South Yorkshire and Bassetlaw Integrated Care System

You said, We will…

In developing our Plan, we carried out significant patient, public, staff and stakeholder engagement across each of our five Places. The specifics of the work, which was supported by local Healthwatches and ICS partner organisations, is detailed in the two independent reports on the ICS website here.

The reports outline the key findings and themes that the public and patients and staff and stakeholders highlighted as areas that were important to them and what they would like to see happen in the future. The table below shows how their comments have helped to shape the Plan.

Public and patient feedback		
You told us	What we're doing	We will
Prevention, independence and self-care		
People recognise that prevention is cheaper than treatment, and agree that people should be taking greater ownership of their own health, although they understand that it can be difficult to get people to change their behaviour.		We are developing a range of programmes and activities to support prevention.
Many feel that alcohol reduction, healthy eating and increasing exercise levels should be the key areas of focus within prevention.		Reducing harm from alcohol and obesity is one of the five areas that we will focus on to improve population health and reduce inequalities.
Support for investing in Social Prescribing as an alternative to traditional NHS services is particularly high.	There are already well-established voluntary, community and social enterprise led social prescribing services in all of the five Places in SYB.	We are going to expand the social prescribing offers across South Yorkshire and Bassetlaw.
Working with GPs and other health professionals to ensure they get the right care is particularly important to people, however people feel the access to GP appointments needs	We are now providing extended access GP appointments on evenings and at weekends for 100% of our population.	Primary care colleagues, who are now working in Networks, are starting to appoint new roles to their teams to improve access. They are also increasingly offering telephone

improving.		consultations via Primary Care Network Hubs.
Local pharmacies are seen to be working well, and more should be done to promote these services.		Pharmacists are an important part of Primary Care Networks and will be working with their Network colleagues to ensure the offer to Neighbourhoods is meeting people's needs.
Key to success in this area also depends on: • Educating the public - particularly young people. • Providing more local services, activities and support - and ensuring these are accessible to all. • Training staff to talk to people about managing health conditions/self-care. • Increasing awareness of the different services available. • Considering how information is delivered (e.g. using social media, text messages, different languages etc.).	Raising awareness of services is a fundamental part of how our organisations work and they will continue to do this. As above.	Our prevention programme will support the development of messaging and materials that connect with lots of different audiences. The 30 Primary Care Networks and partnership in each Place are focused on providing as much care as close to home as possible. We will help our workforce to have supportive conversations with patients as part of the prevention programme and we are committed to developing our staff.
Mental Health and Emotional Wellbeing		
People agree with the proposed areas of focus (92% agree) and that physical and mental health should be treated together (83% agree):		Mental health and learning

• Physical and mental health are inter-dependent, and a person should be treated holistically. • Many feel this area is the most important of the four areas in the plan.		disabilities and autism services are in our top priorities (for our major health conditions work programme).
Investing in supporting children and young people is seen as a key priority – in particular investing in specialist support in schools and colleges.	Children and young people who are struggling with mental health are already benefitting from the rolling out mental health support teams in schools in SYB.	We are committed to investing in and expanding support in communities for children and young people.
Other priority areas include improving waiting times for mental health services, raising awareness and improving early intervention: • There is a perception that mental health services are currently only offered once a high threshold or a crisis has been reached, and more should be done to support people before crisis point.		We are making many commitments in this area. For example, we are developing specialist community perinatal mental health support, putting a suicide prevention programme in place, supporting adults with severe mental illness, developing specialist clinics for problem gambling and many more initiatives.
People would like to see more local mental health services, and different options for people in a crisis.		We are going to expand emergency mental health support for people who are experiencing a crisis. This will include 24/7 access.
Mental health services need to be working in a more joined up way with other services.		We are committed to working with partners to develop our approach. This is at Neighbourhood, place and System levels.
There are mixed views on whether target setting on waiting times is appropriate or whether it has become a tick box exercise and will actually		We agree and are working with our regulators to review the approach to performance across our System. The NHS Constitution Standards are enshrined in the NHS Act and

result in poorer initial care.		we must meet these but we also want to measure our progress in ways that are about the person, not the organisation. We will keep people updated on the progress on our approach on our website.
Other key themes include focussing on increasing social interactions, educating health professionals more on mental health and removing the stigma.		In addition to our commitments to improving mental health services we are also developing our workforce and working in partnership in Neighbourhoods, Place and across the System to tackle health inequalities
Some concerns were expressed around the need to support dementia patients better, the fact that learning disabilities are inappropriately put under the mental health umbrella, and the need for more support directed at males.		We will continue to develop and implement plans in each Place to support those living with multiple long term conditions or living into old age with frailty or dementia. We will also ensure out of hospital approaches continue to consider the needs of those living with dementia and their carers so we can strengthen community support Developing our approach for people with learning disabilities and autism is a separate programme . We usually refer to it together with mental health (ie mental health and learning disabilities and autism). We know from our data that men would be benefit from some services and we will target these at the people who need them.
Care in the Neighbourhood		
People strongly agree with the proposed areas of focus (95% agree).		
People do not want to go to hospital unless absolutely		Section three of our Plan describes in detail how we will

necessary and feel investing in local services will both keep people out of hospital and enable them to stay at home longer and/or be discharged quicker.		support people to stay well in their communities and work in more integrated ways in Neighbourhoods and in Place.
People feel more people will access local services, which could mean problems are identified sooner.		Accessing local services will be made simpler and easier as Primary Care Networks and local partnerships develop
In order for 'Care in the Neighbourhood' to be a success: • Local services will need to be more accessible and adequately (and appropriately) staffed: • In particular, people would like to see more services provided at GP practices, and more specialist health professionals working in the local community. • Access to services, esp. GP appointments, need to be improved. • The third sector should be involved more, and supported in their involvement. • Health and social care need to work in a more joined up way. • Community infrastructure may need investment.	The voluntary, community and social enterprise sector is already working with many Primary Care Networks in Neighbourhoods and this is set to grow even more We have had access to transformation funding over the last three years and been able to invest significantly in primary care (including access funding, digital funding and cancer), secondary care (including mental health, urgent and emergency care, pathology and maternity) and prevention (including suicide prevention, care homes and social	Accessing local services will be made simpler and easier as Primary Care Networks and local partnerships develop and people have greater choice through their GP practice. We have a strong vision to embed VCSE participation at every level of the ICS Joining up health and social care is and has always been a fundamental element of our Plan. Rather than focusing on just when someone is unwell, we will take a population health approach - working with our partners and local communities - to improve physical and mental health and wellbeing and reduce health inequalities across the entire population of South Yorkshire and Bassetlaw We will continue to invest in primary, community and the

	prescribing)	voluntary services to support the development of more care where people live.
Whilst all areas are seen as important, for many people improving care home standards and supporting carers should be key priorities.		We are developing new Primary Care Network led arrangements with Care Homes. Some of our Places are already making progress with this
Digital		
The majority of people would like to be able to access services digitally (using phones or computers).		We are committed to providing all citizens with an online/digital service to manage their health and care needs, with provision for those who are digitally excluded
The sharing of medical records should already be happening – people generally welcome the information sharing between different health services.		We will deliver unified/integrated health and care records across SYB for professionals and citizens which integrate with the Yorkshire and Humber Care Record
Whilst increased digitalisation of the NHS, and particularly online appointment booking, is welcomed, this should not be at the expense of personal, face-to-face interactions: • People still want to be given options of how they interact with health services. • Some would be happy for video link consultations, but many would still prefer to be able to have face-to-face interactions.		We are committed to providing all citizens with an online/digital service to manage their health and care needs, with provision for those who are digitally excluded We don't want to replace face to face interaction and have no intention to do so – rather, we want to offer digital services for those who want it.
There is some concern that increased digitalisation of services will exclude those who are less IT literate or don't have online access, and a minority		We are committed to providing all citizens with an online/digital service to manage their health and care needs, with provision for those who are digitally

are concerned about the security of their personal data.		excluded We understand people are concerned about the security of their personal data and we are committed to delivering stable, performant, secure (including cyber security) and cost effective infrastructure across SYB
Whilst having access to personal records could potentially be empowering for patients, the ability to 'manage' their own personal records received mixed views.		As we develop this area of work we will be mindful of the different views that people have.
Cancer		
Overall, the people consulted feel the key areas for focus should be: • Earlier detection through encouraging discussion, improving awareness, earlier screening and regular health checks. • Improving the speed of diagnosis and receiving results in order to lower the stress levels of patients. • GPs need more training on early diagnosis. • Support needs to be provided for families as well as patients.	The work of the SYB Cancer Alliance is already promoting earlier diagnosis by enabling primary care to implement new tests and care pathways 1,300 extra patients are accessing support services through the Living With and Beyond Cancer programme	We will help Primary Care Networks to further engage communities to reach optimal uptake of vaccination and cancer screening with the biggest increase in those living in most deprived areas We will introduce lung health checks and rapid diagnostic centres to enable earlier and faster diagnosis We will build and network diagnostics to enable our workforce to operate as a single cancer service to meet demand and deliver national operational standards We will increase the provision of very brief advice within clinical practice. Provide SYB commissioned brief advice and behaviour change training for all new post holders in Primary Care Networks

Staff and stakeholder feedback		
Staff and stakeholders feel that a seamless pathway of care will need to focus on delivering truly patient-centred care. For example, staff and stakeholders would like to see: • Healthcare directed towards goals of patients and what matters to them, not clinicians or services • A single pathway of care, not individual illnesses treated separately • Treated by the right specialists in the right place at the right time • One-stop clinics; one appointment for multi-morbidities • An easier referral system • Easier transfers of patients across services		We are one NHS, working as a System. We work with other partners, such as Local Authorities and the voluntary sector, in Neighbourhoods, Place and across the System when we have a common purpose and where it makes a positive difference to people's lives. Our aim is to break down organisational barriers so that we can wrap support, care and services around people as individuals Rather than focusing on just when someone is unwell, we will take a population health approach - working with our partners and local communities - to improve physical and mental health and wellbeing and reduce health inequalities across the entire population of South Yorkshire and Bassetlaw We will systematically implement the Comprehensive Model for Personalised Care by 2023/24, working with primary care networks, wider NHS services, people with lived experience and partners in local government and the voluntary and community sector
Staff and stakeholders feel that to provide a seamless pathway of care will need to involve more integration of teams, services and organisations, in particular: • Greater integration between all services: clinical, non-clinical, community, acute, social care…		There are now 30 Primary Care Networks (PCNs) in South Yorkshire and Bassetlaw, all preparing to extend the range of convenient local services and create integrated teams of GPs, community health and social care staff. We will build on the work we have started to give patients more options, control, better support and joined up care at

• Shared ownership of health needs and priorities • Sharing of information • Joint ownership of patient pathways • Reduction/removal of silo working • Sharing of resources and less protectionism over money • Potentially a single pot of funding • Move from competitive to collaborative • No asset stripping, or competition for funding, staff or activity • A single, shared workforce		the right time in the best care setting. In the next five years, we will accelerate the recently formed Hospital Hosted Networks to ensure everyone has the same high quality standards and equal access Our Plan aims to tackle nursing shortages and secure current and future supply, make the NHS in South Yorkshire and Bassetlaw the best place to work and improve our leadership culture while introducing new roles, rostering and programmes that enable flexibility for staff We will establish the basic digital capabilities across integrated health and care, ensure greater use of information and advancing capabilities and digitally enable citizens and professionals In addition to strengthening the connections we have in Neighbourhoods and in Place with our local authorities and the voluntary sector, we want to build on the role we play in the local and regional economy
Improving and integrating IT across the system is also considered essential in order to provide a seamless pathway of care, in particular: • Integration of IT systems across all parts of the system • Primary and secondary care • Health and social care • Across different Trusts • The sharing of patient records, which would		We will establish the basic digital capabilities across integrated health and care, ensure greater use of information and advancing capabilities and digitally enable citizens and professionals Our digital programme includes a phased approach to improving and integrating IT across the System

remove the need for duplication and reducing paperwork • Same software – not Lorenzo! • Increased use of digital/mobile technology for both staff and service users • Offer a variety of access routes – remote technology, Skype, phone consultations in addition to face-to-face consultations • A focus on improving 'background' processes and data quality		
In five year's time, staff and stakeholders feel progress would involve a reform of social care, in particular: • The integration of health and social care • A system that tackles social isolation and loneliness • More, and better in-home nursing care (more, and better carers needed) • Improved care homes and an increased number of nursing home beds • More supported living services • NHS funded facilities and less privatisation	Over the last three years all five places in SYB have established mature integrated care partnerships (ICPs) with their local authorities and other place partners. The Place partnerships have become the bedrock of SYB place development and relationships in each ICP continue to evolve and flourish through ambitious joint strategic plans to integrate health and care locally. ICPs have implemented a range of joint working arrangements and mechanisms to drive forward joint working with local authorities and providers including joint commissioning, provider alliances and provision, population health management and digitally enabled care	Joining up health and social care is and has always been a fundamental element of our Plan. Andrew's foreword explains this best We will develop the Place partnerships even further and also work with the Sheffield City Region and Local Authorities on social isolation, complex lives, and active travel We are developing new Primary Care Network led arrangements with Care Homes Some of our Places are already making progress with this
Progress in five year's time will rely on the System taking more of a focus on prevention, in		We are developing a range of programmes and activities to support prevention.

particular: • A focus on earlier intervention for mental health support to prevent crises • Overall health prioritised rather than physical illness • A focus on health education, particularly amongst young people • More regular health checks and widespread screening, for both physical and mental health issues • More local and accessible support groups • All SYB engages in QUIT programme		We are making many commitments in this area. For example, we are developing specialist community perinatal mental health support, putting a suicide prevention programme in place, supporting adults with severe mental illness, developing specialist clinics for problem gambling and many more initiatives. Rather than focusing on just when someone is unwell, we will take a population health approach - working with our partners and local communities - to improve physical and mental health and wellbeing and reduce health inequalities across the entire population of South Yorkshire and Bassetlaw Our prevention programme will support the development of messaging and materials that connect with lots of different audiences. Our partners are signed up to the Healthy Hospital Programme. The QUIT programme, which will embed the Systematic Treatment of Tobacco Dependency, will start in all Acute and Mental Health Trusts early 2020
A key area that staff and stakeholders would like to see change is more services being delivered both within the community and in-home, including: • Improved access to GPs: • Easier access to GP appointments • More out of hours appointments		The 30 Primary Care Networks and partnership in each Place are focused on providing as much care as close to home as possible. Primary care colleagues, who are now working in Networks, are starting to appoint new roles to their teams to improve access. They are also increasingly offering telephone consultations via Primary Care

• More GP home visits • More services provided in primary care hubs/in the community • Increased social prescribing • Improved flexibility in accessing services across boundaries • Improved integration of community pharmacies	We already have well-established voluntary, community and social enterprise led social prescribing services in all of the five Places in SYB.	Network Hubs. We are going to expand the social prescribing offers across South Yorkshire and Bassetlaw. We will systematically implement the Comprehensive Model for Personalised Care by 2023/24, working with primary care networks, wider NHS services, people with lived experience and partners in local government and the voluntary and community sector. We will enable people to take more control of their health and care, providing more options, coordinated support and care at the right time and right place Pharmacists are an important part of Primary Care Networks and will be working with their Network colleagues to ensure the offer to Neighbourhoods is meeting people's needs..
Success in five year's time would also mean more equality of care and equality of services, in particular staff and stakeholders would like to see: • Mental and physical health treated equally • Improved access to Mental Health services, and decreased waiting times • Children's and adults services treated equally • Different specialties treated equally • Equality across localities and between different Trusts		Rather than focusing on just when someone is unwell, we will take a population health approach - working with our partners and local communities - to improve physical and mental health and wellbeing and reduce health inequalities across the entire population of South Yorkshire and Bassetlaw We are making many commitments in mental health. For example, we are developing specialist community perinatal mental health support, putting a suicide prevention programme in place, supporting adults with severe mental illness, developing specialist clinics for problem gambling and many

• Equality with other regions nationally		more initiatives. We have been working as a partnership for three years and throughout this time, our goal has remained the same: For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer. We are one NHS, working as a System. We work with other partners, such as Local Authorities and the voluntary sector, in Neighbourhoods, Place and across the System when we have a common purpose and where it makes a positive difference to people's lives. Our aim is to break down organisational barriers so that we can wrap support, care and services around people as individuals. We agree to take shared responsibility (in ways that are consistent with individual legal obligations) for how we can use our collective resources to improve quality of care and health outcome
For many staff and stakeholders, progress will depend on improving the staffing situation, in particular improving staff morale and therefore improving retention of trained staff through: • Recognition of work done • Better pay and equality of pay across regions Better working conditions, including: More manageable		We have developed a strategic approach to making workforce improvements. These include making the NHS the best place to work (eg we will take a System approach and implement the new national core offer for staff and build on NHSI/NHSE programmes to improve retention) and tackle urgent nursing shortages and securing current and future supply (eg we will accelerate new roles across key professional groups, work together to attract staff to SYB

caseloads More flexible contracts Less paperwork More robust HR system and equality of HR policies Discounted/free staff car parking Better staff training and therefore improved staff skills sets Improved staff understanding of services A common training offer to allow cross-organisational working In addition, staff and stakeholders would like to see increased numbers of staff, particularly amongst nursing and admin staff, and an improvement in staff recruitment processes.		as a place to live and work and set up a placement Pilot Scheme to increase and improve placements)
Staff would like leaders to be more visible, more accountable and for leadership teams to work more collaboratively across the System. Examples of comments include: • More accountability of leaders • Leaders spending more time spent on shop floor • Leadership that focuses on patients, not activities to further individuals' careers • Changes only made for the good of the service		Our strategic workforce approach includes a commitment to improve the leadership culture (eg promote an agreed systems leadership framework and ensure current and future senior leaders access and use leadership development).

their staff provide • Better workforce planning • A more consistent plan and vision across the ICS		
Other (less prominent) themes from respondents included: • Patients and communities involved more: improved understanding of services, increased co-design • Improved local hospital facilities: better equipment, improved waiting areas, a new hospital • Wider system changes and involvement, e.g. increased use of VSCE, stronger co-production with local government, improved transport and social housing etc. • Improved marketing and communication: communication of services and marketing of NHS roles • Reduced wastage and duplication in every area • A hub and spoke system • Be a leader on environmental issues		Patients and communities will continue to be involved in service development, in Neighbourhoods, Place and across the System We will move from a functional approach to estate management to a System approach