Item 4b

Report of the Executive Director Core Services and the Integrated Care Partnership, to the Overview and Scrutiny Committee (OSC) on 29 November 2022

Development of Integrated Care in Barnsley & Access to Primary Care

1.0 Introduction

1.1 At the last time of attending the Overview and Scrutiny Panel in April 2022 the Health and Care Bill was completing its journey through Parliament and the NHS was working with sector partners to put in place the new arrangements described by the Bill from 1 July 2022. The South Yorkshire Integrated Care Partnership (ICP) and NHS South Yorkshire Integrated Care Board (ICB) are now established. The latter taking on duties and functions from the four CCGs in South Yorkshire, along with delegated arrangements with NHS England and a selection of new duties that together, represent the shift to collaborative working and providing an opportunity for us to improve the experience of local people and communities. This report provides an update on the development of the South Yorkshire Integrated Care System (SY ICS) and Barnsley Place Partnership as part of the SY ICS.

1.2 Health and care services continue to experience very significant challenges and operational pressures in Barnsley and across the country. Factors include persistent high levels of demand for urgent and emergency care, the elective care backlog that was a result of the COVID pandemic and increased levels of sickness absence and staff vacancies. The State of Care report recently published by the Care Quality Commission notes that "health and care staff are doing their utmost for patients and there are many examples of good care across the country. However, they are working under increasingly intolerable conditions."

1.3 Performance of the health and care system locally compares favourably to many other parts of the country to the benefit of residents and service users. The recently published Barnsley Adult Social Care Local Account describes how the system has continued to develop and improve despite the challenging circumstances. There are several others, including the discharge to assess pathways, elective recovery, urgent community response, personalised care teams in primary care, mental health, learning disabilities and autism partnership and children and young people's emotional health and wellbeing single point of access.

1.4 During the pandemic, public attitudes towards the NHS were very positive, with evidence patients adjusted their expectations about care at a time when the NHS was under pressure. However, in the latest survey results, satisfaction with primary care has fallen significantly. Improving access to primary care is a priority area of focus both nationally and locally. This report provides an overview of how primary care is changing in Barnsley and the steps being taken to ensure that residents have timely access to health education, advice, and treatment when they need it.

1.5 Members of the Overview and Scrutiny Panel are asked to –

- Recognise the challenges facing health and care locally but also the progress being made to recover from the COVID pandemic and improve access, experience, and outcomes
- Encourage engagement and involvement from residents/communities in the development of the longer-term strategy and plans for Barnsley Place Partnership and South Yorkshire Integrated Care System
- Promote understanding amongst residents of the range of services they can access in person or online, 24 hours a day, 7 days a week and new ways of working in primary care including new roles in general practice, including first contact practitioners

2.0 Background

2.1 **Integrated care -** the NHS Long Term Plan (2018) set out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.

2.2 Central to the delivery of the Long-Term Plan was to create Integrated Care Systems (ICSs) that bring together local organisations in a pragmatic and practical way to make shared decisions on population health and service redesign and GP practices working together through Primary Care Networks (PCNs) to deal with pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff.

2.3 Integrated Care Systems **(**ICSs) have existed in one form or another since 2016, but for most of this time have operated as informal partnerships using soft power and influence to achieve their objectives. Following the passage of the 2022 Health and Care Act, ICSs were formalised as legal entities with statutory powers and responsibilities.

2.4 Statutory ICSs comprise two key components: **integrated care boards (ICBs):** statutory bodies that are responsible for planning and funding most NHS services in the area and **integrated care partnerships (ICPs)**: statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop a health and care strategy for the area.

2.5 Working through their ICB and ICP, ICSs have four key aims:

- improving outcomes in population health and health care
- tackling inequalities in outcomes, experience, and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

2.6 ICB are directly accountable for NHS spend across their areas, commissioning of health services and arranging healthcare for the population with a key focus on quality and performance within the ICB area.

2.7 ICBs brings together partner organisations in a new collaborative way with a common purpose, having a duty to integrate services and work with wider partners across the system to drive forwards collective priorities to improve population health, reduce health inequalities, deliver sustainable services, and improve the quality of care for our population.

2.8 ICPs are being designed to provide a forum for NHS leaders and local authorities to come together as equal partners with other key stakeholders including the voluntary sector. ICPs are a forum and not an organisation. Guidance is clear that ICPs should support place-based partnerships and coalitions with community partners which are well-situated to act on the wider determinants of health in local areas. Bringing together both statutory and non-statutory interests of places together. It is expected that by complementing place-based working and partnerships, ICPs will play a critical role in facilitating joint action to improve health and care outcomes and experiences across their populations, influencing the wider determinants of health, including creating healthier environments, inclusive and sustainable economies.

2.9 **The role of Places within Integrated Care Systems -** While strategic planning is carried out at ICS level, places will be the engine for delivery and reform. Place-level governance and accountability is through Place Partnerships. Place governance provide clarity of decision-making, agreeing shared outcomes, managing risk, and resolving disagreements between partners. All places need to develop ambitious plans for the scope of services and spend to be overseen and section 75 will be reviewed to encourage greater pooling of budgets. Place Boards will require shared insight and a holistic understanding of the needs of their local population, listening to the voices of service users.

2.10 **Primary Care Networks** have been brough about through the five-year framework for GP contract reform: “Investment and Evolution”. These reforms include –

- More funding for health services in local communities
- More healthcare staff working in and with GP practices including more GPs, nurses, pharmacists, physiotherapists, paramedics, physician associates and social prescribing link workers
- These bigger teams of staff will work with other local services to make sure people get better access to a wider range of support for their needs
- New community health teams will provide support to people in their own homes to keep them well and out of hospital
- An expansion in the number of services available in local GP practices

2.11 Changes to primary care mean that patients can now access a range of vital local services in person or online, 24 hours a day, 7 days a week. Patients can call NHS 111 or visit either NHS 111 online or the award-winning NHS website to access a full range of health and wellbeing information. The NHS app is now also widely available to download for people who want to register for advice or to review their records, make online GP appointments and book repeat prescriptions.

2.12 For issues that people cannot deal with themselves, they can drop into a local pharmacy, doctors’ surgery, dentists, or opticians, for convenient healthcare from a number of specially trained and experienced professionals.

2.13 Primary Care Networks provide enhanced services to patients including –

- Structured medication reviews
- Enhanced health in care homes
- Early cancer diagnosis
- CVD prevention and diagnosis
- Tackling neighbourhood inequalities
- Personalised care

3.0 Current Position

3.1 Engagement early in 2022 with Health and Wellbeing Boards, their elected members and lead officers in Barnsley, Doncaster, Rotherham, and Sheffield led to the development of a proposal to establish the **South Yorkshire Integrated Care Partnership (ICP).**

3.2 The initial membership of the South Yorkshire ICP was proposed from each place with five nominations sought from each Health and Wellbeing Board and a further ten nominations from an ICB and wider South Yorkshire system. The South Yorkshire ICP is Chaired by Oliver Coppard, South Yorkshire Mayor, and met for the first time in September 2022.

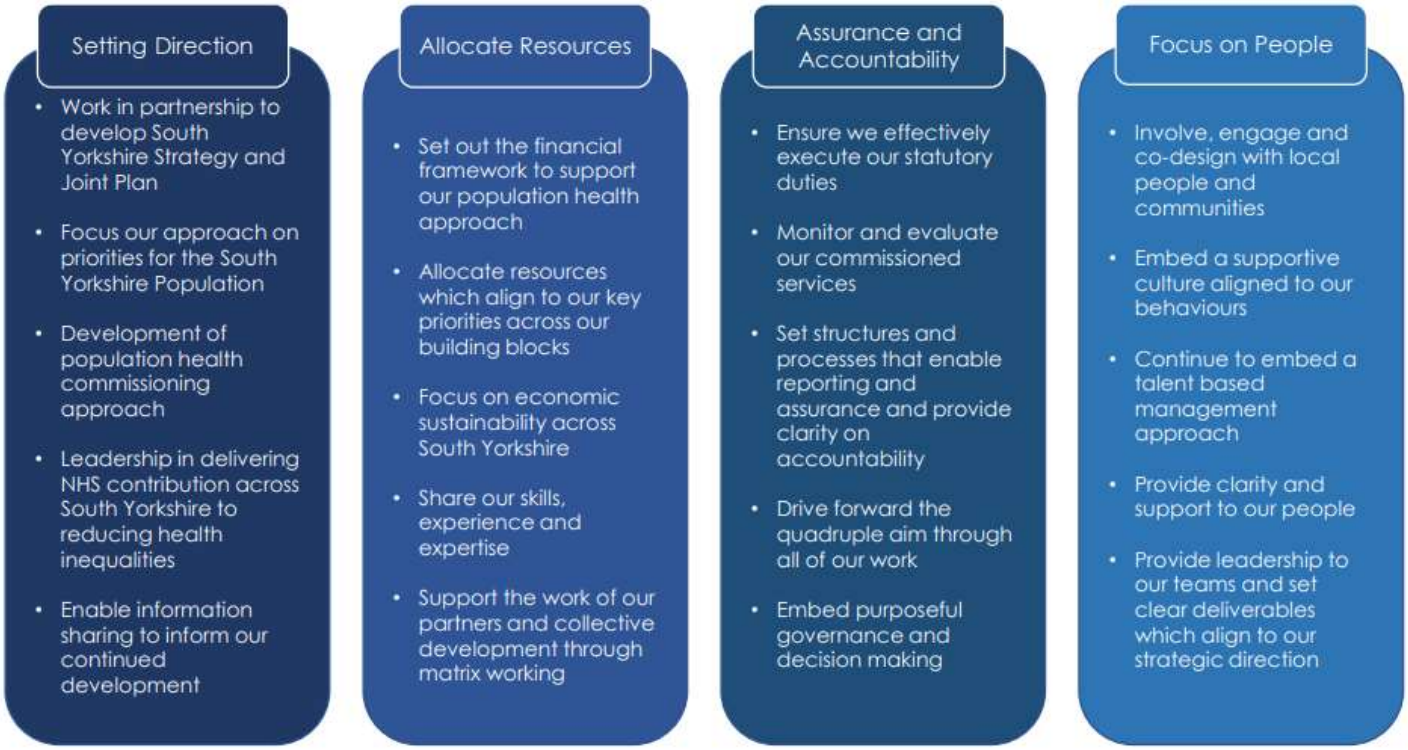
3.3 A working group has been formed to develop a South Yorkshire Integrated Care Strategy by the end of December 2022.

3.4 The **NHS South Yorkshire Integrated Care Board (SY ICB)** was established on the 1 July 2022.

3.5 As part of establishing arrangements for the new statutory body, teams across South Yorkshire collaborated to develop outline operating arrangements and associated governance processes along with outlining an approach to deliver statutory requirements.

3.6 SY ICB’s purpose is to improve health and wellbeing, the quality and experience of care, eliminate health inequalities, and ensure South Yorkshire’s people have access to the services they need to live well throughout their lifetime. Its vision is to be a system leader and a trusted partner who has South Yorkshire’s people at the heart of what it does. SY ICB intends to think differently and work creatively to transform the health and wellbeing of our communities.

3.7 In its three key roles as a Statutory Health Commissioner, Partner, and Employer, the ICB will add value through setting direction, allocating resources, assurance and accountability and focus on people.



3.8 SY ICB adopted South Yorkshire's current strategy, the South Yorkshire ICS Five Year Strategic Plan and all underpinning plans, recognising that significant work on shared priorities and integration had already started. A process has now begun to refresh the strategy and plans.

3.9 In September the ICB confirmed its priorities for improving population health and tackling health inequalities in 2022/23 as follows –

- Decrease inequalities in maternity care and the early years of life
- Enhance the prevention, early identification and management of the three main causes of early death and unwarranted variations in care in South Yorkshire – CVD, Respiratory Disease and early diagnosis of Cancer
- Prevention and early intervention for children, young people and adults with deteriorating mental well-being
- Taking a holistic and personalised approach to people's health and wellbeing, focusing on 'what matters most' to individuals, and connecting to the full range of system provision including Voluntary, Community and Social Enterprise (VCSE) and local authorities.
- Build on existing and Covid related Place based partnership working to build resilient, healthy communities, focusing on the geographic communities with the highest levels of deprivation and health need and the identified 'PLUS' communities of interest.

3.10 Wendy Lowder has been appointed as Executive Place Director for Barnsley. Wendy is continuing to be responsible for Adult Social Care in Barnsley, with her title as Executive Director of Place Health and Adult Social Care. The Executive Place Directors each have accountability for Place delivery plans, and associated commissioning responsibilities aligned to the needs of local populations.

3.11 The ICB will continue to work alongside local communities in Barnsley, Doncaster, Rotherham, and Sheffield aligned to the principle of subsidiarity. Therefore, all ICB people resources remain in these communities. The ICB Barnsley and BMBC Adult Social Care Senior Management Teams will be operating together as a forum for the exchange of ideas and for identifying opportunities for collaboration to enable the ICB Executive Place Health and Adult Social Care to effectively discharge her responsibilities.

3.12 **Barnsley Place Partnership Board,** which sits as the Barnsley Place Committee of the SY ICB, and the Barnsley Place Partnership Group, has developed new Terms of Reference and refreshed the Place Agreement. Partners continue to work towards a shared vision that the *People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.*

3.13 The purpose of the Place Partnership Board is to provide visible leadership, direction and commitment to the vision and objectives for developing integrated care in Barnsley (as set out in the Place Agreement) and ensuring effective governance, communication, and delivery of the objectives.

3.14 The Place Partnership Board is forming working groups to lead system development –

- Place Partnership Equality and Engagement Group
- Place Partnership Quality and Safety Group
- Place Partnership Finance, Performance and Efficiency Group
- Place Partnership Delivery Group
- Barnsley Clinical and Care Professional Senate

3.15 The initial focus of the Place Partnership Board, in its new guise, has been continued support to deliver the Barnsley Health and Care Plan 2022/23, oversight of quality, equality and engagement and system performance through the Integrated Care Dashboard, that is linked to the Barnsley Health Outcomes Framework, and to develop the Barnsley Place Target Operating Model.

3.16 At a Place Partnership Board development session in October, members discussed how organisations and services can deliver joined up, person-centred and community-oriented care and support and improve population health. The extract below describes how health and care will be different in the future to improve the health and wellbeing of residents.

Roman Nowak 34yo with learning disabilities, he currently lives at home with his family. He has little social interaction outside the home and would like to play sports.		
	Roman's experience now	**Roman's experience in the future**
Accessing support when I need help	Roman is unsure where to get help and he and his family are struggling. He used to attend a day centre which is no longer open. He would like to spend his time mixing with people more and hopefully getting a job.	Roman accesses information in the local library about Creative Minds and a Good Mood Football League he would like to join. The library worker gives him a leaflet about the job centre where special help is available for people to get into work for the first time.
Providing information about me	Roman sees his GP when he needs to but isn't in touch with health or social care professionals on a regular basis.	Roman attends his GP practice for his annual health check due to him being known as a person with a learning disability and has been put in touch with stop-smoking services and healthy living groups as part of a health action plan to meet Roman's health needs. If Roman needs help to understand his health then the local community learning disability team can support with developing easy read information so Roman can manage his own health needs as well as possible.
Planning my care and support	Roman doesn't have a care and support plan	Roman sees a worker at a coffee morning at his local community centre has an assessment under the Care Act 2014 and his parents have a Carers assessment. He is eligible for an individual budget for him and his family to build a support plan around his individual needs.
Building on my strengths	Roman has little contact with other young people and often feels bored and restless	Roman uses his individual budget to employ a personal assistant (PA) to accompany him to football sessions and weekly trips to town. He is gaining more confidence in getting out and about and becoming less dependent on his mum and dad. His PA also accompanies him to the job centre where DWP run weekly groups on getting into a job, he enjoys this and is considering volunteer dog walking supported by the local learning disability services employment scheme.
Meeting my needs	Roman and his family try their best to find things for him to do but he is making little progress with his life and the family are stressed. His mum is struggling with anxiety about his future.	Roman's care and support plan is put in place, designed by him and his family, with the help of a social worker at the community centre. In the neighbourhood there is a welcome café run by IAPT where his mum can drop in for advice. From this she accesses IAPT services for her own mental health and starts to cope with things better.
Coordinating my care and support	The family don't know anyone other than their GP so tend to go to the surgery when there are problems	Roman and his family lead their own support with input and advice from a community worker around self-directed support. There are cafes and support groups on a drop-in basis at the centre close to their home where they know they can go for a friendly face and practical input when needed. When Roman goes to his GP his health record is joined up with his support plan so everyone is on the same page, and a hospital passport can be developed with Roman and his family in case he has to go into hospital, so that his needs can be met and the hospital staff know what is important to Roman.

3.17 Barnsley health and care partners continue to deliver some of **best integrated hospital discharge arrangements** in the country, ensuring the patients are supported to get home from hospital as soon as they are able, to continue their recovery in the best environment for them. Colleagues shared this good practice, along with the **successful launch of the Community Diagnostics Centre in the Glassworks** at the South Yorkshire Systems Leadership Executive in October. Both exemplary initiatives have attracted interest from health and care organisations in the wider region and nationally.

3.18 GP practices across the country are experiencing significant and growing strain with declining GP numbers, rising demand, struggles to recruit and retain staff and knock-on effects for patients.

Additional roles in primary care, digital and new ways of working with community services are critical to meeting the changing demands on general practice in the coming years.

3.19 **Primary Care** in Barnsley has been at the leading edge of developing new roles, even before the NHS Long Term Plan was published, with the expansion of clinical pharmacist roles, reception care navigators and healthcare assistants. These roles supplement the "traditional" general practice workforce as well increase the offer of care and support available closer to home.

3.20 Barnsley PCN employ 122 staff working in additional clinical and non-clinical roles through the national Additional Roles Reimbursement Scheme (ARRS), with plans for further expansion. This includes 17.2 Social Prescribing Link Workers, and 16.8 Health and Wellbeing Coaches who work as part of an integrated Personalised Care Team (PCSPs) whole time equivalents. There are also 31.2 Care Coordinators embedded within GP practices supporting the development of PCSP's working with individuals as part of our proactive care approach. Barnsley PCN utilises 12 of the available roles. These staff deliver more than 1,600 appointments per week.

3.21 There were more than 1.4million GP practice appointments for Barnsley registered patients in the 12 months to September 2022. This equates to more than five appointments per registered patient in Barnsley and is an increase from the previous years. Approximately 80% of these appointments are face-to-face. Nearly 50% of all appointments happen on same or next day. The total does not include extended access services and many of the additional roles.

3.22 There are 31 GP Practices in Barnsley. Practices are independent from each other and have different ways of meeting contractual requirements. The approach, as much as is possible, is shaped around patient demand and requirements.

4.0 Future Plans & Challenges

4.1 **System Strategy Development -** ICPs are expected to publish an interim Integrated Care Strategy by the end of December 2022. There is an acknowledgement nationally that this timeline is challenging and as such the initial strategies are expected to be a starting point and will evolve over time.

4.2 The integrated care strategy must set out how the assessed needs (identified in the joint strategic needs assessments) of the integrated care board and integrated care partnership's area are to be met by the exercise of functions by the integrated care board, partner local authorities, and NHSE (when commissioning in that area).

4.3 The South Yorkshire Integrated Care Strategy will build on existing strategies and plans and be aligned closely to Health and Wellbeing Strategies. It will focus on a small number of key strategic priorities where whole health and care system working together can add the greatest value. A refresh of South Yorkshire Population Health Needs and Outcomes has been shared and discussed at the first meeting of the SY ICP to shape and inform the emerging strategy and its areas of focus.

4.4 ICBs and partner NHS Trusts/NHS Foundation Trusts are required to publish Five-Year Joint Forward Plans before the start of the next financial year 2023/24. The Joint Forward Plans should set out how the ICB and partners will work together to deliver the Integrated Care Strategy agreed by the ICP. The five-year forward plan must be reviewed annually.

4.5 **Barnsley Place Partnership Plan –** The Barnsley Place Partnership has been developing a Target Operating Model that describes how organisations and services will deliver joined up, person-centred and community-oriented care and support and improve population health.

4.6 Over the coming months the Barnsley Place Partnership Board will be refreshing the Health and Care Plan for 2022/23. This will happen concurrently with work across South Yorkshire to agree the Integrated Care Strategy and ICB Joint Forward Plan. The Barnsley Place Plan will be bold and ambitious with the aim of exploiting the new opportunities presented by the Health and Care Act 2022 to achieve the Target Operating Model.

4.7 **Improving access to primary care -** In May 2022, the CCG (now ICB Barnsley Place Team) received the Healthwatch Barnsley report on Access to GP services in Barnsley. This report along with other

feedback and insights (including GP patient survey) has informed our plans and the ICB is continuing to work with Healthwatch to raise awareness of developments and improvements aimed to improve access and patient experience.

4.8 From October 2022, the GP extended hours and out-of-hours service “i-Heart Barnsley” is changing. The Service Delivery model will be provided through a combination of GP practice and i-Heart Hub locations across Barnsley. Appointments will be delivered from three hubs, supported by 24 practices, with one central booking system. In the first month of operation the service delivered over 400 hours of additional hours per week which was well above the 273 hours required.

4.9 These enhance access appointments are delivered by a range of professionals including GP's, advanced nurse practitioners, nurses, nurse associates, physicians’ associates, first contact physiotherapists, health and wellbeing coaches and social prescribers, and are offered face to face, online or via telephone. The enhanced service provides urgent same day appointments and appointments up to two weeks ahead. This includes routine appointments, screening, and vaccinations.

4.10 The SY ICB Barnsley Place Team and Barnsley Healthcare Federation are working with GP practices to grow their individual and collective engagement channels with registered patients and local communities through –

- Practice patient groups
- Barnsley Patient Council
- New opportunities through the population health management

4.11 Two new communications campaigns are launching in November 2022 to support residents to choose well. These are –

- Help Us to Help You (including extended hours)
- NHS 111 online (target 18- to 30-year-olds)

4.12 Other initiatives to improve access and experience of primary care include –

- Further training in care navigation
- Expansion of cloud-based telephony is in place for over 50% of practices.
- Developing a primary care estates strategy
- Community events happening (including large workplaces) to identify people with elevated Blood Pressure
- All practices have access to additional home Blood Pressure monitors to support patients to manage their condition
- Understanding and sharing best practice to prevent did not attend appointments (DNAs)
- Primary and Community Alliance in Barnsley between BHF and SWYPFT to work more collaboratively to meet the needs of patients in the community
- Establishment of the South Yorkshire Primary Care Alliance

4.13 **Challenges –** health and wellbeing has been impacted negatively by the COVID pandemic and the cost-of-living crisis. The links between poverty, insecurity and wellbeing are undeniable. The health and care system has seen persistent high demand for urgent and emergency care as well as unpredictable and unprecedented spikes in operational pressures over recent months. These are expected to continue over the coming months. Higher rates of influenza are expected which will add to this pressure, alongside challenges of recruitment and retaining staff.

4.14 The difficult circumstances that residents will be experiencing now and over the coming months is also likely to be a factor in the increased levels of Did Not Attends (DNAs) appointments that further exacerbate capacity challenges.

5.0 Background Papers and Useful Links

5.1 The following links have been used in the preparation of the report and may be useful for further information:

Barnsley Metropolitan Borough Council: Adult social care local account
https://www.barnsley.gov.uk/media/23812/local-account-cabinet-final.pdf

Care Quality Commission: The state of health care and adult social care in England 2021/22
https://www.cqc.org.uk/publication/state-care-202122

HM Government: Health and Care Bill
https://bills.parliament.uk/bills/3022

HM Government: Policy paper Health and social care integration: joining up care for people, places and populations
https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

Local Government Agency (LGA) response to "Health and social care integration: joining up care for people, places and populations"
https://www.local.gov.uk/parliament/briefings-and-responses/lga-response-health-and-social-care-integration-joining-care

NHS Confederation: The integration white paper: what you need to know
https://www.nhsconfed.org/sites/default/files/2022-02/Integration-white-paper-what-you-need-to-know.pdf

NHS England and the British Medical Association: Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan
https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

NHS England and Improvement: 2022/23 priorities and operational planning guidance
https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/

NHS Long-Term Plan
https://www.longtermplan.nhs.uk/

South Yorkshire Integrated Care Board
https://southyorkshire.icb.nhs.uk/

6.0 Glossary

ARRS	Additional Roles Reimbursement Scheme (Primary Care)
BHF	Barnsley Healthcare Federation
BHNFT	Barnsley Hospital NHS Foundation Trust
BMBC	Barnsley Metropolitan Borough Council
CCG	Clinical Commissioning Group
ERF	Elective Recovery Fund
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
JFP	Joint Forward Plan
LTP	NHS Long Term Plan
NHS	National Health Service
PCN	Primary Care Network
STP	Sustainability and Transformation Partnership
SWYPFT	South West Yorkshire Partnerships NHS Foundation Trust
VCSE	Voluntary, Community and Social Enterprise Sector