a locally proposed metric.

Better Care Fund support offer in 2017-19

In implementing the BCF from 2017-18 to 2018-19, the joint Better Care Support team hosted by NHS England will continue to:

- Provide support to local areas to ensure effective implementation of agreed plans;
- Build an intelligence base to understand the real impact of the BCF on delivering integration;
- Support local systems to enable the successful delivery of integrated care in 2017-19 by capturing and sharing learning, building and facilitating networks to identify solutions;
- Promote and communicate the benefits of health and social care integration;
- Monitor the ongoing delivery of the BCF – including quarterly reporting on national metrics and spending; and
- Support areas that are proposing to graduate or have graduated from the BCF.

4. Integration now - Graduating from the Better Care Fund

Overview

The Government's Spending Review 2015 set out that "areas will be able to graduate from the existing Better Care Fund (BCF) programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution."

It is the Government's ambition that all areas will be able to work towards graduation from the BCF to be more fully integrated by 2020, with areas approved in waves as they demonstrate maturity and progress towards greater integration. The best areas are showing that greater levels of integration bring positive benefits in terms of improving people's health, wellbeing and experience of care, particularly in wrapping services around people's needs and shifting the focus to keeping people well and happy at home, with reduced demand for hospital and other health and care services.

These areas can apply for 'earned autonomy' from the BCF programme management. Graduation will mean that we will have a different relationship with these local areas; with reduced planning and reporting requirements and greater local freedoms to develop agreements appropriate to a more mature system of health and social care integration. This will include a bespoke support offer for areas that graduate, in addition to them no longer being required to submit BCF plans and quarterly reports.

We are planning to test the graduation process with a small number of areas (6 to 10) in the first instance. We are inviting areas that believe they can demonstrate that they meet the criteria for graduation now to put themselves forward prior to the deadline for submission of first plans, with a view to graduating from the BCF in this first wave.

Subsequent waves of areas will have the opportunity to graduate over the course of this spending review period. Departments, the LGA and NHS England will work with graduated areas to role-model how integration can support better outcomes for populations across health, social care and housing.

A "first wave" of Better Care Fund graduation

We have no set targets for the numbers of areas that graduate from the existing BCF programme management in each year. In the first round, we are planning to test graduation with a small number of areas (between 6 and 10), and will use this learning to refine the criteria and process going forward.

Graduation proposals should be made, at minimum, across an entire Health and Wellbeing Board geography, but could be aligned to Sustainability and Transformation Plan (STP)

footprints or devolution deal sites, as long as all relevant Health and Wellbeing Boards included in the proposal are supportive.

The eligibility criteria are set out below. Areas interested in participating in the first wave of graduates should benchmark themselves against these criteria and discuss their interest with their Better Care Manager.

The process of graduation will utilise sector-led improvement principles, supporting areas through peer review and development. This will culminate in a "graduation panel", which will provide face-to-face support and challenge to local areas to agree the conditions for graduation.

Eligibility criteria for Better Care Fund graduation

To keep the application process simple, all partners in an area wishing to apply for graduation will need to complete an Expression of Interest and demonstrate that they:

a) **Have in place a sufficiently mature system of health and social care with evidence of:**
    - Strong shared local political, professional, commissioner and community leadership;
    - An agreed system-wide strategy for improving health and wellbeing through health and social care integration to 2020. The government supports a range of models of health and social care integration, as set out in Chapter 5. You should reference your choice of model in your integration strategy or action plans and their links to wider health and local government strategies; and
    - A robust approach to managing risk, including adequate financial risk management arrangements proportionate to the level of risk in the system, for example, if any CCG is subject to financial directions, a clear appraisal of any additional risk and approach to managing it.

b) **Can demonstrate the application is approved by all signatories required by BCF planning**

c) **Provide evidence of improvement and/or approach to improving performance on BCF national performance metrics and how graduation will enable the area to accelerate improvement on these metrics. This should include current performance data and stretch targets.**

d) **Set out plans to pool an agreed amount greater than the minimum levels of the BCF or align the commissioning of an equivalent or greater scope of services. Set out plans to maintain joint investment in integrated services, including:**
    - Maintaining the NHS contribution to social care and NHS commissioned services in line with inflation;
    - Maintaining additional contributions from CCGs and local authorities to the pooled fund, in addition to the 'Improved Better Care Fund' grant funding to local government; and

- Continuing to meet grant conditions attached to the newly allocated funding within the Improved Better Care Fund.

e) Are committed to a 'sector-led improvement' approach in which they are willing to act as peer leaders, working with national partners to support other areas looking to graduate.

Selection criteria

As the first wave is testing the process, we will use the Expressions of Interest and other available information, including the following additional criteria, to select a small pool of 6-10 applicants, as follows:

a) The applicants commit and have the capacity to participate in the selection process which is set out below, participate in the pilot evaluation and share learning with peers and with national organisations supporting integration work.

b) The applicants have discussed their proposal with their local Better Care Manager.

c) The pilot cohort covers a range of different care model types as set out in Chapter 5.

d) The pilot cohort covers a spread of geographical locations and local authority type.

The selection process will include graduation workshops to help local leaders identify the steps necessary to graduate from the BCF and progress integration, in line with the 2015 Spending Review commitments. The workshops are based on the existing LGA sector-led improvement model, and will involve a half-day session for senior local health and local government leaders; these workshops will run in May and June, in order to complete the pilot in the agreed timeframe. The process will culminate in graduation panels (in early-to-mid July) with representatives from Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services, and will agree with local leaders, clear, measurable and transparent objectives and milestones for integration locally to 2020. We also intend to develop a dedicated package of support, building on the learning and experience of sites which have graduated from the pilot.

We are seeking areas which have made the most progress in moving beyond the requirements of the BCF. We recognise that the restricted number of pilot areas is likely to mean some areas are unsuccessful. We do understand that this will be disappointing for those areas not selected, but subsequent graduation waves will not be restricted in numbers in the same way. In addition those areas which are not selected for the pilot can continue to prepare for subsequent waves.

Expression of Interest process and timelines

- Applicants should submit to England.bettercaresupport@nhs.net an Expression of Interest, which demonstrates how local organisations meet the eligibility criteria a) to e) above by 5pm on 28th April 2017; this should include an indication of the discussion with their local Better Care Manager, which should take place before 19th April 2017.
- All applications will be assessed by the selection panel, with results communicated by 10th May 2017.
- Graduation workshops will run in May and June, with graduation panels taking place in early-to-mid July.

Guidance on submitting an Expression of Interest

The form should specifically address the eligibility criteria outlined in a) to e) above. Any submitted documents, including any covering letters, must not be longer than 6 pages, and have no embedded or attached appendices. Any attached or embedded documents will not be considered by the selection panel.

The Expressions of Interest will be assessed by a panel of representatives from the Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services. Its decision will be based on the evidence provided against eligibility criteria a) to e), with adjustments made to ensure a fair selection of pilots across geography, care model and local authority type in order to maximise the potential for learning from the pilots.

The support offer

We will put in place an ongoing support offer for areas, before, during and after the process of graduation. This will include:

- **Before –** Seminars, workshops or individual support for areas preparing for graduation (second and subsequent waves), including peer support from areas that have graduated;
- **During -** Advice and support for areas shortlisted for graduation to develop the core essential characteristics for integration including those required as evidence for graduation;
- **After -** Support for a peer network of graduated areas to share experience and evidence of what is working;

Once an area has been selected for graduation, we will aim to support them to achieve and/or maintain their integration vision. Areas that have 'graduated' from the BCF will continue to be subject to the normal local authority and CCG reporting requirements on finance and performance. We will develop with the first wave the format and process for providing a self-certifying annual report. In the unforeseen circumstances of serious financial or performance

issues or a breakdown in local partnership's ability to realise their integration plan, it may be necessary to reinstate some or all of the BCF programme management. This would be considered a last resort to support local leaders. Local areas would be given adequate advance notice, before any assurance or reporting requirements are reinstated.

BCF graduates will be at the forefront of demonstrating how integration of health and care is becoming a reality by 2020 and we expect that early graduates will work with national partners to share learning with others and provide leadership in delivering fuller integration by 2020.

5. Integration future - Integration to 2020

Overview

At the Spending Review 2015, the Government announced its ambition to integrate health and social care by 2020 so that it feels like one service. As noted by the Nuffield Trust there "is no one model of integrated care that is suited to all contexts, settings and circumstances".[15]

The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches, which reflect models the government supports. For example:

- **Greater Manchester –** a devolution area pooling health and social care budgets within 10 HWB localities. Where there are clear benefits, services will be commissioned across the footprint through the joint commissioning board (comprising the CCGs, local authorities and NHS England). Each locality has its own individual plan for integrating services which feeds into the overarching health and social care strategy.
- **North East Lincolnshire –** a lead commissioner model, in which the CCG exercises the Adult Social Care functions on behalf of the local authority;
- **Northumberland –** a single Accountable Care Organisation (ACO), taking on responsibility for general practice, primary care, hospital and community services, adult social care and mental health services.[16]

	Joint commissioning	Lead commissioning	Accountable Care Organisation (ACO)[17]
Characteristics	Some or all CCG/LA commissioning decisions made jointly. Budgets (and other resources) pooled or aligned in line with extent of joint commissioning.	One body exercises some or all functions of both the CCG and the LA, with the relevant resources delegated accordingly.	CCG and LA pay a set figure (possibly determined by capitation) to an Accountable Care Organisation to deliver an agreed set of outcomes for all health and care activity for the whole population, using a multi-year contract. The ACO decides what services to purchase to deliver those outcomes. MCPs and PACs are types of ACOs.

[15] Nuffield Trust, An overview of integrated care in the NHS. What is integrated care? (London: Nuffield Trust, 2011), 20.
[16] Northumberland is a PACs vanguard site, but the ACO goes well beyond simply combining primary and secondary acute care.
[17] M McClellan et al., Implementing Accountable Care to achieve Better Health at a Lower Cost, WISH 2016 http://www.wish-qatar.org/wish-2016/forum-reports

An integrated health and social care service should have full geographical coverage, with clear governance and accountability arrangements. As part of this, we would encourage areas to align their approach to health and care integration with STP geographies, where appropriate. This may be supplemented by initiatives for particular groups, such as Enhanced Health in Care Homes and Integrated Personal Commissioning.

The Government recognises the integration efforts that are already happening, including through the Better Care Fund (BCF), STPs and local devolution. There will be no separate process for integration plans. **Instead, we will simply require local areas to set out how they expect to progress to further integration by 2020 in their BCF 17-19 returns.**

Next Steps

To help areas understand whether they are meeting our integration ambition, we will develop integration metrics for assessing progress, particularly at the interface where health and social care interact. This will combine outcome metrics, user experience and process measures. The metrics will build on work already carried out on behalf of Government (see Annex C) and the Integration Standard tested on the Government's behalf by the Social Care Institute of Excellence (SCIE) found at Annex D. SCIE found that the standard identified helpful integration activities such as risk stratification and multi-disciplinary community teams, but was process-focused and did not tell the whole integration story. We therefore want to bring elements of the standard into the wider integration scorecard. SCIE's full report is available here: www.scie.org.uk/integrated-health-social-care/integration-2020/research

Further work involving SCIE and key stakeholders will develop these integration metrics. If you have any thoughts on what to include in these, please email: Bettercarefund@dh.gsi.gov.uk

Following the development of the metrics we will ask the Care Quality Commission (CQC) to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care and will not cover wider council social care commissioning. This should lead to a tailored response to ensure those areas facing the greatest challenges can improve rapidly.

Other actions will include:

a) Consideration of Section 75 arrangements

The Department of Health, working with NHS England, is now considering what further changes could be made to secondary legislation to support more integrated, place-based approaches to health and social care, for example:

- The commissioning functions that can be included in scope
- The governance and partnership working arrangements that are permissible, for example Joint Committees

Before NHS England can make arrangements involving combined authorities and local authorities for example, regulations would need to be made prescribing those bodies for the purposes of such arrangements. The Department is also considering whether further amendments to the section 75 partnership regulations would support local areas to extend the benefits of partnership working as they take forward their integration vision.

b) Developing our evidence base on integration, through independent evaluation and sector-led engagement

We will build on our evidence base on what good integration looks like through:

- **The final report of the system-level evaluation of the Better Care Fund will be ready in winter 2017-18.** An interim report is expected in spring 2017, including a typology analysis of integration activities, initial findings from the comparative evaluation, and a BCF policy background paper (a documentary analysis of official BCF literature).

- **Learning from LGA's sector-led support using the Integration 'self-assessment' tool**[18] developed by LGA, ADASS, NHS Confederation and NHS Clinical Commissioners. The peer-led tool assesses local leaders' readiness, capacity and capability to integrate. We will build on this to facilitate graduation panels.

- **NHS England and NHS Improvement evaluation of the New Care Models Programme.** There is a wide range of national, local and independent evaluation of the NCM. Evaluations are progressing at pace.

- **DH and CQC testing the feasibility of a national survey of people's experience of integrated care.** This will be piloted in 2017-18 with a view to national roll out in the future.

Resources:

The LGA has developed a library of resources, signposting local areas to evidence, case studies, tools and resources which will support the development of integration ambitions locally.[19] The resource is organised around the essential integration characteristics, such as leadership, governance, prevention, housing and planning, co-production, care models and workforce. Organisations may also find the slides on Integration, produced by consulting firm Oliver Wyman, a useful resource.[20]

[18] http://www.local.gov.uk/sites/default/files/documents/stepping-place-integratio-f0b.pdf
[19] http://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund/integration-resource-library
[20] http://www.oliverwyman.com/our-expertise/insights/2016/nov/global-health-strategy-hub.html

Annex A: Further information on the national conditions for 2017-19

NATIONAL CONDITION	DEFINITION
Condition 1: **Plans to be jointly agreed**	Local areas must ensure that their Better Care Fund (BCF) Plan covers the minimum of the pooled fund specified in the BCF allocations spreadsheet, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area. The plans should be signed off by the Health and Wellbeing Board itself, and by the constituent councils and Clinical Commissioning Groups. The Disabled Facilities Grant (DFG) will again be allocated through the BCF. As such, areas are required to involve local housing authority representatives in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing. In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans. During these discussions, it will be important to continue to meet local needs for aids and adaptations, whilst also considering how adaptation delivery systems can help meet wider objectives around integration. For both single tier and two tier authorities, areas are required to set out in their plans how the DFG funding will be used over the two years. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people.
Condition 2: **NHS contribution to adult social care is maintained in line with inflation**	For 2017/18 and 2018/19, the minimum contribution to adult social care will be calculated using the assured figures from 2016/17 as a baseline. This will apply except where a Health and Wellbeing Board secures the agreement of the Integration Partnership Board to an alternative baseline. The NHS contribution to adult social care at a local level must be increased by 1.79% and 1.9% (in line with the increases applied to the money CCGs must pool) in 2017-18 and in 2018-19 respectively. Local areas can opt to frontload the 2018-19 uplift in 2017-18 and then carry over the same level of contribution in 2018-19 as in 2017-18. The funding must be used to contribute to the maintenance of adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, the Department of Health wants to provide flexibility for local areas to determine how this investment in adult social care

	services is best used. The additional funding for adult social services paid directly to local authorities by the government in each year (please refer to page 17) does not replace, and cannot not be offset against, the NHS minimum contribution to adult social care.
Condition 3: **Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care**	Local areas should agree how they will use their share of the £1.018 billion in 2017/18 and £1.037 billion in 2018/19 that had previously been used to create the payment for performance fund (in the 2015-16 BCF). This should be achieved by funding NHS commissioned out-of-hospital services, which may include 7-day services and adult social care, as part of their agreed BCF plan. This can also include NHS investment in the high impact change model for managing transfers of care (linked to compliance with national condition 4), although CCGs can commission these services from funding outside of this ringfence. Local areas can choose to put an appropriate proportion of their share of the £1.018bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including 7-day services and adult social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 2016-17). Further guidance to support local areas on deciding whether to hold back a proportion of funds as part of a risk share agreement will be provided in the Integration and Better Care Fund Planning Requirements.
Condition 4: **Managing Transfers of Care**	All areas should implement the High Impact Change Model for Managing Transfer of Care[21] to support system-wide improvements in transfers of care. Narrative plans should set out how local partners will work together to fund and implement this and the schemes and services commissioned will be assured through the planning template. Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, ensuring that all partners are involved, including relevant Accident and Emergency Delivery Boards. Quarterly reports will be provided, as required by the Department of Health and the Department for Communities and Local Government.

[21] Including arrangements for a Trusted Assessor model, as per the following link: http://www.local.gov.uk/sites/default/files/documents/Impact change model managing transfers of care %281%29.pdf

Annex B: Maintaining progress on the 2016-17 national conditions

We have made changes to the national conditions and reduced the number of conditions to reflect wider changes in the policy and delivery landscape.

For the policy areas that are no longer national conditions of the Better Care Fund (BCF) in 17-19 (see table below), we encourage areas to continue taking action through their BCF plans or other local agreements to ensure these policy priorities and critical enablers for integration continue to feature in local planning and delivery.

National condition	Update for 2017-19 Better Care Fund planning
1. Plans to be jointly agreed	This is a condition for 2017-19 (see Annex A)
2. NHS contribution to adult social care is maintained in line with inflation.	This is a condition for 2017-19 (see Annex A)
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admission to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Improving services through the implementation of the 7-day service clinical standards remains an important priority.[22] All areas should be working to make progress on implementing the 4 priority clinical standards, supported by NHS England and NHS Improvement, so that by April 2018, 50% of patients have access to these standards of care every day of the week with this rising to everyone by 2020. Sustainability and Transformation Plans are providing an opportunity for areas to come together to consider the delivery of 7-day services across geographical areas. Although not a requirement for accessing BCF funding in 2017-19, BCF areas should continue to make progress locally, building on the action taken in 2016-17, on implementing standard 9 of the 7- day hospital service clinical standards which concerns the transfer of patients to community, primary and social care. Standard 9 sets out that: 'Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken, 'Academy of Medical

[22] https://www.england.nhs.uk/ourwork/qual-clin-lead/seven-day-hospital-services/the-clinical-case/

	Royal Colleges (2012): Seven day consultant present care'. Without the timely transfer of patients across settings of care there can be detriment to both existing hospital patients and newly-arriving patients. All BCF areas should work together to avoid unnecessary delays in patient pathways, including taking the actions to reduce delayed transfers of care set out in the section on DTOC below.
Better data sharing between health and social care, based on the NHS number	Data sharing is no longer a condition of the BCF but it remains an important enabler to delivery of BCF or wider integration commitments. To enable effective information sharing for direct care, Parliament introduced the Safety and Quality Act in 2015 which now makes it a legal requirement to share information where it is likely to facilitate the provision of health or care services and is in the individuals' best interests. The Safety and Quality Act also now makes it a legal requirement to use a consistent identifier (such as the NHS number) to support local information sharing. There are examples of where leadership commitment is enabling information sharing at a local level. In addition, through Local Digital Roadmaps, local areas are outlining ambitions for the use of information sharing and technology to support the delivery of care. There are existing examples across the country of where local areas are joining up local systems to give a single health and care record to support the delivery of direct care. These approaches will enable improved coordination of care and support information sharing across health and care settings. The National Data Guardian has also published a review of data security, consent and opt outs across health and care. The report proposed a set of ten data security standards for the health and care system and made a series of recommendations to support information sharing. This includes a commitment to refresh the current Information Governance Toolkit, so that it becomes a portal to support organisations across health and social care to demonstrate increasing resilience and compliance with the standards. Local areas should consider how best to implement these recommendations in conjunction with national policy and services such as CareCERT. The review builds on the previous two Caldicott reports to emphasise the

	importance of building public trust in data security and information sharing, and encouraging public bodies to ensure they engage with citizens regarding how their information is shared.
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	This is no longer a condition of the BCF; however, BCF plans should have embedded within them, an integrated and proactive approach to planning and managing care with other health and care professionals.
Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans	This is no longer a condition of the BCF but areas should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people (as set out in condition 1 for 2017-19)
3. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	This is a condition for 2017-19 (see Annex A)
Agreement on local action plans to reduce delayed transfers of care (DTOC)	There is an improved condition around Managing Transfers of Care (National Condition 4), which requires areas to implement the High Impact Change Model for Managing Transfers of Care. Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, including setting out the intended impact on reducing delayed transfers of care. This will also support the target of a reduction in total delayed transfers of care to 3.5% by September 2017 (recognising existing variation between areas), which is referenced in the Mandate to NHS England for 2017-18.

Annex C: Draft Interface Metrics

Proposed scorecard for measuring effectiveness of social and healthcare interfaces

A Main performance indicators

A1 NEL admissions (65+) per 1,000 65+

A2 NEL admissions (65+) with length of stay >30 days per 1,000 65+

A3 Emergency readmission (65+) per 1,000 emergency admissions 65+

A4 Institutionalisation bed days (65+) per 1,000 65+

A5 DTOC – overall and due to social care placement or package per 1,000 65+

B Supporting overarching indicator

B1 Index of 'User reported quality of life' and 'Proportion of people feeling supported to manage their LTC'

C Contextual indicator

C1 Index of multiple deprivation (IMD)

Additional contextual indicators to collect in the future:
- Public health and social care spend per capita for 65+
- Proportion of 65+ with shared care records in place which are accessible by all care manage teams

Annex D: Integration Standard

	Objective	Improvement to person's experience	System change needed to deliver this objective
1	**Digital inter-operability**	"I have access to a Digital Integrated Care Record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data)"	• Areas reach **digital maturity**, including universal use of the NHS number as the primary identifier and fully interoperable IT across providers and commissioners.
2	**Resource targeted at key cohorts to prevent crises and maintain wellbeing**	"If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital." "If it would benefit me, I will be able to access a personal budget, giving me greater control over money spent on my care."	• Areas use health and social care data to **risk stratify** their populations, identifying those most at risk of unplanned admissions and allocating resources according to need. • Areas will allow greater access to **Integrated Personal Commissioning**, for identified groups who could benefit. • Areas use **capitated budgets** where appropriate
3	**Value for money**	"I receive the best possible level of care from the NHS and my Local Authority."	• Areas deliver against a **clear plan for making efficiencies** across health and care, through integration.
4	**Single assessment and care plans**	"If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care."	• Areas use **multi-disciplinary integrated teams** and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week.
5	**Integrated community care**	"My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it."	
6	**Timely and safe discharges**	"If I go into hospital, health and social care professionals work together to make sure I'm not there for any longer than I need to be."	
7	**Social care embedded in urgent and emergency care**	"If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them".	

Department for Communities and Local Government

NHS England

Department of Health

Integration and Better Care Fund planning requirements for 2017-19

The Better Care Fund

NHS England Publications Gateway Reference 06945

CONTENTS

Introduction

1. The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published a detailed policy framework[1] for the implementation of the Better Care Fund (BCF) in 2017-18 and 2018-19. This was developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England. The framework forms part of the NHS England Mandate for 2017-18. It requires NHS England to issue these further detailed requirements to local areas on developing BCF plans for 2017-18 and 2018-19.

2. The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF). The Spring Budget 2017 announced an additional £2 billion to support adult social care in England. This money is included in the IBCF grant to local authorities (LAs) and will be included in local BCF pooled funding and plans.

3. This BCF planning requirements document supports the core NHS Operational Planning and Contracting Guidance for 2017-19.[2] It is being published jointly with DH and DCLG in order to disseminate it directly to LAs.

4. The legal framework for the Fund derives from the amended NHS Act 2006 (s. 223GA), which requires that in each area the CCG(s) transfer minimum allocations (as set out in the Mandate) into one or more pooled budgets, established under Section 75 of that Act, and that approval of plans for the use of that funding may be subject to conditions set by NHS England. NHS England will approve plans for spend from the CCG minimum in consultation with DH and DCLG as part of overall plan approval.

5. The DFG and IBCF Grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003.

6. The NHS Act 2006 also gives NHS England powers to attach additional conditions to the payment of the CCG minimum contribution to the Better Care Fund to ensure that the policy framework is delivered through local plans. These powers do not apply to the DFG and IBCF.

[1] https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019
[2] https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

Policy requirements

7. Key changes to the policy framework since 2016-17 include:

- A requirement for plans to be developed for the two-year period 2017-2019, rather than a single year; and
- The number of national conditions which local areas will need to meet through the planning process in order to access the funding has been reduced from eight to four.

8. The four national conditions require:

i. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;
ii. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
iii. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
iv. All areas to implement the High Impact Change Model for Managing Transfer of Care[3] to support system-wide improvements in transfers of care.

9. The reduction in national conditions is intended to focus the conditionality of the BCF, but does not diminish the importance of the issues that were previously subject to conditions. These remain key enablers of integration. Narrative plans should describe how partners will continue to build on improvements locally against these formal conditions to:

- Develop delivery of seven day services across health and social care;
- Improve data sharing between health and social care; and
- Ensure a joint approach to assessments and care planning.

10. In addition, local authorities now benefit from the additional funding for social care announced in the Spring Budget 2017. This was provided for the purposes of:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- Ensuring that the local social care provider market is supported.

11. Annex B of the policy framework sets out the Government's ongoing policy requirements in relation to the former national conditions. Areas should note that the High Impact Change Model for Managing Transfers of Care includes seven day integrated working to support discharge.

[3] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

Further integration of health and social care

12. The 2015 Spending Review set out the Government's intention that, by 2020, health and social care will be more fully integrated across England. BCF plans must set out how CCGs and local authorities are working towards fuller integration and better co-ordinated care, both within the BCF and in wider services. Narrative plans should set out the joint vision and approach for integration, including how the work in the BCF plan complements the direction set in the Next Steps on the NHS Five Year Forward View[4], the development of Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation in the area covered by the plan. This could also include alignment with work through Transforming Care Partnerships or other NHS programmes such as Integrated Personal Commissioning.

Planning requirements

13. Local partners will need to develop a joint spending plan that meets the national conditions. In developing BCF plans for 2017-19, local partners will be required to develop, and agree, through the relevant HWB(s):

    i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions; and how their BCF plans will contribute to the local plan for integrating health and social care; and

    ii. A completed planning template, demonstrating:
    - Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
    - A scheme-level spending plan demonstrating how the fund will be spent; and
    - Quarterly plan figures for the national metrics.

14. Plans will be assured and moderated regionally. Recommendations for approval of BCF plans will be made following moderation at NHS regional level of assurance outcomes by NHS England and local government and cross regional calibration of outcomes to ensure consistent application of the requirements nationally.

15. Overall plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once NHS England and the Integration Partnership Board have agreed that the conditions attached to that funding have been met. For the first time BCF plans will be agreed for a two year period. Arrangements for refreshing or updating plans for 2018-19, for instance to take account of progress against metrics, will be set out in separate operating guidance, which will be published later in the year.

16. The below table sets out where the information to fulfil the above planning requirements will be collected and how it will be assured:

[4] https://www.england.nhs.uk/five-year-forward-view/

Requirement	Collection method	Assurance approach
Narrative plans	Submitted to NHS England regional / local Directors of Commissioning Operations (DCO) teams in an agreed format	Assured regionally by relevant NHS teams and local government assurers, with regional moderation involving the LGA and ADASS at NHS regional level
Confirmation of funding contributions	BCF planning template (spreadsheet). CCGs should ensure consistency between the figures recorded in the BCF planning template and their core financial returns	Assured regionally by relevant NHS teams and local government assurers following collation and analysis nationally
National conditions	Detail submitted to NHS England regional / DCO teams through narrative plans (as above), with further confirmations submitted through the BCF planning template	Assured regionally by relevant NHS teams and local government assurers, with regional moderation involving the LGA and ADASS at NHS regional level
Scheme level spending plan	Submitted to NHS England regional / DCO teams through the BCF planning template	Assured regionally by relevant NHS teams and local government assurers following collation and analysis nationally.
National Metrics	Submitted through UNIFY and through the BCF planning template	Collated and analysed nationally, with feedback provided to relevant NHS teams and local government assurers for regional moderation and assurance process

Confirmation of funding contributions

17. Under the Mandate for 2017-18, NHS England is required to ring-fence £3.582 billion for 2017-18 rising to £3.65 billion in 2018-19 within its overall allocation to CCGs to establish the BCF. For 2017-18, the remainder of the £5.128 billion fund will be made up of the £431 million DFG, and a new £1.115 billion grant allocation to local authorities to fund adult social care, first announced in the 2015 Spending Review: the IBCF. The Spring Budget 2017 included a significant increase in IBCF allocations. For 2018-19, the remainder of the £5.617 billion fund will be made up of the £468 million DFG and £1.499 billion IBCF grant to local authorities.

18. NHS England has published allocations for CCG contributions to the BCF at individual HWB level for 2017-18 and (indicatively) for 2018-19, along with the

detailed formulae used, on its website.[5] The IBCF and DFG monies are paid to local authorities directly under Section 31 of the Local Government Act 2003, with grant conditions requiring that the funding is pooled in the BCF.

19. The Government has attached conditions for the new IBCF grant to local authorities (see below). It is subject to the joint NHS England and local government assurance process.

20. As soon as plans for use of the IBCF funding have been locally agreed, IBCF funding can be spent through the pooled budget in line with the grant conditions.

	2017-18 (millions)	**2018-19 (millions; indicative)**
Minimum NHS ring-fenced from CCG allocation	£3,582	£3,650
Disabled Facilities Grant	£431	£468
Additional funding paid to local authorities for adult social care (IBCF)	£1,115	£1,499
Total	£5,128	£5,617

21. All local partners will need to confirm mandatory and any additional funding contributions to all plans to which they are a partner. This will include confirming that individual elements of the funding have been used in accordance with their purpose as set out in the policy framework, relevant grant conditions and the guidance below. This confirmation will be collected nationally through the BCF Planning Return. Detailed instructions on completing this are included in the guidance section of the return template.

Direct Grant to Local Government – the Improved Better Care Fund.

22. This funding, totalling £1.115 billion in 2017-18 and £1.499 billion in 2018-19, will be paid directly to LAs as a direct grant under Section 31 of the Local Government Act 2003 for adult social care[6]. The following grant conditions, detailed in the Grant Determination, apply to the entire IBCF allocation (i.e. the original grant announced in 2015 and the additional funding announced in the 2017 Spring Budget).

[5] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

[6] The Liverpool City Region, consisting of six local authorities, Liverpool, Halton, Knowsley, Sefton, St Helens and Wirral, is participating in a pilot programme to test a new model for retention of business rates locally. As a result, the allocation of funding for the Improved Better Care Fund will not be paid as a grant to these authorities, but instead, the pilot areas will be required to pool their allocation from locally raised business rate income that has been retained.

23. The grant conditions for the IBCF require that:

> Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.
>
> A recipient local authority must:
>
> a) pool the grant funding into the local Better Care Fund, unless an area has written Ministerial exemption;
>
> b) work with the relevant Clinical Commissioning Group and providers to meet national condition four (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and
>
> c) provide quarterly reports as required by the Secretary of State.
>
> The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans for spending the grant have been locally agreed with Clinical Commissioning Groups involved in agreeing the Better Care Fund plan.

24. The BCF planning template will be populated with the provisional grant allocation for each HWB area. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

25. Areas must agree, within their BCF Plans, how this money will be spent, ensuring that the grant conditions are met. In May 2017, DCLG confirmed the department's requirements on quarterly reporting for the IBCF. Updates on progress in implementing the High Impact Change Model for Managing Transfers of Care will be included within the monitoring of national condition four.

26. DH and DCLG have made clear in their letter of 28 March to LA chief executives that there are three purposes of this funding, one of which is to reduce pressures on the NHS. When areas agree this local investment, it will therefore contribute to meeting the ambition in the 2017-18 NHS England Mandate for NHS organisations to reduce delayed transfers of care (DToC) to occupying no more than 3.5% of hospital bed days by September 2017. In order to meet this, daily delays need to fall to around 4,000 in September 2017. This would in turn meet the ambition to free up the 2,000-3,000 hospital beds across England set out in Next Steps on the NHS Five Year Forward View.

27. The funding can be allocated across any or all of the purposes outlined above as the LA and CCG(s) best determine to meet local pressures and reduce delayed transfers. No fixed proportion needs to be allocated across the purposes, nor should the funding be restricted to funding the changes in the High Impact Change Model.

28. DCLG has also required LAs to certify (via their Section 151 officer) that spending of the additional money provided at the 2017 Spring Budget will be additional to previous plans for adult social care spending. The IBCF is allocated over three years (until 2019-20) and is intended to support sustainable approaches to stabilising the social care market and relieving pressure on the NHS. The Government has committed to improve social care and bring forward proposals for consultation.

29. The Government has announced a package of measures to address DToC across the health and social care system. This package includes:

- A dashboard showing how areas are performing against a range of metrics across the NHS-social care interface;
- Targeted CQC reviews to examine performance in the areas with the worst outcomes across these metrics, with a view to supporting them to improve;
- Considering a review, in November, of 2018-19 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care; and
- Guidance on implementing a Trusted Assessor model.

Disabled Facilities Grant

30. Following the approach taken in previous years, the DFG continues to be allocated through the BCF. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people to live independently in their own homes for longer, and to take a joined-up approach to improving outcomes across health, social care and housing. Innovation in this area could include combining DFG and other funding sources to create fast-track delivery systems, alongside information and advice services about local housing options. In 2016-17, the housing element was strengthened through the national conditions, with local housing authority representatives required to be involved in developing and agreeing BCF plans. This has been retained for 2017-19.

31. As in previous years, DFG will be paid to upper-tier authorities. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate DFG from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

32. In 2017-19, in two-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county council to district councils (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans. During these discussions, it will be important to continue to ensure that local needs for aids and adaptations are met, whilst also considering how adaptation delivery systems can help meet wider objectives around integration. Where some DFG funding is retained by the upper tier authority, plans should be clear that:

- The funding is included in one of the pooled funds as part of the BCF;
- The funding supports a strategic approach to housing and adaptations that supports the aims of the BCF; and
- The relevant lower-tier authorities agree to the use of the funding in this way.

33. All areas are required to set out in their plans how the DFG funding will be used over the two years. Since 2008-09, the scope for how DFG funding can be used has been widened to support any LA expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables authorities to use specific DFG funding for wider purposes.

34. This discretionary use of the funding can help improve delivery and reduce the bureaucracy involved in the DFG application process, helping to speed up the process. For example, LAs could use an alternative means test, increase the maximum grant amount, or offer a service which rapidly deals with inaccessible housing and the need for quick discharge of people from hospital. The Care Act also requires LAs to establish and maintain an information and advice service in their area. The BCF plan should consider the contribution that can be made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues.

Care Act 2014 Monies

35. The BCF minimum allocation to CCGs includes funding to support the implementation of the Care Act 2014 and other policies. BCF plans should set out how informal or family carers will be supported by LAs and the NHS. Further guidance and details of the exact breakdown has been set out in the Local Authority Social Services Letter, sent by DH to Directors of Adult Social Services.

Former Carers' Break Funding

36. The CCG minimum allocation to the BCF also includes, as in 2016-17, £130m of funds previously earmarked for NHS replacement care so that carers can have a break. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes. In doing so, local areas may wish to make use of An Integrated Approach to Identifying and Assessing Carer Health & Wellbeing, an NHS England resource that promotes and supports joint working between Adult Social Care services, NHS commissioners and providers, and third sector organisations.

Reablement Funding

37. The CCG minimum allocation to the BCF also includes, as in 2016-17, £300m of NHS funding to maintain current reablement capacity in LAs, community health services, and the independent and voluntary sectors to help people regain their independence and reduce the need for ongoing care.

National conditions

38. Local partners will be required to include a clearly articulated plan for meeting each national condition in their BCF narrative, as set out in the policy framework and operationalised by the guidance contained in this document, as well as in the scheme details entered in the planning template. This should include clear links to other relevant programmes or streams of work in place locally to deliver these priorities. There will also be a requirement to confirm whether plans are in place to meet the conditions as part of the BCF planning template. More details on each condition are set out below

National condition one: A jointly agreed plan

Narrative plans

39. The BCF plan should build on approved plans for 2016-17 and demonstrate that local partners have reviewed progress in the first two years of the BCF as the basis for developing plans for 2017-19. Local providers must be involved in the development of plans. This includes NHS trusts, social care providers, voluntary and community service partners and local housing authorities.

40. The narrative plan will also need to demonstrate that local partners have collectively agreed the following:

i. The local vision and model for sustainable systems and better co-ordinated care through the integration of health and social care – showing how services will be transformed to meet the Government's vision to move towards more fully integrated health and social care services by 2020, as set out in the policy framework and how the plans support a shift to a more community based, preventative approach to care and the role the BCF plan in 2017-19 plays in that context;
ii. A coordinated and integrated plan of action for delivering the vision, supported by evidence;
iii. A clear articulation of how they plan to meet each national condition, including the national commitment for each local area to free up its share of 2,000-3,000 hospital beds across England; and
iv. An agreed approach to performance and risk management, including financial risk management and, where relevant, risk sharing and contingency.

41. In all cases these elements can be demonstrated and referenced from existing plans or initiatives. Where a plan makes reference to other documents, the information being referenced should be made clear and contextualised and, in the interests of transparency, narrative plans should be coherent as standalone documents.

42. The policy framework describes the Government's expectation that areas continue to make progress against the national conditions from the 2016-17 BCF that have now been removed. These are set out in Annex B of the policy framework. Narrative plans should briefly describe how areas will continue to make progress against these former conditions, referencing other plans where appropriate.

43. Local partners should consider how the activities in their BCF plan will address health inequalities in the area in line with duties in the Health and Social Care Act 2012 and reduce inequalities between people from protected groups in line with the Equality Act 2010. Local strategies for reducing inequalities across the constituent organisations can be referenced where appropriate, but the narrative plan should give an overview of any priorities and investment to address health inequalities or to address inequalities for people with protected characteristics under the Public Sector Equality Duty in the Equality Act 2010.

Managing Risk

44. All plans must set out the approach to managing risk locally. This should include financial risks that impact on the delivery of the BCF plan as well as delivery risks. The assurance process will no longer involve separate assessments on plan quality and risk to delivery. Instead, all narrative plans must include an assessment of key risks to plan delivery, the approach to managing these risks and a risk log, setting out mitigations consistent with the level of risk in the plan. Assessment of risk should be consistent with wider assessments by partner organisations, provider market and strategic challenges set out in the plan's evidence base, such as market position statements, Joint Strategic Needs Assessment and other external assessments – for example from the Care Quality Commission.

45. Plans can include links to organisational risk logs as part of the plan-level risk mitigation. Further information can be found in the local plan development, sign-off and assurance section of this document.

National condition two: NHS contribution to social care is maintained in line with inflation

46. Local areas must include an explanation within their plans of how the use of BCF resources will meet the national condition that the NHS contribution to adult social care is maintained in line with inflation. This condition gives effect to the commitment in the Spending Review to continue to maintain the NHS minimum mandated contribution to adult social care to 2020. This contribution to social care can be used to support existing adult social care services, as well as investment in new services. Maintaining existing services is essential in managing demand, maintaining eligibility and avoiding service cuts. Furthermore, in the light of the acute funding pressures on adult social care, HWBs need to be able to review the schemes funded through the BCF and reallocate resources in order for local authorities to continue to meet their adult care statutory duties.

47. In 2017-18 and 2018-19, the minimum contribution to adult social care will be calculated using the figure agreed through the 2016-17 plan assurance process as a baseline, uprated for each subsequent year in line with the CCG minimum contribution. This means that the minimum required contribution will rise by 1.79% in 2017-18 and 1.90% in 2018-19. Local areas will have the opportunity to query the baseline used for this calculation if they believe that it is not an accurate reflection of the CCG minimum allocation for social care in 2016-17. Grounds for this could include that:

- The baseline in the planning template includes non-recurrent payments. In this case, all partners must agree that the funding in question was not intended to be part of the baseline; and
- The baseline is not correct due to mis-coded spend lines.

48. Areas need to query their baseline with the Better Care Support team by 31 July 2017. Agreement to any changes to the baseline, and resultant minimum required contributions, will be made by the Integration Partnership Board. Further details are at **Appendix 4**.

49. Areas can agree larger contributions if they wish. Any area proposing increases to social care funding from the CCG minimum contribution significantly above inflation should provide supporting evidence to set out the reasoning and benefits to the wider system of this increase. Local areas can opt to frontload the 2018-19 uplift in 2017-18 and then carry over the same level of contribution or a smaller increase in 2018-19, provided the contribution is greater than, or equal to the minimum requirement for 2018-19 published in the planning template.

50. The BCF planning template will be pre-populated with the required minimum contribution to social care from CCG minimum contributions in each year. In setting the level of contribution to social care, localities should ensure that any change does not destabilise the local health and social care system as a whole. This will be assessed compared to 2016-17 figures through the regional assurance process.

National condition three: Agreement to invest in NHS-commissioned out-of-hospital services

51. The policy framework establishes that a minimum of £1.018 billion of the CCG contribution to the BCF in 2017-18, and £1.037 billion in 2018-19, will continue to be ring-fenced to deliver investment or equivalent savings to the NHS, while supporting local integration aims. Each CCG's share of this funding will be set out in allocations and will need to be spent as set out in the national condition. This should be achieved in one of the following ways:

- Where areas do not plan for reductions in non-elective admissions (NEAs) beyond the CCG operational plans they may use the full allocation to fund NHS-commissioned out-of-hospital services. These services should have a clear evidence base and are expected to lead to reductions in acute activity and unplanned admissions. This could include a wide range of services including community nursing, therapeutic and adult social care, to be determined locally. Funding from the ring-fenced out-of-hospital spend can be used to pay for health related activity to meet national condition four (managing Transfers of Care), although funding from other parts of the CCG contribution can also be used. CCGs and local authorities should include a breakdown of planned expenditure, including the amount they identify as NHS-commissioned spend, within the scheme level spending plan; or

- If a local area is planning additional NEA reductions, it must consider putting part of its ring-fenced funding for NHS-commissioned services into a contingency fund equal to the value of the planned reductions in NEAs. In the event that NEA activity is higher than the metric in the BCF plan, an

appropriate amount can be withheld from the fund and used to cover the additional cost of unplanned admissions to the CCG, with the balance spent on NHS-commissioned out-of-hospital services.

52. Where local partners agree to use a contingency fund the default approach should be to base this on the 2015-16 payment-for-performance approach, as set out at **Appendix 2**. Any risk share agreement linked to National Condition 3 should relate solely to funding from the ring-fenced funding for out-of-hospital services from the CCG minimum contribution and should not result in any part of the minimum transfer of funding to maintain social care being held 'at risk'.

53. As part of BCF planning returns, local areas will need to demonstrate that they are using their share of the NHS-ring-fenced fund in the way described above. The template includes confirmation of the local share, and calculates the amount invested in NHS-commissioned out-of-hospital services from the spending plan.

Risk shares and financial contingency not linked to national condition three.

54. Areas can agree local approaches to risk sharing or creating contingency reserves to cover costs incurred if preventative approaches are not successful. In designing these schemes, local systems must ensure that the financial position of CCG(s) or the LA(s) are not compromised. Any risk share agreement involving an LA should not result in any part of the minimum transfer of funding to maintain social care being held 'at risk'.

National condition four Implementation of the High Impact Change Model for Managing Transfers of Care.

55. National condition four requires health and social care partners in all areas to work together to implement the High Impact Change Model for Managing Transfers of Care. BCF plans should set out how local areas are implementing the model, which was agreed by local government and health partners in December 2015 and republished in April 2017[7]. This model sets out eight broad changes that will help local systems to improve patient flow and processes for discharge and so help reduce delayed transfers. It provides a framework to assess local services and offers practical options to support improvements. The changes cover:

- Early discharge planning;
- Monitoring patient flow;
- Discharge to assess;
- Trusted assessors;
- Multi-disciplinary discharge support;
- Seven day services;
- Focus on choice (early engagement with patients and their families/carers); and;
- Enhancing health in care homes.

[7] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

56. Areas should agree a joint approach to funding and implementing these changes, building on existing successful local practice and tailored to local circumstance. If one or more of the changes are in the process of being implemented, plans should set out the target date for implementation. Where one or more of the changes is funded from budgets that are not included in the BCF, this should be set out in the narrative plan. Areas should set out a coherent and comprehensive set of measures to manage transfers of care. Where all parties in an area have agreed to a variation on the model or not to implement one of the changes (for example if an existing, successful, approach would be duplicated by elements of the eight change model); the plan should briefly explain the rationale for this and provide assurance that a comprehensive approach to managing transfers of care and meeting their obligations on DToC reductions is in place. All partners, including relevant A&E Delivery Boards, should be involved in agreeing the approach.

57. The Better Care Support Team will monitor progress against implementation of the model through the BCF reporting mechanisms.

58. The High Impact Change Model includes implementation of Enhanced Health in Care Homes. This approach is being demonstrated through the New Care Models Vanguard Programme. More details and guidance can be found in the Enhanced Health in Care Homes Framework'[8].

59. In addition to the High Impact Change Model, National Partners have produced a number of guides that areas can draw on in developing plans, including:

- Quick guides on:
  - 'Improving hospital discharge into the care sector'[9];
  - 'Discharge to Assess'[10];
  - 'Better use of care at home'[11];
  - Supporting Patients' Choices to Avoid Long Hospital Stays[12].
- 'a Simple Guide to the Care Act and Delayed Transfers of Care'[13] published by ADASS, the LGA and NHS England; and
- The BCF resource on Delayed Transfers of Care, available through the SCIE website[14].

Scheme-level spending plan

60. A scheme-level spending plan will be required to account for the use of the full value of the budgets pooled through the BCF. These plans will need to include:

[8] https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf
[9] http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf
[10] http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
[11] http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-better-use-of-care-at-home.pdf
[12] http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf
[13] http://londonadass.org.uk/wp-content/uploads/2015/11/DToC-Simple-Guide-Final.pdf
[14] http://www.scie.org.uk/integrated-health-social-care/better-care/guides/delayed-transfers-of-care/

- Area of spend;
- Scheme type;
- Commissioner type;
- Provider type;
- Funding source;
- Total 2016-17 investment (if existing scheme); and
- Total 2017-18 investment and indicative 2018-19 investment.

61. Detail on scheme-level spending plans will be collected nationally through a BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

National metrics

62. The BCF policy framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2016-17, with only minor amendments to reflect changes to the definition of individual metrics. In summary these are:

a. Non-elective admissions (General and Acute);
b. Admissions to residential and care homes[15];
c. Effectiveness of reablement; and
d. Delayed transfers of care;

63. Information on all four metrics will continue to be collected nationally. The table below sets out a summary of the information required and where this will be collected. Further information on the data to be provided for each metric can be found in the guidance section of the BCF planning return template.

Metric	Collection method	Data required
Non-elective admissions (General and Acute)	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Return	Quarterly HWB level activity plan figures for 2017-18, mapped directly from CCG operating plan figures, using mapping provided, against the original 2014-15 baseline and 2015-16 metrics
Admissions to residential and care homes	• Collected through nationally developed high level BCF Planning Return	Annual metric for 2017-18 and 2018-19
Effectiveness of reablement	• Collected through nationally developed high level BCF Planning Return	Annual metric for 2017-18

[15] The ASCOF definition of this metric has changed. The revised definition is now used in the full specification of metric at the end of this annex.

Metric	Collection method	Data required
Delayed transfers of care	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Return	Quarterly metric for 2017-18. Each HWB area must submit their agreed DToC metrics by 21 July 2017 alongside their first quarterly return for IBCF spending

Non Elective Admissions (NEAs)

64. The detailed definition of the NEA metric is set out in the Planning Round Technical Definitions[16]. BCF plans will need to establish a HWB-level NEA activity plan. This will initially be established by mapping agreed CCG-level activity plans to the HWB footprint using the mapping formula provided in the planning return template. Figures submitted in CCG operating plan returns have been pre-populated into the template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for meeting targets to reduce NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.

65. Areas that are planning additional reductions in non-elective activity beyond those in CCG operating plans should clearly identify these in the BCF planning return. This reduction should be set at a level which the CCG and local system feel can be achieved. Where an additional reduction is planned, partners should consider placing an appropriate amount of the ring-fenced allocation intended for NHS-commissioned out of hospital services into a contingency reserve as per national condition three.

Delayed Transfers of Care

66. The NHS England Mandate for 2017-18 sets a target for reducing Delayed Transfers of Care (DToC) nationally to 3.5% of occupied bed days by September 2017. This equates to the NHS and Local Government working together so that, at a national level, delayed transfers of care are no more than 9.4 in every 100,000 adults (i.e. equivalent to a DToC rate of 3.5%). This joint achievement would release around 2,500 hospital beds. This is a system wide obligation and responsibility for delivery is not limited to the BCF. Nevertheless, it is expected that activity in BCF plans will contribute to meeting it.

67. Each CCG and NHS Trust is already agreeing a trajectory to meet this requirement and maintain it for the remainder of 2017-18. This will reflect agreements between NHS Improvement and NHS England for each area.

68. Each Local Authority is now being required to agree a target for reducing social care attributed DToCs in 2017-18 as part of BCF planning.

69. In both cases, DToC levels will need to be reported in the quarterly BCF returns.

[16] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

70. Ministers are clear that the health and social care system should work together to achieve reductions in DToC and that the agreed trajectory for doing so should reflect ambitious targets for reducing delays attributed to both NHS organisations and social care.

71. In drafting BCF narrative plans, areas should set out how CCGs, LAs, NHS providers of acute, community and mental health bed-based services and providers of social care will work together to achieve the local, agreed ambition for DToC. In setting the DToC metric in the BCF planning template, areas should describe how the schemes and services commissioned will contribute to the system-wide DToC ambition agreed for each system. This will include activity in relation to national condition four to implement the High Impact Change Model for Managing Transfers of Care and use of the BCF where appropriate. Ministers have set out an expectation that the target reduction in delayed transfers should involve an equal reduction in DToCs from both social care and the NHS nationally. Metrics should be agreed locally and should reflect challenging but realistic ambitions to reduce NHS and social care attributable delays to free up 2,500 hospital beds based on the indicative reduction levels published by DH[17]**.** The locally agreed reduction in both NHS and social care attributable delays should be reported in the BCF plan.

72. Each area should therefore set a metric that reflects the target agreed by a) the CCG(s) in support of the reduction in DToC in the NHS mandate and b) the Local Authority in support of the reduction in social care attributed DToC set out by Ministers on 3 July 2017. Where the metrics or contribution to them from either social care or the NHS are not sufficiently ambitious, a more stretching metric may be set as part of the assurance process as a condition of approval for the plan.

73. Government will consider a review, in November, of 2018-19 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care.

74. The BCF DToC metric in plans for 2017-18 and 2018-19 will continue to be calculated as total delayed days per 100,000 population. The BCF plan should link to the wider activity plans for reductions and ensure that ambitions set for the BCF plan are in line with the targets agreed locally for daily delays by relevant CCGs. Both metrics calculate the number of delayed days, so the BCF metric should reflect the CCG targets locally.

75. In order to verify that trajectories for reducing DToCs are consistent with the ambition in the NHS Mandate as soon as possible, areas must submit their provisionally agreed BCF DToC metrics for 2017-18 and 2018-19 to the Better Care Support Team on 21 July 2017, at the same time as their first quarterly reporting return for the IBCF.

[17] https://www.gov.uk/government/publications/local-area-performance-metrics-and-ambitions

Reporting of metrics

76. The detailed definitions of all metrics are set out at the end of this document. HWBs will be required to set challenging but realistic plans in relation to each metric. The national requirement to agree and report a local metric has been removed, but areas are still of course able to agree local metrics, where this will support improved performance. Areas will be able to review metrics for 2018-19 as part of any plan refresh at the end of 2017-18.

Local plan development, sign off and assurance

77. The Better Care Support Team will provide a range of resources to help local areas develop their plans, including signposting to existing support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice.

78. The assurance of plans will be streamlined into one stage, with an assessment of whether a plan should be approved, not approved, or approved with conditions. Plans should be submitted by 11 September 2017, having been approved or set to be approved by the relevant HWB(s). All plans will be subject to regional assurance and moderation. Judgements on potential support needs through the planning process, will be 'risk-based'. The IBCF funding can be spent as soon as the LA and CCG(s) agree.

79. BCF plans will be submitted and assured in the following way:-

80. The BCF submission will consist of a narrative plan, including a description of how the national conditions will be met, the alignment of the plan with the area's approach to integration of health and social care, assessment of risks in the local system and how the planned activity will help to address these. Areas should also complete and submit the BCF Planning Return, detailing the technical elements of the planning requirements. This will include funding contributions, a scheme-level spending plan, national metric plans, and any local risk-sharing agreement linked to NEAs under national condition three. At this point, local areas will also be asked to confirm that plans have been agreed between the LA and CCGs for spending IBCF grant to provide stability and capacity in local care markets. Plans should be agreed by the HWB.

81. CCGs should ensure that these returns mirror their operational planning returns for 2017-18 and 2018-19, submitted through central UNIFY and finance return templates. This will include some of the same data – including funding contributions and baseline NEA metrics agreed in the CCG operational plans and targets for reductions in DToCs should be consistent with the targets agreed by CCGs with NHS England. There will be a national reconciliation process to ensure the data provided matches in all cases. If any additional NEA metrics are planned as part of the BCF, these should be entered in the planning template.

82. Areas are asked to send copies of both the planning template and narrative plan to the relevant DCO team, copied to england.bettercaresupport@nhs.net. The Better Care Support Team will collate data from the planning template to assist regional assurance. Narrative plans will not be assured nationally, but will be used for identifying promising approaches to integration, wider trends to inform

our support offer (including development of benchmarking and support tools) and policy making.

83. The assurance process, including reconciling any data issues, will be a joint NHS England and local government process. NHS England assurance will take place within NHS England's Director of Commissioning Operations (DCO) teams and regional NHS England finance teams. NHS England will seek input from NHS Improvement regional teams at agreed points in the assurance process, to provide feedback on the quality and ambition of plans from a provider perspective. Local government has been funded to carry out assurance via regional local government leads. BCMs and the Better Care Support Team will work with these teams to ensure they are fully briefed on the requirements of the BCF for 2017-19 and have capacity in place to participate in the process. A set of consistent key lines of enquiry (KLOE) have been produced to support the assurance process and will be available to local areas as a guide in developing plans. The assurance document sets out the main planning requirements for the BCF, and associated KLOEs. The document is intended to clarify the minimum requirements for a local Better Care Plan to be assured and the NHS funding elements approved.

Moderation, calibration and plan approval

84. Plan assurance will include moderation at NHS regional level, led by Better Care leads for each region, with appropriate representation from Regional NHS and local government.

85. Following moderation, the Better Care Support Team will co-ordinate a cross-regional calibration exercise to provide assurance to the Integration Partnership Board and NHS England that plans have been assured in a consistent way across England. The national team will provide data on assurance outcomes and facilitate the cross-regional discussion in order to agree a consistent approach nationally. Advice on approval will be provided to the Integration Partnership Board, which is jointly chaired by DH and DCLG, with representation from partners including the LGA, ADASS and NHS England.

86. The minimum elements of the funding have different legal bases:

- The CCG minimum contribution to the fund is governed by the amended NHS Act 2006 (s. 223GA). The Act gives NHS England powers to approve spending and set conditions on this money. NHS England will approve plans for spend from the CCG minimum in consultation with DH and DCLG as part of overall plan approval.

- The DFG and IBCF Grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003. LAs are legally obliged to comply with grant conditions and the IPB will confirm, following assurance that it is content that the conditions are met in BCF plans.

87. Formal approval of BCF plans and authorisation for CCGs to use the CCG minimum element of the BCF will be given by NHS England under s.223GA (4) of the NHS Act 2006, following agreement with the Integration Partnership Board that all conditions, including the conditions of grant for the IBCF and DFG

are met. These decisions will be based on the advice of the moderation and assurance process set out above. Where plans are not initially approved, the Better Care Support Team may implement a programme of support, with partners, to help areas to achieve approval as soon as possible or consider placing the area into formal escalation.

88. Following formal approval, CCG funding agreed within BCF plans must be transferred into one or more pooled funds established under section 75 of the NHS Act 2006. If a plan is not approved, the area should not proceed with the signing of a Section 75 agreement in relation to NHS monies. Consideration will be given by the regional assurance panel, working with the Better Care Support Team, as to whether further support should be provided or whether the area should enter formal escalation.

Assurance categories

89. Assurers will check that plans meet all key lines of enquiry, including that they:

- Meet all national conditions;
- Have agreed a spending plan for the IBCF grant;
- Set out a vision and progress towards fuller integration of health and social care by 2020; and
- Have in place a robust approach to managing risk to plan delivery, including adequate financial risk management arrangements, proportionate to the level of risk in the system.

90. Assessment of the overall risk in the plan will be based on:

- The overall quality of the plan, based on the compliance with the national conditions, degree to which key lines of enquiry have been met and quality of the narrative plans overall;
- An assessment of whether the plan has adequately assessed and addressed risks to successful delivery; and
- The current performance, capacity and financial position of the local health and social care system in relation to plan delivery, using information from NHS England, NHS Improvement and local government.

91. Based on this assessment, the plan will be classified as Approved, Approved with Conditions or Not Approved. Following assurance, a moderation exercise will be carried out to ensure that the planning requirements have been applied consistently across each NHS region. This exercise must include representatives from DCO teams, NHS finance and local government. Following assurance, and moderation, the Better Care Support Team will co-ordinate a cross-regional calibration exercise with assurers. This exercise will help areas to make sure that they are assuring plans in a way that is consistent with other parts of the country. This may result in some regions needing to re-visit judgements for particular areas.

92. If an agreed plan is not submitted by the deadline, the Better Care Support Team will work with the local BCM to agree appropriate support for the area to agree a plan promptly. Areas will be expected to take up this support. If it appears that a plan is unlikely to be agreed locally within a reasonable timeframe, escalation will be considered.

93. If, following moderation, a plan is not approved or is approved with conditions, more in-depth support will be agreed for the area in consultation with the BCM, the regional assurance panel and Better Care Support Team. In some instances, the conditions imposed may be the provision of further information or clarifications, but in instances where there are more substantial conditions to meet, areas will be expected to access the support on offer in order to meet the conditions specified. All areas will be expected to submit a compliant plan by the date set by the regional moderation panel.

94. The three assurance categorisations are as follows:

Category	Description
Approved	• Plan agreed by HWB • Plan meets all requirements and KLOEs, including locally agreed targets for reducing NHS and social care attributed delays which achieve each area's share of the national commitment to free up 2,000-3,000 hospital beds.

Approved with conditions	• National conditions one, two or three are met
	• Most but not all remaining planning requirements met, – i.e. one or more KLOEs not satisfied; for example:
	  • Narrative plan (vision, approach to risk management) needs improvement; or
	  • National condition four not fully met
	  • Not all metrics agreed
	• Progress is being made (including on national condition) and, provided feedback is incorporated, there is confidence that a compliant plan can be produced
	• Assurance panel are confident that the area can agree a plan

Not approved	• One or more of the following apply:
	  • Plan is not agreed
	  • One or more of national conditions 1-3 not met,
	  • No local agreement on use of the IBCF
	  • DToC ambition is not in line with the targets agreed with NHS England (for CCGs) and/or necessary to achieve expected reductions (for Local Authorities).

Plans approved with conditions.

95. If a plan is approved with conditions following moderation and this categorisation is agreed by the IPB and NHS England, the area will receive authorisation to enter into a formal Section 75 agreement and the CCG authorised to release money from the BCF ring-fence. The notification will make clear:

- The planning requirements that were not met, the actions required to receive full approval, and the date by which this should be done; and
- Escalation action and powers of direction/clawback will be used in the event that these conditions are not met by the date specified.

96. Areas that receive an Approved with Conditions classification should address all unmet requirements and resubmit their plan to their BCM by the date specified.

97. The overall assurance process is illustrated in the schematic at **Appendix 3**. More detailed guidance for those involved in assurance has been developed and published to aid local areas.

Escalation and use of Direction Powers

98. In the event that:
- Signatories to a plan are not able to agree and submit a draft plan or:
- The Health and Well-being Board do not approve the final plan; or
- Regional assurers rate a plan as 'not approved'.

The Better Care Support Team, in collaboration with the relevant Better Care Manager, will commence an escalation process to oversee the prompt agreement of a compliant plan.

99. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. Senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to an Escalation Panel meeting to discuss concerns and identify a way forward.

100. The escalation process will involve the following steps.

1. Trigger - following failure to submit a plan, or a decision not to approve a plan during assurance	The Better Care Support Team in consultation with the BCM will consider whether a plan should be escalated. If escalation commences, a formal letter will be sent, setting out the reasons for escalation, consequences of not agreeing a plan and informing the parties of next steps, including date and time of the Escalation Panel
2. Escalation Panel	The Escalation Panel will be jointly chaired by DCLG and DH senior officials with representation from: • NHS England • LGA/ADASS • Better Care Support Team Representation from the local area needs to include the: • Health and Wellbeing Board Chair • Accountable Officers from the relevant CCG(s) • Senior officer/s from LA The Escalation Panel meeting is the opportunity to use national and local insight to consider the planned approach being put forward by the parties to the BCF plan to deliver a compliant plan and agree actions and next steps, including whether support is required. It is expected that in line with the principle of 'no surprises', issues will have been raised through ongoing relationships with Better Care Managers, NHS England regional offices and local government regional peers.

3. Formal letter and clarification of agreed actions	The local area representatives will be issued with a letter, summarising the Panel meeting and clarifying the next steps and timescales for submitting a compliant plan. If support was requested by local partners or recommended by the Panel, an update on what support will be made available will be included.
4. Confirmation of agreed actions	The Better Care Manager will track progress against the actions agreed and ensure that a locally agreed plan is submitted within the agreed timescale for regional assurance. Any changes to the timescale must be formally agreed with the Better Care Support Team.
5. Consideration of intervention options	If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include: • Agreement that the panel will work with the local parties to agree a compliant plan • Appointment of an independent expert to make recommendations on specific issues and support the development of an agreed plan – this might be used if the local parties cannot reach an agreement on certain issues. • Appointment of an advisor to develop a compliant plan, where the panel does not have confidence that the area can deliver a compliant plan The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off.

101. The Escalation Panel members will consider all relevant information, including financial and performance issues. This could include:

- Wider financial context, such as whether the LA has taken sufficient action to protect its funding for social care – including, but not limited to, making use of precepting powers, the balance of financial risk between parties and appropriate use of reserves;
- Whether all financial commitments mandated in the BCF have been met, including passporting of Care Act funding, funding for social care managed reablement and carers' breaks;
- Whether the agreed transfer to social care from CCG minimum contributions represents a real terms maintenance of allocations. This will also include consideration of transfers prior to the establishment of the BCF

102. NHS England has the ability to direct use of the CCG contribution to a local fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that can be approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and/or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DH and DCLG ministers, (as required under the 2017-18 NHS Mandate), with the final decision then taken by NHS England. In accordance with the legal framework set out in section 223GA of the NHS Act 2006 (as amended by the Care Act 2014), NHS England powers are only applicable to the minimum contribution from CCG budgets set out in the policy framework.

103. The Escalation Panel may make recommendations that an area should amend plans that relate to spending of the DFG or IBCF. This money is not subject to NHS England powers to direct. A BCF plan will not be approved, however, if the IBCF or DFG grant conditions are not met. Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

Timetable

104. The submission and assurance process will follow the timetable below

Milestone	Date
Publication of Government Policy Framework	31 March 2017
BCF Planning Requirements, BCF Allocations published	4 July 2017
Planning Return template circulated	w/e 7 July 2017
First Quarterly monitoring returns on use of IBCF funding from Local Authorities.	21 July 2017
Areas to confirm draft DToC metrics to BCST	21 July 2017
BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local authorities). All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net .	11 September 2017
Scrutiny of BCF plans by regional assurers	12 – 25 September 2017
Regional moderation	w/c 25 September 2017
Cross regional calibration	2 October 2017
Approval letters issued giving formal permission to spend (CCG minimum)	From 6 October 2017
Escalation panels for plans rated as not approved	w/c 10 October 2017
Deadline for areas with plans rated approved with conditions to submit updated plans.	31 October 2017
All Section 75 agreements to be signed and in place	30 November 2017
Government will consider a review of 2018-19 allocations of the IBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care.	November 2017

Graduation from the Better Care Fund

105. The policy framework describes the approach that will be taken from 2017-18 to graduation from the BCF – the process for enabling areas that have integrated their health and social care commissioning or provision, to the extent that they exceed, and will continue to exceed, the requirements of the BCF.

106. Areas that graduate will no longer be required to submit BCF plans and quarterly returns, with the exception of evidencing ongoing compliance with funding contributions and national conditions, which can be demonstrated through annual self-certification. The footprint for graduates can be a single Health and Wellbeing Board area or more than one – for example a devolution deal area or STP geography if the relevant HWB(s) agree.

107. Areas (as defined above) will be able to put themselves forward for graduation over the next two years. Requests to graduate from the Fund will be considered through graduation panels that will take place at regular intervals over the period of the programme. The panels will include central government departments, NHS and local government stakeholders (LGA and ADASS). The sessions will focus on helping areas to both challenge their assumptions and readiness to move on from the BCF, and also to provide advice on where the proposal could develop further.

108. Panels will consider:

- The key enablers to integration, common to all systems;
- A self-assessment of local leadership, accountability and joint vision for integration;
- How integration supports better outcomes for populations, including performance against key metrics (including DToC reductions) and assessing the use of own management data; and
- Agreement of a clear, measurable and transparent objectives and milestones for fuller integration by 2020.

109. There were 17 first wave Expressions of Interest to graduate from the BCF. The short-list (who will go through graduation panels in the Autumn), is being finalised.

Appendix one - Specification of Better Care Fund metrics

Metric One: Total Non-elective spells (specific acute) per 100,000 population

Outcome sought	A reduction in the number of unplanned acute admissions to hospital.
Rationale	Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings.
Definition	**Description**: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population. Numerator: Number of specific acute non-elective spells in the period. Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency. Number of specific acute hospital provider spells for which: • Der_Management_Type is 'EM' and 'NE' **Where** 'EM' = Emergency and 'NE' = Non-Elective Please refer the Joint Technical definitions for Performance and Activity (2017/18-2018/19) and see Appendix A- SUS Methodology for details of derivations and Appendix B for full list of Treatment Function Code categorisation. **Denominator:** ONS mid-year population estimate for all ages (mid-year projection for population
Source	Secondary Uses Service tNR (SEM) - SUS tNR is derived from SUS (SEM) and not the SUS PbR Mart. For more details see Joint Technical definitions for Performance and Activity (2017/18-2018/19). Population statistics (ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections)
Reporting schedule for data source	Collection frequency: Numerator collected monthly (aggregated to quarters for monitoring). Denominator is annual. Timing of availability: data is available approximately 6 weeks after the period end.
Historic	From 2017/18, total number of specific acute non elective spells replaces non elective (general and acute) episodes metric

Metric Two: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Outcome sought	Reducing inappropriate admissions of older people (65+) in to residential care
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
Definition	**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by NHS Digital **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework: NHS Digital - SALT: http://content.digital.nhs.uk/socialcarecollections2016) Population statistics (ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections)
Reporting schedule for data source	Collection frequency: Annual (collected Apr-March) Timing of availability: data typically available 6 months after year end.
Historic	Data first collected 2014/15 following a change to the data source. The transition from Adult Social Care Combined Activity Return (ASC-CAR) to SALT resulted in a change to which admissions were captured by this measure, and a change to the measure definition. Previously, the measure was defined as "Permanent admissions of older adults to residential and nursing care homes, per 100,000 population". With the introduction of SALT, the measure was redefined as "Long-term support needs of older adults met by admission to residential and nursing care homes, per 100,000 population." More details about the change can be found on page 18 of the 2014-15 data report.

Metric Three: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Outcome sought	Increase in effectiveness of these services whilst ensuring that those offered service does not decrease
Rationale	Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from SALT collected by NHS Digital. **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December. This data is taken from SALT collected by NHS Digital Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework: (NHS Digital - SALT: http://content.digital.nhs.uk/socialcarecollections2016)
Reporting schedule for data source	Collection frequency: Annual (although based on 2x3 months data – see definition above) Timing of availability: data typically available 6 months after year end.
Historic	Data first collected 2011-12 (currently five years data final available (2011-12, 2012-13, 2013/14, 2014/15 and 2015/16) **Resubmitted 2014/15 SALT data** - as part of the extensive SALT validation process for the 2015/16 submission, councils have also had the opportunity to resubmit their 2014/15 return. The 2014/15 data in the current release is the resubmitted data. Due to the known data quality issues of the original data, Adult Social Care Outcomes Framework (ASCOF) scores previously published in the 2014/15 publication should no longer be used.

Metric Four: **Delayed transfers of care from hospital per 100,000 population**

Outcome sought	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.
Definition	Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate (mid-year projection for 18+ population) *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month.
Source	DToCs (NHS England, http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/) Population statistics (ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections)
Reporting schedule for data source	Collection Frequency: Numerator collected monthly (aggregated to quarters for monitoring). Denominator is annual. Timing: data is published approximately 6 weeks after the period end.
Historic	Data first collected Aug 2010

The Baseline used for each metric is the latest period available prior to the collection period in the plan for each metric. For example for monthly/quarterly measures the baseline will be the corresponding period of the previous year where this is available. I.e. the baseline for NEA and DToC metrics in 2017/18 will be the corresponding quarter in 2016/17.

Appendix two – Requirements for contingency in national condition three

1. All CCGs must ring-fence a proportion of their overall BCF allocation to invest in NHS-commissioned out of hospital services. These allocations are set out in CCG financial planning templates for 2017-18 and 2018-19.

2. National condition three requires that all areas should consider holding back part of this ring-fenced funding in contingency, linked to performance against any **additional metrics to reduce Non elective admissions agreed in the BCF plan.**

3. The 'HWB metrics tab of the BCF Planning Template will be pre populated with the area's non elective admissions target, taken from CCG operating plans for 2017-18 and 2018-19, mapped to HWB areas. Each area should consider setting an additional NEA reduction metric linked to their BCF plan. Metrics should be stretching, but proportionate. The national condition only applies to risk share agreements linked to these additional metrics on NEAs. Areas are free to agree risk shares linked to other schemes within the BCF, but these do not form part of the national condition.

4. As in 2016-17, the default model for calculating the value of the contingency fund should be the Payment for Performance mechanism for 2015-16. Areas that did not meet their NEA activity reduction targets in 2016-17 should actively consider agreeing an additional reduction metric. Where a metric is set, a contingency fund should be considered. Arrangements made as part of this condition should:

    - Cover the full risk to the CCG of not achieving the reduction based on the tariff for NEAs. In other words the value of the risk share should be equivalent to the cost of the emergency admissions that the plan seeks to avoid.
    - Hold this amount, from the ring-fenced allocation for NHS-commissioned out of hospital services, in a contingency fund outside of funds pooled in the BCF.
    - Release money into BCF pooled funds based on performance against the additional NEA metric. Areas should agree, in advance, how this money will be spent.
    - Agree frequency of payment and baselines locally across the two years of the BCF plan.

5. Assurance of plans will include an assessment of whether CCGs are financially protected if investment in out of hospital services does not result in planned additional reductions in emergency admissions.

6. The value of the contingency fund should calculated based on the number of additional reductions in non-elective admissions, multiplied by the value of these admissions, based on national reference costs for a non-elective admission. Again, areas can agree a local costing, but must set out their reasoning in their plan. As in 2015-16 areas can measure performance quarterly, releasing funding into the BCF based on performance in the previous quarter, commencing with quarter 4 (January to March) 2016-17.

Example

7. A Health and Wellbeing Board has a target, based on CCG core operational plans to reduce NEAs to 50,000 in 2017-18 and 49,000. As part of their Better Care fund plan, the LA and CCGs agree a further reduction metric of 1000 admissions avoided in both 2017-18 and 2018-19. The amount held back in each year is calculated based on the national tariff of £1490 per admission.

Year	**A: Target level of NEAs – operational plan**	**B: Agreed reduction through BCF plan**	**C: Target level of NEAs – BCF plan**	**Funds held in contingency (Column B x £1490)**
2017-18	50,000	1,000	49,000	£1,491,000
2018-19	49,000	1,000	48,000	£1,491,000

The quarterly reduction targets are therefore

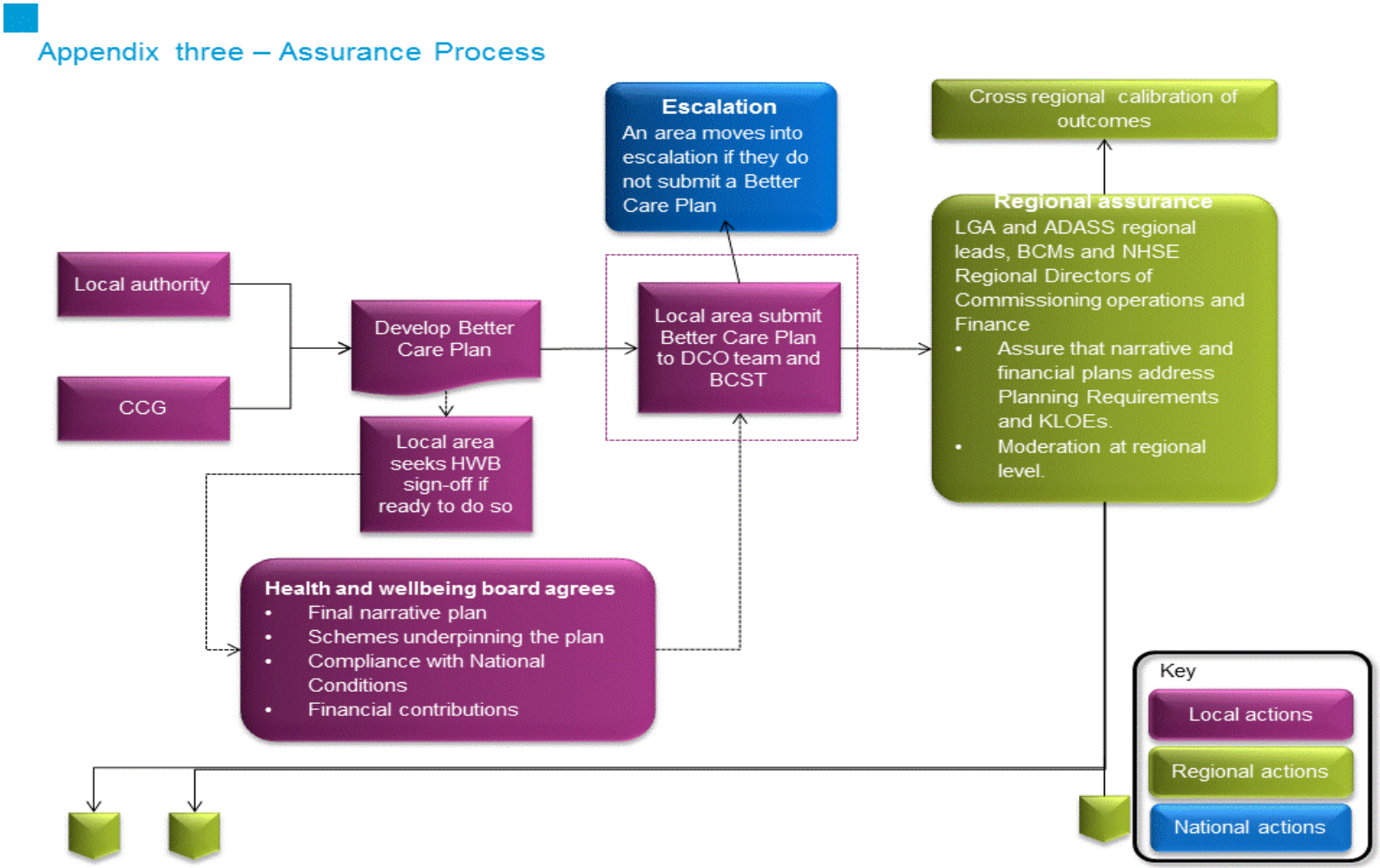
	Q4 2016-17	**Q1 2017-18**	**Q2 2017-18**	**Q3 2017-18**
CCG baseline (quarterly)	12,500	12,500	12,500	12,500
CCG baseline (cumulative)	12,500	25,000	37,500	50,000
BCF stretch target (quarterly)	12,250	12,250	12,250	12,250
BCF stretch metric (cumulative)	12,250	24,500	36,750	49,000
Money held in contingency from CCG minimum (quarterly)	£372,750	£372,750	£372,750	£372,750

8. If the target is wholly or partly met, funding should then be released from the fund, in this case on a quarterly basis; up to the total amount held in contingency. Payment released in each quarter should be calculated based on the cumulative performance against target. Examples are below.

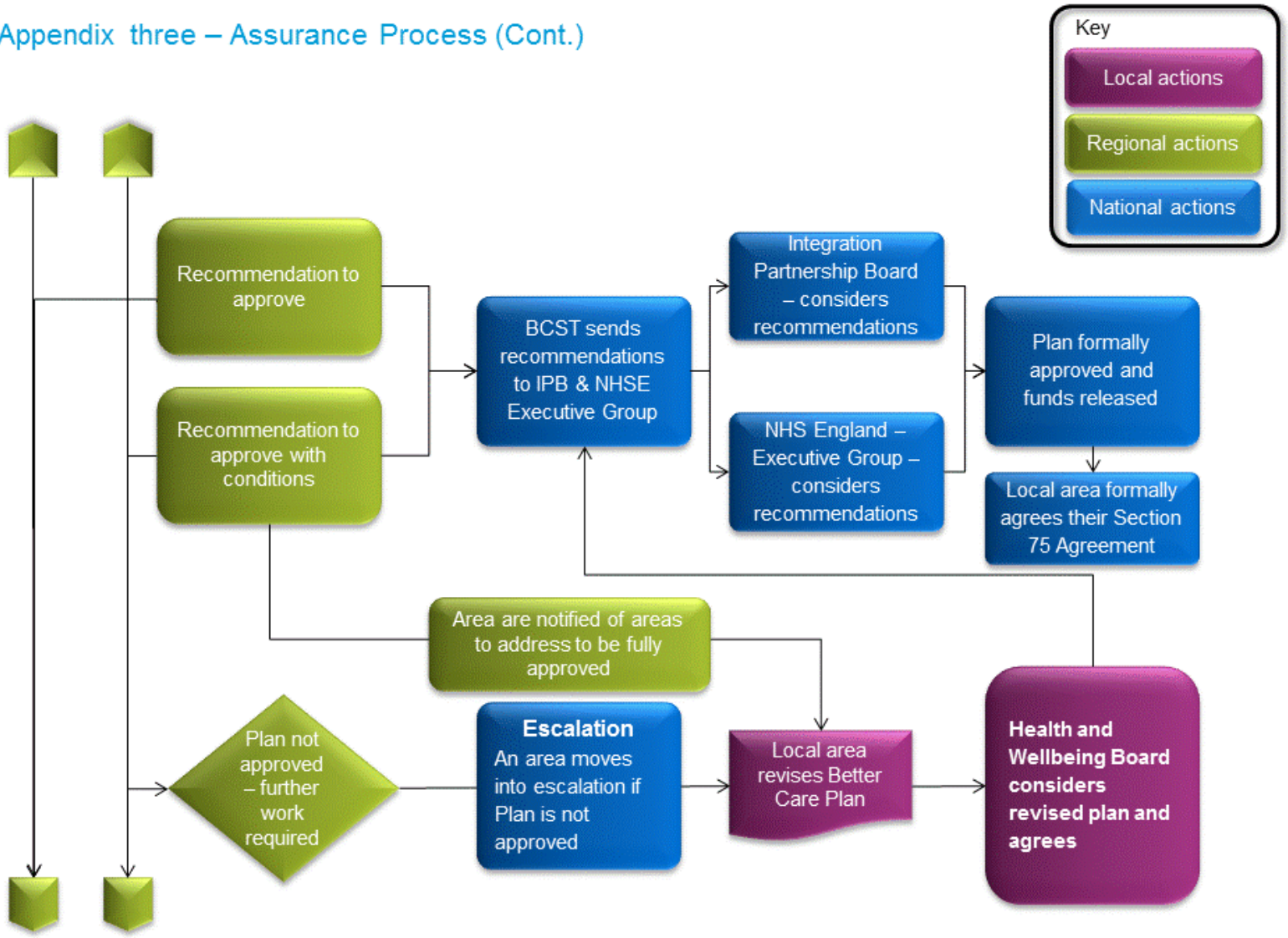
9. Areas should agree how money released from the fund should be spent. The released funds should remain within the pooled fund but can be spent on any activities that are consistent with the aims of the local plan, including social care.

	Q4 2016-17	**Q1 2017-18**	**Q2 2017-18**	**Q3 2017-18**
CCG baseline	12,500	12,500	12,500	12,500
BCF stretch target (quarterly)	12,250	12,250	12,250	12,250
BCF stretch target (cumulative)	12,250	24,500	36,750	49,000
Actual performance (quarterly)	12300	12,200	12,500	12,250
Actual performance (cumulative)	12,300	24,500	37,000	49,250
Money released from contingency reserve (quarterly)	£298,200	£447,300	£0	£372,750
Money released from contingency reserve (cumulative)	£298,200	£745,500	£745,500	£1,118,250

Appendix three - Assurance diagram



Appendix three – Assurance Process (Cont.)



Appendix four – Querying baseline for social care maintenance contributions

1. Required contributions to social care from CCG minimum contributions will be calculated for each Health and Well-being Board area based on inflation level increases to assured contributions in 2016-17 BCF plans. These figures will be pre-populated in the planning template for each HWB area.

2. The use of this baseline to calculate the minimum required contribution is agreed policy and we expect that the contribution in each HWB area will be equal to, or greater than, these figures for each area in 2017-18 and 2018-19. If local planners believe that this baseline is not correct, they will be able to query it. The grounds for doing so include:
   - The baseline in the planning template includes non-recurrent payments. In this case, all partners should agree that the funding in question was not intended to be part of the baseline.
   - The baseline is not correct due to mis-coded spend lines.

Process

3. Areas should inform their Better Care Manager (BCM) if they believe that the baseline for maintaining social care spend for 2016-17 is wrong by 31 July 2017, setting out their reasoning and any supporting documents. Areas must confirm that both the relevant CCG(s) and LA(s) agree that the baseline is not correct and certification should be provided from the chief executive in the relevant LA and the Accountable Officer(s) of relevant CCGs.

4. The query and supporting evidence will be reviewed by the Better Care Support Team with the Better Care Manager. Recommendations for amending a baseline will be made to the Integration Partnership Board (IPB). If the IPB agrees to amend a baseline, areas will be notified as soon as possible. All decisions will be made before 25 August 2017.

5. Where local planners believe that the baseline, as set out in the assured 2016-17 planning template, is wrong due to mis-coding; they should identify specific schemes that were coded wrongly and set out the reasons for changing the scheme classification or the value of the scheme.

6. Where a payment that has been included in the baseline for 2016-17 that was intended to be a non-recurrent payment, an area will need to provide details and demonstrate that there was mutual understanding that the payment was a one off. Government policy is that spending on social care services from CCG minimum contributions should be maintained in real terms through the period of the Spending Review. Areas must demonstrate therefore that
   - The payment was not part of the 2015-16 contribution to social care.
   - The payment was clearly intended to be to alleviate short term pressures or for specific, one-off purposes.
   - That both the CCG and the LA agreed at the time that this was the case.

Appendix five - Quarterly reporting from local authorities to DCLG in relation to the Improved Better Care Fund

This appendix replicates the reporting requirements issued by DCLG to local authorities confirming the reporting requirements attached the additional funding for the IBCF confirmed in the Spring Budget 2017.

Overall we are expecting to see a narrative report for the relevant quarter about how you are using the additional funding announced at Spring Budget 2017 to deliver the purposes of the grant, in meeting adult social care needs generally, reducing pressures on the NHS (including DToC) and stabilising the care provider market.

One of the grant conditions is to work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19. We expect the Better Care Fund will pick up reporting with regard to this however as the Planning Requirements are not yet published, we are asking for this information in your Q1 return. We will confirm whether this is necessary for additional quarters.

<u>Quarter 1 (April – June 2017)</u>

A. *For Q1 you should provide a scene-setting narrative and then consider and address the following questions which will form the basis of further quarterly reports:*

    - *How has this money affected decisions on budget savings that may otherwise have been required?*
    - *What initiatives / projects will this money be used to support? Please describe briefly their objectives / expected outcomes. You will be expected to comment on progress in later quarters.*
    - *Have you engaged with your care providers in the light of this funding? If yes, what action have you taken? If no, outline your plans for engaging with your care providers.*
        - *What were your unit average costs for home care (per contact hour) and care home provision age 65+ (per client per week, excluding full cost payers, 3rd party top ups and NHS FNC) in 2016-17?*
        - *On the same basis, at what level are you setting costs for 2017-18?*

B. *What impact do you anticipate – in comparison with plans made before this additional funding was announced – on:*
    - *Number of home care packages – provide figures*
    - *Hours of home care provided – provide figures*
    - *Number of care home placements – provide figures*

C. *Please provide any further information you wish us to be aware of, and use whatever further specific metrics you consider appropriate for your area; for example this might include on reablement, timeliness of assessments, carers, staff capacity etc. You will be expected to update these each quarter.*

D. *The grant determination requires you to work with the relevant CCG and providers to meet NC4 of the Integration and Better Care Fund. NC4 states that*

all areas should implement the High Impact Change Model for Managing Transfers of Care to support system-wide improvements in transfers of care. Please set out, from the local authority's perspective, what progress is being made to implement the High Impact Change Model with health partners and the intended impact on the performance metrics, including Delayed Transfers of Care.

Quarters 2 (July – Sept 2017) and 3 (Oct – Dec 2017)

A. *A narrative report for the quarter which follows up the information you provided at Q1, including updates and progress reports on the initiatives / projects and further information you identified at Sections A and C in Q1.*

B. *Report actual impact of additional funding on:*

- *Number of home care packages – provide figures*
- *Hours of home care provided – provide figures*
- *Number of care home placements – provide figures*

C. *Update on additional metrics you identified at Section C in Q1.*

D. *[To be confirmed.] Update on progress.*

Quarter 4 (January – March 2018)

A. *A final report which provides a self-assessment against the information provided at Q1 including final updates and progress reports on the initiatives / projects and further information you identified at Sections A and C in Q1. This should include final comparative data on unit costs for home care and care home provision for end of year.*

B. *report on actual impact of additional funding on:*

- *Number of home care packages – provide figures*
- *Hours of home care provided – provide figures*
- *Number of care home placements – provide figures*

C. *Final report on additional metrics you identified at Section C in Q1.*

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by the Better Care Support Team, Operations and Information Directorate.

If you have any queries about this document, please contact the Better Care Support Team at: england.bettercaresupport@nhs.net

For further information on the Better Care Fund, please go to: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

This page is intentionally left blank

REPORT TO THE HEALTH AND WELLBEING BOARD

1st August 2017

Presentation of the Carers' Strategy 2017-2020

Report Sponsor:	Wendy Lowder Executive Director Communities BMBC
Report Author:	Elaine Equeall Volunteering and Engagement Manager BMBC
Received by SSDG:	16th May 2017
Date of Report:	27th July 2017

1. Purpose of Report

1.1 To provide the Health and Wellbeing Board with background to and current progress on the implementation of the Carers Strategy 2017-2020

2. Recommendations

2.1Health and Wellbeing Board members are asked to:-

- Note progress on the development of the new Carers Strategy
- Recommend how the Strategy informs and contributes to the wider Health and Wellbeing priorities
- Recommends how the Board and its' partners will contribute to the implementation of the strategy

3. Introduction/ Background

3.1 The current Carers Strategy ran from 2013-2016. Since then there have been a number of changes in Health and Social care policy and strategic thinking, most notably the implementation of the Care Act 2014 placing a duty on local authorities to provide Carers Assessments.

3.2 Carers have been supported indirectly through commissioned services and more widely through Carers Grant (Better Care Fund) which has generated a wide variety of initiatives required to meet the objectives identified in the last Carers strategy as part of the application process.

3.3 A recent review of existing commissioned services, changes to policy and consultation with service providers and carers has identified the need to review and refresh the strategy.

4. Summary

4.1 Carer Support is currently fragmented in Barnsley, which means that there are still significant gaps in how carers are supported. We still don't know the full extent of carers in Barnsley but using national indicators on the value of carers the amount they contribute to health and social care is significant.

4.2 The strategy, developed using a co-produced model, identifies the gaps in support for carers and provides the outcomes we need to work towards to ensure that carers are supported as a major contributor to not only the health and wellbeing of the population but also to the Early Help and prevention agenda.

5. Conclusion/ Next Steps

5.1 The strategy acknowledges that there is a need to move towards a more comprehensive solution potentially to pool resource and consider a model which can enable a more co-ordinated and centralised carer support offer.

5.2 The strategy provides the direction to support a review of current financial and other resources to identify this and other solutions. (A strategic review based on current commissioning and grant activity is being undertaken to inform the business case and potential future commissioning intention to support this)

5.3 A strategy steering group comprising of Carers, providers, partners (including many who have contributed to the strategy development so far) will need to be established to identify and drive forward the actions we need to achieve the outcomes.

5.4 The implementation of the strategy relies on a borough commitment which can ensure that everyone can contribute to making Barnsley a carer friendly community

6. Financial Implications

6.1 A review of current financial arrangements that support carers is in progress to support the business case and options. It is envisaged that there could be an increased cost to support a new model which may not be covered by existing commissioning and grant resources used to support carers.

7. Consultation with stakeholders

7.1 Extensive consultation has already taken place with carers, providers and partners as follows

- Carers Survey May- September 2016

- Consultation with public through Carers Rights day November 2016
- Consultation with Carers and Friends group – Autumn 2016 – spring 2017
- Awareness raising session with Service User and Carer Board January 2017
- Carer support provider survey – December – January 2017
- Carers strategy planning workshop – February 2017 with representation from Carers and Service Users, CCG, Healthwatch, SWYFT, VCSE providers and BMBC directorate

8. Appendices

8.1 Appendix 1 Draft Carers Strategy

Officer: Elaine Equeall Contact: 773014 Date: 27/07/2017

This page is intentionally left blank

#BarnsleyCares

Carers' Strategy for 2017-2020

A strategy by carers for carers

BARNSLEY
Metropolitan Borough Council

Your Voice Barnsley
Giving a Voice to Service Users and Carers

Why we need a carers' strategy for Barnsley

In 2013 we developed a three-year carers' strategy called 'Caring Together, Building a Future for Barnsley'. In this, we recognised the need to support carers as one of our most valuable assets to the health and wellbeing of Barnsley residents. As a council, we have been working with carers and our partners to continue to find ways to make sure that carers are not forgotten, and can receive the support they deserve.

We knew this was something that could not be quickly or easily achieved and over the last few years we have been presented with new and different challenges; therefore, it is right that we should review and look again at how we can best support carers in Barnsley.

We define carers in Barnsley as:

"Ordinary people whose lives have changed because they are looking after a relative or friend, who because of disability, illness, substance misuse, special condition or the effects of old age, cannot manage without help"

This definition recognises anyone of any age including:

- Adult carers
- Parent carers
- Young carers
- Working carers
- Kinship carers
- Carers from community backgrounds

The definition recognises that carers in Barnsley are diverse. They could be disabled carers, LGBT (Lesbian, Gay, Bisexual or Transgender) carers, BME (Black or Minority Ethnic) carers. This strategy recognises that different carers may require a different type of support and may need to be engaged in a variety of ways. The strategy will, therefore, aim to be flexible to carers varying needs and differences, as well as ensuring that all carers have equal access to the services and support outlined within this strategy (particularly consideration will be given to those carers who may face an additional barrier to accessing these services).

What we know about carers in Barnsley

Anyone can become a carer at any time and because of this, we do not know the full extent of carers in our borough. This information can be difficult to find because many people do not see themselves as a carer or label themselves as one in any data we collect. There is currently no central registration or support centre in Barnsley therefore we have to rely on a number of other measures to get a picture of who our carers are and the impact they have on health and social care in the borough.

27,167
The total number of people providing unpaid care. Equivalent to approx 12% of the population (231,221) of these 15,473 1-19 hours per week, 4,075 20-49 hours, 7,619 50 or more hours

23.2%
The increase since 2005 in the number of people aged 65 years and over. Suggesting a potential increase in the number of individuals who may need future care.

2.8%
The percentage of age 16+ in Barnsley who claimed carers' allowance in 2016. Compared with UK average of 1.7%

1,091
The number of carers who have registered for a carers card (to help with emergency respite for those they care for) since the scheme started in 2009

The amount of unpaid care provided by Barnsley carers in one week is
£8.2 million
(based on £17.20 per hour. Carers UK research. Carers UK is a charitable organisation that campaigns on behalf of carers)

127
people who received carers assessment through our adult social care team in 2016. 63% were female and 37% male 11% were under 30 years old 7% were aged 30-39, 25% 50-59,13% 60-69, 13% 70-79 and 13% 80+

We all have a responsibility to support carers but we know that carers can find it difficult to access the support and advice they need. People like GP's, Social Workers and Pharmacists play an important role in ensuring carers are identified and connected to support services. The Care Act 2014 says that Local Authorities and Health bodies must work together to identify carers.[1]

[1]Department of Health Care and support statutory guidance, Paragraph 2.35
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

What have we achieved?

Our Carers and Friends group have worked hard alongside our partners and providers to support carers in many different ways and the small grants fund has enabled people to work together to find solutions.

Our objectives 2013-2016:	Some examples of how we achieved these:
Improved Services **Develop and implement processes for early identification, referral, assessment and support.**	A pilot programme to help identify carers in GP surgeries by Healthwatch. Delivery of carer Information Support Programme (CRISP) by Alzheimer's.
Enable carers to co-produce and co-deliver solutions to the delivery of services.	Carers were involved in commissioning process for new home care contracts with Barnsley Council. Carers testing of Barnsley Council on-line assessments for social care.
Develop opportunities for support outside caring roles and for carers to be treated as individuals in their own right.	Engaging, learning and creative activities programme with young carers at Barnardo's by QDOS creates. Programme of support for carers of terminally ill through Barnsley Hospice.
Access to advice on financial management and support to employment.	Drop–in carer specific sessions delivered by Citizen's Advice Bureau. Parent support programme for children with Autism and Asperger's.
Promoted health and wellbeing of carers including emotional and physical wellbeing.	Promoted informal support for carers via carers' newsletter. Supported a healthy lifestyles programme at 360 Engagement. Provided health and wellbeing through carers support programmes at Barnsley Beacon.

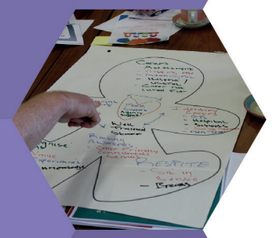
Understanding what more we could do

Whilst we know that what we have accomplished has made a big difference, there is still more that can be done to achieve our goals set out to support our carers in Barnsley.

Over the latter part of 2016 and into early 2017 we asked carers, partners and providers to work with us to identify the focus of our strategy for the next three years.

These included:

- Carers and Friends Group
- Carers at Carers week and Carers Right Day 2016
- Carers via Providers, social media and electronic newsletter
- 360 Engagement
- Age UK
- Alzheimer's
- BIADS
- BMBC Commissioners
- Barnsley Advocacy service
- Barnsley Beacon
- Barnsley council cabinet spokesperson for communities
- CCG
- Healthwatch
- Making Space
- NHS GP Liaison Service
- Parkinson's UK
- Public health
- Recovery college (SWYFT)
- Royal Voluntary Service
- South Yorkshire Eating Disorders Association (SYEDA)
- South Yorkshire Housing Association
- Together for Mental Health



Together we identified the gaps that still exist in the support for carers

- Lack of information and communication, on-line, in person and on paper.
- Support; financial, emotional, practical and psychological.
- Support to maintain employment.
- Developing IT skills.
- Relationships with GP's.
- Being recognised and listened to as a carer by professionals.
- Isolation.
- Support to maintain independence and respite provision.
- Supporting young carers in their transition to adults.
- Greater recognition for kinship carers.
- Support with hospital visits for carers.
- Better awareness across the community.
- Fragmented services for carers.

Our strategy is based on valuing the role carers play by ensuring they are supported.

Our aims for carers

We have based our aims on three outcomes we want for all carers.

Informed and empowered

- Access to good quality information and advice. To not be disadvantaged by the role of carer.
- Knowledge and understanding of the services and policies that support carers in their role and the ability to influence and contribute to these.
- Education and training to support all members of our communities to raise awareness and value the role of carers.

Individually resilient

- Support and improve the physical and emotional health and wellbeing of all carers.
- Enable carers to continue to lead and enjoy their own life through work and play.
- Ensure carers remain safe within their role and free from harassment in the wider community.
- Enable carers to participate fully in their community and increase social connections.

Providers of good quality care

- Ensure carers have the knowledge and skills necessary to support those they care for.
- Improve recognition of carers and their contribution to health and wellbeing of those they care for.
- Work with health care providers to ensure that carers are valued and can be seen as part of health care process.

Achieving our aims

To achieve our aims we will need to focus our future efforts on:

- **Carers being placed at the heart of the health and wellbeing strategy including the planning.**
- **Working together to create solutions that we can all contribute to and will work for everyone.**
- **Making the best use of the resources we have available through commissioning and funding, which not only responds to needs but enables sustainable solutions.**

Carers at the heart of health and wellbeing

Maintaining the health and wellbeing of everyone is a high priority for Barnsley.

We have already acknowledged the role carers have in this, not only regarding the economic value they add to social care, but also the massive contribution carers make in supporting the most vulnerable to remain healthy and independent. There are many factors in our approach to maintaining health and wellbeing and as we develop these we will need to consider:

- **What do carers contribute to this?**
- **How does this affect carers?**
- **How can we support any additional needs this creates for carers?**

Working together to create solutions

Our strategy planning workshop informed us how we would need to focus our attention to support carers and offered some potential solutions. Based on our aims we identified the following outline actions for our future strategy action plan.

	Aim:	Outline actions:
Informed and empowered	**To improve access to good quality information and advice ensuring carers are not disadvantaged.**	To develop Information Hubs and availability of helplines To support carers to develop their digital skills To develop networking opportunities for young carers through social media
	To improve the knowledge and understanding of the services and associated policies that support carers. Carers to be more involved in the development and review of these.	Improve communications between health and social care services, carer engagement and provider feedback. Co-produced services and commissioning.
	Education and training to support all members of our communities to raise awareness and value the role of carers.	Work with schools, Voluntary community and social enterprise sector, faith groups and businesses to raise awareness of carers and help identify hidden carers.

Individually resilient	**Enable carers to continue to lead fulfilling lives.**	Improve access to respite care. Check and challenge how carer friendly the major employers in Barnsley are Develop more activities for young carers
	Ensure carers remain safe within their role and free from harassment in the wider community.	Develop and improve access to safeguarding awareness for carers Develop Peer Support for Carers
	Enable carers to participate fully in their community and increase social connections.	Work with Area Councils to develop awarenmess of carers. Develop 'spot' (ad hoc) support for carers to enable short breaks Develop more befriending and volunteer schemes for carers Work with Universal Services such as Libraries to develop the offer for carers
	Ensure carers have the knowledge and skills necessary to support those who are in their care.	Deliver Carer support programmes such as CRISP (Carers Resource, Information and Support Programme) Provide First aid training and post-care support.libraries.
Providers of good quality care	**Improve recognition of carers contribution to health and wellbeing of those who are in their care.**	Continue to develop the carer registration scheme with the potential to link this to the carers card (an emergency respite care card) Utilise social media to raise awareness of the role and contribution of carers and campaigning where we see disadvantage.
	Work with health care providers to ensure that carers are valued and are seen as part of the health care process.	Work in partnership with health care providers in reviewing the approach to carers in terms of policies and practice.

Making the best use of resources

As part of our strategy planning, we are committed to making sure that any available resources are put to best use. To achieve this, we will need to consider all resources to help achieve the outcomes we have identified; this could include some or all of the following over time.

The next steps in taking our strategy forward

Establish the carers' strategy steering group to build an action plan to show how we can meet the aims we have identified in our strategy, and regularly check the progress on this over the next three years.	April 2017 - March 2020
Build and develop a business case for the options available to provide a comprehensive solution to meet the outcomes we have identified.	Spring - Autumn 2017
Continue to work with all stakeholders to deliver the strategy and report into the Health & Wellbeing Board on progress.	

For more information about this strategy please contact us:

lovewhereyoulive@barnsley.gov.uk
Tel: 01226 773555
www.facebook.com/YVBarnsley/




BARNSLEY
Metropolitan Borough Council

Your Voice Barnsley
Giving a Voice to Service Users and Carers

This page is intentionally left blank

healthwatch

Healthwatch Barnsley

Annual Report 2016/17

Contents

Message from our Chair

It is my pleasure to introduce Healthwatch Barnsley's fourth Annual Report.

Voluntary Action Barnsley was again commissioned by the local authority to host Healthwatch Barnsley for a further two years, with an option to extend this for a further third year.

This year we saw the recruitment of three new members to our Strategic Advisory Board, who were appointed following interviews by a stakeholder panel. We welcomed onto the Board:

- Ian Guest, who has a strong advice work background, including the Citizen's Advice Bureau;
- Wendy Hardcastle, a former lecturer at the Department of Midwifery and Children's Nursing, University of Sheffield;
- Mark Smith, an expert by experience in Mental Health.

I have no doubt that the skills that they bring will further develop and enhance our Board.

This year we also saw our manager Carrianne Stones leave the organisation for a fresh challenge. I would like to extend my sincere thanks to her for all the hard work over the past four years. Carrianne was the first manager of the organisation and had the task of establishing Healthwatch Barnsley from scratch. She will not only be missed by the Board, staff and volunteers but also by the commissioners and providers of Health and Social Care in Barnsley, with whom she had developed mutual trust and respect.

I am pleased to say that Voluntary Action Barnsley have recruited Teresa Gibson as our new manager, who brings a wealth of experience in the voluntary sector and we look forward to working with her in the future.

Also in this report period, our Signposting, Intelligence and Communications Officer Carolyn Ellis left the team. Carolyn is currently studying Speech and Language Therapy, whilst working part time as VAB's Communication Officer, so she is never far away, however she is much missed by the Healthwatch staff team. Carolyn was our font of all knowledge and was much respected both by us and our colleagues in partner organisations. I wish Carolyn every success with her studies and would like to

thank her for her support during her time at Healthwatch Barnsley. Following Carolyn's departure, we recruited Gill Doy to this role. Gill previously worked at the Ministry of Food and has considerable public sector and health service experience. We are delighted to have Gill on board and I'm sure that her sunny personality will help to keep us all happy in our work.

The last twelve months have continued to be challenging, but at the same time exciting and hugely rewarding as we continue to develop and improve the Healthwatch service across Barnsley.

The economic situation has continued to constrain public spending and as a result expenditure must be even more dedicated and focussed around people's needs. Within Health and Social Care provisions locally, it is critical to ensure that there is a balance between value for money whilst safeguarding and improving our exceptionally high quality services.

I reiterate the requirement to meet the challenge, both nationally and locally, in the transformation of health and social care services for the benefit of local people. With the continued passion and commitment that we often see demonstrated by the people working within the sector, the pace of change has accelerated. We continue to see commissioners and providers working even more closely together; with their continued commitment I'm sure that local people will experience the benefits of these transformations. We will continue to support and challenge these changes, to ensure that the outcomes for local people continue to remain at the heart of Health and Social Care.

I continue to be extremely impressed with the commitment that people in the local authority, Clinical Commissioning Group (CCG), NHS service providers, the Health and Wellbeing Board, Community Forums and Provider Forums demonstrate by their desire to improve and develop the current Health and Social Care provisions in Barnsley.

We will continue to collect people's experiences of Health and Social Care services available locally. This material is then used to identify service gaps, as well as exceptional practice; in doing so we can influence and support services so that they are ideally placed to perform well.

The continued commitment of our Strategic Advisory Board, staff team and Healthwatch Champions are exemplary and I offer my sincere thanks to them all for their dedication and hard work over the past year.

Message from our Manager

This is a joint statement from Carrianne Stones, who left the organisation towards the end of the financial year and Teresa Gibson, who has taken over the role.

Message from Carrianne Stones:

Whilst I am enthusiastic for the opportunities that await me in the future, it is with great sadness that I say goodbye to the Healthwatch Barnsley staff team, as well as our volunteers and partner agencies across Health and Social Care and the Voluntary and Community Sector.

My time here over the past four years has been marked by both challenges and triumphs and I will always appreciate the support and the determination I have seen from all of our Healthwatch stakeholders, especially in a difficult and ever evolving Health and Social Care economy.

I could not have done this job if it had not been for a great staff team, our volunteers and without Health and Social Care services collaboration.

I leave this post knowing that we have helped the local Deaf Community to have their say in Health and Social Care provision; we have also raised awareness amongst carers about the importance of registering with their GP and have put forward the views and experiences of individuals accessing mental health services.

I wish Healthwatch Barnsley and all of those involved in it all of the best in its future and leave here enriched, both personally and professionally.

Message from Teresa Gibson:

I am delighted to have been appointed to the role of Healthwatch Barnsley Manager.

I am very much looking forward to working with staff and volunteers to ensure the people of Barnsley are supported to shape the future of Health and Social Care services in the Borough.

My background is in advice, information and community work. For the past 25 years, I have worked in a variety of roles in the voluntary sector across Sheffield, Barnsley and Rotherham, including a significant time within Healthwatch Barnsley and Voluntary Action Barnsley.

Through my work within the sector and with my personal experiences, I have gained extensive knowledge of the issues which affect vulnerable and isolated people. I feel that this knowledge and experience puts me in a very good position to further develop the work we are doing here at Healthwatch Barnsley, both now and in the future.

Highlights from our year

This year we've had 16,170 page views on our website, reached 354 'likes' on Facebook and had 207 new followers on Twitter.

Our volunteers help us with everything from outreach to attending strategic meetings.

We've visited a range of local services.

Our reports have tackled issues ranging from young people visiting the dentist to carers being identified by their GP.

We've spoken to people on topics such as Speech and Language Therapy, why GP appointments are missed and how they value their community pharmacy.

We've met hundreds of local people at our community events.

Who we are

We know that you want services that work for you, your friends and family. That's why we want you to share your experiences of using Health and Social Care services with us – both good and bad. We use your voice to encourage those who run services to act on what matters to you.

We are uniquely placed as a national network, with a local Healthwatch in every local authority area in England.

Our vision

We aim to listen to the views expressed by people living in Barnsley and to make them known to service providers and commissioners. This ensures that these views influence and shape the provision of services.

Mission

We will work with people, communities and organisations to influence the provision, planning, commissioning and delivery of the services that we all depend on. We will work to ensure that everyone has confidence in us and that we achieve positive changes.

Values

We will work in a way that is :

- Accountable: openly reporting activities and impact;
- Honest in what we offer and how we (and the people who lead us) behave;
- Free at the point of contact;
- Well known and well publicised;
- Respectful to everyone;
- Approachable, easy to contact and always ready to listen;
- Safe, maintaining a comfortable environment and managing all risks, such as those around safeguarding;
- Representative of all people, ages and communities. In addition to this, we will provide a service in a way that is equal and available to everybody, including those who are seldom heard.

We believe everyone has a right to high quality health and care services throughout their lives, whatever their circumstances.

Our strategic priorities

We form our priorities based on the feedback we gather from our research and engagement work. Our priorities are then checked against the Public Health Strategy for Barnsley, as well as all other relevant local strategies; through this activity we are able to look at areas to focus on, identify where work is already taking place and seek opportunities to work in partnership and avoid duplication.

Your views on health and care

Listening to local people's views

We tailor our outreach and engagement to the people we work with. We always ensure that the communities with which we engage have the opportunity to become actively involved, using their experiences and knowledge of services when raising concerns.

This year we have engaged with 2,333 people in a range of different venues. We have also collected 396 comments on health and care services via our online Feedback Centre, which allows members of the public to rate services in a very similar way to TripAdvisor. If you have any feedback about a service, please visit our website via www.healthwatchbarnsley.co.uk and share your views.

In this section of the report you will see how we have:

+ Gathered local people's experiences of Health and Social Care services and how their needs are identified.
+ How and why we have engaged with diverse groups and communities in our local area.

Carers Identification Scheme - working with GPs and carers

In 2015, Healthwatch Barnsley identified that there were concerns that carers were not accessing the support and information they were entitled to through their GP. This was due to a lack of information and communication.

In particular people were not aware that they could register with their GP as carers; in doing so they would be entitled to specific support to help them in their daily caring role. Following guidance from Central Government, many GPs set up registers of carers to enable this support to be accessed. Carers could let their GP know they were caring for someone and the surgery could 'flag 'this on their records. This also enabled the GP to see at a glance that a patient was in a caring role, allowing the GP to consider the impact that their caring role might be having on the patient's overall health.

Healthwatch Barnsley was awarded a grant through the Carers Forum to work within GP surgeries. This was in order to identify people who do not usually see themselves as carers and encourage them to register as carers with the surgery. This would give carers access to annual health checks, flexible appointments/double appointments when necessary and annual flu vaccinations.

Three surgeries in the borough were identified and approached to work with us (Royston Practice, Dodworth Surgery and Walderslade Surgery). Our work with Walderslade Surgery was particularly successful; we went on to use this practice as a pilot to demonstrate the effectiveness of outreach and engagement work within a surgery.

Further to our meetings with Walderslade Surgery, we provided staff with awareness training, gave awareness and information training for the Patient Participation Group and delivered three awareness raising sessions for patients during September, November and December 2016 at the surgery.

We also offered a consultation room to patients if they wished to speak to us in private, as well as a Healthwatch Barnsley

outreach session in case there were issues that we could support with in general.

We worked in the reception area in order to speak to patients about the benefits of registering with the surgery as a carer. We explained that registering as a carer would be beneficial to them and gave the reasons why. We also discussed the benefits of Carers Assessments with patients and how to request this for themselves.

Each person we interacted with was given a carers booklet which we produced, along with further information and a list of contact numbers for organisations they might need in the future.

The sessions were informal and many patients were happy to speak to us. In total we engaged with 40 patients, who then went on to register with their GP as carers.

Following on from this, we were invited to look at how organisations can work together to benefit carers and their families in the Hoyland area. At a group meeting consisting of organisations and individuals, each person spoke a little about the work they were doing. We then looked at how working and networking together can benefit carers and their families.

An article for Walderslade Surgery's newsletter was produced, detailing the benefits of letting the surgery know if you are a carer. This introduced the work further into the Hoyland community.

We also met with the Barnsley Carers Forum to provide an update on our work. As a result of this, we provided a Carers I.D. leaflet electronically which went out to organisations and community groups throughout Barnsley. We hope that through the work that we have carried out, that more carers will register with their GPs to access additional support.

We are now in the process of potentially training carers and previous carers to provide peer-to-peer support. We are also considering putting together a toolkit for carers and their families to further support the work we have done. If you are interested in looking at this for your area or practice, please contact us using the details listed at the end of this report.

Working with mental health services

During this year mental health was increasingly seen as both a local and national health priority. We have continued working in this area.

Barnsley Mental Health Crisis Care Concordat

In the last two annual reports, we have detailed our involvement of Healthwatch Champions in this work. This year we said goodbye to Moira Tombs, one of our representatives that left to seek out a fresh challenge. We would like to thank her for her contribution to work in this area.

A responsive project group (mentioned in last year's report) was formed to look at this work, consisting of Mark Smith, Margaret Linquist and Marie Cook OBE. They met to review progress made by members of the Barnsley Mental Health Crisis Care Concordat's (BMHCCC) Action Plan, following the survey we undertook last year. Progress against this action plan was largely dependent upon the actions of the provider South West Yorkshire Partnership Foundation Trust (SWYFT), who produced their own action plan. The implementation of the SWYFT Action Plan is dependent upon the transformation of their

services, which is presently underway. The responsive project group are monitoring progress against the action plan and will continue this in 2016/17, to ensure the recommendations following our survey work are implemented. Patient and care satisfaction will be monitored by consideration of SWYFT internal satisfaction data, information from our feedback centre, local service users and carers forums and other data sources.

Progress is starting to be made on implementation of personal Mental Health Safety or crisis plans by a BMHCCC task and finish group, on which we are represented. It is anticipated patient and carer views on this will be sought in 2017.

Work has been completed on the difficulties encountered by individuals placed out of area, in that they are returned within area as soon as possible and contact is maintained either through that person's care coordinator or treatment team.

Suicide Action Plan

The responsive project group were involved in discussions with the local council's public health function on the content of the borough's Suicide Action Plan. This was produced following on from an audit undertaken by the public health function within the Council's Place Directorate. This audit looked at coroner's reports on people that had taken their own lives. The group had concerns that some of this data had not been utilised in the plan and that it had not taken account of other mental health plans and recommendations. This was fully discussed with public health and the issues have been covered in the Barnsley plan, published in November 2016. It was also noted that the responsibility for suicide action planning within the council has moved from the Place Directorate to the People Directorate, where existing responsibility for mental health lies.

South Yorkshire Police Strategic Mental Health Partnership Board

We were asked to represent all South Yorkshire Healthwatch on the Board. Mark Smith attends these meetings, which have been looking at ensuring that only in exceptional circumstances (such as extreme violence) individuals detained under Section 136 of the Mental Health Act will not be placed in police cells. The roll out of these new procedures started in June 2017 to ensure compliance with revisions to the Policing and Crime Act 2017. This group will be monitoring the effectiveness of these changes, as well as understanding and monitoring the police emergency response to other mental health issues.

Child and Adolescent Mental Health

Following work reported last year that we undertook in relation to Child and Adolescent Mental Health Services (CAMHS), we have continued to monitor this. Data is being collected on lengths of time for assessment and treatment undertaken by the service. This data will be used towards the collection of information from young people and carers later in 2017, once the transformation of this service has been finalised and the resulting changes have been implemented.

Working with Barnsley's Deaf community

We were approached by the DEAForum, Leeds Involving People and Barnsley Council in 2015 to work in partnership to plan an event. This was to look at the barriers the Deaf community face when accessing Assessment and Care Management Services, delivered by Barnsley Council. This event was planned for Saturday 5 March 2016.

Following on from this event and in this report period, we have worked with the Deaf community and Barnsley Council to begin to address the issues outlined on the day and to help improve services and their accessibility.

The report we produced following the event outlined ten recommendations relating to:

- The need to undertake an Equality Impact Assessment;
- How accessible and clear information is for the Deaf community;
- How to raise awareness within the Deaf community in relation to safeguarding and how people can engage with local safeguarding services;
- The needs for awareness raising amongst social care professionals of the issues the Deaf community face;
- The desire of the Deaf community to be proactive in the local community and volunteer;
- To improve access to new technologies.

We then met with the Equalities Manager and the Commissioning Manager for Barnsley Council and Barnsley's Clinical Commissioning Group to discuss the recommendations and how services could be improved.

Responses to our recommendations

Following the event Barnsley Council considered the best approach to take to ensure that the Deaf community were aware of social care services. Training was given to ensure that all staff in the department were aware of the Accessible Information Standards and how statutory services must endeavour to provide information in a way that meets individual communication needs.

At the event there was a request from the Deaf community that they would like a dedicated Deaf Social Worker. Barnsley Council said that they were unable to provide this dedicated service, but they continued to recognise the need for Deaf Awareness Training amongst Assessment and Care Management Teams.

Barnsley Council confirmed that they were considering how technology can be used to improve people's experiences as part of the customer services implementation programme and how it would help to make services more accessible for all people living in Barnsley.

Working with the Adult Safeguarding Board

As a result of the feedback we gained at the event, we were able to feed the comments we received from the Deaf community into the Annual Report produced by the local Adult Safeguarding Board. We provided a case study which was used to highlight that more needs to be done to ensure the Deaf community, and other seldom heard groups, are able to safeguard themselves appropriately and know how safeguarding works in Barnsley.

This information also helped to stimulate conversations within the local authority about safeguarding in general and how to make all communities aware of the work of the Safeguarding Board. This also prompted the Safeguarding Board Manager to meet with the DEAForum in November to answer some of the questions raised at the event. Barnsley Council also confirmed that their new safeguarding website will address accessibility to information in relation to safeguarding for both children and adults.

We also used our feedback to, once again, prompt the national charity, SignHealth, to look at how they can help to raise awareness of safeguarding nationally by producing information in British Sign Language.

Next steps

We will continue to work with the Deaf community and our partners to ensure that the needs of this community are considered when health and care services are commissioned. This will ensure that the services provided are able to meet the needs of the people in Barnsley.

"At the doctors, I had difficulty getting to see a counsellor. I saw Healthwatch Barnsley at the DEAForum and spoke to them. They said they would take some information and look into it for me.

"Next thing I know, I have a letter from my doctor to say that I could receive three sessions of counselling. It took over three months for it to happen, but I finally got to see a counsellor in March, thanks to Healthwatch Barnsley. I am now doing the IAPT course in Barnsley, which is great"

DEAForum member

What we've learnt from visiting services

In this report period we have undertaken seven announced Enter and View visits.

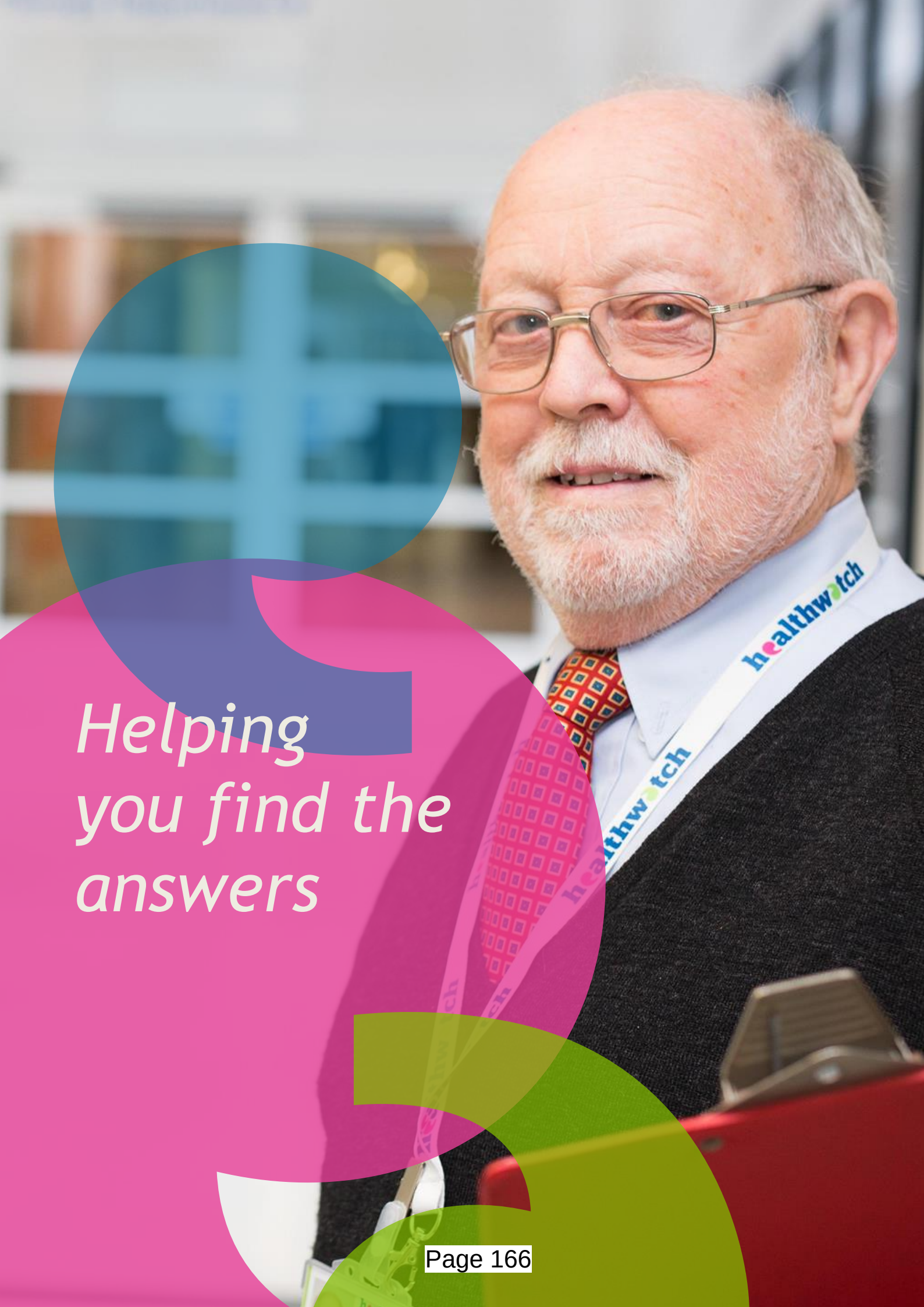
These visits were carried out as part of our work on mental health services, linking in with our Friends and Family Test (FFT) work. Four GP practices in the Dearne helped with this, looking into GP access in this area.

You will read of our work on the FFT and in the Dearne in this report and how we are working with service providers and the local community to ensure that all services meet the needs of the population we serve.

Our authorised Enter and View representatives

The following people are authorised to carry our Enter and View activity for Healthwatch Barnsley:

- Jade Bligh
- Pat Durie
- Teresa Gibson
- James Goodwin
- Chris Green
- Lorna Lewis
- Mark Smith



Helping you find the answers

How we have helped the community access the care they need

We provide a variety of information to ensure that local people are well informed about Health and Social Care services available in Barnsley. We can also advise on people's rights in relation to these services.

Our team has excellent knowledge about services and where further information is required we use provider websites, NHS websites and other resources.

This year the team have dealt with 109 signposting and information requests which is an increase from previous years.

We continue to ensure that we are visible within the local community and are on hand to provide people with information and signposting.

In addition to this, we regularly update our website and social media accounts on Facebook and Twitter to share information with the public about events that are taking place in relation to health and care. We also share local and national news stories, as well as consultations where the public have the opportunity to give their views on service provision in the borough.

DIAL - NHS Complaints Advocacy

Each local Healthwatch has been commissioned slightly differently and in line with local need. In Barnsley the NHS Complaints Advocacy Service is commissioned separately to the Healthwatch service.

The Independent Complaints Advocacy Service (ICAS) continues to work closely with Healthwatch Barnsley, attending community group meetings to promote both services and give information on how complaints are dealt with.

During this report period, ICAS have received a total of 114 new referrals, of which 34 have come directly from Healthwatch Barnsley.

ICAS and Healthwatch Barnsley communicate on a regular basis to share information and advice and to discuss the most effective way to address cases to reach a satisfactory outcome for individual clients. Jo Stanley (ICAS Lead Advocate) and James Goodwin from Healthwatch Barnsley also meet on a quarterly basis to monitor the progress of these cases.

To find out more about DIAL and how they can help, please contact Jo Stanley (Lead Advocate) on 01226 240273, ext. 208.


Making a difference together

How your experiences are helping influence change – Pharmacy Cuts Consultation

At the end of 2015/16 we received a letter from Michael Dugher MP asking us to look into the Government's proposal to cut £170 million from the budget for community pharmacy, which would see the current budget reduced from £2.8 billion in 2015/16 to £2.63 billion in 2016/17.

We responded to inform Mr Dugher MP that we were aware of the consultation and had begun to work with the lead individual at Local Professional Network for Pharmacies, who is also a member of our 'Expert Panel', a group of professionals who we approach when an issue requires their expertise and professional knowledge. We also planned to gather feedback through community outreach to feed into the consultation to ensure the views of people living in Barnsley were represented.

Gathering feedback

The lead for the Local Pharmacy Council supported us to identify seven pharmacies located across the borough that would be happy for us to carry out research with customers at their branch. Three of these pharmacies were independent, four were franchises.

A survey was designed to gather people's experiences of using their local pharmacy, what they used them for, how often and how they travelled there. We also wanted to know what impact, if any, the closure of the pharmacy they were visiting would have upon them.

What we found

As a result of this piece of work we discovered that community pharmacies are a crucial lifeline for many people and are highly valued.

We found many examples where pharmacists and community pharmacy staff went above and beyond their remit to provide a service to their patients, including pharmacies staying open late so patients could collect their much needed medication and how some pharmacists have, in an emergency, delivered medication outside of their usual delivery times.

One customer we spoke to commented, "This service has a family friendly atmosphere. Nothing is too much trouble. The pharmacist gives brilliant advice. I feel like a friend, and it's a pleasure to come in here and talk to everyone." This was just one example of the positive feedback we received about pharmacies across the borough and highlighted how many pharmacies fulfilled a social function, especially for people isolated due to a medical condition.

The feedback we gathered during outreach highlighted how community pharmacies help people to manage their medicines and track medicine usage and wastage, as individuals were able to ask their pharmacist how best to take their medicine and also safely dispose of any unwanted medication.

Feeding back to the consultation

Once the feedback had been collated, a report was produced that emphasised the importance of community pharmacies and how many pharmacists are willing to do much more than they are currently contracted for, in order to relieve pressure on other NHS services.

This information was fed back to the Department of Health as part of the consultation, as well as other intelligence sharing meetings.

Working with other organisations – NHS England

In this report period, we also undertook some work that was funded outside of our core contract. One of these pieces of work was to look at how the NHS Friends and Family Test (FFT) is embedded across mental health services. The FFT was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving care or treatment across the NHS.

Our work on this encompassed the following services:

- Children and Adolescent Mental Health Services;
- Acute Inpatient Mental Health Services;
- Community Clozapine Clinic;

We spoke to a number of staff members and service users in these locations. From the information that we gathered, some of the recommendations that we made included:

- All staff should receive training on the FFT;
- Robust procedures need to be put in place to feedback results to all colleagues, including nursing and medical staff;
- Managers need to consider why and how they are collating this information (appoint a lead on FFT data collected to ensure changes and/or improvements are made as necessary);
- Ensure patients know that you are listening and respond to their views accordingly;
- Reception staff need to give the opportunity to all service users to complete the test and offer advice on how to do this.

Following this, we formulated reports on each service and shared them with providers for comment. We then sent the reports to NHS England to inform their work on embedding the FFT within mental health services.

Working with other organisations – a volunteer's perspective

Margaret Linquist, a member of our Strategic Advisory Board, tells us how she has worked with Barnsley Hospital and the Electronic Prescribing Forum during 2016/17:

For the second year running I was able to take part in the annual Patient Led Assessment of the Care Environment at Barnsley Hospital. Similar assessments take place in all hospitals in the NHS.

Representing Healthwatch Barnsley, I found it very rewarding to be involved. This year I went into areas of the hospital that I have not previously visited such as the Birthing Centre, Antenatal Unit and Ward 37. I was very impressed with the state of the environment in all these areas and the cleanliness could not be faulted. The staff were open and welcoming and clearly proud of the units in which they worked.

During the year I have also been a patient representative at the Electronic Prescribing Forum. This has given considerable insight into the efforts made by the NHS to produce an effective and efficient system which serves patients well.

Working with other organisations – the Care Quality Commission (CQC)

We regularly share information with the CQC when they are planning to inspect services; we also support them to communicate and share information to people living in Barnsley.

We attended the Healthwatch and Care Quality Commission Working Together event in London in April 2016 to look at how information sharing and promotion could improve between local Healthwatch organisations and the CQC.

We have provided information about services (when requested and when available) to assist the CQC with their inspection schedule. We also supported their inspection of Yorkshire Ambulance Service during 2016/17.

We have promoted the following campaigns via our website and social media channels:

- Encouraging older people to feedback on their care
- Looking at end of life care
- #YourMentalHealthCare campaign to gather public experiences of mental health care
- The 'Sandwich Generation' - people caring for children and parents
- #CareForOlderPeople campaign
- The children and young people's survey

How we've worked with our community – South Yorkshire and Bassetlaw Sustainability and Transformation Plans (STP) and 'The Barnsley Local Plan'

In February 2017 Healthwatch Barnsley and Voluntary Action Barnsley were approached by the Commissioners Working Together Team to look at engaging with the local community. This was to be 'a conversation' about the local plans for transforming health services in Barnsley. Healthwatch Barnsley were commissioned to do this work alongside our Healthwatch Partners across South Yorkshire and Bassetlaw.

We were required to engage with seldom heard groups in order to ensure there was a robust debate across the community. We spoke with 13 groups from a variety of backgrounds including Parkinson's and District Branch Group, a learning disability group, Barnsley Lesbian Gay Bisexual and Transgender (LGBT) Forum and Barnsley Independent Alzheimer's and Dementia Support (BIADS). We also ran two focus groups to encourage more in-depth conversations.

The general consensus was:

People agreed with the plan in principle. They also agreed that there is a need to change the way the services work. The basis of the plan, such as to do things differently, engage with the public, work together and make priorities everyone agrees with was welcomed. People also agreed that the public need to take control of their own health. General concerns were that the plan did not indicate how this proposal was going to happen and at what cost.

In discussions with the public on what is important to them when it comes to their health and care, points raised and comments included:

- Give GPs the backing and support that they need to meet increasing demands;
- Look at reductions on organisational structures, spend less at the top and more on the front line;
- Children who are looked after may need a joined up collaborative approach to support them;
- Develop well linked up care packages and respect people's privacy. This came from specific groups who experience difficulties within health services;
- Reduce waiting times for A&E and GP appointments.

The key themes were:

- Communication and Engagement;
- Transport;
- Funding;
- Service change.

People in the community would like to know what happens next, as they have taken part in conversations and are keen for more involvement. This is a good opportunity to engage communities in the ongoing development of the Sustainability and Transformation Plan.

In conclusion and going forward:

Many people had not heard about the Sustainability and Transformation Plan before the conversation sessions. We feel that we have opened up dialogue that will impact on local people and that we have played a significant part in supporting discussions and debate, which we are sure will continue in the future.

Our representative on the Health and Wellbeing Board

The Chair of our Strategic Advisory Board, Adrian England attends the Health and Wellbeing Board to represent us and to ensure that the views of people living in Barnsley are represented. Adrian meets regularly with our Manager and other staff team members as appropriate so that he is able to feed into strategies and policies that will affect how services are commissioned and delivered in the borough.

Our outreach and engagement team, supported by our Healthwatch Champions, gather views and feedback from the community on issues that are affecting them and having an impact on how they access health and care services. This information is also reported to Adrian ahead of the Health and Wellbeing Board meetings

By working in this way we ensure that the views all local people are represented and that this information can influence service delivery, both now and in the future.


It starts
with you

Dental work in primary schools

Each year we form priorities based on the information received from members of the public. This information is cross-referenced with data received through meetings we attend and takes into account the health and wellbeing strategies for Barnsley.

During 2014, we undertook a snapshot survey as part of our involvement with the Children and Young People Health and Wellbeing Strategy Task Group. This highlighted that 43% of the 100+ children and young people we had spoken to had not accessed a dentist within the last six to twelve months. This sparked some interest with our volunteer Healthwatch Champions and Strategic Advisory Board members and subsequently led to our becoming involved in the Local Oral Health Advisory Group. Through our outreach and engagement activities we have been able to raise awareness of the benefits of requesting fluoride varnish treatment.

In 2016 after receiving the Public Health Strategy, we felt that we needed to consult children and young people accessing dentists. The aim of this was to bring their views to the attention of related local discussions.

Gathering information

We engaged with five primary schools in Barnsley and carried out a 45 minute session in each, highlighting the importance of dental hygiene. We also gathered views relating to dentists. In total we spoke to 188 children and young people at the following schools:

- Ward Green Primary school
- Joseph Locke Primary School
- Dodworth St Johns Church of England Primary Academy
- Athersley South Primary School
- Elsecar Holy Trinity Church of England Primary School

The key points asked of the young people in attendance were:

- How many times a day should you brush your teeth?
- How long should you brush your teeth for each time?
- How often should you visit the dentist?
- What is fluoride varnish?

We also asked children and young people about their experiences of visiting their dental practice. The main focus was to find out:

- If children and young people have been to the dentist lately and how often they attend;
- The opinions, experiences, and views of children and young people who have attended a dental appointment;
- If children and young people were aware of the superhero campaign launched by Public Health in 2015.

The feedback we received outlined their experiences and opinions of 20 dental practices covering all six ward areas of Barnsley. The feedback was then shared with our Young Champions who supported our Children and Young People's Engagement Worker to analyse the information, key findings and recommendations for change.

This information will be presented to the Oral Health Advisory Board in June 2017 and shared with all schools and dental practices in Barnsley. An action plan will also be created to allow services to measure what differences and recommendations have been implemented.

Looking at Speech and Language Therapy services in Barnsley

As part of our 360 review last year, we received feedback about the discharge process from Speech and Language Therapy services for children with complex needs. We then held meetings with the Service Commissioner and a parent of a child accessing these services to find out more about the service and how it is currently run.

Gathering views

We decided to hold two open days to gather views and experiences from parents of children with complex needs. This would allow these parents to share their thoughts on the discharge process and the service as a whole. We made sure that these sessions ran from 9am until 7.30pm to take into account the access needs of parents who have caring responsibilities. We advertised the open day in a number of different ways to ensure that as many people as possible knew about the sessions and also included our contact details for any parents who could not make the day.

In addition to this, we designed a survey that we took into clinics. We used the survey as a basis for conversations with staff, patients and parents, in order to gather their views. We also joined Speech and Language Therapists on their rounds to gather the experiences of service users.

As well as obtaining feedback in person through our outreach, some individuals chose to leave feedback via our online Feedback Centre and we were able to include this in our findings.

Analysing the information

Once we had collated all the feedback we had received, we analysed it to see if there were any common themes in relation to the service provision, the referral route and how young people were discharged from the service. We noticed that we had received feedback from both parents accessing the service and professionals referring into the service. With this in mind we separated the comments so that we could get a viewpoint from parents and a viewpoint from professionals, such as teaching assistants, who were either working with or referring children into the service.

Following our analysis of the information, we asked the current service provider to answer specific questions that had been asked so we could get a clear picture of the service and how it works in Barnsley.

Findings and recommendations

On the whole we received positive feedback from people we spoke to and from people who left comments on the Feedback Centre.

We were able to make four key recommendations to the service based on our findings. This was to help ensure that parents felt supported and that the service could meet their needs.

Next steps

This report will be sent to South West Yorkshire NHS Partnership Foundation Trust, who provide Speech and Language Therapy services for young people in Barnsley. We will also share it with service commissioners, Barnsley Council and other partners when the service is reviewed.

The impact of patient 'Did Not Attend' (DNA) appointments at GP surgeries in the Dearne

In November 2015 an issue was brought to our attention by Councillor Gollick, on behalf of people living in the Dearne. The issue was that people were struggling to access their general practice. We started looking at the issue in 2015/16 and our outreach and engagement work continued in this reporting period.

Gathering views and feedback

In order to gather more information and to speak to people living in the Dearne area, we arranged two engagement events at Goldthorpe and Thurnscoe Library. These events were publicised in the local press and via social media. As a result of this work, we spoke to a total of 42 people and found that the issue of people being able to get an appointment at their practice was a common theme.

In order to find out what service providers thought about these access issues, we visited two surgeries in the Dearne and spoke to staff and the practice managers. At both surgeries staff raised the issue that the biggest problem affecting access to appointments was patients not attending appointments they had booked.

In addition to our outreach and engagement work, we were called as a witness at the Overview and Scrutiny Commission led by Barnsley Council, as they had called a meeting to look at the local GP Federation and GP Access. At this meeting we were able to report on our findings to date and our plans for the next few months.

Working with the 'Dearne Approach'

The 'Dearne Approach' is a partnership of different organisations, including Barnsley Council, working to improve the area for the people living there. Access to GPs was one of the issues that residents had identified to the 'Dearne Approach' and we went to meetings to provide an update on our findings and to ask for support. We wanted help to raise awareness of the importance of people cancelling their appointments when they are unable to attend, to ensure that other people could benefit from seeing a medical professional. We informed the meeting that one practice reported that 350 patients did not attend their appointments in one quarter and the resulting impact this has.

The 'Dearne Approach' agreed to support our work and awareness raising with residents and they also agreed to promote community pharmacy services as an alternative to attending GP appointments.

Next steps

In addition to the promotion and awareness raising that the 'Dearne Approach' partners agreed to, we decided to look into the specific issues of why people do not attend their appointments and if there is anything that could be done to make the process easier for residents.

Our Adult Engagement Worker is in the process of speaking to people in the Dearne in a number of community venues to gather their views and feedback on the issue of DNA rates. She is also working with the GP practices in this area to make recommendations and share our findings, which will continue into 2016/17.

Our plans for next year

What next?

In 2017/18 we will continue to ensure that our work focuses on how health and care services impact upon people living in Barnsley. We will remain responsive to any feedback our outreach and engagement team gather and ensure that this information is supplied to service providers and commissioners.

In the next year we will install a new Customer Relationship Management (CRM) system that will allow us to better monitor the feedback and information we receive, as well as deal with requests for information from members of the public more efficiently. This system will also ensure that we continue to be effective and responsive to people's needs.

Priorities for the next year

Our priorities for the next year are as follows:

- Mental Health Strategy (including CAMHS, Barnsley Mental Health Crisis Care Concordat, South Yorkshire Police Strategic Mental Health Partnership Board, Suicide Action Plan for Barnsley and the 'Thrive' programme for primary schools – we need to continue to monitor how accessible mental health services are and the related waiting times for appointments;
- Looking at the Alcohol Strategy for Barnsley and feeding into borough wide public engagement to look at the issues around home consumption of alcohol;
- Engaging with secondary school pupils;
- Continue to engage with children on their experiences of visiting the dentist and how this impacts on their oral hygiene and general health;
- Extend the Carer's Strategy to all GPs to ensure that GPs are able to identify and support carers registered within their practice;
- To continue our work in the Dearne to look at why people do not attend their GP appointment;
- Work with the Equality Forums to ensure the people associated with them are able to access health and care services;
- To recruit new Adult and Young Healthwatch Champions to enable us to gather more views in the community through outreach.

Sustainability and Transformation Plan (STP)

One of the biggest areas that we need to prioritise over the next year is the STP and how this has the potential to change how services are delivered in the future. You will have read earlier in this report that we have started to inform people in Barnsley about the STP and gather their views on the plan for Barnsley.

We are already working with partners via the Stronger Communities Partnership Board to look at how budget changes will impact on spending and investment in different areas in the borough, whilst ensuring that the health and care services that are provided are fit for purpose for the communities they serve.

We will continue to monitor the proposals of the Accountable Care Organisation Partnership Board and the Accountable Care System Board and champion and challenge all operations and decisions.


Our people

Decision making

Voluntary Action Barnsley is contracted to host Healthwatch Barnsley and is responsible for the recruitment, employment and management of staff, payroll and premises.

Strategic Advisory Board

Our Strategic Advisory Board focus on the development and direction of the strategic work plan and support with the prioritisation of key issues relating to health and care.

Our outreach and engagement work ensures that we work with organisations representing the population of Barnsley, including Black Minority Ethnic communities, carers, older people, young people, people with mental ill health and those with sensory impairment.

Individuals and groups can become members of Healthwatch Barnsley. Individual membership is open to anyone living in Barnsley or using local health and care services. Individual members can indicate to what level they wish to become involved in our work and activities. Group membership is open to any voluntary organisation, community group or business organisation that operates in the Barnsley area, wishing to affiliate itself to us and our work.

To ensure we have a Strategic Advisory Board that is truly representative, members of the public can find out more about our voluntary roles through outreach and engagement work and our other promotional activities. Once a potential volunteer has identified that they would like to be a Strategic Advisory Board member, they are given an application pack to complete and send back to the team. These candidates are then shortlisted by other Board members and invited for interview. This ensures there is a broad range of skills, competencies, knowledge and experience on the Board and that it is committed to our strategic vision, mission and aims.

The role of the Chair of the Strategic Advisory Board is also advertised and all potential candidates will be interviewed by a panel of independent experts. The person selected as Chair will then be our representative on the Health and Wellbeing Board and the main spokesperson for us.

The Strategic Advisory Board will work to ensure:

- All sections of the community are represented and their views considered in our work;
- Proactive communication with the wider community, and in particular with hard to reach groups;
- Appropriate resources are allocated to support activities.

The Strategic Advisory Board will also:

- Agree our strategic priorities;
- Approve reports produced by groups working on behalf of, or in collaboration with us;
- Support, whenever appropriate, collaborative work with other organisations including adult and children's care services, the local Clinical Commissioning Group, neighbouring Healthwatch services, the overview and scrutiny committees and foundation trusts;

- Ensure we contribute to the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy;
- Ensure that the views and experiences of people are communicated to commissioners and providers of services and to Healthwatch England.

Our Strategic Advisory Board is structured and represented as follows:

- It should have no more than eight members with a range of specialisms, skills and interests;
- Strategic Advisory Board members will serve for two years. Members will be eligible for re-selection;
- Candidates representing organisations must be nominated by an authorised representative of the organisation and active in health and/or care in that district. The NHS or local authority will be unable to nominate candidates;
- The interview panel for the Board will comprise of our Chair, additional Board members, our manager, along with a representative from the voluntary sector;
- The Board has the power to invite representatives from special interest groups or organisations to attend Board meetings, in order to reflect the need for particular knowledge, experience or skill sets which are deemed necessary for the effective functioning of the Board.

All Strategic Advisory Board meetings will be minuted and we will regularly produce detailed monitoring reports. These will highlight significant achievements and difficulties.

Currently we have the following people on our Strategic Advisory Board:

Adrian England – Chairman
Tony Alcock JP
Margaret Baker
Ian Guest
Wendy Hardcastle
Christine Key
Margaret Linquist
Mark Smith

Healthwatch Champions and Young Champions

Individuals who become our members are given the opportunity to become actively involved as Champions or Young Champions. Anyone who shows an interest is given an application pack to complete before a meeting is arranged with the relevant engagement worker.

Adult Healthwatch Champions

All Healthwatch Champions are supported by our Adult Engagement Worker, Lorna Lewis. Currently we have the following Champions assisting with our work:

Aftab Ali
Marie Cook OBE
Carol Dixon
Patricia Durie
Chris Green

This year one of our most valued volunteers has retired.

Mike Grundy has worked with us since the inception of Healthwatch Barnsley. He was involved in many aspects of our work including Enter and View visits of residential homes and hospital services,

writing reports, engaging with service users and representing us at several meetings.

Mike was always happy to offer a helping hand with any of our work and was a great support to all his colleagues. His kind nature and helpful attitude encouraged other volunteers to get involved; we will all miss him a lot and wish him well with everything in the future.

We have also lost two of our volunteers to our Strategic Board. Mark Smith and Wendy Hardcastle have decided that they want to be more involved in planning our work and in our strategic direction.

We would like to welcome our newest volunteer Carol Dixon to the team. Carol has a background in banking services and brings many skills that she will be able to share with us.

We would like to take this opportunity to thank all our long standing volunteers for their continued support.

Recruitment of more volunteers will be a priority in the coming year.

Young Healthwatch Champions

All Healthwatch Young Champions are supported by our Children and Young People's Engagement Worker, Jade Bligh. Currently we have the following Young Champions assisting with our work:

Stephany Coetrall
Grace Harthill
Lilly Kershaw
Heather Lindsay
Holly Mayes

Our Young Champions have been involved in a number of projects and we appreciate all their hard work as they volunteer to help us, as well as manage their school work, exams and extra-curricular activity.

Staff team

During this reporting period we have seen a few changes in staff roles; Carrianne Stones left the organisation and Teresa Gibson took over as Healthwatch Barnsley Manager, as mentioned previously.

We also recruited a new Signposting, Intelligence and Communications Officer, Gill Doy, who took over from Carolyn Ellis in December 2016. Gill has previously worked in social care, public health and the voluntary sector. Gill currently signposts people and responds to enquiries, collecting intelligence regarding services. She also looks after the website and social media accounts.

The staff team for Healthwatch Barnsley are as follows:

- Teresa Gibson – Healthwatch Manager
- Jade Bligh – Children and Young People's Engagement Worker
- Gill Doy - Signposting, Intelligence and Communications Officer
- James Goodwin – Outreach Worker
- Lorna Lewis – Adult Engagement Officer

For more information about the staff and their roles please visit www.healthwatchbarnsley.co.uk

Tribute to Edith Bird from Lorna Lewis, Adult Engagement Worker

We received sad news recently about the passing of our dear friend and colleague Edith Bird, one Healthwatch Barnsley's founding volunteer Champions.

Even though she was in her 80s, Edith was always spritely and energetic. She was kind and would help anyone she could. For us, she talked to people to gather their views about health and social care services. She worked for us in GP practices, pharmacies, hospitals and at events but her favourite work was visiting residential homes and talking to the people who lived there. She always used to make me smile when she said, "I love visiting old people"; she was just so young at heart!

Edith's smile, humour and compassion made her a friend of many people. The phrase, "If you want something doing, ask a busy person" could almost have been written of Edith. Whilst volunteering for us, she did so for many of the local churches in Barnsley where she played the organ. Some churches rescheduled their services so she could fit them in. She also played for drama groups and on occasion when helping us with engagement work in the community, if there was an organ or a piano in the vicinity she would give people a tune to brighten their day.

I can also recall the time when a new volunteer came to a meeting and noticed Edith chatting to someone in the corner. He went up to her and said, "Do you know that you're a legend?". He went on to tell us all that Edith's photograph took pride of place on the wall of the local Samaritans office. She was their longest serving volunteer, working there for 30 years. Edith then left the Samaritans and came to volunteer for us, where she remained until a few weeks before she sadly passed away.

Edith was a wonderful woman and will be greatly missed by all of us that knew her. I am proud to say that she was part of our lives and we will think of her with great affection for many years to come.

Edith Bird, 1932 – 2017. Gone but not forgotten.

Our finances

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	150,000
Additional income	4,980
Total income	154,980
Expenditure	
Operational costs	18,914
Staffing costs	135,186
Office costs	19,896
Total expenditure	173,996
Balance brought forward	27,780

Contact us

Get in touch
Address: The Core, County Way, Barnsley, S70 2JW
Phone number: 01226 320106
Email: Healthwatch@vabarnsley.org.uk
Website: www.healthwatchbarnsley.co.uk
Twitter: @hwatchbarnsley

We will be making this annual report publicly available on 30 June 2017 by publishing it on our website and sharing it with Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

Heathwatch Barnsley
The Core
County Way
Barnsley
S70 2JW

www.healthwatchbarnsley.co.uk
t: 01226 320106
e:Healthwatch@vabarnsley.org.uk
tw: @HWatchBarnsley
fb: facebook.com/HealthwatchBarnsley

This page is intentionally left blank

REPORT TO THE HEALTH AND WELLBEING BOARD

8TH August 2017

PHARMACEUTICAL NEEDS ASSESSMENT: BRIEFING NOTE

Report Sponsor:	Julia Burrows
Report Author:	Rebecca Clarke
Received by SSDG:	18th July 2017
Date of Report:	8th August 2017

1. Purpose of Report

1.1 This report presents the outline for a combined South Yorkshire approach to support the four authorities to develop their own 2018-2020 Pharmaceutical Needs Assessment (PNA) for approval by individual Health and Wellbeing Boards before the end of March 2018.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to note the:-

- requirement to approve a PNA before the end of March 2018
- process for carrying out the Barnsley Pharmaceutical Needs Assessment set out in this paper.

3. Introduction/ Background

3.1 The Health and Social Care Act 2012 gave Health and Wellbeing Boards the statutory duty to develop and publish PNAs for their areas by 1st April 2015. Barnsley Health and Wellbeing Board published their PNA in February 2015. Health and Wellbeing Boards are required to publish a revised assessment within three years of publication of their first assessment; by end March 2018.

3.2 Requirements for PNAs are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. These cover the minimum information to be included, the matters which must be considered and the process to be followed. This process includes formal consultation with specific stakeholders for a minimum of 60 days.

3.3 The PNA is a key commissioning tool to ensure that local areas have high quality pharmaceutical services that meet local needs. The PNA sets out the community pharmaceutical services that are currently provided and gives recommendations to address any identified gaps, taking into account future needs.

3.4 The PNA supports the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers. It will inform commissioning decisions by local authorities, NHS England and clinical commissioning groups. The PNA is also a key document used in decisions around applications to open new and close pharmacy premises.

Summary of the approach

4.1. The four South Yorkshire authorities have agreed to collaborate on the production of the 2018-2020 PNA. A South Yorkshire project group has been established with lead officers for the PNA in each authority. To ensure:

- the PNA retains fit with local need
- the development of local content
- timely progression through governance structures with sign off by Health and Wellbeing Board.

4.2 Each Health and Wellbeing Board will retain the duty to sign off the PNA for their area but that the production of the PNAs will be made more efficient by sharing common structures and generic wording. This approach retains local oversight but maximises efficient use of resources.

4.3 Given that there is a need for local input a Barnsley project group will meet on a small number of occasions to support and give advice on the PNA's development

4.4 The South Yorkshire Local Pharmaceutical Network is supportive of a combined approach and is therefore well suited to act as a South Yorkshire Steering Group and a source of professional advice.

5. Conclusion/ Next Steps

5.1 An outline timetable for completion has been developed that would bring a final PNA to the 30th January 2018 meeting of the Health and Wellbeing Board for approval.

6. Financial Implications

6.1 No financial implications identified at this time.

7. Consultation with stakeholders

7.1 The PNA is subject to a 60 day statutory consultation period which will take place during October and November 2017. Regulation 8 of the Pharmaceutical Services Regulations specifies that the Health and Wellbeing Board must consult with the following:-

- the Local Pharmaceutical Committee
- the Local Medical Committee
- any persons on the pharmaceutical lists and any dispensing doctors list for its area
- any Local Pharmacy Services (LPS) chemist in its area with whom NHS England has made arrangements for the provision of any local pharmaceutical services
- Healthwatch, and any other patient, consumer or community group in its area which in the view of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area;
- any NHS Trust or NHS Foundation Trust in its area
- NHS England
- any neighbouring HWB.

7.2 Those being consulted will be directed to a draft PNA published on the Barnsley Council website.

Officer: Rebecca Clarke **Contact:** rebeccaclarke@barnsley.gov.uk
Date: 21 July 2017