



Health and care in South  
Yorkshire and Bassetlaw

## **Sustainability and Transformation Plan**





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# Foreword

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Our Sustainability and Transformation Plan (STP) builds on strong partnerships already in place across South Yorkshire and Bassetlaw with a reputation for delivering long term improvements to health and care for our local population.

## **Our ambition is simple:**

We want everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and live longer.

Our STP is the culmination of a wide range of local organisations, patient representatives and care professionals coming together to look at how we collectively shape our future care and services.

This strong community of stakeholders is passionate, committed and realistic about the aspirations set out in this document.

Our thinking starts with where people live, in their neighbourhoods, focusing on people staying well. We want to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we are better at meeting people's needs.

We want care to flow seamlessly from one service to the next so that people don't have to tell their story twice to the different people caring for them, with everyone working on a shared plan for individual care.

Prevention will be at the heart of everything we do – from in the home to hospital care. In line with the GP Five Year Forward View priorities, we plan to invest in, reshape and strengthen primary and community services so that we can provide the support people in our communities need to be as mentally and physically well as possible.

For example, preventable mortality rates from such things as cancer and heart disease are higher in South Yorkshire and Bassetlaw than the national average. We will therefore target smoking, inactivity and obesity in our population to prevent future illnesses developing and empower people to take control of their own lifestyles and wider health needs.

Mental health will be integral to our ambitions around improving population wellbeing. We will put services in place to support individual needs and in the most appropriate settings by transforming services and focusing on early education and prevention.

At the same time, we agree that everyone should have improved access to high quality care in hospitals and specialist centres – and that no matter where people live they get the same standards, experience and outcomes for their care and treatment. Key to this success will be developing innovative, integrated and accountable models of care and building on the work of the Working Together Partnership Acute Care Vanguard. This will ensure care is provided in the right place, at the right time and by the most appropriate staff.

Developing a networked approach to services across South Yorkshire and Bassetlaw, will improve the quality and efficiency of services for our patients, in areas such as maternity services and will simplify the urgent and emergency care system so that it is more accessible.

By also focusing on other factors affecting health including education, employment and housing, this will not only improve the health, wellbeing and life chances of every person in our region but it will help us deliver a more financially sustainable health and care system for the future.

The development of our STP so far has seen all our partner organisations come together to co-create our vision and commit to the ambition of truly improving the health and wellbeing of our combined 1.5 million population. We now want to broaden this and strengthen our work further. By engaging our local people, our workforce of over 74,000 and our associate STP partners in neighbouring regions, we believe we can create a vibrant, successful and healthy South Yorkshire and Bassetlaw.

*Andrew Cash*

**Sir Andrew Cash**

STP lead, South Yorkshire and Bassetlaw,  
Chief executive, Sheffield Teaching Hospitals  
NHS Foundation Trust

See page 48 for our full list of partners.



# Chapter 1

## The South Yorkshire and Bassetlaw context

### Summary

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**There have been some big improvements in health and social care in South Yorkshire and Bassetlaw in the last 15 years. People with cancer and heart conditions are experiencing better care and living longer, and people are more satisfied with their health and care services. We are proud of our local services and the huge progress we've made.**

However, people's needs are changing, new treatments are emerging, the quality of care is variable, and preventable illness is widespread.

We believe that to improve care for people, health and care services need to work more closely together, and in new ways.

By working in this way, we will also be able to contribute to the region's economic growth, by helping people to get into and stay in meaningful, sustained work. As well as supporting their health and wellbeing, this will help to keep South Yorkshire and Bassetlaw economically vibrant and successful.

Along with health and care services across the country, we face financial pressures and our hospitals and other organisations are struggling to balance their books. There is a range of causes for this, including rising demand for care among our population and that many people now often have more complex health conditions, such as obesity and heart disease, which require more complex treatment.

Extra money has been provided for our NHS organisations but we still estimate a gap of around £579 million in the next four years. We need to find new and better ways to meet the needs of local people and do things more efficiently and with less waste. This doesn't mean doing less for patients or reducing the quality of care. Rather, it means more preventative care, and bringing care into communities and closer to home.

We can only make improvements if we all work together. This means patients, the public, carers, GPs, hospitals, local councils, commissioners, universities, and a whole wider range of organisations working in the public, private and voluntary sectors all joining together to agree a plan to improve local health and care services.

## Our ambition

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**“Our goal is to enable everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and to live longer.”**

A long history of collaboration and working together to improve health and care for the people of South Yorkshire and Bassetlaw has given us a solid foundation to develop our Sustainability and Transformation Plan (STP).

We have built on existing relationships to quickly develop our partnership, where we can all see the opportunities and are motivated to deliver significant improvements for our population.

We have a strong community of stakeholders, including more than 10,000 voluntary sector organisations, 208 GP practices, five local authorities, five clinical commissioning groups, five acute hospitals, two of which are integrated with their community services, two associate acute hospital trusts, four mental health providers, five Healthwatch organisations and two ambulance services. We are also working closely with our STP associate partners in West Yorkshire, North Derbyshire, Nottinghamshire and Humber, Coast and Vale. We employ 74,000 staff across health and social care and oversee £3.9bn public funds

Our thinking starts with where people live, in their neighbourhoods focusing on people staying well. We want to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we are better meeting the health and care needs of people. We want care to flow seamlessly from one service to

the next so people don't have to tell their story twice to the different people caring for them, and everyone is working on a shared plan for individual care.

Prevention will be at the heart of everything we do – from in the home to hospital care - supported by our plans to invest in, reshape and strengthen primary and community services. We want to help people in our communities be as mentally and physically well as possible, for as long as possible.

At the same time, we agree that everyone should have better access to high quality care in specialist and hospital centres and units and that, no matter where people live, they get the same standards, experience, and outcomes for their care and treatment. We will do this by working together more closely, by developing a networked approach to services across South Yorkshire and Bassetlaw.

We already benefit from strong partnership working in each of our 'places' – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. Operating across similar geography to South Yorkshire and Bassetlaw, we have three collaborations already: Commissioners Working Together which brings together NHS commissioners across south and mid Yorkshire, Bassetlaw and north Derbyshire; the Providers' Working Together Partnership Vanguard, for NHS providers of healthcare across the same geography; and the Sheffield City Region Combined Authority, which brings together the local authorities of Sheffield City Region. We are also committed to an alliance of the four mental health service providers across the region. Working in this way will enable us to standardise care and bring about change.

We will need to make significant changes between now and 2021, and beyond. We want to have conversations with our staff, patients and the public about how we can do this. Together, we will shape our thinking around what matters to people, focus on keeping the best of what we've already got and putting the changes in place outlined in the plan – creating sustainable health and care for many generations to come.

## Why we need to change

There have been some big improvements in health and social care in South Yorkshire and Bassetlaw in the last 15 years. People with cancer and heart conditions are experiencing better care and living longer. We have also seen improvement in mental health and primary care services. On the whole, people are more satisfied with their health and care services. We are proud of our local services and the huge progress we've made.

However, people's needs have changed, new treatments are emerging, the quality of care is variable, and preventable illness is widespread.

### **We want to improve the quality of care people receive**

We know that quality, experience and outcomes do vary and we know that care is often disjointed from one service to another because our hospitals, care homes, general practices, community and other services don't always work as closely as they should.

In addition, there are some people admitted to hospital beds who could be cared for in the community if the right support was in place. There are growing waiting times for many services and access to primary care needs to be improved.

We have some good Care Quality Commission feedback for our organisations but we also know there are areas for improvement. And we also know that people want their health and care support and treatment in a place and at a time that is right for them. For many, this means care that is provided at home, or closer to home, and not in a hospital.

Equally, there are times when hospitals are the only place the only place where people can get the care that they need and we want to make sure that people can access equally good hospital based care when they need it.

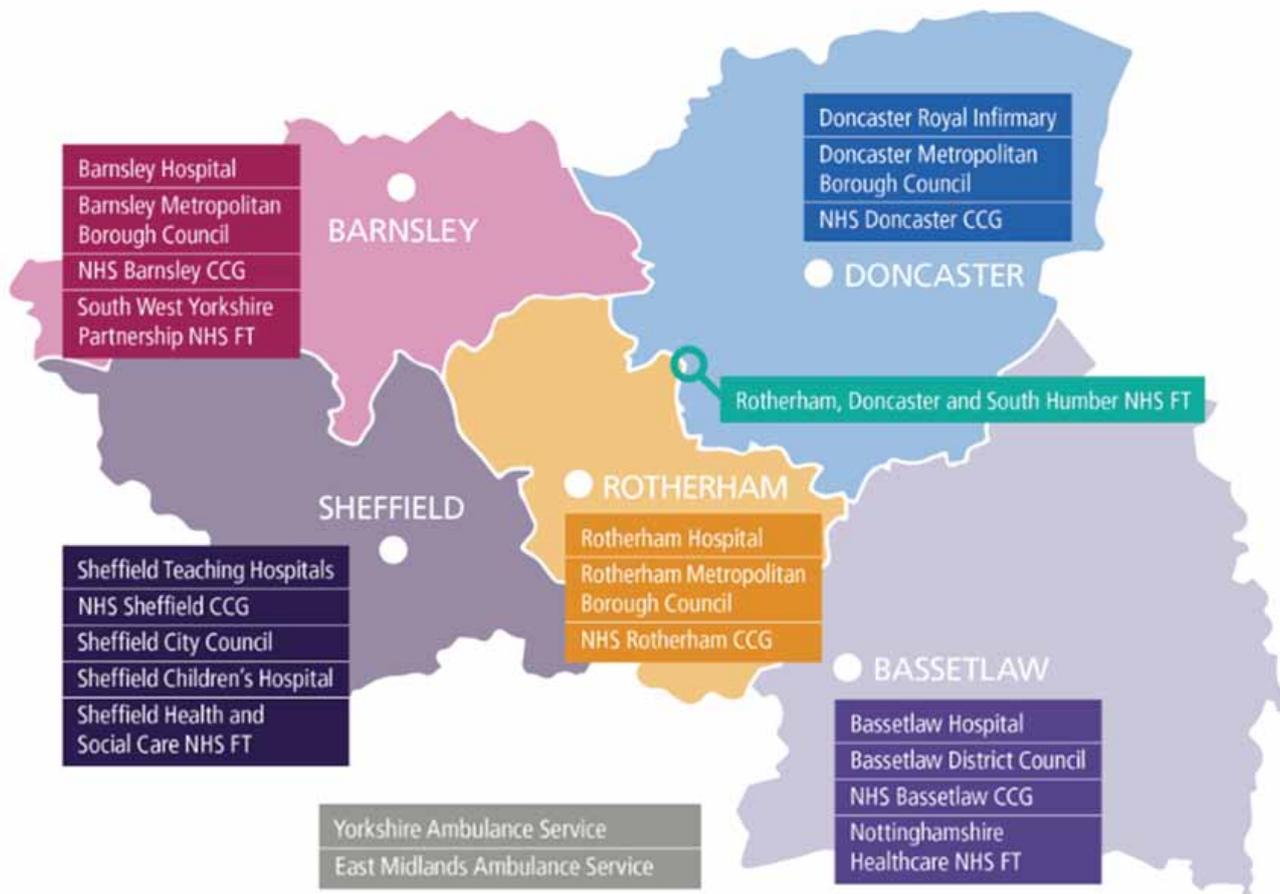
We want the same quality of service for people, as close to them as possible. Doing this jointly means a better solution for everyone – whether people live in Staveley, Shafton, Sharrow or Shireoaks.

### **We want to improve health and wellbeing for everyone**

In South Yorkshire and Bassetlaw, people are living longer, but we have high levels of deprivation, unhealthy lifestyles and too many people dying prematurely from preventable diseases and there are significant inequalities across the region. In areas where deprivation is high, access to services is variable and outcomes can be worse than other areas.

### **We have worse than the national average rates for:**

- Child poverty - the level of childhood poverty remains significantly higher than the national average and this gap is widening
- Mental health - high excess under 75 mortality rate in adults with serious mental illness
- Preventable mortality - we record higher than average deaths in people under the age of 75 years from cancer and cardiovascular disease
- Smoking, physical inactivity and obesity
- Smoking during pregnancy - the proportion of mothers smoking at the time of the birth of their baby is consistently higher than the national average
- Teenage conceptions - teenage conceptions are higher than the national average
- Alcohol related admissions to hospital - we record a higher than average rate of admissions



Poor eating habits can lead to weight gain, which in turn can result in serious complications like type 2 diabetes. Smoking and alcohol consumption, which are particular issues in our region, are obviously harmful and increase the risk of cancer. We also know that there are higher than average deaths in people under the age of 75 from cancer, heart disease and serious mental illness.

Our levels of childhood poverty are significantly higher than the national average and the gap is widening. We also have significant deprivation and inequalities, with a difference in healthy life expectancy of more than 20 years across our area – and we have higher than the national average of teenage conceptions and mums smoking during pregnancy. We also know that people who have mental health issues have less chance of living well and for longer.

Many of these can be prevented by different lifestyle choices and keeping a check on our health and caring for our mental and physical health.

Our health and care services want to support people more to do this – by making it easier to get expert advice and to access free healthy living schemes. We also want to support people to connect with and develop local links and networks in their neighbourhoods, building trust and understanding across communities. And we know that starting well and living well helps people have a better education and are more likely to find employment and stay employed. The simple fact is that a healthier population is a happier population – one which relies less on the NHS and other care services to treat problems that could have been prevented.

**We want to ensure our services are efficient**

Along with health and care services across the country, we face financial pressures and our hospitals and other organisations are struggling to balance their books. There is a range of causes for this, including rising demand for care among our population and that many people often have more complex health conditions, such as obesity and heart disease, which require more complex treatment.

## **Investing in our primary care workforce**

Despite a rise in the number of GPs over the last 10 years, many practices face problems with recruitment and a number of older medical and non-medical staff preparing to retire in the next five years.

Each of our areas is developing a workforce strategy to increase the overall number of staff, as well as developing existing staff and their skills to support and enable delivery in line with our primary and community service ambitions.

Extra money has been provided for our NHS organisations but we still estimate a gap of around £571 million in the next four years. At the same time, social care services have seen a significant drop in funding. We believe there's more we can do to alleviate some of the financial pressures over the next four years. We need to find new and better ways to meet the needs of local people and do things more efficiently and with less waste. This doesn't mean doing less for patients or reducing the quality of care. Rather, it means supporting people to stay well, bringing care into communities and closer to home.

As things stand, if we do nothing, our health and care setup faces an estimated shortfall of around £571 million by 2021. The 'gap' is our view of the difference between the increasing demand for services, the costs of health and care need in the future and the funding that will be available. The way we are organised is out of date and out of sync with how people live their lives. We need to totally rethink how health and care is delivered.

### **We want to develop and support our staff**

Developing and supporting our staff is central to achieving these ambitions. We need the right people, with the right skills in the right place and at the right time – whether this is in general practice, the community and neighbourhoods or in hospitals.

In some areas, there is a national shortage of clinical staff. Indeed, we are already proposing changes to how we provide hyper acute stroke services and some children's surgery in our region because these shortages are having an impact locally.

We want healthcare professionals, such as GPs, to focus on doing the work that only they can do. We can then look at how we integrate and improve local community teams.

We will need to support our workforce, developing ways of working that help people to live healthy lives in their homes and communities and supporting GPs to be as effective as possible. We will connect with our education partners to develop a regional centre of excellence for skills and create flexible career pathways. We will also develop a specialist training programme for nurses and therapists aligned to new ways of working across health and care.

We envisage a flexible workforce that comes together in neighbourhoods, communities and within hospitals to offer people the best and most appropriate care.

## Reforming our services

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To make sure we have truly joined up health and care that gives everyone a great start in life and supports them to stay healthy and live longer, we need to rethink how we invest in, plan for and deliver our services – and how we ourselves are arranged and set up to do to so.

We have a history in South Yorkshire and Bassetlaw of strong partnership working which we will build on, keeping successful local programmes in place and expanding on and sometimes implementing them across the region. We really want to address the challenges facing our health and care services and improve the health and wellbeing of our population. In Rotherham there is a successful 'social prescribing' service where GPs and community nursing teams work with voluntary services and signpost people towards non-medical support for people with long term conditions when it's appropriate and as a result, has reduced the number of people going to A&E, making out of hours appointments and being admitted to hospital.

We have a unique opportunity to improve our services – we will invest more into primary and community care to help people stay well and be independent for longer, support people most at risk of ill-health and will take the same approach and have the same standards everywhere – ensuring everyone has access to high quality local services and ultimately reduce people's needs for hospital and specialist care in the future.

Working together in new ways and with new models of care will enable us to focus on keeping people well for longer and empower our population to take control of their own health, as we want to do with our own system.

Our clinical commissioning groups are already coming together to develop strategic commissioning ambitions across South Yorkshire and Bassetlaw and, based on reviews and cases for change, are leading proposals to improve the provision of hyper acute stroke services and children's surgery and anaesthesia across the region. Commissioning in this way will also expand to other hospital services, as required.

All our hospitals have committed to carrying out an independent review of their services as part of wider work, looking at access, standards and quality which will inform new models of care.

By 2021 we will have well developed, integrated commissioning between health and care, leading to strong accountable care in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.



## Our journey to accountable care

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### What is an accountable care organisation?

An accountable care organisation (ACO) is a group of providers, under one contract with a commissioner which has accountability for all care and outcomes for a population for an agreed period of time.

An ACO may take on a variety of organisational forms, however typically it is expected that in order for an ACO to be truly “accountable” for the delivery of both quality and cost outcomes, they need to work to a minimum population size of at least 10,000 patients and operate as a distinct legal entity.

Population focus may be defined by a number of factors including geography, patient profiling, disease groups or age. There are ACO models, developing nationally, and internationally.

### What is an accountable care system?

An accountable care system takes accountability for the delivery of care and care outcomes for a defined population and geography within an agreed budget. In doing so it designs and delivers services to best meet the needs of its population and improve health and wellbeing outcomes. Accountable care systems take many different forms, ranging from fully integrated systems to looser alliances and networks of hospitals, medical groups, and other providers.

### Overview of South Yorkshire and Bassetlaw:

Our local places – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield - are developing their thinking around what accountable care means to them and their partners. Relationships are well developed between partners, which is creating environments where new models of care can be developed, tested and implemented at pace. New models of care will be focused on broad integration of services to best meet the needs of the local population.



# Chapter 2

## Our Journey

### Our approach

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5 local authorities

5 clinical commissioning groups

208 GP practices

835 GPs

10,000+ voluntary sector organisations

6 acute hospital and community trusts

1 associate hospital trusts

4 care / mental health trusts

2 ambulance trusts

£3.9 billion total health and care budget

1.5 million registered population

74,000 staff across health and social care

37,000 non-medical staff

3,200 medical staff

Plus neighbouring STPs:  
Derbyshire,  
Nottinghamshire,  
Humber, Coast and Vale  
and West Yorkshire

We have built on existing relationships to quickly develop a strong partnership, where we can all see the opportunities and are motivated to deliver significant improvements for our population.

Our approach is collaborative and we are agreed about our leadership and style. We have engaged more than 250 leaders and executives while also collaborating with our associate providers, commissioners and STP leaders in West Yorkshire, Humber, Coast & Vale and Derbyshire. We have also connected with Healthwatch, colleagues from the voluntary sector and the public.

'Place' provides the cornerstone of the plan, together with eight overarching strategic priorities. By place, we mean all our component local areas – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

Each place has engaged throughout with local partners, including faith, voluntary, patient and community groups and Healthwatch around their local 'place' plans. We have also involved voluntary sector organisations and Healthwatch in our guiding coalition events and they have a seat around the table at the executive steering group and interim governance that starts in November 2016.

Our approach to governance allowed our plan to develop at pace while making strong connections and alignment across all leaders and stakeholders. The interim governance approach has been as follows:

- STP guiding coalition – two South Yorkshire and Bassetlaw system wide events shaping and consulting on the plan
- STP executive steering group – all local authority and trust chief executives and clinical commissioning group (CCG) accountable officers meeting fortnightly and also as part of a two day discussion forum

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- STP executive coordinating group – STP lead, plus accountable officer representatives from CCGs, chief executive representatives from trusts and local authorities and the workstream leads met weekly to take the plan forward

Central to the plan's development was the setting up of an STP programme office; bringing together the commissioner and provider Working Together programmes, along with local authorities. The STP programme office worked with the workstream leads to establish the main priorities and to show how South Yorkshire and Bassetlaw would meet the three aims of the Five Year Forward View and create a long term sustainable health and care system for the population.

We plan to consult widely with staff, the public and our stakeholder on our strategic plan in Winter 2016.

## Population health outcomes

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Although people in South Yorkshire and Bassetlaw are now living longer, we know that we have a number of issues that are not as good as they should be when comparing ourselves to similar regions and the national average.

These include:

- Poverty, poor housing and unemployment
- Smoking, physical inactivity and obesity
- Smoking during pregnancy
- Teenage conceptions
- Alcohol related admissions to hospital
- Cancer and heart disease
- Adult mental illness

The majority of these issues and illnesses can be prevented. We will therefore aim to help people early on and prevent future problems developing in a number of ways.

We will change the way we invest in services to help the thousands of people across our region who are long-term unemployed – working with them, and with employers, to increase the number of people who get into and stay in sustained, meaningful work.

We will also invest in primary and community services, making sure that the areas and people who need help the most have easy access to care and support. This will mean changing the way we invest to help people stay well for longer.

Our aims are based on what we know of our people and their health and care but we will also engage with patients and the public across our region to find out what they would also like to see and change.

We will also develop a South Yorkshire and Bassetlaw Healthy Lives programme, delivered locally to improve people's health and achieve the following:

- A reduced gap in healthy life expectancy by 5 years from an average of 20 to 15 years
- 25% less people being admitted to hospital, visiting their GP and needing medication for heart disease and strokes for all 15-64 year olds
- 15% less people being admitted to hospital, visiting their GP and needing medication for all other conditions
- More than halve the number of teenage pregnancies (under 18 years old) from 31.9 to 12 per 1,000 women by 2021
- A reduced number of children and young people between 5 and 15 years old who develop a clinically diagnosable mental health disorder

## Health in its wider context

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### Other factors affecting health

People's health is shaped by a whole range of factors – from our lifestyle and family backgrounds to the physical, social and economic environment around us. At the same time, NHS services tend to focus on treating people who are unwell.

We all agree that being healthy is about more than just providing health services for people who are unwell. It's about taking the 'wider' factors into account. In fact, addressing these factors is even more important if we are to achieve a sustainable health and care system. We know that around 80% of health problems could be prevented and around 60% are caused by the other factors.

In our plan, we focus on keeping people well and slowing or stopping diseases and recognise that how we plan and provide health and care services must take the wider factors into account. These are:

Socio economic status - people who earn less or who don't work tend to have far worse health outcomes, lower life and lower healthy life expectancy than those who earn more. All the places in our plan – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield - are more deprived than the national average.

Employment – people who have jobs generally have better health. Around 5% of the national population age 16 to 64 is unemployed. In South Yorkshire and Bassetlaw, this is around 7%, reaching up to 9% in one of our areas. The proportion of 16 to 18 years olds not in education, employment or training is significantly higher than the national average in some of our 'places'.

Housing – poor housing can cause or add to many avoidable diseases and injuries. Cold homes are behind many winter deaths - through exacerbating circulatory conditions and worsening of other conditions, including dementia and Alzheimer's.

'Non decent' homes – 'Non decent' homes are below the legal minimum standard for 'reasonable' heat and repair.

Access to green spaces – people who are near, or use, parks, gardens and the countryside generally have better mental health. Being able to exercise or just be in outdoor space in our areas is in line with the national average.

Social relationships / communities – studies show that social relationships, individual or in communities, are important when it comes to getting better or not getting unwell in the first place. Adult social care users in Rotherham and Doncaster are below the national average for social contact.

### Public service reform

Improving our population's health and wellbeing, the quality of care they receive and doing things more efficiently and with less waste means we need to think ambitiously and beyond just our health and care services. It means looking at the connections between the £11 billion of public money that is spent in South Yorkshire and Bassetlaw and the £3.9 billion that is focused on health and social care.

It means re-imagining, re-designing and re-forming our public services and public budgets to improve the health and wellbeing of our population. This includes thinking about how public services can be a part of raising awareness of and contributing towards helping people take control of their health. It also includes helping to manage the demands on our services.



We will make significant efforts to give control back to people who are long-term unemployed, supporting them to get and stay in work.

This will include:

- Personalised support to get people into work with ongoing, individual support to help them when they have a job and putting in place new referral routes with better ways to access health support for people out of work, and those who are in work but at risk of long-term unemployment
- A more coherent way of supporting young people who might be vulnerable facing issues such as not being in education, employment or training, recently leaving care, homelessness, substance misuse, mental ill-health
- Improving our investment in primary care so that we can better manage people's needs, with primary care rooted in local 'neighbourhoods' and working closely with schools and wider education
- Developing other local 'wraparound' services, including local voluntary organisations alongside health and care support, for example, debt advice, housing advice, employment support and independent living support.
- Adopting much more of a keyworker approach for people who need extra help, making sure that people can access the right support, in the right order and do whatever they can so that they are in more control of their health and wellbeing
- Making sure we're structured in the best way to be effective to respond to people's needs
- Exploring different financial arrangements so that we can be reassured that we are making our money work to better effect to achieve the outcomes we want
- Reviewing what we know, looking at best practice in other areas and predicting changes so we can continually make improvements and develop our services

## Our priorities and key enablers

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During the start-up phase of our STP we were clear about the priority areas we wanted to focus on and what should be done at what level – whether this be within each neighbourhood, place, across the STP region or across Yorkshire and the Humber as a whole. We also set up five major cross cutting themes that we felt were essential to delivery and covered workforce, digital and IT services, procurement and estates, finance and wider public service reform.

We recognise that we have a strong record of collaboration but can sometimes lack pace around decision making and implementing change. This helped our focus on governance - both as part of the process for developing the STP and also how decisions would be taken at the right level for implementation.

We put a lot of thought into the areas we wanted to prioritise, thinking about how we can work with staff, stakeholders and the public to be innovative and, where needed, radical about possible solutions. We recognise there would be a significant amount of work to do to move from a working hypothesis to a fully thought through and detailed plan for change and as such, have identified the risks that could impact on our ability to achieve our collective ambition.

**Healthy lives, living well and prevention** will be at the heart of everything we do. Supported by our plans to reshape and strengthen **primary and community care** services we want to help people in our communities be as mentally and physically well as possible, for as long as possible.

Around 25% of the population experiences some of kind of mental health problem in any one year. We know that people with severe mental illness can lose 20 years of life and have worse health outcomes. By our strengthening of community based services, within people's own neighbourhoods and expanding such things as social prescribing, we aim to support people who have, and are at risk of developing, poor mental health before the need for clinical interventions.

### Improving psychiatric services in hospitals

At the moment, patients admitted to hospital often don't have their psychological wellbeing assessed alongside their physical health - meaning mental illness can sometimes go undetected and untreated. Alongside improved mental health services in the local community, we aim to adopt a similar approach to a successful model in Birmingham (RAID) so that everyone in hospital has access to a team with psychiatric expertise and specialist mental health training which, we expect, will reduce the number of re-admissions by 1,800 over 12 months.

By having a strong local focus on **mental health and learning disabilities**, we hope to remove the stigma around it and promote the healthy wellbeing – both physical and emotional – of everyone in South Yorkshire and Bassetlaw.

By strengthening primary and community care in local neighbourhoods and communities and reviewing what we currently offer in **urgent and emergency care** services, we feel we can better plan and deliver these services.

The increasing complexity of some patients who come to our region's accident and emergency (A&E) departments, combined with the high numbers of visits and the confusion about alternative options for people in local communities again highlights our pressing need to invest in primary and community services. Similarly, people end up in hospital when they don't need to and, because their needs are around social not health care and there aren't always services or care and nursing homes immediately available, they can get 'stuck' in hospital. By providing effective, easily accessible and joined up care closer to home we hope to reduce the number of people attending A&E, feeling it is their only option or ending up in hospital unnecessarily - which will in turn reduce the current pressure and demand on our hospital staff and services.

Alongside investing in primary and community care, we have also committed to an independent review of our hospital services across South Yorkshire and Bassetlaw.

We also need to further understand what we do well, what we could learn from and what could be improved by working better together, such as **elective and diagnostic services**, so that when people need specialist care that can't be delivered in the community they will have access to the best and most effective services to get them better quickly.

Having healthy neighbourhoods will help to give the region's children the best possible start in life – ultimately helping us to strengthen our maternity and children's services across all levels of care. Currently, our children's and maternity services are under significant pressure with the ways in which we provide services no longer being sustainable. There is a national shortage of specialist paediatric staff, which, coupled with rising demands and needing to meet higher national standards, tells us we need to reshape our **children's and maternity services** across South Yorkshire and Bassetlaw. From community based care to the more specialised and hospital services we have in our region, we want all our children to have the best start in life, local support to stay healthy and more specialist care available should they need it.

An ageing population and a rise in lifestyle risks means that the number of people being diagnosed with **cancer** is increasing. This, combined with the 14,000 people being treated each year in South Yorkshire and Bassetlaw being set to rise by 18,000 by 2030, highlights a further need for our focus on neighbourhoods and prevention. Through education, local community-based support and promotion of healthy lifestyles we aim to reduce people's risk of developing cancer in the first place, meaning they won't have to undergo stressful and complex treatment and have less need for specialist hospital care in the future.

We also think that **spreading best practice and collaborating on support services**, such as our estates, procurement and pharmacy management, will enable us to meet some of the delivery and efficiency challenges we face. Technology and digital integration will also play a major role in helping shape the future of health and care services.

Chapter 4 sets out our ambitions in more detail.

# Chapter 3

## Developing and delivering the plan and agreeing how we make joint decisions

### Principles of the plan

Our plan has so far seen all our partner organisations come together to co-create our vision and commit to the ambition of truly improving the health and wellbeing of our combined 1.5 million population.

Our plan is about working together even better, and in new ways with new models of care.

We aim to bring about financial sustainability through our plan. We plan to buy health, care and support services together, at first across our priority areas but increasingly across all services.

We aim to provide the high quality outcomes and experiences in our services within our resources.

We are imaginative in our approach and use evidence and best practice to rethink and reshape our services.





## Developing the plan

Our STP is built on a history of strong relationships and being able to quickly develop a strong partnership, where we can all see the opportunities and are motivated to deliver significant improvements for our population.

Our plan is built from five place plans which have all involved a wide range of stakeholders.

### Place plans

We have based our plan on our five 'places' – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

Their plans are the foundation of what will be delivered in their area and they set out how the improvements from the new ways of working and prevention will be made. The plans focus on investing in primary and community care so that we are putting our greatest emphasis on helping people in their neighbourhoods and managing demand on services.

The place plans also hone in on improving health and wellbeing and the other factors that affect health, such as employment, housing, education and access to green spaces.

### Workstream plans

Work on our places won't alone address the challenges we face and so we are also focusing on eight priorities:

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities
- Urgent and emergency care
- Elective care and diagnostics
- Maternity and children's services
- Cancer
- Spreading best practice and collaborating on support services

## Agreeing how we work and take decisions together

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To successfully implement our plan and deliver the change that is required for South Yorkshire and Bassetlaw, the statutory organisations involved in health and social care have formally agreed to interim governance arrangements to enable us to start to work and take decisions together.

This interim governance will remain in place until April 2017 during which time we will undertake a review to establish the right governance, learning from those who are already advancing delivery of system plans. This approach will enable us to establish integrated leadership and working founded upon collaboration and evidence-based decisions about services delivered to South Yorkshire and Bassetlaw people.

Commissioning will be undertaken in accordance with statutory responsibilities at locality level or when it is most appropriate, by commissioners collaborating at South Yorkshire and Bassetlaw level through joint strategic commissioning arrangements and part of a regional function.

Our governance system is based on the principles outlined in the South Yorkshire and Bassetlaw Collaborative Partnership Board terms of reference:

- We will support delivery of the NHS Constitution and Mandate
- Decisions will be taken at the most appropriate level
- We will take decisions that are relevant and appropriate to take at South Yorkshire and Bassetlaw level
- CCGs and local authorities will retain their statutory functions and their existing accountabilities for current funding flows, but will be jointly accountable through South Yorkshire and Bassetlaw financial controls and performance and quality metrics.
- Clear agreements will be in place between CCGs and local authorities that have agreed to work jointly or closer together to deliver services more effectively in each of our places.

- Commissioners, providers, patients and public will shape the future of South Yorkshire and Bassetlaw health and care together
- All decisions about South Yorkshire and Bassetlaw health and social care that improve quality and sustainability are to be taken with South Yorkshire and Bassetlaw as soon as possible

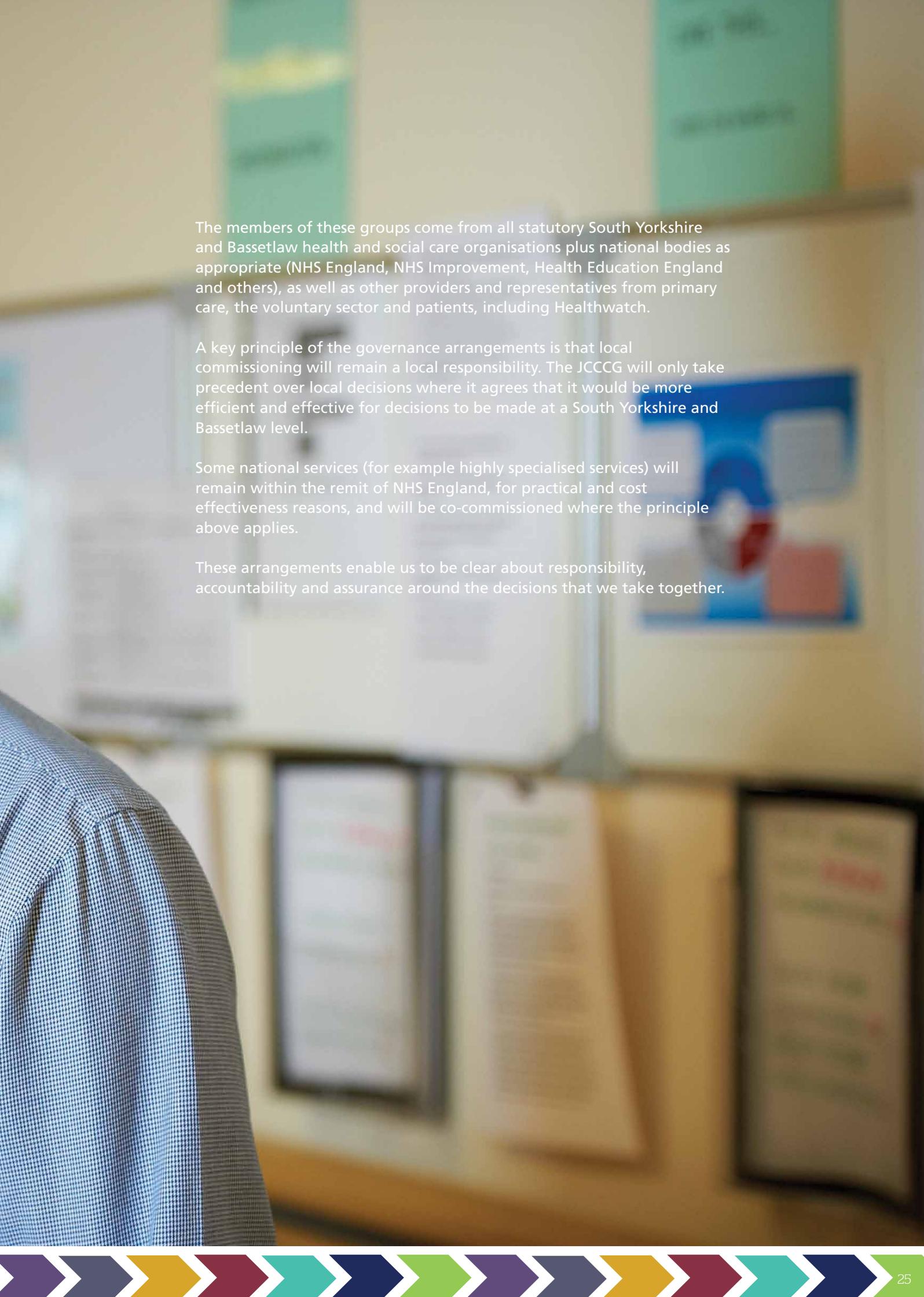
### The new interim governance system has:

- Reshaped current governance arrangements, which will run in parallel with partners' governance and help make decisions.
- A Strategic Oversight Group will provide oversight governance of the Collaborative Partnership Board (CPB).
- A Collaborative Partnership Board (CPB) which sets the vision, direction and strategy for the SYB health and social care economy outlined in this plan
- An Executive Partnership Board (EPB Executive) which supports the CPB and will develop policy and make recommendations to the Board. It will be the engine that drives delivery of the plan and ensures business at the Board is transacted efficiently
- A Joint Committee of Clinical Commissioning Groups (JCCCGs) which commissions services at the South Yorkshire and Bassetlaw level to deliver the vision set out by the CPG. It will produce a commissioning strategy and commissioning intentions in line with the plan. The decisions it takes will be joint and binding.
- An NHS Provider Trust Federation Board where the six acute trusts in South Yorkshire and Bassetlaw have joined together to allow them to work more effectively and efficiently, develop clinical strategy to deliver new models of care.

We are also looking at:

- An overarching Provider Forum which will bring together NHS and non NHS providers (domiciliary providers, private sector health providers, voluntary and hospices) to be part of the development of new models of care
- Primary Care being represented at the CPB and EPB and through the newly formed Primary Care Advisory Group made up of representatives from dentistry, general practice, pharmacy and optometry.





The members of these groups come from all statutory South Yorkshire and Bassetlaw health and social care organisations plus national bodies as appropriate (NHS England, NHS Improvement, Health Education England and others), as well as other providers and representatives from primary care, the voluntary sector and patients, including Healthwatch.

A key principle of the governance arrangements is that local commissioning will remain a local responsibility. The JCCCG will only take precedent over local decisions where it agrees that it would be more efficient and effective for decisions to be made at a South Yorkshire and Bassetlaw level.

Some national services (for example highly specialised services) will remain within the remit of NHS England, for practical and cost effectiveness reasons, and will be co-commissioned where the principle above applies.

These arrangements enable us to be clear about responsibility, accountability and assurance around the decisions that we take together.

# Chapter 4

## Rethinking and reshaping health and care

### Summary

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We know we will not meet the challenges we face over the next four years by making small changes at the edges of our health and care services. At the same time, each of the places in our region cannot achieve the rethinking and reshaping alone. We need to work together, across all our partners, to achieve our ambitions and make a difference to the health and wellbeing of everyone in South Yorkshire and Bassetlaw.

Our current ways of working across health and social care are not meeting the needs of our population or supporting them to prevent illness. We know this will have an impact on future populations.

We want to radically upgrade prevention and self-care and help people to manage their health and look after themselves and each other. To do this, we will need to boost the ways in which we connect with people to help them stay well and also how we detect and diagnose illnesses.

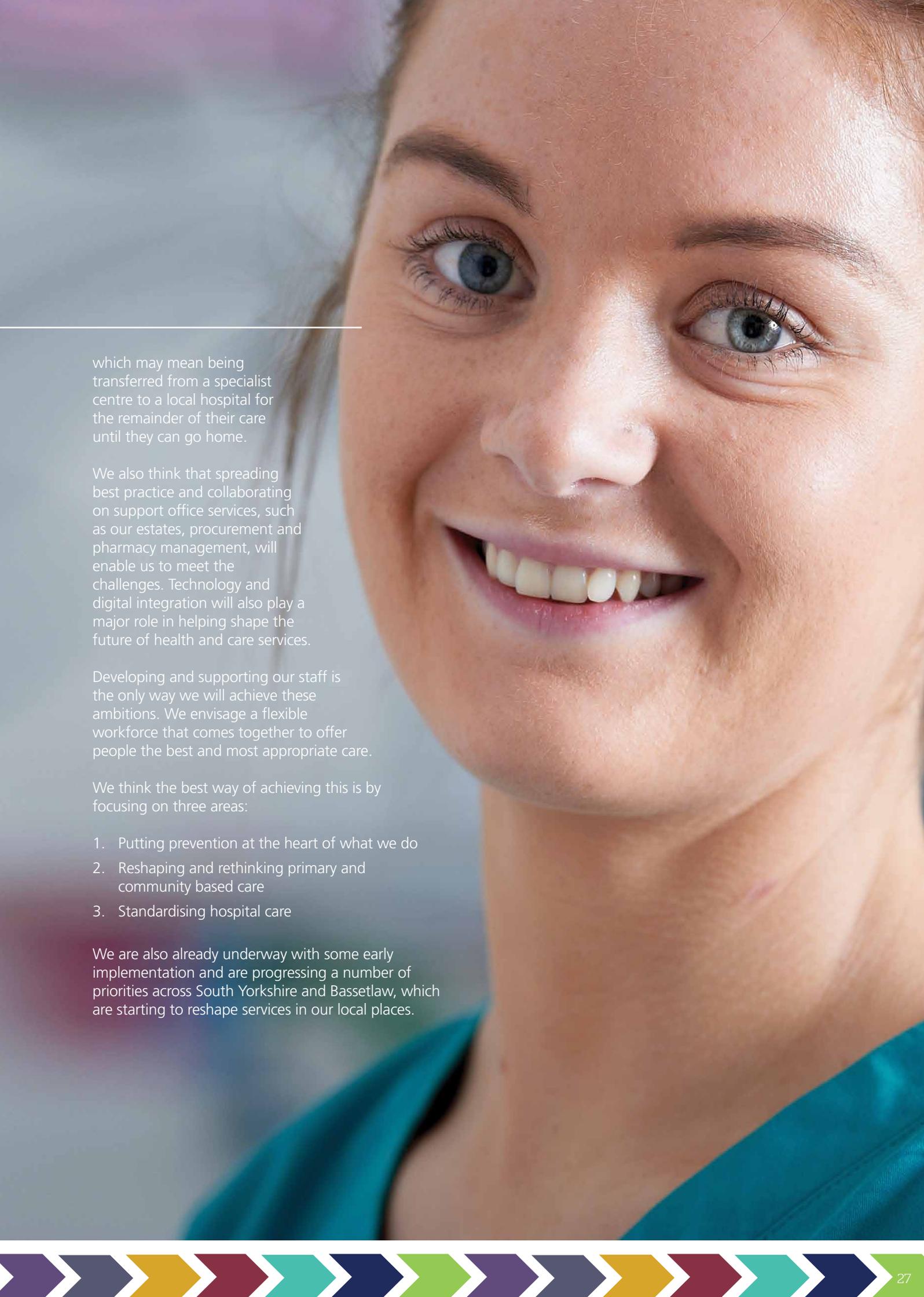
We will transform how we invest in health at community levels. By focusing more on helping people where they live we will also have an impact on people's employment and employability.

Through the transformation of community based care and support we will also improve primary care services, with GPs coming together at the forefront of new ways of working. Through wider GP collaborations, we will be able to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we are better meeting people's health and care needs.

At the same time, we agree that everyone should have better access to high quality care in specialist centres and units and that, no matter where people live, they get the same standards, experience, and outcomes for their care and treatment. We will do this by working together more closely, standardising hospital care and developing a networked approach to services.

A key part of making this successful will be through the way our ambulance and transport services are delivered. Although care will be focused in communities, sometimes people will need hospital or specialist care and sometimes, this will need to be accessed quickly, via ambulance. We will make sure that no matter where people live in our region, they will be able to get to the most appropriate hospital or specialist service as quickly as possible with necessary treatments given en route by our paramedics when needed.

Our focus on community care is further integrated in the need for our ambulance and transport services needing to work differently in that once seen and treated in hospitals, we want people to be taken back home as easily as possible and as soon as they are able –



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which may mean being transferred from a specialist centre to a local hospital for the remainder of their care until they can go home.

We also think that spreading best practice and collaborating on support office services, such as our estates, procurement and pharmacy management, will enable us to meet the challenges. Technology and digital integration will also play a major role in helping shape the future of health and care services.

Developing and supporting our staff is the only way we will achieve these ambitions. We envisage a flexible workforce that comes together to offer people the best and most appropriate care.

We think the best way of achieving this is by focusing on three areas:

1. Putting prevention at the heart of what we do
2. Reshaping and rethinking primary and community based care
3. Standardising hospital care

We are also already underway with some early implementation and are progressing a number of priorities across South Yorkshire and Bassetlaw, which are starting to reshape services in our local places.

# 1. Putting prevention at the heart of what we do

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“We want to deliver a step change in investment in and delivery of prevention across South Yorkshire and Bassetlaw in order to improve our population’s health and reduce the growth in demand for health and care services over the next five to ten years”

Life expectancy in South Yorkshire and Bassetlaw is increasing but healthy life expectancy is not – this means more people living longer in poor health, widening health inequalities, more preventable disease to treat and lost productive time to the economy. The majority of this poor healthy life expectancy is caused by preventable diseases.

Our current health and social care services are not meeting our population’s health needs, delivering prevention, or reducing health inequalities. This will have a big impact on future generations through avoidable illness and complications. It also adds an avoidable cost to the health and care system.

**By getting prevention right in cardiovascular disease alone, we could prevent 5,500 early deaths and free up £58 million to be spent differently**

Some of the biggest short term gains we can make in slowing the demand on services is ensuring conversations or actions around prevention take place in every setting from home to hospital. Preventing ill health is therefore a significant and meaningful part of our plan.

We will need to look closely at how we invest in preventing ill health.

We want to shift the focus of our health and care services so that they help people manage their illness, stay well and live longer.

Some of the issues are:

- Cardiovascular disease (CVD) and cancer are the main causes of preventable death; CVD, mental ill health and musculoskeletal problems are the main causes of preventable ill health
- The main immediate risk factors driving these preventable causes of poor health and early death are smoking, excess alcohol consumption, poor diet and lack of physical activity
- These immediate risks are influenced by other health factors such as poverty, poor housing and unemployment.
- The impact of these is far greater for people with mental health problems or learning disabilities

We need to:

- Turn the desire to address the other factors affecting health in our plan into meaningful action.
- Commit to a radical upgrade in preventing ill health by increasing the size of our shared resource on prevention.
- Transform health and care through the development of new organisational forms such as accountable care organisations and multispecialty community providers, which will shift our focus to improving our population’s health by encouraging the delivery of outcomes rather than activity. We will align payment mechanisms and other incentives in order to support this.

**Over the next four years our focus will be on three key areas:**

1. Make a real effort, including investments to reach deep into the thousands of people who are long-term unemployed, to drive a step change in employment and employability across the footprint.

Across Sheffield City Region, a new supported employment pathway for people furthest from the labour market and those currently trapped on benefits is being introduced.

A £15 million investment has been secured from the Department for Work and Pensions to take this work forward. It is made up of four Sheffield City Region wide investments to deliver increased number of employment outcomes for residents unemployed where they have a health condition or disability.

We know that we're not joined up between health, employment and the welfare system, which results in large numbers of potentially employable people unnecessarily in long-term unemployment or being able to work. The funding will help us to better join people and services together, improve referrals and trial innovative ways of supporting people into, and during employment.

2. Widen the offer in the community far beyond medical interventions, and ensure disproportionate investment in areas/population groups with greatest need.

This means improving neighbourhood and primary care services so that they enable people to better manage their own health and stay well in their communities. This will include a range of professionals supporting patients and the wider population appropriately and seamlessly and an extensive range of services that have only previously been accessible in hospitals. These will be provided across a wide range of community settings

**In Bassetlaw, the Larwood and Bawtry practices have collaborated to jointly develop a new model of care for their registered patients. The primary care home is a national pilot supported by NHS England and the NHS Confederation and is a form of multispecialty community provider (MCP) model.**

3. Invest levels of resources in developing and implementing a South Yorkshire and Bassetlaw Healthy Lives programme to improve health, reduce health inequalities and reduce the growth in demand for health and care services.

We will deliver this programme in each place and each local programme will focus on developing employment opportunities; scaling up brief interventions in clinical practice; refreshing current lifestyle services and strategies; delivery of healthy public policies; and reviewing best practice to help those with the greatest needs.

The programme will focus on areas such as smoking cessation, weight loss and alcohol interventions.

National estimates show that only approximately 5% of total healthcare expenditure is spent on prevention, despite at least 40% of illness being avoidable or 'delay-able'; and despite this preventable illness being a substantial cost to the NHS.

By putting these actions in place we aim to achieve:

- More money spent in communities with greater needs.
- Health and care incentivised to deliver population health outcomes.
- A reduction in health inequalities by reducing the gap in healthy life expectancy by five years, from an average of 20 years to 15 years.
- A 25% reduction in hospital admissions, GP visits and prescriptions related to coronary heart disease and stroke for 15-64 year olds.
- A 15% reduction in all other hospital admissions, GP visits and prescriptions for 15-64 year olds.
- A reduction in the under 18 conception rate from 31.9 conceptions per 1,000 females (2014) to 12 per 1,000 females by 2020 (reported in 2022).
- A reduction in the number of children and young people between the ages of 5-15 years that will go on to develop a clinically diagnosable mental health disorder.

## 2. Reshaping primary and community based care

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Our focus on early intervention and prevention is central to our plans to rethink and reshape health and care but at the same time, we must also ensure that services in neighbourhoods and communities are not only built up, but joined up as well.

Patients, carers and families consistently tell us that health and care services are not connected. This lack of co-ordination can have a big impact on people's chances to get better faster, on their families and on employment.

We want care to flow seamlessly from one service to the next so people don't have to tell their story twice to the different people caring for them, and everyone is working on a shared plan for individual care.

By bringing GPs, community pharmacists, social workers, hospital doctors and community nursing teams together around neighbourhoods, we want to help make the connections between social and medical support and strengthen communities. By improving access to care at home and in communities, we will also reduce the demand for urgent care in hospitals.

We want GPs to be the senior decision maker in taking forward prevention, integration with social and voluntary sector partners and managing complex patients with long term conditions in the right place.

GP groups and other collaborations will be central to making this happen. They will help to increase capacity and the range of services that can be safely provided locally. By providing more local services in neighbourhoods, we will improve access to services for people.

Each of our places – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield – are developing new and different ways of working across health and care that will better fit the needs of their populations, such as accountable care and new models of care.

These include:

### **Improving self care and the management of long term conditions**

Around 30 per cent of the population has one or more long term conditions and use around 70 per cent of health care resources. Not only does the evidence show that having greater control improves their outcomes, the people with long term conditions tell us that they want more self care and to be able to manage their own health

We will increase telehealth monitoring, personal and GP planning to proactively help people who have long term conditions, such as diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.

We will improve signposting to services and support people with education to help them manage their medicines and pain control.

RightCare Barnsley is a telephone based care coordination centre for healthcare professionals seeking a care solution for their patients. Wherever possible, care is delivered in the home. If the patient requires hospital intervention this will be arranged by RightCare Barnsley ensuring that the right care is provided in the right place, first time. It won an award from the Health Service Journal in 2016.

### **Social prescribing**

We will build on the successful social prescribing services, provided in partnership with the voluntary sector, already underway in some of our places.

Social prescribing is a way of linking people with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being.

In Rotherham, the social prescribing service targets the top 5% of patients at risk of hospitalisation using a process that helps to identify those most at risk of a hospital admission and the judgement of their GP. Non medical interventions have been identified for over 5000 patients with significant success, saving money and improving outcomes. The next phase of development will be increasing interventions for mental health and targeting the top 10%.

A team working with Sheffield Hallam University looked at social outcomes and hospital episodes from the Rotherham pilot and found that the people who had used the service had around 50 per cent less outpatient appointments, accident and emergency visits and hospital admissions in the six months after the scheme.

The same scheme has high satisfaction rates from those people using it.

## **Social prescribing**

By investing in social prescribing, as has been popular and effective in Rotherham, we can reduce health inequalities by making sure that traditionally hard to reach communities have access to support and advice, reducing A&E attendances by 1.4%, emergency admissions by 2.6% and also allowing an extra £3.8 million to be spent in other areas by 2021

## **Early detection and intervention**

We have a high incidence of and mortality from cancer in South Yorkshire and Bassetlaw.

Early detection and intervention are crucial to helping people live better for longer and we want to focus on this across breast, colorectal and prostate cancers.

Early detection has been linked to a number of positive outcomes, for example:

- >90% bowel cancer patients will survive the disease for more than five years if diagnosed at the earliest stage
- >90% of women diagnosed with breast cancer at the earliest stage survive their disease for at least five years compared to around 15% for women diagnosed with the most advanced stage of the disease
- >90% of women diagnosed with the earliest stage ovarian cancer survive their disease for at least five years compared to around 5% for women diagnosed with the most advanced stage of the disease
- Around 70% of lung cancer patients will survive for at least a year if diagnosed at the earliest stage compared to around 14% for people diagnosed with the most advanced stage of the disease

In the community, we will focus on identifying cancers. We will do this through:

- Continually supporting and educating our primary care workforce in identification and referrals
- Using prediction software
- Connecting with national awareness campaigns
- Reducing variations in screening uptake

We will also look at the challenges around cancer prevention, detection and treatment through our Cancer Alliance, working with partners across South Yorkshire and Bassetlaw and North Derbyshire.

### **Urgent care intervention and treatment closer to home**

By looking at the attendance information for people who go to accident and emergency services, we know that a significant number of those in South Yorkshire and Bassetlaw would not need to go if alternative services were available.

Improving support for people who are in crisis and developing more services where people live are key parts of our plan. This includes hospital triage in communities, rapid response teams and increasing the offer for social, nursing, medical and mental health care in people's homes and nursing homes.

More treatment closer to home for people should lead to improvements in access and outcomes and impact on health and wellbeing. At the same time, this will free up capacity in hospitals.

### **Investing in urgent care**

By 2020, if we improve our urgent and emergency care services by investing in primary and community care, we will reduce the current high demand on our accident and emergency departments.

### **Care co-ordination**

Care co-ordination is the management of patient care between two or more partners or organisations to ensure services match the needs of the person. We want to increase care co-ordination and integration across primary, hospital and social care.

Where possible, we will expand and improve local services where these currently exist and create them where they are needed. Our plans include:

- Personalised health care plans and programmes
- Community based multi-professional teams, based around community hubs or GP surgeries
- Intermediate care, case management and support for home based care
- Co-ordinated assessment of care needs and joint care planning
- Developing care navigators who will guide people through their journey
- Digitally share clinical records across teams
- Integrated urgent care services

### **Better care co-ordination**

By better co-ordinating a person's care across services and specialties, viewing their needs holistically as opposed to per need, we can reduce A&E attendances by 3%, emergency admissions by 2.6%, unnecessary outpatient appointments and time spent in hospital. This will improve patient experience by making services more suited to their needs.



## 3. Standardising hospital care

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There are ten foundation trusts providing acute, mental health and community care across South Yorkshire and Bassetlaw. Amid rising demand for care and with many people now having more complex health conditions, our dedicated staff continue to provide high quality care.

However, the way our health and care services are currently provided are not financially sustainable and depending on where people live, some patients have better experiences and access to services than others. If we continue as we are, the forecast deficit for our provider organisations is around £571 million by 2020/21.

We know we need to rethink and reshape services so that we can meet the needs of our population in modern and sustainable ways.

Underpinning our plan is an investment and expansion of prevention and integrated primary and community services – but at the same time we agree that everyone should have better access to high quality care and so that no matter where people live, they get the same standards, experience, and outcomes for their care and treatment. We will do this by working together more closely, by developing a networked approach to services.

We believe the investment in primary care will stabilise and eventually reduce the demand for some hospital services and it is at this point that we will be able to make a decision on reshaping our services, across all settings. This will ensure we have strong and sustainable hospital services in the future.

Some of the ways we are looking to standardise care within our services are:

### Reshaping services

Any plans for changing our hospital services will be developed with the public, patients and carers. As we develop cases for change around potential service changes, we will engage with all our stakeholders – including the public - through the process and ensure their views and feedback are considered and included in proposals before we formally consult. This will also be informed by our independent review of hospital services, due to take place in 2016/17.

### Managing referrals

We want to better manage referrals. There is wide variation in referrals for hospital care and we think we can improve care and quality for people by boosting:

- Support for staff working in primary care to develop and maintain their professional skills, knowledge and experience
- Resources to check referral guidelines
- On the spot advice and guidance from more qualified clinicians
- Redirection of inappropriate referrals
- Peer reviews

A new approach to managing musculo-skeletal conditions, including empowering and educating patients, clinician education and support and cross specialty and sector clinical leadership has developed in Sheffield. This includes multi disciplinary assessment of referrals and direction to the most appropriate setting first time.

### Managing follow up appointments

The number of outpatient appointments across South Yorkshire and Bassetlaw has been steadily increasing, with numbers forecast to increase further. Evidence shows that these are not always needed or could be done in ways that are more convenient for people.

Evidence from where these changes are already happening show high levels of patient satisfaction. We are already doing things differently by providing aftercare in the community for people with breast and bowel cancers. Our Living With and Beyond Cancer partnership with Macmillan is taking this work even further across South Yorkshire and Bassetlaw.

We are proposing that we look at introducing:

- Virtual clinics – by email, web-based or telephone
- Group consultations – involving more than one patient or doctor
- Nurse or other health care professional led consultations

### **Diagnostics and treatment**

An ageing population and a rise in lifestyle related risk factors means that cancers are increasing, with 14,000 people being treated a year in South Yorkshire and Bassetlaw. This number is expected to rise to 18,000 by 2030.

The percentage of cancers detected at early stages grew across all our places between 2012 and 2014, with the largest numbers in Sheffield. Diagnosis rates across our places are lower than they are for England.

As well as improving interventions for detecting cancers in the community, we also want to make changes around diagnostics and treatment. We will:

- Increase direct access to diagnostics
- Look at options for multi-disciplinary diagnostics, including virtual diagnostic centres
- Review 'bottlenecks' in the patient's journey, standardise quality and access and improve experiences
- Review our multi-disciplinary team way of working, looking at one team across an area for all cancers
- Look at our workforce and delivery models in surgery, radiotherapy and the role of cancer specialists in local communities
- Review chemotherapy services – major advances in treatment mean it can now be given outside of hospitals

### **Reviewing local and out of area placements in mental health services**

Caring for people with mental health issues locally and not outside our area helps them to regain their independent living. Local services also means they can keep connected to their families and communities, critical factors in mental and physical health outcomes.

The Royal College of Psychiatrists estimates that 22% of all people that are in out of area placements translates to an annual spend of £330 million.

We know that in Sheffield, bringing back people from out of area placements has enabled the Sheffield Health and Social Care Foundation Trust to invest £2 million in extra community services.

We want to plan better and target rehabilitation for people who are in out of area placements by:

- Building a mental health alliance between our mental health providers
- Invest more in local delivery
- Increase co-ordinated care

We also want to review urgent care and acute based psychiatric liaison services. We will also put in place a 'transforming care' programme to support patients with learning disabilities to receive care as close to home as possible.

### **Specialised services**

Specialised services are central to improving health and care outcomes for South Yorkshire and Bassetlaw's population.

Working with NHS England to agree local priorities and develop plans for any change, we will focus on the outcomes that matter most to patients, ensuring a stronger focus on prevention and connecting the commissioning of specialised services more strongly to the prevention and personalised medicine agendas.



We will work collaboratively across our STP partners and with NHS England to develop a whole system, pathway led approach to provision and commissioning of services, particularly where transformational change is required.

Understanding the variation that currently exists across the region and identifying opportunities to challenge this in order to ensure equity of access, outcomes and experience for all patients. This will include working together to ensure that care pathways work in a consistent way to support this in all areas.

With NHS England, we will build on our knowledge of patient flows and the relationship between services to determine new and innovative ways of commissioning and providing services, in order to improve quality and cost effectiveness.

We will pilot new innovations and evaluating the impact, where this is positive we will seek to spread best practice as quickly as possible.

Priority areas for 2017/18 include children's and neonatal, vascular, cancer (including chemotherapy and pancreatic services) and some specialist mental health services.

### **Reducing out-of-area placements**

**By investing in mental health services locally with improved planning, co-ordination and more targeted rehabilitation, we expect to reduce the number of out-of-area placements (people being treated in hospitals or units outside of South Yorkshire and Bassetlaw) by 63%.**

## Early implementation

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In addition to the STP, we are already progressing a number of priorities across South Yorkshire and Bassetlaw to start to reshape services and many of them are already happening in local places. These areas were already underway in the programmes of work being carried out by Commissioners Working Together and the Providers' Working Together Partnership Vanguard.

We are agreed that we want to take these forward together, using the governance framework we have put in place for the STP. The early implementation areas as an STP are:

### Spreading best practice and collaborating on support office services

Our hospitals, through the Provider Working Together Acute Vanguard have been working in partnership on a range of collaborative activities over the last three years.

The partners are looking at how they can integrate, standardise and collaborate on a range of corporate services, including payroll, finance, human resources, legal services, procurement services, information management and technology, estates, and governance and risk. The plans for these services are at different levels of development but include the sharing of best practice across all the provider organisations and standardisation of systems, processes and policies which can help to deliver significant efficiencies across all hospital functions, as well as exploring more integrated delivery models without affecting care services.

A clear mandate and board level commitment are recognised as critical success factors and all provider trusts in South Yorkshire and Bassetlaw have confirmed their commitment to the process and development of plans to maximise efficiencies, deliver joint initiatives and consolidation of services, where appropriate.

### Children's surgery and anaesthesia

Over the last eighteen months we have been reviewing children's surgery and anaesthesia services and are now proposing changes to make sure all children in our region are able to get the best possible and safest care they deserve should they need an operation in one of our local hospitals.

For most services, most of the time, nothing will change but for a small number of unplanned operations, at night, at weekends or when children need to stay overnight in hospital, we are proposing they are done differently.

Across the region, there is only a small number of children needing operations of the sort we are proposing to change, which means staff aren't being used in the best way, which, combined with a national shortage of expert staff who are qualified to operate on children, means that in the future, children may not have access to the high quality care they need.

If we use our services and staff in a different way, we will be able to care for children in a consistent way - whilst maintaining the high standards of care we expect to provide.

For some people, this may mean travelling further than their local hospital for the services we are proposing to change but it will also mean children will receive consistently high quality and safe care in the future - with children being treated by the right people, in the right place and at the right time.

Between Monday 3 October 2016 and Friday 20 January 2017, members of the public are invited to share their views on the three proposed options for the future of these services – with a final decision expected to be made by clinical commissioners in February 2017.

The new proposals will affect around 1 in every 10 children needing an operation across South and Mid Yorkshire, Bassetlaw and North Derbyshire. Children would still have 'day case' operations (where they do not stay overnight in hospital) at all local hospitals. Very specialist services, for children with very complex conditions, will also remain the same with children from across the region being treated at Sheffield Children's Hospital as the only specialist centre in our region – as they are now.

## Hyper acute stroke services

At the moment, some of the stroke teams in South Yorkshire and Bassetlaw don't treat as many patients as teams in other hospitals, meaning they have fewer opportunities to develop their skills and introduce new treatments – which could mean that in the future, some of our patients may not get the best care they deserve should they have a stroke.

This, combined with a national shortage of specialist staff, means we need to act now and use our staff and facilities in a different way to make sure that everyone in our region has access to the best services and fast treatments after having a stroke.

For some patients in Barnsley and Rotherham, this could mean being treated in a hospital that isn't their local one for the first 72 hours – but it also means they would receive high quality specialist care and we have been working with our ambulance service colleagues to make sure that all patients will be taken to their next nearest hyper acute stroke service unit within the critical time of 45 minutes.

After the first 72 hours of care, or sooner if medically possible, people would be transferred to their local stroke ward for the remainder of their care. Rehabilitation services, such as speech and language, physio and occupational therapies which help people get better once they have gone home from hospital, would also remain closer to where people live.

This is also out to public consultation within the same timescales as children's surgery and anaesthesia services.

## Acute Gastrointestinal (GI) Bleeds

At present, in some hospitals at night and at weekend we can't always guarantee quick access to a specialist doctor. Also, there are very few patients that present out of ours for this service. We want to make some small changes to the way in which we organise ourselves to resolve this and our work in this area is looking at how we can safely and effectively provide care across hospitals for patients with acute gastrointestinal (stomach and intestines) bleeding, with a particular focus on improving equity of access to services for all patients.

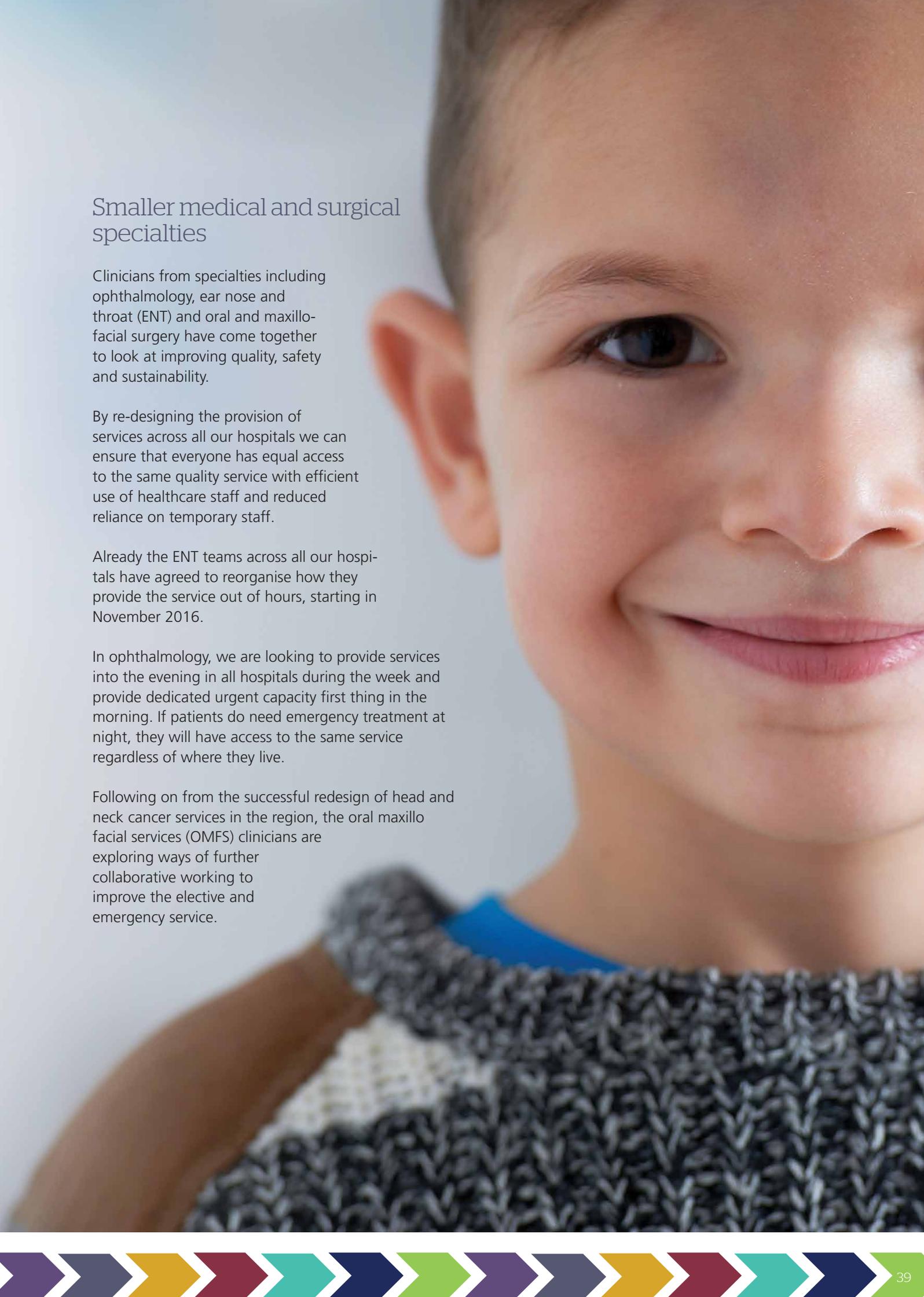
We want to develop our workforce in the most efficient way and reduce the reliance on temporary staff.

Significant data collection and analysis has suggested that the most effective and safe way to provide the service is in specialist hubs. This will mean that a very small proportion of patients (less than one per week in the whole region) will transfer to the specialist hubs. Also, care pathways will be standardised across the region to ensure that every patient receives the same, high quality care.

## Radiology

Demand for radiology continues to increase every year, for a number of reasons – better screening programmes and more people surviving cancer who require follow up investigations, an ageing population, better direct access for GPs to tests and the requirement for seven day services. If we did not address this and look at expanding the workforce, there would be a growing gap between the demand for the service and our ability to perform and report all investigations effectively.

We want to ensure access to the same radiology test for everyone and improve safety and effectiveness, reduce the use of temporary staff, increase speed and efficiency in reporting, facilitate faster decisions and discharge, plus 24/7 healthcare provision, provide equity of access to interventional radiology procedures and make better use of resources.



## Smaller medical and surgical specialties

Clinicians from specialties including ophthalmology, ear nose and throat (ENT) and oral and maxillo-facial surgery have come together to look at improving quality, safety and sustainability.

By re-designing the provision of services across all our hospitals we can ensure that everyone has equal access to the same quality service with efficient use of healthcare staff and reduced reliance on temporary staff.

Already the ENT teams across all our hospitals have agreed to reorganise how they provide the service out of hours, starting in November 2016.

In ophthalmology, we are looking to provide services into the evening in all hospitals during the week and provide dedicated urgent capacity first thing in the morning. If patients do need emergency treatment at night, they will have access to the same service regardless of where they live.

Following on from the successful redesign of head and neck cancer services in the region, the oral maxillo facial services (OMFS) clinicians are exploring ways of further collaborative working to improve the elective and emergency service.

# Chapter 5

## Finance

### The financial challenge

We currently invest £3.9 billion on health and social care for the 1.5 million population of South Yorkshire and Bassetlaw. This includes hospital services, mental health, GP services, specialist services and prescribed drugs, as well as public health and social care services.

After taking into account the resources that are likely to be available and the likely demand for health and social care services over the next four years, we estimate that there will be a financial shortfall of £571 million by 2020/21.

If we do nothing to address our shortfall, £464 million would be the health service gap, while £107 million relates to social care and public health.

The scale of the challenge demonstrates why radical change is needed, both in the way services are delivered and in the way people use them.

If we are to achieve our ambitions, we need the £3.9 billion investment to work differently.

### Our assumptions

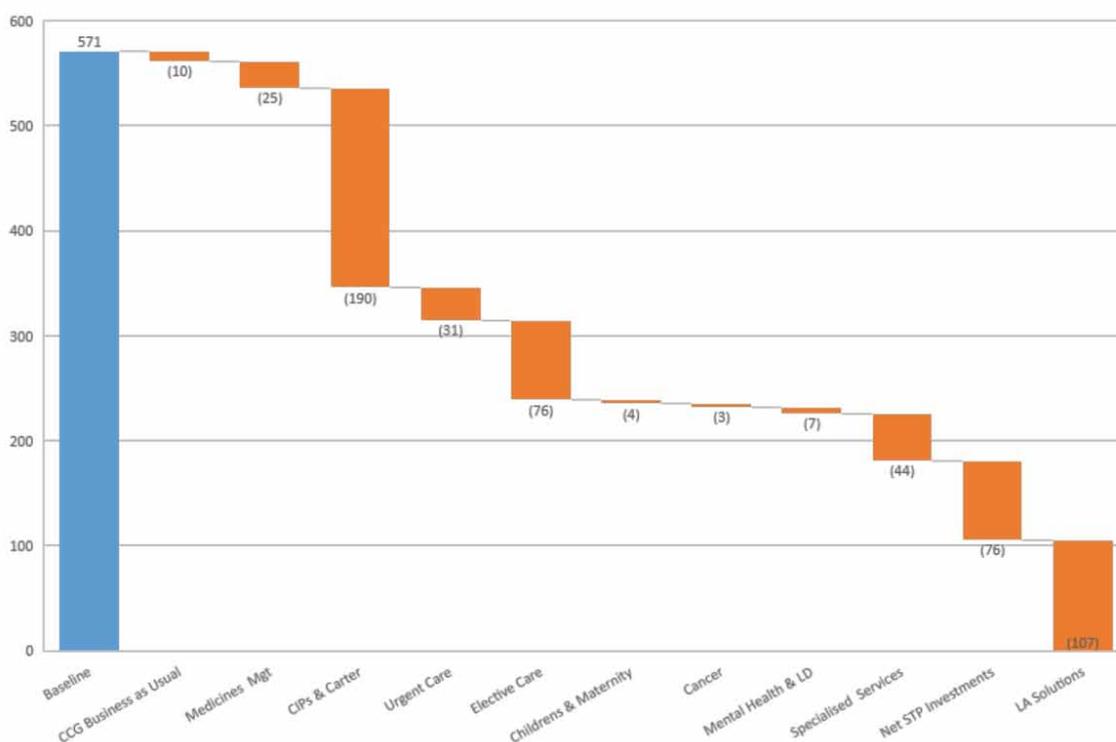
We start our assumptions based on data and information from previous years that we keep about how people access our services.

Our financial challenge assumes that all NHS organisations within the STP will work within their budgets and make the savings they have planned for the financial year 2016/17.

Our financial gap takes into account local investments to deliver the GP and Mental Health Five Year Forward Views.

We assume we will receive all of our £105 million indicative share of national sustainability and transformational funding by 2020/21 to support closing the financial gap.

We have also assumed that hospitals will meet all the quality standards agreed with their CCGs.





## Bridging the 'gap'

In order to bridge our financial gap we need to be ambitious. Our high level planning assumes a significant reduction in demand for hospital services and potential changes to services which, if fully developed into cases for change, would require public consultation in the future.

Based on national and international best practice and successful local programmes, our plans consider a number of ways of doing things differently. We have modelled the likely impact of these ways of working on our baseline, using the outcomes of similar interventions.

In addition to our interventions, we anticipate that other savings would come through:

- CCG quality, improvement, productivity and prevention plans
- Improving the management of prescribed medicines
- Cost improvement plans (CIPs) in hospitals
- Achieving the savings highlighted in the 'Carter Review'

We recognise that while savings will be made through our STP, some investment will be needed to make the changes to improve the services we offer and to meet the aims of the Five Year Forward View. We anticipate this investment will come in the form of funding for transformation.

The result of this financial modelling suggests that we should be able to bridge our financial gap and achieve a balanced position by 2020/21. However, there is a very high degree of risk attached to delivery of some of the changes.

### Next steps

Whilst our modelling gives us a balanced position, it also highlights that planning and rethinking and reshaping health and care services can result in swings in surplus and shortfall positions across the individual hospitals, which may mean we need to change the flow of funding. We think that a system wide budget, as mandated by national planning guidance, will help with this.

Considerable further work is required to move to detailed business cases which will help us to assess whether the financial modelling is realistic and capable of being implemented.

# Chapter 6

## Putting the plan into action

### **This is our offer for South Yorkshire and Bassetlaw:**

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1. We will reduce inequalities for all and help you live well and stay well for longer
2. We will join up health and care services so they are responsive to your needs and accountable
3. We will invest in and grow primary and community care, with general practice at the centre
4. We will treat care for the whole person, looking after their mental and physical health
5. We will standardise acute hospital and specialised care - improving access for everyone, reducing inequalities and improving efficiencies
6. We will simplify urgent and emergency care, making it easier for people to access the right services closer to home
7. We will develop the right workforce, in the right place with the right skills - for now and in the future
8. We will use the best technology to keep people well at home, to support them to manage their own care and to connect our people so they can provide joined up care
9. We will create a financially sustainable health and care system
10. And we will work with you to do this.

To do this, we will need to make significant changes between now and 2021, and beyond. We want to have conversations with our staff, patients and the public about how we can do this. Together, we will shape our thinking around what matters to people, focus on keeping the best of what we've already got and putting the changes in place outlined in the plan – creating sustainable health and care for many generations to come.

# Engagement

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We have an ambitious plan for South Yorkshire and Bassetlaw and all partners are now working together to move from plan to delivery.

## Listening to our staff and communities

Between November 2016 and February 2017, we will connect and talk with the staff in each of our partner organisations and local communities about these plans. We want to hear their views and will be working with Healthwatch and our voluntary sector partners to ensure we connect with all groups and communities.

We will take account of all views and feed these back into our plans before any further work takes place.

We have already established a communications and engagement group with communications and engagement colleagues from across all partners. Strategically led by the Commissioners Working Together and STP programme management office communications and engagement team, the group has already successfully engaged with thousands of people during pre-consultation for hyper acute stroke and children's surgery services.

Together, we developed a communications and engagement strategy to deliver these two public consultations, which are now underway, and we will use this as the foundation for our work to connect and talk with people about the plan.

Our partners have also come together to hold local events with wide involvement – from faith groups to voluntary sector, carers and patients - to discuss what needs to happen to improve health and care. All local conversations are reflected in our wider STP approach.

In Barnsley, a joint public workshop was held between NHS Barnsley Clinical Commissioning Group and Barnsley Metropolitan Borough Council, as well as the wider health and wellbeing strategy for the city. Attendees at the group included members of the Council's service user and carers board, equality groups, the patient council and also local Healthwatch champions and active residents on local Area Councils who wanted to gain a wider knowledge and understanding of the plans and were able to share their views and experiences – helping to shape and develop the future of health and care priorities in Barnsley.

Similarly in Bassetlaw, public and patient engagement has taken place through the strong networks already developed between the CCG and local provider, voluntary and other partnership organisations, including GP practice members across the area, Bassetlaw Health Partnerships Community Services and also local authority organisations.

In Doncaster, engagement on intermediate care services was carried out through extensive interviews with service users and their families. In partnership with Doncaster Metropolitan Borough Council, further engagement has been carried out with carers and their families that has been crucial to the development of the borough's new carer strategy – supporting the focus on making sure more services are available in the community and close to home.



In Rotherham, the approach to communications and engagement has focused on informing, sharing, listening and responding to the people in the town. Specific communication and engagement has taken place with a variety of stakeholders in developing each of their five priority initiatives. This has included gathering feedback at their annual general meeting, via local health champions, surveys in care homes, focus groups, workshops and telephone surveys.

Sheffield's thinking has been developed using patient and public feedback collected by NHS Sheffield Clinical Commissioning Group. This included the main themes included in their quarterly 'What you've been telling us' briefings which are based upon feedback received from all public engagement activities carried on through their existing networks. There have also been two stakeholder events under the banner of #ShapingSheffield which have brought together local statutory partners and community organisations to talk about and help shape the thinking around health and wellbeing of people in Sheffield.

### **Listening to our staff and communities**

As well as some being residents, there are around 74,000 people working in health and social care services in South Yorkshire and Bassetlaw. They are an important group and critical to the success of our plans.

Building on their existing networks and extensive reach, each of our partners will lead engagement within their organisations – ensuring that staff are not only kept informed but are ambassadors for change.

The communications and engagement team within the programme management office of the STP will continue to provide strategic oversight and support for all communications and engagement as our plans are put into action and by building on relationships with the voluntary sector and Healthwatch organisations, will engage with the public, as key partners, on our plans and future proposals.

We will take account of their views and feed these back into our plans before any further work takes place.

# Plan on a page

“Our goal is to enable everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and to live longer.”

**£571**  
million health and social care gap



**£25.8b**  
Broader overall economy GVA

**£11b** **£3.9b**  
Wider public sector spending Public spending on health and social care

## Leadership

- Our approach is collaborative
- Health and care leaders have been engaged throughout the development of the STP
- We have built on existing relationships to create a credible coalition of partners
- We have created and own a common vision and ambition
- We have built trust and mutual respect

## Accountable care

- All of our localities are starting to develop accountable care
- Our CCGs are moving forward with plans, for example:
  - Barnsley is six months into development
  - Bassetlaw is shaping its direction through its integrated care board
  - Doncaster is developing a local integration model
  - Rotherham has set out a framework for jointly providing services
  - Sheffield is forming neighbourhoods in primary care, central to its plan for accountable care

## Priorities

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities
- Urgent and emergency care
- Elective and diagnostic services
- Children's and maternity services
- Cancer
- Spreading best practice and collaborating on support services

## Place

- Prioritise and invest in strengthening primary and community services
- Focus on intervention and prevention
- General practice central to our ambition
- Develop integration and accountable care
- Development of neighbourhood models and identify our most vulnerable

## Governance

We have established a governance framework to enable delivery of our STP:

- An STP Oversight Group made up of members, chairs and non-executives
- A Collaborative Partnership Board (CPB) - made up of all chief executives and accountable officers. It will set the vision, direction and strategy
- An Executive Steering Group will oversee delivery on behalf of the CPB
- An NHS provider trust federation board has been set up
- A joint committee of the clinical commissioning groups has been set up to consider commissioning services at a South Yorkshire and Bassetlaw level

## Objectives

1. We will reduce inequalities for all and help you live well and stay well for longer
2. We will join up health and care services so they are responsive to your needs and accountable
3. We will invest in and grow primary and community care, with general practice at the centre
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9. We will create a financially sustainable health and care system
10. And we will work with you to do this

# Timeline



Healthy lives,  
healthy living,  
prevention



Reshaping  
primary and  
community care

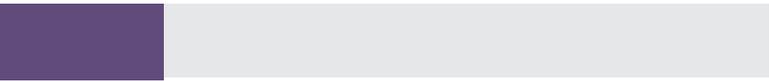
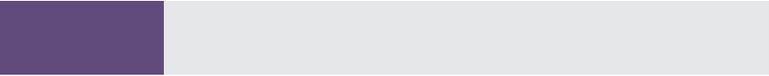


Standardising  
hospital  
services

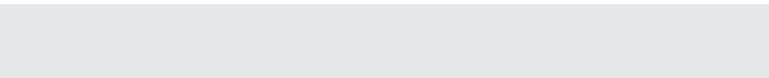
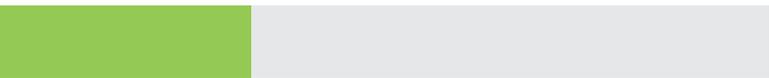
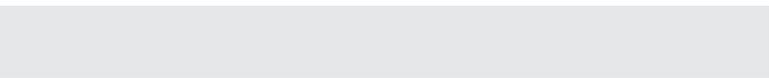
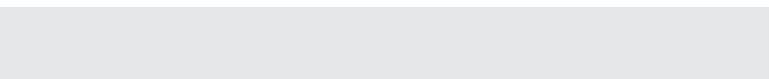
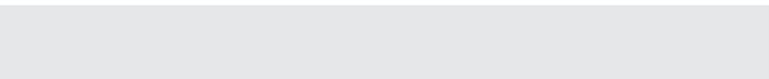
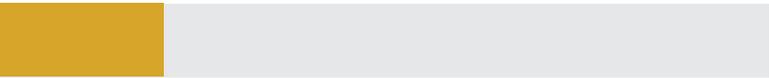
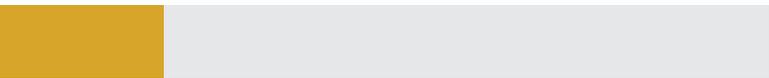


Early  
implementation





Healthy Lives Programme



The South Yorkshire and Bassetlaw Sustainability and Transformation Plan has been developed in consultation with chief executives and accountable officers from the following organisations:

NHS Barnsley Clinical Commissioning Group - Lesley Smith, chief officer  
Barnsley Hospital NHS Foundation Trust - Diane Wake, chief executive  
Barnsley Metropolitan Borough Council - Diana Terris, chief executive  
NHS Bassetlaw Clinical Commissioning Group - Idris Griffiths, interim chief officer  
Bassetlaw District Council - Neil Taylor, chief executive  
Chesterfield Royal Hospital NHS Foundation Trust - Simon Morritt, chief executive  
Doncaster and Bassetlaw Hospitals NHS Foundation Trust - Mike Pinkerton, chief executive  
Doncaster Children's Services Trust - Paul Moffat, chief executive  
NHS Doncaster Clinical Commissioning Group - Jackie Pederson, chief officer  
Doncaster Metropolitan Borough Council - Jo Miller, chief executive  
East Midlands Ambulance Service NHS Trust - Richard Henderson, acting chief executive  
NHS England - Moira Dumma, director of commissioning operations Yorkshire and the Humber  
Nottinghamshire Healthcare NHS Foundation Trust - Ruth Hawkins, chief executive  
Nottinghamshire County Council - Anthony May, chief executive  
The Rotherham NHS Foundation Trust - Louise Barnett, chief executive,  
NHS Rotherham Clinical Commissioning Group - Chris Edwards, chief officer  
Rotherham, Doncaster and South Humber NHS Foundation Trust - Kathryn Singh, chief executive  
Rotherham Metropolitan Borough Council - Sharon Kemp, chief executive  
Sheffield Children's Hospital NHS Foundation Trust - John Somers, chief executive  
Sheffield City Council - John Mothersole, chief executive  
NHS Sheffield Clinical Commissioning Group - Maddy Ruff, chief officer  
Sheffield Health and Social Care NHS Foundation Trust - Kevan Taylor, chief executive  
South West Yorkshire Partnership NHS Foundation Trust - Rob Webster, chief executive  
Yorkshire Ambulance Service NHS Trust - Rod Barnes, chief executive

**And in partnership with:**

Healthwatch Barnsley - Adrian England, chair  
Healthwatch Doncaster - Steve Shore, chair  
Healthwatch Nottinghamshire - Jez Alcock, chief executive  
Healthwatch Rotherham - Tony Clabby, chief executive  
Healthwatch Sheffield - Judy Robinson, chair  
Voluntary Action Barnsley - Christine Drabble, chief executive  
Bassetlaw Community and Voluntary Service - Catherine Burn, director  
Doncaster Community and Voluntary Service - Norma Wardman, director  
Voluntary Action Rotherham - Janet Wheatley, chief executive  
Voluntary Action Sheffield - Maddy Desforges, chief executive





