South Yorkshire and Bassetlaw Integrated Care System

Our work so far

Review 2016 - 2019

We have much to celebrate and this Review captures the work that has been taking place across the system over the last three years.

Contents

Foreword

The South Yorkshire and Bassetlaw Integrated Care System has evolved from a Sustainability and Transformation Partnership (January 2016) to an Accountable Care System (in April 2017) to becoming one of the first and most advanced integrated care systems in England.

We have taken a staged approach to becoming an ICS. Although we officially launched in October 2018 we have been working collaboratively at a system level since January 2016. Throughout this time we have built on our excellent foundation of working together and started to deliver real and tangible improvements for our population.

We have much to celebrate and this Review captures the work that has been taking place across the System over the last three years. With support from staff, the public and stakeholders we are making real inroads into transforming the way we do things at a system level so that people continue to receive high quality services but in ways that are more convenient and with better outcomes. You can read about some of the initiatives making a difference to people's lives across the region from page 20 onwards.

Just some of our successes include:

- A new, perinatal mental health service has been established across Doncaster, Rotherham and Sheffield.
- We have new pathways for lower GI, prostate and lung cancers – helping to diagnose and treat people earlier and improve overall outcomes.
- We have invested more than £1 million into our Local Maternity System to improve care for all mothers and babies. 85% of women now have a Personalised Care Plan.
- We have 21 clinical pharmacists, 135 trainee nurse associates and 825 care navigators supporting primary care services across the region.
- We are providing extended access GP appointments, at evenings and weekends, for 100% of our patients.
- We have practically eliminated adult mental health out of area placements in four of our five areas with plans to improve this even further.

We are in a transition year in 2019/20 as we start to take on more responsibilities for our health system. This includes increasing collective accountability for health performance and finance and we are continually evolving our governance in line with these developments. We are not a legal entity and each partner within the ICS is accountable to the public through its own Board or Governing Body but we are committed as a collective to be open and transparent in our work.

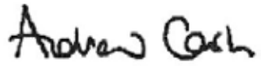
As an ICS, our focus has mostly been on the NHS, but our work is not just about the NHS. It is also about how we can work more closely with all partners who can influence health – from Local Authorities, to schools, to big employers, to industry and more. As our journey continues, our work is increasingly connecting across sectors so that we can help people to live well for longer.

I would like to place on record my thanks to the Chief Executives, Accountable Officers, Clinical Leaders and their teams from all the organisations who support the work of the ICS and for their continued efforts in strengthening how we work together.

In Autumn 2019 we will publish our refreshed strategy for the next five years, which is our System response to the NHS Long Term Plan. While I expect the themes, challenges and opportunities to be similar to those in our Sustainability and Transformation Plan (October 2016) our planning and thinking will take into account our shared learning and delivery as well as the clear direction of travel set out in the Long Term Plan.

The ambition we set out in 2016 was for everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and live longer. This is as true today as it was then and we will continue to pursue our ambition at the same time as aiming to be the best delivery and transformation System in the country.

Together we have a real opportunity to strengthen our position and to work together even better to deliver the best care for people – wrapping support, care and services around people as individuals, removing organisational barriers, tackling health inequalities and putting the needs of people first.



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

Who we are

South Yorkshire and Bassetlaw Integrated Care System

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

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

Throughout this time, our goal has remained the same:

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

We are a partnership of NHS organisations and NHS organisations working within partnerships with others such as Local Authorities and the voluntary sector. We join forces where is makes sense to do so and where it makes a positive difference to patients, staff and the public. Our aim is to break down organisational barriers so that we can wrap support, care and services around people as individuals and positively change lives.

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

How the ICS works

The majority of the work across the ICS takes place locally, in neighbourhoods or in 'Places' (our Places are Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield). Only when improvements can be made across a wider scale are services planned or projects planned at a regional, or ICS, level.

- We have 36 neighbourhoods with populations of 30,000 to 50,000. At this level, primary care is strengthened by working in networks.
- We have five Places with populations between 250,000 and 576,000. At this town/city/council level, health and care works together more closely.
- We have one System with a population of 1.5 million. At this level, strategic planning and improvements take place for the benefit of all, as well as having an overview of system finance and performance.
- At a System level our health system is really joining up to ensure we are delivering health services across our population where it makes sense to do so.

Our Places

Barnsley Integrated Care Partnership (ICP)

In Barnsley there is an Integrated Care Partnership Group with chair and chief executive membership from across Barnsley Hospital NHS Foundation Trust (BHFT), South West Yorkshire Partnership NHS Foundation Trust, Barnsley Metropolitan Borough Council (BMBC), Barnsley Healthcare Federation and NHS Barnsley Clinical Commissioning Group (CCG). Barnsley Primary Care Network has also recently joined the Partnership Group. Barnsley Hospice, Healthwatch Barnsley and Barnsley Community and Voluntary Services are also actively engaged.

The Partnership is committed to delivering integrated care in each of its six local clinical network areas (which comprise the Barnsley Primary Care Network). The local clinical areas are also closely aligned to the six council areas operated by BMBC. An example of how integrated care has been developed can be seen in the Dearne locality network where partners have come together to deliver coordinated care. This approach has been so successful that the Partnership is now rolling out the approach to the other five local clinical network areas.

As a Partnership, there has been a consistent focus on frailty, with a place based approach now agreed that improves the identification of the frail population in primary care, and coordinates appropriate care around the person. BHFT has also introduced an Acute Frailty Unit, which has prevented unnecessary admissions into hospital. The care coordination centre, Rightcare Barnsley and therapy led re-ablement Acorn Unit are other examples of successful partnership working.

Barnsley now has one of the lowest delayed transfer of care numbers in England. Another recent Partnership success has been the co-production of one unified Outcomes Framework for Barnsley, led by Public Health and the CCG, and now adopted officially by Barnsley Health and Wellbeing Board.

Bassetlaw Integrated Care Partnership (ICP)

The ICP in Bassetlaw is a partnership of chief executives and senior leaders from Bassetlaw Community and Voluntary Services (BCVS), Bassetlaw District Council, NHS Bassetlaw CCG, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Healthwatch Nottingham and Nottinghamshire, Nottinghamshire County Council, Nottinghamshire Healthcare NHS Foundation Trust and three Primary Care Networks.

Underpinned by a local memorandum of understanding, through the ICP the Board support the district's three Primary Care Networks, overseeing the performance of the partnership, and enabling developments and strategy best delivered at place level, for all Bassetlaw's 116,000 residents.

Primary Care Networks seek to link staff from general practice, community-based services, hospitals, mental health services, social care and voluntary organisations to deliver joined-up care for populations of approximately 30,000-50,000. In Bassetlaw, the three Primary Care Networks:

- Retford and Villages
- Newgate
- Larwood and Bawtry

The ICP also locates place-based developments within the South Yorkshire and Bassetlaw Integrated Care System and the Nottinghamshire Sustainability and Transformation Partnership.

The Bassetlaw Place Plan 2019-2021 sets out the strategic direction for the ICP in Bassetlaw, and focuses on priorities most appropriately led at Place level.

The partnership has already supported:

- Better connected children and young people's services – an inventory of health and wellbeing services has been published and downloaded hundreds of times, there is a more holistic approach to wellbeing, and there has been an increase in referrals of children to emotional wellbeing support.
- Workforce events with schools and more young people are taking health and care as a GCSE option.
- Staff at Bassetlaw Hospital site to view social care records.
- Bassetlaw people to do extra miles equivalent to the equator with the physical activity initiative 'Miles in May'.
- New bus routes to primary care venues to reduce home visits and reduce isolation and joint transport bids submitted.
- A joint outcomes framework, including broader population wellbeing measures.
- Primary Care Networks delivering more integrated, locally focused services, such as pain courses with the voluntary sector and links to employment support via the Department for Work and Pensions.

Doncaster Integrated Care Partnership (ICP)

Doncaster ICP is a partnership of senior leaders from Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBH), Doncaster Childrens Trust (DCT), Doncaster Local Medical Committee (LMC), Doncaster Metropolitan Borough Council (DMBC), Fylde Coast Medical Services (FCMS), NHS Doncaster Clinical Commissioning Group (NHS Doncaster CCG), Rotherham, Doncaster & South Humber NHS Foundation Trust (RDASH) and GP Federations.

In developing a joint vision and plan, Doncaster ICP maximises the value of collective action and, through joined up efforts, is accelerating the ability to transform the way services are delivered. This approach builds on individual partners' plans taking a common lens and identifying key areas of collaboration.

The Doncaster approach is focussed on prevention, integration and crucially, co-production with citizens and communities. Progress includes:

- Redesigning urgent care services, leading to the transformation and delivery of a streaming service at the front door of A&E. Doncaster's Urgent and Emergency care model is currently being refreshed and we will be engaging with patients and members of the public during Summer 2019.
- Reviewing mental health services which resulted in redesigned crisis support 24/7, accessed via one phone call.
- Re-shaping end of life care resulting in 24/7 access to palliative care and hospice services and the development of hospice at home.
- Refocusing on appropriate residential care, reducing the Doncaster average number of people in long term care and length of stay.
- Implementing a redesigned community nursing service to provide holistic case management through planned and unplanned teams.
- Securing 24/7 equipment delivery direct to patients, significantly reducing waits for equipment.
- Implementing a responsive domiciliary care service for end of life patients that enables more patients to stay at home independently for longer.
- Implementing a nursing service for dementia, providing support for both people with dementia and their carers.
- Extending the integrated health and social care discharge team to provide a seven day service, enabling discharges to happen throughout the week.
- Delivering social prescribing across the full Doncaster geography.

Doncaster's first ever joint health and social care commissioning strategy was also published in April 2019 which was co-produced by Doncaster's ICP, patients and members of the public. Almost 800 people shared their views on Doncaster CCG and Doncaster Councils vision to plan services jointly - to work more efficiently and reduce duplication. The strategy will be co-delivered and evaluated with a series of strategies and action plans aligned to it.

The Doncaster Place Plan is also being refreshed and will be available late Summer 2019.

Rotherham Integrated Care Partnership (ICP)

Rotherham ICP is a collaboration of key partners from across health and social care in Rotherham, working together to transform the way they care for and achieve a positive change for Rotherham people. Rotherham ICP partners are: NHS Rotherham CCG, Rotherham Metropolitan Borough Council (RMB), The Rotherham NHS Foundation Trust, Voluntary Action Rotherham, Connect Healthcare Rotherham (GP Federation) and Rotherham Doncaster and South Humber NHS Foundation Trust.

The second ICP Place Plan has been developed, approved by all partners, and endorsed by the Health and Wellbeing Board. The ICP Place Plan sets out how partners across health and social care are working together to make the most of our collective services, with the public at the very centre of everything we do. It closely aligns to the refreshed Health and Wellbeing Strategy.

The shared vision is:

Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery.

Examples of key transformations include:

- Rotherham Health Record (RHR) provides a single common interface for all users regardless of the setting where they work. It enables health and care workers to access patient information to make clinical decisions. RHR has been rolled out to all GP practices, RMBC social care, Rotherham Hospice and Rotherham Doncaster and South Humber NHS Trust.
- Rotherham Health App is a brand new service providing online access to manage healthcare 24 hours a day. As of the middle of June 2019, around 1700 people have signed up to App and 2000 people have had their medication reviewed via the App.
- Rotherham partners wished to expedite work on sustainable, place-based health and care models for the people of Rotherham.
- The Integrated Discharge Team (IDT) ambition, by working together across health and social care, is to improve patient experience, reduce delayed transfers of care and provide better value for money. The team recently won a Health Service Journal Value Award.
- Significant progress has been achieved with Child and Adolescent Mental Health Service (CAMHS) with extensive service change leading to substantial improvement in both assessment and treatment and waiting times.
- Launch of the Five Ways to Wellbeing Campaign took place in May 2018.

Sheffield
Accountable Care Partnership (ACP)

The Sheffield Accountable Care Partnership (ACP) brings together seven partners in the city to focus on issues that are best addressed as a collective endeavour. The partners are: Sheffield Children's NHS Foundation Trust, Sheffield City Council, NHS Sheffield Clinical Commissioning Group, Primary Care Sheffield Ltd, Sheffield Health and Social Care NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust and Voluntary Action Sheffield.

Sheffield is home to two acute hospitals also providing specialist tertiary services to South Yorkshire and Bassetlaw and beyond; Sheffield Health and Social Care Trust; two universities, supporting education, research and development; Primary Care Sheffield an established Primary Care organisation; 15 Primary Care Networks, 11 of which are research active.

The ACP benefits from sitting within a well-established Health and Wellbeing Board and Sheffield City Partnership Board, which include membership from the police, faith, education and business sectors.

The Partnership aims to reduce health and wellbeing inequalities across the city through adopting a shared purpose and has identified three priorities:

- **Fully Integrated Primary and Community Care**, including, shared care records, Primary Care Networks/Neighbourhoods, mental health and an integrated Active Support and Recovery (intermediate care) service
- **Prevention**, with a focus on Adverse Childhood Experience
- **Workforce**

The achievements of the partnership to date include:

- **Integration and partnership working:** Such as a new model and employment services for people with common and complex mental health problems; 'CASES' (Clinical Assessments, Services, Education and Support); providing a joined-up approach to patient care with GP peer reviews supported with consultant mentorship; and Neighbourhood Transformation Projects including schools, mental health, voluntary and community sector, social care, community nurses and police.
- **Success in prevention and wellbeing:** Such as a 4.5% reduction in smoking; a Move More Empowered Communities project; supporting patients with atrial fibrillation who are at high risk of stroke; becoming a World Health Organisation (WHO) Breast Feeding Friendly City; recognition from the WHO as a great example of innovation for our Ageing Better programme.
- **A strong person centred approach:** Such as a commitment to becoming a person centred city; being a National Mentor Site for Patient Activation Measure and a Demonstrator Site for Personalisation
- **Mental Health and Learning Disabilities:** Such as a significant reduction in number of inpatient beds for people with learning disabilities and complex needs; a 'Core 24' liaison mental health service; and psychological therapists working alongside physical healthcare clinicians.
- **Workforce Development:** Such as a Leadership Programme for the ACP; a GP Mentor Programme; and a Physician Associate (PA) Training Programme.

We will continue to build upon these successes and the strengths of the city within the Integrated Care System; focussing on working as partners to deliver our priorities to provide a truly integrated health and care system that empowers and supports people to live well and independently as far as possible.

Latest System Performance

Our overall performance across the South Yorkshire and Bassetlaw system is good.

Nationally, 2018/19 was challenging for all but we performed well across most areas and met the vast majority of the NHS Constitutional standards.

There were four standards where we need to put extra focus so that we can continue to improve our position, become the best delivery system in the country and provide the best possible care for our population.

Only 2.8%

Delayed transfers of care

A delayed transfer of care occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. The national standard is 3.5% or below.

90.5%

Four hour waits in Emergency Departments met

The four hour standard is set out in the NHS Constitution that at least 95 per cent of patients attending EDs should be admitted to hospital, transferred to another provider or discharged within four hours.

92.1%

Referral to treatment (RTT)

The NHS Constitution says patients should wait no longer than 18 weeks from GP referral to treatment. The national standard is 92% of patients.

100%

Primary care extended access

Extended access is the offer to registered patients of a practice of pre-bookable appointments outside of core contractual hours, either in the early morning, evening or at weekends. The national standard is for 100% of practices to offer this.

0.5%

Diagnostics

The NHS Constitution says patients should wait no longer than 6 weeks for their diagnostic tests. The standard is no more than 1% of patients.

These were the 2 week wait for breast cancer patients, the 31 day and 62 days cancer waits and total waiting list size.

0%

Waits over 52 weeks

This standard says that no-one should wait more than 52 weeks for their treatment.

94.7%

Cancer two week wait

This standard covers patients seen by a specialist following an urgent GP referral for suspected cancer. The operational standard states that 93% of patients should be seen within 14 days of the referral.

81.3%

Early intervention in psychosis

The standard for early intervention in psychosis (EIP) services requires that more than 50% of people experiencing first episode psychosis will be treated within two weeks of referral.

- **Cancer 31 days** (95.3% against 96%)
- **Cancer 62 days** (79.8% against 85%)
- **Two week wait (breast)** (91.6% against 93%)
- **Total waiting list size** (2.7% against 0%)

These are challenging areas for our hospitals but with support from the Cancer Alliance and commitments from our Chief Executives, we have an action plan in place to ensure that we see improvement in these areas.

4.75%

Improved Access to Psychological Therapies (IAPT)

The national ambition is for at least 25% of people (1.5 million) with common mental health conditions to be able to access psychological therapies through the IAPT programme each year by 2021.

The assessment of whether IAPT access thresholds have been met is based on performance in the last quarter of the year - 4.75% by the end of Quarter 4. (This then provides a total improvement figure over the course of the year).

52.2%

IAPT recovery

The standard states that at least 50% of people who complete treatment should recover.

Financial performance

Introduction

South Yorkshire and Bassetlaw Integrated Care System has a Memorandum of Understanding (MOU) which includes a System improvement plan value. In 2018/19, the ICS had £5.7 million of organisational funding linked to system financial performance.

An 'improvement plan value' is the agreed budget that an organisation can work with. In the ICS, the improvement plan value is an amalgamation of all the partner values plus an adjustment for any organisation that doesn't agree a total.

NHS provider control totals are set and amended by NHS Improvement. NHS commissioner control totals are set by NHS England. NHS financial plans were agreed in accordance with the business rules set out in the national planning guidance published jointly by NHS England and NHS Improvement.

We have close working relationships with the Local Authorities in South Yorkshire and Bassetlaw which give us a fuller understanding of the pressures and demands on them and the NHS. The Local Authorities do not form a part of the ICS improvement plan value.

At the start of the year, financial performance was routinely monitored and reported monthly to the Executive Steering Group (ESG). In November 2018, a Finance and Activity Committee (FAC) was formed to support the oversight of financial performance and planning. Financial performance is reported to both the FAC as well as ESG.

The strength of our financial performance is testament to our relationships and collaborative approach.

Financial Performance

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

Provider Sustainability Funding (PSF).

Provider organisations can receive sustainability funding in year as part of a national financial agreement. It is awarded when they meet targets or perform better than planned.

Our strong system financial performance meant that we received additional PSF for the system.

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

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

The table below shows the System control total and performance against plan.

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

Transformation Funding

In 2018/19 the ICS had access to £30.7m of transformation funding from NHS England and ad hoc contributions.

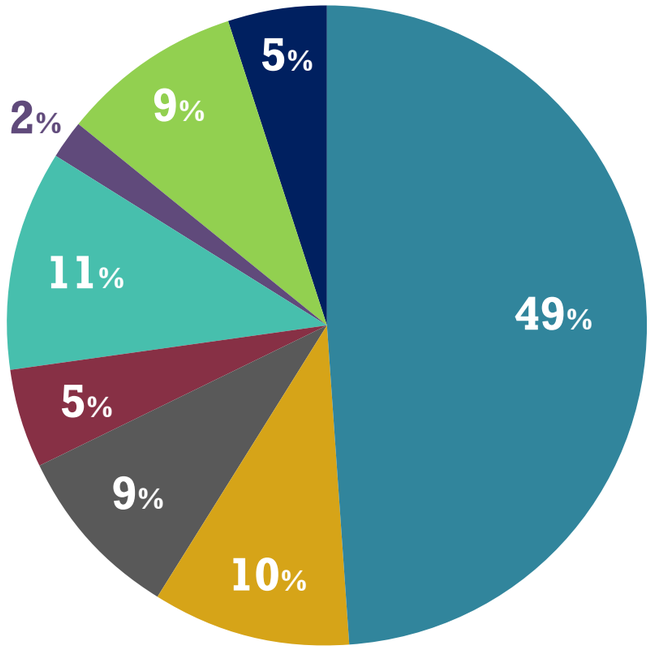
The ICS used the funds to support providers and CCGs where appropriate and agreed. This included:

- Primary Care £12.9m (including access funding, digital funding and cancer)
- Secondary Care £11.5m (including mental health, urgent and emergency care, pathology and maternity)
- Prevention £3.7m (including suicide prevention, care homes and social prescribing)
- Overall, infrastructure costs were £2.0m

All the investments were underpinned by governance through the Executive Steering Group (now the Health Executive Group).

NHS spend within South Yorkshire and Bassetlaw

The expenditure of the five clinical commissioning groups in South Yorkshire and Bassetlaw totalled £2.4b in 2018/19 and was spent as shown:



Efficiency

The ICS introduced a System Efficiency Board (SEB) which aims to:

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

The SEB carried out research to prioritise which areas of work should be explored at a System level and agreed four areas. These are outpatients reform, use of theatres, e-rostering (for some workforce) and where possible, bringing back work from the independent sector. Further work will be carried out in these areas over the coming months.

Our Work

Three years ago we set out a number of areas which we agreed would be our ongoing focus as a System.

In our Sustainability and Transformation Plan in 2016 we acknowledged the big improvements in health and social care in South Yorkshire and Bassetlaw that had taken place in recent years. For example, people with cancer and heart conditions are experiencing better care and living longer and on the whole, people are more satisfied with their health and care services.

We also recognised that we have to continually move forward. There have been advances in science, technology and how we live our lives generally. We need to provide health and care services within this context and also take into account the wider determinants of health, such as employment, housing and education.

And so as a partnership, we set out a number of areas which we agreed would be our ongoing focus at a System level. These were:

- 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

We also said we would spread best practice, collaborate on support services, carry out an independent review of hospital services, develop our workforce and look at how we could use technology to support people at home and manage their own care as well as connect our services so they can provide more joined up care.

This section gives you an update on our progress in these areas, as well as some others which have emerged as our partnership work has evolved.

Healthy lives, living well and prevention

Our health is shaped by a range of factors – from our lifestyle choices and family backgrounds to the physical, social and economic environment around us – what we call the 'wider determinants of health.' Instead of just focusing on treating people when they are unwell, we want to increase our focus on helping people to live well, for longer and slowing and stopping illnesses from developing in the first place.

For example, many common diseases such as heart disease, stroke, respiratory disease and some cancers can be prevented through healthy lifestyle choices, eg, not smoking, having a healthy, balanced diet, regular exercise and moderating the amount of alcohol we drink.

Health and care services have worked together to address these factors for a long time, with some successes in some areas – but we know we need to do more. As an ICS, we will make sure that the ultimate impact on our population's health is at the heart of all we do, ensuring that all wider factors are taken into account.

To do this, we will work much more closely with our local communities, local authorities, the voluntary sector and others to improve the overall health and wellbeing of people across South Yorkshire and Bassetlaw and we have already agreed some key priority areas that will build on some of the great work happening at Place – more on which can be found on page 53.

CASE STUDY

Social Prescribing

All five Places in South Yorkshire and Bassetlaw have a social prescribing service, with over 10,000 people accessing some kind of social prescribing support each year.

Social prescribing enables health and care services to refer people to "link workers" who act as a connector or liaison between local services, community groups or organisations depending on a person's individual needs – whether they be practical, physical or emotional.

For example, someone may be feeling isolated or depressed due to money worries, self-confidence, physical or mental health conditions and may not know the best place to get help. A link worker works with each individual to understand their needs and connects people to what is often non-medical sources of support – local community groups, charities or other voluntary sector agencies who may be of interest or who can help.

Each individual will work together with their link worker to develop a plan to improve their overall health and wellbeing, based on their own hobbies or interests, their needs and focuses on people feeling more in control and connected to others.

There are multiple videos on the ICS website showing how social prescribing has so far helped people across South Yorkshire and Bassetlaw and we are committed to developing even more link workers across our communities to help even more people at this local level.

CASE STUDY

Saving lives through QUIT

We are adopting a radical new approach to support people to quit smoking.

Smoking is a chronic addiction that should be treated as a disease – tobacco dependency – rather than considered as a lifestyle choice.

We are initially focusing this new approach on patients who are admitted to hospital or who are in contact with specialist mental health services.

Research shows that by supporting people who smoke to stop while they are in hospital with medicines such as nicotine replacement and advice from specialist stop smoking advisors, they are much more likely to stay quit and less likely to need further hospital care in the future.

A similar approach has been taken by health services in Canada where they have reduced the number of people who smoke dying within two years of a hospital admission by almost 40% and saved thousands of pounds by preventing other related health problems.

For us, the scheme is in its early stages and set for a big launch across all our hospitals, mental health and acute, in early 2020.

The QUIT programme is based on four steps:

Q

Ask the question - all hospital patients will be asked if they are a current smoker.

U

Understand their addiction.

I

Inform patients about smokefree sites and where they can access support for nicotine replacement.

T

Initiate treatment.

In South Yorkshire and Bassetlaw, the average rates of smoking-attributable deaths in England are much higher than the average (319.5 per 100,000 compared to an England average of 272.0 per 100,000).

The estimated cost to the public of smoking in South Yorkshire and Bassetlaw is £388 million.

Smoking is the single largest cause of ill health and preventable death in England and kills about half of all lifetime smokers.

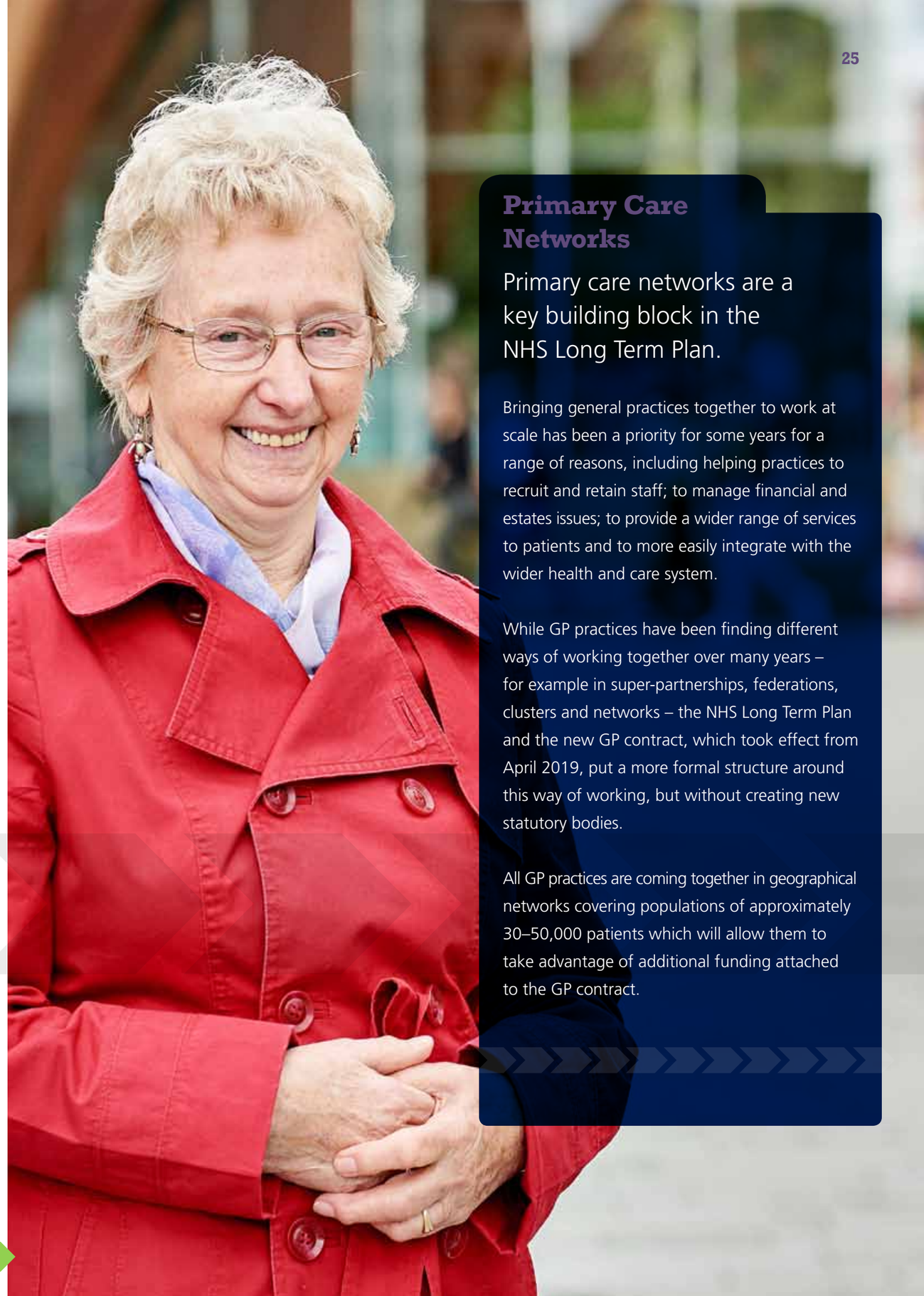
Primary and community care

Through Primary Care Networks we will expand the workforce through the introduction of new roles – for 2019 these include Clinical Pharmacists and Social Prescribing Link Workers. We are also developing digital connection between practices, including access to records and data sharing agreements in Place; ability for patients to access on-line booking, repeat prescription requests and access to health record and test results, as well as the implementation of GP WiFi.

Some of our successes include:

- All 36 of our neighbourhoods in South Yorkshire and Bassetlaw are covered by Primary Care Networks.
- We provide extended access at evenings at weekends for 100% of our patients.
- There are now 21 clinical pharmacists in general practice.
- We have developed the Primary Care Workforce and Training Hub. See case study example on page 46.
- We are attracting international GPs through the International GP Recruitment Programme.
- Over the last three years more than fifty per cent of practices have benefitted from funding to support to them to become more sustainable and resilient, better placed to tackle the challenges they face and to secure continuing high quality care for patients.
- There has been an increase in the number of new roles employed in South Yorkshire and Bassetlaw, for example, the number of Physicians Associates posts has increased from 2 to 17.
- CCGs across the ICS have promoted national and local funds/schemes to support leadership and development of Practice Managers. 123 Practice Managers have been supported to complete local development programmes through increased opportunities to develop their skills.
- We have funded training for reception and clerical staff to undertake roles in active signposting and management of clinical correspondence.
- 71% of practices in SYB have trained care navigators, who are actively signposting patients to the most appropriate service for their needs.

Primary Care Networks will ensure services are better connected at a neighbourhood level, offering increased support and access to services when and where people need them the most.



Primary Care Networks

Primary care networks are a key building block in the NHS Long Term Plan.

Bringing general practices together to work at scale has been a priority for some years for a range of reasons, including helping practices to recruit and retain staff; to manage financial and estates issues; to provide a wider range of services to patients and to more easily integrate with the wider health and care system.

While GP practices have been finding different ways of working together over many years – for example in super-partnerships, federations, clusters and networks – the NHS Long Term Plan and the new GP contract, which took effect from April 2019, put a more formal structure around this way of working, but without creating new statutory bodies.

All GP practices are coming together in geographical networks covering populations of approximately 30–50,000 patients which will allow them to take advantage of additional funding attached to the GP contract.

Mental health and learning disabilities

The vision for our Mental Health and Learning Disabilities (MHLD) across South Yorkshire and Bassetlaw is to provide holistic services, delivering the right support and care, in the right setting, by the right people. This includes the increasing need for prevention services, looking after people as close to their homes as possible and in the least restrictive environments, appropriate to the patient's needs.

Research shows that being in steady employment can also improve overall health and wellbeing, particularly when it comes to mental health. This in turn has a wider positive impact on the health economy of our region. We have been working on two projects in this area.

First and thanks to more than £1 million worth of new investment, people living with severe and enduring mental ill health in South Yorkshire and Bassetlaw will soon be able to access further tailored help to get back into, or stay in work if they wish to. The money will be used to deliver Individual Placement Support (IPS) through Community Mental Health Teams across all areas of the region. The IPS approach consists of employment specialists who are co-located with clinical staff in mental health teams giving personalised coaching and advice to people living with serious mental ill health who want to get into or stay in work.

In a separate project, and in partnership with the Department for Work and Pensions and Sheffield City Region, over 3,000 patients in South Yorkshire and Bassetlaw, who are living with long term physical or mental ill health, are receiving further support as part of the Working Win Health Led Employment Trial. We have been supporting the trial which aims to address the wider determinants of health and the links between healthcare, wellbeing and the wider economy.

In 2019, a new Perinatal Mental Health Service was launched across Doncaster, Rotherham and Sheffield thanks to £880,000 of funds secured by the ICS.

The new service means that women across the region will benefit by having access to specialist treatment in community services closer to home or inpatient mother and baby units when they need it. Specialist community perinatal mental health teams offer psychiatric and psychological assessments and care for women with complex or severe mental health problems during and after pregnancy. They can also provide pre-conception advice for women who are planning a pregnancy and have a current or past severe mental illness.

The service is being run in partnership between the Sheffield Health and Social Care NHS Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust and Light, a local perinatal peer support charity.

Clinicians and other health and care professionals came together for a workshop to discuss the service provision challenges for people with Autistic Spectrum conditions; this work continues to develop and aims to set consistent service standards across SYB for access to diagnosis services and ongoing support after diagnosis.

We have also virtually eliminated out of area adult mental health placements in four of our five places with plans to reduce this even further.

We also teamed up with our local media and communications leads in our partner organisations to run a workshop to support them in how they report and communicate suicides to reduce further anguish for bereaved families and friends.

The workshop was just one element of a partnership approach to reducing suicides and is supported by local campaigns and improved support available to people across South Yorkshire and Bassetlaw; including comprehensive training programmes and a retrospective coroner's audit, implementation of real time surveillance (sharing information across agencies in a timely fashion) and improving bereavement services.

CASE STUDY

The Transforming Care Partnership

The Transforming Care Partnership (TCP) programme of work is an integral part of our work looking at mental health and learning disabilities.

The work focuses on reducing hospitalisation and out of area placements for people with a learning disability; increasing investment in community provision, improving access to services including annual health checks, increasing the number of children receiving Care, Education and Treatment Reviews (CETR) prior to hospitalisation and working to reduce health inequalities for those with a Learning Disability.

South Yorkshire and Bassetlaw has a higher suicide rate than the England average and partners working within the South Yorkshire and Bassetlaw Integrated Care System (ICS) are aiming to reduce this number by at least 10%

Doncaster, Rotherham and Sheffield have all been awarded trailblazer status to take forward work with children and young people to improve partnerships with mental health services, raise awareness of mental health concerns and improve referrals to specialist help where needed.

Urgent and emergency care

Our vision for urgent and emergency care in South Yorkshire and Bassetlaw is to ensure we have high quality primary and community urgent care services (for treating non-life threatening injuries or conditions). We want the urgent and emergency care services within our hospitals to be the best - with world-class facilities and the specialist expertise to treat and care for those with serious or life threatening emergency needs.

Key achievements so far have been:

- Meeting our regionally agreed four-hour standard for seeing and treating people in the six emergency departments (EDs) in South Yorkshire and Bassetlaw. This includes five adult EDs and one for children.
- Supporting timely discharge with the roll out of a capacity tracker tool which records bed availability in nursing and residential homes. The tool gives staff information to support their conversations with patients and their families which care home they want to choose.
- NHS 111 Online was also launched across the region allowing patients to get urgent healthcare advice online. It also helps to manage increasing demand on 111 telephone services. When people go to 111.nhs.uk, they enter their age, sex, postcode and main symptom and are then asked a series of questions about their health problem. They can:
  - find out how to get the right healthcare in their area, including whether they need to see a GP or seek urgent care
  - get advice on self-care
  - in most areas, get a call back from a nurse, doctor or other trained health professional if they need it
- Doncaster Royal Infirmary (DRI) opened a new urgent treatment centre within its Emergency Department. The service, which treats minor ailments, is staffed by skilled emergency nurse practitioners and supported by the consultant team and is integrated with to the current Emergency Department (ED).
- Worked to put in place the South Yorkshire and Bassetlaw Regional Stroke Service. (See case study opposite.)
- £7 million awarded from the Department of Health and Social Care for a new hub for Yorkshire Ambulance Services NHS Trust in Doncaster.
- £2.5 million awarded for the co-location of the children's emergency department and assessment unit at Barnsley Hospital NHS Foundation Trust.
- System partners came together to identify pressures in services, particularly highlighting winter pressure and times of peak demand. Work on this continues to help us understand how services can support each other at the busiest times.
- Commissioned an Integrated Urgent Care Service from the Yorkshire Ambulance Service that provides integration with our five Place based urgent care services, providing more clinical advice to patients and the ability to directly book appointments for a greater range of services dependent on patient need.

This new service offer with local services working more collaboratively with the 111 service aims for more patients to be seen by the service that is right for them and reduce demand on Emergency Departments across our Places.

CASE STUDY

Saving lives and reducing disabilities - a new stroke service launches in South Yorkshire and Bassetlaw.

Receiving specialist treatment in the first 72 hours after having a stroke is vital for patients to survive and thrive (NHS England and NHS Improvement).

The NHS across South Yorkshire and Bassetlaw is now better able to provide this specialist care. After significant work, clinical input and public consultation, from 1 July 2019 for Rotherham patients and 1 October 2019 for Barnsley patients, anyone who has a stroke in South Yorkshire and Bassetlaw will be taken to one of three hyper acute stroke units:

- **Doncaster Royal Infirmary, Doncaster**
- **The Royal Hallamshire Hospital, Sheffield**
- **Pinderfields Hospital, Wakefield**

All of these hospitals provide specialist hyper acute stroke care and clot-busting treatments 24 hours a day, seven days a week and patients will be taken to the hyper acute stroke unit closest to them.

After being looked after in a specialist unit, patients will either:

- Go straight home with a rehabilitation and support package (if needed)
- Be taken to their local hospital for further support and care until they are well enough to no longer need hospital care (eg. Barnsley patients will be taken to Barnsley Hospital's acute stroke unit and Rotherham patients will be taken to Rotherham Hospital's acute stroke unit.)
- Be taken to a rehabilitation centre for further support until they are well enough to go home.

Hospital staff will work with each individual patient and their family/carers to provide the care that is the best and most appropriate for them depending on their condition, where they are from and what ongoing support needs they may have, including signposting to any extra travel support where required.

" Stroke patients should have access to the best possible treatment and care and we know that reorganising stroke services to create larger Hyper Acute Stroke Units with the equipment and experts to treat patients all day, every day, can save lives and improve recoveries.

" We know that some people may be worried about smaller stroke units no longer providing this kind of care but the evidence is clear that working in this way provides better, more effective stroke care with patients more likely to not only survive, but to survive with less disabilities and an improved overall chance of recovering well."

Stroke Association, 2019

Elective care and diagnostics

Elective care is planned care. It is when someone is referred for tests (diagnostics) by your GP and need a further opinion, treatment or a procedure in the same, or a different setting - usually a hospital. When needed, we want this journey and experience to be as smooth, quick and effective as possible.

At the moment, some people have better experiences than others if they are referred by their GP for hospital care.

More people are needing elective and diagnostic services and sometimes organisations don't speak to each other as well, or as often, as they could - meaning you may end up waiting longer than we would like to find out what treatment you may need and have your procedure.

We want to reduce the amount of unnecessary or inappropriate follow up appointments and support the delivery of more care closer to home. So once people have been looked after, they don't need to go back to a hospital if they don't need to or if they could be seen somewhere else.

Our work to date includes improvements in waiting times for diagnostic investigations resulting from both recovering and maintaining the standard across different test areas. This has included the sharing of capacity across Hospital Trusts. We have also established the South Yorkshire and Bassetlaw Radiography Academy and now have a second cohort of radiographers training to report which will further ease some of the pressures.

Other successes include:

- We have introduced a new integrated pathway for lower GI symptoms. These include two tests for Faecal Immunochemical Test (FIT) and Faecal Calprotectin Test from 1st April 2019. (See case study opposite.)
- Our clinicians have agreed a standardised pathway for hip and knee replacement follow up across the System.
- We have put in place a single Commissioning for Outcomes policy to ensure everyone receives the same access to treatments across the System, particularly in relation to procedures that have limited clinical benefit to patients.

Follow up ECHO services changed to reduce pressure and improve patient experience

Over the last year, clinicians and teams from across our hospitals and wider ICS came together to better understand how we could reduce some of our diagnostic waiting times, particularly for those we were struggling with such as follow-up echocardiograms (ECHO) after surgery at our specialist centre - Sheffield Teaching Hospitals.

We agreed that we could better provide this service, reduce the waiting times and also make a positive difference for patients needing this kind of scan if instead of asking all patients to have follow ups in Sheffield, we provided the service at each of our local hospitals - meaning patients can have their follow-up scans closer to home, reducing their need for travel and reducing the pressure on our specialist centre.

This new way of delivering follow up ECHO services has been in place since July 2019 and we expect will make a great impact on both the efficiency of the service and patient experience within a year.

CASE STUDY

Elective and Diagnostic/Cancer: Patients to beneFIT from new diagnostic test.

More and more people are requiring elective and diagnostic services.

We are committed to making sure, whatever the referral and procedure, patients have consistently high-quality experiences of hospital care.

A key priority is reducing the amount of unnecessary or inappropriate appointments and supporting the delivery of more care closer to home. One of the ways they are achieving this is through the introduction of a pioneering new approach to managing lower gastrointestinal (GI) symptoms across South Yorkshire and Bassetlaw.

Previously, patients experiencing lower GI symptoms may have automatically been referred for an endoscopic procedure where the inside of your body is examined using a long, thin, flexible tube with a camera at one end allowing images of the inside of your body to be relayed to a television screen.

However, in South Yorkshire and Bassetlaw, patients are starting to benefit from an alternative approach - the new Faecal Immunochemical Test (FIT). Introduced across South Yorkshire and Bassetlaw, FIT it is a more sensitive way of detecting traces of blood in stool samples and possible signs of bowel disease. Importantly, it allows patients to test in their own home avoiding invasive endoscopies.

This test recognises human blood in the patient's stool sample – if blood is present then the patient will be referred for further tests. The use of FIT will reduce the need for invasive tests for those patients who don't need it and save the NHS thousands of pounds in potentially unnecessary investigations.

Children's and maternity

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

To help make this happen, we have set up networks of health professionals from across primary and secondary care organisations; secured significant transformation funding to plan the design and delivery of maternity services as set out in the national Better Births plan; and agreed a new approach (a 'Service Specification') for the delivery of Children's Surgery and Anaesthesia.

With this in place, we will now push on with our work to:

- Improve our models of care for acutely unwell children. This includes work to expand and diversify our workforce; development of new clinical guidelines between hospitals and primary care across the System; and work to look at much closer collaboration between some of our hospitals;
- Implement our new Children's Surgery Service Specification, improving access to specialist care for children who need an operation;
- Ensure that mothers are given a choice of options around where they have their babies, including in midwife-led environments and at home; and we will increasingly be able to offer women a maternity service where they are cared for by a small team of midwives who are familiar with their individual needs. We will continue to deliver high quality services in line with the Saving Babies' Lives initiative.

CASE STUDY

Expectant Mothers Receiving Improved Care across South Yorkshire and Bassetlaw

Following the publication of NHS England's Better Births in 2016, new investment of £1.08 million was provided to the South Yorkshire and Bassetlaw Integrated Care System to improve safety and the experience of women having a baby and the care both mother and child receive after birth across all local hospitals in the region.

Over the last three years maternity services in South Yorkshire and Bassetlaw have achieved or exceeded key targets from Better Births:

A reduced number of still births and pre-term deaths to 3.7 or fewer in every 1,000

'Saving Babies' Lives' is a care bundle designed to tackle stillbirth and early neonatal death. It focuses on a collective effort to improve care for babies in the antenatal and intrapartum periods, with the specific objective of reducing stillbirths.

This target is now being met across South Yorkshire and Bassetlaw.

40% of women having a Personal Care Plan

A woman should develop a personalised care plan, with her midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses.

In South Yorkshire and Bassetlaw 85% of women have been helped to develop a Personal Care Plan.

20% of all women having 'Continuity of Carer'

Every woman should have a midwife, who is part of a small team of four to six midwives based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.

This target was exceeded in South Yorkshire and Bassetlaw, with 22% of our expectant mothers receiving continuity of carer.

Cancer

An ageing population and a rise in lifestyle related risk factors mean that the number of people being affected by cancer is increasing. There are currently 14,000 people being treated each year in South Yorkshire and Bassetlaw and this is expected to increase to 18,000 by 2030.

We want to work together to reduce the risk of people developing cancer, quickly diagnose and treat those who do, and develop services based around the whole person, not just their cancer.

To do this, we work together as the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance as well as continuing with our partnership with Macmillan's Living With and Beyond Cancer team.

This supports the overall vision of the ICS and better care for and support people with cancer and their families across our region.

To ensure people get timely access to our services, we have undertaken a series of reviews to ensure that we are building capacity for diagnostic services where it is needed and also supporting our services by providing further investment. Our hospitals have implemented RAPID diagnostic pathways to ensure patients get a faster diagnosis or assurance that they do not have cancer helping to relieve their anxiety. These changes to how and when we can diagnose cancer mean that we are now at the national forefront of delivery in shaping the ambition for what a Rapid Diagnostic Centre can achieve.

Key achievements so far have been:

- Cross workstream project: Roll out of a single integrated lower GI service which includes both FIT and faecal calprotectin. See case study on page 35
- Lung health checks to be rolled out, which have already started in Doncaster
- Be Cancer SAFE social movement campaign created over 12,000 cancer champions in the five Places helping to raise awareness of signs and symptoms, improve screening uptake and overall earlier diagnosis for patients across South Yorkshire and Bassetlaw.
- 1,300 extra patients accessing support services through the Living With and Beyond programme

Be Cancer SAFE: **There are now more than 16,000 Cancer Champions in South Yorkshire and Bassetlaw - and the number is growing!**

CASE STUDY

Cancer

In 2015, updated NICE guidance for those suspected with having a cancer diagnosis was published.

It was recognised for the first time that the reason why some types of cancer are diagnosed at a late stage is because patients present to their GP with vague symptoms such as unexplained weight loss, loss of appetite, fatigue and recurrent non-specific abdominal pain. These patients are often difficult to assign to recognised two-week wait referral processes.

New pathways have been set up across Barnsley, Rotherham, Doncaster, Bassetlaw and Chesterfield to more effectively manage these patients presenting to their GP.

Previously, patients with these symptoms could have attended their GP practice on multiple occasions, seen many different clinicians and had many trips to the hospital for different tests or outpatient clinics. Unfortunately, the time taken to make a diagnosis would result in a cancer being diagnosed at a later stage and potentially reducing the effective of treatment, resulting in a poorer outcomes and experiences.

The new pathways enable Primary Care and GPs to request a range of diagnostic tests straight away, including x-rays, blood tests and CT scans. In some areas, they are also able to speak with a radiology advice line to get advice on the next best test.

These pathways support GPs and Primary Care to better manage patients presenting with vague symptoms, improve the patient experience and reduce the time from first presentation to diagnosis. This means that cancers can potentially be diagnosed at an earlier stage with better treatment options. The pathways also improve the speed of recognising some non-cancerous conditions and allow those with no evidence of cancer to be reassured about that in a short time.

Between March and December 2018, there was a total of 504 referrals across the pathways across South Yorkshire, Bassetlaw and North Derbyshire. Although early days, the pathways have proved to be popular with GPs and have delivered outcomes in line with the projected figures seen in the National pilots.

Together we have a real opportunity to strengthen our position and to work together even better to deliver the best care for people - wrapping support, care and services around people as individuals, removing organisational barriers and putting the needs of people and patients first.

Commissioning development

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

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

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

We are committed to building on this work and strengthening our ability to deliver our ambitions by having further developed arrangements in place for 2020/21.

As a System, we have started to take a much more integrated approach, recognising the significant contribution our range of partners can have in commissioning processes.

Hospital Services Review

An Independent Review set up to ensure people across South Yorkshire, Bassetlaw and Chesterfield continue to receive excellent hospital services now and into the future made a series of recommendations in a report published in 2018. It recommended that to continue to provide high quality services across the region, hospitals must work together even more closely and in ways that connect teams across all sites.

The central theme was for local people to continue to get as much hospital care as possible in their local District General Hospital (DGH). This included a recommendation to keep all seven emergency departments (EDs) in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham, the Major Trauma Centre and ED at the Northern General Hospital in Sheffield and the ED at the Sheffield Children's Hospital.

In new networks of care, it was proposed that different hospitals take the lead for each of the five clinical services reviewed. The responsibilities of local hospitals could include strengthening the workforce and making sure that all patients get care to the same high standards.

The review also identified real challenges in sustaining some services in every DGH, in particular children's and maternity services. Work is ongoing to explore different options, looking at how far we can address the challenges we are facing by transforming our existing services. Work across partners has been ongoing since the recommendations were published and the Networks are now starting to be established.

The "Hosted Networks" which will also have a named, lead clinician, are as follows:

Gastroenterology
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Maternity
The Rotherham NHS Foundation Trust

Paediatrics
Sheffield Children's NHS Foundation Trust

Stroke
Sheffield Teaching Hospitals NHS Foundation Trust

Urgent and Emergency Care
Barnsley Hospital NHS Foundation Trust

Also among the proposals were two new regional centres of excellence to support the Networks. A Health and Care Institute would link the region's universities, colleges and schools with the NHS and local authorities to focus on region wide workforce solutions. As well as recruiting and nurturing the workforce of the future, it would include a single joint approach to developing and putting shared ways of working in place.

The creation of an Innovation Hub, in partnership with the Yorkshire and Humber Academic Health Science Network, will spot and quickly roll out innovation schemes across the System, such as new technologies. Both the Institute and Innovation Hub have been set up and are in the early stages of development.

In the last three years.....

1,300
Additional patients are accessing support through the Living With and Beyond Cancer programme

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

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

be CANCER SAFE
Social movement campaign has created over 12,000 cancer champions in the five Places; raising awareness of signs and symptoms to support the earlier diagnosis of some cancers

Worked in partnership with the Department for Work and Pensions and the Sheffield City Region on a health led employment trial
supporting over 3000 people
with long term physical and mental health conditions to find and stay in work

Extended social prescribing
support to mental health services

We continually met the 18-week waiting times target for elective and diagnostics across the region

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

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

We have made **extended GP access** at evenings and weekends available for **100%** of patients

OPEN
Mental health liaison services
have been put in place in Rotherham & Sheffield Emergency Departments

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

Established **36 primary care networks** covering 100% of the population, ensuring more joined up services at a local level

825 non-clinical members of staff
are now working as Care Navigators across the system, freeing up GP appointments by signposting patients to different services that might be more beneficial to them so they get the quickest and best care that is appropriate for their needs

Set up and launched the first **AHP Council** in the country where a broad range of Allied Health Professionals, including physiotherapists, dietitians and paramedics, come together to develop new ways of supporting health and care services

Completed procurement for Integrated Urgent Care

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

Partnership working has brought **c£200m** into the ICS

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

Set up **5 Hosted Networks** for the hospital services covered in the Hospital Services Review, with each one of our South Yorkshire and Bassetlaw acute trusts taking the lead for an individual service, co-ordinating it's running and supporting the future planning in closer collaboration with partners

Reduced **extended length of stay and delayed transfers of care** (helping patients get home quicker when they are medically fit for discharge)

South Yorkshire and Bassetlaw Regional Stroke Service launched to save even more lives and reduce disabilities for anyone having a stroke in South Yorkshire and Bassetlaw

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

Digital and IT

Our vision is to develop a fully integrated digital service across South Yorkshire and Bassetlaw, making more effective use of the technical expertise we already have and allowing our digital abilities to develop in line with the advances in technology we're seeing all over the world.

By improving our ability to connect with each other and share things like patient records between our organisations it means that no matter where a patient goes for care or treatment, anyone involved in their care can access their records without the need for people to repeat themselves to different parts of the system, or rely on paper records which are easily misplaced or damaged. With permission to share records, health and care staff can have immediate, up to date access to the information they need, when they need it to improve the care they give.

Work on the Yorkshire and Humber Health and Care Record (YHCR) for all citizens has been progressing well. Yorkshire and Humber was awarded £7.5 million to undertake this work, which will focus on records for cancer and urgent and emergency care service users. An approach has been developed to ensure clinicians, social services and service users are informing and approving what the YHCR looks and feels like to use.

£11.25 million of NHS England funding is being invested in South Yorkshire and Bassetlaw over three years to improve patient record systems in hospitals. The funds are awarded to NHS Trusts by a year on year bid process. In 2018/19, £2.5m was awarded, with a further £2.9m hoped for in 19/20.

Across primary care, a HealthCare App is being developed and implemented to help all our citizens access online services, and the implementation of technology to support the management of resources across GP practices is progressing well. A more secure and better performing ICT network (HSCN) and free WiFi for service users is being implemented.

Public WiFi is available in many hospital sites and was completed across the majority of the 282 GP practices across 5 CCGs by May 2019. Some LIFT buildings remain but work has been scheduled and should be complete by end of Summer 2019.

CASE STUDY

Digital triage solution supports seamless experience for patients

In September 2018, SYB ICS brought together a team to work on an online consultations project.

The aim was to implement an online platform where patients can register and input symptoms in order to access to the right care at the right time.

A single and centrally managed procurement process was coordinated by SYB ICS, and health-tech start-up Doctorlink has been appointed to provide four CCGs with a clinically approved digital triage and advice tool.

The digital triage solution is specifically designed to create a seamless experience for patients, while also removing administrative burdens for GP practices.

We are now supporting the next steps with Doctorlink and initial planning of rollout. We expect full rollout to complete by end of March 2020.

Medicines optimisation

Medicines represent the second largest spend in the NHS at £17.4 billion a year. With £1 in every £7 currently spent on medicines, they are the most common intervention given to patients. We are continually striving to work together to ensure that our investment in medicines is put to best use and are helping patients get the best treatment and care. This is being achieved through a number of successful projects we are delivering across South Yorkshire and Bassetlaw focused on reducing spend on medicines.

Our 569 Million Reasons Campaign (see case study opposite) successfully highlighted the £569m which the NHS spent nationally on prescriptions for medicines for minor conditions such as constipation and athletes' foot, which could have been bought over the counter from a high street pharmacy or supermarket.
By reducing what we spend on treating these common conditions that are self-limiting or lend themselves to self-care, we will have more money to spend on high priority areas that have a greater impact for patients.

In South Yorkshire and Bassetlaw, we are also tackling the issue of wasted or unused medicine - estimated to cost the NHS £300m every year – by improving ordering systems and staff training.

We are working with GPs and other healthcare prescribers to ensure they use the lowest cost type of a medicine to generate savings without compromising patient care.

Care homes is another key area of work for our Medicines Optimisation team which is delivering the national Medicines Optimisation in Care Homes initiative for South Yorkshire and Bassetlaw. This involves recruiting pharmacists and pharmacy technicians to start providing a service to care homes, working with health and social care colleagues, care homes staff, patients and their families.

CASE STUDY

569 Million Reasons Campaign

In 2017 the NHS spent approximately £569 million on prescriptions for medicines for minor conditions which could have been bought over the counter from a high street pharmacy or supermarket.

By reducing what we spend on treating conditions that are self-limiting or lend themselves to self-care, we will have more money to spend on high priority areas that have a greater impact for patients, to support improvements in services and to deliver transformation that will ensure the long-term sustainability of the NHS.

The SYB Integrated Care System delivered a public engagement campaign designed to gather insights and attitudes to the withdrawal from prescription of some common over the counter medications. A dedicated web platform 569millionreasons was created as the central place to coordinate the campaign and access the survey, test the messaging and view self-care/help educational resources.

Toolkits for practices, CCGs and pharmacies were provided as were face to face staff on-boarding workshops held at CCGs which involved CCG and practice staff, Patients Participation Groups / Community / Community and Voluntary Sector and a Press toolkit.

More than 14,000 people took part in the patient and public engagement survey and shared their views on purchasing over the counter medicines for minor conditions.

An independent report which included the insights from the public and prescribers is informing our next steps.

Workforce issues are a key driver for much of the work of the Integrated Care System.

Workforce

Workforce issues are a key driver for much of the work of the Integrated Care System. We have over 48,000 members of NHS staff – 72,000 if we include all health and care workers - who work to meet the needs of 1.5 million people across South Yorkshire and Bassetlaw.

Our staff provide services 24 hours per day, 365 days a year, and we must continue to support them to do the best possible job they can do. In line with national challenges, we also have a number of vacancies across our System which sometimes mean that providing these services 24 hours a day, seven days a week can be a challenge. Collectively, we are one of the largest employers in the region – and we must continue to be an employer of choice for our local population; offering more opportunities, being more flexible and encouraging school leavers and people looking to gain skills and employment to join our teams.

We also need to become better at "retaining" our workforce – so not only attracting people to work with us, but allowing and enabling them to develop and grow with us, enhancing their skills, opportunities and career progression. This in turn can have a huge impact on health, wellbeing and the local economy.

We have a Workforce focus within the ICS spanning a number of areas and have already supported the establishment of a "Workforce Hub" in the ICS and the successful recruitment of 96 trainee Advanced Practitioners and 160 trainee nursing associates. The creation of a Primary Care Training Hub is also having a significant impact on the provision of training both to staff who wish to work in primary care and those in post who wish to take on additional skills.

Some of the successes include:

- A Workforce Hub supporting bands 1-4 and encouraging new ways of working and new kinds of roles to address workforce shortages and improve patients' overall experience. We have 21 clinical pharmacists, 135 trainee nurse associates and 825 care navigators supporting primary care services across all five Places. See further example in the case study on page 46.
- The Primary Care Workforce Hub has created an opportunity for five newly qualified GPs to work in leadership roles following a successful bid to secure funding.

The funding, totalling around £90,000, was secured jointly from Health Education England (HEE) and NHS England (NHSE) between December 2018 and February 2019 with the aim of creating five leadership posts to aid workforce development in networks across South Yorkshire to address inequities in access to primary care.

We secured £200k from Health Education England to work with the Academic Health Science Network to help transform the mental health workforce. This work will start in Autumn 2019 and explore ways we can improve ways of working to better meet people's needs.

CASE STUDY

South Yorkshire and Bassetlaw leads 'trailblazing' training to tackle nurse shortage and meet demand

South Yorkshire and Bassetlaw is one of the first areas in the country to roll-out a 'trailblazing' primary care training scheme for nurses to meet increasing demand in GP practices, tackle staff shortages and build a workforce 'fit for the future'.

The Primary Care Nurse Vocational Training Scheme allows newly qualified nurses to be trained in the context of general practice in posts specifically designed for work in general practice and primary care. This compares to the traditional route of early careers in hospitals, with subsequent re-training required for the switch to practice nursing which can often take a further 18 to 24 months before they are fully able to contribute.

In September 2019, 18 trainees will start the scheme which has been set up by South Yorkshire and Bassetlaw Primary Care Workforce and Training Hub with the support of local CCGs.

The one-year training programme will include placement rotations in GP practices across South Yorkshire and Bassetlaw and cover a wide variety of needs from management of chronic conditions to health screening and advice, taking smears, and providing immunisation and vaccinations.

The Primary Care Workforce and Training Hub forms part of the wider workforce hub for South Yorkshire & Bassetlaw Integrated Care System (ICS), which also includes the Excellence Centre (SYREC) and the Faculty For Advanced Practice. This work is aligned with the National Training Hub agenda as part of the GP Workforce 10 Point Plan.

This programme is part of additional work the Primary Care Workforce and Training hub has been able to undertake following a series of successful bids for funding from both NHS England and Health Education England hub in 2018, amounting to around

£380,000

CASE STUDY

Allied Health Professionals leading the way to more integrated care

With over 2000 Allied Health Professionals (AHPs) working across services in South Yorkshire and Bassetlaw, the AHP workforce is the third largest staff group across the system and we are the first area in the country to develop and launch an AHP Council.

The term 'AHP' is a broad one and represents a number of highly skilled staff who work across a broad range of services, often acting as a crucial bridge for patients in their health and care journey. Given their links across all sectors, AHPs are vital to supporting and achieving the overall ambition of the SYB ICS to give people the best possible start in life, with the support to stay healthy and live well for longer.

An AHP strategy has been developed through work with all partners and a broad cross-section of AHPs. The strategy describes how the AHP workforce will work collectively to ensure all services – across community, primary and secondary care – are utilising the skills and capability of AHPs in the best possible way to meet the needs of our patients, which in turn, will support collaboration between services, reduce duplication and variation and provide innovative and integrated solutions across all levels and areas of the system.

CASE STUDY

Region's nursing scheme wins prestigious national award

In order to make sure nursing staff are available to provide care when and where needed, we brought all local acute hospitals together to work together rather than compete with each other for staff.

Previously, bank nurses could only work at one of the trusts in the region. Now, the innovative use of a single nurse bank provider (NHS Professionals) for the whole of South Yorkshire and Bassetlaw means that for the first time, local bank nurses can work at any of our local acute hospitals meaning the workforce is now much more flexible and can provide the same high quality standard of patient care no matter which hospital they work in.

The innovative scheme, which has boosted nursing support to frontline hospital care and saved £1.2m of public money in the process, won the Workforce Contribution in Health & Social Care Systems' category (sponsored by NHS England) at the Healthcare People Management (HMPA) Awards in 2019.

Communications and engagement

We have built on the strong communication and engagement networks in South Yorkshire and Bassetlaw to ensure the public, patients, staff and stakeholders are aware of the work of the ICS, how it fits with their local health and care services and how they can get involved in planning and shaping services across the System.

We have continued to work closely with our communications and engagement colleagues in the statutory NHS organisations as well as building stronger working relationships with our Local Authority, voluntary and community sector partners. This approach has enabled us to deliver consistent messages through trusted sources while strengthening our engagement mechanisms with communities and groups who are less heard.

Sustainability and Transformation Plan

During our first year as a collaboration, we worked with our Healthwatches and the voluntary sector across South Yorkshire and Bassetlaw to engage with groups and communities, with a particular emphasis on the seldom heard to capture and report their feedback on our Sustainability and Transformation Plan. We also asked partners to raise awareness and to hold discussions in their organisations to gather feedback.

More than 1,000 people gave their views which were fed back and discussed by partners at the Collaborative Partnership Board. The themes have continued to influence our thinking.

Hospital Services Review

We have also undertaken extensive involvement work with the public and patients to inform the ongoing work of the Hospital Services Review.

This has comprised of three phases:

- **Phase 1 (August-September 2017):** To understand what makes a sustainable health service, what is important to people about hospital services and to support the development of a series of principles to inform the selection of services to be reviewed.
- **Phase 2 (October 2017-February 2018):** To receive patient and public input into the development of evaluation criteria to be used to assess options going forwards, to engage with patients and the public to understand their main concerns around the five services and to ask for their ideas on good practice.
- **Phase 3 (June-October 2018):** Through analysis of the data captured so far on our involvement with the public and patients and with our Citizens' Panel's advice, we identified communities from whom we had not yet heard views. A series of events and conversations were set up over the Summer 2018 to enable meaningful engagement with these communities.

The findings from phase one were considered as part of the analysis to determine which services were to be reviewed, the findings from phases two and three have been independently analysed, with phase two findings influencing the Strategic Outline Case and the phase three findings used to inform the next stages of the work.

Patient and public involvement

Throughout the development of the Partnership, we have been working with community, patient and voluntary groups as well as staff to have conversations to inform our work across a range of areas. In addition to the Hospital Services Review, this includes NHS 111 procurement, over the counter medicines and ophthalmology services and transport and travel with regard to accessing services.

Citizens' Panel

In January 2018 we launched a Citizens' Panel in recognition that as our work develops, it is vital that the voice of local people is at the heart of what we do. The Panel brings together people from across South Yorkshire and Bassetlaw to provide an independent view and critical friendship on matters relating to the work of the Integrated Care System. There are currently 13 volunteers who sit on the Panel with all areas of the region represented. The Citizens' Panel spoke to different communities about the Hospital Services Review, contributed to the 569 million reasons medicines campaign, shared their views on the orthopaedics pathway for hip and knee replacements as well as the NHS 111 procurement.

Transport and Travel Panel

Following the recommendations from the Hospital Services Review, a Transport Panel comprising of patients and members of the public from each area of South Yorkshire and Bassetlaw was set up in November 2018. The Panel looks at the potential impact changes to services would have on patients, the public, carers and families with regard to travel including testing journey times where possible to provide realistic insight into the impact of any service change. The Panel looks at how to improve transport and travel planning and infrastructure around NHS services.

NHS 111/ Integrated Urgent Care Service Procurement

The Citizens' Panel supported the procurement of a £17.6 million contract which awarded an Integrated Urgent Care Service for the people of Yorkshire and the Humber to Yorkshire Ambulance Services (YAS). The new enhanced service has been procured in partnership by Yorkshire and Humber CCGs and started in April 2019. The Citizens' Panel were involved throughout this procurement work providing the patient representative voice.

Long Term Plan

The NHS Long Term Plan was published by NHS England in January 2019 and sets out how the NHS will improve the quality of patient care and health outcomes. It also explains how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years.

We are working with partners to develop our local response by producing an ICS five-year strategic plan by the Autumn of 2019. Significant patient and public engagement on the Plan has been undertaken across each Place with support from the local Healthwatches, ICS partner organisations and the SYB ICS communication and engagement team. Involvement with staff and stakeholders in Place has been led by partners.

Discovery Days

In November 2018 we worked with NHS England and all South Yorkshire and Bassetlaw partners to develop a co-designed communications and engagement approach. In January 2019 the organisations came together again to develop a co-designed action plan for clinical engagement and leadership.

Corporate services

By taking a collective approach to some of our corporate services we can tackle waste and deliver improved efficiency and effectiveness. In 2018/19, Trusts saved £1.45 million by continuing to work together on joint procurement schemes. This means that they can focus resources on improving patient care and services.

Trusts also worked together to tackle temporary staffing, with a collaborative medical bank model initiated in April 2018 that is supporting sharing of medical staff and reduction of agency spend.

A non-medical bank system was also procured from July 2018, which has saved over £400k in administration fees, and delivered over 90,000 additional nursing hours.

CASE STUDY

Joint procurement schemes save £1.45m

Colleagues from six acute trusts and two mental health and community trusts from across South Yorkshire and Bassetlaw work together with a focus on strategic purchasing. This joint working means that more than one, if not all, of the collaborative will benefit.

The market is reviewed collaboratively with procurement organisations to determine the best route into the market and what levers need to be applied to get the best outcome for all involved.

There is normally a combination of determining factors which link back to the Lord Carter Report and centre around best price, added value, standardisation and improved quality. Only the best price can be quantified in terms of returning cash-releasing savings to frontline care, while the other three factors have less tangible but still direct benefits to patient outcomes.

Some of the schemes that have contributed to the £1.45m saving in 2018/19 include: disposable continence, minimally invasive surgery products, tissue adhesives, sutures and paper hygiene.

Capital and Estates

Our populations are already starting to benefit from our collective bidding success when we were awarded almost £20 million for various system-wide projects.

Our successful bids were:

- The additional CT scanner at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (£4.8m)
- The new hub for Yorkshire Ambulance Services NHS Trust in Doncaster (£7m)
- The co-location of the children's emergency department and assessment unit at Barnsley Hospital NHS Foundation Trust (£2.5m)
- Improvements to the configuration of hyper acute stroke unit at Sheffield Teaching Hospitals NHS Foundation Trust (£4.6m)

The Department of Health and Social Care announced the expected £1 billion funding for capital projects.

Our analysis of estate and investment needs demonstrates an urgent need to invest both in infrastructure and transformation to ensure that we continue to deliver and enhance care and services for our patients and we will be working through the established ICS Estates Board and partnering with organisations to ensure that our capital, estate and Investment planning continues to be as strong as possible in order to get the best possible outcomes for South Yorkshire in any future investment rounds.

Leadership and organisational development

System leadership is where we work beyond organisational boundaries on collective strategy and planning or on issues or mutual concerns that cannot be solved by a one person, partner or organisation. To support this, we are working in partnership with our local Yorkshire and Humber Leadership Academy to develop our leaders to meet the emerging challenges of System leadership.

Across health and care in SYB new systems of delivery are being developed, formed and created to enable a population based approach to health and care. New forms of networks and partnerships encompassing cross sector partners are being developed across the ICS and the statutory organisations we recognise are embarking on a journey of significant change. These new, local systems need support to develop leadership processes and systems that are able to deal with the complex, uncertain, emerging and locally specific landscapes in which they operate.

We are at the beginning of our leadership and Organisational Development journey but underpinning our approach is a 'virtual' leadership academy and the development of a suite of development programmes. These will build on the infrastructure, development activity, programmes and delivery partnerships that already exist in SYB, in particular with the Yorkshire and Humber Leadership Academy and the work of our Regional Leadership Council. Our approach is to integrate systems leadership development and talent management across our partnership.

To support our System approach, members of the ICS programme management team have already benefitted from a short programme developed to equip them with skills, knowledge and application to achieve more in complex system working.

How we are run

The majority of our work takes place locally in neighbourhoods. Only when improvements can be made across a wider scale, are services or projects planned at a System level.

We have 36 neighbourhoods with populations of 30-50,000. At this level, primary care is strengthened by working together in networks. We have five places with populations between 250-500,000. This town or city level, health and care works together more closely. Each of our Places has a plan which sets out what the partners want to achieve together to improve health and wellbeing and other factors that affect health, such as employment, housing and education.

We have one System with a population of 1.5 million. At this level, strategic planning and improvements can take place for the benefit of all, as well as having an overview of System performance and planning.

To achieve our aims as a System, we have governance in place that has been agreed by our NHS partners. This governance is a collection of strategic forums where issues are debated, priority work areas agreed or performance assured. In September 2018 our partnership supported a review of governance and ways of working. Following the review, it was agreed that interim governance for one year would start from April 1, 2019.

This includes the:

- **Health Oversight Board**
  where health partners' collective resources to improve quality of care and health outcomes and work programmes are overseen by non-executives and the wider system such as Chairs from Healthwatch and Health and Wellbeing Board. It meets quarterly.

- **Health Executive Group**
  where health partners come together to discuss and agree work programmes across the SYB footprint. It meets monthly.

- **Integrated Assurance Group**
  where health partners come together to review and assure collective health system performance and the work programmes. It meets monthly.

We also come together with all health and care partners to agree and discuss joint work programmes for partners across South Yorkshire and Bassetlaw in the **Collaborative Partnership Board**. We are currently reviewing this forum to better suit the needs of members. It meets quarterly.

We work closely with our NHS regional team (North East and Yorkshire) and are supported by our Regional Director.

Looking ahead

In Autumn 2019, we will publish our Five Year Plan.

This will be the conclusion of hundreds of conversations with the public, patients, clinical and non-clinical staff, partners – statutory and voluntary, pharmacy and community colleagues on the Long Term Plan and what it means for South Yorkshire and Bassetlaw. It will set out our priorities for the next five years and be our blueprint for delivery as a System.

We have made tremendous progress in the last three years, joining forces on projects and services where it is right to do so and where we can make a real difference. We will continue on our collaborative journey by building yet stronger connections, working together even more closely on all opportunities for improving patient care and services at a System level.

We already know that there are some areas we will want to focus on thanks to feedback we have so far. These are: cancer care, care in your neighbourhood, mental health and learning disabilities, bringing the NHS into the digital age and prevention.

A recurring theme in our work and our conversations is the role we as a System and a collection of partners play in the local and regional economy. Serving the same population, we share a number of ambitions with the Sheffield City Region and we have agreed some key priority areas that will be developed across health and social care, strengthening our partnership working with our local authority colleagues.

We will build on some of the fantastic schemes happening at Place, extend our work to prevent cardiovascular disease, improve our economic standing, reduce smoking prevalence and roll out the following schemes looking at:

These are:

- **Loneliness/connectedness**
  Building on and extending existing exemplar social prescribing schemes like those in Rotherham.
- **Complex lives/rough sleeping**
  Extending the existing good work in Doncaster which has seen homelessness reduce to 16 with 115 people having been supported by the multi-agency, multi-disciplinary approach.
- **Active health**
  Building on the successful Move More partnership in Sheffield to create a culture of physical activity across the five places and improve overall population health and wellbeing.

There is some great work happening to develop primary care in each of our Places and in the year ahead we will continue to better develop our relationships with our 36 Primary Care Network Clinical Directors to ensure the System as a whole is being as supportive as we can possibly be.

Our conversations with the public, staff and partners have been informing our work programmes since we came together as a partnership in 2016 and we are excited to share our co-produced refreshed strategy when it is ready later in 2019.






The year ahead will see our Primary Care Networks evolve and develop. Each of our Places has strong relationships with their primary care colleagues and we will ensure that we continue to align the delivery of our collective strategic ambitions.






South Yorkshire and Bassetlaw Integrated Care System

Our work so far

Thank you for reading.

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