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BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 4 December 2018
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 2nd October, 2018 (HWB.04.12.2018/2) *(Pages 3 - 8)*

3 Minutes from the South Yorkshire and Bassetlaw STP Collaborative Partnership Board held on 10th August, and 14th September, and 19th October, 2018 (HWB.04.12.2018/3) *(Pages 9 - 38)*

4 Public Questions (HWB.04.12.2018/4) *(Pages 39 - 40)*

For Decision/Discussion

5 Barnsley Wellbeing Service - Cath Bedford (HWB.04.12.2018/5) *(Pages 41 - 70)*

6 Health and Wellbeing Performance Report - Will Boyes (HWB.04.12.2018/6) *(Pages 71 - 78)*

7 Barnsley Hospital NHS Foundation Trust Strategy - Richard Jenkins (HWB.04.12.2018/7) *(Pages 79 - 166)*

8 Delivery of Cancer Priorities Across the Barnsley Locality - Bob Kirton (HWB.04.12.2018/8) *(Pages 167 - 172)*

9 Healthwatch Annual Report - Adrian England (HWB.04.12.2018/9) *(Pages 173 - 198)*

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 or email governance@barnsley.gov.uk

Monday, 26 November 2018

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 2 October 2018
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

MINUTES

Present

Councillor Sir Stephen Houghton CBE, Leader of the Council (Chair)
Councillor Margaret Bruff, Cabinet Spokesperson - People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson - Communities
Wendy Lowder, Executive Director Communities
Julia Burrows, Director Public Health
Lesley Smith, Chief Officer, NHS Barnsley Clinical Commissioning Group
Adrian England, HealthWatch Barnsley
Bob Kirton, Barnsley Hospital NHS Foundation Trust
Salma Yasmeen, Director of Strategy, South West Yorkshire Partnership NHS Foundation Trust
Helen Jaggar, Chief Executive, Berneslai Homes

10 Declarations of Pecuniary and Non-Pecuniary Interests

Councillor Platts declared a non-pecuniary interest in Minute 22 in respect of the Hospital Services Review in her capacity as a Member of the Barnsley Hospital NHS Foundation Trust Council of Governors.

11 Minutes of the Board Meeting held on 5th June, 2018 (HWB.02.10.2018/2)

The meeting considered the minutes of the previous meeting held on 5th June, 2018.

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

12 Minutes from the Children and Young People's Trust Executive Group held on 27th April, 8th June, and 13th July, 2018 (HWB.02.10.2018/3)

The meeting considered the minutes from the Children and Young People's Trust Executive Group meetings held on 27th April, 8th June and 13th July, 2018.

RESOLVED that the minutes be received.

13 Minutes from the Safer Barnsley Partnership held on 9th May and 8th August, 2018 (HWB.02.10.2018/4)

The meeting considered the minutes from the Safer Barnsley Partnership meetings held on 9th May and 8th August, 2018.

RESOLVED that the minutes be received.

14 Minutes from the Provider Forum held on 13th June, and 12th September, 2018 (HWB.02.10.2018/5)

The meeting considered the minutes from the Provider Forum meetings held on 13th June and 12th September, 2018.

RESOLVED that the minutes be received.

15 Minutes from the Stronger Communities Partnership held on 21st May and 20th August, 2018 (HWB.02.10.2018/6)

The meeting considered the minutes from the Stronger Communities Partnership meetings held on 21st May and 20th August, 2018. The meeting noted the work of the Partnership to develop a forward plan of activity and that this would be circulated to this Board for information.

RESOLVED that the minutes be received.

16 Minutes from the South Yorkshire and Bassetlaw Shadow Integrated Care System Collaborative Board held on 9th February, 2018 (HWB.02.10.2018/7)

The meeting considered the minutes from the South Yorkshire and Bassetlaw Shadow Integrated Care System Collaborative Board held on 9th February, 2018.

RESOLVED that the minutes be received.

17 Public Questions (HWB.02.10.2018/8)

The meeting noted that no public questions had been received for consideration at today's meeting.

18 Barnsley Safeguarding Adults Board Annual Report 2017-18 (HWB.02.10.2018/9)

Bob Dyson, the Chair of the Barnsley Local Safeguarding Adults Board, attended the meeting to present the Board's Annual Report for 2017/18. The meeting noted the Board's priorities and achievements during the year, as set out in the report, which was written in a briefer, more accessible, style, supplemented by a number of videos available on line. The meeting noted the positive contributions made by all agencies in the work of the Board in maintaining the overall commitment in Barnsley to keeping vulnerable adults safe.

RESOLVED that the Annual Report be received and the progress being made by the Safeguarding Adults Board be welcomed.

19 Barnsley Safeguarding Children Board Annual Board 2017-18 (HWB.02.10.2018/10)

Bob Dyson, the Chair of the Barnsley Local Safeguarding Children's Board, attended the meeting to present the Board's Annual Report for 2017/18. The meeting noted the Board's priorities and achievements during the year, as set out in the report,

which was written in a briefer, more accessible, style, supplemented by a number of videos available on line. The meeting noted the positive contributions made by all agencies in the work of the Board in maintaining the overall commitment in Barnsley to keeping vulnerable children safe.

The meeting noted that the Ofsted Inspection of Children's Social Care in Barnsley had started on 1st October. Bob Dyson commented that Barnsley was well placed to respond positively to the inspection, in view of the improvements he had seen during his time as Board Chair.

The meeting noted the liaison arrangements that were in place between the Safeguarding Adults, Safeguarding Children and Safer Barnsley Partnership Boards to consider the connections and interdependencies between those areas of work and to streamline activity/processes where possible.

RESOLVED that the Annual Report be received and the progress being made by the Safeguarding Children's Board be welcomed.

20 Public Health Strategy 2018 - 2021 - Renewing Action for a Healthier Barnsley (HWB.02.10.2018/11)

The meeting received a report on proposals to refresh the Public Health Strategy for 2018-2021, retaining the focus on the previous three priority areas whilst adding three new priorities in relation to alcohol, emotional resilience and food. The refreshed Strategy sought to respond to those issues raised by residents of the Borough in the production of the 2018 Director of Public Health Report. The three earlier priorities, smoking, physical activity and oral health, had now had established work programmes and were progressing successfully with significant results, and similar work programmes would be developed for the three new priorities.

The Board commented on the step change that had been achieved in dealing with the initial three priorities, particularly in relation to making smoking invisible. The contribution of partner agencies was acknowledged, and similar contributions would be sought in taking forward the three new action plans.

RESOLVED:-

(i) that the Public Health Strategy for 2018-2021, that has been produced in consultation with key partners, be noted; and

(ii) that the Health and Wellbeing Board and individual partner agencies support the delivery of the new Public Health Strategy and further work be undertaken with partner agencies to develop action plans and programmes of activity.

21 Public Health Food Plan (HWB.02.10.2018/12)

The meeting received a report setting out the proposed Public Health Food Plan to take forward one of the priorities in the refreshed Public Health Strategy. The action plan envisaged a range of activity to promote access to good quality food and, developing the local supply chain, as well as seeking to reduce calorie intake. In particular, the Plan envisaged working with hot food takeaways to develop more

healthy options, and perhaps provide accreditation of “healthy takeaways” alongside the normal food hygiene ratings to encourage behavioural change.

The meeting noted that the work with the hot food takeaway trade provided an opportunity to promote greater environmental awareness, particularly to reduce reliance on single use plastics and other materials.

RESOLVED:-

(i) that the aims and priorities of the Public Health Food Plan is supported; and

(ii) that partner agencies assist in the implementation of the Plan and offer support in its delivery.

22 Hospital Services Review - Strategic Outline Case (HWB.02.10.2018/13)

The meeting received information on the progress of the Hospital Services Review, with the development of a Strategic Outline Case following the publication of the final report in May 2018. The document set out the overall direction for the South Yorkshire and Bassetlaw Integrated Care System, with particular focus on shared working between acute providers, a shift of activity out of hospital into the primary and community care sectors, and transforming workforce roles and clinical pathways. The document also considered modelling options for the maternity and paediatrics services, moving to three or four sites for emergency gastrointestinal bleeds out of hours and considering options to support stroke services through better joint working. It was confirmed that the current distribution of district general hospitals would remain and, in general, patients would receive care in their local hospital.

The arrangements for better joint working between Trusts between South Yorkshire and Bassetlaw were already underway. It was likely that work on reconfiguration would begin in January 2019, with progress being reviewed through the Health and Wellbeing Board.

AGREED that the report be noted.

23 Excess Winter Deaths and Cold Related Illnesses (HWB.02.10.2018/14)

The meeting received a report and presentation on progress in the multi-agency work to tackle excess winter deaths and cold related illnesses in Barnsley and prepare for Winter 2018/19 and beyond. The presentation identified the activity progressed following discussion at the Health and Wellbeing Board in April 2018 and the action plan for 2018-2021, focusing in particular on prevention and early help, with a range of collaborative actions across partners.

The presentation noted the importance of agencies working together to identify and assess vulnerable adults at risk from early winter deaths and cold related illnesses and to support in particular the development and delivery of the Warms Home Single Point of Access. The meeting noted in particular the importance of a joint communication plan in this area, but using media most likely to reach those groups most affected provided through a range of settings. The meeting discussed the importance of focusing on respiratory issues as a key component to tackling excess winter deaths. The use of specialist respiratory nurses through the Breathe service

was important, and there was also a need to focus on flu vaccination and ensuring the availability of rescue medication for patients. The meeting also discussed the importance of connecting this work to the A&E Delivery Board, which was also aware of the issues related to social care and discharge/reablement arrangements.

RESOLVED:-

(i) that the progress made on the action plan for tackling excess winter deaths and cold related illnesses as set out in the report and presentation be welcomed;

(ii) that the proposed calls for action for the Health and Wellbeing Board and partner agencies be supported, including:

- Identification of vulnerable adults at risk from excess winter deaths and cold related illnesses;
- Support for commissioning arrangements for the Warm Homes Single Point of Access;
- Ensuring that planning includes identifying relevant local interventions and providers across integrated care, including assessment, admission and discharge arrangements;
- Support for the joint communication plan for tackling early winter deaths; and

(iii) that arrangements be put in place for the necessary action and communications across stakeholders to take forward the action plan.

Chair

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South Yorkshire and Bassetlaw Shadow Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

10 August 2018

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

Decision Summary

Minute reference	Item	Action
59/18	**Matters arising** **Overview of Health and Wellbeing in South Yorkshire and Bassetlaw** The Board was informed that the population health timeout for members to discuss this matter and identify the priorities will be progressed in late September / early October.	**WCG**
61/18	**SYB Governance Review** Following discussion the acting Chair noted the request from the Board for improved communication, reassuring openness and transparency, expenditure and expected outcomes on the ICS workplan and agreed to review the communication model between the ICS and partners with the Senior Management Team.	**LS/ SMT**
63/18	**Hospital Services Review** **Strategic Outline Case** Members agreed that Governing Bodies and Foundation Trust Boards would be required to arrange extraordinary meetings to support the development and the review process.	**CPB members**
64/18	**Digital/IT update against funding awards** The Board asked for detailed analysis of place digital capital funding and bids; funding principles and guidance.	**NHA**
65/18	**Finance Update** Members were informed that an early warning escalation system is being developed to inform the work of the Finance and Activity Committee and will be shared with the Executive Steering Group on 21 August.	**JC**
66/18	**ICS Highlight Report** SROs were asked to consider the report and identify recommendations to future reports. Comments should be forwarded to Lisa Kell. Members agreed to engage in using the Escalation Management System (EMS) wide and asked for clarity on the added value and relevance.	**CPB SROs** **CPB members**

South Yorkshire and Bassetlaw Shadow Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

10 August 2018

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

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw Shadow ICS	ACS Lead/Chair, Sheffield Teaching Hospitals NHS FT, CEO		✓	
Adrian England	Healthwatch Barnsley	Chair	✓		
Ainsley Macdonnell	Nottinghamshire County Council	Service Director		✓	
Alison Knowles	Locality Director North of England,	NHS England	✓		
Alan Davis	South West Yorkshire Partnership NHS FT	Director of Human Resources	✓		
Nicola Haywood-Alexander	SYB ICS	Programme Director	✓(pt)		
Andrew Hilton	Sheffield GP Federation	GP		✓	
Andrew Pepper	South Yorkshire and Bassetlaw ICS	Strategic Finance Lead	✓(pt)		
Ann Gibbs	Sheffield Teaching Hospitals NHS FT	Director of Strategy		✓	
Anthony May	Nottinghamshire County Council	Chief Executive		✓	
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/Tim Moorhead
Catherine Burn	Voluntary Action Representative	Director	✓		
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer	✓		
Chris Holt	The Rotherham NHS FT	Deputy Chief Executive & Director of Strategy and Transformation		✓	
Clare Hodgson	EMAS	Assistant Director of Strategy Development & Commercial Services		✓	
Clare Morgan	Sheffield Teaching Hospitals NHS Foundation Trust	Programme Director (Chief Executives Office)		✓	
David Pearson	Nottingham County Council	Deputy Chief Executive		✓	
Des Breen	SYB ICS	Medical Director		✓	
Dominic Blaydon	Rotherham Hospital FT	Associate Director of Strategy &	✓		

		Transformation			
Diana Terris	Barnsley Metropolitan Borough Council	Chief Executive		✓	
Greg Fell	Sheffield City Council	Director of Public Health		✓	
Frances Cunning	Yorkshire & the Humber PHE Centre	Deputy Director – Health & Wellbeing	✓		
Helen Stevens	South Yorkshire and Bassetlaw Shadow ICS	Associate Director of Communications & Engagement	✓		
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer		✓	
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer	✓		
James Scott	South Yorkshire and Bassetlaw Shadow ICS	Senior Programme Manager		✓	
Janet Wheatley	Voluntary Action Rotherham	Chief Executive		✓	
Jeremy Cook	South Yorkshire and Bassetlaw Shadow ICS	Interim Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive		✓	
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Jo Miller	Doncaster Metropolitan Borough Council	Chief Executive		✓	
Julia Burrows	Barnsley Council	Director of Public Health	✓		
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive	✓		
Kirsten Major	Sheffield Teaching Hospital FT	Interim CEO	✓		
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive		✓	
Lesley Smith	NHS Barnsley Clinical Commissioning Group	SYB ACS Deputy System Lead, Chief Officer NHS Barnsley CCG	✓		
Lisa Kell	South Yorkshire and Bassetlaw ICS	Director of Commissioning Reform	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive		✓	
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer		✓	
Mags McDadd	South Yorkshire and Bassetlaw Shadow ICS	Corporate Committee Administrator, Executive PA & Business Manager	✓		
Matthew Groom	NHS England Specialised Commissioning	Assistant Director	✓		Sarah Halstead
Matthew Sandford	Yorkshire Ambulance Service NHS Trust	Associate Director of Planning & Development		✓	
Mike Curtis	Health Education England	Local Director	✓		
Moira Dumma	NHS England	Director of Commissioning Operations		✓	
Neil Priestly	Sheffield Teaching	Director of Finance		✓	

	Hospital FT				
Neil Taylor	Bassetlaw District Council	Chief Executive		✓	
Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		✓	
Patrick Birch	Doncaster Metropolitan Borough Council	Strategic Lead for Adult Transformation	✓		
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Executive Director		✓	
Richard Henderson	East Midlands Ambulance Service NHS Trust	Chief Executive		✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS FT	Chief Executive	✓		
Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Chief Executive	✓		
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		✓	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive	✓		
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health	✓		Jo Miller
Ruth Hawkins	Nottinghamshire Healthcare NHS FT	Chief Executive		✓	
Sarah Halstead	NHS England Specialised Commissioning	Senior Service Specialist and RightCare Associate		✓	
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive		✓	
Simon Morritt	Chesterfield Royal Hospital NHS FT	Chief Executive		✓	
Steve Shore	Healthwatch Doncaster	Chair		✓	
Teresa Roche	Rotherham Metropolitan Borough Council	Director of Public Health		✓	
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		✓	
Victoria Mc Gregor Riley	Bassetlaw CCG	Director of Primary Care	✓		Idris Griffiths
Will Cleary-Gray	South Yorkshire and Bassetlaw Shadow ICS	Chief Operating Officer	✓		
Yvonne Elliott	Primary Care Sheffield	Deputy Chief Executive Officer	✓		

Minute reference	Item	Action
56/18	**Welcome and introductions** The Chair welcomed members to the meeting.	
57/18	**Apologies for absence** The Chair noted the apologies for absence.	
58/18	**Minutes of the previous meeting held 8th June 2018** The minutes of the previous meeting were agreed as a true record and will be posted on the website after this meeting. **www.healthandcaretogethersyb.co.uk**	
59/18	**Matters arising** **Overview of Health and Wellbeing in South Yorkshire and Bassetlaw** The Board was informed that the population health timeout for members to discuss this matter and identify the priorities will be progressed in late September / early October. All other matters arising are on this agenda.	**WCG**
60/18	**National Update** **CEO ICS Report** The acting Chair presented the Chief Executive Officer's report to the meeting. This monthly report provided an update on: • The work of the ICS CEO over the last month. • The number of key priorities not covered elsewhere on the agenda. The report gave a concise update to members regarding the following: • Memorandum of Understanding (MOU) • National ICS Leads meeting – July 2018 • Chief Executive System Leads • Capital Bids • ICS Governance Review • Hospital Services Review update • Hyper Acute Services The Board noted that a draft version of the MOU would be shared with partners in the coming weeks for comment, before taking though individual boards and governing bodies in September for agreement and sign off. Will Cleary-Gray provided feedback to the Board of the NHSE/I operating model – system strategy and development design workshop which he attended earlier this week. Michael McDonnell, National Director, Transforming Health Systems NHSE and his team are supporting the development of the ICS. The main objectives of the workshop were: • to articulate what the operating models should be and how to implement regulators working together; • one headquarters (made up of three organisations – NHS England, NHS Improvement, Monitor), seven regional teams (integrated NHSE and NHSI) forty two Sustainable and Transformation Partnerships (STPs); • a proposal is expected by the end of August. A question was raised in relation to the legal framework in support of the operating model. Will Cleary-Gray responded saying that governance assurance is being applied to the process.	

61/18	**SYB Governance Review** The Collaborative Board received this report from Will Cleary-Gray, Chief Operating Officer ICS. The Board was asked to note the progress being made to review the ICS governance including: • Confirmation of external support • Timeframe for the review • Review the steering group The membership of the governance group is drawn from partner organisations together with non-executive membership from each of the five places, in the form of an audit chair member. The proposed framework for the review by partners will be developed between August and October. Alison Knowles requested the following: • The establishment of a Remuneration Committee. • Boards to record mitigated risks in future. Following discussion the acting Chair noted the request from the Board for improved communication, reassuring openness and transparency, expenditure and expected outcomes on the ICS workplan and agreed to review the communication model between the ICS and partners with the Senior Management Team. The acting chair thanked Will Cleary-Gray for his report.	**LS/ SMT**
62/18	**ICS Capital Bids** The acting Chair welcomed Andrew Pepper to the meeting and invited him to give his presentation to the meeting: Andrew updated the Board on the draft Estate Strategy and Capital Bid submissions made on 16th July. This process enabled all stakeholders the opportunity to input and influence the preparation, review and assurance of bids; including place-based representatives, organisational representatives, workstream-managers, finance-leads and estates-leads. Andrew thanked each organisation for contributing to the process and enabling the ICS to submit a set of coherent system-wide proposals. A consolidation and prioritisation proposal was reviewed by the Executive Steering Group on 19 June 2018 taking into account relative importance of the measurement criteria (being value for money as the highest ranked component, followed by service need and transformation, patient benefit and demand management, deliverability and estate strategy). This was also reviewed by the Strategic Estates Group on 21 June 2018. The bid prioritisation was as follows: ➢ Priority 1: System Sustainability (including Hospital Services Review) ➢ Priority 2: Acute and Elective Reconfiguration of Doncaster and Bassetlaw Hospitals ➢ Priority 3: ICS-wide Cancer Reconfiguration It was noted that should the ICS be successful in its capital bids, the revenue consequences will need to be further reviewed as part of the Business Case process and that all schemes were proposals at this stage. Any changes to how services are currently provided would be subject to NHS assurance and processes and possible public consultation. To date, revenue assumptions include efficiencies identified by organisations, planned income increases linked to productivity improvements and prospective ICS-wide efficiencies based on assumptions from the finance strategy. It was noted that Capital announcements are expected in the Autumn Statement.	

	The acting Chair thanked Andrew Pepper for his presentation and attendance at the meeting.	
63/18	**Hospital Services Review** **Strategic Outline Case** The Collaborative Partnership Board received the report from Will Cleary-Gray, Chief Operating Officer, ICS SYB. Many partner organisations have already given detailed response to the review and board/governing bodies responses received were mostly supportive of the system to take the review and its recommendations to the next stage. The final version is to be circulated on 24th August for discussion at Boards and Governing bodies in September. Members agreed that Governing Bodies and Foundation Trust Boards would be required to arrange extraordinary meetings to support the development and the review process. The Collaborative Partnership Board: • Noted the development of the Strategic Outline Case • Considered the next steps and timeline for the work going forward • Noted the update on workstreams to prepare for the next steps. The acting Chair thanked Will Cleary-Gray for his report.	**CPB members**
64/18	**Digital/IT update against funding awards** The acting Chair welcomed Nicola Haywood-Alexander, Programme Director for the Digital Workstream, SYB ICS, to the meeting and invited her to give her presentation to the meeting. The Collaborative Partnership Board was asked to note the digital priorities, bids and funding and current position: The system-wide priority programmes were noted at follows: 1. Digital interoperability along the patient pathway (82% of Chief Information Officers reported that as highest priority) 2. Population health information and intelligence The Board asked for detailed analysis of place digital capital funding and bids; funding principles and guidance. The acting Chair thanked Nicola Haywood-Alexander for her presentation and attending the meeting.	**NHA**
65/18	**Finance Update** The Collaborative Partnership Board received a verbal update from Jeremy Cook, Finance Director, SYB ICS. The reported position across the ICS at month 3 was reported as a favourable variance against plan of £1.6 million, with all organisations currently forecasting break even against plan before PSF. The System Improvement Plan value is measured before Providers Sustainability Fund (PSF). The Board was asked to note that there is significant risk in the second half of the year due to shortfalls in year to date achievement of efficiencies and plans which are back-ended loaded especially for providers where 67% for Cost Improvement Programmes (CIP) is phased in the second six months. Members were informed that an early warning escalation system is being developed to inform the work of the Finance and Activity Committee and will be shared with the	**JC**

	Executive Steering Group on 21 August. The Collaborative Partnership Board was asked to note the position at month 3 and the risks to achievement of the system improvement plan.	
66/18	**ICS Highlight Report** Lisa Kell, Director of Commissioning Reform SYB ICS introduced the Workstream Highlight Report to the meeting. The Collaborative Partnership Board was asked to note the summary updates on the progress of the Hospital Services Review and in particular the following: • The development of the Strategic Outline Case • Next steps and timeline for the work going forward • Updates on workstreams to prepare for the next steps SROs were asked to consider the report and identify recommendations to future reports. Comments should be forwarded to Lisa Kell. Members agreed to engage in using the Escalation Management System (EMS) wide and asked for clarity on the added value and relevance. The acting Chair thanked Lisa Kell for her report.	**CPB SROs** **CPB members**
67/18	**Minutes of the ICS Governance Group** The minutes were circulated to Collaborative Partnership Board members for their information.	
68/18	**Minutes of the National Primary Care Leads Meeting – Confidential** The minutes were circulated to Collaborative Partnership Board members for their information.	
69/18	**Any Other Business** There was no other business to consider.	
70/18	**Date and Time of Next Meeting** The next meeting will take place at 9.30am to 11.30am on 14th September 2018 in the Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU.	

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South Yorkshire and Bassetlaw Shadow Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

14 September 2018

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

Decision Summary

Minute reference	Item	Action
74/18	**Matters arising** **Digital/IT update against funding awards** The Board was informed that the Executive Steering Board would receive a detailed presentation on Tuesday 18th September. The Board requested clarity on the following: • funds relating to the digital pathology system • funding priority bids submitted All other matters arising are on this agenda.	NHA
75/18	**National Update** **CEO ICS Report** The Board was asked to note that the ICS is mindful of time pressures and the number of meetings CEOs are expected to attend. Therefore a review of the current meeting structures will take place over the coming weeks. HS will produce a summary of all meetings generated by programme directors for review by the SMT.	HS
76/18	**Place Updates** The Chair requested for Alison Knowles to prepare a report for the next meeting in October to include the following: - The integration journey each of our places is on - The timeline for each place - Key system consideration this may require Following discussion, on microsystem coaching, the Board asked Kirsten Major to oversee a scoping exercise on what is offered at a national level and report back to members.	**AK** **KM**
77/18	**Engagement on the Long Term Plan for the NHS** It was noted that the timeframe had been extended in order to collate themes at a Place level. The Board was informed that more responses are expected and a final collated report would be presented to the Collaborative Partnership Board in October.	**LS**

81/18	**ICS Highlight Report** The Board requested that future reports include a summary cover sheet capturing the main highlights on progress for the ICS workstreams and major associated risks.	**LK**

South Yorkshire and Bassetlaw Shadow Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

14 September 2018

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

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw ICS	Chief Executive, SYB ICS	✓		
Adrian England	Healthwatch Barnsley	Chair		✓	
Ainsley Macdonnell	Nottinghamshire County Council	Service Director	✓		
Alison Knowles	Locality Director North of England,	NHS England			✓
Alan Davis	South West Yorkshire Partnership NHS FT	Director of Human Resources		✓	
Andrew Hilton	Sheffield GP Federation	GP		✓	
Ann Gibbs	Sheffield Teaching Hospitals NHS FT	Director of Strategy		✓	
Anthony May	Nottinghamshire County Council	Chief Executive		✓	
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher	✓		
Catherine Burn	Voluntary Action Representative	Director		✓	
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer		✓	
Chris Holt	The Rotherham NHS FT	Deputy Chief Executive and Director of Strategy and Transformation		✓	
Clare Hodgson	EMAS	Assistant Director of Strategy Development and Commercial Services		✓	
Clare Morgan	Sheffield Teaching Hospitals NHS Foundation Trust	Programme Director (Chief Executives Office)		✓	
David Pearson	Nottingham County Council	Deputy Chief Executive		✓	
Des Breen	South Yorkshire and Bassetlaw ICS	Medical Director	✓		
Dominic Blaydon	Rotherham Hospital FT	Associate Director of Strategy and Transformation		✓	
Diana Terris	Barnsley Metropolitan Borough Council	Chief Executive		✓	
Greg Fell	Sheffield City Council	Director of Public Health	✓		
Frances Cunning	Yorkshire & the Humber PHE Centre	Deputy Director – Health and Wellbeing	✓		
Helen Stevens	South Yorkshire and	Associate Director of		✓	

	Bassetlaw ICS	Communications and Engagement			
Ian Atkinson	NHS Rotherham CCG	Deputy Chief Officer	✓		Chris Edwards
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer	✓		
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer	✓		
James Scott	South Yorkshire and Bassetlaw Shadow ICS	Senior Programme Manager		✓	
Janet Wheatley	Voluntary Action Rotherham	Chief Executive		✓	
Jeremy Cook	South Yorkshire and Bassetlaw Shadow ICS	Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive		✓	
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Jo Miller	Doncaster Metropolitan Borough Council	Chief Executive		✓	
Julia Burrows	Barnsley Council	Director of Public Health	✓		
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive		✓	
Kirsten Major	Sheffield Teaching Hospital FT	Interim CEO	✓		
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive		✓	
Lesley Smith	NHS Barnsley Clinical Commissioning Group	SYB ACS Deputy System Lead, Chief Officer NHS Barnsley CCG	✓		
Lisa Kell	South Yorkshire and Bassetlaw ICS	Director of Commissioning Reform	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive	✓		
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer	✓		
Mags McDadd	South Yorkshire and Bassetlaw Shadow ICS	Corporate Committee Administrator, Executive PA and Business Manager	✓		
Matthew Groom	NHS England Specialised Commissioning	Assistant Director	✓		Sarah Halstead
Matthew Sandford	Yorkshire Ambulance Service NHS Trust	Associate Director of Planning and Development		✓	
Mark Janvier	NHS England - North	Head of Operations and Delivery	✓		Alison Knowles
Mike Curtis	Health Education England	Local Director		✓	
Moira Dumma	NHS England	Director of Commissioning Operations		✓	
Neil Priestly	Sheffield Teaching Hospital FT	Director of Finance		✓	
Neil Taylor	Bassetlaw District Council	Chief Executive		✓	

Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		✓	
Patrick Birch	Doncaster Metropolitan Borough Council	Strategic Lead for Adult Transformation		✓	
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Executive Director		✓	
Richard Henderson	East Midlands Ambulance Service NHS Trust	Chief Executive		✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS FT	Chief Executive	✓		
Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Chief Executive	✓		
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		✓	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive	✓		
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health	✓		Jo Miller
Ruth Hawkins	Nottinghamshire Healthcare NHS FT	Chief Executive		✓	
Sandra Crawford	Nottinghamshire Healthcare NHS FT	Associate Director of Transformation Local Partnerships Division	✓		Paul Smeeton
Sarah Halstead	NHS England Specialised Commissioning	Senior Service Specialist and RightCare Associate		✓	
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive		✓	
Simon Morritt	Chesterfield Royal Hospital NHS FT	Chief Executive	✓		
Steve Shore	Healthwatch Doncaster	Chair		✓	
Teresa Roche	Rotherham Metropolitan Borough Council	Director of Public Health		✓	
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		✓	
Will Cleary-Gray	South Yorkshire and Bassetlaw ICS	Chief Operating Officer	✓		
Yvonne Elliott	Primary Care Sheffield	Deputy Chief Executive Officer		✓	

Minute reference	Item	Action
71/18	**Welcome and introductions** The Chair welcomed members to the meeting.	
72/18	**Apologies for absence** The Chair noted the apologies for absence.	
73/18	**Minutes of the previous meeting held 8th June 2018** The minutes of the previous meeting were agreed as a true record and will be posted on the website after this meeting. **www.healthandcaretogethersyb.co.uk**	
74/18	**Matters arising** **Digital/IT update against funding awards** The Board was informed that the Executive Steering Board would receive a detailed presentation on Tuesday 18th September. The Board requested clarity on the following: • funds relating to the digital pathology system • funding priority bids submitted All other matters arising are on this agenda.	**NHA**
75/18	**National Update** **CEO ICS Report** The Chair presented the Chief Executive Officer's report to the meeting. This monthly report provided an update on: • The work on of the ICS CEO over the last month • The number of key priorities not covered elsewhere on the agenda. The report gave a concise update to members regarding the following: • Memorandum of Understanding (MOU) • ICS ways of working / governance review • Commissioning Review • Chief Executive System Leads • Hospital Services – Strategic Outline Case (SOC) • Long Term Plan The Chair provided feedback to the Board of the ICS Leads Development Day which he attended on 12th September. The main objectives of the day were: • Inspecting Systems – insight from the CQC • NHS 10 year plan – presented by Ben Dyson and Ivan Ellul • Financial regime 2019/20 • Deep Dive – Mental Health • Learning from the ICS The Board was informed that ICS Leads had the opportunity to input to the emerging system architecture with NHS England and NHS Improvement. The Board discussed in detail the key themes of the day and in particular workforce issues, primary care and the establishment of neighbourhood and the financial framework. It was noted that Sheffield Teaching Hospitals NHS Trust are hosting a visit from NHS Improvement in 1st October to establish a clear view of the benefits of group	

	models. The Board was asked to note that the ICS is mindful of time pressures and the number of meetings CEOs are expected to attend. Therefore a review of the current meeting structures will take place over the coming weeks. HS will produce a summary of all meetings generated by programme directors for review by the SMT. The Chair added that the South Yorkshire and Bassetlaw ICS needs to consider new ways of working to respond to changes nationally, in line with new governance arrangements. It was noted that new arrangements from April 2019 would consider a Guiding Coalition to include an inclusive cohort of all provider and CCG Boards, Governing bodies, Healthwatch, local councils and the Citizens' Panel. The Chair advised that members would have the opportunity to contribute to the new ICS structure over the coming month.	**HS**
76/18	**Place Updates** The Chair requested a representative from each 'place' to provide a brief verbal update on progress: <u>Doncaster</u> - System transformation arrangements are now in place - Currently reviewing governance - Testing new models of service delivery - Moving towards integration with joint partners and progressing to look at teams. - Ongoing work with the local authority on neighbourhood model - Progress to support new contracting arrangements - Some front line staff are now using a new Integrated Digital Care Record and hope to roll this out further - Progressing with streamlining and simplifying commissioning. <u>Bassetlaw</u> - Established a programme team. Programme Directors (job share) in post, currently appointing administration and project manager to support. Posts jointly funded by partners to the place partnership - Springboard event held identifying population health priorities and supporting workstreams - Social care commitment with alignment of staff with Primary Care Homes (PCH). - Exampled of PCH initiatives include the establishment of a Citizens Advice service in a GP practice; children's counselling service and a social prescribing triage clinic - Collaborative working with local authorities to establish accommodation units linked to hospital discharge to support vulnerable patients - Progressing the integration of community and mental health services alongside patient centred care and use of patient activation <u>Rotherham</u> - Rotherham Place Plan updated – to be agreed by partners - 24/7 Mental Health liaison service planned to go live from October - Integrating physical and mental health care e.g. Care Co-ordination - Established a new intermediate care vision <u>Sheffield</u> - Workstream update – ongoing - Prioritising: reduce smoking; reduce obesity; improve older care - Sheffield outcomes project; early parenting; hospital admissions - Working through financial reforms - Ongoing reviewing of commissioning <u>Barnsley</u> - Noted the place based approach to integrating service provision and commissioning activities and the publication of the Strategic Outline Case outlining that vision for Barnsley. Currently exploring the novel	

	contract route via the ISAP process versus how far can we go towards full integration through collaboration and partnership working. Following discussion the Board agreed that it would be helpful to put some structure around the 'place' updates. The Chair requested for Alison Knowles to prepare a report for the next meeting in October to include the following: - The integration journey each of our places is on - The timeline for each place - Key system consideration this may require Following discussion, on microsystem coaching, the Board asked Kirsten Major to oversee a scoping exercise on what is offered at a national level and report back to members.	**AK** **KM**
77/18	**Engagement on the Long Term Plan for the NHS** The Collaborative Partnership Board received this report from Lesley Smith, Deputy System Lead and Chief Executive System Lead for the Strategy, Planning and Transformation Delivery. The report provided a high level overview of the key themes emerging from system partners as part of the engagement on the Long Term Plan for the NHS from system partners. The Board was asked to note the need to develop and establish a workforce that is equipped to deliver the national and local priorities to support integrated service delivery. It was noted that the timeframe had been extended in order to collate themes at a Place level. The Board was informed that more responses are expected and a final collated report would be presented to the Collaborative Partnership Board in October. The Chair thanked Lesley Smith for her report.	**LS**
78/18	**Hospital Services Review** **Strategic Outline Case** The Collaborative Partnership Board received the report from Alexandra Norrish, Programme Director, Hospital Services Review, SYB ICS. Boards, Governing Bodies and members of the public have now given their feedback on the recommendations within the report. Partner organisations largely support the recommendations and therefore the Strategic Outline Case (SOC) reflects this support with two main changes: • It gives greater emphasis and focus to the need for transformation of the workforce. • It outlines that the Clinical Working Groups on maternity and paediatrics will be asked to explore a wider range of clinical models that could satisfy interdependencies between maternity and paediatrics. The SOC had been discussed and approved at the Governing Bodies of Bassetlaw; Doncaster, Rotherham, Barnsley and Sheffield CCGs. Governing Bodies had been asked to confirm in writing their formal sign off of the SOC. The Chair thanked Alexandra Norrish for her report. The Collaborative Partnership Board noted the contents of the report.	
79/18	**Finance Update**	

	The Collaborative Partnership Board received the report from Jeremy Cook, Finance Director, SYB ICS. The Board noted that there is a risk of loss of system provider sustainability funding (PSF) if the system does not meet its quarterly phased system improvement plan value up to an annual cap of £5.7m. As Q1 is confirmed the residual risk for the remainder of the year is £4.8m. It was noted that both the year-to-date and the forecast position before PSF are showing favourable variances, however, there is a need to improve the current run-rate in order to deliver the system improvement plan value – the current forecast is £0.840 million better than plan. Year to date position at Month 4 is also a favourable variance against plan of £4.2m excluding PSF, all organisations are forecasting break even or better against plan before PSF. CIP and QIPP schemes are behind plan year-to-date and forecast. There is a need to ensure that a strong focus remains on CIP and QIPP delivery: The key financial risks were noted as follows: • Plan Alignment Gap: There is a £15.6m plan alignment gap between commissioners and provider within the Doncaster and Bassetlaw and Sheffield systems; • CIP / QIPP delivery gap: There is a £29.2m stretch on CIP/QIPP delivery compared to 2017-18 out-turn; • CIP / QIPP phasing: CIP plans are phased 67% in the last six months and QIPP plans are phased 55% in the last six months. The ICS Director of Finance informed the Board that he will be visiting local-systems in September to review risk and mitigation plans on a place-basis where risk is considered to be high. The proposed Finance and Activity Committee will provide ICS-level scrutiny of risks, mitigations and recovery plans. The Collaborative Partnership Board was asked to note the contents of the report and in particular the position at Month 4 and the risks to achievement of the system improvement plan. The Chair thanked Jeremy Cook for his report.	
80/18	**Memorandum of Understanding** The Collaborative Partnership Board received the report from Will Cleary-Gray, Chief Operating Officer, SYB ICS. The Board was asked to note the final version of the national Memorandum of Understanding (MOU) for South Yorkshire and Bassetlaw Integrated Care System. The MOU is consistent with previous drafts which were shared with partner organisations for discussion. The MOU will now be considered in context of feedback from partner discussions and review of governance and ways of working across the South Yorkshire and Bassetlaw system. The Board was asked to note the date for final sign off is 1st October 2018. The Collaborative Partnership Board noted the contents of the report. The Chair thanked Will Cleary-Gray for his report.	
81/18	**ICS Highlight Report** The Collaborative Partnership Board received the ICS Highlight Report from Lisa Kell, Director of Commissioning, SYB ICS. Unfortunately, as the meeting had overrun, the report was not discussed in detail. The Chair requested that this agenda item appear at the beginning of future Collaborative Partnership Board agendas.	

	The Board requested that future reports include a summary cover sheet capturing the main highlights on progress for the ICS workstreams and major associated risks. The Chair thanked Lisa Kell for her report.	**LK**
82/18	**SYB ICS Yorkshire and Humber Applied Research Collaboration (ARC) bid** Richard Stubbs, Chief Executive, The Yorkshire and Humber Academic Health Science Network provided a verbal update to the Board. The Board were informed that the bid was submitted and anticipating a response by the end of September 2018. The Chair thanked Richard Stubbs for the update.	
83/18	**Any Other Business** There was no other business to consider.	
84/18	**Date and Time of Next Meeting** The next meeting will take place at 9.30am to 11.30am on 19th October 2018 in the Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU.	

South Yorkshire and Bassetlaw Shadow Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

19 October 2018

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

Decision Summary

Minute reference	Item	Action
88/18	**Matters arising** **Place Update – Microsystem Coaching** Richard Jenkins agreed to undertake a scoping exercise and report back to the Executive Steering Group.	**RJ**
91/18	**Development of Integrated Care in Places** The Board requested that the slides be circulated to members following the meeting.	**MM**

South Yorkshire and Bassetlaw Shadow Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

19 October 2018

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

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw ICS	Chief Executive, SYB ICS	✓		
Adrian England	Healthwatch Barnsley	Chair		✓	
Ainsley Macdonnell	Nottinghamshire County Council	Service Director	✓		
Alison Knowles	Locality Director North of England,	NHS England	✓		
Alan Davis	South West Yorkshire Partnership NHS FT	Director of Human Resources	✓		
Andrew Hilton	Sheffield GP Federation	GP		✓	
Ann Gibbs	Sheffield Teaching Hospitals NHS FT	Director of Strategy		✓	
Anthony May	Nottinghamshire County Council	Chief Executive		✓	
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher		✓	
Catherine Burn	Voluntary Action Representative	Director		✓	
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer	✓		
Chris Holt	The Rotherham NHS FT	Deputy Chief Executive and Director of Strategy and Transformation		✓	
Clare Hodgson	EMAS	Assistant Director of Strategy Development and Commercial Services	✓		
Clare Morgan	Sheffield Teaching Hospitals NHS Foundation Trust	Programme Director (Chief Executives Office)		✓	
David Pearson	Nottingham County Council	Deputy Chief Executive		✓	
Des Breen	South Yorkshire and Bassetlaw ICS	Medical Director	✓		
Dominic Blaydon	Rotherham Hospital FT	Associate Director of Strategy and Transformation		✓	
Diana Terris	Barnsley Metropolitan Borough Council	Chief Executive		✓	
Giles Ratcliffe	Public Health England	Consultant Specialised Commissioning	✓		Frances Cunning
Greg Fell	Sheffield City Council	Director of Public Health		✓	
Frances Cunning	Yorkshire & the Humber	Deputy Director – Health		✓	

	PHE Centre	and Wellbeing			
Helen Stevens	South Yorkshire and Bassetlaw ICS	Associate Director of Communications and Engagement	✓		
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer	✓		
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer		✓	Hayley Tingle
James Scott	South Yorkshire and Bassetlaw ICS	Senior Programme Manager		✓	
Janet Wheatley	Voluntary Action Rotherham	Chief Executive		✓	
Jeremy Cook	South Yorkshire and Bassetlaw ICS	Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive		✓	
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Jo Miller	Doncaster Metropolitan Borough Council	Chief Executive		✓	
Julia Burrows	Barnsley Council	Director of Public Health	✓		
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive		✓	
Kirsten Major	Sheffield Teaching Hospitals NHS FT	Interim CEO	✓		
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive	✓		
Lesley Smith	NHS Barnsley Clinical Commissioning Group	SYB ACS Deputy System Lead, Chief Officer NHS Barnsley CCG	✓		
Linda Crofts	HEE	Workforce Transformation Lead	✓		Mike Curtis
Lisa Kell	South Yorkshire and Bassetlaw ICS	Director of Commissioning Reform	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive	✓		
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer	✓		
Mags McDadd	South Yorkshire and Bassetlaw ICS	Corporate Committee Administrator, Executive PA and Business Manager	✓		
Matthew Groom	NHS England Specialised Commissioning	Assistant Director	✓		
Matthew Sandford	Yorkshire Ambulance Service NHS Trust	Associate Director of Planning and Development		✓	
Mike Curtis	Health Education England	Local Director		✓	
Moira Dumma	NHS England	Director of Commissioning Operations		✓	
Neil Priestley	Sheffield Teaching Hospitals NHS FT	Director of Finance		✓	
Neil Taylor	Bassetlaw District Council	Chief Executive		✓	

Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		✓	
Patrick Birch	Doncaster Metropolitan Borough Council	Strategic Lead for Adult Transformation		✓	
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Executive Director	✓		
Richard Henderson	East Midlands Ambulance Service NHS Trust	Chief Executive		✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS FT	Chief Executive	✓		
Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Chief Executive	✓		
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		✓	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive		✓	
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health	✓		Jo Miller
Ruth Hawkins	Nottinghamshire Healthcare NHS FT	Chief Executive		✓	
Sandra Crawford	Nottinghamshire Healthcare NHS FT	Associate Director of Transformation Local Partnerships Division		✓	
Sarah Halstead	NHS England Specialised Commissioning	Senior Service Specialist and RightCare Associate		✓	
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive		✓	
Simon Morritt	Chesterfield Royal Hospital NHS FT	Chief Executive	✓		
Steve Page	Yorkshire Ambulance Service	Executive Director Quality, Governance & Performance Assurance / Deputy CEO	✓		Rod Barnes
Steve Shore	Healthwatch Doncaster	Chair		✓	
Teresa Roche	Rotherham Metropolitan Borough Council	Director of Public Health	✓		
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		✓	
Will Cleary-Gray	South Yorkshire and Bassetlaw ICS	Chief Operating Officer	✓		
Yvonne Elliott	Primary Care Sheffield	Deputy Chief Executive Officer		✓	

Minute reference	Item	Action
85/18	**Welcome and introductions** The Chair welcomed members to the meeting. The Chair informed the Board that no decisions were required at the meeting and the main focus of today's meeting were: • National update on the Long Term Plan • Cancer – 62 day performance and 31 day performance • SYB ICS Governance review update	
86/18	**Apologies for absence** The Chair noted the apologies for absence.	
87/18	**Minutes of the previous meeting held 14th September 2018** The minutes of the previous meeting were agreed as a true record and will be posted on the website after this meeting. **www.healthandcaretogethersyb.co.uk**	
88/18	**Matters arising** **Place Update – Microsystem Coaching** Richard Jenkins agreed to undertake a scoping exercise and report back to the Executive Steering Group. All other matters agenda arising were actioned or noted on the agenda.	**RJ**
89/18	**National Update** **CEO ICS Report** The Chair presented the Chief Executive Officer's report to the meeting. The monthly report provided an update on: • The work on the ICS CEO over the last month • Update on a number of key priorities not covered elsewhere on the agenda The report gave a concise update to the Board regarding the following: • ICS Performance Scorecard • South Yorkshire and Bassetlaw Integrated Care System official launch • ICS ways of working / governance review • Memorandum of Understanding (MOU) • Public Engagement Workshop • Long Term Plan • Local Health Care Record Exemplar (LHCRE) • Sharing systems good practice – North of England The Chair informed the Board that the ICS performance scorecard highlighted the collective position at July 2018 as compared with other areas in the North of England and other ICSs. It was noted that the two area underachieving are; 31 day cancer standards (currently 95.3% - the standard being 96%) and Cancer 62 day standard (currently 82.9% - standard being 85%). The Board noted that a big emphasis has been put on the increasing number of urology referrals, predominantly influenced by the high media attention from celebrities and this has been felt locally, as well as an increase in breast symptomatic referrals.	

	The Board was advised that a number of recovery incentives are in place and additional transformation funding has been allocated nationally to support improvements of which the North will receive a proportion. The Chair added that the system is working with colleagues across NHSI and NHSE on an overall plan to support the Cancer Alliance to achieve a more stable position and get a long term sustainable result in trust performance. The Chair informed the Board that the governance review is progressing within the timeframe, with the ambition to have a draft proposal for discussion in December 2018 and new arrangements commencing from April 2018. It was noted that any new arrangements would be within the current legal framework and would not change any of the statutory accountabilities of organisations. The Board was asked to consider the proposal of an ICS place based meeting in Q3 and Q4 to identify improvement issues at a system level. The meeting would be chaired by Sir Andrew Cash with representation from NHSE and NHSI. This meeting would be in addition to place meetings already scheduled with NHSE/I. Alison Knowles added that a report will be presented to the Senior Executive Team on 23rd October for consideration. The Chair concluded that the proposal required careful consideration and would take on board the views of the members. The Chair asked the Board to note that Yorkshire and the Humber have received funding of £7.5m for the Local Health Care Record Exemplar (LHCRE) – the ambitious objective is to integrate health and care records across the region to improve care.	
90/18	**ICS Highlight Report** The Collaborative Partnership Board received the ICS Highlight Report from Lisa Kell, Director of Commissioning, SYB ICS. The report provided a summary identifying progress and key risks in relation to each of the SYB ICS workstreams. SROs were asked to consider the report and identify recommendations to future reports. Comments should be forwarded to Lisa Kell. The risks identified relate to the following workstreams – Cancer Alliance performance; Children and Emergency, Digital, Elective and Diagnostics, Mental Health and Learning Disabilities, Prevention and Radiology. This new format of reporting was welcomed by the Board. The Chair thanked Lisa Kell for her report.	
91/18	**Development of Integrated Care in Places** The Collaborative Partnership Board received a report and powerpoint presentation from Alison Knowles, Locality Director – NHS England North (Yorkshire and Humber). Alison Knowles presented the current position on digital priorities, bids and funding. The digital vision is for all residents in South Yorkshire and Bassetlaw to have access to and to use digital technology and information in order to improve or maintain their own health and wellbeing. The Board noted that Mark Janvier is leading this project and will be contacting each place for representation to join the working group. The Board requested that the slides be circulated to members following the	MM

	meeting. Alison Knowles proceeded to present her report on Development of Integrated Care in Places. The Board noted that following verbal updates for each place at the previous Collaborative Partnership Board, it was agreed to produce a report capturing a structured, standardised approach at place, next steps and key priorities. The report provided updates on: • The development of the national policy around integrated care as part of the forthcoming NHS Long Term Plan • The progress made within each of the five places. It was noted that a quarterly update in this format will be produced so that the wider ICS can understand the progress in each place and consider the opportunities for collaborative working as a system. The report provided detailed updates from each place structured around five domains: Governance; Population health; Data and information; Payments and incentives, Co-ordinated delivery. The next steps for the five places were noted as follows: ➢ Focus on Population Health ➢ Payments and incentives ➢ Governance ➢ Co-ordinated delivery Following discussion, the Board agreed for Alison Knowles to attend the Programme Director's meetings at each place to support the data collection for future reports. The Collaborative Partnership Board was asked to note the contents of report. The Chair thanked Alison Knowles for her report.	AK
92/18	**Long Term Plan** The Collaborative Partnership Board received this report from Helen Stevens, Associate Director Communications and Engagement STB ICS. The report provided the high level overview of the key themes from system partners as part of the engagement on the Long Term Plan for the NHS. The Board was asked to note that the Long Term Plan is due to be published in late November / beginning of December 2018. From December 2018 – March 2019 staff, patients, the public and other stakeholders will have the opportunity to help local health and care organisations determine what the plan means for their area, and how best the ambitions it sets out can be met. Partners within SYB ICS will want to determine how this will work in each place and at a system level. The Chair asked the Board to note the dates of the Long Term Plan Engagement Event taking place in London on 22nd October and York on 29th October. The Board was encouraged to attend where possible to ensure representation from SYB ICS. The Chair thanked Helen Stevens for her report.	
93/18	**Population Health Management** The Collaborative Board received this report from Lisa Kell Director for Commissioning, SYB ICS, Maddy Ruff, SYB Chief Executive System Lead for	

	Primary Care, Population Health and Prevention and Dr Rupert Suckling Director of Public Health, Doncaster. The Board was informed that NHSE had mandated through its 2018/19 MOU with the ICS, the development of a population health function that facilitates the integration of services focused on populations across each place that are most at risk of developing acute illness and hospitalisation. Systems will build skills and capacity to implement population health management and make significant progress towards full maturity of the three NHSE population health management capabilities through a system-wide plan setting out locally determined population health priorities. The report provided an overview of the approach being taken to introduce population health in South Yorkshire and Bassetlaw and the next steps. Maddy Ruff asked the Board to note that engagement with Health and Care partners was imperative and that population health approaches should underpin all ICS workstreams. A PHM delivery group has been established with representation from the five places. The Board was informed that a progress report will be presented at the next meeting. The Chair thanked Maddy Ruff, Dr Rupert Suckling and Lisa Kell for their report.	
94/18	**Prevention and Social Prescribing** The Collaborative Board received this report from Dr Lisa Wilkins, Consultant in Public Health Medicine, SYB ICS. The report provided an update on progress of the three agreed priority areas within the ICS Prevention Workstream as follows: 1. Embedding tobacco treatment dependency in secondary care – the QUIT programme 2. Systematic quality improvement in the identification and management of clinical risk factors for cardiovascular disease (Atrial fibrillation,, hypertension and cholesterol) 3. To increase access for a wider range of residents for South Yorkshire and Bassetlaw to social prescribing; a gateway to accessing non-medical forms of support and to empower clients to enhance their own well-being. The Board noted that as part of the QUIT programme, Tackling Tobacco Dependency in Secondary Care Event is taking place on, 7th November 2018, 9-12 noon, St Mary's Conference Centre, Sheffield. The event is supported by a number of executive and senior executives. The Board was asked to encourage representation from their organisations. The Board was informed that all five places in South Yorkshire and Bassetlaw have a social prescribing service, Although all the services have developed differently to meet local needs, all have the same core principles. The objective is to further increase the social prescribing offer through collaborative partnership, stakeholder engagement including the voluntary and community sector and citizens, volunteers and the public; building on existing services and sharing best practice. The Board noted the contents of the report and the recommendations listed within the report in order to progress with the three prevention workstream priorities. The Chair thanked Dr Lisa Wilkins for her report.	
95/18	**Hospital Services Programme Update** The Collaborative Board received the Hospital Service Programme update report from Alexandra Norrish, Hospital Services Programme Director.	

	The Board was informed that all CCG Governing Bodies have signed off the Strategic Outline Case (SOC) of the Hospital Services Review (HSR) and the SOC will be published following ratification at this meeting. The report included details of feedback received from the governing bodies and trusts. Following discussion the Collaborative Partnership Board agreed the sign off of the SOC and the plans for publication. Alexandra Norrish informed the Board that in light of feedback received from Boards, governing bodies, and various groups and organisations around the final HSR report, a small number of changes was proposed in the following areas: 1. Access – Transfers of Care / Choice / Bed capacity 2. Quality – Out of area transfers / Improving or maintaining quality 3. Equality Following discussion, the Collaborative Partnership Board agreed to the refresh of the evaluation criteria for the Hospital Services Programme as detailed within the report. The Board received an update on the progress of the HSP Reference Group from their meeting on 22nd September 2018 and the Board will continue to receive progress reports. The Board was asked to formally approve the new name for the HSP going forward as "Working Together on Hospital Services". The Board approved the recommendation. The Chair thanked Alexander Norrish for her reports.	
96/18	**Finance Update** The Collaborative Partnership Board received the report from Jeremy Cook, Finance Director SYB ICS. The Board noted that the planning guidance for 2019/20 is due in November 2018. A System Efficiency Board workshop was held on 29th September with a further workshop scheduled for 16th November. The Board was advised that the financial positon at month 5 is a favourable variance against plan of £2.3m with all organisations forecasting achievement against plan. This is despite efficiency savings showing an adverse variance against plan at month 5 of £1.8 m and a forecast adverse variance of £2.7m. The key financial risks are in delivery of the efficiency savings in the second half of the year as a number of plans are back end loaded. The Board received an update on the financial framework 2019/20 and the workshop attended by Jeremy Cook on 21st September. A co-ordinated response collated from feedback from South Yorkshire and Bassetlaw Directors of Finance and Chief Operating Officers was submitted to NHSE/I on 4th October for consideration. The planning guidance for 2018/20 is due to be published in November. The Chair thanked Jeremy Cook for is report.	
97/18	**Any Other Business** There was no other business to consider.	
98/18	**Date and Time of Next Meeting** The next meeting will take place at 9.30am to 11.30am on 9th November 2018 in the Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU.	

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Health & Wellbeing Board
4th December 2018

Public Questions

The following question has been received from Councillor Malcolm Clements:

In the light of a series of adverse CQC inspection reports, which question whether the Barnsley Healthcare Federation is a fit and proper organisation to provide healthcare to Barnsley residents, will the Board request reports on the effectiveness of the Federation in delivering against Health & Wellbeing Strategy priorities?

Lesley Smith, Barnsley CCG Chief Officer, will respond orally at the meeting.

Barnsley MBC,
Core Service Directorate
20th November 2018

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REPORT TO THE HEALTH AND WELLBEING BOARD

4th December 2018

Barnsley Wellbeing Service

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1. Purpose of Report

1.1 To update HWB on the current and proposed Business Case for the Barnsley Wellbeing Service

2. Delivering the Health & Wellbeing Strategy

2.1 The new Wellbeing Service will contribute significantly to the delivery of the strategy – primarily around its approach to widely improve Health and Wellbeing and to reduce health and social inequalities across Barnsley

A key feature of the new service also supports the whole system actions to;
- Focus on the greatest areas of need
- Build strong and resilient communities
- Make prevention everyone's business

3. Recommendations

3.1Health and Wellbeing Board members are asked to:-

- Consider the principles set out in the Business Case for developing a new Wellbeing Service that focuses on the root causes of ill-health and tackling inequalities.
- Support the commissioning of the new interim service from January 2019 to test out and measure the outcomes.

4. Introduction/ Background

4.1 The business case presents a proposal for the development of community-based support for people to improve their physical and mental well-being. A more holistic approach has been considered to address health inequalities, focusing resources and efforts on

tackling the root causes of ill-health, many of which also present significant public health problems in Barnsley. We are calling this approach **Barnsley Wellbeing Service**.

4.2 This comes following the withdrawal of the current Healthy Lifestyles provider, Be Well Barnsley (Person Shaped Support) - the contract finished on 31st October 2018. This decision was taken by PSS in April 2018 on the strength of the service being unsustainable, which led to a review of the service and an opportunity to look at what is being delivered and whether this continues to be fit for purpose.

4.3 Many of the groups that were co-ordinated by PSS were often delivered in partnership with other organisations e.g. Fit Reds, Barnsley Premier Leisure, or commissioned locally through e.g. Area Councils. It is anticipated that some of these groups will continue, but we propose to offer funding to extend or develop new groups based on local needs. In addition, positive developments in 'My Best Life' Social Prescribing, Befriending (RVS) Peer Support (DIAL etc) and Supported volunteering (VAB) are all examples of projects designed to help and empower people to improve their own sense of wellbeing in their local communities.

4.4. Importance of Addressing inequalities

In line with local and national strategies, we aim to reduce health inequalities, all of which are linked to circumstances in which people are born, grow, live, work and age, and broadly described as the social determinants of health. Our proposal is to move away from services that traditionally and solely focus on 'unhealthy' lifestyle behaviours that often lead to health conditions such as obesity, type 2 diabetes, cancers and heart disease. All of these issues remain important, and a number of support services will remain in place to provide health related support to change behaviour etc.

4.5 The Marmot Review (2010) details key actions to reduce health inequalities, in order to break links between disadvantage and poor (health) outcomes; including the development of social capital. Local authorities have a role to play in this (Kings Fund 2013) and there is growing recognition that whilst some communities and social groups experience the greatest health inequalities, they also have assets at the social and community level that can help improve health, strengthen resilience and improve health outcomes. This work has already begun in Barnsley through Area Governance arrangements and the place based agenda.

4.6. Positive health outcomes can only be achieved by addressing the factors that protect and create health and wellbeing and many of these are at a community level. Community life, social connections and having a voice in local decisions are all factors that have a vital contribution to make to health and wellbeing. These community determinants build control and resilience and can help buffer against disease and risk factors like smoking, obesity, and drug and alcohol use. (Health Matters, PHE 2018)

4.7 The rising levels of rising obesity in Barnsley remain a priority, but again, recommendations from NICE (2012) and Public Health England promote a system-wide approach to tackling obesity, and not focusing solely on individual behaviour change to e.g. lose weight as a single outcome. The determinants of obesity are complex, including factors of; genetic disposition, early life nutrition and growth, individual lifestyle, psychological issues, the physical and cultural environment, food production and consumption, education, social and economic factors and the influence of the media (Foresight 2007).

4.8 As the evidence for achieving Weight management outcomes and sustained weight loss in the longer term is limited, we are focusing on a more population based approaches and developing some of the other behaviour change techniques, where evidence is still emerging. These include; Social Support (Practical and emotional) changes to the social environment, goal setting, self-monitoring (NICE Behaviour Change Individual Approaches (2014) and NICE Weight Management: lifestyle services for overweight or obese adults (2014a)

4.9 What do our residents say?

Barnsley Council has also taken a closer look at what health means to local people as part of the DPH Annual Report. In 2017, 'A Day in the Life' involved the completion of a short diary by local residents about their physical and mental health, and what made it better or worse. This work confirmed that health is shaped about 'where and how we live' and that there is still a need to '….reduce the stark inequalities which mean the most vulnerable and most deprived bear the heaviest burden of disease' and so it is important to create and sustain good health and wellbeing across the life course in Barnsley (DPH 2017).

There were a number of themes that residents identified and these were broadly categorised as; sleep, resilience, reference to Five Ways to Wellbeing, physical activity and connections – very few people identified specific 'lifestyle' behaviours as something they associated with their own sense of 'wellbeing.' We know that Lifestyle behaviours are not always prioritised by individuals, primarily because they are managing other issues in their lives that also impact on health and wellbeing. Given that obesity prevalence continues to increase, there is some suggestion that traditional weight management programmes have not provided a sustainable solution, and provides a rationale for different approach.

4.10 This provided some good local intelligence about how people are feeling about their health and wellbeing with some examples of people who feel that they 'can' and do take control of their own health and wellbeing, and those that 'can't' or 'won't' because of their personal circumstances or confidence/resilience to do so.

No single agency or solution can address this problem. A wide range of partners should work together to develop and implement community-wide approaches to tackle these determinants.

5. Developing a new Wellbeing Service for Barnsley

The development of the new Wellbeing Service for Barnsley will be in line with local (and national) strategy to reduce health inequalities, all of which are linked to circumstances in which people are born, grow, live, work and age, and broadly described as the social determinants of health, that are well recognised to have an impact on our health and wellbeing, and demonstrate the complexities of factors that impact on health.

There is also an increased focus on empowering people to take more control over their health and wellbeing, and this can be facilitated through effective engagement and connections within their own communities, but also ensuring that for those people who find it difficult to engage – support is available to help them do so.

5.1 Proposed Approach.

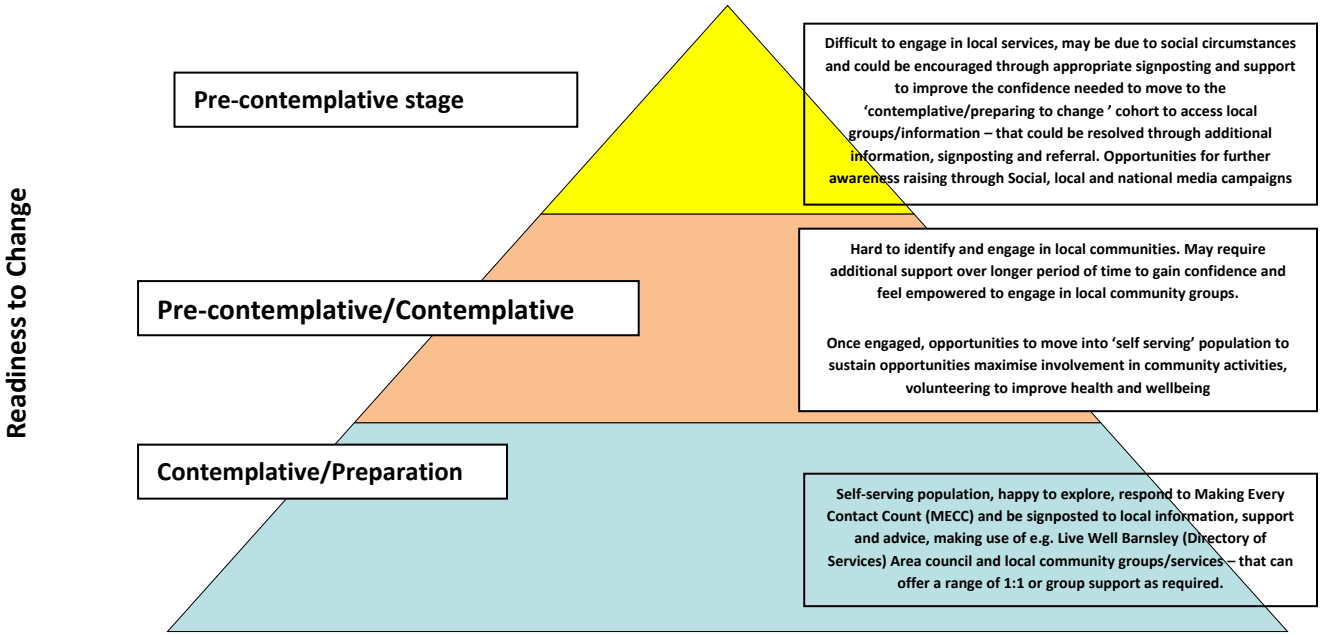
We will commission 2 types of services to help people engage with their wellbeing. These are:

1. Locally defined population based support services/groups/projects delivered through Area Teams where local needs can be identified and services/projects can be built to address wider Wellbeing and public health outcomes in local communities.
2. Planned 8-12 week Wellbeing Support Programme to offer 1:1 (and/or group) support to address specific issues around physical activity and diet/nutrition in local community settings – this was identified as a gap in current service, especially for those requiring more specialist support.

The development of these proposals has not been done in isolation. The basis of the work has been to ensure that where possible, we join up and add value to existing provision rather than re-invent similar or new services and run the risk of duplication. The view is that much of the support is available already for people – the key is around engagement and access to these services, 'readiness' to change and how to empower and enable people to self-serve.

5.2 Proposed Service Model

Prochaska and DiClemente's Transtheoretical Model of behaviour change (1983) describes the various stages in the process of people's 'readiness' to change. In light of the available evidence relating to health inequalities and community engagement, it is important to consider those who are ready (contemplative stage) and those that are not ready to make changes (pre-contemplative – they don't consider their behaviour to be a problem) which may for a range of reasons including lack of capacity, support, knowledge or skills.



5.3 Proposed Framework & Outcomes

Working together to take action on a broad range of issues impacting on health and wellbeing is a process that should lead to improvements in the determinants of health, which will enable people to feel more in control of their own health and wellbeing. Five Ways to Wellbeing offers an evidence based framework that are fundamental to improving people's sense of mental wellbeing. It is proposed that the framework will be used as the basis for allocation of Area Team Wellbeing grants:

CONNECT – Provides opportunities to promote/offer regular contact with people such as family, friends, work colleagues or neighbours e.g. through local interest groups, cook & eat sessions for families, luncheon clubs, reducing social isolation/loneliness, peer support initiatives
BE ACTIVE – Links to activities promoting Physical activity or ways to reduce inactivity through e.g. walking groups, dancing, gardening, or just keeping moving.
TAKE NOTICE – Encouraging awareness of the world around and its impact on individuals/communities. Be curious and notice what needs to change and how that might happen. Reflecting on experiences to help appreciate what is important. E.g. building healthier, supportive and strong communities
KEEP LEARNING – Opportunities to learn or try something new, or rekindled a previous interest, e.g. developing skills and knowledge around healthy lifestyles (weight management, smoking and alcohol), supporting access to employment (job clubs, budgeting) housing (warm homes, fuel poverty)
GIVE - Provides opportunities to give time to something or someone in the community e.g. volunteering, time-banking, befriending

5.4. This is undertaken with a view to achieving the following outcomes identified by Five Ways to Wellbeing 2011

- Build infrastructure and resilience in Communities
- Empower people to feel more in control of their health and wellbeing
- Increase access to appropriate support and connections within local communities to enable people to be more independent and live well for longer.

Appropriate evidence of how the outcomes will be achieved will need to be provided as part of the terms and conditions of the funding. Examples include; demographic data collection, case studies, customer feedback, use of validated measurement tools for improved levels of wellbeing e.g. Warwick Edinburgh Mental Wellbeing Scale.

There is some variation in the evidence that suggests that engagement in public health is more likely to require a 'fit for purpose' than a 'one size fits all' approach – it is important to consider those that are 'ready' to change (contemplative/Preparation stages) behaviour and those who are still in pre-contemplative/contemplative stage (not considering a change in behaviour or thinking about it, but unsure where to start) due to lack of capacity, support, knowledge or skills – it is these individuals that the new service will support.

6. Conclusion/ Next Steps

This proposal is a move away from traditional lifestyle behaviour change, and it provides an opportunity to implement and evaluate a *different* approach to support people at greatest risk of health inequalities. It will offer information, support and enable people to access local community assets, empowering those who can, to make changes for themselves, but also works to engage those who require further help to achieve change.

6.1 Community engagement and outreach are vital components of behaviour change interventions, and the support from peers who share similar life experiences can be a powerful tool for improving and maintaining health. (PHE 2015) Health behaviours are determined by a complex range of factors including influences from those around us, and may not be prioritised by individuals who have complex lives. Addressing social determinants of health e.g. poor housing, access to services and increased social isolation are associated with higher risks of mortality and morbidity. But with the right support, people can improve their wellbeing, and this enables and empowers them to continue to maintain social connections and improve their quality of life in their local communities.

People need appropriate support to do this and the new Wellbeing Service in Barnsley provides an opportunity to do this.

7. Financial Implications

None for the HWB

8. Consultation with stakeholders

Initial consultation and discussion with BMBC and the CCG has taken place via the Healthy Lifestyles Task & Finish Group. Wider consultation will continue follow approval of the work going forward and will include;

BMBC's Healthier Communities
BMBC's Stronger Communities
BMBC's People Directorate
BMBC's Place Directorate
BMBC's Public Health
Barnsley's Clinical Commissioning Group and other Health Partners
Community Voluntary Sector
Barnsley's 0-19 Service

9. Appendices

9.1 Appendix 1 – Wellbeing Service Business Case
Appendix 2 – Wellbeing Service Grant Criteria

10. Background Papers

References

- The NHS Five Year Forward View (2014) NHS England.
- The Marmot Review 'Fair Society, Healthy Lives' (2010)
- NICE (2007) Behaviour Change

- NICE (2006) Obesity Prevention
- NICE (2016) Community Engagement: Improving health and wellbeing and tackling health inequalities
- NICE (2015) Older People: Independence and Mental wellbeing
- Health Matters Public Health England (2018) A guide to community-centred approaches to health and wellbeing Public Health England
- Public Health England/University College, London Health Equity (Sept 2015) Local action on Health Inequalities; Reducing Social Isolation across the Life Course
- 'No Health Without Mental Health': A Cross-Government Mental Health Outcomes Strategy for People of All Ages (Feb 2011)
- The Kings Fund (2018) The connection between mental and physical health
- Prochaska & DiClemente (1983) Transtheoretical Model of Behaviour Change
- Health Foundation (2009) Engaging Communities for Health Improvement
- Our Public Health Strategy 2018-2020.
- Barnsley Health & Wellbeing Strategy 'Feel Good Barnsley' 2016-2020
- Barnsley Place Based Plan (2016)
- Director of Public Health Annual Report (2017) 'A Day in the life'
- Future Council 2020 BMBC
- Barnsley Health & Care Together – Integrated Care Partnership

Officer: Cath Bedford **Date: 4th December 2018**

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BARNSLEY
Metropolitan Borough Council

Communities Directorate - Healthier Communities

Barnsley Wellbeing Service
Business Case
September 2018

Executive summary:

This business case presents a proposal for the development of community-based support for people to improve their physical and mental well-being. We are calling our approach Barnsley Wellbeing Service.

In line with local and national strategies, we aim to reduce health inequalities, all of which are linked to circumstances in which people are born, grow, live, work and age, and broadly described as the social determinants of health. The Barnsley Wellbeing Service proposes to fund a number of community based services, targeting those who cannot or do not engage and which is known to impact negatively on their mental and physical health and wellbeing.

Our proposal is to move away from services that traditionally focus on 'unhealthy' behaviours that often lead to diseases such as obesity, type 2 diabetes, cancers and heart disease. But a key part of the new Wellbeing Service aims to support people to improve levels of mental wellbeing and resilience, through more active engagement in local communities to tackle some of the wider issues affecting health e.g. housing, employment, education, crime etc. This in turn, will build confidence and skills to address other aspects of their health and wellbeing, including giving up smoking, losing weight, increasing levels of physical activity.

Recommendations from NICE (2012) and Public Health England promote a system-wide approach to tackling obesity, and not focusing solely on individual behaviour change to e.g. lose weight as a single outcome. As part of this system wide approach in Barnsley - there are already a number of local services in place that provide some health-related support around individual behaviour change; to lose weight, improve diet, stop smoking e.g Yorkshire Smokefree (Stop Smoking Service provided by SWYFT) Weight Watchers, Slimming World, Barnsley Premier Leisure (BPL) Centres, as well as a broad range of Area Council funded community groups and many community voluntary sector organisations across the borough, many of which can be found on the Live Well Barnsley website.

Whilst the rising levels of obesity in Barnsley remain a priority, the determinants of obesity are complex, including factors of; genetic disposition, early life nutrition and growth, individual lifestyle, psychological issues, the physical and cultural environment, food production and consumption, education, social and economic factors and the influence of the media (Foresight 2007). As part of the plans for the Wellbeing Service to tackle health inequalities, we will also address some of these determinants relating to obesity.

No single agency can address these priorities. A wide range of partners should work together to develop and implement community-wide approaches to tackle these determinants.

We will commission 2 types of services to help people engage with their wellbeing. These are:

1. Locally defined population based support services/groups/projects delivered through Area Councils where local needs can be identified and services/projects can be built to address wider Wellbeing and public health outcomes in local communities.
2. Planned 8-12 week Wellbeing Support Programme to offer 1:1 (and group) support to address specific issues around physical activity and diet/nutrition in local community settings – this was identified as a gap in current service, especially for those requiring more specialist support.

Many of these services are not new to Barnsley – but we plan to strengthen and add value to meet local needs – e.g. extending existing provision where capacity is stretched, but also or to develop new opportunities to fill local gaps in services that support wellbeing, opportunities for peer support & information – some of which have been highlighted through other service providers. For example, feedback from Area Councils, local services like 'My Best life' and the Community Voluntary Sector are able to highlight areas where there may be gaps (or duplication) in services that offer support round a specific aspect of wellbeing, or where there is limited/no provision in certain areas of the borough. This also links to Live Well Barnsley which provides a maintained directory of local services, with a view to enabling and empowering people to access community based support that can improve their wellbeing. We continue to work with the Live Well team to promote this more widely and ensure the system is as easy to navigate as possible, supporting professionals and local people to help themselves. Our intention is to commission the following;

1. **Area Council Wellbeing Grants** to encourage people and groups to initiate activities to support and improve their physical and mental wellbeing. Examples:

Community Transport: to make a big difference to people's lives especially people with disabilities, older people and socially isolated people.

Social events: To help people meet new people in a warm and supportive environment with speakers to run activities relating to wellbeing.

2. Develop an **8-12 week Wellbeing Programme** of 1:1 support through Barnsley Premier Leisure available within local community settings. This will:

Wellbeing course & support planning: helping people through a time limited programme become more active, improve their diet and nutrition, lose weight and feel better.

Timescale for development & evaluation

January 2019 – March 2020

Funding to Area Council teams to Administer and allocate Wellbeing Grants with specific criteria to measure outcomes, using the evidence based framework 'Five Ways to Wellbeing'. Development of the Wellbeing Programme which offers group and 1:1 support/action planning to help people become more active and engaged, improve their diet and nutrition, lose weight and feel better.

1. Background

The Health and Social Care Act 2012 gave the responsibility for Public Health to local authorities. Since 1st April 2013, local councils have been responsible and accountable for improving and protecting the health of the people in their areas.

This has often included the commissioning of lifestyle 'behaviour' support services e.g. promoting weight loss, healthy eating, stopping smoking and increasing physical activity for individuals, families and communities, but these services are not specifically mandated.

As part of ongoing austerity measures faced by the council, a decision was taken in 2016 to make a reduction in the total 'lifestyle' budget by 31 March 2019. This lead to a separation of a previously 'integrated' lifestyles service, and meant that the council was responsible for contract monitoring the Healthy Lifestyles service (known as Be Well Barnsley) and the Stop Smoking Service (delivered by SWYFT). The planned reduction to the budget would affect Be Well Barnsley only, noting that there has, in effect, been a £70k increase in the stop smoking service since 2017. The reduction was communicated to the current healthy lifestyles provider organisation, Person Shaped Support (PSS) in November 2017. In April 2018, PSS gave formal notice of their decision to withdraw from the Healthy lifestyles contract with BMBC, citing that the reduction in budget made it difficult to sustain current service provision at a local level.

This early withdrawal provided an opportunity to review current provision, which will end on 31st October 2018, and work has continued with PSS to plan an appropriate exit strategy and consider how the service should be developed, maintained and/or re-commissioned going forward.

The Stop Smoking Service is not in scope as part of this review and remains a priority for the Council. This is commissioned through a separate contract and separate business case will be developed for this, ready for recommissioning in October 2019.

1.1 Context of the Well Being Review

Healthy Lifestyles Services have traditionally focused on 'unhealthy' behaviours causing Obesity and associated health conditions like diabetes, cancers and coronary heart disease. This review provides an opportunity to explore a move away from services that focus solely on individual behaviour change to e.g. lose weight, as a single outcome. Recommendations from both NICE (2012) and Public Health England promote a system wide approach to tackling health inequalities and obesity.

The development of a new *Wellbeing* Service will be in line with local (and national) strategy to reduce health inequalities, all of which are linked to circumstances in which people are born, grow, live, work and age and the proposed approach will focus more broadly on the improvement of Physical and Mental Wellbeing. The Marmot Review (2010) details key actions to reduce health inequalities, in order to break links between disadvantage and poor (health) outcomes; including the development of social capital. Local authorities have a role to play in this (Kings Fund 2013) and there is growing recognition that whilst some communities and social groups experience the greatest health inequalities, they also have assets at the social and community level that can help improve health, strengthen resilience and opportunities for peer support and improve health outcomes.

1.2 National & Local Strategy

Barnsley's Health and Wellbeing Strategy 'Feel Good Barnsley 2016-2020' sets out how the Health and Wellbeing Board will drive integration, with a focus to improve services, join up care and support people in Barnsley to better help themselves by improving health and wellbeing and reducing health inequalities across the borough with the vision of:

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

This will be achieved through four principles; focus on efficiencies and outcomes, inspire and empower, connect, collaborate and co-produce and go further faster supporting the outcomes set out in the Future Council 2020 plan, as well as a number of other local/national strategies; Barnsley Health & Care Together (Barnsley Place Based Plan) and the GP/NHS Five Year Forward View. The Public Health Strategy for Barnsley has recently been reviewed for 2018-2020, and the three priorities identified are likely to be supported by the new service; Alcohol, Food, and Emotional Resilience – all of which can be supported by the development of a broader Wellbeing service.

The Director of Public Health's annual report has taken a closer look at what health means to the people of Barnsley over the last couple of years. In 2017, 'A Day in the Life' involved the completion of a short diary by local residents about their physical and mental health, and what made it better or worse. This work confirmed that health is shaped about 'where and how we live' and that there is still a need to '….reduce the stark inequalities which mean the most vulnerable and most deprived bear the heaviest burden of disease' and so it is important to create and sustain good health and wellbeing across the life course in Barnsley (DPH 2017). There were a number of themes that residents identified and these were broadly categorised as; sleep, resilience, reference to Five Ways to Wellbeing, physical activity and connections – very few people identified specific 'lifestyle' behaviours as something they associated with their own sense of 'wellbeing.'

This provided some good local intelligence about how people are feeling about their health and wellbeing with some examples of people who feel that they 'can' and do take control of their own health and wellbeing, and those that 'can't' or 'won't' because of their personal circumstances or confidence/resilience to do so.[1]

Do what makes you happy.
Change what makes you sad.
A healthy life is what you identify as being healthy. To me a healthy life is: health, family, happiness, adventure and making my family proud.

I leave to go to the luncheon club at 11.30am. I love to go for the dinner and the company. We are all friends and enjoy each other's company

I do worry about what support network I actually have because I don't feel like anyone does anything for me or helps me.

Physically I'm sure I look fine but internally I'm not sure.

I feel as miserable as every other day. I work for a rubbish company, poor prospects for the future, life is rubbish. Not much makes me feel well. I should have just rung in sick. I felt in pain, tired, fed up. No high points. Low points, all of them.

I am the only man in the company of all women who seem to be completely addicted to mobile phones. Why do I hate that? I guess I feel isolated.

It's been a cold, wet, grey, miserable day. I've run the heating for fifteen minutes at a time because of the cost, but I was bitterly cold at lunchtime. I've wasted my day browsing the internet. I do this as a distraction from facing up to tasks that I ought to do but can't bear starting. My life sounds miserable. It is.

[1] DPH Annual Report 2017

There is a commitment to partnership working across organisations in Barnsley that will also help us to achieve this. The focus of the last three decades has been on reducing health inequalities (Marmot (2011), Acheson (1998) & Black (1987)) but also demonstrate that no one single agency or organisation can address this range of complex population needs. The objective for us all therefore, is to improve outcomes for individuals and families across the life-course; to improve people's physical, mental and wider well-being.

1.4 Purpose of the document

This paper sets out the business case for future commissioning of a Barnsley Wellbeing Service, including an opportunity to evaluate and review the development of the service, with a view to put forward recommendations to inform BMBC's commissioning intentions from March 2020.

Key partners/stakeholders are asked to support the proposal to develop this new service and to be actively engaged in its promotion and development to evaluate the impact and outcomes during the next fifteen months.

2. Current services, resources and performance

Be Well Barnsley (Person Shaped Support)

A number of services are currently co-ordinated and/or delivered through Be Well Barnsley. This includes;

- Personal Health Planning (including 1:1 support for tier 2 weight management)
- Programmes of physical activity, diet and nutrition for specific cohorts;
- Connections and signposting to other services: Fit Reds, Barnsley Premier Leisure
- Funding through Area Council/Ward Alliances for specific groups

There is some evidence that particular areas of work were delivered well; the 1:1 work in GP practices, work in developing local health champions (volunteers) and some of the work with Children and Families. Some of the services delivered under the brand of Be Well Barnsley offered a more co-ordinated approach to provision, working with a range of local providers, but services were not always provided by the Be Well staff. Some of these will continue and are listed below. This business case concentrates on gaps in provision and through the proposed model to commission bespoke local provision, we will aim to ensure local needs are met.

Live Well Barnsley

A mapping exercise was undertaken using the Live Well Barnsley Website as a basis for identifying the range of local services and groups that are available to local people, with particular focus on those that would remain even when Be Well Barnsley was no longer delivering services in the borough. Encouraging the use of this site as a 'one stop' directory of services is crucial for both professionals to understand the range of community groups/services available, but also members of the public.

There is a great deal of provision already in place in Barnsley (see Appendix 1) that may not all be detailed on the website but that also connects into the Wellbeing agenda; examples in Children and Families,

Weight Management, Physical Activity, Social Prescribing, Befriending and other Community Voluntary sector services.

In order to maximise value for money and outcomes, it is essential to avoid duplication going forward, and look to develop/extend provision to meet local needs. It is important to note that a number of existing services will continue from 1st November 2018 including;

- **Fit Reds**: Delivered by Be Well Barnsley in partnership with Barnsley Football Club. Fit Reds have also recently appointed a health co-ordinator to ensure this work continues. There are opportunities to extend this further and they are keen to receive referrals from e.g. primary care to support this.
- **Fit Mums**: Aqua natal and group support delivered by Be Well Barnsley in partnership with Barnsley Premier Leisure
- **Active Volunteers**: Supported and trained by BWB, now working across different local areas on e.g. community garden projects, over 35s football, community shop – support required going forward
- **Dearne Stay Fit -** Chair based exercise groups (some local groups now self-sustainable)
- **Children and families support through Family Centre provision –** e.g. Cook & eat, Access to Fruit & Veg through Alexandra Rose Vouchers
- **Ward Alliance funded projects** that focus on physical activity, healthy eating, e.g. Forge Community Partnership **–** offering cook & eat sessions for families

2.1 Finance & Resources

Budget

The proposed timescales to develop and evaluate the new Wellbeing Service concept will be for approx. 15 months, from January 2019 – 31st March 2020.

The proposed budget during this period is detailed below;

Full annual budget £190,000

Area Teams Maximum 130,000,

- Funding will be allocated on the basis of inequality (funding formula has been devised based on Indices of Deprivation across 147 LSOAs in Barnsley)
- Funding criteria has also been developed to ensure achievement of appropriate wellbeing outcomes and links back to Public Health Outcomes.

Barnsley Premier Leisure - pilot Maximum 60,000

- A Service Specification to offer sustainable support to a targeted cohort people for 8-12 weeks on a 1:1 or group basis as required. This is designed to support those people who are motivated to e.g. lose weight, be more active but require support to do make sustainable change.
- The offer will build in a clear exit strategy to help them maintain a more active lifestyle through peer, family and/or community support.

3. Evidence Base

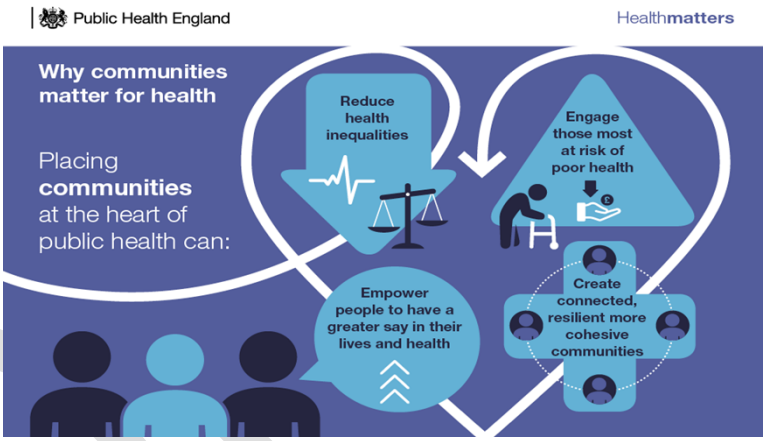
There is a great deal of national and local evidence surrounding the development of the new Wellbeing Service, which focuses on reducing health inequalities linked to the wider determinants of health and promotion of social capital, which is supported strongly by the Marmot Review (2010) highlighting the

need to improve community capital and reduce social isolation across the social gradient. We know that many of the factors that underpin wellbeing and increase resilience are largely social, not medical, and this creates an ideal opportunity to develop a range of co-produced solutions with local organisations and people (LGA. 2010).

Community Centred Approaches and Engagement

There is a growing interest in the UK in community-centred approaches to enhance individual and community capabilities, create healthier places and reduce health inequalities. These approaches are not just community based, but it is about mobilising assets within communities, promoting equity, and increasing people's control over their health and lives. This can be done in a number of ways; using non-clinical methods, participatory approaches where community members actively involved in service design, delivery and evaluation, looking at ways of reducing barriers to engagement, using and developing the local community assets, collaborating with those most at risk of poor health and changing the conditions that drive poor health. (Health Matters, PHE, Feb 2018)

Why communities matter for health (Public Health England, Health Matters, Feb 2018)



Positive health outcomes can only be achieved by addressing the factors that protect and create health and wellbeing and many of these are at a community level. Community life, social connections and having a voice in local decisions are all factors that have a vital contribution to make to health and wellbeing. These community determinants build control and resilience and can help buffer against disease and risk factors like smoking, obesity, and drug and alcohol use. (Health Matters, PHE 2018)

Peer Support and Volunteering

NESTA and National Voices have done significant work in 'Realising the Value' (2016) and the impact of Peer and community support in local communities. It comes in various different forms '….. formal or informal support between people with similar conditions or experienced in a community, that can often help people combat isolation and help to sustain knowledge, confidence and skills over time'

Isolation and Loneliness are recognised as public health priorities, in a similar way to smoking and obesity, affecting people of all ages throughout the lifecourse (LGA 2018). Coping, self-esteem, and psychosocial health are significant moderating factors for perceived isolation and feelings of loneliness. Loneliness is associated with higher rates of depression, high blood pressure and dementia. It is said to lead to higher

rates of premature mortality comparable to those associated with smoking and alcohol consumption – around 30 per cent higher than for the general population. (LGA 2018)

We cannot underestimate the value of volunteering to impact on physical and mental wellbeing for both the volunteer themselves and those that they support, particularly for those who may be housebound and/or at risk of isolation or loneliness.

Obesity & Physical Activity

Recommendations from NICE (2012) and Public Health England promote a system-wide approach to tackling obesity, and not focusing solely on individual behaviour change to e.g. lose weight as a single outcome. Obesity is a 'major public health challenge' (PHE 2016) and is linked to a range of health conditions including type 2 diabetes, cardiovascular disease and cancer. The resulting NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year (Foresight 2007).

The rising levels of rising obesity in Barnsley remain a priority, but the determinants of obesity are also complex, including factors of; genetic disposition, early life nutrition and growth, individual lifestyle, psychological issues, the physical and cultural environment, food production and consumption, education, social and economic factors and the influence of the media (Foresight 2007).

No single agency can address this problem. A wide range of partners should work together to develop and implement community-wide approaches to tackle these determinants.

Physical inactivity is the 4th leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities. The estimated direct cost of physical inactivity to the NHS across the UK is over £0.9 billion per year. The Chief Medical Officer currently recommends that adults undertake 150 minutes (2.5 hours) of moderate activity per week, in bouts of 10 minutes or more." (Public Health England, 2016).

Behaviour Change

Community engagement and outreach are often a vital component of behaviour change interventions and the support from peers who share similar life experiences can be a powerful tool for improving and maintaining health. (NICE 2007)

Prochaska and DiClemente's Transtheoretical Model of Behaviour Change (1983) describes the various stages in the process of people's 'readiness' to change. In light of the available evidence relating to health inequalities and community engagement, it is important to consider those who are ready (contemplative stage) and those that are not ready to make changes (pre-contemplative – they don't consider their behaviour to be a problem) which may for a range of reasons including lack of capacity, support, knowledge or skills. This has been adapted to develop the proposed Wellbeing Service model.

The evidence for achieving weight management outcomes and sustained weight loss in the longer term is limited, but there are a series of behaviour change techniques for consideration where evidence is still emerging. These include; Social Support (Practical and emotional) changes to the social environment, goal

setting, self-monitoring (NICE Behaviour Change Individual Approaches (2014) and NICE Weight Management: lifestyle services for overweight or obese adults (2014a)

Programmes that support weight loss should support self-management, foster independence and provide ongoing support from local community, family/friends etc – provision for this is available throughout the borough e.g. Slimming World/Weight Watchers.

There is some variation in the evidence that suggests that engagement in public health is more likely to require a 'fit for purpose' than a 'one size fits all' approach – and this is what the service will aim to develop.

4. Identifying and evaluating options

Options appraisal - The following options are presented:

Option 1 – Do nothing This option is not to commission any service at all, and for the resource to be used elsewhere.

Reducing both health inequalities and obesity levels remain a priority for Barnsley, and engaging local communities in this agenda is key to its success. Given the evidence around system-wide approaches to tackling these issues, it would not be appropriate for Barnsley Council to do nothing.

Option 2 – Commission a Healthy Lifestyles Service, based solely on the health needs and priorities identified through National and Local Public Health Data and focusing on at risk groups or people with diagnosed health conditions often linked to unhealthy lifestyle behaviours relating to inactivity, poor diet/nutrition and smoking. Outcomes for this type of service focus solely on a medical model of individual behaviour change and traditionally relate to % weight loss, quits, increased levels of activity – where sustainability after 12 months is often difficult to maintain. However, it is recognised that some people would benefit from a more intensive support service to help them achieve a healthier lifestyle, and for those who are motivated to change, this can be successful. The resource required for this sort of intensive support for people is costly and given the levels of funding available would not be able to help a large number of people a less resource-intensive community based approach is likely to achieve better outcomes and value for money.

This type of service would not necessarily address the wider issues around wellbeing. Local evidence from a 'Day in the Life' suggests that the residents of Barnsley do not necessarily prioritise healthy lifestyles as having the biggest impact on their lives, regardless of what medical evidence suggests - if they don't prioritise these issues, they are much less likely to want to change their behaviour. For those residents that do prioritise their lifestyle and wish to make changes, there are a number of services available across the borough and for those people who wish to undertake an activity or access support around these issues, information is available online and via local service providers.

Given the financial position and the requirement to reduce inequalities and help those that need it most, who are more likely to be affected by the root causes of ill health (wider determinants) this would not be a justifiable option.

Option 3 – Commission a service on those who are 'pre-contemplative' (not ready) or prepared to change that focuses on effective community engagement to address inequalities in health. This

service would support the wider aspects of Wellbeing and is more in line with the views of local communities regarding their priorities for health and wellbeing. People who are at increased risk of health inequalities are also more likely to experience one or more of the following; unemployment, live in an area of high deprivation, live with a long term health condition, poor quality housing, poor education, may be lonely or socially isolated and find it difficult access services, and are also more difficult to engage in local services.

What this may not do is offer a more intensive 1:1 support service for people who need it or for those who do not feel confident in engaging in local groups. But there are opportunities through the Wellbeing Grant fund for Area Councils to commission bespoke services based on local needs – which may include offering 1:1 support including befriending, peer support/buddying services to increase confidence and reduce social isolation.

This more population based approach to Wellbeing focuses on effective engagement within local communities, focusing on where people live & work, and where they are more likely to create and maintain support networks. This promotes community resilience and wellbeing using a place-based approach that involves the identification of local assets and strengths within communities, as well as identifying opportunities to fill gaps and develop new services/support within and local area.

Option 4 – Commission a Wellbeing Service - This option offers two elements. Firstly, one that primarily focuses on a population based approach to engage larger numbers of people to improve their physical and mental wellbeing from the services/support within their local communities, and the second focuses on specific access to help/support for a smaller, more targeted number of people to help them achieve goals. Effectively, this will offer a combination of options 2 and 3.

Building on existing provision to support people who are at greatest risk of health inequalities can also strengthen community infrastructure, enabling the sustainability of local groups/services that we know are already meeting the needs of local people who can and will access local services, but through effective engagement and support, to empower those who are less able to help themselves to do so with the support of their local community.

Identifying a provider to deliver 1:1 healthy lifestyles support for a smaller number of individuals will also be developed but with a clear focus on creating sustainability and exit strategies – to become engaged and supported within their local communities, helping people to help themselves and reducing reliance on the health and social care system. The clear focus will be working with people to identify their own needs and priorities, rather than on the basis of the health condition or lifestyle they currently adopt.

The preferred option to move forward is Option 4

As a Council, we understand that building sustainable relationships with our residents will be crucial in empowering and nurturing individuals, families and communities to take more responsibility for their own health and wellbeing. BMBC's Future Council Priorities highlight our commitment to support this model by building strong and resilient communities and supporting people to achieve their potential.

Focus around these particular workstreams is not being developed in isolation – we are keen to join up and add value to existing provision rather than re-invent similar services and run the risk of duplication.

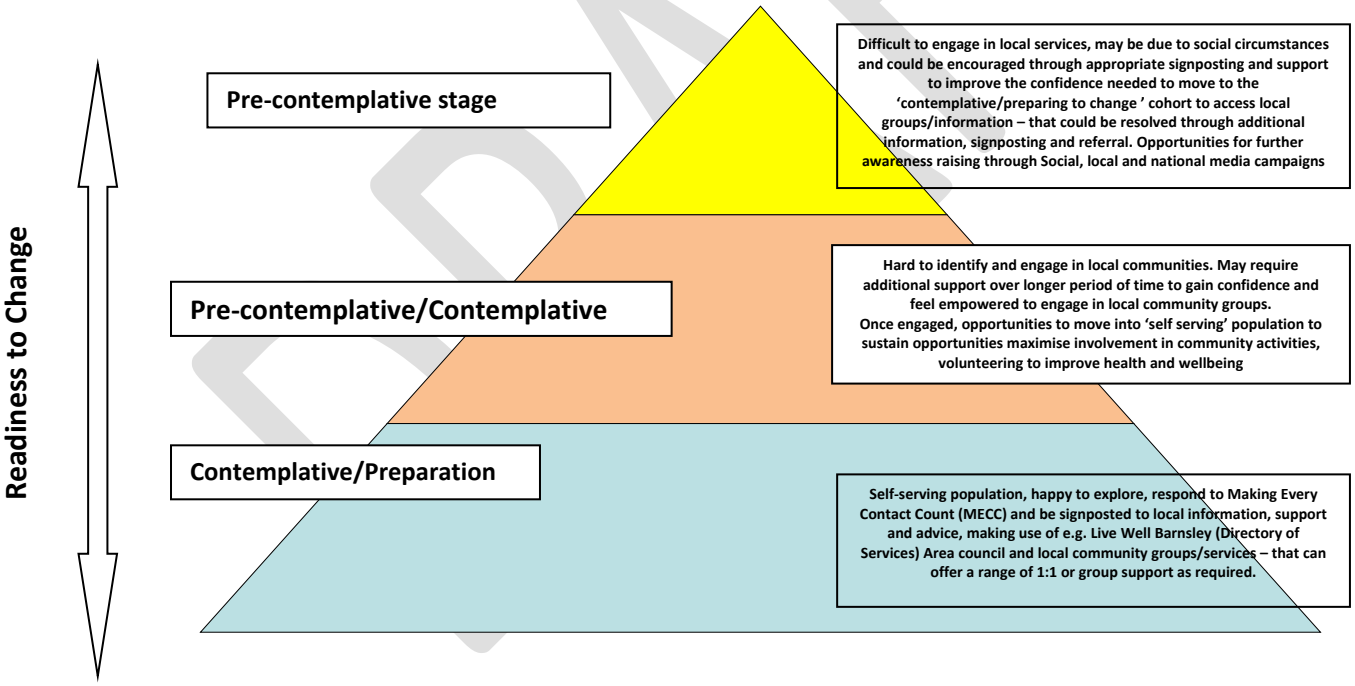
The view is that much of the support is available already for people – the key is around engagement and access to these services to enable people to self-serve.

5 Proposals for the new service

As described, the focus of the work will be to tackle health inequalities, and promoting both physical and mental wellbeing and community resilience will be the priorities going forward. The proposed service model will be delivered using a well-established place-based approach to address local needs affecting people's physical and mental wellbeing, and will include some of the challenges that sit behind some of the 'unhealthy' behaviours that put them at increased risk of ill health and dependence on health and social care.

This offers a longer term, preventative approach to tackle some of the root causes of ill-health, and focusing on improving wellbeing and resilience to empower people to take more control of their own health and wellbeing in future.

Proposed Wellbeing Service Model – Focus of resource



Adapted from Prochaska & DiClemente 'Stages of Change' (1983)

The model requires a focus on embedding some of the ethos and principles from a community perspective to find sustainable solutions, providing opportunities to strengthen community infrastructure (through social support, as well as 'groups' and 'services') where appropriate, so that options can be developed based on local need.

5.1 Wellbeing Outcomes

Working together to take action on a broad range of issues impacting on health and wellbeing is a process that should lead to improvements in the determinants of health, which will enable people to feel more in control of their own health and wellbeing. Five Ways to Wellbeing offers an evidence based framework that are fundamental to improving people's sense of mental wellbeing.

It is proposed that the framework will be used as the basis for allocation of Area Team grants:

CONNECT – Provides opportunities to promote/offer regular contact with people such as family, friends, work colleagues or neighbours e.g. through local interest groups, cook & eat sessions for families, luncheon clubs, reducing social isolation/loneliness, peer support initiatives

BE ACTIVE – Links to activities promoting Physical activity or ways to reduce inactivity through e.g. walking groups, dancing, gardening, or just keeping moving.

TAKE NOTICE – Encouraging awareness of the world around and its impact on individuals/communities. Be curious and notice what needs to change and how that might happen. Reflecting on experiences to help appreciate what is important. E.g. building healthier, supportive and strong communities

KEEP LEARNING – Opportunities to learn or try something new, or rekindled a previous interest, e.g. developing skills and knowledge around healthy lifestyles (weight management, smoking and alcohol), supporting access to employment (job clubs, budgeting) housing (warm homes, fuel poverty)

GIVE - Provides opportunities to give time to something or someone in the community e.g. volunteering, time-banking, befriending

With a view to achieving the following outcomes identified by Five Ways to Wellbeing 2011

- Build infrastructure and resilience in Communities
- Empower people to feel more in control of their health and wellbeing
- Increase access to appropriate support and connections within local communities to enable people to be more independent and live well for longer.

Appropriate evidence of how the outcomes will be achieved will need to be provided as part of the terms and conditions of the funding. Examples include; demographic data collection, case studies, customer feedback, use of validated measurement tools for improved levels of wellbeing e.g. Warwick Edinburgh Mental Wellbeing Scale.

Public Health England also cited a useful framework for community-based prevention which provides an even broader picture of the some of the outcomes that the Wellbeing Service could be measured against – including the potential impact of this work on individuals, communities and organisations.

Individual	Community Wellbeing & Process	Organisational
Health literacy – increased knowledge, awareness, skills, capabilities **Behaviour change** – healthy lifestyles, reduction of risky behaviours **Self-efficacy, self-esteem, confidence** **Self-management** **Social relationships** – social support, reduction of social isolation **Wellbeing** – quality of life, subjective and objective wellbeing **Physical and Mental health status** – mortality, morbidity	**Social capital** – social networks, community cohesion, sense of belonging, trust **Community resilience** **Changes in physical, social and economic environment** **Increased community resources** – including funding **Community leadership** – collaborative working, community mobilisation/coalitions **Representation and advocacy** **Civic engagement** – volunteering, voting, civic	**Public health intelligence** **Changes in policy** **Re-designed services** **Service use** – reach, uptake of screening and preventive services **Improved access** to health and care services, appropriate use of services, culturally relevant services

Personal development – life skills, employment, education	associations, participation of groups at risk of exclusion	

Some of these outcomes naturally contribute the Public Health Outcomes Framework as well as a range of other national and local frameworks and indicators including the NHS Outcomes Framework, Adult Social Care Outcomes Framework; whilst also supporting the priorities of Barnsley Place Based Plan and BMBC's Future Council Strategy 2014-2017.

5.2 *New* Service principles

The new Wellbeing Service provides an opportunity to do the following;

Wellbeing Service Principles

Extend resource to Area Teams with a specific Wellbeing Grant funding stream;

- to support/sustain local community groups and local infrastructure,
- Identify/fill service gaps as identified through local needs
- Improve opportunities to engage individuals who are 'not known' to services or who are 'hard to reach'
    - widowed home owners living alone with long-term health conditions
    - unmarried, middle-agers with long-term health conditions
    - young renters with little trust and sense of belonging to their area.
    - Other groups identified through local intelligence data (area council teams)
- Provide additional capacity for existing services to extend support to specific groups/individuals to improve their wellbeing .

BPL Offer to provide flexible 1:1 and/or group support to help people improve their physical wellbeing and lifestyles –

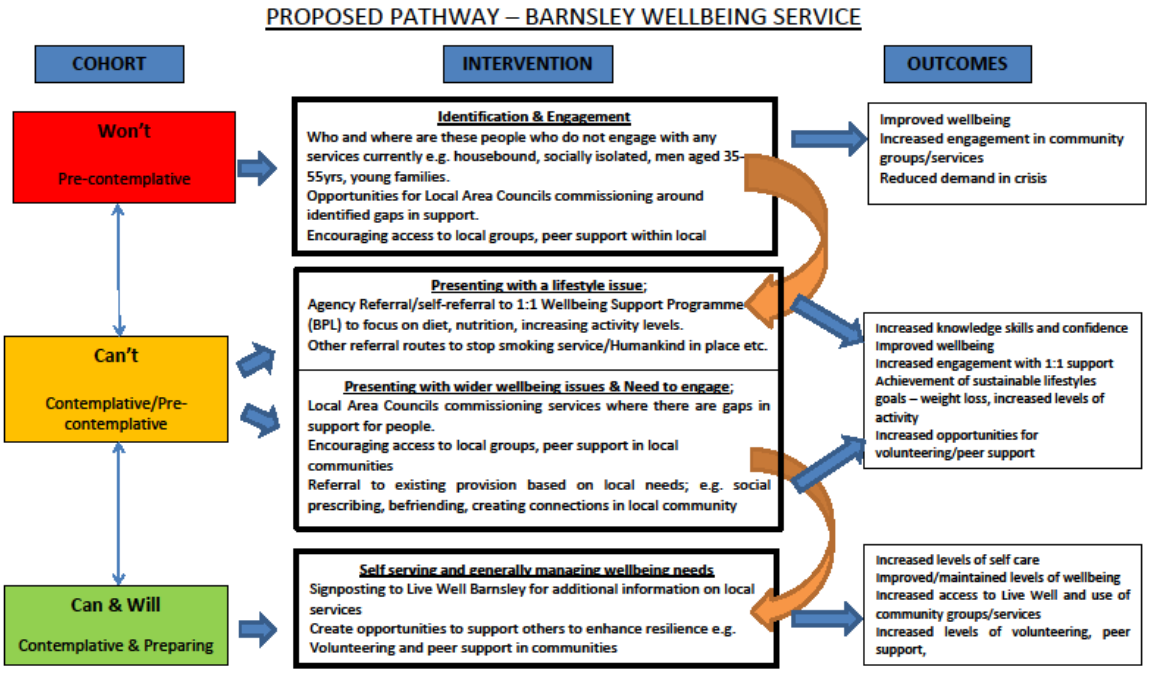
- GP/self-referral to provide sustainable solutions around physical activity, diet and nutrition for people who are motivated to change, but require support to do so
- To develop positive relationships, increase confidence and encourage social connections to improve wellbeing, providing opportunities to sustain positive behaviour change

For the general population

- Promote and signpost people to access Live Well Barnsley offering a 'one stop' directory of services across Barnsley, encouraging access and engagement with local community groups/support.

5.3 Proposed Wellbeing Service Pathway

Also see Appendix 2 for definitions of cohort



5.4 Wellbeing Service Plans – January 2019 – March 2020.

We will commission 2 types of services to help people engage with their wellbeing. These are:

1. Locally defined population based support services/groups/projects delivered through Area Teams where local needs can be identified and services/projects can be built to address Wellbeing outcomes in local communities.
   - Wellbeing Grants criteria will be developed for increasing local capacity around Health and Wellbeing including targeting specific cohorts detailed above, administered by Local Area Council teams.
   - Allocations will be monitored quarterly and measured against Five Ways to Wellbeing and Public Health Outcomes Framework.

2. Planned 8-12 week Wellbeing Support programme to offer 1:1 and/or group support to address physical activity and diet/nutrition.
   - Development of specification for extending BPL Health Referral Scheme to target specific groups of people (not eligible through Get Fit First (GFF) – an interim scheme is temporarily funded by

the CCG until March 2019) and include links to nutritional advice, physical activity and options for 1:1 weight management; this would be developed as follows;

- Health Referral Plus - includes Diet & Weight management element offering 1:1 or group support as required for those motivated to make sustainable lifestyle change. Would promote GP/other professional or Self-referral options.
- Ensure the BPL resource is aligned with existing local provision/groups working closely in partnership with Area Teams/Ward Alliances to ensure integration with other community activities

6. Conclusion

This proposal is a move away from traditional lifestyle behaviour change, and it provides an opportunity to implement and evaluate a *different* approach to support people at greatest risk of health inequalities. It will offer information, support and enable people to access local community assets, empowering those who can, to make changes for themselves, but also works to engage those who require further help to achieve change.

Community engagement and outreach are vital components of behaviour change interventions, and the support from peers who share similar life experiences can be a powerful tool for improving and maintaining health. (PHE 2015) Health behaviours are determined by a complex range of factors including influences from those around us, and may not be prioritised by individuals who have complex lives. Addressing social determinants of health e.g. poor housing, access to services and increased social isolation are associated with higher risks of mortality and morbidity. But with the right support, people can improve their wellbeing, and this enables and empowers them to continue to maintain social connections and improve their quality of life in their local communities.

People need appropriate support to do this and the new Wellbeing Service in Barnsley provides an opportunity to do this.

7. Key documents & References

Public Health England (2015) A guide to community-centred approaches to health and wellbeing
Local Government Association (2018) Loneliness: How do you know if your council is tackling loneliness
Local Government Association (2016) *Helping people look after themselves; A guide on Self Care* Local Government Association
NICE (2012) Obesity: Working with local communities
NICE (2007) Behaviour Change
NICE (2006) Obesity Prevention
NICE (2016) Community Engagement: Improving health and wellbeing and tackling health inequalities
NICE (2015) Older People: Independence and Mental wellbeing
Foresight Report (2007) Reducing Obesity: Future Choices. Government Office for Science
Public Health England/University College, London Health Equity (Sept 2015) Local action on Health Inequalities; Reducing Social Isolation across the Life Course
Local Government Association (January 2016) Combating Loneliness: A Guide for Local Authorities
Local Government Association (2010)
Local Government Innovation Unit (LGiU) (Feb 2016) Loneliness and Social Isolation in Older People

MINDSPACE (2010) Influencing behaviour change through public policy
Department of Communities and Local Government (2015) The English Indices of Deprivation 2015 Technical report.
Barnsley Metropolitan Borough Council. 'A Day in the Life of……Director of Public Health, Annual Report 2017'
Barnsley Metropolitan Borough Council (2018) 'Our Borough profile'
'No Health Without Mental Health': A Cross-Government Mental Health Outcomes Strategy for People of All Ages (Feb 2011)
The Kings Fund (2018) The connection between mental and physical health
NESTA (2016) At the Heart of Health: Realising the Value of People and Communities
National Voices & NESTA: (2014) Peer Support: What is it and does it work?

APPENDIX 1 ***Other existing service provision***

There is a great deal of further provision in place (or planned) that may not be detailed on the website but that also connects into the healthy lifestyles agenda. The links are less clear between some services or what the impact/outcomes of these services are. Other locally commissioned services or initiatives are included below;

Children & Families Support

BMBC Public Health Nursing Service – Support, advice & Information, NCMP data
Early Help Services for Families – Family Centres, Troubled families Programme
The Forge Foundation – Cook & Eat sessions
Area council/Ward Alliance funding & developments

Weight management - other

Tier 3 weight management – Change4life - referral only (CCG)
Tier 4 weight management – referral only (bariatric surgery) (CCG)
Commercial provision - Slimming World/Weight Watchers (Pilot/interim until March 2019)
National Diabetes Prevention Programme (Barnsley Programme – CCG ends March 2019 and expected to be recommissioned after March 2019)
NHS Health Checks – Barnsley Programme

Physical activity programmes/services

Change 4 life – BHNFT (Barnsley Hospital)
Barnsley Premier Leisure – borough wide
Walking for Health Groups
Active Travel (Access fund) developments inc Cycle Hub
Barnsley Leisure Card Scheme
Barnsley Football Club – Fit Reds
Private Gyms/health clubs
Area Council/Ward alliance funding & developments

Social Prescribing/social connectors/Befriending/information/Volunteering

'My Best Life' – CCG commissioned borough wide service (No self-referrals – any health professional in Barnsley, including GPs, Nurses and social workers)
Age UK – Social isolation projects
Together UK – Befriending Services
Royal Voluntary Service – Befriending in selected communities
Area Council/Ward Alliance funding & developments – varying across communities
Live Well Barnsley website
Voluntary Action Barnsley

National Programmes/campaigns that support healthy Lifestyles;

National Diabetes Prevention Programme
NHS Health Checks
NHS choices website
National media/television programmes; BBC Eat Well For Less, Channel 4 Food Unwrapped,

APPENDIX 2 ***Definitions of Cohort – Wellbeing Service Model***

Barnsley Wellbeing Service Pathway

Definitions

The Wellbeing Pathway offers a range of options to people who wish to access appropriate support. As identified in the Service Model, people can be identified in three different cohorts and are designed to help recognise an individual's current level of skill, confidence and motivation to access services;
Broadly speaking these are;

- Contemplative/Preparing to change (Can & Will)
- Contemplative/Pre-contemplative to change (Can't)
- Pre-contemplative (Won't)

Each of these cohorts is defined more clearly below, and will enable people to access the right support from the right place at the right time, with a view to increasing personal and community resilience and empower people to progress to the 'Can & Will' category;

Can and will:
Individuals are generally self-sufficient and can confidently identify and address their own wellbeing needs. These individuals are motivated and most likely to Self-serve/support but also feel empowered to identify and refer themselves to services as required. There are opportunities for this group to act as local health champions, and may be able to offer peer support or volunteer within their community.

Can't:
This group may be aware of their own health/wellbeing needs, and are motivated to address these, but are unable to do anything about these without support. This may be due to lack of confidence, skills or personal/social circumstances, and they are unable to make changes. These individuals may already be known to some services, but often find it difficult to access the right support at the right time. If needs continue to be unmet or the support offered is not fit for purpose, this could lead to a breakdown in motivation and they will eventually stop seeking help – becoming at risk of using crisis/reactive services, creating high levels of DNAs and not accessing support at the right time. The aim for these individuals is to build confidence, knowledge and skills, empowering people to feel more resilient and be more connected within their communities.

Won't:
This group may not be known to services, and if they are, they have chosen to disengage and usually create high levels of DNAs. These individuals are likely to have complex needs some of which may prevent them from accessing a group/service(s). These barriers will be multifactorial and can be represented in various forms; disengagement or poor experiences from services, lack of awareness of wellbeing needs, or lack of motivation/willingness to seek help and support.

Wellbeing Service Grant
Application Guidance

The Barnsley Wellbeing Service is designed to provide place-based support for people who are not engaging services that can help to improve their physical and mental well-being. In line with local and national strategies the service is designed to reduce health inequalities, all of which are linked to circumstances in which people are born, grow, live, work and age, and broadly described as the social determinants of health.

The *Five Ways to Wellbeing* offers an evidence based framework that can be used to motivate behaviour change in individuals across a number of different settings, as well as supporting population level initiatives aimed at the general public.

There are opportunities to support specific community/population groups e.g. older people, social housing tenants, men's groups, pregnant women, staff or volunteers or offer population level approaches in universal settings or through social media and community events.

CRITERIA FOR THE WELLBEING GRANT

Five Ways to Wellbeing will be used as the criteria/framework on which applications will be evaluated. Every application must provide evidence that their proposed project supports at least two direct links to the following themes and some indirect links to all the others of the following themes;

CONNECT – Provides opportunities to promote/offer regular contact with people such as family, friends, work colleagues or neighbours e.g. through local interest groups, cook & eat sessions for families, luncheon clubs, reducing social isolation/loneliness, peer support initiatives

BE ACTIVE – Links to activities promoting Physical activity or ways to reduce inactivity through e.g. walking groups, dancing, gardening, or just keeping moving.

TAKE NOTICE – Encouraging awareness of the world around and its impact on individuals/communities. Be curious and notice what needs to change and how that might happen. Reflecting on experiences to help appreciate what is important. E.g building healthier, supportive and strong communities

KEEP LEARNING – Opportunities to learn or try something new, or rekindled a previous interest, e.g. developing skills and knowledge around healthy lifestyles (weight management, smoking and alcohol), supporting access to employment (job clubs, budgeting) housing (warm homes, fuel poverty)

GIVE - Provides opportunities to give time to something or someone in the community e.g. volunteering, time-banking, befriending

Funding will be available for each of the six Area Teams, with an allocation for each area to fund projects/campaigns/services based around the Five Ways to Wellbeing. Applicants will be required to identify at least one of the five themes that their proposal will support and how the impact of the project will be evaluated in line with these themes and public health outcomes. This fund can help with but is not limited to;

- Developing/extending a service/support group based on the needs of your population
- New support groups addressing local needs including equipment for existing services or costs of venue hire.
- Promoting use of technology, communication or promotional material in local communities
- Funding interim roles to extend capacity in existing services
- Promoting opportunities for joint commissioning between area councils where appropriate

LINKS TO PUBLIC HEALTH & WELLBEING OUTCOMES

The key wellbeing outcomes linked to the Five Ways to Wellbeing framework that applicants will be measured against are:

- Build infrastructure and resilience in Communities
- Empower people to feel more in control of their health and wellbeing
- Increase access to appropriate support and connections within local communities to enable people to be more independent and live well for longer.

Appropriate evidence of how the outcomes will be achieved will need to be provided as part of the terms and conditions of the funding. Examples include; demographic data collection, case studies, customer feedback, use of validated measurement tools for improved levels of wellbeing e.g. Warwick Edinburgh Mental Wellbeing Scale.

In addition, evidence of impact or contribution to the achievement of specific Public Health Outcomes will also be required. Applicants are also asked to see how their project links to one or more of the following Public Health domains as part of their application – a full list of the Public Health outcomes in each domain will be included in the appendix.

1. **Wider Determinants of Health** – these are the elements in our lives that can make a difference to our health and wellbeing e.g. where we live, having a job, attending and achieving at school, access to services, support from friends and family, feeling safe in our communities

2. **Health Improvement** e.g. reducing the number of people who are overweight, those who smoke, drink too much alcohol, and how to make people more active and improve their mental wellbeing

3. **Health Protection** – increasing vaccinations e.g. flu, HPV and screening for cancers,

4. **Preventing early death** - How do we help people to live a longer and healthier life

AVAILABLE FUNDING

Interim Period 1 – 1st Jan 2019 – 31st March 2020

Total Funding for Area Teams is £130,000

This will be allocated on the basis of the number of Local Super Output areas linked to the indices of deprivation. Allocations will be made across the following localities.

Dearne
North East
Central
Penistone
South
North

This process will be evaluated by the Healthy Communities Public Health team both during and at the end of the funding period. Following the success and impact of the grants, a decision regarding budgets and any future funding will be made on the effectiveness of the Wellbeing Service Approach.

WELLBEING SERVICE GRANT TIMETABLE

The timetable for this funding round is from Jan 2019 – March 2020;

The decision on the frequency of funding rounds can be made locally, but monitoring of this fund is planned to be undertaken on a quarterly basis.

Ensure plans for spend is committed before end March 2020.

- Applications must be considered using the Wellbeing Service criteria by the appropriate Area Team Funding Panel
- A member of the Public Health team must be included on funding panel to provide some external verification for the grants.
- Written confirmation and terms and conditions will be sent to successful applicants and monies will be released on receipt of signed/dated returns. All monies should be spent within 12 months from allocation
- Quarterly Project Monitoring/Evaluation Forms will be requested, as well as an end of report to provide evidence of outcomes

ELIGIBLE ORGANISATIONS OR GROUPS

Applicants from both statutory and non-statutory organisations are encouraged to apply for grants to develop existing services, make joint bids and fund one off projects or pieces of work which will have an impact on improving Health & Wellbeing by contributing towards the Public health Outcomes Framework and Council corporate plan.

All organisations or groups applying for a grant must have an independent bank account for the grant to be paid into. Grants of over £5,000 will require that a Group has a written constitution.

CONTACTS:

Please do not hesitate to contact the Area Team Manager in the first instance. If you want more details about the grant criteria, please contact the Healthy Communities Team **Tel:** 07500 891582 **Email:** Samuelcrowson@barnsley.gov.uk

REPORT TO THE HEALTH & WELLBEING BOARD

Performance / Activity Update

Report Sponsor:	Karen Sadler
Report Author:	Will Boyes
Received by SSDG:	12/11/18

1. Purpose of Report

To provide the board with an updated performance dashboard and a summary of key progress against HWBB action plan updates (April to November 2018).

2. Recommendations

2. Health & Wellbeing Board members are asked to:-
   - Note the performance and action plan updates

3. Introduction/ Background

3.1 The document attached at appendix 1 provides the board with a headline summary of performance, alongside action plan highlights. This supports the board to challenge the respective leads, where progress may not be on track to achieve priorities.

3.2 Appendix 2 provides a more detailed analysis of performance against any updated whole population level indicators. Trend and benchmarking data to support the analysis is now presented via an online dashboard, available via the following link.

3.3 SSDG was consulted on this approach and identified indicators that align with the priorities in the 2016-20 Health and Wellbeing Strategy. The indicators are drawn from nationally available datasets (such as the Public Health Outcome Framework). This allows Barnsley's position amongst comparators to be identified. However, it does also mean that data used is often subject to a time lag in reporting.

3.4 When the last performance and activity update was presented to the board in April, members raised queries regarding the alignment of activity and accountability for performance.

This report does not identify definitive links between activities delivered and shifts in population level indicators. One option to address this in future reports would be to adopt an Outcome Based Accountability approach, which helps to draw stronger links between activity and population level change.

4. Link to Joint Strategic Needs Assessment

4.1 The performance indicators included within this report are aligned with data from the current JSNA. The board will be provided with updates as and when the updated JSNA is available.

5. Conclusion / Next Steps

5.1 This report sets out an approach to tracking progress against board priorities. Further updates will be provided, which continue to review key indicator data alongside activity updates.

6. Financial Implications

6.1 No direct financial implications have been outlined in this report. However, this approach is intended to provide an overview of the impact of activities and interventions on headline indicators, which would encompass discussions regarding the effective use of resources.

7. Alignment / Delivery of the Health & Wellbeing Strategy

7.1 This report supports the board to review progress against the strategy.

8. Alignment / Delivery of the Barnsley Place Based Plan

8.1 This report aligns with key issues identified within the Place Based Plan.

9. Stakeholder engagement / co-production

9.1 The proposed approach has previously been shared with key partners via SSDG.

10. Appendices

10.1 Appendix 1 – Health & Wellbeing Board Strategic Priorities – Performance & Action Plan summary

Officers: Will Boyes (willboyes@barnsley.gov.uk) **Date**: 05/11/18
Karen Sadler (karensadler@barnsley.gov.uk)

Reducing harm caused by smoking and alcohol

Performance Summary	**November 2018**	
	Areas for Improvement	Areas of Strength
		• Smoking prevalence – routine/manual occupations
	March 2018	
	• Admission episodes – alcohol related conditions	• Smoking status at time of delivery
	October 2017	
	• Smoking prevalence – routine/manual occupations • Admission episodes – alcohol related conditions	• Smoking status at time of delivery
Activity	• The 'Make Smoking Invisible' programme of work was awarded 'Highly Commended' at the LGC Awards. An e-poster on this also won an award at the 2018 National Public Health England conference. • A toolkit for schools and branded smokefree schools signage has been delivered to all primary schools in Barnsley, with initial positive responses. • The Smoking in Pregnancy team is being strengthened to provide designated staff to support women through their whole pregnancy journey, until handover to health visitors. The team are also exploring options for using the Baby Clear Accreditation. • 13 town centre bars accredited by the Best Bar None Scheme in September 2018. • An Alcohol Plan has been developed. A stakeholder workshop to agree priorities will be held in December.	

Improving services for older people

Performance Summary	**November 2018**	
	Areas for Improvement	Areas of Strength
	• Permanent admissions to residential / nursing care (2017/18 data) • Dementia: Rate of Emergency Admissions	
	March 2018	
	• Emergency hospital admissions due to falls • Permanent admissions to residential / nursing care (2016/17 data)	
	October 2017	
	• Dementia: Rate of Emergency Admissions • Emergency hospital admissions due to falls	• Permanent admissions to residential / nursing care (2015/16 data)
Activity	• A dementia webpage is now available. It provides easy access to information and events relevant to people with dementia and their carers. It links to Live Well Barnsley and provides an events page for easy access to local activities. • The Integrated Care Partnership Group has identified frailty as one of its programmes for 2018. This is being supported locally by a multi-stakeholder group. The Falls work contributes to the wider agenda of the frailty programme. • The Safe & Well Checks pilot was launched from Cudworth fire station in October 2018. This will run for 6 months before evaluation. • Carers are currently being consulted on the development of a set of short films to be made as a result of the Barnsley Dementia Summit. The films will address the 'here and now' for carers caring for people with dementia. The mayor has allocated funds to this project.	

Improving early help for mental health

Performance Summary	**November 2018** Areas for Improvement Areas of Strength • Hospital admissions as a result of self-harm (10 to 24 year olds) **March 2018** • Suicide rate **October 2017** • Prevalence of depression and anxiety • Long term mental health problems • Employment of people with mental illness or learning disabilities • Hospital admissions as a result of self harm (10 to 24 year olds) • Self-reported wellbeing • Prevalence of severe mental illness • Positive satisfaction with life amongst 15 year olds
Activity	• Schools-led mental health therapeutic team (MindSpace) has a website, designed by young people for young people and their parents. Schools have a link to the MindSpace site on their pupil login page. • The council's educational psychology team, in partnership with MindSpace, have delivered emotional literacy support assistant (ELSA) training to 20 primary and secondary school staff. This was successful and plans are in place to deliver further training. • Chilypep deliver Youth Mental Health First Aid (YHMFA) training, as well as bespoke mental health training to school staff. All but two secondary schools have at least one YMHFA trained member of staff. • The council's Public Health service, MindSpace, CCG and Chilypep were successful in a bid for Beyond Places of Safety funding. The bid aims to develop an app to complement the MindSpace website, enhancing the website for a wider audience and offering a digital form of counselling. • Suicide Prevention Day campaign, #AlrightPal?, supported by mental health services locally and Barnsley Football Club, hit a social media audience of 60,000. The campaign also featured in Barnsley Chronicle, BBC Look North and BBC Radio Sheffield. • Since March, the Barnsley Crisis Care Concordat and Suicide Prevention (CCCSP) partnership has operated as an alliance to improve the mental health of Barnsley residents. The partnership is mapping training available to staff, which will identify any gaps. It is also working with not for profit charities and service users (Mental Health Forum and OASIS) to design a local mental health webpage and Crisis Cards. • The More and Better Jobs Taskforce is now promoting Work Readiness Competencies. These are being rolled out across educational institutions and employment support services in Barnsley. Northern College are piloting a first step engagement programme, targeted at individuals with the most complex barriers to work (including mental health). The competencies have been translated into a signed video and easy read format, both of which are on the council website.

Building strong and resilient communities

Performance Summary	**November 2018** Areas for Improvement • Patient experience of accessing primary care • Proportion of workless households Areas of Strength • Childhood obesity **March 2018** • Excess winter deaths • Childhood obesity **October 2017** • Childhood obesity • Utilisation of outdoor space for exercise / health reasons • Children in low income households • Patient experience of accessing primary care

Activity	• The Integrated Care Partnership Group (ICPG) has developed a workstream focused on neighbourhoods. The group held a system-wide workshop to establish understanding and direction of travel. Since then, the Dearne area has been a pilot area for developing arrangements, which could be rolled out across Barnsley. The group are holding a workshop in November to develop this further. • Live Well Barnsley continues to go from strength to strength. Further promotion is needed to encourage staff and organisations to access it. It is expected to be a key feature of the neighbourhoods workstream; empowering people to find appropriate services and support within their local communities. • The principles of self-care will be embedded into the neighbourhoods workstream, with the aim of empowering and enabling local communities to manage their health and wellbeing, where appropriate. This will ultimately reduce demand in the system. • A competitive procurement exercise to commission a new carers service has been completed. This follows consultation and scoping with the Carers Strategy Steering group, and the Carer and Friends Group. The contract was awarded to Making Space and the service, known as the Barnsley Carers Service, commenced in August. • Empty Homes programme has progressed significantly, with the establishment of dedicated resources. Funding has been secured to deliver the Stock Conditions Survey in 2019.

Integrating Health & Social Care / Changing the way we work together

Performance Summary	**February 2018 update** Areas for Improvement • Emergency admissions (65+) **October 2017** • Emergency admissions (65+)	Areas of Strength • Delayed discharges • Delayed discharges • Reablement
Activity	• Neighbourhood Nursing Service: The Core Offer to Care Homes is reaping dividends with clarity given to how the NNS can support care homes. The service is training care homes in areas such as: basic observations, sepsis training and blood glucose monitoring. • The Integrated Care Partnership Group (ICPG) has responded to the BCCG Strategic Outline Case on how commissioners and providers could work towards an ICO, through deepening partnership working and collaboration. This will be further explored at a workshop in November 2018. • The ICPG is supported by the Integrated Care Delivery Group, who are progressing 3 worksteams on fragility, CVD and neighbourhoods. • Local Digital Roadmap - a high level plan has been formulated and agreed by South Yorkshire and Bassetlaw Integrated Care System. It is anticipated that the Shared Care Record Solution for Barnsley Place (BHNFT, Primary Care, SWYFT, and BMBC) will go live in 2020/21, following approval of business cases in each organisation. • Migration of Map of Medicine pathways to the BEST website completed. Appropriate flags and referral forms have been incorporated in clinical systems. • Approach developed to deliver an Integrated Respiratory Service in Barnsley, BREATHE, covering primary, secondary and community healthcare. This involved healthcare providers (BHNFT, SWYFT and Barnsley Health Care Federation) working together as a single team, with a multidisciplinary approach, to integrate care and deliver a seamless service.	

H&WB Strategic Priorities – Performance update

The new online dashboard report provides an overview of the latest position for Barnsley, against a range of whole population level indicators. This aligns with the priorities in the 2016-20 Health and Wellbeing Strategy and supports comparisons with national averages and our comparator groups.

The analysis below reflects the indicators where data has been updated since our last report. Analysis on the remaining indicators is available in previous reports.

Improving Population Health & Wellbeing and Reducing Inequalities

Reduce harm caused by smoking & alcohol

- 2017 Annual Population Survey data on **smoking prevalence in adults** (current smokers) shows an improved position for Barnsley. 18.2% of adults were current smokers in Barnsley; a reduction from 20.6% in 2016 and a narrowing of the gap to the national average of 14.9%. Amongst statistical neighbours, Barnsley sits in a group of local authorities with higher levels of smoking; only Doncaster had a higher figure in 2017 (19.7%). The best performing area amongst statistical neighbours is Dudley (13.7%).

- The same data source shows a sharp decrease in Barnsley in **smoking amongst adults in routine and manual occupations**; the first decrease in 4 years. The gap to the national average has narrowed significantly. 27.5% of adults in routine and manual occupations were current smokers in 2017, compared to a national average of 25.4%. Amongst our statistical neighbours, Barnsley now sits outside the group of worst performing local authorities, ranking 6th of 16. The best performing area amongst our comparators is Halton (17.7%).

Improving services for older people

- 2017/18 data (from the 2017/18 Adult Social Care Outcomes Framework) shows a significant increase in the rate of **permanent admissions to residential and nursing care** for those aged over 65 in Barnsley. Reporting against this indicator was brought in line with the national definition in 2017/18; this involved including those adults who fund their own care, but where the local authority has completed an assessment. The national average has been falling for a number of years, resulting in the gap to the Barnsley average (and that of most of our comparators) widening in 2017/18. Amongst our comparators, Barnsley had by far the highest rate at 932.7 per 100,000, with the next local authority (Durham) having a markedly lower average of 751.3.

- **Dementia related emergency admissions** in Barnsley and nationally have increased continually over the four year years between 2012/13 and 2016/17. Data for the latter year shows a marked increase and widening of the gap between Barnsley and the national average. Amongst our comparators, only one local authority (Telford and Wrekin) has a rate below the national average. Barnsley ranks 5th in the comparator group.

- 2018 data shows a decline in the **estimated dementia diagnosis rate** for Barnsley, falling to 68.6% from 70.6% in 2017. This has narrowed the gap to the national average (67.5% in 2018). Barnsley's average sits towards the lower end of our comparator group range, which varies from 62.7% in Telford & Wrekin to 90.2% in Doncaster.

Improving early help for mental health

- After decreasing in 2015/16, the latest data (2016/17) shows an increase in the **prevalence of depression and anxiety** in Barnsley, rising to 16.9% from 15.6%. The national average has been increasing for some time and increased at a higher rate in 2016/17, ensuring the gap to Barnsley is largely consistent. Amongst our comparator group, Barnsley ranks 4th of 16.

- The recorded **prevalence of severe mental illness** rises steadily each year, locally and nationally. Barnsley continues to have the lowest prevalence amongst our comparator group.

- There remains a higher rate of **long-term mental health problems** in Barnsley, compared to the national average, although the gap narrowed in 2016/17. Barnsley remains amongst the group of worst performing areas in our comparator group, ranking 2nd of 16.

- **Adults with a mental illness or learning disability** in Barnsley are less likely to be **in employment**, when compared to the national average. Quarterly data for 2016 does however show a significant narrowing of the gap to the national average. Barnsley's position amongst our comparators has improved and no longer sits in the group of worst performing areas. Barnsley now ranks 4th best the 15 areas.

- The rate of **hospital admissions as a result of self-harm** (10 to 24 year olds) fell both locally and nationally in 2016/17, with respective figures for both returning to levels seen in 2014/15. Barnsley sites well outside the group of worst performing areas in our comparator group, ranking 5th of 16.

Building strong and resilient communities

- The latest **childhood obesity** data (2017/18) shows increases in the proportions of reception and year 6 pupils with excess weight. However, Barnsley maintains a very strong position amongst comparators, ranking 16th out of 16 for both age groups.

- Data published for 2015 shows marked decreases in the proportion of **children in low income families**, both nationally and locally. The rate of decrease nationally was slightly higher, widening the gap to Barnsley. Amongst our comparator group, Barnsley ranks 4th out of 16.

- Barnsley continues to have a higher proportion of **workless households**, when compared to the national average. The gap widened noticeably in 2017, with an increase in Barnsley to 21.1%, and a continued decrease nationally to 14%. Amongst our closest comparators, Barnsley ranks 2nd of 16, with only St. Helens having a higher proportion of workless households. Neighbouring Wakefield has the lowest proportion of workless households at 13.6%.

- The latest data from the GP Patient Survey continues to highlight unsatisfactory **experiences related to making GP appointments** in Barnsley. Changes in methodology were introduced for the 2018 survey, which mean comparisons with historical data are no longer appropriate. The latest data shows Barnsley to have the lowest ranking amongst our closest comparators, with 62% reporting a good experience, below the national average of 68.6%.

Integrating Health & Social Care / Changing the way we work together

The data presented in the dashboard is taken from the NHS Social Care Interface dashboard. Two indicators within the dashboard were updated in August 2018. The analysis below reflects those updates.

- Barnsley has the lowest number of **delayed discharges** (total) per 100,000 population (over 18) amongst our closest comparators.

- Conversely, Barnsley continues to have the highest rate of **emergency admissions** (over 65s) amongst our closest comparators.

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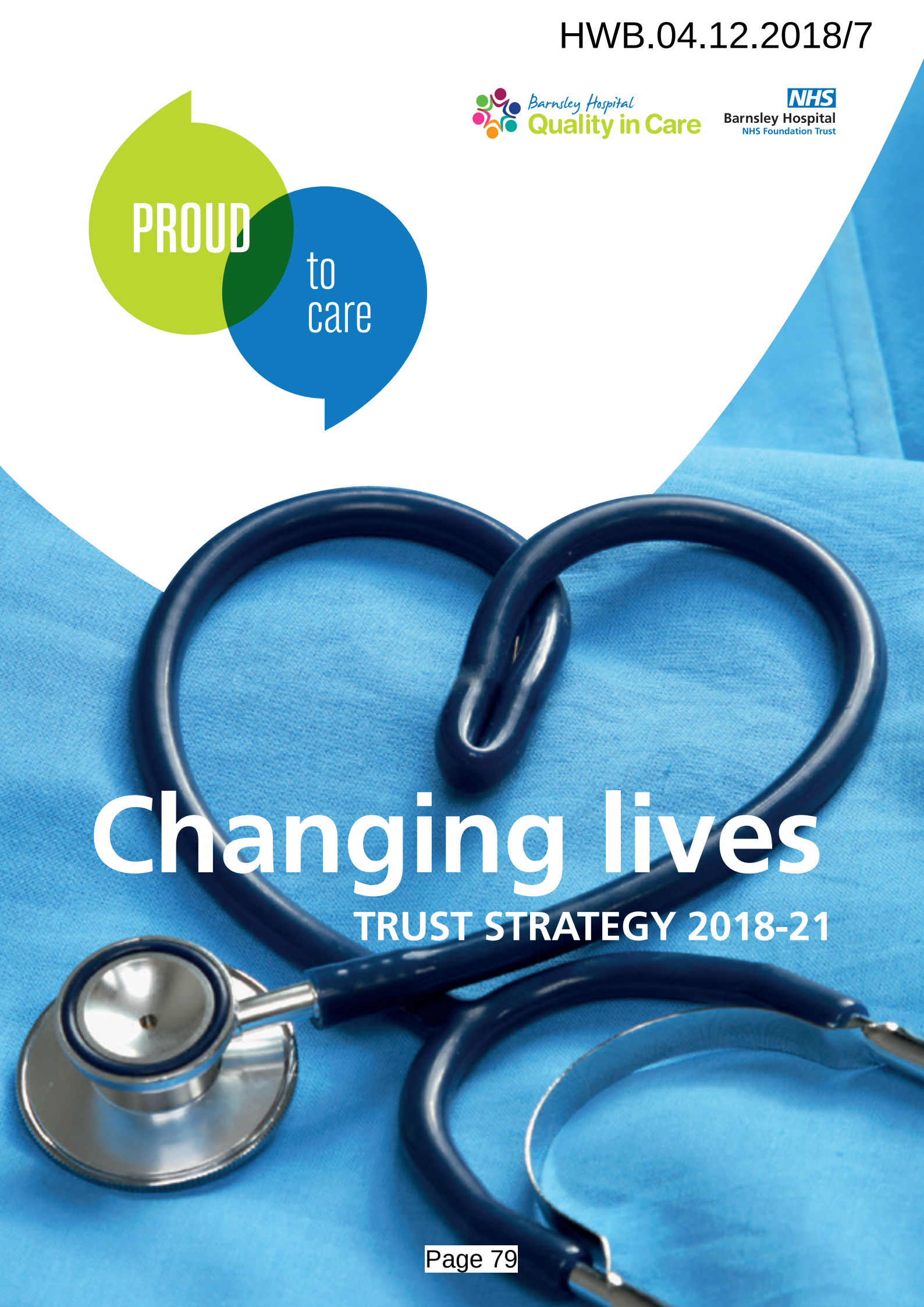
Barnsley Hospital Quality in Care

NHS Barnsley Hospital NHS Foundation Trust

PROUD to care



Changing lives

TRUST STRATEGY 2018-21

Contents

Message from CEO/Chair

We are immensely proud to have led Barnsley Hospital over the last few years. The Trust has come a long way since 2014/15 when our last Trust Strategy (2014-2019) was developed and our teams have achieved a significant amount in that time. We have seen this Strategy set a framework for the success of the organisation and the work that has been delivered from this plan has resulted in turning the Trust around and creating a solid foundation on which we can build and maintain a sustainable future to provide outstanding care for our patients.

In 2014 the Trust had significant financial issues, elective market share had declined in Barnsley, our core market, and there were concerns with a number of our services. The Trust also had a breach of licence imposed for 4 hour Emergency Department performance, governance and finance.

Since that time the Trust has worked closely with its staff, commissioners and partners to achieve the ambitions laid out in our five year Strategy. With this support the Trust has successfully implemented a number of key initiatives including overall improvements in quality and patient safety, sustainably stabilising our financial position and achieving our Cost Improvement target three years in succession. Operational performance has been maintained and we have seen the lifting of our licence breaches for the 4 hour target, governance and finance. We have also grown our Barnsley elective market share significantly and repatriated Orthopaedic and Urology services. 2017 also saw us make a successful bid to deliver Ophthalmology services.

This new Strategy has built on these excellent achievements. Although we have come a long way, there is still lots of work to do and this plan has been created to deliver our visions, aims and objectives over the next three years.

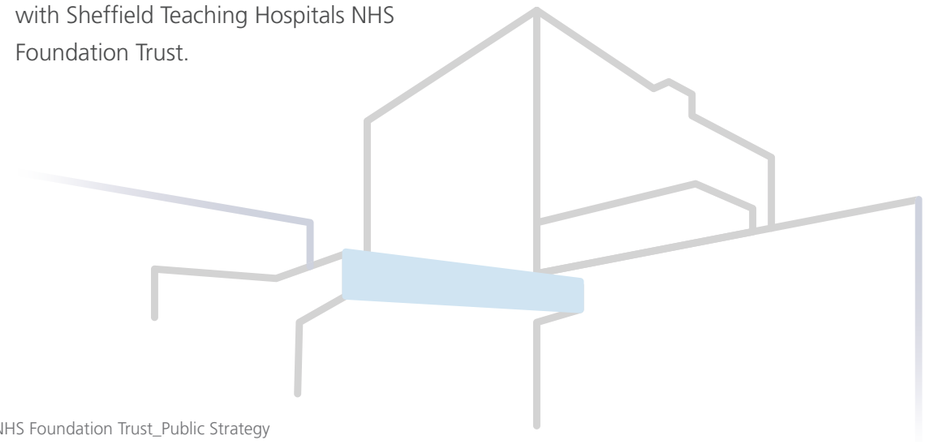
The Strategy has been built around the needs of our patient population while at the same time identifying the changes required of healthcare for the future as set out in the Five Year Forward View, working with our partners locally in the Integrated Care Partnership and regionally through the South Yorkshire and Bassetlaw Integrated Care System.

We look forward to leading the Hospital through the next three years and, based on the excellent work to date, we cannot wait to see what our teams will achieve through delivery of this Strategy.

About Our Trust

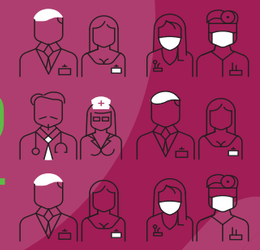
Barnsley Hospital NHS Foundation Trust is a district general hospital, built in the 1970s and serving a population of approximately a quarter of a million people within the boundaries served by Barnsley Metropolitan Borough Council.
In 2005 the Hospital gained Foundation Trust status and today provides a full range of district hospital services to the local community and surrounding area. These acute hospital services include emergency and intensive care, medical and surgical care, elderly care, paediatric and maternity, along with diagnostic and clinical support. The Trust also provides a number of specialised services, such as cancer and surgical services in partnership with Sheffield Teaching Hospitals NHS Foundation Trust.

Operationally, there are three Clinical Business Units (CBUs). Each CBU is led by a team made up of a Clinical Director, Associate Director of Nursing and an Associate Director of Operations, who are supported by Matrons and Service Managers together with human resource, finance and data analyst teams.

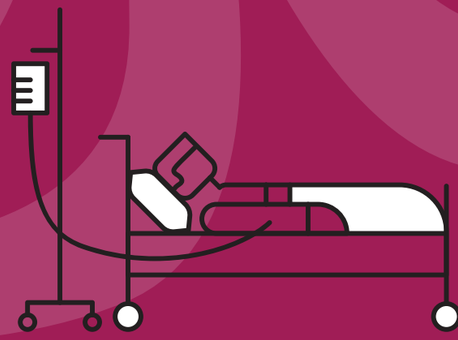


About Us

We have **3,522** employees

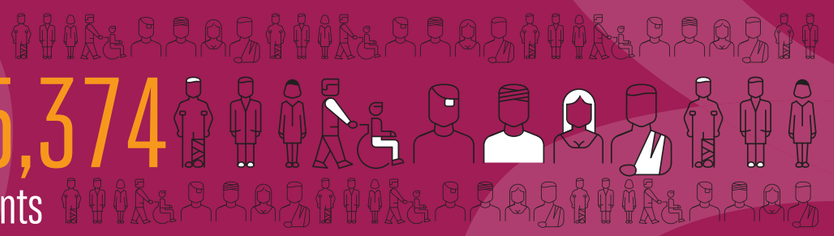


In 2016-2017



We cared for **412,833** patients

We saw **265,374** outpatients



We saw **83,545** patients in our Emergency Department

About our Place: Barnsley

The health of people in Barnsley is varied compared with the average in England. Barnsley is one of the 20% most deprived districts/unitary authorities in England and about 25% (10,600) of children live in low income families.

The Trust is central to the development of an Integrated Care Organisation (ICO) in Barnsley. Working alongside Barnsley Clinical Commissioning Group (CCG), Barnsley Healthcare Federation, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Barnsley Council and local community and voluntary organisations. Together, we aim to deliver the very best care, in the right place, for our local population.

We want to ensure people in Barnsley access seamless service delivery when accessing services at any given point. We are already delivering services in partnership including RightCare Barnsley, a new intermediate care service and the integrated respiratory service, BREATHE.

The vision for health and care in Barnsley is:

> A happy, healthy, and empowered Barnsley community; supported by a single person centred health and social care system that meets people's care needs now and in the future.

Key principles include:

Breaking down boundaries

- A joined up health care system for Barnsley
- No organisational barriers
- Patients experience continuous care, with familiar faces that are concerned regardless of where they are seen
- People and patients supported by 'One Team', delivering without duplication

Putting people at the centre

- A simpler, joined up health and care system to focus on how we offer services
- We will move from treating patients with health problems to supporting Barnsley community to remain healthy in the first place
- We'll move from "doing to and for" to"doing with"

Right care at the right time

- A focus on supporting healthy independent living across our borough
- Where this is not possible, we will support patients to feel equipped and skilled to care for themselves and to manage their own health and wellbeing
- Making sure health and care services are available when people need them

The Barnsley Plan has been developed through partnership across the public sector and voluntary community sector organisations. The vision of this plan is that people of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, whoever they are and wherever they live.

More information can be found about The Barnsley Plan here:
https://bit.ly/2saW4Bs

About our Place:
South Yorkshire and Bassetlaw

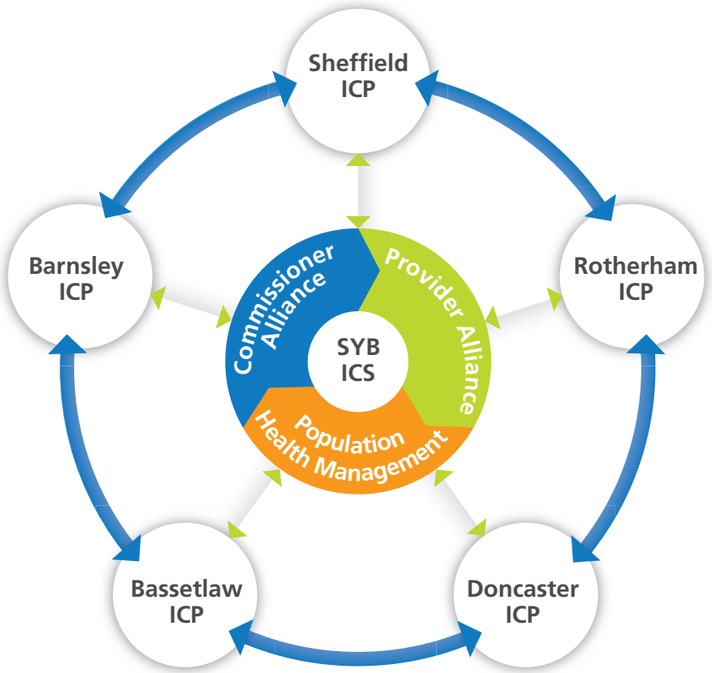
The Trust has been working together with other acute providers in South Yorkshire and neighbouring areas over the past 5 years. Key achievements include; improvements in Information Technology (IT) connectivity and procurement savings of over £1m.

In summer 2017 health and care partners came together across the region to form one of the first Integrated Care Systems (ICS) in the country. This involves over 40 organisations, covering a collective budget of £3.9bn, 1.5m population and 72,000 staff.

Working in partnership regionally allows us to have:

- Local version and way of implementing the Five Year Forward View
- Overarching strategic plans, defined geography, building on local work and collaborations
- Whole systems coming together to find solutions to local challenges. Vision, ambition and priorities
- Opportunity to refocus on supporting people to stay well for longer in communities, illness prevention and to develop new models of integrated care

There is an overall Integrated Care System (ICS) governance structure with Integrated Care Partnerships (ICP) within each place, e.g. Barnsley. The relationships within the partnership are shown below:



Setting Our Strategy

To develop our strategy we undertook extensive information gathering and analysis of the organisation including a full scale Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis, horizon scan, a comprehensive service sustainability review and engagement with all key stakeholders.
The SWOT analysis is summarised below:

Strengths

- Successful track record of delivery
- Quality of service delivery
- Strong sustainable services
- Quality and stability of Trust Board
- Excellent nationwide performance status
- Good Care Quality Commission (CQC) rating
- Positive General Medical Council (GMC) survey
- National recognition for sustainability work
- Development of front of house services
- Significant growth in elective market share
- Strong Executive team
- Part of a national exemplar Integrated Care System
- Key partners in Barnsley Integrated Care Partnership
- Good relationship with our Barnsley partners
- Strong track record of Cost Improvement delivery
- Commitment to CBU clinical leadership
- Excellent business intelligence systems
- Strong governance processes
- Track record of embedding technology
- Staff that care

Weaknesses

- Sustainability of emergency access target
- Financial rating of 3 due to on-going financial breach
- Limited ability to expand at times of pressure
- Some areas of estate require investment
- Re-admission performance
- New to follow up ratios
- Loss of income due to capture/coding issues
- Negative Service Line Report position of certain services
- Cost of escalation due to poor patient flow
- Difficulty in recruitment of skilled workforce
- Level of high value legacy NHS Resolution claims
- Incumbent Electronic Patient Record (EPR) system
- Lack of fully developed succession plan for Executives
- Critical Care capacity
- Lack of capital funds
- Productivity levels in some areas
- Lack of fully developed People Strategy
- Ability to influence change due to size of Trust
- Parts of culture very traditional/resistant to change

Opportunities

- New and integrated services
- Pathology Partnership
- Improved patient flow
- Out-Patient Modernisation Programme
- Embedding the Intermediate Care Service
- Neighbouring Trusts requiring support
- Integrated Care System (ICS) Hospital Services Review
- Getting It Right First Time (GIRFT) and Carter Programmes
- Long term clinical partnerships with other Trusts
- Marketing beyond traditional boundaries
- Expansion of wholly owned subsidiary company
- Issues with activity capture/coding
- Improved facilities
- Consolidation of services across Barnsley/region
- Partnership working
- Expansion of collaborative working arrangements
- Reducing levels of additional spend/agency payments
- External funding
- Paperless agenda 2020
- To improve the deficit financial position of some core services
- New funding deal for the NHS

Threats

- Lack of suitably trained people externally
- Outputs of the ICS Hospital Services Review
- Increasing demand for services
- Impact on activity levels from integrated services
- Impact of Regional Acute Stroke Service Review
- Insufficient capital funds
- Continued high level of additional payments
- Elective growth thresholds
- Continuation of loss making services
- Financial deficit position of the Trust
- Financial position of the CCG
- Competition from other public and private providers
- HM Revenue and Customs reviewing subsidiary model
- Staff survey results
- Potential Government change
- On-going cost cutting by the Government
- Increasing demand on Emergency Departments
- Failing care homes
- Rise in social media

PROUD to care

Our Vision, Aims and Objectives for the next three years

We have set our vision, aims and objectives for the next three years based on our extensive analysis and information gathering:

Our Vision:

To provide outstanding, integrated care

Patients:
will experience outstanding care

We will deliver our Quality Strategy (2017-20) and goals:

- Provide care that is based on the best evidence for every patient, every time
- Continuously seek out and reduce avoidable patient harm
- Deliver good patient experience

We will deliver our Clinical Strategy (2018-21)

We will ensure a more sustainable approach to patient flow both internally and with partners across the system

We will deliver the Barnsley Hospital Digital Roadmap

Barnsley Hospital Quality in Care

Partners:
we will work with partners to deliver better, more integrated care

We will work with all of our partners in Barnsley to deliver the Barnsley Plan priorities

We will play a leading role in 'Barnsley Health and Care Together', building on existing relationships with key partners

We will continue to work with partners across South Yorkshire to ensure sustainable local services and support others regionally

People:
will be proud to work for us

We will deliver our People Strategy (2018-21) to ensure a sufficient, capable, motivated and sustainable workforce:

- **Talent**
  Develop all leaders to influence and motivate effectively
- **Engagement**
  Motivate our people to be the best that they can by living our values and creating a culture of trust
- **Quality**
  Ensure we have the right people, in the right place, at the right time, doing the right things
- **Well-being**
  Ensure that we create an environment where our people are physically and emotionally sustained

Performance:
we will achieve our goals sustainably

We will work closely with our Clinical Business Unit teams to ensure that the right support is in place

We will deliver all of the constitutional standards and other agreed targets

We will hit our financial plans and work towards a back to balance position by:

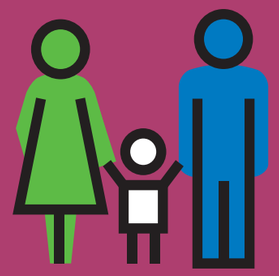
- Cost reduction and a focus on increased efficiency and productivity including standardisation of practice and minimisation of variation
- Exploration of further commercial opportunities through our subsidiary company and formal partnerships
- Expansion of existing services and introduction of new services allowing us to reinvest in patient care

Our Values:

Treat people how we would like to be treated ourselves
We work together to provide the best quality care
We focus on your individual and diverse needs

We will refresh our objectives each of the three years in line with the vision and aims.

Our Strategy



Patients:
will experience outstanding care

OBJECTIVES:

We will deliver our Quality Strategy (2017-20) and goals:

- Provide care that is based on the best evidence for every patient, every time
- Continuously seek out and reduce avoidable patient harm
- Deliver good patient experience

We will deliver our Clinical Strategy (2018-21)

We will ensure a more sustainable approach to patient flow both internally and with partners across the system in 2018-2019

We will deliver the Barnsley Hospital Digital Roadmap

Quality

Quality in patient care is one of the Trust's core objectives and is key to all we do. We take pride in ensuring that the patient is at the heart of everything we deliver, believing that our patients and their families deserve the highest quality service and care and that every patient cared for in our Hospital is treated with respect, dignity and compassion.

Goal 1: Reduce unnecessary variation in patient care
Achieve the highest level of reliability for clinical care
Aim to eliminate avoidable death

Goal 2: Reduce harm from poor communication and ineffective team working
Reduce patient harm from the most common known causes
Maintain focus on eliminating avoidable patient harm

Goal 3: Work with patients as partners in improvement
Enable patients to be in control of their own healthcare
Improve information and communication with patients
Use patient insight and feedback to improve experience

Clinical

Our Clinical Strategy is designed to develop our ways of working to provide better services for our patients. It looks at the type of care we deliver and how we need to develop over the next three years.

This translates into nine key clinical workstreams:

Our Key Clinical Workstreams

1 Outpatient Care
2 Inpatient Care
3 Frailty Services
4 Community Care
5 Intermediate Care
6 Safer Care
7 Bed Management and Patient Flow
8 Theatres and Critical Care
9 Partnerships with Other Trusts

Patient Flow

Through delivery of the Urgent & Emergency Care Plan we will:

- Implement a new flexible bed base model to meet seasonal variations in demand
- Develop a short stay model that supports overall patient flow
- Develop new models for discharge planning and long stay patients
- Develop a new GP referral/ admission model to avoid unnecessary admissions
- Standardise ward rounds to reduce variation
- Implement a new IT solution for bed status reports

New Facilities

We will improve patient experience through:

- Delivery of a new Neonatal Unit
- Co-location of the Children's Assessment Unit and the Paediatric Emergency Department
- Continued refurbishment of our Women's & Children's Block

Cancer Services

We will develop and deliver the Trust's Cancer Strategy to improve patient care in this area.

Barnsley Hospital Digital Roadmap

We will implement technology to allow our patients to access services when and where they need them, including remotely at home through:

- Delivery of patient facing technologies; access to records, remote care and schedules of appointments
- Delivery of Paperless Electronic Records safely by 2020
- Support for our staff to effectively deliver direct patient care through the use of technology

Partners:
we will work with partners to deliver better, more integrated care

OBJECTIVES:

We will work with all of our partners in Barnsley to deliver the Barnsley Plan priorities

We will play a leading role in 'Barnsley Health and Care Together', building on existing relationships with key partners

We will continue to work with partners across South Yorkshire to ensure sustainable local services and support others regionally

The face of health care is changing. The future landscape involves integrated working with partners both locally and regionally to provide patient care that exceeds organisational boundaries. Extensive work has already been undertaken in this area with the introduction of some integrated services but we intend to build on this work over the next three years:

Existing Partnerships

- We will continue our partnership working with other Trusts locally such as Rotherham Foundation Hospital and Mid Yorkshire Hospitals
- We will work with other Providers and Commissioners to identify ways to improve local care delivery
- We will work with partners on agreed priorities such as cardiovascular disease, frailty and neighbourhoods.

Barnsley Health & Care Together

- We will continue to work with partnership services through the Barnsley Alliance including RightCare Barnsley, Respiratory BREATHE Service, Intermediate Care
- We will deliver the new Barnsley Integrated Diabetes Service (BIDS) in partnership with the GP Federation
- We will work with partners on delivery of the Digital Roadmap, Estates Strategy and Barnsley Engagement approach
- We will recruit a new Public Health Consultant to continue to support public health priorities, working with all public health agencies on the Barnsley Plan including smoking cessation and alcohol/tobacco control.

South Yorkshire & Bassetlaw Integrated Care System (ICS)

- We will work with our partners across South Yorkshire to ensure sustainable local services and support others regionally
- We will work with partners to deliver South Yorkshire and Bassetlaw Integrated Care System priorities and actions.

Our Strategy

People:
will be proud to work for us

We will deliver our People Strategy (2018-21) to ensure a sufficient, capable, motivated and sustainable workforce:

- **Talent**
  Develop all leaders to influence and motivate effectively
- **Engagement**
  Motivate our people to be the best that they can by living our values and creating a culture of trust
- **Quality**
  Ensure we have the right people, in the right place, at the right time, doing the right things
- **Well-being**
  Ensure that we create an environment where our people are physically and emotionally sustained

Our people are important to us and we want them to be proud to work for Barnsley Hospital. We are committed to building a sufficient, capable, motivated and sustainable workforce and our plans over the next three years support this approach:

- We will work with our Clinical Business Units (CBUs) to develop robust workforce plans and help shape our future workforce
- We will develop a strategic approach to engagement, organisational culture, well being, talent and quality which promotes effective leadership and organisational development
- We will address areas of concern from the staff survey and ensure that improvement plans are implemented
- We will focus on the health and well being of our staff
- We will enable staff to access training and development
- We will continue to engage our local community and equality forum partners to promote the Trust as an employer of choice and to improve patient and staff experience

Performance:
we will achieve our goals sustainably

We will work closely with our Clinical Business Unit teams to ensure the right support is in place

We will deliver all of the constitutional standards and other agreed targets

We will hit our financial plans and work towards a back to balance position by:

- Cost reduction and a focus on increased efficiency and productivity including standardisation of practice and minimisation of variation
- Exploration of further commercial opportunities through our subsidiary company and formal partnerships
- Expansion of existing services and introduction of new services allowing us to reinvest in patient care

Performance is key to the success of the organisation. Our aim is to deliver on all of our constitutional standards and at the same time build on the significant work to date to ensure the organisation is sustainable moving forward:

Clinical Business Units and Performance

- We will embed the Clinical Business Unit triumvirate approach across the Trust
- We will refresh our Integrated Performance Framework
- We will deliver development sessions for our Clinical Business Unit teams
- We will explore different ways of working
- We will continue delivery of our constitutional standards e.g. four hour target, Referral To Treatment (RTT), Cancer and Diagnostics

Financial Sustainability

We will deliver a sustainability strategy over the next three years which will implement a number of initiatives based on four key themes. Below are some examples of these:

Cost Reduction, Increased Efficiency and Productivity
- Reduce additional payments
- GIRFT/Carter Programmes
- Improve patient flow
- Reduce Re-admissions
- Out-Patient Modernisation
- Control of CNST Costs

Significant Service Change and Partnership Working
- Care of the elderly/frailty
- Dermatology Improvement Plan
- Paediatric ED/CAU
- Critical Care Expansion
- Stroke Services
- Neonatal Unit

Service Growth and Expansion
- Elective Service Expansion
- Gastro/Endoscopy
- Plastic Surgery

Commercial Opportunities
- Barnsley Facilities Services Expansion
- Pathology Partnership

Our Supporting Strategies

A range of key supporting strategies work together to form the overall Trust Strategy 2018-21. Each of these strategies is monitored by an appropriate Board Sub-Committee to ensure delivery:

How We Are Held to Account

Robust Governance Structure

Our Governance Structure is robust and provides assurance around delivery of this Strategy. The Board of Directors is accountable and responsible for ensuring that Barnsley Hospital NHS Foundation Trust has an effective programme for managing all types of risk which is achieved via the Board Assurance Framework and review of the Corporate Risk Register.

The Board is chaired by the Chairman, a Non-Executive Director, and meets monthly.

The Council of Governors holds the Trust's Non-Executive Directors to account for the performance of the Board and represent the interests of members and the Public.

The Trust has a fully embedded Governance structure together with a clear Assurance and Governance Framework, which compliments the Performance Management Framework also in place.

The Board Assurance Framework (BAF)

The BAF is designed to monitor the major risks to the delivery of our strategic priorities.

The BAF is reviewed by all committees on a monthly basis and the Board on a quarterly basis.

Committee Structure

The Committee structure has been fully operational since September 2014 and consists of the following committees who review detailed strategic plans and receive strategic delivery progress reports regularly:

Finance and Performance Committee

The Finance and Performance Committee is one of the key committees of the Board, responsible for Governance. It's purpose is to provide detailed scrutiny of financial matters and operational performance in order to provide assurance and raise concerns to the Board of Directors and to make recommendations, as appropriate, on financial and performance matters to the Board of Directors.

Quality and Governance Committee

The Quality and Governance Committee is another of the key committees of the Board responsible for Governance. It's purpose is to provide detailed scrutiny of quality and safety across the Trust in order to provide assurance and raise concerns to the Board of Directors and to make recommendations, as appropriate, on quality and safety matters to the Board of Directors.

Audit Committee

The Audit Committee plays a key role in the Trust's Governance Structure and the escalation framework implemented in 2014. The Committee is responsible for providing oversight of the activity of internal and external audit, local counter fraud services and the assurance on internal controls, including compliance with the law and regulations governing the Trust's activity.

Partnership Governance

The Trust are fully engaged with the South Yorkshire and Bassetlaw Integrated Care System and Integrated Care Partnership in Barnsley and recognise this within their governance as well as being clear that the Non-Executive Directors are accountable to the Council of Governors, statutorily to Parliament and therefore the people of Barnsley. We ensure full representation at all partnership meetings and any information/ proposals are brought back into Trust governance via our Executive Team, other governance committees, Trust Board and the Council of Governors.

This Trust Strategy was approved by our Board of Directors in April 2018.

Barnsley Hospital Quality in Care

NHS
Barnsley Hospital
NHS Foundation Trust

Gawber Road, Barnsley S75 2EP
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PROUD to care

Barnsley Hospital Quality in Care

NHS
Barnsley Hospital
NHS Foundation Trust

Clinical Strategy 2018-21

Patients will experience outstanding care

Table of Contents

Executive Summary

This document describes how we will develop our clinical services consistent with this vision and in conjunction with the Trust's Five-Year Strategy in order to meet the health needs of the people of Barnsley and South Yorkshire. It outlines how we will work with partners to provide new flexible models of care, tailored to the needs of patients.

Introduction

The purpose of this strategy is to help shape how Barnsley Hospitals NHS Foundation Trust (BHNFT) will deliver services over the next three years. The needs of patients are continuously changing and our understanding of how to deliver effective and safe care has progressed, it is important that the Trusts considers best practice from around the UK and the world in developing and shaping the strategy. The Trusts has had an overarching Strategy before, this is the first time a "Clinical Strategy" has been described; the aims of this are set out in the following document.

The Trusts previous overarching 5-year strategy included a range of objectives that included clinical developments (such as bringing ophthalmology services back under the Trust management). The purpose of this clinical strategy is not to give full detail about all of the services that are delivered, but to develop proposals for our services, in particular how our working practices will change to support the services we deliver. The full detail about all the BHNFT services will be described in the "refresh" of the Trusts overarching strategy in April 2018. The overarching strategy includes a number of supporting documents, such as the Workforce Strategy, the IT Strategy and the Quality Strategy and should be read in conjunction with this document.

Changing Healthcare

Foundation Trusts (like Barnsley) have been relatively stable over the last few years. However, there have been major changes recently to healthcare structures, brought about by the need to find new ways of working, changes in our supply of workforce and changes in patient demographics (in particular an ageing population with increasing health needs). This has led to the creation of an Integrated Care System (ICS) for the whole of South Yorkshire and, more locally, to "The Barnsley Health & Care Together Partnership". The impact of the development of the ICS may well have an impact on the type and scope of healthcare that is delivered in Barnsley; however, at this stage, this strategy will not explore the unknown impact of these proposals. This strategy will consider the known issues and requirements relating to the BHNFT 'Place' needs in the short term. The "Barnsley Health &Care Together" Partnership will lead to greater integration of care within Barnsley. This strategy will consider and align itself to these local changes in conjunction with our own vision, which is "To provide outstanding, integrated care."

As with most areas, Barnsley has its own set of unique requirements which lead to particular demand in health services. We know that we have a number of deprived areas and that we have high levels of smoking and obesity. The growth of the population in the elderly age group is significant and this creates a number of challenges. A full description of the local Barnsley demographics can be found in The Barnsley Place Based Plan (link below).

http://www.barnsleyccg.nhs.uk/CCG%20Downloads/strategies%20policies%20and%20plans/Barnsley_Plan_2016.pdf. Further information can also be found in the Barnsley via the following link - https://www.barnsley.gov.uk/media/3559/health-profile-nhs-profile-barnsley-2015.pdf

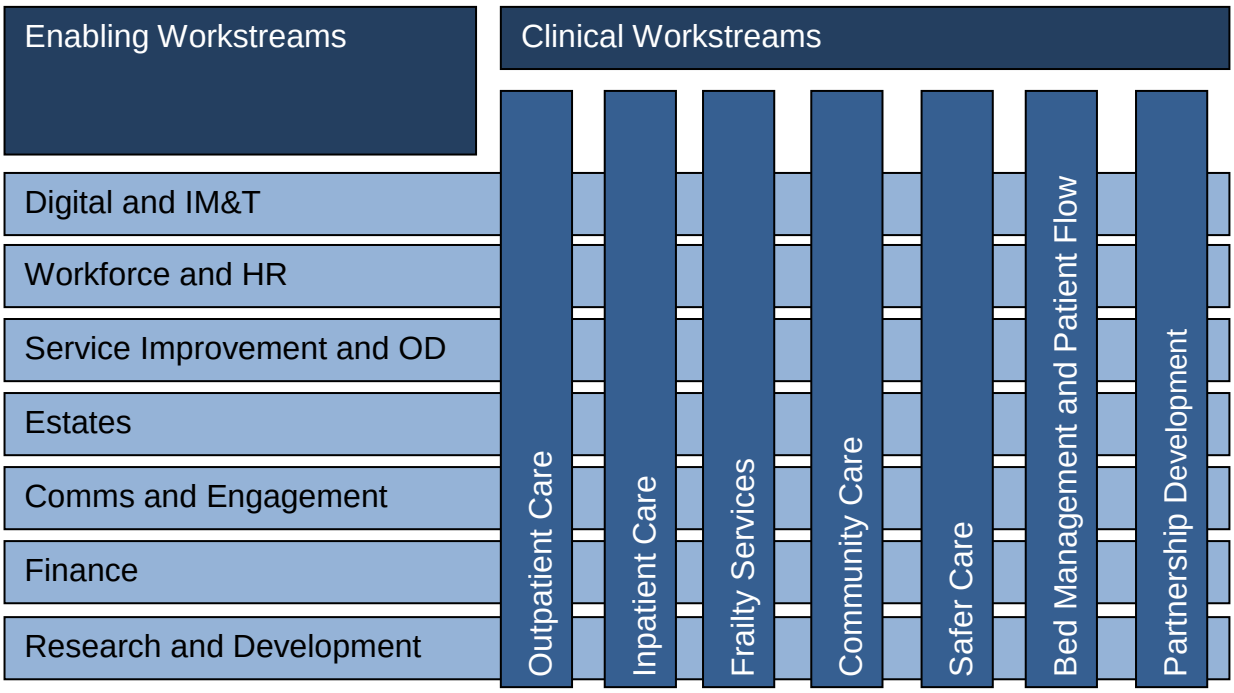
The current funding arrangements of the NHS have placed a greater emphasis on delivering efficiency with existing and reducing budgets. This gives NHS Trusts the opportunity to at look at how services are delivered differently, at the same or higher quality but at less cost. A number of initiatives have already seen significant improvements (e.g. Ambulatory Care); however, Trusts are required to constantly how they work and seeking ways to reduce 'inefficiencies' (such as unnecessary blood tests, procedures of limited value and paperwork).

The development of this strategy has considered where there is scope to develop our ways of working to provide better services for our patients. The Trust has reviewed different approaches in other organisations and considered best practice guidance from across the UK. In addition, the Trust has obtained published 'Clinical Strategies' from other Trusts. The focus of these strategies varied some were about what services are delivered and some focused-on aspects that would be more aligned to the Trusts 'Quality Strategy'. This review gave the Trust a number of ideas to take forward in consultation with both our internal and external stakeholders A number of workshops with various groups of staff have been held, including a wide range of roles from clinical, to management and support services. The outputs of these sessions have been used in conjunction with other information, described earlier, in the production of this strategy. This document itself has had input from our clinicians, commissioners, managers, Trust Governors and other local stakeholders.

Structure of this Strategy

The strategy is divided into two complementary parts. The first looks at the types of care the Trust delivers and their development needs over the next three years. The second picks up a range of underlying enabling strategies and the specific aspects of them that will underpin the changes in clinical work.

The work streams, both clinical and enabling are described in the diagram below:



The strategic intentions of each of these work streams will be described, including all major developments and the implementation plans for them. For each work stream, a brief introduction is followed by the recommended area for development and why. Detailed delivery plans will be developed and coordinated through a Clinical Strategy Steering Group.

The strategy is aimed at delivering proposals for the most pressing challenges the Trust faces; it also tries to identify and capture any opportunities that are available to the Trust. The strategy does not attempt to propose solutions for every clinical specialty but rather looks at new approaches to care by point of delivery e.g. Outpatients. The strategy will be backed up by policies. This document is intended to give a high-level overview of the Trusts strategic intentions for its clinical and support services; it is not intended to give in depth detail about the services described in the figure above. This detail will be provided by each of the work streams identified.

CLINICAL WORKSTREAMS

OUTPATIENT CARE

Background

The traditional structure of Outpatient clinics has been in place for many years. The usual process is that a patient's General Practitioner (GP) refers a patient to a hospital specialist, the patient waits, an appointment is sent, the patient waits, the patient attends the clinic and waits again, all before a short meeting with a clinician. Sometimes that clinic visit was necessary, and the advice/treatment given is very helpful and productive. At other times, the problem, which the patient has, is straightforward and could have been managed much more quickly and efficiently in other ways than waiting for a hospital appointment. Different ways of working are now available to patients through a number of new digital approaches.

Alternatives to traditional clinics can now be provided, these range from "virtual clinics" through to simple 'advice and guidance' responses. Virtual clinics are suitable for any patient for whom GPs may require initial discussion and advice, but not necessarily a direct referral to the specialist.

The virtual clinic provides direct contact to a named Consultant by email or telephone at specified times each week. The approach is useful for patients who are new to the service or re-presenting (i.e. those who have been seen previously and then discharged). Virtual clinics can be supported by the use of video connections and the patient can have a face to face discussion with a clinician, via their phone, tablet or computer. This change should enable a GP to choose the right type of response for a patient's needs in a way that is quicker and cheaper than existing approaches.

In addition to the different forms of clinical interaction, there is also a large administrative burden generated in connection with clinics. The Trust has recently implemented electronic transfer of all clinic letters to GPs. This means the GP gets the letter more quickly, the patient experience is quicker and better, there is a reduced risk of a letter going astray and the costs of postage are avoided. To support this, voice recognition to help in producing the letters from clinic is another innovation that will reduce the time taken for staff to produce a letter.

The traditional model of care for outpatient clinics is Consultant led. The outpatient strategy will consider and propose changes to the clinical workforce to improve the experience for patients, staff and organisation. New and more innovative workforce models that employ specialist nurse practitioners and other non-medical staff, provide a faster, more resilient and cost-effective service to patients.

What we propose to do and why?

What: Move to fully electronic referral process using Electronic Referral System (ERS)
Why: Referrals are received more quickly and cannot be misplaced

What: Review all ERS referrals within 72 hours
Why: Inappropriate referrals can be redirected to the correct service; priority of referral can be amended accordingly.

What: Introduce 'advice and guidance' and/or telephone advice for all specialties
Why: Many problems that currently generate a referral to clinic could be dealt with through advice to the GP

What: Explore video clinics and virtual clinics
Why: Some clinical interactions between healthcare professionals and patients do not need the patient to travel to hospital

What: Expand nurse-led or therapy-led clinics
Why: Many clinical skills that were traditionally limited to medical staff are now shared by other groups such that clinics no longer need to be delivered by medics.

What: Move some hospital clinics into the community
Why: Coming to hospital can be difficult for patients so we will trial delivering some clinics, starting with urology, in community settings.

What: Trial voice recognition software to produce first drafts of clinic letters
Why: Voice recognition has advanced significantly in recent years and has been shown to speed up the production of letters

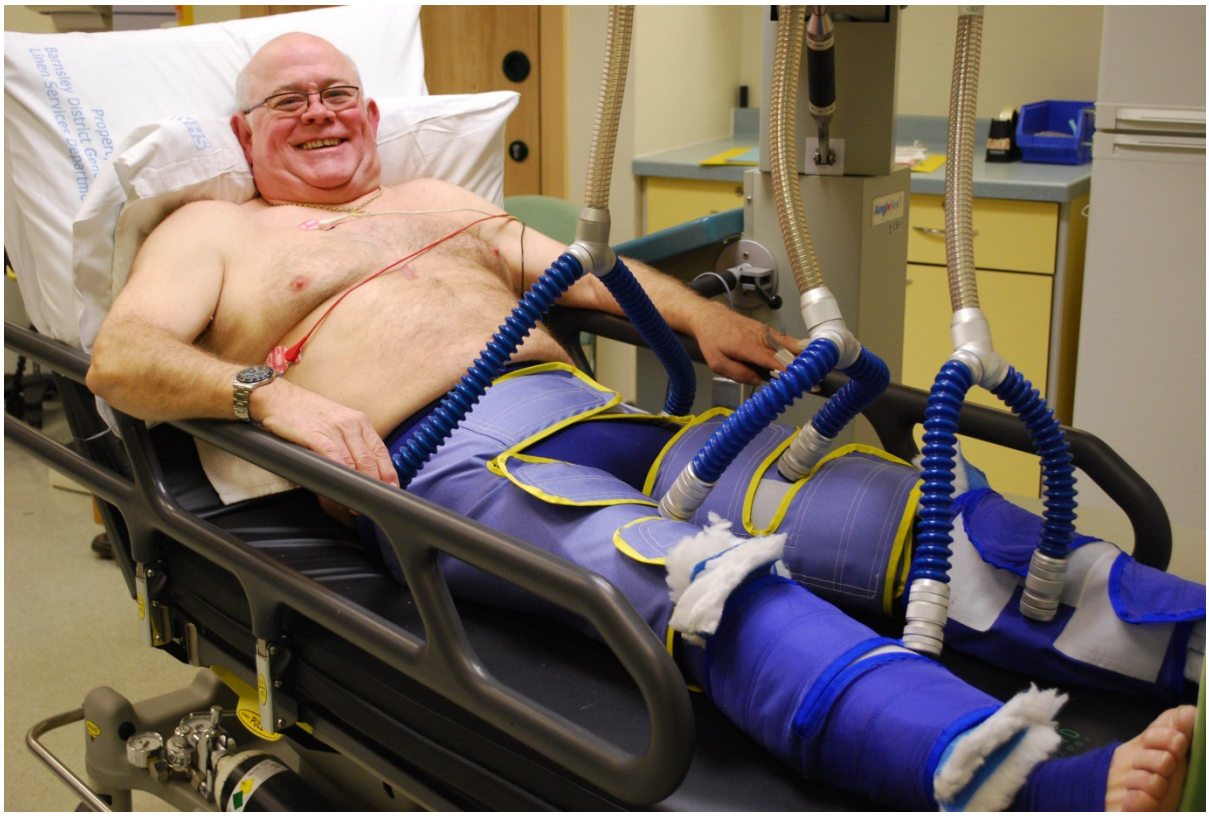
What: Expand the use of pre-clinic test protocols and patient-completed assessment proformas
Why: Face-to-face time in clinic is valuable and can be made more effective if necessary tests are arranged before a first visit. In addition, much of the clinic time is spent collecting information about the patient that could be provided by the patient in advance of their first attendance.

What: Utilise 'Map of Medicine' to guide GPs in effective use of OP services
Why: 'Map of Medicine' is an electronic resource linked to GP information systems that allows Trusts to include their referral and management pathways so that GPs can effectively choose the right services and arrange necessary tests prior to referral.

INPATIENT CARE

Background

It has been shown recently that many patients who present to hospital as an emergency can be managed extremely well without the need to stay in hospital as an inpatient; this is known as ‘Ambulatory Care’. New approaches to the treatment of a wide range of conditions have changed the nature of inpatient hospital care. Conditions such as Deep Vein Thrombosis (DVT) that would have previously required an inpatient stay of up to 7 days are can now be managed on an outpatient basis.



Community teams deliver intravenous antibiotics and ambulatory units such as the Ambulatory Medical Assessment Clinic mean that those patients that do need admission tend to be more complex, dependent and sicker than in years gone by. These changes have allowed hospitals to manage increasing numbers of emergency presentations with fewer inpatient beds, but it is clear that this needs a different type of input from healthcare professionals.

This consequence of the change to the Model of Care means that the patients who are in a hospital bed are, on average, sicker (often called a higher “acuity”). The impact of this is seen in the level of nursing support required on inpatient wards. Nursing ratios on wards may need to be increased over time aligned to the acuity and dependency of patients. The government and department of health have been clear in their intentions to provide a seven day a week health service. In certain services (e.g. Emergency Services), this is provided as a matter of course. However, inpatient services do not have the same level of cover at weekends and in the evening, compared to core working hours. As a consequence of the proposals, input from doctors will need to be more routinely provided at a senior level on a seven days per week basis. The Trust has already begun to implement changes to align itself with this strategic intention; however, more work will be needed over the next few years.

The number of patients accessing Emergency Departments (ED) who require on-going emergency care has been increasing in recent years. It is helpful to try to understand what is driving this rise in activity. At the lower end of the acuity scale, patients commonly report coming to the ED because either they have been unable to see their GP, or they believe they would be unable to do so. In addition, a number of patients are no longer registered with a GP and use the ED as a GP service. These patients are thought to comprise about 25% of ED attenders. Ideally, these patients would be seen by a primary care team (GPs and nurses) away from the hospital. However, another approach would be to stream patients who attend ED to a minor injury service provided in collaboration with a primary care partners in the Barnsley Healthcare Federation. The ED at BHNFT is currently undergoing reconfiguration to change the Physical footprint to aid in the streaming of patients and the support of this aim.

A recent piece of analysis that considered the higher end of the acuity scale found that the increase in ED was due to a number of factors. However, the main reason for the increase, circa 37%, was due to the improvements in treatments of critically ill and/or frail people. The impact of this was that more patients were surviving episodes of life threatening illnesses, which meant that they had continuing healthcare needs which they obtain from acute services. This is a marker of the success of what our teams do but coupled with an ageing and frailer population, it means that the types of patients needing our help are more complex.

One of the biggest problems NHS Trusts are facing is their ability to safely discharge patients following an acute or elective episode of inpatient care. Patients who are known as ‘Medically Fit’ or ‘Medically Optimised’ no longer benefit from inpatient hospital care and this can result in further deterioration of the patient if they remain in hospital. There is no longer anything that can be done for the patient within the hospital environment; however, they do have on going healthcare needs from a rehabilitation or care perspective, that need to be delivered in an out of acute hospital setting. The problem is that the capacity available to care for the patient in their own home or community has reduced in recent years and Trusts are unable to discharge patients to a safe and appropriate service or setting. These patients are known as stranded patients and were formerly described as a Delayed Transfer of Care or DTOC. Based on NHS England data it is estimated in 2016/17, that nationally the number of patient bed days lost as a result of this was 2,254,821. This is equivalent to roughly 7,000 inpatient beds or 7 large district hospitals. There are a number of specific reasons for these delays and some are the responsibility of acute Trusts; however, a large proportion is due to external factors outside of the control of NHS Trusts. BHNFT perform well with regards to stranded patients. There is a system wide and partnership approach to minimising the effect of this, led by RightCare Barnsley whereby Senior Managers and Service leads discuss pressures across the whole system on a daily basis, make decisions and take action to maintain and facilitate flow. There is a real culture of this being a Barnsley problem to resolve rather than that of a particular Service or provider.

In December 2017 a new model of Intermediate care was introduced which has significantly reduced this issue for Patients needing to access Intermediate Care bed-based services. There are number of initiatives available to allow Patients to be discharged from Hospital for on-going care and assessment out of the acute Hospital, including "Discharge to assess beds" and re-ablement. There still remain challenges with accessing Social Care and Intermediate Care for Patients living in non-Barnsley Local Authorities which accounts for the majority recorded in BHNFT.

The traditional workforce groups involved in ward care are going to change with the introduction of new roles. Nurse Associates and Physicians Associates are two important groups that will form an increasing part of the frontline staff at BHNFT. These groups will be considered in more detail later in the strategy.

What we propose to do and why?

What: Explore new ward team structures to incorporate new workforce groups.
Why: Existing staffing groups are not always available in sufficient numbers or flexible enough to provide the right combinations of competencies forward care.

What: Roll out the 'Careflow' system as a means of electronic handover and communication within teams
Why: To reduce the reliance of bleeps and telephones and create an audit trail of communication previously not captured. A pilot of 'Careflow' in Gastroenterology has been successful and is likely to be effective in many other clinical areas as well. By making this the universal solution to handover between teams, both safety and efficiency should improve.

What: Expand "ambulatory care" to a wider range of emergency conditions
Why: Although we have made good progress in this area, we know that we can offer this service to a larger number of patients with a number of conditions. We would also like to treat patients at the end of their inpatient stay in this way, meaning that they can get home sooner.

What: We will pilot use of an acute advice service as a means of avoiding admission for some patients
Why: Other areas have found mechanisms to allow GPs to easily seek expert advice to manage acute problems without admission to hospital. These may be as simple as a phone-based approach or as complex as a commercial IT system. Either way, there may well be benefit to patients of giving GPs a wider range of options to obtain immediate advice from a specialist.

What: Patients with higher acuity will be managed in appropriate settings with correct monitoring and observations.
Why: These patients are likely to have improved outcomes.

What: We will continue to increase our compliance with the seven-day care standards
Why: Patients should experience the same care regardless of which day of the week it is. We have augmented our weekend services significantly over the last few years but have more to do to meet the 2020 national aspirations.

What: We will introduce the SAFER care bundle as a standard ward approach to care

Why: The SAFER bundle is a national recommended group of measures that helps standardise ward processes and leads to proactive management of inpatients through their admission.

The SAFER Patient Flow Bundle

S - **Senior** Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – **All** patients will have an **Expected Discharge Date and Clinical Criteria for Discharge**. This is set assuming ideal recovery and assuming no unnecessary waiting.

F - **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – **Early discharge. 33%** of patients will be discharged from base inpatient wards before midday.

R – **Review**. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

What: We will continue to develop our system for identifying and responding to sick patients called “VitalPAC”. This system allows us to recognise deterioration in patients early. We continue to roll out the system to all of our hospital areas including the Emergency Department.
Why : This will enable us to identify and treat sick patients more quickly and hopefully improve their outcome.

FRAILTY SERVICES

Background

More people are living to old age. This is a major achievement but means that more patients are presenting to Healthcare providers with a number of medical conditions related to their frailty. These people are generally living full and active lives with their medical conditions, but often it is a relatively minor issue (such as a fall or urine infections) which leads them to need hospital care, because there are now fewer alternatives.

Whilst being in hospital is the right thing for people with serious illness, it can lead to problems especially in the frail elderly. The inactivity that accompanies admission to hospital has been termed ‘pyjama paralysis’ and leads to loss of muscle strength and ability to function. We also know that older people are at high risk of falls, pressure ulcers and healthcare-associated infections whilst in hospital.

There is an expanding evidence to support taking a different approach to supporting a frail older person and their family through an acute illness. Early access to an appropriately trained healthcare professional with expertise in comprehensive geriatric assessment can ensure someone has a tailored care plan that suits their needs.

Close collaboration between families, social care and healthcare is essential. These patients are often those that end up becoming stranded as described earlier in this document. This cohort is not seen as ambulatory by definition; however, a number of patients can be treated on an on-going or outpatient basis.

As a result, their outcome improves and they are less of a burden on NHS Trusts. Key to the Frailty pathway is identifying and streaming patients to the correct service(s) when they access the Trusts services. The development of this pathway of care will be the key aim of this work stream.

What we propose to do and why?

What: Ensure we recognise and assess frailty in people who attend hospital and ensure they receive the expert care needed to maximise their chances of a rapid return home without admission
Why: Early recognition of frailty allows an appropriate person-centred care plan to be developed and implemented.

What: We will develop a 'Frailty Service" to support the assessment and early care for frail people needing a short time in a designated hospital.
Why: Early expert assessment and multidisciplinary care allows rapid turnaround and discharge in order to maximise return to independence or usual level of care.

What: We will work with commissioners, community services and GPs to find ways to support frail people to remain in the community, particularly those in care homes
Why: Some of the New Model of Care Vanguards have developed proven methods of proactive and reactive care for people in institutional care that maximises remaining well and avoids the default admission to hospital that may otherwise accompany an illness.

What: Continue to develop our new therapy-led Intermediate Care Facility to maximise people's chances of returning to their usual level of independence after an illness.
Why: An effective rehabilitation service closely linked to the inpatient facility and to community services will support frail people to have the best chance of maintaining their functional abilities and independence.

COMMUNITY CARE

Respiratory

It is clear that respiratory disease presents a very significant challenge to the population of Barnsley that inevitably affect the local health economy. Under 75 mortality from respiratory disease is 28% higher in Barnsley than the national average (2013-2015). In 2014, 22.3% of Barnsley's adult population were smokers, compared to 18% for England.

In March 2016, there were 8,170 people on Barnsley COPD primary care QOF registers. This is 3.2% of the GP registered population (75% greater than the English rate of 1.8%) and higher than the Public Health England predicted prevalence of COPD for Barnsley of 6,642 people.

With regard to emergency admissions to hospital with a primary diagnosis of COPD in 2015/16 for patients registered with a Barnsley CCG GP:

- 771 patients had a total of 1,141 admissions – a 20% increase compared to 2011/12.
- 74 patients had 3 or more admissions, accounting for 27.6% of all COPD admissions.
- Average length of stay was 4.5 days – down from 6.4 days in 2011/12.
- There has been a marked increase in the number of admissions with a 0 length of stay, which accounted for 17% (196 admissions) of COPD admissions in 2015/16.
- 83% of admissions came via A&E.

With this background, The CCG developed an ambitious specification to deliver integrated respiratory services with the aim of improving the diagnostic process, management of exacerbations and on-going respiratory care.

BREATHE
Barnsley Respiratory Assessment and Therapy

What we propose to do and why?

What: We will continue to develop and deliver an integrated respiratory service that meets the needs of the respiratory population and the health care teams in Barnsley.
Why: By providing education, supervision, easy access to expert respiratory opinion and rapid access to clinical care, we will improve the standard of respiratory care.

What: We will create a borough-wide respiratory network that will serve the professional community by becoming the local voice of respiratory: producing guidance, guidelines and pathways for all aspects of non-malignant adult respiratory care.
Why: There needs to be local ownership and governance of the production and updating of clinical respiratory guidelines in order that any clinician presented with a respiratory patient can see quickly what the current best practice for an aspect of care is.

What: We will assess all patients admitted with an exacerbation of COPD and aim to get patients home safely as soon as possible. For those patients who need a longer inpatient stay we will provide post discharge home support at approximately 2 weeks post discharge.
Why: Home care as an alternative to the average five-day length of stay for an exacerbation of COPD has been proven to be a safe alternative. Post discharge follow up should help identify those patients who re-exacerbate early and provide an opportunity to intervene promptly.

What: We will work with primary care teams and deliver surgery-based specialist respiratory medical and nursing clinics.
Why: Early, accurate diagnosis of COPD maximises the potential of altering disease trajectory by ensuring that patients are educated, stop smoking and enrol on pulmonary rehabilitation, as well as having pharmacological therapy optimised. Providing easy community access to an expert respiratory opinion for patients with severe disease will improve advance care planning.

What: We will deliver a comprehensive and cost effective home oxygen assessment and review service in line with British Thoracic Society guidance and Standards of care. This includes moving the service into the home setting thereby significantly reducing the need for patients to have lengthy outpatient visits.
Why: Home oxygen is needed by the sickest of respiratory patients, and modern technology allows near patient blood gas testing therefore we can significantly improve the patient experience and maximise on the benefits of home visits by delivering this community service.

What: we will continue to work with partners in SWYFT to increase the uptake of pulmonary rehabilitation
Why: Pulmonary rehabilitation has a wealth of evidence of benefit in terms of improvement in quality of life, improvement in self-efficacy and reduction in health care resource utilisation. Patients are often reluctant to enrol onto rehab and the service will encourage all suitable patients to accept a referral at every contact.

Diabetes

What: We will seek to deliver a wider range of community services in Barnsley
Why: Joining up the community and hospital components of care pathways is likely to improve the experience of seamless care for patients and also to be more efficient.

What: We have won the Diabetes tender in partnership with the Barnsley Healthcare Federation
Why: The combined expertise of the existing hospital diabetes team consultants, specialist Diabetes Nurse team and local GPs would allow a high quality joined up approach to integrated diabetes care in Barnsley.

In collaboration with the GP Federation we won the tender process to deliver the primary care service for diabetes across the borough of Barnsley. This will enable us to provide a fully integrated service for the diabetic population of Barnsley from April 2018. The service will afford the opportunity for patients to be seen by specialist Doctors and Nurses in collaborative clinics with Primary care colleagues General Practitioners and practice nurses, in primary care locations, including their own General practice, enhancing skills and knowledge of the condition and treatment programmes including education across all primary care localities. Complex care will continue to be delivered in the secondary care environment.

Transitional Care

Traditionally, the Trust has had little role in delivering community services but the move towards closer integration with other Barnsley organisations, has allowed the opportunity to take a broader reinterpretation of the Trusts role in the local health community. The role should not just be to help someone with a medical emergency or to provide a central building to house diagnostic test departments or outpatient clinics. The aim is to find new ways that the expertise that resides within the hospital and its professionals can have a larger impact on the health of local people. The Trust has already started to do this through successfully bidding to be the lead provider of the new integrated respiratory service in Barnsley and also taking on a Transitional Care ward.

Some aspects of how the Trust will develop its local contribution to delivering services in the community are picked up in other parts of this strategy and are not duplicated here.

What we propose to do and why?

In December 2017, BHNFT opened the doors of a 24 bed Therapy led intermediate care ward in collaboration with The GP Federation providing primary care overview to the patients cared for on the ward. The therapy led model of intermediate care provides rapid therapeutic assessment of patient needs with short term goal setting and intensive therapy for patients within a 14 day stay. Right Care Barnsley overview and gatekeep the transfer of patients in and out of the unit alongside community intermediate care services ensuring that patients are placed in the right location and environment for their needs.

What: We will take an active role in the local Public Health agenda and will intend to appoint a Public Health specialist.
Why: People in Barnsley have greater health needs and on average greater deprivation than in other parts of the country. The wide range of contacts we have with local patients and our influence in the Borough allows us to positively contribute to improving Public Health

SAFER CARE

Background

Safer care can provide a better experience for the patient and improve clinical outcomes. As well as reducing financial costs it can also help reduce harm to patients. It was estimated a few years ago that every time a person has an MRSA bacteraemia, it costs the NHS £25,000 on top of the risk to the individual.

There is now plenty of evidence that how we work clinically has an impact on safety over and above issues of technical competency. Understanding how internal and external conditions affect our ability to provide high quality care can help to maintain safer practice.

Whilst much of the work to improve our safety fits better within the Quality Strategy, a few key issues are covered in this section, as they are inextricably linked to how the clinical staff at BHNFT work together in teams.

Human factors are a scientific discipline used in may safety critical industries. Using Human Factors to underpin patient safety and quality improvement enables us to reduce the risk of human error and its consequences. The Trust has introduced training for its staff in Human Factors along with Quality Improvement training. Other initiatives such as Safety Huddles give our teams the opportunity to raise and address any safety issues they have identified in their wards or departments.

What we propose to do and why?

What: All identified key staff, such as ward sisters and care teams will have "Human Factors" Training by 2020
Why: Awareness of the role of Human Factors in safety has developed significantly through other industries, such as aviation and by acknowledging human limitations, it has minimised error and its consequences

What: All identified key staff to have Quality Improvement or Continuous Improvement Training by 2020
Why: Quality Improvement or Continuous Improvement is a well-developed set of methods or ways of working, that enable improvements to be made by the staff who do the work. Some of our teams have expertise in these methods and we have started using some of the tools, such as Statistical Process Control charts in our performance reports, but we need to make this the norm not the exception.

What: Safety huddles to be embedded in all clinical areas by end of 2019
Why: Safety huddles are brief and routine meetings for sharing information about potential or existing safety problems facing patients or workers. We have rolled safety huddles out to clinical areas over the last 1-2 years and using the expertise of our 'safety huddle coaches', we can ensure that areas get the support they need to continue using safety huddles.

What: We will continue to improve our safety in the areas of patients who deteriorate especially with Acute Kidney Injury (AKI) and Sepsis
Why: Both AKI and Sepsis are being recognised as major causes of patients staying in hospital and being unwell. We need to continue to develop our systems (including VitalPAC) for early recognition and treatment of both conditions and they remain a high priority for overall patient safety.

What: Develop our systems for "Learning from deaths". We have changed our system of responding to deaths and its causes and we will continue to develop the learning from our "Structured Judgement Reviews" into deaths
Why: If we look closely at the care given to patients who have died in our care, we will learn a great deal of information, which can then be used to improve our systems of care, especially around "end of life"

BED MANAGEMENT AND PATIENT FLOW

Background

Over the years, hospitals have found new ways to care for people that are less dependent on hospital beds. As a result, hospital beds have closed and we manage higher levels of activity through fewer beds and have a shorter length of stay.

Consequently, it is clear that the numbers of beds needed changes over time. There are other patterns of bed need - Trusts need more beds on Mondays and Tuesdays than they do later in the week and more beds are needed in winter than in summer.

Regardless of the number of beds, effective systems are required to ensure that the flow of patients through the hospital is efficient and minimises delays to patients. The Trust has traditionally done this through a bed management team and the operational management team. BHNFT has also used the Medworxx bed utilisation system to support bed management teams.

The introduction of a Deputy Director of Nursing who leads on patient flow and clinical operations will also strengthen the leadership in the bed management team and enable a critical review to take place in relation to the proposed changes that need to take place in 2018/19.

What we propose to do in the next 12 to 24 months and why?

What: Consider the introduction of a flexible approach to the bed base allowing flexibility to match patient demand throughout the year.
Why: The capacity of the bed base needs to match the changes in demand through the week. Flexing the bed base in a planned way should minimise the disruptive unplanned use of escalation beds than can occur at times.

What: We will review how we provide additional capacity all year, including the peak in winter months
Why: Rises in bed requirements need to be planned effectively. Traditionally we open an escalation ward but this is difficult to staff effectively and has a significant impact on staff satisfaction and the ability to utilise both nursing, AHP and medical resources effectively. We will review alternative ways to flexibly increase the bed base on all core in-patient areas so we can have flex beds on each ward that will open and close depending on demand.

What: We will review and implement effective bed utilisation tools
Why: There are various different approaches to bed utilisation tools. The current system of Medworxx is under review alongside other approaches, which have proven to be effective.

What: We will review the Trust's approach to bed management
Why: Optimising our use of beds is essential to ensure acutely ill patients have prompt access and also that we do not keep people in hospital longer than their clinical condition requires. Part of this work stream will be to review the bed management, case management and out of hours nursing teams to ensure that the right personnel are in place to deliver this agenda.

What: We will ensure we have a robust and embedded process in place to review all long length of stay patients in the acute bed base.
Why: A timely and robust review will ensure patients are treated in the right place and that we are optimising the care we deliver to them. It will also assist us to understand our internal processes and identify any blocks we have in clinical pathways, ward areas or Trust wide.

What*:* Introduction of a GP assessment area for all GP admissions into medicine.
Why: Patients can be triaged and managed through an appropriate pathway which may be ambulatory or as an inpatient.

THEATRES AND CRITICAL CARE

Assistant Theatre Practitioner Development

Due to the shortage of registered nurses, both nationally and locally the NHS has been forced to consider new ways of working. One of the recommendations from NHS England and Health Education England is a review of current skill mix and the introduction of the Assistant Theatre Practitioner Role.

What: The assistant theatre practitioner role will be an integral part of the multi-disciplinary team working within the operating theatre environment. They will perform circulating and scrub roles within an agreed framework working alongside surgeons and registered practitioners ensuring a safe and high quality environment for service users. BHNFT will train 17.52wte assistant theatre practitioners over the next three years.

Why: The new role will replace the third scrub nurse in the theatre team, resulting in a theatre team comprising of a team lead, a scrub nurse, an operating department practitioner, an assistant theatre practitioner and a support worker.

Nurse Prescribing Development (Day Surgery)

Non-medical nurse prescribing is a key qualification needed for anyone wanting to become an advanced practitioner or operate in an advanced practice role. The benefits to patients are improved access to medications, reducing treatment delays and improving the patient experience.

What: Nurse prescribing will enable the leads to prescribe analgesics and wound management aids as required. It is excepted that all four staff members will be qualified by 2020, with the facilitation of two staff members commencing the 12 month course in September 2018, and a further two commencing the course in January 2019.
Why: For the Trust the benefits are reduced delays and more efficient services for patients. Delays in treatment and discharge times is a common problem on Day Surgery, and we therefore plan for non-medical nurse prescribing to become an integral part of the band 7 and band 6 lead roles on Day Surgery.

Surgical First Assistant Development

Due to the changes to the junior doctors rota, and shortages in the surgical doctors rotas nationally and locally, many Trusts are training staff to become surgical first assistants.

What: Working in collaboration with the service managers and specialties, an analysis will be completed to determine how many surgical first assistants will be required to support each specialty.
Why: Surgical first assistants are registered healthcare professionals who provide continuous competent and dedicated assistance under the direct supervision of the operating surgeon throughout the procedure.

Critical Care

Reconfiguration of our specialty doctor workforce plus a small amount of additional investment will allow us to provide separate dedicated medical cover for ICU and obstetrics 24 hours a day.

We plan to develop ICU capacity to allow us to meet the demands of the service, in particular the elective patients requiring post-operative critical care support.

Critical Care nursing skill mix will be improved through the prioritisation of critical care specific training for nurses at all levels. Our recently appointed clinical nurse educator will be key to this, and her development in this new role is also a key priority.

Getting it Right First Time (GIRFT)

GIRFT is a national programme which is led by expert clinicians that has been introduced to improve quality, safety and reduce clinical variation in a number of different areas. A national GIRFT team will analyse data produced and then visit an organisation, helping them to improve in various areas, compared to national best practice. The programme began in Trauma/Orthopaedics but has since translated across to a number of different surgical specialties. Over the next few years, the same methodology will be used in a number of Medical specialties. Barnsley has embraced the programme and recently appointed a Clinical Lead with management support. We have already had a number of GIRFT visits and we will continue to support the programme and make changes to improve patient care.

What*:* Provide dedicated management support and leadership to clinical teams to implement the best practice standards identified by GIRFT. Engage with the GIRFT process and develop action plans to deliver safe, effective and sustainable clinical services for the benefit of patients, staff and the Trust.
Why: GIRFT is a product of the national productivity review (Lord Carter Review 2016). The process is clinically led by clinicians who are at the forefront of the development of clinical services. It is the right thing to do and has been shown to drive safety and productivity.

PARTNERSHIP WITH OTHER TRUSTS

Background

The developing Integrated Care System in South Yorkshire and Bassetlaw should help local Trust's to provide services in a more resilient and joined up way. We already have a track record of effective partnership working and it is likely that this will develop further in future. The geography of Barnsley has been taken into account; the links to other Trusts and Providers in South Yorkshire, but also West Yorkshire has been an important consideration in forming alliances with other Healthcare Providers. Some of our existing partnerships are:

- Shared urology consultant on call with Mid Yorkshire Hospitals
- Shared Pathology service with Rotherham Hospital
- Joint haematology posts with STH
- In reach services in neurology, oncology, vascular with Sheffield Teaching Hospitals
- Shared Interventional Radiology rota with Mid Yorkshire Hospitals
- One ICE reporting system across the Working Together Partnership
- Shared weekend on call rota in ENT with Sheffield Teaching Hospitals
- Ophthalmology – Introduction of a shared rota with South Yorkshire and Mid-Yorkshire Hospitals.

What we intend to do and why

What: We will seek to recruit stroke consultants in partnership with the ICS
Why: Within the ICS are the regional Hyper Acute Stroke Units (HASU) at Sheffield and Doncaster and Bassetlaw and new consultants are likely to want to spend some of their time working in a HASU.

What: We will liaise with South West Yorkshire Partnership NHS Trust to consider closer working relationships between our Acute Stroke Unit and their Rehabilitation and Early Supported Discharge stroke service based at Kendray Hospital
Why: The stroke workforce is limited and there may be advantages for local patients to have a more seamless joined up approach to stroke care in Barnsley.

What: We will work with Sheffield Teaching Hospitals to consider closer ties with their Renal Service.
Why: AKI is getting more common and provision of a bigger outreach service on our site would enable more local people to access their care locally. There may also be the possibility of a joint Acute Medicine and Nephrology appointment to provide onsite expertise and to support the Barnsley Hospital based dialysis unit.

What: We will work with the Mid Yorkshire plastic surgery team to explore whether they could provide an outreach plastic surgery service on the Barnsley Hospital site
Why: Patients needing plastic surgery procedures, for example for skin cancer, currently have to travel to a regional centre for surgery.

ENABLING WORKSTREAMS

1. DIGITAL

Background

Digital technologies affect all aspects of our lives, often in ways we would never have anticipated only a few years ago. Very few of us would be without our smartphones . The Trust has already started to take advantage of these technologies with the roll out of the VitalPac system and moving to a smartphone replacement for our bleep system. Some of these technologies, such as PACS, ICE, and VitalPac have allowed the Trust to do things that are beyond the capability of paper based, analogue systems that they replaced.

However, not all development has been popular with staff, other IT systems that have made tasks harder as they lack a user friendly interface and are not intuitive. This has meant that tasks are harder and take more time than more traditional methods . It is essential that the Trusts is selective and take care to identify and implement the IT systems that will enable the delivery of healthcare in better ways that are more time efficient and easier for staff to use.

Some aspects of the digital strategy that relate closely to how the Trust delivers its clinical services are covered in other parts of this document and this should be read in conjunction with the IT Strategy. The actions described here are broad and should be beneficial across multiple aspects of the Trusts services.

What we propose to do and why?

What: We will systematically move to electronic methods of requesting all in-house tests using either ICE or e-forms
Why: Paper requests get lost, may be incomplete and are sometimes illegible. Electronic requests address all those issues and also speed up the process.

What: We will electronically file all test results using the ICE system during 2018 and by that point will no longer print paper results.
Why: ICE is a fully auditable system with all the functionality needed to robustly file and act on results. Cessation of the use of paper will also save resources.

What: We will pilot the use of e-forms to 'outcome' clinics and if successful, roll out this approach to all clinics. We will develop our e-forms as part of discharge communication to patients and GPs
Why: This should be more efficient and reliable way for clinicians (including GPs) to ensure patients receive the follow up they require.

What: We will procure and implement an electronic prescribing system by 2020
Why: e-prescribing systems remove some of the risks inherent in a paper based prescription system.

What: We will procure an electronic patient record system (EPR) to replace the existing Lorenzo system.
Why: A decision has been made to procure a new system which is responsive to the needs of the organisation.

What: We will develop our internal Bleep system (including cardiac arrest calls) to move away from our outdated system and move to a fully auditable electronic message system
Why: the current bleep system can be unreliable and is not supported by our telephonic/switchboard

WORKFORCE

Background

The types of healthcare professionals working in hospitals have changed little over the last few decades, being based on the traditional groups of nursing, medicine, therapies, pharmacy and so on. More recently, due to a number of factors (such as changing patient needs and staff shortages in certain areas) it has been necessary to re-examine the roles and duties carried out by the different groups. A positive result of this has been the recognition that competency for a task (based on training and ability) is more important than which profession undertakes that task. For example, many duties that have been undertaken by doctors can now be performed by a range of healthcare professionals.

In recent years, supply of staff in critical areas has been a determinant of service viability. In Barnsley, loss of consultants in stroke medicine has had a detrimental impact on our service. In general, BHNFT has done well at attracting and retaining clinical staff but the Trust needs to be more innovative and flexible in order to maintain the right workforce to deliver high quality services in Barnsley.

The Trust is now at the forefront of developing a number of new types of healthcare professionals, including Physicians' Associates, Associate Nurses, Assistant Practitioners, Prescribing Pharmacists and extending the skills of Allied Health Professionals. These groups bring a different set of skills to the workplace and BHNFT need to be creative in finding ways to offer rewarding careers and retaining these staff.

This gives the Trust the opportunity to redesign our inpatient and outpatient multidisciplinary teams to incorporate these new staff. To be a success, it is vital that the development of new roles is supported by a programme of training and education.

The NHS Constitution commits to innovation and to the promotion and conduct of research to improve the current and future health and care of the population. BHNFT is a research active Trust and is a partner organisation to the NIHR Yorkshire and Humber Clinical Research Network (YHCRN).

The Trust recognises that research contributes to the quality agenda as well as encouraging innovation and promoting clinical excellence. A research active culture can bring a host of benefits for patients, clinicians and the NHS. Research drives innovation, enables better and more cost-effective treatments and creates opportunities for staff and patients.

There is now clear evidence across a range of conditions that research activity is associated with better outcomes, lower mortality and with considerable cost savings. The R&D department is committed to developing an environment where patients, service users, staff and visitors are given the opportunity to participate in high quality health research in line with the Trust's objectives. The research team manage a large number of portfolio studies including commercial Clinical Trials Involving Medicinal Products (CTIMPs). The Trust aspires to ensure high quality research becomes culturally embedded in all aspects of clinical service delivery, improving healthcare outcomes and contributing knowledge to further improve the provision of evidence-based practice.

It is an ambition of the Trust to widen the opportunity for research participation for our patients and staff, thereby ensuring access to research across all service lines. This will require the development and maintenance of a thriving research culture supported by an appropriate infrastructure.

We will work with clinical teams to focus research in areas of strategic and clinical priority and raise our profile as a centre of excellence for research, ensuring research benefits as many of our patients as possible. There is opportunity to grow research, offer patients cutting edge treatments and generate significant income through commercial contracts at BHNFT if we invest in our workforce and facilities to deliver the research of the future.

What we propose to do and why?

Summary of New Clinical Roles

1. Physician Associates
2. Advanced Nurse Practitioners
3. Nursing Associates
4. Prescribing pharmacists
5. Healthcare scientists
6. Allied Health Professionals –new roles

Physicians Associates

What: We will progressively recruit Physicians Associates and build their roles into existing hospital and community clinical teams
Why: Physician Associates (PAs) have many useful competencies that will complement existing staff groups, particularly junior doctors. By rotating posts between primary and secondary care we believe we will attract PAs to Barnsley.

Physician associates are healthcare professionals with a generalist medical education who work alongside doctors, physicians, GPs and Surgeons to provide medical care as an integral part of the wider multidisciplinary team.

Nursing Associates

What: We will train and employ Nursing Associates
Why: This new nursing role will allow more fine adjustment of skill mix on wards and support Registered Nurses in delivering compassionate care.

Current position - Following a successful bid to Health Education England we are the lead partner for the implementation pilot of Trainee Nursing Associates across Barnsley and Rotherham with the support of the University of Sheffield as the education institute partner. Eight trainees are currently undertaking the two year course to become Nurse Associates.

Plan for the next 1-2 years – To apply for third wave funding to train further Nursing Associates to support the nursing workforce plan

Aspirations/ambitions – To have a career pathway through nursing that ensures all nurses are able to progress to the level they aspire to throughout their career.

Nurse Practitioners

What: We will train and employ Assistant Practitioners
Why: Assistant Practitioners will have competencies that will complement existing staff groups.

Current Position – We are currently piloting the Assistant Practitioner role within the pre-assessment service and continence service. Five staff are employed in this role undertaking a work based Foundation Degree in conjunction with Sheffield College.

Plan for next 1-2 years - Review this role and where it can make a difference follow the pilot.

Aspiration/ambitions – The role to become integrated in practice areas and to become a career pathway for non-registered staff.

Prescribing Pharmacists

These are pharmacists who are able to prescribe and administer medications.

What: We will aim to have 50% of our pharmacists trained to be prescribers by 2019.
Why: Prescribing pharmacists can help improve patient safety and enhance patient flow and discharge.

Advanced Clinical Practitioners

What: We will support more staff to become Advanced Clinical Practitioners
Why: These roles support staff to work at the very top of their competence and become autonomous practitioners that help maintain the safety of patients and are professionally rewarding for staff.

Current Position – Following funding for the study course and backfill money from Health Education England we are supporting both new and existing teams to expand our numbers of Advanced Clinical Practitioners in Nursing. New areas include the AMU and SAU to help with the safe flow of patients through the trust.

Plan for next 1-2 years – To review the impact of current Advanced Clinical Practitioners in maintaining patient safety and review where further roles may be required as services are reviewed such as paediatrics.

Aspirations/ambitions - To have a career pathway through nursing that ensures all nurses are able to progress to the level they aspire to throughout their career.

Health Care Scientists

What: We will appoint a Lead Healthcare Scientist and the Medical Director will be the professional lead for these staff at Executive level.

Why: Healthcare scientists are a vital part of our organisation but do not get the recognition they deserve. By having a Lead Healthcare Scientist and greater executive support we hope to improve the recognition, recruitment and retention of these important staff.

Allied Health Professionals

What: The Director of Nursing and Quality has taken on the professional leadership for Allied Healthcare Professionals (AHPs).We will develop the scope of practice of AHPs in a number of areas (such as physiotherapy).
Why: This change of Executive portfolios should raise the profile of AHPs and provide greater support for their development.

1. **People Strategy**
   https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/comms/Shared%20Documents/People-Strategy.pdf

2. **ESTATES STRATEGY**

3. **Communications and Engagement**
   https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/comms/Shared%20Documents/Communications%20and%20Engagement%20Strategy%202015-19.pdf

4. **Finance**

5. **Research & Development**

Monitoring and review of the clinical strategy

This strategy is sets out the Trusts aspirations for developments over the next few years. Work is underway in our Clinical Business Units to translate these aspirations into operational plans. This is BHNFT's assessment of future developments at this time and, in line with our approach of continuous improvement, will be subject to continuous evaluations as healthcare nationally and locally continues to develop. The strategy will be jointly led by the Director of Nursing and Quality and the Medical Director.

A Clinical Strategy Steering Group will be set up and will coordinate delivery of the strategy. This will include detailed implementation plans with lead officers and timelines for completion. Quarterly reports will be received by the Quality and Governance Committee and six-monthly reports by Trust Board. This will help the Trust to determine that we are achieving the commitments set out in the strategy.

Next steps and communicating the strategy

The Strategy will be reviewed at the Quality and Governance Committee in March and will be launched in April 2018 to align with the publication of the overall Trust Strategy 2018 - 2021.

A Clinical Strategy Steering Group will be established who will oversee development and management of all delivery plans.

The Strategy will be communicated to staff and key stakeholders through a number of mediums:

1. Trust Team Brief
2. CBU Briefing Sessions
3. Staff Appraisals
4. Trust Hub/External Internet Site
5. Barnsley Hospital News
6. Social Media

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PROUD to care

Barnsley Hospital Quality in Care

NHS
Barnsley Hospital
NHS Foundation Trust

Our People Strategy 2018-21

People will be proud to work for us

Table of Contents

1. PURPOSE

The People Strategy sets out the strategic direction for our people over the next three years. It sets out the interventions that are required to ensure we develop as a Trust that is continuously fit for purpose, lives its values and delivers its objectives. It seeks to enable and equip people within the organisation with the necessary knowledge , skills experience and attitudes to deliver outstanding healthcare.

The People Strategy compliments the organisation's parallel and interdependent strategies, including its Sustainability Strategy, acting as an enabler for improving workforce capability and engagement and enabling this both at an organisational and Clinical Business Unit level

Delivery of this strategy will ensure the highest standards of leadership and management are in place to sustain a motivated and engaged workforce that fosters an organisational culture which truly embraces the diversity and individuality of people and the need for inclusiveness. Through a capable, sufficient, motivated and resilient workforce we will enable more efficient care for our patients.

2. WHERE ARE WE NOW? (JUNE 2018)

The Health Education England Workforce strategy has been produced and is the first national document that they have produced for 25 years, clearly demonstrating that there is now a national refocus on People. It seeks views on what we should do next to ensure our workforce provides the best quality care to patients, service users, carers, and the public.

The Regional Hospital Services Review recommends the creation of a South Yorkshire and Bassetlaw(SY&B) (Mid Yorkshire and North Derbyshire) Health and Care Institute which will be responsible for delivering system-wide functions related to workforce and clinical variation.

In addition, Barnsley is also one of five 'places' of Accountable / Integrated Care Partnerships (ACPs) that form the South Yorkshire & Bassetlaw Integrated Care System.The SY&B ICS is one of eight nationally selected to pioneer the development of integrated care systems. This involves organisations across health and care formally aligning to ensure the right care in the right place for our patients.

Our workforce costs are 68% of our revenue budget, and so planning and leading our workforce to ensure that it is efficient, effective and fully engaged in providing our patients with the quality of care we can all be proud of, is critical to our success in delivering our plan.

We face challenges in recruiting, retaining and developing our health care workers in an increasingly competitive market. And ensuring the engagement of our People in this challenging healthcare agenda.

We have a CQC rating of Good overall and aim to be rated Outstanding. Therefore mapping our People strategy aims and measuring our progress against the CQC well-led domain Outstanding rating characteristics for People will be essential to ensure our success in delivery of this strategy.

3. TRUST VISION, VALUES AND AIMS

The Trust's Vision: To provide outstanding integrated care.

Core to the delivery of this vision are our people who we will support to ensure excellent staff experience, ensuring they are fully developed, engaged and motivated in order to further support the Clinical Business Units to have the right capabilities and leadership.

Our strategic aims are:

1. Patients will experience outstanding care
2. Partners: we will work with partners to deliver better, more integrated care
3. People will be proud to work for us
4. Performance: we will achieve our goals sustainably

Our Values are:

- We treat people as we would like to be treated ourselves
- We work together to provide the best quality care
- We focus on individual and diverse needs

The People Strategy is a key enabling strategy to achieve these strategic aims and is designed particularly to deliver the strategic aim 3: "People will be proud to work for us".

4. STRATEGIC AIM 3: PEOPLE WILL BE PROUD TO WORK FOR US

The strategic objective under this aim is: To build a sufficient, capable, motivated and sustainable workforce.

The structure of this Strategy is that it is organised around 4 pillars as follows:

Talent (Capable)

We will develop all leaders to influence and motivate effectively, giving them the behavioural, process and business skills to effectively serve our patients. We will maximise impact through identifying and developing all our Talent at every level in the organisation to perform to the best of their ability

Engagement (Motivated)

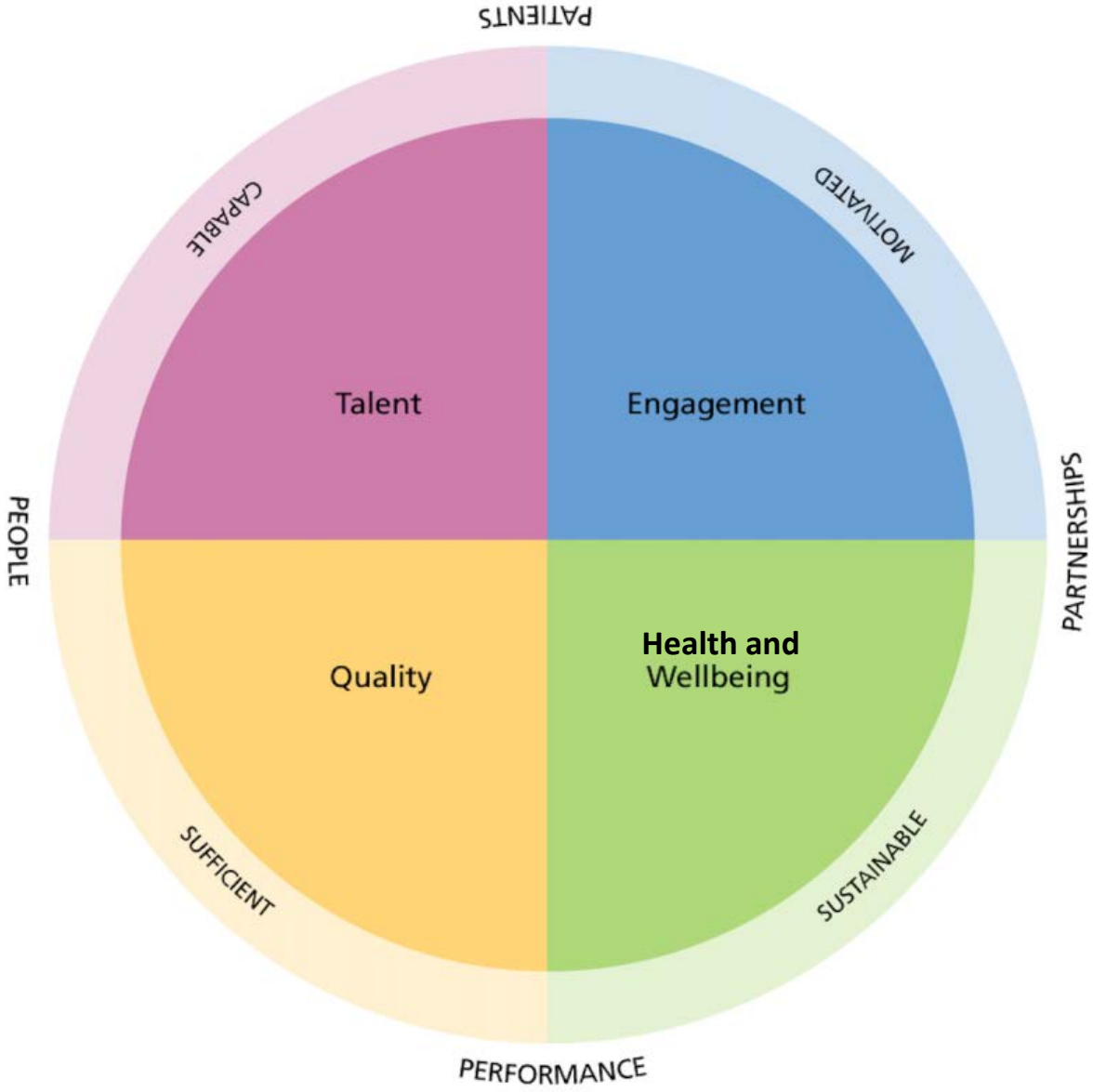
We will motivate our People to do the best that they can by living our Values and creating a culture of Trust and real Engagement

Health and Wellbeing (Sustainable)

We will ensure that we create an environment where our People are physically and emotionally sustained to enable them to give their best and to be able to be at work more of the time in order to better serve our patients

Quality of Policy and Process (Sufficient)

We will provide robust infrastructure and Quality process, policy, procedures and Assurance Framework to support and monitor our ability to lead our People in Barnsley. Also to ensure we attract, select, recruit, develop, performance manage and retain the right people, in the right place at the right time, doing the right things, with the optimum level of motivation.



The People Strategy is underpinned by other corporate strategies and also by the work in each area of our HR & OD directorate service offering and the programmes of work which support it:

- The Operational Plan
- The Clinical Strategy
- The Quality Strategy
- The ICT Strategy
- The Estates Strategy
- The Equality, Diversity & Inclusion Strategy
- Staff Engagement Strategy
- Occupational Health and Well Being Strategy
- Library & Resource Centre Strategy
- Education Strategy
- Investors in People Action Plan
- Staff Survey Action Plans

5. KEY OUTCOMES OF OUR PEOPLE STRATEGY

The following outcomes are expected from the delivery of this strategy:

- All staff employed by the organisation will have a clear understanding of the knowledge, skills, experience, abilities and attitudes required and expected of staff within BHNFT in order for it to achieve our vision, purpose and values.
- All staff employed by BHNFT will have a clear understanding of leadership and the contribution of leadership towards the effective performance of the organisation.
- Compassionate, inclusive and effective leaders at all levels.
- A robust infrastructure and quality assurance process to support and monitor leadership performance and development will exist which encourages all *to live their values*…and those of the Organisation
- People Data intelligence will be readily available and provided in a timely and accessible manner to support planning, decision-making and strategic implementation and to assure commitment from the board in the delivery and sustainability of the strategy.
- Leaders will exist within the organisation, with the agility and the versatility to gain and sustain commitment to change, improvement and excellence through using the right style to influence and motivate individuals and teams.
- Coaching for influencing improved performance and productivity, transformation, commitment and engagement in fulfilling our vision will be evident.
- Leaders will be supported by an effective performance management process and strong succession planning and development process to reach their potential.
- The organisation cultivates the knowledge, skills and capabilities that create the conditions where equality, diversity and inclusion thrive.

6. KEY ACTION AND PRIORITIES OF OUR PEOPLE STRATEGY

Our Key actions/priorities are to:

- Launch the People Strategy fully in the Trust and deliver underlying implementation plans
- Monitor progress on a monthly basis at People & Engagement Group and quarterly at Finance & Performance Committee
- Develop a process to enable Clinical Business Units and Corporate Services complete robust workforce plans to help shape our future workforce
- Develop a new approach to engagement, organisational culture, wellbeing, talent and quality which promotes effective leadership of change, values and organisational development
- Improve engagement and staff motivation by addressing and improving areas highlighted by our staff survey and ensuring that improvement plans are developed and supported for those areas
- Goal for the staff survey overall engagement score to be within the top 20% of NHS employers
- Retain our Investors in People accreditation
- Continue to focus on improving the health and wellbeing of our staff in order to help reduce sickness absence, improve patient and staff experience, improve staff survey result of staff feeling unwell due to work related stress, offer health and well-being advice and education, introduce Schwartz Rounds, ensure flu vaccine take up, and achieve health & well-being CQUIN as a result of this work
- Retain our Safe, Effective, Quality Occupational Health Service (SEQOHS) accreditation
- Continue to enable staff to access training and development to support clinical business units and corporate services achieve their mandatory and statutory training (MAST) targets, and support the appraisal process, talent management programmes and apprenticeship roles
- Continue to engage our local community and equality forum partners to promote the Trust as an employer of choice and to improve patient and staff experience

7. LOCAL & NATIONAL CONTEXTS

Our workforce costs are 68% of our revenue budget, and so planning and leading our workforce to ensure that it is efficient, effective and fully engaged in providing our patients with the quality of care we can all be proud of, is critical to our success in delivering our plan.

The Group has a workforce of 3,759 staff (of which 3,575 are Trust staff and 184 are Barnsley Facilities Services staff including bank staff. There are 3,226 Trust staff and 170 BFS staff excluding bank) and is facing major challenges in delivering a financial turnaround plan, which will ensure that it is sustainable for the future.

The Trust is also part of a wider sustainable hospital services review (HSR) across the South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire ICS footprint, of which workforce is a key priority. The HSR report published in May 2018 recommends the creation of a SYB(MYND) Health and Care Institute which will be responsible for delivering system-wide functions related to workforce and clinical variation. This will include-amongst other functions – the delivery of a comprehensive workforce strategy and a central intelligence function for collecting and analysing data on unwarranted variation.

In addition, Barnsley is also one of five 'places' of Accountable / Integrated Care Partnerships (ACPs) that form the South Yorkshire & Bassetlaw Integrated Care System. The other ACPs are Bassetlaw, Doncaster, Sheffield and Rotherham. The SY&B ICS is one of eight nationally selected to pioneer the development of integrated care systems. This involves organisations across health and care formally aligning to ensure the right care in the right place for our patients.

Three initial workforce priorities for the ICS are:

1. Developing the SY&B Region Centre of Excellence (unregistered workforce)
2. Creating a Faculty of Advanced Clinical Practice for the region
3. Expanding the primary care workforce.

As a Trust we need to make recurrent Cost Improvement Plans. As spend on our workforce accounts is the majority of the Trust's total financial expenditure the circumstances demand that our future workforce be leaner and more efficient, whilst not compromising on quality and safety.

The Trust's wholly owned subsidiary company has been set up and expanded to enable efficiencies to be achieved in delivering non-clinical support services through Barnsley Facilities Services Ltd (BFS) (operational from 1st September 2017).

The Trust has also signed up to and is actively engaged in the ICS Streamlining Programme which engages 7 local Trusts to work together to identify efficiencies and increase productivity within the system. This has a focus on recruitment, medical staffing, mandatory training and occupational health services. The Trust is the nominated lead for delivery of the mandatory training and occupational health services streamlining and standardising work streams.

We have a CQC rating of Good overall and aim to be rated Outstanding. By well-led (within the well-led domain), the CQC mean that the leadership, management, governance of the organisation assures the delivery of a high quality and person-centred care, supports learning and innovation and promotes an open and fair culture. The CQC well-led ratings characteristics are shown at appendix A. (Of the 8 areas ie W1-W8, the following are not relevant to People; W2,W4 and W6 and so they have been taken out). Mapping our strategy aims and measuring our progress against the CQC well-led domain Outstanding rating characteristics for People will be essential to ensure our success in delivery of this strategy.

8. NATIONAL STRATEGIC CONTEXT

Nationally there are a number of reviews and strategies developed for the whole health and social care system which have an impact on how services are provided in the future which has implications for the Trust and wider NHS workforce.

The Trust actively supports these reviews and this strategy aims to provide a supporting framework to enable the Trust to deliver against these key issues.

These include:

- The Five Year Forward View October 2014 (and the Next Steps Plan issued March 2017) describes the future of the NHS and the importance of developing new care models to support the increasing demands on the service. These new models require a workforce which is reflective of their local community, has the right numbers, skills, values and behaviours with the ability to work across organisational boundaries. Trusts will need to consider new roles, ways of working, working patterns, terms and conditions and reward to develop the future workforce

- Lord Carter's review of Productivity in the NHS February 2016 identifies clear workforce implications including better performance management practice, better use of nursing staff, clear setting of staffing levels, better management of sickness and annual leave and better use of e-rostering.

- The NHS Leadership Academy's 'Towards a New Model of Leadership for the NHS 2013' details the links between leadership and service outcomes. Lord Rose's review 'Better Leadership for tomorrow 2015' makes recommendations for improving leadership in the NHS and the updated NHS Leadership framework provides the skills and competencies NHS leaders should have.

- The outcomes of the Francis Inquiry February 2013 are still relevant to Trust workforce strategies. There is a need to continue to develop a culture of care with safe staffing levels and the ability for staff to be able to raise concerns.

- New agency rules were issued by NHS Improvement in 2015. This includes working only with recommended suppliers; monitoring usage and spend; and adhering to the hourly cap on rates. Whilst the Trust has fully engaged with these rules it is providing challenges for managing temporary staffing. The Trust is working towards reducing non-capped agencies, the challenge is managing risk to patient safety in inpatient environments.
- Changes to the removal of the nursing and AHP tariffs with effect from September 2017 will have a potential impact on the future supply of nurses and AHPs. Bursaries are no longer available for students to undertake nursing and AHP training potentially resulting in a change to the age and demographic of students.
- Talent for Care Framework and Widening Participation strategy have been introduced to support opportunities for people to start their career in a support role and develop their career through a learning pathway.
- The introduction of an Apprenticeship Levy in April 2017 to support apprenticeship training.
- The Health Education England Workforce strategy has been produced and is the first national document that they have produced for 25 years designed to present the facts and stimulate debate. It describes the current state of the NHS, health and care workforce from 2012, outlines recent strategic workforce interventions; describes key decisions that will impact on the future workforce through to 2027; and seeks views on what we should do next to ensure our workforce provides the best quality care to patients, service users, carers, and the public.
- The NHS Constitution pledges to staff are as follows:
    - The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and careers and communities.
    - The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.
    - The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.
    - The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

9. KEY CHALLENGES

The key challenges facing the Trust include:-

- Recruiting, retaining and developing our health care workers in an increasingly competitive labour market.
- Flexing and redesigning the workforce across an integrated health and care system which challenges traditional roles and professional boundaries both within the Trust and in the community.
- Adapting our services and the workforce skill set to meet the increasing needs of patients identified as being “at risk‟ of developing illness, through lifestyle or other factors, as well as those who present with an acute hospital episode.
- The engagement of our workforce in this challenging healthcare agenda.
- New models of care requiring the development of professional staff through practice development. At the same time, we are developing the unregistered workforce, such as Health Care Assistants, in the light of the Cavendish review and ensuring appropriate supervision and development to encourage a team approach to high quality patient care.
- The use of technology, and the switch from existing platforms to Electronic Patient Record, requires significant investment to ensure that staff are confident in using it.
- Reviewing pay flexibilities that support better health outcomes, including team-based incentives and support the transition between clinical and managerial roles for senior doctors e.g. responsibility payments.
- Embedding integrated leadership at middle management level to ensure and sustain delivery of patient care and to develop the desired diverse and inclusive culture.

10. DELIVERY OF OUR PEOPLE STRATEGY UNDER PILLAR 1 - TALENT

Talent (Capable)

We will develop all leaders to influence and motivate effectively, giving them the behavioural, process and business skills to effectively serve our patients. We will maximise impact through identifying and developing all our Talent at every level in the organisation to perform to the best of their ability

10.1 OUR APPROACH TO TALENT

People development, leadership and talent management and succession planning are essential in addressing workforce challenges, in particular, shaping the current and future workforce to meet service needs.

The People strategy will enable improved performance management and people development by focusing on the provision of the following:

- **A new simplified appraisal documentation and process**. Also monitoring appraisal returns to ensure that training needs are identified and incorporated in to reporting, product design, programme procurement, and actions required
- We will be flexible, creative and offer learning opportunities and solutions.

We will design, develop and deliver a talent management framework for the Trust. Our talent management processes and development will aim to:

- Create a tangible means of identifying, selecting and deploying outstanding talent.
- **Be proactive around talent spotting, and succession and establish a 'Talent pool'.**
- Become and remain responsive to changing business needs through increased capability.
- Strengthen feelings of accountability by making development goals clear and measurable and visible across the organisation through appraisal review.
- **Utilise apprenticeship levy to map to new role development and leadership programmes.**

10.2 OUR APPROACH TO LEADING PEOPLE

Leadership within our organisation will be inclusive and span the entire organisation. It will be a reflection of how we are perceived as a professional and credible organisation/ business, and the provider of choice.

Teams are more inclusive and well-led when they are well-structured and have effective processes that include: clear vision and values; shared team leadership; valuing diversity as a positive element of the team; and a pattern of listening to and valuing all voices within the team. The key elements necessary for cultures of inclusion are also associated with high-quality health care.

There will be clear distinctions between different levels of leadership, and we will ensure that leadership development is geared towards meeting the needs of specific levels of leadership, and by removing barriers to give greater clarity of vision and strategic direction, permission to act, confidence, consistency and improved team-working across our Clinical Business Units.

We will promote:

- **The definition of 'Excellent Leadership' as the ability of any individual to inspire, influence** and maximise the efforts of others towards the achievement of a common goal.
- A model for Leadership which aligns to the **NHS 'Developing People-Improving Care' national framework** for action on improvement and leadership development in NHS-funded services (the five conditions which underpin the framework are shown at appendix B).
- **The development and nurturing of leaders at all levels in the organisation.**
- Creation of a culture where our staff are given permission and the confidence to act effectively.
- A clear focus on values, ethics, knowledge, personal responsibility and developing skills for the greater good of our organisation.

10.3 OUR APPROACH TO LEADING CHANGE

We will adopt an approach to leading change which will enable us to give clarity, obtain commitment and ultimately, ensure we have the capability to lead and sustain change where required.

People at all levels will understand the vision for the future and the need for change, will be engaged in the change seeing it as essential and part of their responsibility and we will ensure that leaders and teams have the skills and ability to enable change to be delivered.

We will promote a consistent, values based process underpinned by policy and the capacity and capability of our leaders to lead change, and will support all our people to better balance and manage themselves through personal change in a healthy and constructive way.

11. DELIVERY OF OUR PEOPLE STRATEGY UNDER PILLAR 2 - ENGAGEMENT

Engagement (Motivated)

We will motivate our People to do the best that they can by living our Values and creating a culture of Trust and real Engagement

11.1 OUR APPROACH TO ENGAGEMENT

In order for us to meet the challenges that our NHS faces, we must ensure that staff are committed and loyal to our organisation, and that they feel so inclined to give their very best to their roles and our patients. We want our people to be engaged in our operational strategy and also, in our culture and in living the values of our organisation.

The People Strategy will support improved engagement and motivation of our staff by the development and cascade of:

- **An Excellent Leadership Framework** and training and development tool kit for leading people and leading change
- A values based behavioural framework for all staff
- **The setting up and on-going support and facilitation of Schwartz Rounds** (confidential, multi-disciplinary forums designed for staff to come together once a month to reflect on the emotional and social experiences associated with their work)
- **A review and refresh of our current reward and recognition schemes including the introduction of an Inspiring Leader award**
- **The creation of an instant pulse check system and focus on pulse check questions and results**

We will monitor our progress as follows:

- through **our Staff Survey and associated pulse checks, stress surveys, family & friends test**
- by ensuring we understand and act on all feedback that influences our staff morale, through our Occupational Health, HR, L&OD and employee relations services.

12. DELIVERY OF OUR PEOPLE STRATEGY UNDER PILLAR 3 – HEALTH AND WELL BEING

Health and Wellbeing (Sustainable)

We will ensure that we create an environment where our People are physically and emotionally sustained to enable them to give their best and to be able to be at work more of the time in order to better serve our patients

12.1 OUR APPROACH TO STAFF HEALTH & WELLBEING

We want the experience of working for Barnsley to be a positive one, and to have a positive impact on the health and wellbeing of our employees.

Responsibility for health and wellbeing at work belongs to both employers and employees. The key factors that we believe can determine whether workers will have a positive or negative relationship with work are:

- The relationships and communication between line managers and their people
- Whether employees are involved in organisational issues and decisions and feel empowered and involved in our organisation
- Job design and practicality, flexibility and versatility of role
- Appropriateness and volume of workload
- Availability and acceptability of flexible working
- Awareness of occupational health issues and encouragement to invest in themselves and their wellbeing.

We therefore aim to:

- Create a resilient, physically healthy and emotionally balanced Workforce.
- **Educate and support our workforce to be proactive in their health and wellbeing** encouraging the up-take of Lifestyle Checks to inform healthy lifestyle choices e.g. alcohol, weight reduction and smoking.
- **Reduce levels of sickness absence across the Trust**
- Assess the effects of health on work and work on health

- Occupational Health services continue to be SEQOHS accredited
- **Meet our health and wellbeing CQUIN**
- **Reduce stress and improve mental wellbeing of staff** by offering education and training sessions providing knowledge and skills to equip managers and staff to have better awareness to manage and improve their mental health coping strategies e.g. resilience training, sleep management, mindfulness.

13. DELIVERY OF OUR PEOPLE STRATEGY UNDER PILLAR 4 – QUALITY OF POLICY AND PROCESS

Quality of Policy and Process (Sufficient)

We will provide robust infrastructure and Quality process, policy, procedures and Assurance Framework to support and monitor our ability to lead our People in Barnsley. Also to ensure we attract, select, recruit, develop, performance manage and retain the right people, in the right place at the right time, doing the right things, with the optimum level of motivation.

13.1 A ROBUST PROCESS FOR SUCCESSION AND WORKFORCE PLANNING

We will use succession planning as a proactive process that works to address talent needs before they exist and which then cultivates internal talent to meet those needs. This incorporates linking workforce planning to business planning to inform future leadership requirements and determining the key roles that will have the greatest impact on the stability, productivity and effectiveness of the organisation.

We will:

- Put systems and processes in place to support the succession planning process in order to have a positive organisational impact and to **fully enable our CBU Leads to make decisions about the numbers, roles, skills and development requirements of the resources required to effectively run their services.**
- Use effective leadership planning to equip the organisation with the essential leadership qualities, knowledge, skills and behaviours required to build effective leadership.
- **Provide accurate information around gaps and ensure that future planning decisions are made around robust data.**
- **Support the recruitment of the right people into the right places with the right skills through provision of gap data, and ensure that succession planning is credible and accurate**
- Support the Business Units to be able to make effective workforce plans to realise their business plans.

- Work with regional /external stakeholders where required to ensure that we align our workforce plans and succession plans to the wider, national agenda as required.

13.2 OUR APPROACH TO EMPLOYEE RELATIONS PROCESS AND POLICIES

It is important that managers have access to information and guidance to help them line manage their employees effectively. A number of toolkits will be developed and made easily accessible to line managers on key HR issues including sickness management, capability, flexible working, how to deal with grievances and how to manage organisational change projects successfully.

The toolkits will be supported by a “quick reference guide” that will act as an easy reference tool for things like special leave, annual leave and sickness as well as frequently asked questions for each subject matter.

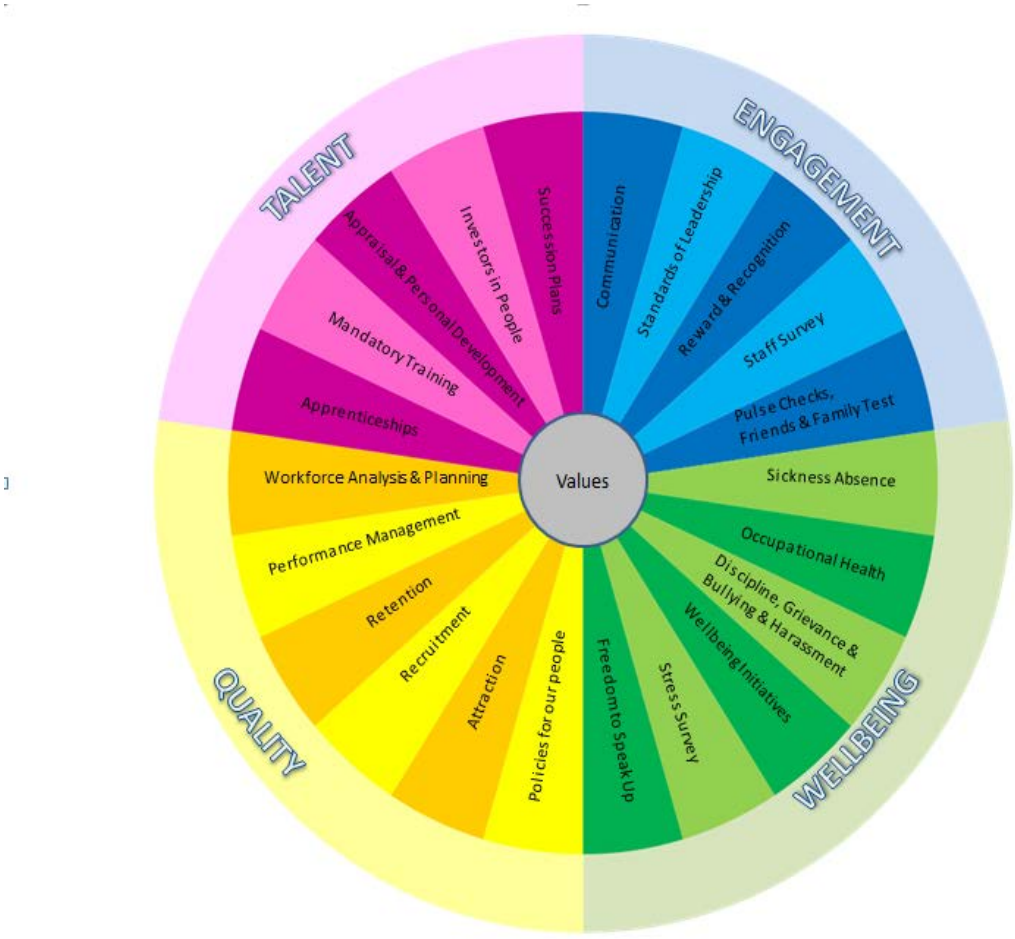
The HR Business Partner intranet page will be revamped – ensuring that the page can be easily navigated and that the toolkits and guidance documents are easy to find.

14. OUR PEOPLE DASHBOARD

All Plans will be monitored through our People & Engagement Group and to the Board via Finance and Performance Governance Committee on a monthly basis through our Workforce Performance dashboard and our People and Engagement Group Chairs Log. Our KPIs will include qualitative in addition to quantative measures, and will offer CBUs service line information. The People Dashboard will enable leaders to monitor and communicate Performance and will be included in the CBU performance review meetings, reviews and governance committee reviews.

Our dashboard will be based on the 4 pillars of our People Strategy: Talent, Engagement,

Health and Well being and Quality. Within these 4 pillars, we will measure our success under the following headings:



15. OUR KEY PERFORMANCE INDICATORS

Under the 4 Pillars of our People Strategy, we will develop our KPIs and measures to include:

Talent

- Return on Investment of training and development outcomes
- Metrics for measuring talent and cultivating a collaborative and consistent approach to managing performance and understanding workforce performance drivers.
- Mandatory training compliance
- Appraisal rates completion and quality of appraisal discussions
- Apprenticeship Levy spend
- Investors in People accreditation

Engagement

- Pulse checks, annual staff survey and staff engagement scores
- Manager communication via Team Brief etc completion rates and quality of Team Briefs
- Progress towards the NHS Equality Delivery System EDS2, WRES, WDES compliance

Health and Well Being

- Sickness absence rates
- Occupational Health service referrals
- SEQOHS accreditation
- Health and Wellbeing CQUIN
- Stress Survey

Quality of policy and process

- Vacancy levels
- Turnover
- Time to recruit
- Agency usage and spend
- Employee relations measures such as Employment tribunals, suspensions, disciplinaries

16. OUR PEOPLE STRATEGY DELIVERY – RISKS IDENTIFIED

Area	Risk	Mitigation
People	Skillset of Organisational Teams • Any skills gap could result in either a delay or the failure of plans. • Lack of a substantive Director of HR & OD • Lack of capacity to deliver programmes highlighted requiring OD support	• The Trust has previously undertaken a capacity, skill and capability review of both the Executive and of the Board to ensure that the Trust is able to deliver plan and strategy. • The Trust has re-profiled the Executive structure and utilised an interim HR & OD contract to kick start the work on People Strategy. There is a plan to recruit a substantive Director of HR & OD. • Expectations to be set with all staff through clear objective setting, values-based appraisal and performance meetings- this will be refreshed and reviewed as part of the planned strategic activity.
People	Adequate internal resources • Potentially insufficient internal resources exist to maintain ongoing services and to fully support People Strategy programmes of work. The complexity and effort to drive them should not be underestimated. • Resource constraints could lead to either a delay or the failure of the People implementation plans.	• The Trust will, for each function affected by the Plan, complete an internal capabilities review to identify whether the current resource has the necessary capacity to support the plan. • For each planned scheme, resource will be reviewed.

Area	Risk	Mitigation
People	• Organisational ability to lead change and lack of clarity of approach to change.	• Use of forward plan, horizon scanning and project reviews at performance and ET meetings • Strategy plans to be part of weekly ET review of performance • OD & personal/leadership development of Trust Board and Exec team to define approach to change and leadership, organisational definitions and further agreement on ways of working • Performance meetings to include strategy/implementation plan reviews of progress

Area	Risk	Mitigation
Culture	• There is a risk that some Trust employees will be resistant to the changes detailed within this plan which, if not addressed, could delay implementation.	• The Plan is underpinned by Trust's change to "can do" culture. • The Trust wants all staff at every level to fully understand the Plan and their role within this plan. Accordingly the Trust will deliver a series of interactive roadshows which will provide details of the plan, explain key milestones, what is expected of the staff regarding the delivery of the plan. The Trust will also ensure that there are regular follow on communications to re-emphasise the key message regarding the plan, updates on its delivery and further need for change and work proactively with staff representatives across the workforce to deliver changes in partnership. • As part of further change, targets and milestones are being set, met and delivered. • Recognition and reward strategy. • Workforce flexibility & support for staff health and well being.

17. ENGAGEMENT, INVOLVEMENT & PARTICIPATION IN THE PEOPLE STRATEGY

Employee engagement will be fundamental in delivering the outcomes of the People Strategy, and will be based on building trust in our service.

We will therefore maximise engagement by ensuring that our programmes and interventions:

- Equip our leaders with the skills and motivation to allow them to deliver real and meaningful action based on their opinions and ideas
- Support the offerings of other enablers – e.g. OD to ensure that development is 'joined up' and practically supports making working lives easier and outputs more efficient.
- Give clarity, an improved 'systems' view and make clear links to the benefits realised as a result of 'what we do' in People Development.
- Regularly gather feedback to improve our People Development service.
- Support anything that we do with clear concise communication and easy access to support open conversations around improving our service.
- Ensure we have a clear, professional and recognisable brand for People Development in the organisation and an improved People intranet.

18. LOOKING AHEAD – WHAT WILL HAPPEN IN YEAR 1?

Action	Owner	Delivery Date	Comments
We will embed People as a key component within the Finance and Performance Committee	Michael Wright	Q1	The terms of reference for the Finance and Performance Committee have been expanded to capture enhanced People focussed data.
We will fully collaborate in the HR work streams of the SY&B ICS	Michael Wright	Q1-Q4	We are currently leading on the MAST and Occupational Health streamlining work streams.
We will establish the Schwartz Rounds and fully evaluate their impact within the Trust	Michael Wright	Q1/Q2	The first Schwartz Round was held on the 5th June 2018. The Schwartz Round Steering Group provides regular updates to the People and Engagement Group.
We will develop a number of toolkits for managers on key HR issues including sickness, annual leave and flexible working to help them line manage their People effectively	Michael Wright	Q1/2	The sickness management toolkit is now available on the HR Intranet site. The annual leave toolkit is currently in development.

We will implement actions necessary to deliver the Health and Wellbeing CQUIN	Michael Wright	Q1-Q3	The Health and Wellbeing CQUIN Action plan was presented to the Executive Team on the 5th June 2018.
We will establish a Workforce Planning Steering Group with key CBU and Corporate Leads to make decisions about the shape of our future workforce and produce a Trust Workforce Plan	Michael Wright	Q1-Q4	The Workforce Planning Steering Group is established and terms of reference have been approved. A key action of the group is to develop a workforce plan aligned to the Trust's Operational Plan.
We will complete all actions in the Investors in People Trust action plan including the introduction of the Excellent Leadership Framework, the Staff Behavioural Framework and a refresh of the appraisal process and documentation	Michael Wright	Q1-Q4	First drafts of the Leadership Framework and Behavioural Framework have been presented at the People and Engagement Group.

We will introduce qualitative measures into our People performance dashboard KPIs including staff engagement scores and quality of appraisal discussions through the introduction and use of regular pulse check surveys data collection and analysis	Michael Wright	Q2	A mechanism to run regular pulse checks is being scoped.
We will seek the appointment of a Director of HR & OD	Richard Jenkins	Q3	Currently exploring the potential for a joint appointment with the Rotherham NHS Foundation Trust.
We will seek the appointment of a Head of OD	Richard Jenkins	Q3	Currently exploring the potential for a joint appointment with the Rotherham NHS Foundation Trust.
We will develop an agreed approach to CBU Triumvirate leadership development.	Michael Wright	Q4	This will be developed following the commencement of the new Head of OD.

We will map our strategy aims and measure our progress in delivering the strategy against the CQC well-led domain Outstanding rating characteristics for People and against the NHS 'Developing People – Improving Care' national framework for action on improvement and leadership development in NHS-funded services.	Michael Wright	Q2-Q4	The CQC well-led ratings characteristics for People are attached at appendix A The five conditons which underpin the 'Developing People-Improving Care' national leadership framework are attached at appendix B

Appendix A

CQC Well Led Outstanding Ratings Characteristics for People

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

Outstanding	Good	Requires improvement	Inadequate
The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.	The leadership, governance and culture promote the delivery of high-quality person-centred care.	The leadership, governance and culture do not always support the delivery of high-quality person-centred care.	The delivery of high-quality care is not assured by the leadership, governance or culture. Normally some regulations are not met.

- **W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?**
- **W3: Is there a culture of high-quality, sustainable care?**
- **W5: Are there clear and effective processes for managing risks, issues and performance?**
- **W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?**
- **W8: Are there robust systems and processes for learning, continuous improvement and innovation?**

W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?

Outstanding

- There is compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There is a deeply embedded system of leadership development and succession planning, which aims to ensure that the leadership represents the diversity of the workforce.
- Comprehensive and successful leadership strategies are in place to ensure and sustain delivery and to develop the desired culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.

W3: Is there a culture of high-quality, sustainable care?

Outstanding

- Leaders have an inspiring shared purpose, and strive to deliver and motivate staff to succeed. There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. There is a strong organisational commitment and effective action towards ensuring that there is equality and inclusion across the workforce.
- Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process.
- There is strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.

W5: Are there clear and effective processes for managing risks, issues and performance?

Outstanding

- There is a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviews how they function and ensures that staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems are identified and addressed quickly and openly.

W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

Outstanding

- There are consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account.
- Services are developed with the full participation of those who use them, staff and external partners as equal partners.
- Innovative approaches are used to gather feedback from people who use services and the public, including people in different equality groups, and there is a demonstrated commitment to acting on feedback.
- The service takes a leadership role in its health system to identify and proactively address challenges and meet the needs of the population.

W8: Are there robust systems and processes for learning, continuous improvement and innovation?

Outstanding

- There is a fully embedded and systematic approach to improvement, which makes consistent use of a recognised improvement methodology.
- Improvement is seen as the way to deal with performance and for the organisation to learn.
- Improvement methods and skills are available and used across the organisation, and staff are empowered to lead and deliver change.
- Safe innovation is celebrated. There is a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There is a strong record of sharing work locally, nationally and internationally.

Appendix B
Developing People – Improving Care

Condition 1: Leaders equipped to develop high quality local health and care systems in partnership

Leaders of organisations in local health and care systems are able to collaborate with partners including patient leaders across organisational, professional and geographical boundaries in trusting relationships to achieve the same clear, shared system goals1 for their communities.

Condition 2: Compassionate, inclusive and effective leaders at all levels

Compassionate leadership means paying close attention to all staff; really understanding the situations they face; responding empathetically; and taking thoughtful and appropriate action to help. Inclusive leadership means progressing equality, valuing diversity and challenging existing power imbalances It may sound a 'soft' and timeless leadership approach given current urgent pressures. But evidence from high performing health systems show that compassionate, inclusive leadership behaviours plus established improvement methods2 create cultures where people deliver fast and lasting improvement in quality and efficiency.

Condition 3: Knowledge of improvement methods and how to use them at all levels

Individuals and teams at every level know established improvement methods and are using them in partnership with patients, communities and citizens to improve their work processes and systems. Enough people can lead improvement project teams to release the full benefits of this knowledge.

Condition 4: Support systems for learning at local, regional and national levels

There is sufficient training, coaching and organisation development capacity to meet development needs and enable and support learning and improvement. Data and knowledge-sharing systems to support improvement and leadership development are in place and there are networks for sharing improvement knowledge and experience locally, regionally and nationally.

Condition 5: Enabling, supportive and aligned regulation and oversight

The regulation and oversight system gives local organisations and systems control of driving learning and improvement. At the same time, central organisations help local systems find the support and resources they need. The constituent parts of the oversight system behave consistently and 'speak with one voice'.

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1 Including continuously improving care, population health and value for money.

2 These methods include Total Quality Management (TQM), Model for Improvement (including Plan Do Study Act or PDSA), Statistical Process Control, Six Sigma, Lean, Experienced-based Co-design, Theory of Constraints, and Business Process Re-engineering. See www.health.org.uk/sites/health/files/QualityImprovementMadeSimple.pdf

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REPORT TO THE HEALTH AND WELLBEING BOARD

Date 22/11/2018

TITLE OF REPORT: Delivery of Cancer priorities across the Barnsley locality

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Report Sponsor:	H&WB member
Report Author:	Georgia Thompson and Andrew Stephenson
Received by SSDG:	Date
Date of Report:	22/11/2018

1. Purpose of Report

1.1 To provide the Board with an understanding of the key priorities of the SYB&ND Cancer Alliance and some examples of how these are being delivered locally to meet the needs of the Barnsley population.

2. Delivering the Health & Wellbeing Strategy

2.1 The work of the SYB&ND Cancer Alliance regionally and locally in Barnsley aligns completely to the vision of the Strategy – with a greater emphasis on cancer prevention and early diagnosis than ever before. The Cancer Alliance's delivery plan draws on a truly collaborative approach, inspiring and empowering stakeholders from across organisational boundaries and sectors to come together in achieving solutions and tangible change. Utilising a person-centred approach to achieve transformational change - actions focus on doing things differently rather than doing more. This makes efficient use of resource and strengthens links across health and social care. The aim is to maximise health; improve people's experience and clinical outcomes; and reduce variation where it exists.

3. Recommendations

3.1Health and Wellbeing Board members are asked to:-

- Note the contents of this report and work underway
- Provide support and promotion of the cancer priorities in their respective organisations/sectors as appropriate
- Support attendance at the Board in early 2019 by a person affected by cancer, to share their 'lived' experience of some of the improvement work underway.

4. Introduction/ Background

The national strategy for cancer 'Achieving world Class Cancer Outcomes' (Cancer Taskforce 2015) outlined a wealth of recommendations aimed at improving the experience and outcomes of people affected by cancer in England. This directly influenced the priorities identified by the SYB&ND Cancer Alliance and subsequently reflected in the Cancer Delivery Plan 2017/18 – 2020/21. This plan drew on the well established collaborative working around cancer, already in existence across the region; recognising that success can only be achieved if undertaken in a truly integrated way. There are 4 key priority areas within the Plan and these are:
1. Cancer Intelligence – to develop an Alliance wide approach to cancer performance including fostering a sense of shared accountability across providers and commissioners.
2. Prevention and Early Diagnosis – tackling variation in service provision to address cancer risk factors and screening uptake; and to develop and implement best practice recommendations to maximise earlier cancer diagnosis.
3. High Value Pathways – delivering transformational improvements across tumour site specific pathways which extend from presentation/referral/diagnosis, through treatment and beyond. These pathway improvements will be directly influenced by users (patients/carers) and multiple stakeholders who will work collaboratively to achieve the best results. Work-streams will also include review of and improvement to the regional Chemotherapy delivery model; work to maximise MDT (multi-disciplinary team) effectiveness; and to create more direct links to relevant research opportunities.
4. Living with and beyond cancer (LWABC) – this work primarily focuses on the experiences of people affected by cancer beyond the acute phase of treatment; and how people can be better supported to live 'happy, healthy and longer lives' - resuming a meaningful role in their family, community and wider society. As part of a Macmillan funded regional programme, priorities include implementation of The Recovery Package (a group of core improvements shown to bring benefit to patient experience and onward pathway quality (National Cancer Survivorship Initiative)) and risk stratified models of follow up care that are tailor made to an individual's clinical and holistic needs. Local work spans across sectors and beyond the conventions of specialist cancer resource.
The local Barnsley Cancer Plan reflects these key priorities – considered in the context of our own local population needs and health inequalities. A range of stakeholders including people affected by cancer, work collectively to define, implement and evaluate deliverables – coming together in a number of forums and within a clear governance structure.

To date, multiple work-streams are underway within the over-arching remit of each priority area. There is a significant focus on promoting health and well-being – increasing our population's awareness of cancer and the opportunities afforded to prevent or diagnose cancer early; reduce the impact on quality of life which can be adversely affected as a consequence of cancer and its' treatment; and building on excellent End of Life foundations to promote person centred, effective advanced care planning.

This paper gives a high level outline of just three areas of work underway which demonstrate the integrated approach around cancer. This aligns to the 'Feel Good Barnsley's' guiding principle to 'Connect, collaborate and co-produce'.

5. Three examples of local cancer improvement work:

- Be Cancer Safe (part of the Prevention and Early Diagnosis programme) – this fantastic initiative draws on the learning that real improvements around health can not be achieved in isolation and that fostering the power of community can have a huge impact. Within the Barnsley locality (and following a procurement process), staff from Voluntary Action Rotherham, Cancer Research UK and members of the national Screening Programme are working together to target communities and specific populations to promote understanding and awareness around cancer prevention, cancer awareness and screening. This initiative falls under the premise of a social movement – creating cancer champions within our local population who will continue to disseminate messages about cancer longer term – utilising existing opportunities within communities and natural communication channels to pass information and learning on. This has been enormously successful so far – with an initial target of 1560 social champions created in Barnsley by April 2019, already far exceeded at 1770 to date. NHS Barnsley CCG has drafted a proposal to extend the duration of this work and feedback from the initiative is being presented to the Prevention and Early Diagnosis Group on the 23rd November 2018.
- Work and cancer (part of the Living with and Beyond Cancer programme) – there is a strong evidence base that people often struggle to return to and remain in work following a cancer diagnosis and treatment. This can be due to the significant emotional and physical impact on an individual that cancer can have; and often a lack of awareness amongst employers of the rights and needs of people affected by cancer in their workforce. Members of the cancer workforce at BHNFT have been working in partnership with third sector, occupational health and council partners to improve the work support for people affected by cancer in Barnsley. Initial work has created a partnership approach between The Well (cancer complementary therapy service) and a Macmillan sponsored in-reach occupational health advisory service – which collectively can help address the emotional, physical and social barriers which may be negatively impacting local people with cancer trying to return to work. This partnership also links to the Macmillan Welfare and Benefits service provided by BMBC to ensure the financial impact for patients is addressed at the same time. Additional work with BMBC's Workplace Health Officer is focusing on how cancer specialists can better support employers to understand the impact of cancer for the workforce; and promote healthy lifestyle and prevention messages. One example of recent work includes a link to BHNFT's Breast Cancer Specialist Nursing Team from a local large employer, who has requested input to teach their employees about breast self-examination and breast cancer awareness.

There is an intention to have a structured plan around this element of the work in 2019.

- HOPE – Helping Overcome Problems Effectively (part of the Living with and beyond cancer programme). A key deliverable of the national cancer strategy and subsequent regional and local LWABC plans is the availability of health and well-being opportunities for people affected by cancer. These can take a range of formats and localities are exploring a number of models including tapping in to existing H&W being resources for the general population and other long term conditions (working differently rather than doing more). One approach currently being piloted and developed in Barnsley is the availability of the HOPE programme which is a validated Macmillan self-management course. Both people living with (non curative) or beyond cancer (cured) in Barnsley are offered to attend the programme which extends over 6 weeks (2.5 hours a week) and covers core topic areas including fear of cancer recurrence, anxiety and depression, handling stressful situations, regaining confidence, sexuality and body image; and managing consequences of treatment e.g. fatigue. The programme stems from extensive learning from patient reported outcomes about the impact of cancer and how this does not 'go away' when treatment ends. It aims to equip people with the knowledge, skills and ability to manage any cancer related issues for themselves – able to seek out support from different resources when needed, but reducing reliance on traditional healthcare resources; which have historically not always been able to address the wider holistic, specific needs of individuals.
  The 5th HOPE programme has just been delivered locally and evaluation has been overwhelmingly favourable - with attendees reporting a real positive difference to their health and well-being following the course. One great benefit found has been that of peer support – even when that has included people living with palliative disease and those who are cured.
  The integrated approach to this initiative is reflected in the people undergoing facilitation training and coming together to deliver the course – facilitators include patients, cancer nurse specialists, Hospice team members, complementary therapists and a staff member from The Recovery College (SWYPFT). Interest in facilitation has also been expressed by community nurses; and the Barnsley LWABC Project Manager is actively promoting this engagement and cross sector working – so the programme extends beyond the confines of the acute Trust and is a true local, shared resource.
  There is intention to provide HOPE on a rolling basis and potential as an 'opt-out' part of some risk stratified follow up models; but also to take the programme to different localities across the Barnsley geographical area to ensure equity of access.

6. Conclusion/ Next Steps

6.1 Work continues at pace to bring about the tangible improvements needed around cancer and ensuring our Barnsley population have better or comparable outcomes with the rest of the region and the UK.

It is proposed that further updates are provided to the Board as work progresses; and that specifically, people affected by cancer can bring their 'lived' experience of some of these improvements, to present to the Board in early 2019.

7. Consultation with stakeholders

8.1 Local delivery of the cancer agenda involves a multi-stakeholder approach with patients at the heart. There are well established steering groups with representation across organisations and sectors and including patient representatives. There is a strong link to the local cancer patient user group – the Barnsley Cancer Action Group - who facilitate a co-production approach to many aspects of the work.

8. Background Papers

Achieving world class cancer outcomes (national strategy) –

https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

SYB&ND Cancer Alliance Delivery Plan –

https://smybndccgs.nhs.uk/application/files/9814/8467/0317/Cancer_Alliance_Delivery_Plan_2017_2021.pdf

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healthwatch Barnsley

Annual Report 2017/18

Contents

Message from our Chair, Adrian England

It is once again, my pleasure to introduce Healthwatch Barnsley's fifth Annual Report.

Voluntary Action Barnsley (VAB) was commissioned by the local authority to host Healthwatch Barnsley for a further year, with an option to extend this for a further year. We are grateful to VAB for the support that they have offered the organisation over the past year.

In 2017 we saw our manager Carrianne Stones leave the organisation for a fresh challenge, initially the manager's post was covered by Teresa Gibson, but we then advertised to recruit a permanent replacement. This recruitment took a little longer than expected, but eventually we were very fortunate to appoint Susan Womack to the permanent position as Healthwatch Barnsley's manager. Sue brings a wealth of experience in Health and Social Care at managerial level within the Voluntary Sector.

During the period of recruitment, Lorna Lewis stepped up to act as manager and the other staff Gill Doy, James Goodwin and Jade Bligh also provided additional support; myself and the rest of the members of the Strategic Board recognise the exceptional dedication of all the staff during this difficult period; and this commitment meant that the services offered by the organisation were not diminished in anyway.

As you can see, the last twelve months have continued to be even more challenging, but at the same time they have been stimulating and hugely rewarding for all concerned.

The economic situation has continued to constrain public spending and as a result expenditure has been even more dedicated and focussed around people's needs. Within Health and Social Care provisions locally, it has been critical to ensure that there has been a balance between value for money whilst safeguarding and improving all our exceptionally high-quality services. It is important that the spending of the "Barnsley pound" continues to be centralised within the Borough.

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 been enhanced. It has been good to see that commissioners and providers are working even more closely together; and, with their continued commitment I'm sure that local people will experience the benefits of these transformational changes. We will continue to support and challenge these changes and ensure that the outcomes for the people of Barnsley continue to remain at the heart of Health and Social Care system reform.

I continue to be extremely impressed with the commitment that the officers of the Local Authority, Clinical Commissioning Group (CCG), NHS and other service providers, the members of the Health and Wellbeing Board, Community Forums and Provider Forums, and the "Third Sector" Voluntary Organisations, who all demonstrate, by their desire and hard work together to improve and develop the current Health and Social Care provisions in Barnsley.

Healthwatch has maintained its position on these Boards and other Forums as well as our representation at regional level via membership of the South Yorkshire and Bassetlaw Shadow Integrated Systems Care – Working Together Partnership Board and; at a local "place-based planning", the Barnsley Health and Care Together Partnership Shadow Board levels.

I commend the report and remind readers that more information on the organisation, our work plans and reports can be found on our web page.

www.healthwatchbarnsley.co.uk

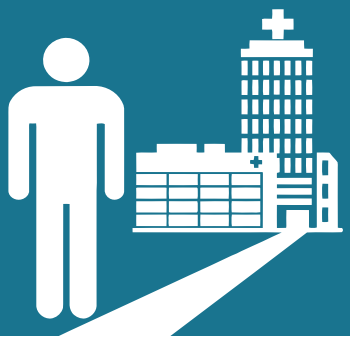
Highlights from our year. This year we have:

Spoken to 2718 Barnsley people

233 new followers on Twitter

Received 308 reviews on our feedback centre

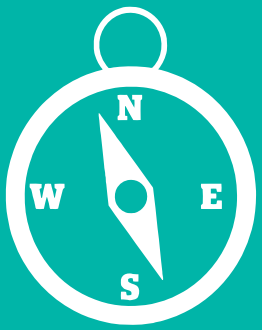
Visited 84 local groups & events



Tackled issues ranging from Dental to Sexual Health in our reports

Spoken to 280 young people about sexual health

Given 89 people information & advice



Who we are

You need services that work for you, your friends and family. That's why we want you to share your experiences of using health and care with us - both good and bad. We use your voice to encourage those who run services to act on what matters to you.

As well as championing your views locally, we also share your views with Healthwatch England who make sure that the Government put people at the heart of care nationally.

Health and care that works for you

People want health and social care support that works - helping them to stay well, get the best out of services and manage any conditions they face.

Our purpose

To find out what matters to you and to help make sure your views shape the support you need. People's views come first - especially those who find it hardest to be heard. We champion what matters to you and work with others to find ideas that work. We are independent and committed to making the biggest difference to you.

Our Strategic Priorities

Priorities are determined by taking into account the feedback we gather through our research and engagement activity. Our priorities are then checked against the Health & Wellbeing Strategy for Barnsley, as well as other local strategies; as a result of this process we are able to look at areas to focus on.

Meet the team

Lorna Lewis
Adult Engagement Officer

James Goodwin
Outreach and Information Officer

Jade Bligh
Children and Young People Engagement Officer

Gill Doy
Signposting, Intelligence and Communications Officer

Sue Womack
Healthwatch Barnsley Manager

Your views on health and care

Listening to people's views

- We tailor our outreach and engagement to the people we work with
- We ensure the communities we engage with have the opportunity to become actively involved, using their experiences and knowledge of services when raising concerns
- This year we have visited 84 groups and events including Blind and Partially sighted groups, Health and Equality Conference, Mind, Carers groups, Age Friendly Conference, Diwali Festival, schools and academies and many more.
- We have carried out targeted engagement activity to produce a number of reports, a sample of which are highlighted in this report

Each year we form priorities based on the information received from members of the public. These comments are cross-referenced with data received through the range of meetings we attend and the local health and wellbeing strategies for Barnsley.

Dental Survey

Our former dental survey highlighted that in Barnsley the average number of decayed teeth in some wards is five times higher than in other less deprived wards of the borough and that there are a significant number of Barnsley children and young people being admitted to hospital every year for the removal of decayed teeth.

In 2016, after receiving the Public Health Strategy, we felt that there was something practical that we could do in terms of seeking the views and experiences of children and young people accessing dentists in Barnsley, bringing their views and opinions to the forefront of local discussions.

We subsequently engaged with five primary schools in Barnsley and led a 45 minute session in each, highlighting the importance of dental hygiene, as well as gathering the views of young people relating to dentists.

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

This information was presented to the Oral Health Advisory Board in June 2017 and shared with the dental practices and schools in Barnsley. Following on from this the recommendations in our report were included in the Oral Health Action Plan and included in the Barnsley Oral Health Needs Assessment.

DNA Report (Did Not Attend) relating to GP appointments

Patients not attending appointments at their general practice is a major issue and cost to the National Health Service (NHS).

DNA rates have an enormous impact on the health care system in terms of cost and waiting times, significantly adding to delays along the patient pathway.

Following on from concerns raised with us, we agreed to explore the issues relating to DNAs with service users and General Practices across the Dearne. We agreed to raise awareness about the importance of keeping appointments or cancelling appointments where necessary.

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.

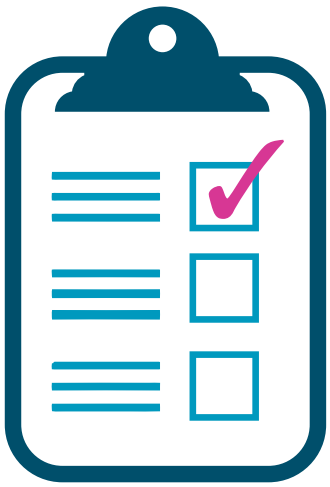
As a result of this initial work, we spoke to a total of 42 people and found that the issue of people not being able to get an appointment at their practice was a common theme.

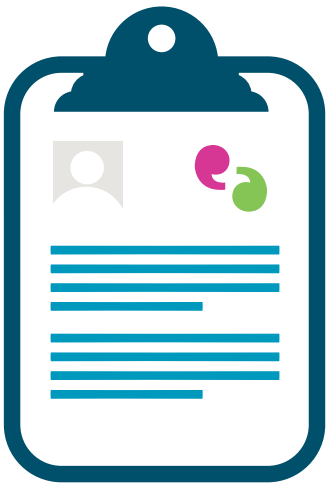
In order to find out what service providers thought about these access issues, we visited two surgeries in the Dearne and spoke to staff and the practice managers.

At both surgeries staff felt that the biggest problem affecting access to appointments was patients not attending appointments they had booked.
To gather more information we spoke to 350 patients living in Thurnscoe, Goldthorpe and Bolton upon Dearne. We also spoke to four general practices about DNA's and the impact they have on their surgery.

From this research we could clearly identify a problem in the Dearne with patients not attending booked appointments at their GP Surgery. The research also highlighted a wide range of reasons for patients not attending booked appointments. Consequently the report made a number of recommendations and was widely circulated.

In next years Annual Report we will report on the Actions taken following the Recommendations in the Report.





Sexual Health Report

During 2015 our Children and Young People's Engagement Officer carried out a survey on sexual health and wrote a report outlining the findings on C-Card access and sexual health services for young people in Barnsley.

A C-Card scheme is one type of condom distribution scheme, which provides registered young people with a C-Card – a paper or credit card-style card – which entitles them to free condoms.

Barnsley's Our Public Health Strategy 2016-2018 highlighted the challenges around under 18s conceptions as they still remained a concern in some electoral wards when compared to national, regional rates. It was acknowledged in the strategy that work was needed to:

- Ensure sexual health services, including contraceptive services, are accessible, personalised and effective
- Ensure under 18s conceptions continue to reduce
- Commission sexual health and contraception services for Barnsley residents.

Following on from our previous findings and in conjunction with the areas highlighted in the Public Health Strategy a similar piece of work was undertaken in 2017. This was to see if there had been any improvements in the young people's knowledge of C-Cards and the sexual health services in Barnsley.

The report outlines the views of children and young people who took part in the sexual health survey that we carried out.

We engaged with 280 young people from Barnsley, aged between 13 years to 17 years.

Key findings from the 2017 Survey:

- 98% of the young people surveyed did not have a C-Card;
- Only 6% of young people surveyed have accessed a sexual health clinic in the past 12 months;
- 19% know where sexual health services are located;
- 253 young people surveyed have accessed a Relationship and Sex Education (RSE) session within school, of these 234 young people rated the session between very good and ok;
- 210 young people did not know if the school had a sexual health drop in; this could be because the school does not provide one or it is not promoted effectively.
- As a result of our findings we outlined a number of recommendations for providers and commissioners.

As a result of our findings we outlined a number of recommendations for providers and commissioners.

In next years Annual Report we will report on the actions taken following the recommendations in the report.

Sustainability and Transformation Partnership Project (STP)

Following on from discussions with the Commissioners Working Together team, it was agreed that local conversations with local communities would be a good approach to adopt to gather information about public perception of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

The preferred vehicle for managing the local conversations was through Healthwatch Barnsley and Voluntary Action Barnsley.

It was agreed with the Commissioners Working Together team that, due to time constraints and a need to focus conversations, Healthwatch Barnsley and Voluntary Action Barnsley would use their existing networks and links within communities and community groups to deliver a number of community conversations and focus group sessions.

Following on from the initial piece of work a decision was made by Healthwatch Barnsley to gain some feedback from young people.

We worked with 51 young people to gain their views on the STP and the feedback was gained through small group sessions within a secondary school. The feedback was then provided to the Commissioners Working Together team, to incorporate into their full report.

Hospital / Doctors Consultation

We consulted with 180 young people to gain their views on what they liked and disliked about Barnsley Hospital.

Within the survey we asked questions about their visit to the hospital, and how the doctor or nurse and other hospital staff made them feel.

From the feedback we received, the comments were entered on our feedback centre and used to provide us with local intelligence in relation to the hospital and to identify trends, which may result in a future piece of work for Healthwatch.

The same process was followed for surgeries in Barnsley and 164 young people completed our survey giving us feedback on what they liked and disliked about their surgery.

Outreach

Over the past year our Children and Young People's Engagement Officer has been building on our good relationships within secondary schools in order to carry out future engagement work.

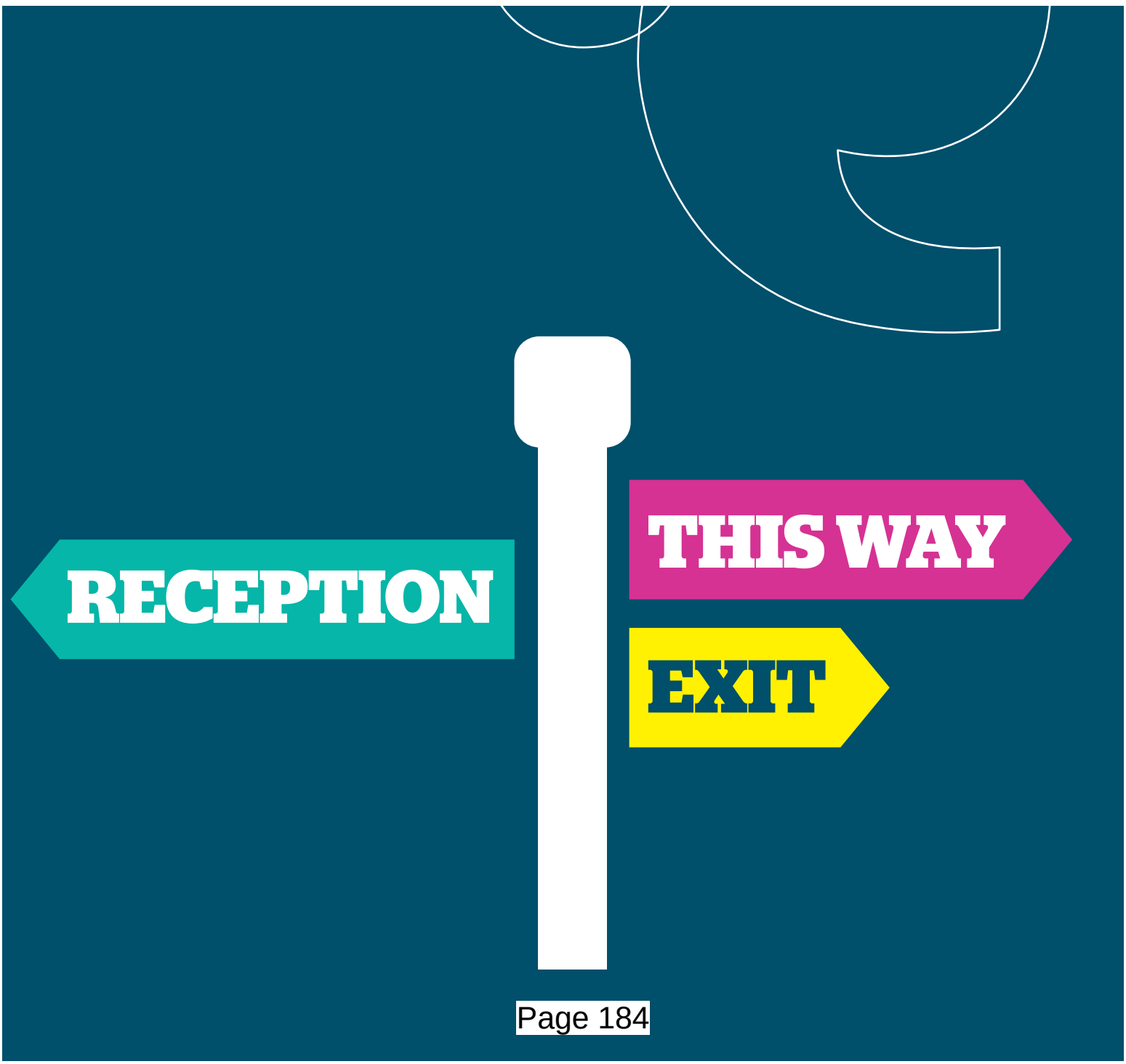
She has also carried out general outreach sessions in primary schools, local parks and community events.

Blind and Partially Sighted Service Provision in Barnsley

In response to questions and concerns raised by a number of individuals, regarding lack of services, Healthwatch Barnsley arranged a meeting with visually impaired people to talk about the services available to them in Barnsley. An invitation went out to all of our networks and via the hospital, social services, Sight and Sound in Rotherham and Sheffield Royal Society for the Blind. Although the initial response was high, only a few people attended the meeting. As a result of the group discussion Healthwatch Barnsley have spoken to current and potential service providers in the area - This piece of work is ongoing.

Our full reports are on our website **www.healthwatchbarnsley.co.uk**

Helping you find the answers



We have provided Signposting, Advice and information to 89 people.

This might not seem like many, however quite often one of these cases can result in detailed and time consuming enquiries lasting over many weeks.

As an example; one query we received this year was in relation to the potential requirement for payment for a specific service. This had caused the patient a degree of anxiety and with the assistance of NHS England, we managed to address her concerns and provide reassurance.

Our signposting advice and information service is always on hand to point people in the right direction for their health and social care needs. We have received requests for information and advice via telephone and email but we do have a walk in service, where people can ask for us at reception at Priory Campus.

We will always do our best to help, whether it is linking people to support groups for their health conditions or signposting to organisations that can help with aids and adaptations in the home to assist with a disability.

We have had requests for information and support to make a complaint, and depending on the nature of the complaint will determine where we signpost the complainant to.

Further reasons for contact have been about a lack of responsiveness from services when the patient has a sense of urgency that they do not feel is being reciprocated by the service providers, on these occasions, Healthwatch Barnsley will seek clarification on behalf of the patient as to the nature of the delays and monitor any trends.

This is by no means an exhaustive list of the issues that we have been asked to help with. We also provide signposting and information at the many outreach and engagement activities that we attend, offering a further channel for people to get in contact with us.

Where we receive three or more concerns regarding the same service we will generally speaking take a closer look at what is happening, this would also form part of the intelligence that we would share with our partners.

Providing Signposting and Advice through Engagement work

While visiting a GP surgery a Barnsley resident who is partially sighted had no information regarding help and support available. Healthwatch Barnsley informed the resident of the Low Vision event, and the Barnsley Blind and Partially Sighted and Macular group.

The resident was also in need of a shopping service and a befriending service. As a result Healthwatch Barnsley referred to the Eye Clinic Liaison Officer (ECLO) and due to our association with Voluntary Action Barnsley, was able to appoint a befriending service.

Outreach and Engagement

This year our Outreach and Information Officer has carried out more collaborative promotional work for Healthwatch Barnsley. This has been in partnership with Jo Stanley, Lead Advocate for the Independent Complaints Advocacy Service (ICAS). We have carried this work out to ensure clarity for members of the public in relation to our role and the role of ICAS.

During this period, we have spoken to numerous people at scheduled events throughout the borough, to raise awareness.

At these events we usually begin with some general information about our services, such as signposting, information, advice and guidance.

This leads into the complaints process, (where ICAS pick up), taking the attendees through the process, from the initial referral and the routes into the process, through the stages of a complaint and what could conceivably be expected at the end of it.

Healthwatch Barnsley give examples of our work and describe how we have helped people in the past.

This further consolidates the understanding of the group regarding what both services do and brings our work to life. So far we have received some good feedback and people are generally interested to learn about the breadth of our service.

We leave the group with our promotional materials, as well as our contact details. This ensures that the reach of our promotional work extends beyond our actual talk with the group that day.

This collaborative approach has worked well for us and we endeavour to raise awareness of our work with more groups in the future.

During this year Healthwatch Barnsley has attended 84 different events to promote our work and engage with different communities across Barnsley.

Making a difference together

Working with other organisations

CQC

We regularly share and receive information with the Care Quality Commission (CQC) when they are planning to inspect services in our area; we also support them to communicate and share information to people living in Barnsley and have helped in promoting campaigns and reports including 'Care aware' campaign, 'are we listening' review and 'your birth plan' campaign.

Enter and View

As part of our statutory activity, we have the right to Enter and View health and social care services. During 2017/18 we did not need to carry out Enter and View activity.

Our reports and recommendations

We communicate with health and social care providers and commissioners in a range of different ways. For example, where significant and similar issues have been identified, we share the information gathered through reports. These outline key findings and recommendations for service providers and commissioners.

Health and Equality Conference

On the 31st January 2018 a Health and Equality Conference was held at Barnsley Town Hall, hosted by the Health and Equality Group. Healthwatch Barnsley were invited to facilitate two of the workshops and to produce a report following on from the event.

The purpose of the conference was to provide an opportunity for health providers and commissioners to inform representatives from some of Barnsley's diverse communities about the work that they are doing to improve health access and outcomes across the borough.

This partnership approach has led to a 'next steps' meeting to determine the new way forward for the future work of the Health and Equality Group. A report summarising this work will be sent to the Senior Strategic Development Group.

Meetings

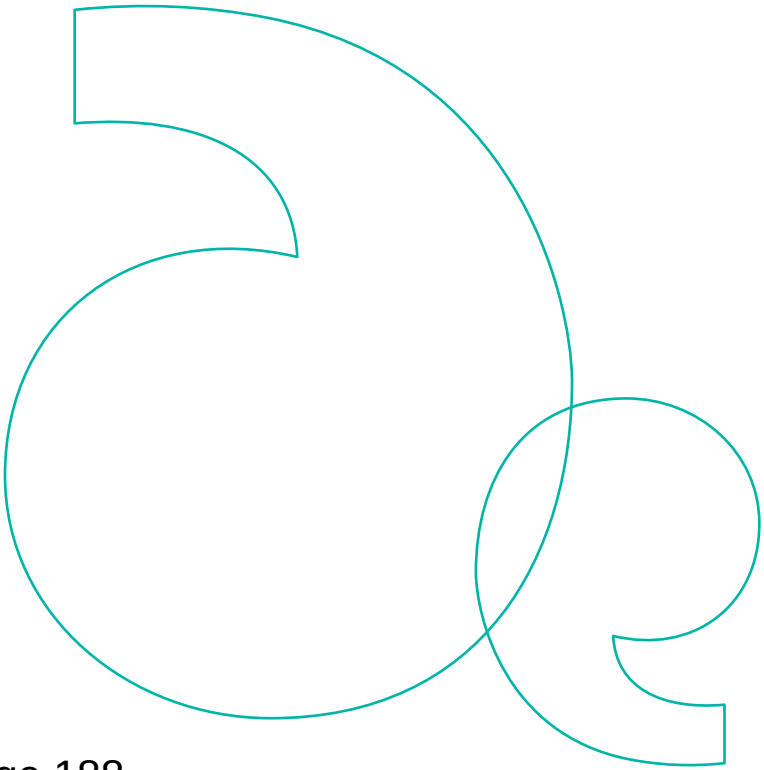
Healthwatch Barnsley is represented by staff and volunteers at a wide range of strategic meetings across Barnsley, and South Yorkshire and Bassetlaw where appropriate.

The reason for attendance at these meetings is to ensure that Healthwatch Barnsley is in a position to share the local intelligence that we have received from members of the public, providing us with a platform to share both good and bad feedback.

It also enables us to keep up to date, and comment on the health and social care environment in Barnsley, allowing us to share information with the public on issues that may affect them, through our social media outlets.

Health and Wellbeing Board

The Chair of our Strategic Advisory Board, Adrian England attends the Health and Wellbeing Board to represent Healthwatch Barnsley and to ensure that the views of people living in Barnsley are represented. The Chair has regular meetings with the Healthwatch Manager to share local intelligence.



Our plans for next year

Our plans for 2018/19

Healthwatch Barnsley has chosen its priorities for 2018/19 based on the information we have received, and the comments collected over the previous 12 months.

We will however continue to collect service user feedback and comments which will help to shape any additional focused work we undertake.

We will continue to be responsive to the information we receive and where it is indicated that change needs to happen, we will use this intelligence to influence service commissioners and providers.

Our top priorities for next year

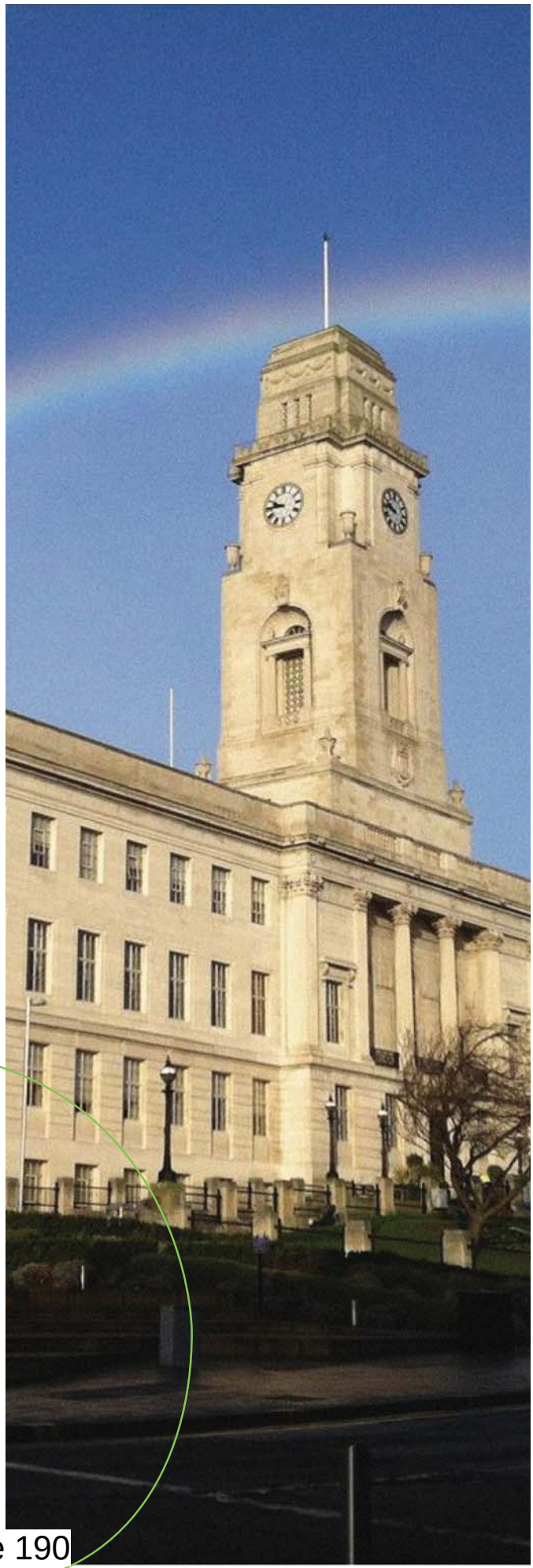
1. **South Yorkshire and Bassetlaw Hospital Services Review**
   Keeping You Informed.

2. **Child and Mental Health Services (CAMHS)**
   Looking at waiting times for assessment and waiting times for treatment and comparing with our previous findings.

3. **Young Carers**
   Looking at support / services and need as identified by the young carers themselves.

4. **Health Equality**
   Working with seldom heard communities in conjunction with the Health and Equality Group.

5. **Membership**
   Developing our Membership.



Our people

Decision making

Voluntary Action Barnsley is contracted to host our organisation and is responsible for finance, payroll and premises and the recruitment, employment and management of staff.

Strategic Advisory Board

Our Strategic Advisory Board focus on the development and direction of the strategic work plan and decide on the prioritisation of key issues relating to health and care in compliance with the Decision Making Procedure.

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 our members. 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.

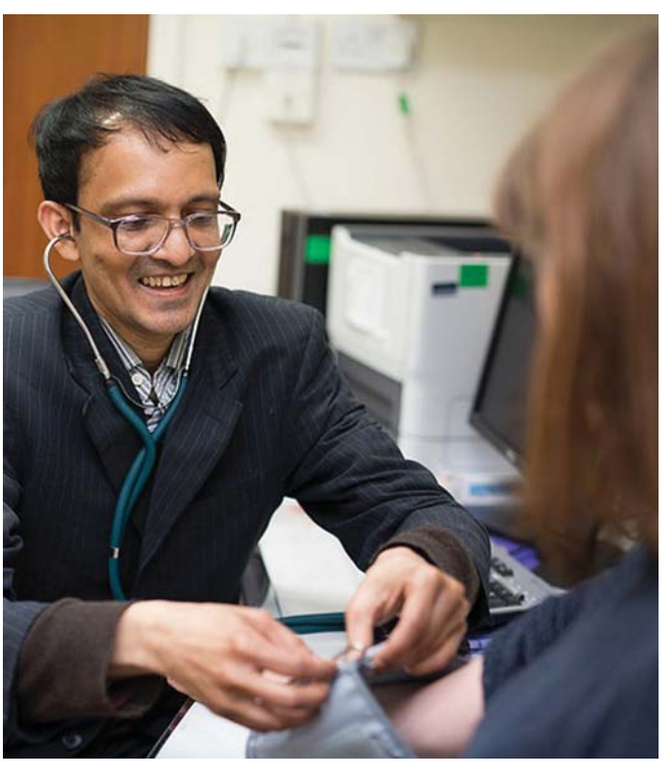
To ensure we have a Strategic Advisory Board that is truly representative, members of the public can find out more about our voluntary roles through outreach and engagement work and our other promotional activities. Once a potential volunteer has identified that they would like to be a Strategic Advisory Board member, if there is a vacancy they are provided with an application pack to complete and return.

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 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 and other providers.
- 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:

- 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 displayed on our website, 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
Mark Smith – Vice Chairman
Tony Alcock JP
Margaret Baker
Ian Guest
Wendy Hardcastle
Christine Key
Margaret Lindquist

Healthwatch 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 Manager or relevant team member.

Currently we have the following Champions assisting with our work:

Marie Cook OBE
Carol Dixon
Patricia Durie
Chris Green

We would like to take this opportunity to thank our volunteers for their continued support.

Recruitment of more volunteers will be a priority in the coming year.

For more information about the staff and their roles please visit **www.healthwatchbarnsley.co.uk**

Our finance

Financial Reporting Period 1 April 2017 - 31 March 2018

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	£150,000.00
Additional income	£14,806.42
Total income	£164,806.42
Expenditure	**£**
Operational costs	£42,915.87
Staffing costs	£100,880.50
Office costs	£15,850.00
Total expenditure	£159,646.37
Balance brought forward	£5,160.05

We have sustained our practice of collecting people's experiences of Health and Social Care services available locally. This material has been be used to identify service gaps, as well as exceptional practice; in doing so, we continue to influence and support services so that they are ideally placed to perform well on behalf of the population of Barnsley.

Adrian England
Healthwatch Barnsley Chair

Contact Us

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S71 5PN

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Website:www.healthwatchbarnsley.co.uk
Twitter:@Hwatchbarnsley

Our annual report will be publicly available on our website by 30 June 2018. We will also be 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.

healthwatch Barnsley

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