Sheffield Health and Care Partnership

Health and Care in Sheffield in 2030

Draft Report

Version 3.2

Last updated 08 November 2021

Contents

Executive Summary

Our partnership vision is for our health and care services to be **integrated**, joined up, and seamless; to reduce and remove **inequalities** in health outcomes and access to support, by playing our full role as anchor organisations in our city, and to do all this in a way that **involves people, their experiences and our communities** at the centre of our work.

This vision has been developed through conversations across Sheffield, including the NHS, Sheffield City Council, Sheffield's voluntary and community sector and members of the public. It builds on local and national strategies and as such is part of an ongoing journey in Sheffield, not the start or end of one. This document is written as an ambitious vision and it doesn't set out the route to achieve it. We will bring forward accompanying documents setting out nearer term priorities, focus, and milestones.

Sheffield has excellent assets. People who care deeply about their work and our communities work across our health and care services. We have a thriving voluntary and community sector; high quality health and care services; committed local businesses and leading academic institutions. Most importantly, Sheffield citizens have pride in our city and a willingness to work together to create a future that better responds to the needs and aspirations of us all.

We have identified three strands for our work over the medium and longer term:

1. For our health and care services to be integrated, joined up and seamless

In 2030, people will find it easier to access high-quality health and care. Health and social care will be more streamlined and more cost-effective, and better at recognising and responding to the particular needs of individuals and communities.

Primary and community-based services will bring together a wide range of different disciplines from across mental and physical health and social care, together with the voluntary and community sector, working with children and young people, their families, individuals, carers and communities.

We will increasingly blur the distinction between primary care and other specialists. This 'generalist'-'specialist' domain will be one of the biggest opportunities for transformation over the next decade.

We have high quality commissioning teams and expertise in Sheffield, which are essential in planning and shaping services; prioritising resources to best meet the needs of our population; and focusing on health outcomes and health inequalities. We consider the retention of our local commissioning expertise as a part of the new Integrated Care System (ICS[1]) arrangements to be an integral element of our Sheffield partnership.

- We will work to **ensure the integration between commissioners and providers strengthens**, based on **joint development of pathways with a strong emphasis on outcomes.**

[1]At the time of writing, are waiting for the Health and Care Bill to pass into legislation. The terminology for the combined Integrated Care Partnership (ICP) and Integrated Care Board (ICB) is yet to be determined. Throughout this document we use the term 'ICS' to refer to *both* the ICP and the ICB.

- We will enhance integration and **reduce "handoffs" between our different organisations so that service users and our workforce can navigate with ease** to receive and provide support.
- We will work **constructively and supportively within the South Yorkshire Integrated Care System.**
- We will do all this while preserving our excellent asset base and our ability to provide excellent primary, secondary and tertiary services. This will clearly require some innovative approaches if we continue to be constrained financially, which we expect to be. We have the determination and expertise across our communities and our organisations to achieve this.

2. Reduce and remove inequalities

In 2030, our health and care offer will be person-centred, focused on the communities in which we live, and those with which we identify.

Building on our learning from the COVID-19 pandemic, working to reduce and remove health, racial and structural inequalities will be central to our partnership. We will focus on improving key public health indicators through prevention, targeting resources at areas of greatest need and addressing the causes of ill-health and the widening gap in healthy life expectancy across different populations. We acknowledge the critical role that the voluntary and community sector play, and also the broader role of our institutions and businesses in this agenda. By 2030, our Sheffield Health and Care Partnership (SHCP) partners will be more "outward-facing" in proactively working with others and fulfilling our roles as anchor organisations in the city. This will include explicit ambitions to improve the environmental sustainability of health and care.

- We will put even more emphasis on what we can do as organisations and as a partnership, to **prevent and reduce key physical and mental health inequalities**, particularly in early years from birth through school years.
- We will enhance the capability of **primary care and community-based services** so that they play a more integrated role within our communities.
- We will significantly expand the involvement of our relevant voluntary sector organisations by increasing their ability to lead, influence and enable change.
- We will proactively work with other city anchor institutions, to actively **support the city's sustainable economic regeneration** and attract private sector investment and jobs.

3. Involving people, experiences and communities at the centre of our work

As a partnership, we will continue to **listen to and work with people in all our communities, including those less often heard**, who experience the worst inequalities in our society. With their input we will identify how we can improve health and care provision, with clear milestones against which we can judge our progress and be judged. We want people's experiences of our health and care system to be fairer and much more seamless, based on their priorities and what is important to them.

In 2030, our health and care system will be different for people working in it: we will develop new career pathways; build multi-disciplinary and integrated teams; and have a learning and development prospectus that provides the skills and experience to work within a closely inter-connected system. Our workforce profile – at all levels – will better reflect the population that we serve.

- We will consider how we can **significantly grow and expand** the successful **'*What Matters to You*'** and other **person-centred approaches** that already exist in Sheffield.
- We will work to break down organisational siloes through joint learning/sharing experiences.
- We will work closely across our communities and with education providers; to increase the appeal and reach of health and social care as a career choice, and to develop new training pathways.

1

Context

1.1 Our city

We are proud to be Sheffield. The outdoor city, the steel city. The home of 'Hendo's' and the Arctic Monkeys and the city which gave football to the world; we have much to be proud of and our health and care services are no exception. We don't always put ourselves forward on the national stage, and could be seen to be lacking the ambition or confidence of some of our near-neighbours, but we have world-class institutions, a talented and committed workforce, and rooted communities which deserve the best health, care and support we can provide.

We know that stories are important. They may be less tangible than new buildings, technology or ways of working, but having Our Sheffield Story, our own case studies that explain the kind of Sheffield we want to live in, what it means for people at each stage of their lives here, and how our teams work together to enable that story, will be just as critical to our success as changes in systems and practice.

We have the ability to influence our own destinies, both as a Health and Care Partnership and as a city. Each of our partners brings specific expertise, experience and assets to the table. Together, we represent a significant section of the Sheffield workforce and economy, with links into broader regional and national development.

Part of developing the vision for what we can achieve over the next 10 years is to ensure that as organisations we are working to support each other and Sheffield as a place and be greater than the sum of our parts.

'Sheffield needs to establish a clear identity both as a city and as a key player in the system'

1.2 Developing this vision

Developed within the first 12 months of the COVID-19 pandemic through a series of conversations with SHCP leaders and Sheffield citizens, building on previous work with organisational and professional leaders across our partnership, this vision document is designed to be the start of a broader conversation within and across our organisations, with our people and service users, and with our communities around the future of health and care provision in Sheffield and our role in the broader future of the city.

Trying to envisage Sheffield in 10 years' time in the midst of a period which has seen unprecedented disruption to our society, economy and services, a tragic toll on our communities and rapid, still-evolving change, might seem at best ambitious, at worse a distraction from other more immediate priorities. In parallel, we have been working collectively to respond to the current emergency and as part of broader national, regional and local planning.

However, as a partnership we are also being asked to make decisions which will affect the future of our organisations and our population over the coming decade and beyond. The forthcoming Health and Care Bill provides us with an opportunity to transform the way that we commission and deliver health and care across our city and more broadly as a member of the South Yorkshire Integrated Care System (ICS).

To do so effectively, to be able to respond to current opportunities and challenges, to be able to access and harness new funding sources, and to support Sheffield's longer-term recovery, we recognise the value of having an agreed, longer-term plan: one which allows us to step outside the way we are structured and

work right now, and one which provides a shared "compass" to support each other and steer our collective efforts in the face of the uncertainties ahead.

As such, this document does not try to answer all the questions around what Sheffield health and care services will look like at the end of the period, nor to define a set of fixed steps to get there; these are articulated elsewhere. Instead it articulates the key differences we all would like to see, and sets out our shared view of how we move towards these from where we are today.

We hope that this document will act as a catalyst for change and for bringing together individuals, teams and organisations to plan and invest in Sheffield over the longer term.

'There are clear health economic benefits if we work as real partnership, recognising that return on investment might not be in one's own organisation and might not be immediate'

1.3 The strategic context

The strategic context in which Sheffield operates is complex: encompassing local, regional and national partners which all play important roles across our health and care system.

At city level, the Sheffield Health and Wellbeing Strategy outlines the ambitions for a healthier city from "Starting Well" through "Living Well" to "Ageing Well". All the organisations which form the SHCP have signed up to these ambitions and have committed to aligning individual organisational priorities to promote them.

Sheffield forms part of the South Yorkshire Mayoral Combined Authority (SYMCA) and is one of five places which form the South Yorkshire and Bassetlaw ICS[2]; formally launched as an ICS in October 2018. The ICS' direction of travel was set by the 2019 NHS Long Term Plan,[3] and will develop into a statutory body following the forthcoming Health and Care Bill.

The NHS Long Term Plan explicitly covers the next decade of development of health services in England, and as such is broadly contemporary with this document. Alongside the developments above, the Long Term Plan identifies the drivers and rationale for these changes, including:

- **A growing and ageing population**
- **The need to address areas of longstanding un-met health need**
- **Medical innovation and new treatment possibilities**
- **The imperative to give people the right care at the right time in the optimal care setting**
- **Improving prevention of avoidable illness and its exacerbations**

These five factors are drivers of increased demands on health and care services, not just at national level, but also in Sheffield. The recent local plans, strategies, vision statements and initiatives in Sheffield reflect these and are attempts to develop effective solutions.

The COVID-19 pandemic has added an additional set of challenges: balancing routine care with emergency responses; adapting and responding quickly on the basis of rapidly changing information;

[2] This will become one of four places in the South Yorkshire ICS from April 2022
[3] NHS Long Term plan (2019). Accessible here.

sustaining and prioritising service provision with fewer resources and greater demands, including substantial built-up demand; and caring for people presenting with more complex issues (which span across physical health, mental health and their wider life circumstances impacted by the pandemic) at a higher level of acuity.

Within Sheffield, as elsewhere, we have seen unprecedented levels of collaboration between health, local authority services and the voluntary and community sector; increased use of digital technologies to provide safe access and to co-ordinate joint working around at-risk and vulnerable individuals and communities; and a revisiting of fundamental principles for the funding of our health services (including the "Payment by Results" system) in the light of the need to pull together and do "whatever it takes" to safeguard life and respond to the pandemic.

The experiences and lessons of this period will be needed, both as we address the ongoing threats that the health service faces and as we plan for a social, economic and health recovery which will likely take us to 2030 and beyond.

1.4 Existing local strategies and plans

Much work has been done in Sheffield and in our wider ICS in recent years to address local and national priorities, and this document is not designed to replicate or replace those efforts.

Our SHCP brings together Sheffield City Council, NHS Sheffield Clinical Commissioning Group (CCG), Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health & Social Care NHS Foundation Trust, Primary Care Sheffield Ltd and Voluntary Action Sheffield.

Collectively, as a partnership, we focus on issues that can best be addressed together, in order to bring about major changes in the way services are planned and delivered and to improve the health and wellbeing of everyone living in Sheffield. Since its establishment in 2017 we have been working to improve population health and wellbeing as part of our journey towards better integrated, person and community-centred care, as described in our Shaping Sheffield plan.

Covid isn't the only emergency that the services will face. The health and care system both have a part to play in delaying climate change, and can do this more effectively together, and needs to respond to the public health challenges that it will present. Sheffield is aiming to achieve net zero carbon as a city by 2030, and all the organisations in the city will have a part to play, and the health and care sector have both a vested interest in, and a responsibility for, taking action.

In our development of our vision for 2030, we have worked to reflect these ambitions, along with those of Sheffield's Joint Health and Wellbeing Strategy, and to understand over that longer timeframe where radical change will be required if these ambitions are to be realised.

2

Moving from collaboration to *integration*

2.1 Mainstreamed integrated care

Integration can be a vague term and what this means in practice is explored further throughout this section.

A key principle of our work is that people experience care that is well coordinated and consistent, and that professionals and organisations work together, on the basis of well-developed, high-trust relationships without barriers created by different IT systems, processes or culture getting in the way of providing what the person needs. Integration and seamless delivery of activity need to operate vertically (from front line services through middle managers to the top of each organisation) as well as horizontally (across organisational boundaries).

A further requirement of successful integration is that services and support need to be easy to access. Right now, it is predominantly the patient, carer or service user in Sheffield who must do the integration, often having to navigate a maze of different organisations and professionals to get the help and support they need. By 2030, we need to take positive steps to ensure that there is "no wrong door" for people to knock at; and that when someone has made contact in search of help, our pathways and systems are set up to respond accordingly.

A key characteristic of the system we are seeking to create is seamless and smooth pathways of care, support and treatment. This means that referral criteria based on meeting thresholds will need to change to increasingly collaborative approaches, which focus on meeting people's needs within a pathway. Current criteria can stifle professional judgment and pose barriers to people accessing the services they need. This is a particular issue for young people moving into adult services but is encountered in other parts of the system as well.

Alongside this is the aspiration that people should receive care as close to home as is practical and safe. With the growth of the use of remote consultations, telehealth and telecare, many different forms of health and social care are increasingly being provided in people's homes. Even prior to the pandemic, people told us that they do not want to be in hospital or residential care, unless there is no other choice. There is an opportunity between now and 2030 to ensure they have that choice.

'Personalised care, through a network of centres focused on wellbeing and prevention, will be the most conducive to a sustainable integrated health and care system'

2.2 Consistent, well organised care

Our vision is that across all areas where people's care transfers between settings and organisations, (including between specialisms, and from children / adolescent services to adult services) care remains undisrupted and people are supported through the transitions.

This will involve balancing the development of person-centred, community-based care with the need to reduce complexity and unwarranted variations in access and outcomes through improved standardisation and practice.

'You recognise the care worker you are given, you know where they come from, it all looks the same to you from the outside even though it's complex on the inside'

We believe that the need to ensure access to best-practice care, at scale, is supportive of and not inconsistent with achieving a fully personalised health and care system in Sheffield by 2030.

By working as a partnership to develop shared pathways, shared records and joint-working across disciplines and settings, we will ensure that everyone in Sheffield can benefit from the best quality care and support and reduce the risk of people falling through the cracks, suffering repeatedly negative experiences, or having to do the work of coordinating care because we as professionals are not communicating effectively enough.

Shared primary care, community, acute and social care records with the informed consent and under the control of the person concerned will underpin this "core offer" to our local population and will be accessible to help people with self-management of their mental and physical health and wellbeing and with key administrative tasks, such as booking appointments and managing their medications.

The widespread implementation of electronic record systems will support changes to the way we work, providing improved communication between people and those that care for and support them. The ability to integrate citizen-generated data will become increasingly important as the use of apps and self-care devices becomes more widespread. As well as improving productivity, reducing errors and incorporating guidelines or pathways, these systems will improve the consistency of care. They will also allow our partners and Primary Care Networks (PCNs) to analyse data, plan and target services that meet the needs of the population much more effectively. **Apps and data are important, but we know that it is people, not technology that drive integration.**

For professionals and for people, carers and service users alike, the overly complicated nature of the current system will be simplified and become easier to navigate, not least through further development of single points of access for each area that will route people and professionals rapidly to the right place; through pooling funding and resources; and through empowering those providing support and care to make shared decisions with the support of relevant specialists from across the SHCP.

'Someone needs to own the whole of the individual's treatment and engage with their family over the long-term, a holistic single point of contact'

2.3 Integrated, person and community-centred local services

Our vision for Sheffield in 2030 involves joined-up services that improve outcomes across our population as a whole and within each of our neighbourhoods and communities. Integrated, person and community-centred health and care is at the heart of this vision and the Long Term Plan for the NHS. This is reflected in not just how people tell us they would like their services to operate in the future but also how (often as a cause of major frustration) individuals, carers and families expect services to operate today.

Whilst some progress has been made on a local, regional and national level, the reality is that most people's experiences of care remain disjointed. In developing our vision for 2030, we have heard from

senior executives, from clinical and other frontline professionals, and from patient representatives about some of the inefficiencies, inequities and poor outcomes that this lack of integration creates.

'Bouncing people across providers is an inadequate response'

2.3.1 Community-based multidisciplinary primary care

Primary Care will remain a fundamental building block of our health and care system and will be a key enabler of person-centred, community-based care across Sheffield.

In Sheffield, we benefit from having strong Primary Care leadership which is well connected across the system at different levels. At a city level through Primary Care Sheffield (PCS): our GP federation and 'primary care at scale' provider that as well as directly delivering services at a city scale where it is appropriate to do so, provides strategic leadership and a strong voice for primary care provision. At neighbourhood level through 15 well-established Primary Care Networks (PCNs), with Clinical Directors meeting regularly and connected into both PCS's governance and broader system discussions and decisions. And through four city localities – where groups of practices and PCNs come together and focus on shared areas of challenge in their part of the city.

PCS has been an important and founding member of our partnership and this leadership, involvement and, where appropriate, city-scale delivery will continue over the next decade. Through PCS, PCN's, localities and Sheffield's Local Medical Council (LMC), we need to ensure all GP practices are fully engaged, including in the work of their PCN and through localities with the work of neighbouring PCNs and practices. We need to define more broadly what we mean by subsidiarity - the level at which specific services are best planned and delivered - not just between our ICS and SHCP, but also at place level or through PCNs, networks of PCNs, and at individual practice level.

Over the next 10 years, primary care, including GP practices, PCNs, and PCS, will be critically important for our integrated health and care system. They will be integral to our overall vision for improving population health, as well as providing infrastructure that enables primary care to operate at scale across our city.

By 2030 PCNs and support to associated GP practices will be fully operational, based around extended multidisciplinary teams including nurses, health coaches, physiotherapists, pharmacists, mental health specialists, social workers, and people working in the voluntary and community sector. In each area, the exact mix will be determined on the basis of local needs. Local needs depend not just on age and disease prevalence, but also factors such as the proportion of people who speak English as a first language, health literacy and others often correlated with socio-economic wellbeing and deprivation. Local needs analysis will determine not only the appropriate allocation of resources, but also the required workforce skill mix and estate provision.

Social care staff, other council employees and the voluntary and community sector will be core to the work of these teams. GPs consistently report that people come to them with problems that go beyond healthcare, for instance support with housing, which nonetheless have a direct impact on the health and wellbeing of those involved. The reverse is also true, where people come into social care because of a change in health needs. Therefore the way the health and social care systems interact is vitally important as is recognising people as complex individuals whose needs are not clearly delineated along organisational boundaries. Those working in primary care and social care will be conversant with these issues and confident in their ability to connect people to local resources and services.

Whilst we have commenced this journey, it feels like there is a long way to go. We have seen in our shared response to COVID-19, professionals and communities coming together to flexibly and holistically address the needs of whole sections of our population, including the vulnerable and shielding. It is incumbent on us to use this learning to inform and drive the next 10 years of our development to make this the norm; supported by contracting and funding arrangements as described further in section 5 of this document.

By 2030, when we talk about multidisciplinary primary care we will not need to say "including mental health". Through the embedding and city-wide rollout of the Mental Health Transformation Programme we will further expand people's access to talking therapies and equip practice-based staff with extended training in supporting those with mental health needs. Professionals in PCNs will have close relationships with community mental health staff and mental health consultants. Whether in dealing with a young person showing the first symptoms of an eating disorder, or an older person with multiple long-term mental health conditions, community teams will be supported by specialists who "have their back"; and who have similarly benefited from the opportunity to work much more directly in primary and community settings as part of their training and continuous professional development.

We anticipate a similar model in other areas of secondary care that is closely related to the management of specific conditions or cohorts, e.g. geriatric medicine, or diabetes. The experience gained in the development of the Clinical Assessment, Support and Education Service (CASES) and the musculoskeletal model (MSK) provides a strong platform for our further development of this approach.

Over time we would expect to see the scope of this approach expand and an even greater level of joint working removing the distinction between primary care and other specialists in the system. We want to see each GP practice having well-developed relationships with the relevant specialists they need to consult (social work, mental health, geriatric medicine, respiratory medicine, diabetes, paediatrics, gynaecology, etc.) to manage people's short and longer-term health and wellbeing. Discussing complex cases, with peers and with specialists achieves two goals: on the one hand, it is a valuable way of incorporating professional development into everyday work; and on the other, it promotes a consistency of approach and methods across the system, reducing unwarranted variation in the access to and impact of the leading specialist care available within Sheffield's acute providers.

Joint working between practices, across our PCNs, and PCS will provide the critical mass to support shared functions and infrastructure to provide a range of enhanced services. Examples of shared functions include amongst others; professional management, IT support and back-office administration. In parallel, sharing resources will create the critical mass to operate extended opening hours in a sustainable way and to create shared diagnostic capability, to allow more rapid access to investigations by GPs in locations more convenient to local people.

As a result, GPs are likely to spend less time on non-clinical tasks and be able to redirect their focus to enhanced services. These include case management for the most complex cases, same-day consultations for urgent conditions, GP-first telephone appointment models and longer appointments for people who need them. These types of activity allow GPs and other practice-based staff to better tailor their work to their skills and preferences, reducing burnout and providing a more rewarding professional role.

Mutual accountability between team members and active participation of patients and service users will be core features of this model of working. In many cases this simply reflects the best of primary,

community and social care today - but with enhanced capacity, capabilities, and support from the PCNs and SHCP partners, the opportunity is to extend these relationships and models to become the way in which care in Sheffield is delivered in the future. Key outcomes will include:

- Rapid access for minor conditions.
- Remote consultations and triage to support this.
- Longer consultations for people with complex issues – particularly important if care is to be based on their preferences and goals (person-centred).
- Close links to specialists and the ability to get specialist opinions without using outpatient referral.
- Easy access to point of care tests (POC), echocardiograms and other complex imaging.
- Integrated mental health support with easy connection to specialist mental health services.
- Close connections to a range of community and local authority services and resources, including social care, housing and the voluntary and community sector.

2.3.2 A model for acute care that others will follow

In Sheffield we are fortunate to have three Foundation Trusts providing high-quality specialist care, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust and Sheffield Children's NHS Foundation Trust.

As a partnership we will work to support and promote the development of these as centres of excellence, for our local population and the broader region, whilst looking for opportunities to share resources and capacities. In addition to ongoing changes in the traditional outpatient model (for example, through the adoption of virtual clinics and patient initiated follow ups) and an expansion of innovative care models (such as the MSK service and an enhanced and expanded CASES model), by 2030 we will have achieved significant further transformation in the way in which services are delivered.

We recognise that the growth in multimorbidity, resulting from an ageing population, means that increasingly people do not fit with the specialised model of traditional hospital medicine. Careful needs analysis and localised population projections as part of an overall investment to population health management will help us to identify the required changes in the balance between the number of generalist physicians and specialists, will drive the enhanced training of specialists with a strong generalist expertise, and the development of rapid cross-specialty consultations built around the needs of individual patients.

Strong localities with enhanced community and social care services provide the opportunity to deal with people who currently have extended hospital stays but who could be cared for at home or in a more appropriate setting than an acute hospital ward. Expanding intermediate care, rehabilitation and homecare services will allow for more rapid hospital discharge and reducing avoidable hospital admission. This has implications for our hospitals: the average patient may be sicker, have more complex needs, and be moving through more quickly. This is likely to require lower occupancy rates, more staff per patient and a shift in the balance towards higher qualified staff. Together with the development of enhanced home nursing and rehabilitation teams, this has further implications for workforce planning that will require action now to be ready to meet future demands.

'We will bring patients into hospital by choice rather than by failure of the system'

2.3.3 Progressing beyond parity of esteem in mental health

Whilst parity of esteem across physical and mental health may seem some way away, by 2030 we need to have gone beyond this if we are to achieve our broader ambitions for Sheffield.

Currently 8% of our total budget is spent on specialist mental health and we know this has not been sufficiently integrated into other activities across the health and care system.

In addition to neighbourhood-working with primary care we also expect closer working between specialist mental health services (including some specialist voluntary and community sector organisations) to support people with more complex needs in the community. These services will need to be tailored to the communities they serve. For example, people with complex lives and living in areas of significant deprivation may find Improved Access to Psychological Therapies (IAPT) simply does not meet their needs and require a different mix of services and support.

By 2030 through earlier and better co-ordinated support to children and families, we will have reduced the number of people who need life-long support. However, we recognise that the transition to adulthood will continue to be a challenging time for those with long-term mental and physical health needs, as well as those with learning disabilities and autism, and this has not been supported well in the past.

We will work to ensure that as part of developing person-centred approaches we will work to remove the artificial distinction between someone's needs as a young person and their needs as an adult, ensuring that when they are in need of support we work with them as a partnership and not as a collection of disconnected organisations and pathways; building on their abilities, and their aspirations, as the starting point. **The development of provider collaboratives in mental health offers us the opportunity to improve the management of tertiary mental health services and upstream investment to reduce the longer-term demand for these services.** Broader investment (particularly in prevention) along with organisational development and staff training to support increased neighbourhood working will pay long-term dividends in better health and wellbeing.

Investing in prevention means shifting resources in a way which builds over the long-term. This will not be quick or easy. Clear benefits can be achieved by investing in the prevention of mental ill health; promoting a better quality of life will impact positively on mental health. As a partnership we will need to work to identify and bring together the resources to do this, knowing that the benefits may not be felt immediately within our own organisations, but over time, and across the system and population as a whole.

Our support for transformation in mental health is not simply a matter of redesigning mental health services and will need to extend to investment beyond traditional service delivery. Effective co-design of prevention activities with service users and the wider community requires a genuine commitment of time and financial resource but will be critical to our success.

'Although it is challenging, we need to find the balance of both horizontal and vertical integration in mental health'

2.3.4 Integration with and across social care

Section 2.3.1 outlines our vision for community-based multidisciplinary primary care, with social care a core part. However, we know that the social care market has considerable complexity, with multiple different types and scales of providers in domiciliary care and care homes, typically less closely involved in our partnership work to-date.

Developing a more robust and diverse independent sector, with a more stable and highly-trained workforce, whilst providing clinical, managerial and training support to the workforce in Sheffield offers opportunities to improve the quality of care, lower the need for emergency admissions to hospital and reduce staff turnover as part of our future integrated care model. We will only achieve this by firstly recognising the vital role that care home and domiciliary care providers play, and secondly by finding ways to work more closely with them in both long-term redevelopment of our care models and in immediate responses to the pressures and challenges we are facing across Sheffield as a whole. Sheffield City Council will be critical to this work, as will our Primary Care Networks, with the opportunity to build on the experiences of Covid and develop ever closer links between individual care providers and the PCNs and GP practices that serve their areas.

Technology will be used to support those working across social care and to improve the quality of care provided, by enabling staff to access specialist nursing and medical advice without unnecessarily moving residents.

Across our care homes and homecare workforce, we will work to increase the sense of agency and connection to broader health services involved in supporting many of the same people and service users, developing parity of esteem with its health partners, better morale, job satisfaction, health and wellbeing for those providing vital care services and the experience and outcomes of care for those being supported.

'We need to think about the employment model for the social care workforce to ensure people find those roles rewarding and worthwhile'

2.3.5 Our voluntary and community sector

Our city is fortunate in having a vibrant and active voluntary and community sector (VCS) but whilst it is diverse, it is sometimes fragmented, some areas are less well-served and long-term funding is a huge issue. The voluntary sector is, and will continue to be, a key partner in the SHCP and has a crucial role in:

- **Working with and as part of expanded primary care** in particular providing support to people in relation to social isolation, economic distress, trauma and broader wellbeing, avoiding people becoming unnecessarily medicalised.
- **Providing health and care services with a wider perspective** about the needs of the communities and bringing lived-experience to our enhanced offer of support.
- **Playing a core role in developing the economic and social capital of the city** including in building and sustaining community assets.
- **Helping to mobilise and co-ordinate volunteers** as part of our response to the challenges facing our system and services, building on the willingness experienced during the pandemic of local people to provide support within their communities to those who are vulnerable and in need of additional help.

The VCS in Sheffield is already a key part of our SHCP, whether through commissioned services or through the support provided to individuals and communities using charitable funding. Given this key role we need to support its long-term future. Although a number of VCS organisations in Sheffield have been in existence for longer than some of our statutory partners, sustainability and funding remain common challenges, exacerbated to critical levels by COVID. Funding processes have been known to stifle progress and effective ways of working, whilst our VCS representatives have described the tension between the intentions of commissioning leads to work with the sector in a supportive and strategic way, and the requirements of commercial teams and procurement processes. This is reflected in a wider concern about the extent to which the appetite for a strategic relationship with the VCS is embedded in the culture across and throughout our organisations.

To a large extent the pattern of voluntary and community services in Sheffield has developed through chance rather than planning. Some places have poor health outcomes and do not have strong VCS because of a lack of resources or individuals to sustain it, reflecting in part the approach to community development on the part of the statutory sector. VCS organisations in Sheffield recognise the value in developing their own vision of the future and working as equal partners with the statutory sector to develop networks and provide mutual support. There are examples of strategic partnerships between the statutory sector and the VCS in neighbouring areas such as Bradford and Doncaster to act as potential models as we further invest in these relationships.

In thinking about this key strategic relationship, the challenge to the statutory sector is to value the "otherness" which VCS partners bring. The VCS can be recognised as disruptors, challenging the status quo and thinking differently about the delivery of better outcomes with and within communities. Simply sub-contracting elements of service delivery risks understating the benefits which can be achieved and perpetuates an assumption that VCS services are simply cheaper alternatives to statutory providers. If we are serious about working with communities, community reference groups will need to share the same status as clinical reference groups as service plans are developed, with a shared focus on the social determinants of health alongside medical models of healthcare. The experience of working together during the pandemic has helped to build a greater understanding of this complementary value that the VCS brings.

We recognise that the need for "parity of esteem" for the voluntary sector extends to workforce planning. There is a real value in building relationships between workers in the statutory sector and voluntary sector through, for example, shared training, and the development of opportunities for people to build meaningful work experience across organisations in a structured way, as is the case for health and care professionals. This requires a long term and strategic approach to resourcing the VCS and should show a return on investment as people within both sectors grow in confidence to explore different approaches and apply them in their daily roles. Representatives from the VCS have spoken to us highly of the Leading Sheffield programme as a good example of shared development. We understand the need similarly to recognise, support and invest in unpaid carers, as a core part of the health and wellbeing of our population.

2.3.6 Education, research and innovation

Our schools are an important part of shaping the service users of 2030. Health education, currently overlooked, needs to be integrated into citizenship studies to normalise and accelerate developments in areas such as telehealth, community healthcare, and personalised health that empowers the person, service user and carer. Our SHCP has a key role to play in helping to create these new models of proactive

healthcare. A 10-year plan means children in primary school will be young adults by 2030 when our vision is delivered. As a partnership, we will need to work with other public services over this period to ensure that children and young people enjoy the best possible start in life, wherever they are in our city.

With Sheffield Hallam University and the University of Sheffield, we have seen a deepening of relationships and collaboration, including in the sharing of lab staff and equipment, and flexibility around student placements during the COVID-19 pandemic. Looking to the longer term, we have an opportunity to build on conversations with Sheffield Teaching Hospitals, Sheffield Children's and Sheffield Health and Social Care, and to use their well-established research and innovation strengths and ambitions as "*catalysts for levelling up, improving population health, and enabling the economy to build back better; transform the skills base for the advanced economy – boosting productivity and driving economic growth; tackle entrenched social and health challenges to ensure the benefits of growth are felt by all – helping our region to level up; find answers to pressing environmental questions, helping the UK to achieve net zero carbon emissions by 2050; and provide a model for change that can be adapted and replicated in other parts of the UK.*"

We want to deepen our involvement as anchor organisations in the broader local economic recovery and regeneration, and we will work together and with Sheffield citizens to ensure that we maximise opportunities to develop Sheffield as a thriving centre of research, development and economic growth.

'Schools shape our future citizens for decades to come'

3

Tackling inequalities

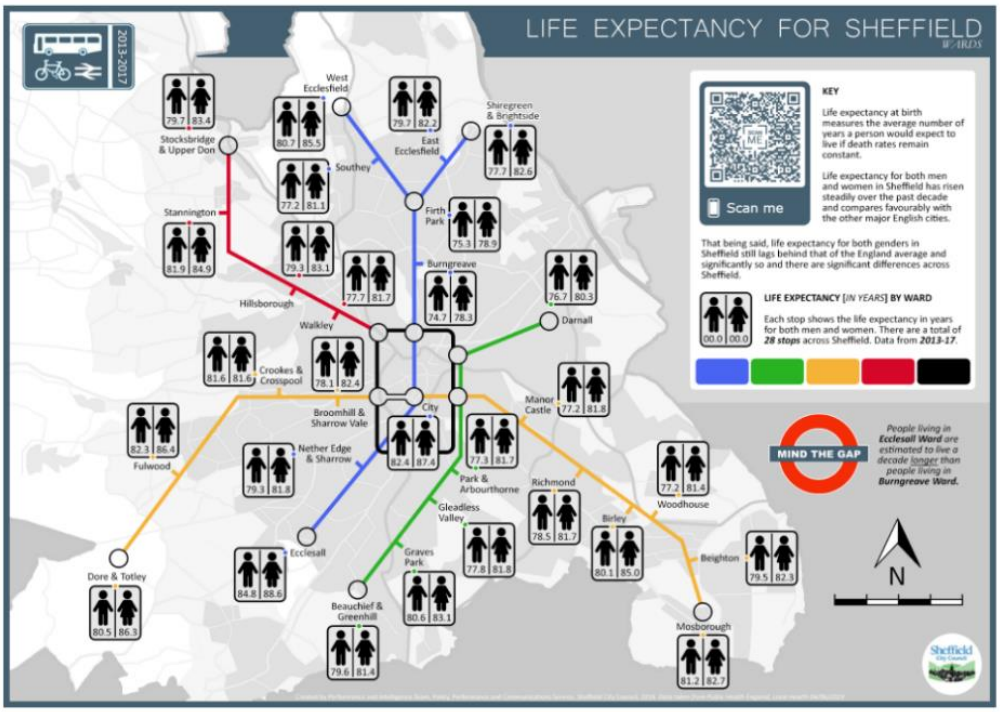
3.1 Inequalities in Sheffield: context

Sheffield is one of the 20% most deprived local authorities in England, whilst at the same time having some of the most affluent 1% of areas in the country. Outcomes in Sheffield reflect these extremes.[4]

There is significant inequality in health and causes of ill health in Sheffield, including:

- **The gap in healthy life expectancy:** for example, a gap of 20 years for women between most and least deprived areas - one which right now continues to worsen.
- **Teenage conception rates:** higher than the England average.
- **Low birthweight:** a higher than average proportion, with 12% still smoking at the time of their child's birth.
- **Healthy weight:** one in three children aged 10 to 11 are overweight, and one in five is obese.
- **Employment rate:** 4% for people with learning disability and 6% for those in contact with secondary mental health services and on a care pathway.
- **Alcohol related mortality:** higher than the national average
- **The impacts of climate change** are recognised as being a public emergency of a much greater magnitude than Covid. Those people with the poorest health in Sheffield are likely to be those who experience the most negative impacts, including worsening health.

Sheffield's most recent Joint Strategic Needs Assessment (JSNA) put a spotlight on the continuing variation in life expectancy across our city:



"A man or woman living in Ecclesall ward is estimated to live over a decade longer than a man or woman living in Burngreave ward."[5]

[4] Sheffield ACP Shaping Sheffield 2019-2024 Place-based plan
[5] Sheffield Joint Health & Wellbeing Strategy 2019-2024

"Marmot Indicators" provide further insight into how Sheffield compares to the rest of the country on other determinants of health, health outcomes and social inequalities:

- The proportion of people reporting **low life satisfaction** is significantly higher than the England average.
- The proportion of **achieved 5x GCSE A*-C** including English and Maths is significantly lower than the England average.
- The rate of **unemployment** is significantly higher than the England average.
- The rate of people who are **long term claimants of Jobseeker's Allowance** is significantly higher than the England average.
- The proportion of people who experience **fuel poverty** (for high fuel cost households) is significantly higher than the England average.[6]

As "Shaping Sheffield" highlighted, the principal driver of demand for healthcare in Sheffield is illness rather than age, although an ageing population is a factor too.

In Sheffield, much of our burden of disease is associated with preventable conditions and circumstances:

- **Smoking** accounts for 12% of all morbidity and 20% of deaths.
- **Obesity** is the second most common modifiable risk factor.
- **We are an increasingly "multi-morbid" city** where 23% of people have two or more long term conditions.
- **Prevalence of multi-morbidity increases with age** with onset 10-15 years earlier for people in most deprived areas.
- **Socio-economic deprivation is particularly associated with mental health** related multi-morbidity.

The main causes of illness in Sheffield today are cardiovascular disease, cancer, mental ill health, musculoskeletal, neurological and respiratory conditions. The main causes of death in Sheffield today are cancer, cardiovascular, neurological and respiratory disease.

Our population in 10 years' time:

"*between the 2011 Census and the Office for National Statistics (ONS) 2018 mid-year population estimates there has been a 5.6% increase in the population overall. The largest percentage change was a 13.6% increase in the 5-11 year old group, followed by a 8.6% increase in older people (65+). Conversely there were percentage decreases in the number of babies and infants (-3.6%) and the number of young people (-0.6%).*"[7]

This pattern of growth is set to continue; according to Office of National Statistics projections, it is expected that the population in Sheffield will grow by 4.8% by 2030 (equivalent to 28,550 more people).[8]

In particular, the number of people over 65 is predicted to increase by 13.8% by 2030.

This means that in 2030 there will be 13,100 more people over 65 living in Sheffield. This can also be seen in the wider region of Yorkshire and The Humber, where projections predict a 3.2% population growth to

[6] Marmot Indicators for Local Authorities in England, 2015 – Sheffield (Public Health England).
[7] JSNA
[8] Population projections (accessed here on 06/10/2020).

2030 (equivalent to 177,769 people) and a 19.0% growth in the number of people over 65 (equivalent to 198,596 people).

The Sheffield Joint Health and Wellbeing Strategy recognises that "*long term ill health tends to be associated with later life*". An increasingly older population will put Sheffield's health and care services, already under significant strain prior to the COVID-19 pandemic under significant additional pressure - to deliver more interventions, to people who need care for complex long-term conditions, for longer. This additional pressure will not start in 2030 but will build incrementally as our population grows and ages each year for the next 10 years (and beyond).

This means that by 2030, and starting now, we need to take concrete action both in relation to primary prevention - preventing people from becoming ill - and secondary prevention - early detection of disease and proactive intervention to stop it getting worse if we are to tackle the impact of long-term health and broader inequalities across our population, and to ensure we have a sustainable health and care system for our city.

'Our health needs have changed towards chronic disease management'

Successfully addressing long-standing inequalities requires a long-term approach to investment and decision-making. It is not something that any one part of a local system can achieve alone - it implies active involvement of local government, health, employers, the voluntary and community sector and other organisations both local and national that have a direct influence on the socio-economic determinants of health.

- The climate is changing – we are looking at hotter, drier summers; warmer, wetter winters and more extreme weather events – we are already seeing these and this will continue to 2030 and beyond.
- The impacts of climate change are recognised as being a public emergency of a much greater magnitude than Covid. Those people with the poorest health in Sheffield are likely to be those who experience the most negative impacts, including worsening health.

Our SHCP can ensure that we are doing our part - including by targeting and shifting resources and effort both to the areas of greatest need, and to address the root-cause of ill-health and disparities in healthy life expectancy. Colleagues have identified not only the critical role of the voluntary and community sector as being often best placed to take forward this work at a neighbourhood level, but also the broader role of our institutions and business in this agenda. By 2030 we believe Sheffield HCP needs to be "outward facing" in its work, whilst not losing focus on the key health and care services where we are directly responsible for performance in relation to health inequalities.

'We can influence some wider determinants of health, there is an opportunity to be a big player to influence the local businesses, infrastructure, to affect pollution and speed limits'

3.2 Inequalities: framing our response

The NHS Long Term Plan estimates that "the extra costs to the NHS of socioeconomic inequality have been calculated as £4.8 billion a year in greater hospitalisations alone". Recent PHE evaluation of the disproportionate impact of the COVID-19 pandemic has further highlighted the human impact of long-term health and broader inequalities on our minority ethnic populations, on older people, those living with one or more long-term conditions, and in areas of identified deprivation. There is both a financial and a moral imperative to ensure that we do not repeat the mistakes of the past.

All partners in our SHCP recognise the challenge of growing inequalities in Sheffield, and the impact this has on people, our workforce and our services. At the same time, we also face long-standing challenges to provide an effective solution:

- **The length of political cycles** is shorter than the time it takes to develop, implement and measure the effectiveness of initiatives to reduce inequalities. This has led to short-term projects and funding that have not been able to deliver sustainable positive changes.
- **There are no proven "off-the-shelf" solutions or models to address inequalities**. While in principle we agree that more investment (not just money, but also staff) should be directed towards the most deprived areas if this involves compromises elsewhere, to date, this has been very hard to make work at an impactful scale. The best approach is likely to be bespoke and tailored to the needs of a small area, and based on several iterations, with rigorous mechanisms to regularly assess what works to keep moving in the right direction.
- **Funding mechanisms, payment structures and outcome measures do not facilitate the kind of work** that could effectively tackle inequalities. Inequalities arise due to a broad range of factors, many of which sit outside core health and care services - NHS England research has suggested that "*wider determinants of health […] have a significant impact as only 20% of a person's health outcomes are attributed to the ability to access good quality health care*".[9] As a result, addressing inequalities requires co-ordinated investment but in a way which current funding mechanisms do not make easy. Outcome frameworks and performance measures often focus on metrics that can be impacted in the short term, such as delayed transfers of care or the four-hour A&E target. However, initiatives that try to improve inequalities are likely to take years if not decades to show an impact.
- **Professionals in health and care need specific training and skills to work with communities who live in deprived circumstances.** Education curricula and continuing professional development for all our professionals and teams need to be developed to build confidence and competencies in this field. This is challenging not just because of the inevitable time lag between the time it takes to train a professional and when that person enters the workforce, but also because it requires health and care providers to work together with education providers to design appropriate courses and ongoing support. In section 4, we have identified the role that investment in our workforce, and in integrated training and education, will play; we need to ensure that this helps us to develop not just excellent medical care, but a broader understanding of the "social model" of care: how we see and think about the people we work with and how we empower them to achieve what's important to them, on their terms.

In Sheffield, we agree there is no silver bullet to solve these issues and that the most effective way to deal with this issue is a combination of initiatives and methods, tailored to the specific needs of each area

[9] Population Health and the Population Health Management Programme (accessed here on 6th October 2020).

and pursued as part of an ongoing, long-term commitment. *All* partners in our partnership have a responsibility to address health inequalities both organisationally *and* collectively.

3.2.1 Population health management

NHS England defines population health as "*an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population*." Specifically, this involves the use of "*data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources… to understand what factors are driving poor outcomes in different population groups*."

Partners in our HCP broadly agree that a population health management approach is an effective way to identify the differing needs of key groups living in our city and enabling a differentiated response – for example by geography, by demographic and by condition. It allows us to gain a deeper understanding into what is happening locally, going beyond recognised divides (driven by affluence) and identifying other communities of shared interest that are spread around the city e.g. differential health and care access and outcomes for people of different ethnic backgrounds, stark differences in life expectancy for people with mental illness, unacceptable variations in outcomes for people with learning disabilities and autism. Population health management is an essential tool in developing the most appropriate response to the inequalities facing our communities.

'Population health management is about identifying different groups living in the city and understanding their different needs, and therefore differentiating our response – by geography, by demographic, by condition …'

3.2.2 The role of our partners as anchor institutions

While primary prevention and the creation of a healthy environment have often been seen as falling outside the core scope of health and care services, our partners are major employers, with substantial purchasing power in the local Sheffield economy, existing involvement from, and the opportunity to deepen relationships with, other city partners including our schools and universities.

All of this gives the SHCP significant influence over the health and wellbeing of people living and working in and around Sheffield beyond the results of direct provision of care and the treatment of disease.

The long-term economic effects of COVID-19 are likely to be felt for many years to come and will impact the resources available both to our public sector partners and to the voluntary and community sector in Sheffield. It is imperative over the next decade that we break the cycle of worsening economic and health conditions leading to greater demands on all our services, at a time when we are likely to have fewer resources to meet such demand.

By adopting a holistic view of population health and wellbeing, including doing everything we can to support social and economic regeneration with improved recognition of, and investment in, individuals and communities as assets, Sheffield HCP has one of the best opportunities over the next decade for putting health and care provision in Sheffield on a sustainable footing; maximising our collective power for the wider benefit of Sheffield's population.

3.2.3 Prevention

In recent years, there has been an increased focus on prevention within our partnership.

Developing preventative programmes nonetheless faces political and systemic obstacles. The benefits of prevention normally do not show in the financial timeframe within which organisations are required to report, nor is it always easy to draw a causal link between specific interventions and broader system activity and performance (particularly at a time of growing overall system pressure and demands).

We recognise as professionals and in our work with all our neighbourhoods and communities over the next decade, we will need to take specific steps on all three types of prevention:

- **Primary prevention**, to prevent injury or illness before it occurs and stop people from needing services in the first place. An example of a primary prevention is promotion of healthy eating and the benefits of exercise.
- **Secondary prevention**, to reduce the impact of existing illnesses or conditions and reduce the continued demands on services. Examples of secondary prevention include early detection and improved population health management.
- **Tertiary prevention**, to minimise the impact of morbidity and empower the person to self-manage their condition. Examples of tertiary prevention are rehabilitation programmes and 'expert patient' training programmes.

All these different types of prevention combine to achieve the double aim of preventing illness and promoting wellness, ensuring people have a good quality of life and stay independent and well for as long as possible.

Too often immediate priorities and response to crises absorb the largest amount of our focus and resources. The negative impact of failures in these areas is immediately apparent - without decent urgent and emergency services, we rapidly lose our ability to address critical needs, the confidence of our population, of those charged with regulating health and care services, and of our elected representatives; and create an environment where it is even harder for professionals to engage in longer-term planning and delivery.

However, the impact of not investing in prevention is less visible, with negative outcomes that occur over 10 or 15 years from now. Without their local walking group, a community of older adults could develop frailty much sooner than they would have otherwise, which impacts their quality of life and increases the level of support they need but is unlikely to be seen in the same context as cuts to emergency services.

'We need to commit as a city to overcome short political cycles and accept that we need to invest now to see benefits later on'

4

People *at the heart of our vision*

4.1 Person-centred approaches

The concept of person-centred approaches is core to approaches across health and social care; including the 'Putting People First' programme driven through Directors of Adult Social Services and the NHS Long Term Plan. It is fully embedded within both Shaping Sheffield and the SHCP's workforce strategy. It is the foundation of existing visions for future services in Sheffield. As an approach, it starts with the question of what matters to people; understanding them in terms of their goals and priorities, not simply as a collection of medical conditions to be treated. Self-care and involvement in the management of their own care is a key part of the approach, it is central to the SHCP workforce strategy and is already being put into practice across all our partners.

We recognise that different people will have different levels of ability, motivation and need, we also recognise the need to be sensitive to increasing inequalities. The use of remote and digital channels to deliver care has grown during the pandemic and is likely to continue to grow. Whilst we have seen significant expansion of access to internet services across all demographic groups and ages over the last 10 years, and we would expect the digital literacy of the population and workforce to continue to grow over the next 10, specific effort will be required to help people who do not have digital skills, have difficulties using technology, or are digitally-excluded for other reasons. We will need to adopt different approaches at different times and be agile enough to accommodate these; for minor issues, rapid access may be more important than seeing a professional that the person already knows.

Across the country we see leadership, structures, systems and people who naturally still feel an allegiance to their organisation rather than to the individual person, community, and overall health and wellbeing outcomes. Whilst 10 years may be a long time in terms of technology, it is not a long time in relation to cultural change - a holistic approach to care will require significant changes to the way our frontline professionals are trained, organised and supported, if it is to be our default model of care delivery in Sheffield in 2030.

'We should be prepared to give control to people, listening to and believing what they say'

4.2 Citizens, families, and communities as partners

People in Sheffield do not exist in isolation - they are parts of families and communities, which can feel overlooked in the way in which our services have traditionally been organised.

Re-designing services that reflect the complex needs of individuals and those around them means working proactively with people, communities, staff and other stakeholders to co-design services and co-produce outcomes which address the needs and respect the wishes of our communities.

'Without real coproduction we are never going to get a mandate. We need the public and experts by experience to mandate what we are doing'

While the places that people live are important, people are also part of communities that cut across geography including around cultural, religious and other important characteristics. Co-designing with excluded or "seldom heard" communities can be seen as particularly challenging and requires adequate

preparation, resources, training and time. However, only through engagement with communities will the opportunity to build and make greater use of local assets, and to connect the efforts of statutory and voluntary and community groups, be likely to lead to a more holistic approach to health and care. To achieve this we will need to invest in these groups, not just as a one-off set of initiatives and projects, but to ensure they too are thriving in 10 years' time.

'To be effective, preventative services need to be much more culturally sensitive.' **All of this speaks to the required model of change for Sheffield.** Evidence to date suggests that successful models of care do not just evolve from existing ways of working, nor are they simply the product of policy or strategic direction. No single organisation in Sheffield can design and deliver an integrated set of community-centred services. Only by consistently working together as a partnership, collectively with the citizens of Sheffield, will we be able to bring together the knowledge and resources both to co-design and deliver this type of care.

'We need to see real decision-making power given to those working in neighbourhoods'

4.3 Workforce

4.3.1 Engaging our workforce

There is a strong consensus about the main elements of the way that healthcare will operate. This may require significant changes from current structures, many of which will develop over time. It is nonetheless important that we have a shared view on how health and care will be delivered, starting with those working on the frontline, and how these changes will support and enable the development of their roles in supporting our neighbourhoods and communities.

This standardisation of approach combined with multidisciplinary working and shared information systems also means that our workforce will be able to operate across professional boundaries and build trust in each other's judgements in individual care planning. This will reduce the need for people to undergo multiple overlapping assessments or default to non-specific offers to care and support. Significant progress on "trusted assessor" models has already been made and this can be further enhanced. We want to see collaborative approaches that support clinicians, other frontline professionals, volunteers and carers[10], and people themselves to access the right pathway for them and to be assisted at each stage to stay well and to recover independence after periods of ill-health.

4.3.2 Workforce development and retention

Developing and retaining a skilled workforce will be key to the success of this strategy. A wide range of activities within our partnership and across the ICS will be needed to support this.

We will need to design integrated approaches to the training and development of our workforce to ensure that people understand and are comfortable operating alongside the capabilities and roles of other parts of the system. More integrated models of working, combined with continuous professional development

[10] Carers are explicitly considered to be part of Sheffield's health and care workforce under the SHCP workforce strategy, with a number of commitments made under the theme 'valuing the unpaid workforce'

that supports this approach, will help to sustain and develop better integrated, person and community-centred care.

Core aims of integrated training and development are to promote parity of esteem and to break down the barriers between primary and secondary care between health and social care, and between physical and mental health services, often working side-by-side to support the same people.

'If we get it right, they will feel part of something bigger, better and less siloed than they are now.'

These activities promote mutual understanding of different approaches in areas such as risk management between different parts of our system and how the interfaces between them need to be managed effectively to provide safe and high-quality services which are able to respond to our population needs.

Our key priorities in developing truly integrated working include:

- **Workforce support -** Designing a system that supports the workforce in all parts of our system (including mental health professionals, carers and voluntary and community sector staff). Mechanisms that build relationships across organisations and professions will facilitate this, including opportunities to meet peers; mentoring; coaching; remote advice lines across primary and secondary care; and job-shadowing.
- **Skills and competencies -** Our new model will require a breadth of skills and competencies, not just to provide clinical services, but also to lead and manage them, underpinned by a strong understanding of and commitment to person-centred approaches. The development of a shared culture and cross-SHCP relationships will support learning and building of a deeper understanding of the role that each part of the system has to play, including different capabilities and specialisms. This will include processes that enable consultants to set aside time to train GPs in specialisms relevant to their locality and pass on skills in that neighbourhood. Ultimately, our future workforce will need to think of itself through the lens of competencies across pathways, rather than traditional professional groupings while all roles will have true parity of esteem, regardless of which part of the SHCP they are based within.

'Hospital trainees can do some of their training in the community to promote more integration from the point of training.'

- **Workforce planning** - It takes significant time to train professionals (5 – 10 years). The numbers and skill mix for our workforce in 2030 needs to be planned and agreed from now. This process will need to take into consideration that the workforce mix is sustainable and flexible to respond to changes in the population need. And the need to ensure we have robust, shared data to enable development of our plans.
- **Recruitment -** Our SHCP will work jointly to enhance the perception and understanding that people have of a career in health and care and focus on positioning all roles in an appealing way. This involves reframing the story of what it means to live in Sheffield and promoting our city to encourage people to come and contribute to our communities. Schools will pay a key role in developing and realising this narrative.
- **Equality -** Our vision is to remove barriers to minority ethnic communities and other marginalised groups and take proactive action to ensure people from all socio-economic backgrounds, ethnicities, genders, religions and circumstances have the opportunity to play an equal role in the health and care system. We will commit as a partnership and as system leaders to ensuring decision-makers represent all the communities we serve in Sheffield.

'A key thing is moving away from professional backgrounds towards competencies, having a variety of people from different backgrounds who can bring that richness and rotate across pathways'

5

Critical enablers

5.1 Leadership, governance, decision making and culture

This vision is based on having a shared view of our future at a system level, that leaders are prepared to take back to their individual organisations and advocate for at all levels. We recognise that our workforce is very proud to represent their organisations. We need our people to be equally proud of working in health and care in Sheffield as a whole. We recognise that this will be both a driver and an outcome of our success over the next 10 years in developing better integrated working, focussed on individuals and communities and not the structures that serve them.

Our shared experience and response to COVID-19 has been a catalyst to this process, but we are aware of the risk that ongoing pressures as a result of the pandemic, and in the period that follows, will cause us to revert to previous and familiar modes of behaviour and working. We recognise the role of physical environments and systems in driving culture and of the opportunities that come from co-locating professionals and teams, but we also know we need to build broader trust and confidence in our ability as a city to meet the needs of local people.

At the time of writing this long-term vision, we are anticipating a new Health and Care Bill to formalise Integrated Care Systems and put a welcome and increased emphasis on place partnerships. This is an opportunity for us to renew, strengthen, and formalise our place partnership. We envisage an integrated health and care partnership and will build upon and bring together our joint commissioning arrangements and provider collaboration. Our default will be to have these partnership conversations together as one, rather than as separate commissioning and provider strands, though we recognise that there will still be times when separation is appropriate. We see that the '*so what*' of integration won't come from governance arrangements that we put in place; rather through the specific collaborations to improve services, and tangible steps towards the achievement of the vision in this document.

The key requirements of leaders in our 2030 system are:

- **Commitment to a vision** - Commitment in this context is not about a point in time, but a journey and our leaders need to be prepared for challenging and honest conversations. However, once the debates are over, leaders will own the vision and promote it both within and outside their own organisations. The vision will evolve, reflecting how Sheffield and its people are changing, but the ownership needs to stay constant even as individuals change roles. We commit to continuously revisiting this vision with our teams and those we serve, to ensure it is fit for purpose, whilst not allowing this process of reflection and improvement to stand in the way of getting on with the things we know we collectively need to do.
- **Building trust -** Leaders across all organisations in our partnership will lead by example and demonstrate trust in each other, applied in our daily work. This starts from recognition that our different organisations are at different stages of development. We will work with this complexity, rather than ignore it, being prepared both to offer and accept mutual aid wherever it is in the interest of our population and those we are supporting. Where we have centres of excellence in Sheffield, we will commit to supporting, developing and championing them, whichever organisation they sit within.
- **Consistent communication** - we will design communication mechanisms to ensure messages are cascaded throughout our local system. This includes celebrating success: as part of shaping Sheffield as a place to live and work, we will recognise more openly what works well. Celebrating successes is also key to creating pride and a sense across our workforce of identification with the city as a whole.

This is key to promoting staff engagement, ensuring that leaders do not just engage with each other, but that they also take our workforce along with them.

- **Empowering our teams through this change** - though we are looking for fundamental change, this cannot come top-down, or at the cost of allowing our citizens or our workforce to fall through the cracks as new systems are implemented. We will strike the right balance between caring for people now, and delivering sustainable change for the future, and we will support each other through this process including working across South Yorkshire to help shape future management and regulation of the integrated care system as a whole.

A key part of this will be building upon the use of collaborative quality improvement and team coaching methods to redesign pathways and systems and to develop leaders. Sheffield is seen as an innovator in this field and we have a strong track record of empowering teams across boundaries through our Microsystem Coaching Academy (MCA) and Flow Coaching Academy (FCA). These have already successfully brought about effective change and improvement in frailty, end of life care, stroke, head and neck cancer, long covid and dementia. Strategically spreading and scaling this work and enabling more pathways to use this expertise will put Sheffield in a very strong position to deliver our SHCP vision.

By 2030, we aim to be working with a very different and more inclusive decision-making structure. The Health and Care Bill will have become the 2022 Health and Care Act, with an emphasis on subsidiarity, a strengthening role for place partnerships and more provider collaboration across our system. These changes, combined with Sheffield City Council's establishment of Local Area Committees and move to a modern committee system of governance offer opportunities to rethink our approaches to decision making, public involvement, and public accountability. In particular, there are **opportunities for greater public involvement and engagement** in the difficult decisions about where and how we focus; how we identify and resolve different priorities in different parts of the city; and how we involve more and different voices in decisions about resource allocation and prioritisation, in particular the voices from those communities experiencing the greatest health inequalities. As a sector, we will influence those strategies which address the wider determinants of health in the city and beyond.

Accountability for public spending, and for the performance of our health and care system will change too. While individual organisations are likely to retain their statutory accountability arrangements, there is a substantial opportunity for us to set out – publicly – **the outcomes we are aspiring to across our health and care system** for all of Sheffield's population, and how well as a system and a city we are achieving these outcomes. This outcomes framework is already under development with substantial involvement from the public and different organisations.

'Engagement is key, we need all leaders to sign up to the shared vision'

5.2 Finance

Finance and funding have been described as the "elephants-in-the-room" of our partnership: a core issue we are working hard to address through the development of our place partnership. Whilst funding was perceived as less of an issue in the NHS in the immediate response to the pandemic, COVID-19 has exacerbated existing financial pressures and has proven much more immediately challenging for our local authority and voluntary and community sector partners.

Over the next 10 years we will need to support the broader economic recovery of Sheffield, whilst putting all of our services on a sustainable financial footing for the decades to come. The key changes that we believe will support this vision are:

- **Aligned incentives and contracts -** Tariffs and Payment By Results have driven an unhelpful divide between primary and secondary care in Sheffield. Targets have too often been designed around the activities of the acute hospital. Having aligned contracts, incentives and objectives that reflect the whole range of health and care services provided to our population will help drive and enable the change needed to support better integration. One of the key pillars of this new model is a shared caseload, enabled by digital technologies, across multiple multi-disciplinary team members. Contracts and methods of moving resources will facilitate the creation of shared caseloads across providers, avoiding unnecessary and unhelpful competition. There are many areas where working more closely across the health and care could benefit from economies of scale, for example the financial cost of reducing carbon emissions.
- **Commissioning** - True integrated commissioning means that planning and contracts focus on managing outcomes of the whole population, and are commissioned and managed collectively across the SHCP, as opposed to in a single organisation. Clinical leadership is key to support this process. We know we are at the start of a major change in the commissioning of health services, with implications for local government and the voluntary and community sector partners. Empowered statutory and voluntary and community sector providers have been a key part of our COVID-19 response, tasked with successfully creating solutions to critical problems, collaboratively. We recognise the ongoing importance of both the functions that underpin effective commissioning of health and care services in Sheffield - including strong planning and assurance of services and quality - with the need for increasingly close working between these functions and those delivering services on the ground, if we are to co-produce our ambitions for our population as a whole.
- **Investment in the right places** - We need to be brave about the decisions we make to invest in some areas and disinvest in others. Robust health economic analysis, underpinned by IT solutions that can collate and share relevant data, will show which areas need more resources and how this investment will realise benefits to the system as a whole. This links to scaling initiatives – Sheffield often carries out successful pilots, which are not scaled more broadly. We will address the funding issues that prevent successful pilots from going further and provide the shared leadership to push this forward. Proper resource allocation does not just involve organisations, but also people. Contractual and financial arrangements will enable easy movement of staff between providers across the city, to both make better use of our workforce and encourage the development of relationships that contribute to a shared Sheffield health and care identity.

'The key thing is that the resources should follow the patient pathway, not the other way around'

- **A long-term investment plan in place across the whole Sheffield system** - Investment needs to go beyond the next financial year – particularly for preventative interventions. A deeper understanding of the desired outcomes and of the organisations that can help achieve them will shape the investment that needs to take place. Voluntary and community sector organisations are too often undermined by short-term funding and performance management based on unrealistic outcomes: acknowledging that a VCS intervention can easily span a five-year period and can demonstrate results over an even longer timeframe will help set up investment mechanisms that facilitate their operations as opposed to hinder them.

5.3 Digital and other technology

The experience of COVID-19 has enabled our workforce, the public, patients and service users, to realise some of the potential of digital technologies including phone, internet and video, to deliver health and care services.

'The facilitation of patient interface with clinicians would never have progressed as quickly as it has, were it not for the pandemic. If we can move quickly on this, we can move quickly on systems design that allows the unification and personalisation of patient medical records'

The desire to provide safe and accessible services has helped to overcome some previous reluctance and we expect to see the use of technologies develop further, whilst being mindful of the need to ensure technology addresses, and does not make worse, existing inequalities.

'We need to be wary of digital poverty and exclusion, working with schools and different environments, knowing there are families who do not have the ability to access things, to ensure equity of access'

The main areas where we expect technology to support our vision are:

- **Shared care records -** Vital to facilitate multidisciplinary working, reduce fragmentation and duplication of work, promote continuity and improve the quality of our care. Creating mechanisms for aggregating and linking data will allow better use of predictive analytics to help target at risk individuals, as well as providing an important planning tool. These developments will be a part of the wider strategy for interoperable information systems across the South Yorkshire ICS.
- **Patient portals -** We will create a platform that links to the shared record; supports people in managing their own care and communicating with clinicians; and simplifies administrative tasks such as booking appointments.

'The other aspect of tech is about how we get patients looking after their own health. Patient-led health, they need to be empowered'

- **Video links and other communication systems -** These will facilitate better dialogue between professionals, for example allowing GPs to contact a consultant via video-link during a consultation, and will reduce the need for further appointments, thus saving time to people and professionals, and resources to the wider system and reducing carbon emissions. It will also enable the bringing together of people from different parts of health and care in a 'team around the person' approach.

Future digital innovation and the potential benefits it will bring will need leadership and investment and more focused city-level leadership and resources than we have committed to this agenda to date**.** As a partnership, we need to be clear what we are prepared to do jointly, even if this is harder than investing in individual solutions, and to create a shared roadmap for which capabilities we need to prioritise, by when.

In parallel, our ambition to be able to deliver care closer-to-home, enabled by remote working in primary, community, acute and social services as well as by voluntary and community sector partners, will need to take into account that these routes are not suitable for everyone. On current trajectories some people in Sheffield may not have access to the necessary technologies, even in 10 years' time. It is important that these groups are not disadvantaged or excluded as a result of this and we will ensure that alternatives are readily accessible. We will support work to help people overcome the barriers they face in accessing digital technologies, so they can use future services more effectively.

'Digital opportunity and potential is massive: mental health is one of those areas where we have been doing a lot more group work and sessions digitally, young people prefer it'

'We need to be consistently exploring the digital space for prevention and promotion, as well as treatment'

5.4 Estates

Just as it takes time to develop people, our approach to the future facilities we will need to deliver health and care services closer to home, will require planning and investment now if we are to achieve our vision by 2030 whilst contributing to the decarbonisation challenge.

We have already seen radical changes in working through the pandemic, including the ability for many more people to work from home. In parallel, as we plan for and recover from COVID-19 on an individual, organisational and Sheffield-wide basis, we know that having access to high-quality, safe working environments for providing support, diagnostics, treatment, rehabilitation and long-term care will be critical to helping people to start, live and age well and reduce our carbon footprint. We will continue to need safe and supportive environments for high-acuity patients, including those requiring psychiatric intensive care.

Our estates strategy for the next decade will need to encompass the changing nature and scope of services, the balance between neighbourhood-based practices and the ability to deliver at-scale in community settings, the need to continue to invest in our acute trusts including research and development of next-generation clinical therapies and practice.

'Most buildings are old and Victorian, we need to deliver more and more services in centres in the community and to do this we need more new buildings'

'Some services are appropriately delivered in secondary care, but outside of that do we need a hospital? Can services be more community based, can we find the least restrictive environment to receive support?'