South Yorkshire and Bassetlaw

Sustainability and Transformation Plan: Workshop

25 April 2016

SIR ANDREW CASH

Chief Executive, Sheffield Teaching Hospitals and South Yorkshire and Bassetlaw STP lead

JOHN MOTHERSOLE

Chief Executive, Sheffield City Council

LESLEY SMITH

Chief Officer, Barnsley Commissioning Group

Who is here today

- People who use NHS services
- Voluntary sector
- Patient and public champions
- Local Authorities

- NHS organisations from across South Yorkshire and Bassetlaw
- Research colleagues
- Education colleagues

Sheffield Hallam University

VoluntaryAction Rotherham

Bassetlaw DISTRICT COUNCIL — North Nottinghamshire —

Doncaster CVS

Voluntary Action Barnsley

healthwatch

Doncaster Metropolitan Borough Council

Yorkshire & Humber Academic Health Science Network

The University Of Sheffield.

Barnsley Metropolitan Borough Council

Sheffield City Council

BCVS Bassetlaw Community and Voluntary Service Encouraging Community Action

Rotherham Metropolitan Borough Council

VAS

NHS

What is today about?

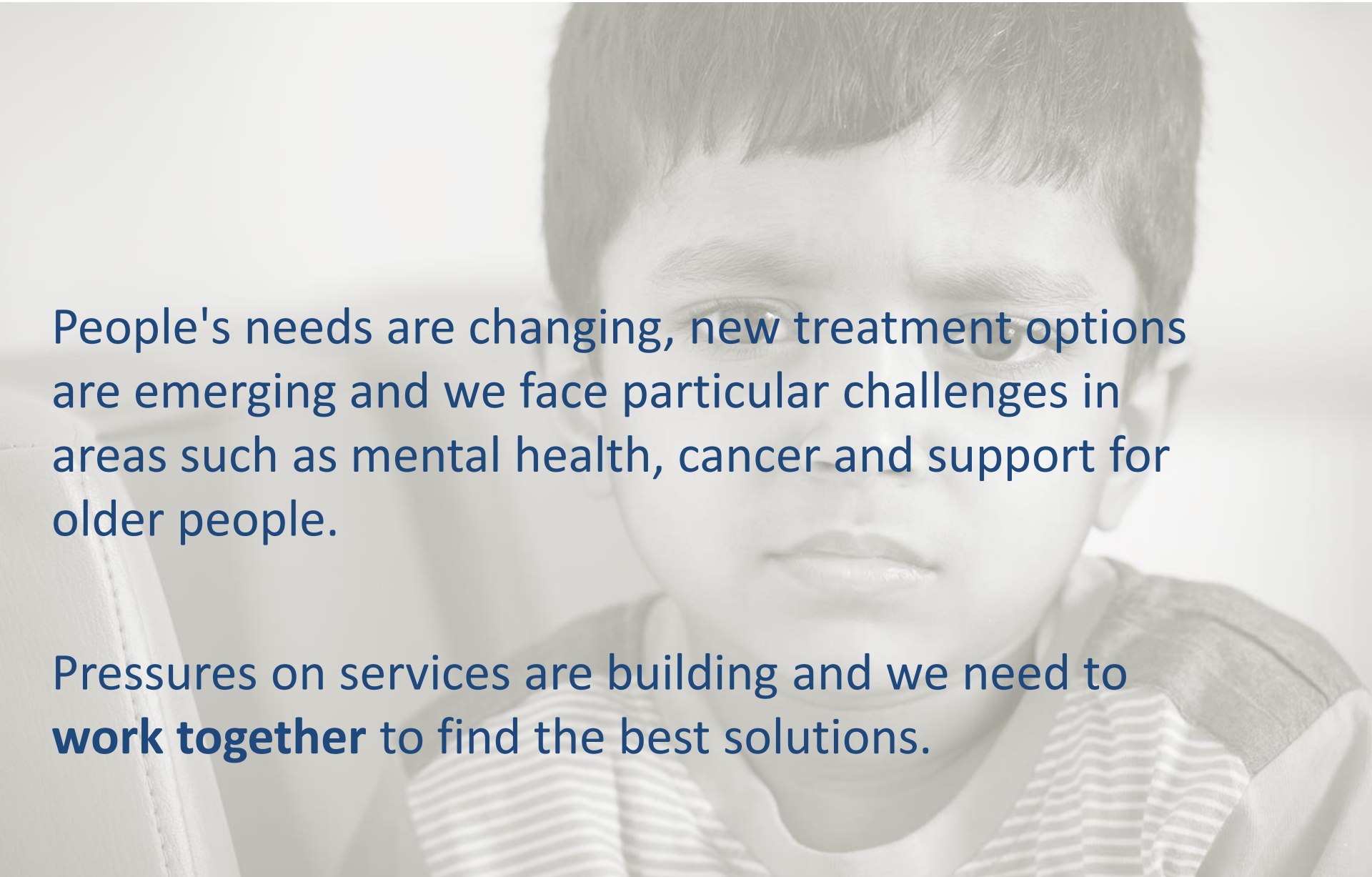
- **Bring you up to speed** with the South Yorkshire and Bassetlaw Sustainability and Transformation Plan process
- **Shape the plans** for our region
- Get **involved**

Why do we need an STP?

There have been some **big improvements** in healthcare in the last 15 years…

People with cancer and heart conditions are experiencing better care and living longer.

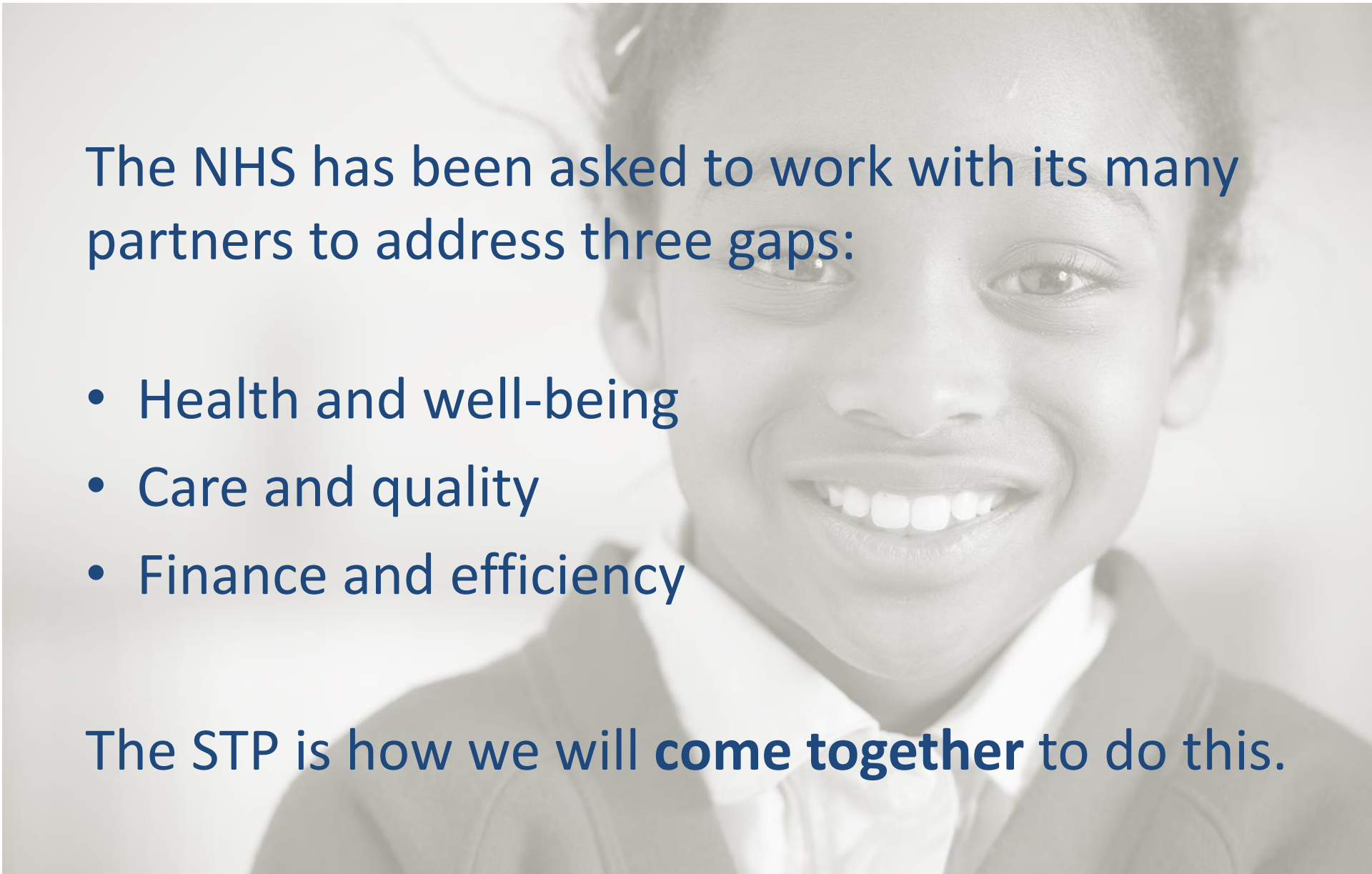
Waits are shorter and people are more satisfied – but the **quality of care** is **variable**, **preventable illness** is **widespread** and **health inequalities deep-rooted**.



People's needs are changing, new treatment options are emerging and we face particular challenges in areas such as mental health, cancer and support for older people.

Pressures on services are building and we need to **work together** to find the best solutions.

Three gaps



The NHS has been asked to work with its many partners to address three gaps:

- Health and well-being
- Care and quality
- Finance and efficiency

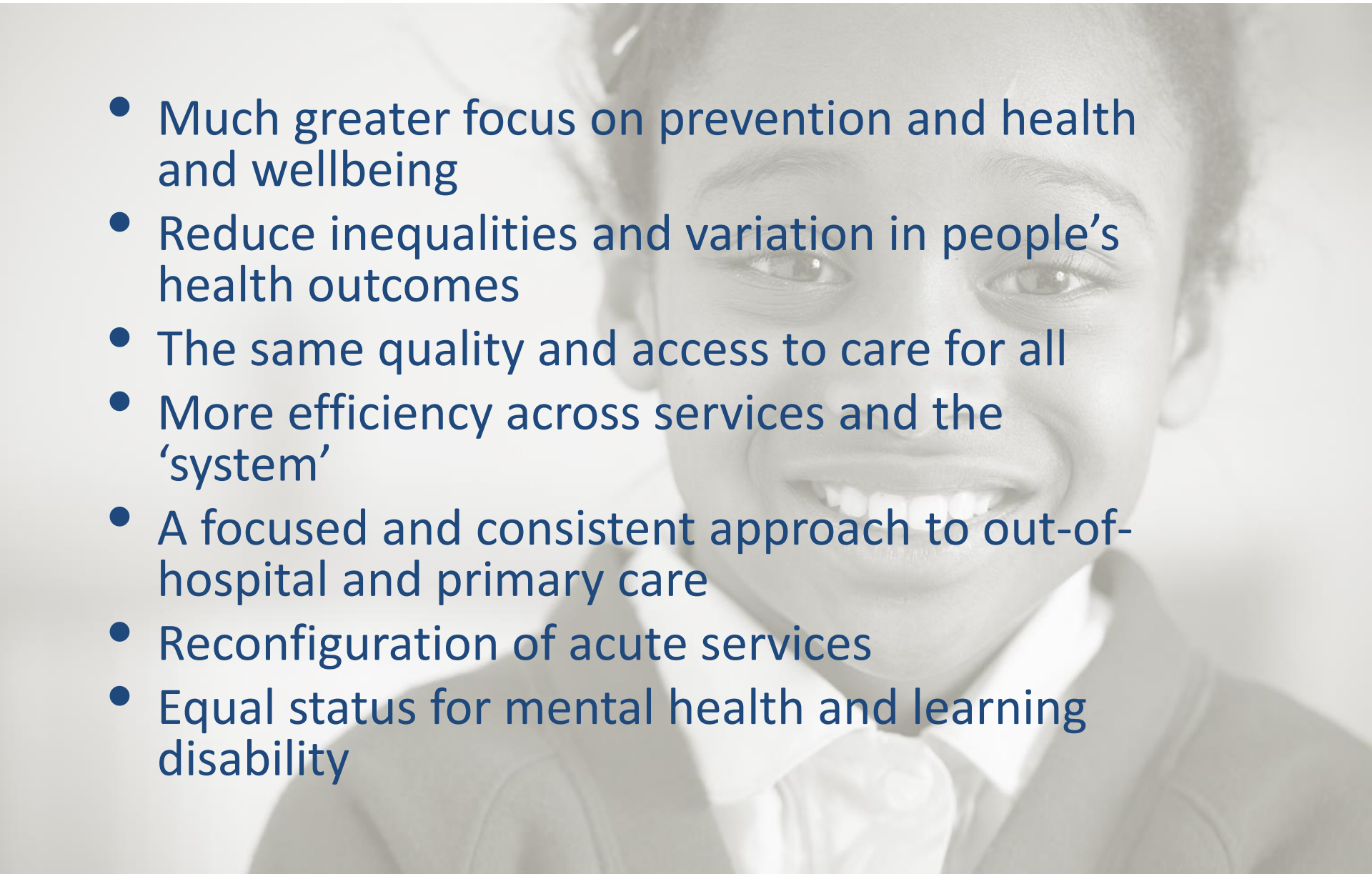
The STP is how we will **come together** to do this.

Our aim

We want to **work with you** to create plans that address and close the gaps.

This afternoon is just the start …

What is our focus?



- Much greater focus on prevention and health and wellbeing
- Reduce inequalities and variation in people's health outcomes
- The same quality and access to care for all
- More efficiency across services and the 'system'
- A focused and consistent approach to out-of-hospital and primary care
- Reconfiguration of acute services
- Equal status for mental health and learning disability

Engaging with the public

- **Engaging** and **listening** via our partners' networks online and in person
- **Matty** and **Lynne** are here today to keep us focused
- Our **voluntary** and **charity** sector partners are also here today

Engaging with our partners

- Regular **communications** to keep you updated and informed
- **Steering** group
- **Co-ordinating** group

Building on what we have

Our CCGs are already making good progress in a number of areas.

Our acute care hospitals are also making good progress with the Vanguard and clinical networks are coming together.

This combination of **local CCG** and **STP level** planning provides a top-down and bottom-up approach and ensures that:

- Localities are responsive to the needs of their local communities
- There is coordination across the footprint

There are also a number of themes that cut across the different levels of planning, and which will be relevant to all plans.

Whole system opportunity

It’s a fantastic opportunity to come together without boundaries, without walls.

If we are ambitious and joined up, we could attract significant investment to support our ideas.

This might be an NHS plan, but it’s a whole system opportunity. If we get this right, we can all make a real difference.

The public health perspective

Greg Fell

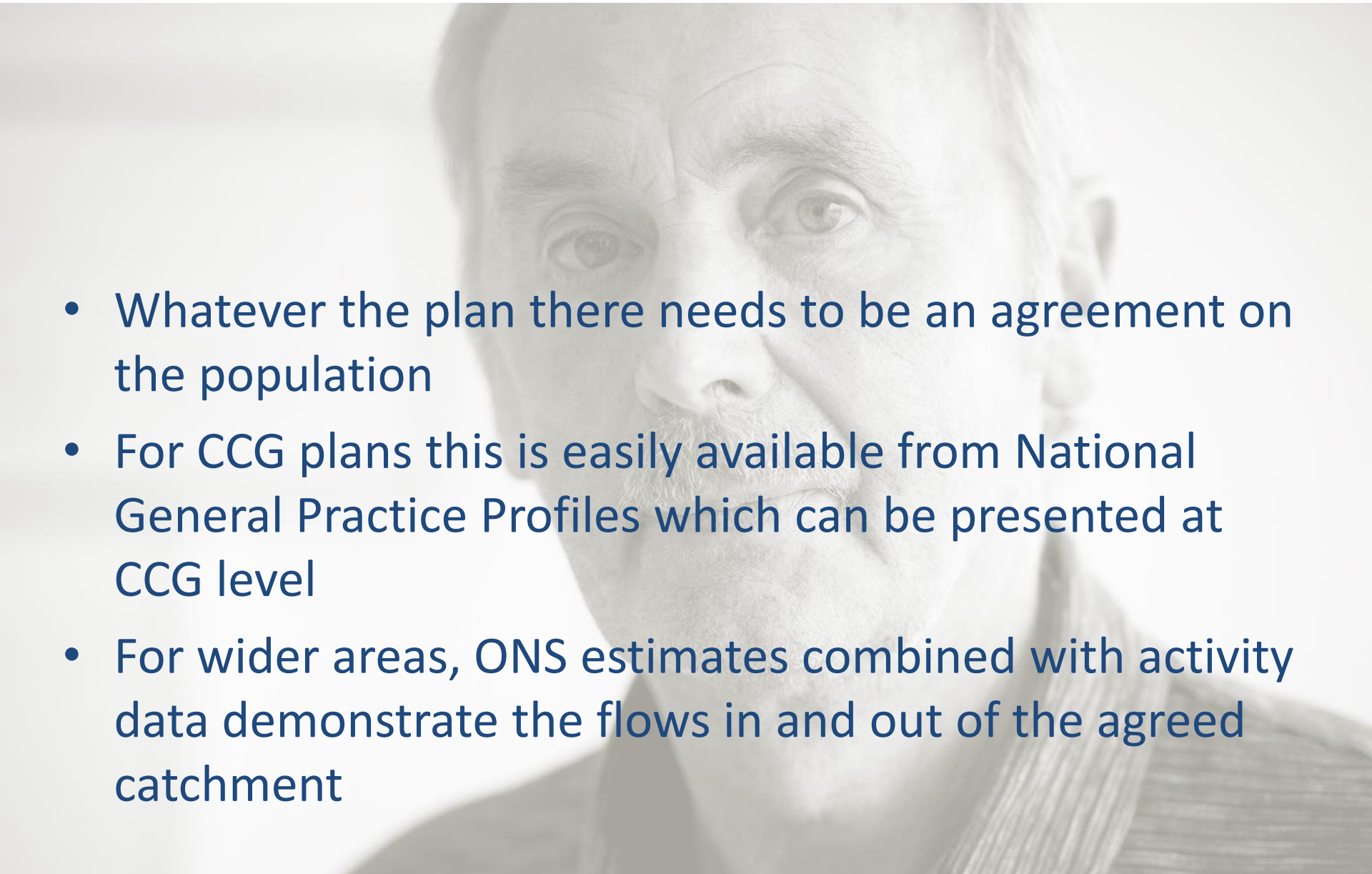
On behalf of all the directors of public health across South Yorkshire and Bassetlaw

And with thanks to Public Health England and the Yorkshire and Humber Academic Health Science Network

What is our focus?

The people of South Yorkshire and Bassetlaw

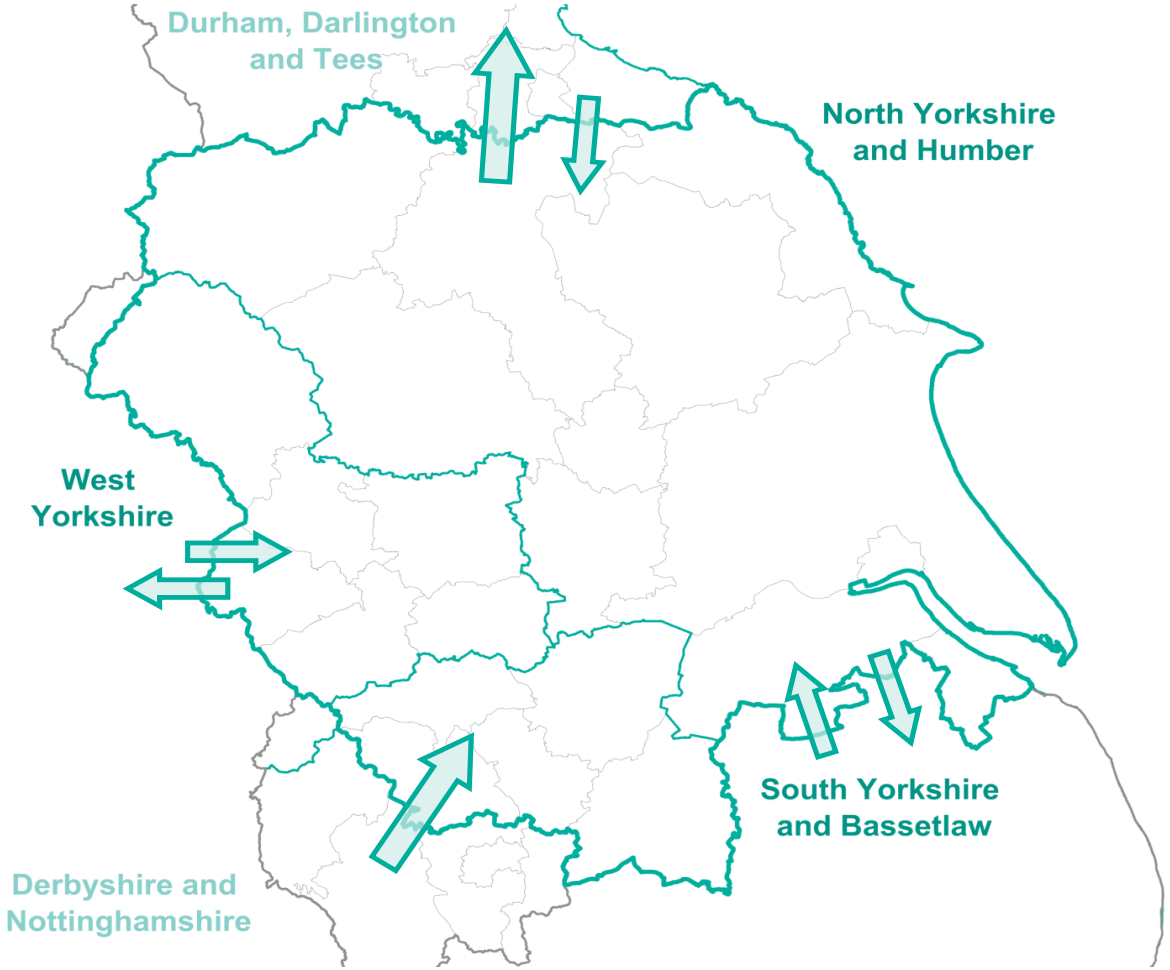
People



- Whatever the plan there needs to be an agreement on the population
- For CCG plans this is easily available from National General Practice Profiles which can be presented at CCG level
- For wider areas, ONS estimates combined with activity data demonstrate the flows in and out of the agreed catchment

For South Yorkshire and Bassetlaw the catchment population is 1.5m

- 1.5m population resident
- Health care flow wise – mostly self contained
- Some flow in from North Derbyshire



People

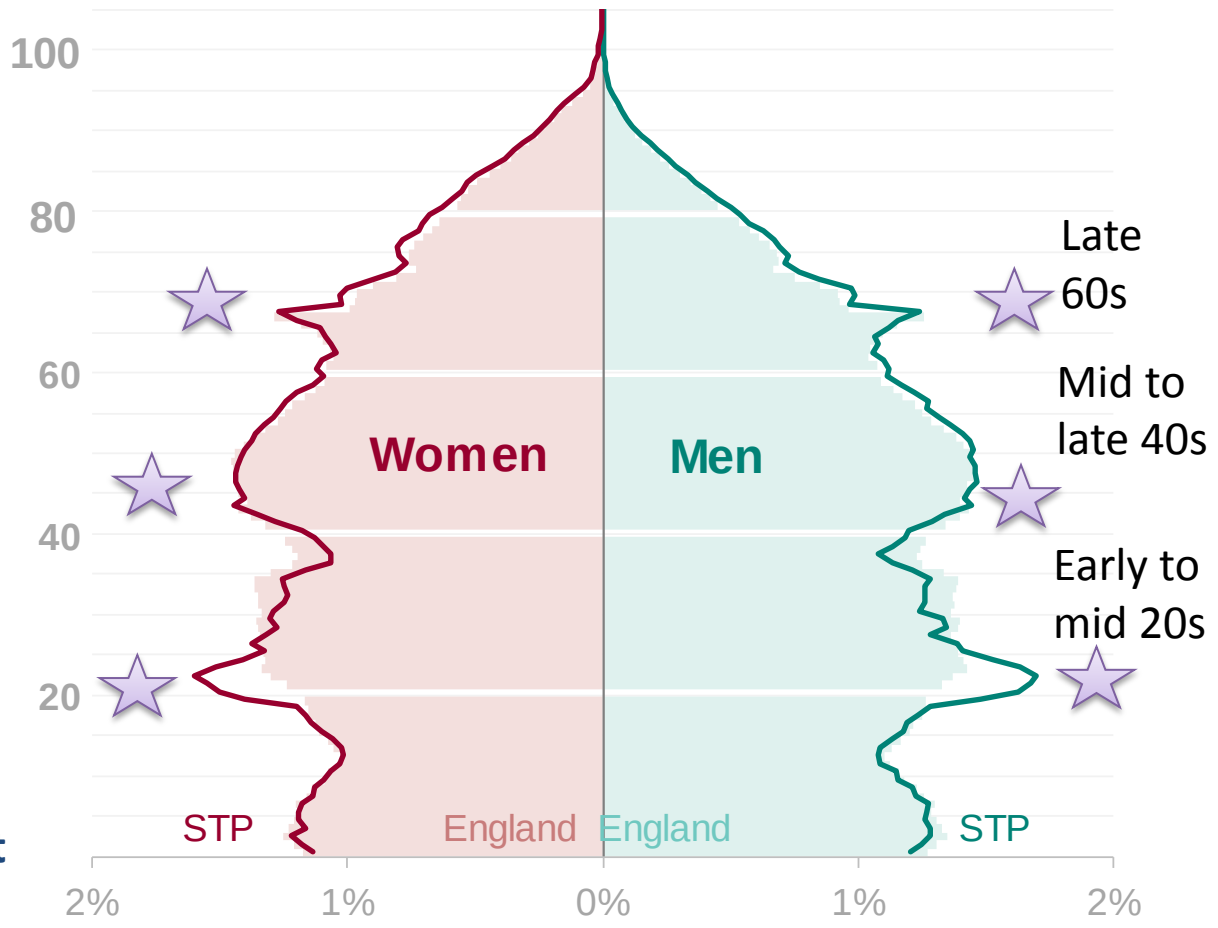
3 key peaks which will influence health service provision in the future.

Early twenties is the only one larger than the national average (universities & colleges)

The is also a dip for people in their late thirties that is greater than the national average

Don't forget early years – best value investment for health outcomes

Age pyramid for South Yorkshire and Bassetlaw

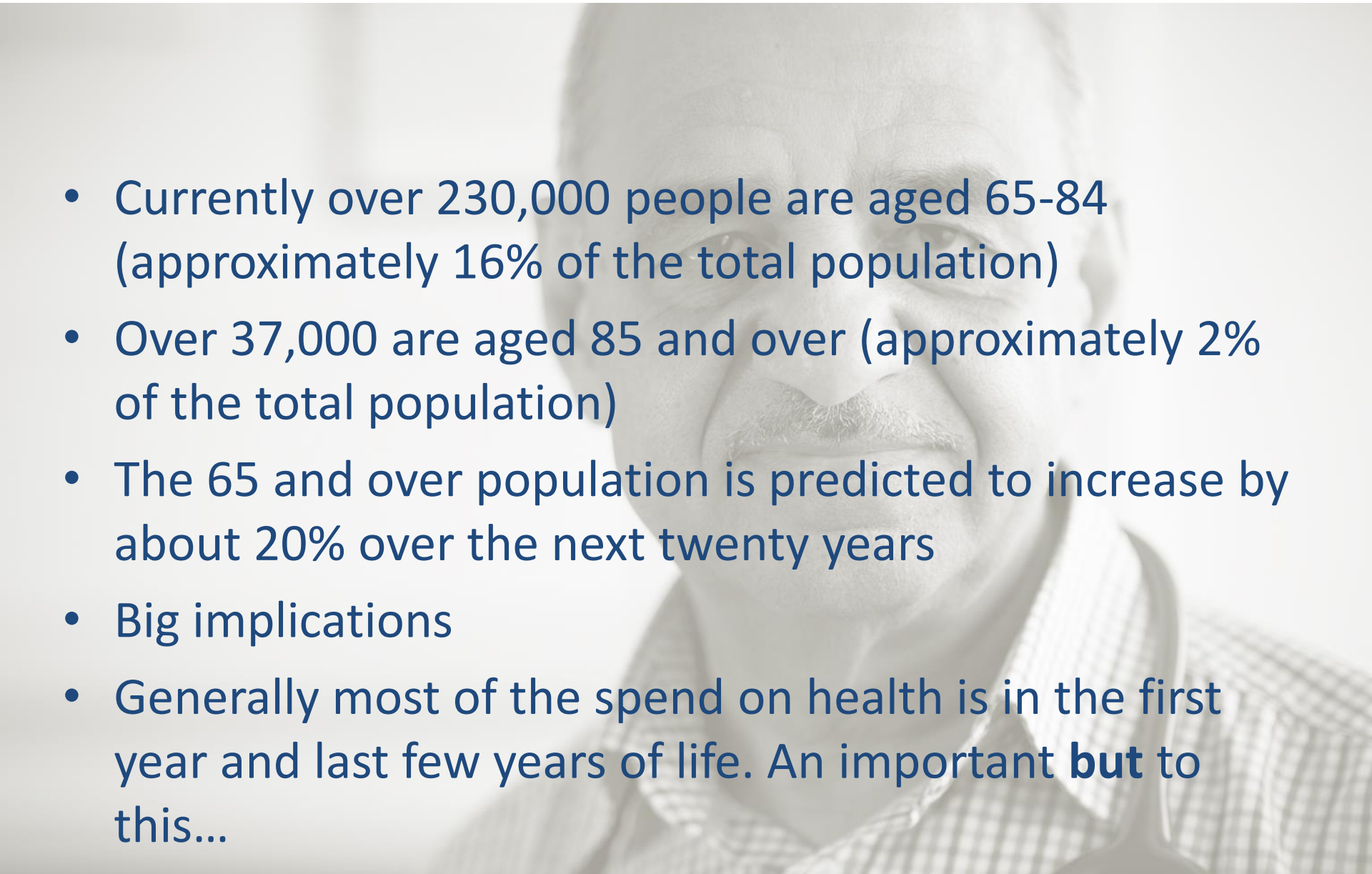


Source: ONS 2014 population estimates

People - children

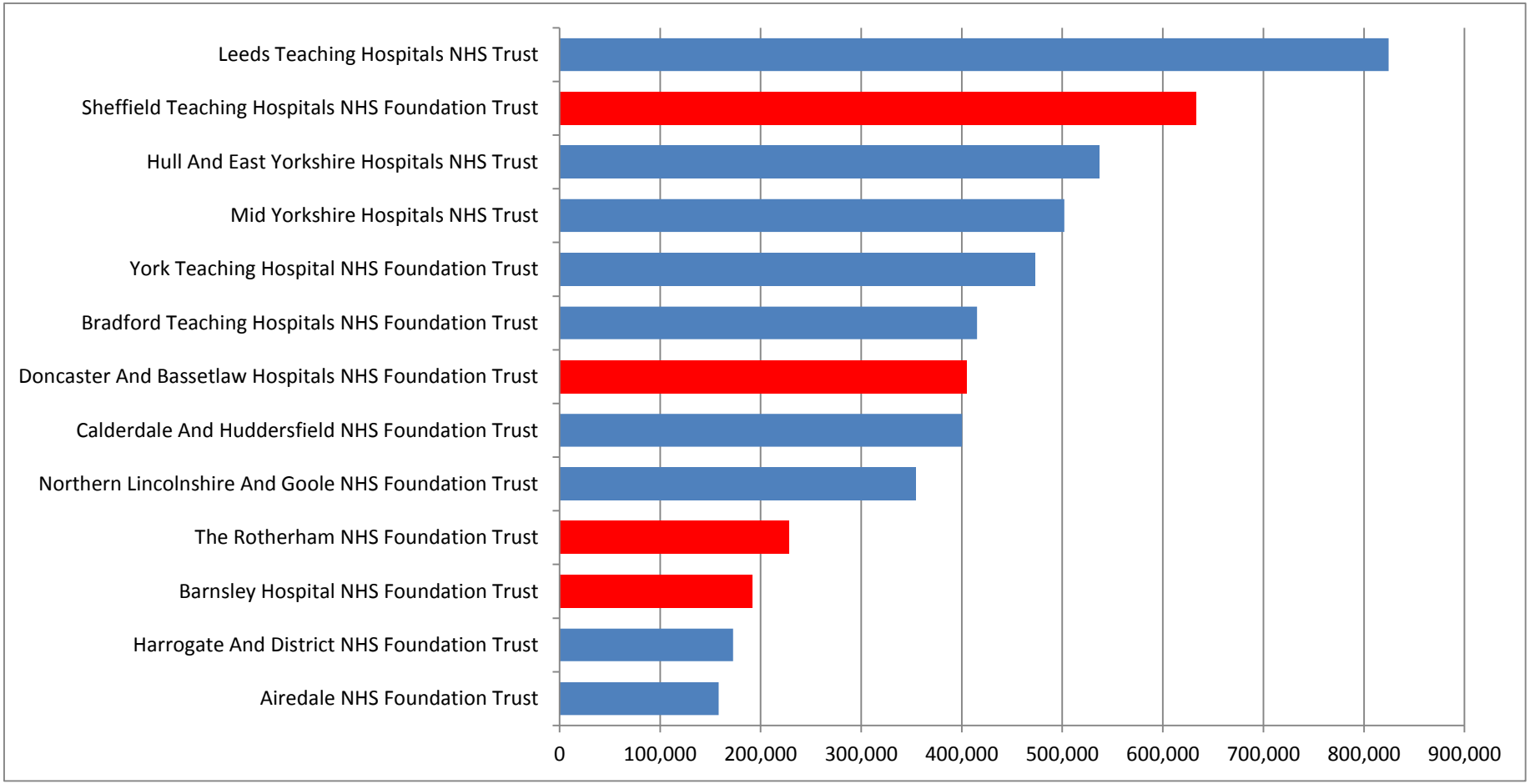
- The marked increase in live birth rate up to 2012, the birth rate has dropped since
- Overall, we expect around an increase of about 5,000 children under 16 between 2014 and 2018

People – older adults



- Currently over 230,000 people are aged 65-84 (approximately 16% of the total population)
- Over 37,000 are aged 85 and over (approximately 2% of the total population)
- The 65 and over population is predicted to increase by about 20% over the next twenty years
- Big implications
- Generally most of the spend on health is in the first year and last few years of life. An important **but** to this…

People – provider catchments
(district general hospital level)



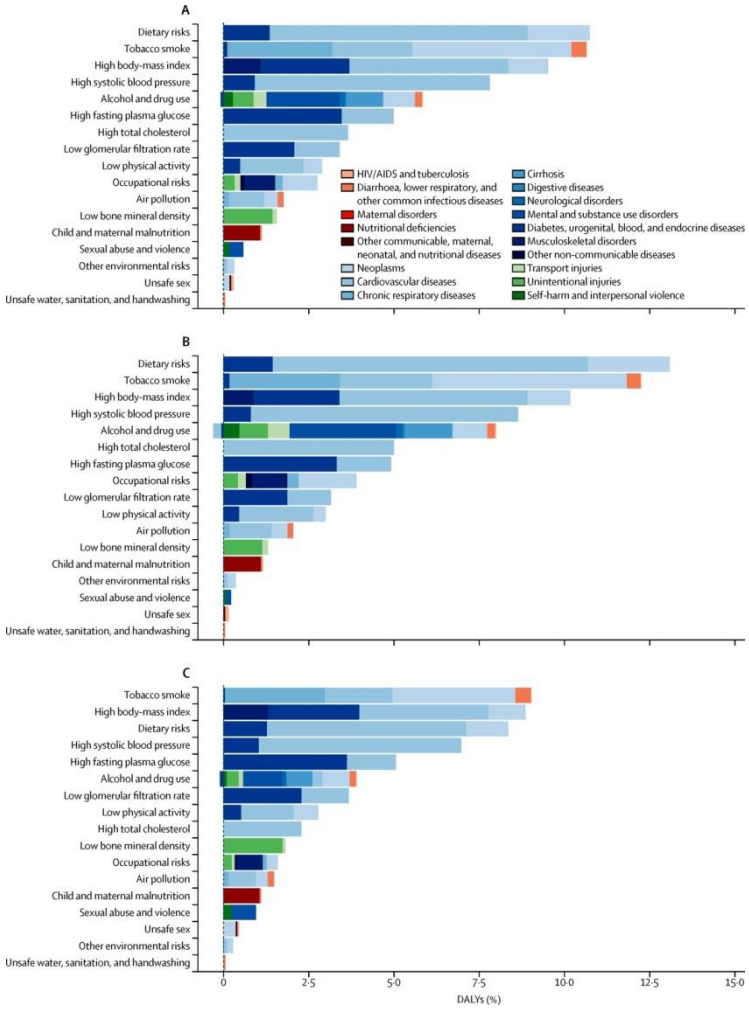
Getting the flow and footprint right for different models

People - children

- Continued rises in need for children and young adults
- Early years represent best value investment
- Increasing need for the ‘middle-aged’ cohort as they move into older age – healthy ageing
- Local services need to be planned in partnership to maintain viable and sustainable provider catchments

Need, risks, outcomes JSNA forms the basis

Risks – behavioural risks to England burden of disease



The usual list

Fat, cigs, booze, lack of sweat, too many pies

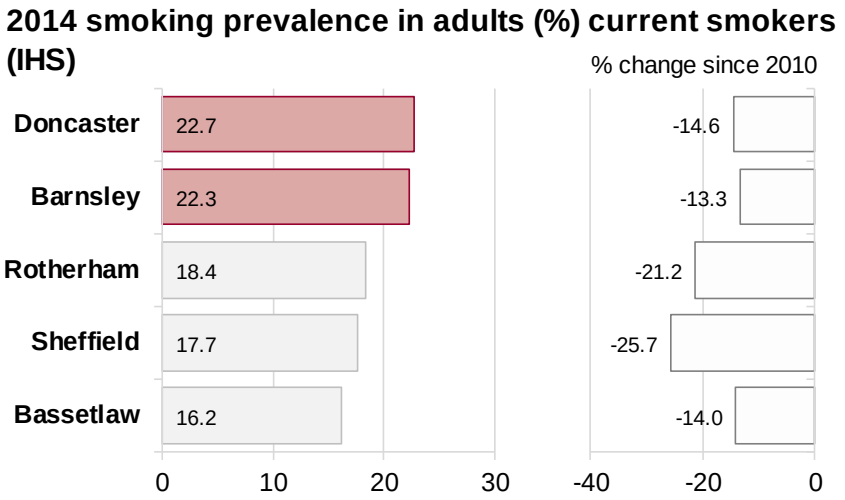
The downstream consequences of these things

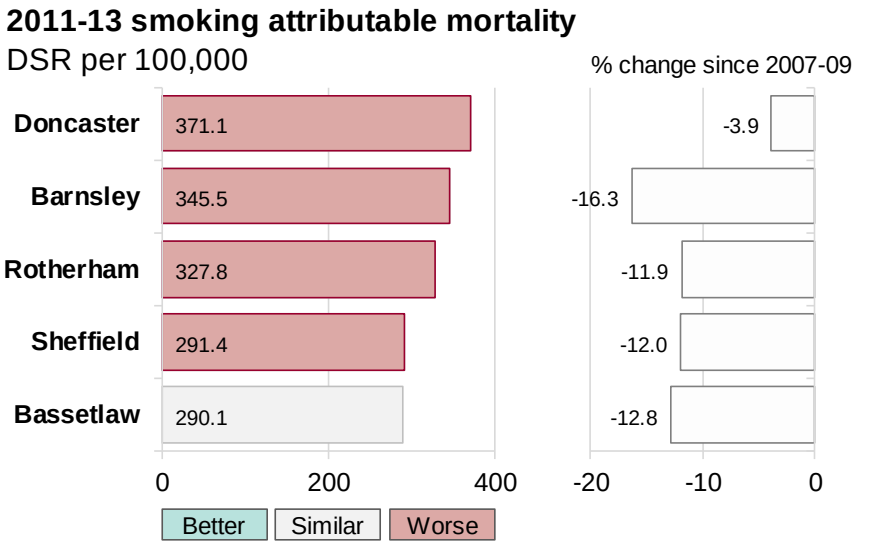
Disability-adjusted life-years (DALYs) attributed to level 2 risk factors in 2013 in England for both sexes combined (A), men (B), and women (C)

Tobacco

- Smoking prevalence is going down
- Faster in some areas than others
- It remains the most important risk factor
- Between 16% and 23% of the population smoke
- Not evenly spread

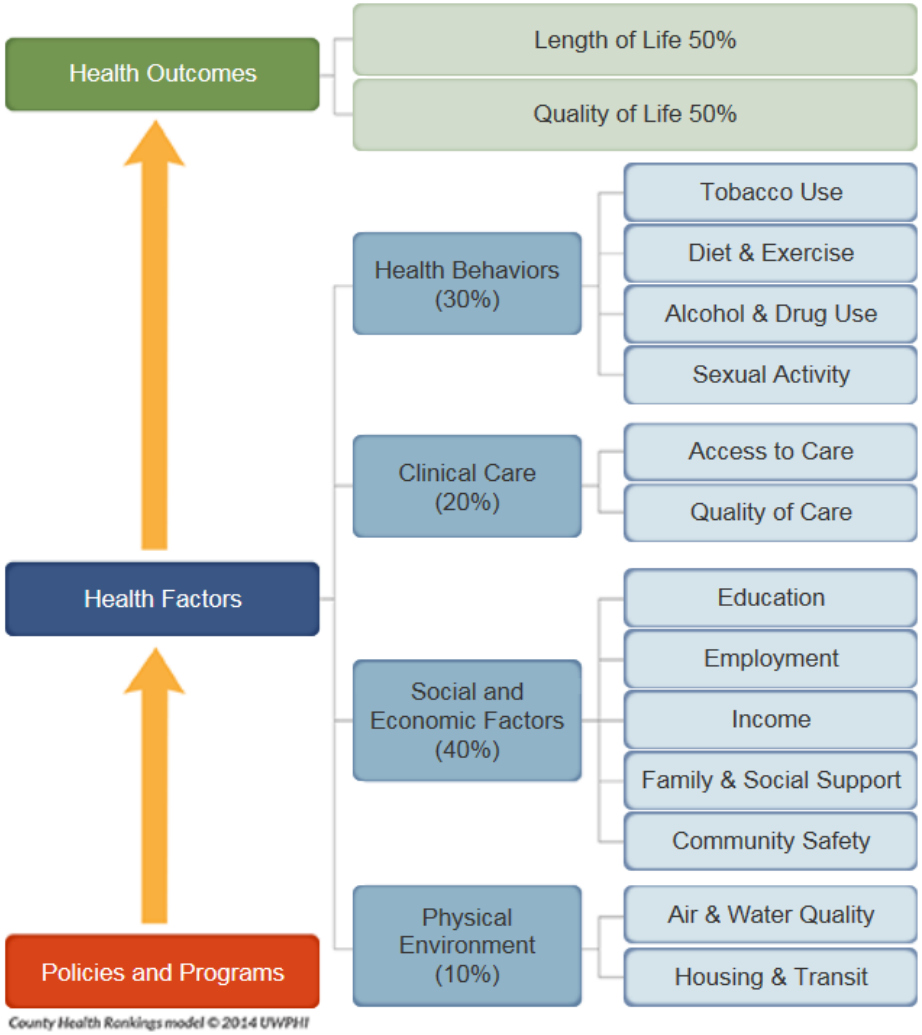
2011-13 smoking attributable mortality is significantly higher than England in all local authorities except Bassetlaw. Rates have been decreasing since 2007-09





Source: Local Tobacco Control Profiles for England

But it's not just care or behaviour that determines health

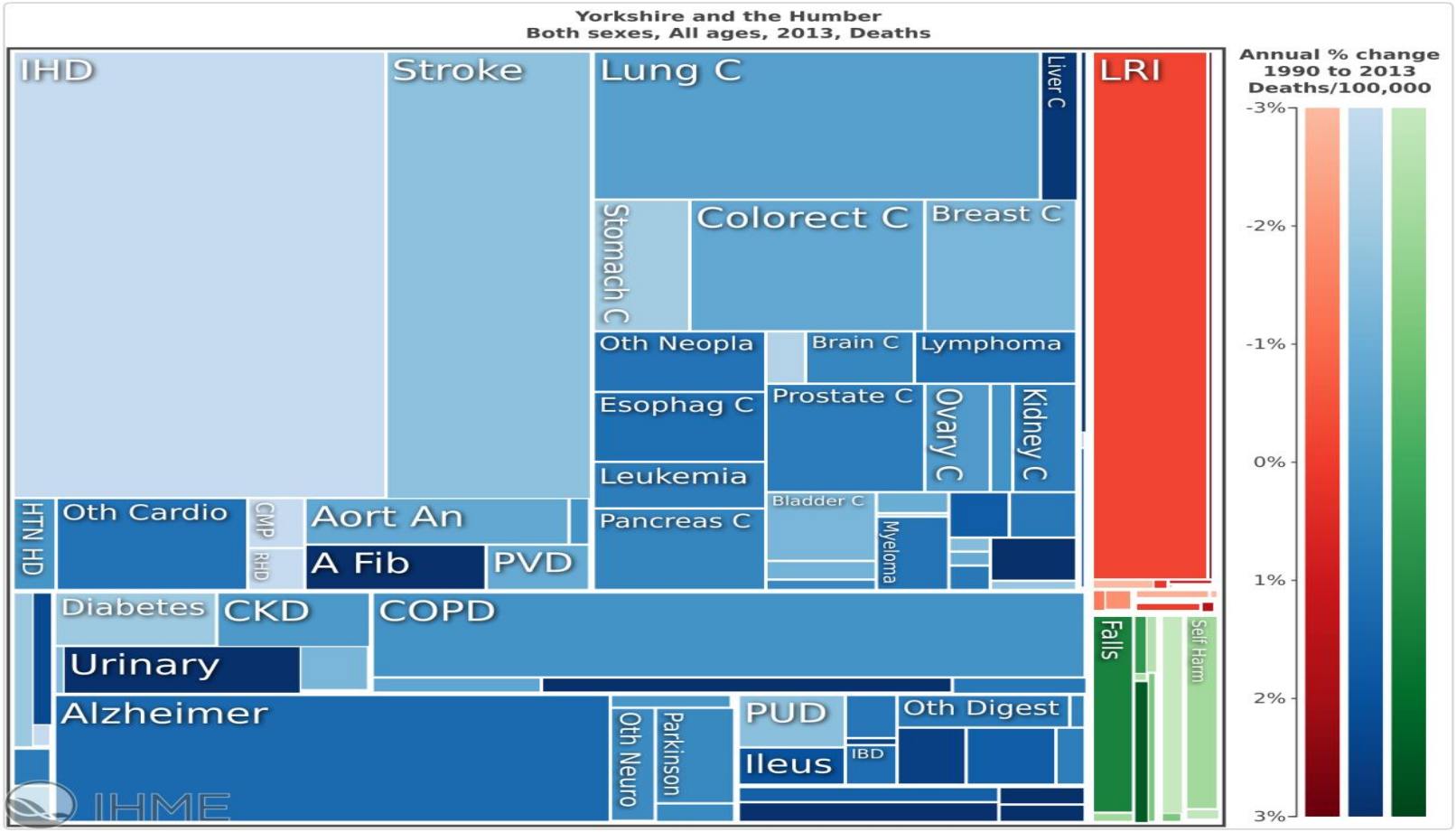


http://www.countyhealthrankings.org/Our-Approach

This has a bearing on how we plan the broad model of care and well being

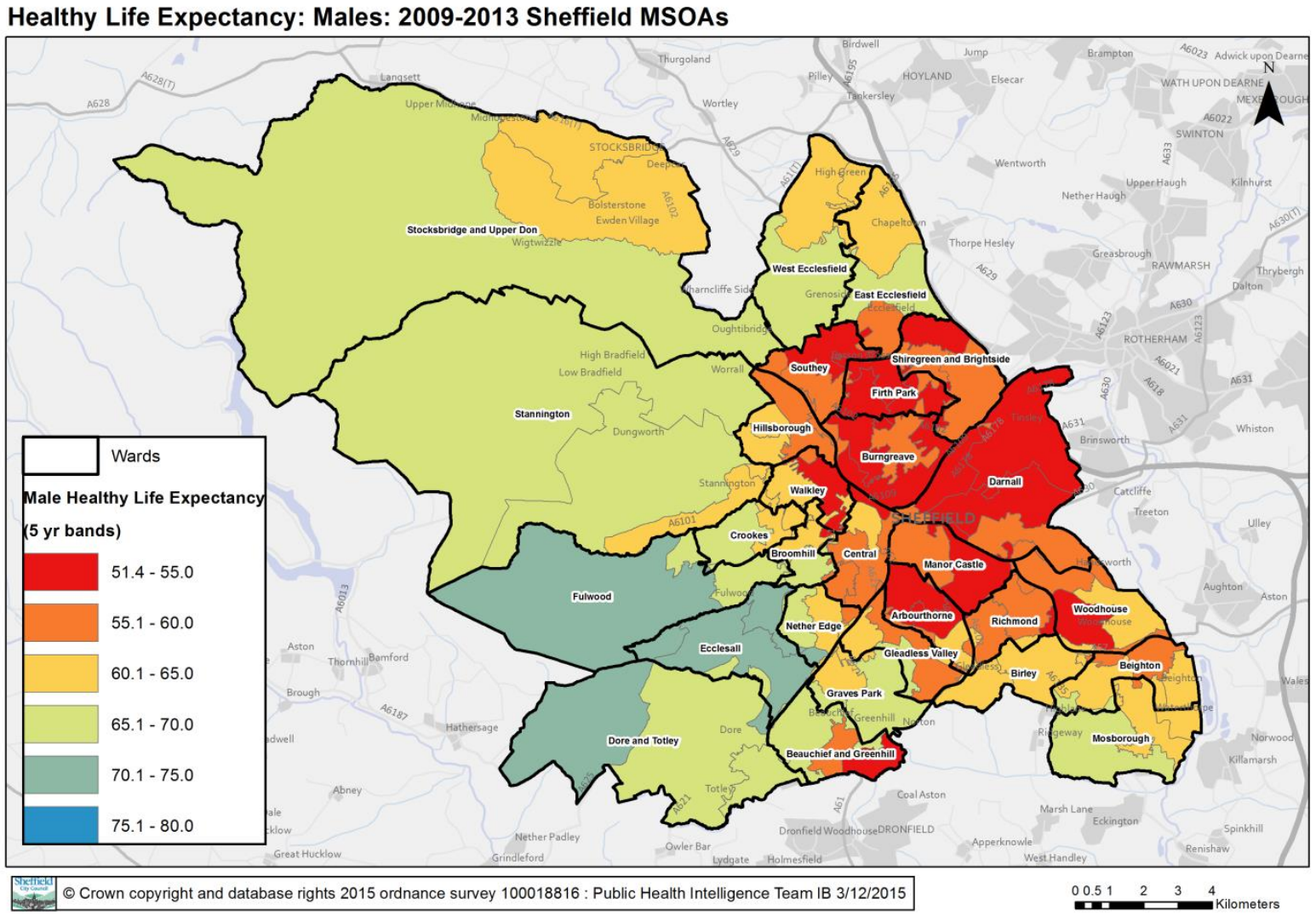
What kills us in Yorkshire and the Humber?
In a single picture

2013



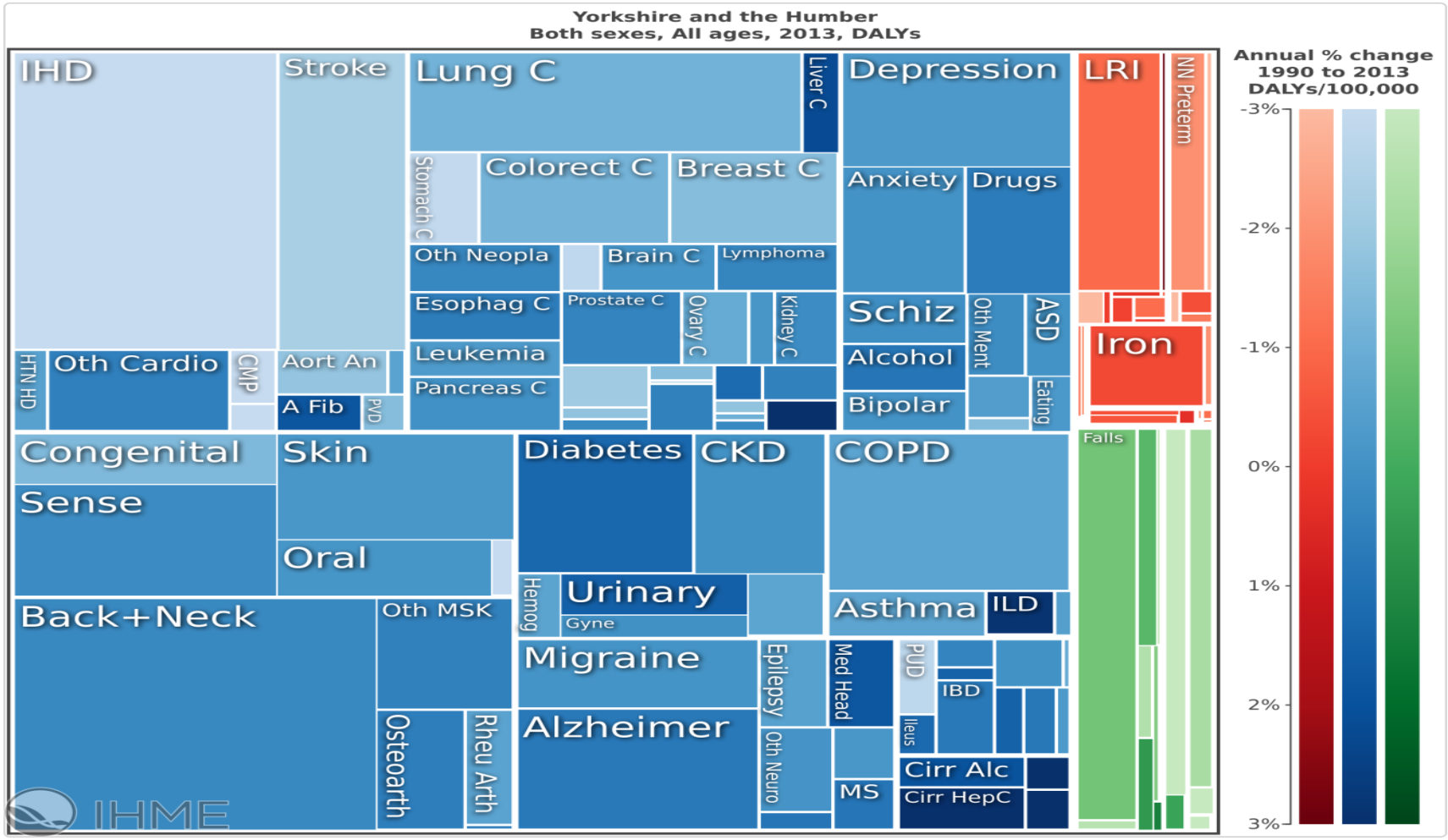
Newton et al
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00195-6/abstract
http://vizhub.healthdata.org/gbd-compare/

Metrics that matter – healthy life expectancy – the 20 year gap in males



What causes us to be poorly in Yorkshire and Humber – DALYS? In a single picture

2013



Newton et al
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00195-6/abstract
http://vizhub.healthdata.org/gbd-compare/

The ageing population myth
Multi morbidity – it is NOT all about the ageing population
It is not age per se that drives health care use, but morbidity
Age is a poor proxy for morbidity.

Aged 50-54 **18.3%** have >1 morbidity in **most affluent**.
36.8% in most deprived
10-15 year difference in age at onset of MM

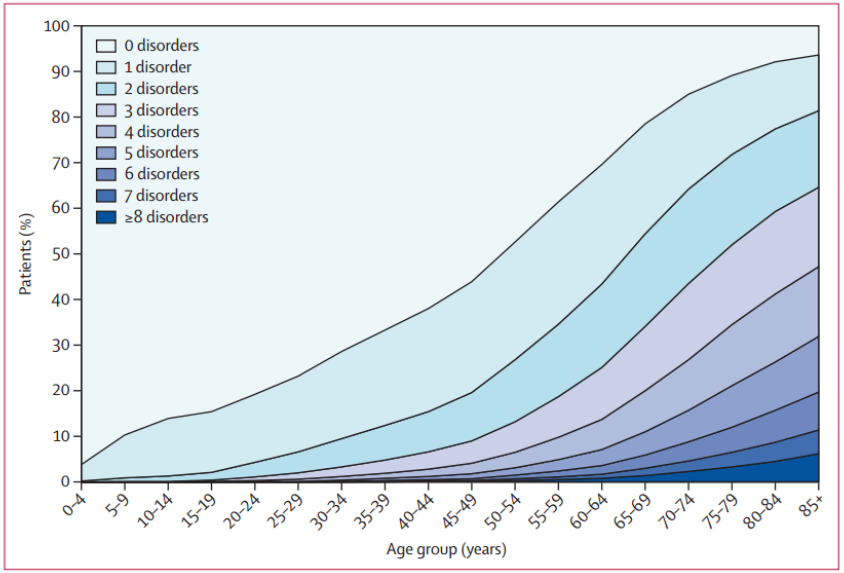


Figure 1: Number of chronic disorders by age-group

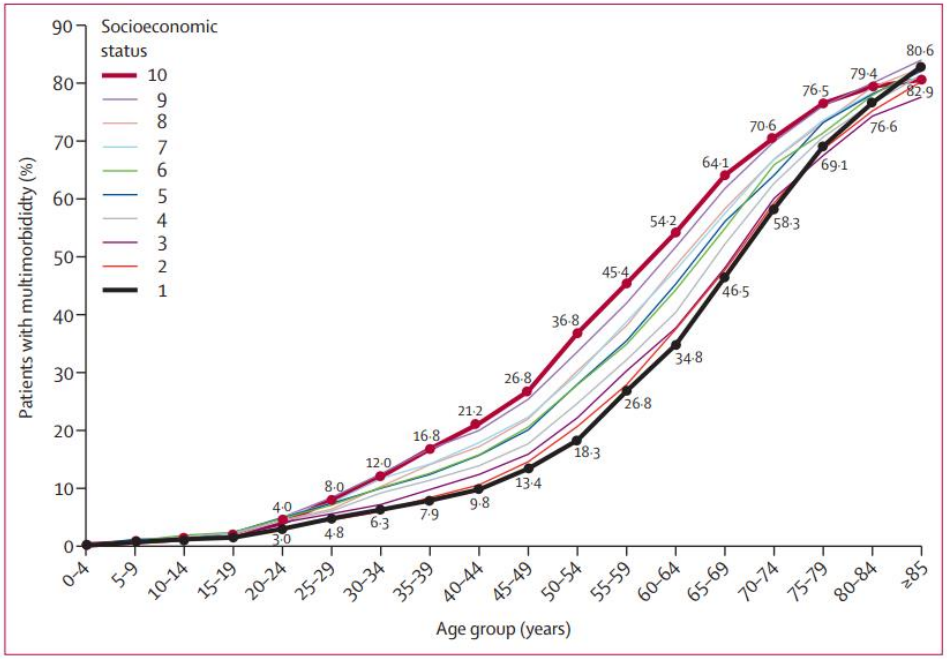


Figure 2: Prevalence of multimorbidity by age and socioeconomic status
On socioeconomic status scale, 1=most affluent and 10=most deprived.

Lancet 2012; 380: 37–43

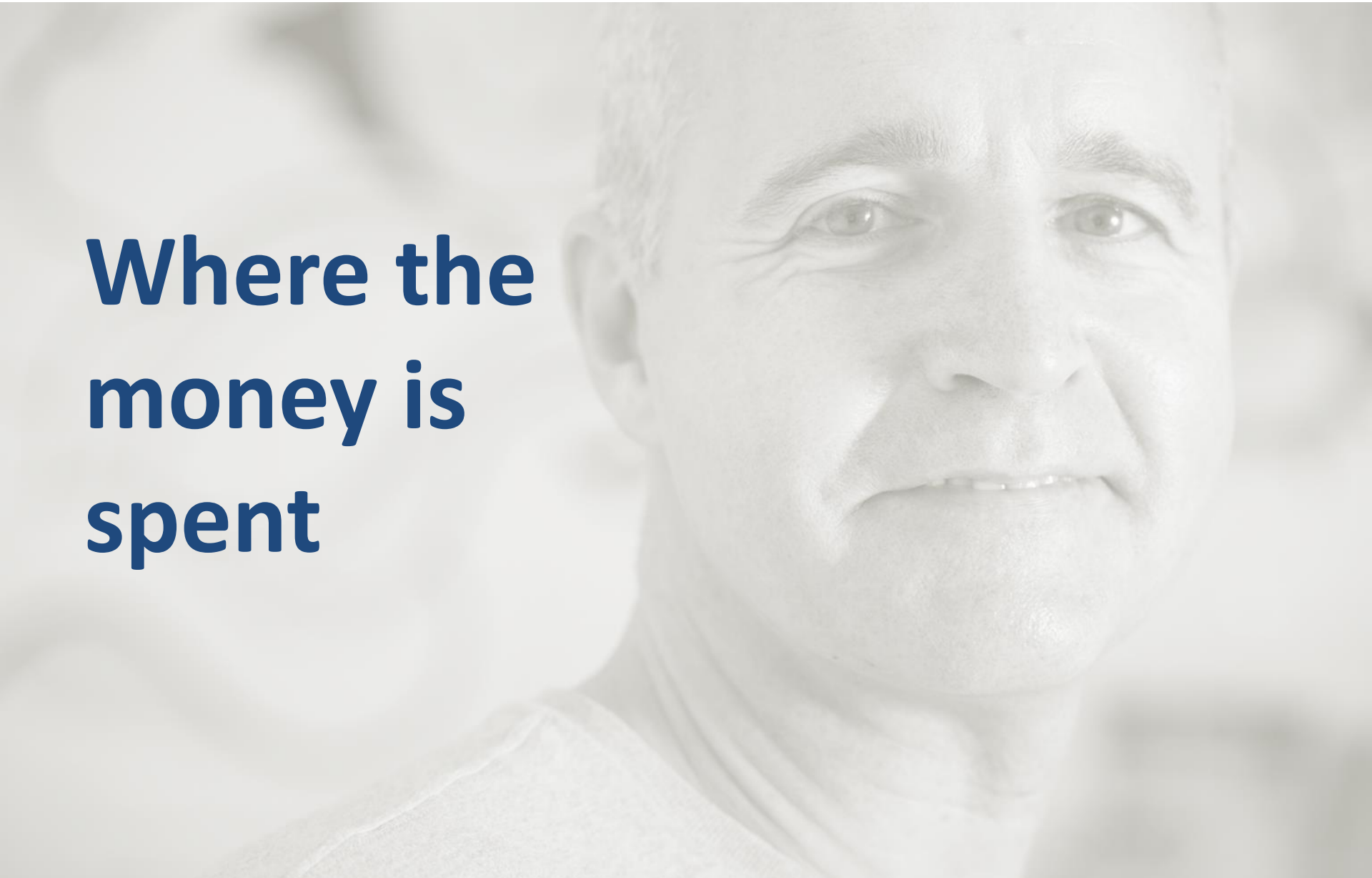
Services for population outcomes

Cancer, mental health and learning disabilities, urgent and emergency care, maternity and children, elective

I haven’t put the data up

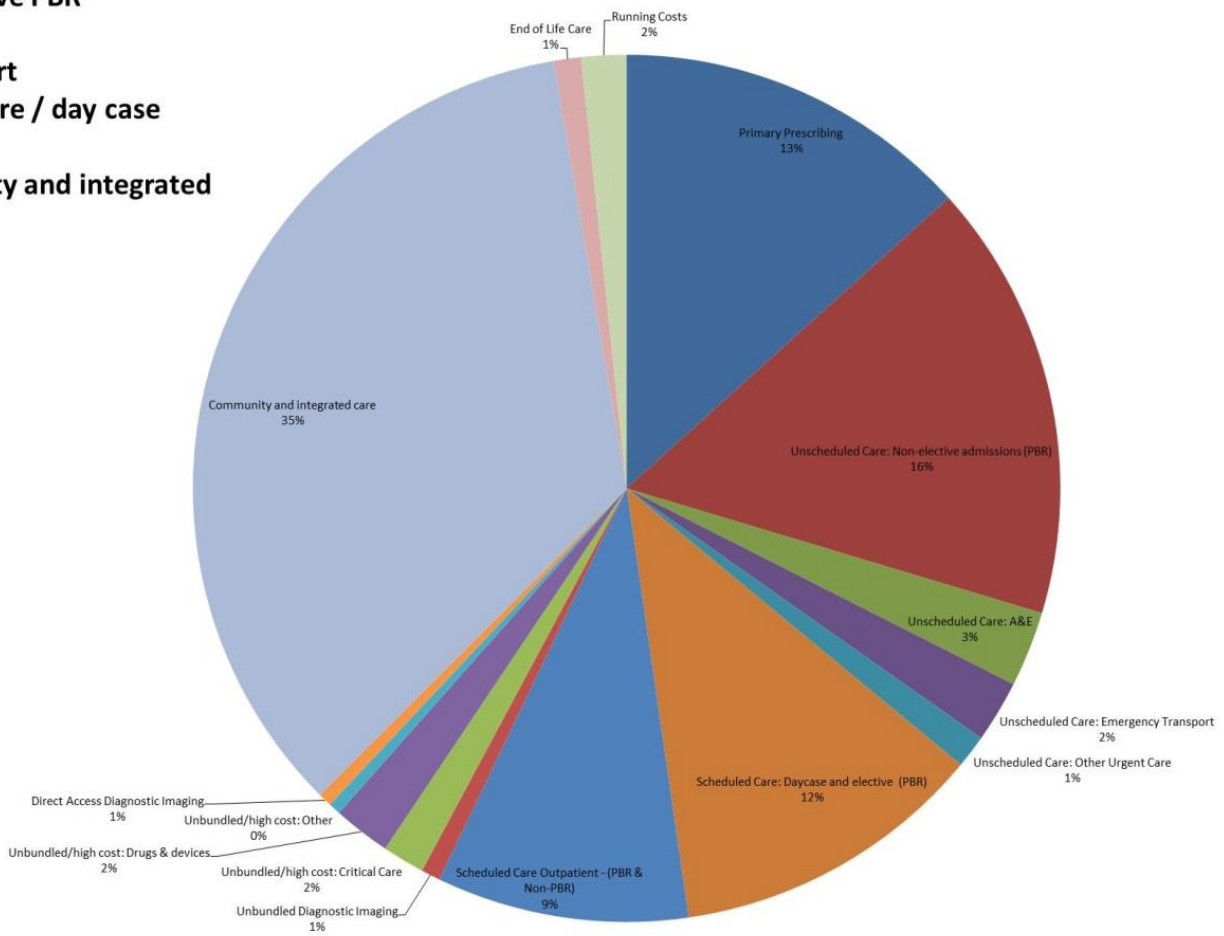
- The data doesn’t matter?
- **Systems** of care for **populations** focus on **outcomes, and equality of access / care** / **institutionally blind** – addressing fragmentation and the archipelago
- Focus on where the **value** is (and isn't)
- **Focused effort on prevention** at **every level**
- Primary, to tertiary prevention. Across large population, over a long time period matters
- **Moving upstream at every opportunity**
- **Population level management of large risk factors**
- Our biggest killers share the **same risk factors**

Where the money is spent

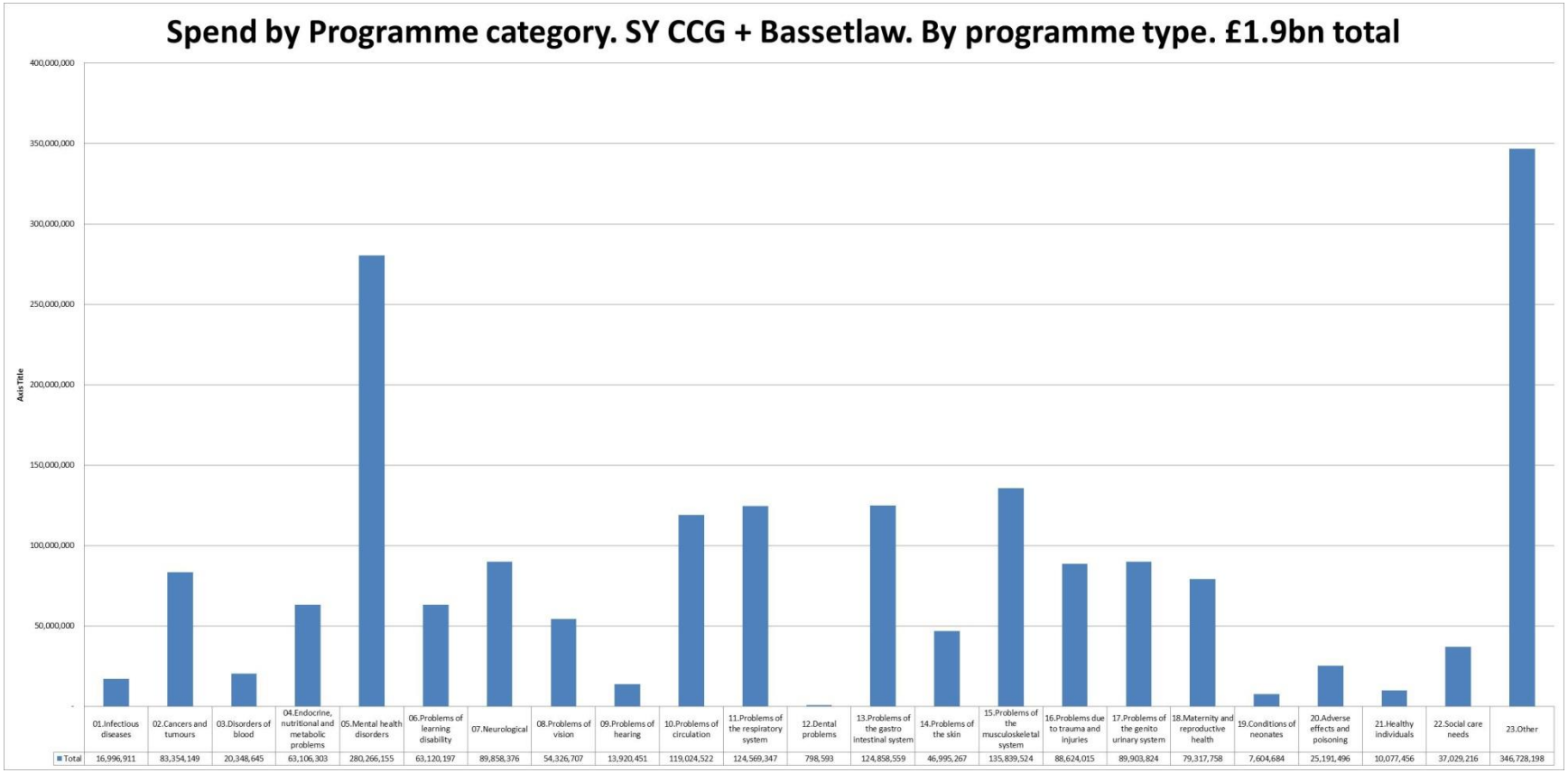


Where the money is spent

£1.923bn on health care in SYB.
£256m Px
£313m Non Elective PBR
£54m ED
£44m Em Transport
£224m elective care / day case
£180m OP care
£669m COmmunity and integrated



Where the money is spent



GPs at the deep end
The steep slope of need and the flat slope in funding

Gary McLean, Bruce Guthrie, Stewart W Mercer and Graham CM Watt

General practice funding underpins the persistence of the inverse care law:

cross-sectional study in Scotland

Abstract

Background
Universal access to health care, as provided in the NHS, does not ensure that patients' needs are met.

Aim
To explore the relationships between multimorbidity, general practice funding, and workload by deprivation in a national healthcare system.

INTRODUCTION
Although the principal social determinants of health operate outside health care, health care can mitigate the effects of poor health, by reducing the severity and delaying the progression of conditions.[1] Whether health care reduces or increases health inequalities depends on the extent to which it is delivered in proportion to need across the socioeconomic spectrum.[2]

group and then applied to general practice populations in 2011–2012.

Deprivation was measured using the 2009 version of the Scottish Index of Multiple Deprivation. Practice deprivation scores were obtained from the Information Services Division (ISD) of NHS Scotland, based on an aggregates of patient postcodes within practices.[8,9] Practice scores were then used to divide practice populations

GP funding & consultations not matched to clinical need as measured by different measures of multi morbidity

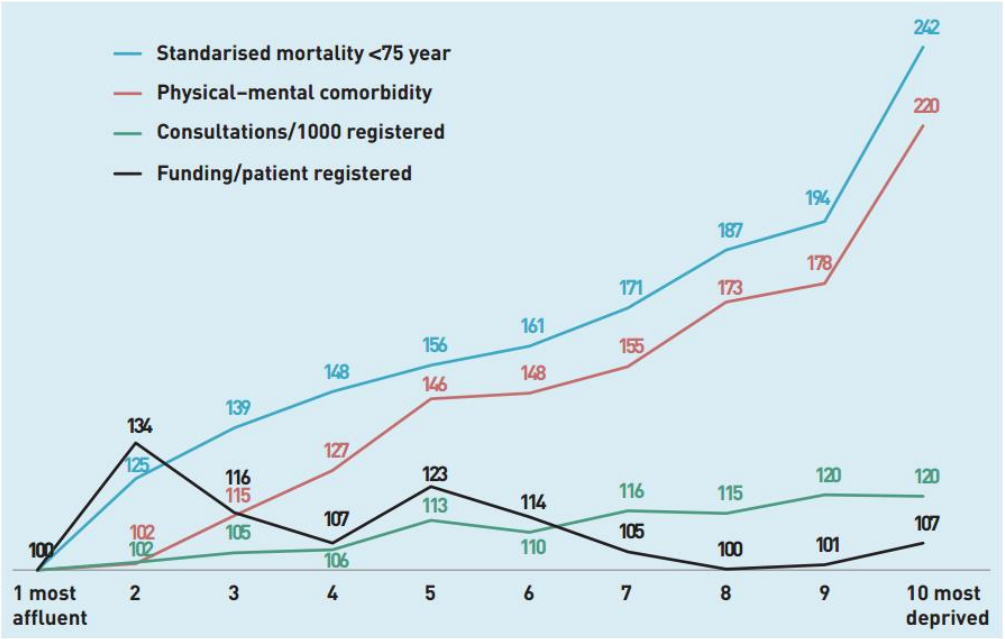


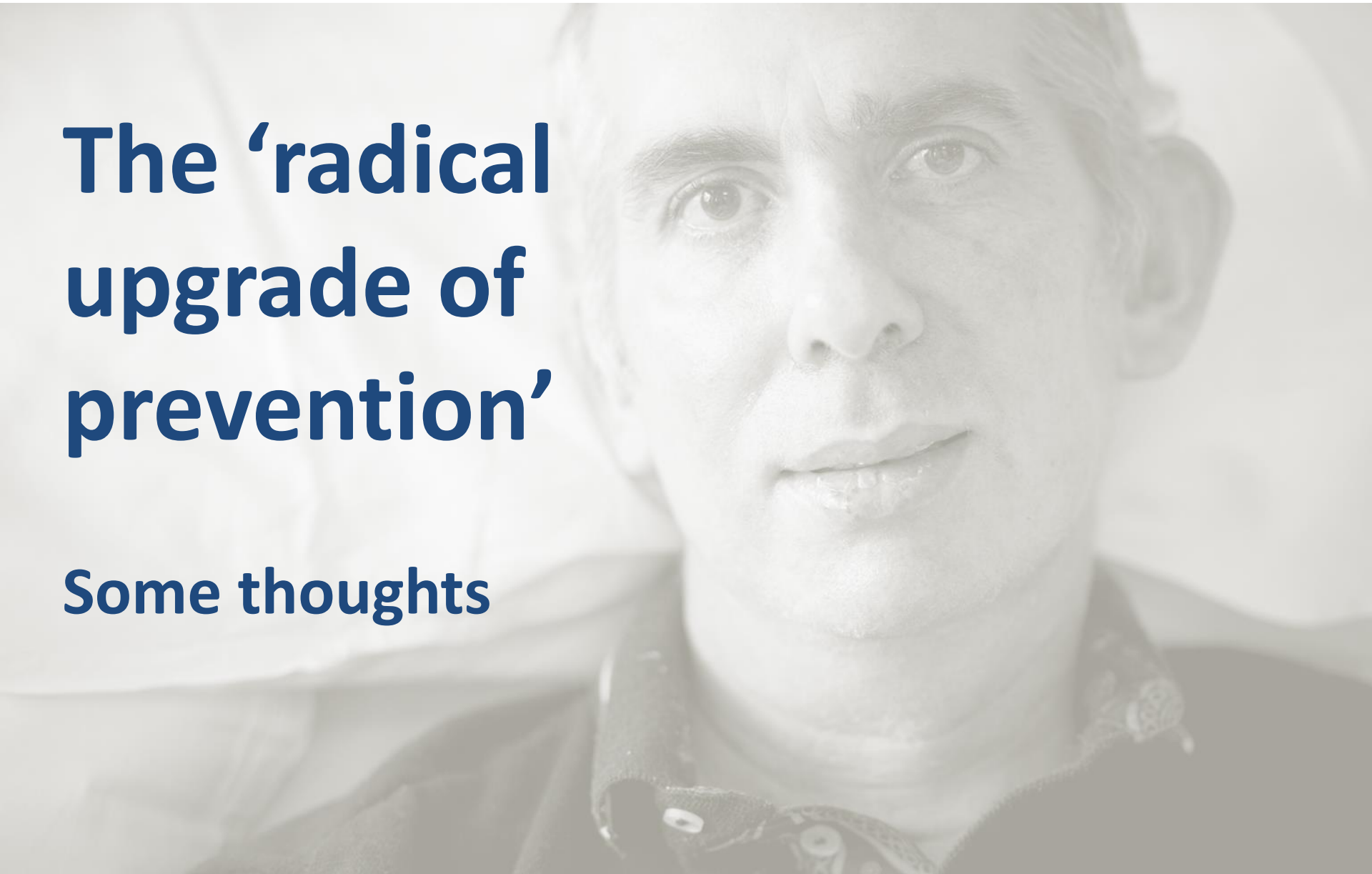
Figure 1. % Differences from least deprived decile for mortality, comorbidity, consultations, and funding. Least deprived decile = 100.

(£0.03 per patient increase in funding with every unit increase in consultations), with the weakest association found for mortality.

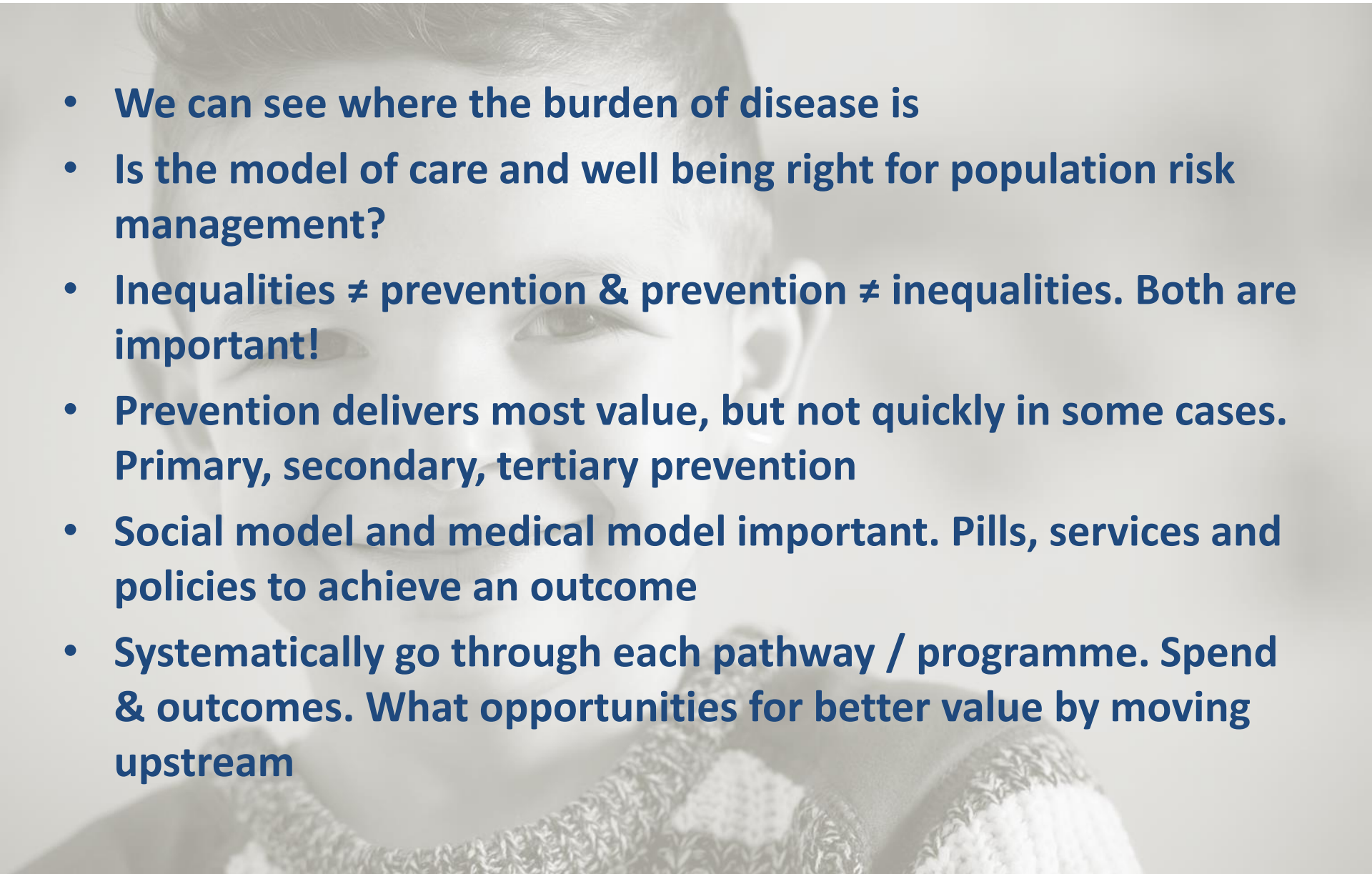
Br J Gen Pract 2015; DOI: 10.3399/bjgp15X687829

The ‘radical upgrade of prevention’

Some thoughts



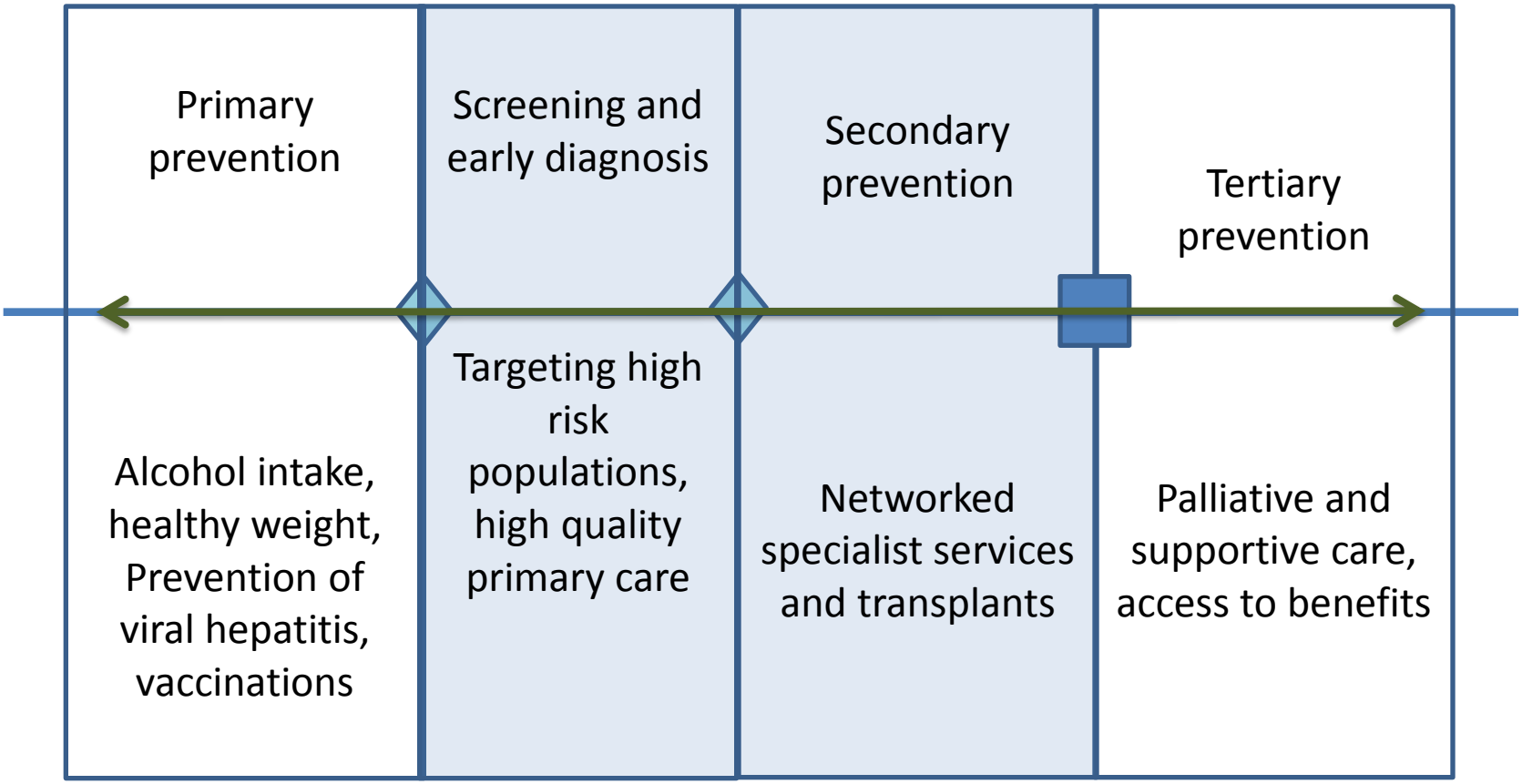
Some perspectives on prevention



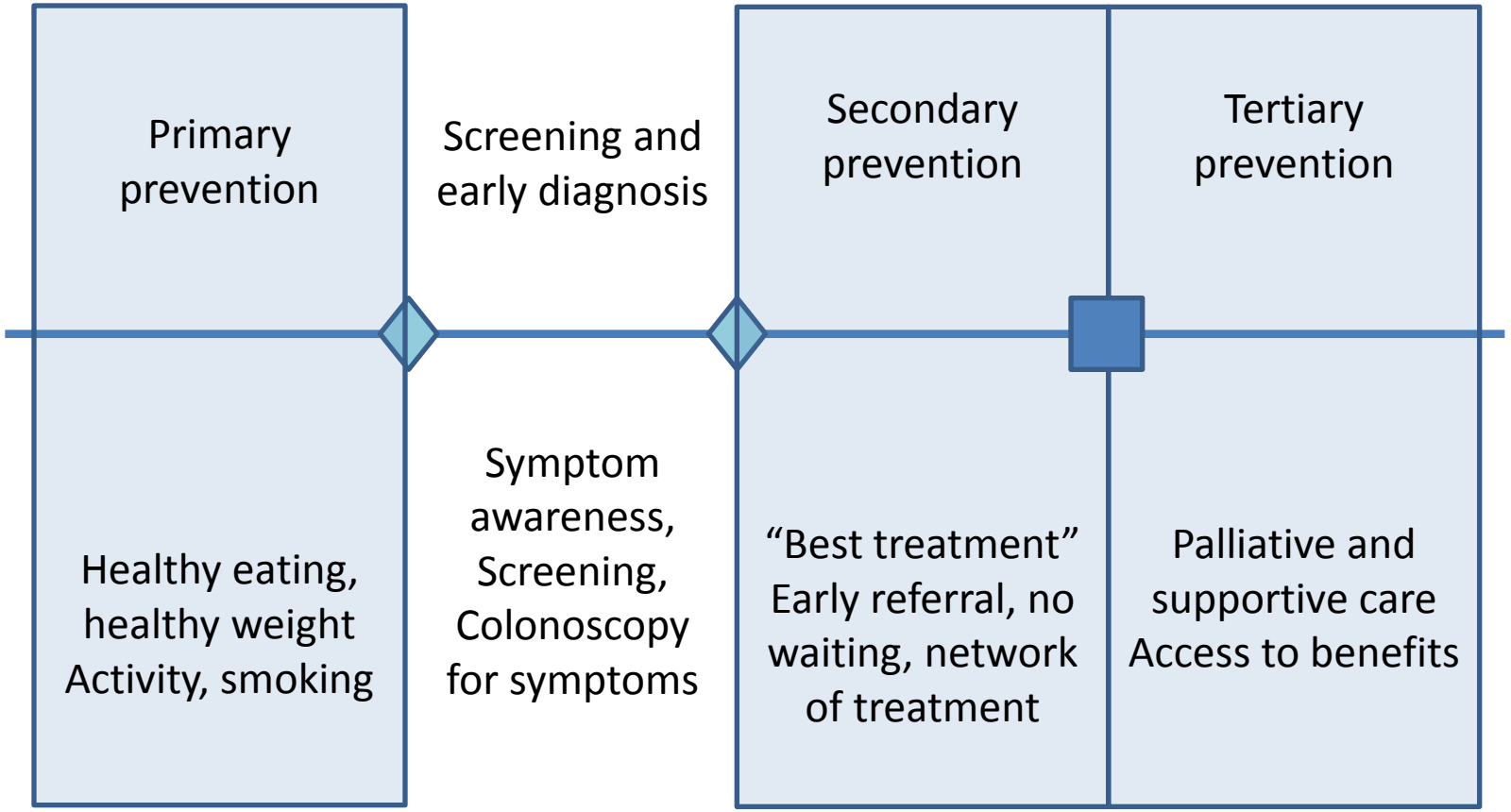
- We can see where the burden of disease is
- Is the model of care and well being right for population risk management?
- Inequalities ≠ prevention & prevention ≠ inequalities. Both are important!
- Prevention delivers most value, but not quickly in some cases. Primary, secondary, tertiary prevention
- Social model and medical model important. Pills, services and policies to achieve an outcome
- Systematically go through each pathway / programme. Spend & outcomes. What opportunities for better value by moving upstream

Prevention and liver disease

Specialist services make a unique contribution through networked services, and through effective drugs which can reduce onward transmission

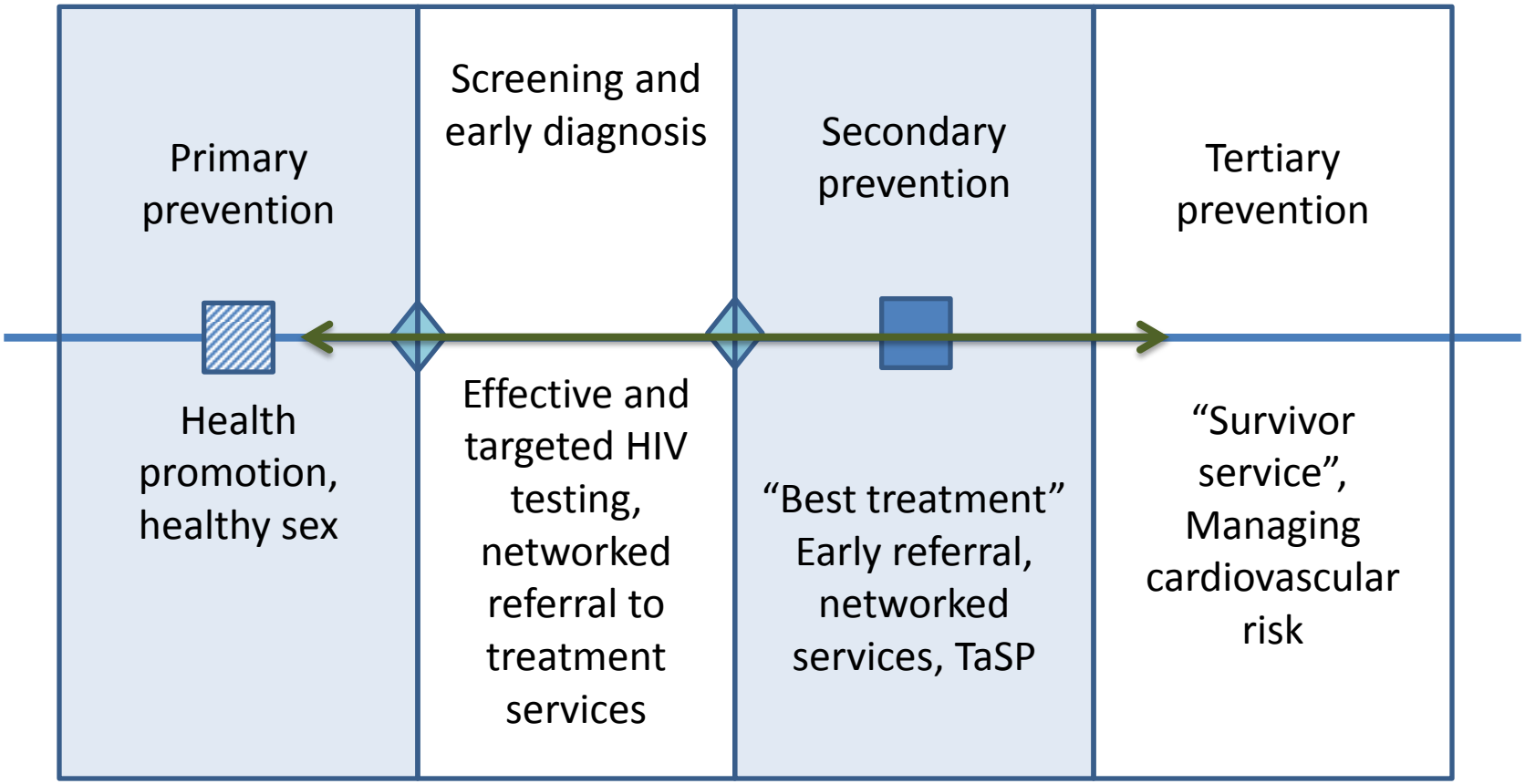


Prevention and cancer



HIV prevention is not just HIV prevention, but burden of disease in HIV

Specialist services make a unique contribution to prevention and early diagnosis



The STP in a broader context

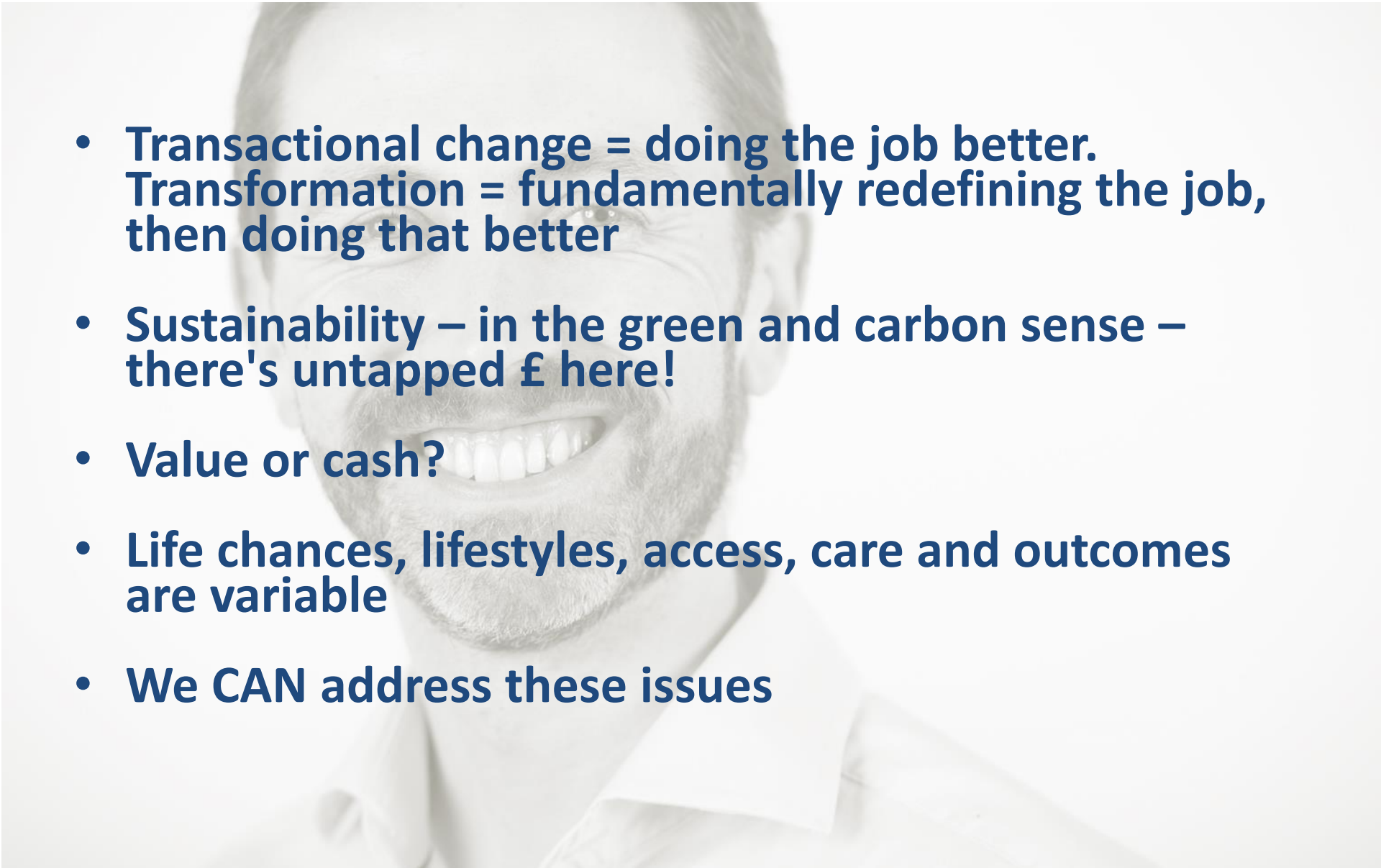
Key messages:

- Population
- Transforming and sustaining
- Prevention
- Broader context

Key messages: Population

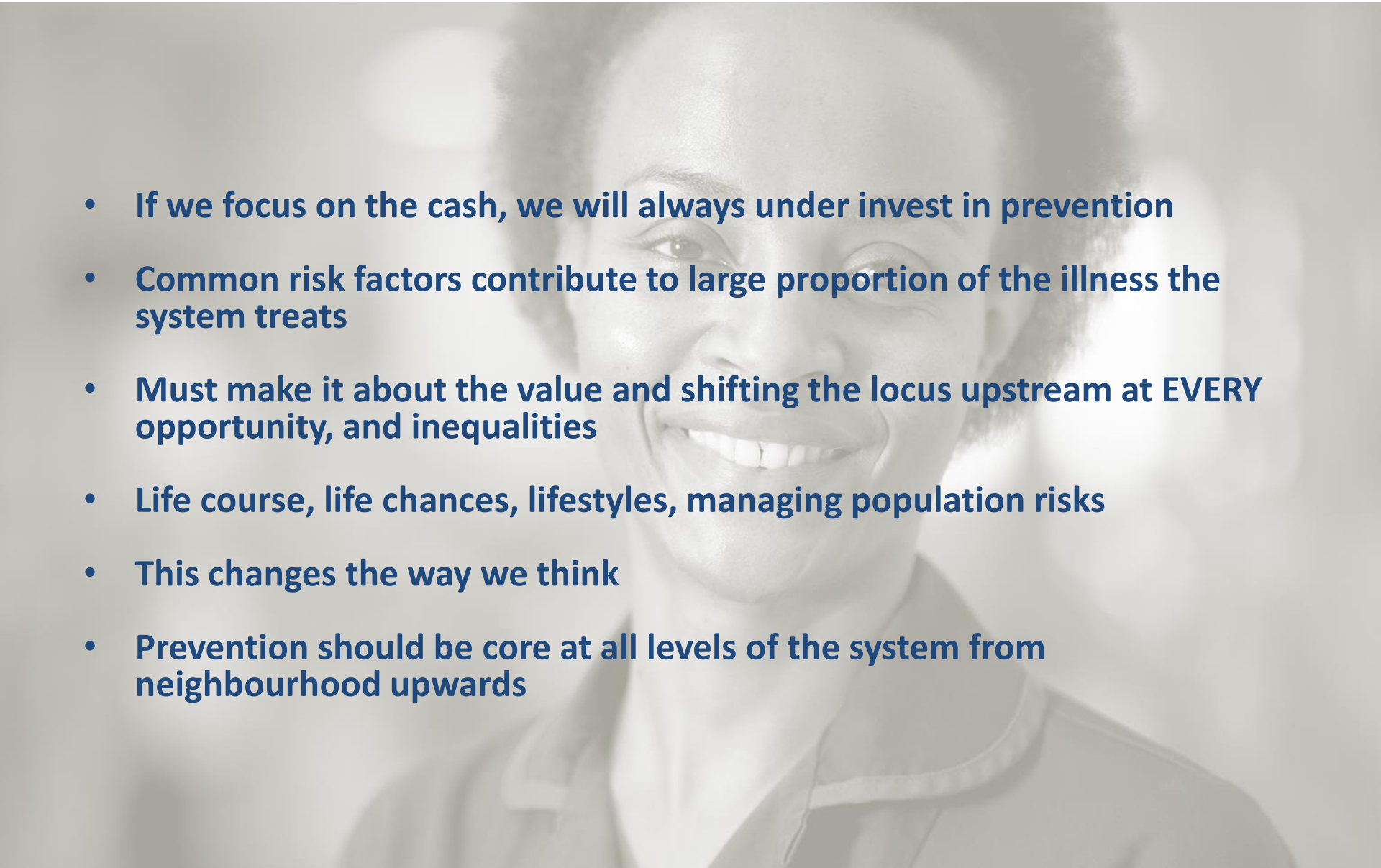
- Planning for young people, alongside the increasing needs of the ageing middle-aged cohort is key
- For cancer, CHD and mental health the population health risk factors highlight the need for coordinated action
- Prevention in local plans should address common risk factors at scale
- Specialised services and urgent emergency care are cross cutting areas which impact across the life course and disease pathways

Key messages: transforming and sustaining



- Transactional change = doing the job better. Transformation = fundamentally redefining the job, then doing that better
- Sustainability – in the green and carbon sense – there's untapped £ here!
- Value or cash?
- Life chances, lifestyles, access, care and outcomes are variable
- We CAN address these issues

Key messages: scaling up prevention



- If we focus on the cash, we will always under invest in prevention
- Common risk factors contribute to large proportion of the illness the system treats
- Must make it about the value and shifting the locus upstream at EVERY opportunity, and inequalities
- Life course, life chances, lifestyles, managing population risks
- This changes the way we think
- Prevention should be core at all levels of the system from neighbourhood upwards

Key messages: STP in a broader context

- Optimise and capitalise on the opportunities – inequality, housing, economy
- This is about life chances, but also about public sector reform
- Better place to live, healthier economy, health and care system as part of the system
- Focus the energy and input to where there is most need – a point about efficiency and inequality

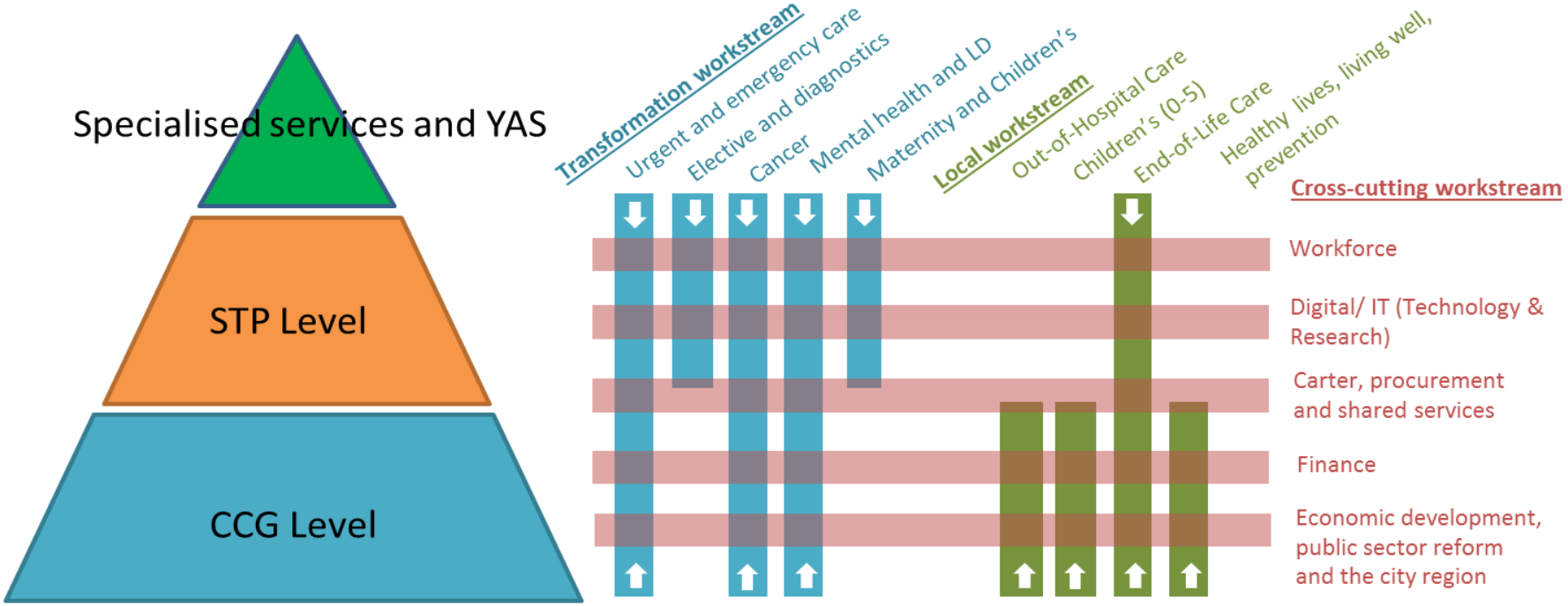
Keep the focus

The workstreams

A whistlestop tour

Emerging priorities

Workstream type*	Definition
Transformation workstreams	Primarily 'top down' from an STP level, with some contribution from 'bottom-up' CCG-level planning
Local workstreams	Primarily 'bottom up' from a CCG-level, with some contribution from 'top-down' STP level planning
Cross-cutting workstreams	Workstreams primarily focused on enablers which 'cross-cut' intersect with local and transformation workstreams



Local workstreams: key themes

Local Workstream	Theme
Out-of-Hospital Care	a. Supporting and developing Primary Care services b. Introducing locally responsive neighbourhood services c. Developing integrated, physical and mental health services d. Providing greater support for individuals to self care
Children's (0-5)	a. Developing multi-disciplinary child health teams b. Linking GP hubs to community child health services c. Developing child health records for sharing with other agencies d. Delivering joint primary/ acute care clinics
End-of-life Care	a. Providing hospice services for children and adults b. Providing palliative and EOL services in community and acute settings c. Delivering the five 'Priorities of care' identified in the report 'One Chance To Get It Right'
Healthy lives, health living and prevention	a. Increasing the focus of prevention initiatives on early years b. Developing upstream prevention initiatives i.e. focused on employment, housing etc. c. Developing downstream prevention i.e. focused on public health etc. d. Developing holistic primary care services

Each CCG in South Yorkshire and Bassetlaw has created place-based plans focused on their specific geographies as part of the operational/ commissioning planning process.
The key themes of planning across all five CCGs are summarised above.

Transformation workstreams: three scenarios

Workstream	Responding to guidance	+ Stretch Targets	+ Radical transformation
Urgent and emergency care	Determine the level of provision that is appropriate for a place setting	Consider and coordinate individual 'places' across the system to ensure consistency and synergy	**Whole-system UEC Reconfiguration reviewing access (designating hot/ cold, major/ minor and 24-7/ non 24-7 provision)**
Elective care (including diagnostics)	Implement the 'rightcare' recommendations	Tackle variation e.g. follow up rates – defining the ask of primary care	**Shift emergency episodes to elective (better care, more efficient and better outcomes)**
Cancer	Standardise quality and access, improve experience and reduce waste	Reconfigure delivery and workforce model across all settings	**Reconfigure system so workforce and treatment follows the patient**
Mental Health and Learning Disabilities	Enhance crisis and liaison services.	Develop alternatives to admission.	**Optimisation of resources/beds within SYB, no patients out of region**
Maternity and Children's services	Development of personalisation in maternity care choice and continuity of care	Develop a framework to offer greater choice and control across a larger geographical footprint	**Whole system redesign, range of maternity choices and personalized care across system**

There are five transformation workstreams that are being developed at an STP-level. A number of scenarios have been developed for each, ranging from 'expanding on the current state' to 'radical transformation'. Examples of options for each of the scenarios are summarised above.

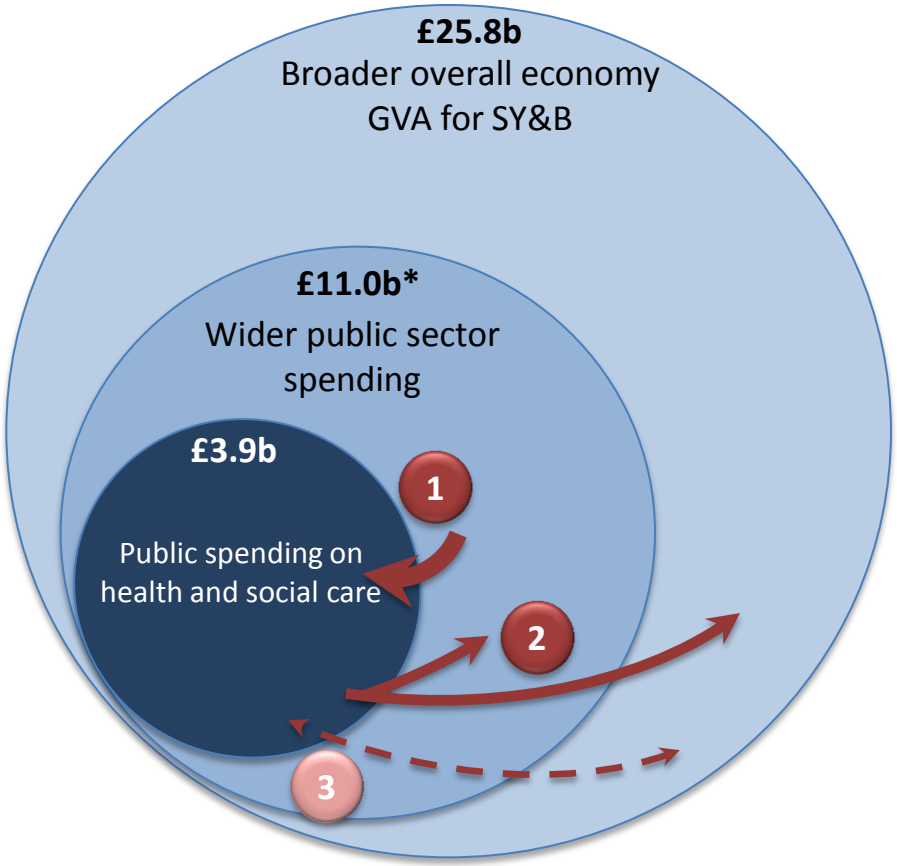
Crosscutting workstreams: three scenarios

Workstream	Responding to guidance	+ Stretch Targets	+ Radical transformation
Workforce	Explore opportunities for sharing workforce between organisations (horizontal)	Explore opportunities for sharing workforce between organisations (vertical)	**Explore opportunities for sharing workforce across the system**
Digital & IT	Provide primary care services online or through Apps	a. Encourage citizens to use tech as part of a H&W campaign with academic evaluation b. Important to deliver demand reductions in SY STP plan; Pilot?;T2DM, AF, post acute MI	**a. Issue all at risk and over 50's with a wearable linked to a GP led prevention campaign, reduce ill health** **b. Transfer 50-80% of LTC management to digitally delivered self-care**
Carter, procurement and shared services	Conduct shared service reviews e.g. HR, Finance, Procurement and IT	a. Extend shared services to MH trusts where appropriate b. Align corporate strategies	**Create common policies and procedures and joint key posts across the system**
Economic development, public sector reform and the city region	Significant investments in community capacity: seeing primary care seen as including but much more than General Practice	Create community hubs offering a 'one-stop-shop' for OOH health and public services, including social prescribing approaches	**More people supported to avoid spending time in expensive and inappropriate health and care settings**

There are five cross-cutting workstreams. Again a number of scenarios have been developed for each (finance will be presented later in the process), examples are summarised above.

Scope: this is primarily about leveraging public services to pursue our overall health system ambitions… interplay of "health" with housing, education, economy, inequality etc

Indicative size of different aspects of SY & B economy



1. **Focus 1: how can we re-imagine, re-design, 're-form' public services so that they can better support our overall aspirations to improve the health and wellbeing of our population**

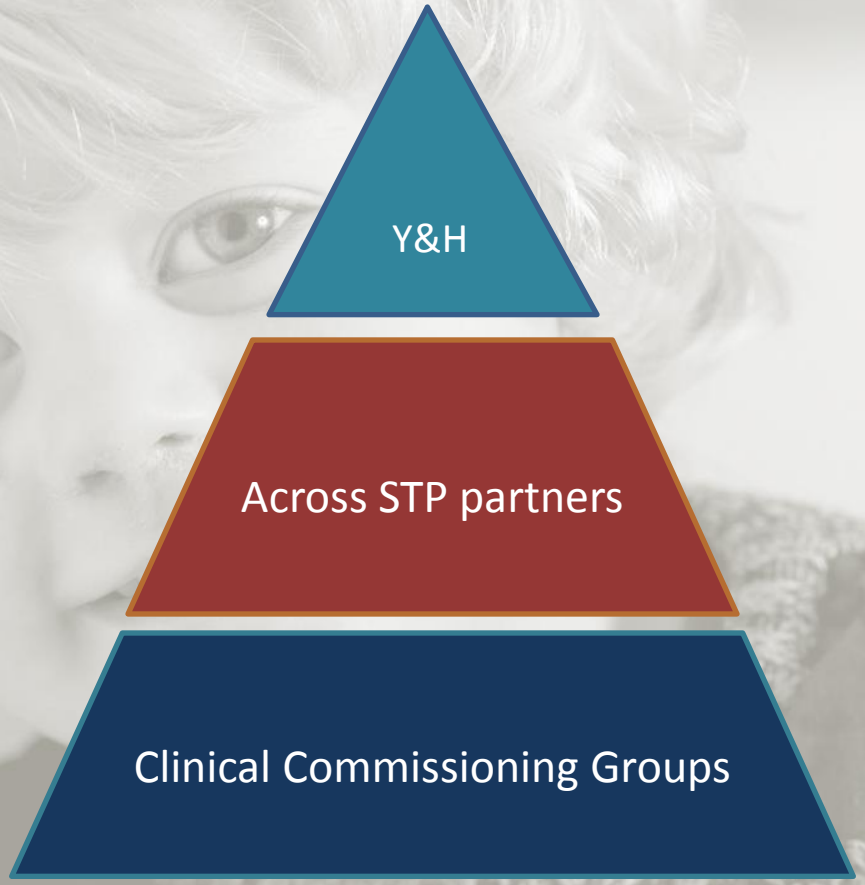
2. **Focus 2: what is the impact on the wider public sector economy, and economy more generally, of improving the health and care system. Note – important arguments to be constructed here if we want to pursue devolution opportunities – see later**

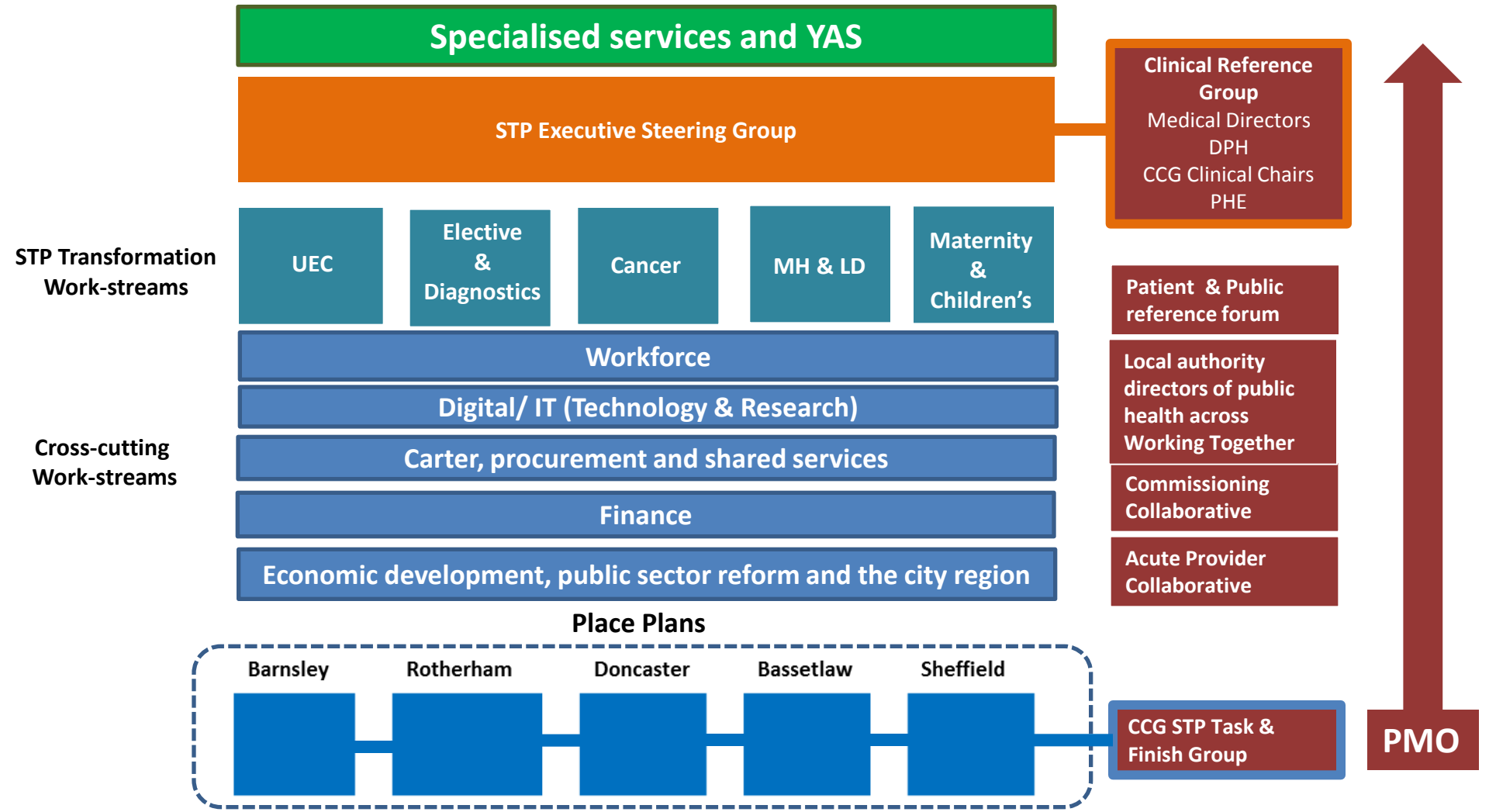
3. Proposing <u>not</u> to focus on the interplay between health system and parts of the regional private sector economy (e.g., pharmaceutical, medical devices, medical innovation etc.)

* Includes £4.9b on social security spending and £940 m on 'education'

Source: Public spending from New Economy Manchester Public Expenditure Tool; GVA analysis from ONS, Regional Gross Value Added (Income Approach), Dec 2015

How will we work?



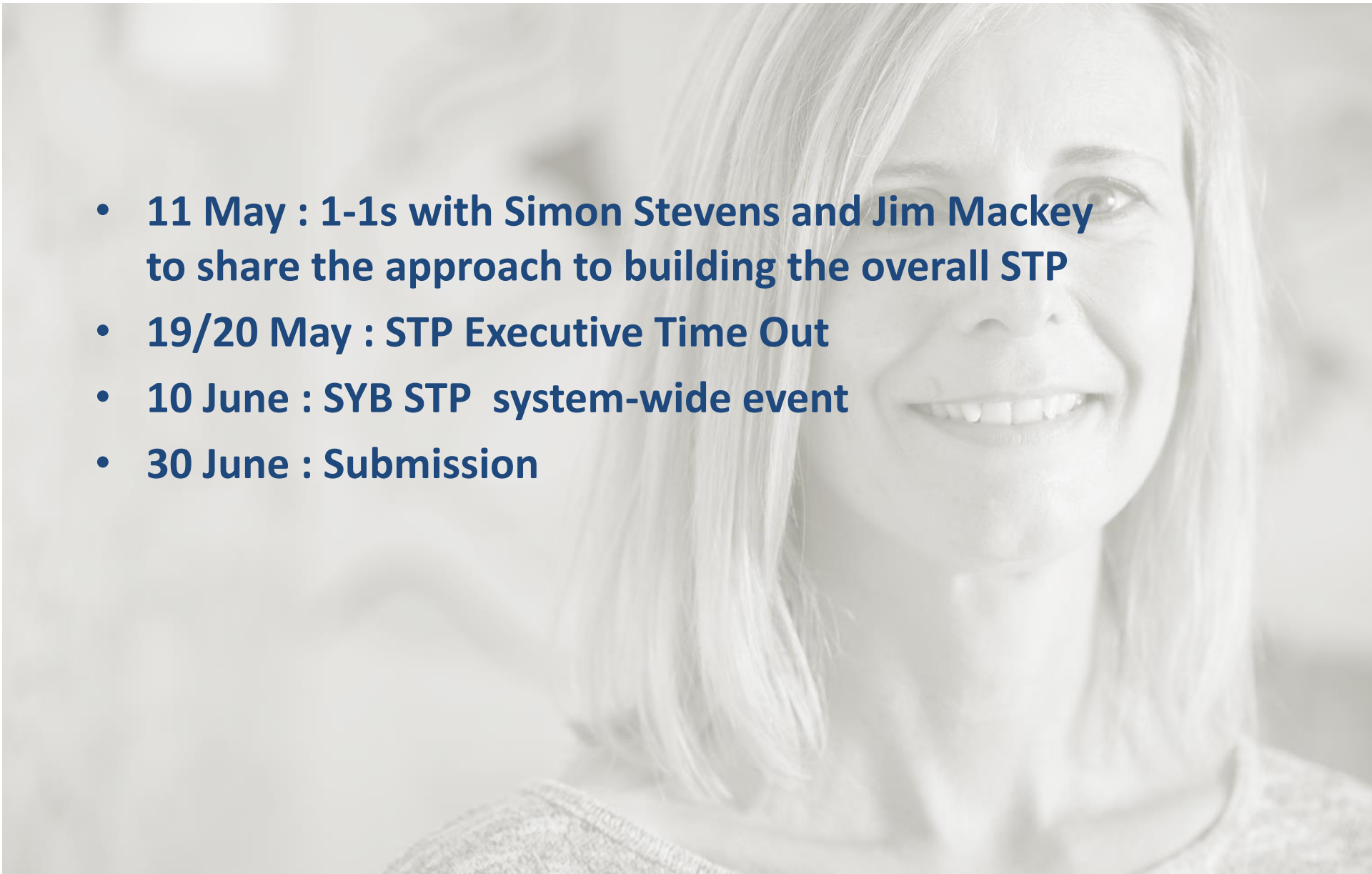

Specialised services and YAS
STP Executive Steering Group
Clinical Reference Group
Medical Directors
DPH
CCG Clinical Chairs
PHE
STP Transformation Work-streams
UEC
Elective & Diagnostics
Cancer
MH & LD
Maternity & Children's
Workforce
Digital/ IT (Technology & Research)
Cross-cutting Work-streams
Carter, procurement and shared services
Finance
Economic development, public sector reform and the city region
Patient & Public reference forum
Local authority directors of public health across Working Together
Commissioning Collaborative
Acute Provider Collaborative
Place Plans
Barnsley
Rotherham
Doncaster
Bassetlaw
Sheffield
CCG STP Task & Finish Group
PMO

Breakout sessions

Feedback

Next steps

Key dates and milestones for building the plan



- 11 May : 1-1s with Simon Stevens and Jim Mackey to share the approach to building the overall STP
- 19/20 May : STP Executive Time Out
- 10 June : SYB STP system-wide event
- 30 June : Submission


Thank you