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Primary Care Sheffield

Sheffield City Council

NHS

Sheffield Children's NHS Foundation Trust
Sheffield Clinical Commissioning Group
Sheffield Health and Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield Accountable Care Partnership (ACP) Board

Programme Director Report for ACP Programme Board

31 October 2018

Author(s)	**Rebecca Joyce**
Sponsor	**Kevan Taylor (Chair of EDG)**
Date	**23rd October 2018**

1. Purpose

1.1 To provide headlines from the progress of the Accountable Care Programme.

1.2 To provide an overview of ACP Programme Activities.

2. Introduction / Background

2.1 A short written overview of the Programme activities is provided by the Programme Director for the ACP Board.

2.2 This is the report for the 31 October ACP Board.

3. Is your report for Approval / Consideration / Noting

For noting

4. Recommendations / Action Required by Accountable Care Partnership

See attached actions within the report.

5. Other Headings

N/A

Are there any Resource Implications (including Financial, Staffing etc.)?

N/A

Programme Director Report – October 2018
ACP Programme Board

This brief report will fall into three sections: Strategic, Delivery and Development.

1. Strategic

National/Regional

- A Place Response for Sheffield has been submitted for the NHS Long Term Plan consultation. All partners were involved in its development and it is attached as Appendix 1.
- On 20 September 2018, The King's Fund published "A Year of Integrated Care Systems: Reviewing the Journey so Far". In population terms, Sheffield is comparative to many of the ten vanguard ICS footprints. Hence there is significant applicable learning for place development as well as at ICS level. A summary of recommendations from the report is provided below:

Recommendations for local systems

- **Invest in building collaborative relationships at all levels of the system** – this can only be done locally and takes time and commitment.
- **Promote and value system leadership** – ICS leadership should be developed with a continuing emphasis on collective and distributed leadership, ensuring leaders have dedicated time to fulfil their roles.
- I**ntegrate at different levels of the system, building up from places and neighbourhoods** in line with the principle of subsidiarity, ICSs should set the overall vision, provide leadership across the system and undertake functions that are best performed at scale.
- **Draw on the skills and leadership of frontline staff** – staff should be front and centre of plans to redesign services, with clinical leadership at the fore.
- **Build governance in an evolutionary way to support delivery** – this should be iterative and locally led, ensuring that it does not conflict with accountabilities of statutory organisations.
- **Develop system-wide capabilities to gather, share and act on public insights** – ICSs must take active steps to listen to and work with the public on an ongoing basis, and to bring together dispersed insight and feedback data from across the system.
- **Develop active strategies to facilitate wider adoption of new care models** – this requires an active approach centred around peer-to-peer learning and networks.
- **Build robust evaluation into the ICS programme that supports learning and improvement and measures progress** – metrics should reflect the breadth of ICSs' priorities, and recognise that much of the impact will emerge in the long term.
- **Look beyond the health and care system to improve population health** – this requires deeper local authority involvement and closer working with the voluntary and community sector, independent sector organisations and communities (*see* Figure below).

https://www.kingsfund.org.uk/publications/year-integrated-care-systems

- A group of Sheffield leaders attended the first of four days of the King's Fund ICS Learning Network on 4 October 2018. The network brings together ICS/ACP/STP groups alongside sharing evidence from international case studies of integrated care systems.

- NHS England has launched a consultation on the contracting arrangements for Integrated Care Providers (ICPs) link
    - Sheffield colleagues attended events in Leeds and at Sheffield CCG and a summary was considered at October EDG.

Refreshed Place Plan

- At EDG on 9 October, the Communications work stream set out their overall Communication Plan for the ACP. Staff, stakeholders and the public will be involved in a set of deliberative workshops to widen the reach of discussion on the ACP and key priorities for health and care in Sheffield. This will feed into a refresh of 'Shaping Sheffield: the Plan'. Dates have been identified for the workshops in January/February 2019.
- The intention is that these workshops will bring together staff from across the health system, and therefore a "cross section" of staff from individual partner organisations will be invited. The refreshed plan as a whole will be positioned in the context of the wider Health and Well-Being Strategy.
- Strategy Leads from across the city will support the leadership and design of these events. The Strategy Directors have emphasised the importance of ensuring the core priorities of the plan are fed into partner business planning processes to ensure our system aspirations are tied in with organisational plans and become "real".
- It is intended the draft ACP – Shaping Sheffield plan will be produced by the end of March. During December – February it will also be important there is opportunity for executive and Board teams to feed in to ensure this is a genuinely owned plan by all partners.

2. Delivery

i. CQC Local System Review

A full progress report against plan is provided in the full papers for the ACP Board.

EDG requested an update from each organisation by 21 September 2018 on internal partner governance arrangements. All partners have also confirmed they will release the necessary internal resource (time and people, not necessarily money) to enable the actions they are leading on/involved with to deliver. A summary of partner responses and accountabilities is provided below.

Partner	Lead Executive	Internal Governance Arrangements	Other Notes
Primary Care Sheffield	Steven Haigh, Director of Systems and Access	PCS contributions to the CQC Action Plan to be incorporated within overall performance reports to the PCS Executive.	Full summary of responsibilities and leads against each area of action plan received from lead executive.

Sheffield CCG	Nicki Doherty, Director for Care Outside Hospital	Internal governance arrangements being finalised.	Full summary of responsibilities and leads against each area of action plan received from lead executive.
Sheffield Children's Hospital	N/A	N/A	N/A
Sheffield Council	Jayne Ludlam, Executive Director – People Portfolio	Health and Well-Being Board Scrutiny and Oversight Committee	Leads taking forward different areas of action plan work.
Sheffield Teaching Hospitals	David Throssell, Medical Director	Health Care Governance Committee (sub-committee of the Board)	Leads taking forward different areas of action plan work.
Sheffield Health and Social Care	Liz Lightbown, Executive Director, Nursing and Professions	Regular reports co-ordinated by Fiona Goudie (Clinical Director, Strategic Partnerships) and Jason Rowlands (Director of Strategy and Planning) to clinical change and improvement group Regular updates through Liz Lightbown at Executive Delivery Group	Full summary of responsibilities and leads against each area of action plan received from lead executive.
Voluntary and Community Sector	Maddy Desforges, Chief Executive, VAS	CEO will use mechanisms to talk to and consult with others in the sector and reflect their experiences at both senior and operational levels. The CEO has a mandate to represent the VCSE. Note that governance is appropriately different to other partners – VAS is a membership organisation rather than having the means to control operational delivery.	Some commitments in Action Plan link to agreeing new strategic relationship between VCSE and statutory sector – paper to EDG planned for Autumn 2018.

A cross-system Steering Group comprising the Executive Leads above will meet on a 6 weekly basis to oversee the overall CQC plan. This will feed into Executive Delivery Group and, subsequently, to the ACP Board. Health and Well-Being Board have requested regular updates and SCC Scrutiny and Oversight Committee have indicated their intention to call this in for scrutiny on a 6 monthly basis. Individual aspects of the plan are receiving very close attention – for example the CEO led meetings with Chief Operating Officers on Why Not Home Why Not Today work.

ii. **Overview of Programmes**

The Programme Director is reviewing overall ACP architecture in line with the CEO Away Day decision, in conjunction with work stream teams.

Summary of Programmes – Highlights

Significant activity is now taking place across most ACP workstreams. There are considerable links between all of the programmes, and the overall strategy and vision needs to be developed, with the solid delivery plan underneath. There are three stands to this:

- Developing the coherent strategy: This will be a key focus of ACP work from now until the end of the financial year resulting in the "Refreshed Place Plan" alluded to in Section 1.

- Developing credible underpinning delivery plans: whilst considerable progress is being made here there are workstreams which need further help to increase pace and the strength of their approach. The workstreams are all at different stages but good progress has been made since the last ACP Board meeting.

- Increasingly we need to be redirecting resource across ACP partners to this agenda in order to move this system work at greater pace.

A framework paper will be developed to help guide how we move into a coherent strategy and set of delivery plans, and this will frame consultation with partner organisations.

Core Workstreams

- The Elective work stream has refreshed its focus and had held successful system wide events on **skin and cardiology** with positive priorities to pursue. ENT and Gastroenterology are next priorities. There is an effective system leadership team working together on this and good progress is being made.
- As part of the Urgent and Emergent Care Work Stream, two clinical ACP workshops between CCG and STHFT have taken place on "**Developing Improved Services for Patients at Risk of Unplanned Hospital Admission"**. A headline vision is developing, with a 3rd meeting planned for November. There is an in principle commitment from both organisations to a new supporting contractual framework. A cross-organisational team attended the recent NHS England Large Scale Change Masterclasses with a focus on this project.
- The Children's Work Stream are looking to streamline reporting and **mobilise clinical and leadership** capacity to progress the work. They are developing a refreshed "blueprint" for children's care by April 2019.

- **Long Term Conditions** held a refresh workshop on Friday 28 September, to re-clarify shape and priorities. A discussion with the primary care work stream needs to take place to ensure a joined up approach and in order avoid duplication. A high level programme vision and objectives document will be brought together by end of October to provide direction for the programme.
- The importance of effective **neighbourhood development** is a key theme in many programmes, and a joined up system approach that draws together current system work is essential. Following the September workshop, a second workshop with Local Authority colleagues, with greater input from children's and SCC colleagues will take place on Friday 26th October. From this we need to strengthen the system wide approach to neighbourhood development as part of our "system approach".
- **Mental Health and Learning Disabilities work stream** secured agreement from ACP Executive Delivery Group to think differently about 'transitions' issues in Sheffield (in the context of young person mental health). This has historically been an issue both nationally and locally in Sheffield and despite many attempts to resolve this, problems continue to occur. Taking an "organisational agnostic" system wide approach has been agreed, with a set of more radical options discussed by EDG. It was agreed initial whole system discussions would take place to reach a new vision for an all age service, commencing in December. All partners will be involved in this work and this has been a persistent theme raised by staff around the system to the Programme Director and the MH & LD work stream.
- MH & LD are planning a **programme workshop stock-take** in September 2018 and considering how this takes an all-age focus. The workshop will review progress and plan key next steps for the next stage of the programme.

Enabling Workstreams

- Positive progress is being made for the delivery of **a Sheffield Care Record** and improved Patient Flow. A workshop with CIO leads from Sheffield place partners was completed in October that supported the overall approach and identified priority actions to resolve. Formal initiation of the project is targeted for end October-18, with a Delivery Group meeting in November-18 for the first time. Work is ongoing across Sheffield, Barnsley place and the ICS to finalise an MoU for the delivery of Care Records and Patient flow in Sheffield and Barnsley (Linked by NHS England Business Case and same supplier in use). Target date for signature of the MoU is 1 November. Further communications and engagement activities are required to raise awareness and engage patients and professionals appropriately in the delivery of a Sheffield Care Record. The communications/engagement approach is in development and being based on exemplars such as Rotherham Health Record and the Leeds Care Record, as is the IG/Data Sharing approaches. Alignment between a Sheffield Care Record and the emerging work on Continuing Access to Care is being progressed.
- The **population analytics pilot** commences on 1st September. This will provide good learning for the longer term requirements for the future. Sheffield ACP is linking into ICS work on this topic, alongside considering how the population analytics work and digital workstream need to collaborate. Both will be underpinning foundations of developing integrated care, learning from international case studies.
- The **Pharmacy Work Stream** is making good progress, with a clear focused set of priorities on medicines management, maximising the contribution of pharmacy within primary care and developing shared care. Improved digital inter-operability, matching

prescribing pharmacist to system demand and developing community pharmacy provision are key foundations. The team will have crystallised the vision & headline programme plan by November 2018 when they will report back to EDG.

- The **Workforce programme** is working on four priorities, with varying degrees of progress. The 12 week planning rapid planning cycle for an Older People's workforce strategy commenced with support from GE Finnamore. This is a core part of the CQC Action Plan. A discussion regarding potential integration of the workforce and OD programme is taking place. In conjunction with the **primary care workstream**, the work on developing a primary care workforce strategy is commencing, with good learning from the GE Finnamore approach. Two bids have been submitted to Health Education England to bid for non-recurrent year end funds for the North region linked to this work.
- A set of specific proposals on **system development work**, developed by the **organisational** development work stream were agreed by EDG on 9 October. Specifically these were:
    - Leadership Development (with the Sheffield Liminal Leadership Programme to run twice yearly, with next course, from early 2019)
    - Centres of Excellence (with each partner opening up one "exemplar" developmental activity to all partners)
    - Microsystems Coaching Academy (with a commitment from VCSE and SCC to explore microsystem coaching capability to ensure a common QI language across the city)
    - Identifying support for the ACP Board and Executive Delivery Group (to further develop system leadership skills within our most senior leaders, as individuals and as a team)
    - Providing a bespoke OD offer to priority ACP delivery objectives (with neighbourhood development and person centred care two initial priorities).

The OD group will now start planning delivery, with commitment from all partners at EDG to provide resource to help deliver this.

- **Healthwatch** have been appointed as the **ACP VCSE partner on public and service user voice** and will mobilise in November. Laura Cook from Healthwatch will work into the ACP team on this agenda. This contract will last for 12 months, with the funding source being ACP team pay slippage in 2018/19. This will provide a great opportunity to build the public and service user voice to the strategic and operational development of the ACP, alongside focusing on priorities, such as Older People's experience (as captured by the CQC Local System Review).

iii. **Cross-Cutting Risks**

A set of key themes around programme risks are taken from the highlight reports:

Risk	**Mitigation**
Workforce Development – identified as top risk within Primary care work stream, and within pharmacy programme. Programme resourcing for the Workforce Programme is raised as a key risk.	Essential to have the 2 day a week ICS funded appointment in place. Post will be re-advertised.

UEC have raised the risk of operational pressures impeding transformation work.	Review of links between transformation and performance aspects of workstream taking place
MH & LD, Primary Care work streams alongside other groups around the system have raised the importance of a robust system approach and leadership to neighbourhood development. It is identified as a key risk area by two work streams.	This requires greater system focus and is an identified priority by the CEOs. An initial ACP meeting took place 3 September to explore this, a second workshop planned for 26 October. A refreshed approach will be proposed thereafter.
Some programmes need still to develop greater clarity of focus and direction. The Long Term Conditions Programme in particular is identified by the Programme Director as a particular risk at this time.	Good initial stock-take in October – LTC programme now needs to define this programme and ensure a more robust approach.
Project/ programme management support to help drive programmes forward identified as risk in a number of programmes (primary care, workforce, LTC, elective, finance & payment reform) Mitigation outlined, but we need to start re-shaping some of our collective resource in line with ACP priorities in order to accelerate the system wide work	• LTC: Support from Programme Director to crystallise shape of programme & prioritise • Primary Care: Deputy Director to provide support before dedicated project manager commences in post • Workforce Programme: Deputy ACP Director to support, ICS programme lead to be re-advertised. • Elective: cross system team in place – team need to find sustainable capacity following one colleague's departure in December. • Payment Reform: dedicated system finance post to be advertised in October
Sheffield Care Record: Due to the commercial route to market being via a Barnsley Hospital Trust contract and a need for an MoU across Sheffield and Barnsley, there is a risk that this will delay deployment in Sheffield. Due to the need to establish a Sheffield Care Record alongside existing systems that professionals use, there is a risk that professionals will not adopt/use an integrated care record.	Full discussion on Sheffield Care Record planned at EDG in December 2018 to lift profile of work across all executive leads and ensure the programme team are supported to make rapid progress.

iv. **Governance**

A review of ACP architecture is taking place to ensure as streamlined an approach as possible.

Following legal advice, improved protocols for managing conflicts of interest will be issued during November to all workstreams.

It has been agreed that the governance for the Sheffield Outcomes Fund will fall within the Accountable Care Programme. Individual business cases are already aligned with individual workstreams.

v. **System Metrics**

As the overall population analytics work progresses EDG requires some system metrics to determine whether progress is being made. Sandie Buchan (Head of PMO, CCG) has led this approach and developed an initial draft. This links to the wider Population Health work. This will report back to EDG during the autumn.

vi. **ACP Team Recruitment**

- Jane Ginniver commenced as Deputy ACP Programme Director for Development on 17 September.
- Kathryn Robertshaw was appointed to the ACP Programme Deputy Director - Delivery on 1 October and will commence in post on 7 January 2019.
- The ACP Finance post will be interviewed for in November and the 1 year workforce ICS/and ACP responsibilities will be re-advertised by the end of October.

Conclusions and Recommendations

The ACP Board is asked to note the above report.

Paper prepared by:	Rebecca Joyce, ACP Programme Director
On behalf of:	Kevan Taylor, CEO Chair of the Executive Delivery Group
Date:	23 October 2018

APPENDIX 1

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Skipton House
80 London Road
London
SE1 6LH

To NHS England Long Term Plan Engagement Team

Long Term Plan for the NHS: Consultation - NHS ENGLAND PUBLICATIONS GATEWAY REFERENCE: 08415

Sheffield Place Response

Thank you for the opportunity to comment on the long term plan for the NHS. I am writing on behalf of the Sheffield Accountable Care Partnership comprising seven partners:

- Primary Care Sheffield (our GP Federation)
- Sheffield City Council
- Sheffield Children's NHS Foundation Trust
- Sheffield Clinical Commissioning Group
- Sheffield Health and Social Care Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Voluntary Action Sheffield (the umbrella membership organisations for our Voluntary and Community Sector)

On behalf of the partnership I will respond to your three over-arching questions. Partner organisations across Sheffield have responded to some of the more specific chapters of the consultation.

1) **<u>What are the core values that should underpin a long term plan for the NHS?</u>**

i. The factors that contribute to people's health and wellbeing are multiple, complex and intricately entwined; the majority are beyond the reach of traditional NHS services. The NHS needs to work in partnership with all interested partners, to ensure a whole pathway and population approach is taken. This includes public health, housing, social care, the voluntary sector and other partners that contribute to the wider determinants of health. We need to further shift our focus from treatment to keeping people well and focus on some of the key public health challenges – smoking, obesity and increasing physical activity.

ii. We need to change the current emphasis and political/ media debate and reorient our system to improving health & wellbeing from birth. This includes embedding the value of a whole family integrated working approach throughout the NHS.

iii. We need to commit to enabling an all age approach to care – for example in mental health. Transition between child and adult organisations remains a challenge locally and nationally across physical and mental health services. This value of more seamless "all age" care should underpin our approach – and mechanisms be developed to support this shift.

iv. We need to embed a population approach through our NHS. This needs to be accompanied by acceleration towards integrated commissioning and delivery, with supporting policy and legislation to aid this direction of travel. Rather than being an end in itself structural integration should follow transformation and increased integration in ways of working.

v. As a core value, we need much more explicit acknowledgment of the absolute inter-dependence between health and social care, with a policy environment that shifts us towards integrated delivery. Current policy and relative funding constraints between NHS and local government provide a context which gets in the way of providing joined up, best value care for the vulnerable populations receiving this care.

vi. We need to explicitly value the importance of the voluntary and community sector as a strategic and operational partner in our approach to care.

vii. We need to embed an outcomes focus as a key value within our approach, moving away from performance and financial system based more on activity based inputs and outputs.

viii. We need to be explicit about a core value of valuing our staff –and the social value of those that protect the most vulnerable in society – who "touch our lives at times of basic need where care and compassion are what matter most".

ix. We also need to develop a culture across the NHS and Social Care that genuinely sees the relationship with its people/ citizens as one of equals, underpinned by a real commitment to co-production. This needs to build on pockets of good practice that exist within the statutory sector, but deliver a more cultural shift learning perhaps from the voluntary and community sector.

x. Collaboration and integration as key values needs to be supported by a policy environment that moves away from fragmentation and competition and helps build improving health and wellbeing into every area of local and national government policy to underpin our stated ambition towards integration and a greater prevention

orientation. This should include health and well-being considerations being fully embedded in:

- How we plan and design our towns
- How we educate our children
- Enable an environment that is conducive to good health
- A wider societal culture that promotes good health

xi. Finally, genuinely holistic, person centred care needs to be at the heart of our values – with an expectation of care that reaches across organisations, and mental and physical health. This will require significant training and development of our workforce and an organisational and policy environment that helps provide the conditions for this shift. This needs to be in a set of values that explicitly aims to build the resilience of communities, families, societies to improve our collective health and well-being.

2) <u>What examples of good services or ways of working that are taking place locally should be spread across the country?</u>

A number of good practice examples of integrated working, or developments that more broadly support strategic and operational system wide development at place level are provided below.

i. Our mental health trust Sheffield Health and Social Care NHS FT is significantly less dependent on inpatient care to support people with complex needs or experiencing a crisis and can share learning about intensive community focussed care, step up, down and crisis beds services delivered in partnership with the third sector. This long term strategic focus on delivering socially inclusive support and keeping people at home has involved long term commitment to developing innovative intensive workforce models and services to provide intense support to individuals in the community. This has improved experience and outcomes for service users, many of whom used to be cared for many miles from their homes and families, outside of Sheffield. The Sheffield system has a low bed base, low admission rate, below average lengths of stay, has almost eradicated out of town locked rehabilitation care, made significant investments in community services and also saved the health economy millions by repatriating patients from private residential providers and providing support in the community.

ii. We have developed pooled budgets and commissioning arrangements across Sheffield CCG and Sheffield Council for mental health. This involves a risk and benefit share agreement that includes Sheffield Health and Social Care NHS FT as our main mental health provider. This arrangement ensures all parties are inextricably connected both in terms of budgetary shares and how each respective budget is spent. This has moved to collective accountability and responsibility and “shared issues” across the system. For example, this has enabled us to simply split

section 117 costs on a 50:50 basis meaning assessments are now focused on quality and outcomes not on who should pay for each element of care. Examples of genuine collaborative working include a city wide approach to perinatal, liaison and primary care mental health services.

iii. Our musculoskeletal care model is based on an integrated model of care underpinned by an outcomes based contract. Sheffield CCG and Sheffield Teaching Hospitals have moved away from Payment by Results, based on a transformed model of care, with an integrated virtual triage, enabling patient to be directed to the right service on receipt of referral. The model was co-designed with patients, carers and local patient groups, alongside staff from across community, primary secondary, independent and voluntary sector. Access to secondary care services has significantly improved through the changes, alongside genuinely integrated working across departments and sectors, to ensure patients get to the right place, first time. A patient reported outcomes framework and virtual care record, "My Pathway" has been implemented, which partners in the system intend to roll out to other models of care.

iv. Our single GP Federation for Sheffield (Primary Care Sheffield) is at the forefront of national primary care development. All practices that can are shareholders. This offers a significant strategic opportunity for Sheffield as a city to develop both GP practice and primary care more widely – and we look forward to sharing learning over the coming years.

v. We have made good progress in Sheffield on developing data sharing arrangements across the Local Authority and the NHS on a retrospective basis for analysis. This enables more whole system analysis, through our CCG and public health team.

vi. We have some good examples of collaborative working with the VCS sector including the WHO exemplar Age Better programme and Dance to Health. However, we have acknowledged the need as a place to develop a stronger strategic relationship with our VCSE partners and this is an ambition of our place arrangements.

vii. Our Sheffield Outcomes Fund approach, supported by central government with funds of £80 million over five years, offers an opportunity to test out the value of Social Investment Bonds as a means to pump prime public sector innovation and new outcomes based payment mechanisms. This offers innovation in investment and contracting for some of the most challenging areas facing both local and national government, such as mental health and homelessness. Sheffield would be interested in working with partners in central government to take the learning from the Sheffield Outcomes Fund and apply it to a major challenge facing the public sector, such as adult social care. Expanding the scale of this work, with the aim of identifying solutions in such an area, which would be of national interest, would be a natural progression. This would require the relevant central government

departments/organisations to work alongside the public sector in Sheffield, and to contribute resources and funding to address the identified challenge. This would provide an opportunity both to draw on the lessons from the Sheffield Outcomes Fund, and work on a much larger scale than has been possible under the Fund. Such a piece of work could incorporate elements funded through SIBs and other funding options, and also could be an opportunity to use other innovative commissioning tools such as Innovation Partnerships.

viii. Expanding Improving Access to Psychological Therapies (IAPT) services to include a focus on people with long term conditions and persistent physical symptoms is a national programme of work set out in the 'Five Year Forward View for Mental Health' (Mental Health Task Force, 2016)

Sheffield IAPT is a wave 2 site for IAPT-LTC expansion, and city's new 'Health and Wellbeing Service' (HWS) commenced in October 2017. Commissioned by Sheffield Clinical Commissioning Group (CCG), the HWS service is working in partnership with the CCG, primary and secondary care, city council and community partners to deliver an ambitious and transformational service across ten conditional pathways:

- Pain/Musculoskeletal (including Low Back Pain & Sciatica)
- Respiratory (including COPD, Asthma)
- Cardiovascular Disease (CVD) (including non-cardiac chest pain)
- Diabetes (Type 1 and 2)
- Cancer (following successful treatment)
- Irritable Bowel Syndrome
- CFS/ME/Fatigue
- Generic Long-term Conditions (including Dermatology)
- Persistent physical symptoms (or Medically Unexplained Symptoms)
- Health Anxiety

NHS-E have developed a case study about the low back pain course jointly delivered by colleagues in HWS and 'Physioworks' (Sheffield's community physiotherapy MSK service) https://www.england.nhs.uk/mental-health/case-studies/chronic-pain-and-low-back-pain-pathway-at-sheffield-improving-access-to-psychological-therapies-iapt-service/

Considerable engagement and development work has been undertaken, to support full integration within all ten medical pathways. New health and wellbeing courses and individual support are available across the city.

3) What do you think are the barriers to improving care and health outcomes for NHS patients?

i. Despite recent investment in mental health care, the percentage of the wider NHS budget that is spent on mental health compared to the level of mortality and morbidity attributable to mental ill health remains very low. Challenges are

compounded by the fact that there are long standing gaps in key strategic areas, in particular primary care mental health and a broader approach to emotional wellbeing for children and young people.

ii. Social care funding needs to be increased in line with health care funding and care systems need to be encouraged – either through policy or structural change – to ensure the local pound is spent in the best way – beyond what Better Care Funds were able to achieve. Otherwise investment in the NHS could be undermined is social care cannot meet resultant demand.

iii. We need to be honest and realistic about other areas of public sector reform and their implications for health – for example changes to benefit payments, and wider reductions in local government funding.

iv. We need longer term, cross-party planning at national level to plan and deliver long term improvements for health and well-being. We need to be supported to invest in and develop preventative services that address the wider determinants of health – even when results will not be seen for several years. This might include the development of bespoke housing solutions, investing in green space, encouraging our townscapes to focus on active travel, developing sustainable employment, investing in school based well-being and increasing early years investment.

v. The challenge of shifting our resource profile to provide more resources for prevention cannot be under-estimated. There is also a wide acknowledgement in Sheffield of the challenge of achieving this in the current regulatory and performance context given the importance of maintaining sustainability of all partners in an inter-dependent system. We need to develop a programme of provider payment reform that will better enable the aims of the integrated systems at place level to be met, and incentivise more outcome focused, preventative, population-based models of care.

    a. The need for a shared financial strategy, aligned to population need is crucial if we want to achieve the stated ambition of integration.

vi. In this context, it is hard to underplay the critical importance of upfront transformation investment from central government. We note the around £500 million transformation fund that Greater Manchester received as part of their devolution arrangements. We would welcome additional transformation funding to enable the significant transformation programme we have planned.

    a. We need to acknowledge the particular risk to sustainability faced by our secondary care providers in this context, and “double running” money will be essential to maintain business as usual and statutory and NHS Plan commitments to be met, as our system develops greater prevention orientation over the long term. It is vitally important this transformation

funding reaches “places” when operating within larger footprint Integrated Care Systems such as South Yorkshire and Bassetlaw.

b. We often discuss the 80:20 rule of thumb between Place led transformation and South Yorkshire and Bassetlaw ICS level transformation, and need to be sure transformation investment reflects this split (and is directed in this way from NHS England). In central policy announcements we would welcome more emphasis on “places” within Integrated Care Systems, given the differences in size of ICSs (and therefore the varying profile/ significance of “place”) across the 10 frontrunner Integrated Care Systems.

vii. A lack of inter-operability between IT systems across providers and clinicians across health and care organisations is a major barrier to enabling integrated working across organisations and teams. Our frontline staff across the whole system, frequently raise this as an issue which gets in the way of providing the best, holistic care to the individual across primary care, secondary care, social care and other areas of public service delivery. This lack of inter-operability also causes significant duplication and inefficient work practice. Whilst some progress is being made within individual care economies, this remains a major barrier. Information sharing governance also gets in the way of better, integrated delivery and planning.

viii. Workforce planning, nationally, regionally and locally has historically been poor in the NHS and has led to significant workforce challenges, alongside a slowness to adapt agile, workforce planning processes. We need more expertise nationally to guide workforce planning for the long term, focusing on workforce supply and workforce innovation – to help shape new roles for our changing care models of the future. This will need a cross-sector focus (for example across social care and the NHS as well as within the NHS).

ix. The policy and regulatory environment at times appears confused. We await the developing merger of NHS England and NHS Improvement, and anticipate a regulatory and national policy context that clarifies the role with Integrated Care Systems. There is often considerable confusion for local leaders, and increasing challenges of delivering the organisational day job, alongside system roles, and different or duplicated messages from Integrated Care Systems, local Places and national bodies.

x. Local Consideration needs to be given to future architecture, system support and development. As part of this agenda there will be a shift in roles and responsibilities – and this is starting to be discussed locally. For example, specifically, what will be the future governance around a greater role for primary care and community, if this plays a much broader role in the future? We are interested to understand what help will be given by NHS England to develop systems on this journey of maturity.

xi. Procurement legislation is currently trailing the direction of health and care policy and gets in the way of developing integrated ways of working. We want to benefit

from local providers' relevant service experience, knowledge about the local context, and the cohorts we are targeting; and to benefit from this while proposals are being developed. We often want to develop care models for the long term, locally owned and locally designed and driven, but procurement rules currently get in the way of this integration rules and distract leadership attention to governance rather than transformation. However, the policy landscape is moving faster than the legal or commercial landscape here and it has, at times, felt unclear how to progress the work 'safely' in commercial, procurement and contracting terms.

xii. Further work on estates nationally would also help the changing context. Developing new approaches to where and how people access health and care services recognising there may be an increasing role for virtual, digital enabled access will be important. We would welcome further policy thinking and development in this area from NHS England.

xiii. There are also challenges for smaller providers, particularly in the voluntary and community sector. It is a more complicated process to engage in for voluntary sector providers and there is a strong sense that this is much harder for smaller local groups to do, potentially skewing the process towards bigger players.

I hope this response is helpful. Please do not hesitate to contact me if you have any queries.

Yours Sincerely

Rebecca Joyce

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cc.

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