Item 4b

Barnsley Place Based Partnership

Health and Care Plan 2023-25

Updated April -24

Barnsley – the place of possibilities.

Welcome

Across South Yorkshire, and here in Barnsley, we want everyone to live happy and healthier lives for longer.

We know times are tough with the ongoing effects of Covid-19 and the rising cost of living. Our conversations with local people, communities and those that work or volunteer in health and care show that having access to high quality care and support is important. That's why we're working together as a partnership to make sure you have the support you need.

This plan was created by our newly formed Barnsley Place Based Partnership and will guide us up until 2025. You'll see below that the partnership is made up of a range of organisations - local NHS services, the local authority and the voluntary and community sector. As individual organisations we can't transform health and care alone. When we come together and work alongside local communities we know that we can make a bigger difference.

We are proud of the impact we have had so far working in partnership - this plan builds on that. It focuses on the things we can go better together:

- Providing more seamless care and avoiding duplication - you feel like you are in control of your care and you are clear and confident of who to contact and when.
- Supporting people to remain healthy - you feel able to do things to stay healthier and happier and feel less like things are being 'done to you'.
- Making the best use of the budget - you feel that you are getting the highest quality of service and the best care knowing that we have worked hard as a partnership to use the money that comes into Barnsley as effectively as we can.
- Be at the heart of making Barnsley the place of possibilities - you feel part of a healthy, learning, growing community whether you work or live in Barnsley.

We want this plan evolve through your involvement, because your health and wellbeing is important to us all. Let's work together for a happy and healthy Barnsley.

This plan contributes to the improvements described in the following:

- South Yorkshire Integrated Care Partnership Strategy
- Barnsley 2030
- Barnsley Health and Wellbeing Strategy 2021 to 2030
- Barnsley Mental Health and Wellbeing Strategy 2022 to 2026
- Barnsley Children and Young People's Plan 2019 to 2022
- Barnsley SEND Strategy 2022 to 2025
- Tackling Health Inequalities in Barnsley

Barnsley Place Based Partnership

Brings together organisations involved in health and care from across the borough and is made up of representatives from Barnsley Council, Barnsley CVS, Barnsley Healthcare Federation, Barnsley Hospice, Barnsley Hospital NHS Foundation Trust, Healthwatch Barnsley, NHS South Yorkshire Integrated Care Board and South West Yorkshire Partnership NHS Foundation Trust.

Our vision, aims and objectives

Four aims of Integrated Care Systems

Tackle inequalities in outcomes, experience and access

Improve outcomes in population health and healthcare

Enhance productivity and value for money

Help the NHS support broader social and economic development

Barnsley Health and Wellebing Strategy vision

People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.

Objectives of Barnsley Place Based Partnership

Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each partner delivering their part without duplication.

Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance.

Embed integrated care that delivers the best value for the Barnsley pound.

Play a pivotal role in delivering our shared vision for Barnsley: the place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley.

How we plan to improve health and reduce health inequalities

Tier 1 Increase

The first layer of action is to increase the support we offer to address the key drivers of inequalities.

We will increase:

- Engagement with people and communities who have the least access to health and social care.
- Services and support aimed at raising health awareness; protecting health and wellbeing; and preventing illness.
- Relative investment in communities that have been historically underfunded – especially for preventive, mental health, domiciliary, community and primary care.
- The health awareness and activation so that people with greatest need are best equipped to protect and improve their own health.
- The skills and recruitment to our wider workforce so they support this.

Tier 2 Improve

The second layer of action is to improve all care services in a way that they are targeted at those where we can make the most difference to reduce inequalities.

We will improve how:

- We understand the communities who experience poorer health outcomes and understand their experience of the health and care system.
- We develop the offer made to Barnsley communities to overcome existing barriers to access and engagement with health and care services.
- Decisions are made and services are targeted at greatest need first, thanks to a better understanding of the range of inequalities across communities.
- We resource, commission and develop the health and care system based on need, shifting away from demand or activity driven delivery.
- We measure inequalities and incorporate this into of performance monitoring to generate accountability and resourcing.

Tier 3 Influence

The third layer is to influence those differences in health which are linked to things like housing conditions, the quality of green spaces and clean air, education and income.

We will influence:

- Social mobility by working more closely with partners in education, linking learning and development with our offer of good employment.
- The local economy by buying goods and services from it and investing in it, in ways that generate sustainable, inclusive economic growth in Barnsley and the region.
- The environment and climate by reviewing our policies and services and ensuring we develop to minimise harm and maximise benefit.
- How health and care is co-developed with communities with shared, distributed responsibility and power.
- Our role as large organisations at the heart of the local community using our resources to benefit the economy and environment, learning from others as we go.

How the plan fits with Barnsley 2030

Barnsley – the place of possibilities.

"Barnsley 2030 is our collective long-term vision and ambition for our borough. The strategy helps us to work creatively to improve our borough for everyone. It provides a framework for the ambitions and actions of our partners working across the area and it enables us all to believe in the possibilities of Barnsley". - Cllr Stephen Houghton

Healthy Barnsley 2030 Ambitions

Everyone is able to enjoy a life in good physical and mental health.

Fewer people living poverty, and everyone has the resources they need to look after themselves and their families.

People can access the right support, at the right time and place and are able to tackle problems early.

Our diverse places are welcoming, supportive and adaptable.

2030 Board Commitments

Work as partners to drive forward a joint local healthcare system.

Develop services that supports people to get help early.

Empower local people to build capacity and resilience.

What Barnsley organisations will do

Provide shared services to meet the needs of local people.

Work together to share best practice and knowledge.

Support and empower people to have a health and active lifestyle.

Create inclusive, quality job options which offer positive work and life balances.

How might someone's experience be different through the changes in this plan?

Roman is a 24 year old living with learning disabilities, he currently lives at home with his family. He has little social interaction outside home and would like to play sports.

	Roman's experience now	How Roman's experience could be in the future
Accessing support when I need it	Roman is unsure where to get help and he and his family are struggling. He used to attend a day centre which is no longer open. He would like to spend his time mixing with people more and hopefully getting a job.	Roman sees some information in his local library about Creative Minds and a Good Mood Football League he would like to join. The library worker also gives him a leaflet about the job centre where dedicated help is available for people to get into work for the first time.
Providing information about me	Roman sees his GP when he needs to but isn't in touch with health or social care professionals on a regular basis.	Roman attends his GP practice for his annual physical health check, something which is available to him because he has a learning disability. As part of this, he works out an action plan to help him with the things that matter most to him - he's put in touch with stop smoking services and a healthy living group. His local community learning disability team support with developing easy read information so Roman can manage his own health needs as well as possible.
Planning my care and support	Roman doesn't have a care and support plan.	Roman sees a social worker at a community centre coffee morning and has an assessment under the Care Act 2014 and his parents have a carer's assessment. He is eligible for an individual budget for him and his family to build a support plan around a range of his individual needs.
Building on my strengths	Roman has little social contact with other people and often feels bored and restless.	Roman uses his individual budget to employ a personal assistant (PA) to accompany him to football sessions and trips to town. He is gaining more confidence in getting out and about and becoming less dependent on his parents. His PA also accompanies him to the job centre where he attends weekly groups about getting into a job, he enjoys this and is considering volunteer dog walking supported by the local learning disability services employment scheme.
Meeting my needs	Roman and his family try their best to find things for him to do but he is making little progress with his life and the family are stressed. His mum is struggling with anxiety about his future.	Roman's care and support plan is put in place. In his neighbourhood there is a welcome café run by the talking therapies team where his mum can drop in for advice. From this she accesses the talking therapies services for her own mental health and starts to cope with things better.
Coordinating my care and support	The family don't know anyone other than their GP so tend to go to the surgery when there are problems.	Roman and his family lead their own support with input and advice from a community worker around self directed support. There are cafes at the centre close to their home where they know they can go for a friendly face and practical input when needed. When Roman goes to his GP his health record is joined up with his support plan so everyone is on the same page. A 'hospital passport' can be developed with Roman in case he has to go into hospital, so that his needs can be met and the hospital staff know what is important to Roman.

Looking back on 2022/23

Despite the many challenges in 2022-23 we have made significant progress as a partnership to improve and transform services for local residents. Below are some of the highlights throughout the year. In addition to these, progress has been made to: ensure more families can access early support; expand access to urgent community services; transform traditional hospital outpatient appointments so, where relevant, people are given advice and guidance and they initiate an appointment when they need one, based on their symptoms and individual circumstances ; and increase GP appointments. Waiting times for treatment at Barnsley Hospital are amongst the lowest in our region thanks to the hard work of our clinical front-line teams across our partnership and support from the wider system.

April to June 22

- We joined the national population health management development programme
- First Barnsley virtual recruitment fair
- PROTECT programme launched with general practices to optimise medicines for patients
- Launch of the Barnsley all age mental health strategy
- Changes made for bones, joints, muscles and spine services to reduce waiting times into trauma and orthopaedics
- 'How's Thi Ticker?' campaign to improve blood pressure control

July to September 22

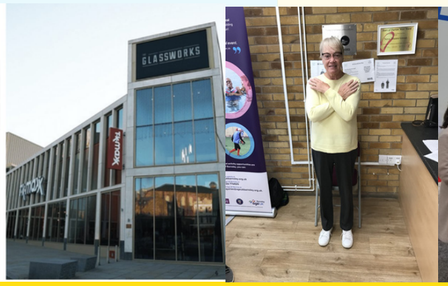
- Launch of the Community Diagnostics Centre in new Barnsley retail venue The Glass Works.
- Adult social care front door established to increase prevention and reduce the escalation of health issues
- First patients admitted onto the virtual wards in Barnsley
- Barnsley Support Hub opens its doors for people in mental health crisis
- Partners come together to agree actions to support residents with the cost of living crisis
- Integrated Personalised Care Team IMPACT expands access

October to December 22

- Publication of the SEND strategy
- First cohort begins Proud to Care training
- 300 older people start the Stride digital pathway to better health
- First referrals to 'Just for you' delivered by Age UK
- Barnsley Mental Health, Learning Disabilities and Autism Partnership launch event
- Psychosocial Engagement Team service recognised as best practice service for suicide prevention

January to March 23

- Funding secured for phase 2 of the Community Diagnostics Centre
- Launch of targeted lung health checks
- Barnsley Hospice rated outstanding by CQC
- A pilot scheme started to push 999 calls from Yorkshire Ambulance Service stack into RightCare
- Second wave of training in Strengths Based Practice for colleagues in Adult Social Care
- Barnsley Older People's Physical Activity Alliance shortlisted for Local Government Awards



Barnsley partnership's shared goals and enablers

Priorities

- Best start in life for children and young people
- A joined up approach to preventing ill health
- Better and fair access
- Coordinated care in the community
- Improve impact on environment, economy and employment

Enablers

- Develop our workforce
- Co develop solutions with residents and service users
- Make the best use of our estate
- Use digital for good
- Tell our part in the Barnsley story
- Improve efficiency and the costs of care for all
- Work more closely with the Voluntary Community and Social Enterprise (VCSE) sector
- Be led by intelligence and equity
- Work and learn across sectors
- Think differently

Best start in life for children and young people

Our priority for 2023 to 2025

We will create family hubs to ensure that all our children, pre-birth to adulthood, are well supported by an integrated offer within their communities.

Why is it important?

The experiences we have early in our lives, particularly in our early childhood, have a huge impact on how we grow and develop, our physical and mental health, and our thoughts, feelings and behaviour. Ensuring Barnsley is a great place for a child to be born, is one of the key priorities for Barnsley's Health and Wellbeing Board.

Adverse childhood experiences, such as physical, emotional or sexual abuse, exposure to domestic violence, or living with someone who abuses alcohol or drugs for example, can have a damaging impact on a child or young person's development and their potential health and wellbeing throughout their lifetime. Those who have multiple experiences have an increased risk of heart disease, cancer, lung disease, liver disease, stroke, hypertension, diabetes, asthma, arthritis and mental health problems. Children living in deprived areas are more likely to have these adverse experiences compared with their more advantaged peers.

In Barnsley, a significant proportion of children and young people, 15 in every hundred, are growing up in households where no adults work and 22 in every hundred children and young people live in low income households.

Recently we have seen significant increases in demand for early help support, children in need and child protection. In Barnsley, there has been an increase in referrals where emotional health and wellbeing is the main concern.

There is no single, non-stigmatising point of access for family services that helps families to navigate the wide-ranging support they need. Families sometimes experience difficulty interacting with the vast range of services having to 'retell their story' to different teams and professionals.

Where do we add value?

Across South Yorkshire, the Local Maternity and Neonatal System (LMNS) is working to develop the workforce and improve quality across maternity services, sharing best practice and resource to meet the NHS operational requirements.

This will improve the experience of families and prevent poor outcomes. The Barnsley Place Based Partnership can ensure a joined up approach across early years services, maternity and public health to deliver wrap around support.

The challenges that children and families experience are multiple and complex so require holistic support. As a partnership we are best placed to understand the needs and preferences of residents and bring together statutory providers, community organisations and leaders and other important stakeholders around a shared vision for better health and wellbeing.

Over the last few years we have strengthened the support available for children and young people with emotional and mental health needs through support teams in schools and single point of access. This has led to more people being supported earlier, reducing the demand on statutory services.

Best start in life for children and young people

Current state

Families have told us that they sometimes experience difficulty interacting with the complex range of services and have to 'retell their story' to different services and professionals. However, there is no single, non-stigmatising point of access for family services that helps families to navigate and receive the wide ranging support they need.

Key issues

- A significant proportion of children and young people, 15 in every hundred, are growing up in households where no adults work, and 22 in every hundred children and young people live in low-income households.
- During the pandemic we have seen significant increases in demand for early help support, children in need and child protection.
- There are higher than average rates of children with an education, health and care plan (EHCP).

Strategy alignment

- Ockenden Review and Better Births
- Ambition within the South Yorkshire Integrated Care Strategy
- NHS Long Term Plan Priority
- Start for Life programme
- Barnsley Children and Young People Strategy and Early Help Strategy
- Barnsley SEND Strategy

Measure for success

- Increased early help assessments
- Reduced escalation to children's social care
- Increased continuity of carer in maternity
- Improved access to perinatal mental health services
- Improved access to mental health support for children and young people in line with the national ambition
- Increased access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism

Outcomes

- Improvements in school readiness and the gap between children from the most and least deprived communities
- Improved identification of, and provision for, children and young people with SEND but without an EHCP
- Reduced waiting times for child and adolescent mental health services
- Increased proportion of children with a healthy weight
- Reduced tooth extractions

What we will deliver

Create family hubs	Deliver the improvement plan and written statement of actions on SEND	Review children and young people's mental health services to improve access to support	Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism	Address over reliance of reliever medications; and decrease the number of asthma attacks	Improved access to perinatal mental health services	Improve oral health for childree

A joined up approach to preventing ill health

Our priority for 2023 to 2025

We will offer every smoker in Barnsley support to stop, making every contact count, and increase the support we provide to help people to address the drivers of inequalities.

Why is it important?

Healthy life expectancy is reducing in Barnsley. More people are living in poor health and depend on health services for treatment, care and support. There is a growing gap between the most and least deprived communities. A significant proportion of ill-health is due to disease that is preventable.

As little as 10% of the population's health and wellbeing is linked to access to health care. Things like economic and environmental factors, such as poverty, good quality housing, good education and employment opportunities and access to green spaces, impact significantly on health and drive health inequalities. In Barnsley, our approach is holistic, to tackle risk factors that impact on the health of the population.

Around 1 in 5 adults in Barnsley are smokers (18.3%), according to the national annual population survey (2019). This is significantly higher than the England rate of 13.9%. Smoking rates have been reducing over the last decade but remain high in some groups such as routine and manual workers, people with mental health and respiratory conditions and those who smoke during pregnancy.

Half of all smokers will die as a result of their addiction. Smoking and hypertension are the biggest contributors to premature mortality across the region. In 2018/19 alone, there were almost 4,000 hospital admissions of Barnsley residents for diseases that were totally or partly due to smoking.

Partners in Barnsley recognise that investing time and energy in prevention is essential to make long term demand for healthcare sustainable, even at a time when managing the every day operational demands feel incredibly challenging.

Where do we add value?

Barnsley Tobacco Control Alliance is leading work across the borough on behalf of the Health and Wellbeing Board. Our vision is to create a smoke-free generation in Barnsley, where smoking prevalence is less than 5% and children and young people can grow up in a place free from tobacco. Through the Active in Barnsley Partnership, health and care providers are working to increase levels of physical activity across our population with the ambition for a healthy and proud Barnsley where active living is part of everyday life for everyone.

Providers and commissioners are individually responsible for supporting people who want to stop smoking to quit. As a partnership we can strengthen this by making smoking a priority so that every contact counts in giving people the opportunity and encouragement to stop smoking.

A strengthened approach to prevention recognises the wider factors that impact on someone's health, as well as smoking, and will ensure that opportunities for interventions are not missed as people move between health and care settings. A quality improvement and behavioural science approach will ensure that we can collectively maximise our impact from brief interventions for everyone accessing healthcare, through to high intensity interventions for those requiring more specialised support.

We will increase the offer we make to the population to support them address the drivers of inequalities.

A joined up approach to preventing ill health

Current state

Healthy life expectancy is reducing. More people are living in poor health, many will depend on health and care for treatment, care and support. There is a growing gap between the most and least deprived. A significant proportion of ill-health is due to disease that is preventable.

Key issues

- High levels of deprivation impacting on the health and wellbeing of our population
- Smoking rates have been reducing over the last decade but remain high in some groups such as routine and manual workers
- Data recorded in general practice shows that smoking levels for people with mental health and respiratory conditions are significantly higher than the overall average
- 70% of smokers offered support to stop in general practice in the last two years
- High premature mortality for cardiovascular disease
- Significant variation in the number of smokers recorded versus the estimated numbers across GP practices
- Variation in treatment – blood pressure recording, blood pressure and cholesterol control

Strategy alignment

- Bold ambition in the South Yorkshire Integrated Care Strategy
- NHS Long Term Plan Priority
- Barnsley Health and Wellbeing Strategy
- QUIT

Measure for success

- Improved recording of smoking status
- Improvement in the proportion of people offered support to stop smoking
- Increased uptake of smoking cessation support
- Increased identification of hypertension and variability of estimated versus recorded prevalence between practices and along the social gradient
- Improved management of blood pressure and cholesterol
- Greater awareness of the risks of smoking, uncontrolled high blood pressure and cholesterol

Outcomes

- Reduced smoking rate in adults and smoking during pregnancy and recorded at time of delivery
- Closing the gap between the general population and routine and manual workers
- Reduced incidence of strokes and heart attacks

What we will deliver

Delivery of PROTECT – identifying potential missed diagnosis, improve lipid management, pharmacy first blood pressure monitoring	Provide more opportunities for physical activity including gym access, community fitness groups, active travel and healthy food	Local targeted campaigns and partnership heart health initiatives to tackle hypertension and stroke. “How’s Thi Ticker?” and “Caught in Two Minds” are working across primary care, local authority, charities, businesses and with residents to raise awareness, blood pressure checks and signpost to treatment.	Continue to build on our successful Making Smoking Invisible programme with a targeted focus on inequalities, building capacity and strengthening partnerships.	Further develop our existing comprehensive place tobacco treatment across community and QUIT services offering to help more people stop smoking and to increase the number of smokers engaging with effective interventions to quit smoking.

Better and fair access

Our priority for 2023 to 2025

We will bring urgent care services closer together by developing "an urgent care front door" that is an alternative to A&E. This will enable people to access the right care when they need it – creating a better service for all.

We will improve access to care and support in the community for emotional and mental health needs, including addiction and substance use.

Why is it important?

Despite GP practices providing more appointments and increasing numbers of face to face appointments, the public report it is difficult get an appointment with a GP and poor experience trying to make an appointment via telephone.

The long term trend is year on year increased in demand for emergency ambulances and A&E in Barnsley. This was interrupted by the pandemic but levels of attendances are now above what they were in 2019/20. Performance against targets such as the four hour target, ambulance response times and handovers suggests this level of demand is not sustainable.

Recent engagement with residents shows that access to services is the number one concern for the public.

Local analysis shows that a significant proportion of demand for urgent care services is linked to mental health, substance use and addiction and social challenges.

We know that there is a strong link between trauma and long term emotional and mental health needs.

Voluntary, community and social enterprise sector partners report that people from health inclusion groups, such as asylum seekers and refugees, find it particularly difficult to access and navigate health and care services because of barriers such as language.

Where do we add value?

The pressures on A&E and urgent care providers in Barnsley continue to grow as the needs of our population continues to change and capacity of services is not matched to the demand.

We have been working together to:

- expand the number of urgent out-of-hours GP appointments available
- provide direct access to the integrated multidisciplinary personalised care team (IMPaCT) – this is Barnsley's social prescribing service that supports people with their health and welbeing
- introduce physiotherapists and mental health practitioners in primary care
- re-establish GP presence in Barnsley Hospital A&E department
- create Barnsley Support Hub – this offers free mental health support in Barnsley town centre out of hours
- support people to start doing the things they love again and to stay in their own homes through dedicated reablement care

There is more to do and we know from feedback that we have received, sometimes residents are not aware or do not understand what services are available to them as an alternative to seeing a GP. We also know that sometimes people find it difficult to get the help they need for lots of different reasons including access to transport and communication barriers. By sharing data and insights we can identify and overcome these challenges.

We will improve the existing services we provide so that care is itself a tool to reduce health inequalities.

Better and fair access

Current state

Some people are accessing services that are not necessarily the most appropriate to their nature of need. Engagement with the public in Barnsley (through the work of the South Yorkshire Integrated Care Strategy) has shown that access to services is their top priority.

Key issues

- GP practices report a significant proportion of appointments relate to mental health problems, high emergency call numbers and A&E attendances for mental health complaints or diagnosis
- Rising demand for same day urgent and emergency care resulting in longer response times from ambulances, handover delays, crowding the A&E department and longer waits to be seen and admitted and impacting on experience and outcomes.

Strategy alignment

- Bold ambition in the South Yorkshire Integrated Care Strategy
- NHS Long Term Plan Priority
- NHS Operating Guidance
- Barnsley all age mental health strategy

Measure for success

- Increased number of people accessing services that can support their needs
- Improvement in community networks and non-health services strengthening community cohesion, support , and engagement
- Improved living conditions circumstances e.g. debt, housing sustainable employment
- Increased number of appointments in general practice including same day appointments
- Reduced appointments in general practice associated with mental health and social vulnerability
- Reduced A&E attendances associated with mental health and social vulnerability

Outcomes

- Improved wellbeing and reduced social vulnerability
- Improved access to urgent and emergency care
- Reduced Did Not Attends (DNAs) associated with mental health and social vulnerability

What we will deliver

Develop and implement an "urgent care front door" that will be an alternative to A&E	Work with the voluntary and community sector to build capacity and capability for trauma informed support	Implement the new GP contract requirements linked to access	Strengthen the access offer from primary care (including community pharmacy) for all with a focus on Core20plus communities	Increase personalised care interventions	Strengthen joint working between substance use and mental health services

Coordinated care in the community

Our priority for 2023 to 2025

We will provide more proactive care and support for people who are frail.

We will help people to live as well as possible until they die and to die with dignity.

Why is it important?

The frail population in Barnsley is growing at a greater rate than the population is ageing. People experiencing inequalities are more likely to experience frailty earlier in their life than expected and those with the greatest need often also have the greatest difficulty in accessing and receiving appropriate care and support.

Physical frailty can potentially be prevented or treated with things such as exercise, protein-calorie supplementation, vitamin D, and reducing the number of medications someone is prescribed or takes.

Across Barnsley approximately 11,500 people living with mild frailty or are pre-frail. Around 1,500 older people move into the frailty group each year. This happens when a person is in their early 60's on average. When this happens healthcare utilisation increases by between 100% (activity) and 300% (cost).

Compared to other areas, Barnsley sees a higher number of hospital episodes for frailty and dementia and year on year these have been increasing along with long lengths of stay (7 days+) in this group.

Barnsley sees particular high levels of people going to hospital because they have fallen, as well as multiple falls, and people being admitted to hospital at the end of their life. However, the proportion of people with end of life care planning in place in those who are frail is low at around only five in one hundred.

Where do we add value?

The term frailty refers to a person's mental and physical resilience, or their ability to bounce back and recover from events like illness and injury. By its very definition, frailty is multi-factorial, and requires a multi-disciplinary, person centred and community oriented response, that can only be delivered by organisations working together.

Similarly, good end of life care is holistic and involves effective communication between the individuals, those close to them and health and care professionals supporting them.

In the last year we have expanded urgent community response services, created virtual wards for frailty and tested a digital service for healthy ageing. We also piloted anticipatory care for older people by linking in with the voluntary and community sector to see how they could support older people with mild frailty.

Experience suggests that people at the early stages of frailty have an appetite for services that can support them to live healthier lives and that there is wealth of knowledge, talents and passion in community to help.

We will improve existing core services we provide so that care is itself a tool to reduce inequalities.

Coordinated care in the community for frailty

Current state

Increasing urgent and emergency care demand relating to growing frailty within our communities. Inpatients beds are often occupied by people with frailty and dementia who are at risk of de-conditioning and would be better supported at their home or place of residence.

Key issues

- High levels of frailty in Barnsley – more incidences in younger people than neighbouring areas
- Higher number of hospital episodes for frailty and dementia than regional and national comparators
- Year on year increasing long lengths of stay in Barnsley (7+days) most evident for respiratory
- High rates of admission for falls and repeat falls
- High rates of admission to hospital at someone's end of life and low numbers of people with frailty and dementia with future care planning in place

Strategy alignment

- NHS Long Term Plan – Healthy Ageing
- Health and social care integration

Measure for success

- Increased screening and assessment of frailty
- Improvements in assessment and treatment of falls, mental health in older people, dementia and bone health
- Increased utilisation of virtual ward capacity
- Increased referrals for preventative and early help interventions
- Increase capacity across the voluntary, community and social enterprise sector
- Increase capacity and capability within the workforce

Outcomes

- Older people are supported to live independently in their own homes for longer
- Reduced unplanned care for older people
- Improved rehabilitation outcomes length of stay, (derby scores and patient experience measures)
- Reduction in the median age of people entering adult social care
- Improved health related quality of life for people with long term conditions and carers

What we will deliver

Develop neighbourhood integrated working	Provide holistic assessments for older people to identify and treat potential health problems earlier	Create an anticipatory care register to be able to identify those with frailty to provide better planning and coordination of care across different services and teams	Review of Intermediate care model and pathways step up and step down beds including intensive recovery service	Undertake a review of the dementia support pathway	Development of integrated care pathways for respiratory	Independent sector market development to meet the changing needs of our population

Coordinated care in the community for end of life

Current state

Palliative and end of life care improves people's quality of life of and that of their families who are facing challenges associated with life-threatening illness. This also improves the quality of life of caregivers.

Key issues

- There are more people needing end of life care and support who are not identifiable on supportive care registers
- People are more likely to be admitted to hospital in the last three months of their lives in Barnsley than in other parts of the country
- Bereavement is an increasingly recorded as a factor in suicides

Strategy alignment

- National ambitions framework for palliative and end of life care
- Statutory duties for Integrated Care Boards

Measure for success

- Earlier identification of people at end of life (last 12 months) – increase the proportion of deaths who are people on supportive care registers
- Improved recording of preferences for treatment, ceilings of care and place of death - increase proportion of deaths that are people with end of life care planning in place
- Personalised care planning in place with support to self-manage and symptom control – improved experience at end of life and people who die in place of choice
- Increased capability and capacity in the workforce to support palliative care and end of life – number of people who have completed training in end of life care

Outcomes

- Improve care and support in the last year of life
- Reduced crisis care in the community for people at end of life – UCR to people at end of life
- Fewer hospital admissions in the last three months of life
- Improved equity of access to end of life care and support – proportion of people with end of life care in place from deprived communities and health inclusion groups
- Better utilised of current resources across the system – number of patients receiving hospice care

What we will deliver

Implementation and roll out of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) tool across all partners agencies in Barnsley	Baseline and mapping exercise for children and young people, adult palliative care and end of life services (including access criteria) against the Ambitions for Palliative and End of Life Care	End of life and palliative care knowledge and skills framework and training needs analysis and training offer	End of life and palliative care workforce plan	Participation in “Dying Matters” week

Improve impact on environment, economy and employment

Our priority for 2023 to 2025

We will establish a network of large organisations who are at the heart of Barnsley communities to improve our impact by the way we do our business

Why is it important?

The impact that the health and care sector has on health and wellbeing in ways other than the services it delivers is huge and can lead to a far-reaching benefit. The way we go about running these large businesses means we have a big impact on our local communities.

These organisations are sometimes called anchor institutions because they are 'rooted in place' and have significant assets and resources which can be used to influence the health and wellbeing of their local community.

Ensuring that we help to address and advocate for the links between the climate and health can lead to a better environment for the people of Barnsley. For example: choosing the right health technologies can reduce or even remove potentially large volumes of waste (e.g. the plastic waste from single-use PPE) and release of harmful gases (e.g. the anaesthetic gas desflurane). We can be a driving force behind the shift to renewable or even local energy and alternatives to private car use.

Ensuring that we support social mobility for Barnsley people will give more people who need the right opportunities for education and employment and, through it, better health. By strengthening health awareness and health and social care opportunities through local education and by making our recruitment and employment more accessible we can get more people into good jobs.

Ensuring that we understand our potential role in the local economy, we can help to build a more stable and inclusive economy, that is without poverty and that generates health and wellbeing through security. By looking at how we spend our money and buy our services, we can generate business and opportunity from and for health.

Where do we add value?

In its 2021-2030 strategy, Barnsley's Health and Wellbeing Board has committed to reducing health inequalities across people's lifetime - helping to ensure every child is given the best start in life, everyone can access the resources they need to live a healthy life and to age well. It also highlights mental health and addressing things like housing, employment and education which impact on our health.

Barnsley 2030 "the place of possibilities" is the social and economic development plan for the borough which looks across all sectors and has four key themes – Learning, Growing, Sustainable and Healthy Barnsley.

There are health related commitments across the plan, with those specific to inequalities including reducing poverty, improving access to quality housing and affordable energy, improving learning and social connections, and improving access to healthy and active lives.

Collectively, health and care organisations in Barnsley: employ around 12,000 people and provide care and support to approximately 40,000 people every week; has a budget of around five hundred million pounds; and consume huge amounts of energy and food, produce huge volumes of waste and generate massive amounts of vehicle use. This all has an impact on the health of Barnsley and it all needs to be factored in when we consider how we do business.

We will use our wider influence on the social, economic and environmental factors to tackle inequalities in Barnsley.

Improve impact on environment, economy and employment

Current state

Whilst there is lots of good work ongoing, the approach to how we do business in the health and social care sector in Barnsley is still very varied and not all of our ways of working and interactions with environment, economy and society incorporate health and wellbeing in the same way the way we deliver our services does.

Key issues

- We produce greater harm on the local climate and environment than we need to
- We spend more money in and procure more contracts from outside the local and regional economy than we could
- Our opportunities for employment can be made more accessible to and inclusive of people from the local communities in greatest need of good jobs

Strategy alignment

- NHS: Chapter Two of the Long Term Plan; Greener NHS; Core20Plus5
- UK's Net Zero Strategy

Measure for success

- Develop 'anchor institution' approaches and plans of partner organisations and as a network of health and social care partners
- Begin to measure of the number and size of contracts made locally
- Support for our workforce with protected characteristics, from inclusion groups and who are worst affected by the rise in the cost of living
- Develop an understanding of the make up of our workforce, including social gradient and representation of protected characteristics
- Review of environmental impact and actions to work within planetary boundaries

Outcomes

- More health and social care money spent locally
- Greater support from the sector to the local economy and business
- Stronger links between and health and social care and education locally
- More good jobs and development for people from more deprived local communities
- A reduction in health and social care waste and harmful emissions
- Better public, active, low-emission and shared transport options for our staff and service users, and more alternative options (e.g. remote and community consultations and care)

What we will deliver

Establish a Barnsley anchor network	Reduce waste and emissions from health and social care, and greater use of resilient and renewable energy	Explore a community development approach to health in our most deprived neighbourhoods working with primary care, community groups and the ward alliances.

Develop our workforce

Our priority for 2023 to 2025

We will fill gaps in the health and care workforce by strengthening routes into careers and providing support for those with additional needs

Why is it important?

There are pressures across the workforce with significant gaps in some workforce groups: with increased sickness absence, more people leaving for jobs and careers outside of the sector or retiring early, and fewer people actively seeking jobs.

There are not enough staff which affects all staffing groups. Local analysis shows that there is a gap between the supply of workforce and workforce demand over the next five years. It has also shown that approximately a quarter of the workforce are approaching retirement age.

As a result of the pandemic there has been an increase in work related stress across many sectors and in the NHS it is reported that this has resulted in people leaving the workforce, particularly older experienced staff, and new starters.

Engagement with local communities has shown that there is a poor perception jobs in care. Like many other lower paid sectors, the cost of living crisis is expected to impact on the care workforce, making roles less attractive than entry level roles in retail, manufacturing and logistics.

Across Barnsley there are relatively high rates of economic inactivity, including people not working due to long term illness or disability. It is a priority of the South Yorkshire Integrated Care Partnership to reduce the gap in employment for people with physical disabilities and learning disabilities and to provide every care leaver the opportunity to work in health and care.

Where do we add value?

The South Yorkshire Integrated Care Board workforce hub delivers a broad range of programme activities relating to future workforce, workforce wellbeing and human resources. This supports provider collaboratives, places, professional groups and individual employers. Working at this scale enables better planning of training places with higher education and allocation of workforce transformation funding.

Where we can add value as the Barnsley Place Based Partnership is working with communities, independent sector employers and employment support organisations to create routes into jobs, particularly entry level positions in health and care that do not require an extended period of study and higher level of qualification.

By working together we can support reshaping of the local workforce, including training and development to meet people's health needs as well as local challenges.

In 2022/23 we have successfully launched our Proud to Care training to employment. Whilst we have had a small number of learners we have seen the appetite of people to get into work despite some of the challenges they face. We have also learned there is a wealth of organisations, expertise and passion in Barnsley to support people furthest from employment into good jobs.

We have also seen our Project ECHO (Extension of Community Healthcare Outcomes) hub grow which provides training and learning across our health and care providers in Barnsley. This shows that our workforce are keen to keep learning and developing their practice to provide better care for our residents.

Develop our workforce

Current state

There are pressures across the workforce with significant gaps in some workforce groups: with increased sickness absence, more people leaving for jobs and careers outside of the sector or retiring early, and fewer people actively seeking jobs.

Key issues

- Not enough staff across the system which affects all staffing groups but particularly clinical, clinical support staff and non clinical roles
- Increased work related stress and burnout
- Approximately a quarter of the workforce approaching retirement age
- Increase in the number of people leaving the workforce, particularly older experienced staff, and new starters
- Poor perception of care, cost of living crisis and ongoing national disputes on pay and conditions making health and care roles less attractive

Outcomes

- The health and care workforce is more representative of local communities
- Fewer vacancies across the health and social care sector in Barnsley
- Improved staff engagement and satisfaction at work

Strategy alignment

- NHS People Plan and Promise
- Health and Social Care Integration
- SY Integrated Care Strategy to reduce economic inactivity and the gap in employment for people with long term health conditions and learning disabilities

Measure for success

- Recruitment via Proud to Care and Expression of interest
- Increased job applications and recruitment from deprived communities
- Increase the number of care leavers accessing apprenticeships and employment.
- Increase the number of students and apprentices in health and care including work experience, T-levels, nursing and allied health professional students and apprentices
- Increase the number of people returning to the health and care workforce through flexible working opportunities
- Reduced the number of leavers in the first five years of careers

What we will deliver

Refresh the Barnsley Workforce Strategy and produce clear delivery plan	Development of the Proud to Care Hub including joint recruitment activity and communications strategy to promote roles in the sector locally	Grow the numbers of students on placement in Barnsley and develop new apprenticeships opportunities and local student pathways	Work with colleagues across South Yorkshire to grow a reservist model and test flexible working opportunities for early careers

Involvement and equality, diversity, inclusion

Our priority for 2023 to 2025

We will work alongside local people and communities to better understand and develop what matters to them

Why is it important?

At the heart of our role is the commitment to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

Research has shown consistently that outcomes and experience of health and care are better where levels of engagement are higher.

Involving people and communities allows us to understand the services and the care that is on offer from the perspective of the people who use them, it can identify what is most helpful and what is most frustrating for them and how to make improvements.

Involvement gives people the power to manage their own health and make informed decisions about their care and treatment; and supporting them to improve their health and give them the best opportunity to lead the life that they want.

Accountability is one of the themes most apparent from the recent engagement in the South Yorkshire Integrated Care Strategy, alongside access, quality of care, improving mental health and wellbeing, and support to live well.

Our collective involvement work has also shown the importance of clear, consistent and regular communications that is accessible, ensuring that health and care services can be flexible and tailored to different people's needs and circumstances and the need to better involve carers and/or family members as equal partners in any planning and decision making that takes place.

Where do we add value?

We have agreed principles across the Barnsley partnership to engage with people to inform our decisions and codevelop services.

- Have a strong local focus and work on both strengths and solutions with local communities
- Value equality and the diversity of local communities
- Make sure information is accessible and jargon free
- Ensure that everyone has a voice and we listen and learn from our staff and communities
- Involve the right people, at the right time and come to you
- Keep it simple and be honest about what you can influence
- Avoid repeating the same conversations
- Be open and transparent with what we know and what we have done and why

Involvement and equality, diversity, inclusion

Current state

We have made progress on the governance and planning of how we come together as a involvement, experience and equality, diversity and inclusion colleagues across Barnsley and with teams working across South Yorkshire.

Key issues

- The recording of demographic data, protected characteristics and accessibility standards, is lower than it should be across some health and care services. This is often a combination of people not being asked some or all of the questions, or people not being comfortable in sharing the information. We know that recording and reporting on inclusion data is also challenging.
- We have lots of existing insights which we could make much more effective use of across the partnership and beyond . This include patient experience data.
- We want to focus on working alongside our diverse communities.
- We want to be better at, and put more focus on, working with local people and communities to produce plans and design services and solutions rather than just asking or informing them.

Strategy alignment

- Barnsley health and care communications strategy
- Barnsley 2030
- NHS South Yorkshire 'Start with People' involvement strategy

Measure for success

- An increase in staff confidence to have the conversation about demographic data collection.
- Re-invigorated primary care patient participation groups in each GP practice, supported by a primary care network involvement plan.
- High satisfaction scores on all involvement activity e.g. clarity and availability of information to make informed decisions, I statements .
- An insight bank in place.
- Inclusion of insights into our dashboards.

What we will deliver

Review and develop our model for engagement	Contribute to a South Yorkshire insight bank which brings Barnsley insights into one place for analysis and sharing.	Roll out a partnership wide campaign to improve demographic data collection.	We will grow and develop existing networks, to increase reach and active involvement across our diverse communities	We will work with programme and project leads to advise on and develop people and communities involvement plans aligned to the three tiers health equity approach.	Primary care network people and communities involvement plan.	Training and development programme to support colleagues to produce and design interventions alongside people who will be using them.

Estates

Our priority for 2023 to 2025

We will make the best use of our collective estate

Why is it important?

Good quality strategic estates planning is vital to making the most of greater cooperation and collaboration through our partnership to fully rationalise our estate, maximise use of facilities, deliver value for money and enhance people's experience when using health and care services.

It is vital that service and estates planning are joined up to ensure that the best estate is available to deliver the best health and care services and make wise, well founded investment decisions.

The estate is used to provide solutions with primary and community teams located in the same place to support multi-disciplinary team working, integrated service hubs across sectors, supporting care delivered closer to the communities where people live, supporting digital solutions and helping with workforce challenges of recruitment and retention.

The pandemic has had a significant impact on how the health and care buildings have been used to achieve social distancing, support remote working, provide “hot” clinics to provide access to services for people with infection and increase the number of planned operations and procedures to recover waiting lists.

The community diagnostics centre at the The Glass Works is an example of where alignment of clinical service and regeneration strategy came together leading to better access to services, providing residents with a more convenient way to receive ultrasound, x-ray, breast screening, phlebotomy and bone density scans.

Where do we add value?

We are committed to improving equity of access to services, deliver more care in communities and joining up care for those most in need.

Across our estates there are many multi-purpose buildings where different partners run services, sometimes alongside services from other sectors.

The health and care estate is not always as well used as they could be and there are opportunities to improve this whilst enhancing the range of services delivered in our communities.

This can only be achieved by collaboration across services and organisations and co-development with residents and communities.

Estates

Current state

There is a lack of understanding and clarity on the estate held across Barnsley and how this can be used more effectively across partners and voluntary sector to meet the needs of our population. Lease arrangements sit with individual organisations and flexibility remains limited on some of the estate across Barnsley.

Key issues

- There is a perception Barnsley estate is underused
- There is a lack of understanding of the estate portfolio across Barnsley
- There is a lack of strategic oversight of estate linked to place plans
- Some estate is not fit for purpose and is not flexible to meet service demands, pressures and change plans

Outcomes

- Estate is used to capacity with plans for development clearly identified to access available funding sources.
- Estate is accessible and meets the needs of people across Barnsley, with one approach to health and care.

Strategy alignment

- Government Estates Strategy

Measure for success

- Estate use increases from current baseline measures
- Estate portfolios are understood across the partnership
- Estate is fit for purpose with development plans clearly identified to meet our strategic aims
- Estate is flexible in its use across clinical, care and voluntary sector services irrelevant of provider

What we will deliver

Develop the Barnsley strategic estates group with a clear delivery plan to be agreed with partners	A place estates strategy – joining together of individual organisation strategy – linked to strategic aims and delivery plans	Mapped out estate across Barnsley, with details of use	Review of lease arrangements across the place to allow flexible use of space	Forward plan of estate development requirement to allow access to capital as it becomes available

Digital and information

Our priority for 2023 to 2025

We will develop a Barnsley digital roadmap and deliver a shared care record solution

Why is it important?

Digital transformation of health and social care is a top priority for the Department of Health and Social Care and NHS England. The long term sustainability of health and social care is dependent on having the right digital foundations in place.

Digital technologies have become an integral part of how people manage their health. They can help access personal health information, and support people to feel empowered and involved in self care. A large review of studies found that text messages can help people quit smoking. Automated text reminders alone increased quit rates by 50% to 60%. Apps can remind people to take their medications on time. Giving people access to their own records can help people understand their conditions, and empower them to take an active role in managing them. Several studies have shown that digital therapy is effective. Technology allows us to connect with others without being physically together.

In 2022/23 the Barnsley Partnership has been making the most out SystmOne by using it to support shared care across organisations and settings. This means for example that hospital doctors and social workers can now view a person's clinical records from primary or community care with their consent to support better care planning.

We have been working with industry partners to deliver a BETA service evaluation of STRIDE which aims to help older people to live strong and independent lives for longer. New technologies have been deployed into care homes to prevent people falling and in primary and community care to support health checks for people with learning disabilities.

The NHS Pathways system has enabled healthcare teams to use the data and information in clinical records and other systems to identify people at risk, optimise and personalise their care.

Where do we add value?

The vision of the Digital Barnsley Strategy is that Barnsley is a connected, smart town with a culture of innovation, collaboration and strong digital leadership.

The strategy helps in delivering all four main areas identified within the 2030 plan including a Healthy Barnsley by connecting health partners to provide better quality care, using digital to connect our communities and addressing digital exclusion to improve connectivity, reduce isolation and exclusion.

Working as a place partnership means that organisations strategies and plans are aligned to ensure that systems resources are allocated to shared priorities for services, patients and residents.

Collaboration will ensure that digital and technological solutions are can work together of across services and settings to deliver best value for money and provide a seamless service for patients.

Shared intelligence means one version of the truth and supports evidence based decision making so health and care in Barnsley is population health, prevention and inequalities led.

Digital and information

Current state

- Established health intelligence group and joint working between partners
- Health intelligence reporting – regular dashboards, agile sprints and bespoke products
- Limited interoperability for direct care

Key issues

- Information sharing between organisations – particular restrictions around primary care and commissioning datasets
- Lack of analyst capacity
- Ability to link data through a common identifier
- Lack of clear digital roadmap and strategy with could result in lack of interoperability or inefficient use of resources (e.g. technology enabled care)
- Clarity on the role of different organisations and teams

Strategy alignment

- National information board – Paperless 2020
- NHS Operating Guidance
- Population health management
- Population health, health inequalities and prevention-led Integrated Care System in South Yorkshire

Measure for success

- People not having to tell their story multiple times to health and care services
- Improved clinical safety
- Improved efficiency – reduced paper letters, repeat requests for tests and referrals
- Effective use of resources – intelligence led system

Outcomes

- Number of organisations sharing and accessing information from the Yorkshire Shared Care Record
- Number of users accessing patient information through interoperability

What we will deliver

Identify services to adopt the use of the Shared Care Record solution to improve access to information supporting the Barnsley partnership shared goals	Develop a digital Roadmap	Work with local groups, combining skills and resources in Barnsley to offer comprehensive support including access to devices, skills and confidence, and connectivity	Work with partners across South Yorkshire on priority digital programmes including digital services for our patients, digitising social care and digital primary care

Working more closely with the (VCSE) sector

Our priority for 2023 to 2025

We will strengthen our partnership with the voluntary, community and social enterprise sector

Why is it important?

Barnsley's VCSE Sector is made up of a huge range of inspirational, passionate people who help our local people. The organisations and groups vary in size from international bodies to groups made up of a small number of people. They work hard to make sure they can ehance our services and help people of all ages in Barnsley live better lives. The diversity of the VCSE sector is a strength to be recognised and celebrated.

The sector brings specialist expertise and fresh perspectives to service delivery that is well placed to support people with complex and multiple needs. The VCSE sector has, and continues to, play an important role in keeping people connected.

Our VCSE Sector reaches deep into communities. They are vital.

In 2023, NHS South Yorkshire Integrated Board and the VCSE sector in South Yorkshire agreed a memorandum of understanding (MOU) that recognises and values the VCSE as a key partner within the health and care system, and sets out how the Integrated Care System and the VCSE will work together to improve health and care. This agreement builds on several years of work to bring together organisations into a network and VCSE alliance. The agreement pledges to embed VCSE participation in every level of out integrated care system.

The ethos of the VCSE Alliance is that there are opportunities to share work that is happening across Barnsley with the other places in South Yorkshire, and share where this is working at a regional level. As part of this, there are clear mechanisms to co-ordinate equitable VCSE involvement from Barnsley and the other places (Doncaster, Rotherham and Sheffield.)

Where do we add value?

Health and care partners in Barnsley have supported the establishment of the Voluntary and Community Sector Strategy Group which has now developed into an engagement structure that all VCSE organisations can engage with. Through this process an Alliance has grown which brings Children's Services together with the children and young people's organisations in the sector.

We have been providing training for volunteers and organisations to support safeguarding and helping with governance and organisational support.

In 2021 we worked with organisations across the VCSE to form the Barnsley Older People's Physical Activity Alliance (BOPPAA) to increase the provision of physical activity programmes that will improve the strength and balance of those over 50 living in Barnsley.

There are over 60-member organisations who make up BOPPA and they deliver over 170 physical activity sessions across the borough.

One activity which has proved popular is the Healthy Bones and Fall Management class which sees over 100 people attend regularly. One person who attended a class commented: "You get wary as you get older about doing things. This has really increased my confidence to be able to do things."

Working more closely with the (VCSE) sector

Current state

- Good working relationship with the VCSE through establishment of the Voluntary and Community Sector Strategy Group
- The VCSE is increasingly being recognised for the role it plays in support better health and wellbeing through offers such as social prescribing
- More people are being supported to get involved with groups and activities provided by VCSE organisations within communities

Key issues

- There are around 250 groups registered on the Barnsley CVS database but it is estimated that there around 1,000 groups in total
- The VCSE can be competitively minded because it has needed to be. However collaboration is growing, particularly through alliances in Barnsley such as the Dementia Alliance, Migrant Partnership, Youth Alliance and Older People's Physical Activity Alliance
- The VCSE bring significant investment into Barnsley. However, our local lottery funding lags behind others
- It is important that VCSE capacity can meet the growing demands for its offer
- Sometimes VCSE organisations are not recognised for the level of training and specialist interventions that they deliver within care pathways and referral processes

Strategy alignment

- Building Strong Integrated Care Systems (ICS) Everywhere: ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector
- Memorandum of Understanding between NHS South Yorkshire Integrated Care Board and the VCSE Alliance
- South Yorkshire Integrated Care Strategy Five Year Plan and System Development Plan 2022

Measure for success

- Mapped out the VCSE sector across Barnsley
- Increased involvement and participation of VCSE representatives across programme boards and working groups
- Increase engagement and involvement from seldom heard communities through VCSE partners
- Increased capacity across the VCSE sector to support health and care priorities in Barnsley

What we will deliver

Support the completion of State of the Sector research	Strengthen engagement with the VCSE sector through emerging structures and alliances	Build opportunities for VCSE organisations to work together	Ensure the VCSE sector has a strong voice in initiatives alongside other sectors	Celebrate and promote the successes of the VCSE sector and volunteers

Operational planning – delivery focus

Area	Priority	Where
1. Urgent and emergency care	(1a) Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 (1b) Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 (1c) Reduce adult general and acute (G&A) bed occupancy to 92% or below	UEC Alliance and Places
2. Community health services	((2a) Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard (2b) Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	UEC Alliance and Places Places and Primary Care Alliance
3. Primary care	(3a) Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need (3b) Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 (3c) Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 (3d) Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	Primary Care Alliance and Places
4. Elective care	(4a) Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) (4b) Deliver the system- specific activity target (agreed through the operational planning process)	Acute Federation
5. Cancer	(5a) Continue to reduce the number of patients waiting over 62 days (5b) Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days (5c) Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Cancer Alliance
6. Diagnostics	(6a) Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% (6b) Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Acute Federation
7. Maternity	((7a) Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury (7b) Increase fill rates against funded establishment for maternity staff	Local Maternity and Neonatal System
8. Use of resources	(8a) Deliver a balanced net system financial position for 2023/24	All building blocks
9. Workforce	(9a) Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	All building blocks
10. Mental health	(10a) Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) (10b) Increase the number of adults and older adults accessing IAPT treatment (10c) Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services (10d) Work towards eliminating inappropriate adult acute out of area placements (10e) Recover the dementia diagnosis rate to 66.7% (10f) Improve access to perinatal mental health services	MHLDA Alliance and Places
11. People with a learning disability and autistic people	(11a)Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 (11b) Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit	MHLDA Alliance and Places
12. Prevention and health inequalities	((12a) Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 (12b) Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% (12c) Continue to address health inequalities and deliver on the Core20PLUS5 approach	Place and Prevention Programme