NHS
South Yorkshire
Integrated Care Board

NHS JOINT FORWARD PLAN
FOR SOUTH YORKSHIRE

June 2024

Contents

Foreword

We are delighted to share with you our updated Joint Forward Plan for South Yorkshire for 2024/25. It has been shaped by the wishes of our communities, that we have heard through our engagement work and refreshed in collaboration with all our partners. It has been shared with each of our Health and Wellbeing Boards and our South Yorkshire Integrated Care Partnership.

Together with our partners we published our initial Integrated Care Strategy for South Yorkshire in March 2023. Setting out our vision for 'Everyone in our diverse communities to live a happy, happier life for longer' and a clear goal to improve healthy life expectancy and reduce the gap in healthy life expectancy across South Yorkshire.

We know that more people in South Yorkshire are living shorter lives than they should with more years in poor health than they need to. Health inequalities show unfair and avoidable differences in health across our population, and between different groups within our communities. However, they are not inevitable, and they are preventable.

As an integrated care system our core purpose is not only to improve outcomes in health and healthcare for all, but to tackle these deep inequalities in outcomes, access, and experience. It is also to prioritise and target our resources to where there is greatest need. NHS South Yorkshire, our Integrated Care Board, has a key role in this.

This refreshed Joint Forward Plan is a delivery plan for how the NHS, working with partners, will deliver on the ambitions set out in our Integrated Care Strategy.

In our initial Joint Forward Plan, we were clear that our priority was to continue to recover our services in a way that offers all our communities equitable access to care and support.

Whilst also being relentless and creative to prevent ill health and help people to stay well. It set out our commitment to work in collaboration with our partners on the wider determinants of health to address health inequalities. Our refreshed plan for 2024/25 reaffirms our commitment to this approach and the continuation of the priorities identified in our 2023 plan.

As we move into 2024/2025 the landscape continues to be challenging with health inequalities heightened by the covid pandemic, the cost-of-living crisis, and front-line health and care services operating under significant pressure. There is increasing demand for our mental health, urgent and emergency services, and longer waits for planned treatments than we would wish. Improving access to services remains a priority but we are also a system with high ambitions to improve the health and wellbeing of our population.

In the past year we have seen exceptional efforts to reduce long waiting times, increase volumes of cancer treatments and to maintain safe services during periods of industrial action. As a system we have delivered tangible improvements including the development of our diagnostic services in Mexborough, our pioneering community diagnostic centre in the Glassworks in Barnsley and opening new elective hub facilities in Sheffield and Doncaster, among others. We will build on this progress in our refreshed plan.

In our new Joint Forward Plan for the NHS, we have strengthened the link with the aims of the Integrated Care Strategy developed jointly through our wider partnerships and particularly to the measures in its Outcomes Framework which we use to monitor progress towards the goal of improving population health.

We have also included in the refresh our developing plans to better address women's health issues, improve our services for people with mental health conditions and those with learning disability and autism, plans for palliative and end of life care services and support. We will also further develop a collaborative approach to ill health prevention such as through tobacco control with the support of our South Yorkshire Integrated Care Partnership. We will continue to improve access to primary care particularly delivering the aims of the national recovery plans for general practice and dentistry. We have also refreshed our priorities in relation to digital, data and technology, further developed our focus on sustainability and updated procurement and finance plans for 2024/25.

The Integrated Care Strategy for South Yorkshire sets out an ambitious plan for improving the health and wellbeing of South Yorkshire people. This was developed jointly through our partnership with the four local authorities, their health and well-being boards and other partners including the voluntary, community and social enterprise sector and the South Yorkshire Combined Mayoral Authority and informed by the views of local communities. The NHS has an important part to play in this and our refreshed Joint Forward Plan describes how we will do this.

There are specific measures to track delivery and we will report our progress regularly through our public Board meetings. The plan will be updated annually, and we will continue to refine our approach based on the views of local people and our partners.

Gavin Boyle
Chief Executive Officer
NHS South Yorkshire Integrated Care Board

1 Introduction

This plan is our NHS Five Year Joint Forward Plan (JFP) for South Yorkshire. It has been developed by NHS South Yorkshire jointly with all NHS Trusts and Foundation Trusts in the South Yorkshire Integrated Care System and in collaboration with wider partners.

The requirement of a JFP is set out in legislation under the Health and Care Act 2022. Guidance was initially published in December 2022 for Integrated Care Boards, NHS Trusts and Foundation Trusts to develop these plans to meet the physical and mental health needs of their populations. Further guidance issued in December 2023 outlined the need for JFPs to be refreshed annually.

Our Plan has been developed during a changing and challenging environment for NHS services. A time when our services and workforce are continuing to respond to the ongoing implications of the covid pandemic, managing increasing operational and workforce pressures, and periods of industrial action across the NHS and wider public sector. It is underpinned by a fresh look at the needs of our population and the insights from what patients, citizens and our health and care workforce across South Yorkshire, have told us matters to them.

Our Plan is aligned with our four Health and Wellbeing Board strategies in each of our Places of Barnsley, Doncaster, Rotherham and Sheffield and it also builds from our Integrated Health and Care Plans in each Place and our previous South Yorkshire Five Year Plan (2019 - 2024).

It is our response to the recently published Integrated Care Strategy for South Yorkshire, co-produced by the South Yorkshire Integrated Care Partnership (ICP). The ICP brings together local authorities, the South Yorkshire Combined Mayoral Authority, the NHS and Voluntary Community and Social Enterprise (VCSE) sector and the wider public sector. This is our South Yorkshire delivery plan for how the NHS, working with local authorities, VCSE and others, will deliver on the ambitions set out in the Integrated Care Strategy. It highlights and addresses how we will work with wider partners to tackle the key issues that South Yorkshire's citizens are telling us matter to them:

- **Accessibility**

  Being able to access care services in a timely and convenient way was the most commonly mentioned concern because it affects the quality of a patient's experience. This was felt particularly strongly in terms of demand for accessing GP services. Removing barriers to accessing information, support and services were mentioned by all.

- **Affordability**

  The costs of transport, parking, medication, treatments, as well as being able to live more healthily, were also mentioned universally. The cost of living challenge provides the context to these responses.

- **Agency**

  Many people want to be in control of their own care and want better access to the information, tools and capacity to manage this.

Our immediate priority must be to continue to recover our services in a way that all our communities have equitable access to the care and support they need. This means delivering on the national operational requirements for 2024/25. At the same time, we must continue to be both relentless and creative to prevent ill health in the first place and in our commitment to working in collaboration on the wider determinants of health to achieve our ambition of eliminating health inequalities for South Yorkshire.

We must also continue the progress made in delivering the key ambitions set out in the NHS Long Term Plan and continue transforming the NHS for future generations. We acknowledge the critical contribution of our workforce, the importance of strengthening our digital capabilities, use of data, intelligence and insights, and need to embrace research and innovation to enable this.

Our Plan starts with a summary of our initial Integrated Care Strategy and the ambition we have to reduce health inequalities and improve healthy life expectancy in South Yorkshire, and goes on to start to outline the NHS response and our shared delivery plans. It is underpinned by a number of more detailed delivery plans.

2 Initial Integrated Care Strategy for South Yorkshire

The South Yorkshire Integrated Care Partnership, chaired by the South Yorkshire Mayor, Oliver Coppard, was established in September 2022 and led the development of our initial Integrated Care Strategy.

Our initial Integrated Care Strategy was informed by a refresh of our South Yorkshire population health needs assessment (Joint Strategic Needs Assessment) and insights from what the public and patients have told us matters to them. It builds on all our existing strategies and plans, including our Health and Wellbeing Strategies, Place Health and Care Plans and our South Yorkshire Strategic Plan (2019-2024).

To ensure this strategy was informed by people living in South Yorkshire and what matters to them about their health and wellbeing, we took a phased approach to engaging with them. Working within the challenging timeline set nationally we started by understanding what matters to people living in South Yorkshire by gathering insight from a wide range of engagement and involvement activities undertaken in South Yorkshire in the last two years by our partners, from 284 different sources.

We then asked our communities a simple question to build on this:

The What Matters to You campaign took place over November and December 2022. Working with our local Healthwatches and voluntary, community and social enterprise sector (VCSE) we reached out to as many people as possible in South Yorkshire. This included our health and care workforce, children and young people, under-represented and socially excluded groups. More than 500 individuals and groups responded.

The insight work identified a need for more information about health prevention and the availability of different health and social care services, to make it easy for people to access them, to remove barriers and to provide people with the information, tools and capacity to manage their own care. These themes of awareness, access and agency were replicated in the responses to the 'What matters to you about your health and wellbeing?' question.

Individuals and groups said their highest priorities were access to and quality of care, improving mental health and wellbeing, support to live well, the wider determinants of health, and affordability, given the pressure on the cost of living. All of these themes were used to inform our initial Integrated Care Strategy and shape our NHS Joint Forward Plan.

2.1

Our working vision, shared outcomes, bold ambitions and joint commitments

Our initial Integrated Care Strategy sets out our working vision, goals, shared outcomes and a small set of bold ambitions and joint commitments.

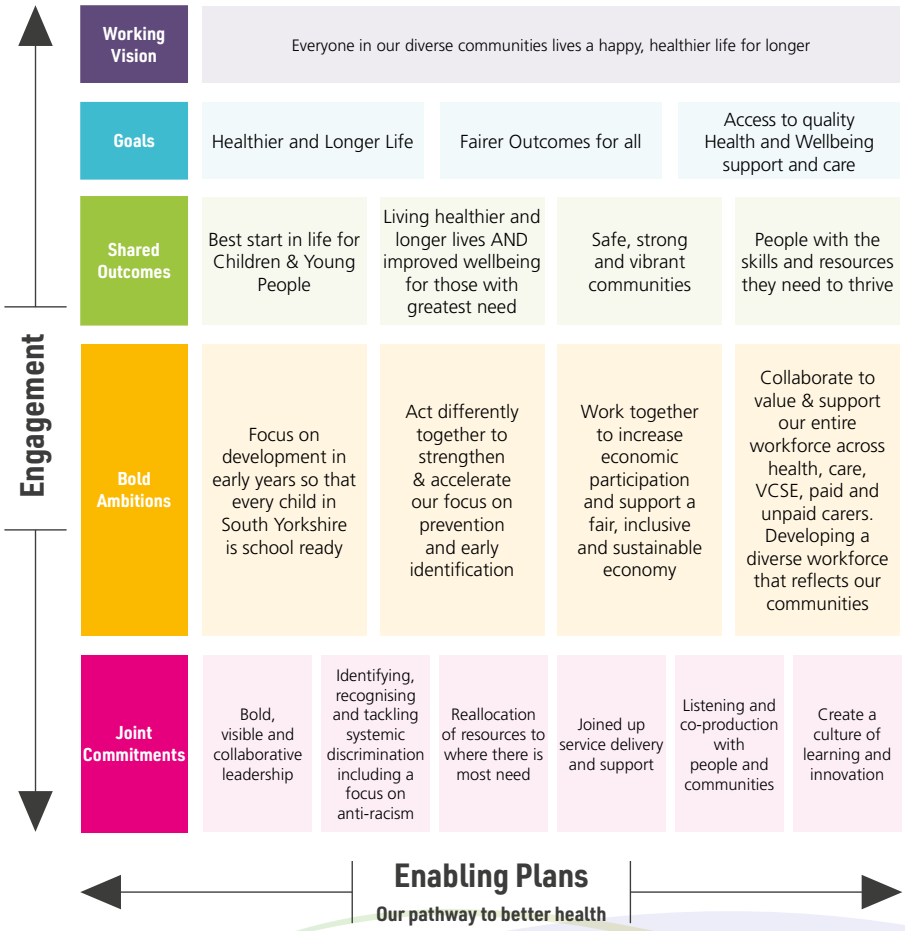
We want to see the people in all our communities, live healthier and longer lives, have fairer outcomes and timely, equitable access to quality health and care services and support. Our success here will ultimately be determined by improvements in Healthy Life Expectancy (HLE), narrowing the gap in HLE between the most and least deprived groups, eliminating inequalities in access and experience, and unwarranted variation.

Our vision and goals are supported by four shared outcomes that are reflected in all of our Health and Wellbeing Strategies and support the life stages of starting well, living well and ageing well.

Our intention is not to duplicate but to focus on a small set of bold ambitions where partners have agreed to align their collective power and influence to enable delivery at pace and scale.

To enable successful delivery we know we need to work with people and communities and our Voluntary Community and Social Enterprise sector as equal partners and strengthen our collaboration as partners. The delivery of our shared outcomes and bold ambitions will require collaborative effort to address the wider determinants of health, including the places people live and work, their housing and employment.

In our strategy we describe a series of joint commitments we are making to enable new ways of working to support delivery. We have also designed an Outcomes Framework to underpin our Integrated Care Strategy and monitor delivery.



Bold Ambitions

Our strategy to better health, recognises the work already ongoing and set out in strategies and plans for each of our Places across South Yorkshire.

The bold ambitions that we have collectively agreed to focus on are set out below. They are referred to throughout this plan where we have indicated areas of action that will support their delivery.

Working together to take forward our bold ambitions we have:

- Established a Working Group to support our Integrated Care Partnership
- Identified System Leads for each of our Bold Ambitions
- Plans to work with partners to hold a series of workshops to bring in new perspectives including lived experience and challenge ourselves. Through this, consider our joint commitments and establish a think, do and act approach
- Maximise opportunities afforded by the Bloomberg Harvard City Leadership Programme and the Health Equity and Advisory Panel chaired by Professor Alan Walker

1	**Focus on development in early years so that every child in South Yorkshire is school ready**
	Raise the level of school readiness in South Yorkshire and close the gap in those achieving a good level of development between those on free school meals and all children by 25% by 2028/30
2	**Act differently together to strengthen and accelerate our focus on prevention and early identification**
	With a focus on the four main modifiable risk factors of smoking, healthy weight, alcohol and hypertension and early identification and management of the main causes of premature mortality in South Yorkshire. Specifically acting together to strengthen our focus on reducing smoking to reduce the levels to 5% by 2030
3	**Work together to increase economic participation and support a fair, inclusive and sustainable economy**
	Reduce the economic inactivity rate in South Yorkshire to less than 20% across our Places by 2028/30
	Reduce the gap in the employment rates of those with a physical or mental health long term condition (as well as those with a learning disability) and the overall employment rate by 25% by 2028/30
	Enable all our young people that are care leavers to be offered the opportunity of good work within health and care by 2024
	Establish a South Yorkshire Citizens' Assembly for climate change and accelerate progress towards environmental statutory emissions and environmental targets
4	**Collaborate to value and support our entire workforce across health, care, VCSE and paid and unpaid carers. Developing a diverse workforce that reflects our communities**
	Develop a Workforce Strategy that will enable us to collaborate across South Yorkshire to educate, develop and support our entire workforce
	For our statutory partners to accelerate progress towards a workforce that is diverse and representative of all our communities
	Contribute to South Yorkshire becoming an anti-racist and inclusive health and care system through everything we do and how we do it with our communities. Committing to real actions that will eradicate racism

3 What did our Joint Strategic Needs Assessment tell us?

We have updated our review of the health needs of South Yorkshire for 2024. The findings from that review, alongside the findings from our engagement work, informed our Integrated Care Strategy and this Joint Forward Plan. The full needs assessment can be found here.

The key findings that have influenced this plan are:

Key Health Outcomes

People of South Yorkshire are living shorter lives than they should. People living in our most deprived areas have both shorter lives and are living those years in poorer health.

Male life expectancy is 77.9 years (England 79.4 years)
Female life expectancy is 81.6 years (England 83.1 years)

Gap in life expectancy between most and least deprived areas in South Yorkshire is for males 8.7 years, for females 7.6 years

Number of years lived in good health is 59.5 years for males and 60.2 years for females (a gap of 3.6 years compared to England)

Males and females living in the most deprived parts of South Yorkshire will live on average 19 years more in poor health compared to those in the least deprived

Our population

Our health as individuals and at population level are determined by a range of factors such as the environment in which we live, the opportunities we have and the health care we receive. To improve the health of our population we need to work collaboratively with all partners across South Yorkshire. We need to pay particular attention to the health outcomes experienced by certain population groups, such as those who live in the most deprived areas or are from ethnic minority populations as these are most at risk of experiencing inequalities in health.

37% of our residents live in the most deprived areas.

23% of our children live in families experiencing relative poverty.

17% of our population are from an ethnic minority group.

Mortality

The biggest underlying causes of deaths in South Yorkshire were heart disease, COVID-19, dementia, lung cancer, stroke and lower respiratory disease.

These conditions account for nearly 50% of all deaths in South Yorkshire.

Morbidity

The biggest causes of living in poor health were attributable to musculoskeletal disease, mental disorders (including depression and anxiety), CVD and diabetes and neurological conditions.

These conditions alone accounted for over 45% of years lived with a disability or ill health.

Prevention

Many of the risk factors associated with our main diseases can be changed through preventative and proactive care and support. Given that 13% of the South Yorkshire population smoke, 30% don't have their blood pressure controlled to target and 67% of residents are overweight or obese, we can have impact on these early deaths by focusing on our role in prevention.

20% of all deaths are attributable to tobacco.
14% to high blood pressure.
13% due to poor diet.

Early detection

Improving early detection and providing a diagnosis for our patients is key to ensuring everyone gets the right treatment at the right time.

We have opportunities to work with primary care to improve the diagnoses rates in populations with dementia, hypertension and cancer.

Those with serious mental illness and those with learning disabilities are more likely to have physical ill health and so early detection and prevention of these conditions through health check programmes are key.

In order to improve early detection and diagnosis as well as supporting people to manage their health, we will improve access to primary care.

Dementia diagnosis rate is 72%, cancer early stage diagnosis is 51% (target is 75%), hypertension diagnosis rate is 68% (target is 80% by 2048).

People with severe mental illness die 15 to 20 years younger than the general population.

Women with a learning disability die on average 18 years younger and men 14 years younger.

In 2019 we offered over 8.2million GP appointments, in the most recent year that has increased by nearly 1million.

Multi-morbidity

We are beginning to see an increase in the prevalence of multi-morbidity (i.e. having more than one long term condition) and an earlier onset, especially in the most deprived parts of South Yorkshire where the onset of multi-morbidity could be as much as 15 years earlier. Currently around a third of our residents have one or more long term conditions. For most long term conditions that require hospitalisation, you can expect a significant proportion of those to develop a secondary condition.

Percentage of patients (by disease) who have an additional long-term condition:

Cancer 70%; CVD or CHD 92%; COPD 92%; Serious Mental Illness; Learning Disability 70%; Dementia 90%

Impact of COVID-19

The pandemic had a significant impact on our elective admission rates as well as our waiting times for interventions.

We also observed that there was an increase in the referrals to children's mental health services.

For South Yorkshire trusts in March 2023, there were 1,522 people waiting more than 65 days for treatment.

17% of our children aged 6 to 23 have a probable mental disorder.

Inequalities

The wider determinants of health are a driver for healthcare service demand and there is an association where those in the most deprived areas have higher emergency admission rates, however, this pattern is reversed when looking at elective care provision, where those in the least deprived areas have higher access to elective care compared to the most deprived areas.

Very poor health and lower average age of death is also often experienced by people who have become socially excluded as a result of multiple adverse events such as homelessness, addiction, racism, violence, crime and complex trauma (sometimes referred to as inclusion groups).

Poor access to health and care services and negative experiences can also be commonplace for these groups due to multiple barriers, often related to the way healthcare services are delivered.

Supporting mothers in their maternity care is fundamental to giving every child the best start in life. National data tells us that maternal mortality is four times higher for black women than white, we have approximately 2,300 births to mothers that are from black and minority ethnic populations in South Yorkshire. The stillbirth rate in children born to mothers in the most deprived area is significantly higher than mothers in the least deprived areas.

Emergency admission rates for those in most deprived areas is 13,500 per 100,000 population, for least deprived it's 9,800 per 100,000 population.

Elective admission rates for most deprived is 14,900 per 100,000 population and for least deprived it's 17,400 per 100,000 population.

Mortality in the homeless, prisoners, sex workers and those with substance use disorders is nearly eight times higher for men and 12 times higher for women compared to the general population.

Women's health

Women in South Yorkshire live longer than their male counterparts but do spend a higher proportion of their lives in poor health compared to men.

Menopause (and perimenopause) affects all women and usually occurs between the ages of 45 and 55, that's around 7% of the total population of South Yorkshire. Menopause can have a high impact on a women's health, work and relationships.

A recent study of children's mental health demonstrated that girls are more likely to develop a mental health disorder by age of 11.
On average, women with severe mental health conditions die 15 years earlier than the general population.

Women are more likely to experience repeated and severe forms of abuse, domestic abuse and sexual violence, which results in injury and death as well as harms regarding the psychological impact.

Proportion of lives that are spent in poor health is 26% for women, 23% for men.

South Yorkshire has a crude rate of 68 admissions per 100,000 adult women.

20% of girls have a probable mental health disorder (15% boys). This proportion increases to 23.5% by the age of 17 to 23, whereas for boys it decreases to 10.7%.

There were over 39,000 domestic abuse related incidents and crimes (a rate of 28 per 1,000 population) which higher than England (25 per 1,000).

Men's health

Men in South Yorkshire die around 3.7 years earlier than women. Men are twice as likely to die from preventable causes of death such as CVD, respiratory and liver disease. Men are also three to four times more likely to die by taking their own life.

Men are more likely to experience risks to health such as higher levels of smoking, alcohol consumption and gambling. Men are four times more likely to be admitted to hospital due to violence compared to women.

Men are also less likely to access treatments such as NHS Talking Therapies, bowel screening, or GP health checks.

Rate of mortality in under 75s from causes considered preventable is 280 per 100,000 in males (150 per 100,000 in women).

95 admissions per 100,000 for males in South Yorkshire due to violence.

The rate of male suicide ranges from 15 per 100,000 in Sheffield to 24 per 100,000 in Barnsley (5 to 9 per 100,000 for females)

End of life

Recent research has found that most people would prefer not to die in hospital but at home, in their care home or hospice. The COVID-19 pandemic had a profound impact on where people died and the support they received. Since the pandemic we have seen a sustained increase in the number of people dying at home. Although increase is less for those aged 75 years or older. National data tells us:

- That nearly three quarters of all people who died, spent time in hospital during the 6 months before they died. Almost half of all the inpatient care provided by hospitals for people aged 85 or older, is for people in their last year of life.
- People who died of cancer were more likely to die at home, people who died of dementia were most likely to die in a care home and people who died from respiratory disease were most likely to die in hospital.

In South Yorkshire 28% of deaths now occur at home compared to 22% in 2013. 46% of deaths occur in hospital, a reduction of 5% since 2013.

20% of residents in South Yorkshire report they have a caring responsibility for those with old age or long term health condition/disability.

8% of deaths had three or more emergency admissions in the last 90 days of life.

Alongside reviewing our population health needs our strategic baseline assessment also helped us to understand our current position across South Yorkshire including:

Delivery Focus

An overview of what health and care services and support we are delivering and where, in our places and through our provider collaboratives and alliances.

Integrated Performance

A closer look into the key aspects of performance, as highlighted through the System Oversight Framework, including, quality, experience, people, operational performance and finance. This includes understanding our waiting times, how people experience our services and our local position in relation to the national objectives in the NHS England Planning Guidance.

Enabling Strategies

An understanding of our enabling strategies, where we have developed a joined-up approach for specific areas, including digital, environmental sustainability and working with people and communities.

Strategic Context

An overview of our journey to date across South Yorkshire. How we are working together in partnership and collaboration to deliver integrated care and joined up services to improve health and healthcare outcomes for people and communities.

Looking ahead

Setting out key considerations for the development of this Joint Forward Plan.

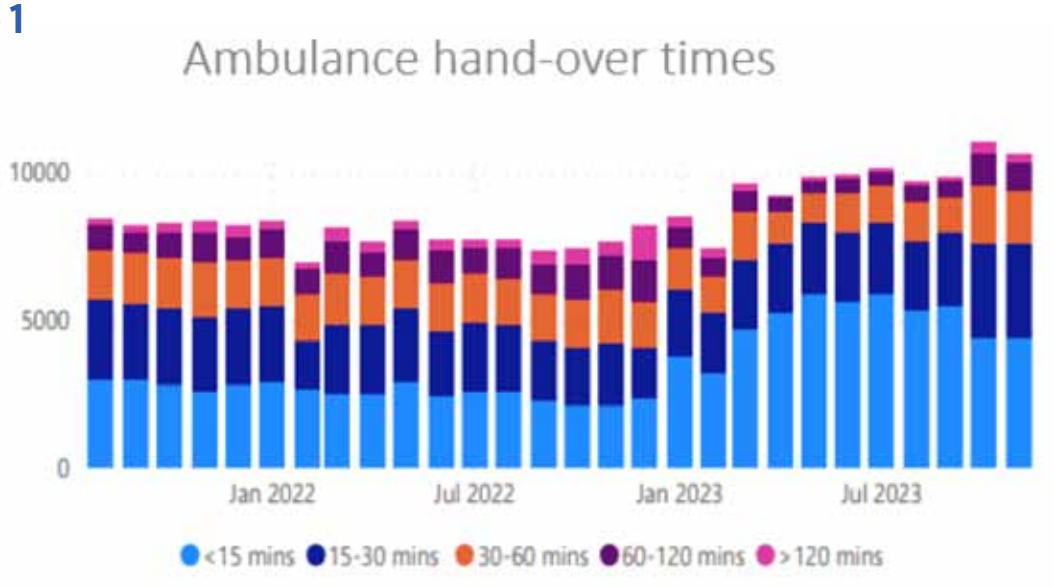
Through our baseline assessment and operational planning for 2023/24 a number of key areas of challenge were identified for South Yorkshire and these challenges continue into 2024/25. These align well with the areas people have told us really matter to them including access to and quality of care and support.

Our challenges in meeting the NHS planning objectives:

On submission of our plans against the NHS planning objectives several challenges were identified that impact on our population's health, our delivery plans as well as our financial position. Four key challenges that continue into 2024/25 are outlined below.

Challenge 1

A&E delays



As demand for A&E services increases, improvements to ambulance response times requires a multi-system response with significant transformation across all elements of the urgent and emergency care pathway including reducing the time it takes to handover a patient at A&E.

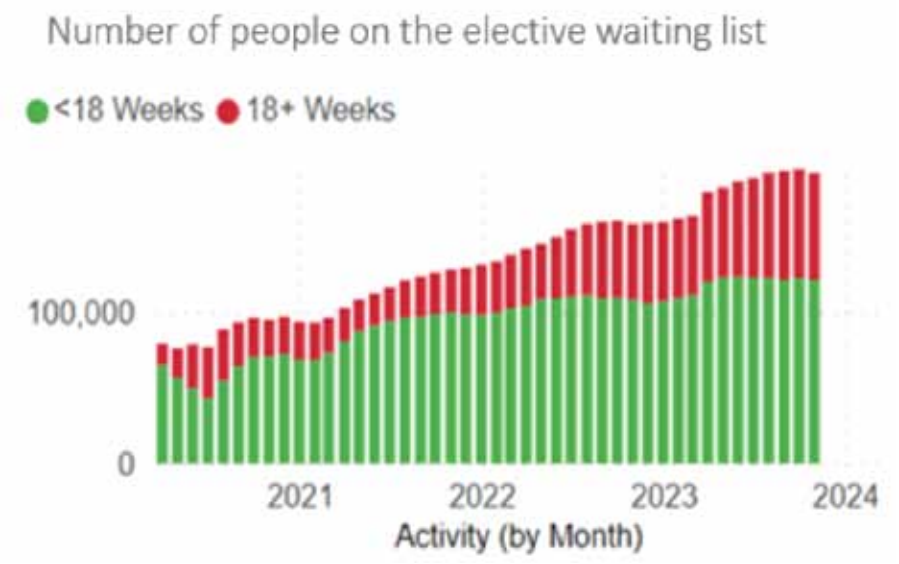
Currently 28% of handovers take more than 30mins which is impacting our overall category 2 response times.

Other commitments in 2023/24 to improve urgent care included:

- Increase the number of patients that can be managed by virtual wards
- Increase the number of urgent community contacts
- Reduce percentage of beds occupied by adult patients who are fit for discharge

Challenge 2

Waiting time pressures



Elective care recovery continues to be a challenge given the impact of the pandemic, continued industrial action and the need to prioritise urgent/unplanned care. The number of people waiting for elective care has more than doubled since the start of the pandemic which has had a knock on effect of increasing the number of people waiting more than 18 weeks. The acute NHS hospital trusts are working collaboratively to reduce elective and diagnostic waiting times including the delivery of additional capacity at elective orthopaedic hubs and community diagnostic centres, by utilising Model Health System data and applying GIRFT principles and pathways.

Following our improvement work we do not expect any patients to be waiting over 78 weeks by 31 March 2024. Regrettably, continued industrial action is likely to disrupt our plan to meet the national ambition of zero people waiting more than 65 weeks within the same timeframe. We will continue to work towards zero people waiting more than 65 weeks in 2024.

Challenge 3

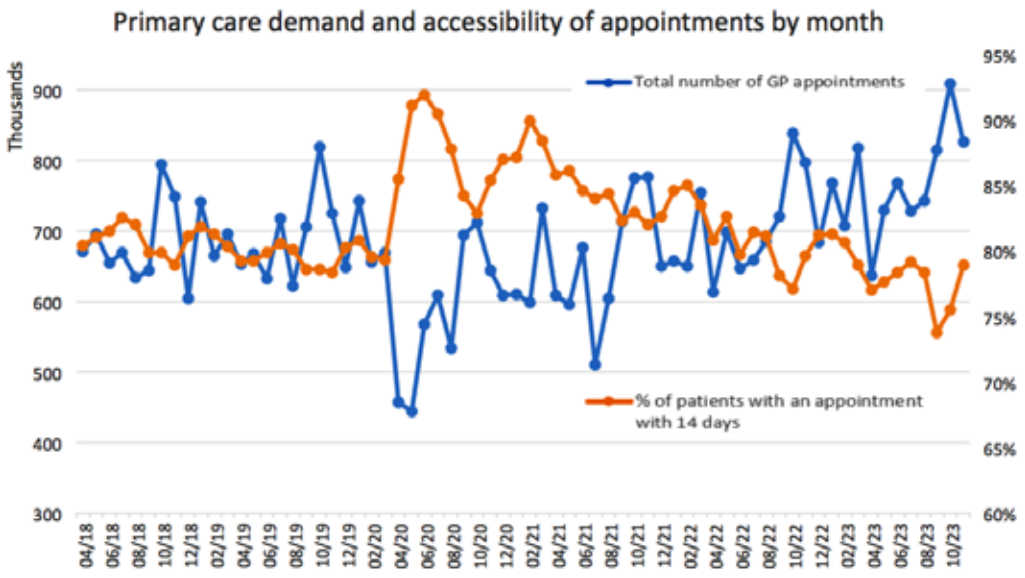
Mental health out of area placements

Reducing the number of mental health patients who are admitted to services out of their local area (inappropriate out of area placements) remains a challenge. Difficulties remain in discharging people who are clinically ready for discharge; this has a significant impact upon flow with inpatient units running at times with 100% occupancy. The impact on flow also results in people waiting for beds, which can result in higher acuity and perpetuating the current pressures.

All partners across the ICB remain committed to reducing inappropriate out of area placements. All providers continue with quarterly multi agency admission and discharge events (MADE) bringing together the inpatient, community teams, local authority, housing providers and ICB teams to review all patients on the ward. This helps to maintain focus on admissions avoidance and strengthens gatekeeping processes to keep people as close to home as possible. Collective work across the ICB and the Mental Health, Learning Disability and Autism Provider Collaborative is planned to further manage this risk.

Challenge 4

Increasing demand for primary care



There is increasing demand and pressure on primary care which is in turn impacting on patient's timely access to services. Non-urgent needs, but which require a telephone or face-to-face appointment in General Practice, should be scheduled within 14 days. However, as the number of GP appointments has increased it has impacted on the numbers that get their appointment within 14 days.

In the last five years we have seen an increase of GP appointments by over 20% and are on track to deliver a further one million more appointments. With the introduction of the Pharmacy First scheme we expect this to also free up more appointments.

4 Listening to our South Yorkshire communities and what matters to them

Building on the engagement to inform our initial Integrated Care Strategy, we made a commitment to ongoing engagement and to help inform our Joint Forward Plan we used what we had heard from our previous engagement alongside continuing the What Matters to You conversation. We also revisited a number of the communities to continue our conversations as part of the 2024/25 refresh of the Joint Forward Plan.

To ensure we heard from a more diverse breadth of our South Yorkshire communities we commissioned Healthwatch Barnsley, Healthwatch Doncaster and Healthwatch Sheffield and Voluntary Action Rotherham to work with our underserved communities, with a focus on the most deprived communities in South Yorkshire (all of which are in the 20% most deprived nationally) as well as other groups from our communities who are known to suffer worse outcomes. It was these communities with whom we had follow up conversations in 2024/25.

As well as this targeted approach we also created a survey for the general population and also commissioned a street survey of people across South Yorkshire who are demographically reflective of the South Yorkshire population. A question was included about whether people had responded to our 'What matters to you' campaign in November 2022 so that we were able to tell who was a new respondent and who was adding detail to their previously submitted response.

Citizen participation in the original JFP involvement exercise	Total number of responses / participants
Public feedback survey (completed online)	**120**
Public feedback survey (competed face-to face)	**1,011**
Staff feedback survey	**730**
Participation in third sector led focus groups / community conversations	**653**
Organisational submission	**1**
TOTAL	**2,518**

The voices heard in the responses received represented many of our underserved communities including:

- Asian women
- Children and young people
- Children leaving care
- Chinese community
- Deaf community
- Digitally excluded
- Domestic abuse champions
- LGBTQ+
- Low-income families
- Mental health support users
- Muslim women
- Older people
- People facing multiple disadvantage
- People living in areas of multiple deprivation
- People needing dementia support
- People seeking asylum in dispersed accommodation
- People seeking asylum in hotel accommodation
- People with lung conditions
- People with visual impairment
- Polish community
- Roma women
- Social housing tenants
- Trans community
- Victims of human trafficking
- West Indian community
- Young people facing substance abuse challenges

A company was employed to independently analyse the findings of our engagement. There are some common themes that are often mentioned among all audiences and which are referenced among all aspects of the insight sought, namely: what's important to people about their health; what barriers exist to accessing services and how quality of care can be improved. These are summarised as follows:

- **Accessibility**

  Being able to access care services in a timely and convenient way was the most commonly mentioned concern because it affects the quality of a patient's experience. This was felt particularly strongly in terms of demand for accessing GP services. Removing barriers to accessing information, support and services were mentioned by all.

- **Affordability**

  The costs of transport, parking, medication, treatments, as well as being able to live more healthily, were also mentioned universally. The cost of living challenge provides the context to these responses.

- **Agency**

  Many people want to be in control of their own care and want better access to the information, tools and capacity to manage this.

Throughout the Joint Forward Plan we have endeavoured to illustrate where our planned actions will address these issues identified by our citizens and communities. There are some elements, particularly related to aspects of affordability such as the cost of public transport, where the NHS does not have direct control and so explicit actions are not identified in this plan, but there is a strong commitment to working with partners and ensuring patients and families are aware of the travel reimbursement schemes in place. The full involvement report can be found **here**.

This final draft of our Plan takes into account the feedback we received on our engagement draft. To inform the development and delivery of more detailed implementation plans we are committed to ongoing involvement, as described in our **Start with People Citizen Involvement Strategy**.

Revisiting a number of the communities to continue our conversations as part of the 2024/25 refresh of the Joint Forward Plan.

To ensure we hadn't missed anything and as part of our commitment to ongoing dialogue with citizens, particularly our underserved and most vulnerable communities, in our refresh of the Joint Forward Plan we commissioned the four Healthwatches in South Yorkshire to revisit the conversation about 'What matters to you' with these communities. The Healthwatch organisations heard from over 800 people. The full report can be read **here** but a summary of what was said includes:

What matters to you about your health and wellbeing? Has this changed from the answer you gave us last year?

Access to Healthcare Services

A significant number of comments reflected on access to health services, and many expressed concerns about the difficulty in accessing healthcare services, particularly in terms of getting timely appointments with GPs and specialists. Issues such as long waiting times, limited availability of appointments, and challenges with communication (e.g., language barriers, difficulty in getting through on the phone) are highlighted.

Social Support and Community Engagement

A sense of belonging and social connection is valued by many respondents. They appreciate community groups, social clubs, and activities that provide opportunities for interaction, friendship, and support. Participants also emphasize the importance of family relationships and spending quality time with loved ones - family or friends, dogs or other pets.

Physical Health and Lifestyle

Many people talked about the importance of physical health in some way, referring to walking, exercise or gyms, healthy eating, and maintaining a healthy weight. Many stated how important it was to get outside, into green spaces, and to take part in recreational activities, and exercise facilities are viewed as essential for promoting physical well-being.

Mental Health Support

Mental health is recognized as a crucial aspect of overall well-being by several respondents. They emphasise the importance of accessible and effective mental health support services, including counselling, therapy, and peer support groups. A number of people also mentioned the importance of having someone to talk to.

Accessibility and Inclusivity

Accessibility issues, such as the availability of wheelchair-friendly facilities and public transportation are raised by some respondents, highlighting the importance of inclusivity and accommodation for individuals with disabilities or mobility limitations.

Communication and Trust in Healthcare

There are concerns about the quality of communication between patients and healthcare providers, as well as issues related to trust and confidence in healthcare services. Some respondents express frustration with the lack of clear communication, broken promises, and a perceived lack of empathy or understanding from healthcare professionals. Several also cited how important it is to access trusted information on health issues and services.

Community Engagement and Empowerment

Several respondents emphasise the importance of community empowerment and involvement in decision-making processes related to healthcare and social support services. They advocate for more inclusive and person-centred approaches that prioritise individual needs and preferences.

When asked specifically about areas we added to the refreshed Joint Forward Plan – Women's health and End of life care, citizens expressed support that these areas be included, and shared thoughts and comments, please see full report **here**.

Within the JFP we have responded to the recurrent themes throughout particularly the need to improve access to healthcare services with our immediate focus on recovery and reducing waiting times across primary, community and hospital services. In our latest JFP refresh we have made a number of specific updates to reflect what we heard from our citizens including:

- On page 56 and 57 we continue to reaffirm the importance of accessible and effective mental health services and support
- Citizens referenced the fact that persistent pain wasn't specifically mentioned in the JFP, reference to this can now be seen on page 38
- Responding to the National Women's Health Strategy and our plans to develop women's health hubs to provide integrated services in convenient locations and offer more support for women going through the menopause can now be seen on page 32
- More detail on our plans to improve end of life care can be found on page 46

5 How are we organised in South Yorkshire?

All the organisations operating in South Yorkshire are largely responsible for the commissioning and provision of NHS services to meet the physical and mental health needs of our population.

Where we work

1.4 MILLION PEOPLE
(including 445,000 children and young people)

72k+ members of staff

186 General Practices

160 Opticians

333 Community Pharmacies

183 Dental Surgeries

36 Neighbourhoods

1 Ambulance Trust

4 Local Authorities

6,000+ Voluntary, Community and Social Enterprise Sector Organisations

5 Acute Hospital NHS Trusts

4 PLACES
(each with a Health and Care Place Partnership)

System Collaboratives and Alliances *(see below)*

1 Integrated Care Partnership

1 Integrated Care Board

£3.9 billion health and social care spend

3 Community Mental Health and Community Trusts

Collaborative arrangements with academic partners, including the University of Sheffield, Sheffield Hallam University and the Academic Health Science Network

South Yorkshire has a strong track record of delivery and a long history of collaboration

In South Yorkshire we have strong organisations delivering health and care services and support. This provides a robust foundation to integrate health and care. We have already started to break down organisational barriers so that we can wrap personalised care and support around people and their families to improve outcomes. We are committed to learning from each other and what has worked well in the past and building on this together.

Place partnerships are already well established in each of our Places (Barnsley, Doncaster, Rotherham and Sheffield), bringing together health, local authority, our diverse voluntary community and social enterprise (VCSE) sector and wider partners. Acute and mental health providers are also continuing to foster collaboration through our developing and maturing provider collaboratives. Together we are increasingly collaborating as a whole system.

System Development

In South Yorkshire we are embracing the opportunity to further develop as an Integrated Care System. Our journey commenced in 2016 when we established our first Sustainability and Transformation Partnership and thereafter we became one of the first non-statutory Integrated Care Systems in England in 2018.

Following the Health and Care Act 2022 through which Integrated Care Systems and Integrated Care Boards became statutory, we have harnessed the opportunity to work with local communities and bring together our Local Authorities, NHS organisations, Mayoral Combined Authority and VCSE to take collective responsibility for planning services, improving health and wellbeing and reducing health inequalities.

We are committed to onward system development and maturing our ways of working to create an enabling culture that fosters collaboration. To enable this developing system leadership, including clinical, care and professional leaders and organisational development capability have been identified as areas to enhance in the early years of our plan. Delivery of our plan will be challenging and require continued system development to be successful.

As an Integrated Care System we are committed to our four core purposes:

1. Improving outcomes in population health and health care
2. Tackling inequalities in outcomes, experience and access
3. Enhancing productivity and value for money
4. Helping the NHS to support broader social and economic development

We are comprised of two key components

An Integrated Care Partnership

A statutory committee jointly convened by Local Government and the Integrated Care Board, to bring together the NHS with Local Authorities, Combined Authorities, the VCSE and wider partners.

In South Yorkshire

Our membership is drawn from our Health and Wellbeing Boards and NHS South Yorkshire. Oliver Coppard, Mayor of South Yorkshire Combined Mayoral Authority, became Chair of the ICP in September 2022 and Pearse Butler the Chair of NHS South Yorkshire is the ICP Vice Chair.

Integrated Care Board (ICB)

An NHS organisation responsible for planning, commissioning and funding NHS services, that fulfils a fundamental role to support and convene the system.

In South Yorkshire

NHS South Yorkshire was established in July 2022 with Partner Board Members, including Healthwatch, Mental Health and the Voluntary Care Sector representation.

There is a clear ambition set out in the legislation for Integrated Care Systems and Integrated Care Partnerships to deepen the integration between health and social care through greater collaboration. During the life of this Joint Forward Plan NHS South Yorkshire will need to develop and evolve and work with partners to meet this ambition. ICBs are relatively new organisations and as such they have an opportunity to do things differently and the flexibility to work out how best to dispatch their duties.

5.1

Our Places, Provider Collaboratives and Alliances

In South Yorkshire we continue to build on our collaborative working arrangements in each of our Places, and through our Provider Collaboratives and Alliances.

A key priority for the development of the South Yorkshire Integrated Care System is maturing ways of working across the system, including Place-based partnership arrangements, provider collaboratives and alliances. It is through these arrangements that we have organised ourselves to share responsibilities to deliver this NHS Joint Forward Plan. Delivery will require us to work differently together, to reduce duplication and realise the benefits of collaboration where we work across places, provider collaboratives and alliances.

For example, our work to improve access and reduce waiting times for elective and diagnostic pathways will be taken forward by our Acute Federation (Provider Collaborative), working with our Primary Care Alliance and our Place partnership arrangements. This will enable us to take a preventative, whole pathway approach considering early interventions and the pre-referral phase with wider primary care and VCSE partners and support people in the community whilst waiting. It will also help exploit the benefits of our hospitals working together to maximise the use of their collective capacity to minimise waits for patients, facilitate delivery of best practice care pathways and reduce unwarranted variation in health care.

In each of our communities of Barnsley, Doncaster, Rotherham and Sheffield we have well established Place-based health and care partnerships already working well together to provide joined up integrated health and social care, support and services.

Our places are all characterised by their strength based approaches to:

- Listening to, engaging with and involving communities to better understand their needs and facilitate co-design to create community owned solutions
- Integrating health, care and VSCE services and support, through the continued development of integrated neighbourhood teams to address both physical and mental health needs
- Focusing on those with the greatest needs to tackle health inequalities including those in health inclusion groups

You can read the individual Place Plans for **Barnsley**; for **Doncaster**; for **Rotherham** and for **Sheffield**.

Barnsley

Sheffield

Doncaster

Rotherham

South Yorkshire Mental Health Learning Disability and Autism Provider Collaborative

"A partnership driven by a commitment to improve outcomes and experience of mental health, learning disabilities and autism services for the population in South Yorkshire."

The partners to the Collaborative are:

- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust

Working with others in our Health and Care System

We aim to achieve the following strategic objectives:

- **Better access**
  Promoting inclusivity and creating services which improve access and quality of care to all members of our community.
- **Address health inequity**
  Working with communities to provide services where they are needed most and building on strengths to support people to live well.
- **Drive quality**
  Collaborating across the health cand care system to deliver improved patient care, enhancing resilience, and sharing evidence based best practice and innovation.
- **Develop workforce**
  Collectively supporting and developing our people by working together to strengthen wellbeing, knowledge, skills and workforce planning.
- **Value for money**
  Working together to deliver better value for money by being efficient and innovative.

To achieve this, we seek to implement models that promote prevention and recovery and key strategic principles that underpin any change are that it must be:

• Evidence led • Person centred and strengths based • Trauma informed • Outcomes focused

Communication, Involvement and Co-production

We work in partnership with people with lived experience, our workforce, other South Yorkshire Alliance and Collaboratives, ICB partners, local authorities, VCSE, Yorkshire Ambulance Service, Education, South Yorkshire Police and many more.

We have dedicated support to help to develop our co-production approach and are working with our member trust Involvement Leads, place based Mental Health Alliances, VSCE colleagues and people with lived experience – building on the excellent work that has already happened on co-production in MHLDA.

Specialised Commissioning Hub

The SYB specialised provider collaborative footprint covers Barnsley, Sheffield, Doncaster, Rotherham and Bassetlaw. There are three SYB NHS-led provider collaboratives, each hosted by a different NHS provider: child and adolescent mental health services (CAMHS) and adult eating disorders (AED), that both launched in October 2021 and Horizon, the SYB provider collaborative for adult secure care, that went live in 2022.

In SYB the specialised collaboratives are supported by a SYB Mental Health Provider Collaborative Specialised Commissioning Hub. The hub supports the three organisations that take on lead provider roles.

Enablers

- Co-production culture
- Workforce joint approaches
- Addressing health inequalities
- Digital, data and insights

Our Vision for the Future

As an important part of the South Yorkshire system, we aim to **improve population health and healthcare, tackle health inequalities, add social and economic value, and enhance productivity and value for money**. With this in mind we worked with partners to identify where we could add value by doing things once at system level across our providers and places. We recognise primacy of place, and our approach is to respect this whilst addressing unwarranted variation, working alongside the ICB teams for Mental Health Long Term Plan and Learning Disability & Autism Plan delivery. With partners we agreed that we would focus on the following areas of opportunity.
We are in the early stages of developing our programme, but a summary is provided below.

Programme Priorities

- Neurodiversity assessment and support for Adults and Children & Young People.
- Collectively implement a South Yorkshire (SY) MHLDA Provider Collaborative approach to a high quality and consistent standard of care across SY in relation to Stopping Over Medication of People with a Learning Disability, autism or both with psychotropic medicines (STOMP) and implementing the STOMP healthcare pledge.
- Urgent & Emergency care - health based place of safety.
- Reduce the number of people (of all ages) in placements for mental health care outside South Yorkshire.
- Address the increase in referrals for AED (and impact of increases seen in covid) and co-design pathways to provide the least restrictive effective options.

How we work together

- We will collectively use our resources and expertise to improve experience and outcomes for all
- We will co-produce with people
- We will always demonstrate mutual respect trust open transparent communication and will act with integrity
- We will share responsibility, accountability, risk and reward
- We will be clinically driven and ensure services are locally owned
- We will reduce health inequalities and deliver inclusive care and support
- We will collectively support and develop our people

Acute Hospital Provider Collaborative

no mention of health inequality

(Including acute, elective and diagnostics, children's and specialist services)

This Clinical Strategy sets out the clinical services frame work for the Acute Provider Federation in its role to support acute service development and delivery.

It is a framework which supports clinical teams to collaborate to provide the safest, highest quality, and most effective care. It aligns with and supports the wider work of the Integrated Care Board 5 year Joint Forward Plan and the South Yorkshire Integrated Care Partnership Strategy.

The full strategy document can be found here

Our purpose:

Quality care	Health equality	Happy staff	Great partner	Waiting times	Effective spending
Working together to drive the quality of care to be amongst the best in the country	Taking a proactive approach to reduce health inequalities for the populations we serve	Collaboratively developing our colleagues and teams so that there are happy staff across all partners	Being a great partner to the rest of the health and care system in South Yorkshire and Bassetlaw	Supporting each other to achieve all the NHS waiting time standards for local people	Seeking innovative ways to more effectively use the NHS pound so there is enough resource for the whole system

The five-year vision

Services at different hospitals across South Yorkshire play complementary roles as part of a **collaborative model**	Shared care to be developed further across primary and secondary care including Mental Health services	Life stages recognised as an important framework for end to end pathways, to support more proactive planning and working
Patients experience high standards of care, no matter which hospital they attend; with constant energy on driving down unwarranted variation	Standardisation for **better outcomes and patient experience**, and taking action on health inequalities	Patients can move seamlessly from one hospital to another in order to access specialist care or faster treatment

A networked workforce build the system for developing opportunities for clinicians to gain experience/support patient services across South Yorkshire

Resilience and sustainability priority criteria for the system future models of care incorporating new ways of working

Greater interoperability across the organisations so that our staff can seamlessly access and share electronic patient information and records

Best use of our **collective** estate to offer choice, access and state of the art facilities

Models of care that optimise new technologies, innovative ways of working and environmental sustainability, learn from new research evidence and change how, where and when we deliver services

Examples of collaborative working

- South Yorkshire and Bassetlaw Cancer Alliance: There are many examples of joint work ing and redesigned services/pathways across cancer sites that are system-wide, from prevention and screening, inpatient pathways for specialist and non-specialist cancers, through to palliative and End of Life care.
- The Children and Young People's Alliancehas supporting networks that focus on the acutely ill child, surgery and anaesthetics and wider collaborative working.
- South Yorkshire Integrated Stroke Delivery Network has evolved with successes in shared clinical pathways/protocols, involvement and support to patients and their families workforce capacity support, developments in video triage, use of Artificial Intelligence and work on health inequalities.
- The South Yorkshire Pathology Network has achieved the national vision to consolidate and optimise local workforce, capacity and support a future model for networked delivery.
- SY ICB Networks for respiratory, cardiology and dermatology have worked together to optimise end to end pathways from primary prevention to tertiary care.
- We have established the Acute Paediatric Innovator Programme which aims to ensure children and young people recieve right care closer to home through Virtual Ward, long waits are to be eliminated for children and young people awaiting ear, nose and throat and secondary paediatric dental services and young people with chronic conditions requiring hospital care will be offered developmentally appropriate healthcare.

Strategic objectives

Maximising digital transformation and partnership approaches to innovation

- Look for new ways of delivering care, further use of research and technology to future–proof changes in care delivery including new diagnostics treatments, drugs and Artificial Intelligence
- Find ways to collaborate and help unlock barriers to collaboration, e.g. IT access, clinical information sharing, funding mechanisms
- Develop further partnerships with academic institutions industry and delivery partners to further research and innovation
- In designing new service models we will look to support the best use of our collective estate to offer choice, access and state of the art facilities

Delivering more coordinated care through maximising the opportunities for our collective workforce

- Through the clinical working groups proactively share opportunities to work collaboratively
- Ensure that clinical leadership development is part of the Acute Federation Organisational Development programme
- Develop system-wide training and education plans to support future models of care
- Support the standardisation of new roles
- Develop and share the learning and insight from collaborative pathways to encourage best practice and continued relationship building
- Develop further the relationships with academic institutions to support future workforce models
- Work together to maximise the retention of trainees offering a wide range of placements, job plans and career progression

Enabling clinically-led standardisation of best practice acute care across South Yorkshire and Bassetlaw

- Create the evidence base, criteria and clinical discussion on areas for collaborative concern and opportunity for development
- Bring together expert and wide clinical knowledge to support service improvement and develop future models of care
- Support the infrastructure to develop further patient and public involvement
- Enable the spread of best practice and provide benchmarks for services
- Develop models that provide clarity on services provided at Place and at wider scale across South Yorkshire and Bassetlaw

Still includes Bassetlaw?

Alliances: Alliance arrangements have also been developed where partners across whole pathway or sectors come together to integrate and improve services and outcomes. These include:

Primary Care Alliance

(including general practice, pharmacists, dentists and optometrists)
The Primary Care Provider Alliance membership is drawn from all four primary care provider groups and creates a vehicle for planning and leading the strategic direction of Primary Care in its widest sense, co-ordinating service transformation and large-scale delivery solutions across South Yorkshire.

Urgent and Emergency Care (UEC) Alliance

The Urgent and Emergency Care Alliance provides strategic direction for assuring the delivery of high quality urgent and emergency care through a whole system approach and working in partnership, which will ensure that the implementation of the UEC recovery plan is supported by all relevant partners.

Children and Young People's Alliance (CYPA)

The Children and Young People's Alliance brings together providers from across all sectors (acute, primary care, mental health, community services, housing, police, education, voluntary organisations, faith based groups) to address areas of local and national priority, with the aim of improving health outcomes and reducing inequalities for children and young people aged 0-25 years.

Voluntary, Community and Social Enterprise Sector Alliance (VCSE)

The VCSE Alliance is a South Yorkshire-wide network of VCSE organisations that aims to develop an equitable partnership with the health and care system and maximise its potential across strategy, delivery, engagement and insight. It will enable VCSE organisations to participate in the Integrated Care System including networking, information exchange and co-design opportunities on shared priorities in relation to both physical and mental health and wellbeing.

Cancer Alliance - South Yorkshire and Bassetlaw

Cancer Alliance is a partnership of organisations aiming to ensure the best possible cancer care across Sheffield, Doncaster, Rotherham, Barnsley, Bassetlaw and north Derbyshire. Our local SYB Cancer Alliance comprises a wide range of partners, including NHS organisations, local councils, voluntary sector organisations, charities, universities and patient groups. Our vision is to work together to develop services based around the whole person, their physical, mental health and wellbeing, not just their cancer, for every stage of support they may need. The Alliance aims to share best practice, optimise services, pilot innovative approaches to reduce health inequalities

Local Maternity and Neonatal Network (LMNS)

The South Yorkshire Local Maternity and Neonatal System (LMNS) is the Maternity arm of NHS South Yorkshire. Our vision is for maternity services across South Yorkshire to become safer, more personalised, kinder, and more family friendly; where every woman or birthing person has access to information to enable them to make decisions about their care; and where they and their baby can access support that is centred on their individual needs and circumstances.

Integrated Stroke Delivery Network (ISDN)

The South Yorkshire ISDN was launched in November 2020 and works with partners to prevent stroke, improve diagnosis and improve access to treatment in 24/7 specialist stroke units. In 2023/24 South Yorkshire ISDN and its partner organisations completed the Pre Hospital Stroke Video Triage Project. This project piloted video triage by paramedics in the field to consult with hyper acute stroke teams to facilitate patients being conveyed to the right place, in the right time so that they can receive the right treatment. South Yorkshire received £100k for this project and are one of nine pilot sites.
If the evaluation shows this to be of benefit we will work to embed this into clinical practice across the whole region.

5.2

Developing role of NHS South Yorkshire as an Integrated Care Board

NHS South Yorkshire was established in July 2022 and plays a fundamental role to support and convene the system.

Taking on new responsibilities, including delegation of primary care and specialised services to NHS South Yorkshire.

During 2022/23 NHS South Yorkshire became responsible for commissioning almost all NHS services to meet the physical and mental health needs of our local population in South Yorkshire, except for pharmacy, optometry (POD) dental and specialised services. In line with national guidance the responsibility for commissioning pharmacy, optometry and dental changed in April 2023 and the responsibility for specialised services is still due to change. The responsibility for both has historically been with NHS England and will now be delegated to NHS South Yorkshire.

The delegation means that NHS South Yorkshire is responsible for commissioning the totality of all four primary care contractor groups, including General Practice, community pharmacy, optometry and dental services since 1 April 2023.
See primary care section.

The NHS England Yorkshire and the Humber Specialised Commissioning and Health and Justice Team currently commission a diverse range of specialist services, including those provided at specialist tertiary centres, within prison settings and specialised inpatient mental health units. The plan is to work through joint collaborative commissioning approaches to manage the change for these services. **See specialised services section.**

Shared role for oversight of NHS Trusts and Foundation Trusts through a Memorandum of Understanding with NHS England and the Integrated Care Board

South Yorkshire ICB will seek to provide the highest quality services to our patients. In order to support delivery of this ambition, the ICB has worked with NHS England to develop a Performance and Improvement Framework (PIF), which sets out the means by which we will conduct assurance and oversight within our system. It ensures that we:

i. Are clear about accountability for delivery;
ii. Provide oversight up to system level;
iii. Co-ordinate improvement and sharing of good practice, and
iv. Are clear about assurance mechanisms.

The PIF is based around the six domains in the NHS Oversight Framework; aligns with the ICB System Delivery Group infrastructure; and sets out the accountabilities, roles, responsibilities and assurance process for individual Foundation Trusts, Provider Collaboratives and Place Partnerships.

6 What are we going to do to support delivery of our Strategy?

To support delivery of our initial Integrated Care Strategy, the national objectives set out in the NHS Planning Guidance and our statutory requirements we have identified a number of areas of focus that underpin and are fundamental to delivery of our Joint Forward Plan.

The objectives are all essential areas of focus across the breadth of our plan if we are to deliver the detailed delivery plans set out in our Joint Forward Plan.

By focusing on these we will also contribute to delivery of our Integrated Care Strategy.

In addition to the objectives set out above, this Joint Forward Plan sets out specific areas of focus for the NHS, the outcomes we are striving to deliver, and more detailed transformation plans across a range of programme areas and key enablers.

The following diagrams provide a summary of the areas covered in our plan and is followed by a summary of the key outcomes we have identified.

South Yorkshire Joint Forward Plan - Summary

Taking a preventative, population health approach and reducing health inequalities in all we do by focusing on those with greater needs

Improving access, quality and transforming care

Working in partnership with people and communities and Voluntary, Community & Social Enterprise (VCSE)

- Improving maternity services and services for children and young people (0-25 years).
- Improving access to Primary Care (GPs, Primary Care Networks (PCNs), community pharmacists, optometrists and dentists).
- Transforming Community Services (Including proactive integrated community teams, delivery of urgent community response and expansion of virtual wards).
- Recovering urgent and emergency care, including developing alternatives to A&E, improving processes, hospital flow and discharge.
- Recovering & optimising cancer, elective and diagnostic pathways, implementing best practice and reducing variation.
- Improving access and transforming mental health services for children and young people and adults.
- Improving access and redesigning specialist services for those with learning disabilities and autism.

Supporting and developing our entire workforce

Maximising opportunities and benefits of digital, data and technology and research and innovation

Making best use of our collective resources

South Yorkshire Joint Forward Plan - Outcomes

This Joint Forward Plan is a key delivery vehicle for our Integrated Care Strategy and has the same ultimate vision and goals, and so the approach we are taking is to build on our existing Outcomes Framework (OF) to include the key measures and metrics that align to the JFP objectives and priorities. The Outcomes Framework can be found here.

The following diagram summarises the outcomes we have identified and each will be considered from an inequalities perspective, with consideration across a range of dimensions including deprivation, ethnic group etc. These will be monitored alongside our Integrated Care Strategy outcomes as well as our key performance indicators relating to the operational planning objectives.

NHS South Yorkshire - Outcomes

Long Term Conditions
- Reduce percentage of adults who smoke
- Reduce hospital admissions for alcohol-specific conditions
- Reduce percentage of adults that are obese
- Reduce the rate of deaths in the under 75s from major diseases
- Reduce the rate of emergency admissions for major diseases
- Reduce prevalence of multi-morbidity in patients with LTC
- Increase proportion of people feeling supported to manage their condition

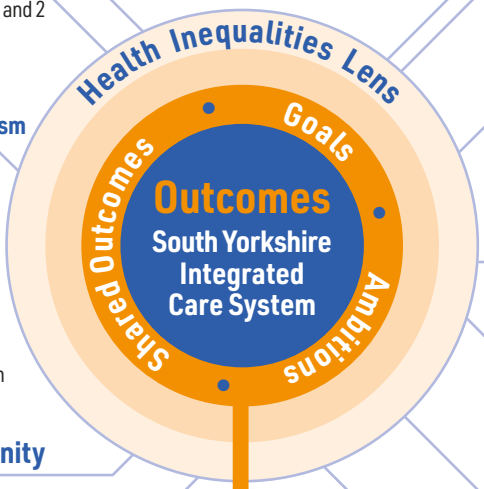
Cancer Services
- Increase percentage of cancers diagnosed at stage 1 and 2
- Increase five-year survival rate from all cancers
- Reduce premature mortality rate for cancer

Mental Health Learning Disabilities and Autism
- Reduce excess under 75 mortality rates in adults with SMI or LD
- Reduce hospital admissions as a result of self harm
- Reduce suicide rates by sex and by LD/A
- Decrease the gap in the employment rate for those with SMI or LD
- Reduce smoking prevalence for those with SMI
- Improve diagnosis rate for dementia
- Improve prescribing of anti-psychotic medication
- Decrease school exclusions for those with LDA

Ensuring the best start in life - Maternity
- Decrease neonatal mortality and stillbirth rate
- Decrease percentage of mothers that reported smoking at time of delivery
- Decrease maternal mortality rate
- Reduce rate of premature births
- Reduce admission rates of babies aged under 14 days
- Increase prevalence of breastfeeding

Children and Young People
- Reduce unplanned admission rates for asthma, diabetes and epilepsy
- Reduce hospital tooth extractions due to decay
- Reduce elective waiting times for children
- Reduce school absenteeism

Our Shared Outcomes
- Achieving Net Zero
- Reduce mortality amenable to healthcare
- Improve patient and family experience measures
- Reduce inequalities in access, experience and outcomes
- See improvements in the Core20 Plus 5 metrics



Integrated Community Services
- Reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Improve numbers of people dying at home/hospital/hospice/care home
- Reduce admissions for falls in older people
- Increase the number of older people still at home after discharge into reablement services

Specialised services
- Improve number of patients accessing thrombectomy
- Reduce stillbirth and neonatal mortality rate
- Increase cancer 5 year survival rate
- Reduce rate of growth in new referrals to renal dialysis

Elective and Diagnostics
- Reduce inequality in elective admissions by deprivation decile
- Improve waiting times for diagnostics and elective care
- Decrease hospital readmission rate within 30 days of discharge

Urgent and Emergency Care
- Improve patient and staff experience of A&E
- Reduce mortality attributable to A&E pressures (TBC)

Primary Care
- Increase patient satisfaction with access to GP and dental services
- Improve dental activity rate
- Increase number of GP practice appointments

Integrated Pharmacy and Medicines
- Reduce antibiotic prescribing rates
- Increase hypertension diagnoses
- Reduce SABA prescribing

Sustainability
- Improve energy consumption and transition to renewable sources
- Reduce NHS Fleet related emissions
- Reduce emissions from Entonox

Enablers

- Data, Digital and Technology
- Continuous Quality Improvement and Research & Innovation
- Developing our Workforce
- Making best use of our resources
- Working with People
- Partnerships including working with VSCE and our role as an anchor

Phasing in our Joint Forward Plan

Our plan is to take a phased approach to delivery.

Our immediate priority is to continue to recover our services in a way that all our communities have equitable access to the care and support they need. Whilst continuing to be both relentless and creative to prevent ill health in the first place, and in our commitment to working in collaboration on the wider determinants of health to achieve our ambition of reducing health inequalities in South Yorkshire. We will also continue to progress delivery of the key ambitions in the NHS Long Term Plan to transform the NHS for future generations. Below sets out the shape of our plan in years 1-2 and 3-5. More detail can be found in subsequent sections of the plan.

Year 1 - 2

- Developing a population health management and health inequalities aware system supporting and enabling our workforce and partners with the skills, tools and capability to improve the health of people living in South Yorkshire
- Refreshing and building intelligence and population health management approaches and engagement mechanisms working with VCSE
- Acting differently together to strengthen and accelerate our focus on prevention and early identification focusing on those with greatest needs
- Focusing on smoking and delivery of the South Yorkshire QUIT Programme connecting with and building on our tobacco control work
- Taking a personalised, preventative approach to long term conditions, implementing management priorities and addressing multi morbidity
- Developing our workforce strategy to support, develop and expand our workforce
- Delivering our Digital Strategy and developing a data and intelligence strategy
- Delivery of the three year Delivery Plan for Maternity and Neonatal Services
- Addressing needs of children and young people by implementing Children and Young People's Transformation Programme (CYP)
- Focusing on immediate actions to recover services, to improve timely access to primary care, diagnostic, elective and cancer pathways, mental health and learning disability services for children and young people and adults, and urgent and emergency care, including delivery of integrated community services, urgent community response and expanding virtual wards
- Delivering the national objectives in the Operational Planning Guidance for 2024/25

Year 3 - 5

- Using population health management data and tools to target multidisciplinary led interventions and personalised care for people with the greatest needs improving health outcomes and demonstrating the best use of South Yorkshire resources
- Continuing to collaborate with partners, focusing on prevention and early identification for those with greatest needs
- Embedding a primary prevention for all approach and working with people and communities to codesign sustainable prevention programmes
- Complete delivery of the three year Delivery Plan for Maternity and Neonatal Services and CYP Transformation Programme
- Deliver new service models that integrate primary, community and hospital services enabled by our Provider Collaboratives and Alliances
- Embed quality improvement, taking an evidence based approach to improve quality of care and health outcomes to reduce inequalities in access, experience and outcomes, address unwarranted variation in care pathways and further contribute to addressing health inequalities.
- Continue to transform and redesign mental health services and learning disability and autism services to improve access and quality of care
- Continue delivery of annual Operational Planning Requirements beyond 2024/25 and NHS universal commitments in NHS Long Term Plan

6.1

Focus on improving population health and reducing health inequalities

Taking a prevention focused population health approach and addressing health inequalities in all that we do.

Measurable outcomes

Link directly to our system goals to:

- **Reduce mortality amenable to healthcare**
- **Improve patient and family experience reported measures**
- **Reduce inequality in access, experience and outcomes**
- **Improvement in outcomes of CORE20PLUS5 national framework - adults and children**

Our plans

Our overall aim is to become a population health and prevention led ICS, using data and intelligence to strategically influence and inform our priorities and decisions. We aim:

- To embed a culture change so we have a clear focus on the needs of our population with prevention and reducing inequalities at the heart of what we do to improve health equity
- To identify opportunities to work at scale where it makes the biggest impact and best use of resources.
- To adopt a primary prevention for all approach and signposting those in hospital to primary prevention and support services and existing support services.
- To focus on improving access and quality of care and reducing inequality in access, experience and outcomes, working with people, communities and VCSE partners and adopting a co-production approach involving people in service redesign.
- To focus on multi-morbidity, rather than individual diseases and taking a personalised approach to treatment plans and enable continuity of care.
- To respond to the impact of wider social and commercial determinants on communities and individuals alongside our partners, including where people live and work, their housing and employment. Working together to address these to aid delivery of our bold ambition to accelerate and strengthen our focus on prevention.
- For NHS partners to recognise and strengthen their contribution to local social and economic development, including how the NHS pound can contribute to addressing health inequalities, not just through service delivery, but targeted recruitment in our more deprived areas and local procurement, fulfilling our roles as anchor institutions.
- To work collaboratively and deliver on the CORE20PLUS5 framework.
- To develop workforce awareness and education tools and resources for population health, prevention and health inequalities.
- To work with partners including voluntary sector and inclusion health communities to increase awareness of the poor health outcomes experienced by inclusion health groups. Listening to stories from those with lived experience is providing an understanding of the levels of poverty, discrimination, marginalisation and subsequent impact on their ability to access services. It is recognised that a collective approach to address the barriers to healthcare is required, whilst being sighted on the wider determinants of health.
- To embed population health management approaches to inform decision making on priorities and where money is spent in responding to greatest need in line with our joint commitment.
- To work with partners to respond to new national strategy developments to improve population health, including the National Women's Health Strategy.
- To develop and mobilise an Intelligence Function across the ICS that allows us to better understand and respond to the wider determinants of health.
- To move towards a 'thriving' level of digital maturity for Population Health Management to support the use of data and intelligence tools to drive change and transformation, enabling the organisation to be 'data-confident'.

Women's Health in South Yorkshire

Responding to the Women's Health Strategy in 2022, South Yorkshire has been working to better understand women's health needs, what women and girls have told us is important and the services currently available in the community, including contraception services, cervical screening services, menopause clinics and breast pain clinics.

Our plan is to build on these to improve access focusing on groups that often experience the greatest health inequalities. This includes supporting women's health provision for sex workers, members of our Gypsy, Roma and Traveller communities, and those experiencing homelessness in Doncaster. We are working with existing health providers alongside Doncaster Club, the Amber Project, and the Changing Lives Programme to offer more support for women's health needs in the community.

Our plans also include the development of an integrated women's hub partnership model in Rotherham and looking at the possibility of having a virtual hub across South Yorkshire.

Alongside this we will continue to support our successful mission menopause programme, where we achieved Henpicked menopause accreditation in 15 organisations which employs 75% of our workforce across all sectors. The plan is to expand further to include Local Authority, Voluntary sectors, and primary care and to continue to raise awareness, upskill, and educate our workforce. We will also be developing material and training to reach out to our diverse communities and workforce to address our menopause ethnicity gap.

Key National Expectations

The Operational Planning requirements for 2024/25 are

Continue to deliver against the 5 strategic priorities for tackling health inequalities. Publish joined-up action plans to address health inequalities and implement the Core20PLUS5 approach, that:

- Address long-term conditions with a particular focus on the Core20plus5 prevention actions
- Build on NHS recovery plans for elective care, UEC and primary care
- Address inequalities facing children and young people and implement CYP Core20PLUS5
- Implement the inclusion health and digital inclusion framework
- Increase the capacity and capability of the workforce to understand their role in reducing healthcare and wider inequalities
- Implement NHS England's high impact interventions for secondary prevention

Reducing Healthcare inequalities five priority actions

- Restoring NHS services inclusively
- Mitigating against 'digital exclusion'
- Ensuring datasets are complete and timely
- Accelerating preventative programmes
- Strengthening leadership and accountability

The NHS Long Term plan requirements include

- Preventing illness and tackling health inequalities
- Reducing local health inequalities and unwarranted variation
- Focused on prevention
- Engaged with Local Authorities
- Driving innovation
- A proactive approach to prevention and reducing health inequalities

Priorities for year 1 and 2 - These priorities aim to develop and strengthen the foundations and building blocks of our strategic approach in South Yorkshire to becoming a population health led system. They focus on creating the environment, relationships and infrastructure.

Becoming population health led

Proactively work with Places and partners to adopt PHM approaches and deliver at scale transformation that improves our population health, physical and mental health and reduces health inequalities

Delivery of the CORE20PLUS5 adults and children through innovative and integrated ways of working that delivers on the requirements of the national framework and demonstrate impact of interventions through the outcomes dashboard

Becoming prevention led

Develop health and wellbeing support offers using make every contact count opportunities and early help to optimise outcomes for our population and patients as part of our primary prevention for all

Continuing leadership and implementation of the ICB prevention priorities and programmes, measure outcomes to demonstrate impact of interventions through the Outcomes Dashboard

Mobilise the Voluntary, Community and Social Enterprise Sector (VCSE) Memorandum of Understanding to establish how we can best engage with our areas of greatest need in prevention approaches

Becoming intelligence led

With partners establish and agree ways of working as an intelligent system across the ICS

Build and embed intelligence and population health management approaches across our system, including a data platform.

Develop and implement PHM digital tools and capability that will transform the way we design and deliver multi-disciplinary patient care focused on improving outcomes

Ensuring the best start in life - Maternity

Outcomes

- **Decrease neonatal mortality and stillbirth rate**
- **Decrease percentage of mothers that reported smoking at time of delivery**
- **Reduce maternal mortality rate (by ethnicity)**
- **Reduce the rate of premature births**
- **Decrease admission rates of babies aged under 14 days**
- **Increase neonatal brain injury (TBC)**
- **Increase prevalence of breastfeeding**

Our plans

- To continue to engage with service users via our Maternity Voices Partnerships and reach out more broadly working with VCSE to engage with our diverse communities to inform our plans and enable co production
- To fully restore services and improve access including access to all vaccinations
- To personalise our offer by embedding personalised care and support plans
- To take a preventative approach, including implementing a diabetes prevention programme, offering smoke free pregnancy support, maternal mental health and wellbeing support and family support for women with complex social situations, addressing the wider social determinant of health
- To continue to develop and implement plans to increase breast feeding
- To implement our Equity and Equality Action Plan (2022 – 2027) to reduce health inequalities including via community hubs in the areas of greatest need
- To deliver workforce plans developed in response to Ockenden
- To transform delivery through continued implementation of continuity of carer
- To digitally enable maternity services and delivery of new models of care including continuity of carer and family hubs
- To implement maternal medicines networks for those with complex needs
- To improve and standardise pelvic health services
- To consider sustainability, promote the positive impact of breast feeding on climate change and understand the environmental impact of Entonox

Maternity and Neonatal Network Equity & Equality Action Plan

The South Yorkshire Local Maternity and Neonatal Network Equity & Equality Action Plan was co-produced in 2022 and reflects and responds to the health inequalities and risk factors in our population and sets out clearly our areas for action aligned to this Joint Forward Plan.

Equity and Equality Action Plan 2022-27

Early Years Pilot

Successfully securing funding in June 2023, this new pilot will build on the ambition for all children to have the best start in life supporting their development in early years by introducing an innovative model of delivery supporting preventative intervention during pregnancy. Delivery will focus on our most deprived neighbourhoods in each place and be primarily through VCSE applying a holistic family intervention model radically moving away from silo working and single service offers. This new model will connect with our developing Family Hubs and the interventions provided by Midwifery Services and the Healthy Child Programme. Collectively contributing to the delivery of our bold ambition focused on development in early years.

Ensuring the best start in life - Maternity

Key National Expectations

The Operational Planning requirements for 2024/25 included

- Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment
- Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities

The NHS Long Term plan requirements include

- Implementing continuity of carer as the default model for all women
- Implementing all elements of Saving Babies Lives
- Preventing pre term birth; implementing preterm birth clinics and improving neonatal optimisation
- Improving smoking cessation services, delivering smoke free pregnancy pathways
- Improving digital care records
- Implementing maternal mental health services
- Achieving Unicef Baby Friendly Initiative (BFI) Accreditation

Three year delivery plan for maternity and neonatal services

Theme 1: Listening to and working with women and families with compassion

- Care that is personalised, Improve equity for mothers and babies, Work with service users to improve care

Theme 2: Growing, retaining and supporting our workforce

- Grow our workforce, Value and retain our workforce, Invest in skills

Theme 3: Developing and sustaining a culture of safety, learning and support

- Develop a positive safety culture, Learn and improve, Support and oversight

Theme 4: Standards and structures the underpin safer, more personalised, and more equitable care

- Standards to ensure best practice, Data to inform learning, Make better use of digital technology in maternity and neonatal services

Maternity - Priorities Year 1 & 2

To contribute to our bold ambition to raise the level of school readiness in South Yorkshire and close the gap in those achieving a good level of development between those on free school meals and all children by 25% by 2028/30

Delivery of Themes 1 and 3

Personalised care and support planning - Co produce and standardise personalised care and support plan offer

Implement the **Equity and Equality** Action Plan 2022/27 to reduce health inequalities, including delivery of smoking in pregnancy pathways linked into QUIT Programme

Work with our MNVPs and Neonatal ODN

Delivery of Theme 2

Workforce strategy and redesign

Workforce expansion including midwifery apprenticeships and MSc shortened course for Nurses

Support Retention through recruiting pastoral leads in each organisation, enhancing midwifery ambassadors

Continuity of carer

Expansion of continuity of carer for those with greatest needs

Delivery of Theme 4

Implement Perinatal Quality Surveillance Model (PQSM)

Reduce still birth, neonatal mortality, maternal mortality and serious intrapartum brain injury

Reduce pre term birth; through preterm birth clinics and improving neonatal optimisation

Working with Partners & New Service Developments Family hubs

Work with CYP Alliances and Places to deliver family hubs

Optimise neonatal service delivery

Including procuring equipment to support neonatal optimisation and to manage brain injury

New service developments

Culturally sensitive genetics services

Standardised pelvic health services

Addressing the needs of children and young people (0-25 yrs)

Measurable outcomes

- **Reduce unplanned admission rates for asthma, diabetes and epilepsy in under 19s**
- **Reduce hospital tooth extractions due to decay for children**
- **Reduce elective waiting times for children**
- **Reduce school absenteeism**

Our plans

- Focusing on development in early years is a bold ambition in our Integrated Care Strategy. To address inequalities for children and young people work will need to support those with the greatest needs including those care experienced and those with additional needs.
- The National Children and Young People's Transformation Programme sets out areas the NHS can directly contribute to this and work with others to enable delivery.
- Our plans include working with VCSE partners to engage children and young people and their families to ensure they have a voice to inform plans and enable involvement.
- Strengthening our South Yorkshire CYP Alliance, working with partners in early years, education, primary, community integrated teams, social prescribers and VCSE.
- To work in partnership with our Local Maternity Network (LMNS) and places in the development of family/community hubs, co locating services in areas of greatest need.
- To work in partnership with places and MHLDA Provider Collaborative to expand mental health services for children and young people to improve access and reduce waits and to understand needs of children and young people with autism and address diagnostic waits for neurodiversity assessments.
- Taking a preventative and personalised approach to improvements in asthma, diabetes, epilepsy and obesity through South Yorkshire Groups in line with CORE20PLUS5 approach, including a diabetes pilot for those with greatest needs to use rtCGM or insulin pumps.
- Supporting delivery of the Core20connecters pilot to reduce the number of children under the age of 10 years requiring tooth extractions.
- Support the model of paediatricians linked to schools where cultural differences inhibit access to services, enabling assessments at school.
- Support the South Yorkshire pilot service working with CYP with complications of excess weight.
- To link with established groups to support improvements in transitions to adulthood with a specific focus on diabetes.
- Support The Healthier Together website providing health & wellbeing information for CYP, parents, carers and professionals.
- To work with our UEC Alliance and MHLDA Provider Collaborative to ensure integrated urgent emergency care meets the needs of children and young people to reduce hospital admissions.
- Support delivery of a violence reduction youth navigator pilot, taking a joined-up approach with partners to support young people's mental health and wellbeing to address life challenges.
- To work with partners to develop a vision, care model and funding model for palliative care and end of life care to meet national standards
- To maximise the opportunity afforded by our Acute Federation Provider Collaborative being selected as one of nine provider collaborative innovators nationally to build an integrated operational delivery model to deliver outstanding care for children and young people.
- Workforce development plans, including the introduction of physician associates.

Child Health Equity Collaborative

Barnardo's and the Institute of Health Equity, led by Prof Sir Michael Marmot, are partnering with South Yorkshire to shape the way ICSs create health and address health inequalities among children and young people. The vision is to guarantee a basic state of health and wellbeing for all children, regardless of circumstance. The aim is for ICSs to give equal weight to children and young people's health creation, as to their health and care service integration: the most cost-effective way to achieve health equity and reduce health inequalities. The focus is on health creation, incorporating the role of the VCSE sector in understanding and acting on the wider determinants of health.

Addressing the needs of Children and Young People (0-25 years)

Key National Expectations

The Operational Planning requirements for 2024/25 included

- A number of requirements in the operational planning guidance are relevant for children and young people, including improving access to primary care, reduce waiting times for planned hospital care, mental health services and community waits e.g. autism and ADHD assessments
- System recovery plans are expected to reflect the needs of all age groups, including children and young people (CYP)
- Specifically improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
- Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and for children and young people

The NHS Long Term plan requirements include

- The Long Term Plan set out the need for more NHS action on prevention and health inequalities, including addressing obesity for children and young people and taking action to improve their health and wellbeing. It had a specific focus on enabling a strong start in life. It also extended the age range to 25 years to reduce inequalities and improve outcomes in aspects of care such as transitions, special educational needs, looked after young people/care leavers and ensuring access to mental health services.

The National Children and Young People's Transformation Programme

- Based on the commitments in the Long Term Plan the National Programme seeks to improve outcomes and reduce health inequalities for all those aged 0-25. This includes:
  - Reduce infant mortality rates
  - Expanding mental health services for children and young people
  - Personalised care and involvement of children and young people
  - Improvements for long term conditions, such as asthma, diabetes and epilepsy
  - Improved cancer outcomes and experience
  - Understanding the needs of children with autism
  - NHS services that keep children well, including through technology
  - Reducing hospital admissions by providing joined up care
  - Improve transition to adult services and move to 0-25 years

Addressing needs of children and young people (0-25) priorities for year 1 and 2

To contribute to our bold ambition to raise the level of school readiness in South Yorkshire and close the gap in those achieving a good level of development between those on free school meals and all children by 25% by 2028/30

Involving children and young people	Child Health Equity Collaborative	Long Term Conditions	New service models and pilots	Children & Young People's Mental Health	Family hubs
Working with VCSE and children and young people to ensure they have a voice and facilitate involvement	Participate in the Sir Michael Marmot and Barnardo's Child Health Equity Collaborative to develop a Health Equity Framework and toolkit to address inequalities	Take a preventative and personalised approach to improvements in asthma, diabetes, epilepsy and obesity, in line with core 20+ Framework	Core20 connectors pilot to reduce tooth extractions New delivery model linking paediatricians to schools to Continued development of The Healthier Together website Work with UEC Alliance to ensure integrated emergency care meets needs of children and young people	Work with Mental Health and Learning Disability Provider Collaborative to expand mental health services for children and young people and understand the needs of those with autism, including neurodiversity assessment pathways	Work with Local Maternity and Neonatal Network and Places to deliver family hubs

Strengthen our focus on prevention, early identification and improve management of Long Term Conditions

Measurable outcomes

- **Reduce the percentage of adults who smoke**
- **Reduce hospital admissions for alcohol-specific conditions**
- **Reduce percentage of adults that are obese**
- **Reduce the rate of deaths in the under 75s from major diseases**
- **Reduce rate of emergency admissions for major diseases**
- **Reduce the prevalence of multi-morbidity in patients with Long Term Conditions**
- **Increase proportion of people feeling supported to manage their condition**

Our plans

Our needs assessment identifies that the main risks associated with our biggest diseases are largely modifiable or preventable, in response to this our plans include:

- To focus on the primary prevention and having impact on the modifiable risk factors smoking, healthy weight (diet and physical activity), alcohol and hypertension, particularly clustered unhealthy behaviours.
- To extend this to work with partners (including VSCE) to address the wider determinants of health, e.g. addressing housing issues, air pollution and mitigating impact of the cost of living.
- To respond to the changing burden of disease as identified in our needs assessment with a focus on multi morbidity, primary prevention, early identification, and continuity of good quality clinical care to prevent early onset of disease and delay further acquisition of LTCs.
- To take a holistic approach to encompass mental health and wellbeing alongside physical health conditions to respond to increasing mental health needs.
- To a focus on early identification and care (monitoring, control and management) of the main causes of our premature mortality, cardiovascular, respiratory and early diagnosis of cancer, targeting those with greatest needs, including those in health inclusion groups.
- This will include improving early detection of causes e.g. high blood pressure, lipids and taking action.
- To promote patient involvement and support patient self management and recovery, including with pain management, rehabilitation prior to cancer therapy and rehabilitation for those with cardiac and respiratory conditions and stroke to delay onset of multi morbidity and frailty.
- To embed innovation and new models of care personalisation approaches to treatment plans and the development of a 'Year of Care' model to coordinate multi-disciplinary care including VCSE.

We need to embed secondary and tertiary prevention opportunities into our LTC management:

- To deliver primary, secondary and tertiary prevention through NHS services.
- To widen access so more patients are eligible for interventions.
- To ensure that models of care available are optimal, quality assured and enable continuity of care.
- To support patients to have the information and tools to self-manage their care and prevent a co-morbidity from occurring.
- Improve patient support and compliance with care plans by supporting those who may need enhanced support.

Strengthen our focus on prevention, early identification and improve management of Long Term Conditions

Key National Expectations - Major Conditions Strategy - Expected during 2024

The Operational Planning requirements for 2024/25 included

- Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025
- Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025
- Increase vaccination uptake for children and young people year on year towards WHO recommended levels
- Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people

The NHS Long Term plan requirements include

- Delivering better care for major health conditions (cardiovascular disease, stroke care, diabetes, respiratory disease) by improving detection and care and implementing new models of care, providing education, rehabilitation and exercise programmes include remote and digital models.
- Make sure that smoking status is assessed on admission to hospital and that every smoker who has a stay overnight is offered advice, support and treatment to stop smoking
- Make sure that smoking status is assessed for every pregnant person and that every smoker is offered with support and treatment to help stop smoking. Partners and household members who smoke will also be offered support to stop.
- Help people using outpatient services for conditions that are made worse by smoking (for example cancer) to quit smoking
- Make sure more people can access support to help control their diabetes
- Support more people to attend weight management services, especially those who are obese and have another condition e.g. high blood pressure
- Make sure that people admitted to hospital with alcohol related problems can be cared for by specialist Alcohol Care Teams
- Continue to use antibiotics sensibly
- Provide digital tools to enable more people to access online NHS services and support self-management and empowering people to better manage their conditions

South Yorkshire Health Inequalities Event held in Rotherham

Rotherham Council hosted an event at Rotherham United's New York Stadium in February where members of the Health and Wellbeing Boards across South Yorkshire, the Integrated Care Partnership (ICP) and Integrated Care Board (ICB), came together to hear examples of current work to address health inequalities, explore areas of potential collaboration and identify opportunities to work on a South Yorkshire footprint.

Keynote speakers included experts and regional leaders, Prof Chris Bentley, Former Director of Public Health in South Yorkshire and Head of the Health Inequalities National Support Team, and Oliver Coppard, Mayor of the South Yorkshire Mayoral Combined Authority, and chair of the SY Integrated Care Partnership, as well as local leads on health inequalities. Professor Chris Whitty, Chief Medical Officer for England, was one of the speakers who joined remotely to give a presentation and led a discussion about prevention in healthcare. The afternoon was used to action plan and identify opportunities for joint working and the output has informed this Joint Forward Plan. A follow up event is planned for 2024.

Barnsley Stroke Campaign

Don't be caught in two minds, you could be having a stroke – that's the key message powering a new local campaign in Barnsley designed to help people act fast on possible stroke symptoms. The campaign features local stroke survivors telling their stories and sharing the symptoms they experienced to help everyone think twice about strokes.

This campaign has been developed in partnership with key health and care partners including the Stroke Association, Barnsley Hospital, the South Yorkshire Integrated Care Board and the Yorkshire Ambulance Service.

Doncaster Primary Care Mental Health Hubs

The role of Mental Health and Wellbeing Practitioners in Primary Care Mental Health Hubs is already making a difference in Doncaster. These roles are working as part of an integrated team offering support and regular engagement with people living with mental health conditions supporting them with access to information and tools to manage their own condition and enabling them to regain their independence.

Strengthen our focus on prevention, early identification and improve management of Long Term Conditions Priorities Year 1 & 2

To contribute to our bold ambition to reduce the percentage of our adults that smoke to 5%

Primary Prevention – focusing on modifiable risk factors	Early identification of Long Term Conditions (LTCs)	Optimal models of care delivery	Support for Self-Management
Smoking Improve treatment of tobacco dependency within secondary care Trusts. Focused work on outpatient pathways where smoking cessation can have the greatest impact (For example, respiratory, stroke, mental health.) Further develop collaborative tobacco control work and structures across SY, including an expanded communications campaign. **Healthy weight and physical activity:** Taking a compassionate approach to review obesity pathways and tier 3 weight management services. Identifying opportunities to integrate physical activity into pathways. **Alcohol:** Improve impact of Alcohol Care Teams and Alcohol Pathway Quality Improvement Programmes on alcohol dependency for patients and their families.	Ensure delivery and increase uptake of health checks with a focus for those with Serious Mental Illness and Learning disabilities. Increase the prevention, detection and management of cardiovascular risk factors e.g. hypertension and cholesterol especially in those people in the areas of highest deprivation. Improve access to diagnostics for those most likely to have undetected disease, including: spirometry for respiratory disease, diabetes, urgent stroke and Cancer.	**Multi-morbidity:** Taking a preventative, personalised and integrated approach to care, embed evidenced based innovation and deliver new models of care that enable continuity of care and optimise LTC management. To prevent or delay onset of additional LTCs. Taking a holistic approach to encompass mental health and wellbeing alongside physical health conditions to respond to increasing mental health needs. **Rehabilitation:** Increase access to quality assured programme of education and exercise-based rehabilitation and increase completion rates for Pulmonary Rehab and Cardiac Rehab. Roll out of the Integrated Community Stroke Rehab model.	Develop and embed collaboration and co-production with VCSE and social prescribing in LTC. Develop digital tools and a support offer for people with long term conditions to increase uptake of self-management offers. Building on existing infrastructure and working with partners to develop new innovative approaches. To support people with the information and tools to manage their own and live healthier lives.

SY QUIT Programme

The South Yorkshire QUIT programme is an innovative approach to make the effective treatment for tobacco addiction part of the routine care offered by all our hospitals. It recognises that smoking is an addiction. The programme has been developed in partnership with Yorkshire Cancer Research and with support from our Local Authority commissioned Community Stop Smoking Services.
To date the programme has enabled over 1,900 people to quit smoking. More importantly the work of the QUIT programme is reaching our populations most impacted by Health Inequalities.

Reducing smoking prevalence is a key priority of South Yorkshire's Integrated Care Partnership and our strategy includes a bold ambition to reduce prevalence to 5% by 2030. To achieve this bold ambition the ICB is supporting, alongside the QUIT programme, work to establish a South Yorkshire wide brand to deliver regional tobacco control, focusing initially on region-wide communications campaigns. Strengthening and accelerating our collaborative working with partners, increasing connectivity of the tobacco control work and maintaining a focus on embedding the QUIT programme will be key to delivering on our bold ambition to reduce smoking prevalence in South Yorkshire.

Supporting Cost of living and reducing inequalities

In 2023, the Sheffield place team allocated grants of £5-20k to 28 VCSE organisations to tackle the wider determinants of health. The groups work in areas of greatest deprivation, with the homeless, asylum seekers and refugees, women experiencing abuse, people with disabilities, and more. The grants were to alleviate the impact of the cost of living crisis as VCSE has the reach, skills and knowledge on how to support people living in poverty. We are building on the relationship with the VCSE and our most deprived communities to develop our inclusion health strategy by embedding a model of co-production, which is enabling us to empower local communities to work in partnership to design a neighbourhood model which spans across the wider determinants of health and creates an environment of community power so local communities have the influence to design services to best meet their needs.

6.2

Focus on quality, access and transforming care

Primary Care

(GP Practices, Primary Care Networks, Community Pharmacy, Optometrists and Dentists)

Measurable outcomes

- **Increase patient satisfaction with accessing GP services**
- **Increase patient satisfaction with accessing NHS dental services**
- **Improve rates of dental activity in adults and children**
- **Increase number of GP practice appointments**
- **Increase annual health checks for those with severe mental illness or learning disability**

Our plans

- Access to and quality of services were identified as what matters most to people in South Yorkshire and a key priority in our plan is to improve access to primary care, with particular emphasis on General Practice, ensuring every patient can benefit from new technologies for communicating and accessing care, developing acute same day urgent care for acute problems and planned care pathways to improve access and deliver personalised ongoing management (see LTC section).
- Our plans include all primary care contractor groups, GP practices, Community Pharmacy, Optometrists and Dentists, creating integrated neighbourhood teams, building on and expanding the clinical roles increasingly employed in Primary Care Networks (PCNs), ensuring that every PCN additional clinical roles through the national ARRS scheme. These roles will increase the number of appointments available to patients in a GP setting, meeting our share of the promised 50m extra appointments (National).
- We will further develop our Workforce Training Hub to provide good quality support, mentorship, training opportunities for existing clinicians and create an environment for learning and development that attracts and retains our new and increasingly diverse workforce in primary care, not only in GP practices but across wider primary care also. Where we do not have access to relevant training and university courses within SY we will work with our educational providers to create the potential to 'grow our own' health and care workforce for the future.
- Our plans will enable delivery in layers of scale, through integrated neighbourhood teams, MDTs established with wider primary care participation, working with VCSE Sector, developing social prescribing and care navigators so that they work across all primary care providers.
- Implementation of the recommendations made in the recent Fuller stocktake including the transformation of primary care led by integrated neighbourhood teams.
- Our wider PC providers will be an equal contributor as we focus on what we can and must deliver in the first two years of this plan. For optometry these plans include optimising minor eye condition schemes, workforce development to include independent prescribing and rolling out Eyecare Electronic Referral System (EeRS) to enable direct referral to Ophthalmology and image transfer.
- For community pharmacy these plans include optimising delivery of discharge medicines service by Trusts, maximising the use of NHS mail to improve communication between GP and Pharmacy, ensuring every GP practice uses the Community Pharmacy Consultation Service whilst we support our Pharmacy teams with workforce development, creating opportunities for development of independent prescribers and recognise the skills of the pharmacy team and the location of pharmacy premises close to local communities when we undertake our review of locally commissioned services.
- For dental our plans will focus on improving access and restoring activity to greater than it was in 2019, enabling equitable access, experience and outcomes aligned to CORE20PLUS5 and population need. To do this we will work with HEE to develop a sustainable and appropriately trained dental workforce.
- We are working to provide better diagnostics, physiotherapy and out of hospital clinics, some which will support patient self referral, and ultimately this requires our population to understand what is on offer and how best to access and use it. Our communications with our SY population will therefore focus on developing an understanding of the many new roles and services, delivered in different settings, possibly by a different professional than they are used to. To help people understand who does what and support them to navigate services.
- Our plans for services and workforce growth could be limited by the restrictions of some of our premises, to try to avoid this we will look to innovative ways of providing access to and delivery of services. We will promote the NHS App and 'digital' consultations with a GP or the most appropriate professional, building on existing developments in our places.

Key National Expectations

The Operational Planning requirements for 2024/25 for primary care and community services are

- Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels

The NHS Long Term plan requirements include

- More healthcare staff working in and with GP practices, enabling people to get an appointment with the right professional depending on their needs.
- More GPs, nurses and 20,000 additional pharmacists, physiotherapists, paramedics, physician associates and social prescribing link workers
- Expansion in the number of services available in local GP practices including better services to diagnose people, physiotherapy and outpatient clinics that have previously only been available in hospital
- NHS App and 'digital' GP consultations

Other

- Next steps for integrating primary care: Fuller Stocktake report
- GP Access Recovery Plan
  - Empower patients by improving the NHS App functionality, increasing self referral pathways and expanding community pharmacy
  - Implement new modern general practice access approach, including new telephony and digital access, care navigation and continuity, rapid assessment and response
  - Build capacity, by growing multidisciplinary teams, expanding GP speciality training, focusing on retention and return of GPs and ensuring primary care is prioritised in new housing developments
  - Reduce bureaucracy, by improving the primary-secondary care interface, building on the Bureaucracy busting concordat, streamlining the investment & impact fund, reducing indicators to free up resources

Primary Care (GP Practices, Primary Care Networks, Community Pharmacy, Optometrists and Dentists) Priorities Year 1 & 2

Improving access

Improving Access

Develop and implement plans that are in line with the recommendations set out in the GP Access and Recovery Action Plan to improve access, including use of technology, expanding the workforce across primary care to create additional appointments and developing acute/same day urgent and planned care pathways

Workforce development

Workforce expansion

Building Integrated Neighbourhood Teams, expanding clinical roles in Primary Care by maximising recruitment through the ARRS scheme

Expanding role of Community Pharmacy through delivering Pharmacy First including the Community Pharmacy Consultation Service

Workforce Training

Further develop the Workforce Training Hub to provide support, mentorship and training for primary care workforce
Increase training in care navigation

Integration & new service models

Integration

Work with community services to implement recommendations in Fuller Stocktake Improving the primary-secondary care interface

Community Pharmacy

Optimise delivery of discharge medicines service, maximise use of NHS mail and ensure GP practices use Community Pharmacy Consultation Service (Pharmacy First)

Optometry

Optimise minor eye condition schemes, workforce development and electronic referrals to enable direct referral to Ophthalmology and image transfer

Dental

Continue to implement service restoration plans with a focus on

- Improving access to dental services through commissioning (through ensuring full investment of the dental budget and flexible commissioning)
- Developing a long-term dental workforce plan
- Working with local authorities on oral health improvement and prevention

Integrated Pharmacy and Medicines Optimisation

Measurable outcomes

- **Reduce antibiotic prescribing rates**
- **Increase case finding of hypertension**
- **Reduce SABA prescribing**

Our plans

- Access to high quality services was the main theme in our engagement work and is a key focus of our Joint Forward Plan. This includes broadening our access offer through maximising the use of community pharmacy and fully utilising their skills. The provision of aseptic shared services will be examined to maximise access to treatment close to home. Improving access for all, including those in our CORE20PLUS5 communities to contribute to reducing health inequalities.
- It also includes supporting our prevention workstreams for hypertension and hyperlipidemia, working with general practice to reach patients and enable early identification, including our CORE20PLUS5 communities. Respiratory work is being undertaken across Places to better manage COPD and asthma patients.
- Workforce planning will improve access to professional supported medicines optimisation for all patients.

- A network of medicines safety officers ICS wide has been establish and have been working on harmonised implementation OF MHRA alerts, this network will be further developed over the course of the year.
- Reducing opioid prescribing and expanding the initiatives to other dependence forming medications will be undertaken this year, with new ICS wide guidance already published on reducing prescribing.
- Our plans also include financial sustainability, medicines value initiatives, reducing duplication of services across the ICS, improving recruitment and retention, support for home care and mental health provision for integrated pharmacy and medicines optimisation.
- Environmental sustainability has also been integrated into the medicines and guidance commissioning process and now the strategic planning process. This includes the reduction in use of short acting MDI inhalers and a refresh of emphasis on products of limited use as per NHSE guidance.

Hypertension Case Finding

The NHS Hypertension Case Finding Service aka BP Check is an Advanced Service provided by 67% of community pharmacies in SY and has two stages:

Stage 1 – Identifying people at risk of hypertension and offering them the opportunity to have their blood pressure measured.

Stage 2 – This is offered if a person's blood pressure reading is high at Stage 1. A person will be offered waking hours ambulatory blood pressure monitoring (ABPM).

The Medicines Optimisation team has been working with GP practices and community pharmacies across SY to facilitate the implementation of this and will be continuing to expand its reach in 24/25. BP check numbers in community pharmacy have increased across SY by around 5000 in the sampled month in the last year with upto 12% of check resulting in a referral for further treatment and monitoring to reduce significant cardiac events.

Integrated Pharmacy and Medicines Optimisation

Key National Expectations

The Operational Planning requirements

- Making it easier for people to access community and primary care services, particularly general practice and dentistry
- Improve staff experience, retention and attendance
- Improving productivity
- Address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people
- Optimise medicines value

The NHS Long Term plan requirements include

- Support primary and secondary prevention priorities and the effective management of long term conditions e.g.: Preventing heart attacks, strokes, management of diabetes and dementia cases
- In community pharmacy, make greater use of community pharmacists' skills and opportunities to engage patients
- Ensure that the workforce is put on a sustainable footing for the long term, including publication of an NHS Long Term Workforce Plan

Integrated Pharmacy and Medicines Optimisation Priorities

WS1 Medicines-related Patient Safety	WS2 Making the Best Use of the Expertise of Pharmacy Professionals	WS3 Supporting Equality of Access	WS4 Improving Patient Outcomes	WS5 Supporting NHS Recovery Through Increasing Capacity	WS6 Delivering Value to the System
Reducing Opioid Use in Chronic Non-cancer Pain	Pharmacy First	HT Case Finding (National Initiative) and Management (Local), CVD Programme and Cardiac Clinical Network	Review of Monitored Dosage System Utilisation / Standardising MDS Tray Processes	Increase DPP Support for IPs	Appropriate Prescribing and Supply of Blood Glucose and Ketone Meters, and Testing Strips
Increase use of newly established MSO network	Independent Prescribing in Community Pharmacy		Improving Respiratory Outcomes While Reducing the Carbon Emissions from Inhalers	Workforce Strategy Task and Finish Group - Ensuring a Sustainable Workforce for Today's Demand	Obtaining Secondary Care Medicines in Line with NHS England Commercial Medicines Framework Agreements
Delivery of antimicrobial resistance (AMR) priorities				Workforce Strategy Task and Finish Group - Improving Retention of Existing Staff	Using Best Value Biologic Medicines in Line with NHS England Commissioning Recommendations
				Workforce Strategy Task and Finish Group - Building a Sustainable Workforce for the Future	Deliver CQUIN and agreed incentive schemes
				Workforce Strategy Task and Finish Group - Creating Opportunities to Extend or Expand Roles	

Care Homes

The Enhanced Health in Care Homes (EHiCH) project team are working with care homes across Rotherham on the Good Hydration initiative. This involves delivering training to care home staff regarding the importance of hydration/effects of dehydration and the implementation of seven structured drink rounds per day. The team encourage staff to theme their drink trollies for special occasions, offer a variety of drinks and to ask residents what they would like to drink rather that if they want a drink. Recorded incident of Urinary Tract infections, antibiotic courses and ambulance callouts have been reduced over the course of this work in the homes supported.

Supporting people in the community (Integrated Community Services)

See also Primary Care Section and Urgent and Emergency Care Section

Measurable outcomes

- **Reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions**
- **Improve numbers of people dying at home vs hospital vs hospice or care home**
- **Increase admissions for falls in older people**
- **Increase the number of older people still at home after discharge into reablement services**

Our plans

- Plans in every place have a focus on supporting people in the community. They include
  - integrated neighbourhood working, joining up primary, community, physical and mental health services, social prescribing and VCSE support.
  - integration and delivery of Urgent Community Response (UCR) services and digital developments to understand capacity and patient flows.
- Collectively our plans to support people in the community will
  - Increase capability and capacity in the community to support self care,
  - reduce frailty and multimorbidity through anticipatory and preventative personalised approaches (to prevent, reduce and delay acquisition of LTCs)
  - prevent escalation and crisis by working in partnership around the person
  - ensure timely response to crisis to avoid admissions wherever possible and
  - enable timely discharge where an admission is necessary.
- Our plans include taking preventative, anticipatory and holistic approaches in the community by integrated working, whilst also ensuring responsiveness to escalating need and crisis management.
- They include transforming community services to improve timely access for all, especially those with greatest needs, our CORE20PLUS5 communities and inclusion groups.
- This includes ensuring effective waiting list management and case management, productivity and efficiency, maximising use of technology and expansion plans.
- Workforce planning for community sector expansion and ongoing training including advanced practice, joint working with PCNs, and building skills to support increased acuity in community settings linked to expansion of virtual wards and hospital at home.
- Developing a robust community workforce is vital to enable integration vertically into pathways to and from acute care, and horizontally into community pathways with primary care, social care and VCSE partners. Working together supports delivery of proportionate levels of care according to individual physical and mental health needs.
- Social care providers are key partners in supporting people in their communities, alongside our developing integrated neighbourhood working.
- Plans include greater use of technologies to support care at home, and enable independence and specific work on improving access to dietetics, falls prevention etc.
- Plans also include development of intermediate care services in line with guidance
- Consideration will also be given to continuing healthcare to develop in line with the recently published NHS National Framework.
- Continued delivery of enhanced health in care homes (EHICH).
- A multi-agency, muti-professional Strategic Board for Palliative and End of Life Care was established in 2023, in line with national guidance. The Board meets quarterly and during 2024-25 will establish a clinical reference group and a forum for people with lived experience to inform the Board. An all age strategy has been developed which has been shaped by feedback from the public, and with contributions from professional stakeholders. During 2024-25 we will develop place specific actions plans to address our key challenges.

Supporting people in the community (Integrated Community Services)

Key National Expectations

The Operational Planning requirements for 2024/25 are

- Improve community services waiting times, with a focus on reducing long waits
- Develop a comprehensive plan by June 2024 to reduce the overall waiting times for community services, including reducing waits over 52 weeks for children's community services
- Support the implementation of faster data flows, submitting timely, accurate data to provide a better understanding of long waits
- Improve alignment of community services to PCNs to support development of integrated neighbourhood working, focussed initially on delivering proactive care to the most complex and vulnerable patients with the aim of reducing avoidable exacerbations of ill-health and improving the quality of care for older people

The NHS Long Term plan requirements include

- A new offer of urgent community response and recovery including:
  - expansion of community and intermediate care services to prevent unnecessary admissions to hospital and ensure timely transfer
  - Reablement care delivered within 2 days of referral
  - Urgent response and recovery delivered by flexible MDT team
  - Extra recovery, reablement and rehabilitation support
- Creation of fully integrated community based healthcare
  - Ongoing training of multidisciplinary teams in primary and community hubs
  - Community hospital hubs
  - Pharmacy - NHS111 direct booking to community pharmacies, and pharmacy schemes for those not requiring primary medical services (see JFP Medicines)
- Support to people in care homes including roll out of enhanced care in care homes
- Supporting people to age well, taking a population health management approach, establishing integrated primary and community teams and falls prevention
- Digitisation of community services
- Improving care to people with dementia and delirium (See JFP for Mental Health)
- Personalised care via personalised care model, personal health budgets and improving end of life care
- Roll out of the Integrated Community Stroke Rehab model

Additional Requirements

- continued recovery of community services and new developments including virtual wards and workforce development to enable this.

Supporting people in the community (Integrated Community Services) priorities for year 1 and 2

Integrated Neighbourhood Teams	Community Services Transformation	Urgent Community Response	Palliative and end of life care
Continue development of integrated neighbourhood teams including primary and community services, embedding prevention, anticipatory, holistic and anticipatory care approaches to meet both physical and mental health needs. To enable better communication between professionals and to ensure people have the information and tools to manage their own health.	Transformation of community services, enabling new direct access pathways and increasing productivity. Respond to the Intermediate care framework for reablement and recovery following hospital discharge (published September 2023)	Integration of urgent community response services including digital developments and integration of urgent community response, expansion of virtual wards, links to CAS, end of life care and care homes to reduce unnecessary hospital admissions	During 2024-25 a clinical reference group and a forum for people with lived experience will be established. An all age strategy has been developed and during 2024-25 place specific actions plans will be developed to address our key challenges, and establish implementation plans for the South Yorkshire wide priorities we want to progress, for example: better integration between services, earlier recognition of palliative care need, ongoing education for health and care professionals, addressing inequalities between different communities and ensuring that people with non- cancerous long term conditions received suitable palliative care in a timely way. We will seek to identify sources of funding which can be used to support innovation and transformation, and to raise the profile of palliative and end of life care within the ICB. We will continue in our role as system co-ordinator to support ReSPECT being embedded across all organisations, facilitate ongoing quality improvement, and utilise learning from audits and patient/carer feedback.

Urgent and emergency care

See also Primary Care Section and Integrated Community Services Section

Measurable outcomes

- **Improve patient experience of A&E services**
- **Improve staff experience for A&E Departments and 111/999**
- **Reduce mortality attributable to A&E pressures**

Our plans

- Access to services and quality were identified as what matters most to people in South Yorkshire and a key priority in our plan is to improve access to urgent and emergency care, by simplifying access points, integrating urgent care delivery, increasing workforce and capacity, and improving patient flow through hospitals.
- To improve access and ease pressure on our urgent and emergency care services that result in increased waiting times for patients in A&E our plans include:
- Continuing to strengthen our Urgent and Emergency Care Alliance
- Maximising workforce capacity, utilising skill mix, expanding roles and recruiting additional staff, developing a flexible and integrated workforce for UEC services.
- Aligning plans to improve urgent and emergency care including development of integrated neighbourhood teams by primary and community services and support alternative pathways to A&E via CAS and urgent community response. Enable the expansion of virtual wards to support people in the community as an alternative to hospital admission.
- Reviewing our directory of services (DOS) to expand alternative pathways.
- Working in partnership with the Yorkshire Ambulance Service in the delivery of their **Strategy**
- Increase clinical support in YAS to reduce conveyances.
- For partners to work together to address challenges in ambulance handovers with improvements to be made aligned to national standard to assist with the recovery of ambulance responses to patients.
- For the UEC Alliance to align Acute Trust escalation policies with YAS escalation policies to enable early action to be taken to address challenges.
- To implement a range of initiatives to increase capacity in the community to innovatively support patients and address delays in discharge from hospital, including expansion of virtual wards, working with local authorities, social services and VCSE partners.
- To explore new delivery models including virtual emergency department.
- To work with partners to support high frequency users of A&E, including those with complex needs, drug alcohol dependencies and those that are homeless.
- To work with MHLDA Provider Collaborative to align developments to improve crisis support and urgent and emergency care for mental health conditions.
- To work with academic partners to explore inequalities in access to care and opportunities to address this for specific groups to reduce health inequalities.
- To work with our Children and Young People's Alliance to include children in plans to improve access to integrated urgent and emergency care.
- To reduce avoidable conveyances to hospital through delivering care at home or accessing alternative pathways to reduce hospital admissions.
- Partners are also reviewing their sustainability plans, including YAS and have identified a potential longer term opportunity to develop a low emission fleet.

UEC Innovation Awards

In partnership with the UEC Alliance, the South Yorkshire Innovation Hub delivered a UEC innovation award programme that awarded c£225,000 to four projects to test innovative ideas to improve care for people living in South Yorkshire and relieve pressures on urgent and emergency care services. Projects funded included the establishment of a social and wellbeing hub at Sheffield Walk in Centre, a discharge medicine delivery service, a frailty virtual ward to facilitate care closer to home, and a moving with dignity project to support more timely discharge. The outcomes of these innovation awards are being evaluated in order to use the lessons learnt to help deliver our priorities for improving urgent and emergency care.

Urgent and emergency care

Key National Expectations

The Operational Planning requirements for 2024/25 are

- Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
- Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25
- Continue to consolidate and integrate services that support admission avoidance and hospital discharge, and support ambulance response times, by treating people in the most appropriate setting for their level of need including urgent community response , virtual wards, acute frailty services, intermediate care and Same day emergency care (SDEC)
- Continue Increase referrals to and the capacity of UCR services, whilst still ensuring a timely response, with a particular focus on developing and standardising referrals from 999, 111, clinical assessment services and care homes
- Expand bedded and non-bedded intermediate care capacity to support improvements in hospital discharge and enable step-up care in the community

The NHS Long Term plan requirements include

- To embed a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20 to support patients to navigate services
- To fully implement Urgent Treatment Centres to deliver a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111
- To ensure coverage of integrated urgent care services, accessible via 11 or online 24/7
- All Hospitals with a major A&E Department to
  - Provide SDEC services (12 hours a day 7 days a week)
  - Deliver an acute frailty service for at least 70 hours a week
  - Record all patient activity in A&E, urgent treatment centres and SDEC within 30 minutes of arrival
  - Further reduce delayed hospital discharges
  - Use CAS as a single point of access for all for integrated urgent care and discharge from hospital

The delivery plan to recover urgent and emergency care includes

- Increasing capacity in hospitals, ambulances and improving flow
- Growing the workforce and enabling flexibility
- Improving discharge, scaling up intermediate care and social services
- Expanding and integrating out of hospital care including virtual wards
- Making it easier to access the right care

Urgent and Emergency Care priorities for year 1 and 2

Improve patient access to A&E Alternatives	Improve operational processes at the front door of hospitals.	Improve flow of hospitals
Review current pathways and develop improvement plans to improve A&E performance Collaborative with integrated community services programme to continue to deliver urgent community response and alternative pathways to A&E	Work together to develop plans to reduce handover delays at ED Develop and deliver plans for a consistent approach and provision of hospital based same day emergency care (SDEC) Develop UEC Integrated Framework memorandum of understanding Ensure admission avoidance provision is consistently in place Deliver plans to support high intensity users	Review current discharge processes and implement improvement plans to reduce delays. Deliver '100 day discharge challenges' deliverables Work with integrated community services, including social care, to ensure sufficient capacity and maximise the use of and support expansion of virtual wards and support developments of intermediate care

Planned hospital services (elective and diagnostics)

Measurable outcomes

- **Reduce slope index of inequality in elective admissions by deprivation decile**
- **Reduce waiting times for diagnostics and elective care**
- **Reduce hospital readmission rate within 30 days of discharge**

Our plans

- Our plans have an immediate focus on recovering elective and diagnostic pathways to reduce waiting times for patients with a specific focus on orthopaedics, ophthalmology, ear nose and throat and general surgery.
- The Acute Federation is also implementing a Clinical Strategy to deliver improvements in the quality of care, reduce unwarranted variation between providers, address inequalities in access and improve resilience and efficiency. This means continuing joint work on urology, rheumatology and gastrointestinal bleeds and developing a methodology for clinical service improvement across providers. Looking at how to develop a networked workforce for resilience and sustainability, increasing interoperability between providers, maximising collective use of estate and embracing innovation and new technology.
- The Sheffield Elective Orthopaedic Centre (SEOC) opened at the Royal Hallamshire Hospital in April 2023 and the Mexborough Elective Orthopaedic Centre of Excellence (MEOC) opened at Mexborough Montagu Hospital in Jan 2024, offering planned orthopaedic surgery to patients. Each elective hub brings the skills and expertise of staff under one roof with protected facilities and theatres, separate from emergency services, so that patients will be more likely to be able to go home the same day and helping to deliver shorter waits for surgery. They are modelled on best practice published by NHS England's Getting It Right First Time (GIRFT) programme and the Royal College of Surgeons of England.
- The Community Diagnostics Centres (CDCs) at Montagu Hospital, Barnsley Glassworks and Badsley Moor, Rotherham are well located to improve access and to contribute to reducing health inequalities. Endoscopy commenced at Montagu in November 2023 and expansion plans at the three CDCs throughout 24/25 will increase diagnostic capacity further; the CDCs are also supporting workforce development plans via apprenticeships and local recruitment.
- The new endoscopy unit at the Royal Hallamshire Hospital, Sheffield provided three more Royal College of Physician-accredited endoscopy rooms, increasing capacity in 23/24 and further in 24/25 as staff expansion occurs.
- A diagnostic workforce strategy, including academy training models to increase imaging and endoscopy staff, improve and standardise training quality, upskill (clinical and non-clinical staff) and improve retention.
- Plans to enable digital transformation and connectivity to join up services, improve access to data for health and care staff and patients, increase safety, improve experience and reduce inequity.
- Work to improve communication with healthcare professionals, enable patient choice and patient centred care, use of virtual consultations and patient initiated follow-up to reduce missed appointments and free up capacity for those in need.
- Clinical decision support software, Robotic Process Automation (RPA) and Artificial Intelligence (AI) to aid referral optimisation, waiting list management
- Text validation and patient portal development to support two way communication with patients to improve safety and inform prioritisation of patients on waiting lists.
- Digital exclusion will be considered in all elective and diagnostic service improvements.
- Utilisation of GIRFT, HVLC, BADS and Model Health System data to benchmark services, share learning from high performers and increase day case rates, OP and theatre utilisation and reduce readmission rates and length of stay.
- Taking a preventative whole pathway approach using guidance e.g. Best MSK, Optometrist First.
- There are plans to screen and risk assess patients waiting for inpatient procedures and to support patients to optimise their health prior to surgery. The Active Wait programme co developed by MSK patients, Sheffield Teaching Hospital, Sheffield Hallam University and the Advanced Wellbeing Research Centre will be evaluated.
- Ensuring information and tools are available to enable people to manage their own health condition and self care.
- Work to disaggregate waiting lists by ethnicity, deprivation and health inclusion groups to better understand those accessing services and those underserved, ensuring board level oversight.
- Estates design based on latest guidance which includes sustainability applied to all developments.

Planned hospital services (elective and diagnostics)

Key National Expectations

The Operational Planning requirements for 2024/25 are

- **Elective Recovery:**
  - Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)
  - Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%. For South Yorkshire our local target is 103% (in line with the national target of 107%) but we have agreed an operational plan of 105.5%
  - Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25
  - Improve patients' experience of choice at point of referral
- **Diagnostic Recovery:**`
  - Increase the percentage of patients that receive a diagnostic test within six weeks in line with regional expectations towards the national ambition by March 2025

The NHS Long Term plan requirements include

- Patient choice at the point of referral and personalised care
- Redesigning and digitally enabling services, including virtual outpatient consultations, straight to test, and specialist advice and guidance
- The development of pathology and imaging networks
- Investing in equipment and staff to expand diagnostics, including pathway development and community diagnostic centres to support cancer best practice pathways
- Enable delivery of multiple successive tests in one visit
- Digital investments, to progress open standards infrastructure to rapidly transfer images to specialist clinician for interpretation/reporting
- Implement decision support software and AI
- Extend use of molecular diagnostics; offer genomic testing to all with cancer it would be of clinical benefit and extend participation in research
- Linking and correlating genomics, clinical data and data from patients
- Include use of Independent Sector provision
- Other, GIRFT, HVLC, Sir Mike Richards Diagnostic Review, model hospital

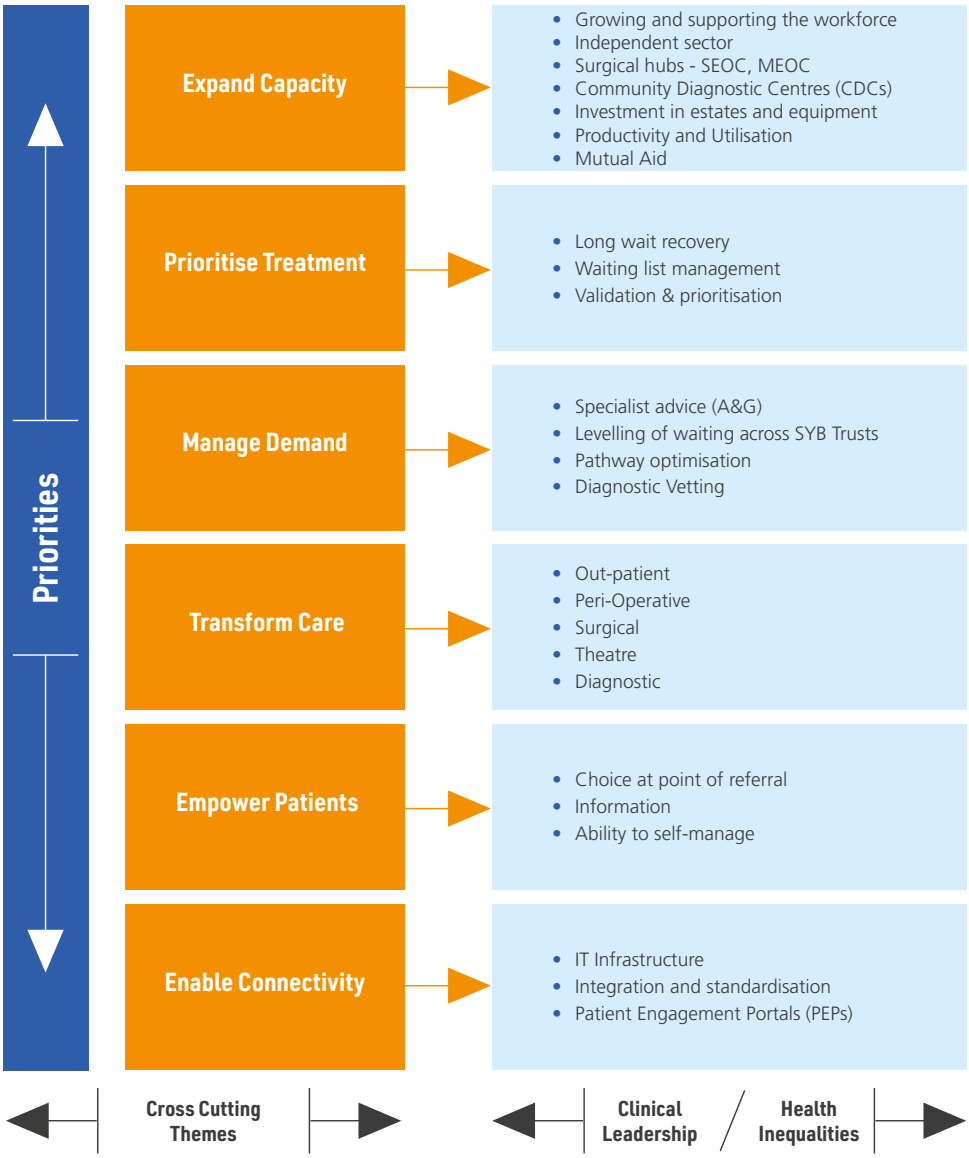
Barnsley Glassworks Community Diagnostic Centre CDC

A pioneering Community Diagnostic Centre (CDC) opened in Barnsley in 2022. Barnsley's CDC is the first of its kind to be sited in a town centre mixed retail and leisure facility.

The initial offer included phlebotomy (blood testing), ultrasound, breast screening and DEXA diagnostic services and contributed to increased breast screening uptake and fewer missed appointments. CT scanning was added in October 2023 and MRI in February 2024 and cardio respiratory diagnostics. The convenient and accessible location in the heart of Barnsley will not only provide greater capacity for these diagnostic services but it is hoped will encourage attendance and contribute to enabling earlier detection of disease and addressing health inequalities.

The development of the CDC has created local jobs, offered apprenticeships and contributed to the local economy including progressive procurement approaches and encouraging footfall into the town centre, all demonstrating the NHS contribution to wider social and economic development.

Elective and Diagnostic Recovery Plan



Montagu Community Diagnostic Centre

The development of a Community Diagnostic Centre at Montagu Hospital in Mexborough commenced in late 2021, by securing CT and MRI mobile scanners to increase diagnostic capacity to address waiting lists. Montagu Hospital is in the Dearne Valley, a relatively deprived area and is well located for Barnsley, Rotherham and Doncaster. £9 million was secured to expand the CDC to include an endoscopy suite which opened in November 2023, with training facilities and multifunctional clinic rooms, contributing to a reduction in waiting times. A further case was supported to build an imaging suite, including CT, MRI and ultrasound scanning facilities to significantly increase the diagnostic capacity to reduce waiting times, meet future demand and support the development of our diagnostic workforce for the future. The CDC is on the same site as the Montagu Elective Orthopaedic Hub, providing joint opportunities to improve diagnostic and elective pathways.

Planned Care (elective and diagnostics) priorities for year 1 and 2

Continued elective recovery

Develop and deliver an elective recovery plan.

Utilise funding to expand the workforce, invest in physical assets/estates, utilise the independent sector and optimise pathways.

Design and implement elective hubs.

Sheffield Elective Orthopaedic Centre phase 1 April 2023 and phase 2 August 2023.

Montagu Elective Orthopaedic Centre opened 15th January 2024.

Clinical prioritisation and ongoing validation work.

Continue to develop system management approaches to facilitate mutual aid to address long waiters.

Outpatient transformation, including implementation and expansion of PIFU pathways.

Continued diagnostic recovery

Utilise funding to expand the workforce, invest in physical assets/estates, utilise the independent sector and optimise pathways.

Continue to develop and deliver diagnostic workforce strategy.

Consolidate delivery through and expand Community Diagnostic Centre (CDC) diagnostic capacity at Montagu, Barnsley Glassworks and Badsley Moor, Rotherham. Maximise the opportunities to align with the Montagu Elective Orthopaedic Centre.

Continue to share best practice, undertake capacity and demand reviews to understand opportunities for improvement and deliver pathway transformation including straight to test.

Implement clinical decision making software, RPA and artificial intelligence.

Pathway improvement and utilisation

Using GIRFT, HVLC, BADs and Model Health System data to benchmark services and share learning to increase day case rates, outpatients and theatre utilisation and reduce readmission rates and length of stay.

Work with place partnerships and other partners e.g. Primary Care Alliance and wider primary care, to take a preventative whole pathway approach using speciality guidance.

Elective Centres

The Montagu Elective Orthopaedic Centre of Excellence (MEOC)

Is the product of a collaboration between Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and The Rotherham NHS Foundation Trust. An investment of £14.9 million created a state-of-the-art hub in Mexborough with two theatres and 12 beds. Construction commenced in June 2023, and following clinical service design and recruitment MEOC opened in January 2024. This centre is expected to provide around 3,400 high-volume low complexity orthopaedic procedures per year once it is fully operational. It will help reduce surgical waiting times for patients requiring orthopaedic procedures and release capacity at the host hospitals for other elective waiting list work.

Sheffield Elective Orthopaedic Centre (SEOC)

Following an investment of £5.5 million capital funding, phase 1 of the Sheffield Elective Orthopaedic Centre (SEOC) opened in April 2023 at the Royal Hallamshire Hospital with the theatre assessment unit admitting all elective orthopaedic inpatients and day case patients and two additional theatres. New ward facilities and an enhanced care unit opened August 2023. With investment in additional staff, there has been a gradual increase in activity and a higher proportion of patients able to go home on the day of surgery, in line with GIRFT and the Royal College of Surgeons guidelines.

The facility is the new home for elective lower limb, foot and ankle, shoulder and elbow and knee surgery, with emergency orthopaedic and trauma care, spinal and limb reconstruction continuing to be delivered at the Northern General Hospital.

Cancer services

Measurable outcomes

- **Increase percentage of cancers diagnosed at stage 1 and 2**
- **Increase five-year survival rate from all cancers**
- **Reduce premature mortality rate for cancer**

Our plans

Cancer is one of the main causes of premature mortality in South Yorkshire. The main risks associated with cancer are largely modifiable and are common with other major disease groups. Our plans therefore include working with partners on modifiable risk factors to promote both primary prevention and embed secondary prevention. Our plan is led by business intelligence to ensure a focus on reducing inequalities, clinically led and co-produced with our Patient Advisory Board to ensure experience is on a par with clinical outcomes.

Utilising a targeted behavioural science approach, we will work with and through our VCSE and our communities to:

- Address health inequalities, by targeting those most at risk of cancer
- Raise awareness of the early signs and symptoms of cancer
- Promote case finding and surveillance of those patients at familial risk of cancer
- Understand barriers to the uptake of screening / case finding and timely access to services in order to co-design services around these communities

Access to services and quality of care were identified as what matters most to people. A key priority is to improve access to and quality of cancer services. This includes:

- Working with primary care to facilitate timely access for those with cancer symptoms, including non-site specific and promoting direct access to diagnostics
- Ensuring there is sufficient diagnostic capacity, including via community diagnostic centres and subsequent elective capacity to ensure timely diagnosis and treatment
- Consistently delivering best practice timed cancer pathways in all our places to ensure equity and reduce anxiety through rapidly confirming a diagnosis. Embedding patient facing care navigator roles
- Embracing the use of technology, to enable care closer to home, redesign services to reduce visits with 'one stop shops' and maximise opportunities for innovation.
- Growing and supporting the workforce, including specific oncology roles, whilst enabling skill mix, role expansion, recruitment, ongoing training and support.
- Working through our clinical and patient led Quality Oversight Group to drive continuous quality improvements and address unwarranted variation in outcomes.
- Building resilience and ensure sustainable services. This includes developing a new model for non surgical oncology that is informed by what matters to people and staff and enhances research capabilities
- Enhancing pre-habilitation and rehabilitation; supporting patients to gain the optimal outcome from their cancer treatment; and promote prevention / management of other long-term conditions.
- Developing a strategic partnership with Macmillan to redesign personalised care packages around 'what matters to me', including mental health and wellbeing
- Recognising and supporting people living with cancer, and other long term conditions, in the community including both their physical and mental health needs ensuring they have the information and tools to manage their own health
- Build on the work underway to accelerate and embed the use of genomic medicine, enabling the development of innovative new service models to deliver the recently published strategy for embedding genomic medicine in the NHS

Key National Expectations

The Operational Planning requirements for 2024/25 are

- Improve performance against the headline 62-day standard to 70% by March 2025
- Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028

The NHS Long Term plan requirements include

- Increasing the proportion of patients diagnosed at early stages 1 and 2 to 75% by 2028
- Improve 1 year survival
- An additional 2,000 people surviving 5 years within South Yorkshire & Bassetlaw

The National Cancer Programme expectations also include

- A population health management approach with plans to address health inequalities that enable delivery of the CORE20PLUS5
- Delivery of best practice timed pathways to facilitate faster diagnosis and treatment
- Maximising the use of community diagnostic centres for cancer pathways and ensuring there is sufficient treatment capacity
- Addressing variation in treatment to improve outcomes
- Delivery of personalised care
- Adoption of innovations at pace and scale, including for example Targeted Lung Health Checks and GRAIL

Nudge the odds

SYB Cancer Alliance established a project to roll out a targeted Behaviour Science approach using nudge interventions and messaging to individuals in areas where attendance at cancer screening programmes was low, areas of high deprivation and within underrepresented population groups, such as those from an Asian, Romanian, Gypsy and Traveller community, to encourage individuals to attend cancer screening programmes. Initially aimed at cervical screening the learning is now being applied to Bowel and Breast cancer screening programmes.

The delivery of the intervention resulted in an increase in patients who have taken up the routine offer of screening in the practices that have adopted the nudge interventions. Phase 2 includes working with VCSE to encourage individuals with worrying cancer signs and symptoms to contact their GP practice. There is early evidence that the nudge interventions have encouraged attendance in primary care and early cancer detected in one of the trial areas.

Phase 3 is looking at creating a Behavioural Science Academy aimed at bringing the nudge theory and messaging to wider health areas other than cancer through a PHM approach.

For more detail:
NHS England Actionable Insights guidance

Cancer priorities for year 1 and 2

Nudge the odds

To reduce health inequalities and enable early diagnosis

Raise cancer awareness, identifying those that would benefit most from targeted behavioural science interventions, screening and case finding

Expand targeted lung health checks (TLHC)

Case finding including lynch, development of regional HPB and liver surveillance group

Prepare for implementation of GRAIL

Support timely presentation and primary care pathways, working with VCSE and aligning plans for local comms with national cancer campaigns

Embed FIT pathway in Lower GI referrals Roll out teledermatology

Optimise utilisation of CtheSigns to ensure timely and effective referral management and expand use to other community practitioners

Support third round of Innovation Grants and evaluate previous rounds.

Review the evidence for 'pinpoint'

Strive for excellence

To develop optimum, sustainable and resilient cancer pathways

Enhance clinical leadership and improvement capability in Clinical Delivery Groups and develop improvement plans for Lower GI, Urology, Skin and Breast. Implement best practice timed pathways for lower GI and prostate. Implement GIRFT recommendations to reduce treatment variations.

Embed non site specific cancer pathways and navigators

Work with Acute Federation to understand demand and capacity to inform future treatment needs and continue to shape Community Diagnostic Centres.

Non Surgical Oncology service redesign

Continued repatriation of SACT delivery

Review of specialised services capital investment

Scope future model for SDEC & acute oncology

Agree five year linac replacement programme. Invest in artificial intelligence to support radiotherapy planning and autocontouring.

Reestablish children's radiotherapy service

Reopen teenage cancer unit

Tip the balance

To embed embody personalised care throughout our work; put patient experience on a par with clinical outcomes; and ensuring secondary prevention is core business

Ensure personalised care interventions, including personalised care support planning based on holistic needs assessment and end of treatment summary are available for all. Addressing both physical and mental health and well

Fully implement PIFU pathways for all suitable patients in breast, prostate, colorectal

Deliver Cancer Alliance psychological support developments.

Work through Macmillan strategic partnership to redesign personalised care packages around 'what matters to me'

Test new models of prehab/rehabilitation

Cancer innovation awards

The SYB Cancer Alliance, the South Yorkshire Innovation Hub and YHAHSN deliver a Cancer Innovation Award scheme in partnership in South Yorkshire. The awards are designed to support innovative ideas to help achieve South Yorkshire's cancer priorities, in particular around improved access to diagnostics, reducing health inequalities and personalised care and support. Thanks to the success of the first two years of the awards programme, the innovation award was expanded in 2023-24 to encourage ideas that address priorities set out within the Joint Forward Plan and community-based approaches to early intervention and prevention.

Improving Mental Health Services

Measurable outcomes

- **Reduce excess under 75 mortality rates in adults with SMI**
- **Reduce hospital admissions as a result of self harm in young people (10-24yrs) and all ages**
- **Reduce suicide rates by sex**
- **Reduce admission rates for those with SMI and another long term condition**
- **Improve patient reported experience and outcomes (TBC)**
- **Decrease the gap in the employment rate of those with SMI and the general public**
- **Reduce smoking prevalence for those with SMI**
- **Improve diagnosis rate of dementia**
- **Reduce prescribing of anti-psychotic medication in people with dementia but without a diagnosis of psychosis**

Our plans

- Achieving parity of esteem of mental health and physical health to ensure they are valued equally is a key overarching ambition of our plan
- Our engagement activities continue to reaffirm the importance of accessible and effective mental health services
- Our Plans to transform mental health services are in line with our Integrated Care Strategy, the NHS Mental Health Implementation Plan, the Long Term Plan requirements and operational planning requirements and include a focus on:
- Perinatal and Maternal Mental health (including access) working with our Local Maternity Network
- Children and Young People's Mental Health (including taking a preventative approach, working with VCSE partners, improving access to services, Mental Health Support Teams in Schools (MHST), new Primary Care roles, crisis support and eating disorder services
- Reviewing the all-age eating disorder offer from community to specialised services (working across the whole pathway in a phased approach)
- Urgent and Emergency Care
    - Adult Crisis Services (including crisis alternatives, Mental Health Response Vehicle (MHRV), crisis lines (phone and text) and suicide prevention/bereavement)
    - Urgent and emergency care – transforming health-based place of safety (S136)
- Community Mental Health Transformation including Early Intervention in Psychosis (EIP), Individual Placement and Support (IPS), physical health checks and rough sleeping
- Delivery of the Inpatient Quality Transformation Programme and reduce out of area placements
- Redesign and reconfigure pathways around specialist services, crisis support and inpatient provision for those with learning disabilities and autism (see next section for details)
- Improving Autism Pathways and focus on early intervention and support including:
    - Neurodiversity (ADHD and Autism) diagnosis access and experience
    - Complex placements/inpatient care for people with learning disability and autistic people
- Improving Health Inequalities and tackling the causes of morbidity and preventable deaths for people with SMI and Learning Disabilities (see following section)
- Continued delegation of specialised mental health services including specialist perinatal
- Taking a preventative approach, working with VCSE partners, enabling early intervention, delivery of the Anticipatory Care Framework and CORE20PLUS5 e.g. by ensuring annual health checks for 60% of those with SMI and improving access for children and young people's mental health services for different cohorts e.g. ethnic groups
- Deliver priorities for specialised mental health provision, e.g. for secure adults increase low security, reducing medium security and procure a Specialist Community Forensic Team. For CAMHS potential procurement of an Eating Disorder Admissions Avoidance and Supported Discharge service. For adult eating disorders, transformation investment into specialist roles to encourage effective flow and aid discharge
- Review pathways with a quality improvement approach and align delivery with research and innovation opportunities
- Working across all our plans to improve communication with mental health care professionals and ensure sufficient information and tools are available to enable people to manage their own mental and physical health.

Improving Mental Health Services

Key National Expectations

The Operational Planning requirements for 2024/25 are

- Improve patient flow and work towards eliminating inappropriate out of area placements
- Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)
- Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery
- Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025
- Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025

The NHS Long Term plan requirements – Implementation Plan for Mental Health

- Access to specialist community perinatal mental health
- Access for children and young people to mental health services (0-25) including eating disorder services and crisis support
- Adult community mental health provision, including IAPT access, IAPT for LTCs and achievement of IAPT treatment and recovery standards
- Adult severe mental illness (SMI), delivery of integrated primary and community care, SMI physical health checks, individual placement and support and delivery of Early Intervention in Psychosis (EIP) standard
- Mental health crisis care, for children and young people and adults, 24/7 provision via 111, crisis alternatives, mental health liaison including in ambulance control
- Reduce adult acute out of area placements, therapeutic mental health inpatient care
- Increase dementia diagnosis rate to 66.7%
- Suicide prevention and bereavement support services
- Problem gambling support, national clinic implementation
- Improve data quality and maximise opportunities of digitilisation
- Achievement of Mental Health Investment Standard

The Parallel Pandemic: Covid and Mental Health, July 2022

- Identified the negative impact of the pandemic on mental across England, particularly in the North.

Children and Young People's Mental Health Services GIRFT Programme National Specialty Report, April 2022

- Identifies an approx. 50% increase in mental health conditions in 1-5 year olds from 2017 to 2020 and almost doubling number of children requiring urgent treatment for eating disorders.

Improving mental health services for children and young people, adults and older adults priorities for year 1 and 2

Perinatal, Maternal Mental Health (including access)	Children and Young People's (CYP) Mental Health (MH)	Urgent Emergency Care	Community Mental Health (CMH) Transformation	Inpatient Quality Transformation Programme
Develop and embed maternal mental health model and integrate with perinatal mental health services	Implement CYP Mental Health Strategic Plan including expanding crisis support, increasing access, further expansion of Mental Health Support Teams in Schools (MHST) and roles in primary care and review of eating disorder pathways/models	Development of crisis alternative services, further roll out of the Mental Health Response Vehicle (MHRV) crisis lines (phone and text) and suicide prevention / bereavement support Develop system model and to transform health based place of safety (HBPOS (s136)	Delivery of plans to transform CMH Teams for those with SMI, integration with primary care, workforce development, physical health needs focus, expansion of provision and employment support. Development of new personalised models of care. Targeted work on: Adult Eating Disorders Personality Disorder and Community Rehabilitation	Continue to implement learning on closed cultures. Implementation of national programme as it develops and guidance for providing acute inpatient services

Redesigning services for those with learning disabilities and autism

Measurable outcomes

- **Decrease the gap in life expectancy between people with a learning disability and the general population;**
- **Reduce suicide rates for those with Neurodiversity**
- **Reduce admission rates into mental health inpatient settings for people with a learning disability and autism**
- **Decrease gap employment rate for those with neurodiversity**
- **Reduce level of school exclusion (TBC)**
- **Increase patient (and families) reported experience and outcomes**

Our plans

- Access to and the quality of services and supporting mental health and wellbeing were identified as what matters most to people in our engagement and a key priority in our plan is to improve access to services and support for people with a learning disability and/or autism.
- This includes reducing waiting times for children and young people and adults for specialist services, digital flagging and workforce upskilling to enable reasonable adjustments across other services and facilitating access through key workers.
- Our needs assessment identifies that there are significant health inequalities faced by people with a learning disability and people who are autistic, as does the LeDer Programme. There is a Strategic LDA Health Inequalities Group overseeing a range of programmes to address these, working with VCSE and people with lived experience in coproduction to design, deliver and evaluate developments.
- For example, improving uptake of annual physical health checks (for SMI & LD) and targeting and upscaling nudge interventions to increase screening uptake for those with LD reducing the disparity in uptake for breast and bowel screening.
- Working in partnership with our Parent Carer Forums and VCSE to develop and deliver programmes with a focus on prevention, early identification and supporting and enabling people in their communities. For example, autism in schools, early identification training and Employment is For Everyone Movement, which supports our bold ambition in our Integrated Care Strategy to support people who are autistic or people with a learning disability into work or meaningful activities.
- There is a key focus on quality improvements, through the MHLDA Quality Improvement Programme and the Learning from Deaths Programme.
- There are plans to redesign and reconfigure pathways around specialist services, crisis support and enhanced community provision and strengthen local protocols around DSR/CETR's to ensure we are identifying our population who are at risk of crisis and admission to prevent admission and deliver better quality of care
- Working in collaboration with the workforce hub to develop and expand the workforce to enable delivery, including work to upskill around autism.
- The work to reduce out of area placements and enable access and support to services locally will reduce journeys and subsequent environment impact.

Redesigning services for those with Learning Disabilities and Autism

Key National Expectations

The Operational Planning requirements for 2024/25 are

- Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population

The NHS Long Term plan requirements include

- Reducing reliance on mental health inpatient care, reduce avoidable admissions, enable shorter lengths of stay and end out of area placements.
- Develop intensive support, forensic and crisis services in line with the national model a 7 day specialist multidisciplinary service and crisis care.
- Expand C&YP keyworker services to ensure every child with a Learning Disability and/or Autism with complex needs can access a keyworker
- Tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people
- Increase number of people having an annual health checks (AHC) including the implementation of Autism only annual health checks
- Expand STOMP STAMP to stop overmedication
- Delivery of LeDeR completing reviews, applying learning
- Implement Learning Disability Improvement Standards
- Reducing autism waiting times for adults and C&YP
- Improve access and offers for autism pre and post diagnostic support
- Improve understanding of the needs of people with learning disabilities and autism, including delivery of Oliver McGowan Mandatory Training
- Digital flags on summary care records to be implemented to ensure reasonable adjustments are flagged

Redesigning services for those with learning disabilities and autism priorities for year 1 and 2

Review and Reconfigure Pathways and Services to meet the needs of the LDA population	Improving Autism Pathways and focus on early intervention and support.	Addressing health inequalities and the causes of morbidity and preventable deaths
Review of LDA Specialist Services pathways and provision Strengthening community infrastructure including better identification of people at risk of admission and ensuring appropriate accommodation and care and support including provision of a safe place/ crisis beds to prevent admission.	Review of current neurodiverse assessment pathways and provision Strengthening our Autism Pre and Post Diagnostic support offers and building on the Autism in Schools Programme to support education Expansion of the C&YP Keyworking Function to support Children and families as well as supporting the wider system.	Continue to embed the Learning from LeDeR and implementing policy requirements Improving access to national screening programmes and health checks. Rollout of Oliver McGowan Mandatory Training

Improving Neurodiverse Assessment Pathways and Support

Improving neurodiverse assessment pathways is a key priority, for children and young people and adults across South Yorkshire.

For example, in Doncaster there is a well established Community Paediatric Group, bringing together multi-agency professionals and families to review pathways.

Work commenced to put plans influenced by people and their families into action during 2023 and work continues to improve neurodiverse assessment pathways and support.

In Sheffield national funding was secured to continue the Autism in Schools Project, with an increased number of schools involved to improve support for neurodiverse children and young people. This includes support groups and resources for school staff and improvements to the school environment.

Specialised services

Measurable outcomes

- **Improve number of patients accessing thrombectomy**
- **Reduce stillbirth and neonatal mortality rate**
- **Increase cancer 5 year survival rate**
- **Reduce rate of growth in new referrals to renal dialysis units**

Our plans

- The Yorkshire and the Humber Specialised Commissioning and Health and Justice Team currently commission a diverse range of services, including those provided at specialist tertiary centres, within prison settings and specialised inpatient mental health units.
- Our plan is to work through joint collaborative commissioning approaches, set out in Roadmap for integrating specialised services within Integrated Care Boards, in May 2022. To explore ways to deliver new service models to integrate specialised services into care pathways. This will enable us to work together to improve access to specialised services, ensuring care as close to home as possible and build upon our clinical engagement to expand new models of service delivery through network approaches
- There is a commitment and intent for future delegation of specialised services that as such we will enter into Joint Working arrangements between the region and NHS South Yorkshire from April 2024.
- Across Yorkshire and the Humber a number of areas of focus have been agreed by ICBs and they are set out on the next page.

Specialised services

Key National Expectations

The NHS Long Term plan requirements include

- Specialised services have an important part to play in the delivery of the long-term plan ambitions.
- Specialised services are key components of broader care pathways
- E.g. mechanical thrombectomy as part of the stroke care pathway and as such have a key part to play in transforming care pathways to improve access and quality of care, reduce inequalities in access, outcomes and experience and unwarranted variation in delivery.

Specialist Services Yorkshire and the Humber Priorities

Healthy childhood	Cardiovascular	Cardiovascular	Cancer	Other	Other
Neonatal Care To work with the Yorkshire and Humber Neonatal Operational Delivery Network and Local Maternity and Neonatal Networks (LMNS) to deliver the 5-year plans for the implementation of the national Neonatal Critical Care Review to reduce neonatal mortality.	**Mechanical Thrombectomy** for Stroke To improve access to Mechanical Thrombectomy across the region by optimising the use of current in-hours services.	**Renal Dialysis** Working through the Y&H Renal Network actively reduce the need for renal dialysis by actively focussing on interventional and alternative treatments.	**Radiotherapy and Chemotherapy** To work with providers of Paediatric Radiotherapy, Chemotherapy, Oncology Services, and Cancer Alliances to develop new and sustainable service models	**Adult Critical Care** Develop an Adult Critical Care Transfer Service that will support best use of critical care capacity across the Yorkshire and the Humber.	**Neurorehabilitation** To review current provision and develop plans for an integrated offer to increase equitable access, improve coordination and reduce out of area placements.

Mechanical Thrombectomy

Thrombectomy, also known as mechanical clot retrieval, is the surgical removal of a blood clot in an artery and is used to treat some strokes caused by a blood clot (ischaemic stroke) and it aims to restore blood flow to the brain. Partners in South Yorkshire continue to work to expand the regional Mechanical Thrombectomy service and develop a robust plan for expansion into weekends. The expansion will improve access and mean more patients across the region can benefit from this life saving and brain saving treatment. This will help to improve patient outcomes and reduce current inequalities in access.

Continuous quality improvement and embracing innovation and research

Our plans

- Our needs assessment outlines that health inequalities are widening and in response to this we must act differently and adopt innovative new models of care and technologies. Innovative technologies have the potential to improve access and address health inequalities. We recognise that innovation and improvement are cross cutting themes and as such are threaded our Joint Forward Plan, with innovation and improvement fundamentally linked to digital transformation see the section on digital.
- In 2024-25, we will continue to build on our system prioritisation of innovation and research and dispatch our statutory duty to promote innovation by delivering on the priorities set out within our Innovation and Research Action Plan, which was co-developed with partners in 2023-24. This plan responds to the latest guidance from NHS England on how ICBs can maximise the benefits of research, and the needs and priorities identified by partners.
- As set out in that plan, priority delivery activity in 2024-25 will include:
  - Maturing our Research and Innovation Forum to build closer working partnerships between academic, industry and health and care partners around areas of priority
  - Further developing the system governance for research and innovation provided by the Digital, Research and Innovation System Delivery Group, including with a focus on:
    - building a systematic collaborative approach to leveraging external funding to support research, innovation and digital transformation
    - providing system sponsorship to innovative projects to maximise their impact and likelihood of success
    - building South Yorkshire's reputation as a place of excellence for health and care innovation, research and digital transformation
  - Diversifying public participation in research, through our Working Together in Research programme and taking forward the actions and recommendations developed through this programme led by voluntary and community sector partners
  - Developing a research prospectus in partnership with academic partners to guide collaborative research activity
  - Working with partners to identify and showcase innovative good practice happening at a local level, and collaboratively supporting this to scale to a system level in order to maximise the benefit of innovative good practice
  - Building targeted partnerships with innovation partners to deliver programmes aligned with system priorities
  - Work with partners to maximise the population benefit of recent investments in South Yorkshire research and innovation infrastructure, including the South Yorkshire Digital Health Hub and South Yorkshire's two health tech research centres
- NHS South Yorkshire is committed to developing a culture of improvement. The creation of NHS IMPACT and the 5 pillars of improvement will further support this ambition. The ICB is using the self-assessment maturity tool to better understand our strengths and opportunities to increase our improvement capacity and capability. This is supported through the spread and adoption of a recognised Quality, Service Improvement and Redesign (QSIR) programme. In addition the development of a Quality Management System to include effective programme management arrangements to support delivery of our key transformation programmes will further embed improvement into our management processes.

Research and Innovation Forum

The South Yorkshire Innovation Hub convenes a Research and Innovation Forum that brings together health and care staff, researchers and academics, and innovators and Health Innovation Yorkshire and Humber to share ideas and develop partnerships in key areas of clinical priority for addressing health inequality. The Research and Innovation Forum launched in 2022, and has since then brought people together to discuss the development of the South Yorkshire research and innovation strategy, and how we can address inequalities and improve outcomes in CVD and respiratory conditions. Going forward, the Forum will continue to bring together colleagues from across South Yorkshire to ensure research and innovation are brought to bear on our big health and care priorities and build close partnerships with the academic and innovation expertise we have in the region.

Continuous quality improvement and embracing innovation and research

Key National Expectations

The Operational Planning requirements for 2024/25 included

- Complete the NHS IMPACT self-assessment (ICBs and providers) and use this to create a shared, measurable plan for embedding improvement, systematically using improvement as the approach to deliver key priorities
- Specific actions include:
  - supporting board and executive development, focused on adopting and embedding improvement
  - building staff capability, including across system partners where appropriate
  - putting in place the infrastructure to support an improvement approach
  - applying best practice in the design and delivery of improvement programmes that include tackling flow, safety, productivity
  - participating in national programmes such as improvement collaboratives and peer learning networks

The NHS Long Term plan requirements include

- An expectation that plans will be updated to prevent ill health including a continued focus on CVD prevention, diabetes and smoking cessation, with plans to be built on successful innovation and partnership working e.g. Covid-19 vaccination programme.

Accelerated Access Collaborative Commitments

- To make the NHS the best place in the world to undertake research
- Every patient will be supported to take part in research that is appropriate for them and every NHs organisation will be involved in clinical research

Continuous Quality Improvement

Continuous quality improvement and embracing innovation and research priorities year 1 and 2

The priorities identified in year 1 and 2 focus on developing the infrastructure and capability to enable us to strengthen our quality improvement approach and embrace innovation and research and will overtime contribute to the outcomes described across other programme areas

Identify opportunities for innovation	Build a shared research & innovation strategy	Establish system governance	Quality Improvement Approach
Work collaboratively to identify opportunities for innovation and adopt proven innovation Create the opportunity to innovate through delivery of: a scale and spread programme a research and innovation forum	Work collaboratively with research and innovation communities to bring world leading expertise to bear on health and care priorities and develop a research and innovation strategy	For research and innovation by developing the Digital, Research and Innovation System Delivery Group	Implement the five pillars in the NHS Improvement Approach: • Building a shared purpose & vision • Building improvement capability • Developing leadership behaviours for improvement • Investing in culture and people and • Embedding a quality management system Implement QSIR training to all staff. Implement a standardised programme management approach across the ICB Implement a South Yorkshire networked approach to Quality Improvement building on and connecting the networks across South Yorkshire and beyond.

Quality Surveillance Oversight and Improvement

Our plans

- Access to high quality care and support is one of the key themes from our engagement work and in response to this we identified it as a goal in our initial Integrated Care Strategy.
- Our Integrated Care Strategy sets out the following principles in relation to quality:
  - We will work together to develop detailed clear standards defining what high quality care and outcomes look like, based on what matters to people and communities
  - Create a shared understanding of accountabilities for the delivery of quality and safety across the system.
  - Focus our resource and embed effective quality governance arrangements appropriately
  - Core to our approach will be to reduce health inequalities and minimise variations in the quality of care and outcomes across South Yorkshire to inform our ongoing improvement
  - Embed a single, consistent approach to measuring quality and safety using KPIs triangulated with intelligence and professional insight
  - Celebrate where we have got things right and share this learning widely to continue our development journey
  - Focus on adopting innovation, embedding research and monitoring care and outcomes to provide progressive, high-quality heath and care policy
- Following the transition to NHS South Yorkshire the ICB has established a robust quality governance framework, with Executive Clinical Leadership from ICB Executive Chief Nursing Officer and Medical Director, with the Executive Chief Nurse having statutory accountability on behalf of the Board for Safeguarding Children and Adults, SEND, CHC (continuing healthcare provision, LEDER and MCA (Mental Capacity Act).
- The Safeguarding Accountability and Assurance Framework (2022) clearly sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. NHS responsibilities for safeguarding are outlined in a range of legislative requirements.
- The duties for the delivery of the quality, safeguarding and safety agenda are being discharged through distributed leadership across the system and at place through the place based Chief Nurses with each holding lead responsibilities.
- This together with our approach to continuous quality improvement will enable us to dispatch our duty to continually improve the quality of care and outcomes.

Quality surveillance

South Yorkshire Integrated Care Partnership (ICP)
Priorities and Strategy development informing the ICB Forward Plan

NHS South Yorkshire Integrated Care Board
Statutory requirements for the commissioning of health services, that meet the need of the South Yorkshire population. Ensuring that services are high quality and delivery of the quadruple aim

NHSE Regional Quality Group
Focussed on the Quality Agenda and any key risks and issues for escalation to the region.

System Quality Group

System Leadership Executive

ICB QPPIE Assurance Committee
Delegated responsibilities from the Integrated Care Board. Including establishing a Work Programme and embedding quality improvement across the ICB. Oversight to the delivery Programme

ICB Place Committee
To provide assurance to the ICB on delivery of health and care in each Place. Key working relationships with Quality and delivery as part of South Yorkshire wide work programme as well as local requirements

Operational Executive
Drawing together ICB Executives and Senior Teams, enables a focus on risk mitigation and delivery

Assurance Reporting and Quality Improvement (PERFORMANCE / QUALITY / EXPERIENCE)

Quality Programmes Reporting and Risk Escalation across

- Cancer Alliance
- LMNS
- Acute Provider Collaborative
- MHLDA
- Urgent and Emergency Care
- Primary Care
- System Delivery Groups

Quality South Yorkshire ICB Delivery Programmes

Individual Placements and CHC
In 2022/23 a focus on review and consolidation along with embedding the new CHC Framework

Safeguarding and Public Protection
A core focus on the citizen's health, wellbeing and human rights. Including quality assurance and improvement. And a focus on the needs of the most vulnerable and at risk groups

Maternity
Sharing the work of the LMNS and focussing on quality and system developments, including current priorities related to quality improvement, experience and outcomes

System Medicines Optimisation
Continuing to embed the four key principles of Medicines Optimisation and consolidating the approach, where appropriate, across South Yorkshire

MHLDA / SEND
Focussed on the delivery of the MHLDA and SEND programme

Infection Prevention Control
Ensuring compliance with the national infection prevention control manual, embedding key work programmes including AMR

Quality and Patient Safety
Delivery of Quality and Patient Safety oversight in each Place Identifying and delivering key priorities including reporting, assurance and a focus on quality improvement

Quality Surveillance and Reporting
Development of a single reporting approach across assurance delivery and escalation related to statutory requirements, quality concerns and reputational risk

ICB CNO Group
Focussed on delivery programme and key risks and issues as well as driving improvements

7 Developing our workforce

Our plans

- Our Integrated Care Strategy set out a bold ambition to value and support our entire workforce across health, social care, VCSE (including volunteers), and paid and unpaid carers. This involves developing a diverse workforce that reflects our communities.
- The South Yorkshire Workforce Hub co-ordinates a range of enabling programmes which support our partner organisations to collaborate and plan, recruit, develop, optimise and retain our workforce.
- In addition to the breadth of our enabling programmes, our Hub supports targeted plans across Place and professional networks to target support tor workforce.
- There are many organisations delivering health and care services across South Yorkshire, and we work with our anchor institution partners to identify ways to improve the experience of our workforce.
- In June 2023, the government published a national NHS Long Term Workforce Plan. This provides a Framework which will inform how our programmes recruit, retain and reform the NHS workforce over the next fifteen years.
- A South Yorkshire workforce strategy will be published which refreshes our plans in light of national and local priorities. As part of this, we will focus ways to improve the health and experience of our current and future workforce.

Priorities	Outline Plans (NHS Long Term Workforce Plan published 30 June 23)
Integrated Working	• Strengthen partnership working • Reduce barriers created by boundaries • Increase number of integrated roles
Developing System Workforce Planning Skills	• Develop system-wide workforce planning skills • Produce appropriate whole workforce baseline, through dashboard • Provide a tool kit for effective workforce planning
South Yorkshire Careers and Employability	• Produce a South Yorkshire platform for careers/vacancies • Strengthen links with education providers • Increase opportunities for all of our communities to join workforce
Education and Training	• Develop strategies for all components of education and training • Deliver joint training, where possible • Expand adoption of apprentice workforce
Supporting Capacity	• Further expand collaborative staff banks • Implement digital staff and training passports • Use non-health workforce to support capacity
New Role Development	• Provide a portfolio of impact on roles in service • Expand ARRS roles across other sectors
Retaining our workforce	• Improve data to support retention activities • Improved sharing of best practice across all sectors • Strengthen engagement for all sectors
Looking after our people	• Wellbeing offers will be extended across whole workforce • Support and develop Wellbeing Champion and Guardian roles • Implement 'Growing Occupation Health' project
Equality, Diversity and Inclusion	• Implement recommendations to be an anti-racist region in line with our bold ambition • Improve recruitment to ensure workforce is representative • Increase the number of diverse leaders across the system
Streamlining employment processes	• Align and streamline recruitment processes • Reduced inefficiencies in systems and practices • Adapt recruitment process to expand opportunities for widening access to jobs

Our Workforce in South Yorkshire

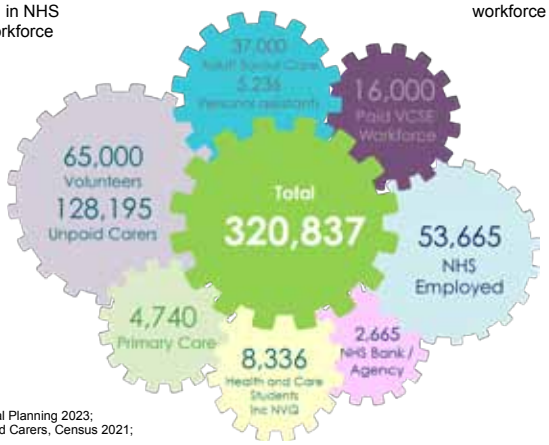
8.5%
growth in NHS workforce over last 3 years, with future growth outlined in NHS Long Term Workforce Plan

10,000
additional social care posts projected to 2035

4.5 m
hours of work per year provided by employed VCSE and volunteer workforce

Sector	Male	Female
NHS	20%	80%
Primary Care	15%	85%
Adult Social Care	15%	85%

Sector	Age 55+	Under 55
NHS	17%	83%
Primary Care	31%	69%
Adult Social Care	29%	71%



Sector	BAME	White
NHS	19%	81%
Adult Social Care	8%	92%

Sector	Vacancy rate
NHS	8%
Adult Social Care	9%

Sector	Turnover rate
NHS	9%
Adult Social Care	32%

Data Sources: NHS & Ambulance/Primary Care – SY Operational Planning 2023; Social Care and Personal Assistants, Skills for Care 2022; Unpaid Carers, Census 2021; Volunteers, VCSE SY Report 2023
Data for Primary Care relates to available General Practice workforce only.
Health and Care Students based on HEI returns and extrapolated NVQ Data

Supporting and Developing our Workforce

Key National Expectations

The Operational Planning requirements:

- Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions
- Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
- Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan
- Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

NHS Long Term Workforce Plan

The NHS Long Term Plan was published in June 2023 and sets out national ambitions over next fifteen years to:

- **Recruit:** Grow the Workforce. Demand for the skills and dedication of healthcare workers is growing around the world so we need to ensure we increase training and retention domestically.
- **Retain existing talent:** by boosting flexibility in roles and supporting the wellbeing of our staff, we can ensure fewer staff leave the NHS over the next 15 years.
- **Reform:** Working, and training differently to maximise the benefit of new technology, therapies and treatment.

Our current Workforce Hub programmes are well placed to support these requirements, and will be reviewed in light of implementation guidance following publication of the plan, as part of the development of our South Yorkshire Workforce Strategy.

Whilst this plan is NHS led, we will work to maximise its reach across our whole health and care workforce.

The full plan can be found here: https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

Summary of Year 1 and 2 Priorities (Supported by engagement with South Yorkshire People Leaders)

1 Integrated Working

We will ensure the system is developed to maximise collaboration and put workforce at the heart of every conversation. We will continue to strengthen our support to current workstreams and engagement and commit to implement integrated roles, and reduce duplication where possible.

2 Developing system workforce planning skills

We will support the development of workforce skills across the system. Recognising that effective modelling and planning is key to ensuring all of our service needs are met, we will provide a toolkit that will help our system to better plan for the workforce of the future. We will also commit to developing a South Yorkshire baseline for all our workforce, through delivery of a dashboard that provides relevant and timely information and data.

3 South Yorkshire Careers and Employability

We will develop a South Yorkshire platform where we can hold information relating to careers, vacancies and opportunities. We will work closely with schools, further education colleges and universities to promote employment within South Yorkshire, encouraging the next generation, as well as ensuring we develop opportunities for all, within our communities.

4 Education and Training

We will develop strategies and plans to extend upskilling, apprenticeships, leadership, pre-registration and entry level roles, taking advantage of opportunities for joint training and innovation wherever possible. We will ensure coverage of the apprenticeship offer across a variety of networks, including non-clinical roles.

5 Supporting Capacity

We will further develop additional capacity to support all of our services across South Yorkshire, developing collaborative banks, and maximising opportunities within volunteering services, reservists, retire and return and other contingent workforce. We will commit to supporting the implementation of staff and training passports, to enable easier movement of staff across the system.

6 New Role Development

We will continue to develop and consider how new roles will support the delivery of all of our services across South Yorkshire. We will develop a portfolio of roles that allow services to understand the benefits these new roles bring. We will continue to support the expansion of additional roles (ARRS) across other sectors

7 Retaining our workforce

We will support all organisations, networks, alliances and places to ensure focus is given to valuing and retaining our workforce. We will share interventions that are developed across the system to reduce the amount of people who leave health and care careers.

8 Looking after our people

We will ensure that our health and wellbeing offers are extended and promoted to all that work across health and care, supporting wellbeing champions, and growing occupational health support. We want to ensure all our people are valued and have the best support we can provide

9 Equality Diversity and Inclusion

We will work collaboratively to recognise improvements in how we support diversity, including a focus on anti-racism, and making our workforce more representative of the communities we serve. We will look at how we improve the profile of our workforce, and how we develop more diverse leaders across our system.

10 Streamlining employment processes

Where possible, we will align and streamline people processes, policies and systems to reduce duplication and ensure commonality across organisations. We will support the review of current practices to reduce inefficiencies, and consider initiatives that will expand opportunities for people to join our workforce.

To fulfil our role as anchor institutions to increase local employment, including supporting those furthest from the labour market as described in our bold ambition.

To address one of the key wider determinants, the need for good, stable employment.

8 Digital data and technology

Our principles

Our plans are guided by the principles in our Digital Strategy for South Yorkshire:

- **Think Big, Start Small, Scale Fast** - We will adopt an iterative development approach to satisfy our users through early and continuous delivery of digital services and products, promoting sustainable development and utilising methodologies such as Agile and the Government Service Standard.
- **User Needs and Collaboration** - We will work collaboratively and transparently across South Yorkshire and with other partners across Yorkshire and Humber and nationally to meet the public and workforce users' needs, ensure we design for inclusion.
- **Ownership of Digital Priorities** - We will work with our partners to collectively develop, iterate, and own the digital roadmap for South Yorkshire including Places, Organisations and Alliances/collaboratives.
- **Maturity and Innovation** - We will seek to Improve digital maturity across South Yorkshire but allow organisations and Places to go 'further, faster' through innovation through a spirit of compromise, iterative delivery and use of common standards.
- **Technical Standards** - We will seek to contribute to and adopt (as far as possible) published technical, interoperability and data standards (including health and social care information standards) professional standards bodies, and national bodies such as NHS England. We will collectively own and maintain a Standards roadmap for South Yorkshire.
- **Appropriate Delivery Responsibility** - We will work in partnership across our system but lead delivery where it is appropriate to do so. We will also act as system conveners and provide subject matter expertise to support realisation of digital transformation throughout this plan.
- **Re-use and Extend, Leveraging SY ICS** - We will converge to form a set of strategic partnerships and platforms to leverage South Yorkshire's value as a system, manage cost-demand pressures, and ensure better integration and interoperability. We will seek to re-use and extend existing services where they meet shared user needs within South Yorkshire rather than procure new.
- **Off-the-shelf Delivery** - We will define and use standardised approaches to ensure all South Yorkshire partners can benefit from any digital procurement or sourcing activity within the region. We will identify legally compliant opportunities to extend services across South Yorkshire, e.g. electronic patient record replacement.

Our plans

- Our plans for 2023/24 and beyond will enable delivery of the requirements in the annual Operational Planning Guidance and the NHS Long Term Plan across the domains of 'What Good Looks Like Framework (WGLL), which sets out guidance to digitise, connect and transform services.
- In addition, we will utilise other national guidance and work closely with local partnerships and places to establish our priorities.

What Good Looks Like Domains

Summary of Year 1 and 2 delivery priorities across Digital, Data and Technology

1 South Yorkshire ICS data and insights strategy

Utilising user-centred design techniques, we will build a data and insights strategy and associated delivery plan in line with system requirements.

This will include creation of an ICS Data and Insight Alliance, which will bring together data leads from across the system to co-create analytical products and build a data-literate system, in line with national guidance.

This will be underpinned by a collaborative analytical environment within which the ICB and partners can co-create insights and products from linked datasets, including patient and public qualitative data and utilise advanced analytical techniques. Outputs will underpin decision-making across the system related to real-time operational delivery, care pathway development, population health and reducing health inequalities, supporting prevention and early identification as per our priority to be intelligence led.

2 Digital, Data and Technology Workforce

We aim to provide the digital tools, training and skills for staff to work safely and effectively, building a digitally literate, resilient, and capable workforce, in line with the **Government Skills and Capability Framework.** This will ensure we support professional development within DDaT and promote South Yorkshire as an attractive place to work.

3 Digital Services for Our Public

Working with partners across the ICS we will co-design and deliver a system wide coordinated approach to the use of digital communication, integrated with NHS app, which provides our public with access to local health and care services, guidance, alerts, and the ability to interact with those services e.g. the ability to book services or submit information, in order to empower our public to take an active role in their health and well-being. This will be underpinned by a strong digital inclusion programme to ensure access for all.

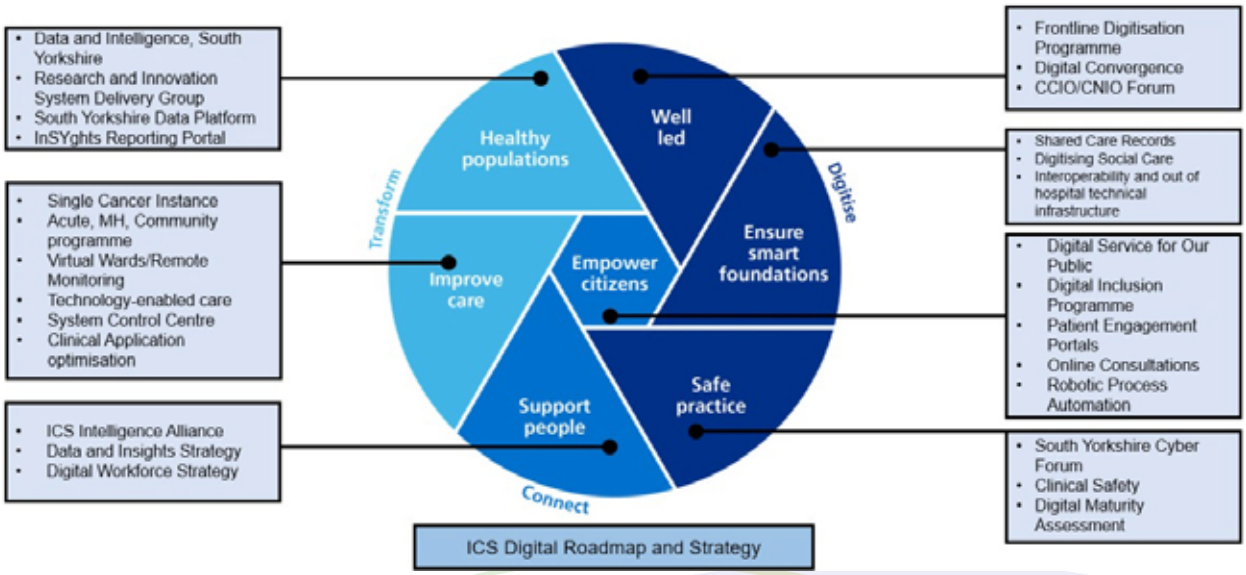
4 Integrating Digital Health and Care

In the coming months we will co-produce a South Yorkshire Digital Transformation Strategy and associated delivery plan to set out and validate our short to long-term objectives in line with local and national, mandatory requirements. We aim to digitally transform health and care through improved user experience, information sharing and convergence of digital tooling (where appropriate to do so) to provide better, joined up and personalised care. We will establish forums and agreed joint ways of working at System and Place level to bring together appropriate partners and stakeholders to promote and facilitate transformational delivery and identify shared opportunities. This collaborative approach will help to ensure South Yorkshire partners are consistently using digital methods appropriately and maximising our use of digital services for the benefit of our workforce and population. We will establish forums and agreed joint ways of working at System and Place level to bring together appropriate partners and stakeholders to promote and facilitate transformational delivery and identify shared opportunities.

5 Safe Practice and Infrastructure

We will work to ensure infrastructure for staff and the public is always available, cyber secure by design, efficient and meets expectations, providing a resilient working environment for today and the future. This will be through the development of an ICS Clinical Safety Function and South Yorkshire Cyber Security Forum and associated Cyber Security Action Plan.

Our programmes of work, linked to the What Good Looks Like Domains.



Digital, Data and Technology – Case Studies

1 South Yorkshire Digital Primary Care Programme

The recently published South Yorkshire Primary Care Strategy recognises the importance of digital transformation, and our opportunity to maximise our use digital services across primary care in its widest sense to help us collaboratively achieve:

- Well informed patients who are confident about how they can access and interact with our services via digital or non-digital methods.
- A confident digital workforce who truly believe digital solutions and online services are making their job easier and improving outcomes for patients.
- Simpler, faster and better methods for sharing information across care settings and with patients.

Our digital activity over the next 12-24 months will be centred around the Primary Care Access and Recovery Plan and helping deliver on our objectives across three key areas: access, workforce and integrated neighbourhoods.

Primary Care Priorities

Access

- Gigabit network upgrades to create fast, reliable internet connections to practices
- Digital telephony implementation to improve patient experience when contacting their practice
- Patient-facing digital services improvements, including increasing NHSApp uptake
- Pharmacy First - use of GP Connect between community pharmacies and practices

Workforce

- Application optimisation for improved productivity
- Business process transformation and automation
- Eclipse Implementation for risk stratification to improve clinical productivity and population health outcomes

Integrated Neighbourhoods

- Digital Services for Our Public – ensuring patients can proactively manage their health
- Digital Inclusion programmes to support people with their use of online and digital services
- Shared Care Records for improved integration across health and care settings
- Utilisation of a data and insight led approach to population health

2 Improving Digital Inclusion

The people most likely to benefit from more effective access to health and care services through digital channels are often those that are least likely to be online. As a result, the key to the success of any public-facing digital offering is taking into account the needs and requirements of people who may be digitally excluded. Local health and care services must work in partnership, alongside others such as the voluntary sector, to improve digital inclusion.

In South Yorkshire, a review of residents across South Yorkshire was conducted to identify recommendations to improve digital inclusion across the system. In addition, there are dedicated digital inclusion programmes at Place, which are closely linked to work to reduce health inequalities and respond to the cost of living crisis.

Over the next two years we plan to work with a local partner to build up a strong, regional social infrastructure across South Yorkshire that can deliver a consistent offer of digital inclusion support to communities in all four of our places, supporting people with their use of online and digital services. The support offer would include access to refurbished devices, data sim cards, skills courses, community digital mentors, and connectivity grants. We are also committed to working closely with our partners on the importance of digital inclusion, and not enforcing 100% digital routes for our population when this might not be the right method for some people for vital engagement, information and access.

Key National Expectations

The Operational Planning requirements include the following

- Establish board governance that regularly reviews digital and data strategy, cyber security, services, delivery and risks, underpinned by metrics and targets
- Invest in and build multidisciplinary teams with clinical, operational, informatics, design and technical expertise to deliver your digital and data ambitions
- Ensure progress towards net zero carbon, sustainability and resilience ambitions by meeting the Sustainable ICT and Digital Services Strategy (2020 to 2025)
- Extend the use and scope of your electronic care record systems, ensuring greater clinical functionality and links to diagnostic systems and electronic prescribing and medicines administration (ePMA)
- Comply with the requirements in the Data Security and Protection Toolkit which incorporates the Cyber Essentials Framework. Establish a process for managing cyber risk with a cyber improvement strategy. Have a cyber security function, including a senior information risk owner and data protection officer (DPO)
- Ensure both new and existing clinical systems and tools meet clinical safety standards as set out by the Digital Technology and Assessment Criteria (DTAC)
- Ensure compliant with NHS national contract provisions related to technology-enabled delivery
- Create and encourage a digital first approach and share innovative improvement ideas from frontline health and care staff
- Support all staff to attain a basic level of data, digital and cyber security literacy, followed by continuing professional development
- Develop and monitor a single, coherent strategy for citizen engagement and citizen-facing digital services that is led by and has been co-designed with citizens
- Make use of national tools and services (the NHS website, NHS login and the NHS App) and local digital services that provide a consistent user experience
- Use digital communication tools to enable self-service pathways such as self-triage, referral, condition management, advice and guidance.
- Have a clear digital inclusion strategy
- Use data and digital solutions to redesign care pathways across organisational boundaries to give patients the right care in the most appropriate setting
- Lead the delivery and development of an ICS-wide intelligence platform with a fully linked, longitudinal data set (including primary, secondary, mental health, social care and community data) to enable population segmentation, risk stratification and population health management
- Contribute to the ICS-wide population health management platform and use this intelligence to inform local care planning

The NHS Long Term plan requirements include

- Create digital access to NHS services to help patients and carers manage their health
- Ensure clinicians can access and interact with patient records and care plans wherever they are
- Use decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition
- Use predictive techniques to support local health systems to plan for healthcare
- Use intuitive tools to capture data as a by-product of care in ways that empower clinicians and reduce the administrative burden
- Protect patients' privacy and give them control over their medical record
- Link clinical, genomic and other data to support the development of new treatments to improve the NHS, making data captured for care available for clinical research, and publish, as open data, aggregate metrics about NHS performance and services
- Ensure NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education
- Mandate and rigorously enforce technology standards (as described in The Future of Healthcare) to ensure data is interoperable and accessible
- Encourage a world leading health IT industry in England with a supportive environment for software developers and innovators.

9 Making best use of our resources

Estates

Our plans

- An Estate Strategy was developed by NHS South Yorkshire during 2021/22. The Strategy is working towards ensuring that we have modern, fit for purpose, sustainable and high-quality estate for the people in South Yorkshire. The plans underpinning its delivery demonstrate how our estate can be improved over time, for the benefit of patients, staff and the local community. We have an estates challenge on the Doncaster Royal Infirmary site and we are reviewing our approach to funding and options for the site.
- Our plan is to increasingly move from a functional approach to managing estate, to one which looks at the whole estate across South Yorkshire, building on the 'One Public Estate' approach and principles.
- Our plans include
  - taking collaborative and innovative approaches to estates management, maintenance and efficiency and strategic development and investment. such as our approach to community elective and diagnostic hubs.
  - Supporting delivery of our clinical strategies and joint plans to maximise use of our assets through greater utilisation of existing estate, co-locating with other agencies and creating multi service hubs with statutory and VCSE partners, creating a better patient environment and reducing carbon emissions linked to our estate.
  - Making best use of our collective assets to fulfil our role as anchor institutions contributing to local economic and social development. Working with our communities to co design services and colocate health, care and VCSE provision to enable more integrated and innovative ways of working.

Key National Expectations

The Operational Planning requirements for 2024/25 include the following

- Modernising our infrastructure is an area of focus in the guidance and systems are asked to work together to develop infrastructure strategies

Modernising infrastructure

- The NHS needs modern and sustainable infrastructure to deliver high-quality and efficient care and our net zero commitment

The NHS Long Term plan requirements include

- As part of its focus on reducing waste and increasing time to care the Long Term Plan outlined that the NHS will improve the way it uses its land, buildings and equipment. To improve quality and productivity, energy efficiency and dispose of unnecessary land to enable reinvestment

National reports with implications for estates include:

- The Carter Report (efficiencies and reduction of non-clinical space)
- Naylor Report (addressing estates in poor condition with high backlog maintenance, disposals of surplus estate and reinvestment)
- Fuller Report (investment in primary care)

Estates priorities for year 1 and 2

Primary Care Capital and Community Care	Space utilisation and fitness for purpose	Sustainability and Decarbonising estate
Progress business cases and delivery plans for primary care capital developments to maximise potential benefits including social value. Ensuring the estate within the primary and community care setting are suitable for service provision.	Identify surplus and void space in existing estate and work with clinical workstreams and partners to develop plans to utilise to meet population health needs and contribute social value. Ensuring the estate is fit-for-purpose and addressing backlog maintenance to enable the delivery of healthcare services.	Review Green Plans across existing estate and identify opportunities to decarbonise. See contributing to environmental sustainability section.

Procurement

Our plans

- System partners are working together to reduce unwarranted variation and release efficiency savings including reducing procurement and supply chain costs.
- Partners are also increasingly leveraging their procurement capacity within South Yorkshire, alongside a local focus on digital, recruitment and estates to add value as anchor institutions contributing to the development of the local economy.
- In South Yorkshire, in the NHS we had previously delivered the recommended Procurement Target Operating Model objectives set by NHS England, the second highest in the country and this puts the ICS Procurement Collaborative in an excellent position to work towards the new national strategy.
- The ICS procurement teams continue to engage well in collaboration to realise mutual benefits. However it is recognised by the procurement leaders that they are approaching the limit of what can be achieved within the existing structure and governance framework.
- A comprehensive review of collaborative procurement arrangements will be conducted to reassess and enhance existing practices. This aims to build upon the progress made so far, refreshing and realigning governance structures.
- The ongoing collaboration as partners will include the full implementation of a joint work planning tool, execution of cost improvement plans, integration of the Consumables Resilience Group, facilitation of mutual aid, formulation of a case for implementing an inventory management solution, and the introduction of a Value-Based Procurement approach.

Key National Expectations

The Operational Planning requirements for 2024/25 include the following

- Drive procurement and commercial efficiencies and value by working to accepted operating models and commercial standards, making full use of the consolidated supplier frameworks agreed through NHS Supply Chain and procuring from frameworks operated by an accredited framework host (where goods, services and works are available via that route)

The NHS Long Term plan requirements include

- As part of its focus on reducing waste and increasing time to care the NHS Long Term Plan included the need to release procurement savings by aggregation of volumes and standardising specifications
- Alignment and adoption of the new Strategic Framework for NHS Commercial

National reports with implications for estates include:

- The Carter Report (efficiencies and optimising non-clinical resources)

Procurement priorities for year 1 and 2

Review of collaborative procurement arrangements

Agree the scope of collaborative procurement in South Yorkshire and develop a business case to achieve the scope. Improve the governance of collaborative procurement across Acute Trusts reporting to the Acute Federation.

Implement and embed

Provider Selection Regime (2023)
Use this to work more efficiently with VCSE partners

Recommendations and direction of travel of the Strategic Framework for NHS Commercial

Implement and embed the new Procurement Regulations due in October 2024

Financial Resources

Our plans

- Our nearer term work in finance includes;
  - Linking our starting financial challenge to the current carrying costs of the system.
  - A targeted approach to CIP and place allocative efficiency to ensure we understand opportunities and harness them.
  - Building on the DBHT driver of the deficit report, as an opportunity for shared learning.
  - Identifying further approaches to joint savings between collaboratives and alliances.
  - Review and implement a financial improvement approach, that includes technical efficiency in providers, allocative efficiency and plans to manage demand through our place partnership plans and developing transformation plans across our provider collaborative and alliances.
  - Track performance against ERF and try and assess local versus national impacts on performance
- Our wider capability work on finance includes;
  - Better tracking and understanding demand in different care contexts, by linking together and reviewing high cost episodic care.
  - Taking a population health management approach and working in partnership with system providers on creating the economic case for "left shift" in terms of social and economic value.
  - Reviewing where institutional barriers and funding approaches limit our ability to deliver transformation and integration and propose changes to remove those limitations.
- The system has an indicative 5 year capital plan that is refreshed on an annual basis as part of operational planning. The system has been advised of the system capital for 2024/25 which is £92.1m for providers and £2.4m for the ICB. There is a further £7.5m of capital that can be earned on achieving financial balance and A&E targets. Currently the system's performance would not earn this additional capital.
  The system is currently updating it's capital plans as part of the 24/25 operational plan.

Our Finance Plan for 2024/25

The fiscal outlook for the NHS continues to be really challenging in 2024/25. Local Authorities also continue to experience significant financial pressure as does our VCSE sector, creating operational and sustainability challenges across sectors.

The final submission of our annual NHS finance plan for South Yorkshire saw the system moving to a system deficit position of £49.1m. This position has been agreed with NHSE and we are now trying to manage the risks associated with delivering that plan, including the delivery of a balanced ICB position.

At a peer review and challenge session where organisations reviewed their respective positions and some further work was proposed on: i) ICB savings, ii) impact of specialised commissioning income, iii) disaggregating the financial challenge to place, iv) Medium Term Financial Plan (MTFP) based on this start point and v) review of our capital plan; which is now underway.

Now we are collectively work on

- An external review of our efficiency plans and approach to further delivery beyond the 3% (on run rate)
- The work scheduled to deliver from our Acute Federation and MHLDA Alliance regarding priorities for cross system work and savings by the end of June
- Better modelling of the impact of the place partnership transformation plans to mitigate growth
- The other measures we may need to balance the plan to try and mitigate the 24/25 deficit, whilst developing our more strategic work

10 Partnership working to deliver our plan

Working with People and Communities

Our plans

- At its formation NHS South Yorkshire made a commitment to listen consistently to, and collectively act on, the experience and aspirations of local people and communities, articulated within our Start with People: South Yorkshire Strategy.
- We will work with all of our NHS partners in South Yorkshire to ensure that citizen voice is embedded in all of our work, including involvement in the programme priorities identified within the Joint Forward Plan, and we will use a range of approaches for this.
- We will work with our partners to create a network/ community of practice of those working in citizen involvement in the NHS to ensure we don't overwhelm our citizens and we have a coordinated and where possible standardised approach.
- From the 10 principles that underpin NHS involvement, we have identified outcomes and outputs and formed an action plan for NHS South Yorkshire. The actions we have identified can be broadly aligned to the following overarching priorities for citizen involvement:
  - Put the voices of people and communities at the centre of decision-making.
  - Embed mechanisms to enable citizen involvement to play a key role in the system focus on tackling health inequalities.
  - Work with people and communities on the priorities identified within the Joint Forward Plan.

Working with people and communities

Key National Expectations

- As well as a commitment to citizen involvement, all NHS partners have a legal responsibility to involve patients and the public in their work.
- The main duties on NHS bodies to make arrangements to involve the public are all set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022: Section 13Q **Public involvement and consultation**; Section 14Z32-64 **General functions for Integrated Care Boards**; Section 242 for **NHS Trusts and Foundation Trusts**; and a requirement to involve the public is also included as a service condition in the **NHS Standard Contract for providers**.
- Working in partnership with people and communities statutory guidance is guidance is for integrated care boards, NHS trusts, foundation trusts and NHS England. It supports effective partnership working with people and communities to improve services and meet the public involvement legal duties.

Priorities for 2024/25

- **Put the voices of people and communities at the centre of decision-making.**
  This includes: Working with system partners on a coordinated and where possible standardised approach to citizen involvement. Developing a 'start with people' minded workforce. Ensuring governance, assurance processes and systems all support this aim. Improving communication and feedback to our communities to build understanding and trust.

- **Embed mechanisms to enable citizen involvement to play a key role in the system focus on tackling health inequalities.**
  This includes: Working with the VCSE, Healthwatch and partners on an approach for ongoing insight capturing, particularly from our underserved communities, to ensure we understand our communities' needs and empowering our people and communities Ensuring systems and processes are in place for a continuous involvement cycle where citizens can talk to us at any point, in any way, and we will listen and gather their insights and use them to inform our work.

  Developing opportunities for coproduction and working hand in hand with our communities to tackle system priorities.

- **Work with people and communities on the priorities identified within the Joint Forward Plan.**
  This includes: Ensuring our future plans involve our citizens, using appropriate involvement levels and approaches, including coproduction and working in partnership with our communities.

  As an example, programmes we are anticipating supporting in system or place include pathway redesign work for autism, eating disorders, diabetes, continuing healthcare policy changes; urgent care pathway developments and involvement in any potential GP practice changes and improvements to primary care (subject to change as a result of national policy and emergent local priorities).

Involving Children and Young People

The South Yorkshire and Bassetlaw Children and Young People's Alliance are committed to ensuring that the voices of children and young people are front and centre in their decision making, and undertook to co-create with young people how they want to ensure this takes place. Initially two online sessions for up to 50 children and young people from across SYB already involved in participation / engagement activities in Healthcare took place to ensure the voices of the children and young people would be heard clearly and would lead to the development of future ways of working and principles for involving young people. A follow up session was then held to agree on a delivery model for young people's participation, based on what had been heard from the young people. The chosen model is called Core and Connect, it sees one organisation leading the CYP youth voice work, connecting with all young people engaged in participation work and ensuring the views of as many YP as possible are gathered with renumeration given to the CYP groups for their work. Core and connect supports all NHS South Yorkshire work requiring youth voices and is used to help represent the views of children and young people at the various system and organisational Board meetings.

Working with Voluntary Community and Social Enterprise sector (VCSE)

Our plans

- Our needs assessment identifies that people die earlier, live longer with a health condition and that health inequalities are stark and widening in South Yorkshire. Our plans to address this include maximising the potential of partnership working with the VCSE.
- The VCSE sector is experienced at supporting people with the wider determinants of health and those most socially excluded or at risk of inequalities. The VCSE sector also holds community assets and is experienced at enabling strength based approaches.
- A VCSE and ICS Memorandum of Understanding signed in March 2023 sets out our vision that underpins our approach to partnership working: An equitable partnership embedding the VCSE at all levels of the ICS, that recognises and values the sector across strategy, delivery, engagement and insight.
- A VCSE practical strategy has been developed, building on the vision and commitments made in the Memorandum of Understanding. We will:
    - Optimise the Alliance model to underpin effective partnership working across the system.
    - Take forward our enabling priorities to **embed** VCSE participation, **engage** through strengthening community connections and insights, and ***invest*** well maximising all potential opportunities and resources.
    - Prioritise opportunities for collaboration on delivery. These include sustaining, strengthening and developing new opportunities in **social prescribing**. Our Places have successfully delivered innovative social prescribing provision, and recent innovations include the launch of a new pilot across South Yorkshire in our stroke pathway, and increasing access to green social prescribing through participation in a national test and learn programme. We will work to identify sustainable approaches, level up community provision and tackle opportunities and challenges. We will also strengthen cross sector **volunteering** through development of a volunteering plan with shared priorities to improve equitable access to volunteering, develop pathways to career progression and employment, support wellbeing, and support capacity. Finally, we will identify **new collaborative opportunities** across the system e.g. testing new collaborative and investment approaches in partnership with the Cancer Alliance.
- Work will commence on a development plan to work with the VCSE sector to drive transformation, consolidating existing good practice and plans, and identifying further opportunities to strengthen ambition and approach.
- Our VCSE is a key partner is supporting all four of our bold ambitions and the key areas that matter to our public e.g. access to services, quality and agency within the Integrated Care Partnership Strategy. We will ensure that the sector is embedded in opportunities to take this forward.

Green Social Prescribing

As one of seven national test and learn sites for embedding and scaling green social prescribing, we have built on the successful social prescribing pathways delivered in our Places and worked with VCSE as key partners. Sheffield and Rotherham Wildlife Trust is our green VCSE lead, working with Place partners to engage communities, build insight, and create a learning community of stakeholders. South Yorkshire Community Foundation has worked as our grants management partner, supporting investment with Place partners into 39 VCSE organisations to increase and diversify community access to South Yorkshires rich green and blue assets.

Key National Expectations

The Operational Planning requirements for 2024/25 include the following

- 'NHS England will support ICBs to describe how they plan to strategically commission and resource arrangements with their partners. This should include an explicit development plan to work with the VCSE sector to drive the transformation'.

The NHS Long Term plan requirements include

- A recurrent expectation throughout the Long Term Plan is to develop relationships with the voluntary sector to enable delivery, improve health outcomes and reduce health inequalities.

Integrated Care System (ICS)- Guidance on partnership working with VCSE sets out

- The need to identify the VCSE sector as a key strategic partner with an important contribution to make in shaping, improving and delivering services, developing and implementing plans to tackle the wider determinants of health
- An expectation that VCSE partnership should be embedded in how the ICS operates, including through involvement in governance structures in population health management and service redesign work, and in system workforce, leadership and organisational development plans
- ICBs are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector.
- These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.

Working with VCSE and developing VCSE Alliance priorities for year 1 and 2

Embed VCSE participation	Strengthen connections and insights between VCSE and ICS	Maximise VCSE investment opportunities
Implement the VCSE and ICS Memorandum of Understanding and the VCSE Participation Payments Policy	Strengthen communications and information sharing between NHS and VCSE partners	Shape commissioning and investment approaches to maximise VCSE partnership potential, including developing guiding principles, new models and mechanisms and new opportunities for commissioning and investment
Work with System Delivery Groups, Provider Collaboratives and Alliances to identify opportunities for VCSE involvement	Further develop the interface between NHS, ICB communication and engagement work and VCSE to strengthen the VCSE partnership role in engagement, qualitative insights and co design.	Work will commence on a development plan to work with the VCSE sector to drive transformation
Coordinate and strengthen work with the VCSE to shape new strategies and plans across the breadth of the system and implement the VCSE practical strategy	Optimise the VCSE Alliance model	Identify and develop external funding investment and leverage opportunities to support a thriving sector
Implement the system volunteering plan that builds on and harnesses the strengths of the VCSE		Identify and develop non financial resource sharing opportunities
Continue to innovate in social prescribing and identify new opportunities for partnership delivery with the VCSE		

Working with Local Authorities

Our plans

- There are four local authorities in South Yorkshire, Barnsley Metropolitan Borough Council, Doncaster Council (City of Doncaster Council from January 2023), Rotherham Metropolitan Borough Council and Sheffield City Council. They also come together in a formal partnership led by an elected Mayor, the South Yorkshire Mayoral Combined Authority (SYMCA). Oliver Coppard was elected as Mayor of South Yorkshire in May 2022 and is the Chair of our Integrated Care Partnership.
- Our South Yorkshire population health needs assessment identified serious challenges we need to overcome. South Yorkshire has a significant proportion (37%) of people living in the most 20% deprived areas nationally. Life expectancy is no longer increasing, people are dying younger and living fewer years in good health. The gap in life expectancy between the most and least deprived areas is widening. Inequalities have been exacerbated by the covid pandemic and the current cost of living challenges.
- It is well understood that health outcomes and inequalities in those outcomes are shaped by a wide range of social, environmental, commercial and economic factors. Our chances of experiencing good health and wellbeing, and maximising the length and quality of our lives, depend on the circumstances and environment within which we are born, live, and work.
- Many of the levers for improving population health, such as quality education, good employment, comfortable quality housing, connectivity, healthy local neighbourhoods, creativity and arts and commercial environment reside with our local authorities and SYMCA.
- Local authorities and SYMCA have an important role that includes direct service delivery, collaboration with other agencies and partners including VCSE, and through their actions as anchor institutions, which includes taking local procurement and recruitment approaches.
- Local authorities also look after many of those with the greatest needs, including children and young people in care and adults who either need support to live independently or who are not able to do so. As well as having responsibility for a number of regulatory functions such as planning, licensing and food safety. All areas that contribute to the conditions that create our health, the wider social, environmental and commercial determinants.
- Our well established Place Partnerships and developing South Yorkshire Integrated Care Partnership are uniquely placed to facilitate NHS partners to work with Local Authorities and VCSE to address the wider determinants of health, prevent ill health and tackle health inequalities. Our Plan is to further support and enable this by strengthening our collaboration building on and embedding our partnership arrangements.

Working with partners to address the needs of victims of abuse

Our plans

- Prior to the new Serious Violence Duty 28 areas in England including South Yorkshire were identified as having high incidences of violence and crime and as a result were requested to make arrangements for Violence Reduction Units (VRUs).
- A Violence Reduction Unit has been in place in South Yorkshire with membership including the South Yorkshire Police, Probation, Youth Justice, South Yorkshire Fire and Rescue and our four Local Authorities. This work has been built upon to establish a Serious Violence Duty Executive Board to ensure the new duty is met.
  The South Yorkshire Integrated Care Board is a core statutory member of this.
- South Yorkshire has four Place Safer Partnerships through which statutory and VCSE partners come together, and a Countrywide Community Safety Partnership that will support delivery of the new duty.
- Oversight and assurance for the new duty is directly under the Home Office.
- The SVD is to produce a Strategic Plan by 31st January 2024, the SY VRU already has a response strategy in place which includes actions for a variety of partners and this will be reviewed to meet the new duty requirements.

Key National Expectations

- The Government Introduced the Serious Violence Duty Preventing and reducing serious violence Statutory Guidance for responsible authorities (SVD) through the Police, Crime, Sentencing and Courts Act 2022.
- The extended new duty came into force on 31 January 2023. The definition of 'serious violence' now includes domestic abuse and sexual offences. This places a duty on specific organisations, known as the 'specified authorities', to plan and collaborate to prevent serious violence in their area.
- The SVD is intended to create the right conditions for authorities to collaborate and communicate, using existing partnerships where possible to share information and take coordinated action.
- By March 2023 areas need to identify an existing or new partnership to deliver the duty and identify a named lead responsible officers for each specified authority.
- The specified authorities are: - SY Police - Criminal Justice – Probation Service and Youth Offending Services - SY Fire and Rescue - Health – Integrated Care Board - Local Authorities – Leads from the four SY Metropolitan Authorities - Three other groups are required to co-operate with Specified Authorities when needed: - Prisons - Youth Custody Establishments - Education.
- The guidance states the need to produce a Strategic Plan to address serious violence informed by the findings of the SNA. This also needs to be delivered by 31 January 2024.

Priority for Year 1

- Build on SY Violence Reduction Units work to establish Serious Violence Duty Executive Board to ensure new duties are met
- Undertake a SY SVD needs analysis
- Develop a SVD Strategy

Maximising our role as anchor institutions

Maximising our role as anchor institutes to support wider socio economic development.

Our plans

- Anchor institutions are described as organisations whose long term sustainability is tied to the wellbeing of the populations they serve
- The NHS, local authorities, Universities and other large employing organisations in South Yorkshire are traditionally described as 'anchor institutes'. They are largescale employers, purchasers of goods and services, land owners and have relatively fixed assets. However primary care networks working with VCSE also have the potential to act as anchor institutions
- Anchor institutes are well placed to make a difference, address the wider determinants and can have a significant influence on health and wellbeing
- In South Yorkshire we made a commitment in our Integrated Care Strategy to harness the role of our anchor institutions to maximise our collective contribution
- Our plans include
  - Scoping the development of an anchor charter to describe the role and expectations of an anchor institute
  - Working together as NHS organisations and with our partners to maximise our role as large scale employers to widen access to good quality work, support the health and wellbeing of our staff and develop the health and care workforce of the future. To deliver our bold ambitions to value our entire workforce and support the development of an inclusive, sustainable economy in South Yorkshire.
  - Scoping the development of an anchor network to develop the charter, share learning and identify opportunities to collaborate
  - Further developing our joint procurement approaches, delivering progressive local procurement that adds social value

Key National Expectations

The Operational Planning requirements

- A number of requirements where maximising our potential as anchor institutes could contribute including improving retention and staff attendance through a systematic focus on all elements of the NHS People Promise.

The NHS Long Term plan requirements include

- Setting out the role of the NHS as an anchor institute, as a large employer and procurer of services with a key role creating social value in communities.

Other

- One of the core purposes of the ICS is to help the NHS support broader social and economic development. The NHS can deliver its role as an anchor institute by
  - Widening access to good quality work – being an inclusive employer
  - Purchasing for social benefit: Purchasing supplies and services from organisations that embed social value to make positive environmental, social and economic impacts
  - Using buildings and spaces to support communities: Widening access to community spaces, working with partners to support high-quality, affordable housing, supporting the local economy and regeneration.
  - Reducing our environmental impact: Taking action to reduce carbon emissions, reduce waste and protect and enhance the environment.
  - Working closely with communities and local partners: Collaborating with communities and work with other anchors to increase and scale impact

Maximising our potential as anchor institutions – supporting wider socio economic development – priorities for year 1 and 2

Anchor Network

Increase understanding of anchor institutions and the significant role they have to contribute to health and wellbeing directly with staff and by contributing to address the wider determinants.

Scope potential to develop an Anchor Network to support delivery of our Integrated Care Strategy.

Anchor Charter

Scope development of an Anchor charter that sets out the role and expectations of anchor institutes.

Environmental Sustainability and Net Zero

Our plans

- Plans to improve population health help to address climate change, the effects of climate change are often felt most by those with the greatest needs. Hence climate action helps to address health inequalities, e.g. cleaner air, improved housing.
- Our Sustainability and Green Plan for the South Yorkshire Integrated Care Board was published in September 2022 and sets out in detail our plans to deliver sustainable healthcare and meet the targets for net zero.
- Plans include direct interventions within estates and facilities, travel and transport, supply chain, procurement and adaptations and medicines. Together with enabling actions, including sustainable models of care, workforce, networks and leadership and funding and finance mechanisms.
- Plans include developing a sustainability network and network of green champions, rolling out an e learning module and carbon literacy training, to upskill staff and enabling inclusion in policies.
- Working with partners, including the South Yorkshire Mayoral Combined Authority on the plans to develop a citizen's assembly on the climate change emergency, as identified as a bold ambition in our Integrated Care Strategy.
- Learn from and link into national work to encourage innovation and research to achieve more sustainable ways of delivering care.
- Plans include initiatives testing the use of reusable instruments, e.g. coils

Improving our Impact on the Local Environment

The Barnsley Place Based Partnership is committed to exploring how it can operate in a way which positively impacts on our local environment.

Barnsley Hospital has been an early adopter in introducing reusable, eco-friendly operating theatre gowns and caps.

This initiative is part of the Hospital's commitment to achieving NHS England's net zero targets and improving its impact on the climate and environment.

To combat the harmful environmental impacts of single-use personal protective equipment (PPE), Barnsley Hospital has created a pilot study in partnership with laundry provider Elis to introduce reusable PPE.

Following the successful results of this pilot, including engagement and feedback from staff, they're now switching from single-use disposable theatre caps and gowns to environmentally friendly, reusable alternatives made from cloth.

The theatre caps will also be personalised with staff names and roles.

Key National Expectations

The Operational Planning requirements

- A number of requirements set out in the Operating Planning guidance, such as delivering diagnostic activity and eliminating waits for elective care require new ways of working, and with this there are opportunities to contribute to the environmental sustainability agenda, e.g. delivering 'one stop shop' care pathways and care closer to home to reduce journeys and emissions.

The NHS Long Term plan requirements include

- A range of requirements in the long term plan make a contribution to environmental sustainability, including boosting out of hospital care, digitally enabling care and delivery closer to home reducing patient travel.
- Taking a preventative and population health management approach, aligns well with planet health.

Delivering a Net Zero NHS (October 2020)

- This sets out a national roadmap to deliver
  - Net zero for emissions the NHS controls directly (the NHS Carbon Footprint) by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
  - Net zero for emissions the NHS can influence (the NHS Carbon Footprint Plus) by 2045, with an ambition to reach an 80% reduction by 2036 to 2039

Contributing to the environmental sustainability agenda together priorities for year 1 and 2

Outcomes

- Energy consumption and transition to renewable sources
- NHS Fleet related emissions
- SABA use in asthma patients and use of DPI inhalers where clinically safe
- Emissions from Entonox

Direct Actions

Development of heat decarbonisation plans by all NHS Trusts

All Trusts to enact specific direct actions including, delivering Net Zero Estates priorities , addressing emissions from anaesthetic gases by decommissioning Nitrous manifolds in theatres, conducting waste audit of Entonox in maternity units and eliminating use of desflurane, and developing plans to transition owned and leased fleet to ultra-low or zero emission vehicles

Evaluate reusable PPE projects and carry out feasibility study to inform scaling up plans

Look at initiatives to promote circular economy and campaign for reduced packaging related waste in the supply chain

All NHS organisations to transition to energy efficient LED lighting

Deliver medicines optimisation initiatives e.g. reduce wastage & promote low carbon inhalers

Apply principles of sustainable procurement – applying social value model and supporting suppliers with carbon reduction plan requirements (see procurement section)

Scope out and develop collaboration opportunities with, VCSE to work together on shared sustainability and net zero priorities. Embed and scale up Green Social Prescribing across the system

Scope out how we can work with and support the MCA and LA on implementing their active travel strategy for SY

Engage with General Practice to support and facilitate their transition to more sustainable practices where ever possible

Enabling Actions

Work to increase uptake of 'Building a Net Zero NHS' e-learning modules

Continue to build Green Champion Network

Work with digital programme to develop plans to implement Sustainable ICT and Digital Services Strategy

Take Digital first approach where it's possible and practical

Pilot national toolkits for low carbon virtual ward pathways, sustainable ED, green theatres checklist

Support Digital first principle, wherever possible

Contribute to the development of robust Equality Impact Assessment processes, that will aid socially responsible decision making across our organisation and partners

11 Delivery risks

Delivery of our Joint Forward Plan will be challenging with a number of areas of key risk identified to be mitigated including:

Workforce risks	>	Mitigating actions
• Increasing workforce pressures across all sectors results in high staff absence and turnover rates. • Unable to plan effectively for future workforce based on short term funding arrangements. • Organisational changes disrupt existing programmes. • Limited or ringfenced funding to support workforce transformation and redesign, and variation in pay across sectors, restricts integrated working. • Attraction of South Yorkshire communities into health and care careers does not maximise skills of people from diverse backgrounds. • Workforce transformation and redesign activities duplicate or are not aligned to system priorities.		Acceleration and amplification of existing programmes and development of long term South Yorkshire Workforce Strategy in partnership with NHS England with a focus on the following priorities: • Integrated working • Developing system workforce plans • South Yorkshire careers and employability • Education and training • Supporting capacity • New role development • Retaining our workforce • Looking after our people • Equality, diversity and inclusion • Streamlining our employment processes

Financial risks	>	Mitigating actions
• Risk of managing the current significantly challenging financial position with substantial efficiency requirements across all 2024/25 plans that will be challenging to deliver • Uncertain future financial framework		• Organisation and systemwide financial monitoring arrangements to enable all to be sighted on progress and take action where necessary • Continued dialogue with national colleagues to inform future financial framework

Operational risks	>	Mitigating actions
• Risk of plan delivery within increasingly operationally challenging environment • Risks of operationally balancing delivery of priorities identified in this plan with operational capacity to deliver, including managing ICB changes as we move into 2024/25		• Continue to identify operational risks at organisational level and at system level to enable collaboration and partnership working to aid management • Capacity planning to match available capacity with delivery of key priorities

Strategic risks	>	Mitigating actions
• Risk of being able to realise the benefits from the legislative change set out in the Health and Care Act 2022 • Risk of balancing immediate operational pressures with mid/longer term ambitions set out in our plan		• Continue system development to create a culture of collaboration and partnership working to maximise the benefits from the Integrated Care System • Ongoing dialog with national colleagues • Ensure plans to respond to operational requirements are cognisant with mid to longer term ambitions, including addressing health inequalities by focusing on those with greatest need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NHS JOINT FORWARD PLAN

FOR SOUTH YORKSHIRE

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