

## Update: South Yorkshire and Bassetlaw Response to the Long Term Plan

**SOUTH YORKSHIRE AND BASSETLAW  
INTEGRATED CARE SYSTEM  
COLLABORATIVE PARTNERSHIP BOARD**

**11 OCTOBER 2019**

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Sponsor	Sir Andrew Cash, South Yorkshire and Bassetlaw Integrated care System Lead			
Is your report for Approval / Consideration / Noting				
For noting				
Links to the STP (please tick)				
<input checked="" type="checkbox"/> <b>Reduce inequalities</b>  <input checked="" type="checkbox"/> <b>Standardise acute hospital care</b>  <input checked="" type="checkbox"/> <b>Create financial sustainability</b>	<input checked="" type="checkbox"/> <b>Join up health and care</b>  <input checked="" type="checkbox"/> <b>Simplify urgent and emergency care</b>  <input checked="" type="checkbox"/> <b>Work with patients and the public to do this</b>	<input checked="" type="checkbox"/> <b>Invest and grow primary and community care</b>  <input checked="" type="checkbox"/> <b>Develop our workforce</b>	<input checked="" type="checkbox"/> <b>Treat the whole person, mental and physical</b>  <input checked="" type="checkbox"/> <b>Use the best technology</b>	
Are there any resource implications (including Financial, Staffing etc)?				
Not at this stage.				
Summary of key issues				
<ul style="list-style-type: none"> <li>• SYB shared its draft plan with the region on 27 September 2019.</li> <li>• Work will continue to engage stakeholders including the guiding coalition planned for 8 October.</li> <li>• Peer to peer process with the 4 systems in the Y&amp;H and NE region took place on 2 October 2019</li> <li>• Draft Plan available for Board, Governing Bodies, Councils and key stakeholders for discussion and input.</li> <li>• An interim submission has been requested from all systems on 1 November 2019.</li> <li>• Final draft due 15 November 2019</li> </ul>				
Recommendations				
The Collaborative Partnership Board is recommended to:				
<ul style="list-style-type: none"> <li>• Received the draft plan shared with the region on 27 September</li> <li>• Note the progress to date and the next steps/timeline.</li> <li>• Share with local governance for discussion and input feeding back by 23 October 2019</li> </ul>				



## Developing the SYB Long Term Plan

### Progress Update: SYB System Strategic Plan

11 October 2019

#### 1. Purpose

1.1 The aim of this paper is to provide an update on:

- Our cross-system and bottom up approach to developing the SYB ICS Strategic LTP narrative response;
- The progress made in developing our Strategic Plan response to the LTP and a the ambition, emerging themes and priorities ;
- Next steps.

1.2 The paper is intended to provide an update of progress and enable discussions on the SYB 1<sup>st</sup> draft strategic plan. The Plan includes key drivers for the strategic narrative, including the need to reduce health inequalities and unwarranted variation, improve population health and outcomes, access, quality of care and patient experience and how strategically we flex our resources across the balance of health and care to best meet the needs of all of our local populations.

#### 2. National LTP Requirements

2.1 The SYB Strategic plan for 2019-24 has taken into account the LTP Implementation Framework (LTPIF) published 27th June.

2.2 It presents systems with a very challenging planning timetable with both strategic and operational planning for multiple years required simultaneously.

2.3 It sets out three core components of the LTP that ICS's must deliver:

- Strategic Delivery Plan – a system narrative that describes the ambition and five- year strategy of the ICS, how it will deliver the LTP requirements.
- Strategic Planning Tool – that sets out five-year plans at ICS/STP level for finance, activity and workforce in support of delivery of the Long Term Plan
- Strategic Planning LTP Collection template - that sets out five-year trajectories at ICS/STP level for the LTP metrics

2.4 The first draft LTP plan was shared with the NE&Y NHSE / I region on 27th September and final plans are expected to be signed off on 15th November 2019.

2.5 SYB will take part in a peer to peer process week commencing 2 October 2019 which is aimed at offering a supportive and development dimension to the NHS regional assurance of plans following which we will receive feedback.

2.6 The LTP plan must be developed following the core principles set out in the LTPIF and which will be used as part of the NHSE/I assurance process. Plans are expected to demonstrate they are:

- Clinically led
- Accessible to the public
- Based on local context

- Reflecting local system priorities
- Addressing health inequalities
- Closing the three gaps (set out in the FYFV and covered in the STP)
- Describe governance and relationships
- Give clarity of service models
- Be focused on delivery
- Have enabling strategies
- Align workforce, activity and finance
- Be clear on risks

### **3. Progress to date to develop SYB Long Term Plan**

- 3.1 The SYB cross-system LTP Task and Finish Group is well established with place and sector representation to provide oversight and coordinate the work to develop our plan. An LTP Finance Group is also in place to oversee the development and population of the financial model. Existing regional infrastructure is coordinating the workforce aspect.
- 3.2 Engagement work is ongoing. A SYB ICS guiding coalition met in early July to influence the development of our plan and is due to convene again in early October. The key themes identified through the engagement work by Healthwatch, the ICS communications and engagement team and the feedback from the public survey have all been shared to inform the initial plan development. The staff survey and opportunity for local politicians to contribute will end in mid-September and together with all the information will be independently analysed with a final report due at the end of September. Interim reports with key themes have been used to inform the ongoing development of the plan.
- 3.3 In addition to developing the plan narrative work has been initiated on the other requirements to populate the Strategic Planning Tool. The Finance Group coordinated populating the strategic planning tool. This process has been challenging as it brings forward traditional operational planning for multiple years to align to the development of our strategic plan over the lifespan of the LTP. It was completed and shared alongside the draft narrative on 27<sup>th</sup> September.
- 3.4 We continue to await finance guidance which will set out trajectories for our system within a revised financial framework for 2020/21 onwards moving away from current financial regimes. Trust workforce leads completed a HEE led workforce submission in early September, similar to that in the tool.
- 3.5 Work has also been undertaken to populate trajectories for the LTP headline metrics. These were also shared on 27<sup>th</sup> September. Alongside this there has also been work to identify key areas where we can improve health outcomes and reduce inequalities.
- 3.6 The draft strategic Plan narrative was shared with the SYB Health Oversight Group on 26<sup>th</sup> September, the SYB Health and Wellbeing Board Leads on 27 September, the SYB Health Executive Group on 8<sup>th</sup> October and initial feedback was given in a number of areas.
- 3.7 We continue to liaise with the SYB DPHs and Public Health England to ensure that we have a common understanding of population health in SYB, our challenges and health inequalities and to harness their expertise in our developing approach to prevention and

reducing health inequalities. More broadly we acknowledge the importance of the wider determinants of health and have identified a number of areas where the NHS can take action to directly impact on wider determinants, to complement boarder joint working with the Local Authorities around these.

#### **4. Building on our local context and a summary of the key emerging themes**

- 4.1 Our first strategic plan was published in 2016 and we have just published our 3 year review of our achievements. Throughout 2019 we have been engaging with the public, patients, staff and partners on what they want to see happen next. We used the NHS Long Term Plan, published in January 2019, as the backdrop for our conversations and building on the work in our neighbourhoods and places and the work taking place across SYB and wider. Feedback from our conversations in 2017, on the back of our first plan, has also informed our thinking, approach and priorities which are set out in the draft strategy.
- 4.2 The feedback and our commitment following the guiding coalition in the summer were to reiterate and reinforce our commitment to tackling health inequalities. Healthy life expectancy is lower in South Yorkshire and Bassetlaw compared to the national average, which means that people are on average living fewer years in good health and many are living with multiple long term conditions.
- 4.3 The shape of our draft plan will begin with expressing our continued journey and our achievements to date which are captured in our 3 year review. It continues to build on the vision we have set out which is “ we want everyone on South Yorkshire to have a great start in life, supporting them to stay healthy and live longer” with our ambitions set out in 4 strategic themes:
- Developing a population health system
  - Strengthen our foundations
  - Building a sustainable health and care system
  - Broadening and strengthening our partnership to increase or potential
- 4.4 We have high levels of the common causes of disability and death, including high rates of smoking, obesity, physical inactivity and hospital admissions due to alcohol. Much of this burden of illness can be prevented or delayed.
- 4.5 Our reinforcing of our commitment will mean we will take a three-pronged approach to systemically tackle the inequalities in health and care, making it central to everything that we do. We will look at interventions at a civic level (with Health and Wellbeing Boards and local Integrated Care Partnerships), in the community (with local community, voluntary, social enterprises and faith organisations and with the voluntary, community and social enterprise sector) and in the health service (across health and care services). Our focus will be on cutting smoking, reducing obesity, limiting alcohol-related A&E admissions and lowering air pollution.
- 4.6 We will build on the work we have started to give patients more options, better support and joined up care at the right time in the best care setting and we reinforce our commitment to this being as close to home as possible. In our 2016 plan we identified significant challenges to the sustainability of acute services in the region and as a result of a comprehensive and inclusive review of those services, we agreed to develop hosted networks.

- 4.7 There are now 30 Primary Care Networks (PCNs) in South Yorkshire and Bassetlaw, all preparing to extend the range of convenient local services and create integrated teams of GPs, community health and social care staff. This will strengthen the neighbourhood model to provide fast support to people in their own homes as an alternative to hospitalisation, as well as increase support for people living in care homes and develop social prescribing offers.
- 4.6 Since our 2016 plan, two of our 'Places' have launched urgent treatment centres to help people get the care they need fast and to relieve pressure on A&Es. The LTP plan asks systems to build on this progress with increasingly 'same day emergency care' as we balance our focus on hospital and out of hospital care with initiatives in the community and in our hospitals we improve processes and standardise practices. By redesigning hospital support, we will give patients the right to alternative modes of appointment such as online, telephone or video consultations. We will also carry out more planned operations and join up care better by increasing access to shared medical records.
- 4.7 We have started to make in-roads in our efforts to improve the quality of care and outcomes in cancer, children's services, stroke and mental health and learning disabilities and will now step these up at the same time as widening our focus to include diabetes, cardiovascular disease and respiratory conditions.
- 4.8 Workforce issues are a key driver for much of the work of the ICS. Our workforce challenge is in part because our workforce has not grown in line with the increasing demands on the NHS and also because the NHS hasn't been a sufficiently flexible and responsive employer. Our Plan aims to put this right by tackling nursing shortages and securing current and future supply, make the NHS in South Yorkshire and Bassetlaw the best place to work and improve our leadership culture while introducing new roles, rostering and programmes that enable flexibility for staff.
- 4.9 In 2016 we set out an ambitious journey to deliver digitally enabled care, but acknowledge that our progress has been limited. Some of our partners have made positive progress in delivering digital capabilities to integrate health and care teams around the person but the context of the LTP informs is that we need to do more. We are determined to ensure that patients and their carers can better manage their own health and clinicians can access and interact with patient records and care plans and decision support where they are. To achieve this, we will establish the basic digital capabilities across integrated health and care, ensure greater use of information and advancing capabilities and digitally enable citizens and professionals.
- 4.10 We also want to strengthen our approach to innovation and have partnered with the Yorkshire and Humber Academic Health Science Network to establish an Innovation Hub which will become the vehicle for system-wide innovation.
- 4.11 Bolstered by national transformation funding for some areas, such as cancer and mental health and primary care, we have been able to accelerate progress for patients in these areas. We need to ensure that achieving improved population health outcomes and optimal health and care delivery is not hindered by how we plan or pay for health and care services. We will deliver for tax payers, taking forward efficiency plans while we work with new payment systems and incentives across our NHS organisations to achieve financial balance.

- 4.12 The STP was underpinned by what we described as three gaps we needed to tackle, the health and wellbeing gap, the quality in care gap and the finance and efficiency gap. Whilst the financial settlement for the NHS is already set out there remain some significant unknowns for the financial context to the LTP and significant challenges remain which include the challenge in funding position in social care. This provides additional context to our strategic considerations and plans and will set the context for the level of ambition our system will need to consider as we develop our strategy and plans.
- 4.13 Our partnership and governance has evolved across the system and within each place. Each of our local places have developed strong partnerships in place across health and care. Across the SYB partnerships and collaborative working has continued to evolve with some adopting more formal arrangements where this make sense to do so. We have already started to broaden and strengthen our partnerships across SYB with Local Government and with the City regions on shared priorities. This is an area of our plan which will need further discussion and time to reflect how we broaden and strengthen out partnerships to achieve our ambitions over the next 4 years.

## **5. Key priorities to improve health outcomes and reduce health inequalities**

- 5.1 A data pack has been developed using health outcome related data from the Public Health England (PHE) and global burden of disease websites. Using this we have identified 5 key areas where there is significant potential for health gain in SYB as follows:

- Best start in life
- Improve mental health and wellbeing
- Reduce smoking, harm from alcohol and obesity
- Improve cardio- respiratory health
- Early diagnosis and increased survival from cancer

- 5.2 For each area we are now in the process of identifying a headline ambition and metric, and a set of sub metrics, aligning to the LTP metrics where possible.

## **6. Next steps and timeline**

- 6.1 Work will continue to engage stakeholders.
- The draft narrative was shared on 27th September with NHS England and Improvement and feedback is awaited.
  - Peer to peer process with the 4 systems in the Y&H and NE region - 2 October 2019
  - Draft Plan available for Board, Governing Bodies, Councils and key stakeholders
  - Final draft due 15 November

## **7. Recommendations**

- 7.1 Boards are invited to:
- Note the national requirements for NHS planning and SYB progress to date
  - Receive the draft plan
  - Note initial sharing of the draft plan on 27 September
  - Provide feedback on key content including the level of ambition within the plan

*Paper prepared by Will Cleary-Gray.  
On behalf of the SYB Cross-system task and finish  
group*

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# South Yorkshire and Bassetlaw Integrated Care System



## Strategic Plan 2019-2024 - 1st Draft

September 27 2019



	Page
<b>Foreword</b>	3
Executive summary	5
Plan on a page	7
Our achievements and progress	8
Our System	10
<b>Section 1: Developing a population health system</b>	
- Understanding health in SYB / Developing a population health system / Tackling health inequalities / Wider determinants of health	11
- Developing a prevention led NHS / Population health management Reducing unwarranted variation	17
- Taking a person centred approach	20
- Getting the best start in life	21
- Priority areas for improving outcomes from major health conditions	23
- Reshaping and rethinking how we flex resources	30
<b>Section 2: Strengthening our foundations</b>	
- Working with patients and the public	33
- Empowering our workforce	34
- Innovation and improvement	38

	Page
<b>Section 3: Building a sustainable health and care system</b>	
- Delivering a new services model in SYB - Neighbourhood, Place, System	40
- Transforming care - Primary Care working in Networks / Out of hospital care/ Partnerships in Place	41
- Transforming care - Reforming emergency Care / Transforming Planned Care / Providers working together / Hospitals working in Networks	47
- Making the best use of resources	51
<b>Section 4: Broadening and strengthening our partnerships to increase our opportunity</b>	
- Partnership with the City region	59
- Anchor institutions and contributions to wider economy, science, research and innovation	60
- Voluntary sector	61
- Our commitment to work together / Governance and ways of working	62
<b>Annex</b>	63



## By Sir Andrew Cash Chief Executive System Lead



**“We are starting to make real and lasting positive changes to people’s lives across the region.”**

It is three years since we published the South Yorkshire and Bassetlaw Sustainability and Transformation Plan. In that time we have made significant progress in delivering our ambitions and we are starting to make real and lasting positive changes to people’s lives across the region.

We have extended GP access at evenings and weekends, supported more than 3,000 people with long term physical and mental health conditions to find and stay in work as part of the Working Win programme led by the Sheffield City Region, invested more than £1 million into maternity services and care, introduced new nursing roles and freed up GP appointments with the introduction of 825 care navigators.

This snapshot of achievements is down to us working together in even better ways than we have before and we are rightly proud of our achievements. We have documented our work so far in a three-year ICS Review [[link to the Review](#)]

We have started to break down organisational barriers so that we can wrap support, care and services around people as individuals and improve people’s lives. Each of our NHS partners has strengthened the way they work with other NHS organisations and with wider partners, such as local authorities and the voluntary sector.

As a System, we have joined forces where it makes sense to do so and where it makes a real difference to patients, staff and the public.

All this has put us in a strong position as we prepare to build on our successes and take forward our ambitions in our refreshed strategy for the next four years.

We have continued to talk with the public, our staff and our stakeholders about their hopes and vision for health and care services in South Yorkshire and Bassetlaw. Those conversations, which built on the ones we had in 2017, focused on the aims and aspirations set out in the NHS Long Term Plan, published in January 2019 [[link](#)].

The feedback [[link to reports](#)] from many months of conversations has informed our thinking which we have since tested with our Guiding Coalition and partners within the System.

The result is our refreshed Plan, which has been clinically led, builds on our work to date, is guided by the NHS Long Term Plan and shaped by our local constituents.



Our pledges in 2016 were to give people more options for care while joining it up for them in their neighbourhood, help them to stay healthy, tackle health inequalities, improve quality, access and outcomes of care, meliorate workforce pressures and introduce new technologies. We paid particular attention to cancer, mental health and primary care, and the two key enablers of workforce and digital technology.

**“Our refreshed Plan has been clinically led, guided by the NHS Long Term Plan and shaped by our local constituents.”**

Our 2019 Plan builds on these but it also focuses on children’s health, cardiovascular and respiratory conditions, diabetes, learning disabilities and autism. It also takes forward the work to strengthen primary and community based care and as a result of the review of hospital services across South Yorkshire and Bassetlaw, the development of Hospital Hosted Networks.

People have told us how proud they are of their local health and care services but they also shared their concerns about funding, staffing and the increasing inequalities from a growing and ageing population.

Our Plan tackles these issues as it sets out how we will make funding go as far as possible, alleviate the pressures faced by staff and redesign care and services so that we continue to offer and deliver some of the best health care services in the world.

By working as an ICS, we have benefitted greatly from more than £200 million in additional transformation funds over the last three years which has enabled us to progress so many schemes. Our refreshed strategy for the next five years includes an indicative £275 million of extra funding which means we can accelerate the progress in our priority areas while working with the new financial rules to drive efficiencies and deliver for taxpayers.

**South Yorkshire and Bassetlaw  
Integrated Care System**



Through our partnership working with Local Authorities and the Sheffield City Region we want to continue to influence and contribute to the development and implementation of a wide range of local ‘Place’ based strategies that are tackling the wider determinants of health, such as inclusive growth plans, housing, transport, employment and thriving communities. At the same time, we want to ensure that all our local communities have equitable access to a full range of health and care services.

Our 2019 Plan recommits our ambition for everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to be healthy and live longer while aiming to be the best delivery and transformation System in the country.

We have a very strong track record and our renewed drive puts us in an excellent position to deliver on our promises. I look forward to working with you on them to provide the best health and care for all our population.

Sir Andrew Cash  
Chief Executive  
South Yorkshire and Bassetlaw  
Integrated Care System



Our journey to becoming one of the first and most advanced Integrated Care Systems (ICS) in the country has been one of steady progress, solid performance and strong delivery. We have built on our excellent foundation of working together and are now delivering tangible improvements for our population.

We have been working as a partnership for three years and throughout this time, our vision has remained the same:

**For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.**

We are in a transition year in 2019/20 as we start to have more responsibilities for our health system, including strategic planning and increasing collective accountability for health performance and finance. We will continue to evolve our governance in line with developments and you can read more about our approach on page 61.

We published our first strategic plan in 2016 and have spent much of 2019 engaging with the public, patients, staff and partners on what they want to see happen next. We used the NHS Long Term Plan, published in January 2019, as the backdrop for our conversations but we are not starting from scratch. Feedback from our conversations in 2017 [ink], on the back of our first plan, has also informed our thinking, approach and priorities.



**Our 2019 Plan builds on our work to date and focuses around four key ambitions:**

## **1. Developing a population health system**

Healthy life expectancy is lower in South Yorkshire and Bassetlaw compared to the national average. We have high levels of the common causes of disability and death, including high rates of smoking, obesity, physical inactivity and hospital admissions due to alcohol. Much of this burden of illness can be prevented or delayed. We will consider the wider determinants of health and tackle health inequalities with a whole population approach that is person-centred. Our focus will be a best start in life, reducing harm from smoking, alcohol and obesity, improving cardio-respiratory health, improving mental health and wellbeing and early diagnosis and increased survival from cancer.

We have started to make in-roads to improve the quality of care and outcomes in cancer, children's and maternity services and mental health and learning disabilities and we have launched the new South Yorkshire and Bassetlaw Hyper Acute Stroke Service and associated Hospital Network. We will now step up our work in these areas at the same time as widening our focus to include diabetes, cardiovascular disease and respiratory conditions.

Bolstered by national transformation funding for some of our work areas, such as cancer and mental health and primary care, we have been able to accelerate progress for patients in these areas. As we take on more responsibilities for our health system for finance, we will increasingly become the route through which System funds flow. We will deliver for tax payers, taking forward our efficiency plans while we work with new payment systems and incentives across our NHS organisations to achieve financial balance.



## 2. Building a sustainable health and care system

There are now 30 Primary Care Networks (PCNs) in South Yorkshire and Bassetlaw, all preparing to extend the range of convenient local services and create integrated teams of GPs, community health and social care staff. Already they have met as a Network of Clinical Directors, supported by the ICS, to discuss how they will start to shape the delivery of local services and provide fast support to people in their own homes.

Since our 2016 plan, two of our 'Places' have launched urgent treatment centres to help people get the care they need fast and to relieve pressure on A&Es. We are also trialling new pathways for urgent care and associated standards but we need to do more. We will increasingly start to treat people as 'same day emergency care' as we focus on out of hospital and in hospital emergency care.

We will build on the work we have started to give patients more options, control, better support and joined up care at the right time in the best care setting. In the next five years, we will accelerate the recently formed Hospital Hosted Networks to ensure everyone has the same high quality standards and equal access.

By redesigning hospital support, we will give patients the right to alternative modes of appointment such as online, telephone or video consultations. We will also carry out more planned operations and join up care better by increasing access to shared medical records.

## 3. Strengthening our foundations

Since 2016, we have had thousands of conversations with the public, staff and our stakeholders – all of which have shaped not just this Plan but our ongoing work in the ICS. We will build on this strong platform with support from our Guiding Coalition and Citizens' Panel to develop an online membership model and better understand how we can positively use the rich sources of patient experience data across the System.

Workforce issues are a key driver for much of the work of the ICS. Our staff provide services 24 hours a day, 365 days a year, and we must continue to support them to do the best possible job they can do.

Our Plan aims to tackle nursing shortages and secure current and future supply, make the NHS in South Yorkshire and Bassetlaw the best place to work and improve our leadership culture while introducing new roles, rostering and programmes that enable flexibility for staff.

In 2016 we set out an ambitious journey to deliver digitally enabled care. Some of our partners have made positive progress in delivering digital capabilities to integrate health and care teams around the person, such as the Rotherham Health App - but we need to do more.

We will establish the basic digital capabilities across integrated health and care, ensure greater use of information and advancing capabilities and digitally enable citizens and professionals.

We also want to strengthen our approach to innovation and have partnered with the Yorkshire and Humber Academic Health Science Network to establish an Innovation Hub which will become the vehicle for system-wide innovation.

## 4. Broadening and strengthening our partnerships to increase our opportunity

Our strategic plan takes account of the majority of the work across the ICS taking place locally, in neighbourhoods or in Places and the partnerships we have and continue to develop are built around these strong local relationships serving local populations.

In addition to strengthening the connections we have in Neighbourhoods and in Place with our local authorities and the voluntary sector, we want to build on the role we play in the local and regional economy. Serving the same population, we share a number of ambitions with the Sheffield City Region and we have agreed some key priority areas that will be developed across health and care with both the SCR and our local authorities.

We are extremely grateful to the public, staff and stakeholders who have taken the time to share their views on the future of health and care services in our region. In doing so they have helped to shape the thinking and contributed to the aims and objectives in this Plan. <sup>6</sup>



## 1 vision

For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

This is the **second** stage of our strategy



# Achievements and progress



<p>South Yorkshire and Bassetlaw Integrated Care System</p> <p><b>In the last three years.....</b></p>	 <p><b>1,300</b> Additional patients are accessing support through the Living With and Beyond Cancer programme</p>
<p><b>CANCER SAFE</b></p> <p>Social movement campaign has created over 12,000 cancer champions in the five Places; raising awareness of signs and symptoms to support the earlier diagnosis of some cancers</p>	<p>Worked in partnership with the Department for Work and Pensions and the Sheffield City Region on a health led employment trial</p> <p><b>supporting over 3000 people</b></p> 
<p>We continually met the 18-week waiting times target for elective and diagnostics across the region</p> 	<p>with long term physical and mental health conditions to find and stay in work</p>
 <p>We have made <b>extended GP access</b> at evenings and weekends available for <b>100%</b> of patients</p>	 <p><b>Mental health liaison services</b> have been put in place in Rotherham &amp; Sheffield Emergency Departments</p>
<p><b>825 non-clinical members of staff</b></p> <p>are now working as Care Navigators across the system, freeing up GP appointments by signposting patients to different services that might be more beneficial to them so they get the quickest and best care that is appropriate for their needs</p> 	<p>Set up and launched the first <b>AHP Council</b> in the country where a broad range of Allied Health Professionals, including physiotherapists, dietitians and paramedics, come together to develop new ways of supporting health and care services</p>
<p><b>Reduced extended length of stay and delayed transfers of care</b> (helping patients get home quicker when they are medically fit for discharge)</p> 	<p>Partnership working has brought <b>£200m</b> into the ICS</p> 
<p><b>South Yorkshire and Bassetlaw Regional Stroke Service</b> launched to save even more lives and reduce disabilities for anyone having a stroke in South Yorkshire and Bassetlaw</p> 	

Although we officially launched in October 2018 as an ICS, we have been working collaboratively at a System level since January 2016. Throughout this time we have built on our excellent foundations of working together and started to deliver real and tangible improvements for our population.

We have much to celebrate and the work we have undertaken over the last three years [LINK to the ICS Review] is transforming the way we do things at a system level.

With support from staff, the public and stakeholders, we are making real inroads into transforming our approaches so that people continue to receive high quality services but in ways that are more convenient and with better outcomes.

Just some of our successes include:

- The launch of a new perinatal mental health service across Doncaster, Rotherham and Sheffield, adding to services already in place in Barnsley and Bassetlaw
- New pathways for lower GI, prostate and lung cancers – helping to diagnose and treat people earlier and improve overall outcomes
- Investing more than £1 million into our Local Maternity System to improve care for all mothers and babies. 85% of women now have a Personalised Care Plan
- Providing extended access GP appointments, at evening and weekends, for 100% of our population

# Achievements and progress

- Over the last three years more than fifty per cent of practices have benefitted from funding to support them to become more sustainable and resilient, better placed to tackle the challenges they face and to secure continuing high quality care for patients
- We have developed a Primary Care Workforce and Training Hub
- We have put in place the South Yorkshire and Bassetlaw Regional Hyper Acute Stroke Service
- Made improvements in waiting times for diagnostic investigations
- Established the South Yorkshire and Bassetlaw Radiography Academy
- 1,300 extra patients are accessing support services through the Living With and Beyond Cancer programme
- Working in partnership with the Department for Work and Pensions and Sheffield City Region we have supported people with long term physical or mental ill health into the Working Win health led employment trial
- Set up five Hospital Hosted Networks for the services covered in the Hospital Services Review (which was commissioned to tackle sustainability of services following our 2016 Plan)
- Secured £200,000 from Health Education England to work with the Yorkshire and Humber Academic Health Science Network to support transformation in the mental health workforce



Improvements to the emergency out of hours ophthalmology service have ensured a sustainable 7-day service for all

**social prescribing**

across SYB is well established

We have **virtually eliminated** out of area adult mental health placements in **four of our five places**



A South Yorkshire and Bassetlaw Workforce and Training Hub has been established - recruiting local people into the NHS and helping them develop

**Completed procurement** for Integrated Urgent Care



Involved over **18,000** members of the public in developing our plans for future health and care services



Hospitals across the region have joined forces in a region-wide approach to support people to quit smoking. The initiative could see as much as a **40% reduction** in smoking related deaths in two years.

Introduced **135 trainee nurse associates**

into health and care services in Doncaster and Sheffield to undertake more routine tasks while better utilising the time of registered nurses in focusing on patients with more complex needs



Implemented **NHS 111** online, including direct booking and clinical assessment service

Established **30 primary care networks**

covering 100% of the population, ensuring more joined up services at a local level



**21 Clinical Pharmacists**

who are able to prescribe have joined the workforce and are now working in general practice



Set up **5 Hosted Networks**

for the hospital services covered in the Hospital Services Review, with each one of our South Yorkshire and Bassetlaw acute trusts taking the lead for an individual service, co-ordinating it's running and supporting the future planning in closer collaboration with partners





The South Yorkshire and Bassetlaw Integrated Care System formally launched as an 'ICS' in October 2018.

We have been working as a partnership for three years, first as a Sustainability and Transformation Partnership, then as a first wave Accountable Care System and now, as one of the leading ICS' in the country.

Throughout this time, our goal has remained the same:

**For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.**

We are one NHS, working as a System. We work with other partners, such as Local Authorities and the voluntary sector, in Neighbourhoods, Place and across the System when we have a common purpose and where it makes a positive difference to people's lives. Our aim is to break down organisational barriers so that we can wrap support, care and services around people as individuals..

We agree to take shared responsibility (in ways that are consistent with individual legal obligations) for how we can use our collective resources to improve quality of care and health outcomes. As a first wave ICS, we are making faster progress than other health systems in transforming the way care is delivered, to the benefit of the population that we serve.

We are a system with a population of 1.5 million with five local Places with populations between 130,000 and 576,000

At a glance, we have:

- ▶ £3.9 billion total health and social care budget
- ▶ 1.5 million population
- ▶ 72,000 members of staff
- ▶ 208 GP practices
- ▶ 36 neighbourhoods
- ▶ 6 acute hospital and community trusts
- ▶ 5 local authorities
- ▶ 5 clinical commissioning groups
- ▶ 4 care/mental health trusts



## 5

### Place partnerships

There are five Place Partnerships, covering populations between 130,000 and 576,000. The Partnerships plan and deliver integrated health and care across the Place, and include:

- Primary Care Networks
- GP Federations
- Clinical Commissioning Groups
- Voluntary, community and social enterprise sector
- Local Authorities
- Healthwatches
- Acute hospital trusts
- Mental health hospital trusts

#### System planning and commissioning



The **System** agrees shared objectives and outcomes

Hospitals are increasingly working in **Hosted Networks**

Partnerships plan and deliver integrated health and care across **Place**

**Neighbourhoods** integrate teams to deliver care where people live

## 5

### Hospital Hosted Networks

There are five developing Hospital Hosted Networks covering gastroenterology, maternity, paediatrics, stroke and urgent and emergency care services. The Networks standardise clinical standards and reduce unwarranted variation.

## 36

### Neighbourhoods

There are 36 neighbourhoods, served by 30 Primary Care Networks. The Networks are GP practices working together to deliver as much care as possible close to where people live. Our Networks cover populations of 19,000 to 50,000, and include:

- GPs
- Pharmacists
- District Nurses
- Allied Healthcare Professionals, such as podiatrists and physiotherapists
- Community Geriatricians
- Dementia Workers
- Teams from social care
- Community Wellbeing Teams
- Teams from the voluntary sector

## 1

### System

There is one System, covering a population of 1.5 million. The System plans and makes improvements for the NHS for the benefit of everyone across South Yorkshire and Bassetlaw. It also has an overview of System NHS finance and performance. It is a Partnership of NHS organisations working with others, such as Local Authorities and the voluntary sector.

# Section 1: Developing a population health system



Understanding health in SYB

Developing a prevention driven NHS

Taking a person centred approach

Getting the best start in life

Priority areas for improving outcomes from major health conditions

Reshaping and rethinking resources and delivery to better meet need

# Understanding health in



## South Yorkshire and Bassetlaw

**1.52 million**  
population

<b>Barnsley:</b>	<b>39</b>	<b>England Local Authority deprivation ranking (of 326, 1 most deprived)</b>
<b>Bassetlaw:</b>	<b>114</b>	
<b>Doncaster:</b>	<b>42</b>	
<b>Rotherham:</b>	<b>52</b>	
<b>Sheffield:</b>	<b>60</b>	

**8.9% population of Black and Minority Ethnic heritage and many people of Eastern European origin**

**57% increase in the 75s and overs by 2028**

People's health is determined by a complex combination of genetics, behaviour, the health care that we receive and the physical, social and economic environment that we live in.

We know that we have a number of health issues that are not as good as they should be when comparing ourselves to similar regions and the national average. We also know that peoples health varies a lot within South Yorkshire and Bassetlaw.

In line with the national picture, life expectancy in South Yorkshire and Bassetlaw is no longer increasing.

The greatest contributors to our gap in life

expectancy in SYB are cancer, cardiovascular disease (CVD) and respiratory disease.

In men, we have too many deaths in early adulthood from suicide, drug related death and violence.

While there has been an overall decrease in premature deaths from CVD and cancer over the last 15 years, this has not been seen for respiratory deaths and the mortality rate from liver disease is increasing.

Alzheimer's disease is now the commonest individual disease causing death in women and fourth commonest in men.

Not only do people in South Yorkshire and Bassetlaw die younger, but they also live fewer years in good health.

More people in SYB reported having a long term disability than the national average in the 2011 Census.

Many people are living with multiple long term conditions. People living in the most deprived areas experience onset of multi-morbidity 10 – 15 years earlier than those in the most affluent areas. The more physical illnesses you have the more likely you are to also have a mental health disorder.

The commonest conditions that lead to a disability are musculoskeletal disorders, mental ill health, neurological disorders and chronic respiratory disease.

Much of this burden of illness can be prevented or delayed. We have high levels of the common causes of disability and death, including high rates of smoking, obesity, physical inactivity and hospital admissions due to alcohol.

Many people are socially isolated and more people report have a mental illness in SYB than nationally. People with severe mental illness in SYB are 3.5 to 4 times more likely to die under the age of 75 than the general population.

People with a learning disability have worse physical and mental health. Women with a learning disability die on average 18 years younger and men 14 years younger .

<b>Healthy Life Expectancy at Birth, 2015/17</b>		
	<b>Male</b>	<b>Female</b>
England	63.4	63.8
Barnsley	59.7	61
Doncaster	61.8	61.1
Rotherham	59.3	57.4
Sheffield	62.5	60.1
Nottinghamshire	65.2	62.7

**9.6 years** life

expectancy difference for women between the most deprived and least deprived areas in SYB

**12.4 years** life

expectancy difference for men between the most deprived and least deprived areas in SYB

# Developing a population

## health system

Many people in South Yorkshire and Bassetlaw are living fewer years in good health compared to those living in similar regions or the English average.

The NHS has traditionally tended to focus mainly on treating people when they are unwell. However, we know that people's health is determined by a complex combination of genetics, behaviour and wider determinants of health – the physical, social and economic environments that people live in – as well as the health care they receive.

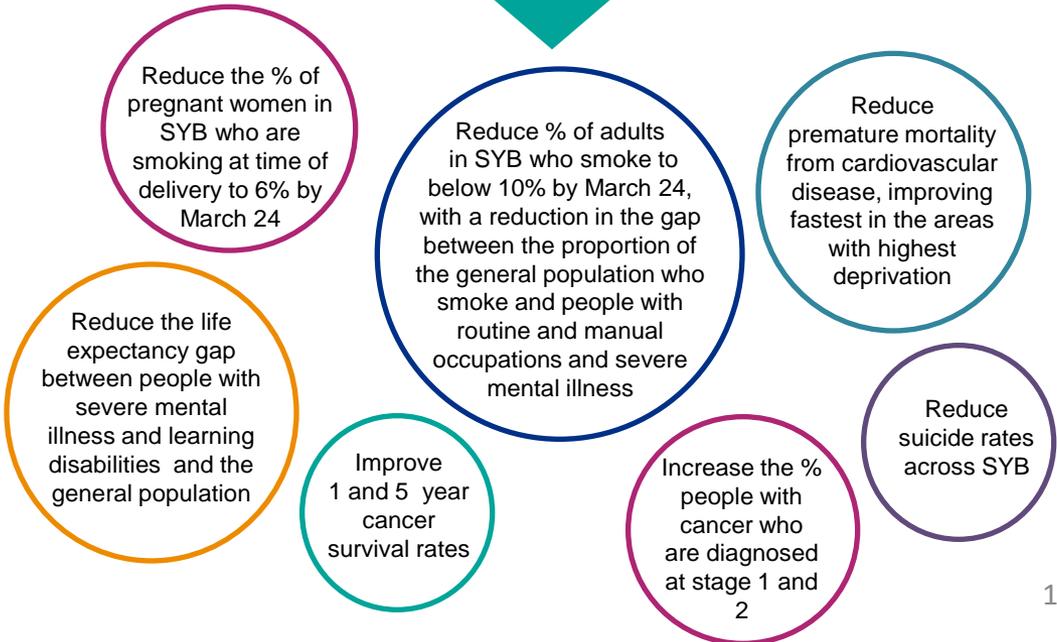
Many of the issues and illnesses leading to poor health and well being can be prevented. If we are to improve health and reduce health inequalities in South Yorkshire and Bassetlaw we need to broaden our approach.

Rather than focusing on just when someone is unwell, we will take a population health approach - working with our partners and local communities - to improve physical and mental health and wellbeing and reduce health inequalities across the entire population of South Yorkshire and Bassetlaw.

Our ambition is to help people early on and prevent future problems developing.

Our 2016 Plan focused on shifting our system to one that is focused on maintaining wellness and slowing or stopping the progression of disease by impacting on all the wider determinants of health. In our 2019 Plan, we set out our next stage ambitions to address health inequalities and improve our population's health over the next five years.

**We have identified five areas that we will need to particularly focus on over the next five years to improve population health and reduce inequalities**



# Tackling health inequalities



We will take a three-pronged approach to tackle health inequalities, underpinned with strengthened partnerships and leadership in Place.

## **Civic**

As partners in our five Health and Well Being Boards, Integrated Care Partnerships and Sheffield City Region we will support and advocate for public policies and strategies that improve the social determinants of health.

As anchor institutions we will maximise the impact that we can have on the wider social determinants of health in the way we run our organisations and support our staff. We will enhance social value in our commissioning, contracting and procurement processes. We will offer more apprenticeship and volunteering opportunities and be leaders in environmental sustainability.

## **Community**

Recognising that most change happens in local communities we will continue to develop local neighbourhood partnerships and local community assets, help people to support each other and take control of their health.

We will:

- Involve local communities in priority setting, service design and evaluation.
- Strengthen local communities and social networks, including through investment in the voluntary, community and social enterprise sector.
- Build capacity for local people to be involved as volunteers, community champions and peer support workers.
- Make sure there is good access to local activities and support for people and groups at risk of poor health.

## **Health services**

Through our core health services we will support people to manage their own health; support population health through the provision of high quality equitable primary care services; develop population health management capabilities and capacity to identify and address unwarranted variations in care. We will provide personalised care, focusing on what matters most to the person.

We will design services to meet the needs of communities with the greatest needs and prioritise services which have the biggest potential to decrease inequalities such as those for children and cardiac, diabetes, respiratory and cancer services. We will take measures to prevent or delay the onset of multi-morbidities and ensure good quality physical and mental health care for people with mental health conditions, learning disabilities and autism.

We will change the culture of the NHS to recognise prevention as a core responsibility of staff and services. We will ensure that prevention measures are commissioned, resourced and delivered at sufficient scale and in a sustainable way, ensuring those that are most disadvantaged benefit the most. We will undertake a range of actions, within the NHS's direct power to do, to support an improvement in the social determinants of health. <sup>15</sup>

# Wider determinants of health



## Education

School readiness is similar to the national average. Fewer children in SYB achieve attainment 8 score. About 6% of 16-17 year olds are not in education, employment or training.

## Employment

Fewer people in Barnsley and Sheffield aged 16-64 are in employment than the national average. Unemployment rates are higher in those with long term conditions.

## Deprivation and income

SYB has high levels of deprivation. All Places, except Bassetlaw, have higher than average rates of children living in low income families.

## Built and natural environment

Areas of poor private sector housing. 30% of adults who use mental health services and 20% of adults with learning disabilities do not live in stable or appropriate accommodation. Air pollution is estimated to cause between 4.4% and 4.9% of all deaths in SYB.

## Social capital and community safety

People using outdoor space for exercise is increasing but still only ranges from 14-19%. The percentage of those who have as much social contact as they would like is 40-49% for adult social care users and 28-43% for adult carers. Violent crime rates are higher than the national average, except in Sheffield.

Through our partnership working with the local authorities and Sheffield City Region we will influence and contribute to the development and implementation of a wide range of Place based strategies tackling wider determinants of health. There is also a range of practical actions that the NHS will undertake.

### Education

We will support children to be ready for school and maximise their potential with improved provision of services such as perinatal mental health, early diagnosis and support for people with learning disabilities and autism and personalised health care for those with long term conditions and disabilities. Identification of children and families who need extra support early and provide tailored response.

### Employment

As major employers in our local communities we will expand our work with local schools, colleges and universities to promote the wide range of NHS career opportunities, offer apprenticeship schemes, provide work experience and improve our staff welfare offer. We will also build on our Working Win pilot with the Sheffield City Region, set up Individual Placement and Support services for people with severe mental illness and enhance access to physiotherapists through Primary Care Networks for people with musculoskeletal problems and continue to improve mental health services.

### Deprivation and income

Through social prescribing and working with local welfare advice services we will support people to access advice and support to claim welfare benefits and debt advice. We will be active partners in Sheffield City Region Inclusive Growth Plans.

### Built and natural environment

We will collaborate with local authorities on planning for housing developments; engage with communities, public transport providers, Sheffield City Region and local authorities to improve links and walking and cycling routes and further develop active transport plans for hospitals; better integrate health services into local support for people who are or at risk of homelessness including providing specialist mental health services for rough sleepers.

### Social capital and community safety

We will expand the provision of social prescribing; continue to invest in the voluntary sector; develop NHS volunteering opportunities for local residents and support our staff to volunteer; work with local communities to ensure NHS services are accessible and responding to local need. Health organisations will play their part in addressing the root causes of violence.

# Developing a prevention led NHS



**Cut smoking**

**Reduce obesity**

**Reduce alcohol related admissions**

**Lower air pollution**

**Tackle anti-microbial resistance**

We will: Reduce % of adults in SYB who smoke to below 10% by March 24, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness.



Healthy Hospital Programme established. QUIT programme embedding the Systematic Treatment of Tobacco Dependency starting in all Acute and Mental Health Trusts early 2020



Wide range of activities across SYB on tobacco control, obesity, increasing physical activity, minimising harm from alcohol & improving air quality. High referral rates to Diabetes Prevention Program



Developing system level joint work with SYB Local Authorities:

- Enhancing social connectedness
- Increasing physical activity

Integrated approach to support people locked in a cycle of rough sleeping, addiction, poor physical health, mental health, and offending behaviour (Complex Lives)

## We will work across the System to:

- Implement partnership place based plans for tobacco, alcohol, obesity, physical activity and air quality.
- Increase the provision of very brief advice within clinical practice. Provide SYB commissioned brief advice and behaviour change training for all new post holders in Primary Care Networks.
- Maximise the prevention opportunities afforded by the new Primary Care and Pharmacy Contracts.
- Further develop the scope of the SYB Healthy Hospitals Programme.
- Increase NHS health and wellbeing offer for staff.
- Implement the national antimicrobial resistance strategy.

## Tobacco harm reduction:

- Roll out the QUIT programme so that from early 2020 all patients (except day case and maternity) admitted to acute and mental health trusts will be asked their smoking status and treated for tobacco dependency if a smoker.
- Further develop and implement plans to decrease smoking in pregnancy, supporting mother and family to quit.

## Reducing obesity

- Work with Local Authorities and Sheffield City Region to promote physical activity. Embed physical activity as a treatment intervention in clinical care. Implement NHS healthy food standards.
- Increase referrals to the Diabetes Prevention Programme; Seek to be a pilot site for enhanced weight management support for people with a BMI of 30+ with Type 2 diabetes or hypertension and low calorie diets for diabetics.
- Review provision of tier three obesity services.

## Reducing harm from alcohol

- Ensure all SYB acute Trusts have an alcohol care team, with a standard SYB service specification in line with national guidance, commencing during 20/21.

## Improving air quality

- Complete clean air consultations in Sheffield and Rotherham and put recommendations in place
- Develop alternatives to face to face NHS appointments
- Encourage staff to travel sustainably and actively
- Install more electric charging points on NHS sites, green the NHS fleet and review energy use and supply

# Population health management



- ▶ We will take a broad approach to population health so that we create the conditions for good health through our role as NHS anchor institutions, using our assets and developing approaches that help build on the strengths of local communities and increase social value.
- ▶ We will develop integrated and compassionate care offers in response to population health and care needs across our local neighbourhoods. We will reduce variation across population groups ensuring we improve health fastest in those with the greatest need. We will look at the whole population needs and not just those accessing services.
- ▶ We will improve the population health management capability across SYB using digital technology that will help to better understand the needs of the population. SYB is part of the Yorkshire and Humber shared care record programme which will enable patient information to be shared across hospitals, primary and community care and social care enabling seamless integrated care regardless of where people are treated.

## We will focus on:

### Outcomes

Health and wellbeing outcomes are often measured as averages, which can hide large variations in outcomes between population groups. We will delve deeper to identify the differences using population segmentation techniques and set realistic expectations for improvement at Neighbourhood, Place and System.

### Expectations

Expectations will be underpinned by a set of interventions and service or practice models that may need to be different from those that improve the health of all population groups.

### Urgency

We will approach this with a new level of urgency, curiosity and vigour.

### Ownership

We will have collective system ownership of the challenges and address them through mutually reinforcing actions.

### Empowering people

We will empower local people and communities with support and tools to help improve health and wellbeing across SYB.

### Interventions

The approach will inform the redesign of services to ensure they meet the needs of those with the most to gain. We will use evidence based risk stratification and segmentation tools to understand and meet our populations needs. We will use Patient Activation Measures to personalise wellbeing support and digital technology to support people to make healthy lifestyle choices.



**Place progress:** Sheffield has whole population linked data analytics capability and population health management intelligence dashboard. A pseudonymised linked data warehouse covers the entire GP population and can link all care services datasets at person level, including social care and modelled predictive risk values. Bassetlaw's Primary Care Networks are pioneering<sup>18</sup> PHM approaches, working to undertake root cause analysis for key population segments



## Our priorities

SYB has areas of unwarranted variation in access, quality, health outcomes and cost of health care services in primary care, secondary and tertiary care.

Differences between the quality of care and the clinical practice followed mean that, in some instances, patients across SYB receive different standards of care and potentially have different clinical and health outcomes. These variations can have significant financial implications.

We know from NHS RightCare that we have more people being admitted to hospital as emergencies with respiratory and cardiovascular disease and that we have marked inequalities in health. We also know from Getting it Right First Time that we have variations in the way services are provided and outcomes. Our challenge is to reduce unwarranted variations in care whilst improving care and outcomes overall and making cost efficiencies that can be reinvested in improving health across SYB.



We've made good progress in recent years, including the consolidation of provision of hyper acute stroke services, standardising commissioning across SYB for some procedures, supporting quality improvement in primary care, standardising a number of secondary care elective pathways and using RightCare and GIRFT data to inform planning, service reviews and Quality Innovation and Prevention Programmes.

### We will work across the System to:

- Work with the combined improvement offer from NHS England and Improvement eg RightCare, GIRFT
- Carry out an annual review of variation against peers on all our main programmes
- Strengthen our population health management analytical capabilities and review the support that's needed for Primary Care Networks
- Support Primary Care Networks to use the Network RightCare packs, national audits and other tools that support a reduction in variation
- Offer targeted support to primary care providers
- Systematically embed NICE and other national guidelines and standards
- Standardise clinical standards and reduce unwarranted variation with the Hospital Hosted Networks
- Continue work on the standardisation of outpatient pathways and the use of medicines
- Focus on cardiorespiratory and mental health
- Increase focus on prevention, with particular focus on reducing harm from tobacco, alcohol and obesity
- Put in place actions that will help to deliver consistent high quality care and access to care for vulnerable communities, such as physical health checks for people with severe mental illness or learning disabilities and continuity of care during pregnancy



# Taking a person centred approach

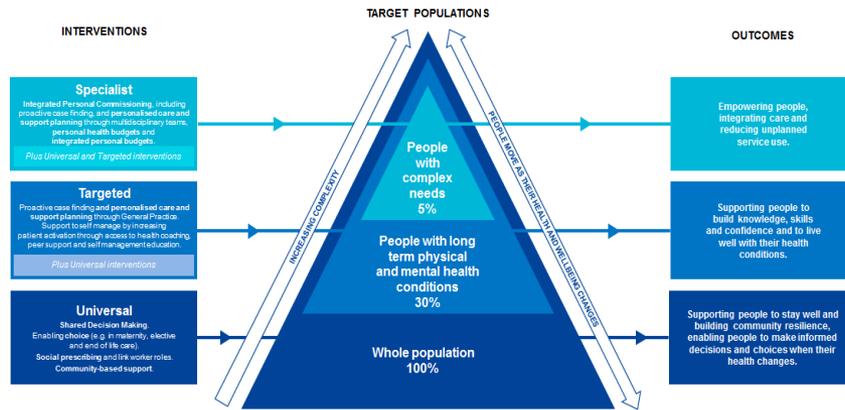


## Our progress

- Personalised care is a system wide priority and SYB places are providing personalised care approaches using the national personalised care comprehensive model. It is a key element of Primary Care Network development and supports out of hospital care and the Long Term Plan deliverables - prevention and early intervention, integrated community care and social prescribing
- SYB is one of 20 ICS' nationally to have committed through an MOU with NHSE to fully implement Personalised Care collaboratively across the system footprint by 2024
- Sheffield CCG is a exemplar site for Personalised Care supporting other systems nationally

### Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care



## We will work across the System to:

- Systematically implement the Comprehensive Model for Personalised Care by 2023/24, working with primary care networks, wider NHS services, people with lived experience and partners in local government and the voluntary and community sector.
- Enable people to take more control of their health and care, providing more options, coordinated support and care at the right time and right place
- Make the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences
- Supporting people with long-term physical and mental health conditions to build knowledge, skills and confidence to live well. Also taking whole-population approaches to supporting people to manage their physical and mental health and wellbeing
- Develop our relationships with, and commissioning of, the local voluntary and community sector.
- Develop our Workforce, Learning and Development strategies to support health and care professionals to further develop their skills and competencies in promoting personalised approaches, choice and shared decision making.
- Further expansion of link workers in Primary Care Networks
- Ensure personalised care approaches are embedded in service redesign

## We will offer personalised care through:

- Choice
- Shared decision making
- Social prescribing and community based support
- Patient Activation Measurement and support for self-management
- Personalised care and support planning
- Personal health budgets

Personalised care means people have a say in how their care is planned and delivered, based on 'what matters' to them, their individual needs and preferences



**Place progress:** South Yorkshire and Bassetlaw are national leaders for Social Prescribing, with well established services in all five Places

# Getting the best start in life



## Children's services

### Our progress

- We have established innovative out of hospital approaches and are looking to translate these across SYB.
- We have strong, mature networks including for children's surgery and anaesthesia and care of the acutely unwell child, through which we have developed new models and standardised pathways for common and urgent conditions.
- The Hospital Services Review recommended accelerating shared transformation for children's services

### Our challenges

- 4/5 Places exceed the England average for the rate of children in low income families
- High neonatal/infant and child mortality
- High child obesity
- Insufficient uptake of some immunisations in some communities
- High under 18 conception rate
- Specialist workforce challenges with particular shortfalls in hospital children's services.
- Agency and locum use is high
- Integrated out of hospital care models exist but application is inconsistent
- Inconsistency in waiting times for some specialist services, such as ADHD, ASD and SEND



We are developing a Children's Hospital Hosted Network

**We will:**  
Reach 95% of children having had 2 doses of MMR by age 5 by March 2022

We are learning from **great examples of integrated care in our Places**, such as the Rotherham team bridging acute and community paediatrics; Recruiting paediatric endocrine, respiratory and tissue viability nurse specialists in Bassetlaw; Integrated service for children with long-term conditions and disabilities in Doncaster and the early intervention and prevention models Healthy Minds and Sleep Project in Sheffield.

In mental health services, we are learning from Rotherham's approach to CAMHS/ASD/ADHD; Barnsley's eating disorder pathway and Bassetlaw's innovative use of the voluntary sector.

### We will work across the System to:

- Leverage the power of the ICS, combining a public health approach and integrated service models, with pathways across primary, community and acute healthcare. We've already done this in our Places and will work to apply this learning consistently and equitably.
- Yorkshire and Humber regional MMR delivery plan is under development and will include great focus on health equity audit
- Create a Children's Hospital Hosted Network, bringing together existing networks, with shared aims and senior ownership. Two of our Trusts (Sheffield Children's and Doncaster and Bassetlaw) will explore closer working
- Continue the work of our networks, including embedding the children's surgery and anaesthesia model.
- Ensure a focus on workforce. The networks, along with our Deanery, Health Education England and academia will deliver an initial series of strategic options for an integrated, sustainable workforce.
- Take a systemic view of mental health services for children and young people to understand gaps in service and capacity across SYB
- Implement the Long Term Plan ambitions. We await and will participate fully in the children and young people transformation programme. Given the opportunity, because of our Royal College links, our mature networks, our specialist Trust and established ICS, we intend to apply to be one of the 5-10 systems chosen to develop an evidence-based approach to integrated care models.
- We will build in work on transitions, taking a 0-25 approach. This is already being evidenced by Sheffield's all-age mental health pathway and work in Doncaster for ADHD.

# Getting the best start in life



## Maternity services

### Our progress

- Our Local Maternity System (LMS) has strong clinical leadership
- We have public health and prevention and perinatal mental health work streams
- The Hospital Services Review recommended accelerating shared transformation as the next step for maternity services

### Our challenges

- High rates of teenage mothers and mothers over 35
- High rates of low birth weight and neonatal and post neonatal deaths
- High obesity and smoking rates during pregnancy and substantial numbers of mothers are classed as intermediate or high risk
- Workforce challenges with shortfalls in maternity and difficulty recruiting midwives and middle grade doctors. This has led to substantial spend on locums.
- Increasing continuity carer will be challenging with existing workforce pressure.

#### We will:

Reduce the % of women in SYB who are smoking at time of delivery to 6% by March 24

We exceeded the Continuity of Care standard as at March 2019 –  
**22.3%** vs  
20% target

**4/5** Places have very low breastfeeding rates at 6-8 weeks

### We will work across the System to:

- Develop a comprehensive strategic approach from pre-conception to transition into children's services
- Create a Maternity Hosted Network (MHN) to work in parallel with our Local Maternity System (LMS) with shared aims and senior ownership
- Undertake a comprehensive review of smoking in pregnancy and implement a range of measures to reduce the percentage of women who are smoking at time of delivery and post natally
- The MHN will focus first on workforce and reducing clinical variance
- The MHN and LMS will continue Better Births implementation, ensuring all plans are fully integrated with wider system plans, such as children's and neonates
- Develop shared approaches to delivering increased Continuity of Care standards and improvements in breast feeding rates
- Ensure that the needs of disadvantaged and vulnerable communities are embedded within our plans to reduce inequalities
- Build on good practice in our Places such as Sheffield's plans to support people in high risk groups (eg diabetes and maternal obesity) to access services
- Develop plans to deliver strong and equitable midwifery led, community and home birth choices in each of our Places. We will build on the good practice in Rotherham where three community midwifery hubs have been introduced
- Work across all our providers to develop a consistent midwifery led approach



#### In Place:

- We are investing transformation funding to deliver *Better Births*
- We have specialist perinatal mental health services in some of our Places
- Each of our Places has a developing and maturing Maternity Voice Partnership

We are developing a  
**Maternity Hospital  
Hosted Network**



# Major health conditions



## Mental health

### Our progress

- On track to deliver majority of Five Year Forward View ambitions
- Funding secured for 2018/19 and 2019/20 with plans in place to deliver enhanced suicide prevention programme
- SYB wide IPS employment service commissioned for people with severe mental illness
- Enhanced perinatal mental health service launched in Doncaster, Rotherham and Sheffield
- 24/7 liaison mental health services established in Sheffield and Rotherham and funding secured for Barnsley and Doncaster
- Approval gained to establish New Care Models for three specialised services through NHS-led provider collaboratives
- Dementia diagnosis rates remain high across the ICS
- All CAMHS LTPs received fully assured status from NHSE and successful Green Paper Trailblazers in Doncaster, Rotherham and Sheffield and waiting list initiatives in Barnsley and Sheffield
- Workforce transformation project targeting high risk areas

#### We Will:

Reduce the life expectancy gap between people with severe mental illness and learning disabilities and the general population

#### We will:

Reduce suicide rates across SYB

### Our challenges

- Increasing demand on mental health services and addressing existing inequalities in health outcomes and life expectancy.
- Maintaining stable and resilient services whilst transforming to meet the Mental Health Investment Standard, Five Year Forward View for Mental Health and LTP commitments
- Enabling more children and young people to access community mental health services and expanding core community teams for adults and older adults through NHS led provider collaboratives for those with severe mental health illnesses (SMI).
- Growing the mental health workforce to deliver quality timely care
- Variation in access and uptake of physical health checks
- Working across boundaries that reside in other ICS footprints
- Suicide rate has reduced, but remains high for some groups.



An integrated approach to support those with complex lives in Doncaster is already demonstrating improvements in outcomes.

### We will work across the System to:

- Work with partners to develop an all age service and investment strategy, digitally enable care and support and develop the mental health workforce.

#### Children and Young People Mental Health

- Continue to deliver on our commitment to invest in and expand access to mental health services for children and young people, expanding community provision.
- Continue to develop specialist community perinatal mental health provision
- Continue to prioritise eating disorders with collaborative commissioning
- Expand timely age appropriate crisis services (24/7) including implementation of Intensive Home Treatment services
- Implement mental health support teams in schools to enable early intervention and offer ongoing support
- Develop a strategic approach to service provision 0-25, including those 18-25 to support transition into adulthood as part of an all age strategy.

#### Adult Mental Health

- Work with partners to delivery the suicide prevention programme including further development of real time surveillance and bereavement support
- Adult Common Mental Illness – Continue to expand IAPT for adults/older adults with a focus on those with long term conditions.
- Severe Mental Health Problems – As a pioneer, trial new and integrated models of primary and community mental health care to support adults/older adults with severe mental illness. Work to increase uptake of physical health checks. Improve physical health with a particular focus on reducing harm from tobacco, obesity & improving cardiorespiratory health.
- Emergency Mental Health Support – Expand services for people experiencing a mental health crisis to include 24/7 age appropriate access to crisis resolution, home treatments and alternative provision. Work with the ambulance service to improve crisis response options, including staff training, response vehicles and expanding the use of 111.
- Therapeutic Mental Health Inpatient – Provide therapeutic environments and work to reduce longer lengths of stay and reduce out of areas placements.
- Problem gambling – Understand the problem in SYB and collaborate regionally on development of specialist clinics.
- Rough sleeping mental health support –Further understand the problem and work collaboratively with Local Authorities to develop approaches to improve outcomes.



## Learning disabilities and autism

### Our progress

- Highest reduction of inpatients nationally, significant reduction of admissions and reduced length of stay in line with learning disabilities (LD) senate guidelines.
- Implemented intensive support teams – now running extended hours, demonstrable success with preventing admissions
- Implemented forensic outreach liaison services and a forensic step up/step down service on transforming care footprint
- Developed key partnerships with experts by experience who are involved in all aspects of the transforming care programme in line with the ladder of participation methodology
- Proactively rolling out LD/Autism awareness training to GPs acute trusts and other mainstream services, delivered by experts by experience
- Developed an exemplar Dynamic Support Protocol for children and young people which is being rolled out in other areas
- Led on the development and implementation of the Yorkshire and Humber enhanced community framework, leading the way with referrals and new ways of working to improve the community offer.
- Embedded learning disabilities and autism into the ICS mental health and learning disabilities programme, to ensure alignment with all age mental health

### Our challenges

- Reducing health inequalities for people with learning disabilities due to low uptake of screening and variations in numbers and quality of annual health checks
- Waiting times vary for children and young people and adults for diagnosis of autistic spectrum disorders (ASD)
- Addressing gaps in provision of post-diagnostic support for autistic children and young people, autistic adults and their families
- Ensuring services work in an integrated way and pathways are seamless across all ages regardless of geography.
- Workforce, both lack of workforce and workforce with the right skills
- Housing, lack of appropriate housing for people with learning disabilities and autism including general and specialist

### We will work across the System to:

- Ensure people who are still living in hospitals are discharged in a timely manner, supporting the local markets and systems to facilitate discharge
- Further invest in intensive community support provision including children and young people, increasing extended hours and crisis response to meet the needs locally and to focus on preventing admission into hospital
- Promote health and wellbeing through My Health Day events targeting people and families with LD and/or autism, raising awareness of annual health checks, STOMP/STAMP, Hospital Passports, Screening programmes
- Continue to roll out the coproduced and co-delivered LD/Autism awareness training until the mandatory training is in place
- Roll out a programme of training around the LeDeR learning priorities utilising the ECHO platform to embed the learning across the system
- Increase the number people receiving AHC's, by working as a system to ensure the right support and reasonable adjustments are in place to deliver the 75% target
- Increase number of children receiving Care, Education and Treatment Reviews (CETR) prior to hospital admission by looking at developing a CETR hub to provide additional capacity to meet the increasing demand and provide a sustainable system for delivery and assurance
- Work with families and people with lived experience to improve pathways and experiences for ASC/ADHD, utilising transformation monies to fund pre and post diagnostic support working with the voluntary sector
- Bring to life the Autism Friendly Charter (under development)
- Work to secure funding to develop a strategic housing needs assessment for people with learning disabilities and autism
- Develop a joint workforce delivery plan to identify gaps and review new roles and new ways of working to address some of the gaps
- Develop the concept of providing neuro disability services on a 'holistic whole family – life span' approach
- Support vulnerable groups from becoming involved in crime
- Work with digital work stream to ensure digital flagging of patients with learning disabilities and autism and ensure QOF registers are up to date and information about AHCs logged appropriately and self-management apps

# Major health conditions



## Cancer

### Our progress

- Our Cancer Alliance is a key partner in driving the radical upgrade in prevention. The Alliance is supporting the QUIT programme to reduce preventable deaths from tobacco use
- Established a clearer understanding of our inequalities and the communities more likely to be diagnosed later
- Launched Be Cancer SAFE social movement to help address inequalities
- Promoted earlier diagnosis by enabling primary care to implement new tests and care pathways
- Invested in our hospitals to deliver RAPID pathways to coordinate tests to provide faster diagnosis
- Our specialist cancer centre, Weston Park, has improved facilities, their research profile and are testing new models providing chemotherapy closer to home
- Enabled a thousand more people to access information and support in their local communities through meaningful conversations.

### Our challenges

- The number of people being treated for cancer is expected to rise from 14,000 to more than 18,000 by 2030. Over 5000 cancers could be prevented through behaviour changes.
- SYB has a significant gap from the national ambition to have three in four people diagnosed at stage one or two.
- This burden on demand is creating additional pressure on diagnostic and treatment capacity and ability to deliver national operational standards.
- Variation in access, care pathways and outcomes.

**We Will:**  
Increase the percentage of people with cancer who are diagnosed at stages 1 and 2

**We will:**  
Improve 1 and 5 year cancer survival rates

1 in 2 people are currently diagnosed at a late stage, with many through the emergency route

1 year survival is improving and narrowing the gap from the England average

45,000 people living with and beyond cancer expected to rise to as many as 78,000 by 2030

5 year survival remains significantly worse than the England average

### The Cancer Alliance will work across the System to:

- Drive prevention priorities around alcohol, obesity and physical activity in addition to smoking
- Utilise Primary Care Networks to further engage communities to reach optimal uptake of vaccination and cancer screening with the biggest increase in those living in most deprived areas
- Introduce lung health checks and rapid diagnostic centres to enable earlier and faster diagnosis
- Embrace innovation and research to bridge the gap on early diagnosis with the SYB Innovation Hub.
- Build and network diagnostics to enable our workforce to operate as a single cancer service to meet demand and deliver national operational standards
- Ensure equitable access to optimal and personalised treatment including access to national and international clinical trials
- Support capital investment plans to ensure specialist cancer services are developed at Weston Park and care in communities closer to home
- Continue to adopt personalised care and support through a 'What Matters To Me' approach



**Place progress:** Doncaster is leading our participation in the national lung health checks programme

# Major health conditions



## Stroke care

### Our progress

- Following consultation, hyper acute stroke services are now centralised in Doncaster, Sheffield and Wakefield to enable equitable access to high quality care, improve outcomes and provide sustainable provision.
- Sheffield Teaching Hospitals are delivering mechanical thrombectomy with plans to expand access over more hours per week.
- Direct to scan pathways have been implemented in Doncaster and access routes redesigned in Sheffield.
- All SYB stroke units contributed to the Hospital Services Review and work to review the wider pathway.

We are developing a Stroke Hosted Network

### Our challenges

- Stroke can be prevented and a leading cause of death and disability. Mortality has decreased, but survivors with a disability has increased
- Most SYB stroke units are improving their performance on the Sentinel Stroke National Audit Programme (SSNAP) but there is still significant variation in care
- SYB thrombolysis rates are below the national average.
- Specialist workforce challenges and shortfalls
- There is significant variation in the commissioning and care delivery of the post HASU pathway, particularly for stroke rehabilitation

### We will work across the System to:

- Develop a Stroke Hospital Hosted Network (HN), with clinical and managerial leadership hosted by Sheffield Teaching Hospitals, and bring together all partners across the stroke pathway, including ambulance services and the Stroke Association to act as the SYB Integrated Stroke Delivery Network
- Work through the Network to reduce stroke incidence by making links with CVD prevention work, increase public awareness of TIA symptoms, need for urgent care and tackle variation in delivery.
- Develop networked provision to deliver the NHS seven-day standards for stroke care and the National Clinical Guidelines for Stroke.
- Embed the centralised hyper acute service and realise the benefits, including equitable access to high quality specialist care and increased access to thrombolysis for eligible patients.
- Work with Health Education England to modernise the stroke workforce, focussing on cross speciality and cross profession accreditation and exploring the use of new roles, including Advance Care Practitioners and new ways of working.
- Enable more consistent access and delivery of stroke rehabilitation. Focus on integrated out of hospital higher intensity rehabilitation models working with the voluntary sector.
- Ensure that early supported discharge is routinely commissioned as an integrated part of community stroke services
- Work with Sheffield Teaching Hospitals to increase availability and equitable access to mechanical thrombectomy, by supporting workforce planning, collaborative working with other neuroscience centres and the use of technology.



**Place progress:** There are existing models of good practice in our Places – eg In patient rehabilitation in Sheffield and early supported discharge in Rotherham

# Major health conditions



## Diabetes

### Our progress

- Expanded provision of nationally accredited structured education programmes and set up a digital pilot in Barnsley.
- Targeted upskilling of primary care to improve achievement of treatment targets and prevent complications.
- Achieved full coverage of the NHS Diabetes Prevention Programme hosted by Bassetlaw in September 2017 and over 9600 referrals to the programme have been made.
- Implemented a 7 day diabetes nursing service at Doncaster and Bassetlaw Teaching Hospitals.

There are **137,000** people at high risk of developing Type 2 Diabetes in SYB

### Our challenges.

- Type 1 diabetes cannot be prevented and is not linked to lifestyle, but Type 2 diabetes is largely preventable through lifestyle changes.
- The cost of diabetes to the NHS is high and the majority of this is currently on treating complications.
- One in every six people in hospital has diabetes. Although diabetes is often not the reason for admission, they often have a longer stay in hospital, are more likely to be re admitted and their risk of dying is higher. More than 500 people with diabetes die prematurely every week.
- There is significant variation in the management of diabetes across SYB and variable achievement of the NICE treatment targets.

The estimated prevalence of diabetes (16+) is **8.6%** of SYB population, similar to the England average

### We will work across the System to:

- Establish a Diabetes Programme Steering Group (DPG), that will oversee the implementation and delivery of the national diabetes programme and all the diabetes LTP commitments in SYB.
- Expand access to the 'Healthier You' NHS Diabetes Prevention Programme to deliver the required (6044) places by 2023.
- Work to ensure that the recently expanded structured education, multi-disciplinary footcare team and diabetes specialist nursing capacity is sustained.
- Work with Primary Care Networks to support them to target support to reduce health inequalities and the decline in treatment target achievement.
- Lead the implementation of the national online education platform for Type 2 diabetes in line with national timeframes.
- Pilot and evaluate 'low calorie diet' programmes aimed at achieving remission for obese people with Type 2 diabetes.
- Ensure that pregnant women with Type 1 diabetes are offered continuous glucose monitoring from April 2020.
- Work with the relevant clinical network to improve the quality of care for children living with diabetes and improve transition to adult services.
- Work with clinical services to ensure equity of access to high quality services for all, including making reasonable adjustments for people with learning disabilities and severe mental illness.
- Evaluate and share learning from the digital pilots.



**Place progress:** Sheffield has reduced the average length of stay for people with diabetes and achieved a measurable reduction in severe foot ulcerations.

# Major health conditions



## Respiratory

### Our progress

- Supported the development of the SYB QUIT Tobacco dependency Programme
- Completed a baseline assessment in each SYB place against the North Respiratory Programme for 2018/19 and developed plans to improve respiratory care pathways
- Our places have over the last 3 years prioritised respiratory disease as a key focus to support more people in the community
- Initiated a review through our ICS Urgent and Emergency Care workstream to reduce respiratory related admissions to hospital

### Our challenges

- Respiratory disease is a leading cause of death, Barnsley, Rotherham and Doncaster have significantly higher under 75 mortality rates from respiratory disease.
- We know from NHS data and intelligence there is unwarranted variation in respiratory outcomes and care in SYB such as detection rates of COPD, provision of spirometry, uptake of pulmonary rehabilitation and the prescribing and use of medicine.
- Emergency admissions for respiratory place significant pressure on the urgent & emergency care system, particularly during the winter period.
- High smoking rates

### We will:

Reduce % of adults in SYB who smoke to below 10% by March 24, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness

Respiratory disease is a leading cause of death in SYB

Barnsley, Rotherham and Doncaster have significantly higher under 75 mortality rates from respiratory disease

### We will work across the System to:

- Establish a clinically led respiratory network to reduce variation, accelerate improvements through the sharing of best practice and standardise respiratory care pathways to improve quality and outcomes
- Participate in the North STP Leaders Programme to ensure that the SYB ICS benefits from collaborative working across the North of England.
- Work with our primary care networks to provide more care closer to home including improving the diagnosis and management of respiratory disease, supporting clinicians and professionals to use systematic tools to identify those at risk.
- We will utilise new roles and approaches in case management in a way that benefits those with respiratory conditions, including clinical pharmacists to optimise medicine use, physician associates and more specialist nurse roles in the community.
- Improve uptake of pulmonary rehabilitation, working with partners such as the British Heart Foundation, British Lung Foundation and Universities to improve access to and completion of rehabilitation.
- We will work with patients and families to develop new models of pulmonary rehabilitation that are more tailored to peoples needs for rehab
- Improve the response for people with pneumonia by reviewing existing pathways and working with public health to maximise the update of flu and pneumococcal vaccination for at risk groups and health care staff.



**Place progress:** Rotherham has developed a new breathing space facility for outpatients which is delivering excellent results

# Major health conditions



## Cardiovascular Disease

### Our progress

- Member of North ICS CVD group and SYB CVD Prevention Task Group and Clinical Lead in place
- SYB is close to the national ambitions for Atrial Fibrillation detection and anticoagulation. Primary care development schemes are supporting quality improvement
- Sheffield is piloting a community pharmacy and GP hypertension shared care arrangement
- All Places have BNP pathway. Consistent referral guidelines in place for secondary care echo referrals
- Barnsley is redesigning its heart failure pathways

**We will:**  
Reduce premature mortality from cardiovascular disease, improving fastest in the areas with highest deprivation

### Our challenges

- CVD is a major contributor to our health inequalities. Deaths from CVD are the second biggest contributor to the gap in life expectancy between SYB and England
- Although premature mortality from CVD has decreased in SYB over the last two decades, all Places in SYB (except Bassetlaw) still have significantly higher under 75 mortality rates than the English average
- High rates of the key risk factors for CVD.
- Barnsley has next to highest non-elective spend on CVD in the country and Doncaster and Sheffield have higher non-elective spends than their RightCare peer group average
- Significant unwarranted variations between GP practices in diagnosis/management of patients with or at risk of CVD and uptake of cardiac rehab is low
- Suboptimal proportion of patients post NSTEMI are receiving their angiography +/- percutaneous coronary intervention within NICE recommended timelines.

More than 1,000 people under 75 die every year from CVD in SYB

Under 75 CVD mortality rates are 4 times higher in the most deprived areas of SYB, compared to the least deprived

### We will work across the System to:

- Prevent CVD – see the section on developing a prevention driven NHS
- Detect early and improve treatment of CVD and its risk factors. We will:
  - Move towards the national ambitions for Atrial Fibrillation, blood pressure and CVD risk
  - Decrease unwarranted variations by providing targeted support to GP practices; support use of CVD Prevent audit; develop quality improvement and population health management capacity and support for primary care
  - Maximise the opportunities of the additional roles in Primary Care Networks and the new community pharmacy contract. SYB CVD training course to be commissioned. Learn from national Atrial Fibrillation pilots
  - Expand the Sheffield community pharmacy shared care hypertension pathway across SYB, if pilot evaluation positive
  - Identify patients who may have Familial Hypercholesterolaemia
  - Link with the Mental Health and Learning Disability work to ensure a focus on CVD within severe mental illness and learning disability Health Checks
  - Continue to work with Local Authorities, to support the delivery of Health Checks
  - Work with Yorkshire Ambulance Service (YAS) and our community and voluntary sector partners to develop CVD prevention champions
  - Support the public with opportunities to check on their health
  - Support practices to enhance their support for patients with or at risk of CVD to self manage eg develop peer educators
- Develop agreed messages for the public, patients and professionals to ensure consistent approach on CVD prevention
- Work with YAS on their restart a heart campaign and support schools in SYB implement CPR training
- Work with partners (British Heart Foundation, British Lung Foundation, universities) and patients to redesign cardiac rehabilitation (including digital options) to increase uptake
- Review GP direct access to echo across SYB & share learning from Barnsley on Heart Failure pathways
- Through the Specialised Cardiac Improvement Programme (SCIP) improve acute care and decrease variations in access to angiography



## how we flex resources

### System finance

As a high performing ICS, we have had access to offsets and used this effectively in delivering the 18/19 financial position.

The System delivered strong financial performance despite significant local and national challenges. Each of our Places delivered a performance better than that planned at the start of the year and only one organisation did not meet its individual control total and was supported by the System to ensure that they received their full share of PSF.

The ICS financial performance at the end of the year was better than planned at £19.6m (excluding PSF). This was a very positive performance and forms a foundation for continued investment in services or infrastructure for the coming years.

The strength of the financial performance is a testament to our collaborative approach. However, much of the surplus has been generated through non-recurrent measures. Next year remains a challenging financial year and requires the continued robust management of finances.

### Transformation funding

We have had access to transformation funding over the last three years and been able to invest significantly in primary care (including access funding, digital funding and cancer), secondary care (including mental health, urgent and emergency care, pathology and maternity) and prevention (including suicide prevention, care homes and social prescribing)

Indicative additional transformation funding of £129 million the next five years will enable us to deliver our plan.

### Commissioning development

Across South Yorkshire and Bassetlaw, commissioning has already started to evolve and adapt to meet the needs of people and patients. This is in line with the NHS Long Term Plan and ensures a stronger focus on population health, the impact on the wider determinants of health and reducing health inequalities. This builds on the work of the Joint Committee of Clinical Commissioning Groups.

In each of our Places, NHS commissioners continue to develop closer working with local authorities; enabling joint working, joint teams and supporting and enabling the development of neighbourhood working, integrated primary and community care and the development of Primary Care Networks.

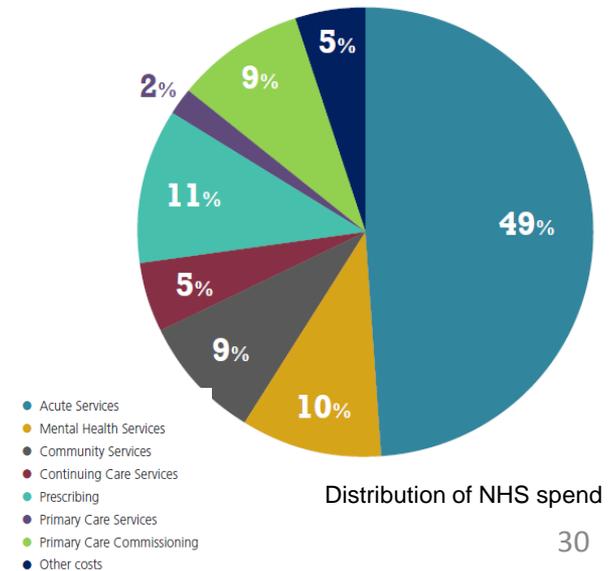
Across the System, commissioners are working jointly with providers to agree joint ambitions and outcomes for the health of their shared population together and will continue to plan together where it makes sense to do so – especially where we can reduce variation in standards, quality or access to services.

We are committed to building on this work and strengthening our ability to deliver our ambitions by having further developed arrangements in place for April 2021.

### NHS and social care spend within South Yorkshire and Bassetlaw

The expenditure of the five clinical commissioning groups totals £2.5bn in 19/20 and the spend is as shown. In addition, there is further £0.5bn on specialised commissioning and the Local Authorities spend £1.4 billion on social care.

To deliver our ambitions, we will need to flex our resources. A population health approach and a focus on prevention will mean a shift in our investment thinking and planning, which will result in a different share of the overall spend.



Distribution of NHS spend

We will move from a functional approach to Estate Management ...

### Hospitals

- £1bn of hospital assets
- 44 separate acute and mental health sites
- £160m of backlog maintenance categorised as critical and high

### Primary Care

- 316 separate GP, third party, NHSPS and CHP assets
- £44m of estate running costs

### Disposals

- 17 different Disposal sites identified
- £28m opportunity
- (£24m fair share disposal target from Naylor Review)

### Finances

- £20m of Wave 1 and Wave 2 schemes (Yorkshire Ambulance Service, Barnsley Hospital, Doncaster and Bassetlaw Teaching Hospitals, Sheffield Teaching Hospitals)
- £118m planned investment in 19/20 (incl £7m information management and technology and £19m equipment)
- Over £400m planned investment through to 2023/24
- £60m annual depreciation
- £150m working capital balances

... to a **System approach**

Acute and mental health	Primary care	Digital and IT
High quality and fit for purpose, sustainable estate which reflects modern patient needs and experience	New facilities reflecting new models of care Support a left-shift in provision	Full connectivity Systems which support data sharing and collaboration
Improved resilience through reduced backlog maintenance	Reconfigured existing estate to enable changes in ways of working No redundant estate	Modern IT infrastructure
New facilities reflecting service developments	Asset Optimisation	
No redundant estate	£57.5m Wave 4 capital	

# Section 2: Strengthening



## our foundations

Working with patients and the public

Empowering our workforce

Digitally enabling our System

Innovation and improvement



## Our progress

- We have built on the strong communication and engagement networks in SYB enabling us to deliver consistent messages through trusted sources
- Strengthened our relationship with the SYB Healthwatches and organisations that work with seldom heard communities which have undertaken engagement on our behalf
- Undertaken extensive involvement work with public and patients to inform the work of the Hospital Services Review
- Worked with community, patient and voluntary groups as well as staff to inform work across a range of areas, including NHS 111 procurement, over the counter medicines, hip and knee pathways, ophthalmology services, autism, emergency admissions from care homes and stoma care
- Carried out comprehensive involvement with staff, patients, public and stakeholders on the NHS Long Term Plan to inform our Five Year Plan
- Established the SYB ICS Guiding Coalition – a strategic advisory forum which includes voices from primary and secondary care clinicians, local authorities, voluntary sector and the public
- Established the SYB ICS Citizens' Panel, bringing together people from across the region to provide an independent view on matters relating to work at System level
- Established a Transport and Travel Panel with patients and the public, also from across the region, to look at the potential impact changes to services would have
- Developed a System involvement duty assurance process

## Our challenges

- Shifting people's view from organisation to Neighbourhood, Place and System
- Articulating the benefits of working across a System to patients, communities and staff
- Working in a matrix style across partners' communications and engagement functions

## We will work across the System to:

- Meet as a Guiding Coalition twice a year to discuss and agree our strategic direction
- Strengthen our links across partner communications and engagement teams to carry out System involvement and meet duties
- Build on our work with the Citizens' Panel and develop an online membership model to support our involvement work on transformation
- Explore how we can triangulate patient experience data from all partner sources to develop a System profile approach to involvement

## Long Term Plan involvement

We worked with our Healthwatches and together we connected with over 1500 people who shared their views through completing the survey online and face-to-face. We also connected with staff and the public through our partner organisations, our ICS Staff Side Forum, other forums and at events. We also asked our MPs and Health and Wellbeing Boards what they thought. Both the Healthwatch report and other key theme findings have all been shared to inform the development of our Plan.

### Key themes from our involvement:

- Seamless pathway of care / true patient-centred care
- Focus on prevention
- Integrated working across teams and organisations
- Integration and improvement of IT systems/digital technology
- Equality within the System
- Improved staffing conditions
- More care provided in homes/in communities
- Social care reform
- Better leadership/senior management

Our involvement work routinely connects with people from seldom heard communities such as asylum seekers, the deaf community, prisoners, young people, people with visual impairment, older people, black and minority ethnic communities, pregnant women and new mothers, Chinese community, people with mental health issues, people with drug and alcohol issues and veterans. We also connect with the 'working well' through our links with South Yorkshire and Bassetlaw employers

# Empowering our workforce



We employ over 48,000 members of NHS staff - 72,000 if we include all health and care workers - who work to meet the needs of 1.5 million people across South Yorkshire and Bassetlaw

## Our progress

- Established an ICS Workforce Hub to support co-ordination of activities across Place and System level
- Commenced core programmes, including: Primary Care Workforce Training Hub, South Yorkshire Regional Excellence Centre and Faculty of Advanced Clinical Practice
- The Barnsley Partnership is delivering a Workforce Transformation plan for out of hospital workforce based on population health. This is supported by a Barnsley wide OD plan, workforce strategy and talent management strategy.
- Launched collaborative staff banks and implemented agency procurement
- Increased portability of staff between organisations
- Supported increase in Advanced Care Practitioners across primary, community and mental health care
- Supported partners to work collaboratively on national initiatives including NHSI Retention Programme
- Delivered eRostering “Masterclass” Programme
- Developed an Allied Health Professions Council

SYB trusts report more than 800 nursing and midwifery vacancies

## Our challenges

- Tackling vacancy gaps in supply and demand impacting our workforce, particularly across nursing
- Aligning workforce planning with service, activity and finance.
- Strengthening the primary and community care workforce to enable care closer to home
- Developing the mental health workforce
- Making the NHS the best place to work, improving retention and engagement
- Work with our schools to promote the NHS and social care to promote health and social care as a career of choice
- Making prevention a core element of every staff member role.
- Equipping existing and future senior leaders to operate successfully system wide in our evolving ICS
- Developing a co-ordinated approach to talent management, with focus on diversity and inclusion

## Strengthening primary care workforce is a priority for the ICS

To support sustainable services and enable care closer to home, we have introduced a Primary Care Workforce Hub supporting:

- Growth in number of GPs
- Development of Primary Care Network Additional Roles such as 1sk Contact MSK practitioners
- Delivery of a Primary Care Nurse Vocational Training Scheme
- Coordination of Undergraduate Nurse Placements Across SYB
- Delivery of targeted apprenticeship scheme for healthcare assistants
- Recruitment of GP Fellows to support transformation projects
- Delivery of a SYB wide Practice Manager Conference
- The roll out of a data collection/workforce tool
- The introduction of physician’s associate role across general practice

# Empowering our workforce



## We will work across the System to:

### Make the NHS the best place to work:

- Take a System approach and implement the new national core offer for staff
- Build on NHSI/NHSE programmes to improve retention
- Support Places, align systems around national Health and Wellbeing Framework
- Improve our health and wellbeing offer to staff
- Monitor sickness, violence and bullying and harassment and target support linking to regional and national programmes

### Improving leadership culture

- Promote an agreed systems leadership framework
- Optimise use of external provision and commission system leadership at ICS level only
- Ensure current and future senior leaders access and use leadership development
- Address the cultural barriers in and between organisations and build trust
- Co-ordinate Talent Management Boards, workstreams and colleagues to ensure integral part of senior Boards, Committees and key forums
- Develop a system wide approach to retain and fully use our talent
- Build HR capability

### Tackling urgent nursing shortages and securing current and future supply

- Develop system level approach to strategic workforce planning
- Accelerate new roles across key professional groups
- Work together to attract staff to SYB as a place to live and work
- Support values based recruitment to attract and retain staff
- Engage partners on collaboration of international recruitment
- Set up a Placement Pilot Scheme to increase and improve placements
- Implement the Future Workforce Programme including schools engagement and employability
- Scale up apprenticeships and access to training to upskill our workforce.
- Develop the voluntary sector as a partner within the system, with VCS staff, volunteers and unpaid carers provided with the same access to support as staff within the statutory organisations

### Releasing time for care

- Deliver e-workforce strategy building on ICS eRostering “Masterclass” programme
- Collaborative bank and agency management

### Delivering 21<sup>st</sup> century care workforce redesign

- Develop Healthy Hospitals Programme
- Enable flexible/streamlined movement of staff between trusts
- Regional Excellence Centre and Faculty for Advanced Clinical Practice
- Implement of collaborative staff banks across medical and nursing
- Embed System level approach to new roles across primary and secondary care eg Trainee Nurse Associates, Advanced Care Practitioners, Physician Associates
  - Engage with AHSN on workforce innovation
  - Develop primary care workforce training hub

### Developing a new operating model for workforce

- Build on existing framework and agree system level workforce responsibilities
- Develop ICS “Workforce Hub” offer
- Develop system wide strategy for education, training and development
  - Implement improved governance including a Strategic Workforce Group and strengthen links between strands
  - Support hosted clinical network development and co-ordination of professional councils eg AHPs
  - Further develop our partnerships across unions, education and local authorities

### Analysis, insight and affordability

- Oversee workforce planning at System level
- Work collaboratively to develop intelligence systems

# Digitally enabling our system



## Our context

Digital remains a key enabler for us and there is significant ambition to deliver digitally enabled care.

There is a mixed economy across SYB that needs to be resolved through implementing the basic digital capabilities for integrated care, whilst providing a framework to allow for innovation and more mature Places to go further faster but in an aligned manner.

Technical standards are critical to enable integration and standardisation in the delivery of digital services (includes online and offline e.g. phone), which SYB needs to adopt in line with published national standards.

## Draft priorities, roadmap, framework

The digital themes and phases have been merged to create a draft roadmap/framework.

Phases have been developed to structure and prioritise the delivery of digital enablers. They support aligned delivery, which can be done in a more agile and incremental approach, where organisations and places can learn from, support and collaborate with one another.

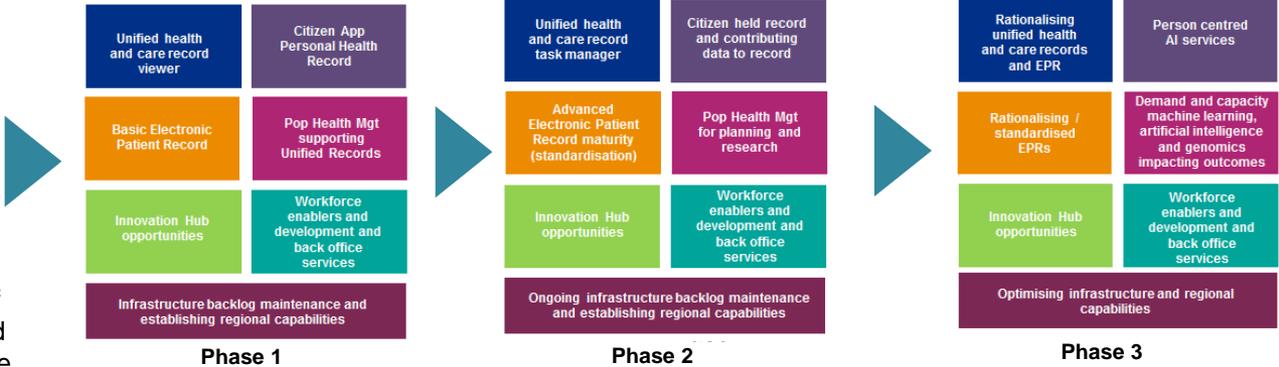
**Phase 1** - Establishing the basic digital capabilities for integrated health and care

**Phase 2** - Greater use of information and advancing capabilities to improve health and care delivery

**Phase 3** - Digitally enabled citizens, professionals and system

## Digital themes

A set of digital themes have been developed based on the needs, priorities and objectives of our transformation workstreams, such as prevention, as well as the relevant digital delivery challenges and capability/category types.



## Impacts and Implications

There are many implications of this proposed strategy, which include 1) significant increase in funding required, 2) additional capacity within clinical/service leads, operational teams to take on the business change and digital delivery, 3) increased risk appetite, 4) more 'digital/agile' delivery culture to prototype changes, deliver incrementally, 5) greater focus on system requirements from organisations, e.g. consider use of existing systems, consider system requirements within procurements.



## Across the System we will:

- Deliver stable, performant, secure (including cyber security) and cost effective infrastructure across SYB, resolving backlog IT maintenance that is a corporate risk
- Achieve 100% compliance with mandated cyber security standards across all NHS organisations by summer 2021
- Deliver unified/integrated health and care records across SYB for professionals and citizens which integrate with the Yorkshire and Humber Care Record
- Provide all citizens with an online/digital service to manage their health and care needs, with provision for those digitally excluded
- Develop basic capabilities to fully digitise Primary Care and Primary Care Networks delivered by 2022, including shared record, citizen access, a Population Health Management capability and support infrastructure services
- Ensure all secondary care providers – acute, community and mental health are fully digitised by 2024
- Deliver a Population Health Management capability across SYB, which integrates with the Yorkshire and Humber Care Record PHM capability
- Establish a consistent maturity of Electronic Patient Record services in NHS Providers and Social Care [GP / Primary Care has this already]
- Establish a hub for digital innovation across SYB, which integrates with the Yorkshire and Humber Academic Health Science Network
- Establish a set of Digital Principles and Standards, which all organisations and Places will commit to and will support more effective system working to deliver digital enablers
- Ensure all service/clinical transformation is underpinned by user centred service design approaches to ensure digital enablers support whole person pathways and wider transformation activity

## Principles and Standards

Seven principles and standards have been developed to support more effective system working across SYB by organisation leaders, digital leaders and their teams, wider users and stakeholders, and to guide digital delivery and investment decisions. The draft standards are available in the Annex



## Our progress

- The SYB ICS has partnered with the Yorkshire and Humber Academic Health Science Network (AHSN) to establish an Innovation Hub which will become the vehicle for system-wide innovation
- The Innovation Hub began operations in June 2019 and is staffed by individuals knowledgeable in innovation who are embedded into the SYB ICS
- To help establish the processes of engagement with the Hub, a number of Innovation exemplar projects have been developed that target major system wide unmet needs

## Our challenges

- Knowledge and awareness of innovations that can help improve practice and address unmet needs is patchy across the sector
- Uptake of innovative technologies, service delivery models and policies has traditionally been slow in the health service
- The process of sharing knowledge and innovative practices from one part of the health service to another is disjointed
- Collaborative efforts to test out new models of working need improvement
- Despite examples of healthcare innovations incubated in the NHS, a culture of innovative thinking does not pervade across all of the services and staff

Led by the AHSN through initiatives such as the Local Health and Care Record Exemplar (LHCRE) programme, the AHSN's Innovation Exchange and the Accelerated Access Collaborative, we will continue the system wide adoption of nationally and locally identified innovation that fit with our priorities.

Our patients can fully benefit from breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery

The Innovation Hub will enable SYB ICS to:

### Match innovation to unmet need

- Establishing and managing a unified approach to capturing, validating and prioritising the unmet needs (problems) of SYB ICS
- Matching and supporting the identification and validation of market ready innovations to help drive improved health outcomes, operational and clinical processes, and patient experience across the ICS health economy

### Target single point of contact

- The Hub will act as a single point of contact for all ICS system wide innovation enquiries and requests for guidance, advice and support
- The Hub will lead on the liaison between key stakeholders across the region including the NIHR Clinical Research Network and Healthcare Technology Cooperatives, academia, the AHSN and others

### Signpost

- Signposting and connecting internal organisations (NHS providers / Commissioners etc.) and those external to the system (Industry partners) This will be aided by partners including the AHSN and others such as Devices for Dignity and Academic institutions

### Build a culture of innovation

- Developing a programme of activities and a platform that will support and encourage staff across the system to continually identify unmet needs and consider better ways of addressing them

In creating a managed and prioritised repository of 'problems' that can be solved through innovation, the Innovation Hub will ensure the ICS is at the cutting edge of identifying, evaluating and embedding innovative and transformational approaches. This will be achieved through effective interactions with the YHAHSN innovation exchange, academia, industry, research funders and providers of health and care.

# Section 3: Building a



## sustainable health and care system

Delivering a new service model –  
Neighbourhood, Place, System

Transforming care with new service models

Making the best use of resources

# Delivering a new service model



In our 2016 Plan we said we needed to rethink how we invest in, plan for and deliver our services – and how we ourselves are arranged and set up to do so.

We have made significant progress in better organising and thinking about how we work and have strengthened our approach so that our entire population has access to high quality local services while addressing health inequalities.

We now work in Neighbourhoods, Places and at a System level. Complementing these are Hospital Hosted Networks for some of our most challenged services and a joint commissioning approach for services and areas of work that apply across the region.

Each of our partner organisations continue to exist as they always have, but their thinking and approaches are now based on collaborations around their local populations; whether those populations are Neighbourhoods, Places or the System.

Of course, the majority of work takes place locally in Neighbourhoods. We have 36 Neighbourhoods with populations of 30-50,000.

Barnsley brings together its six neighbourhoods into one 'super-neighbourhood', bringing our total of Primary Care Networks to 30. At this level, primary care is strengthened by working together in Networks.

In our five Places, health and care works together more closely at town or city level. Each of our Places has a plan which sets out what the partners want to achieve together to improve health and wellbeing and other factors that affect health, such as employment, housing and education.

At the System level, our health system is really joining up to ensure we are delivering health services across our population where it makes sense to do so.

As we mature even further, we will agree an ICS strategic commissioning function, thinking carefully about how this complements the commissioning operations in Place.

We will also expand and develop our collaborations across both acute and mental health providers where appropriate.

## System planning and commissioning



The **System** agrees shared objectives and outcomes

Hospitals are increasingly working in **Hosted Networks**

Partnerships plan and deliver integrated health and care across **Place**

**Neighbourhoods** integrate teams to deliver care where people live

# Transforming care



## Primary Care, working in Networks

### Our vision

To transform Primary Care through the establishment of 'at scale' primary care organisations capable of taking on population health responsibilities, which provide high quality integrated care services accessible seven days a week through collaborative working in neighbourhoods at Place.

### Our guiding principles

- Promote the continuous improvement of primary care and excellent access to services
- Maintain the right balance between operating in a consistent fashion and maintaining appropriate local flexibility
- Demonstrate clear alignment between Primary Care Networks, CCG and ICS strategies and delivery plans
- Deliver the funding guarantee for Primary and Community Care
- Where appropriate 'do once' across SYB

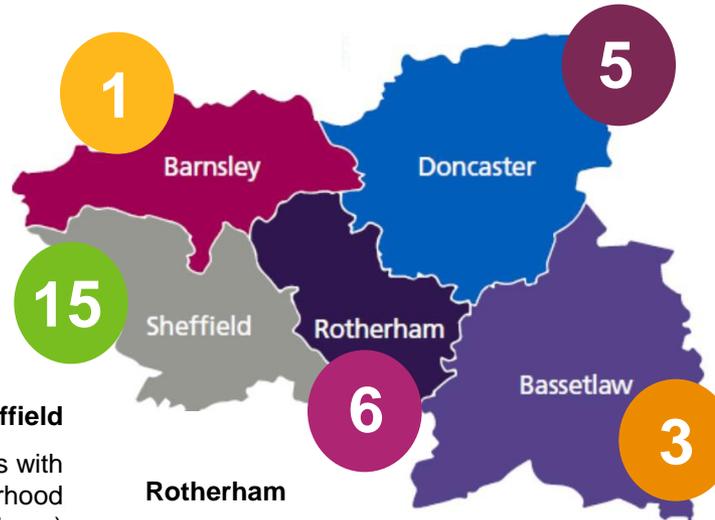
### Our Primary Care Networks

#### Barnsley

Established a single Primary Care Network, with clinical leadership and six sub networks. Integrated neighbourhood teams are aligned to Local Authority area councils. Local PCN development programme to be implemented. Neighbourhoods to agree local health and wellbeing priorities and engaging local communities

#### Sheffield

Established 15 Primary Care Networks with clinical leadership. Neighbourhood transformation programme (1<sup>st</sup> phase) established across 6 PCNs - integrated care and support targeting needs of specific populations, with plans to roll out across the city.



#### Rotherham

Established six Primary Care Networks with clinical leadership in place. Strengthening the primary care workforce through provision of primary care nurse preceptorships, health care assistant apprenticeships and nurse development roles.

#### Doncaster

Established five Primary Care Networks, with clinical leadership. Neighbourhood project coordinators in place linked to GP practices with social care, community nursing, local authority community and wellbeing teams. Early intervention, local solutions and joined up teams working with common operating models.

#### Bassetlaw

Established three Primary Care Networks, with clinical leadership and co located integrated neighbourhood teams. Agreed link workers to be employed by the voluntary sector. Extended access to primary care is available through PCN hubs as well as through individual practices. Increased support for practice pharmacists to undertake clinical reviews. New arrangements developed for PCNs with care homes.



## Primary Care, working in Networks

### Our progress

- Full population coverage with 30 PCNs established across SYB each with a Clinical Director
- The Clinical Directors have formed a 'guiding coalition' of clinical leadership across the developing PCNs
- Agreements between CCGs and practices to target and focus on variation and data analysis used by PCNs to improve Population health ie risk stratification and segmentation
- Emphasis on developing primary and community based care and support
- Local OD approaches to support sectors to work together and engage with communities
- SYB workforce training and development hub well established and delivering schemes to promote new roles and recruitment into primary care
- PCNs appointing paramedics and pharmacists to their multi disciplinary teams
- Neighbourhood teams within PCNs delivering joined up care supporting people to remain or recover at home.
- Integrated neighbourhood teams aligned to Local Authority areas and PCNs. Some co-location achieved with community clinical and social care services. Wider representation from voluntary sector and schools.
- Testing service redesign within community based new care models eg Neighbourhood project coordinators and link workers supporting practices to engage with partner services (social care, community nursing, LA community and wellbeing teams; housing, welfare and employment).

**We have full population coverage with 30 Primary Care Networks. The Network approach enables a focus on population health, prevention, early intervention, and anticipatory care to reduce inequalities.**

### Our Challenges

- Addressing variation while also valuing the differences between practices and Primary Care Networks (PCNs)
- Mobilising the resource and support to develop PCN models at scale
- Culture and behaviour change
- Improving access to and consistency of general practice
- Providing information and intelligence to support Population Health Management
- Facilitating PCNs working differently to reach seldom heard groups.
- Collaboration with acute sector to develop new models of care/delivery out of hospital.
- PCN maturity enabling them to represent primary care in the ICS
- Meeting the funding guarantee for primary and community care

### We will work across the System to:

- Enable PCN progression against maturity matrix, support development plans, including new models of integrated community services as part of PCNs phased over next three years.
- Have GP Federations supporting development of PCNs through lead employer and other arrangements
- Extend access to General Practice via PCN hubs.
- Offer an ICS Support Offer to Clinical Directors to promote system wide leadership and PCNs incorporating national framework & compliment CCG arrangements.
- Recruit into Social Prescribing and Clinical Pharmacy positions during 2019/20 under the GP Contract DES 'new roles' scheme. In some cases voluntary sector recruitment.
- Support practice manager development
- Support practices to increase telephone consultations.
- Invest in Local Enhanced Services, delivering care closer to home and improving management of patients to avoid admission.
- Develop new PCN led arrangements with Care Homes

# Transforming care



## Out of Hospital Care

### Barnsley

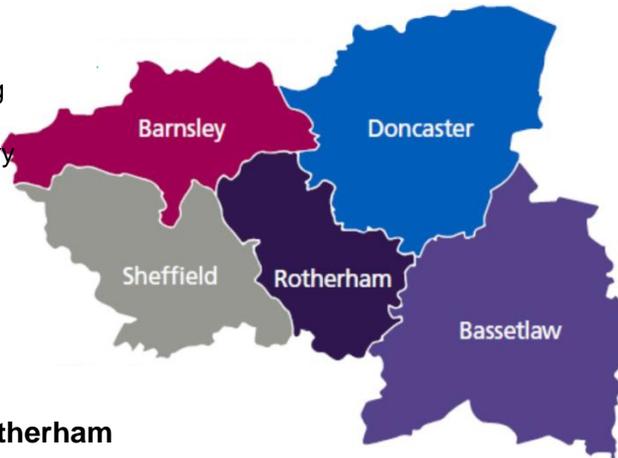
- Partnership of Barnsley MBC, Barnsley CCG, Barnsley Hospital, South West Yorkshire Partnership Foundation Trust, Barnsley Healthcare Federation, Barnsley Hospice, Healthwatch Barnsley and Barnsley Community and Voluntary Services developing the out of Hospital strategy
- One Primary Care Network and six Neighbourhood Networks with 'one team, no boundaries' philosophy to integrate services providing care closer to home
- Integrated model for intermediate care including rapid response Intermediate Care Services
- Integrated community respiratory and pulmonary rehabilitation pathways
- Improved nurse led support to care homes including introduction of digital technology to enable video link up to Rightcare Barnsley to reduce care home hospital attendances

### Bassetlaw

- Introduced community ophthalmology, audiology and pain management services and extended the scope of dermatology services
- Call for Care rapid response providing two hour urgent community response
- Well established Integrated Neighbourhood Teams (INTs) in all three PCNs, with community clinical and social care services co-located with primary care
- PCNs have paramedics and pharmacists in their INTs, a Memorandum of Understanding was put in place for GP led review of care homes

### Our progress

Each Place has established an out of hospital care approach through its Integrated Care Partnerships and delivered through Primary Care Networks working collaboratively with health and care partners to provide care closer to home



### Rotherham

- Aligned community services to work around GP practices in the PCN networks
- Integrated rapid response service, therapies and care co-ordination centre now co-located to support integrated working
- GP practices aligned to care homes, for care continuity
- Rotherham Health Record live across all services enabling services to have the same information for patient care
- Improved hospital discharge, leading to some of the lowest lengths of stay and delayed transfers in the country

### Doncaster

- Integrated intermediate care service introduced with rapid response provided within two hours
- Complex lives service providing proactive care and support to people rough sleeping reducing the risk of admission through better support for addiction, mental health and wellbeing needs
- PCNs established and developing integrated care approaches across health and social care
- Improving care for people with delirium and dementia in the community

### Sheffield

- Mature neighbourhood working established over last four years with a development programme to support leadership across PCNs
- Significant investment to support neighbourhood collaboration across schools, mental health, voluntary and community sector, social care, community nurses and police, including a keeping people well programme
- Enhanced care homes support programme well established
- Joint re-ablement services and provision of care home beds to facilitate assessments and care needs outside of hospital, reducing length of stay markedly over the last 12 month period



## Out of Hospital Care

### Our plans

#### System architecture

- One Primary Care Network with six neighbourhood networks in Barnsley with a shared care record to be deployed in 2020/21
- Established Barnsley Population Health Management Unit (PHMU),
- Community based hubs in Sheffield to be developed offering access to health, social and voluntary services
- Development of a model in the community to escalate and de-escalate patient needs, which will include consideration of the improved crisis response within two hours and re-ablement care in two days.
- Ongoing development of current population health need tools for PCNs such as risk stratification and population segmentation that profiles cohorts people in terms of health and care needs supporting future planning of service needs

#### Pathway change

- New intermediate care service with flexible beds usage and more home based care with a dedicated geriatric nurse led frailty service across Bassetlaw
- Improve care pathways in respiratory, dementia, CVD, diabetes and gastrointestinal across SYB
- Continue to work across primary care and community nursing to improve the interface between the two services and integrated models of care
- Mental health services will be enhanced to ensure timely high quality access for people in crisis.
- Improve flow through the hospital and enhance step up provision to facilitate quicker discharge
- Continued implementation of Enhanced Health Care In Care Homes across SYB

We will work across the System to expand out of hospital care for our local populations to help them care for themselves where they can and receive the right treatment, in the right place, when they need it.

#### Service Transformation

- New care home support to reduce avoidable hospital attendances across all SYB places
- Community health services led by neighbourhood teams of nurses and allied health professionals offering care to keep people at home, supporting timely discharge from hospital and ongoing case management for people with complex needs and at end of life in Barnsley
- Re-configuring intermediate care and re-ablement in Rotherham, reducing the bed base and providing improved care in the community
- Home care provision re-procured in Rotherham to improve quality and support individuals to stay within their preferred place of care
- Continued development of PCNs across Sheffield incorporating risk stratification, multi-disciplinary working, enhanced case management and person centred care planning
- Active support and recovery programme across Sheffield PCNs will build capability and capacity in the community to support people to live well in their own homes and will promote independence.
- Implementing a single point of access (SPA) covering the full range of services available outside of hospital
- Developing a Barnsley proactive care model in primary and community care

# Transforming care



## Out of Hospital Care

As part of their out of hospital approach, each Place is developing and implementing plans to support people to age well

### Supporting people to age well:

- People are increasingly more likely to live with multiple long term conditions, or live into old age with frailty or dementia.
- It is recognised in SYB that extending independence as we age requires a targeted and personalised approach
- Work is well underway in each Place as part of their out of hospital approach and development of primary care networks to support people to age well. This includes:
  - GPs using the frailty index to routinely identify people with severe frailty
  - Proactive population health management approaches focused on the moderately frail
  - Integrated primary and community teams continuing to gather pace to work together to support people to maintain their independence and age well
  - Established falls prevention schemes
- Home based and wearable technology has been tested out to support different cohorts of people across SYB
- The pivotal role undertaken by carers is recognised in each place, and there are strategies and action plans to ensure we identify carers and offer appropriate information and support
- Dementia diagnosis rates remain high across the ICS and there is ongoing work in each Place to provide better support in the community for those living with dementia as we practically translate the NHS comprehensive Model of Personalised Care.

### We will work as a System to:

- Continue to develop and implement plans in each Place to support those living with multiple long term conditions or living into old age with frailty or dementia
- Work with Primary Care Networks and integrated primary and community teams to maximise the use of a population health management approaches to inform a targeted and personalised approach
- Support the deployment of home based and bed based elements of the community response model, community teams and enhanced health in care homes
- Consider the use of home based and wearable technology in our planning and digitally enable community services in preparation for future advances in these care models
- Continue to implement action plans in each to improve how we identify unpaid carers and strengthen support for them to address their individual health needs
- Ensure out of hospital approaches continue to consider the needs of those living with dementia and their carers so we can strengthen community support



**Sheffield:** Active support and recovery programme in Sheffield is supporting people to live and age well in their own homes  
**Bassetlaw:** The home first model in Bassetlaw includes community based rapid response in two hours



## Partnerships in Place

### Integrated care partnerships at place

Over the last three years all five places in SYB have established mature integrated care partnerships (ICPs) with their local authorities and other place partners. These partnerships have become the bedrock of SYB place development and relationships in each ICP continue to evolve and flourish through ambitious joint strategic plans to integrate health and care locally.

ICPs have implemented a range of joint working arrangements and mechanisms to drive forward joint working with local authorities and providers including the following:

#### **Joint Commissioning:**

Joint strategies with local authorities in place, based on life course; Starting Well, Living Well and Ageing Well. Delivery in some Places is supported and facilitated through shared commissioning posts in areas such as children's services, mental health and learning disability. Joint arrangements will continue to develop in line with each ICP's strategic direction, priorities and the requirements of the LTP to integrate care and improve population health outcomes for local people.

#### **Provider alliances and provision:**

ICPs have developed approaches with local providers to align, integrate and incentivise care to improve, quality and access and population health outcomes - for example in services such as mental health liaison, social prescribing, acute services, urgent care and intermediate care.

#### **Population health management :**

Development of strategic partnership work on the wider determinants of health, such as housing, employment, education, homelessness, transport and population health initiatives that incorporate lifestyle change support aligned to PCNs.

#### **Digitally enabled care:**

Shared health and care records have been implemented across most of SYB to enable NHS and social care clinicians and professionals to access patient information to enable seamless care. These databases of information are also being used in the ongoing development of population health management tools for PCNs.

“Our ICP vision for integrated care is to develop a local system where the people don't see organisational boundaries. Instead, they experience continuity of care; regardless of where they are seen, be that in hospital, in the community or at home. Patients and their families are supported and empowered by 'one team'.

“Our goal is to dismantle boundaries at the point of delivery of care to create a simpler, integrated health and care system that supports a shift in focus on treating patients with health problems to supporting the community to remain healthy.”

*Barnsley Integrated Care Partnership*

# Transforming care



## Reforming emergency care

### Our progress

- Procured and mobilised a new model of Integrated Urgent Care, with a regional and local Clinical Advice Service (CAS) Supported by full population coverage of NHS 111 online
- Introduced an Urgent Treatment Centre (UTC) in Doncaster
- Engaged patients and public through the ICS Citizen Panel and Transport Group on plans to reduce avoidable ambulance conveyance
- Rotherham Hospital is a field test site for the new national clinical emergency and urgent care access standard
- Embedded clinical primary care streaming in all SYB A&E departments
- Reviewed and improved system intelligence by piloting an escalation management system for urgent care data and implemented the care home bed capacity tracker
- Strengthened relationships with Yorkshire Ambulance Service and piloted HALO+ to support system escalation pressures
- Mapping to explore digital opportunities to support patient pathways
- Local progress to commission rapid community response services.
- Frailty services in place across SYB

### Our challenges

- Growth in A&E attendances and emergency admissions, exceeding planned activity levels
- Increasing complexity and acuity of patients
- Workforce capacity and resource limitations
- Public expectations, culture and behaviour
- Some places have challenges with delayed transfers of care

### We will work across the System to:

Work collaboratively to continue to improve performance

- **Pre hospital urgent care**
- Simplify patient/public access by further developing a fully integrated urgent care model, developing the virtual clinical advisory service through improved clinical pathways accessible via 111 or 999 and other service access points
- Further designation of additional Urgent Treatment Centres (UTCs) to simplify access for patients where this model fits with the locally commissioned services
- Continue to work with ambulance services to eliminate handover delays
- Develop improved clinical pathways, initially in respiratory and mental health, to avoid conveyance to hospital via 999 services
- Strengthened alignment and work with Primary Care Networks
- Ensure patient flow and demand is clinically managed and supported through transparent comprehensive system intelligence
- Further develop high intensity user programme
- Support care homes to deliver improved patient care by providing better access to clinical advice, access to services and direct support from the ambulance service
- Expansion of NHS 111 direct booking via roll out of GP Connect, initially expanding direct booking into GP services, urgent treatment centres, GP out of hours services and considering further expansion and developments into other community based services
- **Reform hospital emergency care – Same Day Emergency Care**
- Ensure Same Day Emergency Care is in place to complement type 1 A&E departments
- As part of the NHS Clinical Standards Review develop new ways to look after patients with the most serious illness and injury
- **Reduce delays in patients being able to go home**
- Improve system intelligence to support patient flow and demand
- Continue to improve performance to support people home and reduce delayed discharges



Insight from conversations led by the partners in Doncaster to better understand the use of A&E by 18-30 year olds has shaped plans for a streaming model at the 'front door'

# Transforming care



## Transforming planned care

### Our progress

We have developed a range of new care models:

- South Yorkshire and Bassetlaw hip and knee follow up pathway including virtual follow up clinics
- The use of virtual appointment in a range of specialties eg fracture clinic, dermatology, ophthalmology and 'good news calls' to reduce delays in receiving results unnecessarily
- MSK first contact practitioner pilots have been trialed in readiness for roll out across the system
- Teledermatology has been rolled out to primary care in some areas evidencing a reduction in referral levels to secondary care
- Community services in a range of specialties including; heart failure, dermatology, integrated sexual health and gynaecology, ophthalmology, audiology and pain management
- Outpatient reform in a number of specialties including introduction of outpatient follow up protocols
- South Yorkshire and Bassetlaw Commissioning for Outcomes policy

### Our challenges

- Across the system there is increased demand in both elective and diagnostic care across clinical pathways
- A need to maintain and reduce referral to treatment times by growing the amount of planned surgery year on year, to reduce long waits and cut the waiting list
- Redesign services so that patients can avoid up to a third of face to face outpatient visits by reducing unnecessary follow up and offering alternative modes of appointment eg virtual, telephone or video consultations
- Enable increased access to shared medical records for patients and healthcare professionals to support new service delivery models and more joined up co-ordinated care planning.

### We will work as a System to:

- Design and implement a digitally enabled outpatient transformation programme to include:
  - Roll out of clinically agreed outpatient follow up pathways
  - Increased uptake of advice and guidance
  - Increased use of technology and virtual appointments to reduce face to face outpatient appointments as per the Long Term Plan commitment
  - Development of community services/alternative planned provision
- Increase the rollout of first contact practitioners for MSK (or equivalent)
- Implement *Urolift* as part of the range of treatment options for benign prostatic hyperplasia
- Specialty level reviews to agree and implement recommended pathways of care using Rightcare, GIRFT, elective handbooks and other best practice
- To implement technological solutions to support patient information sharing
- Development of the shared care record including the ability to move relevant clinical information across the region to access specialist opinions
- Delivering shorter waits for elective care through more effective use of capacity and choice at 26 weeks



Partners in Sheffield are supporting primary and secondary care to help make sure patients get the right treatment at the right time in the right place with a new elective care model

# Transforming care



## Providers working together

### Our progress

The providers in SYB have a long history of shared working. The mental health providers have formed a provider Alliance, which has identified lead providers for three priority pathways and is looking to establish three provider collaboratives. Mental Health providers are putting into place the governance to support this, with a draft Partnership Agreement in development.

The acute trusts first came together as the Working Together vanguard programme in 2014, which created a collaboration between the five SYB Trusts, Mid Yorkshire and Chesterfield. This has evolved into a wide programme of shared work, which is now formally supported by a Committees in Common model, and overseen by an Acute Federation.

### Our challenges

- Shared working can bring clear benefits for patients and staff. But as shared working has matured we have come to understand better which programmes are best addressed at system level, and which are better done at Place or individual organisation level
- To be done well, shared working needs significant focus and time, streamlined governance and supporting behaviours from all the partners
- In the next phase of shared working, both the acute trusts and the mental health trusts will put the building blocks into place to enable shared working
- Following the review of sustainability of services in the Hospital Services Review we will need to look at developing a clinical strategy which is underpinned by capital resources

### The acute providers will strengthen their ability to work together:

The acute providers are working together to develop an infrastructure of agreements that will make shared working more streamlined and effective:

- Building the underlying infrastructure: shared action, with the rest of the ICS, on digital and workforce
- Greater transparency about risks and challenges, so that trusts are better placed to support each other and to prioritise areas for shared work
- Agreements around how the trusts will work together



### The mental health providers will strengthen their ability to work together:

#### Phase 1

- Develop provider collaborative arrangements for Low/Medium secure inpatient services, eating disorders and CAMHS Tier 4 service
- Form and mature the Collaborative Alliance Board
- Agree partnership agreement which sets out ways of working
- Agree membership for Alliance governance
- Strategic discussions and establish priorities for new care models and other mental health services
- Establish governance and delivery arrangement;
  - Alliance operational delivery group and new care models delivery infrastructure – joint with independent sector and commissioners
  - Align with ICS mental health transformation programme

#### Phase 2

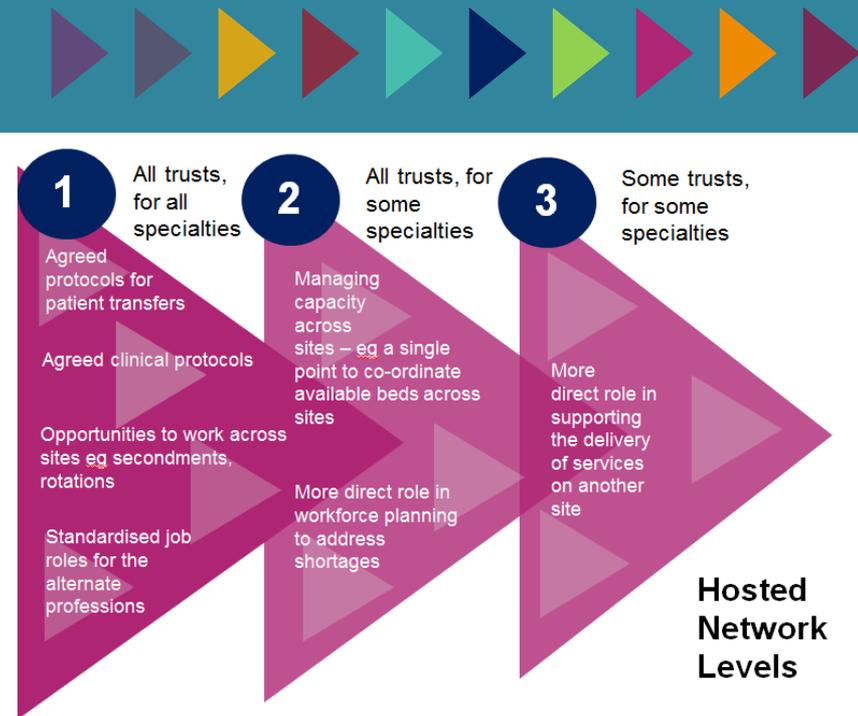
- Embed provider collaborative ways of working in three priority pathways
- Establish formal governance - Committees in Common
- Agree areas for formal delegated decisions making
- Agree additional new care model priorities

# Transforming care

## Hospitals, working in Networks

### Using shared working to improve care

- The shared working that the acute trusts are developing has the aim of improving outcomes for patients. The programmes of work which Trusts are taking forward aim to: improve clinical standards, make better use of our workforce and make the SYB acute providers a great place to work, reduce inequalities and make efficiencies.
- The guiding principle for the acute providers is that the trusts should work together to make sure that all patients can access the best care. The majority of hospital care will be provided in the patient's local hospital, but trusts will work together to give access to more specialist services.
- The SYB acute providers already work in networks eg consolidation of Hyper Acute Stroke Units (HASU) onto three HASU sites to ensure all patients have access to the best life saving treatment; the head and neck cancer multi disciplinary team which has representation from every trust, with major surgery centralised at Sheffield Teaching Hospitals and clinics and diagnostics at every district general hospital; and bilateral arrangements such as Doncaster providing nephrostomy interventional radiology at Rotherham, or Barnsley and Rotherham recruiting joint gastroenterologist posts.
- The SYB acute providers have also developed shared strategic and efficiency work:
  - Shared working on procurement and back office functions, which has saved £5.2 million so far;
  - A review of hospital services, focused on five challenged services, (urgent and emergency care, maternity, paediatrics, stroke and gastroenterology) which looked at the configuration of services and how trusts could work together better. This resulted in the setting up of Hosted Networks which are a structured approach to strengthening shared working.



### We will work as a System to:

- **Develop a new approach to shared working**, called Hosted Networks. We are setting up level 1 Hosted Networks in five specialties. These put a stronger governance framework and support around collaboration to develop workforce planning, clinical standardisation, and innovation across the trusts, while retaining equal status of all partners
- **Make the best use of specialist clinical expertise** to support other Trusts: Developing a level 3 Hosted Network between Sheffield Children's Hospital and Doncaster and Bassetlaw Teaching Hospitals (DBTH): SCH will support the delivery of services on the DBTH sites
- **Develop shared infrastructure** through building our shared capacity e.g. through creating SYB pathology and networking imaging and diagnostics
- **Deliver the national standards for all of our patients**: the acute trusts will work together to deliver the targets in the NHS Constitution. For example, for elective care we will work as a system to match capacity to demand, so that we make better use of the beds and workforce we have, so that we can reduce waiting times for patients

# Making the best use of resources

## System efficiency

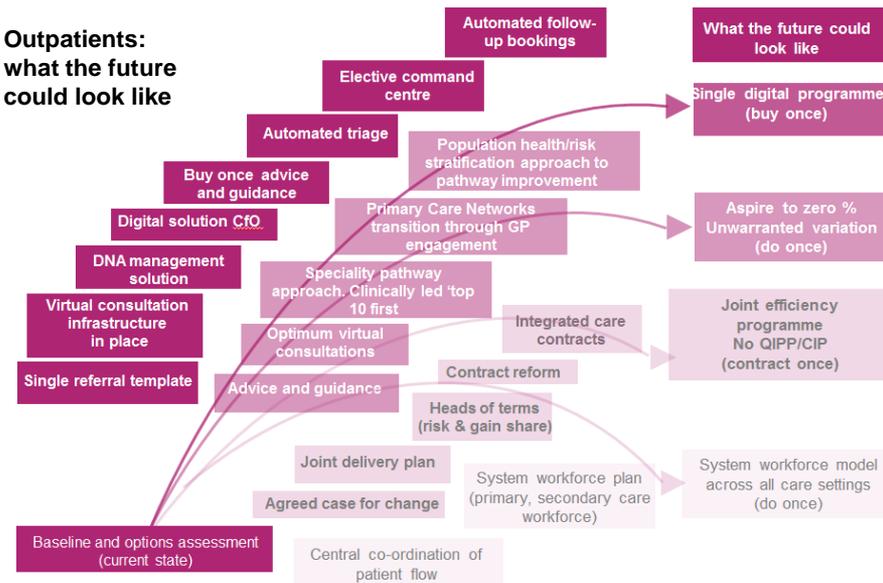
Our System Efficiency Board was set up to:

- Prioritise a small number of efficiency opportunities and ensure the pipeline is developed for creating future efficiencies
- Recommend the schemes that can be best done at scale by building on existing ICS and place schemes avoiding duplication
- Make faster progress on transformation as an ICS than can be done individually

Our progress:

- As part of a rigorous process with partners, we mapped a range of possible projects against value for money, deliverability and quality and strategic fit benefits.
- Four priorities emerged which the System has adopted

Outpatients:  
what the future  
could look like



### E-rostering

**Aim:** to reduce the £92m spend on temporary staffing.  
**Scale of opportunity:** £9m-£18m

**Suggestions being explored:** Centralised and coordinated frontline training, implementing medical rostering (non consultant, System level job planning, System level nurse rostering policy, System level roster contract 2021 renegotiated by the Allocate Regional User Group on behalf of the ICS, Hub and Spoke model – centralised roster helpdesk with satellite local helpdesk officers.

### Outpatients

**Aim:** to redesign outpatients and reduce unwarranted variation - 2.2 million attendances in 2018/19 – with estimated spend of £330-£340m  
**Scale of opportunity:** £9m - £10m

**Suggestions being explored:** Reduction in unwarranted pathway variation (specialty basis), rolling out advice and guidance – roll out, virtual consultations, DNA management solutions, joint efficiency programme and delivery framework, single referral template, automated triage and a System workforce plan.

### Theatres

**Aim:** to increase theatre utilization from 82% currently  
**Scale of opportunity:** £4m-£7m

**Suggestions being explored:** Standardisation of scheduling process so demand and capacity can be managed across the patch, System wide demand and capacity to maximize use of NHS, standardised protocols and processes to enable movement across sites, ECCU – to support demand and capacity review, theatres performance dashboard and maximizing the use of NHS theatres (less activity flowing to IS for additional capacity).

### Independent Sector

**Aim:** to reduce spend which is currently for additional capacity (not patient choice). IS Spend £46m.  
**Scale of opportunity:** <£1m

**Suggestions being explored:** IS framework for managing the market for contracting capacity, ICS standardized contract with KPIs, contracting best practice pathways NHS and IS to free up capacity, ICS Elective Care Coordination Unit (ECCU) to coordinate capacity and demand, System based approach to contract all elective activity (NHS and IS), lead NHS provider model for high volume pathways

# Making best use of resources



## Improving Productivity

Improving clinical productivity to release more time for patient care

Deliver efficiencies in administration costs

Reducing growth in demand through integration and prevention

Maximising the buying power of the NHS

Make better use of capital investment and system assets

Reducing unjustified variation

Supporting the development of pathology networks and of diagnostic imaging networks

Utilising the Evidence Based Interventions Programme

Making better use of capital investments and existing assets

Support pharmacy staff to take on patient facing clinical roles and optimise medicine usage

Utilising the national Patient Safety Strategy

Delivering System wide efficiency

### We will work across the System to:

- Optimise System level collaboration to improve clinical productivity and release more time for patient care. We will take a network approach to develop more efficient rosters and deliver opportunities to manage support contracts
- Maximise the buying power of the NHS through benchmarking and comparing our spend and review opportunities for individual and collaborative savings
- Leverage economies of scale through partnership across SYB and with neighbours
- Continue to work with clinical specialties and the Get It Right First Time programme to adopt recommendations around unwarranted variation and standardisation
- Identify opportunities for efficiencies in our corporate services to reduce running administrative running costs
- Enable the development of an SYB pathology network to enable efficient use of our workforce and capacity to meet demand
- Progress the development of a diagnostic imaging network to improve capacity planning. Continue to develop the imaging academy and workforce plan/strategy
- Optimise medicines management in care homes through clinical pharmacists and pharmacy technicians as part of NHSE Enhanced Health in Care Homes framework
- Redesign pathways to improve medicines management
- Review medicine related resources to ensure they are optimised and identify areas suitable for guidance
- Optimise the management of the interface between primary and secondary care initiatives and innovations
- Generate direct savings linked specifically to medicine costs through rebates and standardisation
- Optimising estate and investment through a System wide strategy
- Working through national programmes at organisation level, Place level and System level to deliver best practice e.g. Right Care, maternity and neonatal

# Making the best use of resources



## System Planning 19/20

- The financial planning approach has been to agree a framework and timetable across the systems and allow Places to work together to agree fully aligned finance and activity plans
- Key planning assumptions have been agreed including:
  - Systems should develop and agree realistic assumptions based on local trends. This should take account of:
  - How funding growth will deal with improving the volume of elective procedures, cut long waits and reduce the size of waiting lists
  - How outpatients will be reformed to remove a third of face to face outpatient visits
- All organisations are required to return to recurrent financial balance over the life of the five year plan or earlier
- For emergency care assumptions for demand growth need to be agreed between providers and commissioners to ensure they reflect recent local trends adjusted for agreed demand management initiatives and national priorities including improving performance on cancer and A&E
- Commitments for increased spend in mental health and primary medical and community services
- All organisations to return to recurrent financial balance over the life of the five year plan or earlier
- Regional teams agreeing a realistic and stretching bottom line each year where providers in balance requiring to deliver 1.1% cash releasing productivity growth and those in deficit delivering at least an additional 0.5% of cash releasing productivity growth

Place	Planned £m	Variance £m	Actual £m
Sheffield System	(20.9)	9.4	(11.5)
Doncaster & Bassetlaw System	(18.1)	0.3	(17.8)
Barnsley System	(15.7)	0.2	(15.5)
Rotherham System	(18.3)	0.2	(18.1)
<b>Sub-total</b>	<b>(73.0)</b>	<b>10.1</b>	<b>(62.9)</b>
Technical Adjustments (including in-year adjustments & CCG drawdown)	(9.5)	9.5	-
<b>Total</b>	<b>(82.5)</b>	<b>19.6</b>	<b>(62.9)</b>

## Capital

- We will prioritise capital plans to inform how the funds will be deployed once we know what system capital is available
- We have agreed a process to evaluate and score business cases
- In anticipation of Wave 4 capital, the ICS identified £445m of capital investment requirements covering all aspects of primary, acute and mental health services
- This included material investment in the digital agenda, clinical strategy, removal of critical infrastructure risk and joined-up system wide investment in cancer services
- Business as usual capital is focussed on maintaining current estate; particularly noting the high and increasing value of critical infrastructure risk backlog maintenance
- The ICS investment requirements are currently being updated in the context of national constraints of capital availability, as well as dealing with critical investment in the intervening period



## Draft STP Planning Tool – Indicative Financial Analysis

### Key issues emerging from the first draft

#### High levels of engagement:

- The ICS has made significant progress in a short space of time to produce a draft strategic financial plan.
- Organisational Boards and Governing Bodies are actively engaged in the process to iterate further submissions reflecting updated intelligence

#### Risk management:

- The 19/20 System Control Total is routinely managed through system governance reflecting the emergent and ongoing risks including demand and performance pressures. Plans have been based on current forecasts

#### Ambition:

- The SYB ambition to return the system to balance by 2023/24 has not yet been realised with a mixed approach to deliverability based on a number of key variables

#### Financial framework:

- The system is awaiting publication of control totals at organisation and system level; and a full understanding of available support monies

#### Cash and support:

- Although organisations have modelled their draft position excluding support monies, there is an urgent need to address support monies associated with the withdrawal of Provider Sustainability Funding (PSF)
- There will be a significant reliance on FRF at a level consistent with the support monies provided into the system this year

#### Efficiency:

- The pace of improvement is different amongst providers and a process of peer review will enable a full and transparent system-wide understanding of the pressures and efficiencies included in plans to deliver a consistent system approach to supporting transformation

#### Drawdown:

- CCGs have significant levels of banked drawdown which they are looking to drawdown and invest in local transformation across the planning period

#### Wave 4 capital:

- Commissioners have reflected the Wave 4+ capital for Primary and Community Care in their draft plans. The timely release of resources will provide much needed investment in the sector

#### Transformation of capital:

- Constraints on capital nationally provides a potential barrier to transformation.
- Providers have sought to cover immediate capital needed through internal sources but major investment is required in the system to deliver service change and resilience to manage critical infrastructure risk. The strategic approach to capital investment will be linked to the ICS Estates Plan

#### Alignment:

- Financial alignment is strong across SYB partners and a process has been developed to improve activity alignment

# Making best use of resources



## Draft STP Planning Tool - Indicative Financial Analysis

### High level outputs

The initial outputs reflect a first draft of the STP Planning Tool  
 The agreed process for developing the system-financial-strategy is provided below

	19/20	20/21	21/22	22/23	23/24
<b>Annual System Deficit</b>	£(52.1)m	£(67.2)m	£(53.8)m	£(44.6)m	£(28.7)m
<b>Avg Efficiency – Provider Trust</b>	2.90%	2.20%	2.10%	2.00%	2.20%
<b>Avg Efficiency – Commissioner</b>	2.30%	2.20%	1.80%	1.60%	1.60%
<b>Total Efficiency – Value</b>	£118m	£105m	£98m	£95m	£103m
<b>Total Capital Investment</b>	£100m	£165m	£128m	£292m	£642m
<b>Financial Alignment</b>	0.90%	1.20%	1.80%	2.40%	3.00%
<b>Activity Alignment</b>					
<b>Outpatient – First</b>	n/a	0.92%	0.91%	0.90%	0.88%
<b>Outpatient – FUP</b>	n/a	5.25%	5.25%	5.25%	5.24%
<b>Elective - Day Cases</b>	n/a	1.90%	1.92%	1.90%	1.88%
<b>Elective – Inpatients</b>	n/a	1.25%	1.24%	1.26%	1.28%
<b>Non-Elective – Inpatients</b>	n/a	3.07%	3.09%	3.10%	3.12%
<b>Non-Elective – A&amp;E</b>	n/a	0.67%	0.78%	0.82%	0.86%



## Draft STP Planning Tool - Indicative Financial Analysis

### Next steps

Item	Current State	Action	Future State
1	There has been a differential approach to delivery of financial balance - with one provider maintaining a deficit in every year; and there are differing levels of efficiency across organisations	ICS DOFs have agreed to jointly understand relative investment and efficiency challenges through development of shared bridge analyses to provide full transparency	A single approach to delivering control totals taking into account the deliverability of efficiencies, level of investment and availability of cash and revenue support.
2	There has been a differential approach to recognition of CCG draw down for future investment	ICS DOFs have agreed to understand place-based investment needs to inform drawdown phasing across the period	A single approach to accessing drawdown taking into account the need to investment in the system to enable transformation
3	There has been a differential approach to capital planning with some providers including additional PDC	ICS DOFs have agreed to review the ICS Estates Strategy and reflect updated assessments of required PDC over and above self-financed capital	A single approach to strategic capital priorities linked to the ICS Estates Strategy recognising the need for additional capital in SYB
4	Activity alignment is not as robust as financial alignment	A detailed process is underway to improve activity alignment at a more granular level	Alignment differences reconciled to at least the level of assurance as financial alignment



# Making the best use of resources



## Our progress

- Effective use of ICS flexibilities (offsets) to secure organisation positions and maximise inward investment
- Strong financial performance in a time of ongoing challenges of activity increases and pressure in the system
- Transparent approach to the utilisation of transformation resources for system investment
- Development of a System Efficiency Board to identify where the system can add value by working differently together to provide more effective implementation or faster progress than can be done individually
- Deliver of a capital and estates investment strategy including £57.5m of capital to improve primary and community facilities

## Our challenges

- Maintaining strong financial performance linked to strong operational performance in a time of increasing activity and workforce challenges
- Inflationary pressures on providers and continued recurrent delivery of stretching cost improvement programmes and challenging control totals
- Upward pressure in all aspects of CCG investment both inside and outside the acute sector
- The complexity of the financial framework (including tariffs) providing uncertainty for the future
- Lack of a strategic capital framework nationally acting as barrier to transformation
- High levels of backlog maintenance across the system requiring urgent injections of capital to ensure resilience

## The NHS financial settlement

- In September 2019, the Chancellor announced an NHS spending increase of 3.1% in real terms (£6bn) including investment in increased training places (HEE), investment in public health, capital investment (of which SYB received £57.5m for primary and community schemes) and investment in artificial intelligence. This was alongside an additional £1bn for social care and a process to review the social care precept
- This built on the budget announcement (October 2018), providing real terms growth of 3.4% (£20.5bn) by 2023/24 taking the overall NHS budget to £148bn
- There is also the commitment to ensure mental health investment grows at the same rate as the overall NHS budget for five years
- The budget announcement reflected the Prime Ministers spending announcement in June 2018 promising real terms growth of £20.5bn (nominal £33bn and £1.25bn pension funding)

**This financial settlement is part of the Long Term Plan which includes five key financial tests for delivery**

**Test 1**  
How organisations will return to or maintain financial balance through providers in balance delivering cash releasing productivity growth of 1.1% per annum

**Test 2**  
Providers in deficit will require delivering additional cash releasing productivity benefits of at least 0.5% per annum. Regional teams will agree a realistic and stretching bottom line position in each year

**Test 3**  
Plans to incorporate system actions to maximise efficiencies and support appropriate reductions in demand for care

**Test 4**  
Reduce variation across the health system

**Test 5**  
Better use of capital investment and existing assets to drive transformation

# Section 4: Broadening and



# strengthening our partnerships

Partnership with the City Region

Anchor institutions and contributions to the wider economy, science, research and innovation

Partnership with the voluntary sector

Our commitment to work together

Governance and ways of working

# Partnership with the City Region



The Sheffield City Region (SCR) works across the Region and brings together public and private sector leaders to make decisions that drive economic growth and create new jobs.

Our Plan recognises that economic prosperity and health and wellbeing are interdependent. A healthy population means less people out of work or retiring early due to ill health, but equally it means that having a good job supports and protects health.

## Our progress

We have been working with the SCR on the Health-led Employment Trial, Working Win. The Trial has been testing individualised employment support delivered by healthcare professionals. It has received over 6,000 referrals demonstrating the demand for labour market interventions delivered with the health sector.

We are committed to exploring further opportunities to work collaboratively to locally design and commission programmes.

**Sheffield  
City Region**

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- We are committed to strengthening the anchor institution role of our NHS organisations. We recognise that the health and care sector is the biggest employer in the City Region and that NHS organisations have huge economic power both as an employer and through commissioning and procurement processes. We will explore the potential of the Public Services Social Value Act across SYB ICS so that we can have a significant impact on health and health inequalities, and also support the local economy
- We will team up with the SCR to explore the significant research strengths and technologies that are being developed locally that could futureproof health services and transform the way care is delivered. We will explore the research strengths in health and wellbeing innovation and technology, children's health, digital, and orthopaedic products and medicines and translate them into health interventions and efficiencies
- As part of our ongoing work and through the SYB Innovation Hub, we will work collaboratively with locally based research and technology, as well as invest in institutions like the Advanced Wellbeing Research Centre and the Olympic Legacy Park
- Our support to the local authority led work on active travel connects directly with the SCR programme of activity to promote healthy and active lifestyles. Through both routes, we will back Active Travel within the region to improve the commute of residents and drive improvements in the health and wellbeing of our population
- A commitment to move to sustainable transportation across the SYB ICS, including enabling active travel for staff, visitors and even for some patients, would have wide reaching benefits for health whilst also helping to reduce air pollution and meet carbon targets
- Through our partnership work to tackle health inequalities, we will also lend our support to prevent ill health amongst the most vulnerable people as part of the Mayor's campaign to end Excess Winter Deaths

# Anchor institutions and

## wider contributions

An anchor institution is one that in addition to its main function, plays a key role in making a strategic contribution to the health and wellbeing of the local population and the local economy.

This includes non-profit organisations like hospitals, local councils, and universities whose long-term sustainability is linked to the wellbeing of the local population.

The NHS has significant influence over population health and is able to enhance its impact by choosing to invest in and work responsibly with other anchor institutes and local communities to collectively harness resources.

Alongside being a system partner there are a number of key areas where the NHS can contribute further as an anchor institute:

**The NHS as an employer** - Given that employment is important for good health increasing the amount of recruitment an NHS organisation does locally is an opportunity to increase the impact that it has on the wellbeing of the local community.

**The NHS as a purchaser and commissioner for social value** - As major procurers and purchasers of services, NHS organisations have an indirect impact on the conditions of workers more widely not formally NHS employed.

**The NHS as a land and capital asset holder** – As a significant land and asset holder the NHS has the potential to manage and develop its land and estates to support broader social, economic and environmental aims.

**The NHS as a leader for environmental sustainability** – Given the significant environmental impact and large carbon footprint the NHS is well placed to take action to support responsible consumption and reduce waste that can have a positive impact on the environment.



### We will work as a System to:

- Maximise the potential role of all anchor institutes in SYB to harness their collective influence on the health and wellbeing of our population
- Maximise the benefits of the NHS and other anchor institutes as employers in SYB to promote local recruitment and widen access to quality work
- As a purchaser promote spend in communities to support local businesses, employ local people and stimulate local economic development
- Promote the consideration of social value into purchasing decisions
- Manage and develop land and estates in a way that benefits local communities
- Take action to support responsible consumption to reduce waste and our environmental impact



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust provides staff with a comprehensive Health and Wellbeing offer which includes support in the following areas; physical health, mental health, financial health, weight management & healthy lifestyle promotion. In January 2019 the offer was recognised by Nottinghamshire County Council and accredited their Platinum Wellbeing @ Work Award."

# Partnership with the voluntary sector (VCSE)



## Our progress

- SYB is home to a large and diverse voluntary, community and social enterprise (VCSE) sector that undertakes wide ranging activities and services that impact positively on the health of our residents
- VCSE representatives sit on the ICS Collaborative Partnership Board, Health and Wellbeing Boards and Integrated Care Partnerships
- VCSE/ICP Chair in Bassetlaw positively impacting on 'parity of esteem' with the public sector
- VCSE organisations influencing ICS workstream priorities
- Expansion of social prescribing an existing ICS priority, building on our well established and highly regarded VCSE led social prescribing services in all five places
- Examples of NHS funded micro commissioning of VCSE via our VCSE infrastructure organisations
- Examples of Primary Care Networks forging relationships with VCSE partners
- Range of VCSE organisations commissioned to provide services wrapping around primary care in Bassetlaw
- Sheffield Accountable Care Partnership investing in additional VCSE infrastructure to strengthen linkage between health services and the VCSE

## Our challenges

- Fragile VCSE but increasing national and local expectations of the VCSE eg due to expansion of social prescribing
- Increasing need of the types of support that the sector can offer people who have complex social, psychological and physical needs, compounded by deprivation
- New approach to commissioning and funding the VCSE needed
- Capacity, on both sides, to engage with such a broad and diverse sector of over 10,000 organisations

## We will work across the System to:

- Develop a strong vision for embedding VCSE participation at every level of the ICS as an equal partner in strategy and delivery
- Co-design a new framework for engagement and development of relationships between the ICS and VCSE, strengthening existing relationships and developing new ones
- Support VCSE organisations and the NHS to better understand each others values and expertise
- Invest in the VCSE sector and infrastructure support, developing new models of funding and commissioning, enabling greater sustainability
- Harness local VCSE expertise and knowledge of local communities to support identification of need and co-design of services to enhance population health
- Embed within care pathway development consideration of the potential role of VCSE services
- Support the development of community assets and services for vulnerable and at risk groups, in collaboration with the VCSE and wider partners
- Further expand social prescribing
- Develop peer support and health champions to support prevention awareness and LTC personalised care
- Maximise the potential benefits for our communities from further developing volunteering opportunities within NHS organisations and the broader health and wellbeing system
- Further develop the potential role of VCSE within secondary care
- Explore the linkages between Trusts as anchor institutions and the VCSE
- Consider VCSE colleagues as core part of multidisciplinary teams

# Our commitment to



## work together

### Shared Principles

We operate within an agreed set of guiding principles which cover the ICS groups and ways of working and shape how we work together:

- We are ambitious for the people and patients we serve and the staff we employ
- We will build constructive relationships with partner organisations, groups and communities to tackle the wide range of issues which have an impact on people's health and wellbeing
- We will do the work once and avoid duplication of systems and processes; ensuring we make the best use of our available resources
- We will apply a subsidiarity principle in all that we do with work and action taking place at the most appropriate level for our System and as local as possible
- We will apply a 'no worse off' principle whereby no place will be worse off as a result of our shared action

We are one NHS, working as a System. We work with other partners, such as Local Authorities and the voluntary sector, in Neighbourhoods, Place and across the System when we have a common purpose and where it makes a positive difference to people's lives.

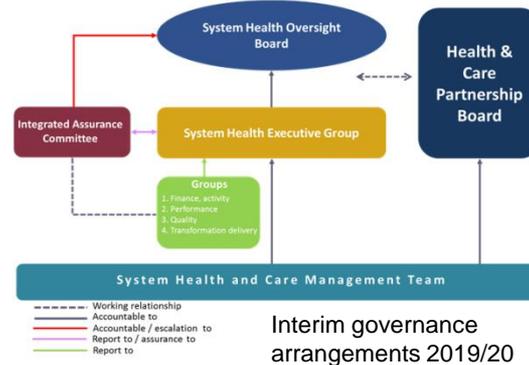
Clinical leaders, chief executives, chief officers and very senior and experienced leaders from NHS Trusts and CCGs support the work of the ICS alongside a team of people seconded or aligned from organisations across the region. It is led by Sir Andrew Cash, the ICS Chief Executive.

There is a range of groups where partners come together to collaborate at a System level. It gives both space and focus for NHS partnership working and NHS partnership working with Local Authority colleague and key stakeholders. Our governance works alongside the governance of our statutory organisations.

**System Health Oversight Board** - provides a joint forum between health providers, health commissioner, NHS England, NHS Improvement and other national arms' length bodies, to respond to the national policy direction for health and implementation of the NHS Long Term Plan.

**System Health Executive Group** - facilitates a maturing of relationships and integrated working between health partners, building on the work locally in each Place and collaborative health groups across the system, including: JCCCG, CsiC, MHA and Primary Care Federations.

**Health and Care Partnership Board** - we continue to work with our Local Authority partners to inform and shape how our system health and care partnership works.



It builds on the SYB partnership working on strategic health priorities requiring closer working across systems. It facilitates a maturing of relationships and System working, building on collaborative working locally in Places and across SYB collaborative health groups of Joint Committee of CCGs (JCCCG), Committees in Common (CsiC), Mental Health Alliance (MHA) and Primary Care Federations.

**Integrated Assurance Committee** - provides assurance to the partners and to regulators on the performance, quality and financial delivery of health and care services within the five places and across the system in South Yorkshire and Bassetlaw.

Links to Annexes:

**(Right click on links to open)**

### **SUPPORTING VIDEOS:**

- Developing our LTP Response: first guiding coalition event 9<sup>th</sup> July :
- Our second LTP guiding coalition event 8th Oct :

### **SUPPORTING INFORMATION:**

- Engagement:  
*Healthwatch Report and Independent Report*
- Understanding the SYB Population our Challenges and Inequalities: - LW slides/Rob data

### **PROGRAMME PLANS:** *Work in progress*

- Cancer Alliance:
- Mental Health:
- Primary Care:
- Digital:
- Workforce:
- Local Maternity System:

### **FINANCE:**

- Finance narrative:

### **OTHER:**