

Barnsley Health and Care Plan Refresh 22/23

Barnsley Place Partnership



Summary

Context

Communities, businesses and public services in Barnsley have shown incredible resilience throughout the COVID pandemic but the persistent uncertainties and system pressures have taken their toll and people are feeling tired. Through the next stage it is important that we pay attention how people are feeling, recovering and responding to the next set of challenges.

The Healthcare Bill is working its way through Parliament with the target to come into act from 1 July. The Government has published two white papers this year that further reinforce the direction of travel towards integrated care that is person centred. -

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

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.

As one of four place partnerships within South Yorkshire, Barnsley Place 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.

We have identified four priorities for 2022/23

1. Growing our workforce
(capacity, capability and resilience)

We will work with partners across our place to increase opportunities for people from deprived communities and those under-represented in the health and care workforce, embed career pathways across health and care and provide exemplary employee assistance and support programmes.

2. Strengthening our joint approach to prevention
(making every contact count)

We will work with our communities, VCSE sector and partners to increase capacity across three tiers of support (self/guided, one-to-one and directed) with an initial focus on preventing and reversing deconditioning for older people, bereavement, emotional wellbeing and resilience.

3. Improving equity of access
(no wrong door)

We will ensure that everyone who needs support can access it at the right time and in the right place. We will start with the customer experience, ensure different point of access in our system operate to the same guiding principles and create safe space for people in mental health crisis.

4. Joining up care and support for those with greatest need (integrated personalised care)

We will work to ensure that care we provide is holistic, person centred and coordinated. To deliver this we will deliver phase three of neighbourhood teams including social care and mental health and developing care pathways for eating disorders, personality disorders, frailty and dementia.

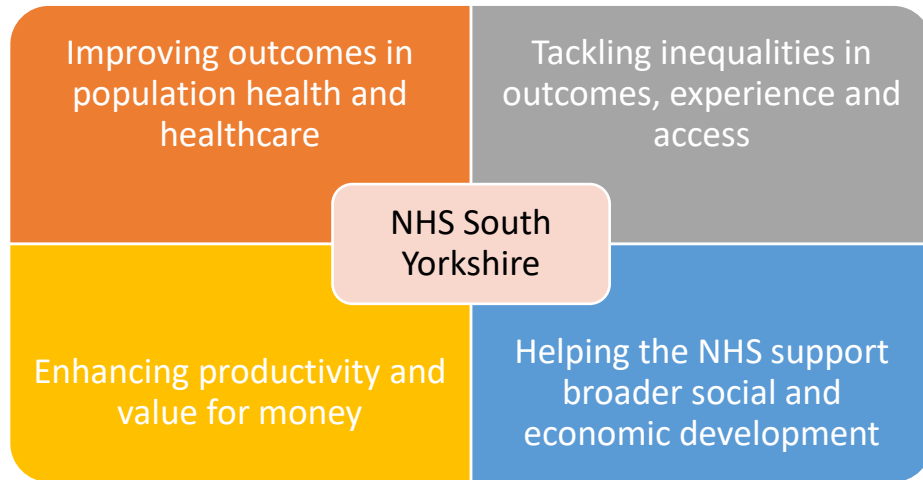
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Our place partnership

About us

Our local partnership is part of a wider system and plan



One vision for Barnsley



Adopting a life-course approach to improving health and wellbeing and creating a system that is accountable for health outcomes and all determinants of health and wellbeing

Start well	Live well	Age well
<p>Services able to intervene early and promote a strengths-based approach to encouraging increased family and community resilience</p> <p>Implement a localised, equitable and integrated health, care and education offer to substantially increase opportunities and reduce social, health and economic inequalities</p>	<p>Individuals and families are healthy, resilient and have the confidence and skills to thrive and achieve their full potential so that collectively our communications achieve the best possible outcomes for themselves, their families and each other.</p> <p>Support to individuals and families will be offered within their community and families will be offered within their community and as close to home as possible</p>	<p>In Barnsley we will support our ageing population by offering person-centred, flexible, integrated care and support in their community or at home.</p> <p>Through early interventions we will aim to maximise people’s health, wellbeing and independence and reduce the need for long term support wherever possible</p>

Common principles

Mutuality	<ul style="list-style-type: none"> Systems leadership encompassing health, social care and wider system partners Strong clinical operational leadership including general practitioners as expert generalists with the patient Enabling the leadership role of citizens, communities and voluntary sector
Population focussed	<ul style="list-style-type: none"> A population health management approach to develop strategies to improve the health and wellbeing of the population and reduce health inequalities Integrated and holistic approach to care including physical and mental health and integrated with social care
Shared values, shared governance	<ul style="list-style-type: none"> Adopt an asset based approach (citizen-led, relationship orientated, asset-based, place-based and inclusion focussed) Provide a proactive and person-centred approach that empowers patients and addresses peoples’ needs Improve quality and efficiency of services through sharing records, data and information including integrated information management and technology A single set of measures to underpin shared objectives
Care closer to home	<ul style="list-style-type: none"> Support the delivery of more enhanced and specialised services in the community where appropriate More investment in general practice in line with national ambition set out in the Five Year Forward View Locality focus for delivery of services whilst ensuring services are wrapped around patients and aligned to GP practices
Staying well	<ul style="list-style-type: none"> Focus on self-care to promote independence and reduce pressures on the health and care system Focus on prevention including the wider determinants of health
Use of resources	<ul style="list-style-type: none"> Single whole population budget Maximise the agreed outcomes within the resources available to deliver best possible value for the Barnsley pound

Involving people | The Barnsley Way

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.

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.

Our local principles align themselves closely with those set out within the national [ICS implementation on working with people and communities guidance](#).

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.

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.

All of above created opportunities to discuss and involve local people to understand the real issues they faced as a result of lockdown and other COVID restrictions.

Have a strong local focus and work on both strengths and solutions with local communities

Value equality and the diversity of local communities

Make sure information is accessible and jargon free

Ensure that everyone has a voice and we listen and learn from our staff and communities

Involve the right people, at the right time and come to you

Keep it simple and be honest about what you can influence

Avoid repeating the same conversations

Be open and transparent with what we know and what we have done and why

Our approach to tackling health inequalities

How we develop our service offer?

- Engaging with people and communities who are experiencing poorer health outcomes to co-create future models of care
- New interventions and services that aim to prevent new illness and deterioration of illness for those individuals and communities that experience poorer outcomes
- Increasing relative investment in areas that have been historically underfunded – prevention/primary care/mental health services

How we deliver our existing core services?

- Engaging with people from communities that experience poorer health outcomes to understand their collective experience of health and care
- Taking account of health inequalities in prioritising people for treatment
- Systematically tackling barriers that people experience when accessing/engaging with health and care services

Helping to drive a more inclusive society and economy in Barnsley

- Contribution to Barnsley 2030 aspirations as anchor institutions
- Improving sustainability of services – social, economic and environmental
- Creating diverse and inclusive workforce and leadership that represents our changing communities in Barnsley
- Providing excellent employment and career opportunities for local communities experiencing inequalities
- Influencing wider socio-economic policy to improve living environments and opportunities for local communities

**Healthy
Barnsley**

**Learning
Barnsley**

**Growing
Barnsley**

**Sustainable
Barnsley**

Gradual shift in our focus and investment as a system to support the needs of all, starting with the most vulnerable; improving health and wellbeing across the whole life-course; and developing a parity across physical, mental, social, environmental and economic health.

Review of 2021/22

What people are telling us

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

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.

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.

What data and intelligence is telling us

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.

There is evidence of high levels of community transmission but with reduced monitoring and surveillance this is difficult to fully understand. There are still low numbers of cases requiring hospital treatment and deaths but relatively higher levels of staff absence due to COVID and operational capacity continues to be hampered by infection prevention and control arrangements.

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 is 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. Barnsley services may need to support efforts across the wider system to bring down waiting lists.

We are 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.

The social care market is still recovering from COVID and adapting to the home first mentality 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.

There is a growing expectation on general practice to increase availability of face to face same-day appointments and at the same time as catch up on some of the work that was put on hold due to the COVID and for the Primary Care Network to deliver new services.

Some successes

Community vaccination

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

Planned Care

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.

Children & Young People/ Best Start partnership

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))

We are ahead of the national target for maternity continuity of carer.

Care Closer to Home

We have continued with mobilisation of integrated neighbourhood teams, increasing urgent community response activity and established community urgent responders for falls.

Urgent & Emergency Care

We have set-up same day emergency care (SDEC) for medicine and surgery Barnsley Hospital and re-established GP streaming in the Accident and Emergency Department

Mental Health

We have produced an all age mental health strategy to underpin delivery across our partnership increasing provision of early support

Design/ICP Development

A Place Agreement signed off by Barnsley Integrated Care Partnership Group and the sovereign boards of member organisations.

Better Lives

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.

Digital and estates

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 estates

Intelligence and inequalities

We have used the Barnsley vulnerabilities index to target support to those most in need because of the pandemic and through a difficult winter

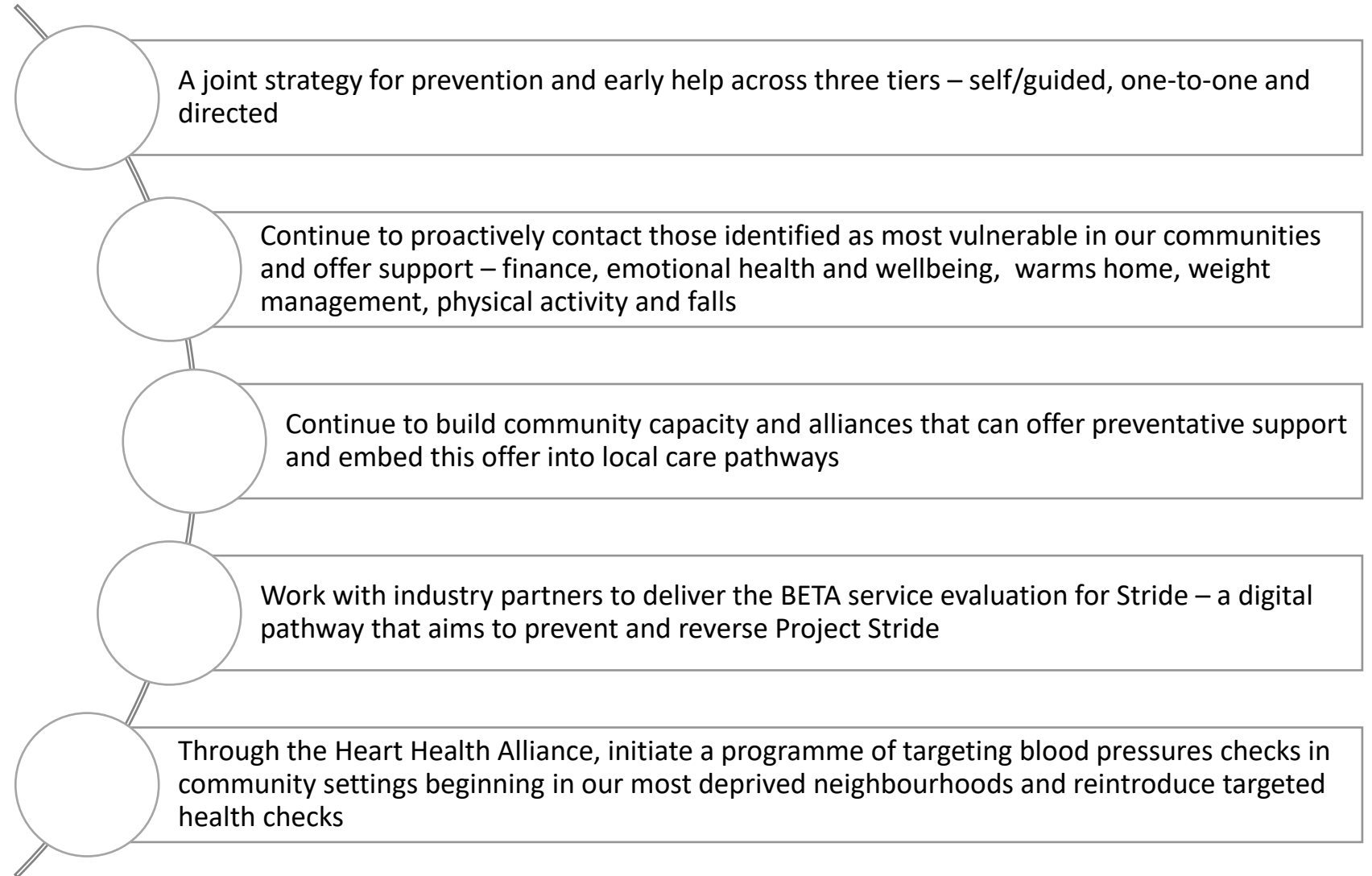
Integrated Workforce

We have delivered Project Echo training to more than 500 workers across health and care

PMO

We have established a partnership PMO with monthly PMO meetings, highlight reporting and programme reporting to ICDG and ICPG alongside a dashboard of indicators.

2. Strengthen our joint approach to prevention (making every contact count)



3. Improve equity of access (no wrong door)

Expand and grow the Children and Young People's single point of access for emotional and mental health wellbeing

Develop our access model for community and adult social care with appropriate professional input to maximise customer experience

Continue our work with iUEC to improve access to urgent treatment and emergency care

Work to improve crisis care including the creation of "safe space"

Establish the lung health checks service

Create a community diagnostics hub at the Glassworks

Expand patient initiated follow up (PIFU) and virtual appointments to improve access and experience for service users and staff

Implement new ways of working to increase capacity and reduce the backlog in elective care

Community reablement pathways and continue to embed strengths-based practice in our approach

Continue to embed new roles in primary care to enable earlier access

Fully implement the six ambitions for palliative and end of life care

4. Join up care and support for those with greatest need (integrated personalised care)

Develop a strategy and delivery plan to develop closer working between the excellent maternity and early years services

Fully implement the recommendations from the recent review of support for special educational needs and disability

Phase three of the neighbourhood teams mobilisation including community mental health and social care

Create a personalised care team in primary care to provide person-centred support including social prescribing, health and wellbeing coaching and care coordination

Create care pathways for eating disorders and personality disorders

Coordinate the local response to the national virtual ward initiative building on the strong service provision in Barnsley and increasing specialist input into community and primary care

Transformation group deliverables

Best start partnership

Closer working between maternity and early years services

Fully implement the recommendations from the recent review of support for special educational needs and disability

Expand and grow CYP single point of access for emotional and mental health wellbeing

Care Closer to home

Pathways for falls, frailty and dementia

Virtual ward

Joint approach to prevention with our communities and the VCSE sector

Phase three of the neighbourhood teams mobilisation

Develop our access model – RCB and ASC

PROTECT programme for medicines optimisation

Better lives

Community reablement pathways

Continue to embed strengths based practice in our approach

Explore opportunities for technology enabled care services (TECS)

Urgent and emergency care

Continue our work with iUEC to improve access to urgent treatment and crisis care

Oversee delivery of Urgent Community Response

Continue to embed new roles in primary care to enable earlier access

Planned care and outpatients

Establish the lung health checks service

PIFU and virtual appointments to improve access and experience for patients

Create a community diagnostics hub at the Glassworks

Implement new ways of working to increase capacity and reduce the backlog

Mental health partnership

Improve crisis care

Reduce self-harm and suicides

Pathways for eating disorders and personality disorders

Enabler group deliverables

Health inequalities action group

Develop Barnsley Vulnerabilities Index

National PHM development programme

Three-tier framework to ensure alignment across partners to maximise impact

Health intelligence cell

Increase data sharing and PHM analytical capacity

Continue to develop the Integrated Care Dashboard

Build experience and insights from people into health surveillance

Workforce

Launch Barnsley CARE academy

Virtual recruitment programme

Student placement expansion

Workforce wellbeing

Five year workforce plan

Estates

Finalise six facet review

Produce Barnsley-wide estates strategy

Create a programme of potential capital schemes for future investment

Digital

Deliver shared care record solution

Produce digital strategy

Comms

Work with the delivery groups to put in place effective communication plans to support our ambitions.

Create an identify for partnership working across health and care in Barnsley

Engagement

Develop joint working across organisations and teams

Create an insights bank

Work with delivery groups to ensure an effective approach to engagement

Design team

Further develop place joint commissioning/ planning

Develop a place clinical and professional forum

Detailed work on management of Quality, Safety and Safeguarding, building on the Quality Executive proposals

Core20plus5 for Barnsley

The Barnsley Health Inequalities Action Group (HIAG) is helping organisations to create action plans and align ambitions across partners. In April 22 we will be starting the national PHM development programme delivered by Optum. Health inequalities will be a theme of this work as we will target underserved communities. HIAG is working with the Health Intelligence Cell to improve data quality and reporting of health inequalities through routine reporting to transformation boards and the integrated care partnership group (ICPG) through the ICPG dashboard. Through 2021/22 we have worked to create a health index for residents by identifying flags of vulnerability from across 27 different datasets and weighting these to create an index score. In 2022/23 we will build on this to create a mapping tool that shows the picture of need and inequalities across the Barnsley population using deprivation, protected characteristics and the applying the vulnerabilities index. HIAG is working with the engagement, equality and experience leads to prioritise engagement with groups who experience health inequalities. The health index is being used to target winter wellbeing calls, affordable warmth. The insights we have gathered are informing our prioritisation of proactive care for frailty.

We are in the process of gathering intelligence and insights to support a targeted programme of work that will see an increase in uptake of physical health checks for people with **Serious Mental Illness**. We are undertaking a health needs assessment for Serious Mental Illness and undertaking engagement with people with lived experience of SMI through the recovery college with the aim of co-producing new interventions.

We are following up patients who have had a high blood pressure reading but not diagnosed/treated for **hypertension** to arrange a review. We have also established a pharmacy BP case finding and ambulatory blood pressure service. In 2022/23 through the Heart Health Alliance, we will begin a programme of targeting blood pressures checks in community settings beginning in our most deprived neighbourhoods. In addition, when the local healthcheck service resumes that will also contribute to BP case finding (probably a targeted model)

Barnsley hospital is ahead of the target for continuity of care in **maternity**. The trust recently completed an engagement project to understand the experience of women from protected characteristic groups – waiting for the findings and recommendations to be finalised

Flu vaccine uptake rates this year are higher than national over the majority of target groups including people with **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.

The Barnsley **Cancer** Steering Group is leading work on behavioural insights/nudge theory with practices. This includes promoting screening through community groups such as the community shop in the Dearne. The Primary Care Network is following up people who have been contacted by screening services but not yet responded to improve uptake. We are creating a community diagnostics centre in the Glassworks Barnsley will improve access to services for deprived groups in Barnsley

Strengthening our
partnership
(design team)

Develop place joint commissioning/planning

Develop a place clinical and professional forum. Ensure it is appropriately resourced, heard and valued

Develop proposals for people and communities engagement ensuring we hear from and respond to the fullest diversity of our population

Develop proposals to enhance the role of our community and voluntary sector and other key players in our future place-based arrangements

Review place-based governance structures

Develop our proposals for partnership involvement in Finance, Performance and Planning at place

Detailed work on management of Quality, Safety and Safeguarding, building on the Quality Executive proposals

Define the place partnership leadership team

Clarify interface and influence with ICS provider collaborative arrangements

Support the development of our place partnership arrangements through the provision of targeted OD support

Key milestones

Better lives

Why is this important	Milestones	Measures
<p><u>Community reablement pathways</u> will improve independence, build greater capacity at a community and neighbourhood level to support health and care services, facilitate improved joint working between and may generate savings because of reduced or delayed use of costly statutory services.</p>	<p>March 2022 – end of pilot phase for Central & Penistone</p> <p>April 2022– review data and complete evaluation</p> <p>May/June 2022 – agree phased roll-out into remaining areas to become BAU</p> <p>June to December 2022 - roll-out dependent on successful recruitment</p>	<p>Increased contacts with people that result in prevention, early intervention, and short-term support</p> <p>Average age of people entering long term support</p>
<p><u>Embedding strengths based approaches</u> will improve choice and control for people who have care needs, promote wellbeing and personal and community resilience, maximise recovery, promote independence and improves the quality of life for people with care and support needs.</p>	<p>April//May 2022 - Initial workshops with all teams</p> <p>April/May 2022 - explore assessment tool opportunities for improvement to support Strength-Based Practice</p> <p>TBC - Implement new assessment tools</p> <p>June 2022 - Impact Framework development</p> <p>TBC - Links to TLAP</p>	<p>Changes to care packages upon review</p> <p>Service users reporting control of their daily life</p> <p>Service users reporting as much contact as they would like</p>
<p><u>Technology enabled care and support</u> can provide people to remain independent, make tasks for care professionals may easier and deliver long term value for the health and care system.</p>	<p>TBC – TECS Project brief and working group to be established</p>	<p>Scale of deployment of TECS and reduced size and cost of care packages</p>

Best start

Why is this important	Milestones	Measures
<p>We will develop closer working between <u>maternity and early years</u> services to ensure that young families get joined up and proactive support.</p>	<p>March 22 – agree scope of joint work</p> <p>April 22 - Establishment of working group</p> <p>TBC – development of maternity strategy</p>	<p>TBC</p>
<p>We will fully implement the recommendations from the recent review of support for <u>special educational needs and disability</u> to deliver the required improvements for children and their families.</p>	<p>March 22 – agree scope of joint work</p>	<p>TBC</p>
<p>We will continue our work to develop our <u>single point of access for children and young people’s emotional health and wellbeing</u> to increased support for children and young people that is accessible and integrated within the existing service offer. This will lead to higher uptake of early interventions preventing problems from getting worse. Over half of mental health conditions start by the age of 14 and 75% start by age 18 and it is often the case that children and young people do not get the help they need, as quickly as they should. As a result, mental health difficulties such as anxiety, low mood, depression, conduct disorders and eating disorders may prevent some young people achieving their full potential and making a full contribution to society (Future in Mind, 2015).</p>		<ul style="list-style-type: none"> • Outcome and experience measures for service users • Uptake of services from vulnerable groups • A reduction in referrals to specialist services by providing early intervention support • Lower levels of exclusions

Care closer to home

Why is this important	Milestones	Measures
<p><u>Pathways for falls, frailty and dementia</u> will ensure proactive and care and support for targeted cohorts. The frail population in Barnsley is growing at a greater rate than the population is ageing and if unmanaged can cause the sufferer to become very sick, very quickly. The COVID pandemic has had a significant impact on frailty due to deconditioning and isolation.</p>	<p>March 2022 - Falls and frailty pathway workshop outputs finalise</p> <p>April/May 2022 - Appointment of lead to review dementia pathway working with the dementia and me partnership</p> <p>June 2022 - Pathway co-design including proactive interventions</p> <p>June to September 2022 – Project Stride BETA service evaluation</p>	<p>Number of people screened for falls/frailty</p> <p>Numbers of people receiving proactive interventions</p> <p>Patient reported outcomes from proactive interventions</p> <p>Rate of ambulance call outs, conveyances, and admissions for falls</p>
<p>We will describe our <u>joint approach to prevention</u> that sets out how our place partnership will work together to tackle the drivers of poor health working with our communities, including peer support. This framework will enable our partnership to identify and address gaps in provision, target investment on areas that will have the greatest benefit and build capacity across our communities. We will be able to monitor activity to understand that population needs are being met.</p>	<p>March/April 2022 - Initiation document</p> <p>April 2022 - Establish working group/lead to take this work forward bereavement service review</p> <p>June 2022 - Co-design framework/strategy with key stakeholders</p> <p>TBC - Interim report from COMPASS on support for CYP</p> <p>July 2022 - Develop commissioning intentions</p>	<p>Signed off strategy/approach</p> <p>Take up of prevention offer as a proportion of the estimated population that would benefit</p>
<p><u>Phase three mobilisation of the neighbourhood teams</u> will ensure that there is capacity and capability in place to meet the local and national requirements for urgent community response and work with partners to describe and mobilise a model of multi-disciplinary working that encompasses mental health and social care. Service users will be empowered to take control of their own care, they will not need to tell their story repeatedly to get the treatment that they need and their care will be person-centred and community oriented.</p>	<p>April 2022 - Neighbourhood teams OD programme begins</p> <p>May 2022 - Design workshop with community health, primary care, mental health, and social services</p> <p>June/July 2022 - Finalised phase three proposals – June 2022</p> <p>July 2022 - Business case for investment required to meet the UCR standards</p> <p>From September 2022 – mobilisation of phase three</p>	<p>Referrals and contacts for neighbourhood teams</p> <p>Patient reporting outcomes – I and We Statements</p> <p>Rates of hospital admissions for people on neighbourhood teams caseload</p>

Urgent and emergency care

Why is this important	Milestones	Measures
<p>We will continue to work <u>with iUEC on the front door</u> to identify opportunities to improve access to urgent and emergency treatment. A&E at Barnsley Hospital has seen a steady year on year rise in attendances. The growing demand was approaching an unsustainable level for the system including the workforce, building and facilities. This level of demand has returned and is continuing to rise. A high number of people getting through to care teams could be managed at first point of contact. People who do not need emergency care will have timely access to urgent treatment services as an alternative to A&E. People who do need emergency care will experience fewer delays because the accident and emergency department will not be as busy. This will lead to a better experience for staff as well as service users.</p>	<p>TBC - Modelling work to identify opportunities to expand access urgent treatment</p> <p>June 2022 – finalise UEC plan for 2022/23</p>	<p>Number of A&E attendances</p> <p>Increase use of NHS 111 and signposting to alternatives to A&E</p> <p>Urgent community response – two hours</p> <p>Reducing 12 hour waits in ED to Zero and no more than 2%</p> <p>Improve against all Ambulance Response Standards (plans to achieve Cat 1 and Cat 2 mean in the 90th percentile)</p> <p>Minimise Handover delays</p> <p>Expand Urgent Treatment provision - moving towards UTC as a front door to ED</p>

Planned care and outpatients

Why is this important	Milestones	Measures
<p><u>Targeted Lung Health Checks</u> will support early detection of cancer. Our rates of early detected cancer will be improved, and early detection of respiratory and cardiac conditions will mean improved management.</p>	<p>Autumn 2022 - Provisional 'go live'</p>	<p>No of TLHC completed</p> <p>No of early detected lung cancers</p> <p>No of people who have started a smoking cessation programme</p> <p>No of people detected early with new long-term condition</p>
<p><u>PIFU and virtual appointments</u> will create capacity within our Acute setting, improve through avoidance of unnecessary follow up appointments and provide increased flexibility to patients who are comfortable with the modality.</p>	<p>April 2022 – roll out across additional specialities</p>	<p>Specified NHS deliverable target of 5% PIFU by March 2023, currently 2%</p>
<p>The <u>community diagnostics centre</u> will increase access to routine diagnostics physiological tests, reduce the number of separate, release estate space at the Acute setting and provide more convenient to access.</p>	<p>May 2022 - Hub fully open</p>	<p>Number of separate diagnostic appointments attended and reduce DNAs</p> <p>Increase in access by people/population groups that traditionally do not attend</p>
<p>Implement <u>new ways of working</u> and joint problem solving will increase capacity and reduce the backlog</p>	<p>TBC</p>	<p>Maintenance of 104+ week wait</p> <p>Reduction in 78+ week waits</p> <p>Reduction in 52+ week waits</p>

Mental health partnership

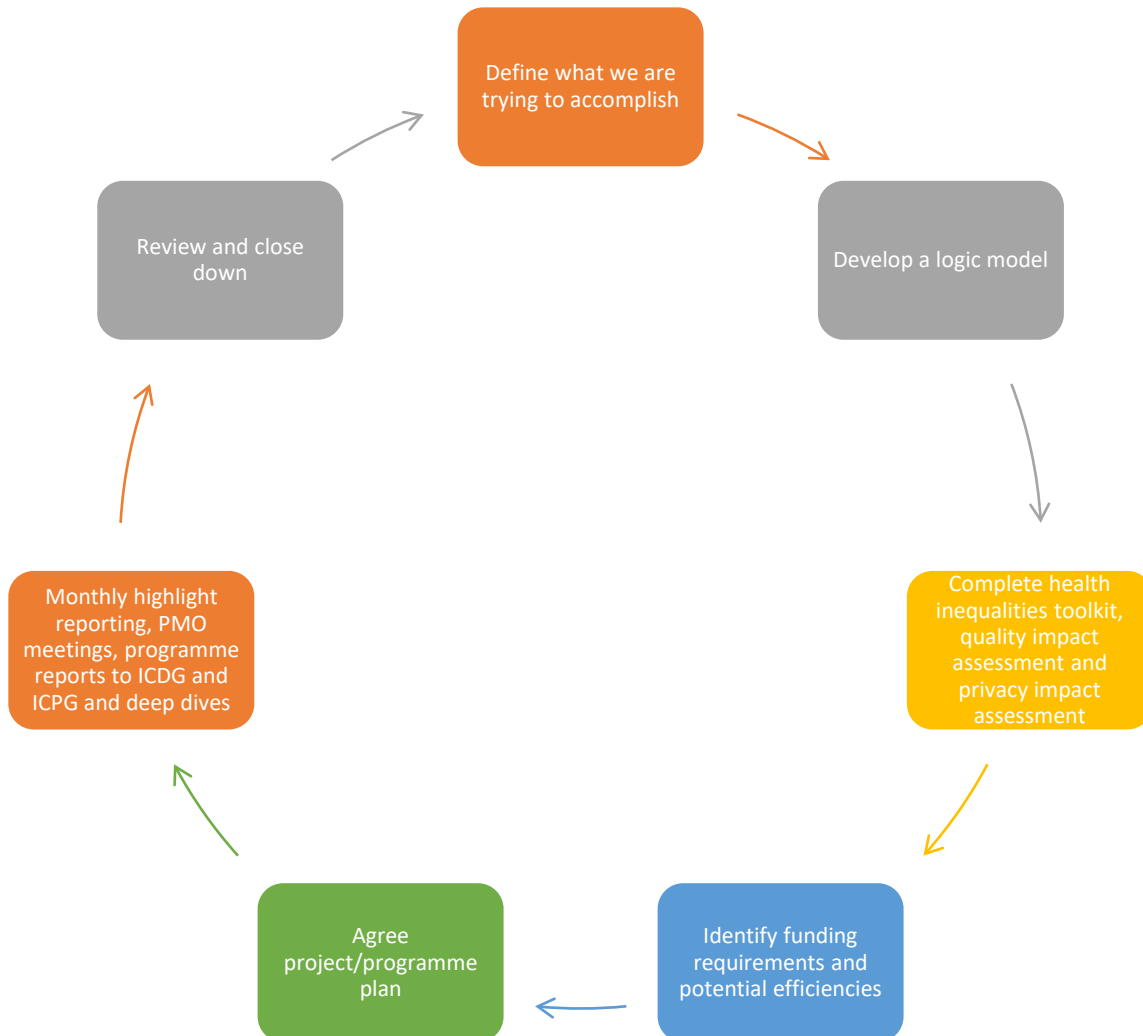
Why is this important	Milestone	Measures
<p>We need to improve our <u>mental health crisis care</u> to ensure that people are supported in the most appropriate way and in a timely manner. The impact of the coronavirus pandemic has seen a significant increase in the acuity of presentations, increase in psychotic presentations and a general increase in demand for crisis services.</p>	<p>June/July 2022 - Stand-alone staffing of S136 Suite</p> <p>August 2022 - Crisis alternative (Safe Space) fully operational</p>	<p>Reduction in A&E attendances with Mental Health as primary cause</p> <p>Reduction in use of S136 Suite</p> <p>Safe spaces are well-utilised</p> <p>Increased usage of mental health helpline</p> <p>Service user satisfaction (surveys/complaints/compliments)</p>
<p>We will improve support for people affected by <u>self-harm and suicide</u>. Barnsley has the highest rate of admissions to A&E for the purpose of self-harm in the 10 – 24-year-old age range within Yorkshire and Humber and has the highest suicide rate in South Yorkshire.</p>	<p>May/June 2022 - Delivery of Compass training and evaluation of impact</p> <p>September 2022 - Robust evaluation of PET service</p> <p>TBC - Ongoing evaluation of the Harmless school work</p> <p>TBC - Implementation of borough-wide self-harm strategy</p>	<p>Reduced numbers in admissions to A&E with self-harm as the primary cause</p> <p>Reduced numbers of people taking their own lives or attempting to take their own lives</p> <p>Service user experience</p>
<p>Currently there is no local <u>eating disorder pathway</u> for adults and the childrens eating disorder pathway is unable to cope with the demand.</p> <p><u>Personality disorder pathways</u> need to be more robust to ensure patients can be looked after within their community rather than being placed in out of area or locked rehab placements.</p> <p>Access to CMHT Transformation funding is dependent upon implementing these specific pathways</p>	<p>TBC</p>	<p>Reduction in the number of eating disorder patients requiring Tier 4 support (in-patient accommodation)</p> <p>Reduction in referrals to CAMHS for eating disorders</p> <p>Reduction in the use of out of area beds and locked rehab for patients with Personality Disorder</p> <p>Service user experience</p> <p>Improved Outcome measures</p>

Workforce

Why is this important	Milestone	Measures
<p>We need to improve our <u>mental health crisis care</u> to ensure that people are supported in the most appropriate way and in a timely manner. The impact of the coronavirus pandemic has seen a significant increase in the acuity of presentations, increase in psychotic presentations and a general increase in demand for crisis services.</p>	<p>June/July 2022 - Stand-alone staffing of S136 Suite</p> <p>August 2022 - Crisis alternative (Safe Space) fully operational</p>	<p>Reduction in A&E attendances with Mental Health as primary cause</p> <p>Reduction in use of S136 Suite</p> <p>Safe spaces are well-utilised</p> <p>Increased usage of mental health helpline</p> <p>Service user satisfaction (surveys/complaints/compliments)</p>
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Next steps

Our programme approach and setup



To ensure effective programme delivery we will

- Strengthen our measurement for improvement approach
- Review and update the ICPG agenda to include metrics relating to intended benefits
- Agree a process for identify and manage efficiencies working with finance teams
- Invite a finance lead to join the Integrated Care Delivery Group (ICDG)