South Yorkshire and Bassetlaw
Integrated Care System

Five Year Plan

Our vision is 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.

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South Yorkshire and Bassetlaw
Integrated Care System

Foreword

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 £1million 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.

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.

The feedback 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 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 over the three years to March 2019 we secured £51m of transformation funding and £78m of capital funding; a total of £129m which has enabled us to progress many schemes. Our refreshed strategy for the next five years includes an indicative £129m of further transformation 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.

Through our partnership working with Local Authorities, the Sheffield City Region, leading universities and world-class institutions 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

Executive Summary

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 positive improvements for our population.

We have been working as a partnership for four 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 how we are organised and administered in line with developments which you can read more about our approach in this document.

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 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, 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. This is called the 'burden of illness' and much of it can be prevented or delayed.

Our approach will consider the wider determinants of health – such as education, employment, the built and natural environment. We will tackle health inequalities by looking at the whole population and the individual person. Our focus will be helping people to have the 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 are setting ourselves ambitious targets to deliver improvements in population health.

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 (HASU) and associated Hospital Network. We are also working with Yorkshire and the Humber Academic Health Science Network (YHAHSN) on a project to improve the self-management of Cardiovascular Disease (CVD) focusing on developing local innovations in primary care which could be delivered at scale. We will continue our work in these areas at the same time as widening our focus to include diabetes and respiratory conditions.

Supported by national transformation funding for some of our areas of work, such as cancer and mental health and primary care, we have been able to step up 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 and organisations work. 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. 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.

3. 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 Integrated Care System (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 Emergency care departments. 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 take forward 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.

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. The ICS is a partnership of many 'anchor' institutions, that is hospitals, local councils, and universities whose long-term sustainability is tied to the wellbeing of the populations they serve. We are committed to working with our partners to have an even greater impact on the factors that make people healthy.

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.

Achievements and progress so far

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 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:

Over the last three years more than fifty per cent of practices have benefitted from funding

to support them to become better placed to tackle the challenges they face and to support continuing high quality care for patients.

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

for lower GI, prostate and lung cancers – helping to diagnose and treat people earlier and improve overall outcomes.

Providing extended access GP appointments

at evening and weekends, for 100% of our population.

We have supported people with long term physical or mental health

into the Working Win health led employment trial through working with the Department for Work and Pensions and Sheffield City Region.

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.

We have made improvements

in waiting times for diagnostic investigations.

We have established the South Yorkshire and Bassetlaw Radiography Academy.

We have 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).

1,300 extra patients are accessing support services

through the Living With and Beyond Cancer programme.

We have secured £200,000

from Health Education England to work with the Yorkshire & Humber Academic Health Science Network to support transformation in the mental health workforce.

Our System

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South Yorkshire and Bassetlaw
Integrated Care System

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Our System

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.

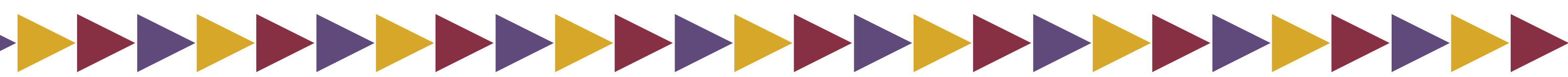
We are one NHS, working as a System. We work with other partners, such as Local Authorities and the voluntary sector, in Neighbourhoods, Places and across the System when we have a common purpose and where it makes a positive difference to people's lives. Our aim is to break down organisational barriers 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:

1.5m	Population
72k	Members of staff
208	GP practices
36	Neighbourhoods
6	Acute hospital and community trusts
6	Local authorities
5	Clinical commissioning groups
4	Care/mental health trusts
£3.9b	Total health and social care budget



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

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 and general practice
- Community pharmacy, opticians and dental providers
- 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

Hospital Hosted Networks

In addition to clinical 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.

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.

1 The **System** agrees shared objectives and outcomes and provides oversight

2 Hospitals are increasingly working in **Hosted Networks**

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

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

Section 1

Developing a population health system

Understanding health in South Yorkshire and Bassetlaw

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 people's 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 the onset of multi-morbidity 10-15 years earlier that 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 having 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 than people without a learning disability.

Statistics

9.6 years

Life expectancy difference for women...

between the most deprived and least deprived areas in SYB.

8.9%

Population of Black and Minority Ethnic heritage...

and many people of Eastern European origin.

12.4 years

Life expectancy difference for men....

between the most deprived and least deprived areas in SYB.

57%

increase in the 75 and overs by 2028.

Healthy Life Expectancy at Birth **2015/17**

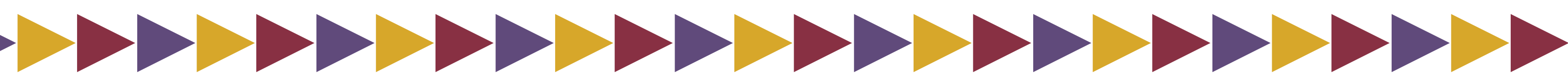
Place	Male	Female
England	63.4	63.8
Barnsley	59.7	61
Doncaster	61.8	61.1
Rotherham	59.3	57.4
Sheffield	62.5	60.1
Nottinghamshire	65.2	62.7

England Local Authority Deprivation Ranking **2015/17***

(Of 326 - 1 being the most deprived.)

Place	Rank
Barnsley	39
Bassetlaw	114
Doncaster	42
Rotherham	52
Sheffield	60

*Data taken from the Ministry of Housing, Communities and Local Government English Indices of Deprivation 2019.



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.

CASE STUDY

Population health

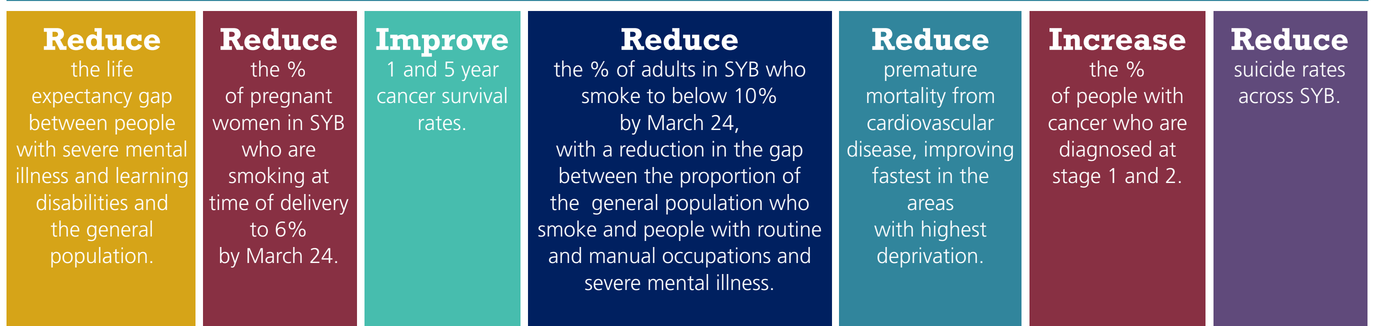
In Barnsley, the Integrated Care Partnership is developing an outcomes framework that could describe the ambition for joint working that would then determine the priorities and programmes.

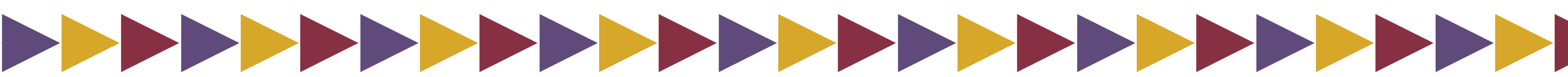
The project began by reviewing existing performance and population health frameworks used by different partners, identifying best practice in other areas and also gaps in our information and intelligence.

The Integrated Care Outcomes Framework has now been adopted by the Barnsley Health and Wellbeing Board, forms the basis of the joint strategic needs assessment and neighbourhood needs assessment and has helped to inform the priorities for service development.

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.

We will:





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 support workers.
- Make sure there is good access to local activities and support for people and groups at risk of poor health.
- Prioritise support for people affected by inequalities in health; people living with learning disabilities, serious mental illness, our veteran population, and those in contact with the justice system, ethnic minority groups and people living complex lives and homeless.

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.

Wider determinants of health

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.

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.

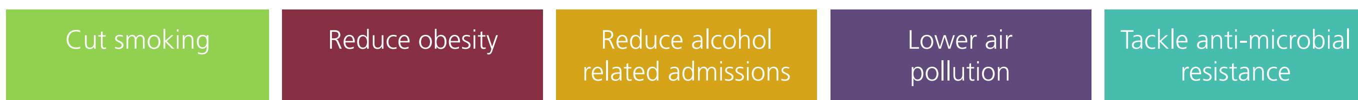
Built and natural environment

30% of adults who use mental health services and 20% of adults with learning disabilities, do not live in stable or appropriate accommodation. Air polution 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 excercise is increasing, but still ranges from 14% - 19%. The percentage of people 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.

Developing a prevention led NHS



We will: Reduce the % 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 tabacco control, obesity, increasing physical activity, minimising harm from alcohol and improving air quality. High referral rates to 'Diabetes Prevention Program'.

Developing system level joint work with SYB Local Authorities:

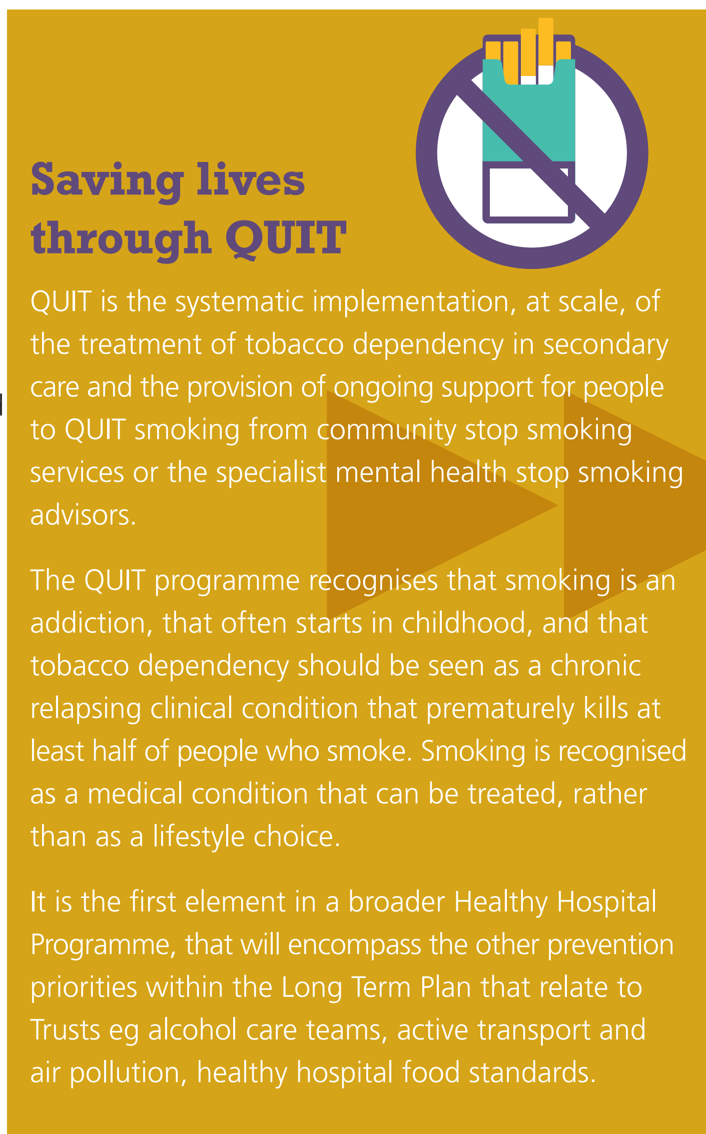
- Enhancing social connectedness
- Increasing physical activity

Integrated approcah 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 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. We also want to maximise the prevention opportunities afforded by the new primary care and pharmacy contracts, further develop the scope of the Healthy Hospitals Programme, increase the health and wellbeing offer for staff and 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.

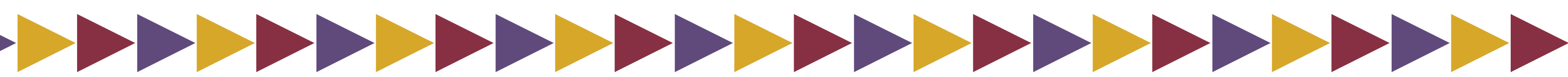


Saving lives through QUIT

QUIT is the systematic implementation, at scale, of the treatment of tobacco dependency in secondary care and the provision of ongoing support for people to QUIT smoking from community stop smoking services or the specialist mental health stop smoking advisors.

The QUIT programme recognises that smoking is an addiction, that often starts in childhood, and that tobacco dependency should be seen as a chronic relapsing clinical condition that prematurely kills at least half of people who smoke. Smoking is recognised as a medical condition that can be treated, rather than as a lifestyle choice.

It is the first element in a broader Healthy Hospital Programme, that will encompass the other prevention priorities within the Long Term Plan that relate to Trusts eg alcohol care teams, active transport and air pollution, healthy hospital food standards.



Reducing obesity

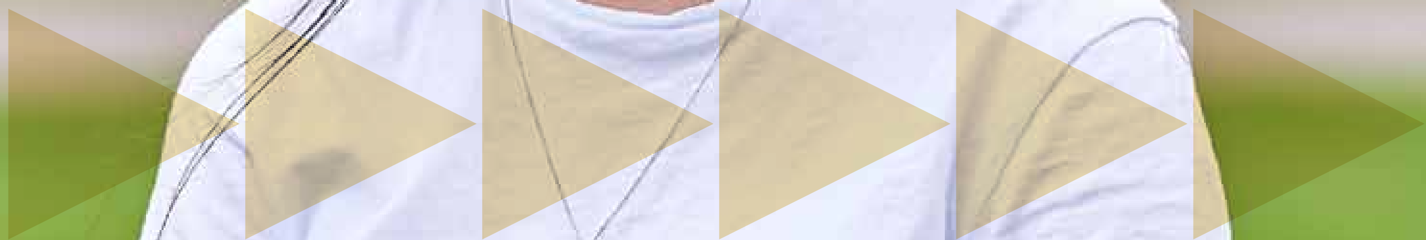
- Work with local authorities and Sheffield City Region to promote physical activity. Embed physical activity as a treatment intervention in clinical care. Implement NHS healthy food standards.
- Increase referrals to the diabetes prevention programme; Seek to be a pilot site for enhanced weight management 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.



Prevention in Place

In addition to implementing the national priorities within the Long Term Plan, our Places are all delivering Place based Health and Wellbeing Strategies and prevention action plans. These are just some examples of the work that is happening in each of our Places.

Barnsley

In Barnsley, collaborative work with the Local Authority on the 2018-2021 public strategy is underway. It focuses on food, alcohol, emotional resilience, oral health of children, creating a smoke free generation and physical activity.

Extending Smoke Free Barnsley by building on the smoke free Town Hall square, smoke free schools and play grounds and teams is a key focus and there are also plans to prevent suicide and reduce harm from alcohol.

Bassetlaw

In Bassetlaw, people who have a high risk of CVD, hypertension, dementia and mental health are being supported with physical activity and there is a focus on helping people to stop smoking and manage their weight in the most at need communities.

Plans are in place to set up a Local Childhood Obesity Commission and a new 'Integrated Wellbeing Service' from 2020. The Commission will look at the determinants of obesity including food environment, parenting, schools, access to physical activity and individual motivation; and the wellbeing service will be offered as part of a lifestyle change service.

The impact of social isolation and mental wellbeing is also a priority.

Doncaster

Teams are working on a 'good food' Doncaster approach including adopting the healthy weight declaration and an alcohol alliance is to be launched to reduce the harmful effects of alcohol.

At the same time, the town's tobacco control strategy is being revised.

There are also campaigns focusing on encouraging physical activity with Get Doncaster Moving and raising awareness around suicides with Another Way. In the communities of Denaby and Hexthorpe early help services for children and families are being piloted and a new frailty service is being tested in Thorne.

Rotherham

In Rotherham, the Place approach focuses on loneliness, weight management, physical activity and mental wellbeing. A loneliness action plan has been developed with a Make Every Contact Count (MECC) pilot underway and the Better Mental Health for All Strategy is also in place.

Improving peoples' physical activity levels is part of several initiatives in the town with the Activity Partnership and Cultural Strategy encouraging people to get active and outdoors.

Sheffield

Partners across Sheffield are putting a tobacco control strategy in place, developing healthy food and drink policies and encouraging people to Move More.

Other areas of focus include a whole school approach to nutrition, reducing sugar levels with a campaign to raise awareness and obestity in maternity.

Colleagues across the city are also developing a strategy that looks at adverse childhood events, hidden harm (supporting children of adults using substances) and a strategy to support volunteers and supporting staff to volunteer.

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 population health management capability 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.

People have different levels of knowledge, skills and confidence to assume responsibility for their own health and well-being. In order to tailor support according to their needs and to increase their capability to look after themselves more effectively, it is important to be able to measure a person's level of activation

The Patient Activation Measure (PAM) is a validated, commercially licenced tool and has been extensively tested with reviewed findings from a large number of studies. It helps to measure the spectrum of skills, knowledge and confidence in patients and captures the extent to which people feel engaged and confident in taking care of their condition.

Reducing unwarranted variation

South Yorkshire and Bassetlaw 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 South Yorkshire and Bassetlaw receive different standards of care and potentially have different clinical and health outcomes.

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 acheived. 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.

NHS RightCare

NHS RightCare data packs (produced across a range of programme areas e.g. CVD, Respiratory, MSK) allow local health systems to consider information from across patient pathways to identify the greatest potential improvements in spend and outcomes.

Getting it Right First Time

Getting It Right First Time is designed to improve the quality of care within the NHS by reducing unwarranted variations.

By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, Getting It Right First Time identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

We will work across the System to 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. We will also 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 and embed National Institute for Health and Care Excellence (NICE) and other national guidelines and standards.

Working across the Hospital Hosted Networks we will Standardise clinical standards and reduce unwarranted variation and continue work on the standardisation of outpatient pathways and the use of medicines.

We will put the spotlight on cardiorespiratory and mental health and prevention and put actions in place 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

Personalised care reframes the relationship between patients and clinicians from 'what's the matter with you?' - to 'what matters to you?'. It is about taking an individualised approach to health care, bringing together different approaches, such as shared decision making, social prescribing and personal health budgets to completely change the way that care is planned and delivered for people living with long-term conditions.

We are an exemplar site and one of 20 ICSs that have committed to fully implement personalised care across our System by 2024.

Working with Primary Care Networks, NHS services, people with lived experience and partners in local government and the voluntary and community sector we will put the comprehensive model for personalised care in place. The model will help us to establish a whole-population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes. It will bring further expansion of link workers in Primary Care Networks and also ensure the approach is embedded in service redesign.

Getting the best start in life

Children's and maternity services

We want to ensure that children in South Yorkshire and Bassetlaw have the best possible start in life. Much of that starts with keeping families well and receiving good maternity care.

At the moment, four of our five Places are higher than the national average for the number of children in low income families. We also have high rates of neonatal, infant and child mortality, high numbers of obesity, high teenage mother rates, high smoking in pregnancy rates and the uptake of some immunisations in some communities is lower than we would expect. We also have high levels of agency and locum cover in some of our children's and maternity services as we face an ever challenging landscape to recruit to them because of a national shortage in specialist staff.

While we've made some great progress with staff working more closely together across networks (such as children's surgery and anaesthesia), are developing new ways of working and standardising how we do things for common and urgent conditions, the overarching picture is increasingly challenging.
It is why our Hospital Services Review paid particular attention to children's and maternity services.

The Review recommended that we create Hosted Networks led by senior clinicians for both children's and maternity. These will bring together existing networks and look at ways to further improve how we deliver services. The Children's Network will explore how a partnership between Doncaster and Bassetlaw Teaching Hospitals and Sheffield Children's could strengthen some services. The Maternity Network, which would work alongside the Local Maternity System (LMS), will focus on pre-conception to transition to children's services and look in particular at supporting women and their families. But we won't stop there.

Working with academic institutions, the Deanery and Health Education England we will put the spotlight on developing staffing to build a workforce for the future.

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, the integrated service for children with long-term conditions and disabilities in Doncaster and the integrated community, early intervention and prevention models Healthy Minds and Sleep Project in Sheffield.

In mental health services, we are learning from Rotherham's approach to Child and Adolescent Mental Health Services (CAMHS), Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD), Barnsley's eating disorder pathway and Bassetlaw's innovative partnership with the voluntary sector.

We want to combine a prevention, public health and integrated service models approach with pathways across primary, community and acute healthcare. We have already done this in our Places and will work to apply this learning consistently and equitably.

The Yorkshire and Humber regional measles, mumps and rubella (MMR) delivery plan is under development and will look at health equity audit, maximising Making Every Contact Count (MECC) and more flexible commissioning and delivery to improve access.

Making Every Contact Count

Making Every Contact Count (MECC) is about encouraging and helping people to make healthier choices to achieve positive long-term behaviour change. To do this organisations build a culture and operating environment that supports continuous health improvement through the contacts it has with individuals. Doing this improves health and wellbeing amongst service users, staff and the general public and reduce health inequalities.

Best practice in safeguarding is also high on our agenda and we want to take a wide view of mental health services for children and young people to understand gaps in service and capacity.

Our plans also include boosting mental health services for children and young people, which includes more services in the community and in schools. In Sheffield, a £2.5 million cash injection is helping with these and we will learn from the development as other Places set them up.

We also want to explore how children and young people can benefit from digital technologies, supporting them and their parents and carers to access information, support and care easily and confidently.

CASE STUDY

To make a referral to the ADHD pathway in Doncaster, a paediatrician carries out a full assessment, which outlines specific concerns.

All referrals are fully screened by the Child and Adolescent Mental Health Service team to determine suitability to the pathway. The pathway accept referrals for assessment of children aged 7 years and above who show ADHD features (hyperactivity, impulsivity, inattention) across at least two different settings, for example home and school. The process of assessment involves information gathered using screening questionnaires, school observation, full developmental history, and a clinic observation.

CASE STUDY

Bassetlaw CCG has mapped out the transition from children and adult health services creating a work-plan to take this agenda forward.

This has resulted in quarterly multi-disciplinary team meetings to plan transitions for individual children and the development of a transition strategy. This enables a clear health plan for each child requiring transitions and seamless approach when moving into adult services.

CASE STUDY

The Rotherham Maternity Transformation programme has made significant progress...

with strong governance and oversight given by the Rotherham Maternity Board which has wide Rotherham Place partnership representation.

There are now Personalised Care Plans being offered to 100% of women and an established Continuity of Carer pathway that is being rolled out through a continuity of carer team based model. The Rotherham Place partnership will be instrumental in ensuring the successful delivery of the community maternity hubs that are being established in three geographical areas of the Borough and in the reduction of women smoking at the time of birth.

The latest data for the number of women smoking at the time of birth shows a decrease from 20.2% to 16.4% between Quarter 1 and Quarter 2 2019/20, which means that Rotherham is now below the target of 18%.

We want to carry out a comprehensive review of smoking in pregnancy and put a range of measures in place to reduce the percentage of women who are smoking at time of delivery and post-natally.

The Maternity Hosted Network will focus first on workforce and reducing clinical variance and continue Better Births implementation, ensuring all local Place plans are fully integrated with wider system plans, such as children's and neonates.

We will also develop shared approaches to standards and improvements in breast feeding rates and ensure that the needs of disadvantaged and vulnerable communities are embedded within our plans to reduce inequalities. We will 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 and also 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.

CASE STUDY

Helping pregnant women with mental health problems

The Sheffield, Rotherham and Doncaster Perinatal Mental Health Service is a specialist mental health service for women with mental health problems who are planning a pregnancy, are already pregnant or have given birth in the last twelve months.

The service is run in partnership between Sheffield Health and Social Care NHS Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust and Light, a local perinatal peer support charity. The service is commissioned by NHS Sheffield Clinical Commissioning Group and supported by a memorandum of understanding with NHS Rotherham Clinical Commissioning Group and NHS Doncaster Clinical Commissioning Group.

The service may see pregnant women with mental health problems who have not yet engaged with maternity care.

Better care for major health conditions

Mental health

People with severe mental illnesses are at higher risk of poor physical health. Compared with the general patient population, patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease and make more use of urgent and emergency care. There is a national commitment to invest more of the NHS budget in mental health services and people in South Yorkshire and Bassetlaw are already benefitting from this promise.

We have made some good progress, aided by an extra £4 million of funding in 2018/19. Some of the funding has been invested in people living with severe and enduring mental ill health to give them tailored help to get back into or stay in work if they wish to. It has also been invested in a new perinatal mental health service across Doncaster, Rotherham and Sheffield and integrating mental health services into Sheffield neighbourhoods, closer to where people live and more aligned to their GP practices.

CASE STUDY

Integrated community mental health support

Mental health services are being embedded into Sheffield neighbourhoods closer to where people live and more aligned to their GP practice. The scheme is a game changer for people with complex mental health issues in Sheffield. It will ensure that people with mental health problems are seen more quickly, in familiar surroundings of either their GP surgery or another place in the community. The mental health workers will work in close contact with GPs, nurses and the voluntary sector to make sure that patients get everything from access to local clubs and activities, to the right medication and psychological support, to help with finding a job.

Adult mental health

Nine out of ten adults with mental health problems are supported in primary care and so we will expand the Improving Access to Psychological Therapies (IAPT) service. We especially want to focus on people with long term conditions. We also want to trial new ways of working in primary and community mental health care to support adults with severe mental illness and improve their physical health, reduce harm from tobacco, obesity and improve cardiorespiratory health.

When we engaged with the public and patients we heard about the importance of timely and easy access to mental health support. We will expand services for people who are experiencing a mental health crisis to include round the clock access and we will work with ambulance services in doing this.

With inpatient facilities, we will make the environment therapeutic and reduce lengths of stay, as well as reduce the number of placements outside of SYB.

We also want to support people who are addicted to gambling and those who are rough sleeping. We recognise that we need to understand these issues better so that we can work with partners to develop approaches.

South Yorkshire and Bassetlaw has a higher suicide rate than the England average and our aim is to reduce this by at least 10%. We will do this through a suicide prevention programme which will include further development of real time surveillance and bereavement support.

CASE STUDY

Rough sleeping in Doncaster town centre dropped by 70% thanks to a concentrated action plan by key public and third sector partners.

Then intensive action plan to support people living on the street has resulted in some of the most entrenched rough sleepers in the town now living in accommodation and receiving rehabilitation for physical and mental health issues.

Named The Complex Lives Alliance teams of professionals from Doncaster Council, South Yorkshire Police, St Leger Homes, Community and Acute NHS Trusts, Rotherham Doncaster and South Humber NHS Foundation Trust, which includes Aspire, the drug and alcohol service, Primary Care Doncaster, NHS Doncaster Clinical Commissioning Group (CCG) Criminal Justice, Department for Work and Pensions (DWP) and community, voluntary and faith organisations all work together to identify and support people off the streets and into the help they need to improve their lives.

Recently awarded an accolade for their work; a local government MJ Award for Care and Health Integration, the specialist team is currently working to support 122 very vulnerable people with complex needs who were all previously rough sleeping. 100 of these are now in some form of accommodation being supported by key workers and personalised wrap around support plans. This includes support with drug and alcohol misuse, physical and mental health, offending behaviours, Job Centre appointments, court appearances and achieving an overall healthier lifestyle.

In the past two years Doncaster, like many towns and cities in the UK, has seen rising challenges related to rough sleeping. This has been mostly centred on the Doncaster Town Centre area and connected with growing public, business and public service concerns about rough sleeping, poor physical and mental health, the use of synthetic cannabinoids, begging and anti-social behaviour.

Children and young people's mental health

Mental health problems affect about 1 in 10 children and young people. They include depression, anxiety and conduct disorder, and are often a direct response to what is happening in their lives.

The emotional wellbeing of children is just as important as their physical health and we want to build on our work to date.

We have started to invest in mental health support teams in schools to help children and young people and are rolling these out across SYB. We will also expand round the clock crisis services and develop transition services for young people aged 18-25. This is on top of continuing the work we have started on expanding community services, eating disorder services and perinatal mental health services.

CASE STUDY

In December 2018, Rotherham and Doncaster were successful in their joint bid to pilot the national Children and Adolescent Mental Health Services (CAHMS) trailblazer.

The pilot is one of 25 phase one pilots to trial mental health support in schools and a four week waiting time to access specialist CAMHS. Mobilisation is now well underway with local schools engaged, staff recruited and trained.

Learning disabilities and autism

We recognise that we need to improve our understanding of the needs of people with learning disabilities and autism. This is not least because they have worse mental and physical health. This is because they are statistically less likely to receive the routine checks (like blood pressure, weight and cholesterol) that might detect symptoms of physical health conditions earlier. They are also not as likely to be offered help to give up smoking, reduce alcohol consumption and make positive adjustments to their diet. In SYB women with a learning disability die on average 18 years younger and men 14 years younger.

Our plans include working with the voluntary sector to improve the experiences of families and people with lived experience, increase crisis response and extend hours of service in the community, promote health and wellbeing and annual health checks and roll out training for staff to increase their awareness. We will also support people who are living in hospitals to move into community settings and increase the number of children having specialist reviews before they go into hospital.

We will also develop housing needs assessments for people with learning disabilities and autism, review our workforce so that we can develop new roles to address any gaps and ensure our patient information systems help staff.

Cancer

Cancer survival is the highest it's ever been with many more people now surviving cancer every year. In South Yorkshire and Bassetlaw, five year survival remains significantly worse than the England average and 1 in 2 people are currently diagnosed at a late stage, with many through the emergency route.

However, thanks to the partnership approach of our Cancer Alliance, we have made some good progress. Cancer Alliances bring together clinical and managerial leaders from different hospital trusts and other health and social care organisations, to transform the diagnosis, treatment and care for cancer patients in their local area. The partnerships enables care to be more effectively planned across local cancer pathways.

Thousands more people are accessing information and support in their local communities through meaningful conversations, we are implementing new tests and care pathways in primary care and our hospitals are enabling faster diagnosis through rapid assessment and pathways.

We want to build on our work to raise greater awareness of symptoms of cancer, lower the threshold for referral by GPs, speed up access to diagnosis and treatment and maximise the number of cancers that we identify through screening. This includes working with Primary Care Networks and screening and immunisation teams to work with communities to increase uptake of HPV vaccination and cancer screening, introducing lung health checks and rapid diagnostic centres, strengthen the workforce by working as a network and use personalised and risk stratified screening.

CASE STUDY

Doncaster is one of ten areas nationally in a drive to save lives by detecting lung cancer early.

A number of initiatives proposed will check those most at risk, inviting people for an MOT of their lungs and a chest scan if needed. The project in Doncaster runs from December 2019 to March 2021. A second phase of the project will also take place to allow for scans and follow up appointments, taking the total project to four years.

The targeted Lung Health Check (LHC) could help detect lung conditions earlier and improve lung cancer survival rates in Doncaster. A recent study showed that low dose CT can pick up lung changes earlier and reduce lung cancer deaths by 26% in men and between 39% and 61% in women.

Based on the pioneering schemes in Manchester and Liverpool, the project will not just identify more cancers quickly but pick up a range of other health conditions including chronic obstructive pulmonary disease (COPD) and cardiovascular disease. Earlier diagnosis allows earlier intervention, support and health education to improve quality of life.

The scheme means people aged 55-74 years and 364 days* who have ever smoked will be invited for a lung health check and be offered a chest scan if they are assessed as high risk at that time. Doncaster Clinical Commissioning Group (CCG) will lead the project, working with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust.

NHS organisations in Doncaster will also work closely with the South Yorkshire and Bassetlaw Cancer Alliance to share best practice across the region. It is anticipated that the mobile clinics will be in operation later this year.

CASE STUDY

In Rotherham, the health and social care discharge teams have been brought together, with 27 discharge destinations streamlined into three pathways.

It is estimated the introduction of a new single electronic referral process saves around 30 minutes per patient, time which can now be spent on care. In addition, the new way of working has saved around half a million pounds of acute bed days. The approach means that delays are minimised and getting patients fit, well and home, with the support they need, is a top priority. The Integrated Discharge Team (IDT), based at Rotherham Hospital, brings a personal approach to the process of leaving hospital and short stay care homes; ensuring patients and their families are supported and have suitable, sustainable care packages in place.

The team is made up of colleagues from Rotherham Council (RMBC) and The Rotherham Foundation Trust staff, working alongside each other to bring expertise and knowledge from all aspects of health and social care.

Stroke

Stroke is a preventable disease and the fourth single leading cause of death in the UK. It is the single largest cause of complex disability.

There is strong evidence that hyper acute interventions such as brain scanning and thrombolysis are best delivered as part of a networked 24/7 service, which is why we recently moved to centralised hyper-acute stroke care in a smaller number of well-equipped and staffed hospitals. In addition, Sheffield Teaching Hospitals is offering mechanical thrombectomy to some patients and plans to do more.

It all adds up to people across our region having equitable access to high quality care and improved outcomes. We still need to do more, though.

Stroke services also face challenges with recruiting specialist staff and were reviewed as part of the Hospital Services Review. The Review recommended a Hosted Network and working in this way will be key to continuing to improve services. The Network will bring together all partners across the stroke pathway, including ambulance services and the Stroke Association. Some of the areas the Network will address include reducing stroke incidence by making links with cardiovascular disease prevention work, increasing public awareness of transient ischaemic attack (TIA, or 'mini stroke') symptoms and tackling variation. It will also look at developing networked provision to deliver the seven-day standards for stroke care and the National Clinical Guidelines for Stroke.

We will also develop the stroke workforce, including cross speciality and cross profession accreditation as well as explore new roles and ways of working, eg. Advance Care Practitioners.

To support people who have had a stroke to recover we will work with the voluntary sector to provide out of hospital higher intensity rehabilitation models and treat physical and mental health together. We will also make sure that early supported discharge is routinely commissioned as an integrated part of community stroke services.

Diabetes

Type 1 diabetes cannot be prevented and is not linked to lifestyle, but type 2 diabetes is largely preventable through lifestyle changes. There are currently 137,000 people at high risk of developing type two diabetes in the region.

For people living with a diagnosis of type one or type two diabetes we want to improve our support offer. We will support people who are newly diagnosed to manage their own health by further expanding provision of structured education and digital self-management support tools.

This includes expanding access to the 'Healthier You' NHS Diabetes Prevention Programme, targeting support to reduce health inequalities and piloting and evaluating 'low calorie diet' programmes for people with Type 2 diabetes.

We will also improve neonatal outcomes by offering continuous glucose monitoring to pregnant women with type 1 diabetes and improve the quality of care for children living with diabetes and improve transition to adult services.

By supporting delivery across primary care we will enable more people to achieve the recommended diabetes treatment targets and drive down variation between CCGs and practices to minimise their risk of future complications. For people who need secondary care support we will ensure that they can access multidisciplinary foot care teams and diabetes inpatient specialist nursing teams to improve recovery and to reduce lengths of stay and future readmission rates.

Respiratory

Respiratory disease affects one in five people in England, and is the third biggest cause of death. In SYB it is a leading cause of death and Barnsley, Rotherham and Doncaster have significantly higher under 75 mortality rates from respiratory disease.

We've already made some progress as over the last three years each of our Places has prioritised supporting people with respiratory disease in the community and we initiated a review to reduce respiratory related admissions to hospital.

Our next steps are setting up a clinically led respiratory network to reduce variation, accelerating improvements through the sharing of best practice and standardising respiratory care pathways to improve quality and outcomes. We will also 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 use new roles and approaches in case management 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.

Improve the response for people with pneumonia by reviewing existing pathways and working with public health to maximise the uptake of flu and pneumococcal vaccination for those aged 65 and over, in at risk groups and health care staff.

Cardiovascular disease

Heart and circulatory disease, also known as cardiovascular disease (CVD), causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. In SYB more than 1,000 people under 75 die every year from CVD.

Deaths from CVD are the second biggest contributor to the gap in life expectancy between our population and England and although premature mortality has decreased over the last two decades, all our Places except Bassetlaw still have significantly higher under 75 mortality rates.

This is the single biggest area where we can save lives over the next ten years. Through lifestyle changes and a combination of public health and action on smoking and tobacco addiction, obesity, tackling alcohol misuse and food reformulation, CVD is largely preventable.

In addition to our prevention work, we will detect the condition and start treatment early. Working with community pharmacists and GP practices we will also provide opportunities for the public to check on their health, through tests for high blood pressure and other high-risk conditions. We will work with our local authorities and ensure we focus on people with severe mental illness and learning disabilities. We will also roll out CVD training for staff across the region.

People with heart failure and heart valve disease will be better supported by multi-disciplinary teams as part of primary care networks and Primary Care Networks will lead this work. We will identify patients at high risk and support practices to enhance their support for patients to take more control of their health.

We will work with patients, the British Heart Foundation, British Lung Foundation and universities to redesign cardiac rehabilitation which will include digital options.

Working with Yorkshire Ambulance Service (YAS) and our community and voluntary sector partners, we want to develop CVD prevention champions, promote the restart a heart campaign and support schools with CPR training.

Reshaping and rethinking how we flex resources

System finances

When we published our first strategic plan, called the Sustainability and Transformation Plan (STP), we described how in five years' time (2021) we would have a financial gap of £571 million unless we started to 'left shift' our services. By 'left shift' we mean providing more care out of hospital and in communities, which the STP started to describe. Left shift also means focusing more on prevention. We have made a good start in these areas at the same time as benefitting from access to financial offsets that have meant we have balanced our books.

Since publishing our Plan, the government announced that the NHS has a secure and improved funding path, averaging 3.4% a year over the next five years, compared with 2.2% over the past five years. While we are in a good position, next year and beyond are challenging financially for us. We will benefit from working as a System on our finances and continue to have a duty to make the extra funding go as far as possible.

To continue to deliver our ambitions, we will need to flex our all our resources. By taking a population health approach and focusing on prevention, it means that over time the NHS pound will increasingly be spent more on services in GP practices and community hubs, identifying illnesses earlier and helping people to stay well for longer.

Transformation funding

We have had access to transformation funding over the last three years, which has been invested 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 over the next five years will enable us to deliver this Plan.

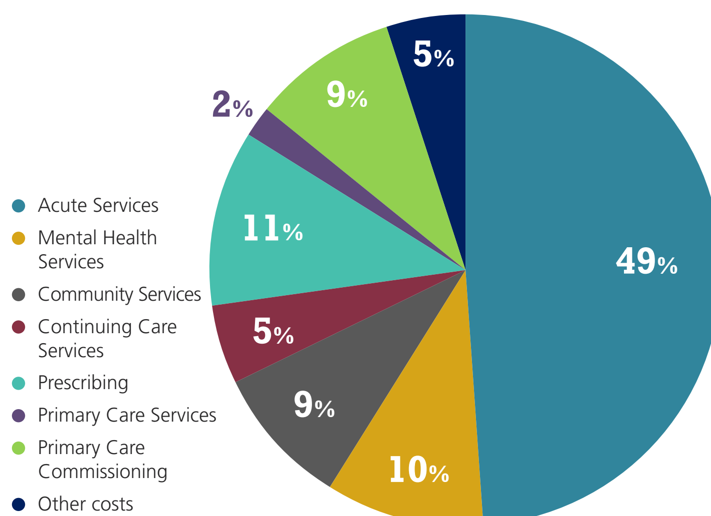
Commissioning development

Across the region 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 and Local Authority commissioners continue to develop closer working relationships enabling joint working, risk sharing, more joint teams and more support to enhance 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 was £2.5bn in 19/20 and the spend is as shown (see diagram above). In addition, there is further £0.5bn spent on specialised commissioning and the Local Authorities spend £1.4 billion on social care.

Estates

At the spring and autumn budgets in 2017, the government announced an additional national allocation of £3.9 billion to speed up estates transformation, tackle critical backlog maintenance issues and support efficiency.

We are already starting to benefit from £20 million funding for schemes at Yorkshire Ambulance Service, Barnsley Hospital, Doncaster and Bassetlaw Teaching Hospitals and Sheffield Teaching Hospitals. A further £57.5 million investment has been announced for new GP surgeries, nurse-led clinics and pharmacies.

There is also £118 million planned investment for estates in 19/20 (including £7 million for information management and technology and £19 million for equipment) and more than £400 million planned investment through to 2023/24.

We are increasingly moving from a functional approach to managing the NHS estate to one which looks at the whole estate across the region.

Section 2
Strengthening our foundations

Working with patients and the public

It is important to us that staff, patients and the public are able to voice their views, needs and wishes, and can contribute to plans, proposals and decisions about services.

Involving patients and the public allows us to better meet the needs of the local populations we serve and we are committed to ensuring that the diverse range of people who live in South Yorkshire and Bassetlaw have the opportunity to have their say and the information that they need to be involved in any decision making.

With support from voluntary sector partners we have undertaken extensive involvement work with public and patients to inform the work of the Hospital Services Review.

We have also 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.

To support the strategic work of the ICS, we 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. We also set up the Citizens' Panel, bringing together people from across the region to provide an independent view and critical friendship on matters relating to work at System level and a Transport and Travel Panel (TTP) with patients and the public, also from across the region, to look at the potential impact changes to services would have. The TTP is currently not meeting as there are no significant changes in the pipeline but it will be reinstated should this change.

Involving people in shaping this Plan

The Barnsley, Doncaster, Nottinghamshire, Rotherham and Sheffield Healthwatches joined forces to co-ordinate conversations with more than 1500 members of the public throughout the spring and summer 2019. They asked people, either by survey or in face to face group conversations about their views on the priority areas that had already been identified by the public in similar conversations in 2016.

We also connected and had conversations with staff and stakeholders online and through partner organisations, our ICS Staff Side Forum, forums and at events. There are three reports outlining the feedback and a summary of how the feedback has shaped the Plan, all available online.

The main themes from the involvement were:

- 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

We will continue to meet as a Guiding Coalition twice a year to discuss and agree our strategic direction and hold a public events before each of these to gather views that will feed in to the sessions. We will also build on our work with the Citizens' Panel and develop an online membership model to support our involvement work on transformation and explore how we can triangulate patient experience data from all partner sources to develop a System profile approach to involvement. Key to all our work will be strengthening links across partner communications and engagement teams to carry out System involvement and meet our legal duties.

CASE STUDY

Listening to people about the NHS Long Term Plan in South Yorkshire and Bassetlaw saw our Healthwatches recognised as the winner in the Outstanding Achievement category at the annual Healthwatch awards.

Working with local Healthwatch partners (Sheffield, Rotherham and Barnsley with Doncaster co-ordinating the response) under the South Yorkshire and Bassetlaw Integrated Care System (ICS), the 'What Would You Do?' campaign saw more than 1,300 responses from people across the region, resulting in service user feedback focusing on self-care, mental health investment and joined-up care. The 38-page report was presented at the regional ICS in July to a fantastic response, with updates delivered to local stakeholders and partners alongside publication on our website.

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.

We attract some of the very best people to our organisations but over the past decade workforce growth has not kept up with need, and the way staff have been supported to work has not kept up with the changing needs of patients.

Nonetheless, we have made some good progress in recent years, not least setting up an ICS Workforce Hub to support the co-ordination of activities across Places and System. We have also launched the Primary Care Workforce Training Hub, South Yorkshire Regional Excellence Centre, Faculty for Advanced Clinical Practice and an Allied Health Professions Council.

In Barnsley, the Partnership is delivering a plan for out of hospital workforce based on population health which is supported by a Barnsley wide strategy.

In Bassetlaw and Sheffield workforce strategies have been agreed and collaborative staff banks and agency procurement across the System are in place.

We have also started an ambitious schools engagement programme as part of a wider plan to promote careers across health and care.

Strengthening our primary care workforce is a priority

To support sustainable services and enable care closer to home, we have developed a primary care workforce hub. It is looking at:

- Growing the number of GPs
- Developing roles such as physician's associates and first contact musculo-skeletal (MSK) practitioners
- Delivering vocational training for nurses in primary care
- Coordinating placements for undergraduate nurses across the region
- Apprenticeship schemes for healthcare assistants
- Recruiting GP Fellows to support transformation projects
- Rolling out a data collection/workforce tool

To make this Plan a reality, we need more staff, working in rewarding jobs and a more supportive culture. Our Plan focuses on five ways in which we will do this.

First, we will make the NHS the best place to work by improving retention with more flexible working opportunities, improving our health and wellbeing offer to staff and supporting their physical and mental health.

Second, we will improve our leadership culture with a systems leadership framework, support partner organisations to achieve Care Quality Commission (CQC) 'well led status', increase our focus on diversity and inclusion, address cultural barriers between organisation, retain and develop our talent across the System and build human resource and workforce transformation capacity and capability.

Next, we will tackle urgent nursing shortages and secure a current and future supply of nurses. We will do this by accelerating new roles across professional groups such as Nurse Associates and Advanced Clinical Practitioners, delivering an ambitious schools engagement programme to engage children in health or care careers from a young age, recruiting internationally, scaling up apprenticeships and access to training to upskill our workforce, and developing the voluntary sector as a partner within the system, with voluntary sector staff, volunteers and unpaid carers provided with access to support.

We will deliver 21st century care workforce redesign. This can only happen by working closely with Places, aligning with service transformation programmes and leading a strategic workforce planning processes on behalf of the System.

We will focus on the out of hospital workforce, staff being able to move easily between organisations, flexible working, returning to work and streamlined career pathways.

We will focus on the out of hospital workforce, staff being able to move easily between organisations, flexible working, returning to work and streamlined career pathways. Developing new roles, integrated roles, apprenticeships and advanced clinical practice will also be key to our success.

And finally, we will develop a new operating model for our workforce. This mostly involves looking at how we will develop the health and social care workforce, integrating services across social care and the voluntary sector and developing partnerships across unions, education and local authorities.

Leadership and organisational development

We want our System leaders to lead beyond organisational boundaries and act in a way that supports the interests of patients and citizens across SYB, ensuring equity and reducing variation across each of our Places. Our leaders must harness the greater impact of collective action while still being mindful of both Place and System and the complexity of organisational and statutory accountabilities.

Supporting leaders to work across a System which is complex and complicated is fundamental to the success of our Plan. We have already made some progress, particularly with our clinical leaders and this includes identifying and supporting clinical leads across our work areas and bringing them together at multi-professional events to discuss clinical pathway design. We also held a recent workshop for 35 clinical directors and are putting in place a iVirtual Leadership Academy for Primary Care Networks for individual, team and network development.

We have set up a shadow board for aspiring executive directors and are tailoring leadership development to support our Hosted Networks. We have also set up professional councils and clinical reference groups (CRG). i.e. Allied Health Professionals and Healthcare Scientists Councils, acute provider CRG, CRG's for five acute hospital services within the Hospital Services Review.

Our future work programme will ensure we have formal Clinical Forums at both Place and System and clinical leads and reference groups for the Hosted Networks. We also want to engage senior nursing leaders to support the delivery of two cohorts of the 'Stepping Up' national programme: one for Bands 7, the other for Bands 5-6 to be delivered post April within the ICS.

Digitally enabling our System

Digital has the potential to completely transform how we deliver health and care. Virtually every aspect of modern life has been, and will continue to be, radically reshaped by innovation and technology – and healthcare is no exception. It is a key enabler for us and we have a significant ambition to deliver digitally enabled care.

At the moment there is a mixed economy across the region that we will resolve by putting in place the basic digital capabilities for integrated care. This will give us a foundation that will allow for innovation and for the more mature Places to go further faster in an aligned manner.

We have developed a set of principles and standards to support the overall transformation that all South Yorkshire and Bassetlaw partner organisations have endorsed and will operate to. For the technical standards, we will re-use national standards and have a roadmap for the development of these that reflects our transformation priorities.

We have endorsed the Digital Health and Wellbeing Charter for Yorkshire and Humber, which commits us to working with our partners across the wide region for the benefit of citizens, staff, and in support of industry and research.

As a Partnership, we have agreed a set of themes and maturity levels. These are described in the diagram, which shows the approach we want to take.

The themes have been developed based on the needs, priorities and objectives of our transformationvwork streams, such as prevention, as well as the relevant digital delivery challenges and capability/category types.

The maturity levels 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.

Maturity level 1

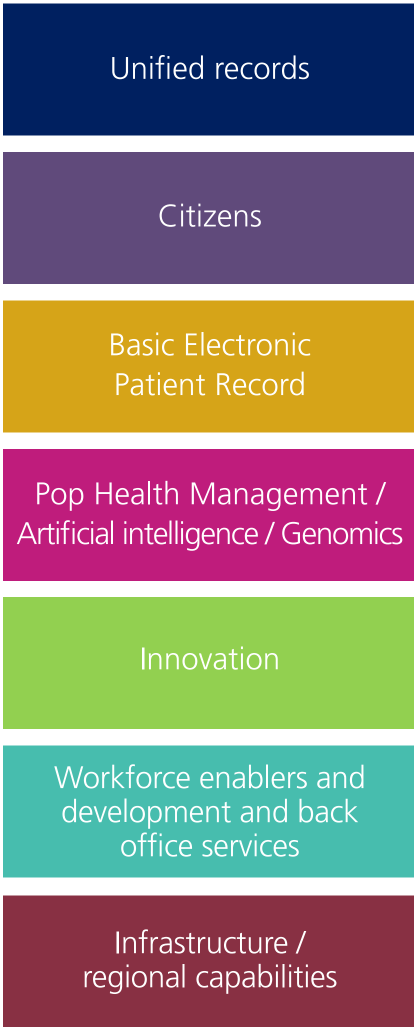
Establishing the basic digital capabilities for integrated health and care.

Maturity level 2

Greater use of information and advancing capabilities to improve health and care delivery.

Maturity level 3

Digitally enabled citizens, professionals and system.



Maturity level 1	Maturity level 2	Maturity level 3
Unified health and care record viewer	Unified health and care record task manager	Rationalising unified health and care records and EPR
Citizen App Personal Health Record	Citizen held record and contributing data to record	Person centred AI services
Basic Electronic Patient Record	Advanced Electronic Patient Record maturity (Standardisation)	Advanced Electronic Patient Record maturity (Standardisation)
Pop Health Mgt supporting Unified Records	Pop Health Mgt for planning and research	Demand and capacity machine learning, artificial intelligence and genomics impacting outcomes
Innovation Hub opportunities	Innovation Hub opportunities	Innovation Hub opportunities
Workforce enablers and development and back office services	Workforce enablers and development and back office services	Workforce enablers and development and back office services
Infrastructure backlog IT maintenance and establishing regional capabilities	Ongoing infrastructure backlog IT maintenance and establishing regional capabilities	Optimising infrastructure and regional capabilities

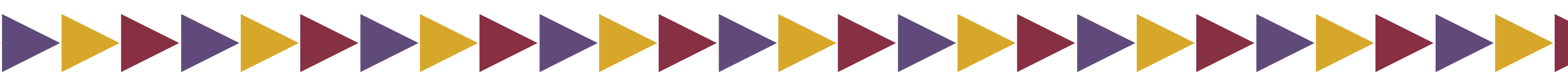
There are many implications of this proposed strategy which include: a significant increase in funding required; additional capacity within clinical/service leads, operational teams to take on the business change and digital delivery; increased risk appetite; more 'digital/agile' delivery culture to prototype changes, deliver incrementally; and a greater focus on system requirements from organisations.

Our approach will enable us to deliver a stable, secure and cost effective infrastructure which will resolve IT maintenance issues and achieve full cyber security compliance. It will also mean unified and integrated health and care records for professionals and citizens and allow all citizens with an online/digital service to manage their health and care needs. This will include provision for those people who are digitally excluded.

We will also support the population health management approach with capability and support infrastructure services as well as ensuring Primary Care Networks and primary care, acute, community and mental health providers are fully digitised by 2024.

Creating the right environment for innovation to flourish is crucial to our ambitions and so we will set up a hub for digital innovation across SYB, working with the expertise and strong relationships that the Yorkshire and Humber Academic Health Science Network has cultivated with academic and science sectors.

To allow rapid progress and keep us on track, we will commit to principles and standards with our partners which will support more effective system working to deliver digital enablers.



In Rotherham, residents are benefitting from digital advances. The Health Record and Health App work together to provide both citizens and health and care staff with information at their fingertips around the clock.

The Health App

The Rotherham Health App is a brand new service providing online access to manage healthcare 24 hours a day. It is available 24/7, on desktop, tablet, or mobile devices. Patients are able to book appointments, manage their medication, view test results, and access their medical record. All Rotherham GP practices are technically enabled for the App and from 1 July practices started offer 25% of their appointments online.

The Health Record

The Rotherham Health Record is an electronic system for sharing patient health information in a secure way with health and care staff who provide care directly. This gives them access to the most up-to-date information so that they can provide better and quicker care. Health and care professionals, including doctors and nurses, who are directly providing care, see a summary of a patient's existing records - such as those held by their GP, hospital or social care provider - to allow them to make the right decisions with the patient and for the patient. Patients only have to tell their story once.

Innovation and improvement

We have partnered with the Yorkshire and Humber Academic Health Science Network (AHSN) to establish an innovation hub which will be our vehicle for system-wide innovation.

The Hub was set up in summer 2019 and already has a number of innovation projects underway that are looking at system wide unmet needs.

CASE STUDY

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 fits 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:

Match innovation to unmet need

- Establishing and managing a unified approach to capturing, validating and prioritising the unmet needs and problems that need solving 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

Provide a 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

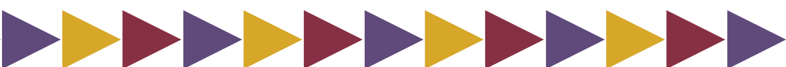
Signpost

- 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 the Health and Care Partnership, 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 services model in South Yorkshire and Bassetlaw - Neighbourhood, Place, System.

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.

We have made significant progress in how we organise and think about the ways 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. Primary care is strengthened by working together in Networks and neighbourhood teams enable us to deliver integrated care pathways where people live.

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 develop even further, we will agree an ICS strategic commissioning function, thinking carefully about how this complements the commissioning operations in place and current commissioning for community pharmacy, dental and eye care provision.

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

System Planning & Commissioning

The **System** agrees shared objectives and provides 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

Primary care networks (PCNs) bring general practices together to work at scale. Working in this way they can improve the ability of practices to recruit and retain staff, manage financial and estates pressures, provide a wider range of services to patients and more easily integrate with the wider health and care system. All our PCNs have clinical leadership.

They are also the footprint around which integrated community-based teams will develop, and community and mental health services will configure their services around PCN boundaries. These teams will provide services to people with more complex needs, providing proactive and anticipatory care.

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 the region

South Yorkshire and Bassetlaw has a long history of practices working together, supported by GP Federations and other primary care providers which has helped with the development of Primary Care Networks. We have full coverage with 30 Networks which will use data analysis to understand the population better and develop support and services around people's needs and in time improve overall population health.

All the Networks across South Yorkshire and Bassetlaw are making good progress and already all the clinical directors have formed a 'guiding coalition' of clinical leadership across the developing PCNs. Some of the PCNs are appointing paramedics and clinical pharmacists to their teams and working closely with community pharmacies. To support, promote and help recruit to new roles in primary care, a workforce training and development hub has been set up.

Neighbourhood teams within PCNs are delivering joined up care and supporting people to stay or recover at home. They have staff from the voluntary sector and schools, with integrated neighbourhood teams aligned to local authority areas.

Many are testing new ways of working within the community. We know that patients want time to talk about what matters to them and medication is not

always the best solution for them. Networks are now employing link workers who are supporting people to find suitable activities that are a better alternative to medication. Many link workers are employed by the voluntary sector and they connect with social care, community nursing, local authority community and wellbeing teams, housing, welfare and employments.

In Barnsley, a single Primary Care Network with six sub networks has been set up. Teams of people with health and social care backgrounds as well as from the voluntary sector – we call these integrated neighbourhood teams - are aligned to the local authority area councils and Neighbourhoods will agree their local health and wellbeing priorities and engage with local communities.

In Bassetlaw, there are three Primary Care Networks with co-located teams of people with health and social care backgrounds as well as from the voluntary sector. Access to primary care services on evenings and at weekends (extended access) is available through the Primary Care Network hubs as well as through individual practices. Practice pharmacists are increasingly carrying out clinical reviews and patients are getting the time to talk about what matters to them and supported to find suitable activities that are a better alternative to medication with new Link workers. Link workers are employed by the voluntary sector. Care homes are also receiving extra support from the Primary Care Networks.

Doncaster has five Primary Care Networks. Neighbourhood project coordinators are linked to GP practices with social care, community nursing, local authority community and wellbeing teams. Early intervention, local solutions and joined up teams are all working with the same, consistent approach.

Rotherham has six Primary Care Networks. They are strengthening the primary care workforce with primary care nurse preceptorships, health care assistant apprenticeships and nurse development roles. Preceptorship is the transition from being newly qualified and starting full time work in the NHS. During this time, nurses are given expert support and learning from best practice in dedicated time.

In Sheffield, there are 15 Primary Care Networks. The first phase of the Neighbourhood transformation programme is established across six of them and there are teams from health and social care providing integrated care and support working, with plans to roll out across the city.

With such excellent foundations, we are well placed for the next phase of our plans. This includes developing new models of integrated community services, developing community pharmacies to build and strengthen their role in Networks and extend access to GP practices even more. Where we have GP Federations and providers of scale they are supporting Network development through lead employer and other arrangements.

We will also support Networks and their practices with leadership development and recruit link workers and clinical pharmacists.

We want to transform services and will roll out care home support across all Places, create a single point of access and continue to build community services to support people to live well in their own homes.

Out of hospital care

Each Place has established an 'out of hospital' care approach through their Integrated Care Partnerships (ICPs) and delivered through the Primary Care Networks. This ensures health and care partners are working collaboratively to bring care pathways together and provide care closer to home.

In Barnsley, there is a rapid response intermediate care service, nurse led support to care homes (including the introduction of digital technology to enable video link up) and patients who need respiratory and pulmonary rehabilitation are benefitting from a community approach.

In Bassetlaw patients who need ophthalmology, audiology and pain management services can now get some of their care in their community and community dermatology services have been extended. There is also now a rapid response service providing two hour urgent community response and the PCNs are working with paramedics and pharmacists.

Doncaster has also introduced a two hours rapid response service and is providing care for people with delirium and dementia in the community. As part of their complex lives service, people who are rough sleeping are getting care and support for addiction, mental health and wellbeing needs.

Rotherham has aligned community services to work around GP practices in the Networks and practices are aligning support to care homes for care continuity. The town also has a rapid response service and improved discharge from hospitals which is leading to some of the lowest lengths of stay and delayed transfers in the country.

In Sheffield, working in Neighbourhoods has been established for some time and this is now being supported with significant investment to develop collaboration across schools, mental health, voluntary and community sector, social care, community nurses and police. The city also has enhanced care home support, joint re-ablement services and provision of care home beds which has reduced length of stay markedly over the last year.

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. This includes developing a model in the community to escalate and de-escalate patient needs and support for Networks to better understand their current population so that they can plan future services.

We will also improve care pathways for patients with respiratory, dementia, CVD, diabetes and gastrointestinal needs and ensure timely access for people in a mental health crisis, improve flow through hospitals and enhance step up provision to facilitate quicker discharge. We will continue to improve health care in care homes and roll out community ophthalmology, audiology and pain management services and extend dermatology services.

Ageing well

People are increasingly more likely to live with multiple long term conditions or live into old age with frailty or dementia.

As part of their out of hospital approach, each Place is developing and implementing plans to support people to age well. This includes GPs identifying and supporting people with severe frailty with the help of population health management approaches, supporting them to be independent and age well, setting up falls prevention schemes, trialing home based wearable technology and recognising the important role of carers and giving them support and information.

Dementia diagnosis rates remain high across the region and there is also ongoing work in each Place to provide better support in the community for those living with dementia.

Partnerships in Place

Over the last three years all five Places have set up integrated care partnerships (ICPs) with their local authorities and other place partners. These partnerships have become the bedrock of Place development and relationships in each ICP continues to evolve and flourish with 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 of health care including:

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.

Reforming emergency care

We have an emergency care system under real pressure and our Plan is focused on ensuring patients get the care they need, fast, and to relieve pressure on our A&Es.

We have already put in place the new integrated urgent care model, with a regional and local Clinical Advice Service (CAS) and supported by full population coverage of NHS 111 online. There is an Urgent Treatment Centre (UTC) in Doncaster and Rotherham Hospital is a field test site for the new national clinical emergency and urgent care access standard.

All our hospitals have front door clinical streaming in A&E so that staff can care for the sickest patients and we are working across organisations to share data to improve how we work as well as track care home bed capacity and strengthen our relationship with Yorkshire Ambulance Service.

But we want to do more. We will develop the integrated urgent care approach that we have put in place and create more urgent treatment centres. We will work with ambulance services to eliminate handover delays, develop improved clinical pathways to avoid conveyance to hospital via 999 services, initially in respiratory and mental health, increasing hear and treat or hear, see and treat rates. We will expand NHS 111 direct booking initially expanding direct booking into GP services, urgent treatment centres, GP out of hours services and look at further expansion into other community based services.

Primary Care Networks will play an important role as they develop further and we will 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.

We are also committed to ensuring same day emergency care. Same day emergency care is an essential part of emergency and urgent care in that it avoids admission overnight into a hospital bed with all the risks and hazards that entails for conditions that can be treated equally as effectively with the patient benefiting from returning to their own bed overnight.

We will also reduce delays in people going home from hospitals by continuing to improve performance to support people home, reduce delayed discharges and length of stay.

Transforming Planned Care

Too often people are travelling for hours to a hospital appointment that lasts a few minutes when they could be saved time, cost and stress by the NHS doing things in a different way. Sometimes people are waiting months to be treated at their local hospital when they could be seen faster elsewhere if they knew where to look.

Our work in this area aims to ensure that patients needing planned care see the right person, in the right place, first and every time, and get the best possible outcomes, delivered in the most efficient way.

We are doing things differently including virtual appointments in some specialties such as fracture clinics, dermatology, ophthalmology and ‘good news calls’ to reduce delays in people receiving their results.

Musculoskeletal First Contact Practitioner pilots have also been trialled in readiness for roll out across the System by 2023/24.

We have also set up community services in a range of specialties including heart failure, dermatology, integrated sexual health and gynaecology, ophthalmology, audiology and pain management and agreed a consistent way of following up patients who have had hip and knee surgery.

As well as giving patients the right to alternative modes of appointment such as online, telephone or video consultations, we want to ensure they have the same access and outcomes no matter where they live. We will introduce standardised outpatient follow up protocols across the region and continue to ensure that when we commission services, we are making sure everyone has the same outcomes.

We will increase access to shared medical records for patients and healthcare professionals to support new service delivery models and more joined up co-ordinated care planning. At the same time, community services and alternative planned provision will continue to grow.

We want to bring down waiting times elective care by looking at using capacity across the region and offering choice at 26 weeks. Specifically, we will put in place proven, minimally invasive treatment that fills the gap between prescription medications and more invasive surgical procedures for prostate hyperplasia.

Hospitals working together and in Networks

Our NHS Foundation Trusts have a long history of shared working. Our mental health trusts have formed an Alliance, which has identified lead trusts for three priority pathways and is looking to establish three Collaboratives. They are putting into place the governance to support this, with a draft partnership agreement being developed.

Since 2014, our acute trusts have been working closely together, starting first as the Working Together Vanguard. Their ever developing shared work is formally overseen by a Committees in Common model, supported by an Acute Federation within the ICS.

Shared working is bringing benefits for patients and staff and as we get even better at it we are develop transformation programmes at the most appropriate level within the System.

In our next phase both the acute and mental health trusts will further strengthen their collaborations to enable shared working. This will mean a greater focus on the 'spine' of supporting services, i.e. the underpinning infrastructure of digital and workforce, rather than expanding the Hospital Services Review to cover additional services.

Our acute NHS Foundation Trusts are building an underlying infrastructure on digital and workforce and developing greater transparency on risks and challenges, so that trusts are better placed to support each other and prioritise areas for shared work.

Our mental health NHS Foundation Trusts are taking their work forward in two phases.

In phase one they will form a Collaborative Alliance Board and agree ways of working. This will enable the development of collaborative arrangements for low/medium secure inpatient services, eating disorders and child and adolescent mental health services (CAMHS) Tier 4 service.

In phase two they will embed collaborative ways of working, establish formal governance with a Committees in Common, agree areas for formal delegated decisions making and additional new care model priorities.

Hospitals working in Networks

Our acute NHS Foundation Trusts are increasingly working together to improve clinical standards and outcomes for patients. They want to make their organisations great places to work while tackling inequalities and making efficiencies. The work they have already done together on procurement and back office functions has saved £5.5m so far.

The guiding principle is that by working together, patients can access the best care. While the majority of hospital care will continue to be provided in the patient's local hospital, trusts working together will give access to more specialist services.

Our NHS Foundation Trusts already work in networks such as the Regional Hyper-Acute Stroke Service and 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. There are also arrangements such as Doncaster providing nephrostomy interventional radiology at Rotherham and Barnsley and Rotherham recruiting joint gastroenterologist posts.

The recent review of Hospital Services, which focused on five challenged services, (urgent and emergency care, maternity, paediatrics, stroke and gastroenterology), 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.

The partners in the ICS are aiming to avoid reconfiguration unless there is believed to be no other way to make services safe and sustainable.

Next steps for Hospital Hosted Networks include:

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.

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.

Our acute NHS Foundation Trusts are increasingly working together to improve clinical standards and outcomes for patients.

Hosted Networks will work in three ways:

Level 1 will focus on shared approaches to workforce, clinical standardisation and innovation

Level 2 will involve a higher level of sharing resources across the system

Level 3 will consist of a closer relationship with one Trust providing or supporting services on another Trust's site(s)

Making the best use of resources

As set out in the NHS Long Term Plan, the NHS is set to benefit from a spending increase including investment in increased training places, investment in public health, capital investment and investment in artificial intelligence. There is also the commitment to ensure mental health investment grows at the same rate as the overall NHS budget for five years.

In South Yorkshire and Bassetlaw, we have strong financial performance across organisations at a time of ongoing challenges and increased activity across NHS services. Nonetheless, as with other Systems and NHS organisations across the country, we must also look at how we can achieve efficiencies while continuing to provide and transform services. Our progress to date has been positive. We have made effective use of ICS flexibilities (offsets) to secure NHS organisation financial positions and maximise investments. We have developed a transparent approach to how transformation money for System investment is spent and set up a System Efficiency Board to identify where the System can add value by working differently together.

As we strengthen how we work as a partnership, we are increasingly taking on more responsibilities for our health system, including collective accountability for health finance. Our financial planning approach starts with Places working together to agree finance and activity plans and agreeing a framework and timetable across the System. All NHS organisations are required to return to recurrent financial balance over the life of the five year plan.

System Efficiency Board

As part of their annual planning process, NHS partners set efficiencies of 2-3% a year so that they can be sure they are getting the best value for taxpayers. Schemes are based on what is achievable within an organisation and include areas such as the use of agency staff, how they buy goods and services and how they buy medicines. The ICS doesn't want to replicate any efficiency scheme that is working well in an organisation or Place but there are some areas where schemes across a region avoid duplication and make faster progress. To explore these, we set up a System Efficiency Board.

As part of a rigorous process with partners, we mapped 17 possible projects against value for money, deliverability and quality and strategic fit benefits.

There were four priorities which emerged and which we are working on:

- **E-rostering**, where we want to reduce the £92m spend on temporary staffing. The opportunity for efficiencies is £9m-£18m.
- **Outpatients**, where we want to redesign outpatients and reduce unwarranted varation. The opportunity for efficiencies is between £9m-£10m.
- **Theatres**, where we want to increase the use of theatre time. The opportunity for efficiencies is between £4m-£7m.
- **Independent Sector**, where we want to reduce the spend which is currently to add additional capacity (ie not patient choice). The scale of opportunity is less than £1m.

System Efficiency

As well as the four priority areas agreed by the System Efficiency Board, we are also looking at additional efficiencies to eliminate the gap between the plans and trajectories. We will revisit the long list of 17 projects and develop further schemes at a System level or through the NHS Foundation Trusts working together.

We also think we can improve productivity across the System and we will do this by working as a groups of partners to maximise the buying power of the NHS, releasing more time for patient care through greater collaboration, adopting recommendations that reduce unwarranted variation and standardisation, reducing administrative costs, developing a regional pathology network. We will also progress the development of a diagnostic imaging network, continue to develop the imaging academy and workforce plan, optimise medicines management in care homes and across care pathways, review the use of medicine related resources and standardise rebates and branded medications.

Capital

Our populations are already starting to benefit from our collective bidding success with £78 million for various system-wide capital projects. Our successful bids are:

£57.5million
For new primary and community buildings across the region.

£4.8million
The additional CT scanner at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

£7million
The new hub for Yorkshire Ambulance Services NHS Trust in Doncaster.

£2.5million
The co-location of the children's emergency department and assessment unit at Barnsley Hospital NHS Foundation Trust.

£4.6million
Improvements to the configuration of hyper acute stroke unit at Sheffield Teaching Hospitals NHS Foundation Trust through greater collaboration.

We will seek extra funding to support capital development in line with clinical need. In anticipation of future capital being made available by government, the ICS has identified £445m of investment requirements covering all aspects of primary, acute and mental health services.

Section 4

Broadening and strengthening our partnerships to increase our opportunity

Partnership with the Sheffield 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.

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 and 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.

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 want to 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 also want to 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.

We are also commited to move to sustainable transportation across the ICS, including enabling active travel for staff, visitors and even for some patients, which would have wide reaching benefits for health whilst also helping to reduce air pollution and meet carbon targets.

Anchor institutions

The impact the NHS has on people's health extends beyond the role as a provider of treatment and care. As large employers, buyers, and capital asset holders, our health care organisations are well positioned to use their spending power and resources to address social, economic and environmental factors that widen inequalities and contribute to poor health.

Being key to making a strategic contribution to the health and wellbeing of the local population and the local economy, the NHS, along with local authorities, universities and other non-profit organisations, is described as an 'anchor institution'. It 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:

As an employer

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. We are committed to maximising the benefits of the NHS and other anchor institutes as employers to promote local recruitment and widen access to quality work.

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. We will promote spend in communities to support local businesses, employ local people and stimulate local economic development and promote the consideration of social value into purchasing decisions.

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. We will manage and develop land and estates in a way that benefits local communities.

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 take action to support responsible consumption to reduce waste and our environmental impact.

CASE STUDY

Anchor institutions

Sheffield City Council has made a public commitment to ethical commissioning and procurement, including the use of local suppliers wherever possible. This is now well embedded across the Council's supply chains. The Council has also had a consistent approach to the insourcing of service delivery over recent years. It is committed to using its influence wherever possible to maintain and share the commitment.

Partnerships with the voluntary sector

South Yorkshire and Bassetlaw 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.

We hugely value their contribution and want to develop a strong vision for embedding VCSE participation at every level of the ICS as an equal partner in strategy and delivery.

Our connection with the sector starts with our Collaborative Partnership Board where they sit as partners. They are also represented at Place on Health and Wellbeing Boards and Integrated Care Partnerships and are influencing ICS workstream priorities.

Across the region there are examples of NHS funded micro commissioning of the Sector via our VCSE infrastructure organisations and some Primary Care Networks are developing strong relationships with VCSE partners. Social prescribing has been hugely successful across all our five Places with highly regarded VCSE led services and we intend to build on this great work.

We want to strengthen the great work that has started and our ambitions start with co-designing a new framework for engagement to build relationships between the ICS and VCSE. We will also support VCSE organisations and the NHS to better understand each other's values and expertise and invest in the Sector and infrastructure support, developing new models of funding and commissioning, enabling greater sustainability.

It is crucial that we harness local VCSE expertise and knowledge of local communities to help identify need and co-design services with them to enhance population health and consider the potential of the Sector as we look at developing services and peer support and health champions for prevention awareness, long term conditions and personalised care. We would also like to consider VCSE colleagues as core part of multidisciplinary teams and develop the potential role of the Sector in secondary care.

We will also support the development of community assets and services for vulnerable and at risk groups, in collaboration with the VCSE and wider partners and maximise the potential benefits for our communities from further developing volunteering opportunities within NHS organisations and the broader health and wellbeing system.

CASE STUDY

Supporting local voluntary, community and social enterprise (VCSE) infrastructure

...delivering on its social responsibility by investing in small, local grass roots initiatives where the monies used could have a genuine impact on capacity building and learning for those organisations.

By utilising the skills and networks of local VCSE organisations, and encouraging neighbourhood based peer to peer conversations, they hear from people who don't traditionally engage.

In Bassetlaw, there is a range of VCSE organisations commissioned to provide services wrapping around primary care and the Community and Voluntary Services Chief Executive is the ICP Chair, positively impacting on 'parity of esteem' with the public sector.

Commitment to work together

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 peoples' 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.

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.
- In pursuing our key objectives we do not increase inequalities or worsen health outcomes for any local populations.

System Health Oversight Board

Provides a joint forum between health providers, health commissioners, 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.

It builds on the SYB partnership working on s trategic 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 the SYB collaborative health groups of Joint Committee of CCGs (JCCCG), Committees in Common (CsiC), Mental Health Alliance (MHA) and Primary Care Federations.

System Health Executive Group

Facilitates a maturing of relationships and integrated working between health partners, building on the work locally in each Place and the collaborative health groups across the system, including: JCCCG, Committees in Common, Mental Health Alliance 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.

Integrated Assurance Committee

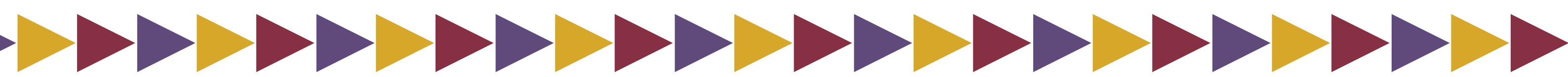
Provides assurance to the partners and to regulators on the performance, quality and financial delivery of health and care services within the five Places and across the System in South Yorkshire and Bassetlaw.

There are a range of groups where partners come together at a System level. It gives both space and focus for partnership working amongst NHS partners and NHS partnership working with Local Authority colleagues and key stakeholders.

The ICS governance works alongside the governance of our statutory organisations (eg. NHS Foundation Trusts, NHS Clinical Commissioning Groups, Local Authorities), that which operates in Place (eg. Health and Wellbeing Boards, Overview and Scrutiny Committees, CCG and Local Authority Joint Commissioning Committees) and the collaborative forums, regulators and arm's length bodies which operate at a System level (eg. Joint Committee of CCGs, Acute Hospitals Committees in Common, Joint Health Overview and Scrutiny Committee, Mental Health Alliance and the Combined Authorities).

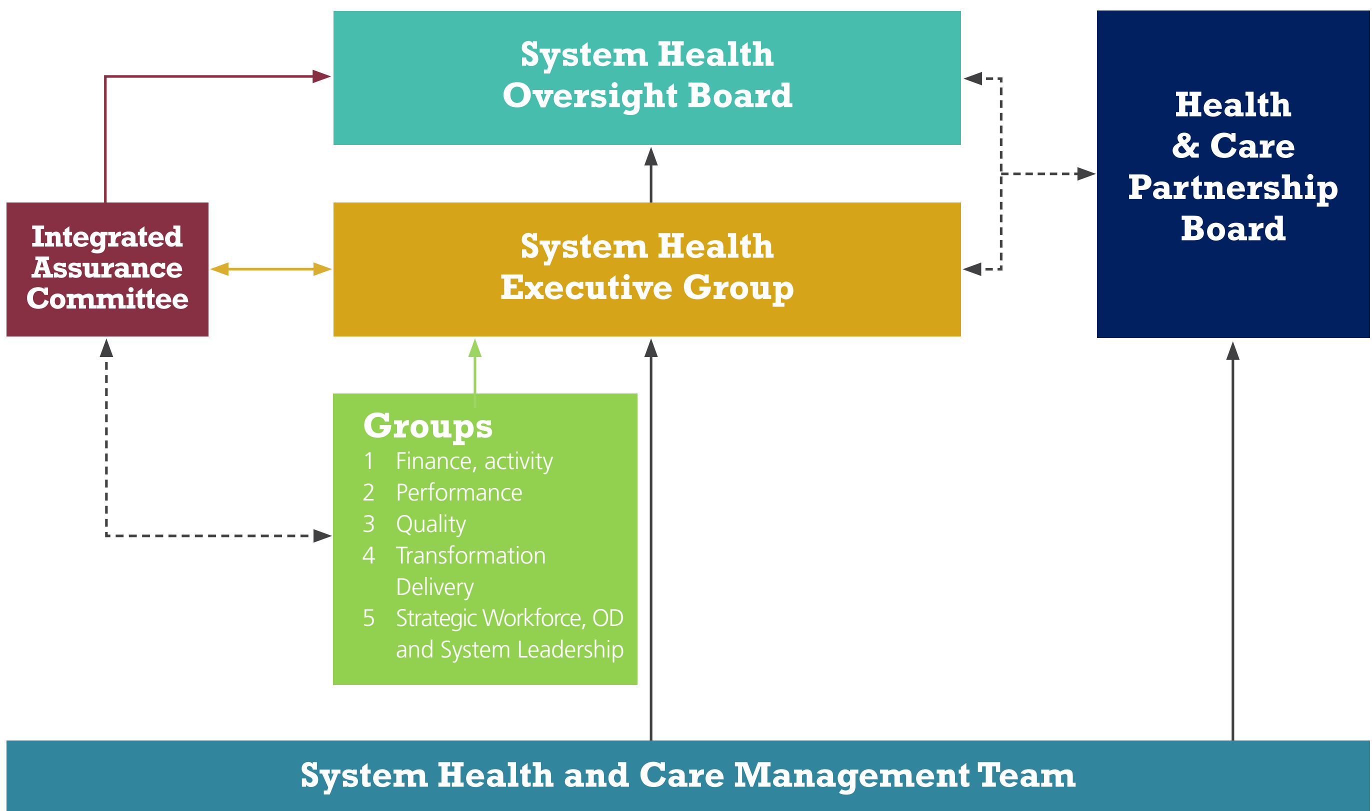
KEY

- Working relationship (dashed dark grey line)
- Accountable to (solid dark grey line)
- Accountable / escalation to (maroon line)
- Report to / assurance to (gold line)
- Report to (green line)



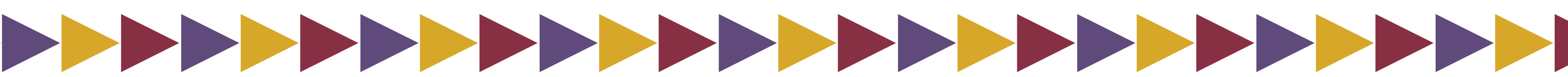
Places

CCG Governing Bodies	Trust Boards	CCG & LA Joint Commissioning Committees	Health & Wellbeing Boards	Councils
Barnsley	**Bassetlaw**	**Rotherham**	**Doncaster**	**Sheffield**
Neighbourhoods 6	Neighbourhoods 3	Neighbourhoods 6	Neighbourhoods 5	Neighbourhoods 15



Regulators, ALBs, Collaborative Forums

NHSE, NHSI, PHE, HEE, CQC	Joint Committee of CCGs (JCCCG)	Acute Hospitals Committees in Common (CiC)	Joint Health Overview & Security Committee of CCGs (JHOSC)	Mental Health Alliance (MHA)	Combined Authorities (CA)



Plan on a Page

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. We are:

1 System

5 Places

36 Neighbourhoods

30 Primary Care Networks

3 Life Stages

- Starting well
- Living well
- Ageing well

4 Themes

- Developing a population health system
- Strengthening our foundations
- Building a sustainable health and care system
- Broadening and strengthening our partnerships to increase our opportunity

1
System Plan

5
Place Delivery Plans

5
Focus Areas

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

5
Outcomes

We want people in South Yorkshire and Bassetlaw to:

- Live longer and have healthier lives
- Live full, active and independent lives
- Have their quality of life improved by access to quality services
- Be actively involved in their health and their care
- Live in healthy, safe and sustainable communities

7
Commitments to improve population health and reduce inequalities

- **Smoking in pregnancy**
  Reduce the percentage of women in SYB who are smoking at time of delivery to 6% by March 2024
- **Smoking in adults**
  Reduce percentage of adults in SYB who smoke to below 10% by March 2024, 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
- **Early death from cardiovascular disease**
  Reduce premature mortality from cardiovascular disease, improving fastest in the areas with highest deprivation and closing the relative gap between SYB and England to 10% or less by 2024-26
- **Life expectancy**
  Reduce the life expectancy gap between people with severe mental illness and learning disabilities and the general population
- **Suicide rate**
  Reduce suicide rates across SYB of 5% year on year up to 2024 (nb rebase in 2017/19)
- **Cancer survival**
  Improve 1 year cancer survival rates to 79% by March 2024
- **Cancer early diagnosis**
  Increase the percentage of people with cancer who are diagnosed at stage 1 and 2 to 58% by March 2024

During the next five years.....

Local partnerships focusing

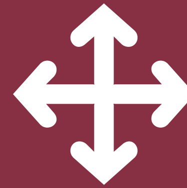
...on delivering together in an integrated way

Planning together as a System

...taking decisions together as a System and prioritising funding as a System

Trust and NHS Foundation Trusts

...working in new and innovative ways



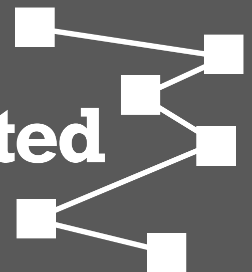
Shift resources to support prevention and reducing health inequalities

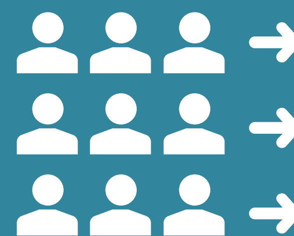
Roll out the Healthy Hospitals programme (starting with **QUIT**) and progress plans to reduce obesity and alcohol related admissions

Establish basic digital capabilities for integrated health and care and enhance the use of information and capabilities to digitally enable citizens, professionals and the System

Increase screening and provide more diagnostic services for people with suspected cancers

Set up and develop Hosted Networks





Design and set up a digital outpatient transformation programme

Detect and improve cardiovascular disease treatment, including rehabilitation

Set up public events to support the **Guiding Coalition** and develop an online membership database

Develop and align our workforce plan

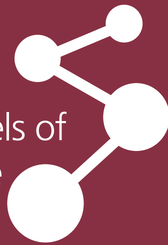
to the national People Plan to include training development and education, engagement with schools and recruitment and retention

Implement Better Births

with Local Maternity Systems, including reducing smoking in pregnancy and delivering continuity of carer

Develop Primary Care Networks

so that they can provide new models of care and integrate teams to include social care and the voluntary sector



Expand access

to the national diabetes prevention programme

Improve access

to pulmonary rehabilitation for people with respiratory disease

With voluntary sector partners

co-design a new engagement framework and invest in their infrastructure and support

Roll out mental health support teams

for children and young people, 24/7 adult mental health crisis resolution and home treatment teams, expand IAPT services and support people with learning disabilities and autism

Provide same day emergency care

get rid of handover delays in emergencies

and embed clinical advice in the **NHS 111 service**

Support people

to live and age well in their community

Set up an Innovation Hub

Get the most out of being ‘anchor’ institutions

and work together with Local Authorities and the Sheffield City Region to increase physical activity and peoples’ social connectedness

South Yorkshire and Bassetlaw
Integrated Care System

Thank you for reading.

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