Item 4b

**Report of the Barnsley Place-Based Partnership,
to the Overview and Scrutiny Committee (OSC)
on 26 April 2022**

Development of Integrated Care in Barnsley

1.0 Introduction

1.1 At the last time of attending the Overview and Scrutiny Panel in April 2021, the Barnsley Place-based Partnership and wider system partners were considering the implication of the White Paper "Integration and Innovation: Working Together to Improve Health and Social Care for All". The Health and Care Bill that followed the white paper is now completing its journey through Parliament and the NHS is working with sector partners to put in place the new arrangements described by the Bill from 1 July 2022.

1.2 This year the Government has also published two additional white papers that reinforce the direction of travel towards integrated person-centred care that have implications for the journey forward for the Barnsley Place-Based Partnership. These are:

- People at the Heart of Care: adult social care reform
- Health and social care integration: joining up care for people, places, and populations

1.3 As one of the first Integrated Care Systems, South Yorkshire is well placed to make the best of the opportunities that these changes present but there are still many unknowns.

1.4 As one of four place partnerships within South Yorkshire, Barnsley Place-Based Partnership will continue to be the engine room for change, prioritising action on improving health and health outcomes, tackling health inequalities, and delivering value for money.

1.5 From 1st April 2022 the district of Bassetlaw will align with the Nottingham and Nottinghamshire Integrated Care System (ICS), moving it from the South Yorkshire and Bassetlaw ICS.

2.0 Background

2.1 Integrated care is care that is planned with people who work together to understand the service user and their carer(s), puts them in control and coordinates and delivers services to achieve the best outcomes.

2.2 Closer working between health and social care is a fundamental part of both national policy and of local strategy and is essential for meeting health and care needs across an area, coordinating services and planning in a way that improves population health and reduces inequalities between different groups.

2.3 Since 2016, NHS organisations and local councils have been working together as part of Integrated Care Systems (ICSs) to plan and deliver joined up services and to improve the health of people who live and work in their area. They exist to achieve four aims:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

2.4 The vision for the Integrated Care System in South Yorkshire is "For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer"

2.5 Following several years of locally led development and based on the recommendations of NHS England and NHS Improvement, the government set out plans to put ICSs on a statutory footing.

2.6 The new arrangements include the South Yorkshire Integrated Care Board (ICB) which will be a statutory NHS body and must be operational from 1 July 2022.

2.7 By September 2022 a South Yorkshire Integrated Care Partnership (ICP) will be established. The main role of the ICP will be to develop a strategy that addresses wider health, public health, and social care needs of the system. The ICB and local authorities will have to have regard to that strategy when making decisions.

2.8 Place-Based Partnerships, where there will be one person accountable for the delivery of a shared plan and outcomes at place level, are expected to be in place by April 2023.

2.9 Finally, the Healthcare Bill will enable provider collaboratives to form. Guidance around provider collaboratives is flexible. It is envisaged that collaboratives will focus on programme delivery and explore common approaches to service transformation and delivery, for example diagnosis and quality improvement. In South Yorkshire there are four provider collaboratives that are forming –

- Primary Care
- Children and Young People
- Mental health, learning disabilities and autism
- Acute Care

2.10 The changes will mean further strengthening the partnership arrangements in Barnsley, establishing them on a legal footing, and enabling resource to flow through from the system to services that can best support improving health and wellbeing for local communities and the vision for Barnsley 2030.

2.11 Current members of the Barnsley Place-Based Partnership are as follows: –

- Barnsley Community Voluntary Services
- Barnsley Healthcare Federation
- Barnsley Hospice
- Barnsley Hospital NHS Foundation Trust (BHNFT)
- Barnsley Metropolitan Borough Council
- Healthwatch Barnsley
- NHS Barnsley Clinical Commissioning Group (CCG)
- South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

3.0 Current Position

Barnsley Health and Care Plan 2021/22

3.1 The priorities of the Barnsley Place-Based Partnership health and care plan for 2021/22 were: –

- Look after our people, including their mental health and wellbeing
- Deliver the COVID vaccination programme
- Accelerate recovery of planned care services for physical and mental health and transform delivery
- Increase uptake of early help for children and young families
- Joining up care and support in thriving communities
- Responsive and accessible care in crisis
- Strengthen our partnership
- Make mental health everybody's business

3.2 Our achievements in these areas in 2021/22 include: -

- We have worked across the South Yorkshire and Bassetlaw ICS to increase access to employee assistance programmes, including making a universal offer available to NHS organisations including primary care, the independent adult social care sector and community and voluntary sector
- We have delivered the COVID vaccination and booster programmes achieving a level of higher level of uptake than regional and national across age and at-risk groups

- We have embedded the use of referral assessment service (RAS) and advice and guidance (A&G) for primary care. We have met the target for rolling out Patient Initiated Follow Up (PIFU) across major specialties.
- We have established Mental Health Support Teams (MHST) in schools across Barnsley and launched CYP Mental Health Contact Point bringing together MHST and Children and Adolescent Mental Health Services (CAMHS)) and we are ahead of the national target for maternity continuity of care.
- We have continued with mobilisation of integrated neighbourhood teams, increasing urgent community response activity and established community urgent responders for falls.
- We have used the Barnsley vulnerabilities index to target support to those most in need because of the pandemic and through a difficult winter
- We have set-up same day emergency care (SDEC) for medicine and surgery at Barnsley Hospital and re-established GP streaming in the Accident and Emergency Department
- We have produced an all-age mental health strategy to underpin delivery across our partnership increasing provision of early support
- We have delivered improvements to the adult social care front-door, run a successful pilot of community reablement pathways and supported the sector to recruit into care roles.
- We have created a Place Agreement signed off by Barnsley Integrated Care Partnership Group and the sovereign boards of member organisations.
- We have appointed a programme manager to support our shared ambitions to exploit opportunities presented by digital technologies and continued work on shared care records
- We have completed a six-facet review of the primary care estate
- We have delivered Project Echo Essentials of Care training to more than 500 workers across health and care
- We have established a partnership PMO with monthly PMO meetings, highlight reporting and programme reporting to ICDG and ICPG alongside a dashboard of indicators.

Operational pressures

3.3 In December 2021 the NHS returned to a level 4 incident following the emergence of a new Covid variant and increased community prevalence. BHNFT saw a rise in the number of patients testing positive for Covid in the week before Xmas. This coincided with a significant rise in staff absence for Covid reasons.

3.4 The winter plan development and execution across the system has been successful, working to manage COVID and seasonal changes in demand safely. BHNFT responded quickly to introduce services such as virtual ward and nMAB (Neutralising Monoclonal Antibodies) delivery to reduce the need for hospitalisation for patients with COVID.

3.5 However, these pressures did impact on delivery in some areas of the health and care plan 2021/22 and priorities carry forward in 2022/23.

Tackling Health Inequalities

3.6 Improving health intelligence continues to be a feature of partnership work in Barnsley. Work to target support to those who are most vulnerable and increase access to COVID vaccinations in communities that have seen relatively low rates of uptake has identified people and households with significant needs that were not being met previously.

3.7 Through a workshop with Executive Director leads for Health Inequalities from across the partnership, partners have devised a three-tier framework to embed action on health inequalities across partner organisations and programmes and linking to Barnsley 2030 ambitions. Barnsley Place-Based Partnership established a Health Inequalities Action Group (HIAG) with representatives from secondary care, local authority, community health, mental health, and primary care.

3.8 HIAG is helping organisations including Barnsley Hospital, SWYPFT, Barnsley PCN and Adult Social Care to use the framework to create action plans on health inequalities and align ambitions across partners. HIAG is working with the Health Intelligence Cell in Barnsley to improve data quality and reporting of health inequalities through routine reporting and provide bespoke intelligence products that support decision making.

3.9 This year NHS England and Improvement has developed the Core20PLUS5 approach to reducing health inequalities that asks systems to prioritise people from the 20% IMD most deprived communities ("Core20"), locally determined target groups ("plus") and five clinical areas. The Core20PLUS5 initiative is welcome and will inform part of our work locally and across South Yorkshire. These five clinical priorities are all areas that are being progressed in Barnsley using local insights on our population.

- Serious mental illness (SMI) – the aim of the Place-Based Partnership is to increase in uptake of physical health checks and improved physical health outcomes as a result. Work is underway to gather intelligence and insights, completing a health needs assessment, engaging with people with lived experience of SMI through the recovery college and exploring opportunities presented by new technologies.

- Hypertension case finding **–** In 2021/22 Barnsley PCN began case finding for hypertension and a community pharmacy scheme for blood pressure testing was commenced. In 2022/23 through the Heart Health Alliance, partners will begin a programme of targeting blood pressures checks in community settings, beginning in our most deprived neighbourhoods.

- Continuity of care in maternity - BHNFT is ahead of the national target for continuity of care and has recently completed a piece of engagement work to understand the experience of women from Black and Minority Ethnic communities.

- Chronic respiratory disease - COVID vaccine efforts continue with a particular focus on community pop-up clinics that target people from more deprived communities where uptake has been lower than other communities in Barnsley. Flu vaccine uptake rates this year are higher than national over the majority of target groups

- Early cancer diagnosis - The Barnsley Cancer Steering Group is leading work on behavioural insights/nudge theory with GP practices. This includes promoting screening through community groups such as the community shop in the Dearne. Barnsley PCN is supporting screening programmes to improve uptake.

<u>Primary Care</u>

3.10 Throughout the pandemic General Practice has continued to be open and available to patients across Barnsley. Demand for appointments is growing. In the three months from November 21 to January 22 there were 372,271 appointments in general practice compared to 352,355 in the same period before the pandemic. This represents a five percent increase overall. During this period practices were also supporting the COVID vaccination efforts.

3.11 Practices in Barnsley are being supported through training and IT to ensure that patients who require an appointment or support are booked into an appropriate appointment with the appropriate service/clinician first time to reduce potential duplication and create capacity. Same day or next day appointments are not always required or preferred, and recovery of long-term conditions management is a priority alongside urgent need.

3.12 Winter Access Funding has been utilised to support additional clinical and admin capacity across to enable recovery, increase extended hours appointments, improve telephony and intelligent call handing (cloud based and hosted systems) and additional clinical space.

3.13 The PCN is working with partners to maximise the use of Additional Roles Reimbursable Scheme to recruit to new roles and increase access including –

- Care Coordinators embedded in every practice – supporting recovery of Long-Term Care (LTC) management and supporting patients to access the right services in a timely manner
- Personalised Care Team (Social Prescribing and Health & Wellbeing Coaches) providing an alternative to GP nurse appointment where appropriate and reducing high intensity users
- Physicians Associates and Trainee Nurse associates embedded into practices to provide additional capacity

- First contact physios in place providing additional appointments for Musculoskeletal issues – plans include exploring opening access for other services to refer directly including ED
- Clinical Pharmacists and Pharmacy Technicians working as part of practice teams – medicines reviews etc
- Mental Health Practitioners in place and working as part of community mental health services

3.14 The Primary Care COVID clinic will be retained into 2022/23 (not counted in GP appointment data) to provide same day appointments for patients who have tested positive for COVID but require other primary care support

3.15 A community pharmacy referral service is in place enabling GP practices to refer appropriate patients to Community Pharmacy.

3.16 The PCN model for Covid Vaccination supported by BHF will continue to minimise the impact of Spring and Autumn Booster programmes on core work of general practice.

Engagement and involvement

3.17 During the COVID pandemic our respective engagement, experience and equality leads have worked together to help ensure that the experiences and perspectives of our residents and service users have informed our priorities and delivery.

3.18 We will build on this to deliver a shared approach to engagement and participation that truly values to perspectives and contributions of people in our place.

3.19 Our local principles align themselves closely with those set out within the national ICS implementation on working with people and communities guidance.

3.20 Understanding the issues, challenges and barriers faced by local people during lockdown and at the height of the pandemic, helped to shape the ongoing COVID response to try and ensure that people were supported appropriately.

3.21 Some of the specific examples of work that involved engagement with local people, community groups/forums and stakeholders from over the past year includes but is not limited to the following:-

- The COVID-19 Emergency Contact Centre (including a wide-ranging offer for food, shopping, prescription & befriending support for the most vulnerable residents)
- The development of COVID community champions (targeting migrant and disabled communities)
- Community Listening events led by Area Council teams, seeking feedback to aid the development of a new All Age Mental Health Strategy, developing a new Carers Strategy and targeted engagement to assist with the ongoing roll out of the COVID-19 Vaccination programme.

3.22 All the above created opportunities to discuss and involve local people to understand the real issues they faced because of lockdown and other COVID restrictions. Throughout much of our collective engagement work, several key themes have again come to the forefront including –

- Having access to different types of support and information.
- The importance of clear, consistent, and regular communication in a range of appropriate and accessible formats
- The importance of joined up thinking and the effective integration of services beyond organisational boundaries and systems
- Ensuring that health and care services can be flexible and tailored to different people's needs and circumstances
- Carers and/or family members are involved as equal partners in any planning and decision making that takes place

3.23 Our focus on engagement and involvement work continues to evolve and develop and this needs to be further strengthened on a system wide footing. There is a requirement as part of the wider ICS developments, but also a recognition of the value in developing more proactive approaches to gathering

and making better use of our collective local insights and experience data to ensure the local voice is at the forefront of developments in Barnsley beyond organisational boundaries across our wider partnership.

3.24 Some of the work focusing on inequalities and engaging with protected characteristics groups has also been reviewed alongside this work with plans to develop a more proactive approach to engaging with local people moving forward, and to strengthen the service user voice through a variety of different ways including but not limited to via forums/groups, individual feedback through champions/connector schemes and links with local partner & community organisations.

4.0 Future Plans & Challenges

4.1 **Health and Care Plan Refresh to 2022/23 –** Barnsley Place Partnership has undertaken a refresh of the local health and care plan for 2022/23. The following priorities have been identified through a process of reviewing asks of the system from national bodies, policy papers, engagement with local residents and service users during 2021/22 and progress with the work programme -

- **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.

- **Strengthening our joint approach to prevention (making every contact count) -** We will work with our communities 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.

- **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 points of access in our system operate to the same guiding principles and create safe space for people in mental health crisis.

- **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.

<u>Five-year strategy by April 2023</u>

4.2 During 2022/23 the Barnsley place-based partnership will be engaging and involving partners, residents, service users and other stakeholders to develop a longer-term plan for health and care services in the borough in line with national planning timelines for ICPs and ICBs.

<u>System Development</u>

4.3 The South Yorkshire ICB has appointed a Chair and Chief Executive Designate and are in the process of appointing to Executive and Non-Executive Director posts. The ICB will begin to meet in shadow form in May 2022.

4.4 The appointment of an Executive Place Director for Barnsley will be a key step in the development of the desired place-based arrangements that have been agreed by partners in Barnsley, to operate as subcommittee of the ICB through a Place Director with delegated authority for allocating resources. The job description for the Barnsley Executive Place Directors is now out to advert, closing date for applicants 7 April and interviews scheduled to take place w/c 25 April. There are three place director positions out to advert (Barnsley, Sheffield, and Doncaster).

<u>COVID and the impact on the workforce</u>

4.5 There is evidence that high levels of community transmission persist but with reduced monitoring and surveillance this is difficult to fully understand. There are still low numbers of cases requiring hospital

treatment compared to the previous peaks of the pandemic but the number of positive cases in hospital remains significant. There are high levels of staff absence due to COVID and infection prevention and control measures continue to put additional strain on the workforce and estate.

4.6 Employers across our health and care system are seeing higher levels of burnout and more colleagues accessing support services but more still who would benefit. BHNFT and SWYPFT have reported higher numbers of staff retiring in the latter part of 2021/22. In some cases, these are colleagues who have delayed retirement to support the pandemic response, but some retirements are reportedly because of burnout.

4.7 Through the next stage it is important that organisations pay attention to how people are feeling, recovering, and responding to the next set of challenges.

4.8 Close monitoring of staff turnover is taking place to develop appropriate plans to support retention and recruitment of staff and already positive work has taken place to support staff's health and well-being including better access to support including counsellors.

Recovery of Planned Care

4.9 The health and care system in Barnsley is in a relatively good position compared to other areas with lower numbers of long waits for treatment. However, supporting people who are seeing their treatment delayed is still creating pressures in general practice and impacting on patient experience. Referrals to secondary care have not recovered to the levels seen in 19/20 before the pandemic but this was an exceptional year.

4.10 As at the end of January 2022 there were 59 Barnsley CCG patients waiting over 52 weeks at BHNFT, the majority of which are under trauma and orthopaedics and general surgery. There were currently 8 patients registered with Barnsley GPs who have been waiting for more than 104 weeks, the majority of which are at Leeds Teaching Hospitals and Doncaster and Bassetlaw Teaching Hospitals. Current performance is in line to achieve zero by March 2022. Barnsley Hospital have zero 104+ week waiters. Overall treatment volumes remain high as ongoing backlog recovery is well underway.

4.11 Overview and Scrutiny recently received a report relating to the recovery of cancer services so this will not be covered in detail.

Urgent and Emergency Care

4.12 Barnsley is seeing high levels of urgent and emergency care across physical and mental health which is further evidence of harms caused by COVID through increased isolation, loneliness, physical deconditioning and fear and anxiety.

4.13 A&E 4-hour performance continues to be below the target and has been impacted by significantly increased activity levels and challenges with flow. High bed occupancy, care home closures and reduced capacity in community services are contributing factors.

4.14 There are severe pressures in other parts of the region with increasing ambulance handover times, delayed transfers of care and out-of-area placements for mental health crisis.

4.15 The social care market is still recovering from COVID and adapting to the home first approach that has been adopted by health and care. There is now greater competition in the jobs market that means despite uplift in pay to the national living wage, the sector is struggling to recruit, this is particularly true in homecare.

4.16 Same day emergency care (SDEC) has been implemented at Barnsley Hospital for medicine and surgery and these pathways are available to RightCare Barnsley to avoid the need for hospital admission where appropriate.

4.17 BHNFT has a dedicated ambulance handover nurse and increase cubicle capacity for handovers.

4.18 Weekly multi-disciplinary team review of patents with a long length of stay - 'Long Stay Wednesday', a live dashboard, local targets and implementation of the SAFER Care Flow Bundle have supported clinical teams to manage and reduce long lengths of stay through winter.

4.19 Barnsley partners have fully implemented the Discharge to Assess model which is an example of best practice nationally.

Mental Health Crisis

4.20 Prior to the pandemic Barnsley had 0 out of area mental health in-patient beds placements and this had been the case for around 10 years. Community Mental Health Teams are well resourced (Including home based intensive treatment team) and sufficient beds commissioned to meet usual, pre-pandemic level of demand.

4.21 However, the pandemic has led to increased acuity, increase in psychotic presentations, increase in A&E attendances, increase in crisis care and increase in overall demand for mental health services.

4.22 Barnsley continues to see low numbers of out-of-area placements in comparison to other areas of South Yorkshire.

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:

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

HM Government: Policy paper People at the Heart of Care: adult social care reform
https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper/people-at-the-heart-of-care-adult-social-care-reform

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

King's Fund: Integrated care systems: how will they work under the Health and Care Bill?
https://www.kingsfund.org.uk/audio-video/integrated-care-systems-health-and-care-bill

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 Improvement: Core20PLUS5 – An approach to reducing health inequalities
https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/#:~:text=Core20PLUS5%20is%20a%20national%20NHS,clinical%20areas%20requiring%20accelerated%20improvement.

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 ICS Implementation Guidance on Working with People & Communities
https://www.england.nhs.uk/wp-content/uploads/2021/06/B0661-ics-working-with-people-and-communities.pdf

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

South Yorkshire & Bassetlaw Integrated Care System
https://www.healthandcaretogethersyb.co.uk/

The Development of Integrated Care Report to OSC 27th April 2021
https://barnsleymbcintranet.moderngov.co.uk/documents/s78594/Item%204%20-%20The%20Development%20of%20Integrated%20Care%20in%20Barnsley%20210427%20FINAL.pdf

Improving Cancer Early Diagnosis Report to OSC 20th July 2021
https://barnsleymbcintranet.moderngov.co.uk/documents/s85188/Item%204b%20-%20Improving%20Cancer%20Early%20Diagnosis%20Report%20to%20OSC.pdf

6.0 Glossary

A&G	Advice & Guidance
BHF	Barnsley Healthcare Federation
BHNFT	Barnsley Hospital NHS Foundation Trust
BMBC	Barnsley Metropolitan Borough Council
CAMHS	Child & Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CYP	Children & Young People
ERF	Elective Recovery Fund
HIAG	Health Informatics Assurance Group
ICB	Integrated Care Board
ICDG	Integrated Care Delivery Group
ICP	Integrated Care Partnership
ICPG	Integrated Care Partnership Group
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
LTC	Long Term Care
LTP	NHS Long Term Plan
MHST	Mental Health Support Teams
NHS	National Health Service
nMAB	Neutralising monoclonal antibody
OSC	Overview & Scrutiny Committee
PCN	Primary Care Network
PIFU	Patient initiated follow-up
PMO	Programme Management Office
RAS	Referral Assessment Services
SDEC	Same day emergency care
SDG	Strategic Digital Group
SEG	Strategic Estates Group
SDP	System Development Plan
SMI	Severe Mental Illness
STP	Sustainability and Transformation Partnership
SWYPFT	South West Yorkshire Partnerships NHS Foundation Trust
VCSE	Voluntary, Community and Social Enterprise Sector