Barnsley Place Based Partnership

Tackling health inequalities in Barnsley

Barnsley – the place of possibilities.

1. Introduction

Health Inequalities are unfair, avoidable and systematic differences in health and related needs, outcomes and services between different people and groups of people. These differences can be due to many factors, such as a person's social, economic or environmental circumstances – we know that greater deprivation in any of these factors is associated with a greater risk of becoming ill earlier and dying younger (Box 1). Certain characteristics are also associated with poorer health, often due to the exclusion people with these characteristics face – we know that people with certain ethnicities, sexual orientation, age and disabilities have a lesser chance of having as long and healthy a life as others.

Box 1 Comparing life expectancy between England's most and least deprived communities

In England, people from the most deprived 10% of the population have a life expectancy at birth that is between 7.7 and 9.4 years less than those from the most affluent 10% and will live between 18.4 to 19.7 years longer in ill health.[1]

These differences are apparent when we compare the population of Barnsley with the average population of England and even more so when we compare Barnsley to the most affluent parts of the country. These differences also occur when we look within Barnsley, where stark differences in health occur between different communities, groups and wards across the borough (Table 1 on page 3).

Due to social, economic and environmental circumstances and other characteristics outside of their control, real people living in Barnsley are likely to spend more of their day-to-day lives in poor-health than people in other areas of the UK and are more likely to die younger (Box 2).

Box 2 Real stories from real people in Barnsley, describing how these inequalities affect lives

Mary lives in Barnsley and finds it difficult to afford her energy and heating bills, especially in winter. This means her house gets cold which makes her osteoporosis (weak bones) and joint pains worse. The only way she can occasionally get warm is to go to her shed and put the small heater on in there. Things are now improving since Mary has been supported by Green Doctors for energy efficient ways to keep her house warm and with a Household Support Grant.

James lives in Barnsley and has had difficulty finding work which is made harder by problems with his legs, blood pressure and maintaining a healthy weight. He has become reliant on his sister for finances and to pay the bills which has put her under pressure. With a combination of support from health and wellbeing coaches and some leg-up financial support he is now getting healthy and has new employment opportunities.

As well as causing suffering for the individuals, their families and communities, these avoidable differences pose a huge cost on societal, economic and health systems. The stalling and probable reduction in healthy life expectancy in England (Figure 3) is unsurprisingly associated with a growing need for healthcare – as investment and action in the cost-effective approaches to maintain health and wellbeing shrinks, the need for less cost-effective diagnostic and treatment services grows. It is estimated that over 40% of premature death in the UK and 40% of the demand for health services in England is attributable to preventive disease.[2] When wider costs are factored in, such as loss of workforce productivity, the overall economic burden of preventable and premature illness is staggering.

While many of the causes of these inequalities are more readily addressed through shifts in national policy and infrastructural changes (e.g. industry), there are things within our grasp locally – we are doing a lot and can do a lot more. This document outlines the current and planned approach that the Barnsley Place Partnership for health and care is taking at all levels to reduce health inequalities and help to improve health for everyone in the borough. The approach is structured across three tiers:

1. Introduce – which new services and sources of support are required to help us to address the key causes and drivers of inequalities;
2. Improve – what are the ways we can adapt and develop all services to reduce inequalities by supporting those in greatest need first;
3. Influence – how do we improve health and reduce inequalities through our wider impact on economy, society and environment.

In recognition of the wider determinants of health, the synergies between health and other key aspects of society, economy and environment the third tier includes collaboration across sectors which is essential for sustainable change, and encompasses the four themes of Barnsley 2030.[3]

Figure 1. The four themes of Barnsley 2030, covering sustainable cross-sectoral development

1. The Health Foundation, Evidence hub: What drives health inequalities?
2. The Long-term Sustainability of the NHS and Adult Social Care Contents
3. Barnsley 2030

2. Health inequalities in Barnsley

2.1 Life expectancy

Table 1 shows the life expectancy and healthy life expectancy at birth for people in Barnsley, the highest and lowest expectancy figures for wards across Barnsley, the average for England and the local authority areas with the highest expectancies in England. This presents some stark truths about the gap in health outcomes, including:

- People in Barnsley experience ill health sooner and for longer in than other parts of the UK, with 19 years difference in male healthy life expectancy between Barnsley and Rutland;
- People living in the Barnsley ward with the shortest life expectancy live almost eight years shorter than in those in the Barnsley ward with the highest life expectancy and nine (females) to ten (males) years shorter than the area of England with the longest life expectancy.

Table 1: Life expectancy / healthy life expectancy in Barnsley and England's average and highest[4]

	Life expectancy (years)		Healthy life expectancy (years)	
	Male	Female	Male	Female
Barnsley	77.1	81.1	55.9	60.1
England	79.1	83.0	62.6	63.1
Barnsley highest	(Penistone E) 83.1	(Penistone E) 86.1	Data unavailable at ward level	
Barnsley lowest	(Worsborough) 74.7	(Stairfoot) 78.6		
England highest	(Westminister) 84.7	(Ken' & Chelsea) 87.9	(Rutland) 74.7	(Workingham) 71.2

Sadly, things aren't improving. Figures 2 and 3 show the trend in life expectancy and healthy life expectancy in Barnsley, the region (Yorkshire and Humber) and nationally (England). These trends show a recent pre-pandemic reduction in both measures, which should cause the alarm bells to ring. They also show a persistent gap across both measures between Barnsley and both region and country – a gap that appears to be widening, especially in men.

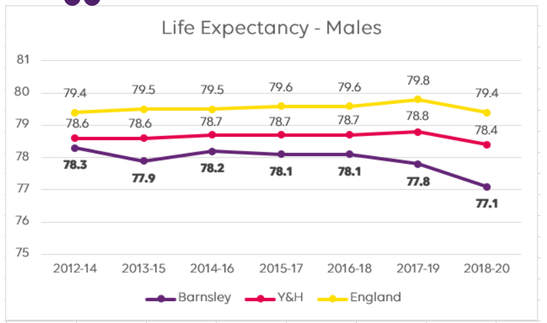
These differences represent underlying and undue suffering for people, families and communities, suffering which all parts of the health, care and wider system can do more to address. They also represent a disutility for all sectors and development ambitions – beyond the suffering, they cause loss of productivity in school and work, and a disease burden that heightens the need for care services which already lack capacity and resource.

Figure 2. The life expectancy in Barnsley, Yorkshire and Humber and England. Barnsley ranks 19th shortest expectancy for all Local Authorities in England.

Life expectancy of Males in Barnsley

77.1 years (-0.7 years)

2.3 years lower than England average



Life expectancy of Females in Barnsley

81.1 years (-0.7 years)

2 years lower than England average

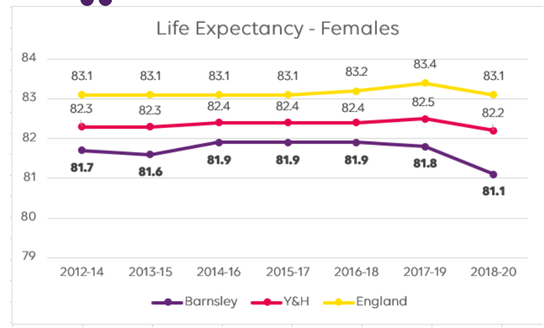
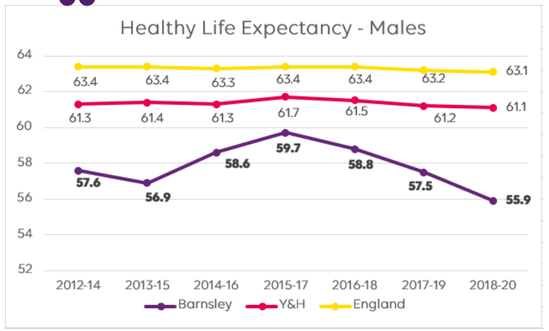


Figure 3: Health life expectancy in Barnsley, Yorkshire and England. For men, Barnsley ranks 4th shortest expectancy of all Local Authorities in England, and ranks 37th for women.

Healthy life expectancy of Males in Barnsley

55.9 years (-1.6 years)

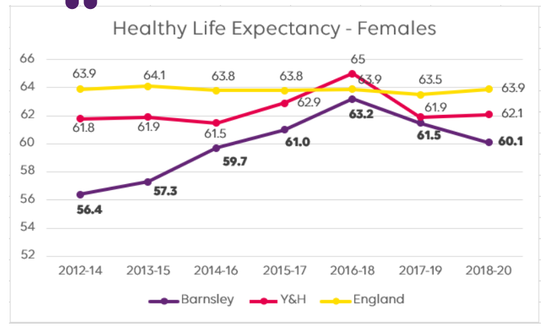
6.9 years lower than England average



Healthy life expectancy of Females in Barnsley

60.1 years (-1.7 years)

3.5 years lower than England average

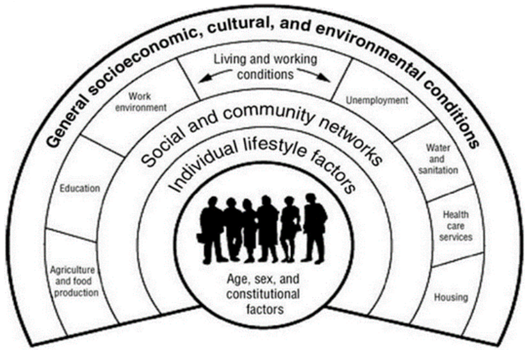


4. Public Health Outcomes Framework

2.2 Who is affected by health inequalities

Health inequalities affect all of us in one way or another. It is not a concept that is unique to a handful of "hard-to-reach" groups, but has a spectrum of impact across the whole population. Three overlapping factors that affect where we feature on the spectrum are who we are (demographic), our general circumstances (social, economic and environmental) and other protected characteristics that might make us susceptible to discrimination (e.g. inclusion groups). These are captured in what Dahlgren and Whitehead (1991) coined the social determinants of health (Figure 4).

Figure 4: The broad circumstances that together determine the quality of the health of an individual group of general population.[5]



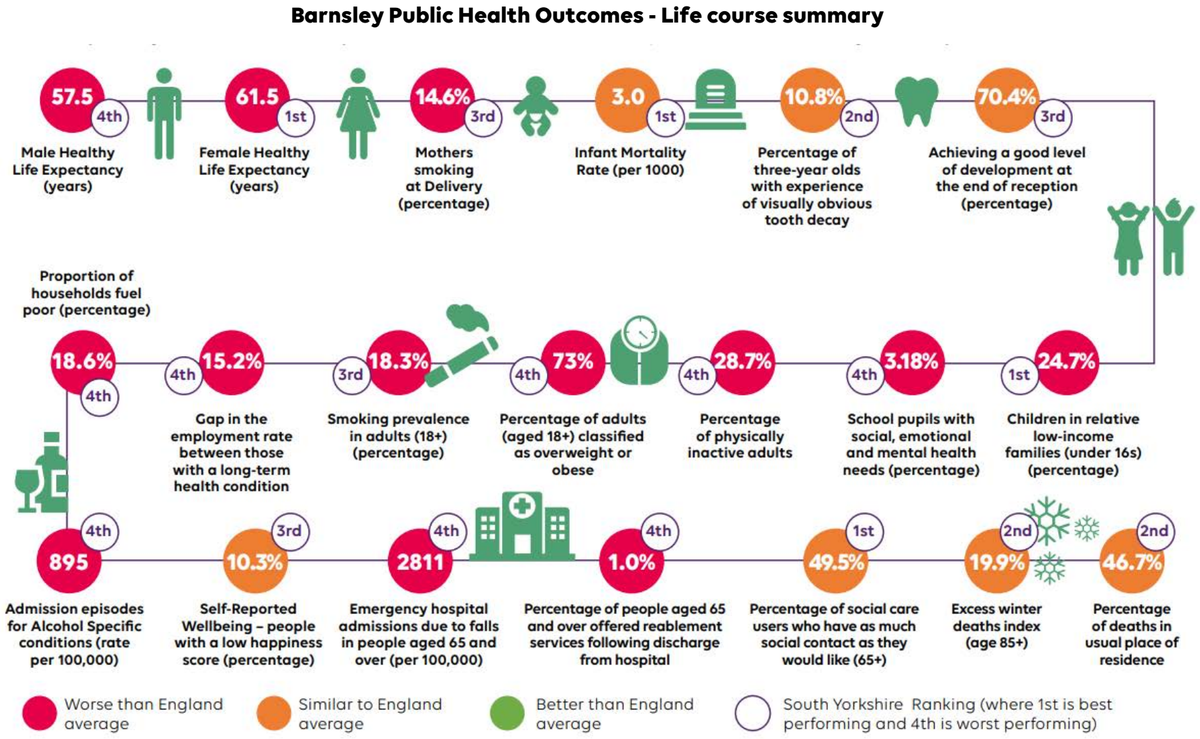
2.2.1 Demographics

This refers to the key statistical measures of individuals and groups such as age, gender, ethnicity and postcode area, although it can include a much broader set of characteristics, including those discussed in the next two subsections. Measurement and data are an important concept to introduce here, as these characteristics tend to be easily determined, routinely measured and readily accessible (which is often not the case for certain characteristics and inclusion groups).

Demographics overlap with the next two factors in a number of ways – e.g. people from Ethnic Minority communities in the UK are at a higher risk of more deprived socioeconomic circumstances and discrimination, and often have worse health outcomes (as seen during the COVID-19 pandemic[6]); older people are at a higher risk of social and digital exclusion, and not being able to afford necessary domiciliary or long term care[7]; the circumstances children are born into and the experiences especially of the first 1000 days of their life have a critical and lasting impact on their health and life.[8]

The life course is a good way to consider how certain demographic characteristics and stages in life have a part in determining health and wellbeing priorities, outcomes and needs (Fig 5). This can help inform how health systems understand the health of an individual or group and how to tailor / develop services and support to best meet the needs of people.

Figure 5. Key health outcomes for people across their life course in Barnsley in 2022 – including how they compare with the England average and whether they are improving or worsening.[9]



5. 2.1 Figure 1: the Dahlgren and Whitehead model of health determinants
6. Public Health England, Disparities in the risk and outcomes of COVID-19
7. Social exclusion of older persons: a scoping review and conceptual framework (European Journal of Ageing, 2017)
8. Unicef: The first 1,000 days of life: The brain's window of opportunity
9. Barnsley Health and Wellbeing Strategy 2021 - 2023: the place of possibilities

2.2.2 Barnsley 2021 census data[10]

Barnsley has a population of 244,600

Our population has increased by 5.8% since 2011 which is just below the national average increase

Our population aged 65 years and over has increased by by 19.2% since 2021

Our population aged 15-64 years has increased by 2.2% since 2021

Our population aged under 15 years has increased by 6% since 2021

95.72% of the local population report English as their first language

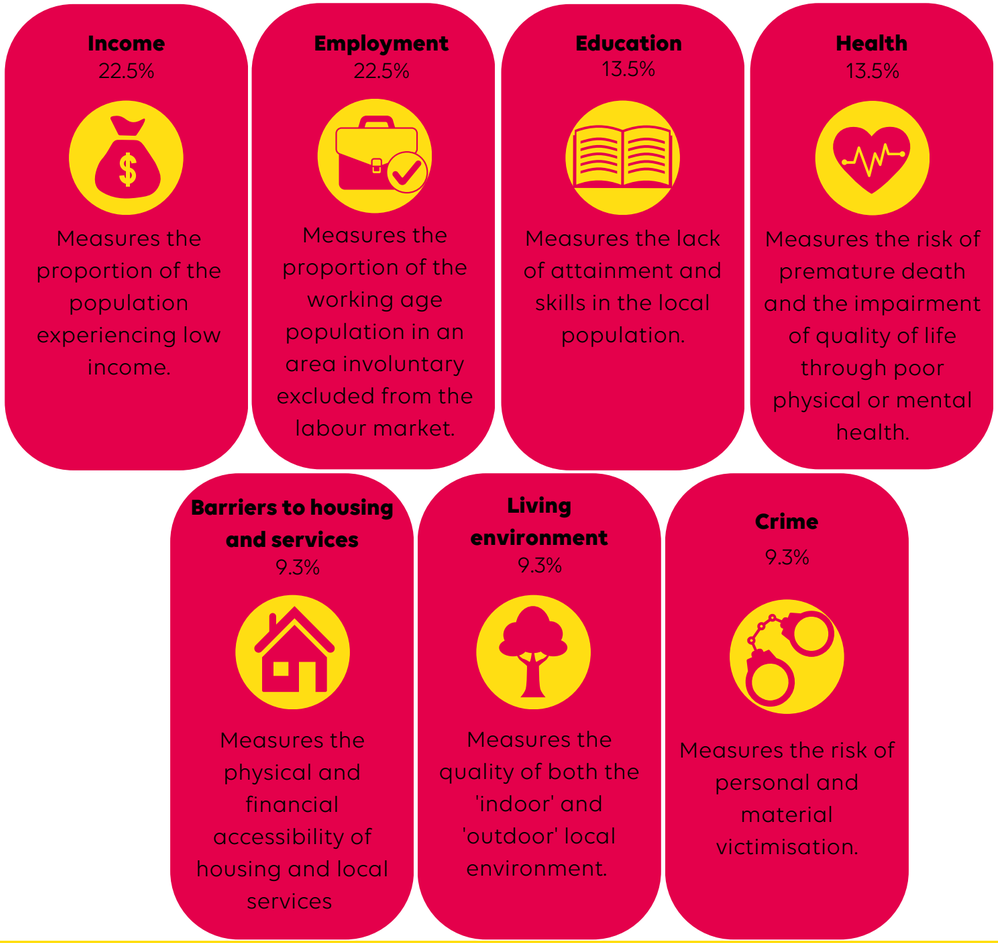
92.6% of the population identify themselves as White British (including English, Welsh, Scottish, Northern Irish or British), with the next largest ethnic group identified being Other White

10. How the population changed in Barnsley: Census 2021

2.2.3 Social, economic and environmental circumstances

These circumstances are incorporated into the indices of multiple deprivation (IMD) – the official measure of deprivation in England based on a composite of social, economic and environmental conditions of communities (down to lower super output areas). IMD includes seven domains: income; employment; health and disability; education, skills and training; crime; barriers to housing and services; and living environment.

Figure 6. The English Indices of Deprivation explained with the % weightings that each domain is given (2019) [11]

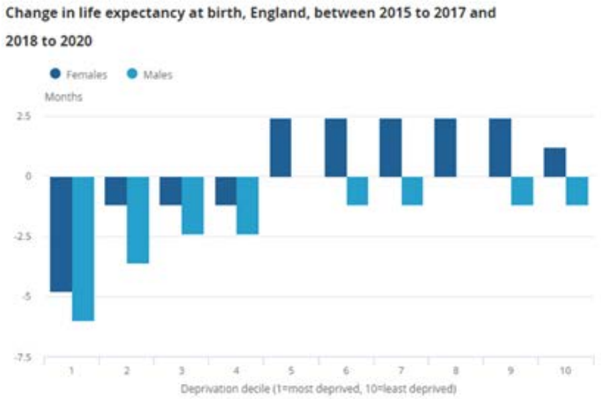


11. National statistics: English indices of deprivation 2019

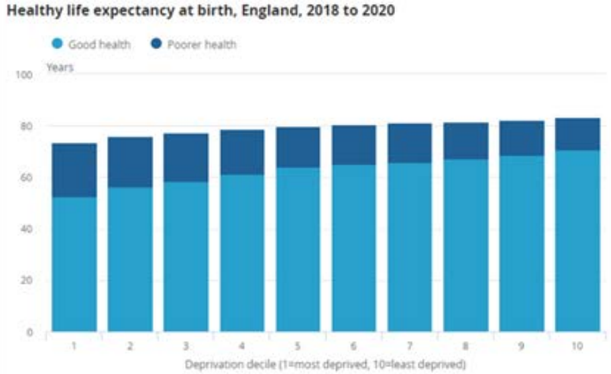
As well as providing a holistic measure of deprivation IMD allows a structured, tried and tested way to monitor and evaluate the needs and service impact of local populations and inform development to reduce inequalities. IMD cuts the general population into five (quintiles) or ten (deciles) equal-sized groups, with the most deprived 20% or ten per cent respectively given an IMD score of one and the least deprived (most affluent) given a score of five or ten respectively.

Figure 7 presents the stark ONS analysis of life expectancy and healthy life expectancy in England against the gradient of deprivation by IMD decile. This clearly shows that with increasing deprivation people will live a shorter life and spend more time in ill health and that the worsening situation in England is affecting people with greater deprivation more than people who are more affluent.

Figure 7. Life expectancy and healthy life expectancy by deprivation (IMD decile) in England and the change in life expectancy between 2015/17 and 2018/20.[12]



Source: Office for National Statistics



Source: Office for National Statistics – Annual Population Survey, 2011

This data represents real people across the country and are as true for Barnsley as anywhere else. Underneath those rather bleak headlines, of life-expectancy and healthy life-expectancy falling and affecting the most deprived more, is a huge burden of disease, loss of productivity and need for health and social care services.

In many ways, the challenge that inequalities present and need to address them is greater for Barnsley than the average area of the country: we are the 38th most deprived local authority in England; and, whilst 10% of the national population fit into the most deprived decile (and 20% in the most deprived quintile), over 20% of the Barnsley population fit into the nation's most deprived decile (and over 40% in the most deprived quintile).

12. Census 2021: Health state life expediencies by national deprivation deciles, England: 2018 to 2020

2.2.4 Specific characteristics and inclusion groups

There are a number of characteristics people might have that are associated with being subject to greater barriers, unfairness and discrimination. These include certain people who:

- are lesbian, gay, bisexual, transgender or queer (LGBTQ+)
- are from different ethnicities
- are a veteran or serving member of the armed forces
- have a physical or learning difficulty
- have mental health problems
- those from inclusion groups.

"Inclusion health is a 'catch-all' term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. People belonging to inclusion health groups frequently suffer from multiple health issues, which can include mental and physical ill health and substance dependence issues. This leads to extremely poor health outcomes, often much worse than the general population, lower average age of death, and it contributes considerably to increasing health inequalities.

Inclusion health includes any population group that is socially excluded. This can include people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery, but can also include other socially excluded groups. There will be differences in needs within socially excluded groups (for example between men and women) and these differences must be understood and responded to appropriately." [13]

The very nature of inclusion groups and some of these other characteristics means it is hard to be sure from any data sources of the numbers of people represented in the local population and, therefore, of their health priorities and needs. This means that engagement is an important source of such intelligence from these groups.

However, we do know some things:

As of 17 November 2022, there were 316 asylum seekers living in dispersed accommodation across Barnsley, managed by Mears Group;

A recent mental health needs assessment found 1,828 people living with Serious Mental Illness (SMI) in Barnsley (according to GP registered conditions);

An estimated seven people sleep rough each night in Barnsley and, in 2020/21, 781 households are threatened with homelessness;

In 2021/22, approximately 15% of school children in Barnsley had a statutory plan or were receiving Special Educational Needs (SEN) support (previously school action and school action plus). There are around 35,000 pupils on roll in Barnsley school.

GP registers show 1,632 people with learning disability (all ages).

According to the Census 2021 data regarding sexual orientation, 91.57% people aged 16 years and over living in Barnsley are straight or heterosexual (versus 92.5% national average) and 5.83% did not answer (versus 7.5% national average).[14]

The council provides a Gypsy and Traveller site at Smithies Lane, off Wakefield Road, on the fringe of Barnsley town centre. There are currently 30 pitches on the site.

13. Inclusion Health: applying All our Health

14. Census 2021: Sexual orientation, England and Wales

2.3 Health inequalities: illness and care

The relationship between health and life expectancy across the gradient of inequalities can also be seen when we look specifically at illness, including multimorbidity (having multiple long-term conditions). Generally, the number of people living with multimorbidity in England is rising, with more than one in four of the adult population now living with two or more conditions. Two key risk factors for this are age and deprivation, so much so that living with numerous and often complex health problems is becoming the norm for older people and those from disadvantaged communities.[15] Table 2 shows how the risk of multimorbidity changes with material wealth.

Table 2: Basic multi-morbidity (MM), complex multi-morbidity, functional limitation (MFL10+) and material determinants.[16]

	Basic MM		Complex MM		MFL10+	
	Odds ratio	95% CI	Odds ratio	95% CI	Odds ratio	95% CI
Household wealth						
High	1		1		1	
Medium	1.13	1.10-1.19	1.20	1.09-1.31	1.28	1.12-1.47
Low	1.47	1.34-1.61	1.73	1.52-1.96	1.90	1.59-2.26
Subjective social status						
High	1		1		1	
Medium	1.04	0.98-1.10	1.11	1.00-1.20	1.15	1.02-1.29
Low	1.14	1.04-1.24	1.21	1.07-1.35	1.37	1.26-1.70
Occupation						
Manager/prof.	1		1		1	
Intermediate	0.93	0.85-1.01	0.92	0.81-1.03	1.04	0.91-1.20
Semi/routine	1.07	1.04-1.24	1.03	0.92-1.15	1.28	1.14-1.46
Education						
A-level+	1		1		1	
0-Level or equiv.	0.93	0.86-1.00	0.92	0.81-1.03	0.89	0.80-1.02
Less than 0-Level	1.02	0.97-1.07	1.04	0.92-1.16	1.12	1.01-1.22

This is true for Barnsley, where we see a clear correlation between deprivation and multimorbidity (Fig. 8).

Unfortunately, we know that this is a vicious cycle for people, as the existence of one physical or mental health problem increases the risk of developing another physical or mental health problem and each long-term condition brings with other stresses than only health-related, including financial and social.

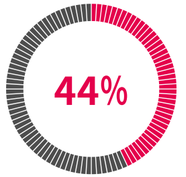
Living with a chronic illness in Barnsley[17]

In Barnsley you are almost 20 times more likely to be living in one of the most deprived communities in England than in the least deprived

There are over 50,000 residents in Barnsley living in the most deprived 10% of communities in England

The difference in lifespan of the most and least deprived communities in England is approximately 10 years. Those most affluent can often live around 20 years longer without illness or disability.

Around 44% of adults in Barnsley are living with some form of chronic illness or disability.



Nearly 1 in 4 of Barnsley residents with chronic illness or disability live in the most deprived 10% of communities in England.

This is compared to less than 1 in 100 people in Barnsley who live in the least deprived area who live with a chronic illness or disability.

15. National Institute for Health and Care Research: Multiple long-term conditions: making sense of the evidence
16. Social determinants of multimorbidity and multiple functional limitations among the ageing population of England, 2002-2015
17. Based on local data regarding population size across IMD deciles combined with national evidence on multi-morbidity

Some of this association with deprivation is linked to the greater prevalence of "lifestyle" risk factors. For example, smoking prevalence is higher in more deprived groups of the population and that will increase the risk of premature illness and death for these people. However, this is only part of the story. We know that deprivation is a direct risk factor, with some evidence suggesting more than half the association between deprivation and multi-morbidity is not related to associated lifestyle risk factors and is the direct result of deprivation.[18]

It is fair to say that since greater deprivation brings greater levels of illness, the more deprived a person is the greater will be their *need* for health and social care. However, greater deprivation is also associated with poorer *access* to health and social care (as well as poorer access to other services). This is known as the inverse care law, a term coined by Julian Tudor Hart 50 years ago, and still very much true today.[19]

Local analysis (Fig. 9) is consistent with this, demonstrating an association between greater deprivation and both greater use of unplanned care services (i.e. increased attendance to A&E and increased emergency admissions) and lesser use of planned care (if considered as use per long-term condition).

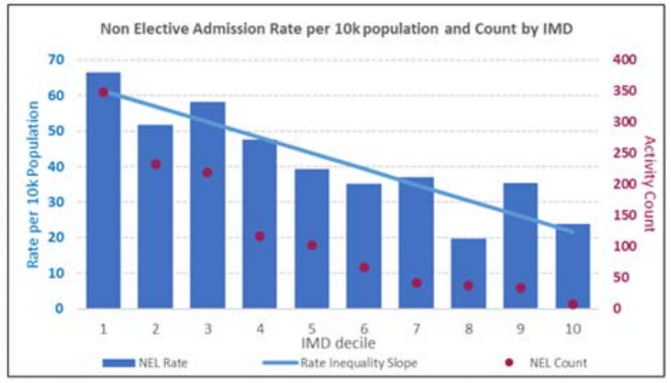
Figure 9. An IMD snapshot of elective and emergency respiratory admissions to Barnsley Hospital NHS Foundation Trust. Similar patterns are seen in other specialities. (2019-20 data)

Elective Admissions

Rates of Elective Admissions per 10,000 population were broadly consistent across all IMD deciles whereas, if proportionate to need, they'd be greater with greater deprivation.

Note, there are very few people in Barnsley in IMD 10, hence the lower rate.
Location of IMD 5 areas are closer to the border of Barnsley, so may access care outside of BHNFT.

Emergency Admissions



In the same period 66% of non-elective admissions for respiratory conditions were for residents from the three most deprived IMD deciles.

Deprivation is also associated with a less coherent referral pathway and uptake, local analysis shows:

- More affluent groups are more likely to access planned care via a GP referral and to attend their appointments
- More deprived groups are more likely to access planned care via emergency care (often a longer less reliable route involving multiple emergency attendances) and not attend appointments (often related to barriers to access)

Deprivation and other drivers of health inequalities are associated with a greater burden of illness and greater need for health and social care. It is also associated with poorer outcomes from illness and care – whether that is health outcomes from an episode of ill health or healthcare,[20] or socio-economic outcomes owing to the pre-existing fragility of the person's circumstances (e.g. no sick pay agreement in their contract of employment and no or low savings).

18. The Lancet Public Health: The effect of socioeconomic deprivation on the association between an extended measurement of unhealthy lifestyle factors and health outcomes
19. The Health Foundation: Tackling the inverse care law
20. National Library of Medicine: Socioeconomic deprivation and long-term outcomes after elective surgery

3. Policy context

3.1 National

The three most relevant contemporary sources of national directive relating to the impact of inequalities in England and the health sector's actions to address them are the government's Levelling Up programme, NHS England's Core20PLUS5 and the NHS Operating Framework shaping delivery of the NHS Long Term Plan.

The government describes Levelling Up the United Kingdom[21] as "a moral, social and economic programme for the whole of government" that "comprises … systems change" that will "spread opportunity more equally across the UK".

Although a lot of the White Paper is appropriately focused on other sectors and it is unfortunately unclear how many of the approaches it describes will reduce inequalities (health or otherwise), it does set out two specifically relevant "missions".

- Health: By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years.
- Wellbeing: By 2030, well-being will have improved in every area of the UK, with the gap between top performing and other areas closing.

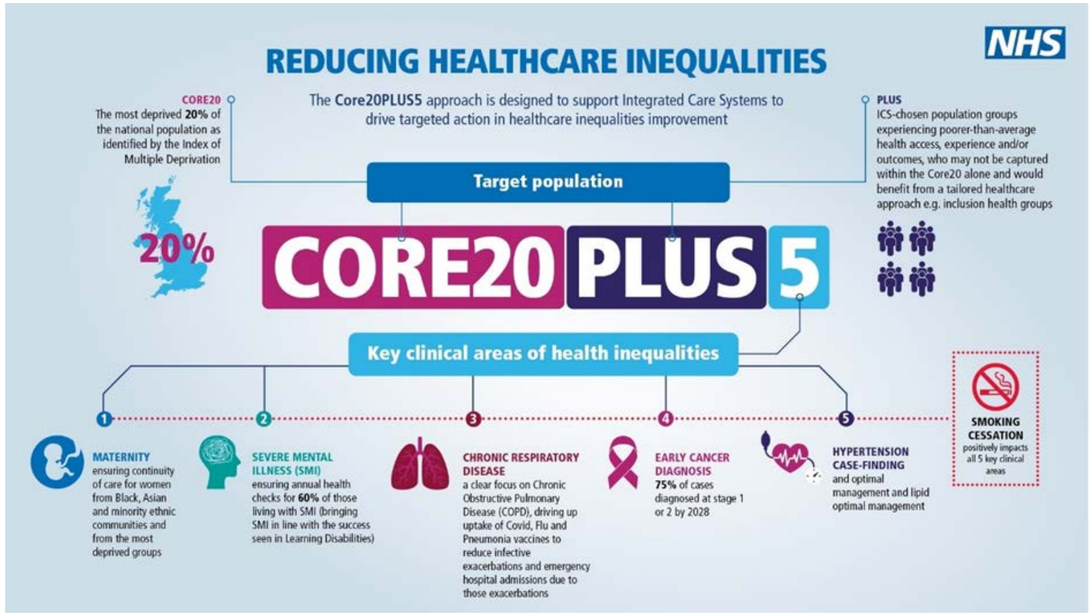
Core20PLUS5[22] is a national NHS England approach to inform action to reduce health inequalities. The "Core20PLUS" component helps to identify and frame the people, communities and populations to target (i.e. those most affected by health inequalities.

- Core20 refers to the most deprived 20% of the national population defined by IMD. As described earlier, unfortunately this accounts for over 40% of the population of Barnsley.
- PLUS refers to groups of the population determined locally as having greater need and being subject to greater inequalities. This might include other demographic characteristics and people from the inclusion groups and with protected or other specific characteristics discussed above.

The "5" component identifies the clinical areas which have greatest capacity to reduce health inequalities in the Core20PLUS target population and thus warrant the greatest (but not sole) focus.

For adults Core20PLUS5 (Figure 10), these are maternity with a focus of continuity of care, severe mental illness with a focus on health checks, chronic respiratory disease with a focus on vaccination to protect people with existing chronic respiratory disease, early cancer diagnosis and the diagnosis and control of hypertension.

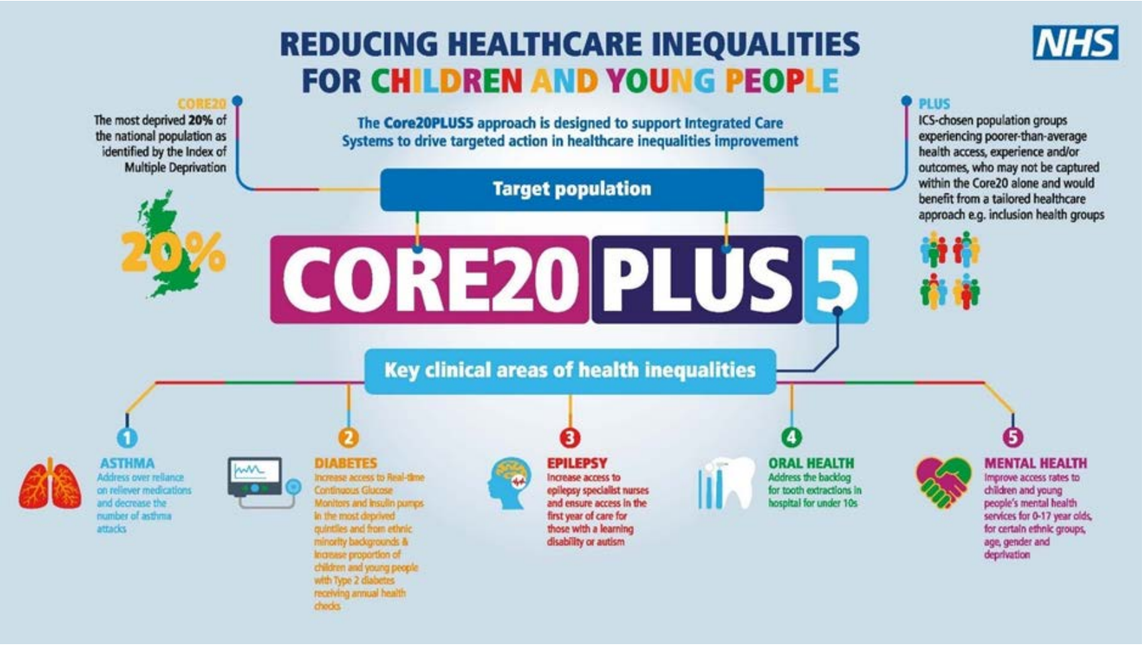
Figure 10: Core20PLUS5 for adults



For children and young people[23] (Figure 11, overleaf), these are asthma to reduce reliance on medicines and reduce attacks, diabetes to increase glucose monitoring and NICE-based control, epilepsy to increase access to a speciality nurse service especially for people with learning difficulties and autism, oral health to reduce tooth extractions and mental health to improve access to care.

21. Policy paper: Levelling Up the United Kingdom
22. Core20PLUS5 (adults) - an approach to reducing healthcare inequalities
23. Core20PLUS5 - An approach to reducing health inequalities for children and young people

Figure 11: Core20PLUS5 for children and young people



Chapter Two of the NHS Long Term Plan[24] published in 2019, described how it was going to take more action to reduce health inequalities. Since then, addressing health inequalities has been cited in a number of key actions and operating frameworks. The latest NHS Operating Framework published in October 2022, talk about three key approaches.

- Leadership that enables local systems and providers to improve the health of their people and patients and reduce health inequalities.
- Translating national strategy and policy to fit local circumstances, ensuring local health inequalities and priorities are addressed.
- Work with partners to build expertise & capability in delivering prevention and early intervention, using personalised approaches focused on inequalities.

3.2 Regional

The South Yorkshire (SY) Integrated Care Partnership (ICP)[25] is a statutory part of the Integrated Care System (ICS) with membership across the range of stakeholders in health, including the Integrated Care Board and Local Authorities (similar in its membership to a local Health and Wellbeing Board).

The SY ICP's strategy, was published in February 2023, includes a four tier outcomes framework with a number of elements specific or related to health inequalities:

- At the top of the framework is the "vision and goals", which include closing the gap in healthy life expectancy between South Yorkshire and England by 2028/30, and reducing by 25% the gap between the most and least deprived groups across South Yorkshire;
- This is supported by "bold ambitions", including raising school readiness levels, moving towards a tobacco-free South Yorkshire, reducing overall economic inactivity and improving employment for people with long term health conditions, disabilities and care leavers, and becoming an anti-racist and inclusive health and care system;
- The final two tiers are the "shared outcomes" (with a range of indicators key to improving health outcomes and reducing inequalities) and measures of the "process and performance" that is required across health and related organisations to fulfil the framework.

Within the SY ICP and Board there is both an executive sponsor and named lead for health inequalities and work to reduce inequalities is coordinated by the Population Health Management Strategic Delivery Group which reports to the Systems Leadership Executive Group.

24. NHS Long Term Plan
25. South Yorkshire Integrated Care Board

3.3 Local

There are three key parts to the Barnsley place health and care system, each with its role in shaping the health of the local population, improving health and related outcomes and reducing health inequalities:

- The place-based integrated care partnership[26] which aims to deliver Barnsley's health and care plan – the 2022/23[27] refresh of the plan wove the thread of health equity through three of its priorities, including strengthening prevention, improving equity of access to care, and joining up support for those with greatest needs;

- In its 2021-2030 strategy[28], Barnsley's Health and Wellbeing Board has committed to reducing health inequalities across the life-course, including helping to ensure every child is given the best start in life, everyone can access the resources they need to live a healthy life and to age well, it also specifically sites mental health and addressing the wider determinants of health inequalities (such as housing, employment and education);

- Barnsley 2030 "the place of possibilities" is the social, enviromental and economic development plan for the borough which looks across all sectors and has four key themes (Figure 1) – Learning, Growing, Sustainable and Healthy Barnsley – there are health-related commitments across it all with those specific to inequalities including reducing poverty, improving access to quality housing and affordable energy, improving learning and social connections, and improving access to healthy and active lives.

Within the Barnsley Integrated Care Partnership and Board (Barnsley Place ICB) there is an executive sponsor for health inequalities and the cross-partners Barnsley Health Equity Group (BHEG) which coordinates the place-based approach to reducing health inequalities and reports into the place Delivery Group of the Barnsley Place ICB).

26 - Barnsley Place, South Yorkshire Integrated Care Board
27 - TBC
28 - Barnsley Health and Wellbeing Strategy 2021 - 2023: the place of possibilities

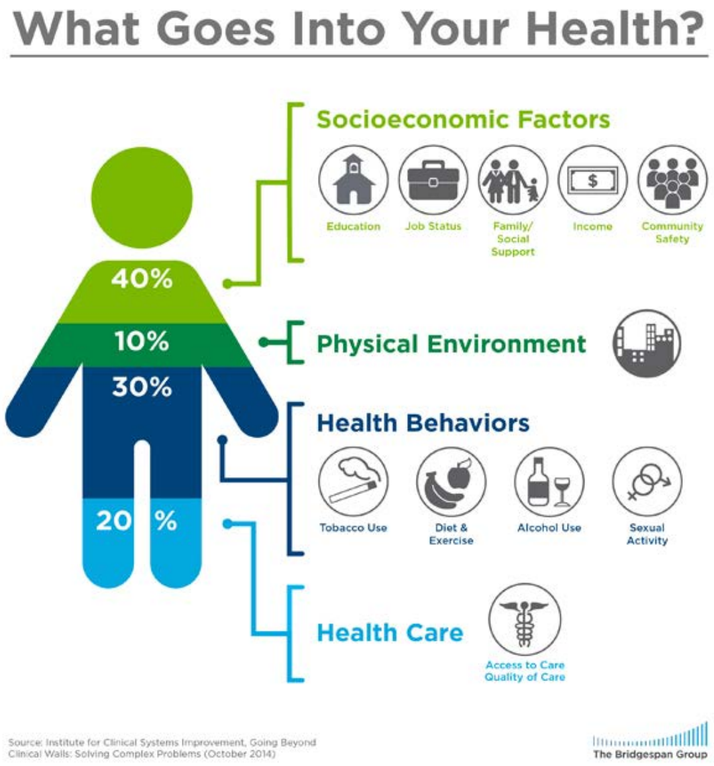
4. Our approach

4.1 A framework for action

"[The] link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus."[29]

It is not reasonable nor sustainable to think that the NHS and wider health and care providers at any level – neighbourhood, place (Barnsley), system (South Yorkshire), regional (Yorkshire and Humber) or national (England) – can continue to manage health by delivering only care and acting only when health has "gone wrong". In Barnsley we are working together to do more to improve health and reduce health inequalities in the local population. This requires action across all the determinants (Figure 12) and, where action is beyond the reach of the health and care sector, working across sectors and with wider partners to make progress.

Figure 12: What goes into your health? An illustration of the impact health care has on a person's health versus non-healthcare factors



29 - Institute of Health Equity: Fair Society, Healthy Lives
30 - The Community Cure for Health Care, The Bridgespan Group, 2016

Under the guidance and coordination of BHEG, organisations across Barnsley's Integrated Care Partnership are aligning their approach to improving public health and reducing health inequalities using a three-tier framework.

How we plan to improve health and reduce health inequalities

Tier 1

Increasing services and support to address the key divers of health inequalities, making every contact count, and co-developing these with people, for people.

Tier 2

Improving all health and care services in such a way that they are targeted to greatest need and reduce inequalities in care.

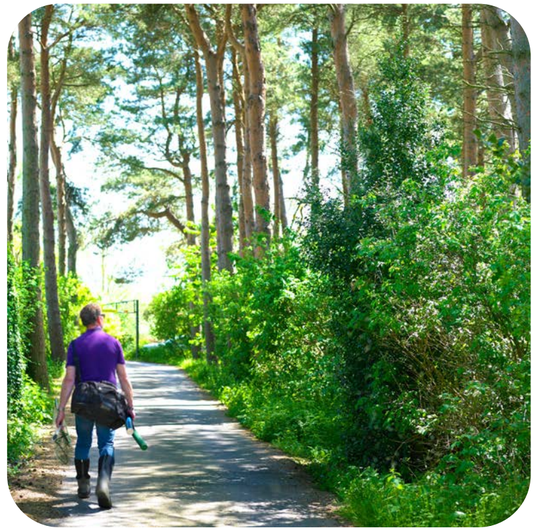
Tier 3

Influence the wider influences on health, by becoming the best anchor institutions and network we can be and advocating for health equity across all sectors.

This framework strikes a balance between "the whole" – acknowledging that what determines our health and wellbeing (and, therefore, the need for health and care services) covers almost all aspects of society, economy and environment – and that which is within the immediate grasp of an integrated care system.

Although in the context of this plan it is intended to guide and shape the approach of the Barnsley health and care system and its partners, it has been developed for use at any level – from service to system.

See Figure 13 on the next page for more detail on how the framework is being used and applied.



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

- Barnsley Hospital NHS Foundation Trust Board approved the framework as a tool to guide its approach and, in November 2021, published its first Action Plan to Improve Public Health and Reduce Health Inequalities.[31]

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

- South West Yorkshire Foundation Trust have used the framework to guide a number of organisational shifts, most notably in stimulating its recently published Social Responsibility and Sustainability Strategy.[32]

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

31 - Barnsley Board Meeting - December 2021
31 - South West Yorkshire Partnership NHS Foundation Trust - Social responsibility and sustainability strategy

How we plan to improve health and reduce health inequalities

Figure 13: Barnsley's integrated care framework for improving health and reducing health inequalities

Tier 1 Increase

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

We will increase:

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

Tier 2 Improve

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

We will improve how:

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

Tier 3 Influence

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

We will influence:

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

4.2 Tier 1: Key questions and case studies

To ensure people have access to support that prevents them getting sick and reduces the drivers of inequality in their life, we can ask a number of questions of health and care services, organisations and partnerships.

- What could you introduce that doesn't already exist to strengthen prevention and/or reduce inequalities in your population and service users?
- Historically, which areas or services have historically been prioritised less than others resulting in inequalities?
- Do you have enough information about the drivers and causes of poor health and inequalities in your population and service users?
- Have you considered what underlying assumptions and biases you have when assessing the needs of your population, area or service?
- How effectively joined up and person-centred are the services that strengthen prevention and reduce inequalities?
- What engagement or resource commitments would help to sustainably reduce inequalities?

By addressing these questions, a number of services have been generated across Barnsley.

Improving Heart Health in working-aged men

Hypertension is the third highest risk factor for death in Yorkshire and Humber. People are dying because of having undiagnosed and/or uncontrolled hypertension. In Barnsley, a priority group for blood pressure support is working-aged men living in Dearne and North. They have high rates of heart disease and yet a higher-than-average rate of missing blood pressure data in their GP records. "How's Thi Ticker?" is a local campaign and partnership initiative working across primary care, local authority, charities and businesses to increase blood pressure checks and treatment. Through marketing and engagement using the Public Health Support Service, priority groups are being supported in the community and, those found to have high blood pressure (around 30%), referred to local pharmacies.

What we have planned as part of Tier 1 action:

"How's Thi Ticker?" is funding Reds in the Community, Age UK and Dearne and District FC to build on the engagement and reach, and is further developing the partnership with community pharmacies Case Finding Service for early diagnosis and treatment.

Supporting people with learning disabilities

People with learning disabilities usually have poorer physical and mental health than the average person and have a shorter life expectancy (18 years younger for women and 14 years younger for men). This is why Barnsley's Metropolitan Borough Council's Healthy Ageing Public Health Team and Barnsley's Primary Care Network have funded two new Care Coordinator roles to assist those with learning disabilities to overcome barriers they face to accessing primary care.

What we have planned as part of Tier 1 action:

The Care Coordinators are helping to provide a targeted and tailored approach to Health Checks for people with learning disabilities in Barnsley and have successfully offered a health check to over 75% of this group locally. They are also (with the support by NHS England) proactively identifying people with learning disabilities who are eligible for the Faecal Immunochemical Test for bowel cancer, breast and cervical screening services and supporting them to complete the test effectively.

Holistic support and prevention

Smoking is the single biggest preventable cause of preventable death in the world. Barnsley has higher than the national average smoking prevalence, with higher rates in more deprived groups. Understanding this, Barnsley Hospital and the South Yorkshire and Bassetlaw team have established their QUIT programmes for tobacco control, in line with Barnsley's ambition to Make Smoking Invisible. QUIT is striving to identify all local people who are addicted to tobacco and support them to stop smoking for good, linking with equivalent services in the community.

What we have planned as part of Tier 1 action:

The success of QUIT has led to the subsequent funding and establishment at the hospital of the Alcohol Care Team and Barnsley Metropolitan Borough Council's Early Help Navigator service for children and families. These collectively make up our Healthy Lives Programme, which is expanding to strengthen support for patients and staff with housing problems, financial difficulties, unhealthy diets and physical inactivity.

Award winning support to strengthen mental, physical and psychological wellbeing

Creative Minds is a charity that brings together over 120 community organisations together who work to provide creative stimulation and cultural activities that enables people to connect, fund purpose and meaning through shared interests. Hosted by South West Yorkshire Partnership Trust, Creative Minds co-produces and delivers creative arts, sports and recreation and leisure activities. By bringing together NHS and community funding they pool resources and are able to extend the offer to more people living in Barnsley.

What we have planned as part of Tier 1 action:

Creative Minds will further strengthen the links and relationships in Barnsley to deliver collaborative projects that focus on things that matter to people positively impacting peoples health and wellbeing. The work they do is part of a growing evidence base that shows that by connecting communities we can address health inequalities and help people reach their potential.

4.3 Tier 2: Key questions and case studies

To ensure that Barnsley's health and social care partners do all they can to provide care and support to those with the greatest need first, services, organisations and the integrated care partnership as a whole can consider switching the old rhetoric around "hard to reach groups" in the local population to one that looks to answer the question of "why are our services often hardest to access for the people who need them most?"

Some of the questions below can help us continue to address this:

- Do we plan, commission, and prioritise based on existing demand or population need?
- Are there disparities between need and service use in certain communities and populations?
- Do we measure inequalities in service use and activity and consider narrowing gaps as a performance target?
- Which populations and communities have not been the focus of support for our services?
- Do some populations have easier / better access to our information and communications than others?
- What training for staff would build on their existing understanding of wider risks to peoples' health and wellbeing?
- How can we increase and co-produce engagement with excluded populations and those at greatest risk to encourage use of services earlier?
- How can we improve peoples' awareness of their own needs and build health literacy and expectations in the people at greatest risk?
- What opportunities are there for providing services in different locations that may improve access to priority groups?

Measuring and reporting on health inequalities

BHEG has developed standard inequality metrics for health and social care providers and a common approach to presenting service data to identify inequalities. This is being rolled out across partners and incorporated into the performance reports.

What we have planned as part of Tier 2 action:

Recording of inequalities data for individuals needs to be strengthened as we take this further but measuring is only one step. To ensure this informs action requires its integration into the routine business of healthcare and analytical capacity with data access. We are recruiting a Barnsley population health analyst, supporting partners to use and apply the measurement, and working with South Yorkshire Integrated Care System colleagues to develop executive accountability and improve data sharing.

More accesible care in the community

Barnsley has opened the Community Diagnostics Centre (CDC) in the town centre, increasing accessibility of care, integrating services with people's daily lives and investing in the local economy. The CDC has already received positive feedback from users and staff and national acclaim, and demonstrated a reduction in the rate of procedures to which people do not attend.

What we have planned as part of Tier 2 action:

Analysis of which local communities are benefiting most from this initiative is underway and will be used to inform planning for phase two of the CDC's development which will include expanding the diagnostic services available. Learning from the CDC will inform development of other community health and wellbeing offers funded by the place partnership, including consideration of integrating a health offer into libraries and other existing facilities that reach further into communities. CDC and related developments will also look to exploit partnerships to broaden its health promotion function.

Targeting support for those most vulnerable and in greatest need

Barnsley Metropolitan Borough Council has developed "vulnerabilities index" that compiles the lists of people who were extremely vulnerable to Covid-19 infection and those who were considered socially vulnerable. This allowed the Barnsley Community Support Service to provide targeted support and to keep people safe. The index has been used target vaccines to higher risk groups, provide winter wellbeing services and identify people requiring financial support.

What we have planned as part of Tier 2 action:

With the clear understanding of the link between deprivation, greater health need and poorer access to care services and the demonstrated benefit of combining health data with wider social and economic data, Barnsley's Health Intelligence Group (BHIG) are building the Barnsley Index of Deprivation (BID). Based on IMD but with household-level information, this will support clinical and care decisions, improve planning care to incorporate a person's wider circumstances and inform service development to increase access for those with greatest need.

Continuity of care in maternity services
Barnsley's maternity services has committed to target the gold standard of continuity of midwifery care for women from Minority Ethic backgrounds and the 10% most deprived households. This means pregnant women will have the same midwifery team throughout their pregnancy, labour and post-natal period, improving the survival, health and experience of the mother and baby.

What we have planned as part of Tier 2 action:
This approach can provide learning for other health and social care services. The Barnsley maternity service is building on the success, strengthening the long-term impact it has on families by improving its health education to parents and exploring how to expand its continuity offer to other communities with the most to benefit.

Wellbeing for people with Severe Mental Illness (SMI)
People living with SMI have a much higher prevalence of long-term conditions (LTC) and a much shorter life expectancy than those without. We have therefore been working to improve the local registers of people with SMI and use these to target Health Checks with these people to prevent, identify and improve management of LTC. As part of this work we have focused on delivering Health Checks with those who have previously disengaged with this offer. This has seen us launch a pilot where Clinical Health and Wellbeing coach has delivered this service in people's homes. Over 84% of people who were re-contacted with the offer took this up, with over 63% having this take place at home.

What we have planned as part of Tier 2 action:
The pilot was carried out at three GP practices in Barnsley by March 2023. We have now started rolling this out across practices in the Dearne Neighbourhood and plan to offer this to all practices by January 2024.

4.4 Tier 3: Key questions and case studies

The impact that the health and care sector has on health and wellbeing by means other than the services it delivers is huge and can lead to a far-reaching benefit if due consideration is given by partners and collectively to how it goes about its business. To "give everything we've got" services, organisations and the wider health system needs to ask questions about more than just the care it delivers:

- What are our values and how do they permeate everything that we do?

- What is our impact on the climate and environment and how do we maximise benefit?
  - How much waste do we produce and how can we manage it?
  - How can we reduce emissions from travel and transport?
  - How can we help to generate green, resilient and sustainable utilities (e.g. energy, water)?
  - How can we use the most sustainable technologies (health and otherwise)?

- What is our impact on the local economy and how can we maximise benefit?
  - How can we procure and spend more locally and regionally?
  - How can we generate local production and supply of what we need?
  - How can we make local supply economically viable through scale?

- What is our impact on communities and society locally and regionally?
  - How can we engage with communities to ensure we are equitable?
  - How can we share and distribute responsibility and power?
  - How can our facilities, estates and assets provide social value?
  - How can we create social mobility through recruitment and staff development?
  - How can we make Barnsley the best place to be born?
  - How can we strengthen education and equal opportunity in Barnsley?
  - How can we make our organisations the best places to work?

- What is our impact through our influence on our partners, our suppliers, other sectors and through our reach into wider policy and development?

A strategy for social responsibility

In 2021, South West Yorkshire Partnership Trust published its Social Responsibility and Sustainability Strategy which aims to use the levers it has to maximise the benefits to local people, communities and places, especially those facing challenge and disadvantage. The strategy builds on its core and current activities and role as an anchor institution.

What we have planned as part of Tier 3 action:

The anchor institutions in Barnsley have ambitious plans to work better together across all these areas and seek scale and impact. BMBC, BHNFT and SWYFT are committing to establish an executive-level anchor network to generate a shared understanding of what it means to be the best anchors in Barnsley, explore the greatest opportunities to benefit the local population and set their organisations on the right direction to make more lasting change and impact across society, economy and environment.

Safe housing for health and wellbeing

People who are reporting difficulty in paying their fuel bill are four times more likely to suffer from mental ill-health. Children who live in cold housing are twice as likely to suffer from respiratory conditions while those who live in homes with damp are three times more likely. In 2021, Barnsley Council commissioned a Health Impact Assessment into 'The cost of private sector housing and prospective housing interventions in Barnsley Metropolitan Council.' The report concluded that there were over 21,000 Category 1 hazards in private sector housing stock.

What we have planned as part of Tier 3 action:

The assessment has already led to 970 interventions to improve housing for health. By responding to all recommendations, it is estimated the that an initial cost of £30.2 million would result in annual savings to the NHS of £4.07 million per year and £28.3 million per year savings to wider society. More than the financial impact, if all serious housing hazards were addressed, 314 Quality Adjusted Life Years could be saved – more people would live longer in good health.

Pledging to make Barnsley an inclusive economy

In 2022, BHEG took its analysis of health inequalities in Barnsley outside of the health sector. At a Barnsley 2030 Board development session, BHEG presented the principles behind health inequalities, the local context and a suite of evidence-based interventions to reduce inequalities to raise awareness and generate action and accountability for inequalities across sectors and the four themes of B2030. A number of pledges were made by board members, including steps to make every child active and alleviate poverty in Barnsley.

What we have planned as part of Tier 3 action:

Making every child active has become a core focus of Barnsley Metropolitan Borough Council and the Active in Barnsley Partnership. This is being developed through a number of cycle promotion work and active travel infrastructure development. The pledge to alleviate poverty has resulted in Barnsley's Inclusive Economy Board working to promote the real living wage across all employers, refresh the More and Better Jobs initiative and develop targeted work to support the economically inactive.

Supporting the apprenticeship levy

The apprenticeship levy that our collective organisation get from central government is often under used and results in funds going back to central government instead of into the local economy. Barnsley Council has committed in its Apprenticeship Strategy to transfer up to 25% of its annual levy contribution to other organisations (equivalent to approximately £145,250 per year). The council began in 2022 to support the Yorkshire Ambulance Service (YAS)in this way. YAS tend to spend all its levy and Barnsley Metropolitan Borough Council has committed £70,000 to support it with a further 10 Level 3 Apprenticeships.

What we have planned as part of Tier 3 action:

Using wider sources of funding to build employment opportunities and respond to health needs is a win across all tiers. Sheffield Council has recently done so by transferring its levy to increase the domiciliary care workforce and improve the lives of frail and elderly. Barnsley is looking at how it can take a similar approach.

5. The way forward

There is lots of good and important work underway in Barnsley and there is lots more to do. The three sections below set out a proposed way to proceed with our work across the place partnership, including who in the Barnsley population we might aim to engage, in what ways we might support them and how we proceed. The ambitions set out in this document have been incorporated in Barnsley's Place Based Partnership's Health and Care plan 2023-25 to ensure this becomes embedded into everything we do.

5.1 Who

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

To identify "who" should be considered a priority for reducing inequalities in Barnsley, BHEG recommends using Core20PLUS in three key ways.

1. Deprivation (aggregated to postcode). Core20 refers to people living in the nationally defined 20% most deprived communities, but BHEG recommends the place partnership focus on the 20% most deprived communities in Barnsley, which approximately equates to those in the nationally defined 10% most deprived communities (see section 2.2.2).
2. Deprivation (at household level). Barnsley Index of Deprivation (see Box 4) is a localised tool to incorporate deprivation into individual care decision making and planning. BHEG recommends the place partnership support its development and integration into all HSC services.
3. Specific characteristics and inclusion Groups (the "PLUS") – The identification of appropriate characteristics and inclusion group(s) should flex to changing needs in the population and depend on the service or approach in question. However, BHEG recommend the place partnership support ongoing work to improve engagement, co-development, services and identification (e.g. through registers, where appropriate) for people who would identify themselves as LGBTQ+, homeless or with insecure housing, minority ethnic, having a learning disability or autism, asylum seekers or refugees.

5.2 What

The place partnership cannot achieve all that is within its gift to reduce inequalities only through actions, initiatives and projects, as this is about a sector-wide shift in the way it works and influencing other sectors. However, to facilitate this, BHEG recommends a three-by-three level commitment.

At the organisation-level, BHEG recommends that every partner organisation:

1. Commit to reducing health inequalities by doing more across the three tiers of this plan and considers, where appropriate, creating an action plan;
2. Improve data capture and sharing on Core20PLUS characteristics and introduce a standardised measurement and reporting on inequalities in performance (see appendix 1);
3. Establish accountability, commitment and delivery mechanisms to reduce the gaps identified and share learning across the place partnership.

At the partnership-level, BHEG recommends that organisations work together to:

1. Help to create a tobacco-free Barnsley by ensuring all staff and every patient / service user contact is used to confirm smoking status, treat all smokers and refer to a specialist service, and target tobacco treatment (e.g. in social housing, A&E, mental health, workplaces);
2. Start an active conversation with Barnsley's Core20PLUS population, to learn from their experiences and needs and co-develop support mechanisms for their health and wellbeing;
3. Establish an anchor network across HSC organisations and wider partnerships (e.g. education) to identify opportunities to work at scale and sustainably.

At the health and social care alliances and transformation groups, BHEG recommends:

1. Providing all pre-school children and their families in the Core20PLUS populations with access to support in the community for the best start through health and wellbeing;
2. Delivering HSC to school- and working- aged people in the Core20PLUS populations, working through community organisations and places of work and learning to enable productivity;
3. Identifying frailty and multi-morbidity in older people in the Core20PLUS populations and providing care in the home and community.

5.3 How

As we continue to strengthen Barnsley Place Partnership's approach to reducing health inequalities, we need to maintain a number of underlying principles and values:

1. Recognising this is the right thing to do to deliver quality care and services, to sustainably manage need for HSC and for the benefit of Barnsley residents;

2. Taking everyone along with us, so the local population, the workforce and any key stakeholders participate and share an understanding of why we are making these changes;

3.Making these commitments and reshaping the way we do things whilst being sympathetic to the hour-by-hour and day-by-day pressures on HSC services and the workforce;

4.Resourcing the right delivery mechanisms and services, generating capacity to guide the work to reduce inequalities and protecting the approach for sustainable change;

5.Challenging our decision making and ensuring we consider the impact on health inequalities in everything that we do.

BHEG will continue to support and guide this work and check in with organisations, the place partnership (directly reporting into the delivery group) and alliances / transformation groups to review progress and evaluate impact.

Where appropriate and felt good value for money, BHEG will also seek to grow capacity and expertise to strengthen and facilitate our work, drawing resources from within and without the partnership, including from the South Yorkshire ICB.

BHEG will also continue to advocate for this approach and build networks beyond Barnsley and beyond on health and care, to share learning and continue development where larger-scale approaches will increase impact.

6. Appendix 1

Barnsley's approach to standardising how we measure and report on inequalities

In Barnsley we have developed three inequality measures that allow us to identify and compare inequality across a broad range of different areas of our health and care system. These measures will help us monitor changes in inequality over time and inform our improvement work. The three measures we have chosen to adopt are simple to produce and interpret, and can be used by different health and care organisations working across Barnsley to better understand the needs of Barnsley residents. The measures can be used to compare any two groups in the population for example, 'people living in the most deprived areas' and 'people living in the least deprived areas', or 'White British' and 'Other ethnic groups' or 'people with a learning difficulty' and 'people without a learning difficulty'.

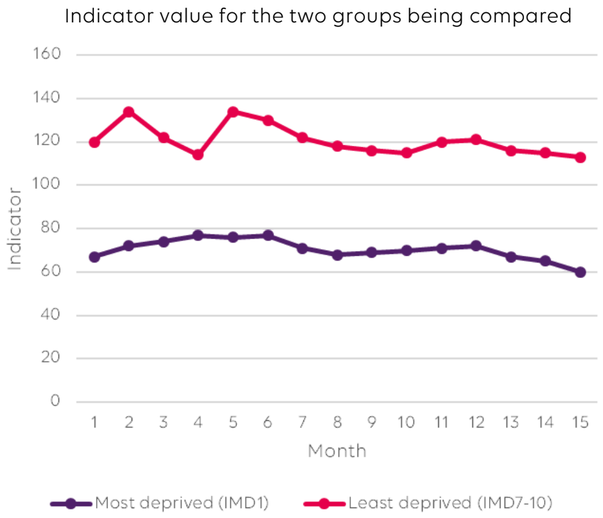
Barnsley's three inequality measures

1. Indicator value for the two groups being compared

To identify inequalities, we need to look for differences between two groups of people. For example, we might want to look at how the missed appointment rate differs between people living in the most deprived areas in Barnsley and the least deprived areas in Barnsley.

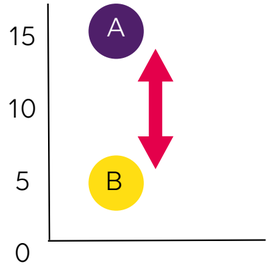
In this example our missed appointment rate measure would be our 'indicator' and our two groups would be those 'most deprived' and those 'least deprived'.

To identify if there is a difference in the missed appointment rate between these two groups, we would first need to record our indicator value for both groups as shown in the run chart on the right.



2. Absolute difference

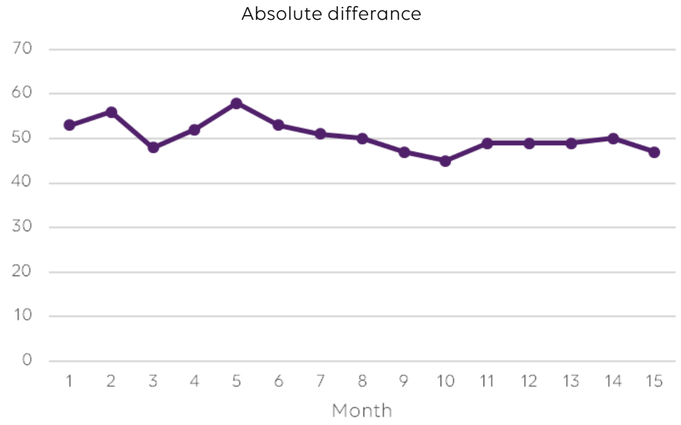
We can then calculate the absolute difference for each of the indicator values for the two groups. For example, if Group A has a missed appointment rate of 15 and Group B has a missed appointment rate of 5 than the absolute difference is 10 as in Figure 15.



Absolute difference: 15 - 5 =10

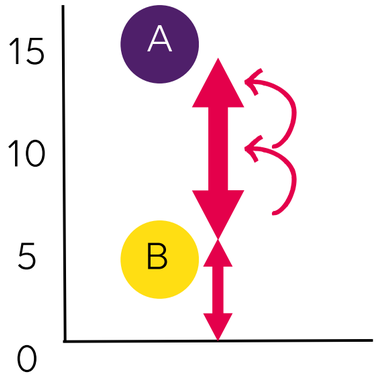
You would record the absolute difference for all your indicator values as shown in the run chart below

This shows the difference between the groups you are comparing and how the difference is changing over time.



3. Inequality score

Finally using your indicator values you are also able to calculate an inequality score. The inequality score is the relative difference between the rate in the two groups, in the previous example this would be a score of 200. This means that the missed appointment rate is 200% greater in Group A than it is in Group B.



Inequality score: (15-5)/5*100 = 200

By recording the inequality score for all the indicator values, shown in the run chart below, we can start to test changes to see if we can make improvements to inequality scores over time.

By presenting inequality measures in a standard way using run charts we can compare different indicators and the levels of inequalities amongst these to help us show where the biggest inequalities are present to help focus our work in Barnsley.