Report of the Executive Director Core Services and the Integrated Care Partnership, to the Overview and Scrutiny Committee (OSC) on 27 April 2021

Development of Integrated Care in Barnsley

1.0 Introduction

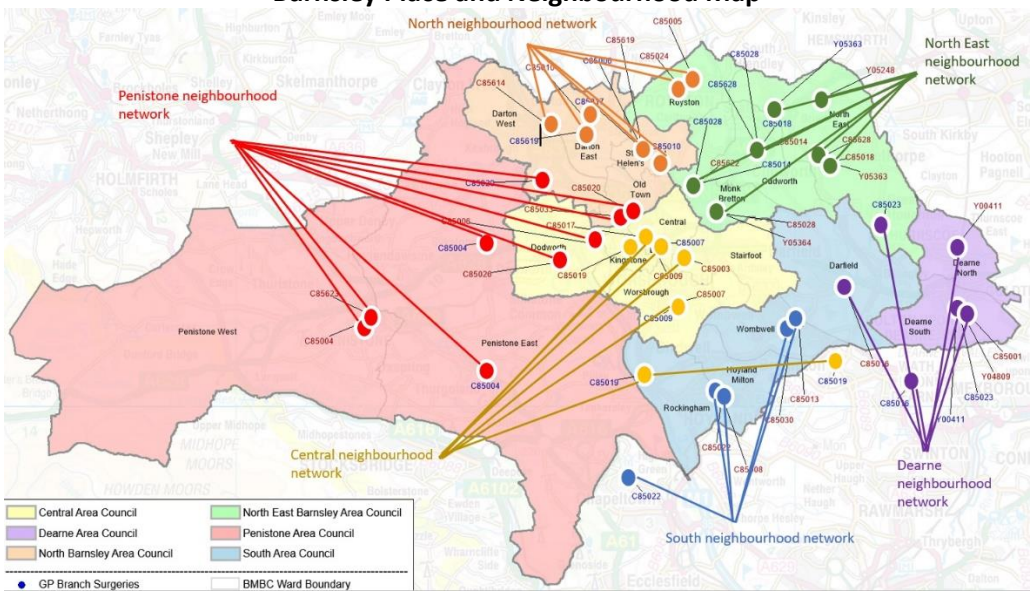
1.1 The purpose of this report is to provide an overview and update to the Barnsley Overview and Scrutiny Committee (OSC) in relation to the development of integrated care in Barnsley, the impact of the COVID pandemic on partnership arrangements, and the opportunities presented by the Government's recent white paper "Integration and Innovation: Working Together to Improve Health and Social Care for All".

1.2 Health and care organisations have been able to respond effectively to the COVID-19 pandemic, maintaining essential services for patients and service users, support staff and work with partners to protect vulnerable people and communities because of the strength of relationships and partnership working that has been developing over recent years. The COVID-19 pandemic has put unprecedented pressure on health and care services and has confirmed integrated working and partnership works. Only by working collectively have organisations been able to deliver at pace and scale, working seamlessly as one and strengthening the building blocks which were formed before the pandemic.

1.3 In February 2021, the Government set out proposals to bring forward legislation that aims to further integrate and improve care at neighbourhood, place, and system level. This presents Barnsley place with an opportunity to further build on partnership working and learning from shared experiences through COVID to improve health and care services for local people.

Level	Size	Example
System	More than 1 million people	South Yorkshire and Bassetlaw
Place	Approximately 250,000 to 500,000 people	Barnsley
Neighbourhood	Approximately 30,000 to 50,000 people	Central, Dearne, North, North East, Penistone and South

Barnsley Place and Neighbourhood Map



1.4 Central to these is the proposal to establish integrated care systems (ICSs) as statutory bodies in all parts of England. These ICSs will merge some of the strategic planning functions currently being fulfilled by non-statutory ICSs or sustainability and transformation partnerships (STPs) with the functions of clinical commissioning groups (CCGs), which will be abolished.

1.5 This provides further opportunity for partners in Barnsley to organise to deliver an ambitious programme to improve health and wellbeing alongside the local population, improve quality of care services and outcomes, increase efficiency and productivity, and reduce health inequalities across the borough and wider region.

2.0 Background

2.1 Closer integration 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.

2.2 In 2016, NHS organisations and local councils were asked to come together to form 44 sustainability and transformation partnerships (STPs) covering the whole of England and set out their proposals to improve health and care for patients. Over time, these partnerships evolved to form an integrated care system (ICS), to take collective responsibility for managing resource.

2.3 The Government White Paper "Integration and Innovation: Working Together to Improve Health and Social Care for All" was published in February 2021. It sets out a vision for integrated working at a system, place and neighbourhood level across England and changes to legislation that may support this shift from competition to greater collaboration within the National Health Service. The proposals include establishing integrated care systems (ICSs) as statutory bodies in all parts of England.

2.4 ICSs exist to improve the health of all residents, better support people living with multiple and long-term conditions, preventing illness, tackling variation in care, and delivering seamless services while getting maximum impact for every pound. They bring together the NHS, local councils and other important strategic partners including the voluntary, community and social enterprise sector. These structures will enable health and care organisations to join forces and apply their collective strength to addressing their residents' biggest health challenges, many made worse and highlighted by the pandemic.

2.5 The Department of Health and Social Care states that it has decided against giving 'place' a statutory underpinning although it is explicit that there will be an expectation that ICS NHS bodies delegate 'significantly' to place level, as well as to provider collaboratives.

2.6 Part of our vision is that decisions about how services are arranged should be made as closely as possible to those who use them. For most people their day-to-day health and care needs will be met locally in the town or district where they live or work. Partnership in these 'places' is therefore an important building block of integration, often in line with long-established local authority boundaries. The strengths of the system is that arrangements can be adapted to reflect what makes sense locally.

2.7 The proposal is that these place-based partnerships be supported by a statutory NHS ICS body to oversee NHS functions across the whole system, and a statutory health and care partnership made up of a wider group of organisations that would bring together a wider group of partners to develop overarching plans across health, social care and public health.

2.8 ICSs will also be expected to work closely with health and wellbeing boards and required to 'have regard to' the joint strategic needs assessments and joint health and wellbeing strategies produced by health and wellbeing boards. The legislation will be amended to assist organisations by enabling decisions to be taken by joint committees and to facilitate increased 'collaborative commissioning'.

2.9 These forms of collaboration and integration will be supported by a range of other measures, including:

- a duty to collaborate across the NHS and local government
- a shared duty on all NHS bodies to pursue the 'triple aims' of the NHS Long Term Plan (better health and wellbeing, better quality health care and ensuring the financial sustainability of the NHS)
- a duty on NHS trusts and foundation trusts to 'have regard to' the system's financial objectives

2.10 Strong place-based partnership arrangements have been crucial in delivering their local and national ambitions for integrated care.

2.11 Health and care commissioners and provider organisations have been working collaboratively across Barnsley to integrate services and provide more care closer to home for local people for some time. In the Barnsley Plan 2016 the Barnsley Integrated Care Partnership (ICP) set out a vision for an integrated joined up health and care system where the people of Barnsley experience continuity of care. Since then the partners have continued to work together and closely with the Barnsley Health and Wellbeing Board to deliver that vision.

2.12 The proposed changes will mean further strengthening the local partnerships arrangements, 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.

2.13 Current members of the Barnsley Integrated Care Partnership are as follows –

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

3.0 Current Position

3.1 **Partnership working through the COVID-19 pandemic -** As a place, partners have responded well to the demands of the COVID-19 pandemic. This has renewed shared commitment to collaborative working to improve health outcomes for local people and prioritise tackling health inequalities.

3.2 Barnsley has seen higher rates of COVID-19 cases and deaths than other parts of the UK. This may in part be due to an older population, higher prevalence of long-term conditions, including chronic respiratory disease and higher levels of social deprivation. We have worked with our local communities to provide support for those who are most vulnerable, including people who were asked to shield, and residents have complied with lockdown and responding to the enhanced testing programme. Like in many other areas, we have seen less people accessing health services during the acute phases of the pandemic, this has included people who would likely need to be referred to secondary care for urgent treatment. Some people are still understandably nervous about accessing health and care services and confused about the best action to take to protect themselves and loved ones from exposure to the virus.

3.3 Throughout the pandemic partners have worked within local, regional and national command and control structures to coordinate contingency planning and ensure rapid escalation and resolution of any operational challenges. This has been a two-way approach, linking what is happening in our services, through to what's happening in our local communities This has included working through the community resilience cell to target support to those most vulnerable to the virus and social distancing measures.

3.4 The local vaccination programme exemplifies the strong partnership that has been developing in Barnsley in recent years. Together, partners quickly and successfully mobilised a significant community vaccination hub service across Barnsley. This has included a full vaccination programme for care home residents and staff, vaccinations to those who are housebound and dedicated clinics for vulnerable groups such as those who are homeless.

3.5 A dedicated post-COVID assessment clinic has been rapidly established to provide timely and equitable access to people experiencing multiple long-term health effects (12 weeks plus) following COVID-19 infections, regardless of whether they were admitted to hospital. The persistent symptoms that patients may experience include breathlessness, chronic fatigue, brain fog, anxiety and stress are commonly known as 'long COVID'. These patients require detailed investigation as well as intensive and specialist

support. The community clinic launched at the end of December 2020 and is provided by Barnsley Healthcare Federation. Patients attending the clinic complete a comprehensive holistic assessment covering physical, cognitive and psychological aspects of health in line with National Institute for Health & Care Excellence (NICE) guidance. The clinic assesses and triage patients to the most appropriate service(s); patients may need therapeutic input, rehabilitation, psychological support, specialist investigation or treatment once they have been assessed at the clinic.

3.6 Information and advice for people recovering from an acute COVID-19 infection, or who think they may have long COVID, is available on the national yourcovidrecovery.nhs.uk website. Additional targeted communications are planned to raise awareness of the service.

3.7 **Tackling health inequalities** - COVID-19 has shone a light on health inequalities, and further increased the inequality gap both nationally and across the borough. The coronavirus pandemic is affecting social, economic, and family lives dramatically and in widely varying ways, and its potential for impacts on inequalities not only now but in the longer term is huge:

- Between the start of March and the middle of April, age-adjusted death rates in the most deprived tenth of areas in the UK were more than double those in the least deprived tenth of areas.
- Older people, people from Black, Asian and minority ethnic (BAME) groups and those from more deprived areas are all more likely to be severely affected by COVID-19.
- Diabetes, other long-term conditions (such as chronic lung disease), smoking and excess weight are all further factors that increase the risk of being severely affected by COVID-19.
- Bereavement, isolation, loss of income and fear are triggering mental health conditions or exacerbating existing ones.
- Many people may be facing increased levels of alcohol and drug use, insomnia, and anxiety.
- COVID-19 itself can lead to neurological and mental complications, such as delirium, agitation, and stroke.
- People with pre-existing mental, neurological or substance use disorders are also more vulnerable to infection - they may stand a higher risk of severe outcomes and even death.
- People living with severe mental illness are more likely to be obese, have heart conditions and/or diabetes, be inactive, smoke, and suffer social deprivation – all factors linked to greater risk of COVID-19.
- Reduced activity levels (due to shielding and staying home more because of COVID-19) resulting in 'deconditioning' of older people and those with long-term health conditions, meaning reduced fitness, mobility, balance, independence and increased isolation and loneliness.
- Excluding key workers, most people in the bottom tenth of the earnings distribution are in sectors that have been forced to shut down, and 80% are either in a shut-down sector or are unlikely to be able to do their job from home – compared with only a quarter of the highest-earning tenth.

3.8 From the collective insight gathered we know that, for example in relation to the move towards digital services (telephone and online appointments), some members of our local communities have been disproportionally affected:

- Many people have embraced digital ways of engaging with services. Telephone and video appointments have been shown to be particularly successful in children's services such as therapies.
- Some people in excluded groups have struggled to access and use healthcare services during the pandemic and have sometimes faced digital exclusion.
- Those in excluded groups have fewer resources and access to support to mitigate against the negative impacts of COVID-19.
- There is never a one size that fits all solution. Therefore, the best solution would be the development of a blended offer, including text, phone, video, email and in person appointments.

3.9 NHS England have set out eight urgent actions to tackle health inequalities, these are to:-

- Protect the most vulnerable from COVID-19
- Restore NHS services inclusively
- Develop digitally enabled care pathways in ways which increase inclusion
- Accelerate preventative programmes which proactively engage those at risk of poor health outcomes

- Particularly support those who suffer mental ill-health
- Strengthen leadership and accountability
- Ensure datasets are complete and timely
- Collaborate locally in planning and delivering action

3.10 In response to this the Barnsley partnership has:-

- Implemented a recovery plan for cancer, including understanding hidden harm and variations in referral patterns. This work is being done in conjunction with the Cancer Alliance. In Barnsley the rate of two-week referrals for suspected cancer recovered quickly after the initial wave of the pandemic, faster than in other parts of the region.
- Detailed analysis of urgent and planned care pathways using indices of multiple deprivation.
- Ongoing work between Barnsley Hospital and primary care to support and prioritise patients waiting the longest for planned procedures. This includes consideration of quality of life and social circumstances to prioritise existing services for those in the greatest need.
- Expanded the Barnsley Hospital Healthy Lives team (secondary care prevention offer). Recruitment to new alcohol care teams and expansion of tobacco control advice service.
- Developed a local mental health projection model to understand the likely impact of COVID on population need and demand over the coming months and years.
- All partners are working continuously to improve data quality, including the recording of ethnicity and other protected characteristics. This leads to better intelligence and insights.
- The health intelligence cell has worked with partners to develop surveillance reporting of health inequalities. This includes COVID 19 vaccine uptake and coverage.
- Barnsley Hospital Population Health analyst has provided tailored health inequalities intelligence to hospital business units to aid strategic planning.
- NHS leaders are present on place-based economic development boards.
- A team of community engagement officers has been established by BMBC to support recovery.
- An engagement and experience leads cell has been established to bring together collective insight, intelligence and experience gathered to help to shape future patient and public involvement.

3.11 **Primary care** - Primary care has seen considerable change in recent years. Following the publication of the NHS Long Term Plan, the Barnsley Primary Care Network (PCN), which includes six neighbourhood networks were formed. This put many of already existing arrangements onto a more formal setting. There is closer working between primary care and the integrated neighbourhood teams of nurses and allied professionals. Across Barnsley there has been a programme of wider system development through integrated wellbeing teams which span health, social care, community and voluntary sector and community leaders. Barnsley has been on the leading edge of developing new roles in primary care including clinical pharmacists, social prescribing advisors, receptionist care navigators and healthcare assistants. Prior to the pandemic Barnsley GPs had started to adopt digital services for example, teledermatology.

3.12 The COVID-19 pandemic has brought about significant changes in general practice and primary care. This has included a GP COVID 19 service for those with confirmed or suspected infection who need access to primary care, providing this at designated clinics and in people's homes. There has been a shift to telephone or video triage first, which means that patients can get access to GP services from their own homes and only need to come into to practice if there is a clinical need for face to face appointments. Non-COVID-19 telephone and video appointments have become a much more significant part of everyday work and form a key component of the 'talk before you walk' model being implemented across health and care. This has been to keep patients and staff as safe as possible and the method of appointment are always based on a clinical decision. GPs have been supporting community services that have had capacity reduced by new requirements for personal protective equipment (PPE), social distancing and supporting the care home population to look after patients in their homes.

3.13 **Urgent and Emergency Care** – Over recent years a priority in Barnsley has been to develop effective out of hospital services which support the direction of travel towards the provision of high-quality care in the community. This has included the development of enhanced primary care services such as IHEART Barnsley, improved care co-ordination through the introduction and embedding of Rightcare Barnsley Single Point of Access (SPA) and strengthened community offers through the Neighbourhood Integrated Teams, BREATHE (respiratory) and the Integrated Diabetes Service. Up to the pandemic, however, we

have continued to see increases in the level of hospital activity, particularly increasing trends in A&E attendances and in unplanned admissions to hospital.

3.14 As a result of the pandemic, A&E attendances reduced to around 50% of the recent levels and non-elective admissions (non-COVID) also reduced.

3.15 The aim of partner organisations is to build on the learning from COVID, lock-in some of the new ways of working, as well as providing a strong alternative offer for patients. Our approach will mean:-

- People can access appropriate services when they require them.
- Those attending A&E are triaged to appropriate care and support, including primary care, as appropriate.
- That pathways are in place to enable patients who require assessment and treatment outside of A&E to access these pathways directly following an assessment by an appropriate healthcare professional (111, 999, GP, Community Services).
- That there is high quality, clear and accessible information available to support patients to choose what is most appropriate. Building on 'talk before you walk' to encourage people to seek advice and guidance as the 'default'.

3.16 **Care Closer to Home** - Prior to the COVID pandemic, the partnership were in the process of mobilising a new neighbourhood teams service specification across Barnsley to create multi-disciplinary teams of nurses and allied health professionals, working closely with general practice, to support people who are at risk of hospital admission or recovery following an episode of illness or injury. Much of this work had to be put on hold as teams turned their attention to preparing for and managing the impacts of the pandemic.

3.17 Work to develop a community single point of access (SPA) has continued through the pandemic. The SPA brings together the RightCare Barnsley and Community Nurse Referrals Service to manage referrals from health professionals to community services, to avoid hospital admissions where it is appropriate and to facilitate discharge from hospital. The teams have been instrumental in ensuring continued patient flow through services during the pandemic, preventing delays in hospital that can lead to poorer health outcomes.

3.18 During the pandemic services were quickly stepped up to support care homes in symptomatic testing, outbreak management and increased wrap around care. Partners implemented discharge to assess (D2A) processes which involve funding and supporting people to leave hospital, when safe and appropriate to do so, and continuing their care and assessment out of hospital. This means people can then be assessed for their longer-term needs in the right place. D2A is one of the areas that demonstrate the benefits of closer working between health and social care to provide seamless care for individuals.

3.19 A partnership Care Closer to Home Board has been established to:-

- Oversee the implementation of discharge-to-assess principles that enable early supported discharge from hospital, prevent delays, and have helped to protect capacity in the secondary care for COVID-19 patients.
- Develop a new model of intermediate care that embeds the principle of "home first". Step up/step down beds will be provided from fewer care homes resulting in a more efficient service. More staff will be supporting people in their own homes, which is shown to improve recovery and is often the preference of service users and their families.
- Create neighbourhood based multi-disciplinary teams working with general practice to support people at risk of hospital admission or to enable smooth discharge and meeting the needs of people with ongoing case managed support.
- Integrate community and primary care in Barnsley to deliver a joined up, person-centred approach.
- Adopt a population health management approach to target interventions to those most in need and those who will benefit the most.

3.20 **Care homes plan -** All local authorities were asked by Government to review or put in place a care home support plan, drawing on local resilience and business continuity plans and submit a planning return by 29 May 2020. The Barnsley Care Homes Plan was developed by partners across social care, primary

care, community health services, public health, and the hospital. The plan ensures that all care homes have access to enhanced health and care services, including community multi-disciplinary teams, to ensure that residents benefit from high quality care and to support the resilience of staff and providers.

3.21 The Barnsley Care Homes Plan covers:-

- Engagement with care homes
- GP practice alignment to care homes
- Personalised care
- Multidisciplinary working to community services and access to consultant geriatrician
- Care planning
- Specialist support - hydration and nutrition, rehabilitation, end of life and dementia care
- Supply and availability of medication and related queries
- Testing/swabbing
- Remote monitoring
- Infection prevention and control including provision of PPE and training
- Data and information sharing
- Supporting care homes with digital capabilities and skills
- Commissioning, contracting and finance
- Mutual aid

3.22 **Planned Care** – the NHS Long Term Plan set an ambition to deliver more diagnostic and outpatient care in the community and closer to home, increase virtual outpatient consultations where this is appropriate and delivers value for money and to improve quality of care provided to patients by minimising the requirement for multiple attendances to a hospital where this can be avoided.

3.23 Through the planned care board, the partnerships have begun to:-

- Capture and permanently adopt planned care pathway changes e.g. non face to face 'digital first' patient care using digital technology / Referral Assessment Service (RAS) / Triage where this is appropriate and expand to all appropriate specialties to give full coverage.
- Develop clinical pathways that see patient initiated follow up (PIFU) protocols across all appropriate specialties. PIFU puts patients in control of making an appointment when they need it and provides them with direct access to guidance when they need it.
- Increase advice and guidance and referral assessment across all appropriate specialties to support referral avoidance and ensure all referrals for planned care follow the appropriate pathway and route for care.
- Ensuring any diagnostic tests required are completed prior to a planned outpatient appointment where this is appropriate.
- Ensure consistency in approach for referrals for both primary care and consultant to consultant referrals.
- Improve communications between primary care and consultants.
- Ensure elective care is delivered in the most appropriate clinical setting, for example procedures being undertaken as part of an outpatient appointment rather than day case or an inpatient admission.
- Embed the national and local Commissioning for Outcomes policies to ensure equality across the population.

3.24 **Digital** – As a result of the pandemic there has been a significant shift to digital channels for direct clinical care in primary care, community, and secondary care. Remote technology now plays a much greater role in management and administration with many more people working from home. Organisations have shared data and information more readily for system intelligence and surveillance, which has partly been enabled by temporary changes to the information sharing regulations to support the health and care response to the COVID pandemic (Control of Patient Information Regulations 2002 (COPI). Organisations have worked together more closely to manage the pressures of the pandemic from clinicians in the frontline to support services and senior management, all supported by increased use of digital.

3.25 The Strategic Digital Group (SDG) is currently in the process of refreshing the digital plan (Local Digital Roadmap (LDR) 2016). The draft digital priorities for integrated care in Barnsley are:-

- Shared Care Record (SCR)
- Digital inclusion (ensuring the benefits of the internet and digital technologies are available to everyone) and literacy (ability to find, evaluate, and compose clear information through writing and other media on various digital platforms)
- COVID 19 recovery
- Change management, stakeholder engagement and communications

3.26 These draft priorities closely align to the ICS four missions:-

- Integrated care
- Digital citizen
- Integrated care/data intelligence
- Change management

3.27 **Workforce development** - There are challenges right across the health and care workforce including shortages in areas of nursing, allied health professionals, registered managers, and carers. In South Yorkshire and Bassetlaw, we tend to grow our own workforce, and this is even more important in the context of increasing unemployment because of the economic impact of the pandemic. Young people are increasing looking at jobs and careers in health and care which we must capitalise on to ensure services are resilient for the future. This means:-

- Looking after our people – improving work conditions, increasing access to training and development, quality health and wellbeing support for everyone and protecting people from discrimination.
- New ways of working – supporting innovation and entrepreneurship, co-designing care with staff and service users, supportive multi-disciplinary team working and new workforce roles.
- Growing for the future – improving how we recruit, train and keep our people, and welcome back colleagues who want to return.

3.28 The workforce strategy has been adopted to support Barnsley partners to move toward greater workforce integration and to ensure that Barnsley is developing the right workforce for the future. Our aim is to create a sustainable, joined up, future proof workforce that is shaped by the needs and preferences of our local population. This will involve strong place-based leadership, co-ordinating workforce planning on a place level, reshaping the workforce, delivering care in teams, ensuring that Barnsley is the best place to work for health and care professionals, community activation and exploiting new technologies.

3.29 Through the integrated workforce group the partnerships has:-

- Completed a workforce modelling project to understand the out-of-hospital workforce required to meet the changing health needs of the local population over the next 10 years. This work is informed workforce planning in primary and community care.
- Successfully launched a local training hub that is delivering clinical skills training to adult social care staff from care homes and homecare agencies via Zoom using the innovative Project Echo methodology. Project ECHO is a distance learning methodology that breaks down hierarchies of specialist knowledge by creating virtual knowledge sharing networks. More information on Project Echo can be found at (https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/project-echo)
- Established a Placements and Learning Environments group that is working to improve and maximise student placements across Barnsley. There remains a placements deficit across the region because of the pandemic and the Government's planned expansion of places University courses. The workforce hub has secured funding to support coordination of pre-registration nurse placements in places and increase the role of digital. Barnsley has secured resource to test place-based allocation of nursing placements and embed a new coaching model for supervision.
- Worked closely with the South Yorkshire and Bassetlaw workforce hub to create a programme of interventions that will promote the diversity of roles in health and care to school children at key points in their school education. This has included engaging with local school leaders to design a simulation tool for secondary school pupils that is currently in development.
- Supported local partners to maximise the use of the apprenticeship levy locally, including facilitating sharing between organisations.

3.30 **Health intelligence** – before the pandemic, the partnership had established a population health management unit. The role of the unit was to provide health intelligence and insight to inform strategy development and operation planning that will improve health outcomes and reduce inequalities. The Unit led on the development of the integrated care outcomes framework, which was adopted by the Health and Wellbeing Board, and the revision to the joint strategic needs assessment.

3.31 Throughout the pandemic the unit evolved into a health intelligence cell to provide surveillance and intelligence for recovery, seeking out and sharing feedback from communities, patients, service users and wider stakeholders, on the proposed changes to services which are identified in the priority work streams.

3.32 The health intelligence cell has continued to produce regular health surveillance reports relating to COVID and the impact on health and care service delivery, wider community, and hidden harms as well as developing information sharing arrangements and population health intelligence capability.

3.33 **Strategic estates -** Prior to the pandemic, the Barnsley Strategic Estates Group (SEG) had agreed a direction of travel for developing an estates strategy. Starting with overall coordination of partner estates strategies which were all in the process of refresh.

3.34 Currently, the SEG is working on increasing out of hospital access and capacity in our community assets. Community Health Partnerships (CHP), a national body has agreed to fund an options appraisal that will consider how our LIFT estate could be adapted and updated to respond to a pandemic situation, now and in the future.

3.35 **Engagement and involvement** – There has been a wide range of patient and public involvement activity, both before and during the pandemic, which has been used to inform the development of our plans to integrate care in Barnsley and across South Yorkshire and Bassetlaw. Knowing what matters to people about the way services join up and their role as individuals or as part of a wider community has helped inform local integration plans so far.

3.36 In addition to the conversations about integrating care in its widest sense, there has been a wealth of information and insight collected from Barnsley 2030. Together, and with other insights collected, there is sufficient insight and input to mean that there won't be a new, stand-alone piece of engagement activity carried out on the national legislation or the local governance arrangements for place-based partnerships.

3.37 It is clearly understood that ongoing collaboration with communities is vital. It is through these mechanisms that the detail sat within the integrated care plans will continue to be discussed and debated to understand how best to navigate what matters most to local people, partners and stakeholders.

3.38 Some examples of the activity and themes that have been coming through are outlined below.

3.39 During spring and summer 2019 we talked to patients, members of the public and a wide range of stakeholders about their views of the NHS Long Term Plan to help shape how we bring the plan to life. This included a workshop with Barnsley Community Voluntary Service (CVS) for the third sector, a workshop with adult learners and several focus groups with members of the public at local venues. Healthwatch Barnsley carried out over 250 surveys and ran some focus groups. The Healthwatch feedback reports are available to view here: https://healthwatchbarnsley.org.uk/home/about-us/our-reports/

3.40 The feedback gathered in Barnsley was brought together with all the conversations that also took place across South Yorkshire and Bassetlaw and these were the broad themes that emerged:-

- Integrated working - The different parts of the NHS need to work together in a more integrated way and it's not just the role of the NHS to achieve the aims set out in the long term plan; the wider system should all be working together to achieve these aims, in particular local authorities, schools/colleges, communities and the third sector.
- A focus on prevention and self-care to manage long-term conditions is strongly supported.
- People want more services to be provided locally and see GP practices as an appropriate place to provide many of these services.

- Improved access to current services is a priority, including appointments at GP practices.
- More investment in clinical staff is needed in both primary and secondary care.

3.41 The emerging themes from the above conversations helped inform how we developed the service specification for neighbourhood networks and teams. This was integral to our collective plans in Barnsley to develop local community services and primary care network during 2019/20 with the overarching aim of ensuring that patients and families experience joined up care and are supported and empowered by what feels like 'one integrated team', each delivering their part without duplication regardless of the organisation they work for.

3.42 The overall engagement approach for this work was a joint one with the CCG, South West Yorkshire Partnership NHS Foundation Trust and Barnsley Healthcare Federation co- hosting seven engagement sessions across the borough. The face to face sessions were well attended and the conversations were productive.

3.43 The key themes that emerged out of this work were as follows:-

- The concepts of 'societal hubs' was raised, outlining the opportunities to link in with, or offer, more community-based services within each neighbourhood network area.
- The areas covered by the six neighbourhood networks - some people asked about the areas included in each of the neighbourhood networks/Primary Care Network.
- Supporting people and giving them confidence to manage a long-term condition is important. People said, it's not just medical, it's motivational.
- Early intervention to provide tailored advice, advocacy and information is also important in developing these services. It can minimise the impact by preventing people reaching those crisis situations, leading to a reduction in stress, anxiety and depression and consequently improving physical and mental health and wellbeing.
- Develop the signposting opportunities or direct referrals for onward support and guidance on non-health specific issues, such as debt and financial advice issues which impact on people's health and where early intervention has positive benefits.
- Integrated approach - Organisations who provide health and wellbeing services and some third sector organisations expressed their interest in being involved in the future development of neighbourhood networks and saw how their work was closely linked.

3.44 There were more specific themes emerging for the following areas:-

- The single point of access (SPA), will be critical to making this way of working happen. The team needs to have excellent knowledge of what is available, when and where. There needs to be the right clinical and administrative skill mix. It needs to be easy and quick for people to refer into. It needs to be flexible and support good communication for everyone using it and not add unnecessary steps into the process.
- In relation to the scope of services included, some people suggested that mental health should be part of the integrated team. People were keen to discuss what else (outside of community services) could form part of an integrated team in the future, such as adult social care, health and wellbeing services, and practice nursing teams. Some people said there should be more detail on how teams work with care homes.
- Consistent response times are important. They need to be developed with consideration of other response times in both health and social care services. They should consider specific profession's guidelines. There should be good communication and conversation with the person receiving care in relation to appointment/visit times for example.
- Having access to the same records and IT systems is important. The systems should support good communications within and across the neighbourhood teams.
- One team. Everyone should feel part of one team, where there is trust and respect for each other's professions and the decisions made. There should be clear leadership. There should be face to face contact within teams. People shouldn't feel isolated, whichever team they work in and wherever they are based. There should be strong professional leadership, which is valued and recognised.

4.0 Future Plans – Challenges and Opportunities

4.1 The Barnsley Integrated Care Partnership is in the process of reviewing and updating the reset and recovery plan, following the publication of NHS planning guidance in March 2021. The updated plan will cover the period up to April 2022 and ensure alignment with longer term plans including Barnsley 2030.

The current priorities agreed for the last half of 2021/22 are below.

- Deliver the local reset and recovery priorities:
  - Coronavirus management and recovery
  - Supporting complex, vulnerable, and shielded people (including the health and care workforce)
  - Understanding the impacts of the epidemic
  - Lock in change
  - Financial balance
  - COVID-19 vaccination programme
- Working together to fully mobilise the Neighbourhood Teams in localities, building stronger shared leadership arrangements across primary and community care in the first instance, whilst also ensuring that Barnsley Primary Care Network (PCN) goes from strength to strength.
- Supporting the development of the Barnsley Health and Wellbeing Board initiated Mental Health Partnership, recognising the increasing need being generated because of COVID-19 and on-going work to ensure parity of esteem.
- Revisiting and further strengthening joint commissioning arrangements between the CCG and the Local Authority, to ensure a one integrated commissioning plan for Barnsley, focussed on the life course – Starting Well, Living Well and Ageing Well.
- Having a clear and consistent one voice for Barnsley within the South Yorkshire and Bassetlaw ICS, through the continued development of our Barnsley Integrated Care Partnership governance.

4.2 **System development and ICS establishment -** The NHS 2021/22 priorities and operational planning guidance aims to support ICSs to deliver their four core purposes of:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience, and access
- Enhancing productivity and value for money; and
- Helping the NHS to support broader social and economic development

4.3 The guidance focusses on system development and ICS establishment that requires all systems to produce or update System Development Plans (SDPs) by the end of June 2021 (Q1), to set out how they will develop the leadership, capabilities and governance required to take on their anticipated statutory responsibilities from April 2022.

4.4 The Barnsley ICP is contributing to the system development plan. Representatives from Barnsley are part of each of the four design groups set up by the SYB ICS to lead on the future operating model for the ICS, how it will work with regional and arm's length bodies of the Department of Health and Social Care (such as NHS England, Health Education England and the Care Quality Commission), place-based partnership arrangements and the future of commissioning.

4.5 As well as supporting the design work for the ICS, the Barnsley ICP is in the process of agreeing a local place development plan that will enable maximum delegation to the partnership from the ICS in April 2022. A design team has been established and is jointly chaired by the Chief Executive of BMBC and the Accountable Officer of Barnsley CCG. The role of the place design team will be to develop proposals for how the Barnsley place partnership might use the direction set out in the White Paper 'Integration and Innovation - Working together to improve health and social care for all', to strengthen further partnership working.

4.6 **Recovery of planned, elective surgeries and treatments –** The pandemic has had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are waiting for treatment. Additional funding has been made available to support the recovery of elective activity, as well as the recovery of cancer services. Systems have been asked to rapidly draw up delivery plans across

elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2021 to September 2021.

4.7 Systems are asked to plan for the highest possible level of activity. Access to the Elective Recovery Fund (ERF) will be subject to meeting gateway criteria including addressing health inequalities, transformation of outpatient services, implementing system-led elective working, tackling the longest waits, and supporting staff.

4.8 In Barnsley, partners have worked hard to prioritise cancer services during the pandemic. The SYB Cancer Alliance and Barnsley Cancer Steering Group are using a behavioural insights approach to minimise these 'hidden harms' from the pandemic. To manage some of the delays and in line with national guidance, all cancer patients have been clinically prioritised to identify which patients need to be treated urgently and which patients do not require diagnostics or treatment in the short-term. The process has been implemented for all new referrals and patients on treatment pathways.

4.9 **Adult social care strategy -** It is unfortunate that there has not been a published national strategy for Adult Social Care at the same time as the NHS White Paper however it is anticipated that this will be shared during 2021 and afford partners an opportunity to create greater synergies in approach to deliver the right service, at the right time in the right place. A continuous improvement programme for Adult Social Care will be tabled at Cabinet in due course.

4.10 **Health inequalities** – the renewed focus and emphasis on tackling health inequalities is welcomed by partners across Barnsley. In line with the NHS Planning Guidance 2021/22 partners are committed to restoring services inclusively, prioritising those people and communities experience inequalities and implementing population health management and personalised care approaches to improve health outcomes.

4.11 All NHS partners now have Executive Director leads within their organisation for tackling health inequalities and all six of the neighbourhood clinical directors within the local PCN are also leads for inequalities. Health inequalities leads and integrated care partnership leads are working to agree a set of priorities and key actions on health inequalities in Barnsley on top of the eight urgent actions set out by NHS England and NHS Improvement in their pandemic phase three letter.

4.12 **Efficiencies Executive -** In an increasingly challenging financial environment, it is important that the partnership has a robust mechanism for identifying and implementing opportunities to maximise the value (in terms of health outcomes) of its resources and ensuring that expenditure does not exceed the Barnsley place health and care financial allocation.

4.13 The Efficiency Executive will be the focal point for managing the efficiencies programme process ensuring a collective approach and responsibility for delivery. It will both support and hold to account clinical leads, management and project leads responsible for the delivery of efficiency projects and provide assurance to the partnership on the delivery of these programmes.

5.0 Invited Witnesses

5.1 The following witnesses have been invited to today's meeting to answer questions from the Overview & Scrutiny Committee:-

- Adrian England, Chair, Healthwatch Barnsley
- Chris Edwards, Accountable Officer, Barnsley Clinical Commissioning Group and Rotherham Clinical Commissioning Group
- Gill Stansfield, Deputy District Director and Clinical Transformation Lead, Barnsley General Community, South West Yorkshire Partnerships NHS Foundation Trust
- Jeremy Budd, Director of Strategic Commissioning and Partnership, Barnsley Clinical Commissioning Group
- Julia Burrows, Director of Public Health, Barnsley Metropolitan Borough Council
- Dr Mehrban Ghani, Chair, Barnsley Healthcare Federation, Accountable Clinical Director, Barnsley Primary Care Network, and GP Partner at the White Rose Medical Practice
- Dr Richard Jenkins, Chief Executive Officer, Barnsley Hospital NHS Foundation Trust

- Wendy Lowder, Executive Director Adults and Communities, Barnsley Metropolitan Borough Council
- Cllr Platts, Cabinet Spokesperson, Adults and Communities, Barnsley Metropolitan Borough Council
- Cllr Andrews, Cabinet Spokesperson, Public Health, Barnsley Metropolitan Borough Council

6.0 Possible Areas for Investigation

6.1 Members may wish to ask questions around the following areas:-

- Over the last 12 months, what has gone well and what new ways of working will continue?
- What does recovery look like for the residents of Barnsley and the work of the partnership?
- What do you consider to be the current strengths and weaknesses of the partnership?
- What are the next steps for integration and how do you expect the Policy Paper to impact on partnership working?
- What mechanisms are in place to hold the partnership to account?
- To what extend does the Health & Wellbeing Board feature in the overall governance arrangements both now and in the future and is there duplication of membership?
- Does the partnership have the capacity and support it needs to drive change?
- What are the barriers that prevent health and social care integrating further and how can these be removed?
- What has been Healthwatch's role in shaping the work of the partnership?
- How do you know that you are considering the right issues, at the right time and with the right information to make the most effective decisions?
- How will you ensure that you do not digitally exclude a section of the community and ensure equity of access to services?
- Can you give an example of how engagement with residents has shaped plans to integrate care?
- Which of the key themes from engagement with the public will be taken forward and what influenced your decision?
- How confident are you that the views captured during the engagement sessions are representative of the community as a whole (eg. BAME, LGBTQ, SEND, carers, care homes, geographic locations, age range etc)?
- When will you know if Barnsley qualifies for the Elective Recovery Fund and how will this be used to improve outcomes for residents?
- What mechanisms are in place to ensure that you maximise the value (in terms of health outcomes) of resources without exceeding the Barnsley place health and care financial allocation and do you consider them to be robust?
- How would you describe the current culture and support offered to the workforce across the partnership and do you consider this appropriate and sufficient to ensure that Barnsley is seen as an employer of choice?

- What do you expect the place-based partnership to look like in 12 months-time and what changes will residents see?

- What can members do to support the work of the partnership in developing integrated care in Barnsley?

7.0 Background Papers and Useful Links

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

The Kings Fund – Integrated Care Systems Explained: System/Place/Neighbourhood: -
https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#systems

Department of Health & Social Care Policy Paper – ntegration & Innovation: Working Together to Improve Health & Social Care for All:-
https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

The Kings Fund – Health & Social Care White Paper Explained:-
https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained

NHS England – Health Inequalities Eight Urgent Actions:-
https://www.england.nhs.uk/about/equality/equality-hub/action-required-to-tackle-health-inequalities-in-latest-phase-of-covid-19-response-and-recovery/

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

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

8.0 Glossary

BMBC	Barnsley Metropolitan Borough Council
CCG	Clinical Commissioning Group
ERF	Elective Recovery Fund
ICP	Integrated Care Partnership
ICS	Integrated Care System
LTP	NHS Long Term Plan
NHS	National Health Service
SDG	Strategic Digital Group
SEG	Strategic Estates Group
SDP	System Development Plan
SPA	Single Point of Access
STP	Sustainability and Transformation Partnership
SYB	South Yorkshire and Bassetlaw
VCSE	Voluntary, Community and Social Enterprise Sector

9.0 Officer Contact

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19 April 2021