Public Agenda

Title of Meeting:	**Rotherham Place Board: Partnership Business**
Time of Meeting:	9am – 10am
Date of Meeting:	Wednesday 15 February 2023
Venue:	Elm Room, Oak House, Moorhead Way, Bramley, S66 1YY
Chair:	**Sharon Kemp**/Chris Edwards
Contact for Meeting:	Lydia George: lydia.george@nhs.net Wendy Commons: wcommons@nhs.net

Apologies:	Chris Edwards
Conflicts of Interest:	
Quoracy:	No Partnership Business shall be transacted unless the following are present as a minimum: a) one Member from each of the ICB and RMBC; and b) two Members from any of the following Partners: TRFT, VAR, RDASH or RPCLG

Item		Time	Pres By	Encs
1	Public & Patient Questions: *The Chair will take questions in writing prior to meetings and will try to respond during the meeting. However, there may be occasions when a response has to be issued in writing afterwards. This being the case, responses will be published as an item for information at the next meeting.*		*Chair*	*Verbal*
	Business Items			
2	Public Health Update: by exception	*5 mins*	*BA*	*Verbal*
3	Learning Disability Mortality Review (LeDer) Annual Report	*10 mins*	*SC*	*Enc 3*
4	Integrated Care Strategy for South Yorkshire	*10 mins*	*Cllr Roche*	*Enc 4*
5	Feedback from the South Yorkshire Integrated Care Partnership Board: (full set of papers available at: Integrated Care Partnership meetings and minutes :: SYB ICS (syics.co.uk)	*5 mins*	*Cllr Roche*	*Verbal*
6	Place Partnership Newsletter: November/December – *for information*	*5 mins*	*CS*	*Enc 6*
	Standard Items			
7	Draft Minutes and Action Log from Public Place Board – 16 November 2022 – *for approval*	*5 mins*	*Chair*	*Enc 7i & 7ii*
8	Communication to Partners	*5 mins*	*Chair*	*Verbal*
9	Risks and Items for escalation to Health & Wellbeing Board	*5 mins*	*Chair*	*Verbal*
10	Future Agenda Items: • Anchor Institutions (TBC) • Prevention & Health Inequalities Outcomes Framework (Mar) • Digital Update (Mar) • Achievements (Monthly) • Partnership Briefing (Bi-Monthly Place)	*5 mins*		
11	Dates of Next Meeting: Wednesday **15 March 2023** at 9 –10am			

NHS SY ICB (Rotherham Place)
LeDeR Annual Report 2021-2022

Lead Executive	**Sue Cassin, Chief Nurse**
Lead Officer	**Tracy Mistry - Head of Mental Health Complex Case Management *(no longer in post)*** **Jennifer Turedi – LD Matron TRFT** **Kirsty Leahy – Head of Quality *(cover paper only)***

Purpose

To update Rotherham Place Board of the LeDeR (Learning Disabilities Mortality Review) Annual Report for Rotherham place.

Background

LeDeR is a service improvement programme which aims to improve care, reduce health inequalities, and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received. It does this by:

• Delivering local service improvement, learning from LeDeR reviews about good quality care and areas requiring improvement.
• Driving local service improvements based on themes emerging from LeDeR reviews at a regional and national level.
• Influencing national service improvements via actions that respond to themes commonly arising from analysis of LeDeR reviews.

Integrated care systems (ICSs) have superseded Clinical Commissioning Groups (CCG's) and are responsible for LeDeR. Ensuring that reviews are completed of the health and social care received by those with a learning disability and/or autistic (aged four years and over) who have died, using the nationally standardised review process. This enables the ICS to identify good practice, what has worked well and not as well, identifying challenges and issues and areas for improvement. Local actions are taken to address the issues identified in reviews. Recurrent themes and significant issues are identified and addressed at a more systematic level, regionally and nationally.

A LeDeR review is not a mortality review. It does not restrict itself to the last episode of care before the person's death. It looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. LeDeR reviews take account of any mortality review that may have taken place following a person's death. Reviews are not investigations or part of a complaints process, and any serious concerns about the quality of care provided should be raised with the provider of that service directly or with the Care Quality Commission.

Learning from lives and deaths – People with a learning disability and autistic people, or LeDeR (formerly known as the Learning from Deaths Review Programme) started in April 2017. It grew out of the Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD)1 and was piloted in parts of the country in 2016. A commitment to continuing the LeDeR programme was made in the NHS Long Term Plan 2019:
Since LeDeR was established, CCGs and their local authority partners have reviewed the health and social care received by over 8,500 people who had a learning disability, and a huge amount has been learned about how best to conduct reviews and the impact of local actions based on

learning from reviews. Feedback from the engagement has shown that there is strong agreement and recognition of the importance of LeDeR and its aims.

However, there was also acknowledgement that the focus so far has been on the completion of reviews. We have not systematically captured evidence that, where recommendations are being made, they are being acted upon or that changes are having the desired impact. Therefore, it has not always been clear how health and care services are using the learning from LeDeR reviews to improve services.

ICSs must systematically act upon findings in LeDeR reviews and improve the care provided by all services (not just learning disability specific services) to stop people dying prematurely and provide better quality services. NHS England and NHS Improvement will hold ICSs to account for the delivery of the actions identified in reviews as part of their assurance processes so that ICSs improve the ways that local health and care services meet the needs of people with a learning disability and autistic people.

The LeDeR programme collates and disseminates anonymised information emerging from completed reviews in order that common themes, learning and recommendations can be cascaded and embedded in both policy and local service improvements.

A fundamental aim of LeDeR is to ensure that reviews of deaths lead to reflective learning which underpins health and social care service improvements.

Analysis of key issues and of risks

Locally the aim is to maintain the consistently high quality of reviews in Rotherham and to ensure that learning from the reviews is embedded in to practice and service improvement, transforming provision for people with learning disabilities with the ultimate aim of reducing health inequalities.

Across Rotherham since the LeDeR programme started in the summer of 2016 to March 31st, 2021, there have been 81 deaths notified, all of which have had completed reviews.

- There are 4 notifications that were received at the end of March 2021, which were not included in the previous year's report due to when they were received. These are included in the data within this report. Of these 4, 3 were adults from a BAME community. There was only 1 death from the BAME community recorded within the previous annual report.
- Within Rotherham 22 deaths were notified to the programme between April 1st, 2021 and March 31st, 2022.
- Of these, there was an equal split of male to female. Of the 4 reported in March 2021 3 were male and 1 was female, the majority being male. The National report tells us that of the deaths that were reported 56% were male and 44% were female.
- Of the 4 deaths notified in March 2021 included in this report 75% were from a BAME community a significant increase from the previous year when none were included in the annual report. Of those notification received for April 2021-March 2022 none were from the BAME community. The CCG/ICS are unclear of the reasons behind the March 2021 increase. National statistics show us 3% of deaths reported were from Asian/Asian British, 3% Black, Black British, Caribbean, or African and 3% Mixed ethnic group.
- Of the 26 individuals, 69% died in hospital compared with 61% nationally occurring in hospital. Of the 4 deaths reported in March 2021 all died in Hospital.
- The most frequently reported cause of death in Rotherham in both 2019, 2020/21 and 2021/22 was pneumonia. Of the 4 deaths reported in March 2021 all related to respiratory disease. Nationally the most common cause of death in 2021 was Covid 19, followed by diseases of the circulatory system, with respiratory system diseases in third place.
- Nationally the figures of pneumonia as a cause of death have dramatically decreased from in 2018 being 52%, to in 2021 this figure now being 21%. This shows a difference in the local findings in Rotherham.
- Under the new process 23 notifications were completed as initial reviews which do not require the reviewer to record a grading of care. Grading is only completed within Focussed reviews. Of the 4 deaths in March 2021 1 was completed as an Initial review and 3 were Focussed due to being from the BAME community.
- There is a marked difference between deaths attributed to Covid-19 in the general population compared to people with a learning disability. The Office of National Statistics (ONS) data

for the general population of England and Wales reports that 47% of deaths from Covid-19 were in people aged 85 years and older. However, for people with learning disabilities, just 4% of people were aged 85 years and older. Nationally there has been an excess of deaths for people with a learning disability from Covid 19 in 2020 and 2021 of 34.3% and 21.5%, which was higher than for the general population (14.5% and 10.4% respectively).

- Locally, between 1st, March 2021, and March 31st, 2022 the most frequent cause of death by ICD- 10 chapter were diseases of the respiratory system at 46% this is very similar to the figure in 2020/21 which was 47%. Four deaths (15%) were attributed to Covid-19 this is lower than 2020/21 which was 23.5%.
- Of the 26 reviews four were completed within the six months of the referral date. Fourteen were not completed within the timeframe, with eight not due as at writing this report. Of the fourteen not completed, one is on hold due to SCR investigation and one is being reviewed under the CDOP process.

The report highlights several key areas: -

- The local LeDeR offer is still not reaching BAME communities effectively as there have been very few notifications to the programme: Further initiatives to address this locally continue to be a priority. This will build on the engagement work already undertaken by REMA.
- In conjunction with increasing the quantity, and of equal importance, the quality, of annual health checks (AHCs) for those aged 14 and over in Rotherham, there needs to be measurable evidence that AHCs improve health outcomes and that they contribute to reducing premature mortality.
- ICB LeDeR Steering Group membership has broadened to include a wider range of stakeholders however this needs to be expanded further to incorporate representation from People with Lived Experience.
- As LeDeR is an additional role to reviewer's substantive posts with no dedicated capacity within which to undertake this work we continue to struggle to recruit and retain reviewers. Given that there was an increase from the usual 14 LeDeR notifications each year, to 22 this year there needs to be a continued programme to recruit reviewers. This may be resolved by the plans around the ICB LeDeR offer and having a central resource. Funding for this will need to be explored.
- Paid carers are often not ensuring that individual's hospital passports are taken with them, when conveyed to hospital, which needs to be addressed locally.
- Like previous years locally there needs to be improved application and documentation in respect of MCA/BI.

Patient, Public and Stakeholder Involvement

None. Business reporting.

Financial Implications

None.

Approval history

NHS SYICB Rotherham Place Quality Team.
NHS SYICB Rotherham Place Executive Team 12.01.2023.

Recommendations

Paper is for noting/comments.

NHS
South Yorkshire
Integrated Care Board
Rotherham

LEARNING DISABILITY MORTALITY REVIEW (LeDeR) PROGRAMME

ANNUAL REPORT

April 01 2021 – March 31 2022

CONTENTS

EXECUTIVE SUMMARY

LeDeR is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received. It does this by:
• Delivering local service improvement, learning from LeDeR reviews about good quality care and areas requiring improvement.
• Driving local service improvements based on themes emerging from LeDeR reviews at a regional and national level.
• Influencing national service improvements via actions that respond to themes commonly arising from analysis of LeDeR reviews.

Responsibility for ensuring the delivery of LeDeR reviews currently lies with clinical commissioning groups (CCGs). As we move into new arrangements in the NHS through 2021 and into 2022, local integrated care systems (ICSs) will become responsible for ensuring that LeDeR reviews are completed for their local area and also, and very importantly, that actions are implemented to improve the quality of services for people with a learning disability and autistic people to reduce health inequalities and premature mortality.

ICSs will be responsible for ensuring that LeDeR reviews are completed of the health and social care received by people with a learning disability and autistic people (aged four years and over) who have died, using the standardised review process. This enables the ICS to identify good practice and what has worked well, as well as where improvements in the provision of care could be made. Local actions are taken to address the issues identified in reviews. Recurrent themes and significant issues are identified and addressed at a more systematic level, regionally and nationally.

A LeDeR review is not a mortality review. It does not restrict itself to the last episode of care before the person's death. Instead, it looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. LeDeR reviews take account of any mortality review that may have taken place following a person's death. Reviews are not investigations or part of a complaints process, and any serious concerns about the quality of care provided should be raised with the provider of that service directly or with the Care Quality Commission.

Learning from lives and deaths – People with a learning disability and autistic people, or LeDeR (formerly known as the Learning from Deaths Review Programme) started in April 2017. It grew out of the Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD)1 and was piloted in parts of the country in 2016. A commitment to continuing the LeDeR programme was made in the NHS Long Term Plan 2019:

The LeDeR Programme was initially led by the University of Bristol including policy, overall responsibility for the direction of the reviews, the operation of the web platform and the analysis of the data; with CCGs conducting reviews. The end of NHS England and NHS Improvement's contract with the University of Bristol in May 2021 meant a timely opportunity to reflect on what has gone well with LeDeR to date and to identify areas of the programme that need to improve.

Since LeDeR was established, CCGs and their local authority partners have reviewed the health and social care received by over 8,500 people who had a learning disability, and a huge amount has been learned about how best to conduct reviews and the impact of local actions based on learning from reviews. Feedback from the engagement has shown that there is strong agreement and recognition of the importance of LeDeR and its aims.

However, there was also acknowledgement that the main focus so far has been on the completion of reviews. We have not systematically captured evidence that, where recommendations are being made, they are being acted upon or that changes are having the desired impact. Therefore, it has not always been clear how health and care services are using the learning from LeDeR reviews to improve services.

ICSs must systematically act upon findings in LeDeR reviews and improve the care provided by all services (not just learning disability specific services) to stop people dying prematurely and provide better quality services. NHS England and NHS Improvement will hold ICSs to account for the delivery of the actions identified in reviews as part of their assurance processes so that ICSs improve the ways that local health and care services meet the needs of people with a learning disability and autistic people.

The LeDeR programme collates and disseminates anonymised information emerging from completed reviews in order that common themes, learning and recommendations can be cascaded and embedded in both policy and local service improvements.

A fundamental aim of LeDeR is to ensure that reviews of deaths lead to reflective learning which underpins health and social care service improvements.

LeDeR reviews are not investigations of care, they aim to promote learning and therefore improve care.

Locally the aim is to maintain the consistently high quality of reviews in Rotherham and to ensure that learning from the reviews is embedded in to practice and service improvement, transforming provision for people with learning disabilities with the ultimate aim of reducing health inequalities.

Across Rotherham since the LeDeR programme started in the summer of 2016 to March 31st, 2021 there have been 81 deaths notified, all of which have had completed reviews.

Between April 1st, 2021 and March 31st, 2022 there were 22 deaths of people in Rotherham with a learning disability notified to LeDeR. There are normally 14 deaths reported per year for Rotherham. This is more than a 50% increase. This could indicate more people are dying with a Learning Disability or that there has been raised awareness of the LeDeR programme and more deaths are being reported.

This annual report will focus on a total of 26 reviews for 2021/22 of which 22 reviews and subsequent findings are from April 1st, 2021 to March 31st, 2022 and 4 reviews received at the end of March 2021 which were not included in the previous report.

The 26 reviews indicate that the mean age at death in 2021/2022 in Rotherham was 56 years, with all notified deaths being in respect of adults. This is a decrease in age of 7 years from 2020/2021. Meaning People are dying Younger than previously in Rotherham.

The median (middle) age at death in Rotherham was 62 years for females and 61 for males. This is a reduction in age at death of 5 years for females and an increase of 3 years for Males since 2020/2021.

Of the 26 notifications, thirteen pertained to males and thirteen to females in comparison to during 2020/2021 when seven pertained to males and ten to females.

Ethnicity of the 26 LeDeR notifications were recorded as: 88% were white British, 8% were mixed or Multiple Ethnic groups and 4% were Black, African, Caribbean, or Black British. This is an

increase on previous years when all notifications apart from 1 were recorded as being White British.

By far the most frequently reported cause of death in Rotherham was pneumonia, this includes aspirational pneumonia, Bronchopneumonia, Covid pneumonia and pneumonia which accounted for nine deaths, two of which were Covid-19 positive, followed by other respiratory causes reported for six deaths, with another two Covid-19 positive. The remaining five non respiratory deaths were attributed to Myocardial Ischemia, Progressive Supranuclear Palsy, Sepsis secondary to pneumonia, Sudden Death in Epilepsy, Urinary Bladder Carcinoma and Vulva Cancer. The main causes of death remain the same as in the previous year.

Of the four deaths attributed to Covid-19, two were female, 2 male and all were white British.

KEY FINDINGS

This report's key findings include:

- There are 4 notifications that were received at the end of March 2021, which were not included in the previous year's report due to when they were received. These are included in the data within this report. Of these 4, 3 were adults from a BAME community. There was only 1 death from the BAME community recorded within the previous annual report.

- Within Rotherham 22 deaths were notified to the programme between April 1st 2021 and March 31 2022.

- Of these, there was an equal split of male to female. Of the 4 reported in March 2021 3 were male and 1 was female, the majority being male. The National report tells us that of the deaths that were reported 56% were male and 44% were female.

- Of the 4 deaths notified in March 2021 included in this report 75% were from a BAME community, a significant increase from the previous year when none were included in the annual report. Of those notification received for April 2021-March 2022 none were from the BAME community. The SYICB are unclear of the reasons behind the March 2021 increase. National statistics show us 3% of deaths reported were from Asian/Asian British, 3% Black, Black British, Caribbean, or African and 3% Mixed ethnic group.

- Of the 26 individuals, 69% died in hospital compared with 61% nationally occurring in hospital. Of the 4 deaths reported in March 2021 all died in Hospital.

- The most frequently reported cause of death in Rotherham in both 2019, 2020/21 and 2021/22 was pneumonia. Of the 4 deaths reported in March 2021 all related to respiratory disease. Nationally the most common cause of death in 2021 was Covid 19, followed by diseases of the circulatory system, with respiratory system diseases in third place.

- Nationally the figures of pneumonia as a cause of death have dramatically decreased from in 2018 being 52%, to in 2021 this figure now being 21%.

- This shows a difference in the local findings in Rotherham.

- Under the new process 23 notifications were completed as initial reviews which do not require the reviewer to record a grading of care. Grading is only completed within Focussed reviews. Of the 4 deaths in March 2021, 1 was completed as an Initial review and 3 were Focussed due to being from the BAME community.

- There is a marked difference between deaths attributed to Covid-19 in the general population compared to people with a learning disability. The Office of National Statistics (ONS) data for the general population of England and Wales reports that 47% of deaths from Covid-19 were in people aged 85 years and older. However, for people with learning disabilities, just 4% of people were aged 85 years and older. Nationally there has been an excess of deaths for people with a learning disability from Covid 19 in 2020 and 2021 of 34.3% and 21.5%, which was higher than for the general population (14.5% and 10.4%) respectively

- Of the 26 reviews four were completed within the six months of the referral date. Fourteen were not completed within the timeframe, with eight not due as at writing this report. Of the fourteen not completed, one is on hold due to SCR investigation and one is being reviewed under the CDOP process.

INTRODUCTION

Background

The national Learning Disabilities Mortality Review (LeDeR) programme was established in 2016 following the Confidential Enquiry into the premature Deaths of people with Learning Disabilities (CIPOLD). It was commissioned by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England from the University of Bristol. It involved reviewing the deaths of all people with a learning disability to identify potentially avoidable contributory factors. LeDeR focuses on the learning that can be gleaned from reviewing the circumstances in which a person with a learning disability died, and their care and treatment through their life.

The LeDeR Programme was initially led by the University of Bristol including policy, overall responsibility for the direction of the reviews, the operation of the web platform and the analysis of the data; with CCGs conducting reviews. The end of NHS England and NHS Improvement's contract with the University of Bristol in May 2021 meant a timely opportunity to reflect on what has gone well with LeDeR to date and to identify areas of the programme that need to improve.

A revised LeDeR review process will be put in place from 1st, June 2021 and will be supported by the new web-based platform and new training for the LeDeR workforce. ICSs will need to implement the changes to the review process from this date. The review process for autistic people will be implemented later in 2021. The University of Bristol platform will not be available after 1st, June 2021. Data held currently on the University of Bristol platform will be transferred over to the new web-based platform.

Definition of learning disability

The LeDeR programme follows the definition outlined in 2001 by the white paper 'Valuing People' which states that

Learning disability includes the presence of: -

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- A reduced ability to cope independently (impaired social functioning) which started before adulthood, with a lasting effect on development.

Confidentiality and Data Sharing

The LeDeR programme is part of a suite of programmes previously known as confidential enquiries. It has approval from the Secretary of State under Section 251 of the NHS Act 2006, to process patient identifiable information without the patient's consent. The reference number for this is 16/CAG/0056.

Initial Review

An initial review is completed for all appropriate notifications to LeDeR.

Building on the wider learning from reviewing deaths in NHS Trusts, the LeDeR methodology places the person at the centre of the review. The 'pen portrait' is a strengths-based summary of the person's needs, preferences, interests, communication style and community presence.

A chronology is also completed detailing at minimum the last year of the person's life. From the information collated, reviewers are required to draw on this information to formulate recommendations based on issues and learning identified. These SMART recommendations signpost where quality can be improved and good practice shared, as well as the identification of local recurrent themes.

Focussed Review

Focused review Situations where a focused review will be carried out are:

1. If the individual is from a Black, Asian, or Minority Ethnic background, a focused review will automatically be completed due to significant under reporting and increased health inequalities in these communities. (This may include, for example, and not be limited to, Romany Gypsy, Irish traveller, or Jewish communities).

2. If in the professional judgement of the reviewer that there is significant learning likely for the ICS from carrying out a LeDeR review.

3. If there are concerns about the quality of care provided to the person by one or more providers, or there is evidence of lack of integrated or co-ordinated care.

4. A family member can always ask for a focused review to be completed. If such as request is made, a conversation should take place between the family and the reviewer about the expected outcome of a LeDeR review. LeDeR is a service improvement approach and cannot satisfy performance issues for a whole organisation or individual staff members, for which there are other processes, including within organisations themselves and via the CQC. Families should be informed by the reviewer about the options which exist to raise issues they have about the care received by their loved one.

5. In the years 2021-2023, all deaths of adults who have a diagnosis of autism but who do not have a learning disability will have a focused review.

A focused review will be completed using the LeDeR web platform to guide the review process. Where a reviewer comes to a view that a review, they are working on is complex, they will work with their senior reviewer and use the expertise of the wider multidisciplinary team of reviewers to support them. In rare cases with very complex and unique circumstances, senior reviewers may carry out reviews – particularly when they are very complex and require significant expertise. We expect these very complex cases to be rare.

Reviewers will need to consider whether any other process, such as referral to safeguarding, provider complaints process or a serious incident investigation should be conducted alongside or in place of a LeDeR review. LeDeR is a service improvement programme therefore, where appropriate, the LeDeR review may arrive at differing learning and recommendations to other reviews or investigatory processes.

ACKNOWLEDGEMENTS

We would like to thank each and every one of the reviewers, their families and care teams. Their unwavering dedication ensured each and every review undertaken was the best it could be for each person and their family. Likewise, without the support of our families, we would not have been able to fully learn from the events their loved ones experienced; ultimately enabling us to positively change services and practice locally.

GOVERNANCE ARRANGEMENTS

The LeDeR programme is part of the national Transforming Care Partnership (TCP) programme and as such local LeDeR performance is reported to NHSE/I through the Sheffield, Rotherham, Doncaster and Bassetlaw TCP Board.

LeDeR updates are fed into the patient safety and quality assurance meetings which in turn inform the Governing Body.(replaced with the Quality, Patient Safety and Experience Dashboard which feeds the Place Executive Team, PLACE Leadership Team, PLACE Board and the ICS)

A six weekly LeDeR Steering Group is established at which relevant guidance, annual reports and related publications are discussed and disseminated and learning from completed reviews are presented by reviewers. A quarterly peer review forum is held for reviewers to meet to support each other and share good practice.

Monthly Quality Assurance panels have recently begun to authorise Focused reviews and ensure that all learning is disseminated, and actions agreed are monitored.

Rotherham second LAC is the Matron in Learning Disabilities and Autism at The Rotherham Foundation Trust (TRFT).

LEARNING DISABILITY DEATHS IN ROTHERHAM NOTIFIED TO THE LeDeR PROGRAMME JANUARY 1 2020 TO MARCH 31 2021

Gender

There has been a significant change in the gender divide in deaths reported in Rotherham to the LeDeR programme: During this reporting period female deaths increased by 3 and male deaths increased by 1 compared to 2020/21.

	Gender	
	Female	Male
2019	5	9
January 1 2020 to March 31 2021	2	1
April 1 2020 to February 2021	8	6
March 1 2021 to March 31 2021	1	3
April 1 2021 to March 31 2022	12	10

Nationally the 2021 LeDeR reporting of gender

Nationally for people with learning disabilities

- 56% were male
- 44% were female

Of the deaths attributed to Covid-19 50% were male and 50% female.

Age at death

The mean age at death in Rotherham in 2021/22 was 56 years which is seven years less than in 2020. Of the 26 deaths reported, one was under the age of 20, four were aged between 20 – 30, seven were between the age of 31 – 59 and fourteen were over the age of 60.

The median age at death in 2021/22 was 62. 62 years for females and 61 for males. The female age is markedly different from last year when it was 48, this is an increase of 26 years, unclear as to why it was so low last year, this year is more representative against the Male age.

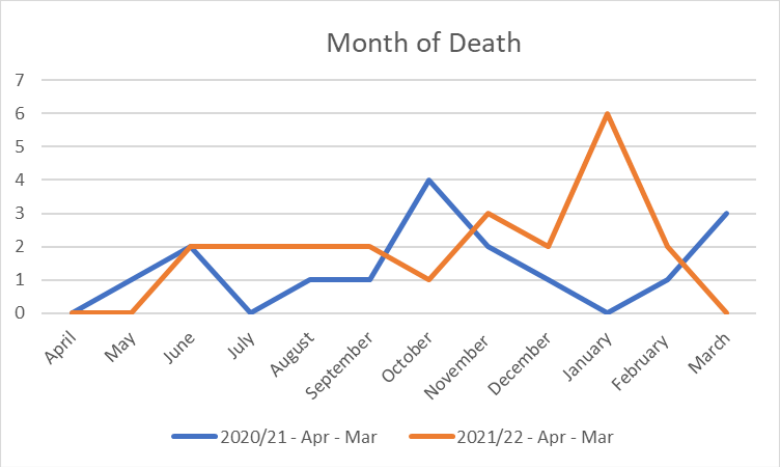
Nationally in 2018 and 2019 the median age at death was 60, in 2020 it was 61. This increase is for both males and females. Nationally the median age at death for males was 61 and 60 for females in 2021.

None of the four deaths attributed to Covid-19 were in the 85 years and over age range which is the highest age range at death for the general population. The median age of these four deaths was 47.

Month of death

In Rotherham, of the twenty two deaths between April 2021 and March 2022, two occurred in June, two in July, two in August, two in September, one in October, three in November, two in December, six in January and two in February.

Most deaths between April 2021 and March 2022 were in January 2022, followed by June, November, and January (2021) respectively. There were no deaths notified during April, May, or March.



Nationally the 2020 LeDeR reporting of month of death

There was a greater proportion of deaths of people with learning disabilities between March 2020 and May 2020.

There was a significant increase in the number of deaths reported during the peak periods of the COVID-19 pandemic, with spikes in deaths occurring during April 2020 and January 2021.

Ethnicity

Of the 26 reviews 88% of deaths pertained to individuals who were British, 8% to Mixed or Multiple Ethnic Groups and 4% to Black, African, Caribbean, or Black British.

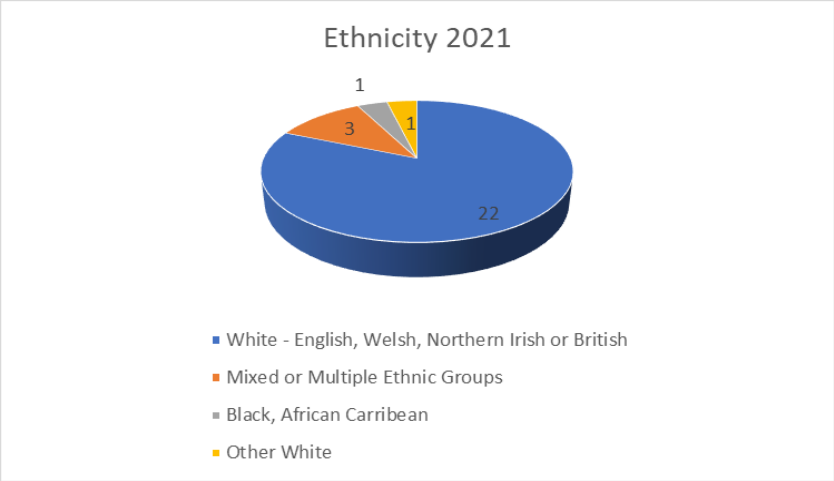
It is likely that this is indicative of under-reporting of deaths of people from minority ethnic backgrounds as opposed to a greater proportion of deaths amongst people from a white British ethnicity.

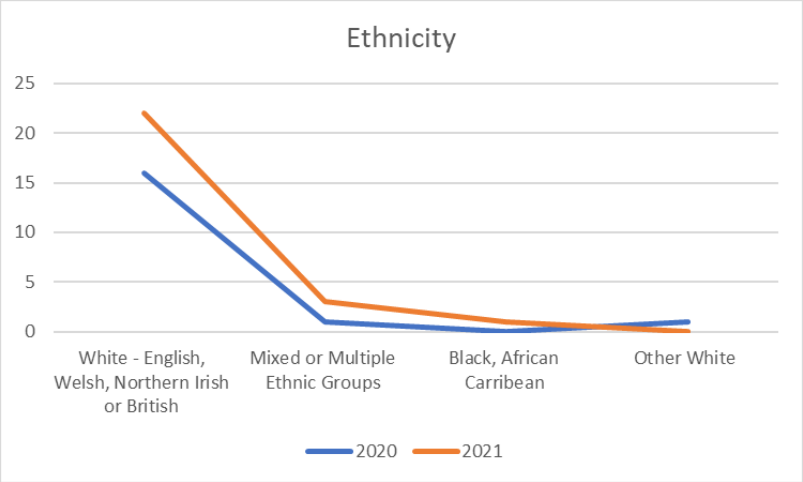
Continued awareness raising of the LeDeR programme and alignment with Medical Examiner's Office reviews will potentially identify more learning disability deaths in BAME communities. Moving forward, this has already increased slightly in 2021/2022.

Rotherham Ethnic Minority Alliance (REMA) completed a report for Rotherham to begin the process of further engagement with the local BAME community. There were a number of actions from this report that are being picked up within a working group, working closely with REMA.

Nationally the 2020 LeDeR reporting of ethnicity

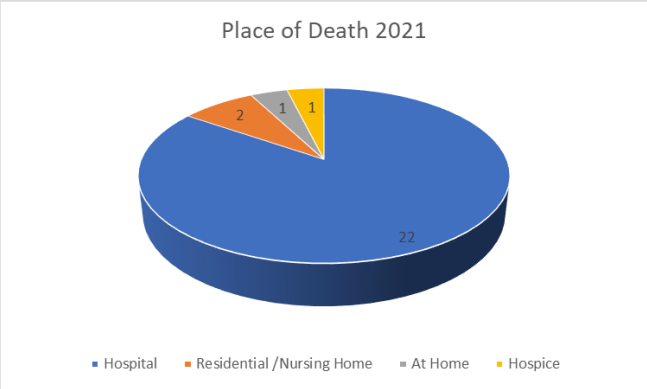
The number of deaths of individuals from different minority ethnic groups is too small to analyse by individual ethnicity. Less than 5% of adults who died were of Asian/Asian British ethnicity.





Place of death

22 individuals died in hospital, three died in their usual place of residence and one died in hospice. There isn't currently a mechanism to record whether the individual died in their place of choice. Further work to promote advance care planning, including End of Life plans and DNACPR decisions have the potential to go some way to supporting this. It is however refreshing to see that a Hospice has been utilised for a Person with a Learning Disability as this has not been recorded as a place of death previously.



Nationally the 2020 LeDeR reporting of place of death

Nationally for people with learning disabilities 60% died in hospital (compared to 46% of general population). This is comparable to the national statistic in 2021 that 61% of deaths were recorded in hospital.

Case study pen portraits (direct lift)

I completed a review for a person who died in June 2021. They were 80 years old. Initially cared for by parents as they were also blind, they moved into supported living upon their death. Two siblings, but only one kept in contact. They visited a few times a year as they were not local. Capacity for small decisions, they had court of protection and an MDT for larger decisions. They lived with staff 24/7 and one other resident in a bungalow. Always busy and active, they enjoyed holiday, shopping, baking and was described as feisty, stubborn and very caring. They adapted to their lack of sight (from birth) with an amazing memory. They could remember outfits just by the texture of the cloth and know what accessories etc would go with it.

By early 2021 they began to lose weight although there was no clear reason. They started to refuse food, and this impacted upon Diabetes. After experiencing a hyper and keto in April they were admitted. A DNACPR was put in place due to age and frailty. Felt to be a possible malignancy, they was discharged home but staff were not informed and did not have correct staff or equipment in place as needs had changed. They were readmitted after the weekend. Staff at the home managed to get things in place to meet needs, but requested extra funding for extra staffing as now needed two people, however, they were discharged into a care home to await social care funding for this.

The review highlighted several areas of poor practice, but essentially death was peaceful and even in an ideal situation, nothing would have changed the outcome.

1. Poor understanding of hospital staff – the person was blind and there was no known attempt at reasonable adjustments. i.e. staff taking blood glucose tests without informing them they were in the room or what they were doing, resulting in a sharp unexpected stab to the finger out of the blue.
2. Lack of hospital staff training around learning disabilities.
3. Hospital passport not followed in hospital.
4. Discharged home without staff knowing and there had been no support offered or reassessment as needs had changed.
5. There was an opportunity to get the patient home, but they were placed under Scheme 2 in a care home until social care funding could be authorised to get them ‘home’. By the time they were readmitted, they were too poorly to move back home to die.
6. Lack of a plan around readmission. Although not felt to be palliative at that time, due to their and frailty this could have been discussed.

The staff at the usual residence were ‘family’. The patient had been there a long time and they knew them well. There was a caring and loving environment and they wanted and tried to get them back home.

M had a diagnosed learning disability and Downs syndrome. She was diagnosed with Dementia in 2018 and had the diagnoses of: Tetralogy of Fallot, Stage 3 kidney disease and cataracts. She had suffered with constipation and sleep difficulties historically. M came from a large family and resided at home with her mother prior to her passing. She moved into a care home in 2002/2003 and was settled within her home for 17 years. M was described by family as ‘amazing’ and ‘a wonderful soul’, it was felt that she had a ‘gorgeous life’ and was surrounded by love. M was described to be ‘music mad’ and loved to listen and dance to music by Abba and from musicals. M was very close with her family and sociable with others. Prior to her diagnosis of Dementia, M had no issues communicating her needs/feelings. Following this diagnosis, M's health gradually deteriorated over the years, and she received support from different health professionals who appeared to work well together to support her needs; this highlighted the importance of effective interprofessional working. Staff within M’s home started to experience difficulties with meeting M’s needs, it was highlighted there was a gap in service provision as a social care referral was made to reassess M’s needs and this took some time before it was allocated. Recommended for future urgent referrals to be reviewed within a timely manner. M’s family also felt it would be beneficial for others to have further training around dementia and rapidly changing needs associated with decline.

Causes of death

The World Health Organisation defines underlying cause of death as the disease or injury which initiated the train of events leading directly to death, or the circumstances of the accident or violence resulting in a fatal injury.

Nationally in 2021 the most common cause of death was Covid 19, followed by diseases of the circulatory system and then diseases of the respiratory system.

The most frequently reported ICD-10 chapters of underlying causes of death within the learning disability population didn't change in 2018 and 2019.

In 2020 the most frequently reported ICD-10 chapter in respect of those with a learning disability was the emergency code for Covid-19. Nationally Covid 19 was the most common cause of all deaths in 2021.

Locally, between 1st, March 2021, and March 31st, 2022 the most frequent cause of death by ICD-10 chapter were diseases of the respiratory system at 46% this is very similar to the figure in 2020/21 which was 47%. Four deaths (15%) were attributed to Covid-19 this is lower than 2020/21 which was 23.5%.

The remaining five reported causes of death were:

- Aspirational Pneumonia
- Bronchopneumonia
- Chest Infection
- Covid
- Covid Pneumonia
- Myocardial Ischemia
- Pneumonia
- Progressive Supranuclear Palsy
- Pulmonary Embolism
- Respiratory Failure
- Sepsis secondary to pneumonia
- Sudden Death in Epilepsy
- Urinary bladder Carcinoma
- Vulval Cancer

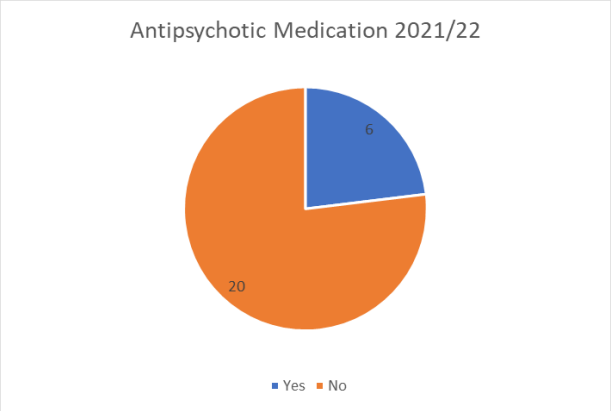
Use of antipsychotic medication

STOMP is a national programme to reduce over medication of children, young people and adults with a learning disability, autism, or both.

Psychotropic medication is used to treat a range of conditions including bipolar disorder, schizophrenia, and psychosis. However, they are also prescribed for people whose behaviour is perceived as challenging and presenting a risk to themselves or others. People with a learning disability, autism or both are more likely to be prescribed these drugs in this way than others.

Remarkably only 23% of the 26 reviews indicated that antipsychotics were prescribed. this is a reduction from last year.

Furthermore, psychotropic medicines can cause a number of side effects and have a negative impact on long-term health.

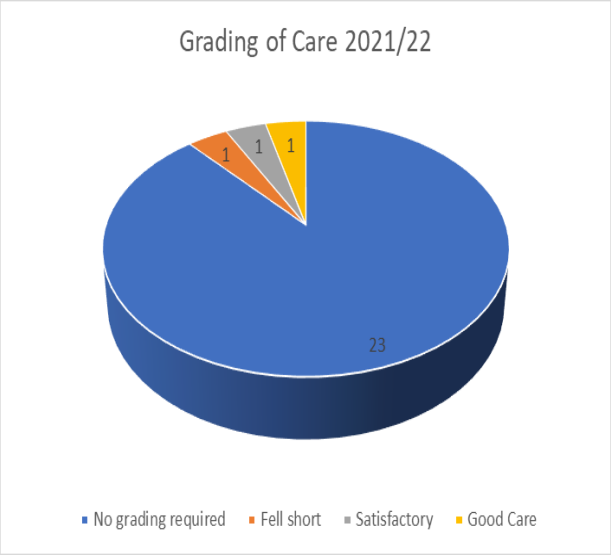


Outcome of review – grading of care

At the end of a focussed review, having considered all the information available to them, reviewers are asked to provide an overall assessment of the care provided to the individual and provide a grade. Initial reviews do not require the reviewer to provide a grading of care.

It is important to note that not all reviews generate learning, with a significant number of reviews demonstrating good care throughout the life, and end of life, of the individual.

Of the 26 reviews, 23 were initial reviews not requiring a grading of care, three were focussed reviews within which quality of care is graded. Of these 3 reviews 33.3% were graded as care fell short, 33.3% were graded this was satisfactory care and 33.3% were graded as this was good care.



Nationally the 2020 LeDeR findings for the overall grading of care

From 2018 to 2020 there has been a steady increase in the number of reviewers who perceived that the individual's care met or exceeded good practice, this increased from 48% in 2018 to 58% in 2020.

Whilst the increase is positive, nationally this still means that 42% of reviewers in 2020 perceived that the individual's care had not met good practice. Standards.

Nationally the statistics look at the older LeDeR review systems in 2021, which found 70.4% identified good practice and 29.6% identified poor practice.

From the new LeDeR review system nationally, in 2021, 71.3% identified good practice and 28.7% of the reviews identified poor practice.

DEATHS FROM COVID-19

Deaths from Covid-19 in the learning disability population in Rotherham were very different than the national and regional findings. Nationally the peak month for deaths attributed to Covid-19 was April 2020, with 59%.

There were four deaths within the learning disability population of Rotherham during April 2021 and March 2022: One was in July, one in August and two in January 2022.

In each region, the number of deaths amongst those with learning disabilities from Covid-19 notified to the LeDeR programme was higher than the number of deaths from Covid-19 in the general population.

Nationally a greater proportion of males than females with a learning disability died from Covid-19, whereas in Rotherham of the four deaths from Covid-19 two were female and two were male.

Consistent with the younger age at death for people with a learning disability, those with learning disabilities who died from Covid-19 were frequently in younger age groups than those in the general population: None of those with covid-19 with a learning disability were aged 85 or over, in comparison to 42% in the general population.

The median age of the four Covid-19 deaths in Rotherham was 47 years. This is significantly lower than the previous year where is was 70 years.

Nationally 21% of people with learning disabilities who died from Covid-19 had Down's syndrome. None of the individuals in Rotherham who died from Covid-19 had Down's syndrome.

In Rotherham 75% of those with a learning disability who died from Covid-19 died in hospital in comparison to 83% nationally. Only one died in residential/nursing care

IMPROVING HEALTH INEQUALITIES FOR PEOPLE WITH LEARNING DISABILITIES AND AUTISM ACROSS SOUTH YORKSHIRE AND BASSETLAW

Addressing health inequalities faced by people with learning disabilities and autism is a key priority for South Yorkshire and Bassetlaw. We have an established Health Inequalities Steering Group which currently meets six weekly that specifically looks at a collaborative approach, sharing best practice to improve our pathways, provision and more importantly raise awareness.

There are a number of projects across the ICS where we are working to address the health inequalities that our learning disability and autism population are still facing. The latest LeDeR report identifies that people are still dying much earlier than the general population, 22 years younger for males and 27 years younger for females.

The LeDeR ECHO Project

Utilising the ECHO platform, a series of ECHO modules have been rolled out to learning disability and autism care homes, supported living settings and domiciliary care which will increase the knowledge, competency, and confidence of staff. Focussing on the key findings and recommendations from the LeDeR reports including the following which will be phase 1 of the project:-

- Constipation

- Epilepsy and seizure control
- Dysphagia/posture
- Sepsis awareness

These sessions were also made available to GP practices, other clinicians, and family carers in 2021/22.

ECHO training – Self advocates from Speak Up have attended ECHO training and are now supporting the rollout of the above modules presenting the case studies.

SAMI/RESTORE 2 mini tool projects

To compliment the above project, there was also a roll out SAMI Restore 2 mini tool training which is an accredited training programme. The programme offers education and training for care support staff within care settings, supported living, care homes and domiciliary care. Carers are taught to recognise measure and report changes to an individual's health status at an early stage, thus preventing deterioration in that person's health and wellbeing and avoiding preventable deaths in line with the LeDeR programme. The aim of the project is to identify early signs of illness, prevent unnecessary hospital admissions/attendances at UEC (Urgent and Emergency Care), and reduce stress for the cared for person, increase confidence of carers, improve communication with primary care and urgent care services. Also, providers were given calibrated equipment including oximeters, blood pressure machines, thermometers, and clinical watches. This work will also link in with the national Oximeter Pilot.

SPEAKUP

SpeakUp are commissioned by the South Yorkshire ICS to embed co-production in all their plans and strategies. SpeakUp employs 16 people with learning disabilities and autistic people in work.

Tackling Health Inequalities is part of this work.

Over the last year we have supported our ICS to do this in the following ways.

1. Facilitating a Big Health Day in Sheffield. Over 100 people came to this event, people had a chance to take part in physical activities and also attend workshops on various topics including Dysphagia and Annual Health Checks. We are planning to run a similar event in September 2022.
2. LeDeR ECHO – Colleagues with lived experience have supported the delivery of LeDeR ECHO training, last year we also co-designed sessions for people with learning disabilities, autistic people, and families to attend. The sessions focussed on LeDeR priorities including, Sepsis, Epilepsy and Dysphagia.
3. Learning Disability and Autism Awareness Training – SpeakUp has developed a training package to raise awareness of learning disability and autism. Last year we delivered 18 sessions to over 450 front line health and social care staff across Rotherham, Doncaster, and Sheffield.

FUNDING

The Local Area Contacts (LACs) and reviewers contributing to the LeDeR programme in Rotherham undertake LeDeR work within their substantive roles. There are currently no dedicated LeDeR focussed posts unlike most other areas.

Non recurrent monies for a 0.2 whole time equivalent Band 7 reviewer was allocated to Rotherham from October 2021- September 2022 to support with the increasing number of notifications.
A piece of work was also undertaken with the Local Authority in an endeavour to recruit more reviewers. This was successful and 3 additional reviewers were recruited to complete reviews. Like the other reviewers this is an addition on top of their normal role, hence completing reviews continues to be problematic.

LOCAL PRIORITIES AND THE EVIDENCE BASE THAT SUPPORTS THEM

1. The local LeDeR offer is still not reaching BAME communities effectively as there have been very few notifications to the programme: Further initiatives to address this locally continue to be a priority. This will build on the engagement work already undertaken by REMA.

2. In conjunction with increasing the quantity, and of equal importance, the quality, of annual health checks (AHCs) for those aged 14 and over in Rotherham, there needs to be measurable evidence that AHCs improve health outcomes and that they contribute to reducing premature mortality.

3. ICB LeDeR Steering Group membership has broadened to include a wider range of stakeholders however this needs to be expanded further to incorporate representation from people with Lived experience.

4. As LeDeR is an additional role to reviewer's substantive posts with no dedicated capacity within which to undertake this work, we continue to struggle to recruit and retain reviewers. Given that there was an increase from the usual 14 LeDeR notifications each year, to 22 this year, there needs to be a continued programme to recruit reviewers. This may be resolved by the plans around the ICB LeDeR offer and having a central resource. Funding for this will need to be explored.

5. Paid carers are often not ensuring that individual's hospital passports are taken with them when conveyed to hospital, which needs to be addressed locally.

6. Similar to previous years locally there needs to be improved application and documentation in respect of MCA/BI.

LeDeR POLICY

The national LeDeR policy, learning from life and death reviews of people with a learning disability and autistic people was published on March 23rd, 2021 which will determine the delivery of LeDeR in the future.

https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf

CONCLUSION

The local LeDeR offer in Rotherham is a robust model which has been further enhanced by reviewers from backgrounds other than nursing, i.e. allied health professionals and/or social care, having recruited during 2021/2022 3 Social workers as Reviewers.

The national LeDeR policy and the proposed ICS approach to LeDeR locally will without doubt further embed LeDeR across South Yorkshire.

APPENDIX 1 - GLOSSARY

AHCs	Annual Health Checks
BAME	Black, Asian, and Minority Ethnic
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
DH	Department of Health
DoLS	**Deprivation of Liberty Safeguards**
GB	Governing Body
HQIP	Healthcare Quality Improvement Partnership
ICS	Integrated Care System
LA	Local Authority
LAC	Local Area Contact
LeDeR	Learning Disability Mortality Review
MAR	Multi- Agency Review
MCA	Mental Capacity Act
NHSE&I	NHS England & NHS Improvement
RMBC	Rotherham Metropolitan Borough Council
TCP	Transforming Care Partnership
TRFT	The Rotherham NHS Foundation Trust

SOUTH YORKSHIRE INTEGRATED CARE PARTNERSHIP STRATEGY

Working together to build a healthier South Yorkshire our Initial Integrated Care Strategy

December 2022

A message for the people and communities of South Yorkshire:

This strategy is a legal requirement for the Department of Health and Social Care and has been developed between September and December 2022 by the newly formed Integrated Care Partnership.

It covers the years up to 2030 and we see it as the beginning of a journey with the people and communities of South Yorkshire.

We will continue to work with you, listen to you, involve you and respond actively to what you tell us.

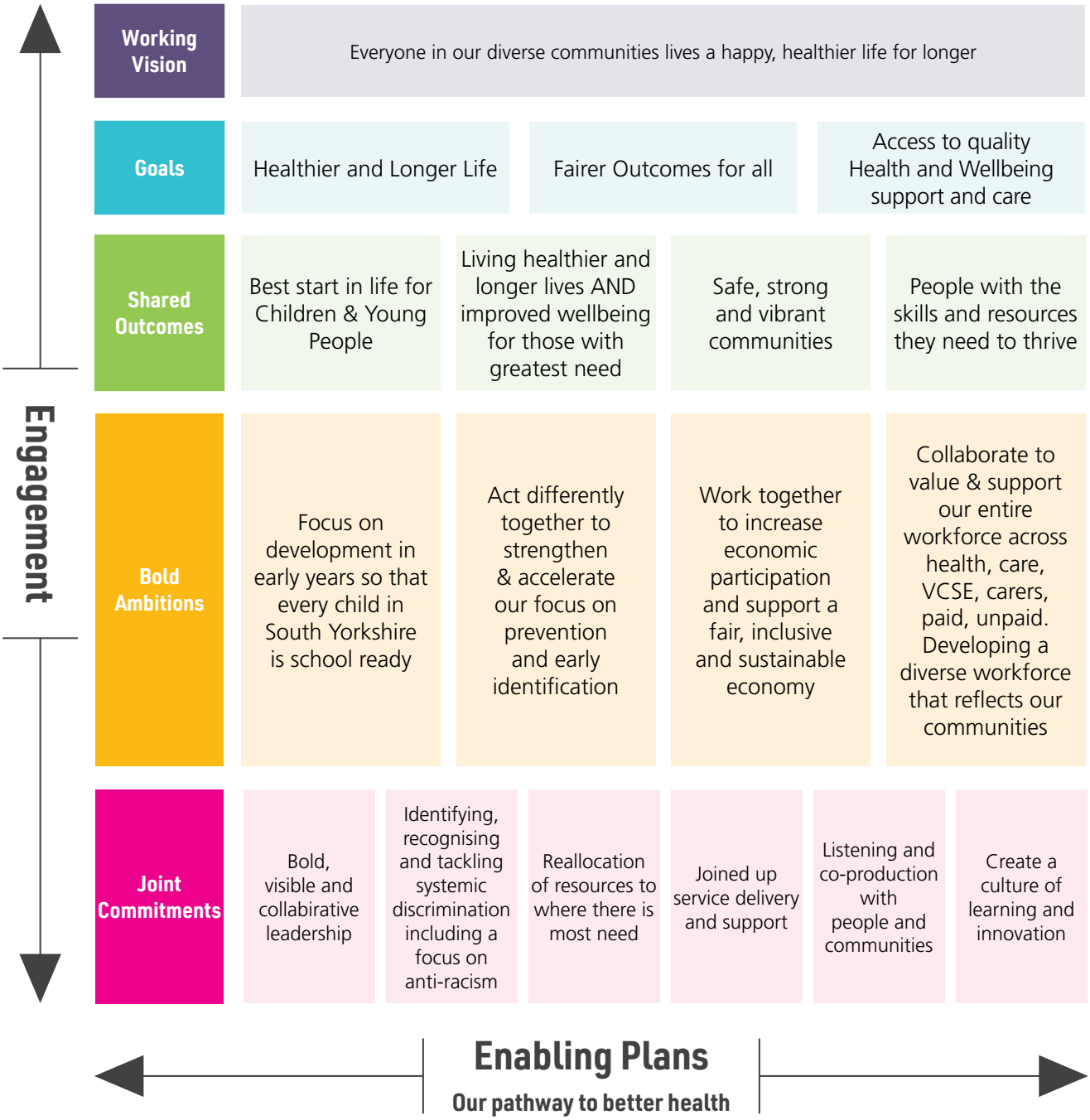
We know from our engagement work that good access to high quality care and support is really important to you and this is an area as a Partnership we are making joint commitments to improve.

This strategy and the plans that support it will change and improve through your involvement.

The health and wellbeing of everyone matters to us all.
We look forward to working with each of you for a happy, healthier South Yorkshire.

Summary Plan on a Page

Our Shared Outcomes, Bold Ambitions and Joint Commitments



Bold Ambitions

This 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. This 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 next step is to do the work to agree together the specific actions we need to take to deliver on these ambitions.

1 Focus on development in early years so that every child in South Yorkshire is school ready

Raise the level of school readiness in South Yorkshire and close the gap in those achieving a good level of development between those on full school meals and all children by 25% by 2028/30

2 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

3 Work together to increase economic participation and support a fair, inclusive and sustainable economy

Reduce the economic inactivity rate in South Yorkshire to less than 20% across our places by 2028/30

Reduce the gap in the employment rates of those with a physical or mental health long term condition (as well as those with a learning disability) and the overall employment rate by 25% by 2028/30

Enable all our young people that are care leavers 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

4 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 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.

Contents

What matters most to me about my health and wellbeing is to live in an equal society. Only through equality can health equity be achieved. I want to live in high-quality housing, in pedestrianised, green, and clean neighbourhoods, with local community facilities and assets prioritised. I want to live in a city that takes care of the most vulnerable, and where everyone is valued. I want to receive compassionate and destigmatising care from health and wellbeing professionals, that empowers me to take control of my life and health. I want to be able to access the resources to take care of myself and my community.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

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. We have worked hard to ensure there is a rich diversity of voices and perspectives represented and will continue to do this across the life of this strategy. 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. By developing our ICP in this way we have built upon our existing partnerships and aligned with Health and Wellbeing Boards. Work continues to increase diversity and inclusion in our Partnership and to further strengthen representation from our Voluntary Sector as an equal partner, linking with the developing Voluntary, Community and Social Enterprise (VCSE) Sector Alliance.

1

Introduction

South Yorkshire has much to be proud of with our strong and vibrant communities, proactive voluntary sector and a broad range of health and care services providing a strong foundation for improvement.
South Yorkshire developed around the industries of mining and steel and this industrial heritage means our close communities have a deep sense of place and identity. These have developed into a diverse and vibrant economy with health and care, advanced manufacturing, research and education being significant industry sectors across South Yorkshire. We are a diverse and welcoming county with outstanding natural, heritage, cultural and artistic assets. We are geographically compact and fortunate in our location, in that we have good access to open green spaces, including the western edge of Sheffield and Barnsley bordering the Peak District National Park. All this contributes to South Yorkshire being a great place to be born, live and work.

There are, however, some serious challenges to overcome. South Yorkshire has a significant proportion (37%) of people living in the most 20% deprived areas nationally. Life expectancy in South Yorkshire is no longer increasing. Not only are people in South Yorkshire dying younger, they are living fewer years in good health. There is also a significant difference in the number of years people can expect to live in good health, with those living in the most deprived areas dying up to nine years earlier compared to people living in more affluent areas across South Yorkshire communities. The gap in life expectancy between the most and least deprived areas is also widening. Our commitment in this strategy is to change this.

[1]Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity

The *'Marmot Review 10 Years on'* report[1] , published prior to the Covid-19 Pandemic, found unprecedented declines in health nationally over the decade before Covid-19. Improvement in health in the UK had slowed dramatically, inequalities had increased and health for the poorest people in society had got worse. The Covid pandemic has further exposed these deep inequalities and it is evident that the current cost of living crisis has further exacerbated these disparities. South Yorkshire with its relatively lower level of earnings and employment is particularly vulnerable. Health inequalities are not inevitable and by definition are preventable. It is within this challenging context that we have come together to develop our South Yorkshire Integrated Care Partnership with refreshed energy and renewed commitment to collaborate as partners and work with our local communities of Barnsley, Doncaster, Rotherham and Sheffield to work differently together to address health inequalities and improve the health and wellbeing of all people living in South Yorkshire.

This is our initial Integrated Care Strategy developed within the challenging timeline set nationally at a time when there is immense pressure across the health and care system. We have endeavored to engage broadly, to listen to what matters to people living in South Yorkshire and actively engage with our wider partners in the development of this Strategy. We will build on this and continue to engage and involve as the Strategy evolves and we translate its ambition into delivery.

2

What is the South Yorkshire Integrated Care System – an overview

Partner organisations across South Yorkshire have a long history of collaboration. The first Sustainability and Transformation Partnership 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.

Partners have already started to break down organisational barriers so that we can wrap support, care and services around people and improve lives. In Barnsley, Doncaster, Rotherham and Sheffield, our Local Authorities, NHS partners, the Voluntary Sector and many others have strengthened the way they work with each other and have joined forces where it makes sense to do so and where it makes a real difference to the public, patients, and staff.

Our pledges in 2016 were to give people more options for care while joining it up in communities and neighbourhoods, to help people to stay healthy, tackle health inequalities, improve quality, access and outcomes of care, meliorate workforce pressures and introduce new technologies. We paid particular attention to cancer, mental health and primary care, and the two key enablers of workforce and digital technology. Since then, much has changed - the impacts of the Covid-19 pandemic and the more recent cost of living crisis provide a very challenging backdrop as we set out our new strategy. But we remain focussed and committed in our goal and undeterred for the people of South Yorkshire. We will build on our commitment to the quadruple aim, set out in our **Health and Care Compact** and use the new system architecture and partnerships and our renewed vision, ambition and commitments to go further faster on health inequalities. We will also build new partnerships with agencies outside the ICS to support improved and more equitable health and wellbeing for all and focus on those with greatest need.

New statutory Integrated Care Systems (ICSs) have been set up to bring local authorities, NHS organisations, combined authorities and the voluntary sector together with local communities to take collective responsibility for planning services, improving health and wellbeing and reducing inequalities.

Integrated Care Systems (ICS) have four key purposes:

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

They are made up of:

- **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 Sector and other partners.

The ICP is set up to facilitate joint action to improve health and care outcomes and experiences across their populations and reduce health inequalities. They are rooted in the needs of people, communities and places, oversee population health strategies, drive integration and take an inclusive approach to involvement.

- **An Integrated Care Board,** which is an NHS organisation responsible for planning 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.

The South Yorkshire Integrated Care Partnership covers the 1.4 million people and families living in Barnsley, Doncaster, Sheffield and Rotherham.

Where we work

1.4 MILLION PEOPLE
(including 328,000 children and young people)

72k+ members of staff

186 General Practices

36 Neighbourhoods

1 Ambulance Trust

4 Local Authorities

6,000+ Voluntary Care Sector Organisations

5 Acute Hospital NHS Trusts

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

System Collaboratives and Alliances *(see below)*

1 Integrated Care Partnership

1 Integrated Care Board

£3.9 billion health and social care spend

3 Community Mental Health and Community Trusts

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

Places, Collaboratives, Alliances and Networks

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 by creating integrated multidisciplinary neighbourhood teams to meet the needs of local people. These are the cornerstone of our health and care system and already have delegated authority from the new NHS South Yorkshire to plan, determine and deliver for local communities.

Collaboratives: Our hospitals, mental health trusts and primary care organisations 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. They include:

- Mental Health Learning Disability and Autism Provider Collaborative (including acute, community and specialist services)
- Acute Hospital Provider Collaborative (including acute, elective and diagnostics children's and specialist services)

Alliances & Networks: Important 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)
- Urgent & Emergency Care Alliance
- Children and Young People's Alliance (CYPA)
- Voluntary, Community and Social Enterprise Sector Alliance (VCSE)
- Cancer Alliance
- Local Maternity and Neonatal Network (LMNS)
- Social Care Networks and Clinical Networks

The **South Yorkshire Mayoral Combined Authority** (SYMCA) is a formal partnership of our four local authorities in South Yorkshire: Barnsley Metropolitan Borough Council, Doncaster Council (City of Doncaster Council from January 2023), Rotherham Metropolitan Borough Council and Sheffield City Council, It covers the same population and is led by an elected Mayor. Its Strategic Economic Plan for the region recognises the critical interdependency of health, the economy and having good work. It aims to deliver a stronger, greener and fairer economy, one which reduces social and health inequalities. Oliver Coppard was elected as Mayor of South Yorkshire in May 2022 and is the Chair of the Integrated Care Partnership. One of his Mayoral priorities is the health and wellbeing of local communities, and he has a personal ambition to make South Yorkshire the healthiest region in the country.

Our chances of experiencing good health and wellbeing, and maximising the length and quality of our lives, depend on **the circumstances within which we are born, live, work and age**. Good health outcomes and health inequalities are rooted in socioeconomic circumstances. Many of the levers for improving population health, **such as quality education, good employment, comfortable, quality housing, connectivity, healthy local neighbourhoods** reside with our local authorities and SYMCA, making our partnership a unique opportunity to make a real difference.

3

Listening to our communities in creating this Strategy

To develop our strategy, 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 ICP partners, from 284 different sources (for more details see page 64).
- Building on this with a campaign to gain new insights: **'What Matters to You'.**

Our early insight-gathering identified the following key themes:

- **Awareness** – the need for more information about health prevention and availability of different health and social care services.
- **Access** – making it easy for people to access health and social care services and removing barriers
- **Agency** – including providing people with the information, tools and capacity to manage their own care.

Our **'What Matters to You Campaign'** took place over November. Working with our local Healthwatches and VCSE we asked people a single question. 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?'** The 'live feedback' from our campaign has been actively used to shape and inform our Strategy. The following key themes have emerged in addition to those from the early insight and they have been used to shape our strategy:

- **Access to care**
- **Quality of care**
- **Improving mental health and wellbeing**
- **Support to live well**
- **Wider determinants of health**
- **Affordability**

All the quotes throughout this Strategy are taken directly from our engagement work and the insight gathered informs our goals, shared outcomes, bold ambitions and joint commitments outlined in the next section. We have endeavoured to engage broadly and acknowledge the national timeline for development of this initial Strategy has made it challenging. There is a strong commitment from ICP members to continue to engage and involve as the Strategy evolves and we translate it into delivery.

4

Our vision, strategic goals and shared outcomes for South Yorkshire

Our strategy to better health starts with people and families living in our communities.

Our Vision is that **Everyone in our diverse communities lives a happy, healthier life for longer**

Our Strategic Goals

Our vision is underpinned by three overarching goals. We want to see the people in all our communities:

1. Live healthier and longer lives
2. Experience fairer outcomes
3. Have access to quality health and wellbeing support and care

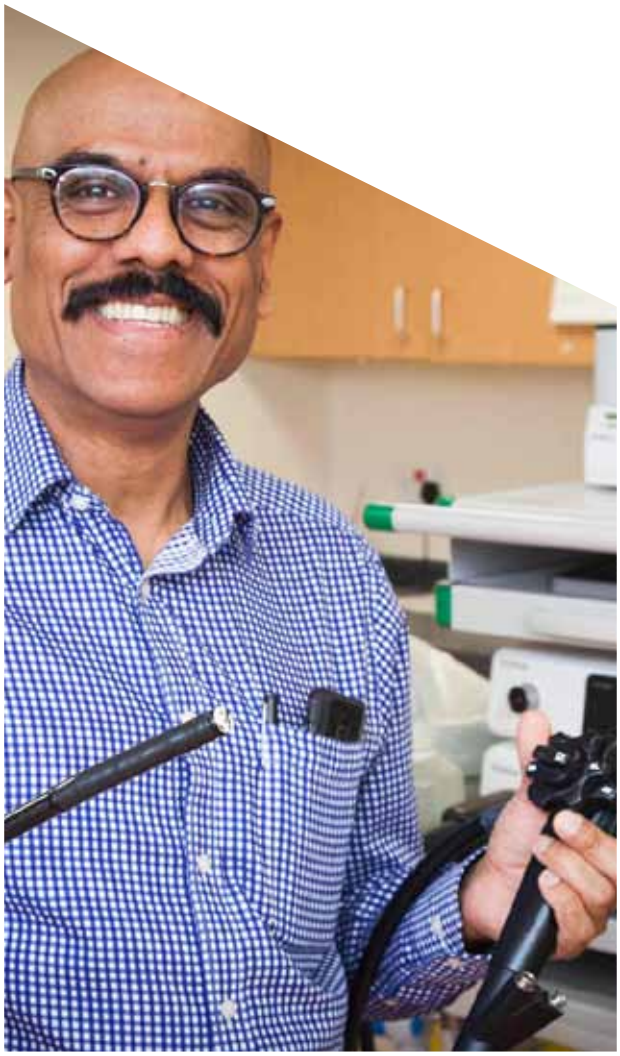
Our success in these goals will ultimately be determined by improvements in Healthy Life Expectancy (HLE), the gap in HLE between the most and least deprived groups, eliminating inequalities in access and experience and unwarranted variation between our communities.

Our aim is to:

Halt the stall in Life Expectancy (LE) in South Yorkshire and improve it by 3 years by 2028/30

Halt the stall in Healthy Life Expectancy (HLE) and close the gap between South Yorkshire and England by 2028/30

Close the gap in Health Life Expectancy between the most and least deprived groups in South Yorkshire by 25% by 2028/30



Our vision and goals are supported by **four shared outcomes** which are reflected in all our current Health and Wellbeing Board Strategies in each of our places. These shared outcomes align well to the life courses of **Starting Well, Living Well** and **Aging well** and act as an enabler in this strategy for current plans. These are:

1	Children and young people have the best start in life
2	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
3	People are supported to live in safe, strong and vibrant communities
4	People are equipped with the skills and resources they need to thrive

Working Vision	**Everyone in our diverse communities lives a happy, healthier life for longer**

Goals	**Healthier and Longer Life**	**Fairer Outcomes for all**	**Access to quality Health and Wellbeing support and care**

Shared Outcomes	**Best start in life for Children & Young People**	**Living healthier and longer lives AND improved wellbeing for those with greatest need**	**Safe, strong and vibrant communities**	**People with the skills and resources they need to thrive**

In this strategy we will set out a focussed number of bold ambitions to support achievement of our shared outcomes which can only be achieved by all partners working together.

5

Where are we now?

The impacts of the pandemic have been unequal and unfair and have highlighted inequalities which have been there for some time in South Yorkshire. Learning from the pandemic has provided us with an expanded view of inequality and to consider the importance and interplay of housing, employment environment, skills and transport (as key wider determinants of health) and their fundamental impact on health and wellbeing. We are fortunate to have many excellent care and support services across South Yorkshire, however as a result of the pandemic and the impact on our workforce these have become stretched and under significant pressure over a prolonged period. We know from our engagement work, our communities value simple and timely access to high quality care and for this to support both physical and mental health needs. Our strategy and delivery plans which follow will address this and our focus will be on enabling equitable access to care and support.

Understanding the Population Health Needs and outcomes in South Yorkshire

Inequalities cost lives. People of South Yorkshire are living shorter lives than they should. The average number of years a baby born today in South Yorkshire can expect to live is 1.5 years less that those living elsewhere in England.

Not only are we dying younger, but we are living fewer years in good health, around 3.6 more years of life in poorer health than other areas in England. 37% (527,000) of people living in South Yorkshire live in the most 20% deprived areas nationally. Men and women living in the most deprived parts of South Yorkshire die around 9 years earlier than those living in the most affluent parts of South Yorkshire.

People who live in the most deprived areas are also more likely to spend longer in poorer health. National data tells us that women in the most deprived areas will spend up to 19 years in poorer health compared to those in the most affluent areas. People living in the most deprived areas will experience the onset of multiple ill health conditions 10-15 years earlier than those in the most affluent areas.

Poor health damages our economy, prosperity and opportunity. Around a third of the productivity gap between the North and the rest of the country is estimated to be attributable to poor health. We are also seeing a rise in older workers leaving the labour market due to poor health.

The conditions that create our health (wider determinants)

To have a healthy society we need a range of building blocks in place: stable jobs, good pay, quality housing and education. Making changes to ensure everyone has equality of opportunity and access to these key buulding blocks is not easy and will require us to be determined in our focus for the people of South Yorkshire.

My health is dependent on my financial stability. If I can afford to heat my home, eat well, socialize, and commute to work safely then I am starting from a good foundation.

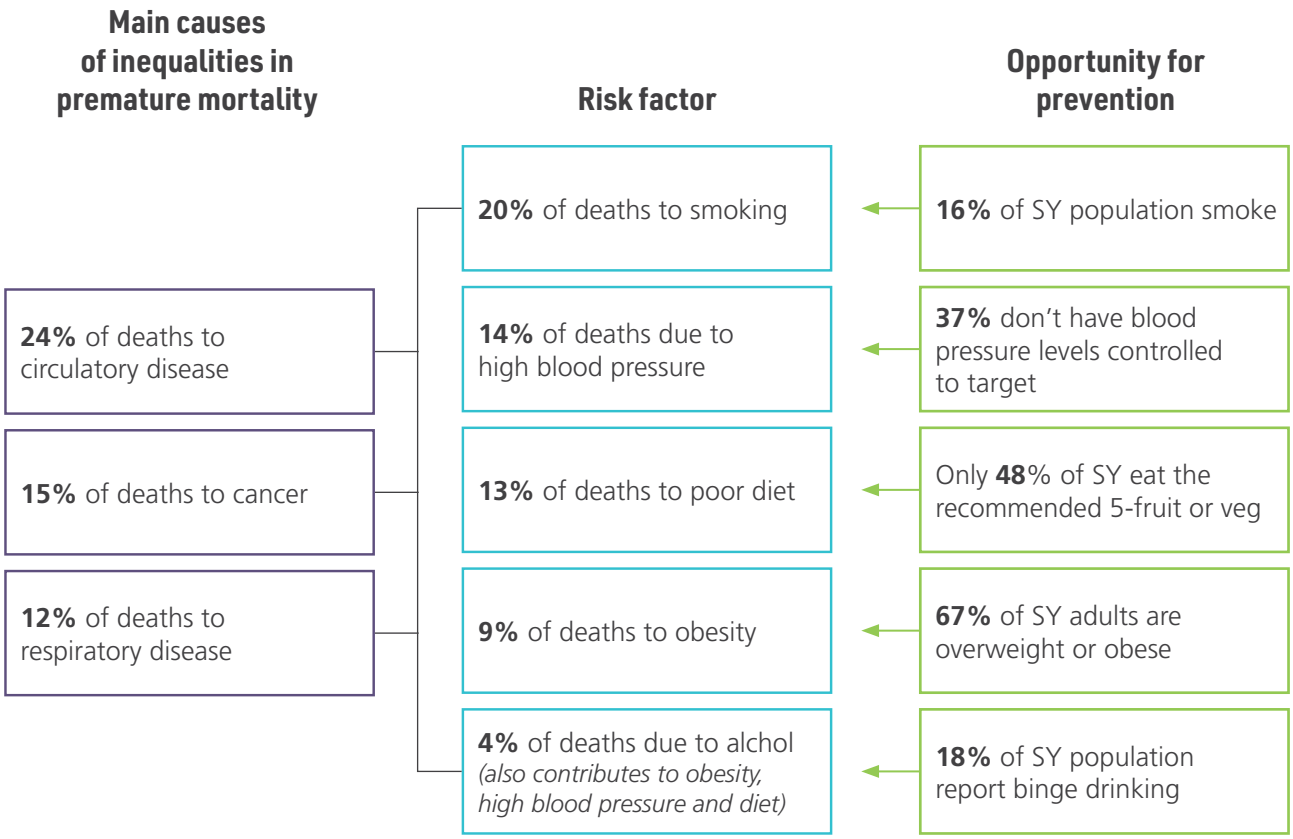
	Theme	Key indicator
	**Housing** Many of the most pressing health challenges such as obesity, poor mental health, physical inactivity are directly influenced by the built and natural environment including access to quality housing.	Nearly 19% of South Yorkshire homes were reported to be experiencing fuel poverty, this is significantly worse than the England average (13%). This is likely to significantly increase given the rising cost of fuel prices and is estimated to impact on at least 42% of households.
	**Access to green spaces and active travel** Access to green space such as woodland, supports wellbeing and allows people to engage in physical activity.	• 14% of adults in South Yorkshire walk for travel. • 16% of South Yorkshire residents make use of outdoor space for exercise or health reasons • All four Places in South Yorkshire are ranked in the top 10 of all local authorities with the highest rates of children being killed or seriously injured on roads.
	**Education** Access to a high-quality education will reduce inequalities in educational outcomes and enable children to maximise their capabilities and have control over their lives.	• An estimated 1,840 (6.2%) young people are not in education, employment or training in South Yorkshire. • 30% of children were deemed to not have achieved the expected level of development at the end of reception.
	**Jobs** Being in good work is good for both physical and mental health/wellbeing	• 73% of South Yorkshire residents aged 16-64 are in employment, this is significantly lower than the England average • The average weekly earnings are only 91% of the England average. • The main reason for sickness absence is MSK– 19% of over 16s report having a long term MSK problem.
	**Inclusive work** To ensure everyone can benefit from the protective factors of being in good work, labour markets should be inclusive and diverse so everyone can access good work with fair pay	• There is a 12 percentage point gap in the employment rate between those with a physical or mental long term condition and the overall employment. This is even worse for those with a learning disability, where the gap is 66% • Those from non-white ethnic minority groups are less likely to be in employment, similarly employment levels are lowest in those in the most deprived areas and those aged 50-64.
	**Crime and violence** Crime is both a risk factor for health and an outcome from a number of other social determinants of health: crime can lead to both the short term effects which can be severe but it can also lead to long term problems such as depression or anxiety-related illnesses and; crime itself has its own risk factors	• There were approximately 46,000 violence offences reported, a rate of 33 offences per 1,000 population, this is higher than the value for England (29 per 1,000). • The rate of deaths to drug misuse was 7.6 per 100,000, that's nearly 300 deaths due to drug misuse (in a three-year period).
	**Air pollution** Poor air quality is the largest environmental risk to public health in the UK as long-term exposure to air pollution can directly result in long term conditions as well as exacerbate conditions leading to hospitalisation.	• Approximately 5% of all deaths are attributable to air pollution. • It is estimated that 200,000 residents of South Yorkshire live in areas that are vulnerable to air pollution

Health conditions amenable to prevention

We have a good understanding now of the main contributors to premature mortality in South Yorkshire. They are cardiovascular disease, cancer and respiratory disease. Inequalities in the wider determinants, risks and behaviours are strongly associated with poorer outcomes. The principal risk factors associated with the main causes of death and ill health are smoking, high blood pressure, diet, obesity and alcohol. South Yorkshire has higher than national rates of these common, but modifiable, risk factors.

Key numbers:

- 14% of population are recorded to have high blood pressure and 7% diabetes
- Rates of deaths from stroke are twice that in the most deprived group than least deprived group.
- Admissions for pneumonia in all 4 places are some of the highest in the country
- Early detection of cancer is most important factor for outcomes, only 51% of cancers are diagnosed early, which is much less than the national target of 75%



The health of groups vulnerable to inequalities

Smoking, poor diet, physical inactivity and harmful alcohol are drivers for early onset of illness and death in South Yorkshire. But people's ability to adopt healthy behaviours is strongly shaped by the circumstances in which they live.

Inequalities in the wider determinants of health; housing, environment, education, jobs and the modifiable risk factors (smoking, healthy weight, alcohol) often cluster in individuals and communities, compounding their overall risks of poor health.

The cost-of-living crisis means many more children, young people and adults in South Yorkshire will be living in poverty. Cuts in income combined with increased costs of living also means for many not being able to eat, heat their homes or keep clean. This impacts on immediate health and ability to access health and care services and support and increases the risk of illness in the short and longer-term health. Poverty impacts on health through the wider determinants, affecting educational outcomes, life chances, choices and opportunities. By having to focus on their immediate needs and threats, people living in poverty may make decisions that are damaging for their health in the longer term.[2]

[2] How poverty affects people's decision-making processes Jennifer Sheehy-Skeffington and Jessica Rea 2017 JRF

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 poverty, violence and complex trauma. This may be experienced, for example, by people who experience homelessness and drug and alcohol dependence. It may also be experienced by vulnerable migrants, Gypsy, Roma and Traveller communities. 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. Further compounding their inequalities in health.

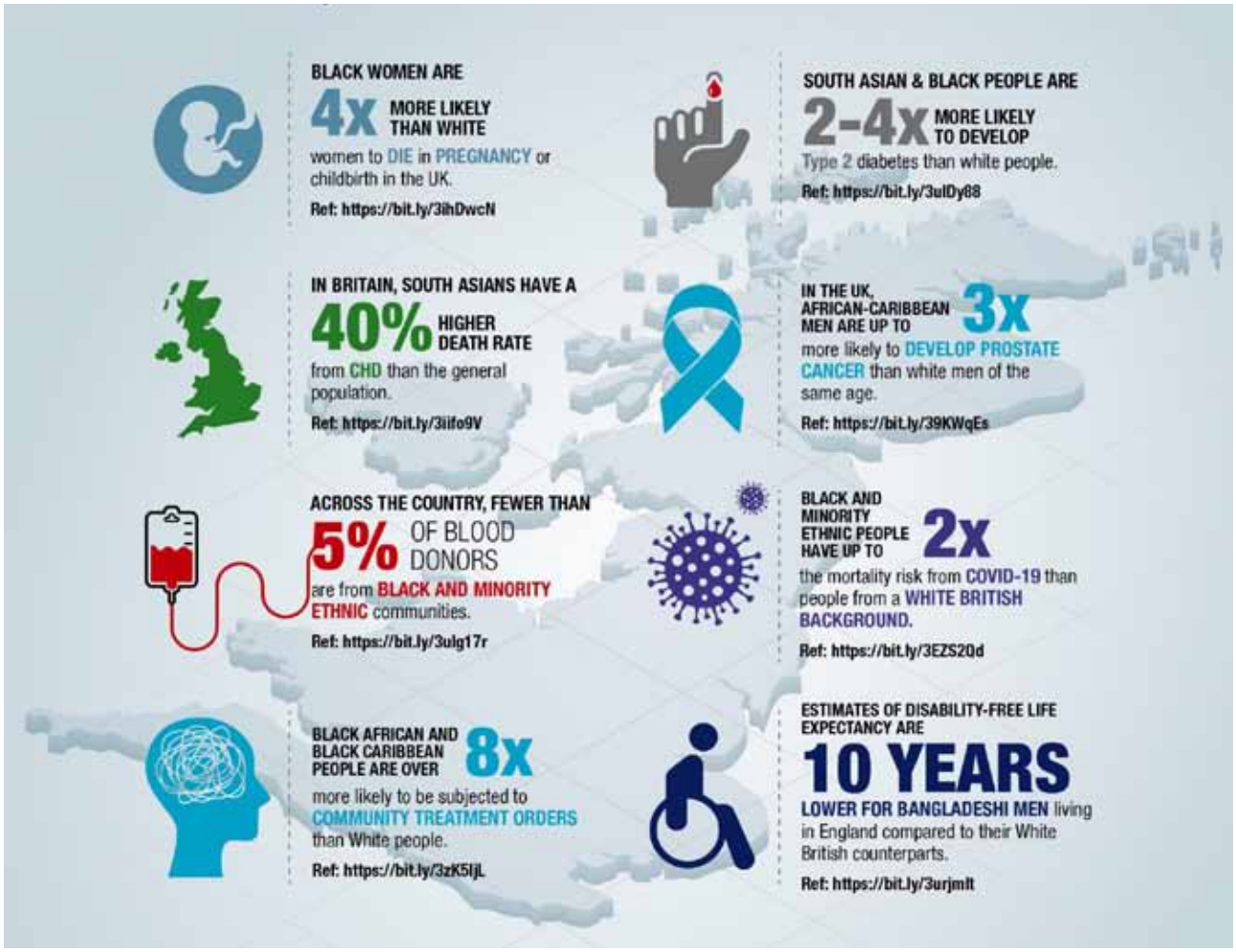
The Covid pandemic has brought to the fore the health inequalities experienced by people from Black and minority ethnic groups in the UK. The recently formed NHS Race and Health Observatory concludes that the health of ethnic minority patients has been negatively impacted by inequalities in access to, experiences of, and outcomes of healthcare and that these longstanding problems in the NHS are rooted in experiences of structural, institutional and

Key Facts:

- People from Black and minority ethnic groups are disproportionately affected by socio economic deprivation
- People with severe mental illness are at greater risk of poor physical health and reduced life expectancy compared to the general population. On average men with severe mental health conditions die 20 years earlier, and women die 15 years earlier than the general population.
- People with a learning disability have worse physical and mental health and women with a learning disability die on average 18 years younger and men 14 years younger.

[3] NHS Race and Health Observatory. Ethnic Inequalities in Healthcare: A Rapid Evidence Review. 2022

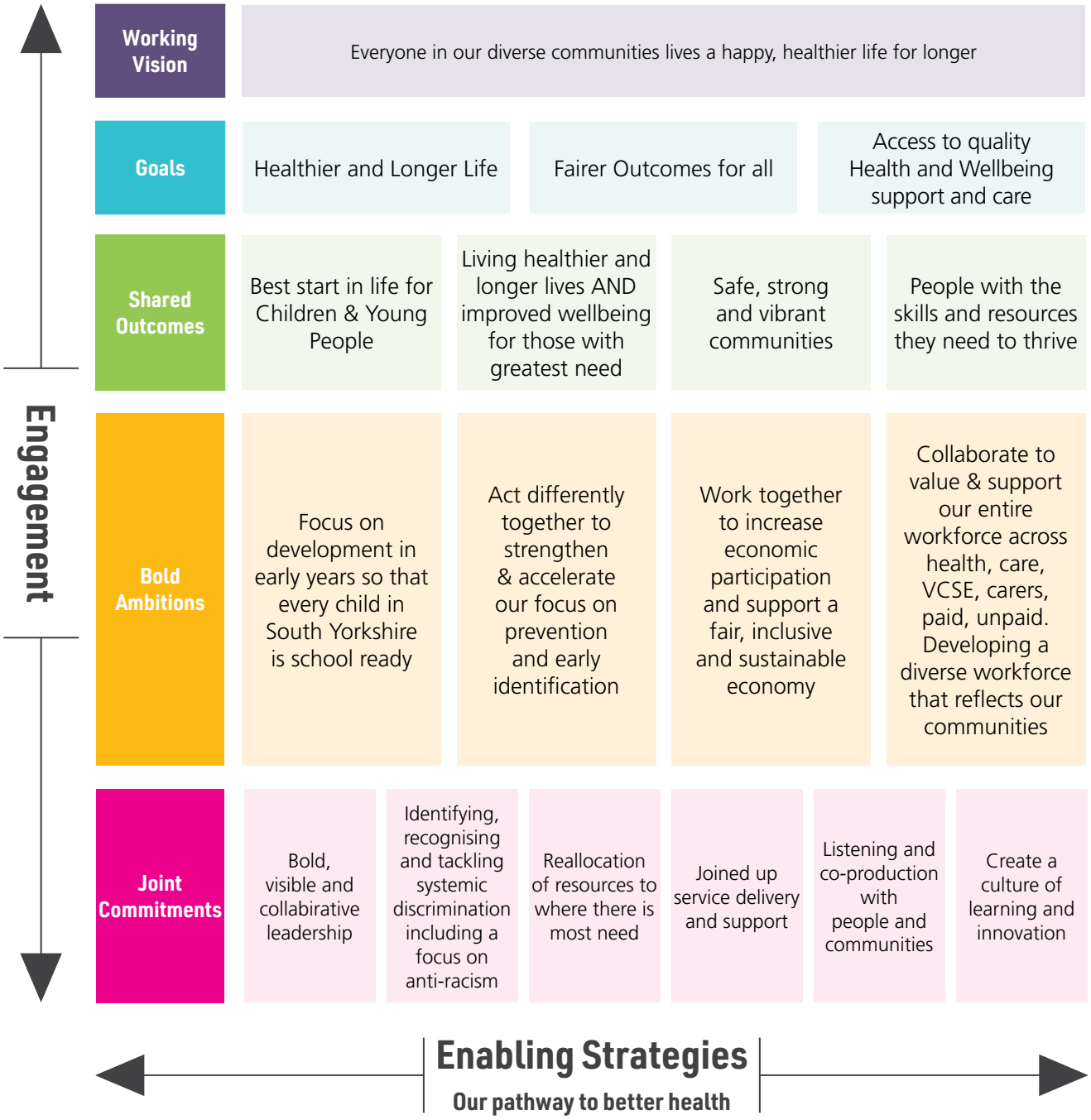
Figure Ethnic Health Inequalities in the UK Source: Ethnic Health Inequalities in the UK - NHS - Race and Health Observatory NHS – Race and Health Observatory (nhsrho.org)



6

Summary Plan on a Page

Our Shared Outcomes, Bold Ambitions and Joint Commitments



Across South Yorkshire and in each of our places we have existing, strong strategies and plans, these include our Health and Wellbeing Strategies, our Place plans, our 5 Year Health and Care Plan and our South Yorkshire Stronger, Greener, Fairer Strategic Economic Plan. It is not our intention in this initial Integrated Care Strategy to duplicate these but to build on them, setting out where, as a whole partnership working together, we can add value and support to go further faster on some of the more challenging and intractable issues to contribute to reducing health inequalities and improving healthy life expectancy.

Our intention is to:

- Ensure that we focus on what matters to people, including good access to high quality care and support, and to demonstrate we have listened we have identified this as one of our strategic goals.
- Amplify or give visibility to exemplars of best practice to support learning, sharing and adoption.
- Identify a targeted number of action focused **bold ambitions** which can only be achieved by the Integrated Care Partnership joining forces to practically align our collective power and influence to enable delivery at pace and at scale.

Our shared Outcomes are:

1. Children and young people have the best start in life
2. 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
3. People are supported to live in safe, strong and vibrant communities
4. People are equipped with the skills and resources they need to thrive

Our Bold Ambitions are to:

1. Focus on development in early years so that every child in South Yorkshire is school ready
2. Act differently together to strengthen & accelerate our focus on prevention and early identification
3. Work together to increase economic participation and support a fair, inclusive and sustainable economy
4. Collaborate to value & support our entire workforce across health, care, VCSE, paid, unpaid & carers and to develop

Our Shared Outcomes

1

Children and young people have the best start in life

I believe in empowering individuals to be self-sufficient and not wholly reliant on healthcare professionals but to take personal responsibility for their health. I believe in getting this right from school age.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Why is it important?

- The 1,001 days from pregnancy to the age of two set the foundations for an individual's cognitive, emotional and physical development[1]. Development in the early years (including in the womb) can have a lifelong impact on health and wellbeing, educational achievement and economic status.
- Childhood is the most important time for enabling the development of behaviours that will have a lifelong influence on health and wellbeing, including physical activity and healthy eating.
- As with adults, the wider determinants of children's health include socio-economic factors, housing, social networks and education. Poverty is a major social determinant and adversely affects children's life chances.
- In South Yorkshire a quarter of children live in poverty which is higher than the national average and the increasing cost of living is placing additional strain on many families in our communities. We have lower rates of school readiness, more children who are obese and the number of children who have dental caries is higher than the national average. In addition, evidence suggests that the pandemic has had a significant negative impact on children and young people and their mental and physical health.

Key Facts:

Compared to the national average, children in South Yorkshire are:

- Less likely to be breastfed at 6-8 weeks after birth
- Have slightly lower rates of school readiness (71% of children achieved a good level of development at the end of reception)
- More likely to be obese (37% of Year 6 and 25% of reception children are overweight or obese)
- More likely to have dental caries (830 admissions per 100,000 population, ages 0-5)
- More likely to die / be seriously injured on roads (37 deaths per 100,000 population of those aged 16 and under
- There were 212 hospital admissions per 100,000 as a result of self-harm in those aged 10-14 (180 of our children).

What are we doing about it?

- We are working in each of our places, with our Local Maternity and Neonatal Network and Children and Young People's Alliance to enable all our children and young people to thrive, have good physical and mental health, high aspirations and to ensure that they are able to maximise their capabilities to participate and contribute to society.
- We are enabling children and young people and their families to have a voice together with the information, tools and resources to manage their own health and wellbeing and to actively participate in how we improve and integrate services.
- We know that there is more we can do together to support families including the development of family hubs in South Yorkshire to ensure that all our children are well supported in their early years and are all school ready and enabled to maximise their potential.
- We are committed to supporting a reduction in healthcare inequalities, using the new Core20Plus 5 framework adapted for children and young people. The 'Core20' is the most deprived 20% of the national population as identified by the national index of multiple deprivation. The plus groups include ethnic minority communities; people with a learning disability, autistic people; people with multi morbidities; and those with protected characteristics. Specific consideration is given to young carers, looked after children, care leavers and those in contact with the justice system.

  As part of the framework five clinical areas have been identified to be focused on by Integrated Care Boards and Integrated Care Partnerships and these are the key areas we are already working on:
  - Asthma
  - Diabetes
  - Epilepsy
  - Oral health
  - Mental health

- We are working together with the Mental Health Provider Collaborative to improve the support of our children and young people's emotional wellbeing and mental health responding to the ongoing impact of the covid pandemic.
- We know the association between exposure to adverse childhood experiences and poor adult outcomes is heightened in looked after access to services and the children therefore we are working to support all our looked after children to enable them to achieve academically and develop the capabilities to maximise their potential.
- Children's social care services are supporting families to stay safely together, with a focus on early help, access to services and preventing them from reaching crisis point.

As a South Yorkshire Integrated Partnership, we will:

- Act swiftly together to galvanise all partners, including partners in education and childcare settings, to deliver our bold ambition to focus on development in early years so that every child in South Yorkshire is school ready.
- Ensure, through our Place Partnerships, Local Maternity Network and Children's and Young People's Alliance that the voice and insights of families, children and young people are central to strengthening our understanding of their needs and enable changes to services to be co-produced.
- Through our Place Partnerships and Local Maternity Network, working closely with our communities, the Maternity Voices Partnership and VCSE, enhance maternity care, to decrease inequalities in maternal and neonatal outcomes.
- Building on existing relationships and multi-agency collaboration, take a strengths-based and coordinated approach to establishing family hubs across South Yorkshire, which have a focus on supporting families with the greatest needs.
- Through our Place Partnerships and Children's and Young People's Alliance, enable all our children to have the information, knowledge, skills and confidence to have good physical and mental health so that they are able to increasingly manage their physical and mental health and wellbeing, maximise their capabilities and have choice and control over their lives.
- Through our Place Partnerships and Mental Health Provider Collaboratives, take action to improve support and access to mental health and wellbeing services for children and young people.
- Maximise the benefit of the Harvard Bloomberg City Leadership Programme for South Yorkshire focussed on Health Inequalities

Our Shared Outcomes

2

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

To live a healthy, long life I want support maintaining my general health and mobility; access to fitness classes that suit me; confidence in my GP; suitable housing, preferably near a family member in case support is needed; enough money to eat reasonably healthily and to heat at least one room of my home.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Why is it important?

- People in South Yorkshire are living shorter lives than they should. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.
- People in South Yorkshire deserve better health and wellbeing.
- We want all citizens of South Yorkshire to benefit from an improvement in their health and wellbeing. We need to ensure that those with the greatest needs and /or most at risk from health inequalities see the biggest and fastest improvements.
- Creating the conditions for good health and wellbeing is key to prevent problems from arising in the first place
- But where problems do arise, we need to focus on preventing them from escalating further, so that people can live happy, healthy, and fulfilling lives for as long as possible.
- Creating good health and preventing ill health is better for people, better for services and better for the planet.

What are we doing about it?

To help improve physical and mental health and wellbeing and to reduce health inequalities action is being taken on a range of fronts:

- Partners are working together in every place with communities to take actions to improve the wider determinants of health such as education and skills, housing, employment opportunities, neighbourhoods and communities, air pollution, climate mitigation and adaptation.
- Place based Partnerships, including the Voluntary Community and Social Enterprise (VCSE) sector are working with communities to support a strengths-based approach to the development of vibrant communities (see later sections)
- Targeted actions are being taken on the main risk factors for the conditions that are leading to premature death – smoking, alcohol, obesity and hypertension. For example, each Place is working to reduce access to tobacco and support people to stop smoking and all Trusts in South Yorkshire are implementing the QUIT Programme.[4] Place Partnerships and the Children and Young People's Alliance are working with schools to promote healthy weight for children and young people.

[4] www.sybics-quit.co.uk

- Healthcare services are taking steps to identify earlier, and improve the clinical management in line with evidence, of the three main diseases that contribute to our premature mortality – cardiovascular disease (heart disease and stokes), respiratory disease and cancer - and of their risk factors (such as high cholesterol, high blood pressure and diabetes).
- We have a well established Cancer Alliance that is leading the way with its focus on health inequalities and early diagnosis using behavioural science techniques, working in partnership with communities, primary care and the voluntary sector.
- We also have regional Clinical Networks for Cardiovascular, Diabetes, Stroke and Respiratory Disease. Our places are all actively involved in delivering prevention and management initiatives linked into these Clinical Networks.
- Place Based Partnerships and the Mental Health Provider Collaborative are working with communities and people with lived experience to improve mental wellbeing, by promoting the importance of mental health throughout every stage of life, identifying those at risk of poor mental health and reducing the factors that contribute to this, including social and economic factors.
- Proactively enabling early intervention to prevent more serious difficulties and preventing suicide. Supporting people with mental ill health to have better physical health and working with primary care to enhance the annual physical health check for people with serious mental ill health.
- Mental Health Trusts now have specialist Tobacco Treatment Advisors who are helping put people in contact with secondary care mental health stop smoking services.
- Adult social care services are helping people to live the life they want while keeping safe and well in their local communities, guided by the 'Making it Real' Framework[5] focusing on what matters most to people.

[5] Making it Real - Think Local Act Personal

- We are being guided by what is important to people, we know that this includes access to services, seeing the right professional, at the right time and getting the right support when they need it. To enable this, we are working together to improve access to services, understand and remove barriers and enable the integration of care. For example Places are developing multidisciplinary teams, bringing together Primary Care Networks, community services, specialist community teams, social care and the VCSE sector.
- We have an effective health protection programme in South Yorkshire and will continue to work with the UK Health Security Agency (UKHSA) and NHSE to deliver health protection, including maximising delivery of routine adult and childhood vaccination programmes and ensuring effective delivery of covid and seasonal flu vaccination programmes. We will also continue to support delivery of health protection through Local Authorities, eg environmental health protection, outbreak management and addressing air pollution.
- Places are increasing their focus on addressing ethnic health inequalities. For example improving access to social prescribing for ethnic minority communities.
- Partners are also developing their approach to the use of data and information from patients and communities to more effectively identify individuals and communities who are at risk or are experiencing poor health outcomes and adapting the way care or broader interventions are delivered to improve patient experience, access and outcomes. For health care services, this is known as taking a population health management approach.
- While progress is being made, if we are to prevent people living in South Yorkshire from having many years in poor health or from dying too early, we need a step change in the focus on wellbeing, prevention and the early identification and management of physical and mental ill health.

As a South Yorkshire Integrated Care Partnership we will

- Through our Place Partnerships, Collaboratives and Alliances, ensure that community voice and insights are central to strengthening our understanding of our population needs and enable changes to services and local programmes to be co-produced with local communities and people with lived experience.
- Work through our Place Partnerships with local communities and the VCSE as equal partners to support local geographic and other communities to identify and address what matters most to them and ensure that prevention interventions are coproduced with local communities, delivered, and funded at sufficient scale to have real impact.

- 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.
- Work together to ensure that people of all ages have the information, knowledge, skills and confidence they need to manage their physical and mental health and wellbeing, have choice and control in their own lives, and are able to use their skills, knowledge and experience to benefit the wider community.
- We will act differently together to deliver our ambition to strengthen and accelerate our focus on prevention and early identification. This will include a focus on improving access and the quality of care and support to reduce inequalities in access, experience and outcomes.
    - This will mean focusing on the: Four main modifiable risk factors – smoking, healthy weight, alcohol, and hypertension
    - Early identification and management of the three main causes of early death and unwarranted variations in care in South Yorkshire – Cardiovascular, Respiratory Disease and early diagnosis of Cancer.
- We will enhance rehabilitation for patients prior to cancer therapy and rehabilitation for people with cancer, cardiac and respiratory diseases and stroke. By doing this we can help to delay the onset of multimorbidity and frailty as well as premature death.
- We will take a personalised approach to support those living with multiple conditions and those with life limiting conditions, enabling choice and control and supporting end of life planning.
- We will work with communities and people with lived experience to improve mental health and well-being and to remodel and integrate mental health services to have a strong focus on prevention, early intervention, resilience and recovery and continue our focus on reducing suicides.
- We will work together to challenge mental health stigma and promote social inclusion and social justice for everyone affected by mental illness.
- We will work with:
    - People with serious mental health conditions and those with learning disabilities and autism to improve their physical health.
    - People with serious physical long-term conditions to enable them to have good mental health.
    - Ethnic minority communities to support improvements in physical and mental health

- NHS partners will commit to increase the focus on reducing inequalities in healthcare using the 'Core 20 Plus 5' an NHS England health inequalities framework to support local health services to focus action on:
    - People living the most deprived neighbourhoods (Core 20).
    - Locally identified priority groups (Plus). Our Places each identified their priorities groups. Examples include people from ethnic minority heritage, Gypsy, Roma and Traveller communities, asylum seekers, people with learning disabilities, homeless, LGBQTrans communities.
    - Five clinical areas that will impact significantly on health inequalities if we accelerate improvement: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension and high lipids.
    - Decreasing smoking.

- We will increase our joint use of data and information to identify those at risk to target improvements in care, treatment and support. This is taking a population health management approach and will help us to support those who need it most.

Our Shared Outcomes

3

People are supported to live in safe, strong and vibrant communities

My health and wellbeing are severely affected by the environment in which we live. Clean air, green space access, safer roads, installation of renewable energy sources in public areas, improved public transport locally, more of it at affordable prices to encourage use.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Why is it important?

- We have many strong, proud and vibrant communities in South Yorkshire, but many communities have seen the decline of their local economy and of their community assets and through this they experience a lack of connectivity to education, employment and opportunities.
- The physical environment where people live and work and how safe they feel in their communities are important in creating good health and health outcomes.
- People living in places with poor quality housing, high air pollution and traffic volumes, poor access to green space and poor active travel and public transport links to jobs, services, family and friends and leisure are far more likely to experience poorer health outcomes. These differences in the quality and liveability of our communities and local places are key contributory factors to the health inequalities we see across South Yorkshire.
- Living in poor quality housing, or homes that you are unable to heat is known to contribute to both physical and mental health problems. We know that this is an issue in South Yorkshire, with the latest published data (2020) estimating around 18% of South Yorkshire homes were experiencing fuel poverty. This is significantly worse than the England average, and likely to have increased considerably with increasing cost of living challenges.

What are we doing about it?

- Health and Care Partnerships in every place are working together to address these wider determinants and support community development. They are enabling the growth of community infrastructure, working to increase access to physical activity in communities, working closely with the VCSE sector and with communities to enable use of our estate.
- Place Partnerships are also working together to ensure sufficient warm, sustainable and affordable housing is built across South Yorkshire and linking housing improvement programmes to public health and wider social care agendas. Places are also aligning services for those with cold homes to address the key drivers of fuel poverty, income, energy efficiency and fuel prices.
- In each place organisations are working to leverage their local economic power to help create more accessible jobs for people in our communities and retain more of our public sector spend within our local areas to deliver additional social value for local people, including building wealth within our local communities through progressive procurement strategies. Progressive procurement is about making it easier for potential suppliers to bid for opportunities and to offer their goods and services to public sector organisaitons in a way that it benefits the local communities.
- Places are taking a strengths-based approach to build on the skills and strengths in different communities to enable positive and sustainable improvements.

- Places are working with local people and the VCSE sector to find solutions to local issues. Taking an asset-based community development approach is important in creating vibrant communities in which people feel happy, safe and proud. Putting more power and control in the hands of local people and local organisations helps to build stronger communities.
- This on the ground approach is enabling us to create more connected local communities. Being part of and feeling like you belong to a connected and resilient community, with opportunities to be physically active and participate in arts and culture, all contributes to people's mental as well as physical wellbeing.
- Work is underway to enable access to green space, leisure and sport facilities in our local communities, and to also enable access to cultural and creative opportunities all of which positively contribute to health and wellbeing.
- Strengthen our action on climate mitigation and adaption to unlock co-benefits for health and reduce health inequalities

As a South Yorkshire Integrated Care Partnership, we will:

- Through our Place Partnerships, Collaboratives and Alliances we will actively support strength based community development, work to enable access to green space, cultural and creative opportunities and ensure decisions are made as close to communities as possible.
- In doing so we will promote physical activity and enable participation in meaningful activities to increase connectivity and reduce loneliness.
- Work through our Place Partnerships with local communities and the VCSE as equal partners to support local geographic and other communities to identify and address what matters most to them and co-produce solutions that address issues and enable community development in a way that contributes to safer, stronger more vibrant communities.
- Support the work in each place to ensure that sufficient warm sustainable and affordable housing is built across South Yorkshire and linking housing improvement programmes to public health and wider social care agendas, maximising the opportunities of working together across South Yorkshire where it makes sense to do so.
- Through our Place Partnerships, Collaboratives and Alliances, and together with our communities to harness our collective role as anchor institutes to aid community development.
- Use our ability as a partnership to share learning and influence wider partners so that all are able to act as an advocate for safer and stronger communities.

Our Shared Outcomes

4

People with the skills and resources they need to thrive

My health is dependent on my financial stability. If I can afford to heat my home, eat well, socialize, and commute to work safely then I am starting from a good foundation.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Why is it important?

- We know that being able to keep well, have choice and control and feel able to manage your own health and wellbeing is important to people in South Yorkshire. Equipping people with the skills and resources they need is vital so people have the information, knowledge, skills and confidence to keep well, manage and improve their own health and wellbeing and know when to seek support.
- To have a healthy society we need a range of building blocks in place as already described, these include stable jobs with good pay, quality housing and education. As outlined socioeconomic factors such as education, employment and income all impact on our health and wellbeing.
- Together with a focus on the first 1001 days access to high-quality education will reduce inequalities in educational outcomes and enable children to maximise their capabilities and have control over their lives. It is also important that learning opportunities are available for adults of all ages to develop the skills and qualifications needed for employment and progression.
- Equipping people with the skills and resources they need to thrive, through formal education, informal life-long learning, adult and community education, enables people to maximise their potential, participate in their communities and secure stable employment or contribute in other ways. It also equips people with the ability to research, ask questions, think critically, be curious and access/find the information and knowledge they need about how to manage their own health and wellbeing behaviours, supporting the wider prevention agenda.
- Being in work is good for both physical and mental health and wellbeing. Currently 72% of South Yorkshire residents aged 16-64 are in employment and this is significantly lower than the England average. Sheffield has one of the lowest rates in the country at 69%. As well as having less people employed in South Yorkshire the average weekly earnings are only 91% of the England average.
- Sickness absence in South Yorkshire is also higher than England. Doncaster has one of the highest rates in England, at 3.1%. There is a relationship between health and productivity, healthy people are more productive in the workplace.
- Affordability has been identified by people in South Yorkshire as an area of challenge and a barrier to enabling them to manage their health and wellbeing. It is anticipated that this will increase further as the cost of living increases, resulting in more children, young people and adults in South Yorkshire living in poverty.

What are we doing about it?

- The South Yorkshire Mayoral Combined Authority is working with partners to enable delivery of the South Yorkshire Stronger, Greener, Fairer Strategic Economic Plan. The Strategic Economic Plan (SEP) sets out local leaders' blueprint to drive our post covid recovery and to transform South Yorkshire's economy and society for people, businesses and places. We are already working to develop an inclusive and sustainable economy. "An inclusive and sustainable economy is one that works for everyone, with no one being left behind. It also protects the needs of future generations by ensuring that these can be met within the means of our planet"
- To enable this, labour markets need to be inclusive and diverse so everyone can access good work with fair pay. The South Yorkshire Skills Strategy which is in development will help support lifelong learning and develop people with the appropriate skills to support the economy. Life-long learning and skills development is important at all ages and in ensuring that people working in unsustainable industries are able to transition into quality, good, green jobs.
- Health and care services are working together to enable people to have the information, knowledge, skills and confidence to improve their health and wellbeing and feel confident about taking control and looking after themselves. Healthy engaged people are more able to work and are more productive in the workplace and thus able to contribute to wider economic prosperity.
- Places are working with communities and the VCSE to understand what matters most to people in our communities and what we can do to help to mitigate the negative health and wellbeing impacts of the increasing cost of living, e.g. ensuring they have a single point of contact and streamlined access to welfare advice and support.

As a South Yorkshire Integrated Care Partnership, we will:

- Strengthen our work together to ensure everyone in South Yorkshire can benefit from being in good work by harnessing the collective power of our anchor institutions and supporting the development of our health and care workforce.
- Take action with our partners to support those that may traditionally find it difficult to get into or stay in work or find other fulfilling ways to make a meaningful contribution, such as those with a physical or learning disability, or a long-term health condition. In South Yorkshire we have schemes in place such as Working Win, but we know we can do more to make a difference.
- Actively promote the development of inclusive labour markets by focusing on work and health, including local recruitment, supporting people to enter and stay in work, especially those with physical and mental health conditions, inclusion groups & in greatest need to address health inequalities.
- Partner with Education and skills providers who offer skills development at all stages of the life-course, in both formal and informal learning settings, to enable people to develop the skills and acquire the knowledge and understanding to look after their own health and wellbeing where possible
- Amplify, sharing learning and actively support the work underway in each of our places with local communities and the VCSE sector to reduce the impact of the increasing cost of living on people living in South Yorkshire, especially for those in the greatest need. Work together to understand those most at risk and to mitigate the impact of cost of living on access to health and care services and support.

Being able to flex my employment around my health needs is the most incredible gift and I cannot thank my employer enough for that, I've had jobs in the past where disability and health have always been a barrier in the workplace but where I currently work the culture and support available is genuinely the best I could ask for.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

I think having a decent standard of living in many aspects such as financial health, whilst taking responsibility for own health is of upmost importance. Finance and health are linked in such a way where you can afford to eat healthy foods, something that has become a challenge in recent months. Everything is interlinked with Mental and Physical Health as well.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Bold Ambitions

This 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. This 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 next step is to do the work to agree together the specific actions we need to take to deliver on these ambitions.

1	**Focus on development in early years so that every child in South Yorkshire is school ready**
	Raise the level of school readiness in South Yorkshire and close the gap in those achieving a good level of development between those on full school meals and all children by 25% by 2028/30
2	**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
3	**Work together to increase economic participation and support a fair, inclusive and sustainable economy**
	Reduce the economic inactivity rate in South Yorkshire to less than 20% across our places by 2028/30
	Reduce the gap in the employment rates of those with a physical or mental health long term condition (as well as those with a learning disability) and the overall employment rate by 25% by 2028/30
	Enable all our young people that are care leavers 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
4	**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 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.

The Voluntary, Community, Faith organisations need support (funding, training & support etc) to support local community members around health & wellbeing

Joint Commitments

To enable successful delivery of our strategy requires us to do things fundamentally differently for our communities. Our commitments underpin delivery of our Integrated Care Strategy.

They are:

- To be **bold, generous, visible and collaborative in our leadership** for the people of South Yorkshire, doing things differently being courageous and taking risks where it improves outcomes or reduces health inequalities.
- To **identify, recognise, and tackle systemic discrimination together** with a focus on anti racism
- To **reallocate our resources to where there is most need** and where they can have the greatest impact on population health outcomes. This means reducing duplication, investing differently and earlier in people's lives. It means reallocating our collective resources towards prevention and those people and areas with the greatest needs.
- To **join up service delivery and support** between health and social care and VCSE where it makes sense to do so in our places and across South Yorkshire
- To **listen** and facilitate **co-production with people and communities**
- To **create a culture of learning and innovation**, where best practice is shared confidently and adopted quickly across communities, places and South Yorkshire as a whole.
- Develop and deliver **inclusive enabling strategies which** support delivery of our strategy **to better health**

What do we mean by these commitments?

Bold Collaborative Leadership

- As a Partnership we are making a joint commitment to bold, visible and collaborative leadership which embraces and empowers leaders at all levels and across all partners working within a distributed leadership model.
- We will harness the power of our collective leadership across the Partnership, including VCSE. We will take an inclusive approach to develop leaders at all levels to reflect the communities we serve and develop a eadership culture which is inspiring and courageous.

Identify, recognise and tackle systemic discrimination with a focus on anti-racism

- As a Partnership we are making a joint commitment to identify, **recognise and tackle systemic discrimination with a focus on anti-racism**. We will identify and make systematic discrimination visible and work together to create the conditions to address it and to ensure fair and inclusive treatment and engagement.
- We are committed to supporting health and care systems, change levers and management leadership behaviours to tackle ethnic health inequalities and promote quality of care, safety, compassion and **a fairer experience** for patients, NHS staff and diverse communities alike.

Reallocate our resources

- As a partnership we are making a joint commitment to **reallocate our resources to where there is most need** and where they can have the greatest impact on population health outcomes. This means reducing duplication, investing differently and earlier in people's lives. It means reallocating our collective resources towards prevention and those people and areas with the greatest needs.
- To deliver this Strategy we know that we will need to be more flexible with the use of our financial resources, rebalancing our spend towards prevention and those with the greatest needs to address health inequalities. This will mean collectively challenging ourselves as partners to operationalise a different approach to allocating our resources. We are committed to working through this together, understanding each other's differing financial regimes, the national constraints we need to operate within and considering what we can do differently, including the scope of our pooled budget arrangements.
- We will continue to strive to make best use of our financial resources, to ensure value for money and work towards a financially sustainable health and care system.

Joined up service delivery & support

- As a Partnership we are making a joint commitment to joined up service delivery and support. Through our engagement work we know that people really value access to high quality health and care services that are easy to navigate, personalised and joined up in their delivery. In every place in South Yorkshire, we are already working to join up service delivery and support by integrating health and care services. General practices are working together as Primary Care Networks, with community health services, mental health, social care, community pharmacy and the VCSE sector. They are working together to integrate health and care services through the creation of integrated multidisciplinary neighbourhood teams. To deliver more preventative and personalised care, treatment and support for people in their local communities.
- Across South Yorkshire Better Care Fund Plans supported integration by enabling joint planning and pooled budgets between NHS commissioners and Local Authorities. Section 75 is a key tool to enable integration and is well utilised in South Yorkshire. Through the Better Care Fund, we have enabled people to stay independent for longer and improved our hospital discharge pathways and reablement services.
- There is still much more we can do to better integrate health and care services, physical and mental health services in each place working with our communities, the VCSE and our developing Provider Collaboratives and Alliances. By joining up service delivery and support we will be able to better meet the needs of individuals and communities in South Yorkshire.

Listening and co-production with people and communities

- As a partnership we are making an ongoing commitment to listen consistently to, and collectively act on, the experience and aspirations of local people and communities.
- We will work creatively and accessibly to reach those whose voices / views / opinions/ experiences that are underrepresented, seldom heard, too often ignored or not sought, working closely with the Voluntary Community and Social Enterprise sector (VCSE) and using flexible methods.
- Understanding the insights and diverse experiences of people and communities from across South Yorkshire is essential to help us build on all the strengths within those communities, enabling us to co design services to address health inequalities and the other challenges faced by our health and care system and our places.

Creating a Culture of Learning and Innovation

- In South Yorkshire we want to create the conditions for a high learning and sharing health and care system, where best practice is shared confidently and adopted quickly across communities, places and South Yorkshire as a whole.
- We want to work together to strengthen our approach to research and innovation and bridging the gap between new knowledge, research and implementing evidence of what works to improve for all our local communities. There are a number of healthcare research and innovation organisations that operate in South Yorkshire that we are already connecting with, including University of Sheffield and Sheffield Hallam University and we have also partnered with the Academic Health Science Network to establish an Innovation Hub.
- We are committed to further forging partnerships between the NHS, Universities and Industry to contribute to improving the health and wellbeing of people living in South Yorkshire. Our aim is to:
    - Increase the pace of adoption and spread of impactful innovation
    - Make data, research evidence and insights more accessible
    - To support researchers and innovators and remove obstacles for those with potentially impactful solutions for health and care
- The South Yorkshire Integrated Care Partnership provides a refreshed opportunity to advocate for increased focus for innovation and research in the primary and social care sectors and explore new opportunities for socially focused research on challenges experienced by our communities, including the wider determinants of health.
- We will develop and use plans for an Academy for Population Health and Health Inequalities as a platform to connect people working across all sectors of our health, care and VCSE system to raise awareness and share knowledge. The academy will develop the confidence and capability of our workforce to enable cultural change to facilitate better collaboration and integration with the intent of reducing health inequalities and improving the health of people across South Yorkshire.

7

How we will achieve our ambitions: Enabling plans and our partnerships

Inclusive Enabling Plans

Developing Our Workforce

- Our South Yorkshire health and care workforce is our greatest asset as an integrated care system. Over 72,000 people are employed across our NHS and care sectors, spanning over 300 diverse roles. In addition, our communities benefit from a strong Voluntary, Community and Social Enterprise (VCSE) sector. Our workforce has grown, but demand is now often outstripping supply and there are ongoing challenges which require us to work together differently as partners.
- In addition to our health and care workforce we also recognise the significant role of unpaid carers, which includes thousands of people providing unpaid care either in volunteering roles or as informal carers. Carers often experience poorer health outcomes themselves and report that the experience of care for their family member, and themselves could be improved.
- Across South Yorkshire we operate a well-established Workforce Hub. The Hub has been developed in partnership with Health Education England and is aligned to the NHS South Yorkshire. It delivers a range of workforce transformation programmes across health and care to support education and training, recruitment, retention, health and wellbeing, equality, diversity and inclusion, and new ways of working.
- It has been agreed with our partners to develop a workforce strategy for South Yorkshire. This will enable us to:
    - Ensure that our workforce feels valued and supported by health and care organisations in South Yorkshire and the system as a whole
    - Drive parity of esteem across sectors and develop a sense of belonging
    - Continue to support the health and wellbeing of our existing workforce
    - Develop our future health and care workforce, supporting local people to enter health and care roles, and those that may traditionally find it challenging to enter and stay in work, such as care leavers or people living with a physical or mental health conditions.

- Recruit and develop a workforce that reflects the diversity of the communities we serve
- Deliver the NHS People Plan ambition for more people, working differently, in a compassionate and inclusive culture and to ensure our workforce and staff find fulfilment and enjoyment in their work
- Progress shared development of innovative new workforce roles to meet emerging needs
- Deliver on our commitment to the Sheffield Race Equality Commission recommendation to become anti-racist employers by 2024
- Work with partners to address health inequalities, especially where protected characteristics have increased those inequalities
- Put in place programmes to support unpaid carers which are coproduced to meet their needs.

Quality and Quality Improvement

- Access to high quality health and care is consistently identified as a key theme that is important to people in South Yorkshire. We know that seeing this through a Health Inequalities lens is critical to delivery of our goal of Fairer Outcomes for All. Our approaches to Quality and Quality Improvement need to build on the principles of fairness and equity. We have embedded an approach to continuous improvement and delivery of high-quality services as a fundamental principle of our collective delivery. We are keen to build on this and to continue to embed a culture of continuous learning and improvement across our Partners.
- Our Partners are committed to delivering high quality services that meet the needs of local communities and are evidence based, and to do this through embedding the voice of our citizens throughout our work; an area we are already progressing through our System Quality Group and our broader delivery programmes. Engaging with the power in the voices of local people, listening to their needs and being driven by high quality, timely, information is core to our continuous development.
- As well as being driven by continuous improvement, we will be responsive in our approach to quality management and understanding the key risks across the systems, working together to respond to pressures across the system, embedding a supportive culture and using our collective experience and expertise to ensure we mitigate any risks to service delivery.
- We have set out a series of key principles for Quality which we deliver through the work of the partnership:
  - 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.

- As part of setting out our governance arrangements, we have embedded an approach to quality and monitoring, which will further develop to complement our work programmes and delivery of services. We recognise, within this, the important role of regulators including the Care Quality Commission (CQC) and Office of Standards for Education, Children's Services and Skills (OFSTED) in ensuring we meet requirements around safety and quality. We will continue to ensure that individually, and collectively, we work with agencies to learn and develop. This will include learning from good practices elsewhere both within and beyond the UK, embedding national policy and recommendations as well as learning from our local service delivery.

Improving Access to Services, care and support

- Access to health and care services is identified by people in South Yorkshire as important to them. Across health and care we know that there is variation in access and that there is more that we can do working with our local communities and VCSE to understand the barriers people face and how to enable these be overcome to facilitate more equitable access.
- Access to primary care is an area specifically identified. In recent years primary care has been challenged by increasing workload, both complexity and intensity and workforce challenges. The expectations of people and professionals are changing and with them the manner and scale in which services are delivered are being adapted, drawing on technology and digital solutions, balancing the need for face to face and remote consultations, whilst building capacity to enable us to meet increasing patient demand.
- The South Yorkshire Primary Care Provider Alliance brings together General Practice, Community Pharmacy, Dental and Optometry. It will develop a strategic plan for primary care which includes recommendations from the Fuller report published by NHS England. This will address the need to enable good access to services delivered at the right scale, whilst retaining the benefits of local neighbourhood services that offer continuity of care. NHS South Yorkshire will commission Community Pharmacy, Dental and Optometry services from April 2024, creating an opportunity to play to the respective strengths of the providers of primary care services, including addressing issues with access to dentistry, widening the range of services available through Ophthalmic Opticians and increasing the role of community pharmacies in providing services and support to local populations.

What matters to me about my health and wellbeing is getting care for me & my family in a timely way when we need it - be it an ambulance, a care home, a GP appointment.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

- Similar to the position nationally, waiting lists for hospital treatment in South Yorkshire have increased through the pandemic. Working through our Acute Provider Collaborative we have a strong focus on reducing waiting times. We are also working through Place Partnerships and our Urgent and Emergency Care Alliance to develop and implement plans for winter to increase capacity and support to deliver more personalised and preventative care and support for people in their own homes.
- The pandemic has also increased demand for mental health services, including children's and young people's mental health and neuro diversity services resulting in increased waiting times. We are working through our Place Partnerships and our Mental Health Provider Collaborative to take action to address this. Our aspiration is in line with 'No Wrong Door', NHS Confederation publication that sets out a vision for mental health, learning disability and autism services in 2032 is that there will be no wrong door to access quality and compassionate care and support.

Estates

- Health and care services in South Yorkshire are delivered in a wide range of buildings and hubs across our communities. An Estate Strategy for South Yorkshire was developed by NHS South Yorkshire during 2021/22. The Estate Strategy is working towards ensuring that we have modern, fit for purpose, sustainable and high-quality estate for the people in South Yorkshire. Its purpose is to demonstrate how our estate can be improved over time, for the benefit of patients, staff and the local community.
- We have been increasingly moving from a functional approach to managing our estate, to one which looks at the whole estate across South Yorkshire, building on the 'One Public Estate' approach and principles. The Estate Strategy embeds this approach and provides a strategic focus and added value via a collaborative and innovative approach to estates management, maintenance and efficiency; and strategic development and investment across the ICB footprint. It supports 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.
- Through this we are committed to taking a strategic approach to managing our estate to get the most out of our collective assets. That includes working with our communities to ensure that we plan and deliver integrated services that are in the right places and furthering our role as anchor institutions by supporting the use of our estate by VCSE and local communities contributing to social value.

Digital, data and technology

- In South Yorkshire we have an ambitious plan for digital transformation. Our vision is to promote and coordinate optimal use of digital tools, integration and interoperability of technologies (how technologies speak to each other and work together) to create a seamless digital experience for people and clinical staff with the aim of increasing safety, improving experience and reducing inequity.

- Our priorities are:
  - Working with communities VCSE and other anchor organisations / institutes to enable digital inclusion
  - Actively supporting improvements in partner digital maturity and digital transformation including delivery of electronic health records and shared care records. This will support joined up service delivery, improve access to data for health and care staff and improve reliability and cyber security.
  - Implementing transformative technologies for our public to remotely interact with their care record, use new remote monitoring technologies to access health and care services and manage their own health and wellbeing.
  - Develop a digital workforce strategy to improve digital and technical expertise and enable new ways of working.

- We are committed to working with partners to co create a high-quality intelligence service for South Yorkshire to enable better use of data to understand our population health needs and health inequalities. Practically this means:
  - Supporting development of a data-literate community across South Yorkshire to develop an insight-led health and care system.
  - Provision of a South Yorkshire data platform, collating not only health and care data, but information integral to understanding wider determinants of health.
  - Supporting, where legally appropriate, sharing of data and information with research partners
  - Expanding our analytical capability to use innovative tools, techniques and advanced analytics to deepen our understanding of outcomes and develop new integrated pathways of care.
  - Building a strong analytical community to promote sharing of data management and analysis skills and expertise across the system

What matters to me is staying healthy to enable me to stay independent and remain in my own home as long as possible.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Sustainability

- A Sustainability and Green Plan was launched by the South Yorkshire Integrated Care System in 2022. It sets out a programme of work that focuses action on a number of areas including estates and facilities, travel and transport, supply chain, medicines and adaptations, alongside workforce and digital. Local priorities were also identified, including primary care. The agreed programme of work set out in the South Yorkshire ICS Sustainability and Green Plan enables us to exploit synergies between partners.
- Climate change and population health are closely linked, the actions needed to promote sustainability and tackle climate change are also those that contribute to preventing ill health and improving population health. Taking a more preventative approach to health also can reduce health sector carbon emissions. Recognising this interdependence, as an Integrated Care Partnership we will collaborate with existing programmes of work and strengthen our commitment as partners to work together and with others to have a wider impact. By joining up our work to raise awareness, educate our workforce and progress initiatives to deliver sustainable travel, active travel, reduce air pollution and other sustainability initiatives.
- Action on climate and the environment also can improve health and reduce health inequalities through other mechanisms. For example improving the energy efficiency of homes results in warmer homes and helps reduce the cost of living, both which are related to better health outcomes and contribute to reducing health inequalities. The creation of good, accessible, green jobs could be targeted to those further away from the labour market and to those needing to transition from carbon intensive jobs.
- There are also many opportunities to boost the local economy collectively as anchor institutions by meeting South Yorkshire's net zero ambition, including the needs of the NHS, by supporting local innovation, local businesses and local jobs.

- Working with partners to support nature recovery will also benefit health by providing more options for nature connectivity for our communities and can also support climate adaptation by reducing flood risk and protecting against high urban temperatures.
- The NHS has committed to reaching carbon net zero. The Health and Care Act 2022 placed new duties on NHS to contribute towards statutory emissions and environmental targets. The South Yorkshire Mayoral Combined Authority and Local Authorities are moving at pace to develop tangible plans for how they tackle climate change, including the Mayoral manifesto commitment to establish a South Yorkshire Citizens Assembly for Climate Change and together this has fuelled our collective ambition.

Broadening & strengthening our partnerships

- As a Partnership we will only be able to achieve our bold ambitions and make progress in relation to our shared outcomes to improve the health and wellbeing of people living in South Yorkshire and reduce health inequalities if we work together as partners and broaden and strengthen our partnerships.

What matters to my health and wellbeing is having care systems that work for the patient. I have complex health needs so I need a health system that connects services together. In theory this happens but in reality it does not. I spend a lot of my time connecting the missing dots, sharing missed letters between professionals so we can have wider conversations about my health as one condition can affect another.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Working with our Voluntary, Community and Social Enterprise Sector (VCSE)

VCSE Sector in South Yorkshire

- South Yorkshire is home to over 6000 diverse VCSE organisations undertaking wide ranging activities and services that impact positively on the health and wellbeing of our communities. This includes small grassroots community associations, community groups, voluntary organisations, faith groups, charities, not for private profit companies and social enterprises.

How will we work in real partnership with VCSE?

- We hugely value the contribution of VCSE organisations to our health and care landscape, and the Integrated Care System is committed to embedding and strengthening the role of the VCSE sector as an equal partner in our work, fulfilling its potential to collaborate on strategy, delivery, engagement and insight.
- To enable and support this, we are working with our VCSE partners to develop a VCSE Alliance. The Alliance will enable VCSE organisations across South Yorkshire (and Bassetlaw where appropriate) to participate in system work in meaningful ways including networking, information exchange, co-designing new opportunities and participating in South Yorkshire level ICS meetings. The Alliance will connect with VCSE organisations and networks in our Places, and will be guided by a Steering Group of VCSE infrastructure leaders (please see diagram).
- A new VCSE and ICS Memorandum of Understanding describes our relationship underpinned by shared values, principles, responsibilities and priorities. This has been co-designed by VCSE partners and conversations with NHS and Local Authority partners and will be adopted in 2022/23.
- Our 'enabling' priorities for partnership working include strengthening our VCSE commissioning and investment approach, enhancing communications, and building a culture of parity of esteem.

What will we do together?

- We will build on successful work already underway such as social prescribing and identify new opportunities and potential for collaboration across our system partners and transformation priorities.
- We have started a conversation about how we value and support the workforce both paid and unpaid across all sectors in South Yorkshire and will co-design a new workforce strategy with voluntary sector partners.
- We will continue to utilise VCSE expertise in our work with VCSE, NHS and Local Authority partners to strengthen and support volunteering across South Yorkshire.
- We are scoping opportunities to understand how our voluntary sector partners can work with us to improve outcomes on a range of pathways including mental health, maternity and stroke.
- With our renewed commitment to enhancing population health and tackling health inequalities, we will harness VCSE expertise and knowledge of our local communities of geography and diversity. Building on our experience of and learning from collaboration during the Covid 19 pandemic, and as we look ahead to a cost of living crisis, this has never been more important.

Working with other agencies including Housing and Education

- Place Partnerships in South Yorkshire are already facilitating multi agency collaboration that enables consideration of the physical, social, structural and commercial environments people live in that directly impact on their ability to lead a healthy life.
- To enable children and young people to have the best start in life we will build on the existing relationships to strengthen our work with education providers. Education is a key factor that influences the health and wellbeing of children, young people. Not being in education increases the risk of a range of negative outcomes for young people. Increasing access to a high-quality education will reduce inequalities in educational outcomes and enable children to maximise their capabilities and have control over their lives.

- To enable people in South Yorkshire to live longer healthier lives we will build on our existing relationships with adult focused education providers, including through the development of the South Yorkshire Skills Strategy. Life long learning is important to enable people to develop the skills to work and for career progression so we will work with Life-Long learning delivery partners and the VCSE to ensure people continue to learn the skills they need to thrive in the fast-changing world of the 21st Century.
- We will also build on existing relationships with housing providers to support people to access the right housing support they need, as the quality of housing, house tenure and affordability are all linked to health and wellbeing.
- As a South Yorkshire Integrated Care Partnership we will strengthen multiagency collaboration through our Place Partnerships and facilitate work with other agencies across South Yorkshire where it adds value to do so. This could be on planning for cross boundary housing developments, engaging with communities and public transport providers across South Yorkshire to improve links, walking and cycling routes and further developing sustainable and active travel.

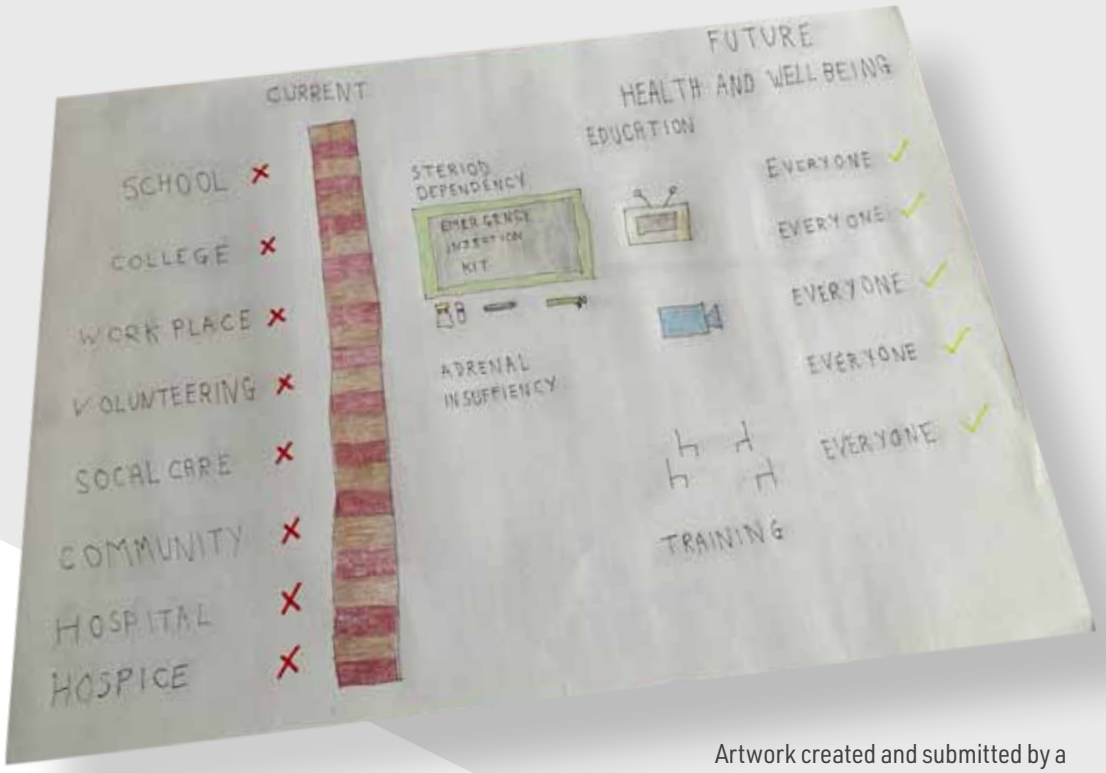
Harnessing our collective role as 'Anchor Institutions' - Working through our Partnerships to develop an Anchor System

- Health, Local Authorities, Universities and other large employing organisation in our communities are 'anchor institutions' which have an important presence in an area. This is usually through a combination of being largescale employers; the largest purchasers of goods and services; controlling large areas of land; and having relatively fixed assets. The term anchor is used because they are unlikely to relocate given their connection to their local community. They can make a real difference to social determinants and have a significant influence on the health and wellbeing of communities.
- In South Yorkshire we are committed to collectively harness our role as 'Anchor Institutions' across the NHS, Local Authorities, Universities, particularly maximising our collective contribution as large scale employers to support the health and wellbeing of our staff, develop the health and care workforce for the future, creating a more inclusive and sustainable economy.

8

Enabling delivery of our Integrated Care Strategy and measuring success

- To enable delivery of our Integrated Care Strategy we will develop a delivery plan overseen by our Integrated Care Partnership.
- The NHS South Yorkshire Five Year Joint Forward Plan to be developed by March 2023 will be a key delivery vehicle for our Integrated Care Strategy.
- We will also develop an outcomes framework to inform and monitor our progress towards our goals and vision.
- The framework will include the multiple levels at which we need to track our progress as reflected in this strategy. We will develop a dashboard to present the selected measures which will comprise:
    - an assessment of the health needs of the South Yorkshire population. This has been largely completed and was used as the basis of this strategy.
    - metrics that reflect the high level goals that underpin our vision
    - the ambitions we have set ourselves where we will work differently as an ICP
    - the metrics that reflect our shared outcomes. These are largely based on existing place plans and outcomes frameworks.
    - the measures and metrics (or proxy measures) that are used by each partner in the ICP to inform and monitor their input to our shared outcomes, ambitions and vision.
    - an initial set of proposed metrics are set out in the appendix but will be developed further alongside the progressing of the ICP and partner delivery plans to make sure our actions can be linked to the outcomes we want to achieve.

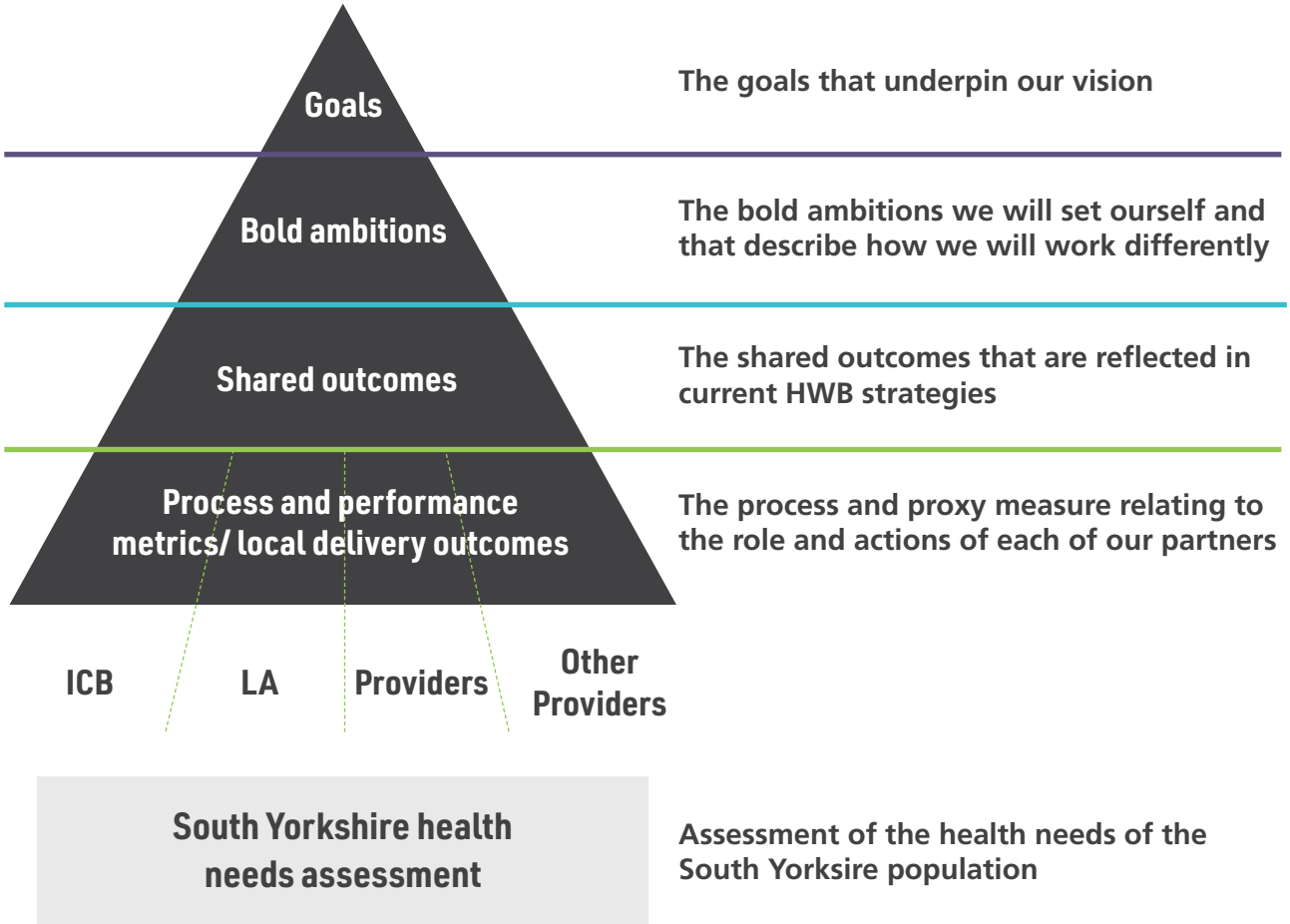


Artwork created and submitted by a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Having a work life balance is crucial to my health and wellbeing, working keeps me well as I love what I do, but on the flipside sharing quality time with my friends and family really makes my heart sing.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Figure 1 Proposed outcomes framework for South Yorkshire Integrated Care Strategy



My health is central to my hopes, ambitions and opportunities.

Quote from a South Yorkshire Citizen submitted as part of the What Matters to You exercise

Appendices

Full Engagement Report:
https://syics.co.uk/application/files/7516/7094/4690/Final_phase_2_report.pdf

South Yorkshire Population Health Needs Assessment:
https://syics.co.uk/application/files/2916/7084/0700/1._South_Yorkshire_Population_Health_Needs_December_2022.pdf

Developing our Outcome Framework:
https://syics.co.uk/application/files/5916/7084/0696/2._Developing_our_Outcomes_Framework_December_2022.pdf

Appendices

Strategy/Plan	Place	Link
Health & Wellbeing Strategies in South Yorkshire	Barnsley	Barnsley Health and Wellbeing Strategy 2021 – 2030:
	Rotherham	rotherham-joint-health-and-wellbeing-strategy (rotherhamhealthandwellbeing.org.uk)
	Doncaster	051115 i9 HWB_Strategy update 2015 Ap4.pdf (moderngov.co.uk)
	Sheffield	Joint Health Wellbeing Strategy 2019-24.pdf (sheffield.gov.uk)
Place Health and Care Plans	Barnsley	Barnsley Health and Care Plan Refresh 22/23
	Rotherham	Rotherham Integrated Care P Place Plan appendix.pdf
	Doncaster	DCCG-Place-Plan-Refresh-2019-22-web-FINAL.pdf (doncasterccg.nhs.uk)
	Sheffield	Shaping-Sheffield-Main-Doc-Final.pdf (sheffieldhcp.org.uk)
South Yorkshire Strategic Five Year Plan	South Yorkshire Strategic Five Year Plan	Five Year Plan (2019 - 2024): SYB ICS (syics.co.uk)
	South Yorkshire Green & Sustainability Plan	https://syics.co.uk/application/files/3816/6609/2460/NHS_SY_Sustainability_and_Green_Plan_V1.0_Sep_2022.pdf
South Yorkshire Strategic Economic Plan	South Yorkshire Strategic Economic Plan	SCR_SEP_Full_Draft_Ja (southyorkshire-ca.gov.uk)
South Yorkshire Housing Prospectus	South Yorkshire Housing Prospectus	Home I Yorkshire Housing

South Yorkshire Integrated Care Partnership Membership Nominations

	Barnsley	Doncaster	Rotherham	Sheffield	South Yorkshire Wide
Health and Wellbeing Board Chairs and other elected members	**Councillor Caroline Makinson**	**Councillor Rachael Blake** **Councillor Nigel Ball**	**Councillor David Roche**	**Councillor Angela Argenzio**	
Local Authority Chief Executive		**Damian Allen,** Chief Executive DMBC	**Sharon Kemp,** Chief Executive RMBC		
ICB Executive and Non-Executive Members					**Pearse Butler,** ICB Chair **Gavin Boyle,** ICB Chief Executive **Will Cleary-Gray,** ICB Executive Director of S&P **Christine Joy,** ICB Chief People Officer **David Crichton,** ICB Chief Medical Officer **Cathy Winfield,** Chief Nursing Officer **Wendy Lowder,** ICB Executive Place Director
Public Health		**Rupert Suckling,** Director of Public Health		**Greg Fell,** Director of Public Health	
Adult Social Care				**Alexis Chappell,** Director of Adult Heath and Social Care	
Children and Young People	**Carly Speechley**, Director of Children and Families				**Suzie Joyner.** Strategic Director Children services, Rotherham (TBC)

	Barnsley	Doncaster	Rotherham	Sheffield	South Yorkshire Wide
Voluntary Sector		**Dolly Agoro** co-chair Doncaster inclusion and fairness forum	**Kate Davis** CEX Crossroads, Rotherham	**Helen Steers** h.steers@vas.org.uk	
Hospitals	**Sheena McDonnell,** Chair - Barnsley Hospital		**Richard Jenkins,** Chief Executive Rotherham and Barnsely Hospitals		
Primary Care			**Dr Jason Page**		
Housing	**Kathy McArdle,** Service Director - Regeneration and Culture			**Juliann Hall** juliann.hall@syha.co.uk	
Education					
CMA					**Oliver Coppard** (Chair) Martin Swales
Workforce					
Mental Health	**Adrian England,** Independent Chair – Mental Health, Learning Disability and Autism Partnership				
	5	**5**	**5**	**5**	**10 (1 TBC)**

Glossary

ICS	**Integrated Care System**	Statutory Integrated Care Systems (ICSs) are being set up to bring local authorities, NHS organisations, combined authorities and the voluntary sector together with local communities to take collective responsibility for planning services, improving health and wellbeing and reducing inequalities.
ICP	**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 Sector and other partners. The ICP is set up to facilitate joint action to improve health and care outcomes and experiences across their populations and reduce health inequalities.
ICB	**Integrated Care Board**	An NHS organisation responsible for planning 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.
SYMCA	**South Yorkshire Mayoral Combined Authority**	A formal partnership of our four local authorities in South Yorkshire: Barnsley Metropolitan Borough Council, Doncaster Council (City of Doncaster Council from January 2023), Rotherham Metropolitan Borough Council and Sheffield City Council. It covers the same population and is led by an elected Mayor.
VCSE	**Voluntary, Community, Social Enterprise Sector**	VCSE sector is a term that refers to the voluntary, community and social enterprise sector, as all working with a social purpose.
LE	**Life expectancy**	**Life expectancy (LE)** is an estimate of how many years a person might be expected to live, whereas **healthy life expectancy (HLE)** is an estimate of how many years they might live in a 'healthy' state. Both of them are key summary measure of a population's health.
HLE	**Healthy life expectancy**	

Core20 Plus 5	**Core20 Plus 5 Framework**	The 'Core 20 Plus 5' an NHS England health inequalities framework to support local health services to focus action the most deprived neighbourhoods (core20), locally identified groups (plus) and Five clinical areas that will impact significantly on health inequalities if we accelerate improvement: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension and high lipids. Alongside decreasing smoking.
PHM	**Population Health Management**	Population health management (PHM) is an approach that uses data and insight to help health and care systems to improve population health and wellbeing, by identifying those individuals and communities who are at risk or are experiencing poor health outcomes and adapting the way we support and care or broader interventions are delivered to improve patient experience, access and outcomes.
BCF	**Better Care Fund**	The Better Care Fund is a programme that supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
CQC	**Care Quality Commission**	The Care Quality Commission, CQC is the independent regulator of health and adult social care in England
OFSTED	**Office of Standards for Education, Children's Services and Skills**	Ofsted is the Office for **Standards in Education, Children's Services and Skills.** They inspect services providing education and skills for learners of all ages.
MSK	**Musculoskeletal**	**Musculoskeletal (MSK)** is a medical condition that can affect your joints, bones and muscles. They can range from minor injuries to long term conditions. It is estimated that over 30 million working days are lost to MSK conditions every year in the UK.
CVD	**Cardiovascular disease**	**Cardiovascular disease (CVD**) is a general term for conditions affecting the heart or blood vessels. CVD includes all heart and circulatory diseases, including coronary heart disease, angina, heart attack, congenital heart disease, hypertension, stroke and vascular dementia.
SMI	**Serious Mental Illness**	**Serious Mental Illness (SMI)** is a term used to describe people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as an SMI.

SOUTH YORKSHIRE
INTEGRATED CARE PARTNERSHIP
STRATEGY

Working together to build a healthier South Yorkshire
our Initial Integrated Care Strategy

December 2022

Email
helloworkingtogether@nhs.net

Address
South Yorkshire Integrated Care Board
722 Prince of Wales Road
Sheffield
S9 4EU

Telephone
0114 305 4487

www.healthandcaretogethersyb.co.uk

Rotherham Place Partnership Update: November/December 2022

RotherHive

https://rotherhive.co.uk/cost-of-living/

Rotherhive provides a range of verified practical mental health and wellbeing information, support and advice for adults in Rotherham.

There is a new **cost of living** section on the Rotherhive site which provides links to financial support as well as tips on looking after your mental health and wellbeing.

Lung Health Checks - lung cancer currently causes more deaths than any other cancer in the UK and Doncaster has the highest risk rate in South Yorkshire, which led to it being the first area where the NHS South Yorkshire Integrated Care Board and Cancer Alliance introduced the Targeted Lung Health Check service in March last year. But with Rotherham and Barnsley ranked joint second, Parkgate Shopping has become the next site to host Alliance Medical's hi-tech equipment and its team of radiographers.

The service offers people aged 55 to 74 who have ever smoked the opportunity to have a lung health check and an assessment of lung cancer risk, including smoking cessation advice and/or referral, while those with a higher risk of lung cancer are offered a low dose CT scan, a lung function test and a blood pressure check. In Rotherham, the eligible population of more than 25,900 people have been identified by their GP practices.

Nearly 180 cancers were detected in Doncaster, 72% of those patients were suitable for curative treatment.

Discharge to Assess Update

- Therapies are piloting assessment at home
- Home care bridging resource in place, which will be grown in the new year
- Urgent response bridging discharge home
- Limitations due to recruitment challenges, urgent community hub supporting flexible allocation of resource. Daily multi-disciplinary team to identify capacity and flex resource being implemented this week

Virtual Ward Update

- Soft launch started in December piloting step up/step down frailty pathway
- Milestone for first reporting period in December will be achieved and the trajectory will increase in the new year according to capacity and acuity levels
- Recruited to the majority of roles including 2 nurse consultants and circa 15 support workers who will work flexibly across our urgent response provision supporting nursing, therapy and reablement requirements
- Working with the ICB to procure a single remote monitoring solution for Rotherham, Barnsley and Sheffield

Rotherham Vaccine Roll out – vaccination of 144,000 people, based on 100% of the eligible population.

Working closely with GP practices and PCN's we have offered coadministration of flu/covid vaccinations to vulnerable cohort in the homes of house bound patients, at care homes for residents & front-line staff, in GP practices and at weekends in mass vaccination sites.

In addition, there has been:

- targeted vaccinations via the vaccination van, supporting walk-ins working with community groups promoting sessions, particularly in areas of inequality
- 'pop up 'vaccination sites across the borough, in community buildings
- Dedicated sessions for the homeless
- More targeted approach specifically for serious mental illness (SMI) patients supported by RDASH

For Covid, Rotherham has vaccinated 66% of the total eligible population, in comparison to South Yorkshire average of 63% and a national average of 59.9%.

Qwell - building on the success of the Kooth digital support offer for Children and Young people in 2021, work has taken place with Kooth digital health care to extend the offer by commissioning Qwell for adults from age 18+. From **1st December 2022** Qwell will be available to all adults registered with a GP practice in Rotherham.

Qwell offers a unique out of office hours' mental health and wellbeing provision that is open 7 days per week, 365 days a year. This ensures those living in Rotherham aged 18+ have access to a welcoming place to seek non-judgemental professional help for any mental health concerns, as and when needed. There are no waiting lists or thresholds to meet, and Qwell is instantly accessible through an internet-connected smartphone, tablet or computer.

As a confidential and accessible digital offer, Qwell has been designed to work alongside other established and existing NHS, Local Authority and VCSE services, and delivers a therapeutic model of online counselling, offering personalised, anonymous, mental health support with no waiting list or threshold.

This text-based support is available to adults aged 18+ and includes emotional wellbeing resources, online community, message facility & online counselling with the BACP accredited counsellors. The online counselling team is available from 12 noon to 10pm Monday-Friday and 6pm-10pm at weekends, 365 days a year, providing a much needed out-of-hours service for emotional support in an accessible and convenient way.

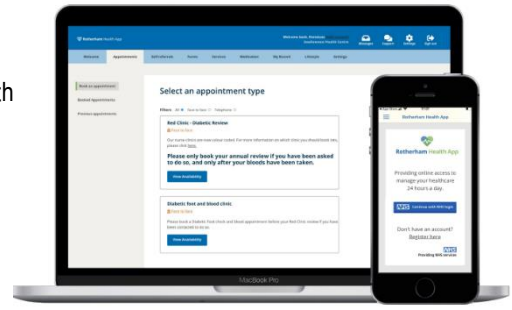
Find out more at: https://www.qwell.io/

ROTHERHAM

ROTHERHAM PLACE PARTNERSHIP I HEALTH AND SOCIAL CARE

The Rotherham Health App (RHA) is a Place-based digital solution, empowering patients to take more control over their health, providing complementary services to the NHS APP, tailored to local pathway needs. It interfaces with a range of local systems across Rotherham Place Partnership, providing a variety of services, from access to GP services, direct booking for Improving Access to Psychological Therapies (IAPT), viewing outpatient appointments, self-referral to health and public health services, such as Get Health such as Rotherhive, GISMO and Kooth. To date the RHA has:

- 45,474 Rotherham patients signed up
- 618,625 medications have been ordered via the platform
- 18,146 GP appointments booked
- 6,820 self-referrals made to alternative services to primary care



Rotherham residents have told us that the App has been beneficial to them, by allowing them to Take better control of their care. Through accessing a range of local services outside normal practice hours, patients can manage their care around their own lifestyles when they want to, rather than at times 'specified' by our services.

Rotherham Patient Flow Command Centre based at Rotherham hospital was recently shortlisted for an HSJ award. The ambition was to create a new clinical operations centre, staffed by health and social care, with embedded real-time and predictive analytics, that connect ambulance, hospital, community and social care data, with connected apps and voice enabled patient care co-ordination.

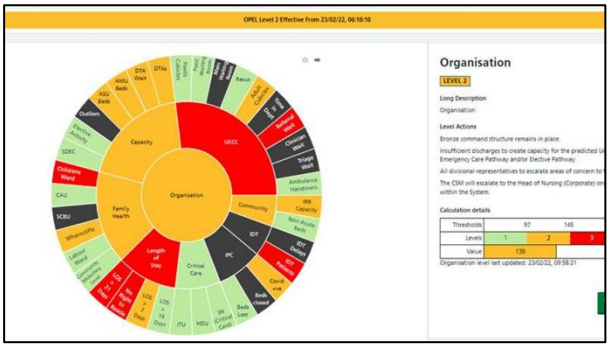
- Real time analytics accessible any time, any place, any device
- Yorkshire ambulance feed shows who is on the way, with predictive analytics
- A&E dashboard, with drill down to patient level
- E-portering enables patients to be re-prioritised from the command centre to facilitate flow
- On call app with access to real time patient flow metrics
- 'Brewster' provides accessible audio version for those on the move

The Integrated Discharge Team are located in the adjacent room to the Control Centre which facilitates quick joint discussions.

The Control Centre links into the recently established South Yorkshire System Control Centre.

The Escalation wheel and capacity dashboard provide a holistic view of system pressures, it has:

- ➢ 130 users, 37 metrics, 31 live feeds
- ➢ Capacity dashboard 70+ users across 8 organisations
- ➢ Facilitates strategic and operational decision making for; escalation, performance and commissioning



The **challenges faced by Rotherham Place** are mostly in line with the rest of South Yorkshire:

- Pressure continues to increase across the health and social care system, these include a deterioration in ambulance hand over times, high bed occupancy rates and pressures on the Integrated Discharge Team
- Significant work took place during the reset week to enable the introduction of the new medical SDEC model, however whilst some success was seen challenges remain to ensure sustainability of the model during times of pressure
- Length of stay for 7,14 and 21 days has reduced meaning the issue is with high volumes of short stay patients
- The significant increase in the number of paediatric attendances linked to potential Strep A has also caused significant challenges
- Work continues to ensure the surge and winter plan is enacted, the Escalation Wheel and the Control and Command Centre provide an oversight of the pressures. There are tiered regular meetings to focus on resolution of any problems, these include executive level escalation meetings three times a week, Tactical Operational meetings four times a week along with participation in the daily South Yorkshire System Control Centre meetings
- Primary Care is under ever increasing pressure, exacerbated by the increased volume of paediatrics.

All partners are experiencing significant issues linked to workforce both in terms of recruitment and the impact of staff absences. This is exacerbated by additional winter pressures in terms of staff sickness and increased numbers of covid / flu in the workforce.

Rotherham is undertaking a centralised spirometry pilot

- Funding from Respiratory Clinical Network to pilot centralised spirometry collaboration between the GP federation and TRFT Medical Physics Department

Workforce - 2 Health Science Apprentices supported/trained via medical physics. Service provides 19.5 hours per week over 3 days – scope to develop hub delivery if continued

Benefits

- Drives up quality – all patients receive the same quality diagnostic
- Cost effective
- Quick documentation – all results sat in the GP clinical record – no waiting
- Time saving for practice nurses to focus on supporting other areas of work
- Demonstrates good partnership working between providers and sets a blueprint for future place collaborations

Results Sept 22 – Nov

- Sept – Nov 288 pts spirometry (diagnostic/reversibility)
- Sept – Nov 56 pts FeNo (fractional exhaled nitric oxide) test

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Minutes	
Title of Meeting:	**PUBLIC** Rotherham Place Board: Partnership Business
Time of Meeting:	9.00am – 10.00am
Date of Meeting:	Wednesday 16 November 2022
Venue:	Elm Room, Oak House, Bramley, S66 1YY
Chair:	Chris Edwards
Contact for Meeting:	Lydia George: lydia.george@nhs.net/ Wendy Commons: wcommons@nhs.net
Apologies:	Richard Jenkins, Chief Executive, TRFT Suzanne Joyner, Director of Children's, RMBC Kathryn Singh, Chief Executive, RDaSH Dr Neil Thorman, Primary Care Representative Ian Spicer, Strategic Director of Adult Care, RMBC
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services. However, no specific direct conflicts/declarations were made relating to any items on today's agenda.
Quoracy:	Confirmed as quorate.

Members Present:
Chris Edwards (**CE**), (Chair), Executive Place Director – Rotherham Place, NHS South Yorkshire Integrated Care Board (ICB)
Sharon Kemp (**SK**), Chief Executive, Rotherham Metropolitan Borough Council
Ben Anderson (**BA**), Director of Public Health, Rotherham Metropolitan Borough Council
Shafiq Hussain (**SH**), Chief Executive, Voluntary Action Rotherham
Dr Anand Barmade (**AB**), Medical Director, Connect Healthcare Rotherham
Michael Wright (**MW**), Deputy Chief Executive, The Rotherham NHS Foundation Trust

Participants:
Gavin Boyle (**GB**), Chief Executive, NHS South Yorkshire ICB
Cllr David Roche (**DR**), Joint Chair of Health and Wellbeing Board, Rotherham Metropolitan Borough Council
Dr Jason Page (**JP**), Medical Director, NHS South Yorkshire ICB
Claire Smith (**CS**), Deputy Place Director – Rotherham, NHS South Yorkshire ICB
Shahida Siddique (**SS**), Independent Non-Executive Member, NHS South Yorkshire ICB
Sue Cassin (**SC**), Chief Nurse - Rotherham, NHS South Yorkshire ICB
Wendy Allott (**WA**), Chief Finance Officer – Rotherham, NHS South Yorkshire ICB
Lydia George (**LG**), Strategy & Delivery Lead - Rotherham, NHS South Yorkshire ICB
Gordon Laidlaw (**GL**), Head of Communications - Rotherham, NHS South Yorkshire ICB
Julie Thornton (**JTh**), Care Group Director, Rotherham, Doncaster & South Humber NHS Foundation Trust
Helen Sweaton (**HS**), Joint Assistant Director, CYP Commissioning, NHS South Yorkshire ICB/Rotherham Metropolitan Borough Council
Rebecca Woolley (**RW**), Public Health Specialist, Rotherham Metropolitan Borough Council

In Attendance:
Leonie Wieser, Policy Officer, Rotherham MBC
Wendy Commons, Support Officer, Rotherham Place, NHS SY ICB

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Item Number	Discussion Items
1	**Public & Patient Questions**
There were no questions.	
2	**Public Health Update: by exception**
Ben Anderson, Director of Public Health updated Members on the current situation with Covid and Flu. With around 31 Covid patients currently in Rotherham hospital, covid infections continue to decrease locally and nationally with around 1 in 40 people having covid. Flu infections have arrived around six weeks earlier than the average year. Cases are now towards the peak and expected to start reducing by the end of November. The advice is to get flu vaccinations early. Members noted the update.	
3	**Spotlight Presentation: Neuro-development Pathway**
Helen Sweaton gave an overview of the pathway and explained that the service is not diagnosis dependent meaning that children and families are given information about what is available without having to wait. She highlighted that the electronic education referral process, the multi-agency screening panel and multidisciplinary team, the comprehensive assessments based on NICE guidance and increased capacity were all working well and had resulted in some positive service evaluations. She outlined the risks as: – The volume of referrals to both diagnostic and post diagnostic ADHD pathway – Growing waiting lists and waiting times – The volume, quality and appropriateness of referrals received into the service – Referral to screening time – The lack of capacity within the post-diagnostic ADHD service It was noted that despite investment in recent years, partnership working and changes to the referral processes, there has been an additional 30% increase in referrals and into the child development service but this is also being seen nationally, not just in Rotherham. HS set out a number of actions that will be taken including: – Reviewing the referral packs and process, requesting evidence of two school terms of intervention prior to referral into the neurodiversity pathway and piloting a pre-screening model to identity the obvious referrals that wouldn't need a multiagency review. – To reduce the amount of clinical time lost due to inappropriate and inadequate referrals, work will be taken on increasing the knowledge of the education workforce and making available other interventions for children with possible ADHD before assessment to access medication. – A review of the contract with Healios will be undertaken. – A review of our data presentation will be undertaken. – Funding into the post-diagnostic service will be increased.	

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Following discussion about Rotherham's high referral levels, HS confirmed that Rotherham is not an outlier in terms of diagnosis and the reasons why more are referred than meet diagnosis is to be explored.

Members thanked HS for the update.

4	**Spotlight Presentation: Prevention and Health Inequalities**

Rebecca Woolley gave an update on the work of the group.

Members were informed of progress made including:

- The development of an interactive tool including a draft assurance framework
- Engagement which will inform the review of the healthy lifestyles prevent pathway and the recommissioning of services.
- Developing a prevention brand and resources.
- Completion of anchor self-assessments for each partner organisation.
- A review of the data and intelligence gathered through the place development programme around research around best practice.
- Work carried out by PCNs to explore opportunities for alignment between Primary Care Network health inequality plans and the wider prevention and health inequalities strategy.

The risks and challenges were highlighted as maintaining momentum during capacity challenges and pressures and strengthening and maintaining primary care involvement with the health prevention programme.

RW went on to outline the next steps including:

- Sharing the finding of the anchor self-assessments and agreeing a way forward for the anchor institution agenda.
- Publishing the tender for integrated services including smoking cessation, tier 2 weight management and access to physical activity.
- Presenting a progress outcomes report on the assurance framework to Place Board.
- Launching the prevention brand and campaign resources including the new section of RotherHive around physical health.
- Developing a case for change on the selected cohort of the population health management place development programme.

Discussion followed on the work undertaken with the Joseph Rowntree Trust on Anchor Institutions. In the next few months, Place Leadership Team will be reviewing the findings from the self-assessments and agreeing a way forward. Place Board will be updated progress.

Members thanked RW for the update.

5	**Place Governance**

Final Place Board Terms of Reference (Part 2 Partnership)
Due to the delegation of some functions from NHS SY Integrated Care Board on 1 July 2002, it had been necessary to update the terms of reference for Rotherham Place Board to reflect the establishment of the ICB Place Committee and the Rotherham Place Agreement.

The key changes in the agreement reflected:

- A commencement date of 1 July 2022 to show the ICB as a signatory.
- The revised structure of the NHS following the Health & Care Act 2022.

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- A proposed initial term from 1 July 2022 to 31 March 2024.
- The revised governance structure for the Place partnership.
- Updating language and terminology to reflect national policy.

In relation to Place Board Terms of Reference the changes reflected the dual role of the board for Place Board – *partnership business* and *ICB Place Committee Business* for Rotherham.

Rotherham Place partners had taken these revised versions into their own organisations and through boards for approval. Comments were received from RMBC that reflected legislation for councils and local governance and changes were made to sections 6e, 6.2 and 10.5 as outlined in the cover paper. No other changes were requested from partners.

It was acknowledged that membership of the ICB business section will continue to be reviewed and reflected upon as we develop and evolve.

Members ***approved*** the updated terms of reference for Place Board in Part 2 of the Place Board terms of reference.

Noted the terms of reference for the ICB Place Committee in Part 3 of the Place Board terms of reference.

Approved in principle the updated Rotherham agreement and ***agreed to delegate authority*** to the Executive Place Director to agree any necessary inconsequential amendments to the final version and to enter into the updated agreement on behalf of their organisations.

Signatories will be added to the final version.

6	**Voluntary, Community and Social Enterprise Sector, Memorandum of Understanding**

SH explained that the ICS Design Framework outlined the requirement for a formal agreement between the voluntary sector and the ICS to engage and embed the voluntary sector in system level governance and decision-making arrangements. Across South Yorkshire, four workshops have taken place with engagement from SY ICB and South Yorkshire voluntary sector organisations to develop this memorandum of understanding which includes a vision, defining values and setting out responsibilities for VCSE and the ICS. Further work will now take place through the VCSE Alliance.

SH advised that Voluntary Action Rotherham has been fully engaged with the process and development of the MOU. Next steps will be for it to progress through governance structures for sign off by the Integrated Care Board in January 2023. Any comments/feedback can be forwarded to SH.

Members thanked SH and VAR for their engagement and support in the development of the agreement and supported its continued development.

7	**Update on Vaccination Data**

CS advised that 60.9% of Rotherham residents have now received the autumn covid booster. Good progress is being made across all of South Yorkshire.

A further push on rollout is planned for the end of November including some increased communications to target specific groups.

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GL reported that work is also being undertaken with school engagement teams to offer flu vaccinations either nasally or by vaccination. Media and communications continue and will be increased in coming weeks.

BA confirmed that there is good evidence that this second-generation vaccine is more effective and working well. However, given that feedback from the public is mainly around the side effects information and advice is being given to manage expectations and actions that can be taken to limit symptoms.

Place Board thanked CS for the update and noted the Rotherham position.

8	**Place Newsletter Update**

The September/October Rotherham Place Partnership Newsletter was shared for information. Partners can share within their own organisations.

9	**Rotherham Place Achievements**

Achievements for the October period were noted.

These included examples from:

1. Community Hospital Admission Avoidance
2. Rotherham Safe Space
3. Safeguarding Vulnerable Children during pandemic
4. NCAP Level 4 'Top Performing' for Early Intervention Team

Place Board welcomed this tangible evidence of the actions and improvements being made across our services which will be shared by partner organisations and the ICB.

10	**Feedback from the Integrated Care Partnership**

DR reported that work continues on developing the ICP Strategy with input through a dedicated workgroup to ensure the timescale of December 2022 can be achieved.

Membership of the Partnership has now been agreed and an exercise is being undertaken to identify any gaps in representation. A workshop has been held to look at develop the priorities of the Partnership the output from which will be shared with partners.

It had also been agreed that the papers from the Integrated Care Partnership meetings can be shared with Place Boards and Health and Wellbeing Boards. Following discussion, members agreed to receive ICP agenda and papers for information at this meeting going forward.

Action: LG

11	**Draft Minutes and Action Log from Public Place Board – 19 October 2022**

The minutes from the October meeting were agreed as a true and accurate record.

The action log was reviewed and up to date.

12	**Communication to Partners**

The Place newsletter will be forwarded to partners for them to consider how they wish to circulate/communicate it within their organisations.

JP/AB/SH will discuss a way of sharing the newsletter with staff in primary care and voluntary services.

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Following a suggestion from SS, Members agreed it would be a good idea to consider developing two-way information flows so that key messages are 'bottom up' as well as 'top-down' and can also provide a mechanism for a one workforce approach to listening and engaging staff.	
13	**Risks and Items for Escalation to Health and Wellbeing Board**
There were no risks or items to escalate from Place Board.	
14	**Future Agenda Items:**
Future Agenda Items: – Anchor Institutions (Jan/Feb) – Health Inequalities Outcomes Framework (Jan) Standing Items – Bi- Monthly Place Partnership Briefing – Place Achievements	
15	**Date of Next Meeting**
Due to a development session being scheduled for December, the next meeting will take place on ***Wednesday 18 January 2023*** in Elm Room, Oak House from 9.00am – 10.00am.	

Membership

Chris Edwards (Joint Chair)	Executive Place Director/ICB Deputy Chief Executive	NHS South Yorkshire Integrated Care Board
Sharon Kemp (Joint Chair)	Chief Executive	Rotherham Metropolitan Borough Council
Ben Anderson	Director of Public Health	Rotherham Metropolitan Borough Council
Richard Jenkins	Chief Executive	The Rotherham NHS Foundation Trust (TRFT)
Shafiq Hussain	Chief Executive	Voluntary Action Rotherham
Kathryn Singh	Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
Shahida Siddique	Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board
Dr Anand Barmade	Medial Director	Connect Healthcare Rotherham (GP Federation)
Dr Neil Thorman	Medical Director	Rotherham Primary Care Leadership Group

Participants

Cllr David Roche	Joint Chair	Rotherham Health and Wellbeing Board
Claire Smith	Deputy Place Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Sue Cassin	Chief Nurse, Rotherham Place	NHS South Yorkshire Integrated Care Board
Wendy Allott	Chief Finance Officer, Rotherham Place	NHS South Yorkshire Integrated Care Board

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Dr Jason Page	Medical Director, Rotherham Place	NHS South Yorkshire Integrated Care Board
Shahida Siddiqui	Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board
Ian Spicer	Strategic Director, Adult Care, Housing and Public Health	Rotherham Metropolitan Borough Council
Suzanne Joyner	Director of Children's Services, RMBC	Rotherham Metropolitan Borough Council
Michael Wright	Deputy Chief Executive	The Rotherham NHS Foundation Trust
Lydia George	Strategy and Delivery Lead	NHS South Yorkshire Integrated Care Board
Gordon Laidlaw	Head of Communications	NHS South Yorkshire Integrated Care Board

PUBLIC ROTHERHAM PLACE BOARD ACTION LOG - July 2022 - March 2023

Mtg Date	Item No.	Agenda Item Title	Action Description	By	Action Status	Comments
16.11.22	10	Integrated Care Partnership	The public session of Rotherham Place Board will receive agenda and papers from the Integrated Care Partnership Meetings for information going forward.	LG	Green	Added as recurrent item on future agendas