Public Document Pack

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Thursday 10 August 2023
TIME:	2.00 pm
VENUE:	Council Chamber, Barnsley Town Hall

AGENDA

Public Session:

1 Welcome and Introductions - Chair

2 Declarations of Pecuniary and Non-Pecuniary Interests - Chair

3 Minutes of the Board Meeting held on 1 June 2023 - Chair (HWBB.10.08.23/3) *(Pages 3 - 8)*

4 Barnsley Place Update - For Information (HWBB.10.08.23/4) *(Pages 9 - 10)*

5 Verbal Update from South Yorkshire Integrated Care Partnership, 27 July 2023 - Kathy McArdle (HWBB.10.08.23/5) *(Verbal Report)*

6 Barnsley Health and Care Plan 2023-25 - Joe Minton (HWBB.10.08.23/6) *(Pages 11 - 46)*

7 Better Care Fund - 2022/23 Year End Report and 2023/25 Plan - Jamie Wike (HWBB.10.08.23/7) *(Pages 47 - 134)*

8 Creativity and Wellbeing Update - Julie Tolhurst (HWBB.10.08.23/8) *(Pages 135 - 140)*

9 Barnsley Children and Young People's Plan (2023-2026) - Anna Turner and Karen Sadler (HWBB.10.08.23/9) *(Pages 141 - 168)*

10 Minutes from ICB Barnsley Place Committee and Barnsley Place Partnership Board, 25 May 2023 - For Information (HWBB.10.08.23/10) *(Pages 169 - 190)*

11 Any other Business - Chair

CLOSE OF FORMAL PUBLIC MEETING

12 Private Discussion on the Joint Strategic Needs Assessment (JSNA) Refresh Plan - Emma Robinson, Joe Minton, Helen Jessop and Freyja Cummings

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

Councillor Wendy Cain, Cabinet Spokesperson – Public Health and Communities (Chair)
Councillor Trevor Cave, Cabinet Spokesperson – Children's
Councillor Jo Newing, Cabinet Spokesperson – Place Health and Adult Social Care
Wendy Lowder, Executive Director Place Health and Adult Social Care for Barnsley, BMBC and Place Director (Barnsley) NHS South Yorkshire ICB
Julia Burrows, Executive Director Public Health, BMBC
Carly Speechley, Executive Director Children's Services, BMBC

Kathy McArdle, Service Director Regeneration and Culture, BMBC
Adrian England, Chair, HealthWatch Barnsley and Chair, MHLD&A Partnership
Salma Yasmeen, Director of Strategy, South West Yorkshire Partnership NHS Foundation Trust
Amanda Garrard, Chief Executive, Berneslai Homes
Jamie Wike, Deputy Place Director, NHS South Yorkshire ICB (Barnsley)
Bob Kirton, Deputy Chief Executive, Barnsley Hospital NHS Foundation Trust
Simon Wanless, District Commander, South Yorkshire Police
Jane Holliday, Chief Executive Officer, Barnsley Community and Voluntary Services
Carrie Sudbury, Chief Executive, Barnsley and Rotherham Chamber of Commerce
Michael Hirst, Chief Executive Officer, Barnsley Premier Leisure

Please contact Andrew Shirt by email governance@barnsley.gov.uk

Wednesday 2 August 2023

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Thursday 1 June 2023
TIME:	2.00 pm
VENUE:	Council Chamber, Barnsley Town Hall

MINUTES

Present

Councillor Wendy Cain, Cabinet Spokesperson - Public Health and Communities - Chair
Councillor Trevor Cave, Cabinet Spokesperson - Childrens Services
Councillor Jo Newing, Cabinet Spokesperson - Place Health & Adult Social Care
Councillor Sue Bellamy, Cabinet Support Member - Place Health & Adult Social Care
Julia Burrows, Executive Director Public Health and Communities
Wendy Lowder, Executive Director Place Health and Adult Social Care for Barnsley
Carly Speechley, Executive Director Children's Services (Virtual attendance)
Wendy Lowder, NHS South Yorkshire, Executive Place Director (Barnsley)
Jamie Wike, Barnsley CCG
Adrian England, HealthWatch Barnsley
Simon Wanless, Chief Superintendent, South Yorkshire Police
Ben Brannan, Senior Public Health Officer, Barnsley MBC
Cheryl Devine, Public Health Senior Practitioner, Barnsley MBC
Jon Finch, Head of Culture and Visitor Economy, Barnsley MBC
Joni Millthorpe, Head of Operations, Barnsley Premier Leisure
Joe Minton, Associate Director – Strategy, PHM and Partnerships
Lorraine Burnett, Director of Operations, Barnsley Hospital NHS Foundation Trust

1 Welcome and Introductions

Councillor Cain, the Board's new Chair, and recently appointed Cabinet Spokesperson for Public Health and Communities introduced herself and welcomed everyone to the meeting.

2 Declarations of Pecuniary and Non-Pecuniary Interests

Councillor Newing declared a non-pecuniary interest as an employee of South West Yorkshire Partnership NHS Foundation Trust.

3 Minutes of the Board Meeting held on 2 February 2023 (HWBB.01.06.2023/3)

The meeting considered the minutes of the previous meeting held on 2 February 2023.

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

4 Barnsley Culture Strategy Engagement - Jon Finch (HWBB.01.06.2023/4)

Jon Finch, Head of Culture and Visitor Economy, Barnsley MBC, delivered a presentation to the update the Board on the progress being made towards the development of a Cultural Strategy for Barnsley.

The Board heard about Barnsley's strengths in relation to culture and arts, noting that there was a very strong Council museum and events offer. There were also wider strengths in Barnsley regarding heritage and music. It was highlighted that there were current gaps in Barnsley relating to Studio Space, SMEs and freelancers. Furthermore, there was currently limited understanding of grassroots activity and local participation.

The Board also heard that Barnsley MBC has an exceptional opportunity to use culture as a key driver to help deliver its Barnsley 2030 Strategy. Culture was for everyone, and it must be rooted in the needs of local people. Every effort would be made to ensure that Cultural Strategy represents all the Borough and be truly diverse.

The Board noted that the Strategy would build on existing successful Area structures by working with teams across Barnsley MBC. Additional engagement would also take place with key community groups. There would also be a focus on wider challenges, primarily health and wellbeing, tackling poverty, skills and employability.

A diagram was presented showing how key themes can work together and benefit all of the people visiting Barnsley.

The timetable for the development of Barnsley's Cultural Strategy and progress made to date was presented. It was noted that there would be four key phases of work, as detailed below:

- Phase 1: Research and development (June to September 2023):
  - Project Governance
  - Creative Engagement workshops with Area Councils and Ward Alliances
  - Stakeholder Engagement
  - Sector mapping
  - Sector Engagement

- Phase 2: Review and next steps (October to November 2023)
  - Review by Project Board
  - Gaps identified for further engagement
  - Report produced

- Phase 3 – Further Engagement with communities and stakeholders (December 2023 – January 2024)
  - Further Stakeholder Engagement
  - Creative Community Engagement

- Phase 4 – Strategy Development (February to March 2024)
  - Priorities identified
  - Strategic directions identified
  - Workshop stakeholders and Councilors
  - Strategy online and published

It was suggested that the Board receives a further update on the development of the Barnsley Cultural Strategy in 6-9 months' time.

The Board asked how engagement would take place with hard-to-reach young adults with learning disabilities and autism. In response, it was reported that, as part of Phase 1 work, discussions would take place with Area Councils, Wards Alliances and with key partners to map where there are currently gaps in order that engagement could be undertaken with those individuals in a sympathetic and sensitive manner.

A discussion took place around the enrichment of children and young people's lives. It was suggested to Jon that a conversation takes place with Carrie Abbott or Nina Sleight with regards to the development and engagement work which is currently taking place around the enrichment of children and young people's lives.

The Chair thanked Jon for his presentation and wished to place on record her congratulations to everyone who was currently working on the development of the Barnsley Cultural Strategy which would enhance residents' health and wellbeing.

RESOLVED:

i) That the presentation be noted.

ii) That the Board receives a further update on the development of the Barnsley Cultural Strategy in 6-9 months' time.

5 Creativity and Wellbeing - Kathy Mcardle (HWBB.01.06.2023/5)

On behalf of Kathy Mcardle, Ben Brannan reported that the Creativity and Wellbeing week held from Monday 15 to Sunday 22 May 2023 had gone very well.

Members agreed that a full report and evaluation of the 2023 Creativity and Wellbeing week be presented at the Board's next meeting.

RESOLVED that full a report and evaluation of the 2023 Creativity and Wellbeing week be presented at the Board's next meeting.

6 Barnsley Premier Leisure Presentation - Joni Millthorpe (HWBB.01.06.2023/6)

The Chair informed Members that Barnsley Premier Leisure (BPL) had been invited, and had accepted, to become a member of the Health and Wellbeing Board.

Joni Millthorpe, Head of Operations, BPL, was welcomed to the meeting to deliver a presentation to provide the Board with an overview of BPL, its impact, the challenges faced as a Charitable Trust and future opportunities for working together.

In summary, the following key points were noted:

- There were currently 2.5m visits to BPL sites each year, with 25,000 fitness members and 9,550 swim school students.
- BPL manage the Barnsley Leisure Card and Barnsley Wellbeing Services.
- There were challenges for BLP in relation to oversubscribed facilities and the location of existing leisure facilities being on the borders of the borough.
- Forecasts for BPL's growth in the Barnsley fitness market to 2030 were presented. By maintaining the market share to 2030, BPL could increase to 22,588 fitness members, if capacity was available. BPL's potential in the

Barnsley fitness market for 2030 was forecast to be 37,000 members, if capacity was available at its sites.

- Currently, there were 5,000 children enrolled on BPL's swim school programme. If there was capacity, this could increase to 8,500 children enrolled in Barnsley by 2030.

The Board noted that BPL had been undertaking work in recent months to break down stigmas around fitness, helping people to make better choices and lifestyle changes. Real stories and real people were now used in marketing campaigns.

It was highlighted that, 15% of the Barnsley population currently accessed local fitness centres. It was now important for BPL to work with Clinical Intervention Teams and Public Health to understand where they could assist in future. An overview was provided to the Board in relation to where BPL could add value by working collaboratively with the Council and NHS.

The Board welcomed and discussed potential areas where they could work together with BPL in the future. It was suggested that BPL becomes involved in the work currently being undertaken by Barnsley MBC in relation to the children and young people's enrichment programme.

A discussion also took place around how BPL could become involved in better connecting leisure services (both at BPL spaces and in people's homes) in order to support people who were currently on a hospital waiting list awaiting an operation, living with conditions and whom may be housebound.

The Board considered that there was also an opportunity for BPL to join up with Barnsley MBC's cultural offer and sports offer to help improve health and wellbeing in the community.

Lorraine Burnett suggested that it would be useful to examine the wellness of the Barnsley population and additionally, the hospital workforce. It was suggested that there could be an opportunity for BPL to work collaboratively on a targeted workforce fitness engagement programme with Barnsley hospital.

The Chair thanked Joni Millthorpe for her presentation.

RESOLVED that the presentation be noted.

7 Health Inequalities Update - Cheryl Devine (HWBB.01.06.2023/7)

The Board received a presentation from Joe Minton, Associate Director, South Yorkshire Integrated Care Board, and from Cheryl Devine, Public Health Senior Practitioner, Barnsley MBC, to provide an update on tackling health inequalities in Barnsley.

The Board noted that the Place Partnership Purple Plan document set out the approaches to tackling health inequalities.

Joe Minton provided the Board with an overview of the current landscape for tackling health inequalities in Barnsley covering both Place and South Yorkshire.

The Board heard that a very successful South Yorkshire Health Inequalities event had been held on 3 February 2023 following a call to action from the South Yorkshire Mayor. The event had provided the opportunity for South Yorkshire health leaders to share best practice.

The Board also heard that Barnsley's Place Based Partnership had aligned its approach to improving public health and reducing health inequalities under a three-tier framework as follows: Tier 1 - Increase, Tier 2 - Improve and Tier 3 - Influence. A summary of the work delivered against the three-tier framework was presented to the Board.

Looking forward to 2023/24, the five goals of the Barnsley Place Based Partnership were presented and noted as follows:

1. Best start in life for children and young people
2. A joined-up approach to preventing ill health
3. Better and equitable access
4. Coordinated care in the community
5. Improve impact on environment and employment

The underlying principles and values for achieving these goals was presented and noted by the Board.

The Board was also provided with an outline of where the Barnsley Place Based Partnership would be focusing its attention during 2023/24, at an organisational level, at a partnership level and via the Core20PLUS5 network.

At an organisational level there was now a commitment to doing more across the three-tier framework to reduce inequalities, improving data capture, sharing Core20PLUS characteristics, establishing accountability, commitment and delivery mechanisms to reduce gaps identified and to share learning.

At a partnership level there would be focus on creating a tobacco free Barnsley. Active conversations would commence with the Core20PLUS population and a network of health and care organisations and wider partners would be established.

Via the Core20PLUS5 network, there would be focus on providing all pre-school children and their families in Core20PLUS access to support in the community. Delivering health and care to everyone in the Core20PLUS working through community organisations and places of work. Identification of frailty in older people in Core20PLUS and provide care in home and the community.

Cheryl Devine provided the Board with an overview of Barnsley MBC's Health Inequalities operational Plan, which was currently in development. It was noted that the Plan was centred around four key strategic drivers:

1. Residents - considering the needs of residents and targeted more support to those in most need.
2. Service Users – recognising that service users have different layers of complexity and need.
3. Partners – using influence and guidance to ensure partners have inequalities at the heart of everything they do.

4. Workforce – making inequalities everyone's business and make all employees aware of the plan their contribution.

There was now an opportunity for health inequalities work to influence the Public Health Outcomes Framework and Levelling Up. It was noted that there was a governance and partnerships approach taking place around health inequalities work.

The Board was invited to provide its comments on the Plan and a proposed phrase which would be used by the Team when talking to residents.

The Board welcomed and thanked Joe and Cheryl for the work undertaken to date. It was suggested that the proposed phrase should be reworded to 'Barnsley is an excellent place to live' where everyone is as healthy as they can be.

A discussion took place around a partnership initiative which had been undertaken to invite people living with a severe mental illness or a learning disability to attend an annual health check.

The Board was informed that the Barnsley Health and Wellbeing Strategy would be refreshed later this year. It was agreed that the current work taking place to reduce health inequalities in Barnsley be included in the refreshed Strategy.

On behalf of Amanda Gerrard, and to feed into the effects of health inequalities, Ben Brannan informed the Board that a hardship fund was available for Berneslai Homes tenants who may be struggling to pay for essential expenses including rent or utilities. In addition, Berneslai Homes would welcome any opportunities to work with the Board.

The Chair thanked Joe and Cheryl for the presentation.

RESOLVED that the presentation be noted.

Chair

Barnsley Place update

Barnsley – the place of possibilities.

Barnsley set to launch new health and care plan 2023-25

Barnsley Place Based Partnership is set to publish its two-year plan on how they will improve health and care for people living in Barnsley this month.

The plan sets out key ambitions from making sure children can have the best possible start in life, people can experience joined up care and accessible services no matter where they live, people are supported to stay healthy and health and care partners work together to develop a talented workforce.

Aligned to South Yorkshire's Integrated Care Strategy and Barnsley's Health and Wellbeing Strategy, the health and care plan sets out key actions that partners will take to help reduce health inequalities in Barnsley and to deliver the ambitions set out in Barnsley 2030.

Over the next two years the partnership will establish new family hubs, support more people to quit smoking, improve access to urgent and emergency care and community access for emotional and mental health support, and will provide improved support for those who are frail or need end of life care.

This will be made available on the South Yorkshire Integrated Care website and will be shared by health and care partners across Barnsley. If you would be interested in reading a copy of this please visit: https://syics.co.uk/barnsley.

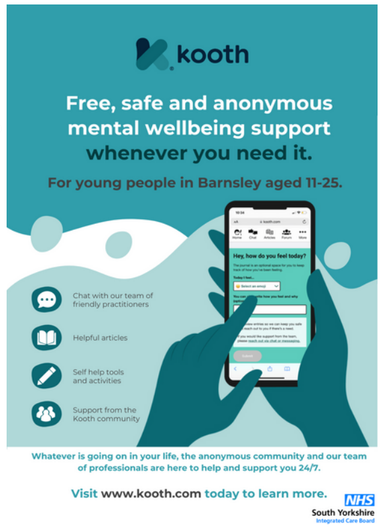
New way for children and young adults to get mental health support launched

A new mental health support website for children and young adults is now available in Barnsley.

Kooth offers a safe and welcoming place for young people aged 11-25 to seek free, confidential and non-judgmental professional help for any mental health concerns they may have.

A key priority for the Barnsley Place Based Partnership is to improve children and young people's access to mental health support. Kooth is available seven days a week, 365 days a year and is designed to work alongside other local mental health services.

There are no waiting lists or thresholds to meet, and you don't need a referral from a GP to get the help you need. It is instantly accessible, once the user is registered, through an internet-connected smartphone, tablet or computer.



Barnsley hosted first ever carers roadshow

To help celebrate carers week, health and care professionals hosted Barnsley's first ever carers roadshow to provide additional support for those caring for a loved one in Barnsley.

Held in Barnsley Market, the event brought together experts from a wide range of different organisations including a large representation from the community, voluntary and social enterprises sector.

The event recieved lots of positive feedback and was well attended by unpaid carers.

Supporting people with severe mental illnesses or learning disabilities

Our community, mental health and primary care teams have joined forces to reduce barriers to the health checks service for people with a severe mental illness or those with a learning difficulty. They've been able to better identify those on severe mental illness and learning disability registers to increase the number of people who have an action plan in place to support their ongoing needs.

Latest data shows that, by December 2022, over 50% of people with a severe mental illness had received a health check. This means over 2,000 people with a severe mental illness or learning difficulty have received an annual health check.

In addition we launched a pilot at three GP practices where clinical health and wellbeing coaches deliver this service in people's homes. Over 84% of people who had previously turned down the service took this up when they were recontacted and over 63% of these people had this at home. We've now started rolling this out across practices in the Dearne and plan to offer this service at home to all practices by January 2024.

New care training programme launched

Our workforce partnership group – have been working to provide new opportunities for those who might be considering a career in care. A new care training programme has launched in Barnsley targeted at those wanting to take their first steps into a rewarding career area.

The four-week training programme will provide people with everything they'd need to know about working well in care and the tools to build their confidence to transition into work.Since launching the programme, they have successfully completed three training cohorts and the next programme will run from Wednesday 3 May.

Barnsley triumphs as winner of prestigious awards

Barnsley Council were crowned Council of the Year at the prestigious Local Government Chronicle (LGC) Awards. This recognises Barnsley's strong performance, innovation, leadership and partnership working and the achievements made during 2022-23 – including the transformations to the town centre and the work we have been doing to improve people's health and wellbeing.

The award submission recognised the hard work that has gone into establishing the Community Diagnistics Centre in The Glass Works, eliminating delayed discharges from hospital and the satisfaction rates of adult social care services.

New app to support dads launched

DadPad®
The essential guide for new dads is now available in Barnsley.

Becoming a new dad will be an exciting chapter in many people's lives. However, as with any big change it can also leave dads feeling left out, unsure and overwhelmed. That's why DadPad a new app has been introduced.

Developed with the NHS, DadPad is a free online app that provides new dads and dads-to-be with the knowledge and practical skills necessary to support themselves and their partner, so that their babies get the best possible start in life.

New workstream to support people into work

Global experts have been enlisted by Barnsley Council and the South Yorkshire Mayoral Combined Authority to identify new solutions to help more of the borough's 6,000 economically inactive residents into work. Barnsley residents are 12 per cent more likely to be economically inactive than the national average. Having 1000 more people in work would mean Barnsley's residents would earn an extra total of £29 million a year, based upon average earnings.

A new Pathways to Work Commission will be chaired by former Cabinet Minister and social mobility champion Rt Hon Alan Milburn and will include leading labour market and health experts as well as local employers and politicians. The Commission will begin its year-long work programme by meeting residents, employers, educators and the Barnsley 2030 Board.

10th August 2023

REPORT TO THE HEALTH AND WELLBEING BOARD
Barnsley Health and Care Plan 2023-25

Report Sponsor: Wendy Lowder and Jamie Wike

Report Author: Joe Minton

1. Purpose of Report

1.1 This purpose of the report is for Health and Wellbeing Board to receive and adopt Barnsley's Health and Care Plan 2023-2025.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to: -

- Receive the Health & Care Plan 2023-2025
- Supports the priority areas and the improvement actions held within the plan.

3. Delivering the Health & Wellbeing Strategy

3.1 In April this year the South Yorkshire Integrated Care Partnership (SYICP) launched its strategy Working together to build a healthier South Yorkshire that expressed a vision where everyone in our diverse communities lives a happy, healthier life for longer. The *Barnsley health and care plan 2023-25* and *Tackling health inequalities in Barnsley* set out the priorities for the Barnsley Place Partnership that are part of delivering the vision, goals, and ambitions of the SYICP and our Barnsley Health and Wellbeing Strategy.

3.2 The plan sets out the actions we will be taking to improve health and health outcomes along the life course – from creating family hubs, to offering every smoker in Barnsley support to stop, improving access to health and care services to helping people to die with dignity.

3.3 The plan also recognises the impact the health and care sector has on health and wellbeing in ways other than the services it delivers is huge and can lead to a far-reaching benefit. The plan sets out actions that partners will be taken to improve impact on the local environment, economy and employment for the people of Barnsley.

4. Reducing Inequalities

4.1 The Barnsley Health and Care Plan 2023-25 has been published on the South Yorkshire Integrated Care System website and shared with partner Boards alongside *Our approach to tackling inequalities in Barnsley.* Our work to develop a shared approach to tackling inequalities in Barnsley began in April 2021 with a workshop for Executive Director Health Inequalities leads from across the partnership and other stakeholders. The three-tier framework for action is being embedded within our organisations, partnerships, and alliances in Barnsley.

4.2 The health and care plan echoes *Our approach to tackling health inequalities*. The plan sets out five shared priorities for the next two years and the work we will deliver collectively to impact on those priorities across the three tiers of action on health inequalities.

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5. Introduction/ Background

5.1 The Barnsley Health and Care Plan 2023-2025 is the first Place Partnership plan to be developed following the implementation of the Health and Care Act 2022 that saw Integrated Care Systems (ICSs) and NHS Integrated Care Boards (ICBs) established on a statutory footing. The Plan is ambitious and aims to take advantage of the new way of working that was signalled by the Act, which is about collaboration between organisations to improve health and health outcomes and a move away from competition as a driver for system change.

5.2 In Barnsley, health and care organisations have been working closely together for several years. We have made significant progress on transforming services for Barnsley people over recent years. Partners have shown that where there is collective ambition and will, we can bring about positive changes to service delivery such as a community diagnostics centre in The Glass Works, suicide prevention, hospital discharge to assess pathways, same day emergency care, improving health checks for people with learning disabilities and a single point of access for children with emotional health and wellbeing needs.

5.3 We are proud of the impact we have had so far working in partnership - this plan builds on that. It focuses on the things we can do better together:

- Providing more seamless care and avoiding duplication
- Supporting people to remain healthy
- Making the best use of the budget
- Making Barnsley the place of possibilities

5.4 The plan sets out five shared priorities for the next two years and the work we will deliver collectively to impact on those priorities across the three tiers of action on health inequalities.

5.5 The plan is our shared commitment to improve population health and the experience of health and care services for our service users, residents, and staff. We want to work with people and organisations across Barnsley who share our passion and drive for a healthy Barnsley: Place of Possibilities.

6. Contributing to Health and Wellbeing Board's key priorities

6.1 *Best Start in Life for Children and Young People* is a priority of the Barnsley Place Partnership for 2023-25 as well as the South Yorkshire Integrated Care Partnership and Integrated Care Board. The plan sets out actions that the Place Partnership will be taking over the next two years, working with the Children and Young People's Trust in Barnsley, including establishing a network of family hubs in Barnsley, delivering the SEND written statement of action and delivering the NHS Core20PLUS5.

6.2 Improving the mental health of people in Barnsley is a theme throughout the plan, relating to a joined-up approach to prevention, better and fair access for people with mental health issues, including maternal, perinatal and children's mental health, and joined care and support for people with mental health and substance use problems. The plan restates the commitment of the Place Partnership to delivering the Barnsley Mental Health and Wellbeing Strategy 2022-2026.

7. Financial Implications

7.1 There are no financial risks explicitly within the plan.

7.2 ICBs/ICSs are required to deliver financial balance by containing expenditure within the allocations received. Across Barnsley and the wider integrated care system there is a significant financial gap with expenditure exceeding allocations. Place Plans should contribute to closing the gap recurrently and it is important that the financial benefits are identified and carefully managed. However, other cost-reduction schemes are also likely to be identified. ICBs are also required to reduce running costs and to achieve this a fundamental review of the operating model and organisation design is being undertaken which could impact upon the programme capacity across the ICB place team.

8 Consultation with stakeholders

8.1 The Barnsley health and care plan has been informed by -

- analysis of existing insight of patient experience and engagement carried by partners in Barnsley and across South Yorkshire
- insights gathered through engagement with the public and patients who were invited to tell the South Yorkshire Integrated Care Partnership 'What matters to you about your health and wellbeing?'

8.2 Co-developing solutions with residents and service users, working more closely with the VCSE sector and telling the Barnsley story are priorities of the

health and care plan. The plan describes the actions that will be taken to achieve this.

9. Appendices

9.1 Appendix 1: Barnsley Health and Care Plan 2023-25 (summary)

9.2 Appendix 2: Barnsley Health and Care Plan 2023-25 (full document)

Officer: **Date:**

Barnsley Place Plan 2023 to 2025 Summary

Why are these our priorities?	How will this support our communities?
Demand for early help support, children in need and child protection continues to grow significantly. Our children's emotional health and wellbeing is our primary focus.	There will be an open and judgement free access point for families to ask questions and get the support they need to live happily and for their children to thrive.
More people are living in poor health and depend on health services for treatment, care and support. A significant proportion of ill-health is due to disease that is preventable.	There will be preventative support offered that will be based on people's needs and strengths. This will support communities no matter where they live in Barnsley.
We are seeing more people in crisis and emergency services are stretched which means delivering the same high quality care every time is challenging. We need to look at alternative models of support to make sure everyone receives the same positive experience and outcomes.	We will shorten waiting times, allow more people to access GP appointments and reduce the number of delays people experience waiting for treatment.
We want to support people in the comfort of their own homes. Demand for hospital beds is increasing particularly amongst people with frailty and dementia. These people are at risk of deconditioning in hospital so would be better supported at home.	We will build resilience in our people and help them live independently at home for longer by delivering more person-centred and community oriented support.
If health and care partners consider how they operate as businesses they can have more of a positive impact on our local environment, economy and employment which will ultimately improve peoples health and wellbeing.	We will work with different sectors to increase education, training and employment opportunities. This will help build a more stable and inclusive economy and better local environment.

Priority	Objective	Deliverables	Measuring success
Best start in life for children and young people 	We will to improve access and the connections between families, professionals, services, and providers, and put relationships at the heart of family support	• Create family hubs • Deliver SEND improvement plan and actions • Improve access to Children's and Young Peoples Mental Health Services • Increase children's access to epilepsy specialist nurses • Make sure children with a learning disability/autism receive access to care in first year • Improve asthma care for children	• Increase the number of parents and carers accessing family hub activities • Increase in the number of whole family early help assessments • Increase in the number of parents and carers reporting that they understand the family hubs offer by March 2025 • Improved access to perinatal mental health services
A joined-up approach to ill-health 	We will offer every smoker in Barnsley support to stop, making every contact count and increase the support we provide to help people to address the drivers of inequalities.	• Further embed the Making Every Contact Count framework across our services • Deliver the medicines optimisations programme PROTECT • Provide more opportunities for physical activity and healthy food • Link up stop smoking services to understand impacts on people • Establish screening and referral processes in locations outside of standard places of care	• Greater awareness of the risks of smoking, uncontrolled high blood pressure and cholesterol • Increased uptake of smoking cessation support • Increased identification of hypertension and reduced variation in identification rates in different locations • Improved management of blood pressure and pre-diabetes
Better and fair access 	We want to improve our services to make sure people can access the right care when they need it most.	• Develop and implement an Integrated Urgent Care Front door (secondary and primary care) • Build capacity and capability to deliver trauma informed support • Implement the Barnsley Mental Health Delivery Plan • Better support those with substance use problems by bringing together current support offers • Implement new GP contract requirements to recover access	• Improved A&E waiting times • Reduced ambulance call out times and handover delays • Improved experience of booking GP appointments • Reduce the number of people attending A&E for mental health related issues including alcohol and substance abuse
Coordinated care in the community 	We will provide more proactive care and support for people most a risk of poor health outcomes, help people to live as well as possible until they die and to die with dignity	• Create an anticipatory care register • Work with the VCSE sector to provide post diagnosis support to those with dementia • Continue to shape services in response to Think Local Act Personal programme • Roll out ReSPECT across all partners in Barnsley • Support people with bereavement by establish a new network who will develop a long term strategy	• Improved screening and assessment of frailty • Increased uptake of Talking Therapies for older people in Barnsley • Increased utilisation of virtual ward capacity • Increase capacity across the voluntary, community and social enterprise sector • Fewer hospital admissions in the last three months of life • Improved equity of access to end-of-life care and support
Improve impact on local environment, economy and employment 	We will establish a network of large organisations across health and social care to improve our impact by the way we do our business	• Complete mapping of where contacts are made and money is spent • Build partnerships with schools, colleges and other education providers • Develop an understanding of the make up of our workforce, including social gradient and representation of protected characteristics	• Workforce is more reflective of the population of Barnsley • More money is invested in the local supply chain • Continued working within planetary boundaries • Reduced waste and emissions and use more renewable energy

Barnsley Place Based Partnership

Health and Care Plan 2023-25

Barnsley – the place of possibilities.

Welcome

Across South Yorkshire, and here in Barnsley, we want everyone to live happy and healthier lives for longer.

We know times are tough with the ongoing effects of Covid-19 and the rising cost of living. Our conversations with local people, communities and those that work or volunteer in health and care show that having access to high quality care and support is important. That's why we're working together as a partnership to make sure you have the support you need.

This plan was created by our newly formed Barnsley Place Based Partnership and will guide us up until 2025. You'll see below that the partnership is made up of a range of organisations - local NHS services, the local authority and the voluntary and community sector. As individual organisations we can't transform health and care alone. When we come together and work alongside local communities we know that we can make a bigger difference.

We are proud of the impact we have had so far working in partnership - this plan builds on that. It focuses on the things we can go better together:

- Providing more seamless care and avoiding duplication - you feel like you are in control of your care and you are clear and confident of who to contact and when.
- Supporting people to remain healthy - you feel able to do things to stay healthier and happier and feel less like things are being 'done to you'.
- Making the best use of the budget - you feel that you are getting the highest quality of service and the best care knowing that we have worked hard as a partnership to use the money that comes into Barnsley as effectively as we can.
- Be at the heart of making Barnsley the place of possibilities - you feel part of a healthy, learning, growing community whether you work or live in Barnsley.

We want this plan evolve through your involvement, because your health and wellbeing is important to us all. Let's work together for a happy and healthy Barnsley.

This plan contributes to the improvements described in the following:

- South Yorkshire Integrated Care Partnership Strategy
- Barnsley 2030
- Barnsley Health and Wellbeing Strategy 2021 to 2030
- Barnsley Mental Health and Wellbeing Strategy 2022 to 2026
- Barnsley Children and Young People's Plan 2019 to 2022
- Barnsley SEND Strategy 2022 to 2025
- Tackling Health Inequalities in Barnsley

Barnsley Place Based Partnership

Brings together organisations involved in health and care from across the borough and is made up of representatives from Barnsley Council, Barnsley CVS, Barnsley Healthcare Federation, Barnsley Hospice, Barnsley Hospital NHS Foundation Trust, Healthwatch Barnsley, NHS South Yorkshire Integrated Care Board and South West Yorkshire Partnership NHS Foundation Trust.

Our vision, aims and objectives

Four aims of Integrated Care Systems

Tackle inequalities in outcomes, experience and access

Improve outcomes in population health and healthcare

Enhance productivity and value for money

Help the NHS support broader social and economic development

Barnsley Health and Wellebing Strategy vision

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, regardless of who they are and wherever they live.

Objectives of Barnsley Place Based Partnership

Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each partner delivering their part without duplication.

Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance.

Embed integrated care that delivers the best value for the Barnsley pound.

Play a pivotal role in delivering our shared vision for Barnsley: the place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley.

How we plan to improve health and reduce health inequalities

Tier 1 Increase

The first layer of action is to increase the support we offer to address the key drivers of inequalities.

We will increase:

- Engagement with people and communities who have the least access to health and social care.
- Services and support aimed at raising health awareness; protecting health and wellbeing; and preventing illness.
- Relative investment in communities that have been historically underfunded – especially for preventive, mental health, domiciliary, community and primary care.
- The health awareness and activation so that people with greatest need are best equipped to protect and improve their own health.
- The skills and recruitment to our wider workforce so they support this.

Tier 2 Improve

The second layer of action is to improve all care services in a way that they are targeted at those where we can make the most difference to reduce inequalities.

We will improve how:

- We understand the communities who experience poorer health outcomes and understand their experience of the health and care system.
- We develop the offer made to Barnsley communities to overcome existing barriers to access and engagement with health and care services.
- Decisions are made and services are targeted at greatest need first, thanks to a better understanding of the range of inequalities across communities.
- We resource, commission and develop the health and care system based on need, shifting away from demand or activity driven delivery.
- We measure inequalities and incorporate this into of performance monitoring to generate accountability and resourcing.

Tier 3 Influence

The third layer is to influence those differences in health which are linked to things like housing conditions, the quality of green spaces and clean air, education and income.

We will influence:

- Social mobility by working more closely with partners in education, linking learning and development with our offer of good employment.
- The local economy by buying goods and services from it and investing in it, in ways that generate sustainable, inclusive economic growth in Barnsley and the region.
- The environment and climate by reviewing our policies and services and ensuring we develop to minimise harm and maximise benefit.
- How health and care is co-developed with communities with shared, distributed responsibility and power.
- Our role as large organisations at the heart of the local community using our resources to benefit the economy and environment, learning from others as we go.

How the plan fits with Barnsley 2030

Barnsley – the place of possibilities.

"Barnsley 2030 is our collective long-term vision and ambition for our borough. The strategy helps us to work creatively to improve our borough for everyone. It provides a framework for the ambitions and actions of our partners working across the area and it enables us all to believe in the possibilities of Barnsley". - Cllr Stephen Houghton

Healthy Barnsley 2030 Ambitions

Everyone is able to enjoy a life in good physical and mental health.

Fewer people living poverty, and everyone has the resources they need to look after themselves and their families.

People can access the right support, at the right time and place and are able to tackle problems early.

Our diverse places are welcoming, supportive and adaptable.

2030 Board Commitments

Work as partners to drive forward a joint local healthcare system.

Develop services that supports people to get help early.

Empower local people to build capacity and resilience.

What Barnsley organisations will do

Provide shared services to meet the needs of local people.

Work together to share best practice and knowledge.

Support and empower people to have a health and active lifestyle.

Create inclusive, quality job options which offer positive work and life balances.

How might someone's experience be different through the changes in this plan?

Roman is a 24 year old living with learning disabilities, he currently lives at home with his family. He has little social interaction outside home and would like to play sports.

	Roman's experience now	How Roman's experience could be in the future
Accessing support when I need it	Roman is unsure where to get help and he and his family are struggling. He used to attend a day centre which is no longer open. He would like to spend his time mixing with people more and hopefully getting a job.	Roman sees some information in his local library about Creative Minds and a Good Mood Football League he would like to join. The library worker also gives him a leaflet about the job centre where dedicated help is available for people to get into work for the first time.
Providing information about me	Roman sees his GP when he needs to but isn't in touch with health or social care professionals on a regular basis.	Roman attends his GP practice for his annual physical health check, something which is available to him because he has a learning disability. As part of this, he works out an action plan to help him with the things that matter most to him - he's put in touch with stop smoking services and a healthy living group. His local community learning disability team support with developing easy read information so Roman can manage his own health needs as well as possible.
Planning my care and support	Roman doesn't have a care and support plan.	Roman sees a social worker at a community centre coffee morning and has an assessment under the Care Act 2014 and his parents have a carer's assessment. He is eligible for an individual budget for him and his family to build a support plan around a range of his individual needs.
Building on my strengths	Roman has little social contact with other people and often feels bored and restless.	Roman uses his individual budget to employ a personal assistant (PA) to accompany him to football sessions and trips to town. He is gaining more confidence in getting out and about and becoming less dependent on his parents. His PA also accompanies him to the job centre where he attends weekly groups about getting into a job, he enjoys this and is considering volunteer dog walking supported by the local learning disability services employment scheme.
Meeting my needs	Roman and his family try their best to find things for him to do but he is making little progress with his life and the family are stressed. His mum is struggling with anxiety about his future.	Roman's care and support plan is put in place. In his neighbourhood there is a welcome café run by the talking therapies team where his mum can drop in for advice. From this she accesses the talking therapies services for her own mental health and starts to cope with things better.
Coordinating my care and support	The family don't know anyone other than their GP so tend to go to the surgery when there are problems.	Roman and his family lead their own support with input and advice from a community worker around self directed support. There are cafes at the centre close to their home where they know they can go for a friendly face and practical input when needed. When Roman goes to his GP his health record is joined up with his support plan so everyone is on the same page. A 'hospital passport' can be developed with Roman in case he has to go into hospital, so that his needs can be met and the hospital staff know what is important to Roman.

Looking back on 2022/23

Despite the many challenges in 2022-23 we have made significant progress as a partnership to improve and transform services for local residents. Below are some of the highlights throughout the year. In addition to these, progress has been made to: ensure more families can access early support; expand access to urgent community services; transform traditional hospital outpatient appointments so, where relevant, people are given advice and guidance and they initiate an appointment when they need one, based on their symptoms and individual circumstances ; and increase GP appointments. Waiting times for treatment at Barnsley Hospital are amongst the lowest in our region thanks to the hard work of our clinical front-line teams across our partnership and support from the wider system.

April to June 22

- We joined the national population health management development programme
- First Barnsley virtual recruitment fair
- PROTECT programme launched with general practices to optimise medicines for patients
- Launch of the Barnsley all age mental health strategy
- Changes made for bones, joints, muscles and spine services to reduce waiting times into trauma and orthopaedics
- 'How's Thi Ticker?' campaign to improve blood pressure control

July to September 22

- Launch of the Community Diagnostics Centre in new Barnsley retail venue The Glass Works.
- Adult social care front door established to increase prevention and reduce the escalation of health issues
- First patients admitted onto the virtual wards in Barnsley
- Barnsley Support Hub opens its doors for people in mental health crisis
- Partners come together to agree actions to support residents with the cost of living crisis
- Integrated Personalised Care Team IMPACT expands access

October to December 22

- Publication of the SEND strategy
- First cohort begins Proud to Care training
- 300 older people start the Stride digital pathway to better health
- First referrals to 'Just for you' delivered by Age UK
- Barnsley Mental Health, Learning Disabilities and Autism Partnership launch event
- Psychosocial Engagement Team service recognised as best practice service for suicide prevention

January to March 23

- Funding secured for phase 2 of the Community Diagnostics Centre
- Launch of targeted lung health checks
- Barnsley Hospice rated outstanding by CQC
- A pilot scheme started to push 999 calls from Yorkshire Ambulance Service stack into RightCare
- Second wave of training in Strengths Based Practice for colleagues in Adult Social Care
- Barnsley Older People's Physical Activity Alliance shortlisted for Local Government Awards

Barnsley partnership's shared goals and enablers

Priorities

- **Best start in life for children and young people**
- **A joined up approach to preventing ill health**
- **Better and fair access**
- **Coordinated care in the community**
- **Improve impact on environment, economy and employment**

Enablers

- Developing our workforce
- Co develop solutions with residents and service users
- Make the best use of our estate
- Use digital for good
- Tell our part in the Barnsley story
- Improve efficiency and the costs of care for all
- Work more closely with the Voluntary Community and Social Enterprise (VCSE) sector
- Be led by intelligence and equity
- Work and learn across sectors
- Think differently

Best start in life for children and young people

Our priority for 2023 to 2025

We will create family hubs to ensure that all our children, pre-birth to adulthood, are well supported by an integrated offer within their communities.

Why is it important?

The experiences we have early in our lives, particularly in our early childhood, have a huge impact on how we grow and develop, our physical and mental health, and our thoughts, feelings and behaviour. Ensuring Barnsley is a great place for a child to be born, is one of the key priorities for Barnsley's Health and Wellbeing Board.

Adverse childhood experiences, such as physical, emotional or sexual abuse, exposure to domestic violence, or living with someone who abuses alcohol or drugs for example, can have a damaging impact on a child or young person's development and their potential health and wellbeing throughout their lifetime. Those who have multiple experiences have an increased risk of heart disease, cancer, lung disease, liver disease, stroke, hypertension, diabetes, asthma, arthritis and mental health problems. Children living in deprived areas are more likely to have these adverse experiences compared with their more advantaged peers.

In Barnsley, a significant proportion of children and young people, 15 in every hundred, are growing up in households where no adults work and 22 in every hundred children and young people live in low income households.

Recently we have seen significant increases in demand for early help support, children in need and child protection. In Barnsley, there has been an increase in referrals where emotional health and wellbeing is the main concern.

There is no single, non-stigmatising point of access for family services that helps families to navigate the wide-ranging support they need. Families sometimes experience difficulty interacting with the vast range of services having to 'retell their story' to different teams and professionals.

Where do we add value?

Across South Yorkshire, the Local Maternity and Neonatal System (LMNS) is working to develop the workforce and improve quality across maternity services, sharing best practice and resource to meet the NHS operational requirements.

This will improve the experience of families and prevent poor outcomes. The Barnsley Place Based Partnership can ensure a joined up approach across early years services, maternity and public health to deliver wrap around support.

The challenges that children and families experience are multiple and complex so require holistic support. As a partnership we are best placed to understand the needs and preferences of residents and bring together statutory providers, community organisations and leaders and other important stakeholders around a shared vision for better health and wellbeing.

Over the last few years we have strengthened the support available for children and young people with emotional and mental health needs through support teams in schools and single point of access. This has led to more people being supported earlier, reducing the demand on statutory services.

Best start in life for children and young people

Current state

Families have told us that they sometimes experience difficulty interacting with the complex range of services and have to 'retell their story' to different services and professionals. However, there is no single, non-stigmatising point of access for family services that helps families to navigate and receive the wide ranging support they need.

Key issues

- A significant proportion of children and young people, 15 in every hundred, are growing up in households where no adults work, and 22 in every hundred children and young people live in low-income households.
- During the pandemic we have seen significant increases in demand for early help support, children in need and child protection.
- There are higher than average rates of children with an education, health and care plan (EHCP).

Strategy alignment

- Ockenden Review and Better Births
- Ambition within the South Yorkshire Integrated Care Strategy
- NHS Long Term Plan Priority
- Start for Life programme
- Barnsley Children and Young People Strategy and Early Help Strategy
- Barnsley SEND Strategy

Measure for success

- Increased early help assessments
- Reduced escalation to children's social care
- Increased continuity of carer in maternity
- Improved access to perinatal mental health services
- Improved access to mental health support for children and young people in line with the national ambition
- Increased access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism

Outcomes

- Improvements in school readiness and the gap between children from the most and least deprived communities
- Improved identification of, and provision for, children and young people with SEND but without an EHCP
- Reduced education health care plans (EHCPs) as a proportion of children receiving SEN support
- Reduced waiting times for child and adolescent mental health services
- Increased proportion of children with a healthy weight
- Reduced tooth extractions

What we will deliver

Create family hubs	Deliver the improvement plan and written statement of actions on SEND	Review children and young people's mental health services to improve access to support	Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism	Address over reliance of reliever medications; and decrease the number of asthma attacks	Improved access to perinatal mental health services

A joined up approach to preventing ill health

Our priority for 2023 to 2025

We will offer every smoker in Barnsley support to stop, making every contact count, and increase the support we provide to help people to address the drivers of inequalities.

Why is it important?

Healthy life expectancy is reducing in Barnsley. More people are living in poor health and depend on health services for treatment, care and support. There is a growing gap between the most and least deprived communities. A significant proportion of ill-health is due to disease that is preventable.

As little as 10% of the population's health and wellbeing is linked to access to health care. Things like economic and environmental factors, such as poverty, good quality housing, good education and employment opportunities and access to green spaces, impact significantly on health and drive health inequalities. In Barnsley, our approach is holistic, to tackle risk factors that impact on the health of the population.

Around 1 in 5 adults in Barnsley are smokers (18.3%), according to the national annual population survey (2019). This is significantly higher than the England rate of 13.9%. Smoking rates have been reducing over the last decade but remain high in some groups such as routine and manual workers, people with mental health and respiratory conditions and those who smoke during pregnancy.

Half of all smokers will die as a result of their addiction. Smoking and hypertension are the biggest contributors to premature mortality across the region. In 2018/19 alone, there were almost 4,000 hospital admissions of Barnsley residents for diseases that were totally or partly due to smoking.

Partners in Barnsley recognise that investing time and energy in prevention is essential to make long term demand for healthcare sustainable, even at a time when managing the every day operational demands feel incredibly challenging.

Where do we add value?

Barnsley Tobacco Control Alliance is leading work across the borough on behalf of the Health and Wellbeing Board. Our vision is to create a smoke-free generation in Barnsley, where smoking prevalence is less than 5% and children and young people can grow up in a place free from tobacco. Through the Active in Barnsley Partnership, health and care providers are working to increase levels of physical activity across our population with the ambition for a healthy and proud Barnsley where active living is part of everyday life for everyone.

Providers and commissioners are individually responsible for supporting people who want to stop smoking to quit. As a partnership we can strengthen this by making smoking a priority so that every contact counts in giving people the opportunity and encouragement to stop smoking.

A strengthened approach to prevention recognises the wider factors that impact on someone's health, as well as smoking, and will ensure that opportunities for interventions are not missed as people move between health and care settings. A quality improvement and behavioural science approach will ensure that we can collectively maximise our impact from brief interventions for everyone accessing healthcare, through to high intensity interventions for those requiring more specialised support.

We will increase the offer we make to the population to support them address the drivers of inequalities.

A joined up approach to preventing ill health

Current state

Healthy life expectancy is reducing. More people are living in poor health, many will depend on health and care for treatment, care and support. There is a growing gap between the most and least deprived. A significant proportion of ill-health is due to disease that is preventable.

Key issues

- High levels of deprivation impacting on the health and wellbeing of our population
- Smoking rates have been reducing over the last decade but remain high in some groups such as routine and manual workers
- Data recorded in general practice shows that smoking levels for people with mental health and respiratory conditions are significantly higher than the overall average
- 70% of smokers offered support to stop in general practice in the last two years
- High premature mortality for cardiovascular disease
- Significant variation in the number of smokers recorded versus the estimated numbers across GP practices
- Variation in treatment – blood pressure recording, blood pressure and cholesterol control

Strategy alignment

- Bold ambition in the South Yorkshire Integrated Care Strategy
- NHS Long Term Plan Priority
- Barnsley Health and Wellbeing Strategy
- QUIT

Measure for success

- Improved recording of smoking status
- Improvement in the proportion of people offered support to stop smoking
- Increased uptake of smoking cessation support
- Increased identification of hypertension and variability of estimated versus recorded prevalence between practices and along the social gradient
- Improved management of blood pressure and cholesterol
- Greater awareness of the risks of smoking, uncontrolled high blood pressure and cholesterol

Outcomes

- Reduced smoking rate in adults and smoking during pregnancy and recorded at time of delivery
- Closing the gap between the general population and routine and manual workers
- Reduced incidence of strokes and heart attacks

What we will deliver

Complete a self-assessment against the Making Every Contact Count framework to identify gaps and opportunities to grow an holistic approach	Delivery of PROTECT – identifying potential missed diagnosis, improve lipid management, pharmacy first blood pressure monitoring	Provide more opportunities for physical activity including gym access, community fitness groups, active travel and healthy food	Ensure the various stop smoking service offers are linked up to tighten the net and make progress measurable across the person's journey rather than individual service	Ensure a person's smoking status is recorded at every admission to hospital and every attendance to GP, community care, social care	Measure and set targets for screening rates for smoking, initial very brief advice (VBA) and nicotine replacement therapy (NRT) rates, specialist referral rates, quit plan and successful quit rates	Develop a process for screening and referring or an in-reach service to priority areas (certain work places, social housing, sports stadiums)	Development of a local campaign to encourage smokers to stop smoking and change their behaviour

Better and fair access

Our priority for 2023 to 2025

We will bring urgent care services closer together by developing "an urgent care front door" that is an alternative to A&E. This will enable people to access the right care when they need it – creating a better service for all.

We will improve access to care and support in the community for emotional and mental health needs, including addiction and substance use.

Why is it important?

Despite GP practices providing more appointments and increasing numbers of face to face appointments, the public report it is difficult get an appointment with a GP and poor experience trying to make an appointment via telephone.

The long term trend is year on year increased in demand for emergency ambulances and A&E in Barnsley. This was interrupted by the pandemic but levels of attendances are now above what they were in 2019/20. Performance against targets such as the four hour target, ambulance response times and handovers suggests this level of demand is not sustainable.

Recent engagement with residents shows that access to services is the number one concern for the public.

Local analysis shows that a significant proportion of demand for urgent care services is linked to mental health, substance use and addiction and social challenges.

We know that there is a strong link between trauma and long term emotional and mental health needs.

Voluntary, community and social enterprise sector partners report that people from health inclusion groups, such as asylum seekers and refugees, find it particularly difficult to access and navigate health and care services because of barriers such as language.

Where do we add value?

The pressures on A&E and urgent care providers in Barnsley continue to grow as the needs of our population continues to change and capacity of services is not matched to the demand.

We have been working together to:

- expand the number of urgent out-of-hours GP appointments available
- provide direct access to the integrated multidisciplinary personalised care team (IMPaCT) – this is Barnsley's social prescribing service that supports people with their health and welbeing
- introduce physiotherapists and mental health practitioners in primary care
- re-establish GP presence in Barnsley Hospital A&E department
- create Barnsley Support Hub – this offers free mental health support in Barnsley town centre out of hours
- support people to start doing the things they love again and to stay in their own homes through dedicated reablement care

There is more to do and we know from feedback that we have received, sometimes residents are not aware or do not understand what services are available to them as an alternative to seeing a GP. We also know that sometimes people find it difficult to get the help they need for lots of different reasons including access to transport and communication barriers. By sharing data and insights we can identify and overcome these challenges.

We will improve the existing services we provide so that care is itself a tool to reduce health inequalities.

Better and fair access

Current state

Some people are accessing services that are not necessarily the most appropriate to their nature of need. Engagement with the public in Barnsley (through the work of the South Yorkshire Integrated Care Strategy) has shown that access to services is their top priority.

Key issues

- GP practices report a significant proportion of appointments relate to mental health problems, high emergency call numbers and A&E attendances for mental health complaints or diagnosis
- Rising demand for same day urgent and emergency care resulting in longer response times from ambulances, handover delays, crowding the A&E department and longer waits to be seen and admitted and impacting on experience and outcomes.

Strategy alignment

- Bold ambition in the South Yorkshire Integrated Care Strategy
- NHS Long Term Plan Priority
- NHS Operating Guidance
- Barnsley all age mental health strategy

Measure for success

- Increased number of people accessing services that can support their needs
- Improvement in community networks and non-health services strengthening community cohesion, support , and engagement
- Improved living conditions circumstances e.g. debt, housing sustainable employment
- Increased number of appointments in general practice including same day appointments
- Reduced appointments in general practice associated with mental health and social vulnerability
- Reduced A&E attendances associated with mental health and social vulnerability

Outcomes

- Improved wellbeing and reduced social vulnerability
- Improved access to urgent and emergency care
- Reduced Did Not Attends (DNAs) associated with mental health and social vulnerability

What we will deliver

Develop and implement an "urgent care front door" that will be an alternative to A&E	Listen to the needs of our communities beginning with those who experience poorer access to healthcare	Work with the voluntary and community sector to build capacity and capability for trauma informed support	Implement the new GP contract requirements linked to access	Strengthen the access offer from primary care (including community pharmacy) for all with a focus on Core20plus communities	Increase personalised care interventions	Strengthen joint working between substance use and mental health services

Coordinated care in the community

Our priority for 2023 to 2025

We will provide more proactive care and support for people who are frail.

We will help people to live as well as possible until they die and to die with dignity.

Why is it important?

The frail population in Barnsley is growing at a greater rate than the population is ageing. People experiencing inequalities are more likely to experience frailty earlier in their life than expected and those with the greatest need often also have the greatest difficulty in accessing and receiving appropriate care and support.

Physical frailty can potentially be prevented or treated with things such as exercise, protein-calorie supplementation, vitamin D, and reducing the number of medications someone is prescribed or takes.

Across Barnsley approximately 11,500 people living with mild frailty or are pre-frail. Around 1,500 older people move into the frailty group each year. This happens when a person is in their early 60's on average. When this happens healthcare utilisation increases by between 100% (activity) and 300% (cost).

Compared to other areas, Barnsley sees a higher number of hospital episodes for frailty and dementia and year on year these have been increasing along with long lengths of stay (7 days+) in this group.

Barnsley sees particular high levels of people going to hospital because they have fallen, as well as multiple falls, and people being admitted to hospital at the end of their life. However, the proportion of people with end of life care planning in place in those who are frail is low at around only five in one hundred.

Where do we add value?

The term frailty refers to a person's mental and physical resilience, or their ability to bounce back and recover from events like illness and injury. By its very definition, frailty is multi-factorial, and requires a multi-disciplinary, person centred and community oriented response, that can only be delivered by organisations working together.

Similarly, good end of life care is holistic and involves effective communication between the individuals, those close to them and health and care professionals supporting them.

In the last year we have expanded urgent community response services, created virtual wards for frailty and tested a digital service for healthy ageing. We also piloted anticipatory care for older people by linking in with the voluntary and community sector to see how they could support older people with mild frailty.

Experience suggests that people at the early stages of frailty have an appetite for services that can support them to live healthier lives and that there is wealth of knowledge, talents and passion in community to help.

We will improve existing core services we provide so that care is itself a tool to reduce inequalities.

Coordinated care in the community for frailty

Current state

Increasing urgent and emergency care demand relating to growing frailty within our communities. Inpatients beds are often occupied by people with frailty and dementia who are at risk of de-conditioning and would be better supported at their home or place of residence.

Key issues

- High levels of frailty in Barnsley – more incidences in younger people than neighbouring areas
- Higher number of hospital episodes for frailty and dementia than regional and national comparators
- Year on year increasing long lengths of stay in Barnsley (7+days) most evident for respiratory
- High rates of admission for falls and repeat falls
- High rates of admission to hospital at someone's end of life and low numbers of people with frailty and dementia with future care planning in place

Strategy alignment

- NHS Long Term Plan – Healthy Ageing
- Health and social care integration

Measure for success

- Increased screening and assessment of frailty
- Improvements in assessment and treatment of falls, mental health in older people, dementia and bone health
- Increased utilisation of virtual ward capacity
- Increased referrals for preventative and early help interventions
- Increase capacity across the voluntary, community and social enterprise sector
- Increase capacity and capability within the workforce

Outcomes

- Older people are supported to live independently in their own homes for longer
- Reduced unplanned care for older people
- Improved rehabilitation outcomes length of stay, (derby scores and patient experience measures)
- Reduction in the median age of people entering adult social care
- Improved health related quality of life for people with long term conditions and carers

What we will deliver

Listen to the needs of older people beginning with those who experience poorer access to healthcare	Provide ageing well assessments to identify and treat potential health problems earlier	Create an anticipatory care register to be able to identify those with moderate to severe frailty to provide better planning and coordination of care across different services and teams	Review of Intermediate care model and pathways step up and step down beds including intensive recovery service	Undertake a review of dementia support with the voluntary and community sector with a focus on post diagnosis support	Continue our work with Think Local Act Personal to ensure that services are responsive to feedback	Continue to roll out strengths-based practice	Independent sector market development to meet the changing needs of our population

Coordinated care in the community for end of life

Current state

Palliative and end of life care improves people's quality of life of and that of their families who are facing challenges associated with life-threatening illness. This also improves the quality of life of caregivers.

Key issues

- There are more people needing end of life care and support who are not identifiable on supportive care registers
- People are more likely to be admitted to hospital in the last three months of their lives in Barnsley than in other parts of the country
- Bereavement is an increasingly recorded as a factor in suicides

Strategy alignment

- National ambitions framework for palliative and end of life care
- Statutory duties for Integrated Care Boards

Measure for success

- Earlier identification of people at end of life (last 12 months) – increase the proportion of deaths who are people on supportive care registers
- Improved recording of preferences for treatment, ceilings of care and place of death - increase proportion of deaths that are people with end of life care planning in place
- Personalised care planning in place with support to self-manage and symptom control – improved experience at end of life and people who die in place of choice
- Increased capability and capacity in the workforce to support palliative care and end of life – number of people who have completed training in end of life care

Outcomes

- Improve care and support in the last year of life
- Reduced crisis care in the community for people at end of life – UCR to people at end of life
- Fewer hospital admissions in the last three months of life
- Improved equity of access to end of life care and support – proportion of people with end of life care in place from deprived communities and health inclusion groups
- Better utilised of current resources across the system – number of patients receiving hospice care

What we will deliver

Implementation and roll out of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) tool across all partners agencies in Barnsley	Baseline and mapping exercise for children and young people, adult palliative care and end of life services (including access criteria) against the Ambitions for Palliative and End of Life Care	End of life and palliative care knowledge and skills framework and training needs analysis and training offer	End of life and palliative care workforce plan	Develop a network of organisations supporting people with bereavement and a long term service strategy	Participation in “Dying Matters” week

Improve impact on environment, economy and employment

Our priority for 2023 to 2025

We will establish a network of large organisations who are at the heart of Barnsley communities to improve our impact by the way we do our business

Why is it important?

The impact that the health and care sector has on health and wellbeing in ways other than the services it delivers is huge and can lead to a far-reaching benefit. The way we go about running these large businesses means we have a big impact on our local communities.

These organisations are sometimes called anchor institutions because they are 'rooted in place' and have significant assets and resources which can be used to influence the health and wellbeing of their local community.

Ensuring that we help to address and advocate for the links between the climate and health can lead to a better environment for the people of Barnsley. For example: choosing the right health technologies can reduce or even remove potentially large volumes of waste (e.g. the plastic waste from single-use PPE) and release of harmful gases (e.g. the anaesthetic gas desflurane). We can be a driving force behind the shift to renewable or even local energy and alternatives to private car use.

Ensuring that we support social mobility for Barnsley people will give more people who need the right opportunities for education and employment and, through it, better health. By strengthening health awareness and health and social care opportunities through local education and by making our recruitment and employment more accessible we can get more people into good jobs.

Ensuring that we understand our potential role in the local economy, we can help to build a more stable and inclusive economy, that is without poverty and that generates health and wellbeing through security. By looking at how we spend our money and buy our services, we can generate business and opportunity from and for health.

Where do we add value?

In its 2021-2030 strategy, Barnsley's Health and Wellbeing Board has committed to reducing health inequalities across people's lifetime - helping to ensure every child is given the best start in life, everyone can access the resources they need to live a healthy life and to age well. It also highlights mental health and addressing things like housing, employment and education which impact on our health.

Barnsley 2030 "the place of possibilities" is the social and economic development plan for the borough which looks across all sectors and has four key themes – Learning, Growing, Sustainable and Healthy Barnsley.

There are health related commitments across the plan, with those specific to inequalities including reducing poverty, improving access to quality housing and affordable energy, improving learning and social connections, and improving access to healthy and active lives.

Collectively, health and care organisations in Barnsley: employ around 12,000 people and provide care and support to approximately 40,000 people every week; has a budget of around five hundred million pounds; and consume huge amounts of energy and food, produce huge volumes of waste and generate massive amounts of vehicle use. This all has an impact on the health of Barnsley and it all needs to be factored in when we consider how we do business.

We will use our wider influence on the social, economic and environmental factors to tackle inequalities in Barnsley.

Improve impact on environment, economy and employment

Current state

Whilst there is lots of good work ongoing, the approach to how we do business in the health and social care sector in Barnsley is still very varied and not all of our ways of working and interactions with environment, economy and society incorporate health and wellbeing in the same way the way we deliver our services does.

Key issues

- We produce greater harm on the local climate and environment than we need to
- We spend more money in and procure more contracts from outside the local and regional economy than we could
- Our opportunities for employment can be made more accessible to and inclusive of people from the local communities in greatest need of good jobs

Strategy alignment

- NHS: Chapter Two of the Long Term Plan; Greener NHS; Core20Plus5
- UK's Net Zero Strategy

Measure for success

- Develop 'anchor institution' approaches and plans of partner organisations and as a network of health and social care partners
- Begin to measure of the number and size of contracts made locally
- Support for our workforce with protected characteristics, from inclusion groups and who are worst affected by the rise in the cost of living
- Develop an understanding of the make up of our workforce, including social gradient and representation of protected characteristics
- Review of environmental impact and actions to work within planetary boundaries

Outcomes

- More health and social care money spent locally
- Greater support from the sector to the local economy and business
- Stronger links between and health and social care and education locally
- More good jobs and development for people from more deprived local communities
- A reduction in health and social care waste and harmful emissions
- Better public, active, low-emission and shared transport options for our staff and service users, and more alternative options (e.g. remote and community consultations and care)

What we will deliver

Establish a Barnsley anchor network	Baseline mapping of where our contracts are made and our money is spent	Build partnerships with local schools, colleges and other partners in education	Listen to the needs of our communities beginning with those who experience poorer access to healthcare	Reduce waste and emissions from health and social care, and greater use of resilient and renewable energy

Developing our workforce

Our priority for 2023 to 2025

We will fill gaps in the health and care workforce by strengthening routes into careers and providing support for those with additional needs

Why is it important?

There are pressures across the workforce with significant gaps in some workforce groups: with increased sickness absence, more people leaving for jobs and careers outside of the sector or retiring early, and fewer people actively seeking jobs.

There are not enough staff which affects all staffing groups. Local analysis shows that there is a gap between the supply of workforce and workforce demand over the next five years. It has also shown that approximately a quarter of the workforce are approaching retirement age.

As a result of the pandemic there has been an increase in work related stress across many sectors and in the NHS it is reported that this has resulted in people leaving the workforce, particularly older experienced staff, and new starters.

Engagement with local communities has shown that there is a poor perception jobs in care. Like many other lower paid sectors, the cost of living crisis is expected to impact on the care workforce, making roles less attractive than entry level roles in retail, manufacturing and logistics.

Across Barnsley there are relatively high rates of economic inactivity, including people not working due to long term illness or disability. It is a priority of the South Yorkshire Integrated Care Partnership to reduce the gap in employment for people with physical disabilities and learning disabilities and to provide every care leaver the opportunity to work in health and care.

Where do we add value?

The South Yorkshire Integrated Care Board workforce hub delivers a broad range of programme activities relating to future workforce, workforce wellbeing and human resources. This supports provider collaboratives, places, professional groups and individual employers. Working at this scale enables better planning of training places with higher education and allocation of workforce transformation funding.

Where we can add value as the Barnsley Place Based Partnership is working with communities, independent sector employers and employment support organisations to create routes into jobs, particularly entry level positions in health and care that do not require an extended period of study and higher level of qualification.

By working together we can support reshaping of the local workforce, including training and development to meet people's health needs as well as local challenges.

In 2022/23 we have successfully launched our Proud to Care training to employment. Whilst we have had a small number of learners we have seen the appetite of people to get into work despite some of the challenges they face. We have also learned there is a wealth of organisations, expertise and passion in Barnsley to support people furthest from employment into good jobs.

We have also seen our Project ECHO (Extension of Community Healthcare Outcomes) hub grow which provides training and learning across our health and care providers in Barnsley. This shows that our workforce are keen to keep learning and developing their practice to provide better care for our residents.

Developing our workforce

Current state

There are pressures across the workforce with significant gaps in some workforce groups: with increased sickness absence, more people leaving for jobs and careers outside of the sector or retiring early, and fewer people actively seeking jobs.

Key issues

- Not enough staff across the system which affects all staffing groups but particularly clinical, clinical support staff and non clinical roles
- Increased work related stress and burnout
- Approximately a quarter of the workforce approaching retirement age
- Increase in the number of people leaving the workforce, particularly older experienced staff, and new starters
- Poor perception of care, cost of living crisis and ongoing national disputes on pay and conditions making health and care roles less attractive

Outcomes

- The health and care workforce is more representative of local communities
- Fewer vacancies across the health and social care sector in Barnsley
- Improved staff engagement and satisfaction at work

Strategy alignment

- NHS People Plan and Promise
- Health and Social Care Integration
- SY Integrated Care Strategy to reduce economic inactivity and the gap in employment for people with long term health conditions and learning disabilities

Measure for success

- Recruitment via Proud to Care and Expression of interest
- Increased job applications and recruitment from deprived communities
- Increase the number of care leavers accessing apprenticeships and employment.
- Increase the number of students and apprentices in health and care including work experience, T-levels, nursing and allied health professional students and apprentices
- Increase the number of people returning to the health and care workforce through flexible working opportunities
- Reduced the number of leavers in the first five years of careers

What we will deliver

Refresh the Barnsley Workforce Strategy and produce clear delivery plan	Review of joint recruitment activity and development of local strategy and Expression of Interest process	Develop and implement a communications strategy including social media presence to promote vacancies across health and care	Create a simplified job application process which is accessible to all communities across Barnsley	Grow the numbers of students on placement in Barnsley and develop new apprenticeships opportunities and local student pathways	Work with colleagues across South Yorkshire to grow a reservist model and test flexible working opportunities for early careers e.g. Allied Health Professional Staff Bank

Involvement and equality, diversity, inclusion

Our priority for 2023 to 2025

We will work alongside local people and communities to better understand and develop what matters to them

Why is it important?

At the heart of our role is the commitment to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

Research has shown consistently that outcomes and experience of health and care are better where levels of engagement are higher.

Involving people and communities allows us to understand the services and the care that is on offer from the perspective of the people who use them, it can identify what is most helpful and what is most frustrating for them and how to make improvements.

Involvement gives people the power to manage their own health and make informed decisions about their care and treatment; and supporting them to improve their health and give them the best opportunity to lead the life that they want.

Accountability is one of the themes most apparent from the recent engagement in the South Yorkshire Integrated Care Strategy, alongside access, quality of care, improving mental health and wellbeing, and support to live well.

Our collective involvement work has also shown the importance of clear, consistent and regular communications that is accessible, ensuring that health and care services can be flexible and tailored to different people's needs and circumstances and the need to better involve carers and/or family members as equal partners in any planning and decision making that takes place.

Where do we add value?

We have agreed principles across the Barnsley partnership to engage with people to inform our decisions and codevelop services.

- Have a strong local focus and work on both strengths and solutions with local communities
- Value equality and the diversity of local communities
- Make sure information is accessible and jargon free
- Ensure that everyone has a voice and we listen and learn from our staff and communities
- Involve the right people, at the right time and come to you
- Keep it simple and be honest about what you can influence
- Avoid repeating the same conversations
- Be open and transparent with what we know and what we have done and why

Involvement and equality, diversity, inclusion

Current state

We have made progress on the governance and planning of how we come together as a involvement, experience and equality, diversity and inclusion colleagues across Barnsley and with teams working across South Yorkshire.

Key issues

- The recording of demographic data, protected characteristics and accessibility standards, is lower than it should be across some health and care services. This is often a combination of people not being asked some or all of the questions, or people not being comfortable in sharing the information. We know that recording and reporting on inclusion data is also challenging.
- We have lots of existing insights which we could make much more effective use of across the partnership and beyond . This include patient experience data.
- We want to focus on working alongside our diverse communities.
- We want to be better at, and put more focus on, working with local people and communities to produce plans and design services and solutions rather than just asking or informing them.

Strategy alignment

- Barnsley health and care communications strategy
- Barnsley 2030
- NHS South Yorkshire 'Start with People' involvement strategy

Measure for success

- An increase in staff confidence to have the conversation about demographic data collection.
- Re-invigorated primary care patient participation groups in each GP practice, supported by a primary care network involvement plan.
- High satisfaction scores on all involvement activity e.g. clarity and availability of information to make informed decisions, I statements .
- An insight bank in place.
- Inclusion of insights into our dashboards.

What we will deliver

We will work with communications colleagues to develop a new narrative and identity for the health and care partnership in Barnsley that creates a sense of place by September 2023	Contribute to a South Yorkshire insight bank which brings Barnsley insights into one place for analysis and sharing.	Roll out a partnership wide campaign to improve demographic data collection.	We will grow and develop existing networks, to increase reach and active involvement across our diverse communities	We will work with programme and project leads to advise on and develop people and communities involvement plans aligned to the three tiers health equity approach.	Primary care network people and communities involvement plan.	Training and development programme to support colleagues to produce and design interventions alongside people who will be using them.

Estates

Our priority for 2023 to 2025

We will make the best use of our collective estate

Why is it important?

Good quality strategic estates planning is vital to making the most of greater cooperation and collaboration through our partnership to fully rationalise our estate, maximise use of facilities, deliver value for money and enhance people's experience when using health and care services.

It is vital that service and estates planning are joined up to ensure that the best estate is available to deliver the best health and care services and make wise, well founded investment decisions.

The estate is used to provide solutions with primary and community teams located in the same place to support multi-disciplinary team working, integrated service hubs across sectors, supporting care delivered closer to the communities where people live, supporting digital solutions and helping with workforce challenges of recruitment and retention.

The pandemic has had a significant impact on how the health and care buildings have been used to achieve social distancing, support remote working, provide “hot” clinics to provide access to services for people with infection and increase the number of planned operations and procedures to recover waiting lists.

The community diagnostics centre at the The Glass Works is an example of where alignment of clinical service and regeneration strategy came together leading to better access to services, providing residents with a more convenient way to receive ultrasound, x-ray, breast screening, phlebotomy and bone density scans.

Where do we add value?

We are committed to improving equity of access to services, deliver more care in communities and joining up care for those most in need.

Across our estates there are many multi-purpose buildings where different partners run services, sometimes alongside services from other sectors.

The health and care estate is not always as well used as they could be and there are opportunities to improve this whilst enhancing the range of services delivered in our communities.

This can only be achieved by collaboration across services and organisations and co-development with residents and communities.

Estates

Current state

There is a lack of understanding and clarity on the estate held across Barnsley and how this can be used more effectively across partners and voluntary sector to meet the needs of our population. Lease arrangements sit with individual organisations and flexibility remains limited on some of the estate across Barnsley.

Key issues

- There is a perception Barnsley estate is underused
- There is a lack of understanding of the estate portfolio across Barnsley
- There is a lack of strategic oversight of estate linked to place plans
- Some estate is not fit for purpose and is not flexible to meet service demands, pressures and change plans

Outcomes

- Estate is used to capacity with plans for development clearly identified to access available funding sources.
- Estate is accessible and meets the needs of people across Barnsley, with one approach to health and care.

Strategy alignment

- Government Estates Strategy

Measure for success

- Estate use increases from current baseline measures
- Estate portfolios are understood across the partnership
- Estate is fit for purpose with development plans clearly identified to meet our strategic aims
- Estate is flexible in its use across clinical, care and voluntary sector services irrelevant of provider

What we will deliver

Develop the Barnsley strategic estates group with a clear delivery plan to be agreed with partners	A place estates strategy – joining together of individual organisation strategy – linked to strategic aims and delivery plans	Mapped out estate across Barnsley, with details of use	Review of lease arrangements across the place to allow flexible use of space	Forward plan of estate development requirement to allow access to capital as it becomes available

Digital and information

Our priority for 2023 to 2025

We will develop a Barnsley digital roadmap and deliver a shared care record solution

Why is it important?

Digital transformation of health and social care is a top priority for the Department of Health and Social Care and NHS England. The long term sustainability of health and social care is dependent on having the right digital foundations in place.

Digital technologies have become an integral part of how people manage their health. They can help access personal health information, and support people to feel empowered and involved in self care. A large review of studies found that text messages can help people quit smoking. Automated text reminders alone increased quit rates by 50% to 60%. Apps can remind people to take their medications on time. Giving people access to their own records can help people understand their conditions, and empower them to take an active role in managing them. Several studies have shown that digital therapy is effective. Technology allows us to connect with others without being physically together.

In 2022/23 the Barnsley Partnership has been making the most out SystmOne by using it to support shared care across organisations and settings. This means for example that hospital doctors and social workers can now view a person's clinical records from primary or community care with their consent to support better care planning.

We have been working with industry partners to deliver a BETA service evaluation of STRIDE which aims to help older people to live strong and independent lives for longer. New technologies have been deployed into care homes to prevent people falling and in primary and community care to support health checks for people with learning disabilities.

The NHS Pathways system has enabled healthcare teams to use the data and information in clinical records and other systems to identify people at risk, optimise and personalise their care.

Where do we add value?

The vision of the Digital Barnsley Strategy is that Barnsley is a connected, smart town with a culture of innovation, collaboration and strong digital leadership.

The strategy helps in delivering all four main areas identified within the 2030 plan including a Healthy Barnsley by connecting health partners to provide better quality care, using digital to connect our communities and addressing digital exclusion to improve connectivity, reduce isolation and exclusion.

Working as a place partnership means that organisations strategies and plans are aligned to ensure that systems resources are allocated to shared priorities for services, patients and residents.

Collaboration will ensure that digital and technological solutions are can work together of across services and settings to deliver best value for money and provide a seamless service for patients.

Shared intelligence means one version of the truth and supports evidence based decision making so health and care in Barnsley is population health, prevention and inequalities led.

Digital and information

Current state

- Established health intelligence group and joint working between partners
- Health intelligence reporting – regular dashboards, agile sprints and bespoke products
- Limited interoperability for direct care

Key issues

- Information sharing between organisations – particular restrictions around primary care and commissioning datasets
- Lack of analyst capacity
- Ability to link data through a common identifier
- Lack of clear digital roadmap and strategy with could result in lack of interoperability or inefficient use of resources (e.g. technology enabled care)
- Clarity on the role of different organisations and teams

Strategy alignment

- National information board – Paperless 2020
- NHS Operating Guidance
- Population health management
- Population health, health inequalities and prevention-led Integrated Care System in South Yorkshire

Measure for success

- People not having to tell their story multiple times to health and care services
- Improved clinical safety
- Improved efficiency – reduced paper letters, repeat requests for tests and referrals
- Effective use of resources – intelligence led system

Outcomes

- Number of organisations sharing and accessing information from the Yorkshire Shared Care Record
- Number of users accessing patient information through interoperability

What we will deliver

Deliver the shared care record minimum viable solution	Develop a digital Roadmap	Barnsley integrated performance report	Information sharing	Improved data capture and standardised reporting of health inequalities	Health intelligence reports for transformation and enabler groups	Continued roll out of strengths based practice	Development of timely service user feedback

Working more closely with the (VCSE) sector

Our priority for 2023 to 2025

We will strengthen our partnership with the voluntary, community and social enterprise sector

Why is it important?

Barnsley's VCSE Sector is made up of a huge range of inspirational, passionate people who help our local people. The organisations and groups vary in size from international bodies to groups made up of a small number of people. They work hard to make sure they can ehance our services and help people of all ages in Barnsley live better lives. The diversity of the VCSE sector is a strength to be recognised and celebrated.

The sector brings specialist expertise and fresh perspectives to service delivery that is well placed to support people with complex and multiple needs. The VCSE sector has, and continues to, play an important role in keeping people connected.

Our VCSE Sector reaches deep into communities. They are vital.

In 2023, NHS South Yorkshire Integrated Board and the VCSE sector in South Yorkshire agreed a memorandum of understanding (MOU) that recognises and values the VCSE as a key partner within the health and care system, and sets out how the Integrated Care System and the VCSE will work together to improve health and care. This agreement builds on several years of work to bring together organisations into a network and VCSE alliance. The agreement pledges to embed VCSE participation in every level of out integrated care system.

The ethos of the VCSE Alliance is that there are opportunities to share work that is happening across Barnsley with the other places in South Yorkshire, and share where this is working at a regional level. As part of this, there are clear mechanisms to co-ordinate equitable VCSE involvement from Barnsley and the other places (Doncaster, Rotherham and Sheffield.)

Where do we add value?

Health and care partners in Barnsley have supported the establishment of the Voluntary and Community Sector Strategy Group which has now developed into an engagement structure that all VCSE organisations can engage with. Through this process an Alliance has grown which brings Children's Services together with the children and young people's organisations in the sector.

We have been providing training for volunteers and organisations to support safeguarding and helping with governance and organisational support.

In 2021 we worked with organisations across the VCSE to form the Barnsley Older People's Physical Activity Alliance (BOPPAA) to increase the provision of physical activity programmes that will improve the strength and balance of those over 50 living in Barnsley.

There are over 60-member organisations who make up BOPPA and they deliver over 170 physical activity sessions across the borough.

One activity which has proved popular is the Healthy Bones and Fall Management class which sees over 100 people attend regularly. One person who attended a class commented: "You get wary as you get older about doing things. This has really increased my confidence to be able to do things."

Working more closely with the (VCSE) sector

Current state

- Good working relationship with the VCSE through establishment of the Voluntary and Community Sector Strategy Group
- The VCSE is increasingly being recognised for the role it plays in support better health and wellbeing through offers such as social prescribing
- More people are being supported to get involved with groups and activities provided by VCSE organisations within communities

Key issues

- There are around 250 groups registered on the Barnsley CVS database but it is estimated that there around 1,000 groups in total
- The VCSE can be competitively minded because it has needed to be. However collaboration is growing, particularly through alliances in Barnsley such as the Dementia Alliance, Migrant Partnership, Youth Alliance and Older People's Physical Activity Alliance
- The VCSE bring significant investment into Barnsley. However, our local lottery funding lags behind others
- It is important that VCSE capacity can meet the growing demands for its offer
- Sometimes VCSE organisations are not recognised for the level of training and specialist interventions that they deliver within care pathways and referral processes

Strategy alignment

- Building Strong Integrated Care Systems (ICS) Everywhere: ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector
- Memorandum of Understanding between NHS South Yorkshire Integrated Care Board and the VCSE Alliance
- South Yorkshire Integrated Care Strategy Five Year Plan and System Development Plan 2022

Measure for success

- Mapped out the VCSE sector across Barnsley
- Increased involvement and participation of VCSE representatives across programme boards and working groups
- Increase engagement and involvement from seldom heard communities through VCSE partners
- Increased capacity across the VCSE sector to support health and care priorities in Barnsley

What we will deliver

Support the completion of State of the Sector research	Strengthen engagement with the VCSE sector through emerging structures and alliances	Build opportunities for VCSE organisations to work together	Support frontline knowledge and creativity in initiatives alongside other sectors	Identify and promote funding opportunities across the VCSE sector	Ensure the VCSE sector has a strong voice in initiatives alongside other sectors	Celebrate and promote the successes of the VCSE sector and volunteers

Operational planning – delivery focus

Area	Priority	Where
1. Urgent and emergency care	(1a) Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 (1b) Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 (1c) Reduce adult general and acute (G&A) bed occupancy to 92% or below	UEC Alliance and Places
2. Community health services	((2a) Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard (2b) Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	UEC Alliance and Places Places and Primary Care Alliance
3. Primary care	(3a) Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need (3b) Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 (3c) Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 (3d) Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	Primary Care Alliance and Places
4. Elective care	(4a) Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) (4b) Deliver the system- specific activity target (agreed through the operational planning process)	Acute Federation
5. Cancer	(5a) Continue to reduce the number of patients waiting over 62 days (5b) Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days (5c) Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Cancer Alliance
6. Diagnostics	(6a) Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% (6b) Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Acute Federation
7. Maternity	((7a) Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury (7b) Increase fill rates against funded establishment for maternity staff	Local Maternity and Neonatal System
8. Use of resources	(8a) Deliver a balanced net system financial position for 2023/24	All building blocks
9. Workforce	(9a) Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	All building blocks
10. Mental health	(10a) Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) (10b) Increase the number of adults and older adults accessing IAPT treatment (10c) Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services (10d) Work towards eliminating inappropriate adult acute out of area placements (10e) Recover the dementia diagnosis rate to 66.7% (10f) Improve access to perinatal mental health services	MHLDA Alliance and Places
11. People with a learning disability and autistic people	(11a)Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 (11b) Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit	MHLDA Alliance and Places
12. Prevention and health inequalities	((12a) Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 (12b) Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% (12c) Continue to address health inequalities and deliver on the Core20PLUS5 approach	Place and Prevention Programme

10 August 2023

REPORT TO THE HEALTH AND WELLBEING BOARD
Better Care Fund – 2022/23 Year End Report and 2023/25 Plan

Report Sponsor: Wendy Lowder
Report Author: Jamie Wike

1. Purpose of Report

1.1 To provide the Board with details of the annual year end return/evaluation of the 2022/23 Better Care Fund (BCF)and inform the Board of the details of the Better Care Fund Plan for 2023-25.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Note the contents of this report including the evaluation of the 2022/23 BCF Plan and the submitted plan for 2023-25.
- Provide any constructive feedback on the BCF for 2023-25.
- Approve the Better Care Fund Plan for 2023-25.

3. Delivering the Health & Wellbeing Strategy

3.1 The Better Care Fund in Barnsley continues to be set within the wider context of the overall Health and Wellbeing Strategy and the Barnsley Health and Care Place Plan.

3.2 It is important that our plans are considered within this context to ensure that our efforts are coordinated and that our plans are connected and come together to maximise the impact that we can make across the whole system for the benefit of Barnsley residents. Our Vision for a Healthy Barnsley, as set out in the Barnsley Health and Wellbeing Strategy 2021 – 2030: The Place of Possibilities is that:
All Barnsley Residents are enabled to enjoy long, fulfilling and healthy lives in safe, strong and vibrant communities where every person is equipped with the skills and resources they need to thrive.

3.3 The vision and principles of integration have become well established and in many respects integrated ways of working are now seen as 'business as usual' for delivering the right service, at the right time and in the right place and a number of the BCF schemes as well as other established core services are delivered in an integrated way bringing health and social care providers together to best meet the needs of individuals.

4. Reducing Inequalities

4.1 One of the key priorities within the Better Care Fund Plan in both 2022/23 and in this current 2023-25 plan is to improve equity of access to care and support and reduce health inequalities; ensuing everyone who needs support can access it at the right time and in the right place.

4.2 Above all we want to improve the quality of life of people in Barnsley and reduce the inequalities that exist in health and wellbeing outcomes. We want to better meet the needs of our population in Barnsley, preventing chronic illness, deaths from preventable causes and see a rise in the number of individuals making informed decisions about their care and support alongside health and care colleagues. The vision of integration in Barnsley is fully aligned to and supports us in delivering the BCF policy objectives:

1. Enable people to stay well, safe and independent at home for longer
2. Provide the right care in the right place at the right time.

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5. Introduction/ Background

5.1 The BCF Plans since 2014/15 have played a key role in helping Barnsley with its integration journey, being delivered within the wider context of our Health and Wellbeing Strategy and Barnsley Health and Care Plan enabling core health and care services to support one another and function as a united approach, to help reduce the pressures on acute services and residential care.

5.2 Our BCF in Barnsley is used to fund services commissioned by the NHS South Yorkshire Integrated Care Board (ICB) and Barnsley Metropolitan Council with the overall BCF plan being supported by a range of services which form part of the wider integration plans being taken forward by the Integrated Care Place Partnership.

5.3 The focus and priorities of our BCF plan have remained consistent over the years to ensure alignment to our vision for a healthy Barnsley and to ensure stability and sustainability of health and social care services whilst supporting integration. The BCF funding is predominantly focussed on out of hospital services.

5.4 The level of funding included in the plan for 2022/23 and within the new plan for 2023/25 has increased in line with required increase in ICB contribution and has been enhanced to include specific discharge funding provided to the Local Authority and ICB for 2023/24 and 2024/25. The BCF funding included

with the Barnsley BCF from 2022/23 up to 2024/25 is set out in summary in the table below:

	2022/34	2023/24	2024/25
NHS South Yorkshire ICB	£23,080,403	£24,386,754	£25,767,044
LA contribution (DFG)	£3,377,046	£3,377,046	£3,377,046
Improved Better Care Fund	£13,450,589	£13,450,589	£13,450,589
Local Authority Discharge Funding	N/A	£1,885,752	£3,130,348
ICB Discharge Funding	N/A	£1,404,000	£2,276,000
Total	**£39,908,038**	**£44,504,140**	**£48,001,027**

6. 2022/23 Better Care Fund Year End Return/Evaluation

6.1 Each year following the end of the Financial Year, a reporting requirement of the Batter Care Fund Policy and Guidance is to submit a year end return assessing the delivery of the BCF Plan.

6.2 The 2022/23 Year End return required information in relation to:

- Confirmation of meeting the national conditions
- Performance against the key BCF metrics
- Confirmation of income and expenditure
- An assessment of key successes and challenges
- Confirmation of actual expenditure against schemes funding through Adult Social Care Discharge Funding in 2022/23

6.3 The template is included at appendix 1 to provide the Board with full details of the evaluation and submission. Learning has been used to inform development of the BCF Plan for 2023-25.

7. 2023-25 Better Care Fund Plan

7.1 The BCF Policy Framework for the 2-year period from 2023 to 2025 sets out the Government's priorities including:

- Improving discharge
- Reducing the pressure on urgent and emergency care and social care
- Supporting Intermediate Care
- Unpaid Carers
- Housing Adaptations

7.2 The vision for the BCF over 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

7.3 As in previous years the BCF Policy Framework and Planning Guidance set out the national conditions for the BCF funding, each of which needs to be demonstrated as being met in the BCF Plan. The four national conditions are:

1. The Plan has been jointly agreed between local health and social care commissioners with engagement and input from other stakeholders including members of the Health and Wellbeing Board and Integrated Care Partnership

2. The NHS contribution to adult social care has been increased in line with the uplift to the CCG minimum contribution allowing for continued investment in all schemes and offsetting cost increase and pressures in Social Care

3. Investment in NHS commissioned out of hospital services is significantly above the minimum required ensuring support is available for those who need it to avoid unnecessary admission to hospital or to recover following an hospital admission.

4. The BCF plan and schemes include key services that support our discharge model and approach to support safe and timely discharge including our embedded home first, discharge to assess model – implementing the BCF policy objectives of enabling people to stay well, safe and independent at home for longer, and providing the right care in the right place at the right time.

7.4 The strategic governance arrangements for the Better Care Fund remain the same as in recent years with oversight being provided by the Health and Wellbeing Board and the BCF being managed within the governance structures of the Health and Wellbeing Board. The BCF programme will be overseen by the Health & Wellbeing Board, supported by the Barnsley Place Partnership Delivery Group who will take responsibility for ensuring delivery against our plans and achievement of our priorities.

7.5 The plan includes trajectories against the four national metrics that are required for the BCF plan. In summary the plan aims to support:

- The reduction in the growth in avoidable admissions to hospital.
- Reducing the number of emergency hospital admissions due to falls in people of 65 years old
- Maintaining the high rates of discharge to usual place of residence
- Reducing the number of people who have their long-term care needs met by admission to residential care
- Maintaining the high proportion of people who are able to remain at home after discharge from hospital into reablement services.

5.6 Further detail, including a full narrative report, financial breakdown, and capacity demand planning are included within the appendices.

8. Conclusion/ Next Steps

8.1 The Board are asked to note the positive evaluation included within the BCF 2022/23 year end return as set out in the appended template.

8.2 The Board are also asked to note the information included in the report and appendices in relation to the 2023-25 BCF Plan and approve these as the final plan for 2023-25.

9. Financial Implications

9.1 The templates attached at Appendix 1 and Appendix 3 provide a detailed breakdown of the income and expenditure/planned expenditure of the Better Care Fund for 2022/23 and 2023-25

10 Consultation with stakeholders

10.1 All members of the Health and Wellbeing Board and the Barnsley (Integrated Care) Place Partnership have been engaged in the development of our vision for integrated health and care and our plans. All partners have been involved through participation in meetings and workshops as active contributing members to the Board.

11. Appendices

11.1 Appendix 1 – 2022/23 Better Care Fund Year-End Return

11.2 Appendix 2 – Barnsley Better Care Fund Plan – Narrative Template 2023-25

11.3 Appendix 3 – Barnsley Better Care Fund Planning Template 2023-25

Officer: Jamie Wike **Date:** 28 July 2023

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Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

ASC Discharge Fund-due 2nd May

This is the last tab in the workbook and must be submitted by 2nd May 2023 as this will flow to DHSC. It can be submitted with the rest of workbook empty as long as all the details are complete within this tab, as well as the cover sheet although we are not expecting this to be signed off by HWB at this point. The rest of the template can then be later resubmitted with the remaining sections completed.

After selecting a HWB from the dropdown please check that the planned expenditure for each scheme type submitted in your ASC Discharge Fund plan are populated.
Please then enter the actual packages of care that matches the unit of measure pre-specified where applicable.
If there are any new scheme types not previously entered, please enter these in the bottom section indicated by a new header. At the very bottom there is a totals summary for expenditure which we'd like you to add a breakdown by LA and ICB.

Please also include summary narrative on:
1. Scheme impact
2. Narrative describing any changes to planned spending – e.g. did plans get changed in response to pressures or demand? Please also detail any underspend.
3. Assessment of the impact the funding delivered and any learning. Where relevant to this assessment, please include details such as: number of packages purchased, number of hours of care, number of weeks (duration of support), number of individuals supported, unit costs, staff hours purchased and increase in pay etc
4. Any shared learning

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.

3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2022-23 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2022-23/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to NHS Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Dischaege to usual place of residence and avoidable admissions at a local authority level to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes and the unavailability of published metric data for one/two of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Income and Expenditure

The Better Care Fund 2022-23 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Adult Social Care discharge fund.

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2022-23 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ASC discharge fund via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2022-23 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2022-23 in the yellow boxes provided, **NOT** the difference between the planned and actual income.
- Please provide any comments that may be useful for local context for the reported actual income in 2022-23.

Expenditure section:

- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2022-23 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please include actual expenditure from the ASC discharge fund.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2022-23.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2022-23 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:
- Strongly Agree
- Agree

- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2022-23
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

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Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Checklist
			Complete:
Health and Wellbeing Board:	Barnsley		Yes
Completed by:	Jamie Wike		Yes
E-mail:	jamie.wike@nhs.net		Yes
Contact number:	01226 433702		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Tue 13/06/2023	<< Please enter using the format, DD/MM/YYYY	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

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Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Barnsley

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

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Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Barnsley

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,290.0	Not on track to meet target	Whilst there was a reduction in the number of admissions in the first half of the year this increase in the second half and is anticipated to be a slight increase on 2021/22. Covid has impacted upon the health of some people with ambulatory care sensitive conditions such as Asthma leading to increased exacerbations and presentation to health services including primary care and hospital services over the winter period	Through Barnsley PCN care coordinators embedded in all GP practices are continuing to support people with LTC's to access regular health checks and the services they need to manage their condition and reduce execerbation that results in hospital admissions	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.9%	On track to meet target	As a result of increased acuity of patients being seen and treated in hospital there has been an increase in the need to discharge patients who do not meet the criteria to reside into intermediate care services prior to being able to return to the normal place of residence.	Home first approach has contributed to enabling appropriate people to continue to be discharged to their normal place of residence or receive additional support in the community before returning to normal place of residence..	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	848	On track to meet target	.	Implementation and embedding of a strengths based approach to supporting individuals with the care and support reguired, working alongside community services has resulted in a reduction in the number of people requiring permanent admission to residential care	Yes

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	90.0%	Not on track to meet target	During 2022/23 we have seen a slight reduction in number of people who are able to remain at home following discharge from Hospital into reablement services. This has been mainly due to increased acuity of patients being discharged from hospital not meeting the criteria to reside which has impacted across discharge pathways and resulted in increased readmissions to hospital.	Reablement services have continued to support increasing numbers of patients in the community as a part of the dischare pathways with the aim of maintaining independence. Good partnership working to ensure integrated approach to care for people following admission into hospital.	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Barnsley

Income

	2022-23
Disabled Facilities Grant	£3,377,046
Improved Better Care Fund	£13,450,589
NHS Minimum Fund	£23,080,403
Minimum Sub Total	£39,908,038

	Planned	Actual		
NHS Additional Funding	£0	Do you wish to change your additional actual NHS funding?	No	
LA Additional Funding	£0	Do you wish to change your additional actual LA funding?	No	
Additional Sub Total	£0			£0

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£39,908,038	£39,908,038

ASC Discharge Fund

	Planned	Actual		
LA Plan Spend	£1,032,001	Do you wish to change your additional actual LA funding?	No	
ICB Plan Spend	£1,520,401	Do you wish to change your additional actual ICB funding?	No	
ASC Discharge Fund Total	£2,552,402			£2,552,402

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£42,460,440	£42,460,440

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	

Expenditure

	2022-23
Plan	£39,908,038

Do you wish to change your actual BCF expenditure?	No

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes
Yes
Yes

Actual	

	ASC Discharge Fund
Plan	£2,552,402

Do you wish to change your actual BCF expenditure?	No

Actual	

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	

Yes

Yes

Yes

Yes

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Barnsley

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Neither agree nor disagree	Throughout 2022/23 there has undoubtedly been continued improvments to joint working across health and social care as the Barnsley Place Partnership continued to evolve and support the delivery of the agreed place priorities including those set out in the better care fund and the Barnsley Place Plan. The BCF in Barnsley has always been seen as one component of the delivery of the wider Health and Wellbeing Strategy and Barnsley Health and Care Place Plan and work to integrate service delivery to deliver better outcomes and more joined up services for Barnsley people and therefore this is not seen as the key factor in improving joint working. It may have increased focus in some areas however joint working arrangements were strong prior to the introduction of the BCF and continue to be so as part of the Integrated Care System with the Barnsley Place Partnership working alongside the Integrated Care Board and taking responsibility for placed based services.	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Agree	.	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Agree	As Q1	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	2. Strong, system-wide governance and systems leadership	H&WB Board and Integrated Care Partnership - Partners locally have a clear shared vision and an agreed outcomes framework for integrated care and an agreed plan for taking forward the shared priorities. The strong foundations in Barnsley have enabled effective partnership working and decision making during 2021/22 to ensure a coordinated and joined up working.	Yes

Success 2	5. Integrated workforce: joint approach to training and upskilling of workforce	The continued development of a Neighbourhood Teams alongside the increasing maturity of the Barnsley Primary Care Network, Neighbourhood arrangements and alignement to local authority Area Council Neighbourhoods has seen the further alignment of primary, community and social care services at a local level providing leadership and empowing front line staff to work in an aligned way with other services to meet the care and support needs of individuals. There has also been good progress in developing integrated workforce planning arrangments including the delivery of joined	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	3. Integrated electronic records and sharing across the system with service users	Sharing of records remains a challenge with many different systems still in place and the vast IG implications. Local plans are now in place and progress is being made linked to the YHSCR however Interoperability and shared care records across all partners are not in place and this continues to be flagged up as a barrier to more effective partnership working.	Yes
Challenge 2	9. Joint commissioning of health and social care	Whilst there is aligned and joined up working taking place as identified above there are further opportunities for alignment of commissioning across some elements of health and social care and the development of more joint commissioning to support further alignment and integration of services. During 2022/23 there will be opportunities to consider how to take this forward alongside the emergence of new Integrated Care Board and enhancements to the place based partnership arrangements.	Yes

Footnotes:

Question 4 and 5 are should be assigned to one of the following categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Barnsley

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.

The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.
1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).
2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.
3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.
4) For 'improvement retention of existing workforce', please state the number of staff this relates to.
5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.
6) For 'Assistive Techonologies and Equipment' , please state the number of unique beneficiaries through the fund.
7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible	Do you have any learning from this scheme?
Additional bridging support hours (Rehablement)	Reablement in a Person's Own Home	Reablement service accepting community and discharge	£15,000	£15,000	600	Hours of care	No		Yes	Additional 50 hours per week from Elder care provided additional capaivity for NRS flow	
Additional discharge transport	Other		£30,000	£38,000	315	N/A	No		Yes	The additonal transport meant that people could be discharged out of hospital safely and in a more timely manner. Meeting Discharge to assess slots earlier in the day.	
Agency Nursing - Support to independent sector nursing providers	Administration		£10,000	£10,000	0	N/A	No		Yes	The use of NHSP contract framework to support nursing homes to increase capacity via agency nurses on a short term basis	
CHC/Complex Cases - funded beds and complex care packages with 1:1/2:1 support	Other		£850,226	£652,994		N/A	No		Yes	Ability to discharge patients who are suitable for discharge with a package of care and 1:1 support if reguired	
Clinical Educator - Criteria to reside	Other		£38,940	£38,940		N/A	No		Yes	Direct focus for criteria to reside - raising awareness across the trust, developing a daily audit tool and live dashboard for 7 day accurate reporting	
Community Equipment	Increase hours worked by existing workforce		£211,235	£211,235	3,901	hours worked	No		Yes	Facilitation of 1590 equipment items designated for community use, with a further 2311 equipment items purchased by this scheme to facilitate future use during 2023/24. Where	
Digital - Assistive Technology	Assistive Technologies and Equipment	Telecare	£10,000	£10,000	30	Number of beneficiaries	No		Yes	30 digital devices procured to monitor vitals of discharged patients in residential care to prevent re-admission to hospital	
Hospice - Increased community support and out of hours	Increase hours worked by existing workforce	Overtime for existing staff.	£100,000	£100,000		hours worked	No		Yes	Offered an additonal 32 places each week (16 in a morning and 16 in an afternoon) through the Orangery Wellbeing hub, increasing the individuals ability to self manage sypmtoms	the need for medication delivery provision was identified as a major
Intermediate Care medical support and oversight	Other		£75,000	£125,685		N/A	No		Yes	ability to step down higher acuity of patients into an intermediate care bed in the community with high levels of medical oversight	
Little Help to Home - Hospital Discharge Service	Other		£258,538	£258,538	452	N/A	No		Yes	Number of actual beneficiaries lower than anticipated / planned, however the provision of the service saved at least 1 day's occupancy of a hospital bed per patient supported	Tailoring specific support interventions to meet the needs and interests of the
Mental Health hospital discharge support	Other		£35,000	£35,000	69	N/A	No		Yes	Additional funding enabled referral target of 55 to be exceed. 21 service users were supported to access other community assets such as creative recovery and reds in the community.	
Mental Health Step Down Bed	Residential Placements	Care home	£10,000	£10,000	12	Number of beds	No		Yes	provided 12 short term bed weeks to deal with delays to deal with delays in securing appropriate step down community provision	
Physical Activity Training	Other		£10,000	£10,000		N/A	No		Yes	physical activity/Otago type activity by volunteers in hospital wards preventing deconditioning and speeding up discharge	
Rapid Response Homecare support	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£50,000	£50,000	1,800	Hours of care	No		Yes	provision of additional homecare capacity to mainatin existing hours of care /plus hospital discharges cases	
Shared Lives - Additional step-down and respite capacity	Other		£50,000	£50,000		N/A	No		Yes	use of shared lives carers for respite	

Short stay placements	Residential Placements	Discharge from hospital (with reablement) to long term care	£150,000	£150,000	216	Number of beds	No		Yes	216 weeks of bed based short term stay provided over the 12 week period for discharges	
Step Down (spot purchase beds)	Residential Placements	Nursing home	£180,000	£318,146	247	Number of beds	No		Yes	Ability to step down patients who are suitable for discharge with continued medical oversight and rehabilitation	
Support payments to homecare providers/in-house reablement team to create additional	Increase hours worked by existing workforce	Incentive payments	£428,463	£428,463		N/A	No		Yes	funding used by providers for staff overtime / other incentive payments to mainly maintain provisioned hours and capacity	
Support to facilitate s17 discharges (of s37/41 patients)	Other		£20,000	£20,000		N/A	No		Yes	facilitated discharged from locked rehab/low secure unit by providing support to test suitability of supported living placement	
Transport support for non-driving care workers	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£20,000	£20,000	968	Hours of care	No		Yes	Allowed selected provider to maintain existing hours of care provision in addition to discharged cases	

HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Barnsley Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

Barnsley Metropolitan Borough Council

NHS South Yorkshire Integrated Care Board

Barnsley Hospital NHS Foundation Trust

South West Yorkshire Partnerships NHS Foundation Trust

Barnsley Healthcare Federation

Barnsley CVS

Healthwatch Barnsley

Barnsley Hospice

Barnsley and Rotherham Chamber of Commerce

Berneslai Homes

South Yorkshire Police

How have you gone about involving these stakeholders?

The Better Care Fund in Barnsley has been developed and is set in the context of the Health and Wellbeing Strategy and the Barnsley Place Partnership - Barnsley Health and Care Plan 2023-25.

All members of the Health and Wellbeing Board and the Barnsley (Integrated Care) Place Partnership have been engaged in the development of our vision for integrated health and care and our plans, including developing and agreeing the BCF Plan. All partners have been involved through participation in meetings and workshops as active contributing members to the Board.

The BCF in 2023-25 has been developed with input from both housing strategy (DFG) lead and Berneslai Homes to ensure that the BCF Plan continues to contribute to ambitions and objectives of the overall housing strategy and that the delivery of the housing strategy also contributes to improving health outcomes for Barnsley residents through more joined up approaches and effective use of DFG.

Governance

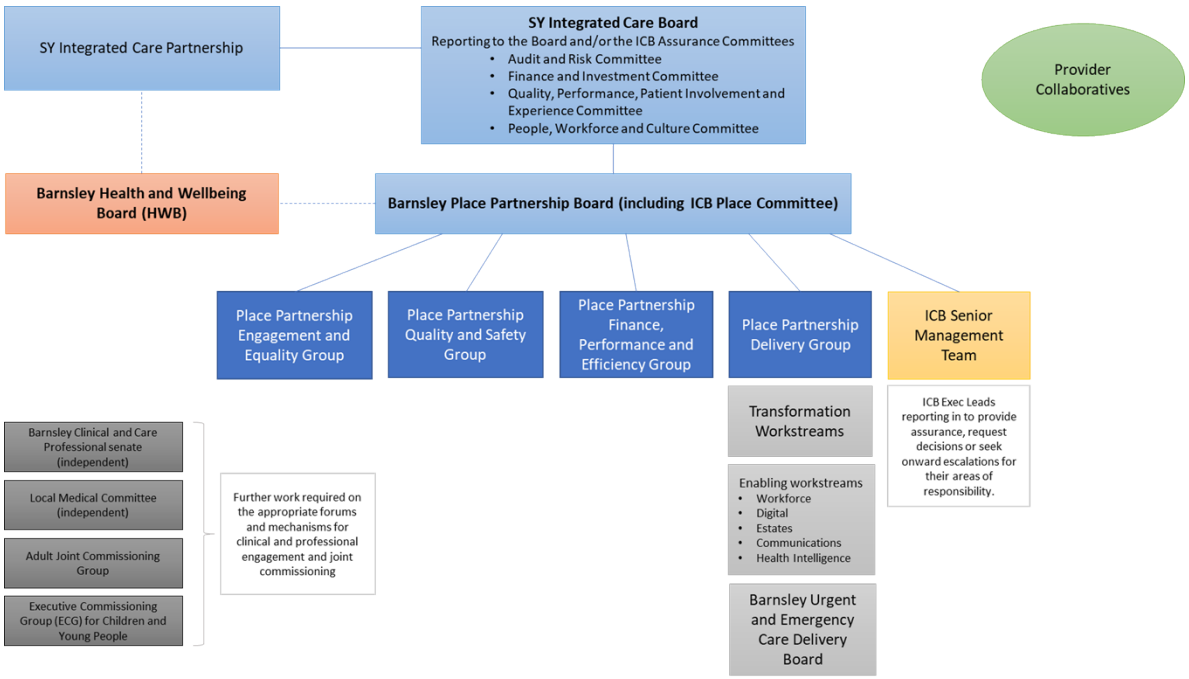
Please briefly outline the governance for the BCF plan and its implementation in your area.

The Health and Care Act 2022 led to South Yorkshire Integrated Care System, comprising NHS South Yorkshire Integrated Care Board and the South Yorkshire Integrated Care Partnership, being established on a statutory footing from 1 July 2022.

In Barnsley the place agreement between health and care partners has been updated in 2022/23 and a formal place committee of the Integrated Care Board has been created. The Barnsley Place Committee is Chaired by the Executive Director of Place, Health and Adults, which is a joint role with Barnsley Council, and the committee comprises directors and a non-Executive Director of the Integrated Care Board. The committee meets alongside the previously established Place Partnership Board.

The NHS South Yorkshire – Barnsley Place Senior Management Team meets jointly with the Barnsley Council Adult Social Care Senior Management Team to support the Executive Director – Place, Health and Adults to discharge her duties across the Council and NHS.

The BCF programme will be overseen by the Health and Wellbeing Board, supported by the Place Partnership Delivery Group which is a subgroup of the Place Partnership Board. The Delivery Group will take responsibility for ensuring delivery of our plans and achievement of their objectives.



During 2023/24 there will be a further review of the Place Governance to ensure that it is streamlined and effective in driving delivery of the Barnsley Health and Care Plan 2023-25, Better Care Fund plan and South Yorkshire Integrated Care Strategy.

A robust programme management approach has been established to support the delivery of our plans with each of the Delivery Groups (shown in the grey boxes) having clear priorities and plans against which delivery is monitored and reported on a regular basis to the Place Partnership Delivery Group and in turn any risks or issues identified for escalation are

reported to the Barnsley Place Partnership Board. The Health and Wellbeing Board will be regularly updated on progress.

The section 75 agreement remains in place and sets out the detailed management arrangements for the BCF plan including how financial risks associated with the services commissioned through the BCF will sit with the commissioning organisation and be managed as part of their financial management arrangements.

Each organisation has robust risk management arrangements in place with corporate risk registers identifying the most significant risk to the organisation. Where risks relate to the services which are funded from the BCF, these are managed and contained by the commissioning organisation in the first instance but where the risks may have a wider adverse impact, these are escalated through the PMO arrangements described above

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

The Barnsley Health and Care Plan 2023-25 has been developed alongside the NHS South Yorkshire Joint Forward Plan and in response to the South Yorkshire Integrated Care Partnership Strategy and NHS Operational Planning Guidance. Our plans have been informed by insights from a wide range of engagement and involvement activities undertaken in South Yorkshire over the last two years and a 'What Matters to You Campaign' public campaign. The following key themes have emerged and have been used to shape our strategy:

• Access to care

• Quality of care

• Improving mental health and wellbeing

• Support to live well

• Wider determinants of health

• Affordability

The Barnsley Health and Care Plan 2023-25 has five shared goals that aim collectively to improve health and wellbeing, deliver services that people want and tackle health inequalities.

Under each shared goal there are several deliverables –

Priority	Objective	Deliverable
Best start in life for children and young people	We will improve access and the connections between families, professionals, services, and providers, and put relationships at the heart of family support	Create family hubs Deliver SEND improvement plan and actions Improve access to Children's and Young Peoples Mental Health Services Increase children's access to epilepsy specialist nurses in first year of care for those with LD or autism Improve asthma care for children Improved access to perinatal mental health services
A joined-up approach to prevention	We will offer every smoker in Barnsley support to stop, making every contact count and increase the support we provide to help people to address the drivers of inequalities.	Further embed the Making Every Contact Count framework across our services Deliver the medicines optimisations programme PROTECT Provide more opportunities for physical activity and healthy food Link up stop smoking services to understand impacts on people Establish screening and referral processes in locations outside of standard places of care
Better and fairer access	We want to improve our services to make sure people can access the right care when they need it most.	Develop and implement an Integrated Urgent Care Front door Listen to the needs of our communities, beginning with those who experience poorer access to healthcare Work with VCSE to build capacity and capability to deliver trauma informed support Better support those with substance misuse problems by bringing together current support offers Increase personalised care interventions Implement new GP contract requirements to recover access
Coordinated care in the community	We will provide more proactive care and support for people most a risk of poor health outcomes, help people to live as well as possible until they die and to die with dignity	Listen to the needs of older people in Barnsley beginning with those who experience poorer access Provide ageing well assessments Create an anticipatory care register Review of Intermediate care model Dementia pathway review Roll out ReSPECT across all partners in Barnsley End of life and palliative care strategy and delivery plan Support people with bereavement by establish a new network who will develop a long-term strategy Continue to shape services through Think Local Act Personal programme Continue roll out of Strengths based practice Market shaping in the independent sector
Improve impact on local environment, economy and employment	We will establish an anchor network across health and social care organisations and wider partners	Complete mapping of where contacts are made, and money is spent Build partnerships with schools, colleges, and other education providers Develop an understanding of the makeup of our workforce, including social gradient and representation of protected characteristics

The funding from the BCF remains broadly consistent in 2023-25 with that of previous plans to ensure sustainability of those health and social care services and is predominantly focussed upon out of hospital NHS services and Social Care services.

The level of funding has been enhanced in 2023/24 to reflect growth in the contribution to Social Care and the continued inclusion of the iBCF.

The Better Care Fund 2023-25 has been developed to meet the national conditions of the Better Care Fund Policy Framework.

1. The Plan has been jointly agreed between local health and social care commissioners with engagement and input from other stakeholders including members of the Health and Wellbeing Board and Integrated Care Partnership

2. The NHS contribution to adult social care has been increased in line with the uplift to the CCG minimum contribution allowing for continued investment in all schemes and offsetting cost increase and pressures in Social Care

3. Investment in NHS commissioned out of hospital services is significantly above the minimum required ensuring support is available for those who need it to avoid unnecessary admission to hospital or to recover following an hospital admission.

4. The BCF plan and schemes include key services that support our discharge model and approach to support safe and timely discharge including our embedded home first, discharge to assess model – implementing the BCF policy objectives of enabling people to stay well, safe and independent at home for longer, and providing the right care in the right place at the right time.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Barnsley has a long history of partnership working across health and social care and is proud of its integration journey, embracing the Health Act flexibilities to develop pooled budgets, joint commissioning arrangements and integrated provider roles, ahead of many other areas.

The 2023-25 Better Care Fund Plan builds on previous plans and continues to be set within the wider context of the Health and Wellbeing Strategy and Barnsley Place Partnership Health and Care Plan for 2023-25, contributing to delivery of the key priorities and enabling us to move towards our vision for improved health and wellbeing through integrated service delivery. We feel that it is important that our plans are considered within this context to ensure that our efforts are coordinated and that our plans come together to maximise the impact that we are able to make across the whole system for the benefit of Barnsley residents.

The Barnsley 2030 Plan sets out our collective long-term vision and ambition for the Borough. A key theme of Barnsley 2030 is Healthy Barnsley, and the ambition is that everyone in Barnsley is able to lead a good life in good physical and mental health, with everybody having a sense of self-worth. The Barnsley Health and Wellbeing Board is the key delivery board for the Healthy Barnsley theme of Barnsley 2030.

Our Vision for a Healthy Barnsley, as set out in the Barnsley Health and Wellbeing Strategy 2021 – 2030: The Place of Possibilities is that:

> All Barnsley Residents are enabled to enjoy long, fulfilling and healthy lives in safe, strong and vibrant communities where every person is equipped with the skills and resources they need to thrive.

Our goal is to dismantle boundaries at the point of delivery of care. These boundaries exist because of the complexity of separate funding, multiple contracts, different organisations with different accountabilities, responsibilities and regulators.

We want people who use our services to be supported and empowered by what feels like ‘one team’, each delivering their part without duplication along common pathways of care. One team that is responsible to the people of Barnsley.

Above all we want to improve the quality of life of people in Barnsley and reduce the inequalities that exist in health and wellbeing outcomes. We want to better meet the needs of our population in Barnsley, preventing chronic illness, deaths from preventable causes and

see a rise in the number of individuals making informed decisions about their care and support alongside health and care colleagues.

The vision of integration in Barnsley is fully aligned to and supports us in delivering the BCF policy objectives:

1. Enable people to stay well, safe and independent at home for longer

2. Provide the right care in the right place at the right time.

The vision and principles have become well established and in many respects integrated ways of working are now seen as 'business as usual' for delivering the right service, at the right time and in the right place. Several of the BCF schemes, as well as other established core services, are delivered in an integrated way bringing health and social care providers together to best meet the needs of individuals.

The vision for integrated care in Barnsley is for:

The Barnsley Place Partnership is continuing its focus on falls and frailty in 2023-25. A priority of the Barnsley Health and Care Plan 2023-25 is to complete a review of the intermediate care tier of services and implement a new model. Barnsley Council and NHS South Yorkshire commissioners have engaged IMPOWER to support this review. Working together partners have agreed the following design principles for the new model –

- Home first, community based approach
- Person centred and outcome focussed
- Clear pathway with single assessment and minimal hand-offs
- A mixed model, moving towards a focus on prevention and avoidance
- Flexible workforce, adopting a 'one team' approach
- Meximise utilisation of wider community offer and technology enabled care
- Clear accountability and governance
- The additional investment in reablement services through the BCF will support the development and implementation of the new model, moving towards having a greater focus on prevention and tackling inequalities.

Services are already moving to more collaborative joint working with the coming together of GP out-of-hours, urgent community response and adult social care rapid response teams to support people out-of-hours to avoid and manage crises leading to hospital admission.

During 23-25 partners will be working together to develop an anticipatory care model for people living with frailty in the community. This builds on a project undertaken during 2022 with support from the System-wide Frailty Network, facilitated by NHS Elect. The project aims to prevent the onset or delay progression frailty through a proactive, joined up and person-centred and community oriented approach. Examples of the progress made over the last year include –

- Mapping of the falls prevention pathway and supporting adoption of international best practice across service areas

- Developed an ageing well assessment and proactive management of frailty in the community pathway that is being rolled out in general practice

- Delivered the second stage service evaluation for a digital healthy ageing pathway

- Strengthened the Barnsley Older People's Physical Activity Alliance (BOPPAA) which is now delivering more than 150 additional physical activity opportunities through more than 40 providers.

- Increased utilisation of the community first responder service for falls that is delivered by the Barnsley Council Assisted Living Team, including developing a push model for the Yorkshire Ambulance Service stack through the RightCare Barnsley Single Point of Access

- Delivered a frailty anticipatory care pilot with Age UK Barnsley that is currently undergoing independent evaluation

Several of these initiatives are funded through BCF schemes for 2023-25.

During 2023-25 the partnership will be taking a review of the dementia pathway along with Voluntary, Community and Social Enterprise (VCSE) sector partners. The review will have a particular focus on improving post diagnostic support for patients and their carers and early onset dementia.

We will also be continuing our work with Think Local Act Personal to improve customer engagement and insight to drive quality improvement and expand strength based practice. A "Big Conversation" with residents and service users is being organised to help shape the future adult social care strategy in Barnsley. The "Big Conversation" aims to enhance the qualitative feedback we already have, identify areas where Adult Social Care needs to improve and inform how Adult Social Care can establish an on-going conversation with people who use services

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Across Barnsley there are six multi-disciplinary integrated neighbourhood teams comprising district nursing, matrons, frailty nurses, specialist pallative care nurses, respiratory specialist nurses, neighbourhood rehabilitation services and urgent community response. The teams are aligned to the GP practice neighbourhood networks, Local Authority Area Council governance and community social work teams. RightCare Barnsley provides the single point of access into the neighbourhood integrated teams. The integrated neighbourhood teams were established to support coordinated care in the community and expand proactive anticipatory care.

Through the Better Lives programme, Barnsley Council has been working to impact positively on people's lives by:

- promoting wellbeing and personal and community resilience

- maximising recovery and promoting independence so people can live independently in their own communities for as long as possible

- improving the quality of life for people with care and support needs

- providing choice and control for people who have care and support needs

Over the past two years, our Adult Social Care teams have been working to –

- Make sure that the first contact with Adult Social Care helps people to stay independent and well. This is thanks to the Front Door team, getting support to people sooner.

- support people in their own homes with the 'Home First' approach. This has helped to reduce admissions to residential care homes by 22%.

- Launch the Reablement Community Pathway. The pathway helps more people regain their independence and confidence, reducing their need for longer-term care.

- Leading South Yorkshire's local supported employment scheme, helping people with learning disabilities or autism to get started in the workplace.

From April to October 2022 Barnsley Place Partnership participated in the national population health management development programme (PHMDP) delivered by Optum on behalf of NHS England Improvement. Through the programme we successfully linked data from across primary, community, mental health and secondary care and engaged a wide range of colleagues from across health, social care, and wider sectors, to identify cohorts within the population who would potentially benefit from targeted proactive interventions.

The interventions were tested in three of the neighbourhoods with mixed results. Overall, the programme has proved very beneficial in improving shared understanding of population health and PHM tools and approaches. The successes and challenges experienced provided helpful learning to inform future work. Following on from the programme, a workshop was undertaken with partners in November 2022, and colleagues across the South Yorkshire Integrated Care Board to assess PHM maturity against the NHS England Four I's Framework and develop a PHM roadmap.

The learning from the programme is being taken forward through proactive care for falls and frailty, targeted personalised care interventions led by three GP practices participating in the national Accelerate Programme and the SY diabetes programme. Population Health and PHM approaches are a feature of the Draft Barnsley Place Plan, and a PHM scheme has been developed for the Practice Delivery Agreement (PDA) in 2023/24 that supports this. PHM is evident across our work with partners and communities to improve screening for early diagnosis of cancer and other lung diseases, the How's Thi Ticker campaign to improve diagnosis of hypertension in our most deprived communities and the healthy lives team at Barnsley Hospital, amongst many other programmes and initiatives.

Examples of BCF schemes which specifically help people to stay well, safe and independent at home -

- Barnsley Older People's Physical Activity Alliance

- Intensive Home-based Treatment Team

- Reablement support, including additional OT capacity

- Extra care housing

- Improved early intervention and prevention model to support planning for independent living for older people

- Neighbourhood nursing

- Equipment and adaptations

- Intermediate care

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified

- where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

A review of actual versus commissioned activity in 2022/23 has shown –

- Activity lower than expected capacity in reablement services (impacted by staff vacancies in reablement)

- Referrals and caseload higher than expected for home-based rehabilitation (neighbourhood rehabilitation service)

- Activity/occupancy as expected within the Acorn Unit (bed-based rehabilitation) but higher than expected spot purchasing of beds in care homes for bed-based rehabilitation

During 2022/23 Barnsley Council has developed a new front door team for adult social care and implemented community reablement pathways so that more people can benefit from prevention and early intervention. Staffing has hampered efforts to expand the reablement offer at the pace expected, but schemes within the BCF for 2023-25 will see it grow more and further integrate community and social care.

In September 2022/23 additional investment was agreed to expand the Urgent Community Response (UCR) service to fully meet the new national service specification. The investment has enabled the recruitment of a clinical lead, additional nursing capacity, support with equipment and extended working hours for therapy. The service is now fully staffed to the new establishment and preventing up to, at times, between 50 and 70 hospital admissions every day. Further work is underway to fully understand the impact on emergency care, interface with virtual wards and develop new pathways, for example, for patients in A&E that require IV antibiotics, who may otherwise be admitted to hospital to begin treatment.

Partners have agreed the design principles for a new intermediate care model. One of the workstreams of the review and implementation will be to identify and implement “quick wins” in the months leading up to the next winter. Potential areas for development include closer working with the voluntary, community and social enterprise sector, technology enabled care and support, strengths-based practice and exploration of referral/move towards single referral.

Community demand predictions are based on activity in 2022/23. These are again limited by data available from routine monitoring. For example, the current dataset does not include source of referral for neighbourhood rehabilitation in a bedded setting so an small audit was undertaken of individual records to create baseline assumptions.

Capacity is currently matched to demand. Across intermediate care settings capacity is calculated based on caseload and number of beds available for bedded settings. Length of stay is variable and experience is that when the system is under pressure e.g. higher than expected demand or reduced capacity due to outbreaks or exceptional staff absence, length of stay increases as resources are stretched which impacts on the intensity of rehabilitation.

During 23/24 we are working to develop and mobilise a new model of intermediate care involving detailed analysis of demand and capacity. Within the BCF there are schemes that support a flexible response to demand pressures, for example short-term placements and care packages, that will ensure optimal flow through the system.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Unplanned admissions for chronic ambulatory care sensitive conditions

Providing coordinated care in the community, including supporting people to age well in order to prevent the onset and progression of physical frailty, is one of the five goals of the Barnsley Health and Care Plan 2023-25.

In the last year we have expanded urgent community response services, created virtual wards for frailty and tested a digital service for healthy ageing. We have also piloted anticipatory care for older people by linking in with the voluntary and community sector to see how they could support older people with mild frailty.

Within our community service offer we have several specialist nurses supporting people with heart failure, chronic respiratory illness, parkinsons and other long term conditions. These teams, work with primary and secondary care to prevent unplanned admissions to hospital.

Examples of schemes which specifically help to avoid unplanned admissions to hospital and permanent admissions to long term residential or nursing home placement include –

- Neighbourhood nursing - provides planned care for housebound patients and complex proactive care at home for patients with multiple health and social care needs. They also support primary care in the delivery of the enhanced health in care homes offer and run the MDT meetings in care homes and do proactive care planning.

- Urgent community response – 2-hour response team that works alongside all other service elements to ensure we have a responsive offer to prevent further escalation of patients to YAS & ED.

- Intermediate care – neighbourhood rehabilitation service that is AHP-led with the ethos of improving or maintaining activities of daily living that promotes a level of independence that means patients can live safely at home. They work closely with social care, reablement and domiciliary care and the D2A therapy team.

- Equipment and adaptations - Provide, deliver and decontaminate a huge range of kit and equipment that enable people to be independent or cared for at home

Emergency admissions following a fall

Barnsley has an ageing population with increasing levels of frailty (18%+ over five years to 2019). The COVID pandemic is known to have increased deconditioning, particularly in older people, leading to organisations such as Public Health England, predicting that the number of older people who fall will increase by around 4%.

Through the BCF, we have invested in VCSE sector to develop the Barnsley Older People's Physical Activity Alliace which has increased access to evidence-based falls prevention activities across the borough, including FaME and OTAGO. The alliance is now delivering "functional fitness MOTs" and has established referral routes from primary, community and social care services.

In primary care, we will be delivering healthy ageing assessments which involve screening and assessing for falls and referring for further treatment as required. Barnsley Council has led a falls pathway review using the World Falls Guidelines, which we aim to embed across clinical services. Through the BCF, we fund the community falls service for patients who

require specialist assessment and treatment that cannot be provided through BOPPAA or primary care.

Over recent years, a community first responder service has been developed for people who have fallen at home, in the community, and require an urgent response. The service is delivered by the Assiste Living Team at Barnsley Council, and has had a positive impact on ambulance conveyances for falls. BCF funding is also supporting pilots of new technologies in care homes that aim to promote physical activity, identify deteriorating patients and reduce the risk of falls.

Permanent admissions to residential or nursing care homes

Work to implement strenght based practice in assessing need and developing plans is anticipated to contiue to see a positive impact on reducing the number of people admitted into long term residential care.

Investment and enhancing the reablement offer now means everyone receives reabelment prior to long term support.

A thematic audit of Adult Social Care approaches to supporting carers found that a third of older persons permanent admissions to residential and nursing care have carer breakdown as a documented factor and it was primary factor in one out of every four admissions. Through the BCF we will be expanding the carers support offer and assistive technology to support people to continue living at home for longer and delay admission to care homes.

Through the BCF in 2023-25 there will be further investment and recruitment to the reablement service and development of integrated approach with intermediate care and development of front door to Adult Social Care to ensure triage and screening of people.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

To drive forward the development of our 'home first' approach and discharge processes we have a strong out of hospital operational group (Bronze Cell) who take responsibility for highlighting and escalating operational challenges, identifying solutions and improving pathways and flow through and out of hospital. This group is made up of partners from all parts of the health and care system including primary care, community care, social care, hospital, and ambulance services ensuring that all developments are agreed by all partners. Each member of the group takes responsibility for engaging with others within their organisations and ensuring formal sign off where required.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

A review of actual versus commissioned activity in 2022/23 has shown –

- Activity below capacity for discharge to assess (D2A) therapy assessments

- Activity lower than expected capacity in reablement services (impacted by staff vacancies in reablement)

- Referrals and caseload higher than expected for home-based rehabilitation (neighbourhood rehabilitation service)

- Activity/occupancy as expected within the Acorn Unit (bed-based rehabilitation) but higher than expected spot purchasing of beds in care homes for bed-based rehabilitation

The higher than expected use of spot purchase beds has predominantly been driven by hospital discharges. Use of spot purchase has meant larger than planned caseload for the neighbourhood rehabilitation service and use of spot purchase beds across multiple care

homes has impacted on productivity. This has driven an increase in length of stay as staff are stretched and the intensity of rehabilitation is reduced.

The hospital discharge demand predictions including the BCF plan are based on the NHS Operational Planning submission in April 23. Exepected demand has been calculated using a review of discharge activity at Barnsley Hospital between 30 January and 5 February 2023. The breakdown of activity by discharge pathway was applied to discharges of Barnsley registered patients from other hospitals. The data used is limited. For example, patients discharged on D2A pathway 1B are assessed in their own homes and this assessment could result in reablement or rehabilitation at home or potentially rehabiliation in a bedded setting if it is deemed unsafe for the patient to remain in their own home. The outcome of the assessment is not part of the discharge monitoring data and predications are based on estimates.

Reablement in a bedded setting is not generally provided to patients to support hospital discharge. Patients would be provided with rehabilitation to improve independence, either in the Acorn Unit or within a care home setting as required. There is no step-down from the neighbourhood rehabilitation service to reablement as it is in the best interests of clients to receive continuity of care to the point they are discharged to live independently or with long term social care support.

If clients are expected to need a longer term care placement then we strive to discharge them directly from hospital into a long term care placement. Similarly, we strive to provide all patients with the opportunity to gain independence when they are discharged home, either through rehabilitation or reablement and thereby avoid short term domiciliary care packages. Short term placements and packages do occur and provisions within the BCF provide flexibility to support this.

Capacity is currently matched to demand. Across intermediate care settings capacity locally is based on caseload and number of beds available for bedded settings, rather than number of new clients. Length of stay is variable and experience is that when the system is under pressure e.g. higher than expected demand or reduced capacity due to outbreaks or exceptional staff absence, length of stay increases.

During 23/24 we are working to develop and mobilise a new model of intermediate care involving detailed analysis of demand and capacity so planned capacity across different areas of service will likely to change.

Within the BCF there are schemes that support a flexible response to demand pressures, for example short-term placements and care packages, that will ensure optimal flow through the system.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

To fully embed the Discharge to Assess / Home-first model we identified a series of pathway workstreams –

Workstream	Aim
Workstream 1 – Pathway 0	Patients returning to their own home that require no input on discharge
Workstream 2 – Pathway 1a	Patients that are medically stable to leave the acute trust and safe to be assessed within their home for further input from social services, reablement, warmer homes or volunteer services.
Workstream 2 – Pathway 1b	Sustainability to complete therapy assessments within patients own home, providing equipment and referring on for ongoing Rehabilitation pathways and into other pathways to meet patient needs.
Workstream 2 – Pathway 1c	This pathway is to maintain patients early discharge for fast track patients, maintaining safe discharge with early packages of care and more accurate care plans as they are developed individually to the patients requirements.
Workstream 2 – Pathway 1d	To maintain patients nursing needs on discharge through the discharge to assess model and to maintain access to medicines management on discharge incorporating support for readmissions and advanced care planning.
Workstream 3 – Pathway 2	To support patients that require inpatient rehabilitation ensuring correct placement and continued ongoing therapy with regular reviews. To feed in from the intermediate care review.
Workstream 4 – Pathway 3	To support patients within a 24 hour care setting either as permanent place of residence or temporary place of residence and ensure smooth transition from acute trust for patients under social services or CHC fast track, and to maintain any therapy needs for patients

Successful implementation of the Discharge to Assess Model in Barnsley involved –

- Rapid redeployment of acute hospital staff out to community
- Rapid change to the therapy pathway to support hospital discharge of patients
- Building a stronger collaborative relationship with teams in hospital and community – breaking down previous barriers
- Memorandum of Understanding quickly developed between two trusts
- Closer working with Reablement Services (including development of new OT role)

During 2022/23 and continuing to 2023-25 key developments have included:

- Further integration of social care reablement into Neighbourhood Rehabilitation and Intermediate Care pathways
- Virtual Ward for Frailty and Acute Respiratory
- Implementation of criteria-led discharge
- Further developments for working to the criteria to reside.
- Proactive Care pilot: Identifying people with moderate frailty score and intervening with a comprehensive assessment and proactive care plan
- Continuing to work with YAS and 111 to refine pathways and the Directory of Service.
- Developing work around the local CAS

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

We have continued to review and self-asses against the High Impact Change in 2022/23.

- Identifying patients needing complex discharge support early

Barnsley Hospital fully implemented the SAFER bundle more than four years ago. This includes identifying patients who are likely to require discharge support early and setting an expected date of discharge. It is recognised that there are inconsistencies around how the expected date of discharge is determined, and the hospital is in the process of reviewing expected versus actual date of discharges to inform targeted support across clinical areas.

Next steps – Barnsley Hospital have begun a programme on discharge and patient flow which includes relaunching the SAFER bundle and criteria-led discharge as well as process mapping the urgent care pathway across all clinical and clinical support services to identify delays and put in place actions to any these.

- Multi-disciplinary discharge planning

At Barnsley Hospital there are daily board rounds on discharging wards that involve different professionals who support discharge planning. There is a regular multi-agency meeting on “Long Stay Wednesdays” to review long length of stay patients (more than 7 days) as well as regular live reviews of the long length of stay position across the trust.

Barnsley Hospital operates a rapid discharge model that aims to discharge patients on the same day that the decision to discharge is made. This means that the discharge team in the

hospital makes decisions around discharge and through RightCare Barnsley and the discharge to assess processes, community and social put in place appropriate support to facilitate the discharge.

RightCare Barnsley is the transfer of care hub for patients required support for discharge. The service has been established for several years. The team includes hospital, community, and social services colleagues.

Next steps – During 2023-24 we will review discharge planning processes so more patients fully benefit from a multi-disciplinary approach, involving community-based teams, to make best use of community assets, digital and assistive technology, to support people to be independent in their own homes.

- Consistency of ward rounds

There are standardised processes across hospital wards to support patient discharge which include daily board rounds using electronic whiteboard (ProWard) to support productivity. There has also been a restructure of Discharge Coordinators aligning this role to support reduce LOS.

The hospital is trialling a modern ward round where patients are reviewed in priority order (sick, going home and then other) and junior doctors break off from the ward round to complete discharge-related tasks to minimise delays.

Barnsley Hospital is undertaking a project to improve the recording of criteria to reside. This involves the discharge team meeting weekly to review patients that are stranded to look at how they can unblock some of the barriers to support discharge. So far, the review meetings they identified opportunities where patients could be managed differently and identified four pathway areas for development. To raise awareness and engagement to support change they have altered the way that patients these pathways are recorded to flag these as no longer meeting the criteria to reside.

Next steps – When the pilot is completed the modern ward round will be rolled out across Barnsley Hospital. The Trust has also recently appointed a Clinical Educator to provide training and education on criteria to reside which will support the improvement work.

- Seven-day working

To enable discharges on weekends partners have put in a place a proforma to identify weekend discharges for medical team. There is a discharge registrar on duty who holds a bleep 7 days, 8am to 6pm whose single purpose is to support with patient discharge. The discharge hub operates 7 days a week, 8am to 8pm and there are discharge to assess slots available 7 days, 8am to 6pm. Social workers and reablement services are also available 7 days, 8am to 6pm and there is a single point of access for community on weekends from 8am to 6pm.

Next steps – a review has been undertaken of the discharge registrar role to see whether it would be beneficial to have a junior doctor (foundation-level) supporting patient discharge working alongside the registrar. Barnsley Hospital Trust is also looking at the possibility of seven day working for discharge coordinators to increase discharges on weekends.

- Treat delayed discharge as a potential harm event

Barnsley Hospital is currently putting arrangements in place to ensure that potential harm from delayed discharge is assessed and there is learning from these incidences.

Next steps – designing of DATIX for reporting of delayed discharges (48hrs plus) and root cause analysis to investigate incidences, identify harm and gather learning to prevent recurrence.

- Develop demand/capacity modelling

At Barnsley Hospital there are clear local targets to achieve for 7-, 14- and 21-day long length of stay patients.

Partners have fully implemented discharge to assess pathways and regularly review activity and demand to optimise system flow and minimise delays. This has included changing the timeslots for discharge to assess and increasing activity of weekends.

Partners have agreed a Memorandum of Understanding to support flexible deployment of workforce across different organisations and settings to manage unforeseen spikes in demand and other operational challenges.

Next steps – A priority of the Barnsley Health and Care Plan 2023-25 is to complete a review of the intermediate care tier of services and implement a new model. Barnsley Council and NHS South Yorkshire commissioners have engaged IMPOWER to support this review. The work involves detailed analysis of demand, activity, workforce, and finance and create forecasts and systems dynamic models to assess future service requirements.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The adult social care discharge fund helps to sustain flow through the health and care system, minimising delayed transfers of care for patients at Barnsley Hospital and supporting the “home first” approach in Barnsley.

Additional investment to create a static team as part of the adult social care front door has increased prevention and early intervention demonstrated by signposting to reablement, along with Age UK, social prescribing, Making Space and RightCare. The approach has been supported by training in strengths-based practice for social work teams, delivered in partnership with the NHS and the National Development Team for Inclusion.

Reablement services have expanded to support more people in their own homes right across the borough and is developing further to support people with mental health problems and learning disabilities. Partners in Barnsley, including Barnsley College, have been working together to support recruitment into reablement teams and the wider adult social care independent sector through the Proud to Care programme. Reablement support, along with assisted living technologies and equipment and adaptations aim to maximise independence. In 2022/23 there has been a reduction in permanent admissions to long term nursing and residential care for older people.

Bed-based rehabilitation services are provided within the Acorn Unit, which is a fixed bed base in a care home, delivered by NHS clinicians with medical oversight from and in care homes. Over the course of 2022 there has been an increasing demand for bed-based rehabilitation and higher demand for rehabilitation at home. To respond to these pressures has required additional spot purchasing of beds in the independent sector. Changing demands on medical cover for the Acorn Unit has made required a new model of medical oversight. The challenges experienced over the winter, and longer term changes in demand and capacity, have prompted the Place Partnership to begin a review of intermediate care services which will lead to the development of a sustainable and more integrated service offer.

Increasingly, there is demand to discharge patients from hospital for a period of recovery or recuperation before their longer term needs can be fully assessed. Additional investment in short term placements in care homes provide service users with the opportunity to recover in a safe and supportive environment to reach the optimal condition to be fully assessed.

The home first approach in Barnsley has led to increasing demand for home care services and fewer permanent admissions to residential or nursing homes. There has been further investment in the homecare sector in Barnsley for service users who would not benefit from reablement services or who have completed a period of rehabilitation or reablemet but still have the need for long term care and support. Additional funding in 2023-25 will meet the increasing demand for homecare as well as provide a rapid response to hospital discharges.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Our Barnsley Carers Strategy sets out a vision that more unpaid carers in our community will be identified and recognised and have access to information, advice, and both practical and emotional support to help them achieve the outcomes which matter most to them. To enable our vision and improve outcomes for carers the BCF funding is used to contribute to a range of information, guidance and support offered to unpaid carers.

This includes -

- Development of a borough wide strategy, co-produced with carers, which highlights seven key priorities that pay particular attention to the carer journey and enable us to focus on the key touch points and make improvements where carers tell us they face challenges and change is needed.

- Section 2 of the Care Act (2014) gives local authorities a general responsibility to prevent needs for care and support from developing. To fulfil this responsibility the council commissions a Carers Support Service which has a strong emphasis on targeted prevention and early intervention with a key aim of preventing, reducing, or delaying carers' needs (and those that they care for) from developing and requiring support from more costly interventions. Central to this approach is a focus on delivering good quality information and advice, guidance and support to enable the carer to continue in their caring role whilst also looking after their own health and well-being and having a life of their own in terms of opportunities for work, training, education, leisure and social interaction.

- A Service is also commissioned to support young carers and siblings to prevent inappropriate caring and provide support to help them balance their caring role with their rights to be children/young people.

- The Council also offers a one-off annual payment of between £150 and to £300 to unpaid carers – this payment is to acknowledge and recognise the valuable caring role that they provide. Monitoring of the grant payments show that a large number of recipients use this payment to fund short breaks. A review of this has now been completed with over 200 carers providing their views and experiences. Analysis of these responses showed that carers were overwhelmingly positive about the scheme and grateful for recognition. The eligibility and criteria for the scheme has therefore been retained. The only change centres around how carers access a payment. To do this carers now need to have a single carers assessment completed alone with a social work practitioner (rather than completing a self assessment). This is to encourage more carers to have a dedicated conversation about the extent of their caring role, the impact it has on their lives and access support earlier if this is appropriate.

- One of the key messages that came from carer feedback was the importance of getting a break from their caring role. Analysis of the short breaks options accessed by carers showed this to be narrow and dominated by residential respite. From July 2023 the council is working for 6 months with carers to co-produce a specification for short breaks for carers.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

The BCF is fully aligned with wider strategies including the Barnsley Housing Strategy 2014-2033. The Housing Strategy includes a specific objective to support people to live independently by improving the range of options for supported housing and providing more choice and options to help vulnerable and older people live independently in their own homes.

The BCF in 2023-25 has been developed to ensure that the BCF Plan continues to contribute to ambitions and objectives of the overall housing strategy and to improving health outcomes for Barnsley residents through more joined up approaches and effective use of DFG.

The BCF continues to support the delivery of housing strategy ambitions through the aids and adaptations and community home loans services and the ongoing funding to provide 24/7 onsite care provision in extra care housing schemes.

The use of DFG funding continues to be aligned to the ambitions of the H&WB Strategy and BCF and aims to support people to live independently within their own home and to return home. The DFG policy and funding has been agreed by the Local Authority as the housing authority in Barnsley. Strategically, DFG is used to provide housing support to help people remain in their own homes and live independently in the following ways:

1. Fund works and adaptations to help disabled and elderly people to live independently in their own homes. Means tested funding is provided to homeowners or tenants to make the adaptations. The DFG policy identifies the additional help and flexibility the Council will offer in relation to providing home adaptations for disabled people in the future.

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

3. Funds discretionary services / spend including Community Home Loans, Equipment and Adaptations and Occupational Therapy aim to ensure that people are able to quickly access the support they need to maintain their independence. Increased occupational therapy support is key to maximising the effectiveness of aids, adaptations and equipment funded through the DFG and through the assessment processes are able to ensure that people are given the best solutions to meet their needs.

Work would continue in 2023/24 to target better use of digital technologies and promoting assistive technology to improve the way people are cared for and supported. We will be looking to increasing use technology around dementia support, manual handling and options that will promote greater levels of independence. Progress in this area include the following:

1. DFG funding has been utilised in supporting the delivery of the pilot project on GPS Trackers for people with Dementia to establish if this should be a core offer, we make across Barnsley

2. It complimented the use of ICB funding to support trial of Fit Bit devices with residential care providers

3. Ran a three-month project on 2:1 support that has identified equipment we can use to support people around manual handling and what training and support we need to staff so they know what to issue for people

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

The Council has maximised the flexibility under the Regulatory Reform Order (RRO) to use a portion of the DFG funding for discretionary support to eligible older people or those with disabilities to help them live independently and to remain in their own homes. Such discretionary support includes the following:

- Affordable warmth scheme – DFG has been used to supplement other Government funding to fund support grants to eligible residents / households to make their homes more energy efficient and includes insulation, heating systems / boiler replacements, installing Smart lighting, etc.

- Equipment / adaptation – DFG used for the provision of equipment (not covered by core revenue funding) to eligible older people or those with disability to help people live independently.

- Assistive Living Technology / Telecare - DFG used to help disabled people to live independently in their own homes by providing them with telecare equipment (e.g., sensors, alarms, etc) and a response/monitoring service

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

£1.4m in 2023/24 (includes one-off £0.5m for affordable warmth scheme)

£0.9m in 2024/25

Equality and health inequalities

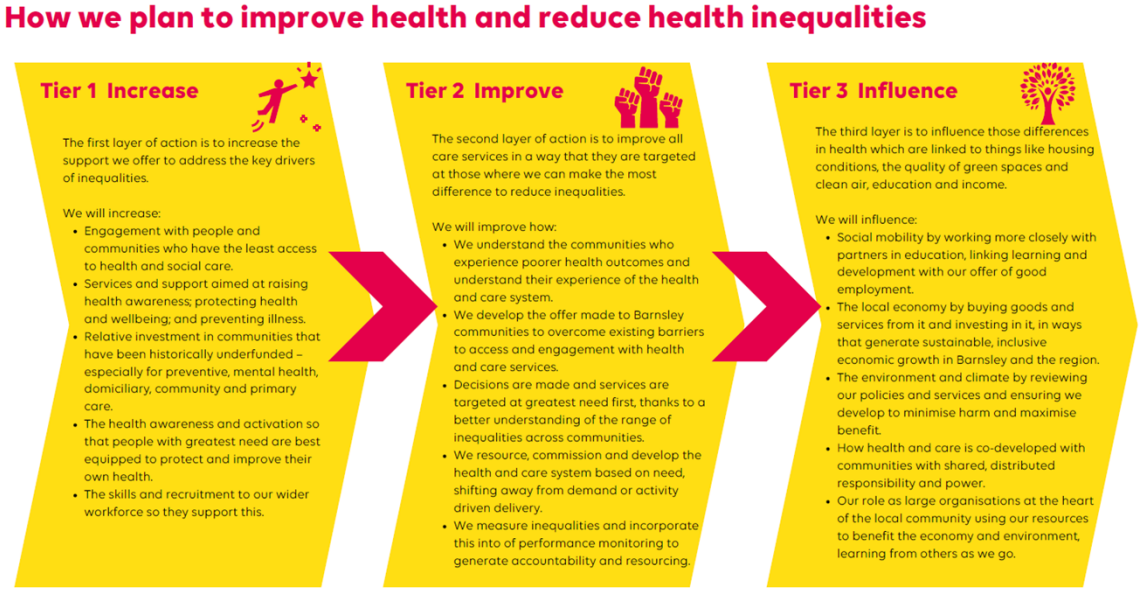
How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Whilst the funding from the BCF remains broadly consistent in 2023-25 with that of previous plans, it is shaped by our ambitions to impact positively on inequality. The BCF in Barnsley and the services funding through the BCF are all aimed at supporting people to maintain independence (social care, falls prevention, supported housing), recover from illness (through rehabilitation and reablement) and received the ongoing care and support that they need whether that be in their own home or in a long-term residential care setting.

When commissioning services or developing schemes either as part of the BCF or wider commissioning work, engagement activity and equality, inequality and quality impact assessments are a core feature of our approach to developing business cases and specifications.

In June 2023 the Barnsley Place Committee approved the Barnsley Health and Care Plan 2023-25 along with the framework for tackling health inequalities which describes our collective approach along with several case studies of impact across initiatives that aim to improve the health and wellbeing of groups within our population that experience the poorest outcomes.



This framework has already been used to strengthen the approach to reduce inequalities across Barnsley and achieve alignment, integration and economies of scale.

- Barnsley Hospital NHS Foundation Trust Board approved the framework as a tool to guide its approach and, in November 2021, published its first Action Plan to Improve Public Health and Reduce Health Inequalities

- Barnsley Metropolitan Borough Council have used the framework to develop an action plan and the Barnsley Inequality Toolkit ('Do Your BIT'), helping services identify how their work can help reduce inequalities.

- South West Yorkshire Foundation Trust have used the framework to guide a number of organisational shifts, most notably in stimulating its recently published Social Responsibility and Sustainability Strategy.

- Barnsley's Primary Care Network have used tiers one and two to guide new care and coordination roles, expanding capacity to deliver prevention and guide care to greatest need.

Barnsley Health Equity Group (BHEG) consider it important to understand health inequalities represent a gradient across the whole population, rather than only a means of identifying small groups of the population; and that addressing inequalities should be done in all health and social care, rather than only through specific services. However, it is also important to ensure that the Barnsley Health and Care Partnership is enabled to focus on those with greatest need and tailor certain services and approaches to meet them. This is especially true in light of the scarce resources and the scale of need there is to address. To identify "who" should be considered a priority for reducing inequalities in Barnsley, BHEG recommends using Core20PLUS in three key ways.

- Deprivation (aggregated to postcode). Core20 refers to people living in the nationally defined 20% most deprived communities, but BHEG recommends the place partnership focus on the 20% most deprived communities in Barnsley, which

approximately equates to those in the nationally defined 10% most deprived communities

- Deprivation (at household level). Barnsley Index of Deprivation (see Box 4) is a localised tool to incorporate deprivation into individual care decision making and planning. BHEG recommends the place partnership support its development and integration into all HSC services.

- Specific characteristics and inclusion Groups (the “PLUS”) – The identification of appropriate characteristics and inclusion group(s) should flex to changing needs in the population and depend on the service or approach in question. However, BHEG recommend the place partnership support ongoing work to improve engagement, co-development, services and identification (e.g. through registers, where appropriate) for people who would identify themselves as LGBTQ+, homeless or with insecure housing, minority ethnic, having a learning disability or autism, asylum seekers or refugees

Local priority actions at an organisation-level –

- Commit to reducing health inequalities by doing more across the three tiers of this plan and considers, where appropriate, creating an action plan

- Improve data capture and sharing on Core20PLUS characteristics and introduce a standardised measurement and reporting on inequalities in performance

- Establish accountability, commitment and delivery mechanisms to reduce the gaps identified and share learning across the place partnership.

Local priority actions at the partnership level –

- Help to create a tobacco-free Barnsley by ensuring all staff and every patient / service user contact is used to confirm smoking status, treat all smokers and refer to a specialist service, and target tobacco treatment (e.g. in social housing, A&E, mental health, workplaces)

- Start an active conversation with Barnsley’s Core20PLUS population, to learn from their experiences and needs and co-develop support mechanisms for their health and wellbeing;

- Establish an anchor network across HSC organisations and wider partnerships (e.g. education) to identify opportunities to work at scale and sustainably

Local priority actions at the alliance/transformation group level –

- Providing all pre-school children and their families in the Core20PLUS populations with access to support in the community for the best start through health and wellbeing

- Delivering HSC to school- and working- aged people in the Core20PLUS populations, working through community organisations and places of work and learning to enable productivity

- Identifying frailty and multi-morbidity in older people in the Core20PLUS populations and providing care in the home and community. The frail population in Barnsley is growing at a greater rate than the population is ageing. People experiencing inequalities are more likely to experience frailty earlier in their life than expected and those with the greatest need often also have the greatest difficulty in accessing and receiving appropriate care and support. Compared to other areas, Barnsley sees a higher number of hospital episodes for frailty and dementia and year on year these have been increasing along with long lengths of stay (7 days+) in this group.

The BCF is supporting initiatives across the three tiers of action. Examples include –

Introduce –

- Expansion of community reablement services and developed a adult social care front-door model that promotes prevention and early intervention.

- Initiatives such as the Barnsley Older People's Physical Activity Alliance have provided more opportunities for people from all parts of the borough and different communities within the borough to access physical activity services, including evidence based falls prevention interventions.

Improve –

- Assertive Outreach Teams providing recovery focussed, personalised approach to engaging with individuals for whom mainstream Community Mental Health Teams had failed

- Further investment in new ways of working and integration with health to ensure that people from Core20PLUS communities benefit from better access, experience and outcomes from health and social care services

Influence –

- Increase pay for the social care workforce to the national living wage recognising that many people working in care are at risk of poverty because of relatively poor pay, conditions and sometimes insecure employment

- The Proud to Care Hub supporting pathways to employment in health and care for people from disadvantaged backgrounds and backgrounds that are under-represented in the health and care workforce

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in ‘yellow’. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:

- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:

- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme

- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Complete:
Health and Wellbeing Board:	Barnsley	Yes
Completed by:	Jamie Wike	Yes
E-mail:	jamie.wike@nhs.net	Yes
Contact number:	07890417382	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Wendy	Cain	cllrwendycain@barnsley.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Wendy	Lowder	wendy.lowder@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Roxanna	Naylor	roxanna.naylor@nhs.net	Yes
	Local Authority Chief Executive		Sarah	Norman	sarahnorman@barnsley.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Wendy	Lowder	wendylowder@barnsley.gov.uk	Yes
	Better Care Fund Lead Official		Jamie	Wike	jamie.wike@nhs.net	Yes
	LA Section 151 Officer		Neil	Copley	neilcopley@barnsley.gov.uk	Yes
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->						

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

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Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Barnsley

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£3,377,046	£3,377,046	£3,377,046	£3,377,046	£0
Minimum NHS Contribution	£24,386,754	£25,767,044	£24,386,753	£25,767,044	£1
iBCF	£13,450,589	£13,450,589	£13,450,589	£13,450,589	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,885,752	£3,130,348	£1,885,752	£3,130,348	£0
ICB Discharge Funding	£1,404,000	£2,276,000	£1,404,000	£2,276,000	£0
Total	**£44,504,140**	**£48,001,027**	**£44,504,140**	**£48,001,027**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£6,930,024	£7,322,263
Planned spend	£11,240,446	£11,876,655

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£13,146,307	£13,890,388
Planned spend	£13,146,307	£13,890,389

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	391.0	343.0	390.0	362.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,845.9	2,823.6
	Count	1277	1267
	Population	47905	47905

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.5%	93.4%	93.1%	92.3%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	871	711

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.7%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes

	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

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Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Barnsley

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	The hospital discharge demand is based on the NHS Operational Planning submission in April 23. Exepected demand has been calculated using a review of discharge activity at Barnsley Hospital between 30 January and 5 February 2023. The breakdown of activity by discharge pathway was applied to discharges of Barnsley registered patients from other hospitals. The data used is limited. For example, patients discharged on D2A pathway 1B are assessed in their own homes and this assessment could result in reablement or rehabilitation at home or potentially rehabiliation in a bedded setting if it is deemed unsafe for the patient to remain in their own home. The outcome of the assessment is not part of the discharge monitoring data and predications are based on estimates

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

(Select as many as you need)

Trust Referral Source	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	1620	1674	1620	1674	1674	1620	1674	1620	1674	1674	1512	1674
OTHER		186	192	186	192	192	186	192	186	192	192	174	192
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	Reablement at home (pathway 1)	83	83	83	83	83	83	83	83	83	83	83	83
OTHER													
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	136	141	136	141	141	136	141	136	141	141	127	141
OTHER		24	25	24	25	25	24	25	24	25	25	23	25
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)												
OTHER													
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)												
OTHER													
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	150	155	150	155	155	150	155	150	155	155	140	155
OTHER		17	18	17	18	18	17	18	17	18	18	16	18
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
OTHER													
Totals	**Total:**	2216	2288	2216	2288	2288	2216	2288	2216	2288	2288	2075	2288

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)												
Urgent Community Response	833	833	834	900	900	900	966	967	967	1034	1033	1034
Reablement at home	112	127	135	148	139	135	148	140	144	124	132	153
Rehabilitation at home	67	67	67	69	67	69	67	69	69	69	62	69
Reablement in a bedded setting												
Rehabilitation in a bedded setting	7	7	7	7	7	7	7	7	7	7	7	7
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	1806	1866	1806	1866	1866	1806	1866	1806	1866	1866	1686	1866
Reablement at Home	Monthly capacity. Number of new clients.	83	83	83	83	83	83	83	83	83	83	83	83
Rehabilitation at home	Monthly capacity. Number of new clients.	160	166	160	166	166	160	166	160	166	166	150	166
Short term domiciliary care	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	167	173	167	173	173	167	173	167	173	173	156	173
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.												

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
	100%	
100%		
100%		

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.												
Urgent Community Response	Monthly capacity. Number of new clients.	833	833	834	900	900	900	966	967	967	1034	1033	1034
Reablement at Home	Monthly capacity. Number of new clients.	114	120	133	146	138	131	154	135	124	106	158	172
Rehabilitation at home	Monthly capacity. Number of new clients.	67	67	67	69	67	69	67	69	69	69	62	69
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	7	7	7	7	7	7	7	7	7	7	7	7
Other short-term social care	Monthly capacity. Number of new clients.												

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
100%		
	100%	
100%		
100%		

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Barnsley

Local Authority Contribution			
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	**Complete:**
Barnsley	£3,377,046	£3,377,046	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£3,377,046**	**£3,377,046**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Barnsley	£1,885,752	£3,130,348	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS South Yorkshire ICB	£1,404,000	£2,276,000	Yes
Total ICB Discharge Fund Contribution	£1,404,000	£2,276,000	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Barnsley	£13,450,589	£13,450,589	Yes
Total iBCF Contribution	**£13,450,589**	**£13,450,589**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
				Yes
Total Additional Local Authority Contribution	**£0**	**£0**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS South Yorkshire ICB	£24,386,754	£25,767,044
Total NHS Minimum Contribution	**£24,386,754**	**£25,767,044**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding	
				Yes
Total Additional NHS Contribution	**£0**	**£0**		
Total NHS Contribution	**£24,386,754**	**£25,767,044**		

	2023-24	2024-25
Total BCF Pooled Budget	**£44,504,140**	**£48,001,027**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

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See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Barnsley

<< Link to summary sheet

	2023-24			2024-25		
Running Balances	Income	Expenditure	Balance	Income	Expenditure	Balance
DFG	£3,377,046	£3,377,046	£0	£3,377,046	£3,377,046	£0
Minimum NHS Contribution	£24,386,754	£24,386,753	£1	£25,767,044	£25,767,044	£0
iBCF	£13,450,589	£13,450,589	£0	£13,450,589	£13,450,589	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,885,752	£1,885,752	£0	£3,130,348	£3,130,348	£0
ICB Discharge Funding	£1,404,000	£1,404,000		£2,276,000	£2,276,000	£0
Total	**£44,504,140**	**£44,504,140**	**£0**	**£48,001,027**	**£48,001,027**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24			2024-25		
	Minimum Required Spend	Planned Spend	Under Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£6,930,024	£11,240,446	£0	£7,322,263	£11,876,655	£0
Adult Social Care services spend from the minimum ICB allocations	£13,146,307	£13,146,307	£0	£13,890,388	£13,890,389	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102

									Planned Expenditure									
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Long Term Care Provision	Contribution towards adult social care provision costs i.e. residential / nursing care, domiciliary care and other community based support for Older People (aged 65+) and adults with Disabilities (aged 18-64	Residential Placements	Care home	NA	80	80	Number of beds/Placements	Social Care	NA	LA			Private Sector	Minimum NHS Contribution	Existing	£6,535,317	£6,535,317	7%

2	Short term and respite provision	Short term residential provision (including support to carers and reablement) for adults with Disabilities (aged 18-64)	Carers Services	Respite services	NA	409	409	Beneficiaries	Social Care	NA	LA			Private Sector	Minimum NHS Contribution	Existing	£810,000	£810,000	100%
3	Mental Health Community Social care team	Adult social care community Mental Health Teams; Assertive Outreach Team; Intensive Home treatment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment	NA				Social Care	NA	LA			Local Authority	Minimum NHS Contribution	Existing	£800,279	£800,279	86%
4	Other ASC provisions - LPS and Access/Contact Team	Liberty protection safeguards (LPS) team and i.e. BIAs, health assessments, training, and Customer Access Team (CAT) & rapid response service	Care Act Implementation Related Duties	Other	Deprivation of Libery safeguards				Social Care	NA	LA			Local Authority	Minimum NHS Contribution	Existing	£421,200	£421,200	65%
5	Commissioned contracts	Includes the Equipment and Adaptions contract (SWYPFT) and other early intervention contracts with the voluntary / independent sector	Assistive Technologies and Equipment	Community based equipment	NA	150	150	Number of beneficiaries	Social Care	NA	LA			NHS Community Provider	Minimum NHS Contribution	Existing	£1,141,366	£1,141,366	100%
6	Reablement provision	Short-term provision to preserve the independence of people	Home-based intermediate care services	Reablement at home (accepting step up and step down users)	NA	2023	2023	Packages	Social Care	NA	LA			Local Authority	Minimum NHS Contribution	Existing	£1,294,000	£1,294,000	77%
7	Extra Care Housing scheme provision	wrap around care model within extra care schemes to improve the authority's accommodation and support offer to older people and to contribute to the reduction in admissions to long term residential care	Residential Placements	Extra care	NA	48	48	Number of beds/Placements	Social Care	NA	LA			Private Sector	Minimum NHS Contribution	Existing	£570,000	£570,000	100%
8	Community Reablement support	extend Reablement offer to all community-based referrals	Home-based intermediate care services	Reablement at home (accepting step up and step down users)	NA	604	604	Packages	Social Care	NA	LA			Local Authority	Minimum NHS Contribution	Existing	£378,130	£378,130	23%
9	Older People - Health & Wellbeing service (BOPPAA)	provision of physical activity programmes that will improve strength and balance of older peoplee	Prevention / Early Intervention	Other	Falls prevention awareness				Social Care	NA	LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£190,000	£190,000	100%
10	Long term care provision (Older People)	contribution to core funding to cover demographic and national living wage pressures	Residential Placements	Care home	NA	184	184	Number of beds/Placements	Social Care	NA	LA			Private Sector	iBCF	Existing	£6,965,188	£6,965,188	8%
11	Long term care provision (Learning Disabilities)	contribution to core funding to cover demographic and national living wage pressures	Residential Placements	Care home	NA	64	64	Number of beds/Placements	Social Care	NA	LA			Private Sector	iBCF	Existing	£2,609,000	£2,609,000	3%
12	Long term care provision (Mental Health)	contribution to core funding to cover demographic and national living wage pressures	Residential Placements	Care home	NA	12	12	Number of beds/Placements	Social Care	NA	LA			Private Sector	iBCF	Existing	£1,250,000	£1,250,000	1%
13	Uplift in weekly fees - stabilisation of the care market	address ongoing pressures for a sustainable fee payment to care home providers	Enablers for Integration	Other	Residential care fee uplift				Social Care	NA	LA			Private Sector	iBCF	Existing	£300,000	£300,000	0%
14	Increased contract management capacity -	effective management of care contracts and maintaining effective	Enablers for Integration	Other	Sup[porting Care Market				Social Care	NA	LA			Local Authority	iBCF	Existing	£65,000	£65,000	0%
15	7 days hospital social work team - Reducing delayed	to ensure timely discharge of people requiring care / support	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)	NA				Social Care	NA	LA			Local Authority	iBCF	Existing	£120,000	£120,000	14%

16	Maintaining care provision (OP Review team +	Mainstreaming the Review Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment	NA				Social Care	NA	LA			Local Authority	iBCF	Existing	£317,500	£317,500	100%
17	Increased service management	expand management to cater for the size and complexity of the service	Integrated Care Planning and Navigation	Assessment teams/joint assessment	NA				Social Care	NA	LA			Local Authority	iBCF	Existing	£330,500	£330,500	49%
18	Support for carers (incl care centre model)	provision of personal budgets for carers and the development of a Care	Carers Services	Other	Personalised budget and information,	409	409	Beneficiaries	Social Care	NA	LA			Private Sector	iBCF	Existing	£225,000	£225,000	100%
19	Community Bridge Building	improve access / signposting to community and universal services	Care Act Implementation Related Duties	Other	Information advice and guidance				Social Care	NA	LA			Charity / Voluntary Sector	iBCF	Existing	£30,000	£30,000	100%
20	Increased social worker / hospital team capacity	Increasing social work capacity in the locality / hospital teams including	Integrated Care Planning and Navigation	Assessment teams/joint assessment	NA				Social Care	NA	LA			Local Authority	iBCF	Existing	£374,400	£374,400	43%
21	Increased Occupational Therapist	additional OT capacity in the Reablement team	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	NA				Social Care	NA	LA			NHS Community Provider	iBCF	Existing	£58,000	£58,000	100%
22	Homecare Bridging contract	To act as a provider of last resort in the event of increased demand	Home Care or Domiciliary Care	Domiciliary care packages	NA	5200	5200	Hours of care	Social Care	NA	LA			Private Sector	iBCF	Existing	£69,300	£69,300	0%
23	Increased domiciliary / residential care	additional care packages to meet increased need	Other		NA				Social Care	NA	LA			Private Sector	iBCF	Existing	£736,701	£736,701	3%
24	Disabled facilities grant funded schemes	housing adaptations, minor equipment, DFG team	DFG Related Schemes	Adaptations, including statutory DFG grants	NA	0	0	Number of adaptations funded/people	Social Care	NA	LA			Local Authority	DFG	Existing	£3,377,046	£3,377,046	100%
25	Carers and Young Carers support contracts	Provides support (information, advice / guidance) to carers and	Carers Services	Carer advice and support related to Care Act duties	NA	0	0	Beneficiaries	Social Care	NA	LA			Charity / Voluntary Sector	Minimum NHS Contribution	New	£301,793	£301,793	0%
26	Staff capacity support in ASC	Additional capacity in ASC to support D2A / hospital discharge cases	Workforce recruitment and retention		NA				Social Care	NA	LA			Local Authority	Local Authority Discharge	New	£300,000	£498,000	14%
27	Short stay placements	Short stay resdential placements prior to agreeing long term support	Residential Placements	Short term residential care (without rehabilitation or reablement input)	NA	824	824	Number of beds/Placements	Social Care	NA	LA			Private Sector	Local Authority Discharge	New	£600,000	£996,000	75%
28	Additional Homecare support	Rapid response to support hospital discharge cases	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess	NA	5200	5200	Hours of care	Social Care	NA	LA			Private Sector	Local Authority Discharge	New	£125,424	£208,204	0%
29	Additional care packages and capacity	To meet increased demand for residential / homecare care packages as well as	Home Care or Domiciliary Care	Domiciliary care packages	NA	37400	59840	Hours of care	Social Care	NA	LA			Private Sector	Local Authority Discharge	New	£860,328	£1,428,144	4%
30	Integrated community model	Investing in new ways of working / integration with health	Community Based Schemes	Other	Capacity building to support				Social Care	NA	LA			Local Authority	Minimum NHS Contribution	New	£704,222	£1,448,304	100%
25	Intermediate Care	Intermediate Care Services	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)	NA	0	0	Number of Placements	Community Health	NA	NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£2,951,676	£3,118,741	32%
26	Intermediate Care	Intermediate Care Services	Community Based Schemes	Integrated neighbourhood services	NA				Community Health	NA	NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£4,805,744	£5,077,749	53%
27	Intermediate Care	Intermediate Care Services	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)	NA	720	720	Number of Placements	Community Health	NA	NHS			Private Sector	Minimum NHS Contribution	Existing	£750,505	£792,984	8%
28	Falls service	Prevention and support service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	NA				Community Health	NA	NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£143,045	£151,141	100%
29	Community home loans	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment	NA	0	0	Number of beneficiaries	Community Health	NA	NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£483,056	£510,397	100%
30	Equipment and adaptions	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment	NA	0	0	Number of beneficiaries	Community Health	NA	NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,341,753	£1,417,696	100%
31	Neighbourhood Nursing Team	Prevention and support service	Community Based Schemes	Integrated neighbourhood services	NA				Community Health	NA	NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£764,667	£807,947	8%
32	Mental health support for hospital discharge	Mental health support for hospital discharge and for high intensity service users.	Care Act Implementation Related Duties	Other	Information Advice & Guidance				Mental Health	NA	NHS			Private Sector	ICB Discharge Funding	Existing	£35,000	£35,000	100%
33	NRS and Equipment service uplift	NRS and Equipment service uplift	Community Based Schemes	Other	Part of Neighbourhood nursing scheme				Community Health	NA	NHS			Private Sector	ICB Discharge Funding	Existing	£211,235	£211,235	100%

34	Additional Discharge Transport	Additional Discharge Transport	Other		NA				Community Health	NA	NHS			Private Sector	ICB Discharge Funding	Existing	£30,000	£30,000	100%
35	Hospice - Increased community	Hospice - Increased community support and out of hours	Community Based Schemes	Other	Community support and out of hours				Community Health	NA	NHS			Private Sector	ICB Discharge Funding	Existing	£100,000	£100,000	100%
36	Step Down (spot purchase beds)	Step Down (spot purchase beds)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)	NA	90	90	Number of Placements	Community Health	NA	NHS			Private Sector	ICB Discharge Funding	Existing	£180,000	£180,000	100%
37	Intermediate Care medical support and oversight	Intermediate Care medical support and oversight	Other		NA				Community Health	NA	NHS			Private Sector	ICB Discharge Funding	Existing	£75,000	£75,000	100%
38	CHC/Complex Cases - funded beds and complex	CHC/Complex Cases - funded beds and complex care packages with 1:1/2:1	Residential Placements	Care home	NA	294	642	Number of beds/Placements	Community Health	NA	NHS			Private Sector	ICB Discharge Funding	Existing	£733,825	£1,605,825	100%
39	Clinical Educator - Criteria to reside	Clinical Educator - Criteria to reside	Other		NA				Community Health	NA	NHS			Private Sector	ICB Discharge Funding	Existing	£38,940	£38,940	100%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Barnsley

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	344.6	332.1	397.3	355.0	There has been an increasing rate of admissions and therefore the ambition is to slow the level of growth during 2023/24	Through the work of the Place Partnership we continue to deliver services and initiatives aimed at preventing admission - examples include activity to support those with frailty such as access to physical activity. The Rightcare Barnsley Service and IC and reablement step up offers also continues to support people in their own homes or the community by providing access to apporpriate community support - The IC model is being reviewed in 2023/24.
	Number of Admissions	936	902	1,079	-		
	Population	245,199	245,199	245,199	245,199		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	391	343	390	362		

>> link to NHS Digital webpage (for more detailed guidance)

Complete:

Yes

Yes

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,863.7	2,845.9	2,823.6	Barnsley has an ageing population with increasing levels of frailty (18%+ over five years to 2019). The COVID pandemic is known to have increased deconditioning, particularly in older people, leading to organisations such as Public Health England predicting the number of older people who fall to increase by around 4%. In Barnsley we have invested in falls prevention (strength and balance) services delivered through the VCSE sector, expanded Urgent Community Response and developed a community first response to falls through the Assisted Living Service at Barnsley Council. This appears to have mitigated against the risk of rising falls resulting in an increase in A&E attendances and hospital admissions.	In 23/24 we will continue to develop the Older People's Physical Activity Alliance (BOPPAA) increasing access to evidence-based falls prevention interventions. In primary care, we will be delivering healthy ageing assessments which involve screening and assessing for falls and referring for further treatment as required. We are undertaken a falls pathway review using the World Falls Guidelines which we hope to embed across clinical pathways. We have reviewed the osteoporosis pathway and we are creating a new local osteoporosis clinic. We expect that these actions will continue to mitigate against the increasing levels of need in our population.
	Count	1,285	1277	1267		
	Population	47,905	47905	47905		

Yes

Yes

Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.1%	92.8%	92.2%	92.3%	In Barnsley the rate of discharge to normal place of residence is high as a result of the comprehensive discharge pathways and community/Social Care services in place to support people to live independantly or with support. Within the acute sector we have seen higher levels of acuity and dependency and there has also been increased demand for rehabilitation within bedded settings. Our ambition is to maintain high levels of patients being discharged to their normal place of residence.	Continued delivery and development of the strong discharge arrangements including D2A. We will be reviewing discharge planning processes so more patients fully benefit from a multi-disciplinary approach, involving community based teams, to make best use of community assets, digital and assistive technology, to support people to be independent in their own homes.	Yes
	Numerator	6,187	6,463	6,479	5,901			
	Denominator	6,644	6,963	7,026	6,392			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	92.5%	93.4%	93.1%	92.3%			Yes
	Numerator	6,604	6,602	6,454	6,003			
	Denominator	7,141	7,069	6,933	6,502			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	871.4	847.7	739.8	711.5	Work to implement strenght based practice in assessing need and developing plans is anticipated to contiue to see a positive impact on reducing the number of people admitted into long term residential care. Investment and enhancing the reablement offer now means everyone receives reabelment prior to long term support. Focus on carers siupport offer and assistive technology to support people to continue living at home for longer and dely admission to care homes.	Continuation of home first strength based practice Further investment and recruitment to the reablement service and development of integrated approach with intermediate care Development of front door to ASC to ensure triage and screening of people	Yes
	Numerator	424	432	377	370			Yes
	Denominator	48,660	50,959	50,959	52,005			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

Selected Health and Wellbeing Board: Barnsley

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Complete:
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes				Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes				Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes				Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes				Yes
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes				Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes				Yes

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes				Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes				Yes

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10th August 2023

REPORT TO THE HEALTH AND WELLBEING BOARD

Creativity & Wellbeing update

Report Sponsor:	Kathy McArdle (SD Regeneration & Culture, BMBC)
Report Author:	Julie Tolhurst (Public Health Principal- Growth & Sustainability, BMBC)

1. Purpose of Report

1.1 To provide an overview of Creativity & Wellbeing Week 2023 evaluation report.
1.2 To update the Board on the development of a SY Creative Health strategy in collaboration with SY ICP & SYMCA
1.3 To seek Health & Wellbeing Board endorsement for the next phase of delivery

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Note the proposed SY ICP recommendations
- Promote key messages via organisational channels.
- Endorse the next phase of delivery for Barnsley's Creativity & Wellbeing programme

3. Delivering the Health & Wellbeing Strategy

3.1 Creativity is key to our health & wellbeing at every stage of the life course from birth through to older age.

3.2 The All-Party Parliamentary Group on Arts, Health and Wellbeing published The Arts for Health and Wellbeing report in 2017[1], which provided strong evidence of creativity and arts addressing many of the challenges facing health and social care around ageing, long-term conditions, poor mental health and loneliness. The APPG recommended that health and social care organisations should have a dedicated resources to leverage the benefits

[1] https://www.culturehealthandwellbeing.org.uk/appg-inquiry/Publications/Creative_Health_Inquiry_Report_2017_-_Second_Edition.pdf

from creativity & arts. For instance, social prescribing workers linked to creativity & arts interventions to showcase the benefits to health.

3.3 Providing opportunities to be involved in creative activity offers a huge contribution to our Health & Wellbeing strategy vision. Creativity enables Barnsley residents to improve their health & wellbeing, be meaningfully engaged in their communities and develop the skills and resources they need to thrive.

3.4 The vision is to embed creativity and creative leadership throughout health and care transformation programmes. This includes shaping key strategic drivers cutting across several sectors, including the ICS strategy, Mental Health, Learning Disability & Autism Strategy, More & Better Jobs strategy and Culture Strategy.

4. Reducing Inequalities

4.1 Embedding creativity into all health and social care related interventions helps to address health & social inequalities. Creativity & arts funding is directed specifically to work alongside groups that have most to benefit, including people living with mental health conditions, Learning Disabilities, Autism, Dementia, and those who are socially isolated.

5. Creativity & Wellbeing week 2023

5.1 This is the second year that we have supported national Creativity & Wellbeing Week 15-21 May, led by the Culture Health & Wellbeing Alliance.

Following Creativity & Wellbeing week in 2022, we have continued to work with key partners to develop a Plan on Page with agreed themes, outcomes and objectives.

One of the critical areas for improvement, is workforce and organisational development for practitioners working across health, social and creative sectors.

In preparation for the week, we organised 2 strands of work:

- Practitioner workshops – focused on workforce skills/organisational development – conversations and themes to use as a springboard to develop a longer-term workforce development programme
- Creativity & wellbeing activities – promoted to staff and residents, with internal and external communications.

This year we co-ordinated our Creativity & Wellbeing activity and communication campaign alongside Dementia Action Week (15-21 June).

5.2 Four practitioner workshops (in-person and on-line) were delivered to explore how we embed creativity and wellbeing into workforce development for

leaders, commissioners and creative practitioners working with residents across the health and care sector. This involved over 80 staff working with people with learning difficulties, children & young people and older people.

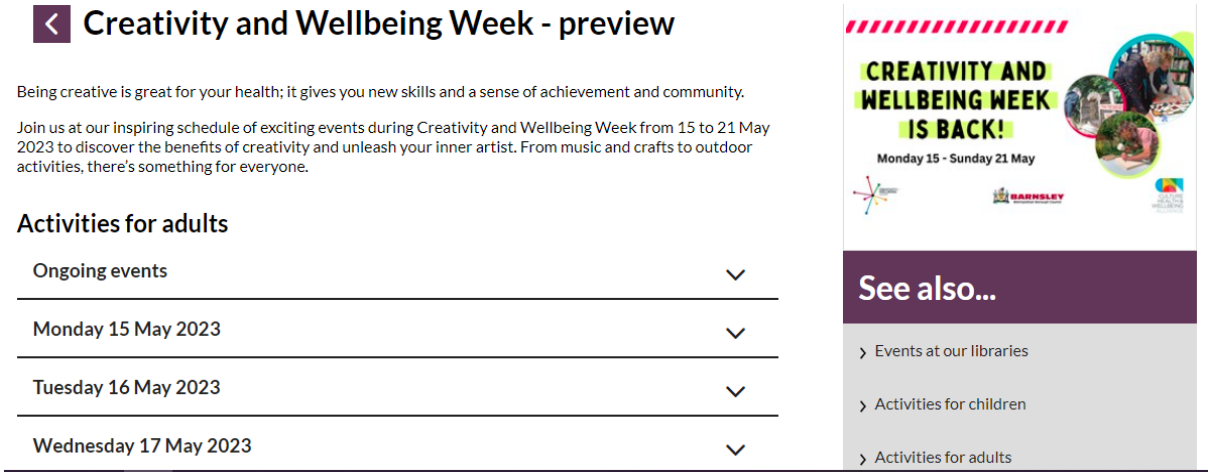
Objectives:

- Outline key creativity and wellbeing workforce skills required in health, care and creativity sectors.
- Show-case examples of skills development working with specific groups (training, peer support, on-job experience)
- Highlight the benefits of creativity and wellbeing projects with a focus on staff skills/experience needed.
- Involve people with lived experience to co-design and deliver the session.
- Explore how collectively we can develop an integrated creativity and wellbeing workforce plan.

5.3 Throughout the sessions, we identified a range of key issues and creative health skills to inform how we develop a workforce development plan.

- Time management
- Coaching skills
- Organisational skills
- Communication and listening skills- validate service users voices.
- Own wellbeing /self-care/emotional wellbeing to be able to work as effectively as possible with residents with challenging behaviours.
- Share a library of creative resources to include on partners websites.

5.4 In addition, a range of creative activities were promoted on our dedicated webpage, along with social media messaging and posters located in key public buildings across the borough.



6. What went well

6.1 The creative health workforce development workshops were very well received. Participants who attended the workshops commented on how much they had learnt about integrating creative health within their practice and challenged their assumptions about with working with different client groups.

6.2 The communications support from partner organisations to share the messages was successful. Multiple channels were used to target key audiences that were mapped in the original communications plan. Partnership working across communications and public health was strong and effective, offering feedback and ideas to ensure the best possible outcomes from each action.

6.3 We were able to successfully implement recommendations from last year's event to provide more accurate understanding of success of increasing awareness and encouraging uptake.

6.4 The campaign was able to forge successful links with Dementia Action Week, highlighting the benefits of creativity for people living with dementia.

7. Key learning

7.1 The workforce development focus provided a useful hook for engagement of staff across the sectors, and we recognised the need to strengthen the involvement with the social care sector and wider CVS.

7.2 Customer feedback from the public facing events showed that promoting popular and regular events lost the impact of it being part of Creativity and Wellbeing Week.

7.3 There was less media interest compared to last year due to the focus on staff workforce development. Alternative approaches could include specifically targeted events for Creativity and Wellbeing Week offering both information and activities.

7.4 Staff dedicated activities or events could improve measurement of awareness of Creativity & Wellbeing Week.

8. Links with South Yorkshire ICS

8.1 On Thursday 27 July, a specific Creative Health item was discussed with key representatives from SY Local Authorities and SY MCA.

8.2 The ICP supported the proposals that the Integrated Care Board establishes a new Creative Health Group that reports directly to it. This would have representation from the four local authority creative health groups, SYMCA, the ICS and have membership from key stakeholders in the region including

voluntary, community and social enterprise groups, patient groups, the universities, and the business sector.

The objectives of the Creative Health Group will be to:

1. Create a unified strategy for optimising the benefits of creative health;
2. Support the development of the ICS enabling plan;
3. Provide leadership and support the development of effective infrastructure for Creative Health for the region;
4. Strengthen approaches to commissioning and investment;
5. Showcase best practice and collate robust evaluations and evidence;
6. Draw down coordinated funding from the Arts Council and other bodies.

Proposed recommendations:

1. ICP Board approval to set up a Creative Health Group for the ICS;
2. Representation on the group from the South Yorkshire ICP and SYMCA;
3. Approval to draft a strategy leading to a plan of action to be launched autumn 2023.

9. Proposed next steps

- Continue to build on the learning from Creativity and Wellbeing Week to improve practitioner engagement and communication around creative health.
- Co-design and implement a workforce development programme for health, care and creative sectors, identifying key resources.
- Build opportunities to develop the South Yorkshire Integrated Care Strategy “Enabling plan” for creative health.

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9. Appendices

Officer: Julie Tolhurst **Date:** 31/07/23

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10th August 2023

REPORT TO THE HEALTH AND WELLBEING BOARD
Barnsley Children and Young People's Plan (2023-2026)

Report Sponsor:	Carly Speechley (Executive Director: Children's Services)
Report Author:	Karen Sadler (Service and Strategy Manager)

1. Purpose of Report

1.1 To inform the Board of the purpose and objectives of the Borough's latest Children and Young People's Plan which was recently approved for adoption by Full Council.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Note the ambitions and objectives of the Barnsley Children and Young People's Plan (2023-2026) particularly in promoting the overall health and wellbeing of children and young people in the Borough.

…

3. Delivering the Health & Wellbeing Strategy

3.1 The ambitions within our Children and Young People's Plan closely correlate with and will support the ambitions for *'Starting Well'* as outlined in the Borough's Health and Wellbeing Strategy, together with the '*Shared Outcomes', 'Bold Ambitions*' and *'Joint Commitments'* identified in the South Yorkshire Integrated Care Partnership as they relate to children and young people.

4 Reducing Inequalities

4.1 The Plan will interface with other Borough-wide plans and strategies aimed at closing the gap in the range of outcomes for children and young people, including the health and wellbeing of vulnerable and disadvantaged groups of young people compared to their peers.

5. Introduction/ Background

5.1 The Borough's refreshed Children and Young People's Plan sets out the proposed 'Vision' for improving the range of outcomes for all children and young people in Barnsley and to promote their overall wellbeing, based upon evidence such as the Barnsley Joint Strategic Needs Assessment. The Plan

is currently depicted as a series of slides *(Please see Appendix 1 to this report)* but, upon publication, on the Council's Web site, it will be developed as an interactive document.

5.2 The Plan has been developed in the aftermath of the greatest challenge to public health in living memory and in the current context of widespread, deepening disparities in health, attainment and income which have been further impacted by global events and the rising cost of living.

5.3 Our Eight 'Ambitions' for Children and Young People in Barnsley

5.4 The strategic objective of the new Plan is to help enable Barnsley in being a children-focused community as part of our overall vision for shaping the Borough as a *Place of Possibilities.* Notwithstanding the financial uncertainty which the country faces it is right that we aim high and want the very best for all children and young people in the Borough in ways which provide value for money and the effective use of resources.

5.5 The Council has, in recent months, agreed to a series of significant one-off and recurring investments to strengthen children's services notably, in enhancing our early help offer; the commissioning of stable and loving placements for looked after children; improving the capacity and resilience of the children's services workforce, together with other improvements in the quality of practice and provision.

5.6 With this in mind and, taking into consideration our recent plans and strategies, including the Education Improvement Strategy, SEND Strategy and Early Help Strategy for children, young people and families, together with the Barnsley 'Supporting Families' Programme, Family 'Hubs' and 'Start for Life' initiative, the Barnsley Children and Young People's Plan serves as the over- arching 'vision' for improving the range of outcomes for all young people in the Borough as well as the narrative *"bridge"* between this vision and our ambitions for shaping the Borough

5.7 As part of this, we have identified 9 ambitions within the Plan which closely align with the priorities of our Council Plan, summarised as follows:

Healthy Barnsley

Ambition 1: Children, young people and their families lead healthy and happy lives

Ambition 2: Children and young people are safe and protected from all forms of harm.

Learning Barnsley

Ambition 3: Children and young people get a good education, are ambitious and able to reach their potential.

Ambition 4: Children and young people are ready for work and are enabled to make progress in their employment.

Growing Barnsley

Ambition 5: All providers of children and family services are valued and supported to thrive.

Ambition 6: Barnsley is a child, young people and family friendly place in which to live, work and visit.

Sustainable Barnsley

Ambition 7: To help protect our place and planet for future generations.

Ambition 8: For children, young people and families to be proud of and active where they live.

Enabling Barnsley

Ambition 9: That the Council and its partners on the Barnsley Children and Young People's Trust will work strategically and seamlessly to achieve more and better outcomes for children, young people and families in the Borough.

5.8 Maintaining and improving the overall wellbeing of all children and young people in the Borough, together with minimising inequalities in health and the impact of multiple forms of deprivation on life chances will, in tandem with other strategic plans and strategies, be a strategic objective of the Children and Young People's Plan.

6. Contributing to the Health and Wellbeing Board's key priorities

6.1 Please see Paragraph 3.1 and Paragraphs 5.1- 5.7 of this report.

7. Financial Implications

7.1 There are no direct financial implications emerging through consideration of this report.

8 Consultation with stakeholders

8.1 The new Plan has been co-produced with our local statutory partners and is significantly informed by the insight of children, young people and families in the Borough, either directly or through bodies, including the Barnsley Youth Council and Care4Us Council into the challenges they face; on the issues which matter most in their lives and what local multi-agency partners can do to help them become more resilient to these challenges and achieve their hopes

and aspirations.

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9. Appendices

9.1 Appendix 1 – Barnsley Children and Young People's Plan (2023-2026) *(Slide presentation version)* .

Appendix 2 – Barnsley Children and Young People's Plan (2023-2026) Equality Impact Assessment

Officer: Karen Sadler **Date:** 26th July 2023

The place of possibilities for children, young people and families Plan (2023-26)

Healthy Barnsley

Learning Barnsley

Growing Barnsley

Sustainable Barnsley

Enabling Barnsley

Welcome

In Barnsley, we want everyone to start their life well, have the opportunity to learn, develop new skills, achieve their personal potential and have a good life. This means everything from a quality place to call home, good physical and mental wellbeing, access to the best possible local facilities, and a sense of self-worth through diverse education and secure employment opportunities. (Barnsley 2030)

Welcome to the latest edition of the Children, Young People's and Families Plan, prepared by the Children and Young People's Trust.

The purpose of this plan is to set out the Trusts 8 ambitions and identified priorities to contribute to the vision set out in Barnsley 2030, the borough's long term plan.

The last couple of years have been marked by the global pandemic and we know that the impact on children, young people and families has been significant. This next period will also bring challenges, including the impact of the cost of living crisis on people and businesses, ongoing health inequalities, pressure on public sector budgets and workforce shortages.

These 8 ambitions are the Trusts commitments to the children, young people, parents, carers, staff and volunteers that make up our communities, that we will continue to work together to improve outcomes.

We are so proud that our children's workforce has shown passion, commitment and dedication and despite the challenges the sector has continued to deliver tremendous work every day in our communities, to change the lives of children for the better.

By working together we have laid solid foundation for system based on early help, with improved access to services including mental health services; and a stronger systems for coordinated support for the children and families who need our help most.

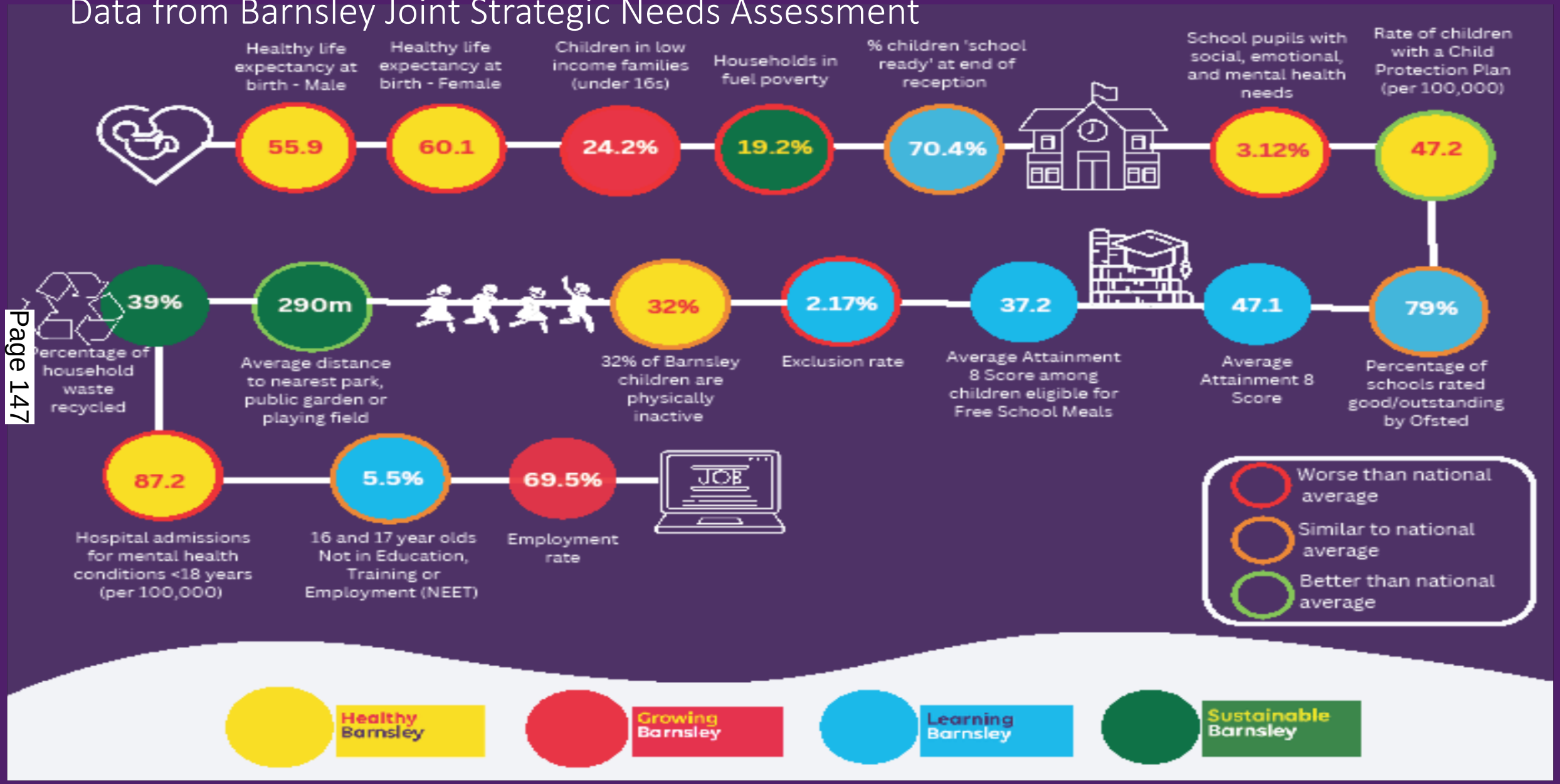
The children's workforce is our strongest asset and we will continue to support the sector to champion inclusivity, innovation and collaboration to make Barnsley the place of possibilities.

BARNSLEY
Metropolitan Borough Council

The Children and Young People's Trust
brings together partners from across health, social care, criminal justice, safeguarding, education, and the community and voluntary sector.

Current position

Data from Barnsley Joint Strategic Needs Assessment



What Matters Most to Young People in Barnsley?

Every year our Youth Council helps to facilitate Barnsley's contribution to Make Your Mark so that young people can have a say and be heard. The results from 2022 identify the top 3 issues in Barnsley for young people are:

1. Jobs, Money, Homes and Opportunities
2. Health & Wellbeing
3. Environment

In addition to the results of Make Your Mark, the Director of Public Health Annual Report (2021) presents the voices of children and young people in 'What matters to me, now' showcasing the prioritise identified by young people pre and post pandemic. The importance of family, home, friendship and belonging came out strong, as did being active, out door space and the environment.

2030

Barnsley – the place of possibilities.

Now more than ever young people told us that they valued having fun, being creative and enjoying experiences, holidays and celebrations.

Our Engagement Promise

Sharing information and involving children, young people and families in what we do and how we do it is key to improving outcomes. This is why as a Trust we are committed to ensuring we:

- Make sure information is accessible and jargon free
- Include everyone, and we listen and learn from our staff and communities
- Use age appropriate and creative ways to engage children and young people.
- Keep it simple and be honest about what you can influence
- Value equality and the diversity of local communities
- Are open and transparent with what we know and what we have done and why

For the families we work with we will work hard to involve you as much as possible, building on your strengths to shaping support plans and approaches that are best for you.

2030

Barnsley – the place of possibilities.

Healthy Barnsley

CYPT Ambition (1)

Children, young people and their families lead healthy and happy lives

This ambition will contribute to the work of Barnsley Health & Wellbeing Board, Barnsley Place Partnership and the Mental Health, Learning Disabilities and Autism Partnership

2030 Barnsley – the place of possibilities.

Our Priorities (for Ambition 1)

I. To provide Families with the Know How – so they can find the information they need to look after themselves and make the most of opportunities and services available.

II. To provide opportunities to build resilience – so that our children, young people and their families can connect, have fun and thrive together.

III. To embed our Early Help Approach – so that children, young people and their families are supported on a whole range of social, health and educational issues, as soon as problems emerge or re-emerge, to reduce inequalities.

IV. To strengthen our education, health and care partnerships – so that our systems and services, informed by the voice of children, young people and families, work seamless together.

Boards Responsible for Delivery →

Starting Well, Growing Well and Moving On

Special Educational Needs & Disabilities Oversight Board

CYP Emotional Health & Wellbeing Group

Healthy Barnsley

CYPT Ambition (2)

Children and young people are safe and protected.

This ambition will contribute to the work of Barnsley's Children's Safeguarding Partnership, Safer Barnsley Partnership and the Mental Health, Learning Disabilities and Autism Partnership

2030 Barnsley – the place of possibilities.

Our Priorities (for Ambition 2)

I. To learn from national and local reviews to deliver safer outcomes for children and young people

II. To keep children and young people safe inside home – by addressing domestic abuse, parental substance misuse, parental mental health and child neglect.

III. To keep children and young people safe outside home – by tackling bullying, online harm, stalking and harassment, child exploitation.

IV. To intervene swiftly when children need help and protection, with high quality interventions to improve outcomes and reduce harm

V. To offer young people alternatives to crime and anti-social behaviour to divert young people away from criminal justice system

VI. To keep children, young people and families stay together. When this is not possible we will develop new models of accommodation through the strengthening of our commissioning arrangements, in order to place children locally.

Boards Responsible for Delivery →

Strengthening Children's Services Development Board

Combatting Drugs Partnership Board, Domestic Abuse Partnership Board, Youth Crime and Anti-social Behaviour Board, CYP Emotional Health & Wellbeing Group

Learning Barnsley

CYPT Ambition (3)

Children and young people get a good education, are ambitious and able to reach their potential

This ambition will contribute to the work of the Inclusive Economy Board, Barnsley Place Partnership and the Mental Health, Learning Disabilities and Autism Partnership

2030 Barnsley – the place of possibilities.

Our Priorities (for Ambition 3)

I. To champion world class education opportunities for all CYPF, ensuring that we meet the needs of vulnerable and disadvantaged groups

II. To secure high quality provision, widen local opportunities and promote equalities

III. To support families to provide an enriching home learning environment

IV. To help young people aim high by championing high quality careers education and guidance that raises their aspirations, skills, qualifications, and aptitudes so that they fulfil their full potential.

V. To provide access to high quality cultural, sporting and social opportunities and expand horizons and international experiences.

VI. To support every young person to be digitally, culturally and financially literate.

Boards Responsible for Delivery →

Barnsley Schools Alliance

Starting Well, Growing Well and Moving On

Special Education Needs & Disabilities Oversight Board

Inclusive Economy Board

Learning Barnsley

CYPT Ambition (4)

Children and young people are ready for work and are able to gain and progress in work.

This ambition will contribute to the work of the Inclusive Economy Board, Barnsley Place Partnership and the Mental Health, Learning Disabilities and Autism Partnership's

2030 Barnsley – the place of possibilities.

Our Priorities (for Ambition 4)

I. To strengthen the links between the borough's employers and learning providers to help young people understand more about the world of work

II. To promote and encourage lifelong learning by enhancing post-16 and post-19 education, volunteering, employment, and training provision

III. To improve employment opportunities for our young people that are care leavers and those who have additional needs.

IV. To promote inclusion and provide support to young person at risk of becoming NEET (not in education, employments or training)

Boards Responsible for Delivery →

Barnsley Schools Alliance

Special Education Needs & Disabilities Oversight Board

Starting Well, Growing Well and Moving On

Inclusive Economy Board

Growing Barnsley

CYPT Ambition (5)

All providers of Children and Family Services are valued and supported to thrive

This ambition will contribute to the work of the Barnsley Place Partnership, Stronger Barnsley Partnership, and Partnership Workforce Development Plans.

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Our Priorities (for Ambition 5)

I. To develop and grow the Children and Young People's Provider Network

II. To increase the level of funding brought into Barnsley to build the children and family sector.

III. To grow, support and shape the sector to deliver service integration and meet workforce development needs.

IV. To develop a stronger digital offer to promote all our children, young people and family services.

Boards Responsible for Delivery

Voluntary Sector Strategy Group,

Starting Well, Growing Well and Moving On

Children & Young People's Commissioning

Growing Barnsley

CYPT Ambition (6)

Barnsley is a child, young person and family friendly place to live, work and visit

This ambition will contribute to the work of the Principal Towns Programme Board, Housing Board, Fusion Partnership and Barnsley's Travel Strategy.

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Our Priorities (for Ambition 6)

I. To support young people to develop a sense of pride and place.

II. To embed the interests & needs of children, young people and families into Housing, Regeneration & Investment plans to maximise the impact of developments and positively contribute to outcomes.

III. To work with children, young people and families to make our urban and local town centre be safe and welcoming places as well as ensuring we have a wide mix of facilities and amenities available for CYP & families.

IV. To promote and increase opportunities and access to Barnsley's art, sport, music, culture and heritage offer.

V. To influence and support a safe, reliable and accessible transport network.

Boards Responsible for Delivery

Principal Towns Programme Board

Housing Board, Fusion Partnership

Sustainable Barnsley

CYPT Ambition (7)

To protect our place and planet for future generations

This ambition will contribute to the ambition to be net Zero Carbon by 2045

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Our Priorities (for Ambition 7)

I. To promote initiatives and project across all partners, that contribution to the borough's ambition to become net Zero Carbon by 2045.

II. To engage children, young people and their families to improve knowledge and understanding of climate change and to take action to reduce, reuse and recycle .

Boards Responsible for Delivery	Positive Climate Partnership

Sustainable Barnsley

CYPT Ambition (8)
For children, young people and families are proud and active where they live

This ambition will contribute to the work of the Stronger Communities Partnership and Barnsley Health & Wellbeing Board

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Our Priorities (for Ambition 8)

I. To influence and support the development of our parks, open and green spaces so children, young people and families can enjoy public outdoor spaces.

II. To influence, support and promote active travel programmes across the borough so that cycling and walking become part of everyday life.

III. To support initiatives for developing community capacity and promoting community wealth building.

IV. To work with the voluntary and community sector and support social action.

Boards Responsible for Delivery	Principal Towns Programme Board Area Councils , Active in Barnsley Partnership

Enabling Barnsley

CYPT Ambition (9)
The Trust will support the system to achieve more and better outcomes

2030 Barnsley – the place of possibilities.

Our Priorities (for Ambition 9)

- To embed the Voice of stakeholders into all aspects of service development
- To improve partnership data & intelligence gathering, and analysis to support all our delivery groups
- To increase capacity and develop the workforce to deliver a whole systems approach
- To identify barriers and challenges that hinders progress of delivery groups
- To develop improved ways to communicate across the trust to reduce duplication

Visual – To Be Developed

Healthy – Ambition 1 C**hildren, young people and their Families lead healthy and happy lives**

Strategic Delivery groups are: Starting Well, Growing Well and Next Oversight Board, CYP Emotional Health & Wellbeing Group, Special Educational Needs & Disabilities Oversight Board

Healthy – Ambition 2 Children and young people are safe and protected from all forms of harm

Strategic Delivery Groups are:

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Implementing & Delivering the plan

This plan draws together the ambitions and priorities from across the system. Further background and details to the ambitions and priorities can therefore be found in the following:

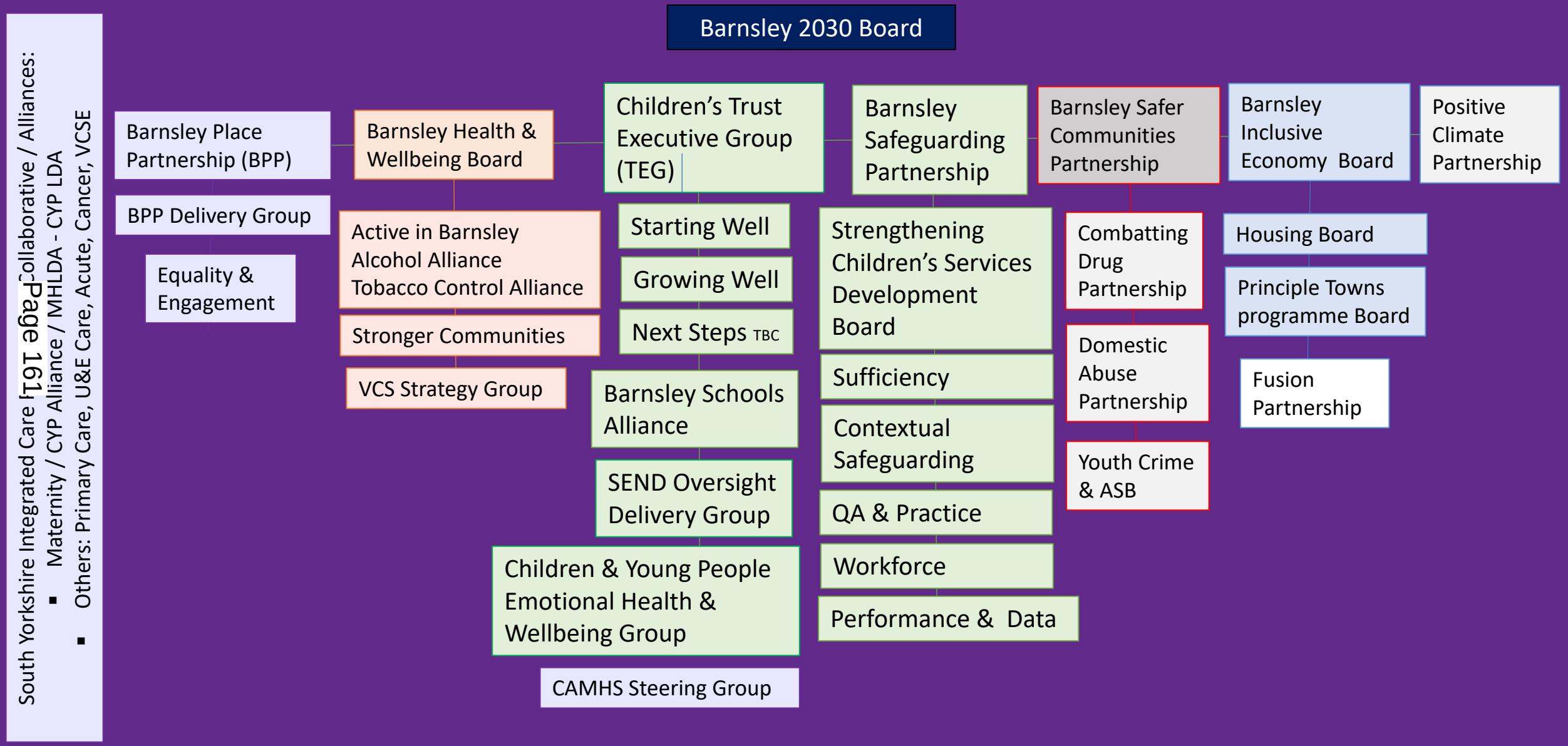
Barnsley Health and Wellbeing Strategy 2021 - 2030
Barnsley Place Health & Care Strategy (in development)
Early Help Strategy 2022-2027
Barnsley Mental Health and Wellbeing Strategy 2022-2026
Send Strategy 2022 - 2025
Autism Strategy (in development)
Carers Strategy

Safer Barnsley Strategy
Youth Justice Strategy
Barnsley School Alliance Education Improvement Strategy-2022-2025
Employment and Skills Strategy - More and better jobs MORE AND BETTER JOBS 2021-2024
Barnsley Transport Strategy
Climate Change
OTHERS>>>>>>>to be added

Barnsley – the place of possibilities.

Updates from across the system will be collected periodically providing the opportunities to track progress and manage risks and challenges.

System Diagram from the perspective of TEG for the delivery of the Children & Young People's Plan



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Equality Impact Assessment

Stage 1 Details of the proposal

Name of service **Directorate**	Education, Early Start and Prevention (Commissioning and Partnerships) Children's Services
Name of officer responsible for EIA **Name of senior sponsor**	Head of Education and Partnerships
Description / purpose of proposal	Barnsley Children and Young People's Plan (2023-2026)
Date EIA started	1st November 2022
Assessment Review date	31st October 2023

Stage 2 - About the proposal

What is being proposed?	The Borough's latest Children and Young People's Plan (CYPP) has been developed for approval and adoption by Full Council
Why is the proposal required?	The new Children and Young People's Plan provides our 'Vision' for ensuring all children and young people in Barnsley should thrive and flourish as part of our overall 'Vision' for Barnsley as *A Place of Possibilities*. As a result, the CYPP outlines 8 ambitions for children and young people which closely align with the priorities of our Council Plan and our aspirations for achieving economic and social prosperity in the Borough

	The new Plan also acts as the basis for our prevailing statutory duty of promoting the overall wellbeing of children and young people in the Borough as we continue to recover and renew following the Pandemic.
What will this proposal mean for customers?	Please see above.

Stage 3 - Preliminary screening process

Use the Preliminary screening questions to decide whether a full EIA is required
√ Yes - EIA required (go to next section) ☐ No – EIA not required (provide rationale below including name of E&I Officer consulted with)

Stage 4 - Scoping exercise - What do we know?

Data: Generic demographics
What generic data do you know?
Underlying data used to ensure equality of provision will include the Borough's Joint Strategic Needs Assessment, our Borough Profile and the results of the Census (2021). This will be supported by internal data on the needs and characteristics of children and young people in the Borough.

Data: Service data / feedback
What equalities knowledge do you already know about the service/location/policy/contract?
Please see above

Data: Previous / similar EIA's
Has there already been an EIA on all or part of this before, or something related? If so, what were the main issues and actions it identified?

This is the first EIA to be published in connection with the Barnsley CYPP

Data: Formal consultation
What information has been gathered from formal consultation?
Information and data gathered for the purpose of developing the CYPP has included the experience of children, young people and families, together with bodies of representatives including the Barnsley Youth Council, Care4Us Council and SEND Youth Forum on the issues which matter most to their lives and those of their peers, together with what should be done to enrich and improve their lives so that they can achieve the best outcomes

Stage 5 - Potential impact on different groups

Considering the evidence above, state the likely impact the proposal will have on people with different protected characteristics

(state if negative impact is substantial and highlight with **red text**)

Negative (and potentially positive) impacts identified will need to form part of your action plan.

Protected characteristic	Negative '–'	Positive '+'	No impact	Don't know	Details
Sex					None anticipated
Age					None anticipated
Disabled *Learning disability, Physical disability, Sensory Impairment, Deaf People ,invisible illness, Mental Health etc*					This matter will be the focus of our developing local 'offer' to children and young people with special educational needs, including disabilities
Race					Targeted support and intervention will continue to be provided to children and young people in need of additional help
Religion & Belief					As above
Sexual orientation					As above
Gender Reassignment					As above

Marriage / civil partnership		N/A			
Pregnancy / maternity		N/A			

Other groups you may want to consider					
	Negative	**Positive**	**No impact**	**Don't know**	**Details**
Ex services					Targeted support and intervention will continue to be provided to children and young people in need of additional help as part of the Armed Forces Covenant
Lower socio-economic					Targeted system-wide support and intervention will continue to be provided to children and young people in need of additional help
Other …					-

Stage 6 - BMBC Minimum access standards

If the proposal relates to the delivery of a new service, please refer to the Customer minimum access standards self-assessment (found at)

If not, move to Stage 7.

Please use the action p… …be taken to ensure the new service complie… …easonable adjustments for disabled people.

Not yet live

☐ The proposal will meet the minimum access standards.
☐ The proposal will not meet the minimum access standards. –provide rationale below.

Stage 7 – Action plan

To improve your knowledge about the equality impact . . .

Actions could include: community engagement with affected groups, analysis of performance data, service equality monitoring, stakeholder focus group etc.

Action we will take:	Lead Officer	Completion date
Analysis and follow up action from annual reviews of the CYPP	Head of Education and Partnerships	October 2023

Engaging with all groups of young people and their families particularly the Youth Council, Care4Us Council and SEND Youth Forum, together with other specific initiatives including the annual *Make Your Mark Survey* and National 'Takeover' Challenge	Head of Education and Partnerships	October 2023

To improve or mitigate the equality impact . . .

Actions could include: altering the policy to protect affected group, limiting scope of proposed change, reviewing actual impact in future, phasing-in changes over period of time, monitor service provider performance indicators, etc.

Action we will take:	Lead Officer	Completion date
Pulse surveys and further consultation	Head of Education and Partnerships	October 2023
Identifying, disseminating and introducing best practice	Head of Education and Partnerships	October 2023

To meet the minimum access standards . . .(if relevant)

Actions could include: running focus group with disability forum, amend tender specification, amend business plan to request extra 'accessibility' funding, produce separate MAS action plan, etc.

Action we will take:		Completion date

Not yet live

Stage 8 – Assessment findings

Please summarise how different protected groups are likely to be affected

Summary of equality impact	All children already benefit from universal education and health care. However, the promotion of inclusion and closing the gap in the range of outcomes between all disadvantaged and vulnerable groups of children compared to peers will be a centrepiece of the Plan as we recover and renew from the ending of Covid restrictions

Summary of next steps	The CYPP will continue our commitment to ensuring the aspirations of children and young people are met. For those individual or groups of children who require additional help, targeted intervention will enable them to achieve their potential and enhance their life chances

Signature (officer responsible for EIA) Date	

**** EIA now complete ****

Stage 9 – Assessment Review

(This is the post implementation review of the EIA based on date in Stage 1 if applicable) **What information did you obtain and what does that tell us about equality of outcomes for different groups?**

South Yorkshire
Integrated Care Board

Minutes of the NHS South Yorkshire Integrated Care Board, Barnsley Place Committee and Barnsley Place Partnership Board (public session)

Held on Thursday 25 May 2023 at 1.00 pm in the Boardroom, Hillder House, 49/51 Gawber Road Barnsley S75 2PY

BARNSLEY PLACE COMMITTEE - MEMBERS PRESENT

Wendy Lowder (Chair Barnsley Place Committee)	Barnsley Place Director
Lesley Dabell	Non Executive Director SY ICB
Dr Madhavi Guntamukkala	Medical Director, Barnsley Place
Roxanna Naylor	Chief Finance Officer Barnsley Place
Jayne Sivakumar	Chief Nurse SY ICB Barnsley Place

BARNSLEY PARTNERSHIP BOARD - MEMBERS PRESENT

Wendy Lowder (Chair Partnership Board)	Barnsley Place Director
James Barker	Chief Executive, Barnsley Healthcare Federation
Kevin Clifford (For Sheena Mc Donnell)	Non Executive Director Barnsley Hospital (Chair, Barnsley Hospital NHS Foundation Trust)
Adrian England (Participant)	Chair, Healthwatch Barnsley
Jane Holliday	Chief Executive Barnsley Community Voluntary Service (CVS)
Dr Richard Jenkins	Chief Executive, Barnsley Hospital NHS Foundation Trust
Cllr Caroline Makinson (For Cllr Sir Steve Houghton)	Councillor Leader, Barnsley Metropolitan Borough Council (Leader, Barnsley Metropolitan Borough Council)
Martine Tune	Chief Executive Barnsley Hospice
Salma Yasmeen (for Mark Brooks)	Deputy Chief Executive and Executive Director of Strategy and Change, South West Yorkshire Partnership NHS Foundation Trust (Chief Executive, South West Yorkshire Partnership NHS Foundation Trust)

IN ATTENDANCE

Michelle Kaye	Group Leader, Housing and Welfare, Barnsley Metropolitan Borough Council (for minute reference 4 only)
Bob Kirton	Chief Delivery Officer and Deputy Chief Executive, BHNFT
Jo Harrison	Deputy Chief Nurse: Head of Quality, Safety & Funded Care Barnsley Place (for minute reference 15 only)
Genna Miller	Head of Finance – Reporting, Transformation and Delivery (Barnsley) (for minute reference 17 only)
Joe Minton	Associate Director – Strategy, PHM and Partnerships SY ICB Barnsley Place (from minute reference 11)
Kay Morgan	Governance and Assurance Manager, SY ICB Barnsley Place (Minutes)
Paige Proud	Risk and Governance Lead SY ICB Barnsley Place (meeting support)
Gill Stansfield	Clinical Services Director South West Yorkshire Partnership NHS Foundation Trust
Richard Walker	Head Of Governance & Assurance SY ICB Barnsley Place
Kirsty Waknell	Head of Communications, Engagement and Equality SY ICB
Jamie Wike	The Deputy Place Director SY ICB Barnsley Place

APOLOGIES – Place Committee Members

No Apologies Received	

APOLOGIES – Partnership Members

Marie Burnham	Chair, South West Yorkshire Partnership NHS Foundation Trust
Julia Burrows	Director of Public Health, Barnsley Metropolitan Borough Council
Mark Brooks	Chief Executive, South West Yorkshire Partnership NHS Foundation Trust
Cllr Sir Steve Houghton	Leader, Barnsley Metropolitan Borough Council
Sarah Norman	Chief Executive, Barnsley Metropolitan Borough Council
Sheena Mc Donnell	Chair, Barnsley Hospital NHS Foundation Trust

MEMBERS OF THE PUBLIC

Pete Deakin	Member of the Public (up to and including minute refence 14)
Nora Everitt	Member of the Public (up to and including minute refence 14)
Luisa Fletcher	Member of the Public (up to and including minute refence 14)

The recording of the meeting was commenced.

The Chair welcomed members, attendees and members of the public to the meeting of the Place Committee and Partnership Board.

Ref	Item	Action
1	**Welcome / Housekeeping**	
	All present in the room, were informed of the housekeeping arrangements for the meeting venue, including fire procedures, nearest fire exit and toilet facilities.	
2	**Apologies for Absence**	
	Apologies received and recorded as above.	
3	**Quoracy - Barnsley Place Committee & Partnership Board**	
	The Barnsley Place Committee meeting was declared quorate The Barnsley Place Partnership Board was declared quorate	
4	**Story from our Communities**	
	The Group Leader, Housing and Welfare, Barnsley Metropolitan Borough Council (BMBC) provided the meeting with a 'Story from our Communities'. This was her experience of services for the Homelessness in Barnsley. Homelessness links into many health and care services but these services are not always connected. Members were informed of the work undertaken during the Covid-19 Pandemic to help rough sleepers. This highlighted the need for BMBC to manage its own accommodation for the homeless, and subsequent business case to provide services for the most complex rough sleepers in Barnsley. Many homeless people have complex heath and care needs but do not have direct access to services or choose not to access them. The Group Leader, Housing and Welfare gave an example of a homeless couple that the service had supported which involved a wide range of health, care and voluntary sector services including substance misuse, tissue viability, diabetes, mental health, domestic abuse. There are a high number of rough sleepers with significant health needs. Since March 2023 there have been 7 deaths in rough sleepers and a total of 36 deaths since 2020. The average age of death in homeless people is 47 years for males and 43 years in females. The Homeless Service are housing specialists, not health specialists. Involvement of health services with homeless people is paramount. Though it is recognised that a Homeless persons engagement with other services is on their terms. All homeless people are registered with a General Practitioner but do get removed from GP lists if they are abusive. Homeless people are asked	

to leave hospital because of their behaviour and then there are subsequent readmissions in a repeat cycle.

The Group Leader, Housing and Welfare advised that a better whole system partnership approach is required to support homeless people in Barnsley.

The Chair thanked The Group Leader, Housing and Welfare and her team for their work and passion in helping homeless people in Barnsley. The significance of early help for the homeless is so important.

The Place Committee and Partnership Board Members provided the following reflections in respect of the 'Story from our Communities'

- As healthcare professionals the story is difficult to hear. The health services offer for homeless people and responsiveness needs to be considered across all partners. Also consider how to stop the next generation of people becoming homeless
- Services for homeless people links to the social prescribing service and health coaches, this being a low level safe approach to support people.
- The Barnsley Hospital has a clear approach to caring for the homeless and staff have compassion, recognising the real ongoing issues for homeless people. As in the Covid narrative, the hospital can support people sleeping in hospital grounds, with outreach workers attending the hospital to assist with rough sleepers. It is hard for Homeless people to be in hospital and also for staff to care for them.
- The story is powerful, homeless people are excluded from society. Volunteers do support the homeless and clients open up to volunteers. The Homeless Service is working with Barnsley CVS to see what can be offered to homeless people. Homeless people need a safe space and companionship.
- Take the opportunity to learn from other areas what is being done to support homeless people.
- The work to prepare for immigrant and asylum seekers, improving pathways and support will link into similar work of the Homeless Service.

The Group Leader, Housing and Welfare, informed the meeting that many people present in a crisis. The Homeless Strategy is being written with a focus on early intervention and preventing homelessness.

In response to a question raised it was clarified that approximately 2,000 people go through the Homeless Service each year with around 60 to 80 complex clients at any one time. These numbers are only the people presenting to services for support, there are other homeless people who do not engage with services.

The Chair concluded discussion advising that there is a real will from the partnership to take stock of services for the homeless, deliver the right impact and galvanise action. Services for the Homeless will be further considered by the Barnsley Place Partnership Delivery Group.

	The Place Committee and Partnership Board noted the Story from our Communities ***Agreed actions*** ***To forward the invite of the Barnsley Migrant and Asylum seekers Group to the Group Leader, Housing and Welfare to the Group Leader, Housing and Welfare, Barnsley Metropolitan Borough Council (BMBC).*** ***To consider Services for the Homeless at a future meeting of the Barnsley Place Partnership Delivery Group.***	JS WL & ALL
5	**Questions From the Public**	
	The Chair reported that 14 questions had been received from members of the public and some of these questions are similar subject areas. From a time perspective there are too many questions and responses to read out at the meeting. The chair read out 4 questions, one of which was an additional question to the Place Committee and Partnership Board meeting on 30 March 2023 regarding the Barnsley Involvement and Equality Group and Involvement plan. The 3 other questions related to public engagement / involvement, public questions to Board meetings and podiatry services. All questions received together with answers are attached to the formal minutes of the meeting and responses will be sent to the relevant individuals. **The place Committee and Partnership Board noted the questions from the public.**	
6	**Declarations of Interest, Sponsorship, Hospitality and Gifts Relevant to the Agenda**	
	The Barnsley Place Committee and Barnsley Place Partnership Board considered the Declarations of Interests Report. The Non Executive Director SY ICB reported that she had retired as Chief Executive for Age UK Rotherham No other new interests were declared. ***Agreed action*** ***To update the declaration of interest for the Non Executive Director SY ICB removing the declaration relating 'CE Age UK Rotherham'.***	PP
7	**Minutes of the Previous Meeting (public session) held on 30 March 2023**	
	The minutes of the previous meeting of the Barnsley Place Committee and Partnership Board held on 30 March 2023 in public session were verified as a correct record of the proceedings subject to following inclusion:	

	• **Minute Reference 13 Barnsley Place Partnership 2023/24 Draft Financial Plan** New third paragraph and additional action to read: The Chief Executive Barnsley Hospice drew members attention to the unsustainable funding model for the hospice. The hospice will have another deficit budget for 2023/24 and highlighted the funding gap as circa £2M. Although a range of actions will be taken to reduce spending where possible and generate more income it looks inevitable that there will be a gap which will be closed from financial reserves - these will not last beyond March 2026 assuming that nothing changes between now and then - and unlike NHS providers who will still carry on business and continue to exist, the hospice will not be able to continue and will cease to exist if it gets to that point. The Chair thanked the Chief Executive Barnsley Hospice for highlighting the issue to the Place Committee and Partnership Board, and commented that it was important to keep the partnership informed of this. ***Agreed action*** ***To present the offer from Barnsley Hospice and how the hospice supports Barnsley Place to the Place Committee and Partnership Board Development Session on 29 June 2023.***	
8	**Matters Arising Action Log**	
	The Place Committee / Partnership Board considered the Matters Arising / Action Log and the following points were noted • **Minute Reference 30.03.23 19 - Development of the Barnsley Health and Care Quality and Safety Committee** It was noted that the Health and Care Quality and Safety Committee are progressing development of the Health and Care Quality report. • **Minute Reference 30.03.23 19 - Development of the Barnsley Health and Care Quality and Safety Committee – Whole System Risk** Members were informed that the NHS SY ICB Chief Executive as part of the organisational design work is undertaking a review of the ICBs governance arrangements/structures. The escalation flows re quality and safety from local Place to the ICB Quality Committee and vice versa is now established. In response to a question raised it was clarified that the SY ICB Risk Register and risks to be managed at Barnsley Place will be considered by the Place Management Team in the first instance and also by the Barnsley Place Partnership Delivery Group on 11 July 2023. The Chief Executive, Barnsley Hospital NHS Foundation Trust commented that the real risks for Barnsley for example oncology provision should be included on the Risk Register. It was	

	highlighted that the SY ICB risk register will contain the risks controlled by Places and provide oversight of other risk across the system. **The Place Committee and Partnership Board noted the Matters Arising Action Log**	
	STRATEGY	
9	**Place Director Update & Barnsley Place Achievements**	
	The Place Director provided her update including the Barnsley Place Partnership Achievements to the meeting. She highlighted that the Barnsley Leadership Team had maintained a focus on the priorities for the Health and Care Plan and approach to reducing inequalities. Members noted: • The commencement of the Proud to Care Training Programme raising awareness of roles in social care and supporting people into career pathways It is important to encourage the right people into caring roles and to measure the conversation rate from people attending the training into caring posts. The benefits of the Proud to Care Training programme being made available across South Yorkshire was highlighted. • The Intermediate Care Review is well underway and shaping the future model of intermediate care in Barnsley with the voice of Barnsley People reflected in the model. • The key achievements and next steps in developing integrated front door options for urgent and emergency care **The Barnsley Place Committee and Partnership Board noted the Place Director update and Barnsley Place Achievements.**	
10	**Feedback from South Yorkshire Integrated Care Partnership Board**	
	The Non Executive Director Barnsley Hospital reported that the South Yorkshire Integrated Care Partnership Board had focussed on Children and Young People, including the work of Barnardo's, Marmot definition of health inequalities and the work being done in Doncaster and Rotherham on speech and language services. It was noted that a presentation will be made to the Children's Trust in June to enable a joined up approach from a Barnsley perspective. The Chair commented that she had joined a conversation convened by the South Yorkshire Mayor re homelessness and use of Harvard Bloomberg initiative to reduce homelessness. **The Place Committee and Partnership Board noted the Feedback from South Yorkshire Integrated Care Partnership Board.**	
11	**NHS 5 Year Forward Plan for South Yorkshire Update**	

	At this point the Deputy Place Director Barnsley and Associate Director – Strategy, PHM and Partnerships SY ICB Barnsley Place joined the meeting The Deputy Place Director Barnsley provided an update on the development of the NHS 5 yr Joint Forward Plan (JFP) for South Yorkshire. Discussion took place, Members noted: • That the South Yorkshire JFP will be submitted to the Integrated Care Partnership and Health and Wellbeing Board in June 2023 for comment. • The citizens involvement to influence and shape the plan and continuation of the 'What Matters to you about Health and Wellbeing' conversations reaching a more inclusive and broader depth of people. • That an equality Impact Assessment is being developed for use across the system. **The Barnsley Place Committee and Partnership Board** **Considered the report and the developing content of the Joint Forward Plan noting:** • **The progress to enable ongoing engagement working with Healthwatch and VCSE.** • **The work underway by place partnerships to refresh Integrated Health and Care Place delivery plans, their alignment to our JFP and fundamental role in delivery.** • **The work by our Collaboratives and Alliances on service focussed practical strategies.** • **Key next steps as outlined above including the planned development sessions with the South Yorkshire System Leadership Executive on May 9 and June 13 to support further engagement and development of the plan.** • **Supported an update to the Integrated Care Partnership on 23 May in Public Session** • **Received the final Plan at the ICB Board meeting on July 5 noting that the final plan will have been shared with NHS England on 30 June**	
12	**Barnsley Health and Care Plan**	
	The Deputy Place Director Barnsley and Associate Director – Strategy, PHM and Partnerships SY ICB Barnsley Place introduced the Barnsley Health and Care Plan 2023-25 including approach to tackling health inequalities to the Place Committee and Partnership Board. In response to a question raised the Associate Director – Strategy, PHM and Partnerships SY ICB Barnsley Place explained that outcomes and measures	

	are the golden threads across the Health and Care Plan and Health Inequalities. It was highlighted that the terminology used relating to, 'grow our workforce' may not be appropriate in this difficult period of cost reduction savings and scrutiny of pay costs. The Health and Care Plan will require adopting by partner Boards and taken on the Road. The Governance Plan for the Health and Care Plan and Health Inequalities work will be considered by the Place Partnership Delivery Group on 13 June 2023. **The Barnsley Place Committee:** • **Approved the Barnsley Health and Care Plan 2023-25 and Tackling Health Inequalities in Barnsley report.** • **Noted the plans to publish and share these documents with stakeholders** • **Agreed how the plans will be shared with partner Boards** **Agreed action** ***To change reference from 'grow our workforce' to 'Development of our workforce'***	JM
13	**Director of Public Health Annual Report 2022 – Tackling the Cost of Living Crisis**	
	The Place Committee and Partnership Board received the Director of Public Health's Annual Report 2022. The report describes the impact of the cost-of-living crisis and how it is affecting households in Barnsley. It shows how the council have responded using grants creatively and working with the community and voluntary sector to help respond to the crisis. The Place Committee and Partnership Board noted that the report is a hard-hitting read bringing to life the impact of the cost of living crisis on individuals. The 'More Money in your Pocket' campaign had provided advice and support to people and allocated money to community groups to help people through the cost of living crisis. The Chair commended members to visit the Community Shops at Athersley and Goldthorpe where people can access low cost foods and personal development support. Cllr Makinson commented that she was pleased that the cost of living crisis had been chosen for the Director of Public Health Annual Report 2022. As a councillor in Royston the 'More Money in your Pocket' grant had helped people in Royston. It was noted that Annual Report had been received by partner Boards. The Chair extended appreciation to Jane Hellowell for coordinating the production of the Annual Report. **Members noted the content of the report**	

	Agreed action ***To share the contact details for the Athersley and Goldthorpe Community Shops.***	WL
14	**VCSE - Memorandum of Understanding (MOU)**	
	The Chief Executive Officer Barnsley CVS and Associate Director – Strategy, PHM and Partnerships SY ICB Barnsley Place presented the Memorandum of Understanding between NHS SY ICB and the Voluntary Community and Social Enterprise Sector (VCSE) Alliance. The MOU provides a framework to connect the VSCE across Places and with system wide health and care work as equal partners and an approach for embedding VCSE within system work. The Chair highlighted that it is important to live the Memorandum of Understanding rather than being words on paper. **Barnsley Place Committee and Partnership Board noted:** • **That the MOU has been adopted by the ICB and VCSE sector in South Yorkshire** • **The links to the Barnsley Health and Care Plan 2023-25 *Partnership with VCSE sector***	
	BREAK	5 mins
	ASSURANCE REPORTS	
15	**Quality and Safety Report**	
	At this point the Deputy Chief Nurse: Head of Quality, Safety & Funded Care Barnsley Place joined the meeting The Chief Nurse and the Deputy Chief Nurse: Head of Quality, Safety & Funded Care Barnsley Place presented the Health and Care Quality and Safety Committee Report to the meeting. The Place Committee and Partnership Board noted the three escalated key issues from Health and Care Quality and Safety Committee (Q&SC) • **Complex nutritional failure patients including eating disorders** The chair advised that it would be helpful for the Place Committee and Partnership Board to receive an update on the joined up partnership and SY ICB work with regard to eating disorders. Eating disorders is also a priority of the Mental Health and Autism collaboration. • **Dynamic Support Register**. It was noted that Care Education and Treatment Reviews C(E)TR is included as an amber risk on the SY ICB Risk Register and queried if the scoring is reflective of the actual risk. • **Provider Quality Monitoring and Levels of Assurance.**	

	The Place Committee and Partnership Board noted the Report **Agreed actions** • **To provide an update to a future meeting of the Place Committee and Partnership Board about Eating Disorders.** • **To contact Marie Purdue at the Mental Health and Autism collaboration regarding their work on Eating Disorders.** • **To provide the SY ICB Chief Nurse Barnsley Place with an extract of the C(E)TR risk from the SY ICB Risk Register.** • **To raise the C(E)TR risk at the SY ICB Chief Nurses meeting for possible review of risk score.** ***At this point the Deputy Chief Nurse: Head of Quality, Safety & Funded Care Barnsley Place left the meeting***	JS/JH JS RN JS
	FINANCE AND PERFORMANCE	
16	**Finance Update – Month 12 – 2022/23**	
	The Chief Finance Officer – Barnsley provided the place committee and Partnership Board with an update on the year end position for Barnsley place which has a delegated budget from the Integrated Care Board (ICB) for the year ended 31 March 2023. The Place Committee and Partnership Board noted the headline position for 2022/23, Efficiency for 2022/23, and the 2023/24 financial position update. All ICS partners had contributed to closing the system deficit gap with an ICS reported outturn position of breakeven (subject to audit) For 2023/24 there is a significant financial challenge and all partners will be required to deliver against the overall position. **The Place Committee noted:** • **The outturn position and summary position in Appendix A.** • **The continued work on the 2023/24 financial plan and critical work to be undertaken at pace on transformation and delivery plans and budgets to demonstrate value for money and improved outcomes.**	
17	**Final Place Financial Plan 2023/24**	
	At this point the Head of Finance – Reporting, Transformation and Delivery Barnsley Place, joined the meeting. The Head of Finance – Reporting, Transformation and Delivery Barnsley Place provided a presentation to the meeting regarding the Barnsley Place	

	Partnership 2023/24 Finance Plan including overview of the Finance Plan, and by organisation, partnership key risks, 2023/24 efficiency target by organisation and next steps for the Finance Group. It was reported that contributions from primary care and the hospice will be captured in future reports to the Barnsley Place Committee and Partnership Board. The Chief Finance Officer Barnsley Place gave a presentation regarding the next steps for the Partnership Board in relation to the Place Financial Plan 2023/24. It was noted that the Place Partnership Delivery Group will undertake a focussed session at the 13 June 2023 meeting to define priorities and delivery plans to support financial sustainability. The Committee considered the presentations and the following comments noted. • The financial analysis is useful but ownership across the partnership is required. • The Deputy Chief Executive BHNFT offered examples of efficiency opportunities; hospital letters, digital inclusion & engagement, services for the homeless. It is important to get in the mindset of the what the partnership can achieve. • The partnership is committed to reduce inequalities for the local population. • What can the partnership do together to drive out inefficiencies. Workout mechanisms differently, identify where are the inefficiencies, integrate acute and community providers to have true integrated pathways of care. Important to look through partnership lens rather than organisational lens. Start with something that the partnership can deliver on and gain energy across the system for success. • The Partnership Finance Group had momentum and help the partnership to make the right decisions. • Be bold, question if services need to be delivered in the same way, think differently and opportunities will become visible. Opportunities to deliver services as a partnership, making a difference and for better outcomes and efficiencies. Reduce cost and maintain care. • Cost sharing opportunities between Hospices are being considered. **The Place Committee and Partnership Board noted the update on the Final Place Financial Plan 2023/24 and that a further report will be submitted to the 27 July meeting.** ***At this point the Head of Finance – Reporting, Transformation and Delivery Barnsley Place, left the meeting.***	
	COMMITTEES / MINUTES	
18	**Committee Minutes and Assurance Reports**	
	18.1 **Senior Management Team Decisions** - Noted	

	18.2	**Adopted Minutes of the Quality & Patient Safety Group held on 16 March 2023** - Noted	
	18.3	**Adopted Minutes of the Finance, Performance & Efficiency Group held on 9 March 2023** – Noted	
	18.4	**Assurance Report Involvement and Equality Group from the Meeting held on 23 March 2023 inc, Adopted Minutes 19 January 2023** - Noted	
	18.5	**Adopted Minutes of the Barnsley Place Partnership Delivery Group held on 14 March 2023** - Noted	
	GENERAL		
19	**Updates and Escalations from Partners**		
	Deputy Chief Executive BHNFT Members were informed that: • Urgent care in general across the Barnsley Place is holding well but there is more to do. The numbers of A&E attendances and calls to primary care were noted. The cost efficiency work may be a way to improve patient flow. • Industrial action by junior doctors is scheduled to take place on 14 to 17 June 2023 and plans are in place to manage this period. • Barnsley Hospital midwives have won a national award 'Outstanding contribution to midwifery services: Perinatal Mental Health Award' from the Royal College of Midwives, demonstrating good partnership working and offer to Barnsley people. **Chief Executive Barnsley Hospice** • Nominations are now open for the 2023 Proud of Barnsley Awards (Run through Barnsley Chronicle) to honour the unsung people living in the Barnsley communities. The partnership may wish to nominate people for the awards. • Barnsley's first Carers Roadshow (driven forward by Barnsley Health Care Federation) will be held on Friday 9 June 2023 in the town centre to provide additional support to those caring for a loved one in the borough. • The need for appropriate comms and messaging for people regarding the Barnsley football match on Friday 26 May 2023 was highlighted.		

20	**Any Other Business -** No items	
21	**Risk and Items for Escalation to NHS SY ICB**	
	One risk was identified for escalation to the SY ICB • Need to be clear what risks we hold for the Barnsley System	
22	**Reflection on how well the Meetings Business has been Conducted**	
	The Chair invited reflections about the meeting form members, the following comments were noted. • The meeting opening 'Story from our Communities' brings home the reason why the partnership must work together for the benefit of Barnsley people. Each organisation could contribute / sponsor a story at future meetings of the Place Committee and Partnership Board. • Important and interesting to receive the many and varied questions from members of the public. • The meeting papers are helpful and clear enables good conversation around a whole Barnsley health and care partnership approach. Significant challenges ahead for the Partnership Board but feels like the right relationships are in place. • Real need to keep momentum and pace with the work of the Barnsley health and care partnership. • It is understood that there is a process for risk management in the SY ICB risks. However, it would feel more comfortable if the partnership should determine the top 5 risks in the Barnsley Health and Care system	
23	**Date and Time of Next Meeting:** • **29 June 2023 at 1.30 pm – Development Session** • **27 July 2023 at 1.00 pm – Meeting in Public Session** The Chair advised that it is intended to hold meetings of the Barnsley Place Committee and Partnership Board in different community settings around the borough. The Chief Executive Barnsley Hospice offered to host the 27 July 2023 meeting of the Barnsley Place Committee and Partnership Board and this was agreed.	

The recording of the meeting was ceased

QUESTIONS SUBMITTED TO THE NHS SOUTH YORKSHIRE ICB BARNSLEY PLACE COMMITTEE AND PARTNERSHIP BOARD MEETING ON 25 MAY 2023 WITH RESPONSES

MEMBER OF THE PUBLIC (1)
5 Questions Received

Question 1 - Additional Public Question to the SYICB Barnsley Place Partnership Board meeting on 30/03/23

Item 21.4 Assurance Report – Barnsley Involvement and Equality Group

a) Why do the public and existing equality forums know nothing of the involvement plan discussed in this Assurance report?
b) How are the public and existing equality forums involved in the development and approval of such an Involvement Plan?
c) Why does the Barnsley Involvement and Equality Group not include anyone representing the voice of the public or of the existing equality forums?

Response to Question 1

a) The involvement plan are the actions outlined in the Barnsley Place Heath and Care Plan which has been in draft form prior to the meeting today.

b) The group developing the plan is made up of colleagues working across the partnership in addition to Healthwatch Barnsley. They have developed the involvement plan to focus on working better together and build on the way we work alongside local people and communities. The group has membership of officers who work with and link to a whole range of forums.

c) It does through the membership of partner organisations who have a role, link or responsibility for some of these forums.

We are committed to developing our approach to co-production and to that end we will be tabling a more comprehensive paper at the July Committee.

QUESTIONS TO THE 25 MAY 2023 MEETING

Question 1

Why – given the response to my questions regarding the mandatory Place ICB membership – was the action in the response to my question that you are seeking clarification regarding the status of the relevant guidance not included in the minutes or in the action log (Item 8) on this month's meeting?

And i wish to inform you that I have presented a Freedom of Information request to NHS England for clarification myself and have also contacted Olivia Butterworth, NHSE
Deputy Director of People and Communities, who developed the Statutory Guidance, on
the matter.

Response to Question 1

This was included in the response to questions which form an integral part of the meeting, with the questions and answers being attached to the minutes

Question 2

a) Why are the responses generally to public questions at your last meeting so disappointing and feel dismissive and disrespectful to the public you serve when compared with the ICB?

b) Are you aware that members of the public, including myself, have been invited to meet with Pearse Butler (Chair SYICB) to discuss how to improve the SYICB public question board item so that board members are informed and public concerns are heard by the ICB?

c) Are you aware that despite all the engagement reports Public Questions to your Barnsley board meetings is the only open, transparent and direct mechanism for Barnsley people to be involved in your decisions?

Response to Question 2

Yes we are aware and look forward to the reflections from the conversation with Pearse to inform our approach across the ICB.

There are several examples where members of the public have participated in shaping services across our health and care system whether that be through pathway re-design, the development of the carers strategy and other examples. Much of the improvement work is led by providers who will lead the engagement and conversation with communities.

We can always do more in this space and we will reflect upon our approach to co-production as stated earlier.

We have a system wide group that brings together engagement leads from across our organisations and we will ensure that we table a paper on this at a future board meeting.

Question 3

Do you know that:

- in Barnsley the podiatry service is so understaffed that patients with long term conditions leading to regular falls and skeletal alignment issues leading to hip and knee problems are being discharged from the service annually and have to ask their GP to re-refer them each year?
- this policy prevents podiatrists from delivering monitoring of conditions and prevention services?
- but other SY Trusts have financial incentives built into their recruitment processes and don't have this policy?

Response to Question 3

Part 1

- ***The recent mapping exercise shows that people are remaining on caseload much longer than anticipated even those who we wouldn't expect to remain on the caseload.***
- ***We have no evidence of increased falls etc***
- ***The analysis carried out by our team and the current waiting lists does not reflect this position.***
- ***It is clear there are podiatrists within the service and possibly patients who are not happy with the service offer because they would like toe nail cutting etc, that is no longer in the scope of the service.***
- ***Podiatry do have some vacancies are not short staffed we have 1WTE Band 5 vacancy and 1WTE Clinical lead (been out to advert twice so we have now done an internal secondment for experience) . We have two members of staff on Maternity leave and attempted to secure agency but none available***

Part 2

We are monitoring conditions set against NICE guidance and good practice , however we are also following the NHSE guidance on the reduction of unnecessary follow ups and are starting discussions on the direct referral route option with primary care and our ICB as outlined in the operational plan

Part 3

This has been discussed across the Trust and it is a Trust wide decision not to offer incentives. I understand it is only STH who are offering this ad this has bene flagged as part of the SY ICB workforce group

Question 4

Was the Barnsley area aware of the NHS Assembly (NSHE) consultation, that runs out tomorrow 26/5/23, which asks the public and other partners ten questions to inform NHSE on how people think the NHS could work better in England – as there was no information shared by the NHS or Healthwatch in Barnsley or even across SY?

Response to Question 4

NHS South Yorkshire is aware of the NHS Assembly's 'NHS@75 conversation' and has been involved in supporting them to gather views from providers, ICB staff and partners in the area. This is line with the ask of local systems, from the NHS Assembly, which was over a short period of time

MEMBER OF THE PUBLIC (2)
1 Question Received

Question 1

Given, the current impending reduction in the running costs (of about 35%) facing SY ICB:

*. How do you intend to ensure that the above has a minimum impact as possible in the running of programmes at Barnsley place level?

And equally,
* How do you intend to ensure that the SY ICP Strategy's aims and objectives will be achieved as planned at the Barnsley Place level?

Response to Question 1

There is no doubt a challenge for the ICB as it considers how best to approach the 35%. In its consideration the ICB is committed to the principles of subsidiarity with work being done as close to places as possible. The ICB is currently progressing through its plans to address the 35% and we will have more information about that in due course.

We remain committed to delivering against the ambitions of the ICP. Our Health and Care plan tabled today demonstrates our ongoing commitment as tabled at the committee today. Delivering these ambitions is about all of our Health and Care colleagues / organisations and wider leadership not only the ICB resource so maximising this will be key.

MEMBER OF THE PUBLIC (3)
7 Questions Received

It is clear that that the document Barnsley health and care plan 2023-25 and Tackling health inequalities in Barnsley has not been produced with any public involvement. Its just telling us stuff not involving us

Question 1

When will there be a structure a forum a group where the public who are service users and are interested in doing so can participate and can become involved in the planning process ?

Response to Question 1

There are an array of involvement mechanisms designed to ensure that we hear from a diverse breadth of our communities and that we put the voices of people and communities at the centre of decision making and governance at every level of our work. This plan has been informed by over 150 responses from Barnsley people to our 'What matters to you?' conversations and we welcome your feedback about the ways we could develop those conversations for the next plan

Question 2

Is this the way forward to involvement /participation in the many process of the NHS with others or am I being asked to become an advisor?

From the documents

SWYPT sustainability and social responsibility plan
Barnsley Place Plan 2023 to 2025 Summary
Involvement and equality, diversity, inclusion

What we will deliver

We want to be better at, and put more focus on, working with local people and communities to produce plans and design services and solutions rather than just asking or informing them.

Training and development programme to support colleagues to produce and design interventions alongside people who will be using them.

We will work with programme and project leads to advise on and develop people and communities involvement plans aligned to the three tiers health equity approach.

Response to Question 2

NHS South Yorkshire, working through the implementation of our Start with People Strategy, is working hard to ensure that we have the right

representation from local people and communities in the right priority-setting and decision-making forums. Our array of involvement mechanisms are designed to ensure that we hear from a diverse breadth of our communities and that we put the voices of people and communities at the centre of decision making and governance at every level of ICB.

Question 3

The above seem like really good ways to move forward, when will this start happening?

Response to Question 3

This work is already in development and subject to the plan's approval today, the focused work will start over the coming weeks

Question 4

Do the panel think that asking the relevant organisations and the public how they would like to informed and if they would be interested becoming involved in the process of developing the Barnsley ICB ?

Response to Question 4

This happens across the Barnsley partnership and we'll continue to look at ways to build on what works and improve where we can

Question 5

The 'Tackling health inequalities in Barnsley' doc mentions engaging with focus groups. Who are the focus groups?

Response to Question 5

These groups were as part of our 'What matters to you?' work which informed this plan and the South Yorkshire Integrated Care Partnership Strategy. The focus groups were targeted to communities we hadn't reached in other ways. The list of groups is available in the strategy

Question 6

Mentioned a few times in the Barnsley place plan , the 'engagement and involvement approach'. What is this?

Response to Question 6

This describes the actions set out in the plan

Question 7

Why is the subject of and enclosure about the patient story not included in the agenda and the minutes?

Response to Question 7

This has been due to the timing of papers but we are committed to including the topic and speaker for future meetings. There are no papers as this is no a formal presentation

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