Enclosure 4

SOUTH YORKSHIRE INTEGRATED CARE PARTNERSHIP

DATE 23rd May 2023

TITLE Developing our Five Year NHS Joint Forward Plan for South Yorkshire

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Purpose of report

The purpose of this paper is to act as a cover paper for the latest working draft of our initial Five Year NHS Joint Forward Plan for South Yorkshire to enable consideration by the South Yorkshire Integrated Care Partnership and Health and Wellbeing Boards.

Recommendations:

The South Yorkshire Integrated Care Partnership is asked to:

- Consider the latest working draft of our initial five year NHS Joint Forward Plan for South Yorkshire and offer feedback to further guide and shape the final draft.

Developing our Five Year NHS Joint Forward Plan for South Yorkshire

23rd May 2023

1. Purpose

1.1. The purpose of this paper is to act as a cover paper for the latest working draft of our initial Five Year NHS Joint Forward Plan for South Yorkshire to enable consideration by the Integrated Care Partnership and Health and Wellbeing Boards.

1.2. Please read in conjunction with the update paper provided for the public meeting setting out the national expectations for Joint Forward Plans, our engagement approach with citizens, patients and carers and how we have worked together taking a distributed leadership approach to develop our draft Joint Forward Plan for South Yorkshire.

2. Latest Working Draft – Five Year NHS Joint Forward Plan for South Yorkshire

2.1. Enclosed for consideration by the Integrated Care Partnership is the latest working draft of our initial Five Year NHS Joint Forward Plan for South Yorkshire. It has been shared simultaneously with each of our Health and Wellbeing Boards and our Place Partnerships.

2.2. It has been informed by an updated refresh of our population health needs assessment and our engagement work steered by the Integrated Care Partnership to inform our Integrated Care Strategy. It will continue to be shaped by the feedback we are hearing from our ongoing engagement work as we work towards a final draft in June.

2.3. It builds on significant work to date, our strategic baseline, work to understand our transformation programmes and develop change plans in the Integrated Care Board, and work undertaken through our provider collaboratives and alliances to bring people together to consider and agree priorities for their respective areas of focus.

2.4. It has been coordinated by a Joint Forward Plan Coordination Group through which we have brought together leads from our places, provider collaboratives and alliances and taken a distributed leadership approach to enable production of our draft plan.

2.5. It is not dissimilar to our Integrated Care Strategy, in that the ask came at a significantly challenging time for NHS and wider partners. The nationally prescribed timescales have also been a challenge, particularly given that some areas of national guidance it is expected the plan will respond to have only very recently been published, for example the delivery plan for recovering access to primary care.

2.6. The draft continues to be work in progress with a number of areas still under development as set out below.

3. Key areas still under development

3.1. Focusing on Outcomes – Work continues to build on our existing Outcomes Framework developed to support our Integrated Care Strategy and expand it to cover the objectives and priorities in our Joint Forward Plan, enabling our plan to be more outcome focused.

3.2. **Feedback from ongoing engagement –** Ongoing engagement with citizens, patients and their families, including reaching into some of our most deprived communities and other inclusion groups is ongoing and feedback will be used to inform and shape our final draft as well as onward more detailed project and implementation plans.

3.3. **Articulating our health care challenges –** Work is underway with analytical colleagues to visually articulate our health care challenges in South Yorkshire to better set the context for our plan and the case for change for our transformation programmes.

3.4. **Responding to recently published guidance** - Work continues to respond to recently published national guidance including the delivery plan for maternity and neonatal services and the delivery plan for recovering access to primary care published in mid May.

3.5. **Alignment with operational and financial planning** - Work is underway to ensure alignment with our NHS Operational Plan Submission for 2023/24, with the updated plan submitted to NHSE in early May and articulate the finance section to align with our financial plan. Noting the need to think beyond 2023/24 in our Joint Forward Plan and consider the joint commitment outlined in our Integrated Care Strategy to target resource at those with the greatest needs.

3.6. **Responding to stakeholder feedback –** This includes feedback from the NHS System Leaders Executive Group in mid May where they identified the following:

- Need to ensure a preventative approach throughout and to be ambitious around this
- Need to continue to create the conditions for collaboration
- Opportunity to explore flexibility and freedoms to enable providers to work together differently and move beyond transactional commissioning and contracting.
- Need to be intentionally biased towards addressing health inequalities in all that we do and that this needs a culture change to enable
- Addressing health inequalities is not separate to our financial challenges and working in a way that supports those with greatest need and tackles inequalities will also contribute to us making better use of our collective resource and finances
- Health inequalities are also an issue for our workforce, contributing to sickness rates.
- The breadth of the JFP means that it identifies a large number of priorities and it is challenging to prioritise, however further consolidating and considering the phasing of delivery will aid deliverability of the plan.

3.7. **System development –** The JFP outlines a renewed commitment for NHS partners in South Yorkshire to work together to ensure a strong NHS contribution to delivery, and for NHS partners to strengthen their collaboration with others, including Local Authorities and VCSE and across South Yorkshire our Mayoral Combined Authority. To enable delivery of our Joint Forward Plan there will be a need for continued system development, through which we strengthen our collaboration and deepen our integration across health and care and take action to work differently together in line with the Joint Commitments set out in our initial Integrated Care Strategy.

3.8. **Development of final draft –** Work has commenced with comms colleagues to design the look of the final draft inline with NHS South Yorkshire branding that will be submitted to NHSE at the end of June. Consideration is also being given to the development of an executive summary and other formats that we can publish to make it more accessible for

our citizens, patients and their families. It will be our initial Joint Forward Plan and it is anticipated that it will evolve further, particularly the years 3-5 ambition.

4. Key Next Steps

4.1. Continue to progress areas of development set out above and further shape draft JFP, including ensuring final draft is shaped by findings from ongoing engagement.

4.2. Take into account feedback from NHS System Leaders Executive Group, South Yorkshire Integrated Care Partnership and Health and Wellbeing Boards to shape final draft.

4.3. For the NHS South Yorkshire Board to consider in private the next draft (near final) on 7th June, NHS System Leaders Executive on 13th June and Trust Boards (dates tbc) working towards being submitted to NHSE by 30th June.

5. Recommendations:

The South Yorkshire Integrated Care Partnership is asked to:

- Consider the latest working draft of our initial five year NHS Joint Forward Plan for South Yorkshire and offer feedback to further guide and shape the final draft.

NHS Five Year Joint Forward Plan

For

South Yorkshire

WORKING DRAFT

19th May 2023

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CONTENTS – to be finalised

WORKING DRAFT May 2023

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1. Introduction

This plan is our draft NHS Five Year Joint Forward Plan 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 Joint Forward Plan is set out in legislation under the Health and Care Act 2022 and guidance was published in December 2022, setting out expectations and requirements for developing a five year plan across Integrated Care Boards and NHS Provider Trusts to meet both the physical and mental health needs of their population. The guidance is clear that the JFP should act as a shared delivery plan for the local Integrated Care Strategy, setting out the NHS contribution to delivery and how NHS services will be arranged to meet population needs in response to local Joint Strategic Needs Assessments (JSNAs) and aligned to local Health and Wellbeing Strategies.

The Joint Forward Plan Guidance was published alongside the annual NHS England Operational Planning Guidance for 2023/24 with a clear expectation of alignment. The 2023/24 Operational Planning guidance asks for a particular focus in 2023/24 on:

- Prioritising recovering core services and productivity
- Return to delivery of the key ambitions in the NHS Long Term Plan (LTP)
- Continue transforming the NHS for the future

The Operational Planning guidance includes 31 national objectives. The Operational Plan for 2023/24 for South Yorkshire includes detailed plans and trajectories to deliver against each of the national objectives and this is aligned to the first year of our Joint Forward Plan.

This Joint Forward Plan for South Yorkshire has been informed by a refresh of our South Yorkshire population health needs assessment (Joint Strategic Needs Assessment), insights from what patients and the public have told us matters to them and is aligned to our local Health and Wellbeing Strategies in each of our places Barnsley, Rotherham, Doncaster and Sheffield. It builds from our existing strategies and plans, including our Health and Wellbeing Board Strategies, Place Health and Care Plans and our South Yorkshire Five Year Strategic Plan (2019 - 2024). It has been designed to start to enable delivery of our recently published Integrated Care Strategy for South Yorkshire.

This JFP sets out our plan for how we in South Yorkshire will deliver the operational requirements for 2023/24, the NHS universal commitments (as set out in South Yorkshire's response to the NHS Long Term Plan), contribute to the four core purposes of our Integrated Care System (ICS) and dispatch our statutory duties and responsibilities. In doing so it acknowledges the critical contribution of our workforce in delivering our priorities and the need for us to continue to strengthen our collaboration. It promotes the use of digital, data and technology, and embracing and adopting innovation to transform the way we work together.

This JFP has been developed during a changing and challenging environment for NHS services. A time when services are responding to the ongoing implications of the covid pandemic, managing increasing operational and workforce pressures and periods of industrial action in the NHS and wider public sector.

In the last twelve months we have also seen Integrated Care Systems and Integrated Care Boards become statutory, and thus relatively new organisation. Alongside increasing collaboration between providers this

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brings an opportunity to further strengthen our partnership working and deepen integration to facilitate delivery of this plan.

This Joint Forward Plan starts with a summary of our initial Integrated Care Strategy and goes on to start to outline the NHS response to it. Ultimately contributing as NHS partners working with others to deliver the aims set out in our Integrated Care Strategy to reduce health inequalities and improve healthy life expectancy in South Yorkshire.

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 including our Health and Wellbeing Strategies, Place Health and Care Plans and our South Yorkshire Strategic Plan (2019-2024).

To ensure that our initial Integrated Care Strategy was informed by people living in South Yorkshire we took a phased approach to engagement. 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 as simple question to build on this:

'What Matters to You'?

This 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, including our health and care workforce, children and young people, under-represented and socially excluded groups, and asked 'What matters to you about your health and wellbeing?'. More than 500 individuals and groups responded.

The insight work identified that there was a need for more information about health prevention and availability of different health and social care services, to make it easy for people to access health and social care services and removing 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 working vision in our Integrated Care Strategy for South Yorkshire is that

Everyone in our diverse communities lives a happy, healthier life for longer.

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

Our vision and goals are supported by four shared outcomes as follows:

- Children and young people have the best start in life
- People in South Yorkshire live longer and healthier lives AND
  the physical and mental health and wellbeing of those with the greatest need improves the fastest
- People are supported to live in safe, strong and vibrant communities
- People are equipped with the skills and resources they need to thrive

These are reflected in all of our Health and Wellbeing Strategies and support the transition through the life courses of starting well, living well and aging well.

Our initial Integrated Care Strategy for South Yorkshire also identifies a small set of bold ambitions where partners have agreed to align their collective power and influence to enable delivery at pace and scale. These are:

- A focus on development in early years so that every child in South Yorkshire is school ready
- Act differently together to strengthen and accelerate our focus on prevention and early identification

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- Work together to increase economic participation and support a fair, inclusive and sustainable economy
- Collaborate to value and support our entire workforce, across health, care, VCSE, carers, paid and unpaid. Developing a diverse workforce that reflects our communities

To enable successful delivery of our strategy we know that we need to do things fundamentally differently working with people and communities, our Voluntary Community and Social Enterprise Sector (VCSE) as equal partners and strengthening our collaboration between NHS organisations and wider partners. In our strategy we describe a series of joint commitments we are making to enable new ways of working to support delivery. They are:

- Bold, visible and collaborative leadership
- Identifying, recognising and tackling systemic discrimination, including a focus on anti racism
- Reallocation of resources to where there is most need
- Joined up service delivery and support
- Listening and co production with people and communities
- Create a culture of learning and innovation

The diagram below sets out our Integrated Care Strategy Plan on a page and is followed by more details on our bold ambitions.

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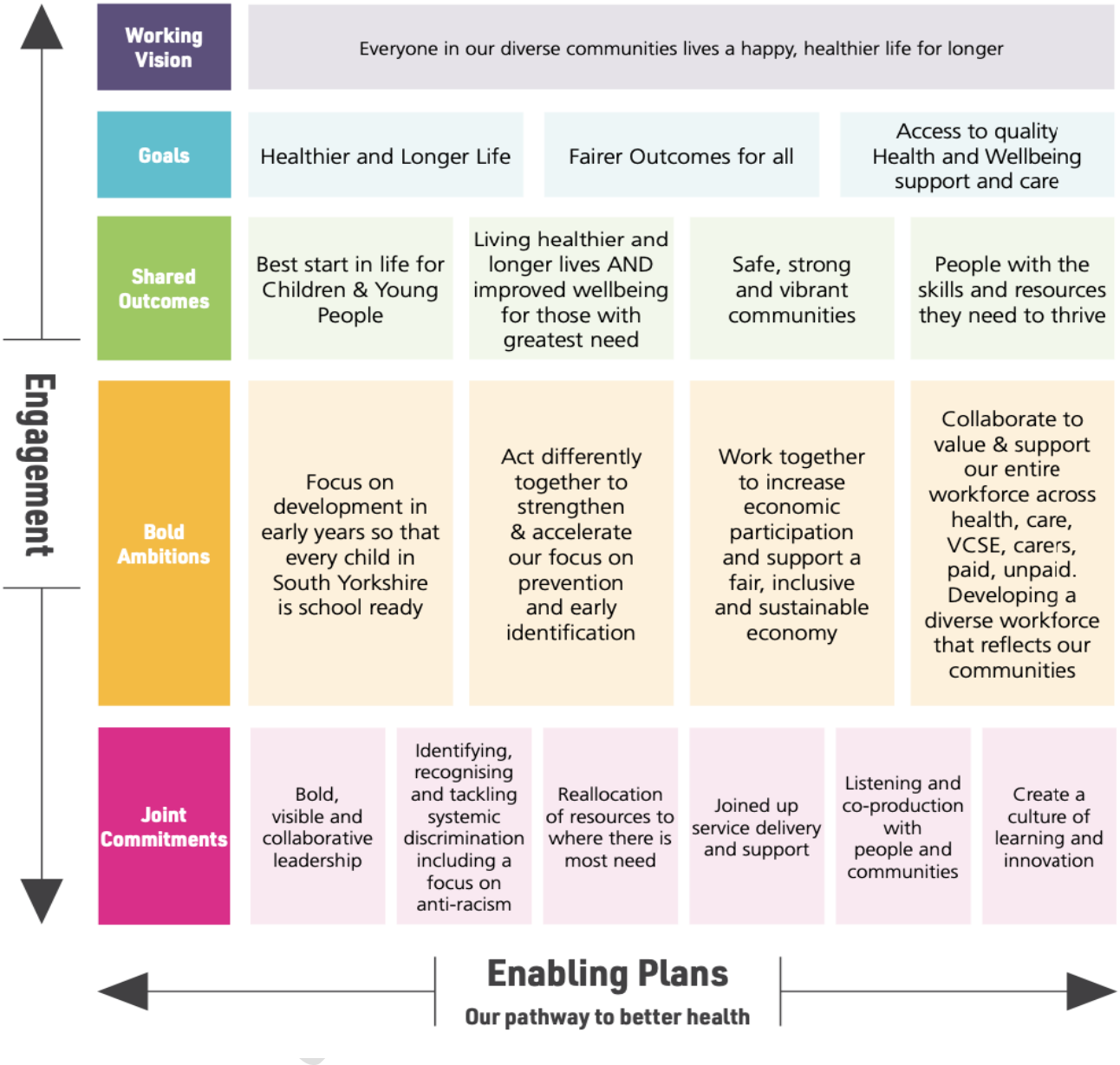
Summary Plan on a Page

Our Shared Outcomes, Bold Ambitions and Joint Commitments



Bold Ambitions –*To be set out as per the summary in our Integrated Care Strategy*

Our strategy to better health, recognises the work already ongoing and set out in strategies and plans in each of our places and across South Yorkshire. Our intention is not to duplicate these but to build on them. Our strategy sets out where, as a whole partnership working together, we can add value to go further faster with a targeted number of action focused **bold ambitions** which can only be achieved by the Integrated Care Partnership joining forces to practically align collective power and influence to enable delivery at pace and at scale. **The bold ambitions are as follows:**

- **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

- **Act differently together to strengthen & accelerate our focus on prevention and early identification**
  With a focus on the four main modifiable risk factors, 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 of smoking to 5% by 2030

- **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 in South Yorkshire 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

- **Collaborate to value & support our entire workforce across health, care, VCSE, carers, paid, unpaid. 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 that we do and how we do it with our communities. Committing to real actions that will eradicate racism.

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Integrated Care Strategy - Outcomes Framework

Our strategy is underpinned and supported by the development of an Outcomes Framework to inform and monitor progress towards our goals and vision.

The Framework includes multiple levels at which we will track progress. A dashboard has been developed to present the selected measures and comprises:

- An assessment of the health needs of the South Yorkshire population
- Metrics that reflect the high level goals that underpin our vision and ambitions we have set ourselves to work together differently
- The metrics that reflect our shared outcomes, largely based on existing place plans and outcome frameworks.
- The measures and metrics (or proxy measures) that are used by each partner in the partnership to inform and monitor their input to our shared outcomes, ambitions and vision

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 expand and build on our existing Outcomes Framework (OF) to include the key measures and metrics for our Joint Forward Plan.

2.2 Taking forward our bold ambitions and joint commitments

Work has commenced to start to translate our strategy into delivery, including holding a system wide Health Inequalities Symposium. Work is also underway to ensure that we maximise the benefit of participating in collaboratives and programmes that will support delivery, including the Marmot Health Equity Collaborative and Bloomberg Harvard Programme, with their focus on children and young people.

To work together to take forward our bold ambitions and joint commitments the plan is to:

- **Establish an ICP Working/Operational Group to support the Partnership** with representation from every place and links to each of our Health and Wellbeing Boards, comprising of a diverse range of partners including VCSE with a mix of expertise across our bold ambitions.

- **Identify a system lead for each of our bold ambitions** to act as a Senior Responsible Owner (SROs) and take a crucial systemwide leadership role. The plan is to identify leads across our bold ambitions from a range of different partners.

- **Hold a series of workshops one for each of our bold ambitions** to engage widely with stakeholders (including places, provider collaboratives and alliances) to better understand what is already taking place, bring in new voices and perspectives, including lived experience and challenge ourselves to look at what we can do differently together. Developing a new South Yorkshire focused group or identifying an existing group to work through for each of our bold ambitions. The work commenced to develop an Outcomes Framework to underpin our Integrated Care Strategy with its set of proposed metrics for each bold ambition will be considered and refined further through these groups to enable alignment with our actions and delivery plans for each bold ambition. These plans as they develop will strengthen, accelerate and add to those set out in our first South Yorkshire Joint Forward Plan in areas that support delivery of our bold ambitions, eg our plans to address the needs of children and young people. In this way we will enable our Joint Forward Plan

to increasingly fulfil its role to act as a shared delivery plan for our Integrated Care Strategy.

- **Establish a set of 'think & do tanks' to explore our joint commitments.** Our joint commitments are the most challenging elements of our Integrated Care Strategy, yet fundamental to successful delivery, so it is proposed that we establish a number of 'think & do tanks' to focus on them. Sponsored by the South Yorkshire Mayor with senior representation from the Integrated Care Partnership, with a mandate to analyse the issues and barriers facing us in achieving our joint commitments and propose some potentially radical solutions for us to test. These 'think & do tanks' also have the opportunity to consider how they can connect in with the Patricia Hewitt's review of Integrated Care Systems (ICSs). This review gives an opportunity to ensure the right balance between central direction and flexibility for local health and care systems to meet the needs of their populations.

- **Review our enabling plans**, consider the status of each and devise plans and next steps for each.

- **Set up mechanisms to ensure that we align opportunities and realise the benefit from external programmes and advisory forums,** including the Bloomberg Harvard City Leadership Programme, the Health Equality and Advisory Panel chaired by Professor Alan Walker, the Health Equity Collaboration with Sir Michael Marmot and Barnado's and the Pathways to Work Commission with our Local Authorities, and others as they arise.

3 What did our Joint Strategic Needs Assessment (JSNA) & Strategic Baseline tell us?

During autumn 2022 we commenced a strategic baseline assessment and as part of this in December 2022, we undertook a review of the health of South Yorkshire's population. The findings from that review, alongside the findings from our engagement work informed our Integrated Care strategy and this Joint Forward Plan. The key findings from the health review that have influenced this plan are

<table>
<tr><td colspan="4"><u>Key health outcomes</u> 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.</td></tr>
<tr><td>Male LE is 77.3 (Eng 78.7)
Female LE is 80.9 (Eng 82.7)</td><td>Gap in LE between most and least deprived areas in SY is for males 8.7yrs, for females 7.6yrs</td><td>Number of years lived in good health is 59.5yrs for males and 60.2years for females (a gap of 3.6yrs compared to England)</td><td>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.</td></tr>
<tr><td colspan="3"><u>Our population</u> Our health as individuals and at population level are determined by a range of factors such as the environment we live, the opportunities we have as well as 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 groups are most at risk of experiencing inequalities in health.</td><td>37% of our residents live in the most deprived areas
26% of our children live in families experiencing relative poverty.
17% of our population is from an ethnic minority group.</td></tr>
<tr><td colspan="3"><u>Mortality</u> The biggest underlying causes of deaths in South Yorkshire were heart disease, COVID19, Dementia, lung cancer, Stroke and lower respiratory disease.</td><td>These conditions account for nearly 50% of all deaths in South Yorkshire.</td></tr>
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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 are modifiable. Given that 16% of the South Yorkshire population smoke, 37% don't have their blood pressure controlled to target and 67% of South Yorkshire residents are overweight or obese we can have impact on these early deaths by focussing 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 need to improve access to primary care.	Dementia diagnosis rate is **69**%, 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 March 2019 we were offering 8,226,100 GP appointments in South Yorkshire. Our Target for March 24 is 9,426,146 but our plan is to deliver 9,535,510
Multi-morbidity We are beginning to see both an increase in the prevalence of multi-morbidity (ie having more than one long term condition) and an earlier onset, especially in those who live 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 South Yorkshire 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.	Recovery challenge is xxx Waiting times are currently xxx **17%** of our children aged 6 to 23 have a probable mental disorder.
Inequalities in 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. But 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.	Emergency admission rates for those in most deprived areas is **14,500** per 100,000 population, for least deprived its **8,700** per 100,000 population.

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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, racism, violence 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. 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.	Elective admission rates for most deprived is **10,800** per 100,000 population and for least deprived its **12,300** per 100,000 population. Mortality in homeless individuals, prisoners, sex workers and those with substance use disorders have mortality rates nearly **8** times higher (for men) and **12** times higher (for women) compared to the general population

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

- **Delivery Focus** – an overview of what we are delivering, where, across South Yorkshire, within our Places and across Provider Collaboratives and Alliances
- **Integrated Performance** – a deeper dive into the key aspects of performance, as highlighted through the System Oversight Framework, including, quality, experience, people, operational performance and finance.
- **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 support 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 have been identified for South Yorkshire. These align well with the areas people have told us really matter to them including access to and quality of care and support.

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Our challenges include

HOLD 1 page for charts and narrative in relation to each of the following:

1. Primary care – *managing demand/workforce challenge/opportunity wider primary care*
2. Urgent and emergency care – *managing demand, ambulatory care conditions, length of stay, hospital flow, delayed discharges…*
3. Diagnostics, Elective & Cancer – *challenge re waiting times*
4. Cancer – *waiting time challenge and late stage diagnosis challenge*
5. Mental Health – *challenge re waiting times including children and young people and neurodiversity diagnostic pathways*

Potential hold for SY position in relation to each of the NHS 31 national objectives to be included here, to set out current position and scale of the challenge.

Together with what people told us matters most to them in our engagement to inform our Integrated Care Strategy, these challenges provide a steer for the direction and priorities identified in this Joint Forward Plan. We continue to listen to our South Yorkshire communities and what matters to them to further shape the detail of this plan.

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

Content to be updated as engagement progresses and include a summary of key findings

Building on the engagement to inform our initial Integrated Care Strategy we made a commitment to ongoing engagement and as part of this ensuring that we hear from those we are yet to hear from and therefore we chose to 'continue the conversation'.

Healthwatch were commissioned to work with our underserved communities and were asked to focus on the most deprived communities in South Yorkshire (all of which are in the 20% most deprived nationally) and to ensure they chose some communities with a high proportion of ethnic minority groups as well as some with lower proportions of minority ethnic communities. They were also looking to engage other groups that suffer worse outcomes, (other than deprivation and ethnicity):

- Inclusion groups such as people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery
- Disabilities - physical as well as mental health and learning disabilities, autism and any carers. We did hear from quite a good percentage of the population who identified themselves as having a physical or mental health disability in our previous ICP involvement though (other than members of the blind community) so I don't think we need to focus as heavily on this one (although tbh I don't know if we heard from Disabled people within the areas of deprivation or the frail/disabled/unheard elderly - the people we only see when they hit crisis)
- Vulnerable children, that includes those in care and those leaving care (17-19 year olds), those with gender identity issues
- Digitally excluded communities (research has shown this is more often linked to deprivation than age)

The engagement report at appendix X details those who we successfully heard from.

Healthwatch developed the following script to use with the communities with whom they engaged:

You and Your Local Health Care

We need to hear from YOU and your local communities. At the moment the health services in South Yorkshire are developing their Joint Forward Plan, which will set out how the NHS will change. By answering the questions below you will be part of that change.

Q1. What matters to you about your health and wellbeing?

Q2. What could you suggest to services to help you and your community live a healthier life?

Q3. What does good access to healthcare look like for you, your community, and others in South Yorkshire?

Q4. a) What barriers, if any, do you and others face to services?

b) How could these be overcome?

Q5. What does good quality health and care look like?

(This could be: a good standard of service when you need it, good communications, seeing the same professional, organisations working together better, more personalised care).

Q6. Do you have any ideas for how we might improve the quality of the care you receive?

Demographic questions were then asked once the above questions had been explored. The demographics questions were updated to capture important information about our paid and unpaid health and care workforce who are contributing their views.

As well as this targeted approach we also used the Healthwatch script to create a survey for the general population.

This was distributed via our 1,500 NHS South Yorkshire membership, which are representative of the communities we serve; via bulletins that reach our 72,000 health and care staff employed by ICP partner

organisations and using other digital channels. A question was added about whether people had responded to our 'What matters to you campaign' in November 2022 so that we are able to tell who is a new respondent and who is adding detail to their previously submitted response.

The Integrated Care System is formed by a number of Collaboratives and Alliances, who have each led on writing a section of the Plan that involves their work.

Colleagues from the NHS South Yorkshire involvement team met with the leads from each of the Collaboratives/ Alliances to understand the involvement mechanisms they had in place, the access they had to citizen/ patient feedback and how they intended to use that to inform the sections of the plan for which they were responsible.

Colleagues from Collaboratives/ Alliances were also provided with collateral from the continued conversation work and invited to share with their networks for input. They also provided details of any key groups from their work from whom we needed to ensure we heard.

Independent Analysis

The findings of this engagement exercise have been independently analysed.

Hold to include a summary of key findings from engagement.

5. How are we organised in South Yorkshire?

To add in 'system infographic with details of all organisations' – page 13 Integrated Care Strategy

All the organisations set out above 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 South Yorkshire population.

NHS Organisations in South Yorkshire have a strong track record of delivery and a long history of collaboration. Place partnerships are already well established in each of our places, bringing together health, local authority, our diverse voluntary community and social enterprise 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.

The first Sustainability and Transformation Partnership in South Yorkshire was established in 2016. This then became one of the first non-statutory Integrated Care Systems in England in 2018. Following the Health and Care Act 2022 a statutory Integrated Care System (ICS) has come together from July 1st.

New statutory Integrated Care Systems provide an opportunity to bring local authorities, NHS organisations, combined authorities and the Voluntary, Community and Social Enterprise Sector together with local communities to take collective responsibility for planning services, improving health and wellbeing and reducing inequalities.

Integrated Care Systems have four key purposes:

- Improving outcomes in population health and health care
- Enhancing productivity and value for money

- Tackling inequalities in outcomes, experience and access
- Helping the NHS to support broader social and economic development

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 Voluntary, Community and Social Enterprise Sector and other partners.

In South Yorkshire the membership of our Integrated Care Partnership (ICP) was proposed by the Health and Wellbeing Boards in the four local authority areas, Barnsley, Doncaster, Rotherham and Sheffield and NHS South Yorkshire. Oliver Coppard, Mayor of South Yorkshire Combined Mayoral Authority became Chair of the South Yorkshire Integrated Care Partnership in September 2022 and Pearse Butler the Chair of NHS South Yorkshire is vice chair.

An Integrated Care Board is an NHS organisation responsible for planning, commissioning and funding NHS services, in our case NHS South Yorkshire established in July 2022. NHS South Yorkshire has been established with Partner Board Members, including Healthwatch, Mental Health and the Voluntary Care Sector representation. Integrated Care Boards are new organisations and as such they have an opportunity to do things differently to their predecessor organisations and flexibility to work out how best to dispatch their duties as a new organisation working with partners.

There is a clear ambition set out in the legislation for Integrated Care Systems (ICS) and Integrated Care Partnerships to deepen the integration between health and social care through greater collaboration and integration between health and care organisations. 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.

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. To respond to our joint strategic needs assessment to meet the physical and mental health needs of our population. To improve access to and quality of healthcare and deliver integrated care and support to improve health outcomes and reduce health inequalities.

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 deliver this NHS Joint Forward Plan. Delivery of this plan will require us to work differently together and share responsibility with our Places and Provider Collaboratives.

For example our work to improve access and reduce waiting times for elective and diagnostic pathways will be taken forward by our maturing 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 support people in the community whilst waiting, whilst also exploiting 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.

Places: 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. These are the cornerstone of our health and care system and have delegated authority from NHS South Yorkshire to deliver plans that meet the needs of local communities.

As our key delivery vehicles they each have an integrated health and care delivery plan:

Insert photos of each place and links to Place Plans (tbc)

Barnsley Link to place health and care plan	**Sheffield** Link to place health and care plan
Doncaster Link to place health and care plan	**Rotherham** Link to place health and care plan

Provider Collaboratives: Our hospitals and mental health trusts have also established strong collaborative arrangements. These Provider Collaboratives have been developed to further strengthen partnership working between our hospital and care providers to support joined up sustainable health and care services building resilience across organisations and pathways of care. Delivery of our Joint Forward Plan will require sharing responsibility with our Provider Collaboratives.

They include:

- Mental Health Learning Disability and Autism Provider Collaborative (including acute and community) – Hold space for summary of MHLDA Provider Collaborative
- South Yorkshire and Bassetlaw Mental Health Specialised Commissioning Provider Collaborative (specialist services – adult secure, adult eating disorders and CAMHS)"

- Acute Hospital Provider Collaborative (including acute, elective and diagnostics children's and specialist services – Hold for 1 page infographic/summary of Acute Federation Clinical Strategy

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

Primary Care Alliance - (including general practice, pharmacists, dentists, and optometrists)
The Primary Care Provider Alliance membership is drawn from all 4 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. It will ensure that services and pathways are coherent and connected across organisational and sector boundaries and firmly connected into Place and transformation programmes. It will provide and develop an environment for shared learning and good practice in Primary Care across the South Yorkshire footprint.

Urgent & Emergency Care 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 to improve health outcomes and reduce 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 in a variety of ways including networking, information exchange, co-design opportunities on shared priorities and participation in South Yorkshire level ICS meetings.

Cancer Alliance - The 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 includes 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, not just their cancer, for every stage of support they may need. The partnership aims to optimise the services and care provided by reducing health inequalities, piloting innovative approaches and sharing best practice.

Local Maternity and Neonatal Network (LMNS) - The South Yorkshire Local Maternity and Neonatal System (LMNS) is the Maternity arm of NHS South Yorkshire. We work with partners and NHS trusts to improve maternity services for women, birthing people, their babies and families. 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.

Networks – There are nationally mandated Clinical Networks and Delivery Networks that operate in South Yorkshire including:

Respiratory Clinical Network – The respiratory clinical network is responsible for design, guidance and promotion of optimal respiratory care pathways which will ensure more people who are diagnosed with a respiratory condition receive high-quality care from diagnosis to acute care, rehabilitation and beyond, building on the priority areas of the NHS Long Term Plan for respiratory disease.

Cardiac Clinical Network – The Cardiac Clinical Network is responsible for working with stakeholders across the cardiac pathway, to improve performance and outcomes for cardiac patients throughout South Yorkshire.

Integrated Stroke Delivery Network (ISDN) - To improve the quality of stroke care across South Yorkshire leading to better clinical outcomes, patient experience and patient safety. A whole pathway approach will be taken from prevention through to life after stroke.

5.2 System Development – SECTION UNDER DEVELOPMENT

In bringing together this NHS Joint Forward Plan in response to our initial Integrated Care Strategy there is a renewed commitment to working together as an NHS and NHS working with wider partners including Local Authorities, the Voluntary, Community and Social Enterprise Sector (VCSE) and across South Yorkshire with our South Yorkshire Mayoral Combined Authority.

Delivery will be challenging and require continued system development for the length of the plan. Developing system leadership and organisational development (OD) capability is identified as an area to enhance in the early years of the plan to facilitate this.

Continuing our development journey to create an enabling culture that fosters collaboration and partnership working will be essential to support our system to develop in line with the joint commitments set out in our Integrated Care Strategy. Building on our places, provider collaboratives and alliances and exploring the potential to create and/or expand delegated arrangements to facilitate plan delivery.

5.3 Developing role of NHS South Yorkshire as an Integrated Care Board

5.3.1 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, dental and specialised services will now 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 will be responsible for commissioning the totality of primary care including all four primary care contractor groups, including General Practice, community pharmacy, optometry and dental services) from 1st 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 during 2023/24 to manage the change for these services.
See specialised services section.

5.3.2 Shared role for oversight of NHS Trusts and Foundation Trusts through an MOU with NHS England and the Integrated Care Board

Section under development

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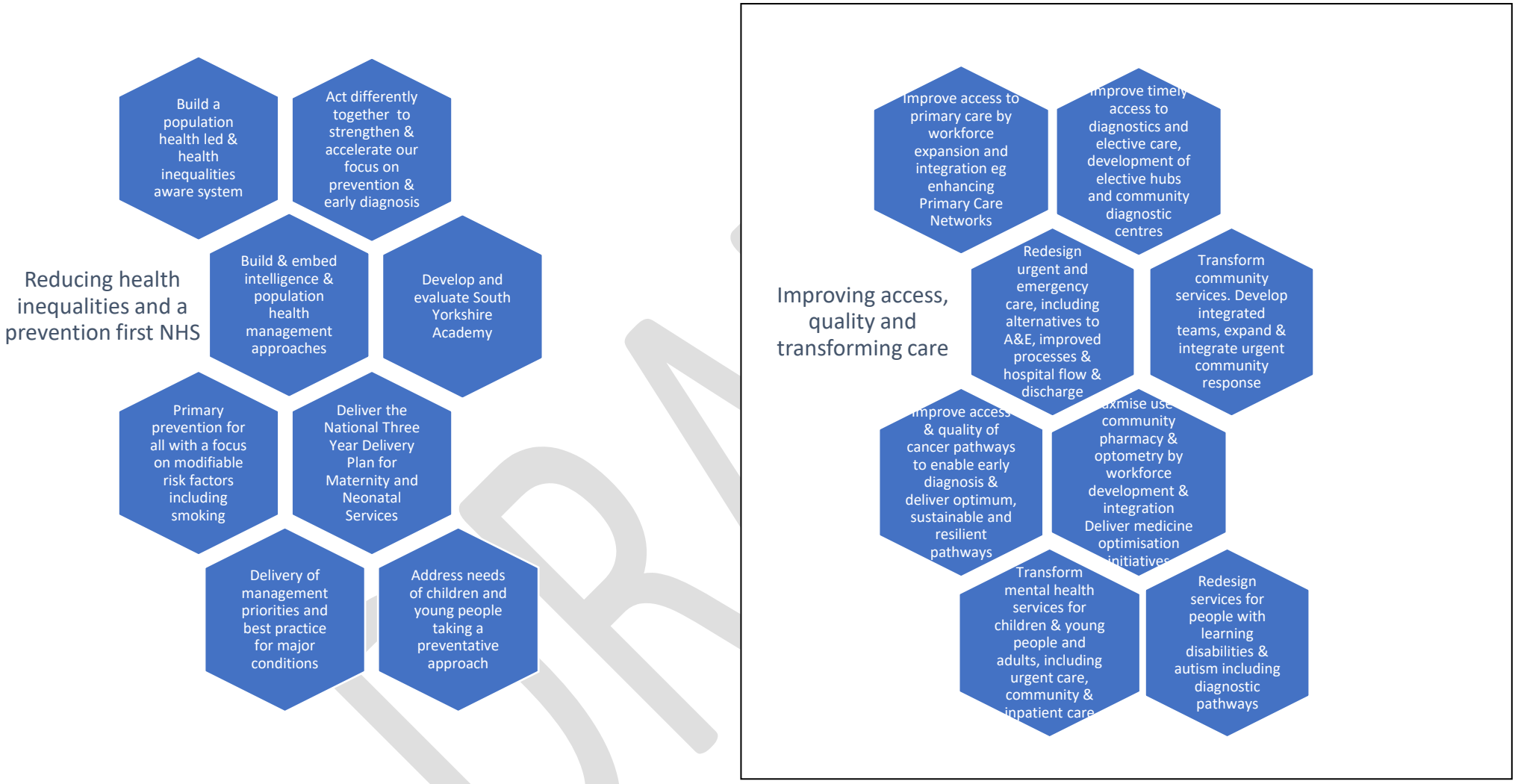
6. What are we going to do to support delivery of our Strategy?

To support delivery of our initial Integrated Care Strategy, the national objectives set out in the NHS Planning Guidance for 2023/24 and our statutory requirements we have identified a set of objectives to focus on in our Joint Forward Plan. By focusing on these objectives described below we will contribute to delivery of our initial Integrated Care Strategy for South Yorkshire summarised in section 2.

Joint Forward Plan Objectives



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

NHS South Yorkshire Integrated Care Board

Taking a preventative, population health approach and reducing health inequalities in all we do by focusing on those with greatest 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, PCNs community pharmacists, optometrists and dentists)	Transforming **community services** (proactive integrated community teams/PCNs & urgent community response)	Developing **alternatives to ED,** including virtual wards, **improving ED processes, hospital flow and discharge**)	Recovering & optimising **cancer, elective and diagnostic pathways,** implementing best practice & reducing variation	Improving access and transforming **mental health services** for children and young people and adults	Improving access & redesigning **specialist services for those with learning disabilities & autism**

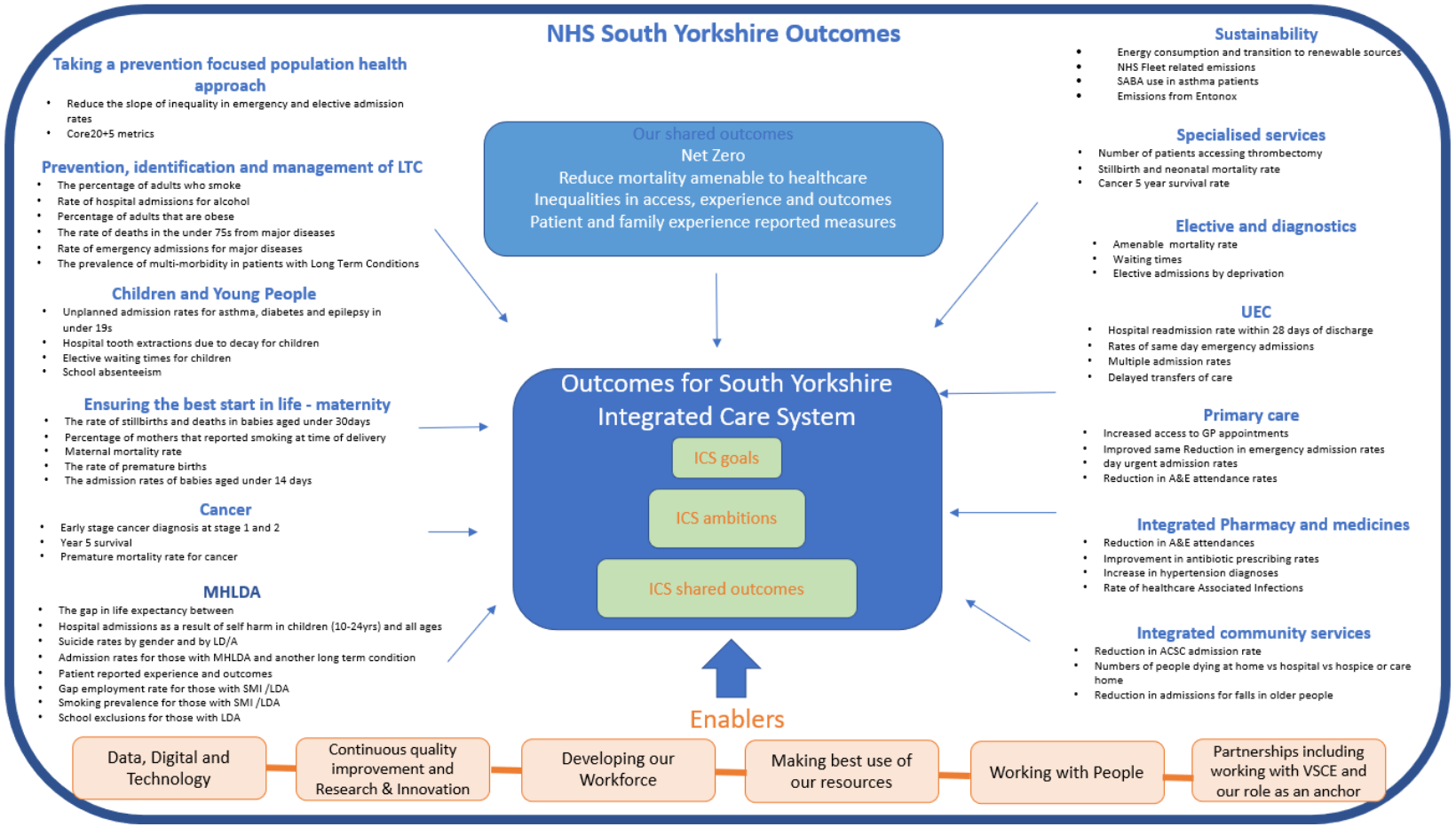
Supporting & developing our entire workforce

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

Making best use of our collective resources

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 following diagram summarises the outcomes we have identified and how they contribute to the goals and vision set out in our Integrated Care Strategy.



The expanded Outcomes Framework will support the ICB and NHS partners in measuring and evaluating their role in improving patient outcomes, population health and system performance as well as progress towards the goals and vision set out in the Integrated Care Strategy.

The Outcomes Framework will provide a comprehensive set of outcomes relating to our priorities including population health outcomes, patient experience, safety, efficiency and equity. The outcomes selected will be measurable so we can track progress over time, and it will be dynamic and flexible to allow for changes in priorities or emerging issues and it should be reviewed regularly. The plan is to be transparent and publish the metrics so that they are publicly available.

The framework will consist of a set of outcome-specific metrics as well as the key performance metrics (KPI) that will inform our progress towards the desired outcomes.

- An 'outcome' measure is one where we can describe the intended benefit for our population such as 'improved access to diagnostics' or 'reduction in emergency admissions for ethnic minorities'.
- A KPI is a measure to inform us on our progress and activities that will bring about the intended outcome such as 'number on waiting list for diagnostics' or 'number of records with ethnicity recorded'.

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Phasing Our Joint Forward Plan

Our plan is to take a phased approach to delivery with more detailed plans in place for year 1 and 2.
Below sets out the shape of the Joint Forward Plan over years 1-2 and 3-5 years. More detail can be found in subsequent sections of the plan.

Year 1-2

- Developing a population health led and health inequalities aware system including building our South Yorkshire Academy
- Refreshing and building intelligence and population health management approaches and engagement mechanisms working with VCSE
- Acting differently together to strengthen & accelerate our focus on prevention & early identification focusing on those with greatest needs
- Focusing on smoking and delivery of the South Yorkshire QUIT Programme
- 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 & Neonatal Services
- Addressing needs of children and young people by implementing Children and Young People's Transformation Programme (CYP)
- Focusing on immediate actions 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 2023/24 and 2024/25

Year 3-5

- Embedding population health management approaches to become a mature population health led system
- Continuing to collaborate with partners, focusing on prevention and early identification for those with greatest needs
- Embedding a primary prevention for all approach & working with people and communities to codesign sustainable prevention programmes
- Complete delivery of the three year Delivery Plan for Maternity & Neonatal Services and CYP Transformation Programme
- Deliver new service models that integrate primary, community and hospital services enabled by our Provider Collaboratives & Alliances
- Embed quality improvement, taking an evidence based apporach to improve quality of care and health outcomes to reduce inequalites 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 disabilty and autism services to improve access & quality of care
- Continue delivery of annual Operational Planning Requirements beyond 2024/25 and NHS universal committments in NHS Long Term Plan

6.1 Focus on improving population health and reduce health inequalities

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

Key National Expectations – Major Conditions Strategy expected summer 23

- **The Operational Planning requirements for 2023/24 include**
  - Continue to narrow health inequalities in recovery, access, outcomes and experience adults and CYP and Quality and Safety in maternity services
  - Elective recovery plans set out recovery of services inclusively, outlining the actions, interventions, and impact to address HIs
  - Prevention and effective LTC management is key to improving population health ICB to develop plan for primary and secondary prevention
  - Continue to address HIs and deliver on CORE 20plus 5 approach adult and children
  - Confirmation that an Equality and Health Inequalities Impact Assessment has been completed and published, or a date given when it will be published by, for elective recovery plans locally.
  - ICSs and trusts have published board papers that include an analysis of waiting times disaggregated by ethnicity and deprivation.

- **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:
  - Focussed on prevention
  - Engaged with Local Authorities
  - Driving innovation
  - A proactive approach to prevention and reducing health inequalities

Our Plans

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

- to embed a culture change across the organisation 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 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 services that are already available.
- to focus on improving access and quality of care and reducing inequalities 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
- to respond to the impact of wider social and commercial determinants on communities and individuals alongside our partners
- to work collaboratively and deliver on the Core20plus approach
- to develop workforce awareness and education tools and resources for Population health, prevention and inequalities through the South Yorkshire Population Health Academy.
- to embed population health management approaches within ICB to inform decision making on priorities and where money is spent in responding to greatest need
- 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 PHM to support the use of data and intelligence tools to drive change and transformation, enabling the organisation to be 'data-confident'.
- To address the needs of victims of abuse, by dispatching our duty as an ICB to undertake a strategic needs assessment and produce a plan to tackle 'serious violence' with partners including Local Authorities and the Police Commissioner. See separate section for details.

Taking a prevention focused population health approach - Priorities for year 1 & 2 –		
Measurable Outcomes: ***Link directly to our system goals to:*** • Halt the stall in life expectancy between South Yorkshire and England • Halt the stall in healthy life expectancy between South Yorkshire and England • Reduce the gap in healthy life expectancy in our most deprived communities **As well as to:** • Reduce the slope of inequality in emergency and elective admission rates • Core20+5 metrics (TBC)		
Becoming population health led Implement and evaluate South Yorkshire Population Health Academy to raise awareness and visibility of population health and health inequalities Proactively work with places and partners to adopt PHM approaches and deliver at scale transformation that improves our population health, mental h and reduce health inequalities Delivery of the CORE20 Plus 5 framework through innovative and integrated ways of working that delivers on the requirements of the national framework for adults and children	**Becoming prevention led** Develop health and wellbeing support offers using MECC opportunities that optimise outcomes for our population and patients as part of our primary prevention for all Continuing leadership and implementation of the ICB prevention priorities Mobilise the VSCE MOU to establish how we can best engage with our areas of greatest need in prevention	**Becoming intelligence led** With partners, establish and agree ways of working as an intelligent system across the ICS Build and embed intelligence & 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 focussed on improving outcomes
Hold for example		

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Ensuring the best start in life - Maternity

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - Delivery of actions identified in final Ockenden report
  - Ensuring every woman receives personalised and safe care, a personalised care plan and is supported to make informed choices
  - Implementing the local equity action plans to reduce inequalities in access and outcomes for those that experience the greatest inequalities
  - Progress towards the national safety ambition to reduce still birth, neonatal mortality, maternal mortality and serious intrapartum brain injury
  - Increasing fill rates against funded establishments for maternity staff
- **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

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 etinox.

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WORKING DRAFT May 2023

Maternity - Priorities Year 1 & 2			
Outcomes • Neonatal mortality and stillbirth rate • Percentage of mothers that reported smoking at time of delivery • Maternal mortality rate (TBC) • The rate of premature births • The admission rates of babies aged under 14 days			
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 & 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

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

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - 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 therapy waits eg autism and ADHD assessments
  - Continuing to deliver against the five strategic priorities for tackling health inequalities, consider the needs of children and young people and reflect the Core20PLUS5 now adapted for children and young people in plans
  - 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)
- **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

Our plans

- Focusing on development in early years is a bold ambition in our Integrated Care Strategy. The National Children & 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.
- To participate in a Health Equity Collaboration with Sir Michael Marmot and Barnardo's to develop a Health Equity Framework and Health Equity Tool Kit to address inequalities.
- Taking a preventative and personalised approach to improvements in asthma, diabetes, epilepsy and obesity through South Yorkshire Groups in line with Core20Plus 5 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 due to dental caries.
- 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 organisational groups to support improvements in transitions, to accelerate the development of safe, high quality, individualised transition care pathways, with a specific focus on the diabetes transitions pathway.
- Supporting The Healthier Together website providing health and wellbeing information for children and young people, 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, set out by NICE.
- To maximise the opportunity afforded by our Acute Federation Provider Collaborative being selected as one of 9 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

Addressing needs of children and young people (0-25) priorities for year 1 and 2					
Measurable outcomes • Unplanned admission rates for asthma, diabetes and epilepsy in under 19s • Hospital tooth extractions due to decay for children • Elective waiting times for children • School absenteeism • Patient (carers and family) experience reported measures (TBC)					
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 & young people Working with VCSE & children and young people to ensure they have a voice & facilitate involvement	**Health Equity Collaborative** Participate in the Sir Michael Marmot and Barnardo's Health Equity Collaborative to develop a Health Equity Framework and toolkit to address inequalities	**Long Term Conditions** Take a preventative and personalised approach to improvements in asthma, diabetes, epilepsy and obesity, in line with core 20+ Framework	**New service models and pilots** 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	**Children & Young People's Mental Health** Work with Mental Health & Learning Disability Provider Collaborative to expand mental health services for children & young people and understand the needs of those with autism, including neurodiversity assessment pathways	**Family hubs** Work with Local Maternity & Neonatal Network & Places to deliver family hubs

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WORKING DRAFT May 2023

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

Key National Expectations – Major Conditions Strategy expected summer 23

- **The Operational Planning requirements for 2023/24 include**
  - Increasing percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
  - Increasing percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%
  - Self-referral routes to weight management services
  - Continue to address health inequalities and deliver on the Core20Plus5
  - Accelerating preventative programmes; covering flu and Covid-19 vaccinations; annual health checks for people with severe mental illness (SMI) and learning disabilities; supporting the continuity of maternity carers and targeting long-term condition diagnosis and management.
  - Effective management of LTC as a continuation of delivery of the NHS LTP working with clinical and delivery networks.
- **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 everyone who has to stay overnight in hospital is given the chance and provided with help to stop smoking
  - Make sure that every pregnant woman is offered face-to-face support to help her stop smoking
  - 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 eg 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

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.
- To extend this to work with partners (including VSCE) to address the wider determinants of health, eg addressing 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 good quality clinical care to prevent early onset of disease.
- To take a holistic approach to encompass mental health & wellbeing alongside physical health conditions to respond to increasing mental health needs.
- To a focus on early identification and care (monitoring, control & management) of the main causes of our premature mortality, cardiovascular, respiratory and early diagnosis of cancer, targeting those with greatest needs. This will include improving early detection of causes eg high blood pressure, lipids & taking action.
- To promote patient involvement and support patient self management and recovery, including 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 into treatment plans and the development of a 'Year of Care' model to co-ordinate 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 the models of care available are optimal and quality assured
- To support patients 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 Priorities Year 1 & 2			
Measurable outcomes • The percentage of adults who smoke • Hospital admissions for alcohol-specific conditions • Percentage of adults that are obese • The rate of deaths in the under 75s from major diseases • Rate of emergency admissions for major diseases • The prevalence of multi-morbidity in patients with Long Term Conditions • Proportion of people feeling supported to manage their condition			
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. Develop QUIT pathways for community mental health **Healthy weight and physical activity:** Review obesity pathways & 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 eg 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. Taking a holistic approach to encompass mental health & 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.

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6.2 Focus on quality, access and transforming care

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

Key National Expectations (NB – GP Access recover plan expected end of March 23)

- **The Operational Planning requirements for 2023/24 include**
  - Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
  - Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
  - Continue the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
  - Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
  - Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
  - Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
  - Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
  - Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
- **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** (published May 2023)
    - 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

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 and planned care pathways to improve access.
- Our plans include all primary care contractor groups, GP practices, Community Pharmacy, Optometrists and Dentists, creating neighbourhood teams, building on and expanding the clinical roles increasingly employed in Primary Care Networks (PCNs), ensuring that every PCN in South Yorkshire is recruiting the maximum affordable number of additional clinical roles through the national ARRS scheme. These roles in turn will increase the number of appointments available to patients in a GP setting, meeting our target 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, 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, signposting people to the most appropriate service or clinician.
- Implementation of the recommendations made in the recent Fuller stocktake will form part of our collective ambition for primary care working collaboratively with community services.
- 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 restoring activity to greater than it was in 2019 and 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 of which will support patient self referral, and ultimately this requires our SY 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.

WORKING DRAFT May 2023

Primary Care (GP Practices, Primary Care Networks, Community Pharmacy, Optometrists and Dentists) Priorities Year 1 & 2						
Measurable outcomes (to be confirmed) • Patient satisfaction with accessing GP services • Patient satisfaction with accessing NHS dental services • Units of dental activity • Number of GP practice appointments						
Improving access	**Workforce development**		**Integration & new service models**			
Improving Access Develop & implement plans that are in line with the recommendations set out in the GP Access & 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 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	**Workforce Training** Further develop the Workforce Training Hub to provide support, mentorship & training for primary care workforce Increase training in care navigation	**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	**Optometry** Optimise minor eye condition schemes, workforce development & electronic referrals to enable direct referral to Ophthalmology & image transfer	**Dental** Continue to implement service restoration plans

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Integrated Pharmacy and Medicines Optimisation

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - Increase pharmacy participation in the Community Pharmacist Consultation service
  - Improve Discharge Medicines Service utilisation
  - Increased productivity by fully using existing skills, adapting skills mix and accelerating the introduction of new roles e.g. Independent prescribers, supporting roles, and pharmacy technicians
  - Introducing cross sector roles for pharmacy professionals
  - Improve mental health pharmacy provision for those not in a mental health setting
  - Level up digital infrastructure and drive greater interoperability between partners.

- **The NHS Long Term plan requirements include**
  - Support primary and secondary prevention priorities and the effective management of long term conditions eg: 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 a NHS Long Term Workforce Plan

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 within will be examined to maximise access to treatment close to home. Improving access for all, including those in our core20plus 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 core20 plus 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.
- Plans also include reducing avoidable harm from medicines by establishing a network of medicines safety officers, improving discharge processes, and reducing opioid and other controlled drug 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. 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.

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WORKING DRAFT May 2023

Integrated Pharmacy and Medicines Optimisation Priorities for Year 1 and 2						
Measurable outcomes (to be confirmed) • Antibiotic prescribing rates • Hypertension diagnoses • SABA prescribing						
Reduce avoidable harm from medicines Including green bag scheme, recruitment of ICB Medicines Safety Officer and support implementation of Discharge Medicines Services from all Trusts	**Delivery of antimicrobial resistance (AMR) priorities** Improve management of urinary tract infections Prescribing – Antimicrobial Stewardship Leadership Reduce risk of Healthcare Associated Infections (HCAI)	**Pharmacy Expertise** Making best use of expertise of pharmacy professions Optimise engagement & referrals to the community pharmacy consultation service by GPs, NHS 111 and UEC providers. Optimise delivery of BP Service	**Embed pharmacy and medicines optimisation support across clinical workstreams** Including implementation of national initiatives, eg hypertension case finding	**Collaboration to reduce unwarranted variation and duplication** Review monitored dosage system utilisation. SABA reduction scheme	**Pharmacy Workforce Transformation** Baseline current position and develop workforce plan to respond to immediate needs and plan for longer term Support implementation of Community Pharmacy Independent Prescriber Pathfinder Programme	**Medicines value initiative** Deliver CQUIN and agreed incentive schemes

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Supporting people in the community (Integrated Community Services)

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - Consistently meet or exceed 70% 2 hour urgent community response (UCR) standard
    - Increase referrals into UCR from key routes focussing on maximising referrals from 111 and 999 (alignment with JFP UEC Plan)
  - Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals. By September 23:
    - Direct referrals from community optometrists to ophthalmology services for all urgent and elective eye consultations
    - Self referral routes to falls response services, MSK services, audiology including hearing aid provision, weight management services, community podiatry and wheelchair and community equipment services
  - **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.

Our plans

- Plans in every place have a focus on supporting people in the community. They include
  - proactive integrated community teams joining up primary, community, physical and mental health services, social prescribing and VCSE support.
  - integration and delivery of urgent community response 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 selfcare,
  - reduce frailty and multimorbidity through proactive and preventative personalised approaches (to prevent, reduce & 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, proactive & holistic approaches in the community 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 core20 plus 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 include 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 & mental health needs.
- 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
- Considering continuing healthcare, in line with the recently published NHS Framework
- Continued delivery of enhanced health in care homes (EHICH).
- Development of a palliative and end of life care forum for South Yorkshire to coordinate work to deliver the National Palliative and end of life care delivery plan
- Continuing to deliver sustainability plans for community services.

Supporting people in the community (Integrated Community Services) priorities for year 1 and 2			
Measurable outcomes (to be confirmed) • Unplanned hospitalisation for chronic ambulatory care sensitive conditions • Numbers of people dying at home vs hospital vs hospice or care home • Reduction in admissions for falls in older people • Proportion of older people who were still at home 91 days after discharge from hospital into reablement services			
Integrated Neighbourhood Teams Continue development of integrated neighbourhood teams embedding prevention, proactive, holistic and anticipatory care approaches to meet both physical and mental health needs.	**Community Services Transformation** Transformation of community services, enabling new direct access pathways and increasing productivity. Respond to new intermediate care guidance once published (anticipated during 2023/24)	**Urgent Community Response** 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	**Palliative and end of life care** Continue to deliver the requirements set out in the national palliative and end of life care delivery plan. Establish SY Palliative and End of Life Care Forum. Implement ReSPECT across South Yorkshire

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Urgent and emergency care

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25.
  - Improve category 2 ambulance response times to an average of 30 mins across 2023/24, with further improvement in 2024/25.
  - Reduce adult general and acute bed occupancy to 92% or below
  - Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard (aligned with JFP Integrated Community Services plan)
- **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

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 with developments in primary care and community services to support alternative pathways to ED, including virtual wards, CAS and urgent community response.
- Reviewing our directory of services (DOS) to expand alternative pathways
- Increase clinical support in YAS to reduce conveyances
- For partners to work together to address challenges in ambulance handovers
- 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 working with the 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 & 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 and contributes to reducing emissions.
- Partners are also reviewing their sustainability plans, including YAS and have identified a potential longer term opportunity to develop a low emission fleet.

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Urgent and Emergency Care priorities for year 1 and 2		
Measurable Outcomes (To be confirmed) • Rates of same day emergency admissions • Handover delays (TBC) • Patient experience of A&E services • Average number of A&E attendances per patient		
Improve patient access to ED Alternatives 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	**Improve operational processes at the front door of hospitals**. 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	**Improve flow of hospitals** Review current discharge processes and implement improvement plans to reduce delays. Deliver '100 day discharge challenges' deliverables Work with integrated community services to ensure sufficient capacity and maximise the use of and support expansion of virtual wards and support developments of intermediate care

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WORKING DRAFT May 2023

Planned hospital services (elective and diagnostics)

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - **Elective Recovery:**
    - No waits for elective over 65 weeks by March 2024
    - 30% more electives than 2019/20
    - 85% utilisation – daycase and theatres
    - Reduce follow-ups by 25% (from 2019/20)
    - Use alternative providers for long wait
  - **Diagnostic Recovery:**
    - Diagnostic activity levels to address elective, cancer backlogs, early cancer diagnosis and the diagnostic waiting time ambition
    - Increase the % of patients that receive a diagnostic test within 6 weeks (March 25 ambition of 95%)
    - Maximise the use of CDCs (clinical diagnostic centres)
    - GP direct access for imaging
    - 10% improvements in pathology & imaging productivity in line with optimal rates for tests
    - Delivery of diagnostic elements to achieve FDS
- **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 rapid, 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

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.
- There are a number of planned quality improvements include elective hubs modelled on GIRFT and Royal College best practice, a Sheffield Elective Orthopaedic Centre (SEOC) at Royal Hallamshire Hospital (RHH) and Montagu Elective Orthopaedic Centre (MEOC).
- There are also plans to expand Montagu Hospital and Barnsley Glassworks Community Diagnostics Centres (CDCs), both well located to improve access and to contribute to reducing health inequalities. They are already providing additional diagnostic capacity with plans for expansion and for a respiratory diagnostic spoke in Rotherham. Both supporting workforce development plans via apprenticeships and local recruitment.
- There are plans to expand endoscopy in Sheffield to provide three more Royal College of Physician-accredited endoscopy rooms, increasing capacity in 23/24 and further in 24/25.
- Broader plans to develop 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 enable patient choice and patient centred care, use of virtual consultations and patient initiated follow-up to reduce DNAs and free up capacity for those in need.
- Clinical decision support software, RPA & 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.
- Implementation of Active Wait programme co-developed by MSK patients, STH, SHU and AWRC
- 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 Care (elective and diagnostics) priorities for year 1 and 2		
Measurable outcomes (to be confirmed) • Slope index of inequality in elective admissions by deprivation decile • Waiting times for diagnostics and elective care • Hospital readmission rate within 30 days of discharge		
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 to open in autumn/winter 23 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 Montagu and Barnsley Glassworks Community Diagnostic Centres (CDC). Developing Montagu as the large CDC hub in South Yorkshire and maximising 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 eg Primary Care Alliance and wider primary care, to take a preventative whole pathway approach using speciality guidance

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Cancer services

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
    - Proportion of patients diagnosed at an early stage. Our local ambition is to achieve 57% of patients diagnosed at stage 1 or 2 by 2023/24. Early cancer diagnosis is one of the plus 5 in the CORE20PLUS5 framework.
    - Reduce the number of patients waiting more than 62 days for cancer treatment to less than 432 by March 2024
    - Delivery of the Faster Diagnosis Standard (75% of patients receiving a cancer or non-cancer diagnosis within 28 days of referral by March 2024)
    - The proportion of patients referred on the lower gastrointestinal cancer pathway who have a FIT test recorded (aim to achieve 80% by March 2024)

- **The NHS Long Term plan requirements include**
    - Proportion of patients diagnosed at early stages 1 and 2. The national ambition is to achieve 75% by 2028.
    - Improve 1 year survival – our local ambition is 79% by 2023/24
    - Nationally 55,000 more people surviving 5 years. This means an additional 2,000 people within SYB leading to a total of 8,000

- **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
    - Addressing variation in treatment to improve outcomes
    - Maximising the use of community diagnostic centres for cancer pathways
    - Delivery of personalised care
    - Adoption of innovations at pace and scale, including for example

Our plans

- Our needs assessment identifies that cancer is one of the main causes of premature mortality in South Yorkshire and the main risks associated with cancer are largely modifiable. In response to this our plans include working with partners on modifiable risk factors (link to prevention).
- **Led by the Cancer Alliance working with our Patient Advisory Board our plans include**
    - raising awareness of the early signs and symptoms of cancer
    - Addressing health inequalities, by targeting those most at risk, including communities with high incidence of cancer and poorer outcomes.
    - Work with the VCSE /PCNs to co-develop behavioural science based targeted interventions to re-design services around these communities to support primary prevention and early diagnosis.
    - Promoting uptake of screening and roll out of national case finding initiatives
    - Embedding secondary prevention in pathways and in cancer care reviews
    - Delivering prehabilitation and rehabilitation
- **Access to services and quality were identified as what matters most to people and 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
    - Recognising and supporting people living with cancer with other Long Term Conditions in the community including both their physical and mental health needs
    - Ensuring sufficient diagnostic capacity, including in community diagnostic centres and subsequent elective capacity
    - Delivering best practice timed cancer pathways
    - Growing and supporting the workforce, including specific oncology roles, but enabling skill mix, role expansion, recruitment, ongoing training and support.
    - Working through our Quality Oversight Group, with lead cancer clinicians, cancer nurses and managers to drive continuous quality improvements and addressing unwarranted variation in treatment and outcomes
    - Improving patient experience of cancer pathways, including a strategic partnership with Macmillan to redesign personalised care packages around ‘what matters to me’, including mental health and wellbeing, and embedding care navigator roles
- Working together to standardise care, build resilience and ensure sustainable services. This includes developing a new model for non surgical oncology that is informed by what matters to people and provides sustainable provision.
- 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.

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Cancer priorities for year 1 and 2		
Measurable outcomes (to be confirmed) • Percentage of cancers diagnosed at stage 1 and 2 • Five-year survival rate from all cancers • Premature mortality rate for cancer		
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 Optimise utilisation of CtheSigns to ensure timely and effective referral management and expand use Support third round of Innovation Grants and evaluate previous rounds. Review pinpoint evidence & consider participation	**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 and implement GIRFT recommendations to reduce treatment variations. Embed non site specific cancer pathways & 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 For radiotherapy 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

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Improving Mental Health Services (for children and young people, adults and older adults)

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - 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)
  - Increase the number of adults and older adults accessing IAPT treatment
  - 5% year on year increase in the number of adults and older adults supported by community mental health services
  - Work towards eliminating inappropriate adult acute care out of area placements
  - Recover the dementia diagnosis rate to 66.7%
  - Improve access to perinatal mental health
  - Take a quality improvement approach to address health inequalities (CORE20 Plus)
- **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 & recovery standards
  - Adult severe mental illness (SMI), delivery of integrated primary and community care, SMI physical health checks, individual placement & 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 5-16 year olds from 2017 to 2020 and almost doubling number of children requiring urgent treatment for eating disorders.

Our plans

- Access to high quality services and support for mental health were key themes in our engagement. Our plans to transform mental health services, in line with the NHS Mental Health Implementation Plan 2019/20 - 2023/24, Long Term plan and 2023/24 operational requirements, support delivery of our Integrated Care Strategy and include a focus on:
- Perinatal and Maternal Mental health (including access) working with our Local Maternity Network
- Children & Young People's Mental Health (including access, Mental Health Support Teams in Schools (MHST), new roles in Primary Care, crisis and eating disorders)
- Reviewing the all-age eating disorder offer from community to specialised services (working across the whole pathway in a phased approach)
- Urgent & 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
- 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 (Provider Collaborative)
  - Complex placements/inpatient care for people with learning disability and autistic people (Provider Collaborative)
- 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, enabling early intervention and delivery of 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 & Supported Discharge service. For adult eating disorders, transformation investment into specialist roles to encourage effective flow and aid discharge.
- Review pathways with a QI approach and align delivery with research and innovation opportunities

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Improving mental health services for children and young people, adults and older adults priorities for year 1 and 2				
Measurable outcomes (to be confirmed) • Excess under 75 mortality rates in adults with SMI • Hospital admissions as a result of self harm in children (10-24yrs) and all ages • Suicide rates by sex • Admission rates for those with SMI and another long term condition • Patient reported experience and outcomes (TBC) • Gap employment rate for those with SMI • Smoking prevalence for those with SMI • Dementia diagnosis rate in those aged 65 • Prescribing of anti-psychotic medication in people with dementia but without a diagnosis of psychosis.				
Perinatal, Maternal Mental Health (including access) Develop and embed maternal mental health model and integrate with perinatal mental health services	**Children and Young People's (CYP) Mental Health (MH)** 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	**Urgent Emergency Care** 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 & to transform health based place of safety (HBPOS (s136)	**Community Mental Health (CMH) Transformation** 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	**Inpatient Quality Transformation Programme** Continue to implement learning on closed cultures. Implementation of national programme as it develops and guidance for providing acute inpatient services (currently in draft form)

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Redesigning services for those with Learning Disabilities and Autism

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024.
  - Increase size and improve accuracy of GP Learning Disability Registers.
  - Reduce reliance on inpatient care, improve the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are in an inpatient unit
  - Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of requirements
  - Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times.
  - Take a quality improvement approach to address health inequalities (CORE20 Plus)
- **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 the 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

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 around 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.

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Redesigning services for those with learning disabilities and autism priorities for year 1 and 2		
Measurable outcomes (to be confirmed) • The gap in life expectancy between people with LD and the general population; • Suicide rates for those with Neurodiversity • Admission rates for those with Neurodiversity and other long term conditions • Gap employment rate for those with LD &A • Level of school exclusions (TBC) • Patient (and carers and families) reported experience and outcomes (TBC)		
Review and Reconfigure Pathways and Services to meet the needs of the LDA population 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.	**Improving Autism Pathways and focus on early intervention and support.** 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.	**Addressing health inequalities and the causes of morbidity and preventable deaths** 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

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Specialised services

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - Specialised services have a key part to play in the recovery of elective care and cancer pathways.

- **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 eg 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.

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 22. 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 for 2023/24 and they are set out below:

Specialist Services Yorkshire and the Humber Priorities for 2023/24

Measurable outcomes (to be confirmed)

- Number of patients accessing thrombectomy
- Stillbirth and neonatal mortality rate
- Cancer 5 year survival rate
- Reduced rate of growth in new referrals to renal dialysis units

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.

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Continuous quality improvement and embracing innovation and research

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - A requirement to combine transformation with continuous improvement, connecting innovation and improvement as complementary approaches.
  - An expectation to make use of change methodologies, such as innovation and improvement tools and techniques as advocated by NHS England.
  - An expectation that plans to prevent ill health will be updated, to be incorporated in Joint Forward Plans, paying due regard to the NHS LTP (see below).
  - A reference to the ICBs statutory duties to promote innovation in provision of health services and in respect of research, facilitating and promoting research on matters relevant to health.

- **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 eg COVID 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

- **NHS Improvement Approach Guidance (to be published in 2023)**
  - Will set out the five pillars required for a culture of continuous improvement

Our plans

- Our refreshed 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 throughout this plan, with innovation and improvement fundamentally linked to digital transformation see section XX - digital.
- We will embrace innovation and dispatch our statutory duty to promote innovation including through our innovation hub include:
  - Working with stakeholders to identify innovation needs and priorities
  - Linking with partners and the Academic Health Science Network (AHSN) to advance innovation and promote local adoption and spread to enable equitable access to innovations that address inequalities in care and outcomes at scale, that are cost effective or cost saving across health and care, drive economic development through ideas and solutions that have commercial potential.
  - Working with others to create a culture in which transformation can flourish, enabling our workforce to embrace innovation and for us to become a learning innovating system. This supports delivery of our joint commitment in our Integrated Care Strategy, to create a culture of learning and innovation.
- We will work closely with South Yorkshire's flourishing research and innovation system, recognising that real strength will come from working collaboratively with the different assets in our region. For example, the universities in our region renowned for their health and care research, the health and wellbeing focused innovation district at the Olympic Legacy Park, and the MedTech accelerators based in South Yorkshire
- Our plans to embrace research and dispatch our duty in respect of research include developing our ability to facilitate and promote research. In NHS South Yorkshire this means developing our plans to:
  - enable systematic use of evidence,
  - consider research when commissioning,
  - encourage providers to support and be involved in research delivery,
  - recognise the research workforce in workforce planning, and
  - support collaboration across local National Institute for Health and Care Research (NIHR) networks.
- NHS South Yorkshire has made a commitment to lead the adoption of a recognised Quality, Service Improvement and Redesign methodology (QSIR), which will include effective programme management arrangements to support delivery of our transformation and improvement programmes.

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 Work collaboratively to identify opportunities for innovation and adopt proven innovation Create the opportunity to innovate through delivery of: a scale & spread programme a research & innovation forum	**Build a shared research & innovation strategy** Work collaboratively with research and innovation communities to bring world leading expertise to bear on health and care priorities and develop a research & innovation strategy	**Establish system governance** For research and innovation by developing the Digital, Research and Innovation System Delivery Group	**Quality Improvement Approach** 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 & 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.

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Quality Surveillance Oversight and Improvement

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - An expectation that as we deliver on 31 nationally identified objectives, and that in doing so we focus on narrowing health inequalities in access, outcomes and experience and we maintain quality and safety of services, particularly maternity services.
  - Many of the objectives require a focus on quality and quality improvement. For example reducing the reliance on inpatient care for those with learning disabilities and autism, whilst improving the quality of inpatient care. Taking action to enable timely access to diagnostics, providing responsive, high quality services to support elective recovery and early cancer diagnosis.

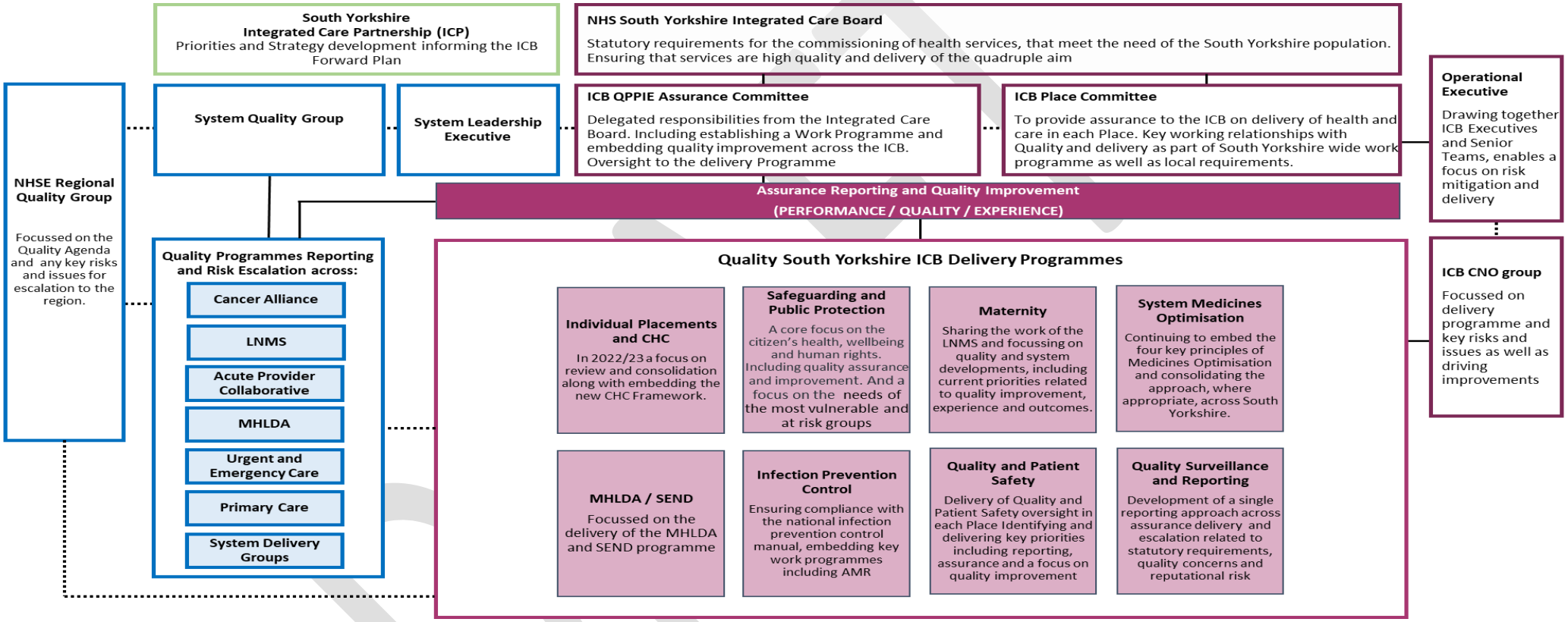
- **The NHS Long Term Plan (LTP) requirements include**
  - As part of the focus on population health and moving to Integrated Care Systems the NHS Long Term Plan set out a greater emphasis by the Care Quality Commission (CQC) on partnership working and system-wide quality in its regulatory activity.
  - The NHS LTP had a clear focus on care quality across all ages & settings, including maternity services and inpatient services and a focus on care quality and health outcomes for all major conditions. A Major Conditions Strategy is now awaited.
  - The NHS LTP drew upon the evidence that good quality care needs good leadership, setting out a plan to nurture leaders, develop and embed cultures of compassion, inclusion and collaboration across the NHS.
  - Systematic quality improvement identified as key to delivery (see previous section)

- **National Quality Board (NQB)**
  - Sets out a shared vision and definition of quality, expectations in relation to quality management and governance and risk management.

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. For the NHS improving access, quality and transforming care is strategic objective within this Joint Forward Plan.
- 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 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 Safety and Improvement : Delivery and assurance



7 Supporting and Developing our Workforce

Key National Expectations

Operational Planning requirements:

- **Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise** Make this a link
- **Improve recruitment rates** into health and care by standardising processes, widening participation, and development and introduction of new roles in clinical pathways
- **Support the wider health and care workforce** to support operational planning and expected elective recovery, understanding that all health and care workforce are integral to the patient pathway

Long Term Plan and NHS People Plan

The national NHS workforce strategy for delivering the Long-Term Plan was set out in the People Plan Make this a link in July 2020. This set out area of focus under four pillars:

- Looking after our people – with quality health and wellbeing support for everyone
- Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face
- New ways of working and delivering care – making effective use of the full range of our people's skills and experience
- Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return.

In South Yorkshire we operate a Workforce Hub which co-ordinates delivery of a range of enabling programmes that support networks and partner organisations to collaborate in delivery of People Plan aims. This includes working closely with NHS England to support alignment of transformation activities.

Our activities over coming months will be informed by publication of a new national NHS Long Term Workforce Plan due in Spring 2023, and ongoing engagement with local leaders.

In South Yorkshire we recognise the importance of integrated working across all sectors to ensure effective care pathways for our patients, and to reduce health inequalities. As a result, where possible our enabling programmes are offered beyond NHS and into care and voluntary sector across South Yorkshire. This includes working closely with South Yorkshire Mayoral Combined Authority (SYMCA) to maximise outcomes from public sector investment in skills and employment.

Our plans

We aim to value and support our entire workforce across health, care, VCSE, carers, paid, and unpaid. This involves developing a diverse workforce that reflects our communities.

Fundamental to all our shared outcomes is the need for a resilient, skilled, sustainable and flexible workforce. The South Yorkshire workforce hub co-ordinates a range of enabling programmes which support service alliances / collaboratives and partner organisations to plan, recruit, develop, optimise and retain our People.

In addition to the breadth of our enabling programmes, we work closely with Place and professional networks to support depth of support to targeted parts of our workforce.

Priorities	Outline Plans (To be informed by NHS Long Term Workforce Plan)
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 • 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 Whole Workforce In South Yorkshire

South Yorkshire Integrated Care System

10,000
additional social care posts needed across SY by 2035, compounded by current turnover of 32%

%
growth in NHS workforce over last 3 years

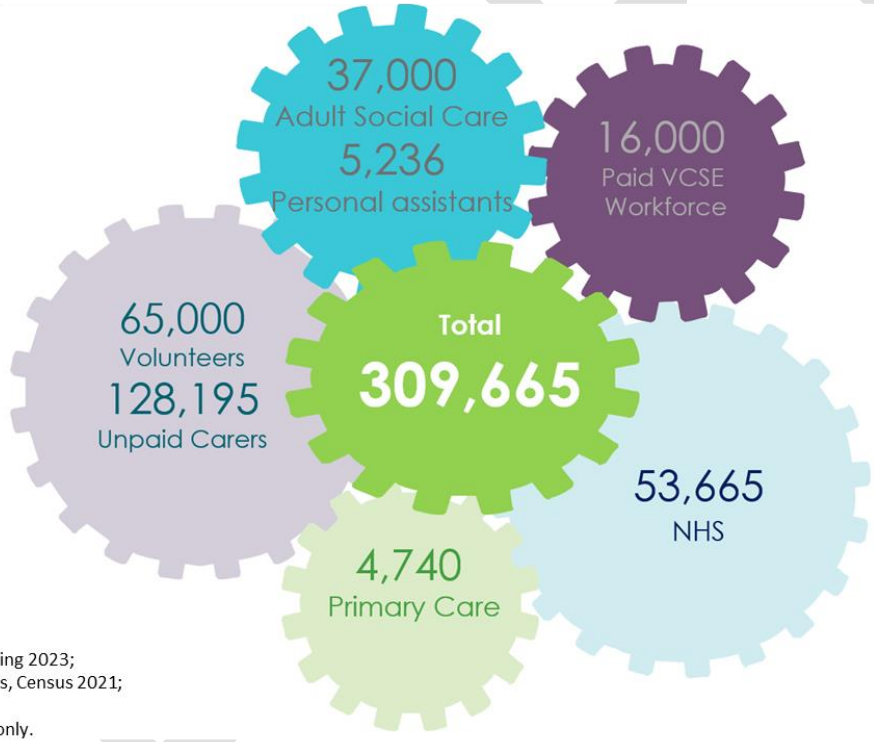
4.5 m
hours of work per year provided by employed VCSE and volunteer workforce

6%
staff sickness across NHS Whilst average days lost for Social care is approx. 9.5 days

▼
Diversity within the workforce across South Yorkshire is amongst the lowest in the country

Sector	Male	Female
NHS	20%	80%
Primary Care		
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%
Primary Care		
Adult Social Care	8%	92%

Sector	Vacancy rate
NHS	8%
Primary Care	
Adult Social Care	9%

Sector	Turnover rate
NHS	9%
Primary Care	
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.

WORKING DRAFT May 2023

Summary of Year 1 and 2 Priorities (Subject to publication of NHS Workforce Plan and 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 & 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 where ever 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

8. Data, digital and technology

Key National Expectations

- **The Operational Planning requirements for 2023/24 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.
- **Milestones for digital technology from LTP (originally set out for 2019 – 2024)**
  - During 2019 controls were introduced to ensure new systems purchased by the NHS comply with agreed standards, including *The Future of Healthcare*.
  - By 2020 five geographies were expected to deliver a longitudinal health and care record platform linking NHS and local authority organisations, roll out to follow.
  - In 2020/21, people were to have access to their care plan and communications from their care professionals via the NHS App.
  - By summer 2021 the aim was to have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.
  - In 2021/22 systems that support population health management were to be in each ICS with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation.
  - By 2022/23, the Child Protection Information system will be extended to practices.
  - By 2023/24 all patients to be able to access a digital first primary care offer.
  - By 2024, secondary care providers including acute, community and mental health services will be fully digitised.
- **What Good Looks Like Framework (guidance to digitise & connect and transform services safely and securing) includes the following domains -** Well led, ensuring smart foundations, safe practice, supporting people, empowering citizens, improve care and health populations.

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Our plans

- Our plans are guided by the principles in our Digital Strategy for South Yorkshire:
  - **Think Big, Start Small, Scale Fast -** We will an adopt 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 & 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 System critical priorities.
  - **Maturity & Innovation** - We will seek to achieve consistent 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) from Yorkshire and Humber Care Record, 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 collaborate to agree the appropriate level for delivery responsibility, with a focus of delivery organisation or place level unless otherwise agreed to deliver once across our system.
  - **Re-use and Extend, Leveraging SY ICS** - We will converge to form a set of strategic partnerships and platforms across SY 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 for 2023/24 and 2024/25 will enable delivery of the requirements in the Operational Planning Guidance for 23/24 and the NHS Long Term Plan across the domains of 'What Good Looks Like Framework (WGLL). WGLL sets out guidance to digitise, connect and transform services.
- Our South Yorkshire Digital Strategy is a key enabler for system priorities across 7 key themes
  - Lens 1 – Enabling delivery of other programmes Theme 6 - Improving Care
  - Lens 2 – Enabling delivery of the key priorities identified across WGLL Framework
    - Theme 1 - Digital Leadership
    - Theme 2- Ensuring Smart Foundations
    - Theme 3 - Safe Practice
    - Theme 4 - Supporting People
    - Theme 5 - Empowering Citizens
    - Theme 7 - Healthy Populations
- Our plans include the development of a South Yorkshire Data Platform. To provide a collaborative analytical environment for the ICB and partners to co-create insights from linked datasets (including both health, care and the wider determinants of health) to underpin decision-making across South Yorkshire related to real-time operational delivery, care pathway development, population health and reducing health inequalities, supporting prevention and early identification.
- They also include developing Digital Services for Our Public (Remote Monitoring). Providing the opportunity for the public to engage with their care record by submitting data (eg blood pressure readings in the home, reablement surveys) to support clinical review and service evaluation, also supporting the aim of prevention and early identification of care and service requirements
- More detail on our plans for the 2023/24 and 2024/25 are set out in the following table.

- Our plans in years 3-5 and beyond will focus on the following:
  - **Digital Services for our Public**- Empower people of South Yorkshire with the skills and digital tools to manage their health and care.
  - **Enabling the South Yorkshire Workforce**- Provide the digital tools and skillsets for staff to work safely and effectively, building a digitally literate, resilient, and capable workforce, in line with the Government Skills Capability Framework.
  - **Integrated Digital Health and Care**- Digitally transform health and care through improved user experience, efficiencies and information sharing to provide better, joined up and personalised care.
  - **Data and Intelligence**- Provide the skills, data and tools to create insights that will help improve the health and wellbeing of the SY population and tackle health inequalities
  - **Excellent Infrastructure** - Ensure infrastructure for staff and the public is always available, secure and meets expectations, providing a resilient working environment for today and the future

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9. Making best use of our resources

Estates

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - A number of requirements where estates can contribute by supporting delivery of clinical services and new service models in fit for purpose modern estate that is well located to improve access and contribute to reducing health inequalities in access and impro
- **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)

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.
- 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.
  - 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 services where possible, creating a better patient environment and reducing the carbon emissions linked to our estate.
  - Making best use of our collective assets, including working with our communities to ensure that we plan and deliver integrated services that are in the right places.

Estates priorities for year 1 and 2		
Primary Care Capital and Community Care 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.	**Space utilisation & fitness for purpose** 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.	**Sustainability and Decarbonising estate** Review Green Plans across existing estate and identify opportunities to decarbonise. See contributing to environmental sustainability section.

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Procurement

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - The guidance is clear that plans should set out measures to release efficiency savings, including reducing procurement and supply chain costs by realising the opportunities for specific products and services.
  - There is also an expectation to improve inventory management. NHS Supply Chain will lead the implementation of an inventory management and point of care solution.

- **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.

- **National reports with implications for procurement include:**
  - The Carter Report (efficiencies and optimising non-clinical resources)

Our plans

- System partners are working together to reduce unwarranted variation and release efficiency savings including reducing procurement and supply chain costs.
- In South Yorkshire we have delivered 85% of the recommended Procurement Target Operating Model objectives set by NHS England, the second highest in the country
- Our work together as partners includes
  - Taking Standardisation of the Standing Financial Instructions (SFIs) across the 8 SY ICS organisations (SY ICB and 7 provider Trusts)
  - Joint e-Tendering and Contract Management platform - Atamis, across the 8 SY ICS organisation (SY ICB and 7 provider Trusts)
  - Joint Work Planning Tool across 80% of SY ICS organisation – with final 20% onboarding in Q1 of 2023/24
  - Delivery of Cost Improvement Plan (CIP) savings in 21/22 totalling £685k and supporting all Trust CIP plans.
  - Established a Consumables Resilience Group which manages, mitigates and works to prevent supply disruption issues which supports clinical staff to deliver uninterrupted high-quality patient care
  - Facilitating mutual aid
  - Social Values and Net Zero introduced to all tenders at a weighting of at least 10%
  - Inventory Management Solution being implemented in 2 of the Acute Trusts with a view to developing business cases for remaining Trusts.
  - Introducing Value Based Procurement by introducing innovation and reducing costs in the whole patient pathway

Procurement priorities for year 1 and 2	
Review of collaborative procurement arrangements To review and further develop arrangements to build on work to date to refresh and realign governance arrangements	**Continue collaborative work as partners**, including full roll out of joint work planning tool, delivery of cost improvement plans, embedding Consumables Resilience Group, facilitating mutual aid, developing a case to roll out an inventory management solution and introducing Value Based Procurement approach.

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Financial resources

Under development - hold 2 pages

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10. Partnership working to deliver our plans

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.
- 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 effectively partnership working with people and communities to improve services and meet the public involvement legal duties.

Our Starting with People Strategy

- From the 10 principles that underpin our Starting with People Strategy, we have identified outcomes and outputs and formed an action plan <link to be added>.
- The actions we have identified within our plan 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.** This includes, developing a 'start with people' minded workforce and ensuring governance, assurance processes and systems all support this aim; and 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; and 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**

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.
- One of the three goals of NHS South Yorkshire is: Involved Communities – To work with our communities so their strengths, experiences and needs are at the heart of all decision-making.
- The South Yorkshire Integrated Care Partnership Strategy also has a joint commitment to listen and coproduce with people and communities.
- As we have committed within our Start with People: South Yorkshire Strategy, we will 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:

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Working with VCSE Sector – developing our VCSE Alliance

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - A number of requirements where partnership working with VCSE could aid delivery including:
  - Continued recruitment of additional roles (Additional Roles Reimbursement Scheme, ARRS) by the end of March 2024
  - Addressing health inequalities and delivering the Core20PLUS5 approach
- **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
  - By *April 2022, 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. (*Later amended to March 2023)
  - These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.

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 developing our VCSE Alliance and working with VCSE sector as equal partners as set out in our initial Integrated Care Strategy. The vision is to develop an equitable partnership and parity of esteem, though embedding VCSE at all levels in our ICS, recognising and valuing the sector across strategy, delivery, engagement and insight (developing insights systematically).
- Access to services and quality were identified as what matters most to people and a key priority is to improve access and quality of NHS services. Plans include working with the VCSE sector and communities to enable equitable access, understand the barriers people face and to overcome them.
- The VCSE sector has a key role in building awareness, upskilling, empowering and confidence building, all identified by people in our engagement.
- VCSE are also skilled in co production and our plans are to harness this approach
- Our initial Integrated Care Strategy identifies four bold ambitions (see page X), one is to act differently together to strengthen and accelerate our work on prevention. The VCSE sector is experienced at supporting people with the wider determinants of health, pyscho social factors and those most socially excluded or at risk of inequalities, including social prescribing. The VCSE sector also holds community assets and is experienced at enabling strength based approaches.
- Supporting and developing our workforce is also a bold ambition in our Integrated Care Strategy and the VCSE sector is a major employer of paid staff, and enabler of employment (employment support, volunteering opportunities) and contributor to our local economy. VCSE workforce priorities have been identified and include developing culture (understanding, values and relationships), developing our intelligence about VCSE workforce (data and insights) and co design opportunities and strengthening VCSE commissioning and investment approaches. Plans are developing to enable investment in VCSE.
- Our plans include building understanding of VCSE, developing principles for systematic, sustainable and effective community engagement and opportunities to collaborate including working with hospitals and other anchor institutes.
- To develop a volunteering strategy
- To work with VCSE to improve the local environment, including through our green social prescribing programme.

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Working with VCSE and developing VCSE Alliance priorities for year 1 and 2		
Embed VCSE participation Implement the VCSE and ICS Memorandum of Understanding and the VCSE Participation Payments Policy Work with System Delivery Groups, Provider Collaboratives & Alliances to identify opportunities for VCSE involvement Coordinate and strengthen work with the VCSE to shape new strategies and plans across the breadth of the system and including a VCSE strategy Develop a system volunteering strategy that builds on and harnesses the strengths of the VCSE Continue to innovate in social prescribing and identify new opportunities for partnership delivery with the VCSE	**Strengthen connections and insights between VCSE and ICS** Strengthen communications and information sharing between NHS and VCSE partners 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. Continue to iterate the VCSE Alliance model	**Maximise VCSE investment opportunities** Shape commissioning and investment approaches to maximise VCSE partnership potential, including developing guiding principles, new models and mechanisms and new opportunities for s commissioning and investment. Identify and develop external funding investment and leverage opportunities to support a thriving sector. Identify and develop non financial resource sharing opportunities

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Working with partners to address the particular needs of victims of abuse

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. 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.
- The local policing body, in South Yorkshire the Police and Crime Commissioner (OPCC), is expected to perform a central convening body for their area, administer funding for the Duty to the specified authorities and monitor progress. The final guidance, funding arrangements and Implementation assessment/support offer have been finalised and shared with the OPCC in the second half of December 2022.
- By March 23 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 4 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 31st January 2024

Our plans

- Prior to the new duty 28 areas in England were identified as high incidences of Violent Crime and as a result were requested to make arrangements for Violence Reduction Units (VRUs), South Yorkshire was one of the original 28 areas that instigated a VRU.
- South Yorkshire has a Violence Reduction Unit managed by the OPCC and with an Executive Board whose membership includes SY Police, Probation, Youth Justice, SY Fire and Rescue and the 4 Local Authorities.
- The new duty does not require an area to establish new groups where there is already established governance but is required to ensure it meets the specified authority requirements in the new duty.
- The current VRU therefore is to be rebranded Serious Violence Duty - SVD and VRU Executive board, a task and finish group will be established to revise the Terms of Reference to ensure the new duties are met.
- South Yorkshire also has both a 4 Place Safer Partnership structure with longstanding ICB representation and a Countywide Community Safety Partnership group and forums which can support delivery of the New Duty.
- Oversight and assurance for the new duty is directly under the Home Office and the OPPC, it is not anticipated that ICB's will need to provide assurance or monitoring requirements to NHSE. However, many of the safeguarding assurance requirements such as Violence against women, Domestic Violence and Domestic Homicides all link to the new duty and would be good practice to share initiatives through the Safeguarding assurance root also.
- In response to the guidance 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. The guidance states that this is acceptable to meet the requirement, however again its proposed using the existing response strategy as a starting point and then developed with partners over the coming year.

Priority for Year 1
Build on SY Violence Reduction to establish Serious Violence Duty Executive Board to ensure new duties are met

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Maximising our potential as anchor institutes – supporting wider socio economic development

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - 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 includes**
  - 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

Our plans

- Anchor institutes are described as large organisations whose long term sustainability is tied to the wellbeing of the populations they serve.
- The NHS, Local Authorities, Universities and other large employing organisation in South Yorkshire are 'anchor institutes'. They are largescale employers, purchasers of goods and services, land owners and have relatively fixed assets.
- 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 institutes 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 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 the bold ambition in our Integrated Care Strategy to focus workforce (see section XX)
  - 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. (Link procurement?)

Maximising our potential as anchor institutes – supporting wider socio economic development – priorities for year 1 and 2	
Anchor Network Increase understanding of anchor institutes 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 (scope tbc)

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Contributing to the environmental sustainability agenda together

Key National Expectations

- **The Operational Planning requirements for 2023/24 include**
  - 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, eg 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

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, eg 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.
- Local research in collaboration with Sheffield Children's Hospital to educate children and young people on good asthma care that is environmentally friendly.
- Plans include initiatives testing the use of reusable instruments, eg coils

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

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Direct Actions	Enabling Actions
Development of heat decarbonisation plans by all NHS Trusts. All Trusts to enact specific direct actions including, those to deliver Estates NZ delivery plan, considering use of nitrous oxide, audit/leak test Entonox manifold cylinders, 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 eg reduce wastage & promote low carbon inhalers Apply principles of sustainable procurement – see procurement section Scope out and develop collaboration opportunities with , VCSE to work together on shared sustainability and net zero priorities. Scope out how we can work with and support the MCA and LA on implementing their active travel strategy for SY. Consider how we can work jointly on climate adaptation and contribute to plans set out in our Integrated Care Strategy to develop a citizens assembly on climate change	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 Pilot national toolkits for low carbon virtual ward pathways, sustainable ED, green theatres checklist Support Digital first principle, wherever possible

11. Plan Delivery

Support requirements

Under development

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Risks

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

Workforce risks • 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.	**Mitigating actions** 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 • Risk of managing the current significantly challenging financial position with substantial efficiency requirements across all 2023/24 plans • Uncertain financial framework for beyond 2023/24	**Mitigating actions** • Organisation and systemwide financial monitoring arrangements to enable all to be sighted on progress and take action where necessary • Continued dialog with national colleagues to inform future financial framework for beyond 2023/24
Operational risks • 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 in 2023/24	**Mitigating actions** • 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 • 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	**Mitigating actions** • Continue system development to create a culture of collaboration and partnership working to maximise the benefits system working • 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 • Ongoing dialog with national colleagues and articulating of support requirements

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South Yorkshire
NHS Joint Forward Plan
WORKING DRAFT
APPENDIX

Detailed plans for 2023/24 and 2024/25

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Taking a prevention focussed population health approach and addressing health inequalities in all that we do			
	Priorities for 2023/24 /25	**Key Actions**	**Key Milestones**
1	**Becoming a population health led and inequalities aware system**	• Develop and implement the SY Academy across the system so it is accessible by all SY health and care and VCSE workforce and partners • Establish Communities of practice (COP) and professional, clinical networks to bring people together from across SY 4 places to share, learn and collaborate. • Support delivery of the CORE20+ framework through funding the implementation of innovative and integrated ways of working that delivers on the requirements of the national framework for adults and children • Embed an inequalities focus within key ICB board reporting • Develop a South Yorkshire population profile to inform strategic needs assessments with a focus on inequalities • Work with places and partners to identify and develop at scale transformation plans based on data and insights to reduce variations in outcomes, experience and access. • Support development of population health commissioning and outcomes-based services with places /partners • Link the ICP Outcomes framework, IPR to incentive-based commissioning approaches, year of care models and outcomes and experience incentivised contracts • Expand the behavioural science approach across programmes	ICSs and trusts have published board papers that include an analysis of key performance data and outcomes disaggregated by ethnicity and deprivation by Q3 23/24. Independent evaluation of the Population Health Academy to commence Q4 23/24 SY health needs profile published Q2 23/24 A Community of Practice on Inclusion Health and connected work programme by Q4 23/24
2	**Becoming Prevention led**	• Embed a primary prevention for all mindset and maximise opportunities for patients to access primary prevention services such as to stop smoking. • Review fitness for surgery policies and move towards a holistic health and wellbeing offer that optimises recovery and outcomes • Mobilise the VSCE MOU to establish how engage with the VCSE in prevention activities. • Develop a shared commitment to move from single disease care planning to multi-morbidity care planning • Utilising alternative workforce models to strengthen the robustness of the service and promote MDT (Multi-Disciplinary Team) approaches to patient care • Use the networks to optimise end to end pathways from primary prevention to tertiary care by providing clinical advice and support to delivery and build stronger collaboration across the LTC networks, sharing learning and adopting models that are the most effective at delivering outcomes • Work through the Place Partnerships, Collaboratives and Alliances to accelerate the move from reactive care to proactive care, taking a whole-person approach and focusing on what matters most to people. • As part of our Anchor role as an employer, set out the prevention opportunities to improve the health of our workforce.	Prevention champions network established with a Terms of Reference in place by Q 2 23/24 Significant proportion of staff accessed training on prevention by Q3 23/24. Roll out of further training by Q4 24/25 A menu of sustainable support offers for referring clinicians and professionals to use and a directory of HWB services that the public can access developed by Q1 24/25. Anchor Charter developed by Q4 23/24
3	**Embedding intelligence and PHM approaches across our system**	• Lead the development of the ICS intelligence function by facilitating a network and providing access to key health care data assets. • Develop an analytics platform with appropriate data flows to inform PHM approaches at GP, PCN, Place and system level	Analytics dashboard available for all analysts in South Yorkshire by Q2 23/24. Fully mobilised platform and achieving 'thriving' status by Q4 24/25

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		• Develop implementation plans for PHM 'front-end' user tools such as ECLIPSE/RAIDR or bespoke locally built tools. • Develop an evidence based Population Segmentation model to better inform population need, inequalities and outcomes monitoring • Develop plans to extend analytics and modelling capacity to inform financial risk and testing impact of intervention on outcomes • Develop pilot projects to model and test predictive analytics to prevent admission • Work with providers and partnerships to develop action plans based on data and insights to reduce variations in outcomes, experience and access. • Develop a capability to analyse patient and public insight (qualitative) data so can be used alongside 'hard data' metrics to inform service design • Learn from and build on behavioural science approaches being taken led by the Cancer Alliance (see Cancer section)	Ways of working as an intelligence function for the ICS established by Q2 23/24 Engagement and mobilisation of key PHM tools with clinicians to inform direct patient care, Q4 23/24 Equality Impact Assessment dashboard developed to inform local/system level health needs assessments by Q1 24/25 Pilot Insights Bank developed by Q3 23/24 to cover Inclusion groups. Specification for a digital solution in place by Q4 23/24. Roll out to other key population groups by Q4 24/25.

Ensuring the best start in life – Maternity			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	**Quality and safety**	• Implement Perinatal Quality Surveillance Model (PQSM) • Procure equipment to support neonatal optimisation and to manage brain injury • Co produce materials to support and standardise personalised care and supporting planning • Implement more continuity of carer teams across all Trusts for those with greatest needs	By quarter 4 23/24 By quarter 4 23/24 By quarter 4 23/24 By quarter 4 23/24
2	**Prevention, equity and equality**	• Establish culturally sensitive genetics services across SY • Establish standardised pelvic health services across SY • Roll out national tobacco model; including introducing incentives and direct supply of NRT • Initiatives to improve breastfeeding rates • Increase referrals to NDPP (previous GDM) and holistic offer of healthy lifestyle support • Improve perinatal and maternal mental health services (link MH section page XX) • Link with Social Prescribing to embed within maternity	By quarter 4 23/24
3	**Workforce and digital (enablers)**	• Increase midwifery workforce by expanding education offers (apprenticeships and MSC programmes) • Enhance digital enablers – Y&H care record; training passport • Embed maternity services within community hub provision • Implement standardised cultural competence training • Improve representation of Maternity Voices Partnerships	Students start quarter 1

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Addressing the needs of Children and Young People (0-25)			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	**Prevention, Equity and Equality**	• Work in partnership with places to support the Best Start in Life deliverables • Work in partnership with Places to develop and embed Family Hubs • Implement the key objectives for the Core20plus5 for CYP for asthma, diabetes, epilepsy, oral health and mental health • Implement the Core20plus5 connectors oral health initiative • Work in partnership with VCSE to collect data to support the Health Equity Collaborative • Develop a Health Equity Framework • Test the assumptions of the health equity tool as it develops	Core20plus5 connectors initiative implemented by Q4 Establish a system partnership group to support the Health Equity Collaborative by Q1 Data collection completed for Health Equity Collaboration by Q4
2	**Long Term Conditions**	• Work in partnership to deliver the NSHEI bundle for care deliverables for asthma, diabetes and epilepsy. All include priorities to improve access to care transitions & access to mental health support • Promote the asthma tiered training offer with education and primary care • Initiate an Asthma Friendly School policy. • Implement an new approach to psychological support for CYP with LTC • Implement improvements to the diabetes transition pathway Ensure CYP with the greatest need have support and access to technology to support the maintenance of their diabetes • Maintain core working groups to support the deliverables. • Maintain clinical leadership to lead the work	Bi-monthly reporting to NHSEI to track progress and milestones for all three long term conditions bundles of care. Asthma Friendly Schools initiative shared with all schools in SY by Q4 Asthma training update to 50% in education and primary care settings be Q4 Diabetes technology support to all YP most in need Rotherham and Doncaster by Q4 Clear approach to psychology support for LTC by Q4
3	**Personalised Care and Involvement of children, young people and their families**	• Develop social prescribing opportunities • Introduce personalise care to the Complications of Excess Weight Clinic • Establish a system approach to engagement with children and young people • Develop a strategic set of principles for all Provider Collaboratives and Alliances to engage with CYP • Establish a directory of all CYP participation groups in SY • Consult and connect with CYP around specific work programme development • Involve CYP in events and conferences • Establish an approach to the Core20plus connectors for oral health • Build a network of YP willing to train as connectors in oral health • Co-create with YP the approach and delivery of the connector programme • Support the CYP connectors to share key messages in their communities • Establish an approach to ensuring CYP are front and centre as part of the Health Equity Collaboration • Consultant YP about what health equity means to them and the key areas of focus from their perspective	Commence social prescribing model as part of the Complications of Excess Weight Service by the start of Q2 Engagement plan and strategy for engagement with CYP by end of Q2 Core 20plus5 connectors approach established by end Q2 CYP involvement in the Health Equity Collaboration by end Q2

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Strengthen our focus on prevention, early identification and improve management of LTC			
	Priorities for 2023/24/25	**Key Actions**	**Key Milestones**
1	**Primary prevention** – by focusing on the modifiable risk factors: smoking, healthy weight, physical activity, alcohol and hypertension	• Fully embed the treatment of tobacco dependency within secondary care Trusts in SYB (QUIT for Patients, QUIT for Parents, QUIT for Staff & QUIT for a smoke free hospital) • Develop QUIT pathways for community mental health patients and outpatients in acute Trusts • Work with ICS partners to scope out a SY public engagement programme on key risk factors such as tobacco and alcohol • Identify opportunities to Integrate Physical Activity within clinical pathways and work collaboratively with partners to embed physical activity strategies. • Review tier 3 weight management services and obesity pathway in line with requirements for the new weight management medications • Improve impact of Alcohol Care Teams and Alcohol Pathway Quality Improvement Programmes on alcohol dependency for patients and their families. • Support development of primary prevention in communities programmes via sharing learning from evaluation of key initiatives such as Glassworks. Expand community blood pressure checks across community teams, pre-operative clinics and maternity services. • Increase uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions • Developing MECC approaches to include primary prevention	Acute Inpatient Tobacco Treatment services across SY to reach 'Delivered' status by Q4 23/24 Development of a SY dashboard detailing performance of Tobacco Treatment services by Q2 23/24. Embedding QUIT programme in Outpatients services, Extension of Healthy Hospital Programme to include other priority areas and Delivery of a SY Joint Comms approach to smoking cessation by Q4 24/25 Develop a physical activity training programme for social prescribers by Q4 23/24. Implementation by Q4 24/25 Increased primary care referrals to the NHS Digital Weight Management Programme, NHS Diabetes Prevention Programme & NHS Low Calorie Diet programme by Q4 23/24 Self-referral into all South Yorkshire weight management pathways by Q1 24/25
2	**Early Identification and widening access -** improve earlier detection and accurate diagnosis of across a range of long-term conditions to ensure that patients receive the right support and care planning and ensure patients are eligible for interventions.	• Increase the number of people receiving NHS physical health checks including those with serious mental illness and Learning disabilities (see sections for mental health and learning disabilities). • Stocktake across LTC to ensure that all LTC disease areas are taking forward best practice in early diagnosis • Design, launch and deliver a SY CVD Plan including a focus on improving detection and management of AF, hypertension, high cholesterol (as described in the CVD high impact areas) • Optimise the use of the NHSE National Community Pharmacy BP Check Service for increasing case finding, 24 hour monitoring as well as for providing routine BP checks referred from general practice (See Integrated Community pharmacy and Medicines Optimisation section) • To improve the access to diagnostics for those most likely to have undetected disease including implementing a sustainable Spirometry model to reduce variation in delivery. • Expand and optimise urgent stroke diagnosis and early treatment pathways • Innovation in models of delivery so services have capacity to see more patients (including co-production models) including review of secondary care moving to joint clinics. • Support the work of the Cancer Alliance to enable early identification and widen access, eg rolling out Lung Health Check and case finding (see Cancer Section for more details)	Improve access and reduce inequalities in access to NHS delivery of Health Check programmes SMI, LD, over 40's by Q4 23/24. Develop a support package for practices to improve the management of hypertension in the highest areas of deprivation by Q3 23/24. Implementation and review by Q4 24/25. Deliver system transformation fund primary care lipid optimisation project by Q4 23/24 and deliver secondary care lipid optimisation clinics across South Yorkshire by Q2 24/25. Sustainable approach to spirometry – by Q2 24/25

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3	**Ensuring that the models of care available are of optimal quality**	• Multi-morbidity – taking a preventative, personalised and integrated approach to care, embed evidenced based innovation and deliver new models of care. Taking a holistic approach to encompass mental health & wellbeing alongside physical health conditions to respond to increasing mental health needs. • Delivery of key management priorities identified in the Long-Term Plan, including Cardiac Improvement Priorities and those aligned to the Respiratory Delivery Board. • Implement new models of care in CVD, Respiratory, Diabetes and Stroke to provide education, rehabilitation and exercise programmes including remote and digital models and ensuring that people with serious physical long-term conditions have access to support to enable them to have good mental health. • Work with the Cancer Alliance to deliver models of cancer care of optimal quality, optimising cancer pathways in line with best practice (see Cancer Section for more details). • Test and pilot a pro-active "year of care model" to support the first LTC diagnoses as well as models that are developed around multi-morbidity to help reduce urgent care demand. • Rehabilitation - Increase access to high quality services to enable more people with heart and lung disease to complete a programme of education and exercise-based rehabilitation and increase completion rates for Pulmonary Rehab and Cardiac Rehab. • Optimise needs-based rehabilitation and progress implementation of the Integrated Community Stroke Service Model • Increase uptake and decrease inequalities in uptake of respiratory related vaccinations to drive up uptake of COVID, flu and pneumonia vaccines reduce COPD exacerbations • Optimise stroke pathways to increase the number of patients receiving high quality stroke services (thrombectomy, thrombolysis and rehabilitation) • Support the Cancer Alliance in their plans to develop and delivery prehab and rehabilitation (see cancer section)	SY PR services registered with PR Services Accreditation Service by Q2 to commence their accreditation journey (12-18 months). Delivery of Thrombolysis offer to all stroke patients who could benefit by Q3 24/25. Roll out of the Integrated Community Stroke Rehab model by Q4 24/25
4	**Support patients to self-manage their conditions**	• Examine current remote monitoring workstreams for long-term condition approaches and consistency for patients. • Develop and embed collaboration and co-production with VCSE and social prescribing in LTC work to scope connections about future methods of delivery. • Develop social prescribing as a core component to aid personalised approaches. Focus on improving confidence in self-management, patient activation and education • Support patients to have choice and control and feel able to manage their own health and wellbeing • Develop guidance on how to improve health literacy of patients and action to remove language barriers. • Work in partnership with the public and people with lived experience to co-produce a personalised approach to long term condition pathways • Enable delivery of anticipatory care plans (see primary care/integrated community services section)	Develop and embed collaboration and co-production with VCSE and social prescribing in LTC work by Q4 23/24 Delivered and evaluated the SQuIRe Social Prescribing Project in all 4 places by Q1 24/25 Review of translation services by Q3 23/24. Implementation plan by Q1 24/25. Apply learning from Diabetes pilot of digital tools in 23/24 to other LTC programmes.

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		• Develop digital tools and a support offer for people with long term conditions to increase uptake of self-management offers. Commencing with diabetes and pre-diabetes and targeted at those who don't usually attend for self-management	

Primary Care (GP Practices, Primary Care Networks, Community Pharmacy, Optometrists and Dentists			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	**Improve Access**	• **Community Pharmacy** Optimise delivery of Discharge Medicines Services across all Trusts in South Yorkshire optimise engagement and referrals in to the Community Pharmacist Consultation Service (CPCS) by General Practices, NHS 111 and UECs. Optimise delivery of the BP Check service. • **Optometry** - Optimise existing Minor Eye Condition schemes to reduce demand on General Practice • **Primary Medical** – Developing the access offer; Acute same day/urgent; planned care pathways, primary care MH • **Dental** – Dental activity levels to be restored to pre pandemic levels; focus on equality of dental access, experience and outcomes (core20PLUS5 principles and population need)	GP Access recovery plans to be developed in Q1
2	**Workforce**	**Community Pharmacy and Optometry** - Continued development of workforce – Higher Qualification. Support implementation of National Community Pharmacy Independent Prescriber Pathfinder Programme (if SY ICB selected to be part of the Programme) and exploring local commissioning opportunities for utilising independent prescribers in community pharmacies. • **Primary Medical** – training and education strategy; embedding Non Medical Prescriber framework and ACP governance matrix. • **Dental –** in partnership with HEE support development of a sustainable and appropriately trained dental workforce , responding to challenges in recruitment and retention, encouraging best use of skill mix.	**Community Pharmacy and Optometry** - Continued promotion of HEE funded training offer from Q1 to Q4. **Primary Medical Care** – full utilisation of ARRS allocation by each PCN by end March 2024.
3	**Integration**	• **Community Pharmacy** - Maximise use of NHS Mail across all Community Pharmacies in South Yorkshire Optimise delivery of Discharge Medicines Services from all Trusts in SY. Optimise referrals from general practice in to the CPCS and BP Check service.	**Comm Pharmacy** - Development of resources guide for Community Pharmacies to aid increased use of NHS Mail during Q1. All Trusts live and increase in referral numbers from Q1 to Q4

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		• **Optometry -** Roll out Eyecare Electronic Referral System (EeRS) across Sheffield and then the rest of South Yorkshire, to facilitate direct referrals to Ophthalmology and image transfer • **Primary Medical** – develop maturity of neighbourhood working; resilience and rescue offer; building integrated teams. • **Dental –** service pathway reviews; CDS including consultant led special care & paediatric dentistry, Urgent dental care Housebound patients including residential & nursing settings Patients with no fixed abode	**Optometry** - Expand Sheffield pilot across the whole STH referral footprint Q1 2023/24. Agree sequence of further roll-out in South Yorkshire in Q1 2023/24 **Primary Medical Care** – delivery within layers of scale, MDTs established with wider primary care participation. Growth in work with voluntary sector.

Integrated Pharmacy and Medicines Optimisation			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	Reduce Avoidable Harm from Medicines	• Green bag scheme • Recruitment of ICB Medicines Safety Officer • Support implementation of the Discharge Medicines Services from all Trusts in SY. Expand the patient cohort from Trusts already live.	TBA
2	Making the Best Use of the Expertise of Pharmacy Professionals	• Optimise engagement and referrals in to the Community Pharmacist Consultation Service (CPCS) by General Practices, NHS 111 and UECs. Optimise delivery of the BP Check service.	TBA
3	Embed Pharmacy and MO Support for ICS Clinical Strategy Workstreams	• Hypertension case finding (national initiative) and management (local) • Integrated approach to Mental Health provision in non-mental health settings	TBA
4	WS4 - Collaboration to Reduce Unwarranted Variation and Duplication	• Review monitored dosage system utilisation • SABA reduction scheme	TBA
5	WS5 Pharmacy Workforce Transformation	• Baselining the current position across all sectors within South Yorkshire pharmacy • Immediately engaging with new cross-sector initiatives • Immediate response to short-term staffing needs • Increase DPPs • Supporting Implementation of Community Pharmacy Independent Prescriber Pathfinder Programme (If SY ICB chosen to be part of programme)	TBA
6	WS6 Medicines Value Initiatives	• C-QUINs and Incentive Schemes	TBA

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Supporting people in the community (Integrated Community Services)			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	Embedding prevention and proactive anticipatory care approaches enabled by integration in neighbourhood teams (including for those with greatest needs, core20plus communities and health inclusion groups)	• Development of collaborative delivery group to co-design / deliver plan • Ensure alignment to neighbourhood teams • Develop intelligence at a neighbourhood level to ensure aligned demand and capacity and identification of gaps in provision / unmet need • Building on schemes within Ageing Well programme, ensure focus on delivery of preventative / proactive / anticipatory and personalised approaches within community • Deliver 23/24 plan for Enhanced Heath in Care Homes / Anticipatory care in line with Ageing Well framework	Plan to deliver national and local strategic priorities agreed at place by XXX
2	Community services recovery and productivity	• Agree recovery and productivity plan with target trajectories for end of Q1-4 • Data quality improvement plan in place with key areas of focus agreed in Q1 and delivery by Q4 • Deliver above in partnership with primary and social care colleagues • Review direct access pathways self assessment and gap analysis and ensure delivery plan in place to meet national requirements by Sept 23	By September 23: Direct referrals from community optometrists to ophthalmology services for all urgent and elective eye consultations Self referral routes to falls response services, MSK services, audiology including hearing aid provision, weight management services, community podiatry and wheelchair and community equipment services
3	Integration of urgent community response services and digital developments (including Virtual Wards, Urgent Community Response, link to CAS, EOLC, care homes) to reduce unnecessary admissions	• Q1/Q2 integrate UCR / CAS / VW responses to maximise number of people in crisis where admission can appropriately be avoided • Q2/Q3 Align EoL / care homes • Digital developments to support integration, understand capacity and flow eg Rotherham plans to develop an integrated digitised acute and community command centre	Rollout of PUSH model with YAS by Q1 23/24 Implementation of Paediatric CAS model by Q1 23/24 See above
4	Palliative and end of life care	• Implement ReSPECT across South Yorkshire. Establish a South Yorkshire ReSPECT Champions group to further embed the ethos of ReSPECT and improve communications/share learning across the system. • Continue to deliver the National Palliative and end of life care delivery plan outlined by NHSE and NHS Improvement. Establish an all age ICB Palliative and end of life care forum and each place to undertake the Ambitions Framework self-assessment tool to determine the overall position for adults and children. Use the output to generate an action plan for NHS South Yorkshire focusing on the NHS triple aim in relation to PEoLC; improving access, improving quality and improving sustainability. • Establish a lived experience PEoLC group, promoting lived experience opportunities in Place. • Identify co-production opportunities.	All places across South Yorkshire to be using ReSPECT Plans as part of advanced care planning by the end of Q4 NHS South Yorkshire to achieve outputs in National Palliative and end of life care delivery plan by 2024/25

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Urgent and emergency care			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	Improve patient access to alternatives to ED	• Review current pathways, develop improvement plans and implement improvements to improve A&E performance • Collaboration with the Integrated Community Services programme to continue to deliver the expansion of the 2 hour urgent community response (UCR) services (see community services section xx) • Pilot to clinically validate Emergency Department dispositions within NHS 111 online • Finalise model for NHS 111 – press 2 for Mental Health Crisis • Scale up falls and frailty services joined up with YAS/UCR and social services • Continue to utilise the push model from the 999 stack into place based teams for CAT 3 and CAT 4 calls – maximising the use of UCR and primary care diverting away from ED • Data collection via the ED redirection kiosk to inform pathways • Promote alternatives to ED with ambulance services/ clinicians and pathways tool. • Develop a consistent approach and provision of hospital based SDEC. Develop and delivery plans to improve access, referrals and reduce variation in SDEC provision • Deliver plans to support high intensity users of urgent and emergency services	76% A&E (all type) performance against the 4-hour standard by March 2024 Reduce adult general and acute bed occupancy to 92% or below by March 24 Continue to exceed the 70% target for 2-hour UCR standard throughout 23/24
2	Improve operational processes at the front door of hospitals	• Implement actions to prevent overcrowding in ED • Work together to develop and deliver plans to reduce handovers at ED to no more than 15 minutes and reduce handover breaches to no more than 2% • Develop and deliver plans for a consistent approach & provision of hospital based SDEC (supports delivery of priority 1) • Development of an ambulance handover hub (modular build) • UEC Integrated Framework (ICF) to be developed as an MoU ensuring clear roles and responsibilities for all partners • Ensure admission avoidance provision is consistently in place at the front door i.e. social workers and therapist (Community Hospital Avoidance Team) • Deliver plans to support high intensity users of urgent and emergency services (supports delivery of priority 1)	Improve category 2 ambulance response times to an average of 30 mins across 2023/24, with further improvement towards pre-pandemic levels in 2024/25. Modular build operational by Q1 23/24 ICF MoU in place across Q1 23/24
3	Improve flow of hospitals	• Review current discharge processes and implement plans to improve to reduce delayed discharges • Work with community services and other partners including local authorities, social services to support their work to increase community capacity and maximise use and expansion of virtual wards to improve patient flow (tech enablement and exploration of opportunities beyond ARI and frailty)	Reduce adult general and acute bed occupancy to 92% or below by March 24 Deliver 80% occupancy of Virtual Wards by September 2023 Continue to exceed the 70% target for 2-hour UCR standard throughout 23/24

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		• Work with partners to improve consistently of urgent community response (see community services section XX) • Monitor & deliver against the "100 day discharge challenges" deliverables • Work with partners to increase intermediate care provision (see community services section XX) • Explore and develop plans to enable delivery of point of care testing to reduce conveyances and admissions • Deliver plans to support high intensity users of urgent and emergency services (also supports delivery of priority 1)	

Planned hospital services (elective and diagnostics)			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	**Continued elective care recovery**	• Utilise available funding to grow our workforce, invest in physical assets/estate, utilise ISP and optimise pathways to narrow the gap between elective demand and capacity • Elective workforce expansion and development. ○ Collaborative service and staffing models/joint appointments to help address fragile services. ○ Use of digital staff passport to support efficient movement of staff between Trusts in SYB ○ Use of enhanced and extended roles across primary and secondary care e.g. 'Optometry first' model of care, development of nurse and AHP injectors in Ophthalmology, First Contact Practitioners in MSK ○ Upskilling of workforce to improve validation and management of waiting lists, including bespoke business administration apprenticeship contextualised to the Patient Tracking List (PTL) and/or cancer care navigator workforce. ○ Health and wellbeing offers to increase morale and retention ○ Workforce planning has been a key consideration as part of SEOC and MEOC business planning and implementation • Design and implement elective hubs and ring-fenced elective capacity modelled on GIRFT and Royal College best practice recommendations and observations of other high-performing centres: ○ Sheffield Elective Orthopaedic Centre (SEOC) cold site at Royal Hallamshire Hospital (RHH) which will include an enhanced recovery area (phase 1 opens April 23 and phase 2 Aug 23). ○ Montagu Elective Orthopaedic Centre (MEOC) due to open in Autumn/Winter 23.	Phase 1 of SEOC operational April 2023 Phase 2 of SEOC operational Aug. 2023 MEOC operational Autumn/Winter 2023/24 Deliver the system elective activity target (103% of 19/20 activity) Xx first OPs, xx ordinary elective procedures, xx day case No patients waiting over 65 weeks by 31 March 2024 25% reduction in OPFU (from 19/20) Deliver 85% day case rate Deliver 85% capped theatre utilisation

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		• Clinical prioritisation and ongoing validation of waiting lists • System management and mutual aid of those patients that have been waiting longest; ensure no patients wait more than 65 weeks by 31 March 2024. • Sharing of best practice to reduce variation and improve services for patients. • Benchmarking to identify opportunities to change clinical practice in OP settings, incl. reduction in unnecessary follow-ups, implementation and expansion of PIFU pathways • System focus and collaboration to recruit and develop administrative staff to support waiting list validation and improve capacity utilisation. Focus on booking, management of cancellations and DNAs to improve clinic utilisation • Identification of recovery initiatives which would be beneficial in 2023/24 and can be appropriately funded and resourced • Referral optimisation to ensure appropriate management of patients' symptoms • Published board reports to include analysis of waiting times disaggregated by ethnicity and deprivation; engagement to understand barriers to access and targeted action to reduce inequalities e.g. to reduce DNAs • Use of digital elective	

2	**Continued diagnostic recovery**	• Utilise available funding to grow our workforce, invest in physical assets/estate, utilise ISP and optimise pathways to narrow the gap between diagnostic demand and capacity
		• Diagnostic workforce strategy development and implementation
		  ○ Use of digital staff passport to support efficient movement of staff between Trusts in SYB
		  ○ Health and wellbeing offers to increase morale and retention
		  ○ Workforce planning a key consideration of CDC and RHH endoscopy business planning and implementation
		  ○ Imaging academy and practice educator training models to increase workforce numbers, improve and standardise multi-professional training across SYB, improve retention rates and reduce added pressure on service staff from training: for sonography, plain film, MR, CT and undergraduate diagnostic radiography students,
		  ○ Proposals to harmonise sonographer employment bandings and pay
		  ○ Reporting Radiographer deep dive and planning to expand numbers and scope
		  ○ SYB-wide recruitment for newly qualified radiographers
		  ○ Develop and implement a pan-Yorkshire Endoscopy training academy (in shadow form from early 2024 until go live in Sept. 2024) and immersion centres to increase capacity, provide a high quality multi-disciplinary training approach, upskill the current trainers and the existing endoscopy workforce (clinical and non-clinical). Deliver JAG courses, immersive training and a clinical endoscopist programme.
		  ○ Deep dive of endoscopy workforce, demand and capacity review and action planning.
			Rotherham Breathing Space CDC operational April 2023
			Endoscopy operational at Montagu CDC Sept. 2023
			CT and MRI operational at Barnsley Glassworks CDC Sept. 2023
			
			Deliver the system diagnostic activity target (xx of 19/20 activity) xx tests
			Delivery of planned reduction in patients waiting over 6 weeks for a diagnostic test (to 5% or less) – Align to Operational Plan Submission
			
			Delivery of diagnostic elements of FDS

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		○ Increased training and support for degree apprenticeships ○ Development of the diagnostic support, assistant and navigator workforce ○ Developing proposal for a SY Radiographer Bank hosted by the SY AHP Faculty ○ DEXA scoping project ○ Develop a system-wide ECHO training model to develop a sustainable workforce, promote good practice and mutual aid • Expand Montagu and Barnsley Glassworks CDCs and open a spoke CDC at Breathing Space, Rotherham to provide additional diagnostic capacity. Continued use of Independent Sector staffed mobile CT/MRI at Montagu until the static imaging unit is built qtr 1 2024/25. Montagu to be our large CDC in 2024/25. Develop solution to support system use of available capacity. Consider case of need for Sheffield spoke. • Sharing of best practice to reduce variation and improve services for patients. • Pathway transformation including straight to test • Prioritisation and ongoing validation of waiting lists. • Implementation of clinical decision support software, RPA and AI to support referral optimisation, management of waiting lists and to free up staffing resource for other tasks • Capacity and demand review of diagnostic modalities to understand opportunities for improvement • Consideration of alternative delivery models for adult hearing assessment	
3	**Pathway improvement and utilisation**	• Utilise 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 LoS. • Whole pathway reform using speciality guidance e.g. Best MSK, Optometrist First • Theatre improvement programmes to optimise scheduling and throughput, reduce on the day cancellations and improve recruitment and retention of staff. Actions include: • Anaesthetic protocols to support enhanced recovery, including reduced use of GA where clinically appropriate. • Therapies teams to support early mobilisation / rehab on day of surgery. • Criteria led discharge as default • Digital pre-operative solution • 6/4/2 scheduling • Review of average procedure times per consultant • Modifications to the waiting list e-form to include standard, agreed times • Pre-call to confirm patients status and fit to proceed with surgery • Building a bank of pre-assessed patients that are willing and able to accept a TCI date at 48hrs notice • Outpatient transformation	TBC

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		• Diagnostic pathway transformation including straight to test	

Cancer services			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	**Nudge the odds** To reduce health inequalities and enable early diagnosis	• **Cancer awareness** - Work to raise awareness and incorporate into work with inclusion groups, eg homeless, sex workers etc • Use evidence-based models, the decay model to identify those that would most benefit from targeted behavioural science interventions regarding cancer awareness, screening and case finding. • Identify top 10 GP practices to focus on bowel cancer screening in minority groups building on the work in cervical cancer for those with a learning disability and from the roma and gyspy communities. • Implement the PCN app to support Yorkshire Cancer Research cancer champions • **Targeted lung health checks** (THLC) - Roll out to Rotherham, Barnsley, Bassetlaw and expand scope of Doncaster to include those near age 55 and eg prison population. Develop plan for Sheffield expansion. Use behavioural science interventions to increase uptake. • **Case finding –** For lynch ensure all colorectal and endometrial tumours are tested and results used to support familial detection Development of Regional HPB and liver clinical group to oversee liver and pancreatic surveillance For liver surveillance support establishment of robust surveillance process and partnership working to increase compliance. For pancreatic aid expansion of palliative and end of life care recruitment to EUROPAC trial for those at higher risk of pancreatic cancer. • Support UoS research proposal for bladder and prostate case finding. • **GRAIL** – prepare for implementation of national programme. Ensuring phlebotomy and NSS infrastructure established • **Timely Presentation & Primary Care Pathways** - Design local campaigns to support national messaging to increase cancer symptom knowledge and body vigilance. Invest in VCSE to work within communities as champions • **GP direct access** ensure consistent access to CXR/ CT and cerebral MRI based on baseline mapping exercise • Embed **FIT pathway** to ensure 80% LGI referrals accompanies by a FIT test • Optimise utilisation of **CtheSigns** to ensure timely and effective referral management expand to other primary care professionals • All places to have access **to teledermatology**	ED trajectory in LTP – 59% staged 1 and 2 Decrease differential uptake for bowel cancer screening in identified communities. Increase in uptake of cervical screening for people with learning disability TLHC: 35,000 invites over year 80% LGI referrals with a FIT test Liver services to invite 80% of patients with cirrhosis to 6 monthly surveillance and support 60% on those invited to attend 100% of GPs able to refer into an Non site specific pathway

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		• **Innovations** - Support third round of Innovation Grant and evaluation of rounds 1 & 2. Pinpoint – review evidence and consider participation. Work with the Academic Health Science Network establish a pipeline, align to the ICB Research & innovation hub	
2	**Strive for excellence** To deliver optimum, sustainable and resilient cancer pathways	• Develop targeted recovery & improvement plans with funding directed to the most challenged providers and pathways. • Enhance clinical leadership and improvement capability within the Clinical Delivery Groups with a focus on developing resilient pathways supported by comprehensive workforce plans for the four key priority pathways LGI, urology, skin and breast • Undertake a deep dive of Urology pathways as the most challenged pathway incorporating digital opportunities in imaging. • Implementation of best practice timed pathways, for Lower GI and prostate cancer pathways (BPTP) • Implement skin pilot of ederma imaging sharing platform platform and community based skills mix model. • Implement breast breast health/pain management clinics • Embed non site specific cancer pathways, including navigator roles informed by evaluation. • Ensure CDC opportunities for cancer pathways are maximised in existing and emerging plans eg skin, gynae, breast, urology, screening and contribute to imaging demand and capacity work to ensure sufficient diagnostic capacity for cancer pathways • **Non Surgical Oncology -** Complete the longer term service review to identified the preferred non surgical oncology service model to support resilient services • Continue repatriation of SACT based on a Consultant Led Team delivered approach and enable ANP development • Review specialised services capital investment scheme • Scope a future model for SDEC and acute oncology for SYB and ND • Agree five year linac replacement programme for radiotherapy • Invest in artificial intellligence to support radiotherapy planning through autocontouring • Re-establish children's radiotherapy service and ensure compliance with national service specification • Reopen teenage cancer unit and support development in line with anticipated TYA service specification • Support timely access to genomic testing • **Research -** Supporting partnership arrangements to developing research expertise within South Yorkshire • **Treatment Variation -** Implementation of GIRFT recommendations for lung to reduce variation in access and timeliness to treatment breast to reduce reoperation rates after	Reduction of 62 day backlog to 423 system total by March 2024 FDS compliance – 75% across all pathways by March 2024. Includes: LGI and prostate cancer pathways meeting all BPTP milestones Breast and skin pathways to achieve 75% FDS % skin patients managed through a teledermatology pathway GIRFT – reduction in variation

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		breast conservation surgery prostate to med with high risk/locally advanced disease are all considered for radical treatment bowel to ensure equity of access to neoadjuvant radiotherapy • **Surgery –** Work with elective and diagnostic programme to support the demand and capacity modelling for imaging modalities to inform future treatment requirements in particular linked to robotic surgery and impact of TLHC. Maximise use of existing capacity and build capacity through community diagnostic centres, elective hub opportunities and utilisation of independent sector. • **Prehabilitation & Rehablitation p**rogramme expansion to prostate from lung & UGI • **Workforce –** Develop a nursing and support strategy, support developments as described, eg new NSO model, SACT delivery.	
3	**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 the following personalised care interventions are available for all cancer patients, and data is submitted to COSD for: Personalised Care and Support Planning (PCSP) based on Holistic Needs Assessment (HNA) and End of Treatment Summary (EOTS) • Fully operational and sustainable PSFU pathways for all suitable patients in breast, prostate, colorectal and endometrial cancer. • Deliver the Cancer Alliances' psychosocial support development based on enhancing level 4 access ,provision of training linked to CancerKnow, levelling up IAPT pathways • Work through Macmillan strategic partnership to re-design personalised care package around "what matters to me" . Year one scoping the model with a focus on cancer care reviews and embedding secondary prevention • Test Prehab / Rehabilitation as an exemplar in commissioning differently for outcomes based on delivery of agreed quality standards • Finalise quality dashboard	Proportion of patients receiving personalised care and support plan Proportion of patients with end of treatment summary All providers having an operational PSFU policy for breast, prostate, colorectal and endometrial pathways.

Improving Mental Health Services (children and young people and adults)			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	Perinatal, Maternal Mental health (Including access)	• Work to develop and embed a local maternal mental health model and integrate with perinatal mental health services to embed and increase access. • Work with West Yorks and Humber & North Yorkshire on delegation of Specialised inpatient Mother & Baby Unit service, ensuring involvement of South Yorkshire families and using opportunity to work collectively to improve access	Local maternal mental health model to be established and embedded by March 2024 Perinatal mental health services to embed and increase access by March 2024 Specialised inpatient Mother & Baby Unit service to be launched October 2023

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2	Children & Young People's Mental Health (inc. access, MHST, Primary Care, Crisis and Eating Disorders)	• Implement CYP MH strategic plan (0-25 age range) including prevention, early intervention, expanding crisis support and community access including MH Support Teams in schools, ensuring eating disorder models are robust and clinical pathways and model of provision links to the specialised Provider Collaborative by reviewing eating disorder offer from community to specialised services (working across the whole pathway in a phased approach) and including interaction with acute providers for management of physical health needs and workforce training	CYP increased access by March 2024 CYP alternatives to crisis in place and accessible by March 2024 MHST rollout to reach 50% coverage by March 2024 Review of existing ED pathways – workshop April 2023 Identified areas for development – June 23 System implementation plan – August 23 (tbc)
3	Urgent & Emergency Care •Adult Crisis Services (inc. crisis alternatives, MHRV, crisis lines (phone and text) and suicide prevention/bereavement) •Urgent and emergency care – transforming health-based place of safety HBPOS (s136)	• **HBPOS -** Workshop with system partners to review adults & CYP & transition years pathway Development of system model and associated implementation and training plan • **Adult Crisis Services -** Development of crisis alternatives services, Rollout of second MHRV, development of crisis lines and implementation of crisis text lines, rollout of NHS 111 press 2 and suicide prevention/suicide bereavement programme of work	**HBPOS** - Agreement on SY model options by July 2023 Timescales for implementation will depend on preferred option **Adult Crisis Services -** Crisis alternatives services to be in place by March 2024 Rollout of second MHRV by April 2024 Implementation of crisis text lines by April 2025 Rollout of NHS 111 press 2 by Summer 2023 Development of suicide bereavement peer support for CYP by March 2024
4	Community Mental Health Transformation	• Delivery of 3 year plan to transform CMH teams. Transform adult community mental health services for those with SMI and integrate with Primary Care with a focus on early intervention for Psychosis, SMI Health Checks, including deployment of remote monitoring devices, interaction with acute providers for management of physical health needs and workforce training and Employment Support. Develop new personalised models of care by moving away from 'traditional' CPA. Targeted work on Adult Eating Disorders (including with acute trusts for management of physical health needs), Personality Disorder and Community Rehabilitation. Development of workforce, including ARRS roles. Achieving/demonstrating implementation of and adherence to the community mental health team adults and older peoples framework. Implementation of 28-day waiting standard for community teams	Delivery of all CMHT transformation priorities by March 2024
5	Inpatient Quality Transformation Programme	• Continue work with Directors of Nursing (Trust and ICB) and Strategic LD team to implement learning on closed cultures. Including • Realtime feedback –digital offer • Restraint and coercion education development	

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		• Shared leadership development, education and training offers • Purposeful admission and activities • Passporting and volunteers • Peer review, advocacy and networking • Implementation of national programme as it develops • Consider system implementation of HOPES Model • Implementation of guidance for providing acute inpatient services (currently in draft form)	

Redesigning specialist services for those with Learning Disabilities and Autism			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	Review and Reconfigure Pathways and Services to meet the needs of the LDA population including specialist services, crisis support and community provision	• Ensure there is appropriate inpatient provision to meet the needs of the LD and Autism population • System approach to meeting the needs of complex patients in the community • Ensure there is provision for crisis beds/unplanned care beds across the system to provide intensive interventions and prevent admission into hospital for Adults • South Yorkshire approach to delivering the Housing Market Position Statement to ensure appropriate supported living and residential accommodation • Implement the update DSR/CETR Policy requirements including ICB Oversight Panel	Development of community of practice Scope out current inpatient provision and opportunities for cross system working Agree Service Specification and MOU Q1 Complete Tender documentation Q2 Procurement Exercise Q2/3 Reset Housing Steering Group with new project manager Q1/2 Refresh housing delivery plan Q2 Follow up housing event Q2
2	Improving Autism Pathways and focus on early intervention and support	• Improve and increase neurodiverse diagnostic provision ensuring more streamlined pathways and compliance with NICE guidelines • Improve and increase pre and post diagnostic autism support offers for C&YP and Adults • Expand C&YP Keyworker Function across South Yorkshire to ensure every child with LDA and complex needs can access one • Scope out a model to implement a South Yorkshire Autism Team • Share learning from Sheffield Autism in Schools Project and offer support to rollout further across SY	Service mapping underway Review of system issues and areas of opportunity April 23 Development of improvement action plan (Adult ADHD services) June 23 Development of draft improvement action plan (Children's ND Services) July 23 Evaluate 22/23 pre /post diagnostic support provision Q1 Learning Event Q2 Scope and implement in Barnsley Q2

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		• Continue to build on the Employment is for Everyone Movement linking in with Centre for Social Justice and DWP	Demand and capacity exercise Q2 Business case to meet demand with cost benefit analysis Q3 Agree proposed structure KW expansion Q1 Develop plan to expand provision, include recruitment Q1 – Recruitment Q2/3 Further scoping of an Autism offer across SY Q2 Identify an Ambassador for E for E Q1
3	Improving Health Inequalities and tackling the causes of morbidity and preventable deaths	• Increase uptake and quality of AHC's including rollout out Autism Only • Implement Learning From Deaths Policy Requirements including ICB Assurance Panel and continue to deliver improvement plan to embed learning from LeDeR • Improve access to national screening programmes and other health checks • Rollout Oliver McGowan Mandatory Training	Scope and Pilot AHC's for people with autism only diagnosis Q2Develop ECHO Programme for AHC's with a focus on quality Q3 Deliver ECHO training Q4 Business case for LeDeR for approval Q1 Recruitment plan Q1 Set up ICB Assurance Panel Q2 Deliver quarterly learning events Q2 Produce overarching SY LeDeR Annual Report and factsheet. Q4 Promotion and awareness campaigns Q1/4 Evaluate screening pilots Q1 Rollout screening pilots Q2/4 Establish Tobacco Control Programme Q1 Develop delivery plan for OMMT rollout Q1 Commence rollout phase 1 OMMT Q2

Continuous quality improvement and embracing innovation and research			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	Work collaboratively with people across South Yorkshire to identify unmet needs and opportunities for innovation, and support the	Across the South Yorkshire System our Innovation Hub will seek to create - The capability to innovate - The opportunity to innovate - The motivation to innovate	Research forums delivered quarterly from April 2023. Scale and spread programme: research and

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	adoption of innovation through the South Yorkshire Innovation Hub	In 23/24, this will involve: Creating the opportunity to innovate: • Scale and spread programme: we will identify and celebrate innovation in SY that helps to reduce health inequalities and support the shift towards early intervention and prevention, and support the scale and spread of promising innovations through the DRI SDG – increasing the impact of these innovations and giving visible support to innovation that supports delivery of our priorities and Integrated Care Strategy • Delivery of a research and innovation forum, bringing clinical staff, academic researchers, patients and the public and innovators together around key areas of priority for reducing health inequalities to share unmet needs and identify shared research and innovation opportunities and actions • Development of a multi-channel approach to innovation needs identification, horizon scanning for potential solutions, implementation and adoption support and subsequent evaluation. This will include: working with alliances and federations, refreshing digital approach to need identification that makes it possible for anyone in South Yorkshire to identify opportunities for innovation in health and care, convening a network of innovation leads at a place/ provider level to co-ordinate need identification across places and have joined up conversations around innovation opportunities. We will work with the Yorkshire and Humber AHSN to identify relevant innovations in the innovation pipeline that address these identified needs, broker relationships with internal and external partners, and support colleagues to develop plans for adoption and implementation. • Building a visible front door for innovation in South Yorkshire through a refreshed comms strategy and delivery plan • Building relationships with industry innovators with relevant offers to SY priorities, and with the other parts of the innovation infrastructure in SY, to help the growth of the innovation sector in the region and support local economic growth Capability to innovate: • Co-designing a staff offer to develop innovation skills and capabilities • Supporting colleagues to evaluate innovative activity and understand its impact We will also work in a responsive and agile way across the ICP to support innovation and other innovation priorities: • Supporting innovation projects, prioritising those that support a reduction in health inequalities and a transition to early intervention and prevention, to be scoped with colleagues. To include pursuing and securing funding to support innovation. For example, in 23/24 supporting the Cancer Alliance to deliver the cross-ICB e-Derma innovation into the dermatology pathway	analysis Mar-Jun, Jul-Aug event planning, Sept event delivery, Oct-Nov prioritisation of scaling activity Individual innovation projects will have their own milestones Other activity is ongoing throughout the year

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		We will co-design a patient and public involvement approach to innovation for the system, so that citizen voice is at the heart of our innovation in South Yorkshire. The Innovation Hub is delivered in partnership with the Yorkshire and the Humber AHSN (YHAHSN) and will through the AHSN draw on their wider network of innovator and industry partnerships and relationships. We will also work in partnership with YHAHSN to engage in local, regional and national innovation programmes commissioned by NHSE and OLS.	
2	Work collaboratively with the research and innovation communities in South Yorkshire to bring their world leading expertise to bear on health and care priorities for the region, and build a shared research and innovation strategy	• We will develop a draft Research and Innovation Strategy and action plan for 23-24 informed by the engagement with the Research and Innovation Forum in Nov 22, attended by university, industry, and clinical staff. • We will engage with researchers, universities, alliances and federations, VCSE and the Digital, Innovation and Research System Delivery Group to develop a longer term Research and Innovation strategy, which will ensure we deliver on our statutory duties in relation to research. • We will develop strategic partnerships with universities and research partners. We will work with them to develop a process for supporting the translation of research into local commissioning and decision-making processes, and to apply research skills to real world system challenges. • We will grow a network of research and innovation ambassadors through the research and innovation forum. • We will develop and maintain a living asset map that supports the development of cross-system and cross-sector collaborations • We will identify process improvements to make research engagement easier and more effective at a cross-ICB level, which will inform the action plan associated with the longer-term research and innovation strategy. • We will make it easier and faster to develop high quality health and care research in the region, by working with colleagues across the Yorkshire and Humber region to develop a Secure Data Environment. This will bring together live health and care data and make it safe for researchers to use and access for research purposes. This will accelerate R&D in the region, not only supporting high quality research but also economic development by making it a leading place to undertake health and care research. We will work with YHAHSN who are leading the coordination and development of the SDE business case.	Draft Research and Innovation Strategy to be tested with DRI SDG in Mar 23 Agree research and innovation strategy Q4 23/24 Q1 23/24 SDE business case to be finalised Q2/3 23/24 work to commence on developing the SDE infrastructure (depending on release of funds from NHSE)
3	Establish system governance for research and innovation	• Establish the Digital, Research and Innovation System Delivery Group, ensuring it has a cross system membership and develops a way of working that enables South Yorkshire to take advantage of system opportunities to support research and innovation • Deliver regular (bi-monthly) DRI SDG meetings that support the creation of a culture of learning and innovation in SY	DRI SDG to first meet in Mar 23. Bi monthly meetings from there forward.

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4	Implement a Quality Improvement Approach across NHS South Yorkshire	• Offer QSIR Fundamentals training to all staff • Deliver QSIR Practitioner training to approximately 90 staff • Identify and support the development of individuals to become QSIR trainers in South Yorkshire • Understand and implement the ask within the expected NHS Improvement Approach Guidance	60% staff trained QSIR F by July 2023 3.3% staff trained QSIR P June 2023 6.6% staff trained QSIR P August 2023 10% staff trained QSIR P November 2023 1% staff trained QSIR College March 2023
5	Implement a robust programme management approach across the NHS South Yorkshire	• Implement standardised PM approach across ICB, to include; • Standardised documentation • Agreed reporting processes • Highlight report and dashboard • Understand and implement the ask within the expected NHS Improvement Approach Guidance development	Q1 PMO proof of concept design Q1 PMO training and implementation Q1 - PMO reporting Q1 Single ICB highlight report produced
6	Implement a South Yorkshire networked approach to Quality Improvement	• SY ICB transformation network established • SY QSIR network to be considered for development Q2 2023	Q1 – ICS Improvement network (already established as peer to peer support - QI leads) Q2 – SY QSIR network

Supporting and developing our workforce			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
	Integrated Working	• Coordinate optimum use of funding (maximise commissioning role/alignment with regional) • Appoint senior SROs responsible for system delivery, and develop leadership skills in workforce conversations (collaborate, Encourage, provoking, influencing, lobbying etc.) • Continue and strengthen current workstreams & engagement • Strengthen volunteering to support service delivery • Identify workforce Digital links into ICS workstreams/ programmes	
	Developing workforce planning skills	• Map workforce baseline against operational plans, with access to relevant and timely workforce information (Dashboard) • Mechanisms to demonstrate we are Listening to the workforce voice and building in to plans • Develop a workforce planning toolkit for adoption by networks	
	Careers and employability	• Drive a system wide platform to promote vacancies & good place to work, including comms • Focused efforts on recruitment to 'high risk' and 'added value' professions/roles • Embrace role as Anchor institutions, promoting employment opportunities and support ICS development of AI Charter	

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		• Embed employability programmes across places & education sectors to maximise recruitment opportunities from H&C students, and hard to reach communities into H&SC roles, including refugees, care leavers	
	Education and Training	• Develop education and training strategies based on priorities, using learning and development needs analysis, focus on: Upskilling /Apprenticeships • Leadership /Pre-registration / Entry level roles, including optimising e-learning uptake • Development of system wide programmes, such as HI, Prevention, sustainability etc • Closer engagement with HEIs and FEs to develop curricula for the future, across workstreams	
	Supporting Capacity	• Development of system wide collaborative banks, facilitating reserves/retire and return and others	
	New Role Development	• Develop a Portfolio of new roles, allowing system understanding of pathways and new roles, to increase capacity across all sectors	
	Retaining our Workforce	• Develop Preceptorship, mentoring, buddying programmes, focus on IR • Support all workstreams to ensure focus is on retention, and making sure interventions are shared to reduced numbers of leavers from health and care	
	Looking after our people	• Define wellbeing offers across all workforce to support increased morale and staff retention • Development of H&WB Framework diagnostic tool • Maintain and continue to expand MH Resilience hub • Support wellbeing champions and Guardians • Accreditation for Menopause friendly system	
	Equality Diversity and Inclusion	• Engage and support the SYMCA Anti racism ambition • Develop a strategy for how we make measurable improvements in equality & diversity in the workforce	
	Streamlining employment processes	• Streamlining of Recruitment processes/HR processes • Improve attendance at work, implementing outputs from NEY attendance and HI reports • Support and deliver initiatives to reduce use and cost of agency workers	

Data, digital and technology			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	**Well Led** (effective leadership of Digital enablement of transformation)	• Ensure digital leadership in place (CCIO, CIO a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation (and CNIO Digital Leadership roles)	Established CNIO/CCIO Forum for South Yorkshire Embedding of digital requirements across all system strategies

2	**Ensuring Smart Foundations** (ensuring we understand our digital infrastructure capabilities and priorities a ross the ICB footprint, working with all ICS partners)	• Implementation of Frontline Digitisation Programme to support levelling up across ICS Footprint • Digital Maturity Assessment (DMA) • Continued expansion of Shared Care Record & Information Sharing (Improving information sharing – linking our place shared records with the wider regional record (YHCR)) • Invest in and build multidisciplinary teams with clinical, operational, informatics, design and technical expertise to deliver your digital and data ambitions through effective IT infrastructure • Digitising Social Care – Implementation of Digitised Care Records, increased use of sensor based falls technology and other technologies across the care sector • Robotic Process Automation • Primary Care Core Systems and Tools • Implementing single sign on access across our Partner's main clinical IT systems ensuring health and care professionals have access to the wider health and care data set without having to log on to the shared record separately – reducing number of log ons and clicks to access key information and improve outcomes for patients. •	Supporting delivery of funding to NHS Trusts to support digital transformation and improvements in digital maturity by March 2024 System Digital Maturity Position available June 2023 Expand YHCR use cases and data provision and consumption by NHS Trusts by Mar 2024 Data and Insights Strategy to be drafted by May 2023 and released by June 2023 following user engagement. Corporate IT strategy to be drafted by June 2023 Implement activity listed in Place Digital Primary Care Plans by 31st March 2024 Implement priority activity in Place Digital Plans supporting priority programmes by 31st March 2024 Delivery of Year 2 Digitising Social Care Records across Care Sector
3	**Safe Practice – Cyber & Clinical Safety** (safety in regard to information & sharing of data)	• Establish Cyber Forum and associated Cyber Security Action Plan for our System • Establish a process for managing cyber risk with a cyber improvement strategy Have an adequately resourced cyber security function, including a senior information risk owner and data protection officer (DPO)	Supporting delivery of funding to NHS Trusts to support digital transformation and improvements in digital maturity by March 2024 Expand YHCR use cases and data provision and consumption by NHS Trusts by Mar 2024 Data and Insights Strategy to be drafted by May 2023 and released by June 2023 following user engagement.

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			Corporate IT strategy to be drafted by June 2023 Implement activity listed in Place Digital Primary Care Plans by 31st March 2024 Implement priority activity in Place Digital Plans supporting priority programmes by 31st March 2024
4	Supporting People (supporting our workforce to consider, embrace and adopt digital technologies)	• To include Workforce, M365 and corporate IT • Building a data-literate health and care system where insights drive decision-making	
5	Empower Citizens (putting patients at the centre of digital enablement to improve health outcomes)	• Make use of national tools and services (the NHS website, NHS login and the NHS App) • Implementation of Digital Services for our Public (DSOP) • Have a clear digital inclusion strategy, incorporating initiatives to ensure digitally disempowered communities are better able to access and take advantage of digital opportunities **Digital Inclusion:** •Dedicated digital inclusion programmes underway in Doncaster and Rotherham •Closely linked with work to reduce health inequalities •Closely linked with response to cost of living crisis •Survey developed to understand more about data poverty and skills needs •Proactive engagement with most likely to be excluded communities to understand their support requirements •Flexible digital support arrangements planned to complement formal digital skills courses already available •Established strong links with communications teams to improve how we share information and guidance with our local populations • •Partnerships with local businesses, colleges and voluntary groups are under discussion	Procurement and build of minimal viable within the NHSApp by August 2023 Migration of patients in Rotherham over to new DSOP platform to commence by March 2024
6	Improve Care (support digital enablement of redesigned care/clinical pathways	**Primary Care:** **Urgent & Emergency Care:**	Digital Plan for FY23/24 developed to continue optimised use of core systems and tools to support primary care

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	to improve outcomes, patient experience)	•Embedding digital in Hospital Flow (also linked to the Ten Best Practice Initiatives that demonstrably improve flow and improve discharge) • Command Centres to enables staff and partners to manage patient flow in near real time, using machine learning, predictive analytics, and integration •Community Assessment Service taking low acuity patients away from ED – information sharing project in pipeline •Virtual Wards – Understanding gaps in information sharing across the end to end pathway to help ensure patients get the best outcomes and can avoid unnecessary hospital (re)admissions and get the care they require in their usual place of residence. **Community Care:** •Digital Transformation for Enhanced Health in Care Homes – dedicated support to care home staff •Rolling out secure access to shared record in care homes to improve information sharing between settings •Enabling key documentation to be uploaded to the local shared record, enabling detailed plans and information to be shared more effectively across care settings **Mental Health:** •Working with Place partners to ensure digital is embedded in Mental Health Transformation projects • Supporting Community Mental Health Reporting requirements (MHSDS specification) for ARRs identifiable activity • Scoping the use of eReferrals for MH service • Development of the Community Mental Health Transformation Hubs • Reconciliation of SMI registers across Place • Deployment of the Bluebox devices for outreach SMI health checks **Elective Care:** •NHS App Wayfinder project being piloted in Doncaster and Rotherham hospitals •Implementation of the NHS App Wayfinder project to help Outpatients view information about their appointments, including letters and instructions via the NHS App •Patients will be able to book, change and cancel their hospital appointments. **Wider digital transformation programmes:**	

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		• •Pilots underway – piloting use of shared record to support MH Navigator service delivered by St Leger Homes in Doncaster	
7	Healthy Population (using data, evidence & insight to plan & improve care for our population through targeted interventions for better outcomes)	• South Yorkshire Data Platform 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 data and resources to the ICS-wide population health management platform and use this intelligence to inform local care planning, utilising other population health analytical tools as required (e.g. Eclipse) • Build real time insights to support system wide coordination of mutual aid to support peritoneal delivery of health and care services. • Adhoc onboarding to ensure health & care professionals are benefitting from the rich data set	MVP to be built containing Core population health data (Fingertips) and user access layer by June 2023 Commissioning data sets to be added July 2023 Additional standard dashboards and access products to be built by September 2023 System Control Centre dashboard version 2 to be released ahead of winter 2023-2024.

Making best use of our resources - Estates			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	Primary Care Capital and community estate	• Development of project initiation documents and business cases for primary care and community care developments	Various dates for completion for individual projects with completion of the Primary Care Capital programme by March 2025
2	Space utilisation and fitness for purpose	• Identification of the surplus and void space in within existing estate and developing plans to utilise, considering service location to match the physical location of assets. • Taking a one public estate approach, working in collaboration with Local Authorities, DWP to maximise use of public estate. • Ensuring the estate is fit-for-purpose and addressing backlog maintenance, disposing poor estate	Action plan by end 2023
3	Sustainability and decarbonising estate	• Reviewing Green Plans across our existing estate and identifying properties that would benefit from refurbishment	As identified in the organisations Green Plans

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WORKING DRAFT May 2023

Partnership working to deliver our plans - VCSE			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	**Embed VCSE participating within the ICS (boards, programmes and strategies)**	• To implement VCSE Participation Payments policy including appointing fund manager (SYCF), promoting EOLC process to VCSE and implementing a continuous review cycle. • Working with System Delivery Groups and Provider Collaboratives and Alliances to identify opportunities for VCSE involvement in shaping and implementing priorities and define specific VCSE partnership ambitions and projects • VCSE participants recruited to join System Delivery Groups and Provider Collaboratives and Alliances, supported in their role and assisted in increasing connectivity with the wider VCSE • Planning undertaken to co-ordinate and strengthen partnership work with the VCSE to shape new strategies	VCSE participants recruited to all appropriate System Delivery Groups, Provider Collaboratives, Alliances and programmes by XX

2	**Strengthen connections and insights between the VCSE and ICS**	• Strengthen information sharing between the ICB/ICS and the VCSE e.g.
		  • Enhance ICB webpage and social media for the VCSE Alliance
		  • Grow the distribution lists and 'reach'
		  • Strengthen the connection between ICB communications with VCSE led communications teams and networks
		  • Develop the interface with wider ICB communications and engagement work and
		  • Develop the interface with System Delivery Groups and Provider Collaboratives/ Alliances
		• Continue to iterate the VCSE Alliance model and terms of reference and implement a programme of VCSE Alliance Steering Group and South Yorkshire Network meetings and events
		• Work with the Communications and Engagement team and wider stakeholders to strengthen the VCSE partnership role in community engagement, qualitative insights and co-production with people with lived experience
		• Work with the digital team to explore the potential for a digitised social prescribing or wider VCSE 'marketplace'
		• Work with social prescribing stakeholders to improve the quality, consistency and utility of data
			Programme of VCSE events codesigned and delivered by end of quarter 4
			
			VCSE TOR signed off end of quarter 1?
			
			Approach to systematically supporting VCSE engagement and incorporating VCSE qualitative insights to PHM and HI work developed by XX

3	**Maximise VCSE investment opportunities**	• Shape commissioning and investment approaches to maximise VCSE partnership potential:
		  ○ Develop and adopt South Yorkshire based principles for commissioning and investment
		  ○ Work with finance and procurement teams to consider options for expanding the available models of procurement and grant giving approaches
		• Influence actual investment in the VCSE
			Principles for investment agreed by X
			Mapping of the South Yorkshire VCSE offer completed by X
			Plan to support VCSE in maximising external investment opportunities developed by end of quarter ?

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		○ Map VCSE infrastructure and frontline offer and identify opportunities for levelling up and/or targeting resources. ○ Work with the prevention team and wider colleagues to develop a case for change in relation to prevention and the important role of the VCSE in supporting the ambition to become a prevention led system ○ Explore opportunities for resource sharing across sectors, financial and non financial ○ Develop approaches to maximise and lever external funding and investment in the VCSE	

Maximising our potential as anchor institutes – supporting wider socio economic development			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	Increase understanding of anchor institutes and scope anchor network development	• Raise awareness to increase the understanding of anchor institutes and the significant role they have to contribute to improved health and wellbeing directly with staff and by contributing to addressing the wider determinants. • Scope the potential to develop a network of anchor institutes across South Yorkshire share learning and identify opportunities for collaboration. Align this to the work to deliver our Integrated Care Strategy and bold ambitions, especially the focus on supporting and developing our collective workforce.	By end of Qtr 4
2	Scope the development of an anchor charter	• Scope the development of a charter for the Integrated Care Board (and NHS Trusts?) that describes the role and expectations of organisations as an anchor institute.	By end of Qtr 4

Contributing to the environmental sustainability agenda together			
	Priorities for 2023/24	**Key Actions**	**Key Milestones**
1	**Direct Actions**	• All NHS Trusts to have a heat decarbonisation plan, identifying and prioritising the phasing out of existing systems • NHS Trusts to look at targets and actions from the Estates NZ delivery plan technical annex and plan how they will achieve the suggested actions and targets for 2023-24 • All trusts and ICB to transition to 100% LED lighting across their estates • All trusts to look at their Nitrous oxide use in theatres and consider decommissioning of manifold where the use is low. • All trusts to carry out an audit or leak testing of Entonox manifold cylinders and take action to reduce any identified waste, based on the results of the audit. • Reducing desflurane usage to only exceptional circumstances – progressing towards complete decommissioning by early 2024	By end 2023/24 All Trusts and the ICB to have taken steps towards decarbonisation as set out in the Estates Net Zero Guidance (specific deliverables to be agreed with partners) Complete removal of Desflurane use in all Trusts across SY Entonox audit carried out in every Trust and results acted upon

		• Continue to work with PCNs and Practices. Encouraging and supporting low carbon, excellent asthma care, prescribing of low carbon inhalers where clinically appropriate and work to increase recycling of used inhalers • Collaborate with the SYMCA, Local authorities and others on active travel initiatives and infrastructure developments • Trusts with a predominantly Petrol/Diesel fleet to produce a plan for how they will transition to Ultra Low and Zero emission vehicles (ULEVs and ZEVs) • Set up remanufactured medical devices collection and use programme initially as a pilot, based on guidance from Greener NHS • Evaluation of the reusable PPE projects in Sheffield and Barnsley Trusts and Sheffield GP practices and carry out a feasibility study of how it can be scaled up. • Apply principles of sustainable procurement and 5 Rs – phased implementation to achieve a predominantly circular economy in our organisations • Prioritise work with the Medicines Management Team on medicines wastage in primary care • Consider how we can work jointly on climate adaptation- identifying the risks and coming up with a mitigation plan • Explore options for how carbon footprint will be monitored which is key to measuring progress and delivery of the net zero targets	
2	**Enabling Actions**	• Work to increase uptake of "Building a Net Zero NHS" e-learning module available on ESR both ICB and Trusts • Communication to encourage uptake of RCGP Net Zero eLearning modules amongst General Practice staff across SY • Continue to build the Green Champion network and collaborate across the system through joint comms and engagement • Work with digital programme to develop a plan for how we will implement the deliverables from Sustainable ICT and Digital Services Strategy (2020-2025) • To enable every organisation to include climate change on its risk register • Implement at least two recommendations from the Intercollegiate Green Theatre checklist in our Acute Trusts	TBC

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