Barnsley Accountable Care Shadow Delivery Board

Putting Barnsley People First

The meeting in public of the Barnsley Accountable Care Shadow Delivery Board to be held on Thursday 25 January 2018 at 1.00pm – 3.00pm at The Core , County Way, Barnsley S70 2JW

PUBLIC AGENDA

Item	Session	Board Requested to	Enclosure Lead
1	Welcome		**Chair** 5 mins
2	Apologies		**Chair** 5 mins
3	Quoracy	Note	**Chair** 5 mins
4	NHS; an alternative view	Note	**Chair** 15 mins
5	Declarations of Interest Register	Note	**ACSDB/25/1/05** Chair 5 mins
6	Minutes of the previous meeting	Approve	**ACSDB/25/1/06** Chair 10 mins
7	Matters Arising	Note	**ACSDB25/1/07** Chair 5 mins
8	Barnsley Health & Care Together	Note	**ACSDB25/1/08** Chair 5 mins
9	Governance	Note	**ACSDB/25/1/09** Chair 5 mins
10	Programme Report	Note	**ACSDB/25/01/10** Jeremy Budd 10 mins
11	Strategy Update	Note	**ACSDB/25/01/11** Jeremy Budd 5 mins
12	Cardiovascular disease (CVD) & Frail Elderly Update	Note	**ACSDB/25/01/12** Jackie Holdich Brigid Reid 15 mins
13	Communication & Engagement Update	Note	**ACSDB/25/01/13 Presentation** 10 mins
14	Questions from the Public regarding Accountable Care Shadow Delivery Board business	Note	15 mins
15	Any Other Business (Notified to the Chair in advance)	All	5 mins
16	**Date and Time of next meeting in Public** Thursday, 29 March 2018 at 12.30pm Location to be confirmed		

ACSDB 25/01/05

Barnsley Accountable Care Shadow Delivery Board

Putting Barnsley People First

BARNSLEY ACCOUNTABLE CARE SHADOW DELIVERY BOARD

25 January 2018

Agenda Item 5

Declaration of Interests, Gifts, Hospitality and Sponsorship Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	*x*	*Information*	
2.	**REPORT OF**		
		Name	*Designation*
	Executive Lead	Jeremy Budd	Director Accountable Care Programme
	Author	Alison Edwards	Governance, Risk & Assurance Facilitator
3.	**EXECUTIVE SUMMARY**		
	Conflicts of interest are defined as a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. The table below details what interests must be declared:		

	Type	**Description**
	Financial interests	Where individuals may directly benefit financially from the consequences of a commissioning decision e.g., being a partner in a practice that is commissioned to provide primary care services;
	Non-financial professional interests	Where individuals may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the CCG;
	Non-financial personal interests	Where individuals may benefit personally (but not professionally or financially) from a commissioning decision e.g., if they suffer from a particular condition that requires individually funded treatment;
	Indirect interests	Where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g., spouse, close relative (parent, grandparent, child, etc.) close friend or business partner.

Appendix 1 to this report details all Board Members' current declared interests to update and to enable the Chair and members to foresee any potential conflicts of interests relevant to the agenda. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict.

Members should also declare if they have received any Gifts, Hospitality or Sponsorship.

4.	**THE BOARD IS ASKED TO:**
	• Note the contents of this report and declare if members have any declarations of interest relevant to the agenda or have received any Gifts, Hospitality or Sponsorship.
5.	**APPENDICES**
	• Appendix A – *Board Members Declaration of Interest Report*

Agenda time allocation for report:	*5 minutes.*

Agenda Item 5.1
Appendix A

Putting Barnsley People First

Register of Interests

This register of interests includes all interests declared by members of the Barnsley Accountable Care Shadow Delivery Board. Members should update any conflict of interest that needs to be included in the register within not more than 28 days of any relevant event (e.g. appointment, change of circumstances) and the register will be updated as a minimum on an annual basis.

Register: Barnsley Accountable Care Shadow Delivery Board

Name	Current position (s) held in the CCG	Declared Interest
Nick Balac	Chairman, CCG	• Partner at St Georges Medical Practice (PMS)
		• Practice holds AQP Barnsley Clinical Commissioning Group Vasectomy contract
		• Member of the Royal College of General Practitioners
		• Member of the British Medical Association
		• Member of the Medical Protection Society
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG

Agenda Item 5.1
Appendix A

Name	Current position (s) held in the CCG	Declared Interest
Jeremy Budd	Director of Accountable Care BCCG	• Director – Your healthcare CIC (provision of community health services and social care services in SW London)
		• Associate Director, Attain Health Management Services Ltd (provision of consulting and transformational expertise in health and social care.)
Suresh Chari	Clinical Lead (Consultant Psychiatrist, SWYPFT)	• TBC
Adrian England	Chairman, Healthwatch	• Member, Schools Forum • Member, Stronger Communities Partnership • Member, Health and Wellbeing Board • Member, Senior Strategic Development Group • Member, Senior Intelligence Board • Chair, HealthWatch Barnsley • Director and Executive Member, Barnsley Governors' Association (Company Ltd by Guarantee) • Trustee and Director, PRIDE Multi Academy Trust (Company Ltd by Guarantee) • Director, The Core, Community Interest Company • Member, CCG Patient Council • Member, Barnsley Accountable Care Partnership Board (independent member, no voting rights) • Member SYB Accountable Care System board (Representing the 5 local Healthwatches) • PLACE inspector Barnsley District Hospital Trust • As Chair of Barnsley Healthwatch: Healthwatch receives reports from and provides independent reports to the CQC • Independent Examiner, St Pauls and St Marys Joint Parish

Agenda Item 5.1
Appendix A

Name	Current position (s) held in the CCG	Declared Interest
		• Observer Board of Trustees (no voting rights), Voluntary Action Barnsley • Prospect Union (life member) – formerly British Association of Colliery Management – Yorkshire Branch Secretary
Julie Ferry	Chief Executive Officer, Barnsley Hospice	• Nil
Mehrban Ghani	Medical Director, CCG	• GP Partner at The Rose Tree Practice trading as the White Rose Medical Practice, Cudworth, Barnsley
		• GP Appraiser for NHS England
		• Directorship at SAAG Ltd, 15 Newham Road, Rotherham
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
John Harban	GP Governing Body Member, CCG	• GP Partner at Lundwood Medical Centre and The Kakoty Practice, Barnsley
		• AQP contracts with the Barnsley Clinical Commissioning Group to supply Vasectomy, Carpal Tunnels and Nerve Conduction Studies services

Name	Current position (s) held in the CCG	Declared Interest
		• Owner/Director Lundwood Surgical Services
		• Wife is Owner/Director of Lundwood Surgical Services
		• Member of the Royal College of General Practitioners
		• Member of the faculty of sports and exercise medicine (Edinburgh)
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
Jackie Holdich	Head of Delivery (Integrated Primary and Out of Hospital Care), CCG	• Husband is a Senior Lecturer at Huddersfield University; undertakes Medical and Nursing research, teaches non-medical prescribing and is a Diabetes Specialist Nurse.
Dr Augustin Iqbal	Consultant Physician in Stoke and Neurorehabilitation Medicine	• Nil

Agenda Item 5.1
Appendix A

Name	Current position (s) held in the CCG	Declared Interest
Bob Kirton	Director of Strategy & Business Development, BHNFT	• Director, BHSS
		• Partner Governor (for Trust), Yorkshire Ambulance Service
Sudhagar Krishnasamy	Associate Medical Director, CCG	• GP Partner at Royston Group Practice, Barnsley
		• Member of the Royal College of General Practitioners
		• GP Appraiser for NHS England
		• Executive member of Barnsley Local Medical Committee (ceased July 2017)
		• Member of the Medical Defense Union
		• Director of SKSJ Medicals Ltd • Wife is also a Director

Name	Current position (s) held in the CCG	Declared Interest
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
		• Undertakes sessions for IHeart Barnsley
James Locking	Finance Director, BHF	• Director of Finance for Barnsley Healthcare Federation CIC and Barnsley Healthcare Federation (BHF) CIC
Stephen James Logan	Chief Executive, BHF	• Owner and CEO of SJM Developments (ceased to be owner and CEO in July 2017)
		• Chief Executive Officer of Barnsley Healthcare Federation
		• Spouse is Dr Scargill, GP Partner at Ashville Medical Centre
		• Owner of Roundwood Clinic which provides physiotherapy services
Wendy Lowder	Director of Communities (Director of Communities BMBC)	• TBC

Agenda Item 5.1
Appendix A

Name	Current position (s) held in the CCG	Declared Interest
Heather McNair	Director of Nursing & Quality, BHNFT	• Nil
Dr A Mistry	Clinical Lead (Chair, BHF)	• Chair Federation CIC company
Sean Rayner	District Director, SWYPFT	• Nil
Brigid Reid	Chief Nurse, CCG	• Volunteer Registered Nurse, St Gemma's Hospice, 329 Harrogate Road, Moortown, Leeds LS17 6QD
		• Partner works at Leeds Teaching Hospital NHS Trust which provides services to Barnsley patients via Specialised Commissioning and could tender to supply others.
Lesley Smith	Chief Officer CCG	• Husband is Director/Owner of Ben Johnson Ltd a York based business offering office interiors solutions, furniture, equipment and supplies for private and public sector clients potentially including the NHS.
		• Board Member (Trustee), St Anne's Community Services, Leeds
Sarah Tyler	Lay Member Accountable Care, Barnsley CCG	College delivers healthcare training, minimal risk.

Name	Current position (s) held in the CCG	Declared Interest
		Monitoring of health contracts with providers who may have a relationship with Barnsley
		Nursery services, minimal risk
		Work relates to patient choice
Michael Wright	Director of Finance (Director of Finance, BHFT)	• Director, BFS

Putting Barnsley People First

Minutes of the meeting of the BARNSLEY ACCOUNTABLE CARE SHADOW DELIVERY BOARD (Public Session) held on Thursday 23 November 2017 at 2.00 pm in the Boardroom, NHS Barnsley Clinical Commissioning Group, Hillder House, 49/51 Gawber Road, Barnsley S75 2PY

MEMBERS PRESENT:

Barnsley CCG

Dr Nick Balac (in the chair)	Chairman (Chair, Barnsley CCG)
Jeremy Budd	Programme Director and Director of Tactical Commissioning (Director of Accountable Care, Barnsley CCG)
Dr Mehrban Ghani	Medical Director (Medical Director, Barnsley CCG)
Dr John Harban	Clinical Lead (Elected Member Governing Body, Barnsley CCG)
Dr Sudhagar Krishnasamy	Clinical Lead (Elected Member Governing Body, Barnsley CCG)
Lesley Smith	Chief Officer for Commissioning (Chief Officer, Barnsley CCG)

Barnsley Healthcare Federation

Jim Logan	Director Primary Care at Scale (Chief Executive Officer, BHF)
Dr Ajay Mistry	Clinical Lead (Chair, BHF)

Barnsley Hospital NHS Foundation Trust

Bob Kirton	Director of Secondary Care (Director of Strategy BHFT)
Heather McNair	Clinical Lead (Director of Nursing, BHFT)
Michael Wright	Director of Finance (Director of Finance, BHFT)

Barnsley Metropolitan Borough Council

Wendy Lowder	Director of Communities (Director of Communities BMBC)

South West Yorkshire NHS Partnership Trust

Dr Suresh Chari	Clinical Lead (Consultant Psychiatrist, SWYPFT)
Sean Rayner	Director of Community Services (District Director, SWYPFT)

IN ATTENDANCE

Tarique Chowdhury	Communications and Engagement Manager
Chris Millington	Lay Member Patient & Public Engagement and Primary Care Commissioning, Barnsley CCG
Sarah Tyler	Lay Member Accountable Care, Barnsley CCG
Jackie Holdich	Head of Delivery Integrated Primary and Out of Hospital Care, Barnsley CCG

APOLOGIES

Julia Burrows	Director of Public Heath (BMBC)
Brigid Reid	Alliance Director (Chief Nurse Barnsley CCG)

MEMBERS OF THE PUBLIC

Cllr Malcolm Clements	Councillor BMBC
Peter Deakin	Barnsley Save our NHS
Nora Everitt	Member of the Public
Wayne Gilmore	Member of the Public
Julie Ingram	Member of the Public
Malcom Ingram	Member of the Public
Tony Nutall	Barnsley Save our NHS
Cllr Margaret Sheard	Councillor BMBC
Tom Sheard	Member of the Public
Philip Watson	Member of the Public

The Chairman welcomed members of the public to the meeting and introductions took place.

The Chairman advised that there would be an opportunity for members of the public to ask questions at the end of the meeting.

Agenda Item		Action	Deadline
BACSDB 17.11.17/01	**PATIENT STORY**		
	The Board received a Patient Story which reflected the experiences of a lady who was interested in finding out more about accountable care and what this would mean for the people of Barnsley. It was noted that the Patient Story was available on the Accountable Care website.		
	The Chairman requested the thoughts of the Board about the Patient Story and the following main comments were noted: • The story was a good example of how Members of the public may be thinking about an accountable care system in Barnsley. • Accountable was a difficult concept to put forward to the Barnsley People. It was the collective role of the Board to make the concept simple and real for Barnsley People. The Chairman concluded discussion indicating that the story articulated the views and perceptions of the public and also showed how members of the public could become involved and engaged with the		

Agenda Item		Action	Deadline
	accountable care system in Barnsley.		
	The Board noted the Patient Story.		
BACSDB 17.11.17/02	**DECLARATION OF INTERESTS**		
	The Board considered the Declarations of Interest Report. It was noted that members would have an interest in agenda item 7, 'Update on Accountable Care Shadow Delivery Board Membership'. The Board noted the declaration of Interest Report. **Agreed Action** **To include declarations for Dr A Mistry in the next Report to the Board**.	**KM**	
BACSDB 17.11.17/03	**ACTIONS FROM THE OCTOBER DEVELOPMENT SESSION**		
	The Board noted the Minutes of the Barnsley Accountable Care Shadow Delivery Board Development Session held on 5 October 2017. The Programme Director confirmed that all actions arising from the development session were included on the meeting Agenda for 23 November 2017.		
BACSDB 17.11.17/04	**ACCOUNTABLE CARE IN BARNSLEY**		
	The Programme Director provided the Board with a presentation detailing the process taken so far with development of accountable care in Barnsley. In summary the presentation included; why there was a need for change in Barnsley, the vision and benefits of an accountable care system, the role of an accountable care organisation and what this would mean for Barnsley people. The Programme Director advised that accountable care systems were the national direction of travel for delivery of care to local populations both at regional and township level		
	The Chairman invited the views of Board members with regard to the presentation and the following main points were noted:		

Agenda Item		Action	Deadline
	• The CCG Chief Officer commented that the presentation gives a feeling that partnership / accountable care work was just commencing whilst in reality over the years there has been a substantial amount of joint working and this should be included in any future presentations. Partnership working was not new to Barnsley. A CCG and BMBC Joint Commissioning Team had been in place for a number of years, commissioning for example Mental Health Services for the people of Barnsley. • It was recognised that the social care provider element comprised a number of smaller private businesses. • The Barnsley Hospital NHS Foundation Trust was pleased to be part of the Barnsley Accountable Care organisation, to continue with and improve the existing partnership working arrangements. Projects such as funding for Barnsley Hospital Childrens Emergency Department and Assessment Unit, front end primary care extended working and reduced delayed transfers of care could not have been achieved without true partnership working. In addition the Barnsley A&E was one of the best performers in the Country, the HSMR (hospital standardised mortality ratio) had reduce and Barnsley was one of the highest performers in the country for cancer waits. • An accountable care organisation, as both commissioners and providers can make best use the Barnsley £ to deliver better outcomes for Barnsley People. • BMBC services were being provided on the Barnsley locality based model of delivery for example Community Nursing and Health visiting with effective outcomes for patients. • From a governance perspective the principles of voting would need to be worked through. The Chairman indicated that the learning from the		

Agenda Item		Action	Deadline
	presentation demonstrated that local health & social care organisations achieved greater things together and at pace. An accountable care organisation would continue to develop improved outcomes for the people of Barnsley.		
	The Board noted the presentation.		
BACSDB 17.11.17/05	**UPDATE ON ACCOUNTABLE CARE SHADOW DELIVERY BOARD MEMBERSHIP**		
	The Board received a report outlining changes to the Membership of the Accountable Care Shadow Delivery Board.		
	It was noted that the BMBC Director of Public Health and the Chair of the Barnsley Healthcare Federation will join the membership of the Board, as Director of Public Health and as a Clinical Lead respectively. In addition the Director of Communities will replace the Director of Social Care on the Board, as the contribution of the Director of Communities would be more relevant to the work of the Board.		
	The Board noted the changes to the membership of the Accountable Care Shadow Delivery Board.		
BACSDB 17.11.17/06	**ENGAGING AND INVOLVING PATIENTS AND THE PUBLIC – DRAFT PLAN**		
	The Communications and Engagement Manager presented the initial plan for engaging and involving patients in accountable care to the Board. The plan set out the aims, objectives and role of communications and engagement activity, the target audiences / stakeholders, proposed key messages, identity for accountable care and a communications activity planner. It was reported that five Comms and Engagement Teams from partner organisations had developed the draft plan.		
	The Director of Communities commented that the draft plan reflected on the BMBC experiences of engagement and provided a real opportunity to build on what was already in place in terms of		

Agenda Item		Action	Deadline
	communications and engagement. As an example locality community researchers in the Dearne had brought about active engagement with local residents**.**		
	The Board considered the draft plan. It was suggested that engagement should be built on the locality model. GPs and practice staff have millions of conversations with patients in the course of the daily work and had a clear understanding of the health and social care needs of their local populations. SWYPT and BHNFT staff had 'rich' conversations with the public on a constant basis providing a wealth of information. Staff engagement was important as all staff had professional and personal contacts with the people of Barnsley.		
	The Board confirmed commitment & support to the Plan for Engaging and Involving Patients and the Public and to make organisation resources available to enact the Plan at pace as per the scheduled activity planner. **Agreed actions** **To build on staff engagement with patients and the public in the draft plan.**	**TC**	
BACSDB 17.11.17/07	**PRIORITY AREAS FOR THE BOARD**		
	The Head of Delivery Integrated Primary and Out of Hospital Care gave a presentation to the Board which provided a progress update on the Programme Priority Areas of Cardiovascular Disease and Frailty including engagement and mapping events with partner clinicians for each of the priority areas, agreed objectives, a patient and professional perspective and areas of work for the partnership with identified next steps.		
	It was highlighted that the presentation demonstrated and was an excellent example of how partners could work together to improve services and outcomes for the people of Barnsley. It was noted that the Clinical Senate was being consulted with regard to the priority areas.		

Agenda Item		Action	Deadline
	The BHNFT Clinical Lead commented that key issue for patients was around communication in particular navigation around services. The BHNFT had a team focussing on frailty and was part of a Frailty Network. The learning from the network would be shared with partners. The Director of Communities BMBC reported that an Independent Living Review was in progress.		
	The Board noted the Report and confirmed their commitment to progress the Programme Priority Areas of Cardiovascular Disease and Frailty.		
BACSDB 17.11.17/08	**ANY OTHER BUSINESS**		
	There were no items of Any Other Business. The Chairman advised that potential items of any other business should in future be discussed with him first prior to meetings of the Shadow Delivery Board.		
BACSDB 17.11.17/09	**QUESTIONS FROM THE PUBLIC REGARDING ACCOUNTABLE CARE SHADOW DELIVERY BOARD BUSINESS**		
	The Chairman invited questions from the Public. A summary of all questions received and responses provided is as follows: **1. Joint Agency Group** **Issue:** The Board were advised that there had been a pre runner to accountable care via a Joint Agency Group (JAG), an all Barnsley Agencies Group. The JAG operated well, there were no blocked beds and joint services were delivered for the people of Barnsley. It was suggested that the learning from JAG could be researched and considered in development of accountable care. **Response:** The operation of JAG to be considered in respect of accountable care. 2. **Patient Involvement - Mental Health & Carers** **Issue:** Request to ensure that mental health & carers are included in patient involvement.		

Agenda Item		Action	Deadline
	Response: Mental Health and Carers will be included in Engagement & Involvement around the accountable care. **3. Privatisation** **Issue:** Accountable Care is a way of privatising NHS services in Barnsley. **Response:** The Accountable Care Partnership, which we are in the process of developing is a partnership ofpublicly owned and publicly funded organisations, primary care organisations and the local authority. **4. Public involvement in terms of engagement** **Issue:** Involvement will not be wide enough to genuinely represent or consult Barnsley People and would not meet statutory duties to consult with the Public. **Response**: We are currently informing the public about accountable care and seeking to learn about their needs, ideas and concerns. This is not a consultation, which is a legal process where significant change to services would need to be consulted on following a due process. We have developed a stakeholder map that both includes wide sections of our local population and which will be added to as we access more groups. We will also be working at community level to have direct conversations about key accountable care issues and seeking to broaden our reach by working with groups to access other representative communities, especially within the Protected Groups audiences. Work has already started to look at channels to reach the public, i.e. Peoples' Forum and community based groups. Reports will be made of all engagement and involvement activity. The Chairman reminded the meeting of his Open Door Policy to any member of the Public weekly on Fridays from 9.30am-10.30am at the CCG offices.		

Agenda Item		Action	Deadline
	Anyone wishing to attend can contact Leanne Whitehead at leanne.whitehead1@nhs.net so we can manage where we could meet within the CCG if numbers were large or if a specific topic was asked to be discussed. **5. Social Care not included** **Issue**: When hearing about the first two priority areas – cardiovascular disease and frailty – there was concern social care would not be included. **Response**: The Local Authority including social care is a key partner and are involved with our conversations and planning as we all work together to develop better outcomes for the people of Barnsley. **6. Accountability** **Issue**: Who is the Accountable Care Shadow Delivery Board accountable to? **Response**: As a Board we are accountable to the Accountable Care Partnership Board, which in turn is widely accountable to all our partner organisations sovereign boards and Governing Bodies, including to the CCG which is is accountable to its GP membership, Healthwatch, , NHS England, SYB ACS, Health and Wellbeing Board, and scrutiny and regulatory bodies, e.g. the Care Quality Commission (CQC). 7**. Accountable Care system / Organisation – Legal Constitution** **Issue**: Is Barnsley Accountable Care legally constituted? **Response:** There is a South Yorkshire & Bassetlaw Accountable Care System with 5 accountable care partnerships underpinning the system, Barnsley was one such partnership**.** There was a collective Memorandum of Understanding between partner organisations as opposed to a formal agreement. Alliance contracts were already in place for delivery of some local service.		

Agenda Item		Action	Deadline
	8. Internet use **Issue**: All engagement and involvement would be based online and that many of Barnsley's older population would be excluded as a result. **Response**: We will develop engagement materials and tools accessible to all people and, whilst this will include online information, it will also include printed and other formats, e.g. larger print. The questioner was invited to meet with theComms and Engagement Manager in November to outline their ideas further. **9. Clarity on Partnership, System or Organisation?** **Issue**: Clarity was sought about if accountable care in Barnsley was as an accountable care 'partnership', 'system' or 'organisation'. **Response**: Accountable care in Barnsley is a partnership, which through the Accountable Care Shadow Delivery Board, would be looking at the detail and options of becoming an accountable care organisation. The accountable care system covered a wider geography of Barnsley and four other areas. **10. GP Appointments** **Issue:** What will accountable care mean for Primary Care and patients being able to get a GP appointment? **Response:** The Chairman agreed to pick this up with the member of the public outside of the meeting as this was a specific issue across primary care. **11. GP shortages in Barnsley** **Issue:** What was being done regarding GP shortages in Barnsley**?** **Response:** Active recruiting of GPs for Barnsley		

Agenda Item		Action	Deadline
	was taking place and also looking at working models to delivery Primary Care services in a safe way for example Clinical Pharmacists, Health Care Assistants & Nurse**s.** **12. General** **Patient Council –** The presentation about Engaging & Involving Patient would be provided to the patient The Patient Council **Meeting Rooms / Venues & timing of meetings -** We will be locating future meetings to allow for better involvement of the public, acoustics and viewing of visual presentations.		
BACSDB 17.11.17/10	**DATE AND TIME OF NEXT MEETING**		
	The next meeting of the Barnsley Accountable Care Shadow Delivery Board will be held on Thursday 25 January 2017 at 1.00 pm in the Conference Room 1, The Core, County Way, Barnsley, S70 2JW		

Putting Barnsley People First

BARNSLEY ACCOUNTABLE CARE SHADOW DELIVERY BOARD

25 January 2018

MATTERS ARISING REPORT

1. The table below provides an update on actions arising from the previous meeting of the Barnsley Accountable Care Shadow Delivery Board held on 23 November 2017.

Table 1

Minute ref	Issue	Action	Outcome/Action
17.11.17/02	Declaration of Interests	To include declarations for Dr A Mistry in the next report to the Board	
17.11.17/06	Engaging and Involving patients and the public.	**To build on staff engagement with patients and the public in the draft plan**	

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

ACCOUNTABLE CARE SHADOW DELIVERY BOARD

25 January 2018

Barnsley Health and Care Together

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*		*Information*	*x*
2.	**REPORT OF**			
		Name	***Designation***
	Executive Lead	Jeremy Budd	Programme Director
	Authors	Kirsty Waknell Tarique Chowdhury	Head of Communications & Engagement, BCCG Communications and Engagement Manager
3.	**EXECUTIVE SUMMARY**		

Barnsley Health and Care Together

Health and Social Care Working With You and Your Community

The Shadow Accountable Care Delivery Board has now signed off the communications and engagement strategy for the Partnership.

In delivering that strategy the recommendation was that we moved swiftly to adopt a single name, which can be used by all partners, and which creates a focus around which people can speak about the work we are doing and when speaking with the pubic and staff about us. The new name will be used across all communication materials and tools.

The rationale for adopting this name is based on public feedback and on the need to better communicate our intentions in Barnsley for closer working between health and care partners. The feedback showed the term “accountable care” is unclear for some at best, or has a negative connotation of how the health and care system is run in the USA at worst.

We need to speak clearly about our vision for joined up health and care with local communities and staff as we now move into a more public phase of our partnership.

The conversation of what to call, or not call, what we are trying to achieve is not unique to Barnsley. We are keen to move this conversation on and provide a name which is clear and is inclusive of the role of organisations and the Barnsley public.

	A number of naming options were reviewed and because of the strength of partnership work in Barnsley, have mostly been used already. The recommendation accepted by the Partnership Board is that we adopt the name: ***"Barnsley Health and Care Together"*** with the supporting line of *"Health and Social Care Working With You and Your Community".* The name reflects the area we work in, the ways we would like to work - as partners and as a local community - and the areas of work which we are focused on improving. This is similar to other vanguard names across the country, such as in Salford, and has been shared and consulted with partners' communication leads in Barnsley. The Accountable Care Partnership Board has approved the proposed name. "Accountable care" as a term will be kept nationally and locally as part of the explanation of the partnership way of working, additionally, there may be need to use the term for governance or contractual reasons and that will continue. However, the terms 'accountable care partnership' and 'accountable care organisation' will no longer be routinely used when referring to this Partnership and when talking to local communities and colleagues across the partner organisations. • The Shadow Delivery Board will be termed the "Barnsley Health and Care Together Board". • A suitable branding will be developed internally within the Partnership to keep costs to a minimum. As the Partnership develops and may move to a different entity, the name can be reviewed to ensure it meets future needs.
4.	**THE BOARD IS ASKED TO:**
	Note the proposed name, which has already been approved by the Accountable Care Partnership Board.

Agenda time allocation for report:	*5 mins*

ACSDB 25/01/09

Putting Barnsley People First

ACCOUNTABLE CARE SHADOW DELIVERY BOARD

25 January 2017

Governance Update

PART 1 – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*		*Information* ✓
2.	**REPORT OF**						

	Name	*Designation*
Lead	Dr Nick Balac	Chair
Author	Jeremy Budd	Programme Director

3. GOVERNANCE ARRANGEMENTS

Members of the ACSDB are asked to note the following governance arrangements.

1. The Accountable Care Partnership Board has approved (20TH December 2017) the Terms of Reference for the Shadow Delivery Board and these are attached here as Appendix 1.
2. The Shadow Delivery Board also acts as the Alliance Leadership Team for the administration of the Alliance Agreement. The Terms of Reference for this role, based upon the Alliance Agreement, are included as an appendix to the Shadow Delivery Board ToR.
3. The Governance structure underpinning the activities of the Shadow Delivery Board is attached as Appendix 2. This shows the reporting lines to the Shadow Delivery Board and the supporting workstreams and current membership. Please note that reporting to the Shadow Delivery Board is split between Shadow Delivery Board *development* activities, which report via the Programme Management Office (please note the membership of this group), and *delivery* activities associated with the Alliance Agreement, which report via the Alliance Management Team.

The Shadow Delivery Board should also note the appointment of Marie Hoyle, the CEO of Barnsley Healthcare Federation (BHF) as the Board's Director of Primary Care at Scale, following the resignation of Jim Logan from BHF.

4. THE SHADOW DELIVERY BOARD IS ASKED TO:

- Note the Terms of Reference that have been approved by the ACPB

	• Read and consider the supporting documents and governance arrangements.
5.	**APPENDICES**
	Appendix 1: Accountable Care Shadow Delivery Board Terms of Reference Appendix 2: ACSDB supporting governance structure, workstreams and membership.

Agenda time allocation for report:	5 minutes

ACSDB 25/01/09

Appendix 1

Putting Barnsley People First

Accountable Care Shadow Delivery Board
Terms of Reference

Putting Barnsley People First

Accountable Care Shadow Delivery Board

1.	**Introduction**	
	1.1	NHS Barnsley CCG (BCCG), Barnsley Metropolitan Borough Council (BMBC), Barnsley Hospital NHS Foundation Trust (BHNFT), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and Barnsley Healthcare Federation (BHF) have, as partners, agreed to explore and develop an integrated system of health and social care in Barnsley working with other partners including Voluntary Action Barnsley, Healthwatch Barnsley and Barnsley Hospice.
	1.2	Developing a system model for Accountable Care. An integrated provider model that is likely to include: • Integrated out of hospital service delivery including primary and community care. • Tier 1 acute services. • Some of the commissioning functions held by Barnsley CCG. These functions are termed as "tactical" commissioning and include amongst others service and pathway redesign.
	1.3	To take the ACO development work (the "Programme") forward the partners established an – • Accountable Care Shadow Delivery Board (ACSDB) which is responsible operationally for the delivery of the Barnsley Plan, Alliance Contract and development of an ACO. • Accountable Care Partnership Board which is responsible for overseeing the ACSDB, providing support and strategic decision making either directly, within their scope of delegated authority, or by making recommendations to sovereign organisation Boards.
	1.4	The development of the ACSDB is supported by the emerging SYB ACS direction of travel and the Memorandum of Understanding, as well as by the work in Barnsley over the last 18 months to develop accountable care in Barnsley. It is important to note that the ACSDB is a transitional arrangement; a step on the route to developing accountable care in Barnsley. The ACSDB and associated governance arrangements will need to be re-visited as we collectively move towards the establishment of shadow operating status from March 2018 and a legal entity from March 2019 or as soon as legally practicable thereafter
2.	**Purpose**	
	2.1	Deliver the Barnsley Plan, in particular those elements that support delivery of the STPs accountable performance contract, including improvement in urgent and emergency care and cancer waiting times as well as progress with improving mental health services and primary care.
	2.2	Oversee the delivery of the current Alliance Contract, acting as the Alliance Leadership Team (annex 1).
	2.3	Support the transition of the ACSDB to a legally constituted ACO by 1 April 2019 or as soon as legally practicable thereafter.

	2.4	Deliver the place based requirements of the SYB ACS.	
3.	**Responsibilities**		
	3.1	Deliver seamless, integrated services for the people of Barnsley; Delivering the Barnsley Plan and the STP Health and Care Plan.	
	3.2	Deliver the agreed Accountable Care Operating Principles.	
	3.3	Makes best use of the Barnsley £. putting Barnsley people first ahead of the needs of individual partner organisations [Note: it is recognised that there will need to be a transition to risk share arrangements between partner organisations and that current regulatory requirements make this challenging].	
	3.4	Provide visible leadership, direction and commitment to the establishment of an ACSDB and to the individuals working within it, establishing and promoting effective communication of the Board's goals and progress.	
	3.5	Ensure the transition from the current to the new system of health and social care is managed effectively, efficiently and safely, ensuring that risks are understood and managed and that the safety of patients and service users is never compromised.	
	3.6	Support the transition of the ACSDB to a legally constituted ACP by 1 April 2019 or as soon as legally practicable thereafter.	
	3.7	Ensure patients and service users, staff and the public are fully engaged and consulted.	
	3.8	Ensure key stakeholders are fully informed with the work of the Board through regular reporting.	
	3.9	Manage appropriately the resources delegated to the Board.	
	3.10	Review and if appropriate, adapt the Board's objectives, milestones and governance in light of internal or external strategic changes.	
	3.11	Provide a mechanism to consistently report on the progress of the Board both within Barnsley but also to regulators.	
	3.12	To operate throughout the proposed transition period before handing over responsibility for operating to the Accountable Care Partnership which is currently being developed.	
	3.13	To act as the Alliance Leadership Team for the purposes of the Alliance Agreement.	
	3.14	To deliver any requirements of the SYB ACS Memorandum of Understanding.	
4.	**Membership**		
	4.1	The membership of the ACSDB will be:	
		4.1.1	CCG Chair – (voting member)
		4.1.2	5 Clinical leads, 2 commissioner, 3 provider (all voting members)
		4.1.3	Director – Primary Care at Scale (voting member)
		4.1.4	Director – Community Health (voting member)
		4.1.5	Director – Secondary Care Services (voting member)
		4.1.6	Chief Officer for Commissioning (voting member)
		4.1.7	Director – Communities
		4.1.8	Director – Tactical commissioning
		4.1.9	Medical Director (CCG)
		4.1.10	Finance Director
		4.1.11	Barnsley Hospice
		4.1.12	Healthwatch
		4.1.13	Public Health Director
	4.2	Membership will be reviewed and adjusted as necessary to ensure the ACSDB meets its responsibilities.	
5.	**Voting and Quorum:**		
	5.1	The Board will operate through the development of a consensus. However, if a decision requires a vote, this will be decided by a simple majority. There is no right of veto.	
	5.2	The ACSDB will be quorate when there is at least one member present from	

		each partner organisation and also when there are at least two clinical leads present.
	5.3	Deputies may be nominated to attend, although there should be a clear and consistent intention to attend by each appointed Director.
6. Admission of Public and the Press		
	6.1	Meetings of the ACSDB will be in public unless the Group considers that it is not in the public interest to permit members of the public to attend a meeting or part of a meeting.
	6.2	The press and or the public may be excluded from the meeting or part of a meeting to prevent disruption or to discuss a confidential issue or where publicity on a matter would be prejudicial to the public interest.
	6.3	Where press or public are excluded, members and employees will be required not to disclose confidential contents of papers or minutes, or content of any discussion at meeting on these topics, outside the ACSDB without express permission of the ACSDB or Accountable Care Partnership Board.
7.	**Accountability**	
	7.1	The Accountable Care Shadow Delivery Board is accountable to the Accountable Care Partnership Board.
8.	**Reporting Arrangements**	
	8.1	Formal minutes will be completed from the meeting and shall be submitted to the Accountable Care Partnership Board on a monthly basis.
	8.2	The ACSDB will also report on a regular basis to the Health & Well-being Board (and the Senior Strategic Development Group) for delivery of the Barnsley Plan
9.	**Administration**	
	9.1	The ACSDB will be supported by Barnsley CCG which will include the administration of meetings.
10.	**Frequency**	
	10.1	The ACDSB will meet on a monthly basis.
11.	**Code of Conduct**	
	11.1	The ACSDB group shall conduct its business in accordance with national guidance, relevant codes of practice including the Nolan Principles, and the CCG's 'Standards of Business Conduct, Managing Conflicts of Interest and Acceptance of Sponsorship, Gifts and Hospitality Policy.'
12.	**Review**	
	12.1	The ACSDB should review on a regular basis its own performance, membership and terms of reference. Any resulting changes to the terms of reference or membership should be approved by the Accountable Care Partnership Board.

ALLIANCE LEADERSHIP TEAM – TERMS OF REFERENCE

1 Purpose

1.1 The Alliance Leadership function will be fulfilled by the Shadow Delivery Board acting as the "Alliance Leadership Team". The Alliance Leadership Team provides strategic direction to the alliance, to manage risk and to hold to account the Alliance Management Team for the performance of the alliance such that it achieves the objectives set for it.

2 Status and authority

2.1 The Alliance is established by the Participants, who remain sovereign organisations, to provide a financial and governance framework for the delivery of the Services. The Alliance is not a separate legal entity, and as such is unable to take decisions separately from the Participants or bind its Participants; nor can one or more Participants 'overrule' any other Participant on any matter (although all Participants will be obliged to comply with the terms of the Agreement).

2.2 The Agreement establishes the Alliance Leadership Team to lead the Alliance on behalf of the Participants. As a result of the status of the Alliance the Alliance Leadership Team is unable in law to bind any Participant so it will function as a forum for discussion of issues with the aim of reaching consensus among the Participants.

2.3 The Alliance Leadership Team will function through engagement between its members so that each Participant makes a decision in respect of, and expresses its views about, each matter considered by the Alliance Leadership Team. The decisions of the Alliance Leadership Team will, therefore, be the decisions of the Participants, the mechanism for which shall be authority delegated by the Participants to their representatives on the Alliance Leadership Team.

2.4 Each Participant shall delegate to its representative on the Alliance Leadership Team such authority as is agreed to be necessary in order for the Alliance Leadership Team to function effectively in discharging the duties within these Terms of Reference. The Participants shall ensure that each of their representatives has equivalent delegated authority. Authority delegated by the Participants shall be defined in writing and agreed by the Participants, and shall be recognised to the extent necessary in the Participants' own schemes of delegation (or similar).

2.5 The Participants shall ensure that the Alliance Leadership Team members understand the status of the Alliance Leadership Team and the limits of the authority delegated to them.

3 Responsibilities

3.1 The Alliance Leadership Team will:

(a) *ensure alignment of all organisations to the Alliance vision and objectives;*

(b) *promote and encourage commitment to the Alliance Principles and Alliance Objectives amongst all Participants;*

(c) *formulate, agree and ensure that implementation of strategies for achieving the Alliance Objectives and the management of the Alliance;*

(d) *discuss strategic issues and resolve challenges such that the Alliance Objectives can be achieved;*

(e) *respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Alliance or any Participants to the extent that they affect the Participants' involvement in the Alliance;*

(f) *agree policy as required;*

(g) *agree performance outcomes/targets for the Alliance such that it achieves the Alliance Objectives;*

(h) *review the performance of the Alliance, holding the Alliance Management Team to account, and determine strategies to improve performance or rectify poor performance;*

(i) *ensure that the Alliance Management Team identifies and manages the risks associated with the Alliance, integrating where necessary with the Participants' own risk management arrangements;*

(j) *generally ensure the continued effectiveness of the Alliance, including by managing relationships between the Participants and between the Alliance and its stakeholders;*

(k) *ensure that the Alliance accounts to relevant regulators and other stakeholders through whatever means are required by such regulators or are determined by the Alliance Leadership Team, including, to the extent relevant, integration with communications and accountability arrangements in place within the Participants;*

(l) *address any actual or potential conflicts of interests which arise for members of the Alliance Leadership Team or within the Alliance generally, in accordance with a protocol to be agreed between the Participants (such protocol to be consistent with the Participants' own arrangements in respect of declaration and conflicts of interests, and compliant with relevant statutory duties);*

(m) *oversee the implementation of, and ensure the Participants' compliance with, this Agreement and all other Services Contracts;*

(n) *review the governance arrangements for the Alliance at least annually.*

4 Accountability

4.1 The Alliance Leadership Team is accountable to the Participants and will *address all regulatory requirements and accountability to relevant stakeholders*.

4.2 The minutes of the Alliance Leadership Team will be sent to the Participants at least 5 working days (one week) before the next meeting.

4.3 The minutes shall be accompanied by a report on any matters which the Chair considers to be material. It shall also address any minimum content for such reports agreed by the Participants.

5 Membership and Quorum

5.1 The Alliance Leadership Team will comprise:

(a) **CCG Chair – (Chair)** (Barnsley CCG)

(b) **5 Clinical leads** (Barnsley CCG, Barnsley Hospital, South West Yorkshire Partnership Trust and Barnsley Healthcare Federation)

(c) **Director – Primary Care at Scale** (Barnsley Healthcare Federation)

(d) **Director – Community Health** (South West Yorkshire Partnership Trust)

(e) **Director – Secondary Care Services** (Barnsley Hospital)

(f) **Chief Officer for Commissioning** (Barnsley CCG)

(g) **Director – Social Care** (Barnsley Metropolitan Borough Council)

(h) **Director – Tactical commissioning** (Barnsley CCG)

(i) **Medical Director** (Barnsley CCG)

(j) **Finance Director** (Barnsley Hospital)

(k) **Barnsley Hospice**

(l) **Healthwatch Barnsley**

5.2 The following persons may attend meetings of the Alliance Leadership Team as observers but will not participate in decisions:

(a) **Lay member for Accountable Care** (Barnsley CCG)

(b) **Lay member for Patient and Public Engagement and Primare Care Comissioning** (Barnsley CCG)

5.3 Other members/attendees may be co-opted as necessary.

5.4 The Alliance Leadership Team will be quorate if two thirds of its members are present, subject to the members present being able to represent the views and decisions of the Participants who are not present at any meeting. Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Deputies must be able to contribute and make decisions on behalf of the Participant that they are representing. Deputising arrangements must be agreed with the Chair prior to the relevant meeting.

5.5 The Alliance Leadership Team will be chaired by Chair of Barnsley CCG (the "Chair").

6 Conduct of Business

6.1 Meetings will be held in public on a bi-monthly basis. Development sessions for the Shadow Delivery Board will be held in private in the intermediary months.

6.2 The agenda will be developed in discussion with the Chair. Circulation of the meeting agenda and papers via email will take place one week before the meeting is scheduled to take place. In the event members wish to add an item to the agenda they need to notify the Programme Officer who will confirm this will the Chair accordingly.

6.3 At the discretion of the Chair business may be transacted through a teleconference or videoconference provided that all members present are able to hear all other parties and where an agenda has been issued in advance.

6.4 At the discretion of the Chair a decision may be made on any matter within these Terms of Reference through the written approval of every member, following circulation to every member of appropriate papers and a written resolution. Such a decision shall be as valid as any taken at a quorate meeting but shall be reported for information to, and shall be recorded in the minutes of, the next meeting.

7 Decision Making and Voting

7.1 The Chair, Clinical leads, Director – Primary Care at Scale, Director – Community Health and Director – Secondary Care Services are voting members of the Alliance Leadership Team.

7.2 It is recognized that there is some cross-over in the membership of the Alliance

Management Team and Alliance Leadership Team and therefore the Shadow Delivery Board reserves the right to change the decision making and voting arrangements specified.

7.3 The Alliance Leadership Team will aim to achieve consensus for all decisions of the Participants.

7.4 To promote efficient decision making at meetings of the Alliance Leadership Team it shall develop and approve detailed arrangements through which proposals on any matter will be developed and considered by the Participants with the aim of reaching a consensus. These arrangements shall address circumstances in which one or more Participants decides not to adopt a decision reached by the other Participants.

8 Conflicts Of Interests

8.1 The members of the Alliance Leadership Team must refrain from actions that are likely to create any actual or perceived conflicts of interests.

8.2 The Alliance Leadership Team shall develop and approve a protocol for addressing actual or potential conflicts of interests among its members (and those of the Alliance Management Team). The protocol shall at least include arrangements in respect of declaration of interests and the means by which they will be addressed. It shall be consistent with the Participants' own arrangements in respect of conflicts of interests, and any relevant statutory duties.

9 Confidentiality

9.1 Information obtained during the business of the Alliance Leadership Team must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information will be to inform new service models and such information should not be used for other purposes (e.g. performance management, securing competitive advantage in procurement).

9.2 Members of the Alliance Leadership Team are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Alliance. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

10 Support

10.1 Support to the Alliance Leadership Team will be provided as part of a programme management approach.

10.2 The programme structure and supporting work groups will be developed and agreed as part of the Alliance Leadership Team work plan.

11 Review

11.1 These Alliance Leadership Team terms of reference will be formally reviewed annually.

ACSDB 25/01/09

Annex B

ALLIANCE OBJECTIVES

The Alliance Objectives agreed by Us are to deliver sustainable, effective and efficient Services with significant improvements over the Term. In particular We have agreed the following:

a) To deliver integrated working transcending organisational boundaries

b) Improved access to primary and community services incorporating extended and out of hours services including but not limited to: out of hours GP services; GP streaming via BHNFT; Community Services and Rapid Response services.

c) Greater integration to meet the mental, physical and social needs of people by sign posting to relevant additional services such as: social care; mental and physical health services and My Best Life (Social Prescribing)

d) Preventing emergency admissions to hospital slowing the incremental rise of demand and admissions

e) Support early discharge from hospital

f) Reduce emergency readmissions

g) Greater focus on rehabilitation and reablement, with fewer people going from acute care in to domiciliary and residential care.

We acknowledge and accept that the Alliance Leadership Team is unable in law to bind any Participant so it will function as a forum for discussion of issues, including but not limited to discussing appropriate allocation of activity, in order to achieve the Alliance Objectives. We will utilise the provisions, mechanisms and flexibilities in the Services Contracts to effect the necessary changes in service specifications, activity plans, etc.

We acknowledge that We will have to make decisions together in order for Our Alliance to work effectively and, except for the Reserved Matters listed at Clause 9.1, We will work together on a Best for Service basis in order to achieve the Alliance Objectives.

ALLIANCE PRINCIPLES

In consideration of the mutual benefits and obligations under this Agreement, We will work together to perform the obligations set out in this Agreement and, in particular, achieve the Alliance Objectives and, subject to and in accordance with the provisions of this Agreement, We will:

(a) Work towards a shared vision of integrated service provision;

(b) Commit to delivery of system outcomes in terms of clinical matters, Service User experience and financial matters;

(c) Commit to common processes, protocols and other system inputs;

(d) Commit to work together and to make system decisions on a Best for Service basis;

(e) accommodate risk reward scheme where We all share in savings generated by reduction in acute activity.

(f) Take responsibility to make unanimous decisions on a Best for Service basis;

(g) Always demonstrate the Service Users' best interests are at the heart of Our activities;

(h) Adopt an uncompromising commitment to trust, honesty, collaboration, innovation and mutual support;

(i) Establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information, subject to competition law compliance;

(j) Adopt collective ownership of risk and reward, including identifying, managing and mitigating all risks in performing our respective obligations in this Agreement; and

(k) Co-produce with others, especially service users, families and carers, in designing and delivering the Service,

(together the "**Alliance Principles**").

Over the life of the Alliance, the actual provision of Services will alter on the basis of the most effective utilisation of staff, premises and other resources (in terms of cost and quality) and whilst there will be co-operation as to the service design this will not:

a) preclude competition between Us in respect of service provision as is needed to achieve the Alliance Objectives and which will be reflected in the Services Contracts and changes to those Services Contracts; or

b) restrict the Commissioner Participant's statutory obligations including obligations under procurement law to contract with provider(s) most capable of meeting the Commissioner Participants requirements, and obligations under Legislation (for example, the Public Contract Regulations 2015 and the National Health Service (Procurement, Patient Choice and Competition)

ACSDB 25/01/09

Appendix 2

ACSDB supporting governance structure, workstreams and membership

Appendix 2

Accountable Care Shadow Delivery Board

Chair (Dr Nick Balac)

5 Clinical leads (Dr John Harban, Dr Sudhagar Krishnasamy, Heather McNair, Dr Chari, Dr Mistry)

Director Primary Care at Scale (Marie Hoyle)

Director Community Health (Sean Rayner)

Director Secondary Care Services (Bob Kirton)

Chief Officer for Commissioning (Lesley Smith)

Director Tactical Commissioning (Jeremy Budd)

Medical Director (Dr Mehrban Ghani)

Finance Director (Michael Wright)

Director of Communities (Wendy Lowder)

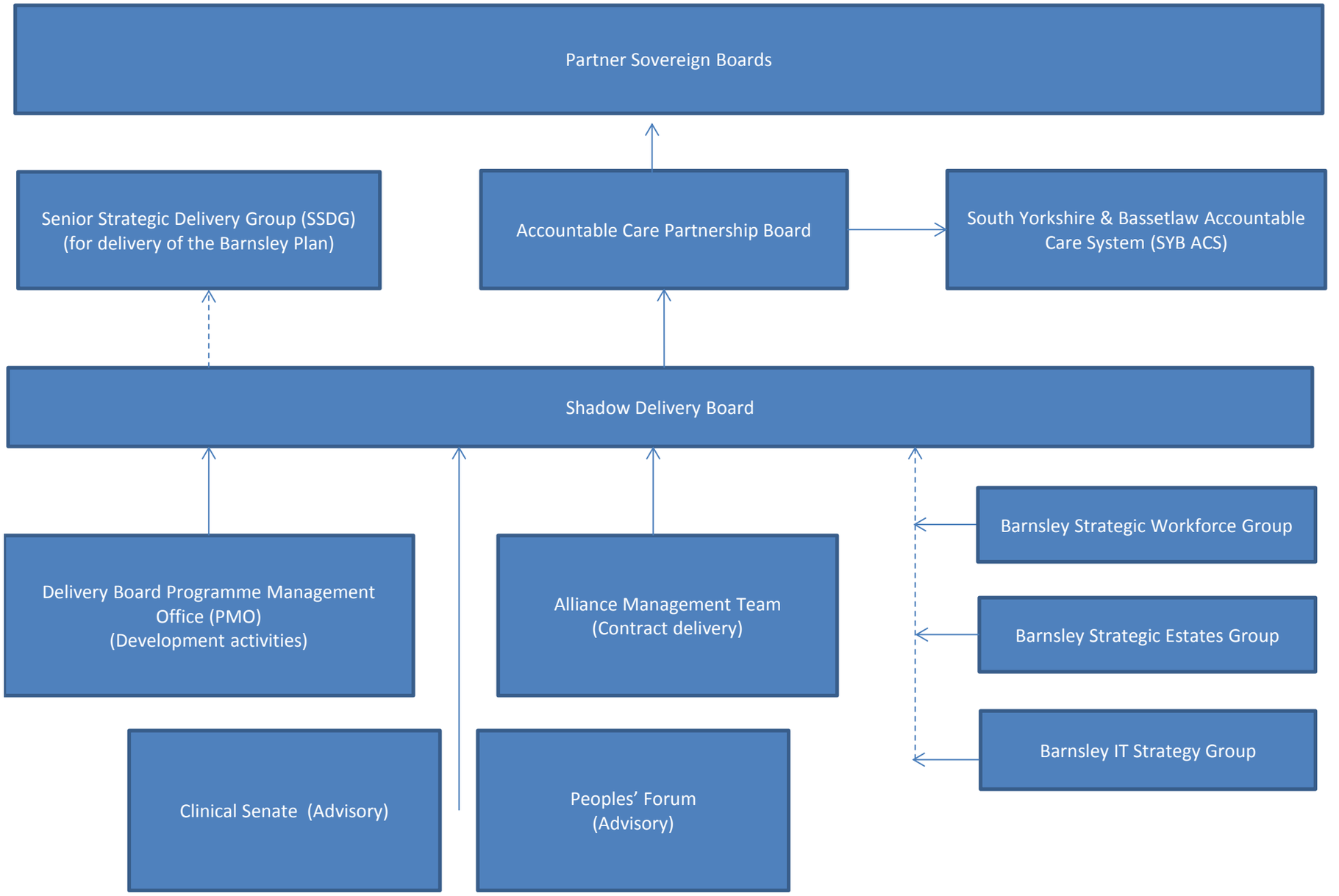
Alliance Director (Brigid Reid)

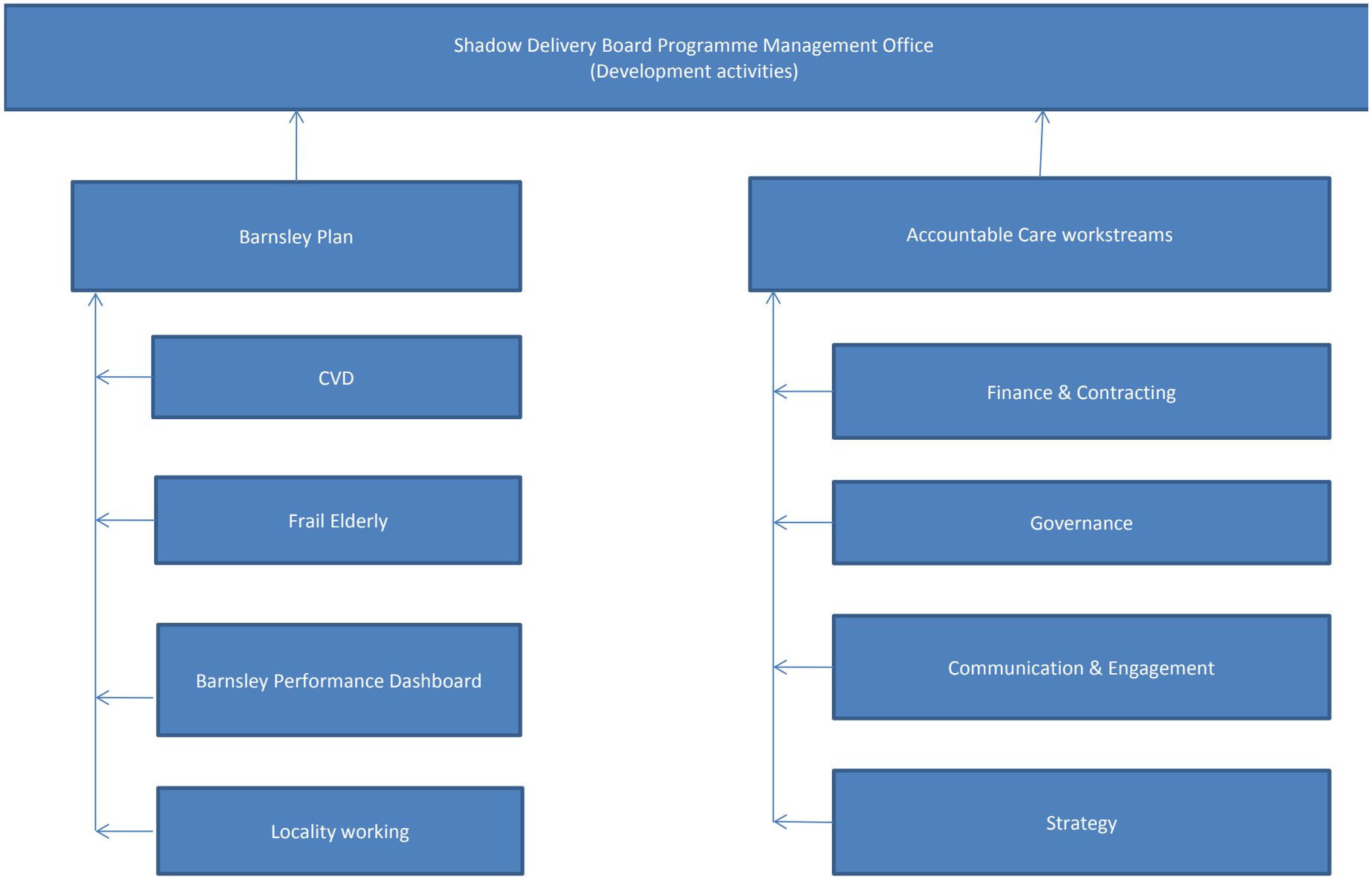
Barnsley Hospice (Julie Ferry)

HealthWatch (Adrian England)

Voting

Non Voting


Partner Sovereign Boards
Senior Strategic Delivery Group (SSDG)
(for delivery of the Barnsley Plan)
Accountable Care Partnership Board
South Yorkshire & Bassetlaw Accountable Care System (SYB ACS)
Shadow Delivery Board
Delivery Board Programme Management Office (PMO)
(Development activities)
Alliance Management Team
(Contract delivery)
Barnsley Strategic Workforce Group
Barnsley Strategic Estates Group
Barnsley IT Strategy Group
Clinical Senate (Advisory)
Peoples' Forum
(Advisory)


Shadow Delivery Board Programme Management Office
(Development activities)
Barnsley Plan
CVD
Frail Elderly
Barnsley Performance Dashboard
Locality working
Accountable Care workstreams
Finance & Contracting
Governance
Communication & Engagement
Strategy

Accountable Care workstreams
Membership

Finance & Contracting		
Name	**Position**	**Organisation**
Michael Wright (Chair)	Director of Finance	BHNFT
James Locking	Director of Finance	BHF
Mark Brooks	Director of Finance	SWYPFT

Communication & Engagement (C&E)		
Name	**Position**	**Organisation**
Tarique Chowdhury	C&E Manager	CCG
Hanna Bailey	Commnications & Marketing Business Partner-People and Public Health	BMBC
James Barker	Director of Business Development & Strategy	BHF
Emma Parkes	Director of Marketing and Communication	BHNFT
Jude Tipper	Head of Communications & Involvement	SWYPFT
Kirsty Waknell	Head of Communications & Engagement	CGG

Strategy		
Name	**Position**	**Organisation**
Jeremy Budd (Chair)	Director of Accountable Care	CCG
Joe Minton	Programme Manager	CCG
Bob Kirton	Director of Strategy	BHNFT
Salma Yasmeen	Director of Strategy	SWYPFT
James Barker	Director of Business Development & Strategy	BHF
Julia Burrows	Executive Director of Public Health	BMBC

Governance (ACPB)		
Name	**Position**	**Organisation**
Nick Balac (Chair)	Chair	CCG
Lesley Smith	Chief Officer	CCG
Dr Richard Jenkins	Chief Executive	BHNFT
Steve Wragg	Chairman	BHNFT
Rob Webster	Chief Executive	SWYPFT
Angela Monaghon	Chair	SWYPFT
Jeremy Budd	Programme Director	CCG
Marie Hoyle	Chief Executive	BHF
Ajay Mistry	Medical Director	BHF
Rachel Dickinson	Executive Director of People	BMBC
Diana Terris	Chief Executive	BMBC
Cllr Sir Stephen Houghton	Leader of the Council	BMBC

ACSDB Members			
Name	**Membership Role/Organisation Role**	**Voting Member**	**Organisation**
Nick Balac (Chair)	Chairman (Chair)	Yes	CCG
Jeremy Budd	Programme Director & Director of Tactical Commissioning (Director of Accountable Care)	No	CCG
Dr Mehrban Ghani	Medical Director (Medical Director)	No	CCG
Dr John Harban	Clinical Lead (Elected Member of Governing Body)	Yes	CCG
Dr Sudhagar Krishnasamy	Clinical Lead (Elected Member of Governing Body)	Yes	CCG
Lesley Smith	Chief Officer for Commissioning (Chief Officer)	Yes	CCG
Brigid Reid	Alliance Director (Chief Nurse)	No	CCG
Marie Hoyle	Director Primary Care at Scale (Chief Executive Officer)	Yes	BHF
Dr Ajay Mistry	Clinical Lead (Chair)	Yes	BHF
Bob Kirton	Director of Secondary Care (Director of Strategy)	Yes	BHNFT
Heather McNair	Clinical Lead (Director of Nursing)	Yes	BHNFT
Michael Wright	Director of Finance (Director of Finance)	No	BHNFT
Wendy Lowder	Director of Communities (Director of Communities)	No	BMBC
Dr Suresh Chari	Clinical Lead (Consultant Psychiatrist)	Yes	SWYPFT
Sean Rayner	Director of Community Services (District Director)	Yes	SWYPFT
Julie Ferry	Chief Executive Officer	No	Barnsley Hospice
Adrian England	Chair	No	Healthwatch

Alliance Management Team - **TOR under review **		
Name	**Membership Role/Organisation Role**	**Organisation**
Brigid Reid (Chair)	Alliance Director (Chief Nurse)	CCG
Amanda Capper	Head of Contracts	CCG
Jackie Holdich	Head of Delivery (Integrated Primary and Out of Hospital Care)	CCG
Bob Kirton	Director of Strategy	BHNFT
James Locking	Director of Finance	BHF
Sean Rayner	District Director	SWYPFT
Jayne Sivakumar	Head of Alliance Working	CCG

ACSDB PMO

Name	Position	Organisation
Jeremy Budd (chair)	Programme Director	CCG
Jackie Holdich	Head of Delivery (Integrated Primary and Out of Hospital Care)	CCG
Bob Kirton	Director of Secondary Care	BHNFT
James Locking	BHF Director of Finance	BHF
Wendy Lowder	Director of Communities	BMBC
Sean Rayner	Director of Community Services	SWYPFT

Accountable Care workstreams
Membership

Finance & Contracting		
Name	**Position**	**Organisation**
Michael Wright (Chair)	Director of Finance	BHNFT
Mark Brooks	Director of Finance	SWYPFT
James Locking	Director of Finance	BHF

Communication & Engagement (C&E)		
Name	**Position**	**Organisation**
Kirsty Waknell (Chair)	Head of Communications & Engagement	CGG
Hanna Bailey	Communications & Marketing Business Partner-People and Public Health	BMBC
James Barker	Director of Business Development & Strategy	BHF
Tarique Chowdhury	C&E Manager	CCG
Emma Parkes	Director of Marketing and Communication	BHNFT
Jude Tipper	Head of Communications & Involvement	SWYPFT

Strategy		
Name	**Position**	**Organisation**
Jeremy Budd (Chair)	Programme Director	CCG
James Barker	Director of Business Development & Strategy	BHF
Julia Burrows	Director of Public Health	BMBC
Bob Kirton	Director of Secondary Care	BHNFT
Joe Minton	Programme Manager	CCG
Salma Yasmeen	Director of Strategy	SWYPFT

Barnsley Plan

CVD		
Name	**Position**	**Organisation**
Lynsey Bowker		CCG
Dr Adekunle		CCG
Cath Bedford		CCG
Rebecca Clarke		BMBC
Katie Hopkins		BHNFT
Sarah Pollard		CCG
Bob Senior		SWYPFT
Frail Elderly		
Name	**Position**	**Organisation**
Jayne Sivakumar		CCG
Paul Bibby		BHF
Dr Ghani		CCG
Phil Hollingsworth		BMBC
Dr Krishnasamy		CCG
Gavin Portier		BHNFT
Dan Slater		SWYPFT
Gill Stansfield		SWYPFT
Emma White		BMBC

Localities		
Name	**Position**	**Organisation**
	To be confirmed	

Barnsley Performance Dashboard
Reporting function only

Barnsley IT Strategy Group		
Name	**Position**	**Organisation**
Tom Davidson (Chair)	Director of ICT	BHNFT
Kieran Baker	Head of Information	CCG
Paul Foster	Head of IT Services & Systems Development	SWYPFT
Dr John Harban	Elected Member Governing Body	CCG
Jackie Holdich	Head of Delivery (Integrated Primary and Out of Hospital Care)	CCG
Sara Hydon	Head of IT	BMBC
Mike Overton	IT Service Delivery Manager	eMBED
David Roberts	Director of IT	BMBC
Catherine Wormstone	Senior Primary Care Commissioning Manager	CCG

Barnsley Estates Group		
Name	**Position**	**Organisation**
Jackie Holdich (Chair)	Head of Delivery (Integrated Primary and Out of Hospital Care)	CCG
Kimberely Beckett		Community Health Partnerships
Nicola Bolton		Community Health Partnerships
Garry Charlesworth		NHS England
Lorraine Christopher		BHNFT
Kevin Gelder		SWYPFT
Tim Hartley		BMBC
Bob Kirton	Director of Secondary Care	BHNFT
Danielle Lewis		Community Health Partnerships
Lesley McGregor		Community Health Partnerships
Nigel Middlehurst		Voluntary Action Barnsley
Nick Phillips		SWYPFT
Jeremy Sykes		BMBC
Tony Taylor		BMBC
Jude Wildgoose		Community Health Partnerships
David Witney		Community Health Partnerships

Barnsley Strategic Workforce Group???		
Name	**Position**	**Organisation**
	To be confirmed	

Barnsley Health and Care Together

Programme Report

December 2016 - January 2017

Purpose

This programme report has been prepared for the Accountable Care Shadow Delivery Board (SDB) to provide an update on progress made, highlight important risks and issues for consideration by the Board that have been escalated from working groups and the achievements of the programme in the preceding period.

It is intended that the report is shared with other related Boards and committees to provide consistent information and assurance for stakeholders. Therefore, a brief summary of the discussion at the previous meeting of the Shadow Delivery Board will be included for wider circulation along with an update from the South Yorkshire and Bassetlaw Accountable Care System (ACS).

A programme report will be produced on a bi-monthly basis to coincide with the public meetings of the Shadow Delivery Board.

Structure

There are four parts to the programme report.

Part A	Summary of progress, stakeholder engagement, linkage with the South Yorkshire and Bassetlaw Accountable Care System, key risk and issues and achievement and outcomes.
Part B	Highlight reports from each of the work programmes.
Part C	Update from the Barnsley Shadow Delivery Board Public Meeting.
Part D	Update from the South Yorkshire and Bassetlaw Accountable Care System (ACS)

Part A

1. Overview

Following on from the first public meeting of the Shadow Delivery Board on 23 November, the programme has been making strides to establish the underlying workstream leadership, governance and objectives.

A weekly Programme Management (PMO) meeting has been established involving senior leaders across the partnership to ensure delivery. This group has been looking at the terms of reference and objectives for each of the workstream areas, ensuring that the work programmes adopt the operating principles for Accountable Care and how resources can be mobilised to support delivery.

Representatives from the partnership attended the national Accountable Care Learning Network at the Kings Fund on 5 December to join national policy leaders and experts along with other areas that are leading the development of Accountable Care local across the country. The event included presentations and discussions around the new national contract for Accountable Care, collaboration agreements and outcomes frameworks.

The programme has adopted an approach of learning and sharing local experiences to prevent "reinventing the wheel" at every stage. This has included establishing links with Sunderland and Scarborough which are areas further ahead with procurement of a multi-speciality community provider model, and Wakefield and Tower Hamlets which are currently progressing with local provider alliances to embed new clinical and business models.

2. Stakeholder engagement

To ensure strategic alignment across the Borough the Director of Accountable Care has been invited to attend meetings of the Senior Strategic Development Group (SSDG) which reports to the Barnsley Health and Wellbeing Board (HWB) with oversight of the delivery of the Barnsley Plan. A programme report has been presented to SSDG in January and will be taken to the next meeting of HWB.

A review is underway to look at the different groups, terms of reference, work programmes and reporting lines to ensure most effective working with the Health and Wellbeing Board and SSDG.

The CCG has engaged the New Business Models team within NHS England that is supporting sites looking to commission a population health model of care. The team are assisting the CCG to understand the future commissioning options that will best support the local ambition for more integrated working across health and care.

3. Key risks and challenges, corresponding actions and status update

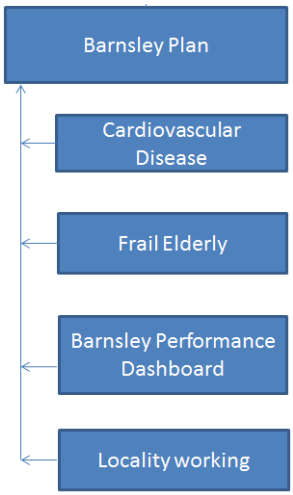
The programme management office is compiling a programme risk register. Key risks and corresponding actions will be including in future programme reports.

4. Summary of activity planned for the next reporting period

Over the next two months the frail elderly and cardiovascular workstreams will be developing and finalising plans for 2018/19 along with system stakeholders, the ACO development group will be developing the Strategic Outline Case (SOC) that includes the local case for change, outlines care model and scope of services and expected outcomes for Barnsley and the Alliance Management Team will oversee next phase in the mobilisation of the new integrated intermediate care service across the borough.

Part B

1. Barnsley Plan

<table>
<tr><th>Governance</th><th>Senior Responsible Officer</th></tr>
<tr><td> 
</td><td>Jeremy Budd (Programme Director and Director of Tactical Commissioning)
Director of Accountable Care
Lead for CVD Jackie Holdich
Head of Delivery (Integrated Primary and Out of Hospital Care)
Lead for Frail Elderly Brigid Reid (Alliance Director) Chief Nurse
NHS Barnsley Clinical Commissioning Group</td></tr>
<tr><td></td><th>Period covered by the report</th></tr>
<tr><td></td><td>December to January 2017</td></tr>
<tr><td></td><th>Report author(s)</th></tr>
<tr><td></td><td>Joe Minton
Programme Manager – NHS Barnsley Clinical Commissioning Group</td></tr>
<tr><th colspan="2">Purpose and objectives</th></tr>
<tr><td colspan="2">To adopt the Accountable Care operating principles through the delivery of programmes of work around frail elderly, cardiovascular disease and locality development and oversee the ACS performance dashboard for tier one services and progress of transformation..
• Provide better, quicker, more consistent care across the whole system
• Better support for carer's (formal and informal)
• Reduce inequalities between Barnsley and England overall as a whole and peer comparator areas and inequalities within Barnsley
• Provider better, more joined up support for frail elderly patients in their own homes and local communities
• Enhance clinical care and support for patients with CVD to self-manage their condition(s)
• Support the development of local care networks which integrate community services with groups of GP practices in each of the six area council geographies across Barnsley
• Develop a local performance dashboard for tier one services in Barnsley
• Monitoring and oversight of performance in line with the requirements of the Accountable Care Service</td></tr>
<tr><th colspan="2">Progress Summary</th></tr>
<tr><td colspan="2">• Logic models have been drafted for the frail elderly and cardiovascular disease programmes based on the outputs from engagement and mapping workshops in November 2016
• There have been initial meetings with organisation leads for frail elderly to develop the model of care and leads for each of the work areas have been agreed
• The Acute Frailty Network visited Barnsley Hospitals and have undertaken a bed occupancy census to identify typical prevalence of frailty within the hospital bed</td></tr>
</table>

base

- The Governing Body clinical leads for CVD attended the Clinical Senate meeting on 30 November along with a Delivery Partner from NHS RightCare to discuss the commissioning to value pack and partnership approach in Barnsley
- Progress has been made to develop a scheme that adopts elements of the Barnsley Health Hearts programme, some of which may be included in the Practice Delivery Agreement in 2018/19
- A locality development plan has been submitted to NHS England in December that focussed on developing place-based working across primary and community care and to deliver the GP Five Year Forward View and development of locality working.

Planned for the next period

- Recruitment of project/programme management support for the cardiovascular workstream
- Identify and allocate resources to support the local delivery of the cardiovascular disease and frail elderly programmes
- Further establish linkages to the relevant work-streams of the SYB ACS including the care homes and carer's group and cardiovascular disease, which is a priority area for the ACS
- A stakeholder engagement event for Frail Elderly and Cardiovascular disease is being planned for 13 March, involving national clinical leads for Cardiovascular Disease Prevention and Older People and Long Term Conditions
- Analysis of the expected prevalence of moderate and severe frailty across Barnsley and associated activity in primary, community and secondary care
- Continued work with the Acute Frailty Network to ensure patients are identified early in hospital and that care is planned effectively to prevent delays
- Introduction of the Rockwood scale for Acute Frailty in the accident and emergency unit and acute areas to identify patients for specific interventions
- Develop plans to utilise the analytical support from Public Health England that has been made available to SYB ACS for work on CVD
- Finalisation of a cardiovascular disease scheme within Practice Delivery Agreement Present (PDA)
- Planning for a locality event on 14 February 2018 that will provide further opportunity to engage general practice in the development of the locality work programme.
- Create a local performance dashboard covering the full scope of tier one services in Barnsley

Issues for escalation
There are no issues to be escalated to the Shadow Delivery Board at this time.

Milestone/Enabler	Planned	Actual	RAG
Wider stakeholder engagement event for Frail Elderly and CVD	January 2018	March 2018	Amber
Locality working event for general practice	February 2018	February 2018	Green

2. Alliance Management Team

Governance	Senior Responsible Officer
	Brigid Reid (Alliance Director) Chief Nurse NHS Barnsley Clinical Commissioning Group
	Period covered by the report
	December to January 2017
	Report author(s)
	Jayne Sivakumar Head of Commissioning and Transformation NHS Barnsley Clinical Commissioning Group

Purpose and objectives

To give assurance that the contract and associated services are being delivered in line with the Alliance objectives and in line with the service requirements outlined in the service specifications:

- RightCare Barnsley
- Intermediate Care
- Neighbourhood Nursing Service
- BREATHE

The group will:

- Ensure effective contract management in the spirit of integrated working and to ensure services are provided to the highest quality while ensuring value for money.
- Agree future and ongoing development of the service.
- Inform appropriate work streams to ensure seamless service provision and aligned strategic development.

Progress Summary

- The Alliance Management Team (AMT) last met on 10 January. The recent focus of the group has been the mobilisation of the new model of intermediate care across the Borough.
- On the 1 December the Halfway Home (transition ward) moved over to BHNFT from SWYPFT with the primary care proactive clinical review being provided by Barnsley Healthcare Federation. Providers are working through the logistics of a new way of working.
- Newly commissioned independent sector beds include a core of 28 residential and two nursing across four care homes. The contract began on 4 December for two providers and third commenced on 18 December although these beds were already in use as part of a spot purchase arrangement.
- A Quality Impact Assessment (QIA) has been completed at every stage of the transition to the new model.
- AMT members reflected on the positive progress that has been made in partnership working

Planned for the next period

- Continue to refine working practices across the new service configuration
- Further work to agree KPIs across individual services and broader KPIs for the provider alliance
- Consideration as part of the KPIs to assess the impact of the alliance way of

working on patient care
- Procurement for the longer solution for independent sector beds beginning in January 2018
- Review of Rapid Response and “Hospital @ Home” elements of the new service

Milestone/Enabler	Planned	Actual	RAG
Review of rapid response	January to March 2018		Green
Review of hospital@home	January to March 2018		Green
Training needs analysis across the intermediate tier	March 2018		Green

Issues for escalation
There are no issues to be escalated to the Shadow Delivery Board at this time.

3. Developing an Accountable Care Organisation

Governance	Senior Responsible Officer
	Jeremy Budd (Programme Director and Director of Tactical Commissioning) Director of Accountable Care, NHS Barnsley Clinical Commissioning Group
	Period covered by the report
	December 2017 to January 2018
	Report author(s)
	Joe Minton Programme Manager – Accountable Care NHS Barnsley Clinical Commissioning Group

Progress Summary

- Terms of reference have been drafted for each of the workstreams (finance and contracting, communications and engagement and new models of care strategy). The Governance work will be taken forward by the Accountable Care Partnership Board and Shadow Delivery Board.
- The Finance and Contracting Group met for the first time in under the new Chairmanship of Director of Finance at Barnsley Hospital NHS Foundation Trust. The initial priorities of the group are to determine scope of services within tier one, current activity and the cost base.
- The partnership has had legal advice around the development of a collaboration agreement which will bring organisations more closely together to support integration and partnership working.
- The strategy group has met in December 2017 and January 2018 and has been developing design principles for the future operating model, looking at the potential extent of the scope of Tier 1 services, building upon work already undertaken within the Finance & Contracting workstream and developing the local outcomes framework with clinical leads

Planned for the next period

- Developing the collaboration agreement
- Development of a local outcomes framework with clinical lead and the Clinical Senate
- Further work to develop the case for change and outline service model (Strategic Outline Case)
- Agreeing the scope of services and phasing of bringing services into the accountable care organisation via work on the outcomes framework
- Continued discussions with the NHS England Regional Team and New Business Models Team

Milestone/Enabler	Planned	Actual	RAG
Collaboration agreement in place across the partnership	March 2018		Amber
Strategic outline case	Governing Body on 8 March 2018		Amber

Milestone/Enabler	Planned	Actual	RAG
Developing the local outcomes framework	March 2018		Amber

Issues for escalation
There are no issues to be escalated to the Shadow Delivery Board at this time.

4. Communications and engagement

Senior Responsible Officer	Jeremy Budd
Period covered by the report	December 2017 – March 2018
Report Author	Tarique Chowdhury Communications & Engagement Workstream

Progress Summary

- SMART communication and engagement objectives applied to work plans
- Operational workstream meeting with Partners' strategic and operational activity
- Stakeholder mapping ongoing
- Access to and updating of Barnsley page on SYB Accountable Care System website
- Programme name confirmed as Barnsley Health and Care Together (BHCT)
- Information factsheets and FAQs in development and in circulation with partners
- Media interview with Barnsley Health and Care Together Chair and Director in Barnsley Chronicle.
- Media briefing accepted by partners, proactive written statements also planned

Planned for the next period

Agreement of roles and responsibilities by all Partners' communication and engagement leads to deliver the agreed action plan to April 2018* and beyond.

- **January 2018:** Creative logo for BHCT name developed and to be 'soft launched' across future materials, supported by brand guidelines for all C&E workstream partners, briefings to media and key stakeholders including staff via partners
- **January 2018:** Confirmation of involvement with Area Councils expected
- **Jan – ongoing 2018**: Deliver mechanisms, and related materials, for proactive involvement and feedback with, and from, affected staff and the general public. e.g. staff engagement, Peoples' Forum and community based research assets
- **Jan – ongoing 2018**: Develop and implement communications products with workstream partners to regularly and consistently inform their audiences about accountable care in Barnsley and its progress
- **Jan - March 2018**: Communications support for Cardiovascular disease/Frail elderly involvement event and engaging with public/Area Council representatives
- **Jan - March 2018**: Meeting with public and activist groups to discuss options and ideas for further public involvement, methods and opportunities

Review

We will review the working strategy in February 2018 and make adjustments to reflect experience and stakeholders views.

Risk

Our communications and engagement activity is based upon the wider accountable care programme making progress in developing its governance structure and in progressing actual change to services, and there being information to either share with, or gain feedback from, our stakeholder audiences. Specific risks will be identified for future highlight reports.

Issues for escalation
There are no issues to be escalated to the Shadow Delivery Board at this time.

Part C

Update from the Barnsley Shadow Delivery Board 23 November 2017

Background
This was the first Delivery Board meeting in public which included the general public, councillors and members of partners' governing bodies. This note indicates issues raised by the public in reaction to the meeting content and to highlight issues which we will be dealing with accordingly:

1. Privatisation

Issue: Accountable Care is a way of privatising NHS services in Barnsley.

Response: The Accountable Care Partnership, which we are in the process of developing, is a partnership of publicly owned and publicly funded organisations, primary care organisations and the local authority.

2. Public involvement in terms of engagement

Issue: Involvement will not be wide enough to genuinely represent or consult Barnsley People and would not meet statutory duties to consult with the Public.

Response: We are currently informing the public about accountable care and seeking to learn about their needs, ideas and concerns. This is not a consultation, which is a legal process where significant change to services would need to be consulted on following a due process.

We have developed a stakeholder map that both includes wide sections of our local population and which will be added to as we access more groups.
We will also be working at community level to have direct conversations about key accountable care issues and seeking to broaden our reach by working with groups to access other representative communities, especially within the Protected Groups audiences.

Work has already started to look at channels to reach the public, i.e. Peoples' Forum and community based groups. Reports will be made of all engagement and involvement activity.

The Chairman reminded the meeting of his Open Door Policy to any member of the Public weekly on Fridays from 9.30am-10.30am at the CCG offices. Anyone wishing to attend can contact Leanne Whitehead at leanne.whitehead1@nhs.net so we can manage where we could meet within the CCG if numbers were large or if a specific topic was asked to be discussed.

3. Social Care not included

Issue: When hearing about the first two priority areas – cardiovascular disease and frailty – there was concern social care would not be included.

Response: The Local Authority including social care is a key partner and are involved with our conversations and planning as we all work together to develop better outcomes for the people of Barnsley.

4. Accountability

Issue: Who is the Accountable Care Shadow Delivery Board accountable to?

Response: As a Board we are accountable to the Accountable Care Partnership Board, which in turn is widely accountable to all our partner organisations sovereign boards and Governing Bodies, including to the CCG which is is accountable to its GP membership, Healthwatch, , NHS England, SYB ACS, Health and Wellbeing Board, and scrutiny and regulatory bodies, e.g. the Care Quality Commission (CQC).

5. Accountable Care system / Organisation – Legal Constitution

Issue: Is Barnsley Accountable Care legally constituted?

Response: There is a South Yorkshire & Bassetlaw Accountable Care System with five accountable care partnerships underpinning the system, Barnsley was one such partnership**.** There was a collective Memorandum of Understanding between partner organisations as opposed to a formal agreement. Alliance contracts were already in place for delivery of some local service.

6. Internet use

Issue: All engagement and involvement would be based online and that many of Barnsley's older population would be excluded as a result.

Response: We will develop engagement materials and tools accessible to all people and, whilst this will include online information, it will also include printed and other formats, e.g. larger print. The questioner was invited to meet with theComms and Engagement Manager in November to outline their ideas further.

7. Clarity on Partnership, System or Organisation?

Issue: Clarity was sought about if accountable care in Barnsley was as an accountable care 'partnership', 'system' or 'organisation'.

Response: Accountable care in Barnsley is a partnership, which through the Accountable Care Shadow Delivery Board, would be looking at the detail and options

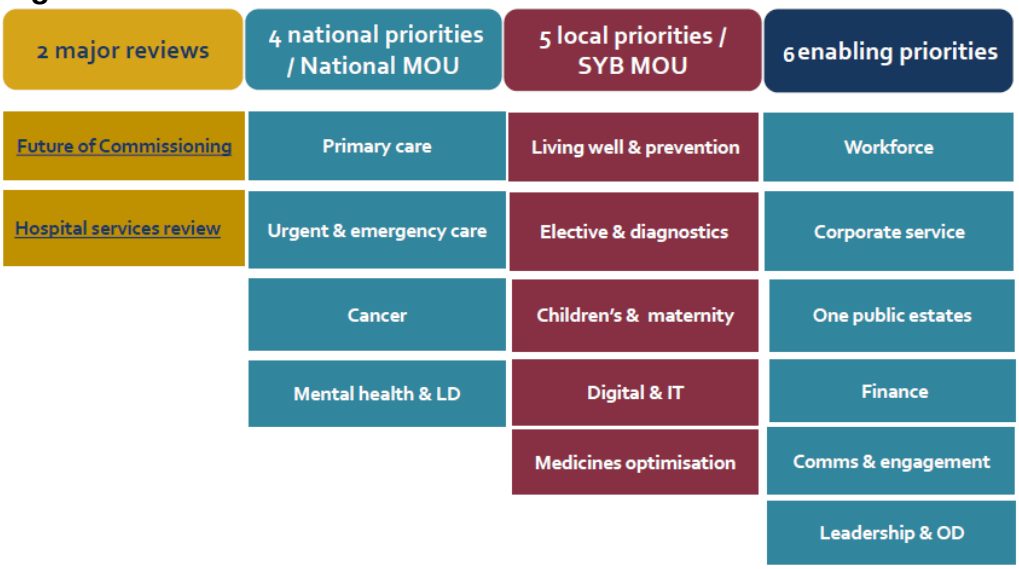
of becoming an accountable care organisation. The accountable care system covered a wider geography of Barnsley and four other areas.

Part D

Update from the South Yorkshire and Bassetlaw Accountable Care System (ACS)

The ACS across South Yorkshire and Bassetlaw is developing at pace. The ACS has set out priorities for the forthcoming year and beyond, including what is expected will be delivered at system, place and organisational level.

Figure 1 SYB ACS Priorities



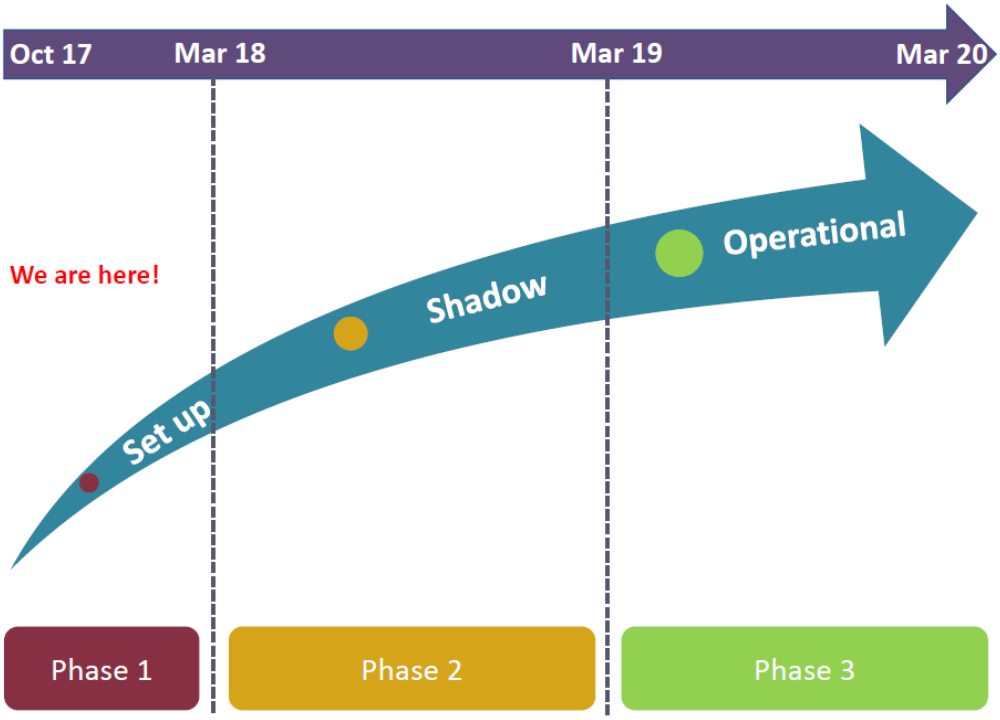


Figure 2 SYB ACS Development timeline

ACSDB 25/01/11

Putting Barnsley People First

ACCOUNTABLE CARE SHADOW DELIVERY BOARD

25 January 2017

Update from the Strategy Group

PART 1 – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*		*Information* ✓
2.	**REPORT OF**						

	Name	*Designation*
Lead	Jeremy Budd	Director of Accountable Care
Author	Joe Minton	Accountable Care Programme Manager

3. EXECUTIVE SUMMARY

The Strategy Group has met twice since the last meeting of the Shadow Delivery Board. The group comprises the Directors of Strategy from each of the provider partners and the Director of Public Health from Barnsley Metropolitan Borough Council. The group is chaired by the Director of Accountable Care at Barnsley CCG. The role of the group is to develop the case for change and vision for the future operating model that best supports the delivery of the principles for Accountable Care.

The work of the group to date has involved reviewing learning from other areas including Sunderland and Scarborough which are further ahead with procurement of a population health management provider model, and Wakefield and Tower Hamlets which are currently progressing with local provider alliances to embed new clinical and business models.

The group has agreed an approach that begins with understanding the health and wellbeing needs of local people and agreeing the population outcomes the system should aim to achieve through service transformation. This approach supports outcomes based accountability (OBA) and the shift towards population health management. The focus will be on Tier 1 services; services delivered in Barnsley, for the people of Barnsley. The Strategy Group has also been looking at the potential extent of the scope of Tier 1 services, building upon work already undertaken within the Finance & Contracting workstream.

Developing and agreeing a local Outcomes Framework is an essential next step as this will drive decisions around the scope of services, care model and finance and contracting strategy. It is recognised that the process needs to involve public health

	colleagues, clinicians from across the partnership and be based on an understanding of the needs and desires of local people and communities. Nationally, substantial work has been undertaken on the development of Outcomes Frameworks, and the Strategy Group has been looking at this in order to ensure that we learn from what others have done and are able to build on that work for Barnsley. The group has developed a set of design principles for the future operating model that align to the operating principles of Accountable Care. These draft principles will underpin the development of the model of care over time. The Strategy Group would like to involve the Clinical Senate in the design of the Outcomes Framework and this has already been discussed with the Chair of the Clinical Senate. The Strategy Group would also like to work with Delivery Board clinical leads in the development of the Outcomes Framework and would like to establish a 'task & finish' group in order to accomplish this over the coming weeks.
4.	**THE DELIVERY BOARD IS ASKED TO:**
	• Note this paper for information • Give consideration to how clinical leads could support the development of the outcomes framework through a 'task & finish' group • Ask the Clinical Senate to advise on and participate in the development of an Outcomes Framework for Barnsley.
5.	**APPENDICES**
	None included.

Agenda time allocation for report:	5 minutes

ACSDB 25/01/11

PART 2 – DETAILED REPORT

1. Introduction

The Strategy Group has met twice since the last meeting of the Shadow Delivery Board. The group comprises the Directors of Strategy from each of the provider partners and the Director of Public Health from Barnsley Metropolitan Borough Council. The group is chaired by the Director of Accountable Care at Barnsley CCG. The role of the group is to develop the case for change and vision for the future operating model that best supports the delivery of the principles for Accountable Care.

Accountable Care seeks to meet the challenge of how financial flows and the commissioning process can best support quality and efficiency improvements across the health and care system to maximise population health and wellbeing. Accountable Care build on previous efforts to integrate services in the NHS and their development draws on experience from health systems around the world.

Adopting the principles of Accountable Care will ensure the best use of collective resources as different parts of provision are better aligned and incentivised to become more integrated and person-centred, delivering high value health and care services.

Accountable care involves a provider or, more usually, an alliance of providers collaborating to meet the needs of a defined population. These providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population. Providers work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years.

2. Background and context

Since 2011, NHS commissioners have been using outcomes based commissioning as an approach aimed at aligning incentives to deliver value through improving outcomes for patients and driving transformational efficiencies. Outcomes-based contracts go further in linking quality outcomes with payment, moving away from payment based on activity to payment for results to a greater extent. These initiatives often involved commissioners contracting with a number of providers, managed by an integrator entity, focussing on pathway transformation for a particular disease.

The NHS Five Year Forward Vies described a number of new care models that focused on whole population health management and outcomes based payment. Since the publication of the NHS Five Year Forward View national bodies have been working with vanguards and Accountable Care Systems to create the blueprint for population health models of care which demonstrate a broadening of the outcomes based commissioning to look at whole populations, integrated services and promotes collaboration between incumbent providers.

As part of the South Yorkshire and Bassetlaw Accountable Care System (ACS), each of the five constituent ‘places’, including Barnsley, is developing a local Accountable Care Partnership (ACPs) that will take responsibility for services delivered locally for local people and it is expected that ACPs move from shadow form into a legally constituted form in April 2019 or as soon as practicable after this date.

3. Strategy development

The integration agenda in Barnsley to date has largely been focussed on out-of-hospital care and particular disease pathways such as respiratory disease and diabetes. This is similar to other areas developing population health models, including some of the new care models vanguards that have begun with a focus or objective around a particular part of the health and care system or setting, such as out-of-hospital care or hospitals working together better. It is also recognised that there are expectations from the ACS around the scope of services that will form part of the local Accountable Care Partnership and that locally the initial focus will be on NHS funded services.

Our ambition for Barnsley is to transform health and care services to improve the health and wellbeing of local people, including how they experience healthcare. Therefore the development of the local operating model should be based on this ambition and the end stage scope of services and care model should be driven by this ambition rather than a necessary focus on a particular setting.

The approach proposed therefore begins with understanding the local health and wellbeing needs of the population to determine a set of outcomes or objectives. This approach, illustrated in figure 1, supports outcomes based accountability (OBA) and the shift towards population health management.

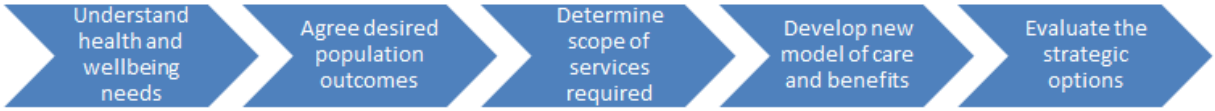


Figure 1 Approach to care model development

The Strategy Group is currently assessing the shared understanding of health and wellbeing needs and any gaps and agreeing how the outcomes framework can be developed in partnership.

The Strategy Group has been looking at the potential extent of the scope of Tier 1 services, building upon work already undertaken within the Finance & Contracting workstream.

4. An Outcomes Framework for Barnsley

Outcomes frameworks are collections of measures used to monitor and contract for services. Developing an outcomes framework is a fundamental part of Accountable Care. An outcomes framework ensures consistent clarity of vision and purpose, provides a way of evaluating progress towards achieving the vision and it supports openness and transparency.

The outcomes which the system aspires to achieve should be grounded in what service users need and want. Developing an outcomes framework will draw on previous local engagement, include research into the needs and wants of patients and service users, consider local intelligence (for example the Joint Strategic Needs Assessment) and involve engagement with colleagues, service users and public engagement.

Whilst some health and care needs will be largely universal across different groups of services users, some will related specifically to life stage and/or health and social care need; for example, people with a long term condition or the frail elderly. Therefore the outcomes framework needs to include both whole population measures and measures associated with different segments or groups. Personalisation is an important aspect of

integrated person-centred care. Therefore outcomes must promote care providers to work with service users to achieve their own personal goals.

Whole population health management models are still in their infancy across the NHS in England. Therefore it is likely that new outcomes measures will be needed to support new ways of commissioning and providing health and care services.

There are examples of good practice from other areas that have used current health and care indicators that are established measures of population health, quality of care and efficiency. These include Northumbria who have worked extensively with the NHS England and the King's Fund to develop there outcomes framework. It is proposed that a similar approach is followed in Barnsley.

The Strategy Group would like to involve the Clinical Senate in the design of the Outcomes Framework and this has already been discussed with the Chair of the Clinical Senate. The Strategy Group would also like to work with Delivery Board clinical leads in the development of the Outcomes Framework and would like to establish a 'task & finish' group in order to accomplish this over the coming weeks.

5. Design principles

Experience from other areas that are progressing with the development a population health model has been that there is great value in adopting a set of design objectives in order to further engage key stakeholders, such as clinicians and patient groups, in the development of strategy. These design principles can be written in to any contract or agreement between provider partners and commissioners.

The Strategy group has developed a set of local design principles that are align to the operating principles of Accountable Care. These draft principles will underpin the development of the model of care over time.

Mutuality	• Systems leadership encompassing health, social care and wider system partners • Strong clinical operational leadership including general practitioners as expert generalist with the patient • Enabling the leadership role of citizens, communities and voluntary sector
Population focussed	• A population health management approach to develop strategies to improve the health and wellbeing of the population and reduce health inequalities • Integrated and holistic approach to care including physical and mental health and integrated with social care
Shared risk and reward	• Maximise the agreed outcomes within the resources available • Work together to agree principles for sharing risk and reward
Shared values, shared governance	• Adopt an asset based approach (citizen-led, relationship orientated, asset-based, place-based and inclusion focussed) • Provide a proactive and person-centred approach that empowers patients and addresses peoples' needs • Improve quality and efficiency of services through sharing records, data and information including integrated information management and technology • A single set of measures to underpin shared objectives
Shift to the	• Focus on self-care to promote independence and reduce pressures on

left	the health and care system • Focus on prevention including the wider determinants of health
Care closer to home	• Support the delivery of more enhanced and specialised services in the community where appropriate • More investment in general practice in line with national ambition set out in the Five Year Forward View • Locality focus for delivery of services whilst ensuring services are wrapped around patients and aligned to GP practices

6. Summary and next steps

The members of the Shadow Delivery Board are asked to –

- **Note this paper for information**
- **Give consideration to how clinical leads could support the development of the outcomes framework through a 'task & finish' group**
- **Ask the Clinical Senate to advise on and participate in the development of an Outcomes Framework for Barnsley.**

Putting Barnsley People First

ACCOUNTABLE CARE SHADOW DELIVERY BOARD

25 January 2018

Cardiovascular Disease

PART 1 SUMMARY REPORT

1.	**THIS PAPER IS FOR**
	Decision ☐ *Approval* ☐ *Assurance* ☐ *Information* ✓
2.	**REPORT OF**

	Name	Designation
SRO	Jackie Holdich	Head of Delivery (Integrated Primary and Out of Hospital Care) Barnsley CCG
Author and Programme Lead	Lynsey Bowker	Lead Commissioning and Transformation ManagerBarnsley CCG

3. EXECUTIVE SUMMARY

Work has continued throughout December 2017 and January 2018 on developing the Barnsley Health and Care Partnership programme of work for cardiovascular disease.

This has included –

- Information gathering and scoping current local initiatives that support the objectives of the cardiovascular disease work of the partnership
- Reviewing the evidence and best practice for cardiovascular disease prevention and cardiology services
- Engaging the Barnsley Clinical Senate with support from the local delivery partner from NHS RightCare programme
- Establishing a working group of clinical and managerial leaders from across the partnership with the expertise and passion to improve local services and pathways
- Working with partners across South Yorkshire and Bassetlaw Accountable Care System (ACS) to identify opportunities for collaboration and how the local areas can support one another to take improvement initiatives forward
- Drafting a logic model to illustrate the relationship between the programmes resources, activities and intended results
- Developing a primary care scheme for 2018/19 using some of the learning

	from “Bradford Healthy Hearts”, a programme which has been shown to avoid strokes and heart attacks by reducing the clinical risk factors • Planning a stakeholder engagement event on 13 March The planning has identified a number of areas of work that align to the key programmes of the ACS. The priorities and work programme will be further developed with stakeholders through further engagement beginning with an event on 13 March. • Prevention of clinical risk factors, • Population health management and lifestyle risk factors, • Identification and health intelligence, • Pathways, • Working Together • Hospital services review. It is proposed that within each of the strands of action, there are a number individual projects delivered by partners from across the partnership, for example, within the population health management and lifestyle risk factors strand sits; NHS Health Checks, which is a service commissioned by Barnsley Council and delivered across Primary Care. The cardiovascular disease programme will ensure that there is alignment across the different areas of work, continue to assess opportunities for greater collaboration as the programme develops, and identify any gaps or potential areas for further improvement.
4.	**THE DELIVERY BOARD IS ASKED TO:**
	The Accountable Care Shadow Delivery Board is asked to consider: • Note the content of this report
5.	**APPENDICES**
	1. Programme logic model

Agenda time allocation for report:	*15 mins*

ACSDB 25/01/12

PART 2 DETAILED REPORT

1. Introduction

Work has continued throughout December 2016 and January 2017 to develop the Barnsley wide Cardiovascular Disease (CVD) Programme. Following a multi-organisational workshop on the 16th November and a further meeting on the 11th December with representatives from Barnsley Clinical Commissioning Group, Barnsley Hospital, South West Yorkshire Partnership Trust, Barnsley Healthcare Federation and Barnsley Council objectives, outcomes and priority areas of work have been agreed.

2. Rationale

CVD is a major contributor to health inequalities in Barnsley. The mortality rate for CVD overall in those aged under 75 is 20% higher than the national average, and 30% higher for coronary heart diseases. In response, the Barnsley Accountable Care Shadow Delivery Board have agreed to focus across the system to improve care for those who have, or who are at risk of developing, cardiovascular disease.

3. Shared Objectives

The overarching objectives of the programme are to;

- reduce the premature mortality from CVD in Barnsley,
- improve primary prevention and risk management,
- reduce health inequalities,
- better support people to manage their own health and keep healthy
- better early management and secondary prevention.

4. Areas of work

4.1. Prevention of clinical risk factors

The Bradford Healthy Hearts campaign brings together local GP practices and the wider NHS with one aim; to reduce the risk of stroke and heart attack. The programme aims to reduce cardiovascular events by 10% by 2020 and in the first 15 months has been estimated to have prevented 74 strokes and 137 myocardial infarctions (MIs). Bradford's population is approximately 35% bigger than Barnsley and has a different demographic mix but with some similar challenges around outcomes for CVD.

A primary care scheme is being developed in Barnsley for 2018/19 which captures the essence of the Bradford Healthy Hearts programme. The scheme will involve –

- review and optimise management of patients at high risk of CVD to enable them to lower their risk,
- improve the identification and management of patients with Familial Hypocholesterolaemia, Lipid Modification: all patients with a CVD risk of >20% will be offered a statin to lower their cholesterol,
- ensure better management of AF: use the National PRIMIS GRASP / AF audit tool to help identify patients with potential AF, including those at high risk of stroke not currently prescribed an anti-coagulant (OAC),

- Improve identification and control of hypertension

NHSE have committed to work in partnership with Barnsley CCG to develop a website which provides information for health professionals and patients, in line with the website developed for Bradford Healthy Hearts. A major section of the website will relate to the prevention of CVD through lifestyle choices, including a guide to making good choices in the areas that are recognised as risk factors for CVD.

http://www.bradfordshealthyhearts.co.uk/

4.2. Population Health Management and lifestyle risk factors

Health Checks

Measures are already in place to ensure high quality and systematic follow up of patients identified during a NHS Health Check as potentially having conditions such as hypertension, diabetes, and atrial fibrillation to confirm the diagnosis and commence medical management.

Smoking

Barnsley Council's ambition is to drive forward 'making smoking invisible' and includes, the development of Smokefree markets, play parks and schools. There is also a Tobacco control Action Plan,' with the aspiration to reduce smoking prevalence to less than 18% by 2020.

Diet

During 2018/19 BMBC's Food Strategy will be developed to focus on tackling sugar, fat and salt and work will commence to supporting achieving its vision (Nourishing our town: good food for all). All directorates within the Council have a part to play. For example, work in collaboration with the BMBC School Catering Service to increase the nutritional value in school meals, and continued action within the Planning Department to address the proliferation of takeaways in the borough.

Alcohol

During 2018/19 a programme of work will be developed to tackle the availability, affordability and acceptability of alcohol use in Barnsley. This will include a revised alcohol strategy for the borough and the development of an alcohol alliance to deliver the actions from the strategy. Public health is leading the relaunch of the Best Bar None (BBN) Scheme in Barnsley. BBN is an annual Accreditation Scheme with National Awards supported by the Home Office which is aimed primarily at promoting responsible management and operation of alcohol licensed premises.

Exercise

Physical activity, active travel and air quality are key priorities. Developing a new strategic physical activity partnership and strategy, along with new investment, will build community assets to increase levels of daily physical activity.

Diabetes Prevention

SY&B ACS (Barnsley, Doncaster, Rotherham and Bassetlaw – excluding Sheffield) are a Wave 2 delivery site for the National Diabetes Prevention Programme (NDPP). The programme aims to identify those at high risk of diabetes and refers them onto a behaviour change programme. The working assumption is that we will receive year 2 funding from NHSE (confirmation expected Feb 2018).

Diabetes transformation

There has been a successful, partnership led application for 'National Diabetes Treatment and Care Funding' to improve the uptake of structured education for Type 1&2 Diabetes and improve the achievement of the NICE recommended treatment targets for HbA1c, cholesterol and BP – total award allocation £263K. The programme is delivered in partnership. The partnership is awaiting confirmation from NHSE on year 2 funding.

4.3. Identification and health intelligence

SY&B ACS is wishing to gain a clear picture of the CVD burden and opportunities across SY&B. Short-term funding has been secured from NHSE to compile an ACS CVD profile, including interpretation and presentation of data in easily accessible format, with commentary. The profiles will look in more detail at QOF data to identify the opportunities for clinical risk factor modification at CCG level and aggregated to ACS level. In addition, CVD practice profiles for primary care practices will be produced at an individual practice level, using Barnsley CCG as a pilot.

4.4. Pathways

A comprehensive transformation programme of work, led by BHNFT, is underway across a number of CHD pathways. This programme will include a series of reviews focussing, on acute chest pain, acute coronary events and heart failure.

The procurement for adult diabetes services in Barnsley has been successfully concluded. Barnsley Hospital in partnership with Barnsley Healthcare Federation will deliver Diabetes Services – Community Specialist Nurses and Out-patient activity. The mobilisation of this new contract is underway with a GO LIVE date for the new service, April 2018. The contract value is £3.075m over a three-year period. This will be a new model of working for Barnsley, aligned to the CCG ambition of right care, right time, right place and locality working.

5. Wider stakeholder engagement

A joint frail elderly and cardiovascular disease stakeholder event is being planned for 13 March 2018. The event aims to share ideas and listen to a broad group of local stakeholders including health and care professionals, patients and representatives, community and voluntary sector groups and area council members. The purpose of the event is to further develop programmes of partnership work to improve outcomes for cardiovascular disease and for frail elderly residents in Barnsley.

Dr Matt Kearney, National Clinical Director for CVD will deliver a key-note speech at the stakeholder workshop.

The objectives of the event are to -

- Share the local context for greater collaboration and integration
- Share and develop the case for change
- Share examples of good practice locally and nationally
- Share the current programme plans (logic models)
- Agree the desired outcomes of the programme
- Further develop the programme plans in partnership using the ideas and suggestions from interested individuals and groups
- Explore how attendees can continue to support and shape the work programmes going forward

6. Summary

The Accountable Care Shadow Delivery Board is asked to:

- Note the content of this report

Appendix 1

CVD

Objectives

- Reduce the premature mortality from CVD in Barnsley
- Improve primary prevention and risk management
- Better identification of very high risk families / individuals
- A reduction in health inequalities between Barnsley, England and RightCare CfV peer comparator CCGs and reduce variations in care across the borough
- Support people to manage their own health and keep healthy
- Better early management and secondary prevention

Inputs	Strands of Work / Activities	Short-term outcomes	Medium-term outcomes	Impacts

Collaborating Partners: BCCG, BMBC, SWYPFT, BHNFT, BHF, VCF, SY&B ACS, NHSE
 	
Communications expertise, social media, materials and printing.
 	
Practice Development Agreement
 	
Population health related initiatives
 	
Analytics / business intelligence (funded through ACS/NHS RightCare)
 	
Clinical leadership time in primary care to be champions and engage colleagues
 	
Capacity in general practice
 	
Capacity in Lifestyle Services
 	
Specialist time from secondary care to support primary care and development of pathways
 	
Intelligence and measurement tools: CVD profiles, PHE Size of the Prize, RightCare CfV, Hospital data (admission rates), national clinical audit results, Prescribing data (ECLIPSE)
	Prevention of clinical risk factors
	• Review and optimise management of pts at high risk of CVD
	• Familial Hypercholesterolemia: Identification and management of pts with FH
	• National Diabetes Prevention programme
	• Lipid Modification: all pts with a CVD risk of >20% offered a statin to lower their cholesterol
	• AF: Use of the National PRIMIS GRASP / AF audit tool to help identify pts with potential AF, inc. those at high risk of stroke not currently prescribed an anti-coagulant (OAC)
	• Hypertension: identification and control,
	Population Health Management and lifestyle risk factors
	• Healthy Hearts; resources for Patients and Health Professionals
	• NHS Health Check
	• Workplace Health Charter
	• Primary Prevention: population approach, brief interventions, lifestyle factors and Social Prescribing
	• Media campaigns and events linked with national campaigns, promotion of apps, etc.
	Identification and health intelligence
	• PHE, Size of the Prize
	• CVD profiles including interpretation and presentation of data – Data reported for: ACS / CCG / Practice
	Pathways
	• CHD pathway reviews:
	  • Acute Chest Pain
	  • acute coronary events
	  • Heart failure
	  • Cardiac rehabilitation
	• Coronary specialist advice, guidance and management
	• Access to diagnostic tests
	• Optimisation of treatment post acute coronary events
	• Heart Failure, inc consideration of IV diuretics service
	• Integrated care for Diabetes
	• Embed self management and health literacy across pathways
	Working Together
	Hyper acute stroke care
	Tertiary cardiac interventions
	Hospital services review
	Post hyper acute stroke care
		Improved and quicker access to information, advice and guidance (patients and health professionals).
		
		More proactive, targeted diagnosis and management of CVD including medicines optimisation.
		
		Increased patient knowledge of conditions; healthier lifestyle choices, increased ability to self-manage.
		
		Increased knowledge and confidence within the health and care workforce.
			Reduced unwarranted variation in care.
			
			Fewer strokes and heart attacks.
			
			Increased capacity and capability in primary and community care; more care provided outside of hospital.
			
			Patients and their carer's are more activated, in control of their care and self-managing.
				Improved outcomes for patients with cardiovascular disease and reduction in health inequalities (associated savings).
				
				Reduced and more appropriate use of secondary care (associated savings).
				
				Improved patient experience of care, better quality of life (associated savings).
				
				Increase empowerment and engagement of health and care professionals.
				
				Reduced health inequalities.
				
				Improved access to care / care closer to home and patient flow through care pathways

Putting Barnsley People First

ACCOUNTABLE CARE SHADOW DELIVERY BOARD

25 January 2018

Frail Elderly

PART 1 SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*		*Information*	✓
2.	**REPORT OF**		
		Name	Designation
	SRO	Brigid Reid	Alliance Director
	Author and Programme Lead	Jayne Sivakumar	Head of Alliance Working
3.	**EXECUTIVE SUMMARY**		

Work has continued throughout December and January to scope the Barnsley wide Frail Elderly Programme. Following a multi-organisational workshop on the 16th November and a further meeting on the 11th December with a representative from Barnsley Clinical Commissioning Group, Barnsley Hospital, South West Yorkshire Partnership Trust, Barnsley Healthcare Federation and Barnsley Council seven potential areas of work have been identified.

1. Public Awareness Campaign
2. Identification and Screening
3. Joint Care Planning for moderate and severe frailty
4. Enhanced care management for moderate and severe frailty
5. Service/Pathway design
6. Training and Education
7. Acute Frailty Network

A joint Frailty and CVD event is being planned for 13th March 2018 to further develop the programme plan.

Work continues for those projects that are already being implemented (and will form part of the Frail Elderly Programme). These include (but are not exclusive to):

	• Co-ordinating Universal Service Provision to Care Homes (CUSP) • Care Homes 'Red Bag Scheme' • Falls - 'Back on your feet' • Barnsley wide Review of Assisted Living Services
4.	**THE DELIVERY BOARD IS ASKED TO:**
	The Accountable Care Shadow Delivery Board is asked to consider: • Note the content of this report
5.	**APPENDICES**
	1. Programme logic model

Agenda time allocation for report:	*15mins*

ACSDB 25/01/12.1

PART 2 DETAILED REPORT

1. Introduction

Work has continued throughout December and January to scope the Barnsley wide Frail Elderly Programme. Following a multi-organisational workshop on the 16th November and a further meeting on the 11th December with a representative from Barnsley Clinical Commissioning Group, Barnsley Hospital, South West Yorkshire Partnership Trust, Barnsley Healthcare Federation and Barnsley Council objectives, outcomes and priority areas of work have been agreed.

2. Rationale

Older people are majority users of health and social care services in the UK and internationally. Many older people who access these services have frailty, which is a state of vulnerability to adverse outcomes. The existing health care response to frailty is mainly secondary care-based and reactive to the acute health crises of falls, delirium and immobility. A more proactive, integrated, person-centred and community-based response to frailty is required.

The partnership has agreed a focus on the Frail Elderly population defined as those over 65yrs living with Frailty. This is because –

- Services for older people are an existing priority of the Barnsley Health and Wellbeing Board
- There is clear evidence that health and wellbeing outcomes for this population can be improved
- There are inequalities across Barnsley with people from more deprived backgrounds experiencing poorer outcomes than those who are more affluent
- There are lots of initiatives underway or being planned which could be joined up in a single approach
- Frail patients often receive fragmented care and would benefit from person-centred, coordinated care
- There is a growing body of evidence that 'hospital at home' for selected patients offers significant benefits in terms of lower mortality and reduced functional decline
- There is the potential to provide more care out-of-hospital in people's neighbourhoods and homes

3. Shared Objectives

Through a process of engagement with colleagues across the health and care system a number of objectives have been agreed.

- Provide better, quicker, more consistent care across the whole system
- Provide better, more joined up support for frail patients in their own homes and local community
- Better support for carer's (formal and informal)
- Better targeting of interventions to reduce health inequalities

4. Areas of work

4.1. Public awareness campaign

A central feature of physical frailty is loss of skeletal muscle function and there is a growing body of evidence documenting the major causes of this process. In terms of modifiable influences, the most studied is physical activity, particularly resistance exercise, which is beneficial both in terms of preventing and treating the physical performance component of frailty. There is also evidence that suboptimal protein/total calorie intake, vitamin D insufficiency and obesity contribute. Social isolation is thought to perhaps have the greatest impact on older people experiencing rapid health decline and going into crises.

The Frail Elderly programme will aim to educate the public around lifestyle factors that affect health decline in older age, provide advice and guidance for people and communities and support community resilience and asset based community development.

4.2. Identification and screening

From July 2017 there has been a requirement for general practitioners to identify frail patients on their practice registers and undertake a review for those who are assessed moderately or severely frail. As part of the Acute Frailty Network, clinical teams in Barnsley Hospital are looking at using a frailty screening tool for patients who present acutely unwell.

The Frail Elderly programme aims to embed a consistent approach to identification and screening of frail elderly people, consistent advice, guidance and signposting for those people that would benefit from additional support and sharing information between providers to provide more joined up care for those who need ongoing care and support.

Work has begun to understand the prevalence of frailty across the Borough and at a GP practice level, identify and develop tools for consistent screening of patients and assessment.

4.3. Joint care planning for moderate and severe frailty

The British Geriartics Society recommends an holistic medical review based on the principles of comprehensive geriatric assessment (CGA) for all older people identified with frailty. This will: diagnose medical illnesses to optimise treatment; apply evidence-based medication review checklists (e.g. STOPP/START criteria); include discussion with older people and carers to define the impact of illness; work with the older person to create an individualised care and support plan.

The Frail Elderly programme aims to support coordinated and person-centred care and support across the Borough by ensuring consistent multi-disciplinary team involvement in care planning and defining the roles of different professionals in the process. This will involve moving towards a standardised approach to care planning and standard

documentation, primary and community care and support for care home residents and advanced care planning.

4.4. Enhanced Case management for moderate and severe frailty

There are a number of examples of services being developed to provide enhanced case management for people at high risk of unplanned hospital admission that demonstrate benefits for the individuals and the system. These are generally older people living with multiple co-morbidities and/or frailty. These include the “Extensivist Care model” being adopted by many of the new model of care vanguards.

The Frail Elderly programme will be reviewing the evidence for these enhanced services and pathways and considering how the learning can be adopted or adapted locally. This will include a particular focus on care coordination, care navigation and sharing information between organisations to support the transfer of care between different settings

4.5. Service/pathway redesign

There are a number of initiatives already underway across the Borough to optimise care pathways for older people who are frail including Falls, Assisted Living Service Review and support for carers. There are also opportunities associated with new technologies which may apply particularly to this population group.

There Frail Elderly programme aims to bring these different pieces of work together to ensure that they align and therefore generate the greatest benefits for the Frail Elderly population and their communities.

4.6. Training and education

It is recognised that new evidence around clinical best practice, implementing changes to systems, processes and pathways and the roles of different individuals and agencies will mean there is a need to provide further education and training to frontline colleagues. There are already education programmes underway that align to the objectives of the Frail Elderly programme, including structured education for care homes staff.

The Frail Elderly programme will ensure that training is provided to meet the changing needs of the health and care workforce with regards to providing effective care and support for this population group.

4.7. Acute Frailty Network

Colleagues from the partnership joined the fifth cohort of the Acute Frailty Network at the launch event in October 2017. This is a 12 month improvement programme designed as a professional network to support participating sites to rapidly adopt best practice to improve emergency services for frail older people. The programme includes national collaborative events, workshops, virtual visits, webinars and individual support for participating communities.

The Acute Frailty Network (AFN) work at BHNFT is progressing. An internal action plan is currently being developed.

5. Wider stakeholder engagement

A joint frail elderly and cardiovascular disease stakeholder event is being planned for 13 March 2018. The event aims to share ideas and listen to a broad group of local stakeholders including health and care professionals, patients and representatives, community and voluntary sector groups and area council members. The purpose of the event is to further develop programmes of partnership work to improve outcomes for cardiovascular disease and for frail elderly residents in Barnsley.

The objectives of the event are to -

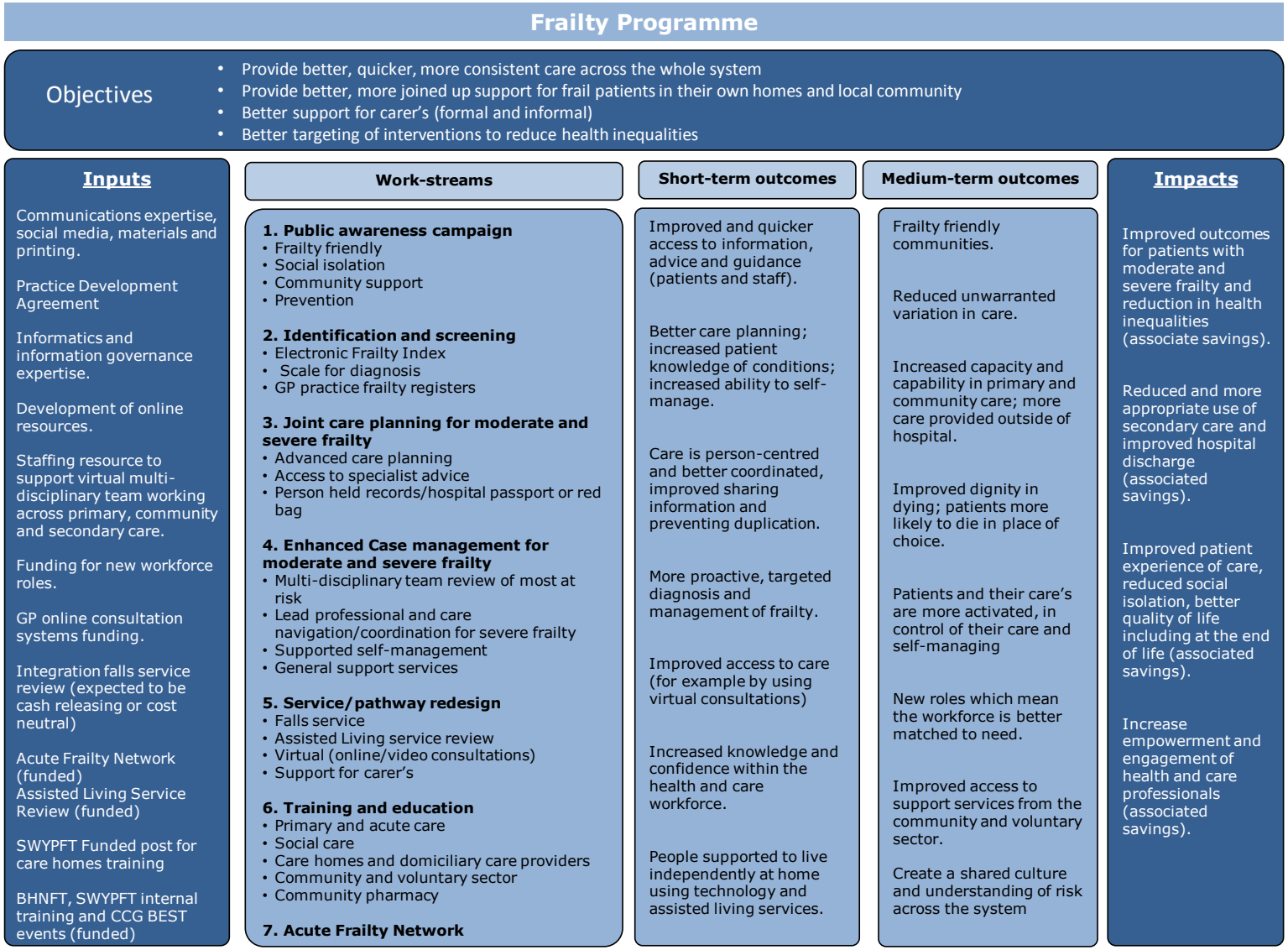
- Share the local context for greater collaboration and integration
- Share and develop the case for change
- Share examples of good practice locally and nationally
- Share the current programme plans (logic models)
- Agree the desired outcomes of the programme
- Further develop the programme plans in partnership using the ideas and suggestions from interested individuals and groups
- Explore how attendees can continue to support and shape the work programmes going forward

6. Summary

The Accountable Care Shadow Delivery Board is asked to:

- Note the content of this report

Appendix 1


Frailty Programme
Objectives
• Provide better, quicker, more consistent care across the whole system
• Provide better, more joined up support for frail patients in their own homes and local community
• Better support for carer's (formal and informal)
• Better targeting of interventions to reduce health inequalities
Inputs
Communications expertise, social media, materials and printing.
Practice Development Agreement
Informatics and information governance expertise.
Development of online resources.
Staffing resource to support virtual multi-disciplinary team working across primary, community and secondary care.
Funding for new workforce roles.
GP online consultation systems funding.
Integration falls service review (expected to be cash releasing or cost neutral)
Acute Frailty Network (funded)
Assisted Living Service Review (funded)
SWYPFT Funded post for care homes training
BHNFT, SWYPFT internal training and CCG BEST events (funded)
Work-streams
1. Public awareness campaign
• Frailty friendly
• Social isolation
• Community support
• Prevention
2. Identification and screening
• Electronic Frailty Index
• Scale for diagnosis
• GP practice frailty registers
3. Joint care planning for moderate and severe frailty
• Advanced care planning
• Access to specialist advice
• Person held records/hospital passport or red bag
4. Enhanced Case management for moderate and severe frailty
• Multi-disciplinary team review of most at risk
• Lead professional and care navigation/coordination for severe frailty
• Supported self-management
• General support services
5. Service/pathway redesign
• Falls service
• Assisted Living service review
• Virtual (online/video consultations)
• Support for carer's
6. Training and education
• Primary and acute care
• Social care
• Care homes and domiciliary care providers
• Community and voluntary sector
• Community pharmacy
7. Acute Frailty Network
Short-term outcomes
Improved and quicker access to information, advice and guidance (patients and staff).
Better care planning; increased patient knowledge of conditions; increased ability to self-manage.
Care is person-centred and better coordinated, improved sharing information and preventing duplication.
More proactive, targeted diagnosis and management of frailty.
Improved access to care (for example by using virtual consultations)
Increased knowledge and confidence within the health and care workforce.
People supported to live independently at home using technology and assisted living services.
Medium-term outcomes
Frailty friendly communities.
Reduced unwarranted variation in care.
Increased capacity and capability in primary and community care; more care provided outside of hospital.
Improved dignity in dying; patients more likely to die in place of choice.
Patients and their care's are more activated, in control of their care and self-managing
New roles which mean the workforce is better matched to need.
Improved access to support services from the community and voluntary sector.
Create a shared culture and understanding of risk across the system
Impacts
Improved outcomes for patients with moderate and severe frailty and reduction in health inequalities (associate savings).
Reduced and more appropriate use of secondary care and improved hospital discharge (associated savings).
Improved patient experience of care, reduced social isolation, better quality of life including at the end of life (associated savings).
Increase empowerment and engagement of health and care professionals (associated savings).