Barnsley Health and Wellbeing Board

Better Care Fund Plan Narrative 2022/23

The Better Care Fund in Barnsley has been developed and is set in the context of the Health and Wellbeing Strategy and the Barnsley Integrated Care Partnership - Barnsley Health and Care Plan 2022/23. All members of the Health and Wellbeing Board and the Barnsley (Integrated Care) Place Partnership have been engaged in the development of our vision for integrated health and care and our plans including developing and agreeing the BCF Plan. All partners have been involved through participation in meetings and workshops as active contributing members to the Board

The following organisations are members of the H&WB Board and Integrated Care Partnership.

Organisation	H&WB	ICP
Barnsley Metropolitan Borough Council	Y	Y
NHS Barnsley Clinical Commissioning Group	Y	Y
Barnsley and Rotherham Chamber of Commerce	Y	N
Healthwatch Barnsley	Y	Y
Berneslai Homes	Y	N
NHS England	Y	N
Barnsley Hospital NHS Foundation Trust	Y	Y
South West Yorkshire Partnership Foundation Trust	Y	Y
Barnsley CVS	Y	Y
South Yorkshire Police	Y	Y
Barnsley Healthcare Federation	N	Y
Barnsley Hospice	N	Y

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Executive Summary

The 2022/23 Better Care Fund Plan builds on previous plans and continues to be set within the wider context of the Health and Wellbeing Strategy and Barnsley Integrated Care Partnership Health and Care Plan Refresh for 2022/23.

We feel that it is important that our plans are considered within this context to ensure that our efforts are coordinated and that our plans are connected and come together to maximise the impact that we are able to make across the whole system for the benefit of Barnsley residents.

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

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

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

One vision (for integration) for Barnsley

Barnsley is now embarking on its next step of the integration journey and building a stronger Integrated Care Place Partnership for Barnsley, as one of the four place partnerships in our wider South Yorkshire Integrated Care System, working with the South Yorkshire Integrated Care Partnership (ICP) and Integrated Care Board (ICB).

The Barnsley Place Partnership brings together commissioners and providers of health and care services in Barnsley to design and deliver integrated services for patients and deliver improved health outcomes for the Barnsley population.

The Barnsley Health and Care Plan 2022/23 sets out our local priorities, reflecting our partnership of health and social care and focus on wider determinants. The plan is very much a continuation and refresh of the 2021/22 plan reflecting on the achievements and progress made but also recognising that in some areas progress has been impacted by the continuing impact of the COVID Pandemic and the focus on recovery of services.

For 2022/23 we have identified 4 priorities as set out in the diagram below:

1. Growing our workforce (capacity, capability and resilience)	We will work with partners across our place to increase opportunities for people from deprived communities and those under-represented in the health and care workforce, embed career pathways across health and care and provide exemplary employee assistance and support programmes.
2. Strengthening our joint approach to prevention (making every contact count)	We will work with our communities, VCSE sector and partners to increase capacity across three tiers of support (self/guided, one-to-one and directed) with an initial focus on preventing and reversing deconditioning for older people, bereavement, emotional wellbeing and resilience.
3. Improving equity of access (no wrong door)	We will ensure that everyone who needs support can access it at the right time and in the right place. We will start with the customer experience, ensure different point of access in our system operate to the same guiding principles and create safe space for people in mental health crisis.
4. Joining up care and support for those with greatest need (integrated personalised care)	We will work to ensure that care we provide is holistic, person centred and coordinated. To deliver this we will deliver phase three of neighbourhood teams including social care and mental health and developing care pathways for eating disorders, personality disorders, frailty and dementia.

There is a clear correlation between some of the schemes included within our 2022/23 BCF plan and the wider health and care priorities identified above. Examples of schemes which specifically help people to maintain independence in their own home, prevent hospital admission by providing earlier intervention or support discharge processes and minimise delayed discharges include:

- Residential and domiciliary (Home) care services
- Services to support carers
- Equipment and adaptations
- Extra care housing provision
- Reablement support
- 7 day Social Work
- Increased Occupational Therapy
- Intermediate care (Step up and Step down) bed based and community/home based
- Falls Services
- Neighbourhood Nursing (including Urgent Crisis Response)

The funding from the BCF remains broadly consistent in 2022/23 with that of previous plans to ensure sustainability of those health and social care services and is predominantly focussed upon out of hospital NHS services and Social Care services. The level of funding has been enhanced in 2022/23 to reflect growth in the contribution to Social Care and the continued inclusion of the iBCF.

The Better Care Fund 2022/23 has been developed to meet the national conditions of the Better Care Fund Policy Framework.

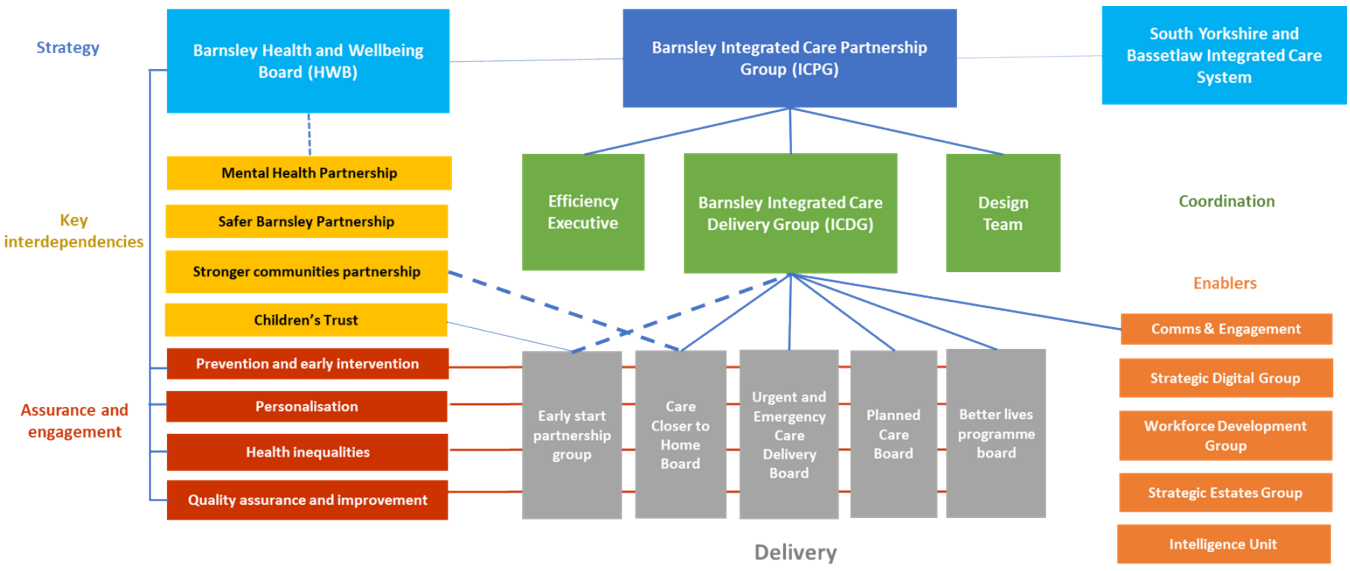
1. The Plan has been jointly agreed between local health and social care commissioners with engagement and input from other stakeholders including members of the Health and Wellbeing Board and Integrated Care Partnership
2. The NHS contribution to adult social care has been increased in line with the uplift to the CCG minimum contribution allowing for continued investment in all schemes and offsetting cost increase and pressures in Social Care
3. Investment in NHS commissioned out of hospital services is significantly above the minimum required ensuring support is available for those who need it to avoid unnecessary admission to hospital or to recover following an hospital admission.
4. The BCF plan and schemes include key services that support our discharge model and approach to support safe and timely discharge including our embedded home first, discharge to assess model – implementing the BCF policy objectives of enabling people to stay well, safe and independent at home for longer, and providing the right care in the right place at the right time.

Governance

The strategic governance arrangements for the Better Care Fund remain the same as in recent years with oversight being provided by the Health and Wellbeing Board and the BCF being managed within the governance structures of the Health and Wellbeing Board.

The BCF programme will be overseen by the Health & Wellbeing Board, supported by the Integrated Care Place Partnership Board and Delivery Group who will take responsibility for ensuring delivery against our plans and achievement of our priorities.

In our planning work we recognise the interdependencies with other partnership groups and forums. The diagram below shows this overall governance structure and the interdependencies, illustrating how we will organise ourselves to deliver:



A robust programme management approach has been established to support the delivery of our plans with each of the Delivery Groups (shown in the grey boxes) having clear priorities and plans against which delivery is monitored and reported on a regular basis to the Place

Partnership Delivery Group and in turn any risks or issues identified for escalation are reported to the Integrated Care Place Partnership Board and through to the Health and Wellbeing Board as appropriate.

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

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

Overall BCF plan and approach to integration – Implementing the BCF Policy Objectives

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

The 2022/23 Better Care Fund Plan builds on previous plans and continues to be set within the wider context of the Health and Wellbeing Strategy and Barnsley Integrated Care Partnership Health and Care Plan for 2022/23, contributing to delivery of the key priorities and enabling us to move towards our overall vision for Health and Wellbeing and integration.

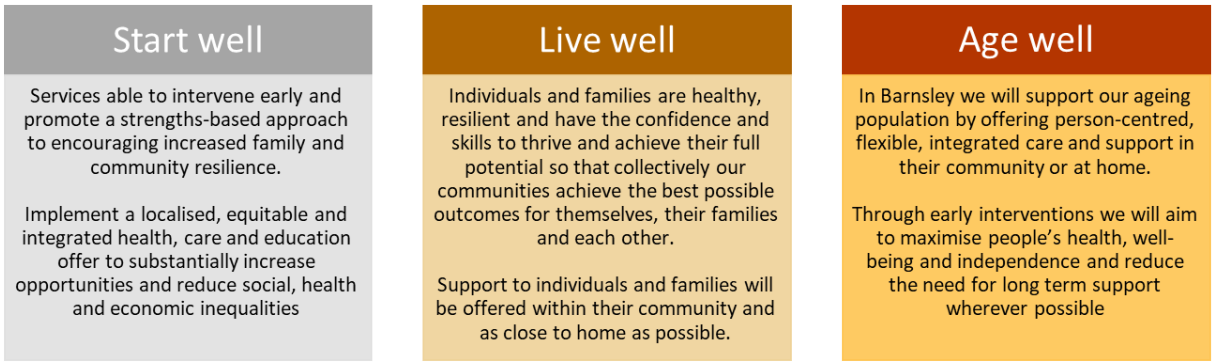
We feel that it is important that our plans are considered within this context to ensure that our efforts are coordinated and that our plans come together to maximise the impact that we are able to make across the whole system for the benefit of Barnsley residents.

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

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

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

The Strategy is set out how we are adopting a life-course approach to improving health and wellbeing and creating a system that is accountable for health outcomes and all determinants of health and wellbeing. We have split this ‘life course’ approach into 3 elements:



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

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

Above all we want to improve the quality of life of people in Barnsley and reduce the inequalities that exist in health and wellbeing outcomes. We want to better meet the needs of our population in Barnsley, preventing chronic illness, deaths from preventable causes and see a rise in the number of individuals making informed decisions about their care and support alongside health and care colleagues.

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

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

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

The vision for integrated care in Barnsley is for:

- An integrated joined up health and care system where people of Barnsley experience continuity of care
- A shift in focus on treating patients with health problems to supporting the community to remain healthy in the first instance
- Patients and their families are supported and empowered by what feels like "one team" each delivering their part without duplication
- Integrated care that delivers the best value for the Barnsley pound

The principles that come with such a vision include:

- System leadership covering the whole system
- A population health based approach
- Person centred and asset based ways of working with people and communities
- Care delivered closer to where people live

- Focus on staying well, prevention and self-care
- A single whole population budget to maximise use of resources

Barnsley is now embarking on its next step of the integration journey and building a stronger Integrated Care Place Partnership for Barnsley, as one of the four place partnerships in our wider South Yorkshire Integrated Care System, working with the South Yorkshire Integrated Care Partnership and Integrated Care Board. The Barnsley Integrated Care Place Partnership brings together commissioners and providers of health and care services in Barnsley to design and deliver integrated services for patients and deliver improved health outcomes for the Barnsley population.

The Barnsley Health and Care Plan 2022/23 sets out our local priorities, reflecting our partnership of health and social care and focus on wider determinants. In determining our priorities we also identified a series of cross-cutting themes. These are also priority areas but the delivery of these priorities span all parts of our system.

Our 4 priorities and 'plan on a page' is set out in the diagram below:

Sitting beneath our priorities are 26 deliverables that are our immediate priorities for the integrated care place partnership. These are included in the table below:

Growing our workforce	Launch Barnsley CARE academy to support employers with recruitment, pre-employment training and work experience and work with education and training providers to put in place provision that supports quality care and career development. Deliver a series of joint online recruitment fairs online and face to face targeting deprived communities and those under-represented in our workforce. Increase student placements and create local enhanced pathways that provide a range of experiences across different settings and services, promoting Barnsley as a great place to start or continue a career in health and care

	Work as a network of employers and with employee networks to share and develop best practice in employee assistance and support, leadership development and talent management that is inclusive. Create a five-year workforce plan for Barnsley place with Health Education England and following principles of population health management.
Strengthening our joint approach to prevention	Create a joint strategy for prevention and early help across three tiers – self/guided, one-to-one and directed Continue to proactively contact those identified as most vulnerable in our communities and offer support – finance, emotional health and wellbeing, warms home, weight management, physical activity and falls Continue to build community capacity and alliances that can offer preventative support and embed this offer into local care pathways Work with industry partners to deliver the BETA service evaluation for Stride – a digital pathway that aims to prevent and reverse Project Stride Through the Heart Health Alliance, initiate a programme of targeting blood pressures checks in community settings beginning in our most deprived neighbourhoods and reintroduce targeted health checks
Improving equity of access	Expand and grow the Children and Young People's single point of access for emotional and mental health wellbeing Develop our access model for community and adult social care with appropriate professional input to maximise customer experience Continue our work with iUEC to improve access to urgent treatment and emergency care Work to improve crisis care including the creation of "safe space" Establish the lung health checks service Create a community diagnostics hub at the Glassworks Expand patient initiated follow up (PIFU) and virtual appointments to improve access and experience for service users and staff Implement new ways of working to increase capacity and reduce the backlog in elective care Community reablement pathways and continue to embed strengths-based practice in our approach

	Continue to embed new roles in primary care to enable earlier access
Joining up care and support for those with the greatest need	Develop a strategy and delivery plan to develop closer working between the excellent maternity and early years services Fully implement the recommendations from the recent review of support for special educational needs and disability Phase three of the neighbourhood teams mobilisation including community mental health and social care Create a personalised care team in primary care to provider person-centred support including social prescribing, health and wellbeing coaching and care coordination Create care pathways for eating disorders and personality disorders Coordinate the local response to the national virtual ward initiative building on the strong service provision in Barnsley and increasing specialist input into community and primary care

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

Our Better Care Fund in Barnsley is used to fund services commissioned by the NHS South Yorkshire Integrated Care Board and Barnsley Metropolitan Council with the overall BCF plan being supported by a range of services which form part of the wider integration plans being taken forward by the Integrated Care Place Partnership. The funding from the BCF remains broadly consistent in 2022/23 with that of previous plans to ensure sustainability of those health and social care services and is predominantly focussed upon out of hospital NHS services and Social Care services. The level of funding has been enhanced in 2022/23 to reflect growth in the contribution to Social Care and the continued inclusion of the iBCF.

There is a clear correlation between schemes included within our 2022/23 BCF plan and the wider health and care priorities identified above. Examples of schemes which specifically help people to maintain independence in their own home, prevent hospital admission by providing earlier intervention or support discharge processes and minimise delayed discharges include:

- Residential and domiciliary (Home) care services – ensuring capacity is in place to continue to deliver high quality care and meet the needs of those people requiring services when they are required.
- Services to support carers, including access to advice and guidance, respite and other support including personal budgets.
- Equipment and adaptations – including use of digital technology and new equipment to maximise capacity of the carer workforce.

- Increased Occupational Therapy to provide timely therapy assessments which support individuals to maintain independence through the use of aids, adaptations and equipment as well as inform the provision of care input.
- Extra care housing provision linking care and support services with housing support .
- Reablement support to help people to regain confidence to maintain independence.
- 7 day Social Work to support discharge planning and ensure timely provision of care packages (links to D2A pathways)
- Intermediate care (Step up and Step down) bed based and community/home based
- Falls Services – linking with the other services to increase the provision of physical activity, strength and balance and falls prevention services across Barnsley.
- Neighbourhood Nursing (including Urgent Crisis Response) to ensure people continue to receive response care and support within their own home.

The work taking place through our Care Closer to Home Board is ensuring that a collaborative approach is taken to commissioning and development of services and pathways linked to many of the schemes identified above.

The Intermediate Care model is a good example of collaborative commissioning with the ICB and Local Authority working together to commission all elements of the service including community elements and beds in our Acorn Unit which is based within an independent sector care home. Reflecting the collaborative approach to Intermediate Care Model is delivered through an alliance approach between hospital, community and primary care providers.

We have also taken a collaborative approach around falls and frailty with a proactive care group established bringing together commissioners and providers to improve coordination and access to a range of services, alongside the BCF funded Falls service to provide strength and balance activities, exercise in the community etc.

Other examples of key activities of the Care Closer to Home Board include:

- Completing the next phase of the neighbourhood teams service to deliver our community operating model, streamline and improve access to out-of-hospital care by bringing together key front-line service to deliver a multi-disciplinary single approach to assessment and provision of care and support in the community.
- Developing our approach to ‘Proactive (anticipatory) Care’ to ensure that we are prepared for delivery of the new anticipatory care requirements across all parts of the health care system in Barnsley.
- Development of integrated pathways for falls, frailty and dementia.
- Implementing a joint approach to prevention with our communities and the VCSE sector.

In Barnsley we are proud of our partnership work to support discharge from Hospital. Historically performance has been good with low numbers of delayed discharges from hospital and a low number of inpatients in in hospital for over 14 days and over 21 days.

We have regularly reviewed and self-assessed against the High Impact Change Model and during 2022/23 have built upon this further as part of the NHS 100 day challenge to ensure that no patient who is fit for discharge does not need to remain in hospital any longer than they need to. Our self-assessment, confirmed via check and challenge across South Yorkshire was that the arrangements that have been put in place in Barnsley over recent years mean that we rate as Green against each of the 10 best practice initiatives:

1. Identify patients needing complex discharge support early

2. Ensure multidisciplinary engagement in early discharge plan
3. Set expected date of discharge (EDD), and discharge within 48 hours of admission
4. Ensuring consistency of process, personnel and documentation in ward rounds
5. Apply seven-day working to enable discharge of patients during weekends
6. Treat delayed discharge as a potential harm event
7. Streamline operation of transfer of care hubs
8. Develop demand/capacity modelling for local and community systems
9. Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges
10. Revise intermediate care strategies to optimise recovery and rehabilitation

The 10 best practice initiatives correlate across the High Impact Change Model 'changes' and therefore we considered the assessment together to identify areas for further development.

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

During 2021/22 and continuing to 2022/23 key developments have included:

- Embedding a new model of Intermediate Care and commencing a review of bed and community capacity to ensure that it continues to meet the changing needs of patients
- Embedded a robust Discharge to Assess model (see further details of model below)
- Supported the implementation of earlier discharge planning with social care involved at the beginning of the process
- Continuation of long stay Wednesdays – to review all patients who have been in hospital over 14 days to identify actions required to support discharge
- Strengthened the delivery of the Enhanced Health in Care Homes model, building on the established MDT approach ensuring input from care home staff, community services, primary care, social services and other professionals as required e.g. Health and Wellbeing Coaches.

Through the use of the BCF and other funding opportunities we have also been able to continue to support the resilience of the care market through the provision of an uplift in fees and funding to support increased payment for care staff to support with recruitment and retention and ensure that carers pay is in line with that in other sectors.

Home First/Discharge to Assess – Case Study

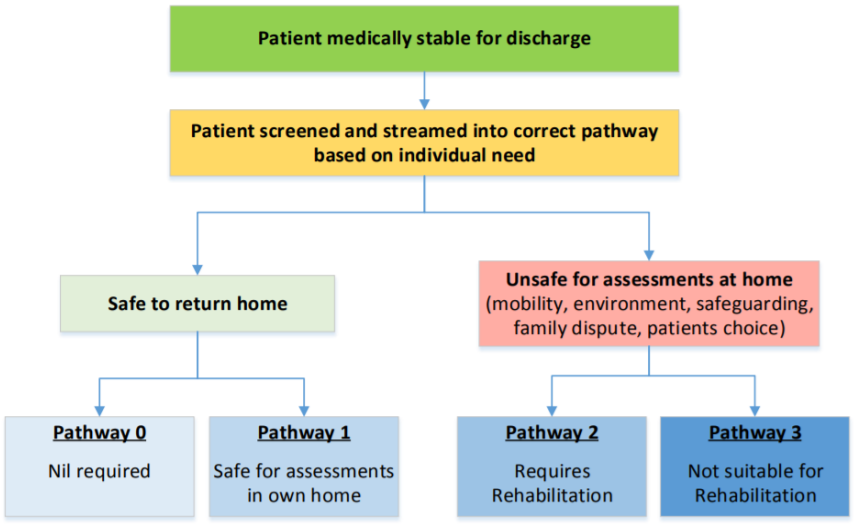
Learning from previous work to implement the High Impact Change Model for Managing Transfers of Care and utilising the guidance included in the High Impact Change Model on Patient Flow and Hospital Discharge we have established a robust Home First/Discharge to Assess model which includes:

- Early Discharge Planning
- Arrangements to monitor and support patient flow including long stay reviews and using red2green.
- Implementation of multi-agency and multi-disciplinary discharge arrangements
- 7 day community and social services arrangements to support discharge
- Development of a trusted assessor model
- Improving work with and support for care homes through implementation of the EHIC framework.

The model is made up of 4 pathways and the aim is to:

- Identify the appropriate discharge pathway based on the patient's individual needs
- Functional assessments to take place in patients own home and not in the acute hospital setting
- Maintain the Discharge Hub within the acute to provide a link between the acute and community to ensure a streamlined approach and track all patient discharges

The Discharge to Assess four patient pathways are:



Supporting Unpaid Carers

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

This includes the following:

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

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

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

- The Council also offers a one-off annual payment of between £150 and to £300 to unpaid carers – this payment is to acknowledge and recognise the valuable caring role that they provide. Monitoring of the grant payments show that a large number of recipients use this payment to fund short breaks. This is currently being reviewed as part of the carers strategy and any changes to the offer to carers will be influenced by the involvement of carers in the development of the strategy.

- Barnsley Council complete more carers assessments when compared to our Y&H partners. The council use the assessment of need to identify the support that carers require to enable them to carry out their caring role and balance . As part of the assessment, support such as direct payments and respite provision are offered to carers so they are able to take a break from their caring role or purchase help and support to assist them.

Disabled Facilities Grant and wider services

The BCF is fully aligned with wider strategies including the Barnsley Housing Strategy 2014-2033. The Housing Strategy includes a specific objective to support people to live independently by improving the range of options for supported housing and providing more choice and options to help vulnerable and older people live independently in their own homes. Ambitions include ensuring extra care provision is fully integrated into the wider health and care pathways and that there is access to aids and adaptations across all tenures.

The BCF in 2022/23 has been developed with input from both housing strategy (DFG) lead and Berneslai Homes to ensure that the BCF Plan continues to contribute to ambitions and objectives of the overall housing strategy and that the delivery of the housing strategy also contributes to improving health outcomes for Barnsley residents through more joined up approaches and effective use of DFG. The BCF continues to support the delivery of housing strategy ambitions through the aids and adaptations and community home loans services and the ongoing funding to provide 24/7 onsite care provision in extra care housing schemes.

DFG Policy is aligned to the ambitions of the H&WB Strategy and BCF and aims to support people to live independently within their own home and to return home. The DFG policy and use of the DFG funding has been agreed by the Local Authority as the housing authority in Barnsley.

The Disabled Facilities Grant (DFG) provides funding (or fund works and adaptations) to help disabled and elderly people to live independently in their own homes. Means tested funding is provided to home owners or tenants to make the adaptations. The DFG policy identifies the additional help and flexibility the Council will offer in relation to providing home adaptations for disabled people in the future.

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

A number of the services and schemes funded through the BCF and aligned to the specific funding for DFG related services, including Community Home Loans, Equipment and Adaptations and Occupational Therapy aim to ensure that people are able to quickly access the support they need to maintain their independence. Increased occupational therapy support is key to maximising the effectiveness of aids, adaptations and equipment funded through the DFG and through the assessment processes are able to ensure that people are given the best solutions to meet their needs.

A new programme commenced in 2021/22, but running into 2022/23, to target better use of digital technologies, aids and adaptations. This area has moved forward in recent years and Barnsley wants to look at how promoting assistive technology and supporting innovation we can improve the way people are supported. We will be looking at use of technology around dementia support, manual handling and options that will promote greater levels of independence. We plan to work with providers and new businesses to help bring to market new ideas and approaches.

Better links have been made with the Housing Teams and the new Housing Strategy includes significant investment to address fuel poverty. Fuel poverty is a key issue amongst private rented accommodation and contributes to excess inter deaths.

Equalities and Health Inequalities

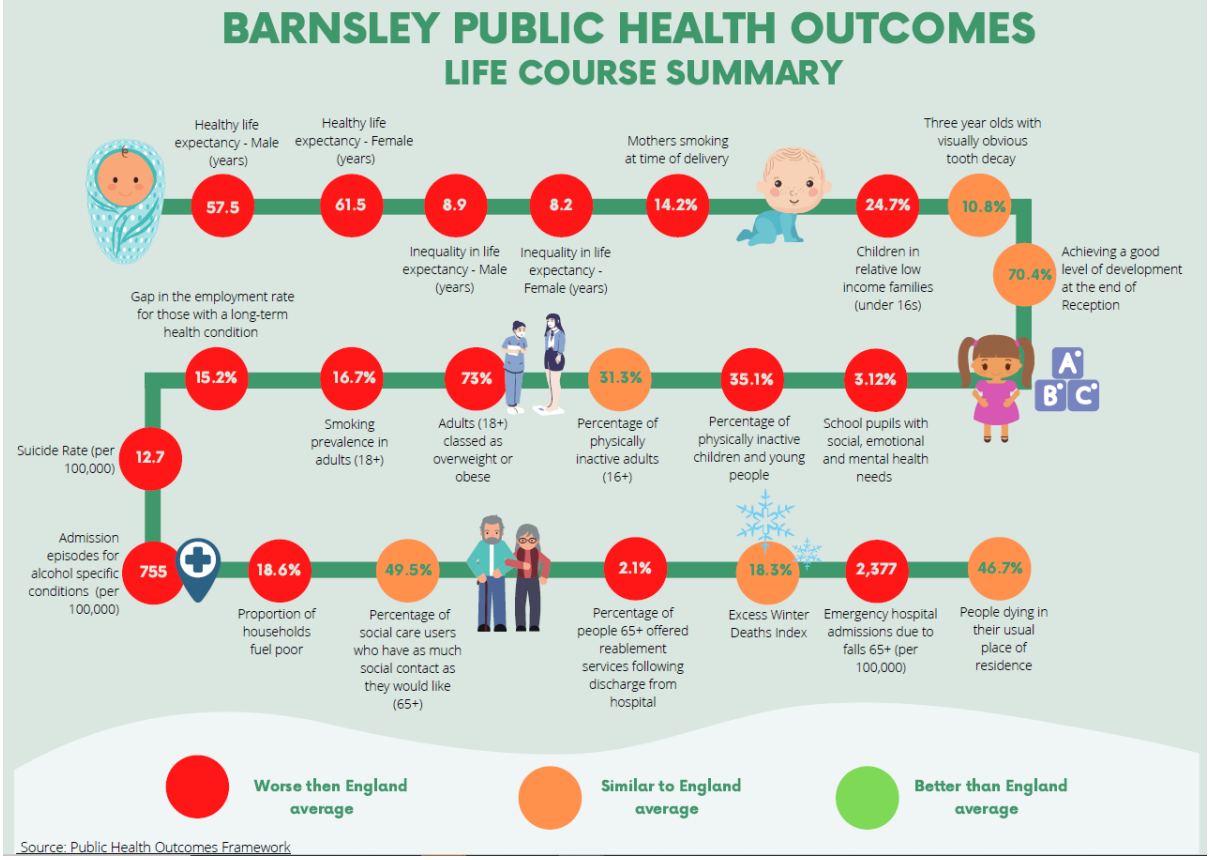
We know we have an issue in relation to health inequalities in Barnsley and we also recognise that making real progress will not always happen quickly and therefore our priorities remain consistent with 2021/22 and the longer-term Barnsley 2030 plan.

Barnsley is the 39th most deprived local authority area in England. Inequalities in social and economic circumstances are key drives of inequality in health and health outcomes. This means residents of Barnsley are more likely to experience ill-health, multi-morbidity, and earlier death from preventable illnesses than the average across the country. This in turn correlates to higher levels of hospital attendance and admission and higher demand on healthcare services to support people with long term conditions.

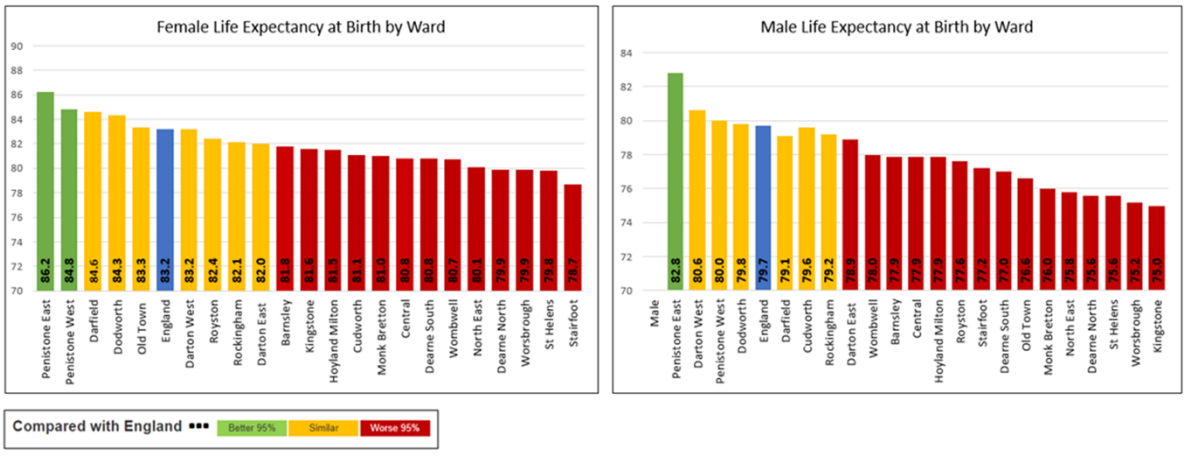
The BCF in Barnsley and the services funding through the BCF are all aimed at supporting people to maintain independence (social care, falls prevention, supported housing), recover from illness (through rehabilitation and reablement) and received the ongoing care and support that they need whether that be in their own home or in a long-term residential care setting. When commissioning services or developing schemes either as part of the BCF or wider commissioning work, engagement activity and equality, inequality and quality impact

assessments are a core feature of our approach to developing business cases and specifications.

The diagram below provides a life course summary of health outcomes in Barnsley and demonstrates some of challenges we face.



There are also inequalities between communities in Barnsley. This is illustrated in the chart below which shows the different in life expectancy by ward.



Life Expectancy at Birth for the latest period available at Ward level is 2015-2019.
Life Expectancy for Barnsley is 1.4 years less than the **England average** for Females and 1.8 years less for Males.
Inequality in life expectancy: For Females, there is 7.5 years difference between the wards with the highest and lowest life expectancy at birth. For males this difference is 7.6 years.

To support our work and also to ensure that action is focussed in the right areas the Barnsley Place Partnership has established a Health Inequalities Action Group (HIAG) with representatives from secondary care, local authority, community health, mental health, and primary care. The group is chaired by a consultant in public health and reports into the Place Partnership Delivery Group and is responsible for developing our framework to reducing healthcare inequalities in line with the core 20 plus 5 approach.

Health Inequalities leads (Exec Director Leads) from across the partnership, have supported the development of our a three-tier framework to embed action on health inequalities across partner organisations and programmes and linking to Barnsley 2030 ambitions and underpinned by a gradual shift of focus and investment from treating advanced illness to keeping people happy and healthy.

For tier one our approach is to use data and insights to identify groups within our population who are experiencing health inequalities, engage representatives in rich dialogue that starts with the assumption that the majority of solutions lie with individuals and within their communities, and then devise a series of initiatives that will improve how health and care organisations serve their needs. This work sits with the Care Closer to Home Board predominantly. Learning from Covid, one of the key areas of work currently taking place is to ensure that carers are able to receive the support they require and are able to access health and care support for themselves. This includes support to access annual health checks and work with GP practices to develop and Carers Support Quality Mark. Linked to this work we are also working with services and carers to reduce the inequalities for people with severe mental health and people with learning disabilities to access their annual health checks and immunisations.

For tier two we will use the best evidence available to determine how we prioritise access to health and care across all of our core services. This work will sit with the planned care and urgent and emergency care delivery groups predominantly.

For tier three we will work with partners to advocate for, promote and prioritise the needs of groups in our population that are currently disadvantaged. This will be achieved through our work on anchor institutions, inclusive economy, Barnsley 2030, workforce development and other areas.

During 2022 we have also commenced our participation in the national Population Health Management development programme delivered by Optum. Health inequalities is a key theme of this work as we look to target underserved communities across the Borough and within our neighbourhoods.

Running alongside the PHM programme and building upon the health index for residents created in 2021, we will build a mapping tool that shows the picture of need and inequalities across the Barnsley population using deprivation, protected characteristics and then applying the vulnerabilities index. The HIAG is also working with engagement, equality and experience leads to prioritise engagement with groups who experience health inequalities.

The HIAG is also helping organisations including Barnsley Hospital, SWYPFT, Barnsley Primary Care Network and Adult Social Care to use the framework to finalise plans and align ambitions across partners. This includes where work is taking place to further develop schemes and initiatives that are included within the BCF Plan for 2022/23.

To help us to understand the impact of our work as a partnership, and the BCF schemes on addressing inequalities, in addition to the four key metrics included in the Better Care Fund, the Care Closer to Home Board and Place Partnership Delivery Group will monitor the following measures. This will support further improvements in the programme design and delivery.

- Inequality of emergency inpatients admission for Urgent Care Sensitive and Ambulatory Care Sensitive conditions (IMD and Ethnicity)
- Inequality of rate of reablement episodes and proportion that go on to longer term care (IMD and Ethnicity)
- Neighbourhood teams caseload (IMD and ethnicity)
- Long length of stay in hospital
- A&E attendances for falls