FINAL DRAFT – SY ICB Response National 10 Year Health Plan

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

Positive framing

- An increased emphasis on the positive work of health and care organisations to improve public perception, not just focusing on our direct delivery, but the contribution we make indirectly as large anchor institutions.

- A focus on creating positive conditions for joined up approaches across public services and industry locally, with significant devolution and local autonomy, linked to a clear outcomes framework supported by governance that enables cross sector working.

A focus on children and young people

- A strong focus on early development for babies and children & young people with a section on maternity and children and young people. Given the significance of the first 1001 days setting the foundations for lifelong emotional, physical and mental health wellbeing. Including parity of mental health, acknowledging the increasing number of children and young people with mental health challenges.

- A strengthened focus on neurodiversity for children, young people and adults, needs led with a whole system response. Reinforcing the need for a collaborative approach to improve diagnostic pathways and support, with greater flexibility to work collaboratively with families and schools around the SEND agenda and ensuring reasonable adjustments are made for those who are neurodiverse.

Working with citizens

- A focus on responding to what matters to our citizens. In South Yorkshire this includes:
    - Accessibility - improving access to services and information and addressing barriers to access
    - Affordability - addressing challenges with the cost of transport, medication and treatment
    - Agency – Greater control of their own care, support and information to navigate the health and care system and access to resources and knowledge to live healthier lives.

- Increased emphasis on the need to understand the insights and diverse experiences of people in communities and a commitment to work with and alongside people to build on what is strong to codesign services to address barriers and reduce health inequalities.

Working with voluntary sector

- A strengthened commitment to working with voluntary community and social enterprise sector as equal partners supported by a commissioning and financial framework that enables this to be sustained. As they are uniquely placed in our communities to support those with greatest needs and reduce health inequalities and their role as a strategic enabler for all three big shifts.

Public health / wider determinants / prevention

- An increased focus on public health, the wider determinants of health, prevention and early intervention in a way that is pro equity to reduce health inequalities. Facilitated by greater alignment of cross government policy action on wider determinants and modifiable risk factors with increased local flexibility to support collaborative action on joint priorities.

- National support for major public health interventions, such as addressing obesity, smoking and water fluoridation, the latter is supported in South Yorkshire as we have a high level of dental extractions.

- A clear national policy direction on prevention at scale, supported by a financial framework, with a commitment to enable long term action at sufficient scale targeted at those with greatest needs. This

includes supporting and expand programmes such as the South Yorkshire QUIT Programme and secondary care alcohol care teams.

- Increased training and continual professional development for all health care professionals and supporting staff in the knowledge and skills needed for everyone to take an effective role in enhancing prevention and decreasing health inequalities, from undergraduate and foundation courses onwards.

- An increased focus on secondary prevention and making every contact count to prevent the acquisition of additional long-term conditions. A focus on optimal long term condition management and managing the increasing levels of multimorbidity, taking a holistic approach rather than silo disease specific care. Facilitated by better-aligned national long-term condition (LTC) programmes including multimorbidity.

- Move away from the yearly SDF funding to recurrent funding for implementation at scale the key high impact secondary preventions identified by NHSE e.g. cardiac, stroke and pulmonary rehabilitation, together with increased flexibility in the national models for rehabilitation to reduce inequities in access.

- Maximising the opportunity to take collective action on the commercial determinants of health to reduce exposure to harmful advertising for our most deprived communities.

- Increased alignment of health and housing with resource, flexibility, and support to drive joint action. Good quality housing is an important protective factor and poor-quality housing can pose a direct threat to people's health and wellbeing. The impacts of poor housing are reflected in health inequalities in South Yorkshire and there is a disproportionate impact on those living in deprived neighbourhoods.

Economic development - maximising health and care anchor role

- More emphasis on the fourth core purpose of an Integrated Care System to maximise the contribution the NHS can make to social and economic development as large anchor institutes. Including increased focus on the relationship between the NHS, health and the economy as articulated in Darzi. The impact of ill health on ability to work is evident in South Yorkshire, with high levels of economic inactivity due to ill health. Resource and support to align and mobilise initiatives focusing on health and work is needed to accelerate delivery. As is the need to strengthen the health and wellbeing offer for our health and care workforce, noting that healthier workers are more productive at work.

- Increased support to maximise the opportunity afforded by the life sciences industry as a growing industry in South Yorkshire that has an opportunity to further contribute to job creation for local people.

Health inequalities

- Rebalancing national priorities between NHS performance and addressing health inequalities with an outcome focussed approach to accountability (covering inequalities and health outcomes). Supported by a national shift to incorporate reporting of inequality gaps within performance reporting of acute and primary care activity (including inclusion health groups). Plus, increased focus on health inequalities in work to reduce waiting lists and support people to keep well as they wait.

- Strengthening the delivery of the CORE 20+ framework for adults and children and young people and advocating models of community support for those with the greatest needs. More support for the delivery of equality and equity action plans via local maternity networks. Continued focus on women's health, improving outcomes and reducing health inequalities for women and girls.

- Strengthened focus on those who are socially excluded, and experience multiple risk factors often described as health inclusion groups, as a cohort that particularly experience poor outcomes.

- Increased parity for mental health, emphasising the need to take a personalised approach encompassing mental health and wellbeing as well as physical health. Increased focus on prevention, early intervention and addressing health inequalities. Strengthened support for providers, including mental health provider collaboratives responding to increasing demand post covid and greater levels of mental health need in children and young people.

- A continued focus on supporting those with learning disabilities and autism to live longer healthier lives, ensuring reasonable adjustments are in place and addressing health inequalities.

- Strengthened connectivity with research and innovation partners with a focus on primary and community care and reducing health inequalities.

- Ensure alignment with action to transform adult social care through the development of the adult social care plan, each contributing to the delivery of neighbourhood health. Use increasing understanding of cross sector cost increases and greater flexibility for joint approaches to find collaborative solutions.

Financial Planning / Regulation

- Realignment of financial incentives to support the shift out of secondary care and encourage prevention.

- Outcome focused policy and financial frameworks that enable greater joint working between health partners, Local Authorities and South Yorkshire Mayoral Combined Authority, with increased flexibility to use resources to support those with greatest needs to improve outcomes and reduce health inequalities.

- A longer-term and more flexible financial planning arrangement that enables multiyear planning.

- Relaxation of CDEL rules regarding private sources of capital.

- Less national specificity around capital funding and the ability to deploy financial resources flexibly between revenue and capital. More timely, predictable capital that is more strategically aligned to transformation programmes that enables the three shifts, alongside meeting maintenance challenges.

- Less emphasis on regulatory oversight, and more focus on creating an environment that enables collaboration, fosters creative approaches, drives continuous improvement and innovation.

- Less emphasis on individual provider performance, increased support for provider collaboratives and an increased focus on improvement and outcomes.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Key challenges in moving care from hospitals to community include:

- Historic perpetual under investment in primary and community health and social care
- Insufficient workforce, capacity and capability in primary care.
- Financial flows that have been misaligned with the policy direction of ‘left shift’ and increased spend in hospitals by default resulting in inability to invest in the community.
- The complexity of community services, in that they are led and delivered differently with a mix of operating models and provider hosts in South Yorkshire with limited resource to collaborate.
- Recruitment and retention challenges in primary and community services
- Delivery of multidisciplinary models and integrating neighbourhood teams with the different cultural approaches of health and care staff and different levers and incentives at play.

- A mismatch of national programmes with time limited, often in year non recurrent revenue funding that incentivises community hub development for different groups e.g. family hubs, women's health hubs, mental health hubs resulting in a complex fragmented approach.
- Limited access to capital funding that supports transformation of primary and community estate
- Challenging discharge processes limited intermediate care facilities and under resourced social care, delays in securing packages and limited nursing, residential care home options.
- Planning and performance and data collection is all focused on the acute sector.
- There has not been sufficient sustained focus and workforce support for wider primary care including dentistry, optometry and pharmacy to enhance their offer in the community.

Key enablers in moving care from hospitals to community include:

- Working with citizens to codesign services in the community that better meet their needs.
- Financial flexibility to enable investment in primary and community care and further development of wider primary care and the primary and secondary care interface.
- Sufficient sustainable funding and development support for general practice and wider primary care.
- Access to timely capital to support transformation of primary and community estate and IT
- A focus on neighbourhood health, integrated working with wider primary, community and social care
- Enhancing digital capability to support primary and community care including access to shared care records, virtual wards and remote monitoring.
- Efficient hospital discharge pathways enabled by well resourced timely social care and care homes.
- Flexible workforce models and skill mix that enable staff to work at the top of their license, make use of technology and digital capabilities to enable remote working and offer rotation opportunities across community and secondary care.
- Partnership approaches including working with local authorities to identify opportunities to co locate and co deliver services and align these with regeneration programmes to support the local economy.
- Maximise opportunities for transformation by resourcing and supporting wider primary care including dentistry, optometry, and community pharmacy.

CASE STUDY

Health on the High Street in Barnsley

- Health on the High Street is a trailblazing initiative in Barnsley that is bringing access to a range of health and wellbeing activities into Barnsley town centre, improving access to health and bringing increased footfall on the high street, a health and wellbeing hub will be at the heart of this approach.
- Phase one of this initiative was the creation of the Community Diagnostic Centre which already offers a range of diagnostic services, such as CT, MRI, ultrasound, x-ray, breast screening, and phlebotomy.
- Phase two is the development of a health and wellbeing hub in the Town Centre. This will see a shift of the major hospital based outpatient services into a high street location. By working with key partners such as Barnsley Hospital, Barnsley MBC, Barnsley Premier Leisure and South West Yorkshire Partnership NHS Foundation Trust (SWYFT) and other partners including the voluntary sector. The Hub will host a range of health and wellbeing services, as well as NHS outpatient services, a gym and wellbeing centre, and mental health services, in addition to other related council services.
- The first services including some outpatients will begin to be delivered in 2025 with the full reconfiguration of the building and fully operational health and wellbeing hub being completed in 2027.
- To date the Community Diagnostic Centre has reduced waiting times, increased uptake rates (e.g. 22% increase in attendance for mammograms and a 24% reductions in DNAs) and improved patient satisfaction. It has also had a positive impact on the workforce, with increased job satisfaction and morale as a result of the central location and working environment. In addition to increased footfall into the town centre (an additional 55,000 visits) contributing to increasing economic prosperity in Barnsley.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Key challenges in making better use of technology in health and care include:

- Slow and uneven implementation of digital transformation programmes resulting in variation in delivery.
- Outdated infrastructure and high cost of IT solutions with a broad and complex marketplace.
- Lack of interoperability of IT systems across health and care.
- Complexity of multiple IT systems and applications in use across health and care in different services.
- Underinvestment in capital and technology, including diagnostic kit and estates, insufficient funding for digital automation and digital transformation all resulting in variation and low levels of digital maturity.
- Shortage of skilled digital professionals and competition with private sector for skilled expertise where pay is more favourable also presents a barrier to digital transformation.
- Limited digital support for the health and care workforce, limited involvement of staff in digital transformation and lack of capacity to contribute.
- National programmes are often time limited with unrealistic delivery timelines that focus on the technology rather than change management and benefit realisation.
- Digital transformation is not always as well connected to strategic infrastructure developments.
- Challenges with information sharing and information governance, date use and security.
- Risk of cyber incidents
- Underinvestment in telehealth care to promote independence and reduce reliance on statutory services

Key enablers in making better use of technology in health and care include:

- Coordinated national programmes with realistic timelines that consider sustainability at the outset.
- Workforce development to enable health and care staff to take full advantage of digital and technological innovations supported by skilled digital professionals.
- Co production of digital initiatives with clinicians, health, and care staff to seek greater ownership and to ensure that the software meets their needs.
- Increased use of digital platforms to enable data and insight-led approaches across health and care.
- Sustained focus on digital maturity, including tools to support population health management, risk stratification, improve access to primary care such as digital telephony, support self care and delivery of optimum LTC management. Alongside digitising community care and enabling shared care records.
- Increased use of digital capability to reduce health inequalities to identify and target interventions to support those with greatest needs and maximise the use of remote monitoring.
- Integration of technology across programmes to reduce health inequalities e.g. learning disability flag on summary care records.
- Simultaneous action on digital inclusion to avoid widening health inequalities through coordinated sustainably funded approaches with partners such as citizens advice.
- Maximise the use of the NHS App, increasing public confidence in its safety and capability.
- Making use of digital/NHS App to develop and maintain directory of services that helps to provide digital services to our public, including information and support to navigate the system and services to offer options including alternatives to hospital.
- Investment in telehealth care to promote independence.

CASE STUDIES

South Yorkshire Digital Inclusion Programme

- Research has shown people living in deprived communities; with long term health conditions; disabilities and/or protected characteristics are more likely to be isolated and digitally excluded.
- The South Yorkshire digital inclusion programme offers comprehensive support including access to devices, skills and confidence, and connectivity. The main aim of the programme is to bridge the digital divide and help people use and access online services safely and with confidence.

- Citizens Advice has been a key partner of our digital inclusion programme and their insight to our local population has helped us to shape and target our support offer. Workstreams led by the Citizens Advice branches include, connectivity, proactive community engagement, digital advice, social infrastructure, and skills training.

Primary Care Digital Telephony

- The Digital Telephony Programme was introduced by NHSE to help GP practices move away from analogue phone solutions to approved digital solutions before the December 2025 deadline.
- There were 33 practices in South Yorkshire (19%) identified as still reliant on analogue solutions, who were eligible to be in Phase One of our Programme. 68 practices in South Yorkshire will have received one-off funding to help them move to cloud-based telephony solutions under this programme. 39% of practices in South Yorkshire have received funding support to move to an approved cloud-based telephony system. Supplier go live dates have been delayed due to this being a UK wide programme but by late Autumn all of our 170 practices in South Yorkshire will be on cloud-based systems.
- Once the cloud-based telephony systems are in use we will be able to better understand patient behaviours contacting practices. This insight into patient demand and access trends will help us understand and support operational pressure in general practice and inform improvement work.

Expansion of Virtual Wards – Remote monitoring

- Virtual Wards provide consultant led acute care to a patient in their preferred place of residence, through remote monitoring (telephone and digital monitoring equipment) and face to face support from community clinicians. The virtual ward service is designed for patients who would otherwise require care in a hospital bed. The delivery of virtual wards is now operational across South Yorkshire.
- The Barnsley VW service is made up of two specialities, frailty and acute respiratory infection, and is delivered across a partnership of acute and community services. Each speciality has four pathways for patients to access the service, step down from an acute bed, step up from community services including Primary Care, identifying patients in ED, and referral via Yorkshire Ambulance Services.
- The Virtual Ward service was designed to provide pathways for integrated early supported discharge and admission avoidance that will improve patient outcomes, provide acute care to patients in their preferred place of care and improve digital working across Barnsley.
- Initial evaluation of the virtual ward provision in Barnsley shows that the average readmission rate for virtual ward patients is lower than the average readmission rates from traditional hospital wards. The feedback received from patients, their families and staff have also been predominantly positive.
- The virtual ward service has also fostered the development of strong relationships across acute and community partners in Barnsley resulting in shorter inpatient admissions, earlier discharges and enhanced digital connectivity across partners.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Key challenges in early identification and addressing causes of ill health include:

- Levels of deprivation and variation in the wider determinants. 1 in 4 residents in South Yorkshire live in the tenth most deprived decile of England. 37% live in the top 20% most deprived areas.
- The complex system of influences shaping people's behaviour makes it difficult to address risk factors like smoking, alcohol use, poor diet, and physical inactivity.
- Significant reduction in public health funding inhibited investment in public health, health promotion, disease prevention and early identification. Alongside disjointed policy and decision making.

- Financial flows have been misaligned with the policy direction of left shift and resulted in increased spend in hospitals and inability to invest in prevention, early identification, and upstream interventions.
- Limited investment in primary and community preventative approaches/initiatives and services.
- Increased levels of mental ill health, as those with mental health issues are more likely to develop preventable physical health conditions.
- Reduced vaccination uptake and increased variation in vaccination rates.
- Prevention is currently given low focus by clinicians working under pressure to meet urgent needs
- Lack of training of staff, including lack of focus on prevention in undergraduate curriculum
- Culture change needed for health care professionals to all see prevention as their role
- Lack of 'out of hours' preventative services e.g. for childhood vaccinations, screening, health checks
- Lack of public awareness of signs and symptoms of common diseases and the measures they can take to reduce their risks and the support available e.g. stop smoking services.
- Inability to get primary care appointments, leading to people delaying seeking care.

Key enablers in early identification and addressing causes of ill health include:

- Coordinated cross government approaches to address modifiable risk factors and wider determinants.
- National support for public health interventions, addressing obesity, smoking and water fluoridation. Including where relevant legislation, working with industry, national campaigns.
- Working with and alongside our communities to codesign services that address barriers to access, meet their needs and thus contribute to reducing health inequalities.
- Increased awareness amongst citizens and staff of the early signs of ill health, e.g. cancer symptoms
- Increased primary care access so people do not delay seeking care.
- Provision of preventative services (e.g. vaccinations, screening, health checks) in evenings/weekends.
- Strengthened delivery of the CORE 20+ framework (adults and CYP) through ensuring frameworks and incentives in place to support implementation.
- Ensuring that national programmes e.g. Cancer, CVD etc are approached as LTCs (including cancer) and pro equity, with a focus on those with greatest needs including health inclusion groups.
- An increased focus on intensive secondary prevention and making every contact count to prevent the acquisition of additional long-term conditions after the first LTC is diagnosed.
- Increased access to rehabilitation and chronic pain management services
- Adequate funding to support the implementation of prevention/LTC related NICE technology appraisals and clinical guidelines e.g. for the new obesity drugs.
- Increased focus on prevention of diabetes and a comprehensive obesity strategy that is well funded.
- Work driven through national programmes that focus on mental health, learning disabilities and autism to address health inequalities with a focus on prevention and early identification of disease.
- Integrated neighbourhood working, including primary, community, mental health and voluntary sector with communities, and roles such as health champions and social prescribing mechanisms.
- Opportunity to maximise the delivery of prevention programmes such as the National Diabetes Prevention Programme, ensuring both face to face and digital options.
- Opportunity to ensure that contracts with wider primary care balance prevention, early identification with delivery of activity e.g. dentists.
- Models of intensive community support working with the voluntary sector to support those with greatest needs, for example the Early Years Pilot work in South Yorkshire.
- Supporting delivery of equality and action plans driven through maternity networks.

CASE STUDIES

Child Health Equity Collaborative

- The Child Health Equity Collaborative (CHEC) is a partnership of the UCL Institute of Health Equity, Barnardo's and three partner ICSs (Birmingham and Solihull, Cheshire and Merseyside, and South Yorkshire). The CHEC is focusing action on the social determinants of health as central to improving outcomes among children and young people, recognising that they are generally not sufficiently included in policies, services and interventions.

- It has coproduced a Health Equity Framework with children and young people. The main purpose of the Framework is to support action for greater equity in children and young people's health and wellbeing. The Framework is being used to inform new ways of working that are set apart from traditional health service-based approaches by testing interventions which will take place outside healthcare settings. An intervention has commenced in Rotherham with health, voluntary sector, local authority and education partners with a focus on those with low school attendance.
- It connects with other South Yorkshire initiatives including the Safe Place to Sleep Programme led by our South Yorkshire Mayoral Combined Authority and supported by our South Yorkshire Integrated Care Partnership and the Early Years Pilot through our Local Maternity and Neonatal Network, which is focusing on intensive community support for families with the greatest needs. Collectively contributing towards the delivery of our bold ambition to improve outcomes and reduce inequalities for children and young people in South Yorkshire.

Sheffield North East Model Neighbourhood Programme

- Sheffield's North East Model Neighbourhood Programme was launched last year as an ambitious initiative to reduce health inequalities in the city by improving the lives and health of four of the most deprived neighbourhoods.
- The model is to empower, strengthen and connect communities to create health rather than providing health care or treating illness. The approach is to devolve power to communities to lead the development of local plans. The aim is to strengthen connections and build community capacity to address issues that are important to them, not us.
- The work is based on the principle that communities have the knowledge, skills and assets which means they are best placed to identify and respond to many of the challenges that they face. The ICB is working alongside local people to enable them to know their neighbours, develop strong relationships and networks of people who support and look out for each other. Working together to build thriving community infrastructure that will also support the local economy.
- The work involves investing in the voluntary sector to boost their capacity to develop community development approaches. This includes ACT, Fir Vale Community Hub, Reach Up Youth and SOAR.

South Yorkshire QUIT Programme

- The South Yorkshire QUIT programme is large scale (£2.5M pa) programme embedding treatment of tobacco addiction in all our secondary care settings. All South Yorkshire acute and mental health Trusts are screening patients on admission and supplying Nicotine Replacement Therapy
- The QUIT programme is fully embedded across all 8 trusts in South Yorkshire (Acute, Mental Health and Children's). The programme has over 25 partners across the NHSE, Local Authority, voluntary sector, Community Stop Smoking Services and the University of Sheffield as evaluation partners. It was recently a runner up at the NHSE Parliamentary Awards.

- The QUIT programme has 4 key strands:
    - **QUIT for patients:**
        - Inpatients – identification of smokers on admission and provision of NRT and specialist support to encourage patients to undertake a quit attempt. Following discharge patients who want ongoing support are referred to Community Stop Smoking Services or if they have a severe mental illness by the MH Trust QUIT teams.
        - Outpatients – specialist support for patients in key outpatient pathways & onward referral to community stop smoking services.
        - Community mental health – specialist support from MH QUIT teams for up to a year.

    - **QUIT for parents** - Sheffield Children's Hospital is the only children's hospital in England that is providing specialist support to children and advice and onward referral of parents to community stop smoking services. Free NRT is available to parents who smoke while their children are in hospital from the hospital's outpatient pharmacy.

- **QUIT for staff -** Over 180 staff members have been supported to quit.
- **QUIT for a smokefree environment** - Supporting Trusts to become smoke free sites

- The QUIT programme has recorded over 2,900 quits. Many more people will have quitted without ongoing support and the Programme is also motivating family and friends to quit as well.
- The 10 Year Health Plan with its focus on treatment to prevention is well placed to ensure sufficient support and resource is committed to support the delivery and expansion of large-scale prevention programmes such as the SY QUIT Programme. It is also well placed to strengthen Health and Wellbeing Boards and Integrated Care Partnerships to proactively support collaborative action on wider determinants and modifiable risk factors such as smoking, through supporting the development of Tobacco Alliances.

Diabetes Transformation Programme

- Diabetes poses a major, and increasing, challenge for the health of the South Yorkshire population and is a significant contributor to health inequalities. Nearly 20% of the South Yorkshire population has diabetes or non-diabetic hyperglycaemia, putting them at high risk of developing type 2 diabetes.

In South Yorkshire we are:

- Decreasing the risk of developing type two diabetes – threefold increase in the number of referrals for people with non-diabetic hyperglycaemia to the National Diabetes Programme through:
  - Health and Wellbeing Coaches supporting practices to systematically identify and refer eligible people.
  - Rotherham Federation has a call centre that identifies patients on behalf of practices and phones them to discuss the various weight management options.
- Increasing the proportion of patients newly diagnosed with type two diabetes who are referred to the Pathway to Remission Programme through the health coach and call centre approach.
- Improving support for young adults with early onset type two diabetes with online resources, and a behavioural change campaign. Guidelines for primary care including pre-conception and pregnancy advice. Nurse education visits in primary care and a pilot of health and wellbeing coaching. Alongside grants given to five community groups to raise awareness in their communities.
- Increasing the uptake of diabetes technology for people with type one diabetes with family support workers in children's services increasing uptake of technology in our most deprived families.
- Implementation of the NICE TA for Hybrid Closed Loop technology.
- Increasing the proportion of people who have all 8 key processes focus on increasing the numbers of people who have urinary ACR completed.
- Improving foot care, sharing learning between Trusts to support improvements
- Improving support for people with diabetes and disordered eating working with SY Eating Disorder Association to increase awareness in specialist diabetes teams and eating disorder services.

Focusing on health inclusion groups e.g. homelessness dental project

- Evidence suggests that socially marginalised groups, including those experiencing homelessness, have significant difficulties in accessing services, including dental services. People in health inclusion groups tend to have poor experiences of healthcare services because of barriers created by service design. This can result in them avoiding contact with services and being least likely to receive healthcare despite having high needs. Resulting in poor health outcomes and earlier death.
- The Homeless project in South Yorkshire started with pilot sites in Doncaster and Sheffield and expanded across South Yorkshire. The aim is to deliver a responsive dental service for those experiencing homelessness to reduce inequalities of access to dental care.
- It uses skill mix in dental teams to enable delivery of 'homeless friendly' practice. It provides evidenced-informed oral health advice appropriate to individual needs utilising oral health prevention methods.

Focusing on work and health in South Yorkshire

- **Work Well Programme** - South Yorkshire was successful in securing funding to be one of the National Work Well Programme pilot sites. The SY Work Well Programme aims to help people with health conditions or disabilities stay in work with low intensity support. Delivery builds on the previously successful South Yorkshire Working Win Programme and infrastructure in each of our places to enable access to work and health support and assessments.
- **The Barnsley Pathways to Work Commission** is paving the way to inclusive access to work in Barnsley. Under the guidance of Rt Hon Alan Milburn, former cabinet minister and social mobility champion the skills and expertise of labour market, skills and health experts came together to hear from a broad range of residents, partners and experts. The Pathways to Work report explores how to reduce economic inactivity with a focus on Barnsley and South Yorkshire, identifying national and local opportunities and challenges - Pathways to Work Commission Report – July 2024
- South Yorkshire has now been identified as a National Trailblazer, this together with the Growth Accelerator and Work Well Programme means South Yorkshire is uniquely placed to combine efforts across partners to address the economic inactivity.
- In each of our places there is specific work underway to reduce the barriers to employment in health and care. For example, in Barnsley we have the Proud to Care Hub which was shortlisted for the parliamentary awards and showcased at the ICB AGM. In Sheffield, Rotherham and Doncaster we have work supporting more people into employment and widening access to health and care roles.

Q5. Please use this box to share specific policy ideas for change.

Please include how you would prioritise these and what timeframe you would expect to see this delivered in.

The enablers outlined in relation to each question/shift advocate a range of policy changes needed to support local delivery of the National 10 Year Health Plan. These include for example water fluoridation to improve dental health. In addition to these local specific policy change ideas include:

- **Healthy hospital programme** – An expansion of the current ask, which is focusing on tobacco treatment and the delivery of alcohol care teams into a more comprehensive healthy hospital programme. The programme would build on what is in place and expand to include other elements starting with physical activity and embedding this in healthcare pathways and beyond working with wider partners in the fitness industry. Next year or so.

- **Integrated neighbourhood working programme/vanguard –** This would build on the integrated neighbourhood working approaches that are already under development in each of our places. It would be a vehicle with a framework and funding to continue to work with communities, VCSE and health and care partners to develop a preventative, pro equity outcome focused approach to health creation. Supported by vertically integrated health and care provision in each of places and neighbourhoods. Will take 2-3 years.

- **Whole system approach to neurodiversity** – A framework to enable a whole system collaborative approach to improve neurodiversity diagnostic pathways and support for families, with increased flexibility to work collaboratively with families and schools around the SEND agenda. Support and local flexibility to collaboratively implement the recommendations in National ISOS report.
  Need to do quickly - next year or so.