Moving towards an Accountable Care System in LLR

Author: SLT Sponsor: John Adler / Mark Wightman **Trust Board paper N**

Executive Summary:

This proposal has been developed following the joint meeting of NHS board members (UHL, LPT and CCGs) together with local authority partners on 18 July 2017 at Leicester Racecourse. The proposal paper was written on behalf of the LLR SLT by a small working group of Dr Peter Miller (LPT CE), Sarah Prema (LC CCG) and Toby Sanders (STP Lead). An early draft of the paper was considered by SLT at its meeting on 17 August 2017 and this updated version, which incorporates discussion and feedback at that meeting, has been prepared for consideration by the boards (or equivalent) of individual partner organisations during September 2017.

Context:

At a recent regional Sustainability and Transformation Partnership event on 3 August 2017 there were clear messages given by NHS England and NHS Improvement about the direction of travel towards the establishment of Accountable Care Systems, the emphasis being that "This is about moving progressively towards more *system* and less organisational perspective". This is not about 'whether' an ACS but 'when'.

Definition:

An Accountable Care System takes accountability for the delivery of care and outcomes for a defined population and geography within an agreed budget. In doing so it designs and delivers services to best meet the needs of its population and improve health and wellbeing outcomes. ACSs may take many different forms ranging from fully integrated systems to looser alliances and networks.

The LLR SLT envisages that an Accountable Care System would see partners working together and over time ceding some individual sovereignty for the current responsibilities they have within LLR into a joint endeavor. Ultimately, this could include all of these aspects:

- Working to a common purpose, vision and values
- A single system plan, objectives, initiatives and metrics
- A single place based budget, distributed across providers on an allocative and aligned incentive basis
- Single leadership teams (at place-based, network and LLR wide level)
- A common platform covering: ICT; business intelligence, improvement tools, methodologies and approaches
- Common governance and regulatory oversight.

It should be clearly stated that Phase 1, (this phase), does not by default commit partners to any next stage in development. There would be clearly identified milestones and gateways set out in a work programme for the ACS at which Boards and Partners would need to give due consideration about movement to the next stage. This would include specific agreement about any formal ceding of sovereignty and formal delegation of responsibilities. A MoU which is operational for Phase 1 would then need to be refined and agreed by Partners to reflect any future changes.

Questions:

All Boards are asked to consider this document with particular emphasis on the following questions:

1. Are you supportive of moving towards the creation of an ACS model across LLR?
2. Do you think this should be done in a phased approach?
3. What issues would need to be worked through in establishing the new model across the three different levels?
4. Are there other issues that impact on integrated/collaborative working that this proposal does not appear to address?
5. Do the Next Steps capture the key actions required to establish the ACS?

Note:

This paper will receive further detailed consideration at our Trust Board Thinking Day (14 September). The full response to the questions posed will then be shared in the Chief Executive's monthly update report to the UHL TB in October.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Not applicable]
Effective, integrated emergency care	[Not applicable]
Consistently meeting national access standards	[Not applicable]
Integrated care in partnership with others	[Not applicable]
Enhanced delivery in research, innovation & ed'	[Not applicable]
A caring, professional, engaged workforce	[Not applicable]
Clinically sustainable services with excellent facilities	[Not applicable]
Financially sustainable NHS organisation	[Not applicable]
Enabled by excellent IM&T	[Not applicable]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes /No /Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Yes /No /Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [The need for PPI / Consultation will form aprt of our feedback to SLT]

4. Results of any **Equality Impact Assessment**, relating to this matter: [Insert here]

5. Scheduled date for the **next paper** on this topic: [October 2017]

6. Executive Summaries should not exceed **1 page**. [My paper does comply]

7. Papers should not exceed **7 pages.** [My paper does not comply]

Better care together
Leicester, Leicestershire & Rutland health and social care

Moving Towards an Accountable Care System in LLR

A proposal from the System Leadership Team on next steps

DRAFT **Version 3** **(25 August 2017)**

Moving Towards Accountable Care in LLR - a proposal from the System Leadership Team on next steps

Working Together as One

> "*The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected episodes of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient."*
> *"Our aim is to use the next several years to make the biggest national move to integrated care of any major western country. This will take the form of Sustainability and Transformation Partnerships covering every area of England, and for some geographies the creation of integrated (or accountable) health systems."*
>
> *Five year forward View*

1. INTRODUCTION

This proposal has been developed following the joint meeting of NHS board members (UHL, LPT and CCGs) together with local authority partners on 18 July 2017 at Leicester Racecourse. The proposal paper has been developed on behalf of the LLR SLT by a small working group of Dr Peter Miller (LPT CE), Sarah Prema (LC CCG) and Toby Sanders (STP Lead). An early draft of the paper was considered by SLT at its meeting on 17 August 2017 and this updated version, which incorporates discussion and feedback at that meeting, has been prepared for consideration by the boards (or equivalent) of individual partner organisations during September 2017.

In terms of context, major challenges around health inequalities, patient safety, financial and workforce sustainability, have led all statutory health and care partners in Leicester, Leicestershire and Rutland (LLR) to work together on a programme of service redesign for the past three years. The overarching aim is to create an integrated health and care system for our population, which is clinically and financially sustainable for the long term.

This work has been brought together within a shared system strategy 'Better Care Together', which sets out the future for health and care services in LLR through a population health approach and the creation of integrated care models.

Significant strides have been made to improve quality and safety in most services, and building capacity within our programme of integration, however the financial position across the system remains extremely challenging. Within this changing context, the original Better Care Together Strategy, whilst still shaping our collective vision, now needs to be enhanced and supplemented by a delivery mechanism that can help us align system ambitions and support our work to integrated models of care.

Furthermore, the national context now requires us to develop and deliver a Sustainability and Transformation Partnership with our partners across LLR, which will cover the next 3-5 years.

As part of the work to consider how we could accelerate and expand the impact of our collaboration, partners have been exploring the development of an Accountable Care System. This is seen as a potentially helpful and necessary vehicle to cement our partnership working and provide a framework to mobilise our effort; and remove the barriers to integration necessary to achieve our aspirations.

At a recent regional Sustainability and Transformation Partnership event on 3 August 2017 there were clear messages given by NHS England and NHS Improvement about the direction of travel towards the establishment of Accountable Care Systems, as detailed below.

“This is about moving progressively towards more system and less from organisational perspective”.

“Increasing expectation that STPs will develop into ACS delivery models”.

“Creating ACS is about STPs locally re-writing the NHS operating model”.

“No organisation can survive on its own – we need collaborative arrangements with commissioners and providers having mature conversations”.

“Working outside the STP is not sustainable”.

“NHS organisations will see more and more business come through the STPs”.

“Investment will only come to high performing STPs”.

“STPs need to repackage their resources to do something different”.

“Smarter CCGs will be pooling resources across their STP area to combine their management resource”.

“The system is too complicated for commissioners to micro-manage providers through service specifications”.

This paper sets out to build the foundation for, and define, our next phase of development, as an Accountable Care System. It is intended to provide a clear signal of intent for our direction of travel and the work programme to support this. It also sets out the high level implications for leadership, decision making and governance.

2. HOW COULD OPERATING AS AN ACCOUNTABLE CARE SYSTEM HELP DELIVER IMPROVED CARE FOR PATIENTS ACROSS LLR?

As described above our local system has taken considerable strides over the past two years to meet the challenges set out in our Better Care Together Programme and subsequently in the Draft LLR Sustainability and Transformation Plan. Despite the good work on integration, improving pathways and clinical service redesign we still as a system face significant challenges and barriers to true integration of care and the development of seamless pathways for patients. Many of these are as a result of the way that the system is structured and tackling these barriers will enable clinicians and organisations to work more effectively together.

Some of the issues faced are described in the table below together with how an Accountable Care System may support the change required.

Now	**What could an ACS support?**
Our system is fragmented, a series of individual services, which leads to multiple hand offs for patients between services and variability which impacts on patient care and outcomes	The ACS will be based on pathways of care with organisations working together to enable patients to move seamlessly into different levels of care at different times of their lives improving quality of care and outcomes for patients
Increasing demand in all sectors is impacting on our ability as a system to maintain financial balance and deliver quality care	Integrated pathways of care will facilitate care to be provided in the right care setting; facilitate more resources into preventative and early detection
The financial platform is not sustainable with all providers and the CCGs under increasing financial pressure Different payment and contract mechanisms across the system inhibit the flow of money around the system and thus stifle the development of integrated pathways and innovation	CCGs and providers will work together to develop a new financial framework including a system wide control total and the ability to flow money around the system in a controlled way to support improvements in patient care and the delivery of the Better Care Together Plan New contractual forms will incentivise the system to deliver optimal care pathways and improve outcomes for patients with the focus on operating cost and value for money not income/activity/price

Competing regulatory requirements impacts on organisations ability to respond to a system agenda Organisational accountability often takes precedence over system needs and can lead to perverse decision making and delays in implementation	The Next Steps on the Five Year Forward View states that ACS will get far greater control and freedom over the total operations of the health system in their area thus enabling us to do the best for the system NHS England and Improvement have indicated a willingness to move to single oversight arrangements for areas working as an ACS
There is often duplication and triplication across the system which leads to inefficiency Decision making process are complex and time consuming leading to delays in implementation	ACS will facilitate the development of integrated care streamline pathways to deliver cost effective care; back office functions will develop into a common platform providing services across the system Commissioners will work more collaboratively together making more joint decisions on system issues leading to coordinated decision making and speedier implementation

The view of SLT is that the development of an accountable care approach across LLR is essential to deliver the BCT clinical model and population health focus. The current system is locked into a regime of annual contracting cycles, organisational rather than system regulation, and payment models which do not create incentives for the outcomes our residents deserve. Too many of our clinicians do not have access to shared records and our staff have different objectives and priorities. These barriers will need to be overcome if we are to have the best chance of achieving our desired outcomes.

We have to be realistic – our challenges will not be solved by just simply creating an Accountable Care System. The total resource available to us in the system, both workforce and financial, will be the same and change will take time. There are also risks that too much focus on delivery vehicle and organisational arrangements could distract from the task of improving services and quality of care. It is equally true that ACS models in this country remain a fairly new and untested concept which, despite the international evidence, suggests that realising the potential benefits will take time to translate into a UK context. Notwithstanding this, ultimately the NHS partners across LLR have to ask ourselves whether on balance the development of an ACS will lead to more functionally effective arrangements that will support the use of our combined resource in a different way and have potential to improve the quality, safety and outcomes of patient care for local people.

3. WHAT IS AN ACCOUNTABLE CARE SYSTEM?

The Next Steps on the Five Year Forward View states that Accountable Care Systems will be an evolved version of a Sustainability and Transformation Partnerships that is working as a locally integrated health system. They will provide joined up, better care and over a number of years may evolve into an Accountable Care Organisation.

Accountable Care System: An Accountable Care System takes accountability for the delivery of care and outcomes for a defined population and geography within an agreed budget. In doing so it designs and delivers services to best meet the needs of its population and improve health and wellbeing outcomes. ACSs may take many different forms ranging from fully integrated systems to looser alliances and networks.

SLT envisages that an Accountable Care System in LLR would see partners working together and over time ceding some individual sovereignty for the current responsibilities they have within LLR into a joint endeavor. Ultimately, this could include all of these aspects:

- Working to a common purpose, vision and values
- A single system plan, objectives, initiatives and metrics
- A single place based budget, distributed across providers on an allocative and aligned incentive basis
- Single leadership teams (at place-based, network and LLR wide level)
- A common platform covering: ICT; business intelligence, improvement tools, methodologies and approaches
- Common governance and regulatory oversight.

The ACS arrangements would bring together a hybrid of commissioning and provider responsibilities on a more functionally integrated basis. With a focus on population health, there needs to be a strong public health focus as well as support to enable communities to take responsibility for their own health and wellbeing.

Accountable Care Organisations: An Accountable Care Organisation is a group of providers, under one contract with a commissioner which has accountability for all care and outcomes for a population for an agreed period of time.

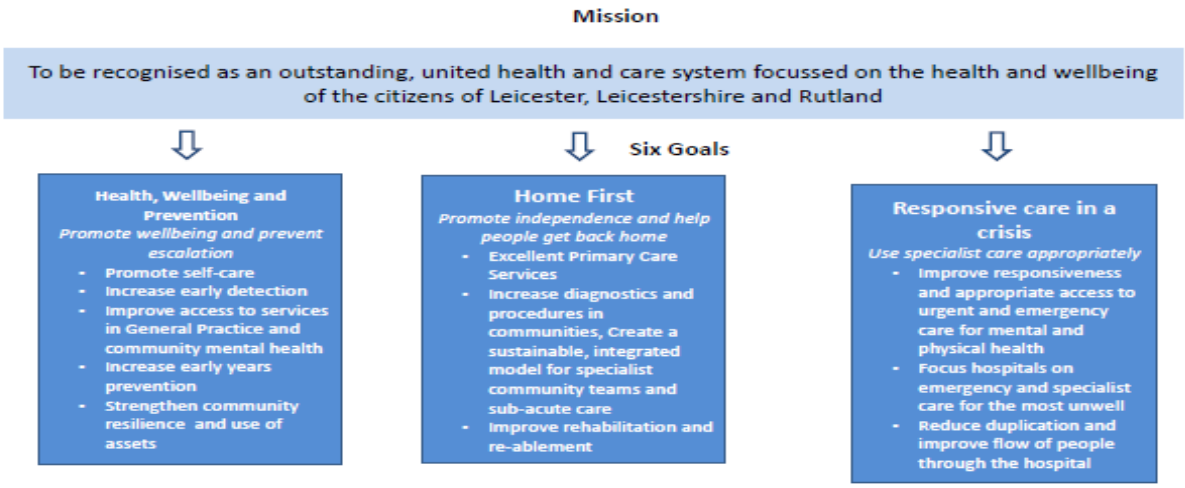
At this stage there are no plans to develop an Accountable Care Organisation in LLR which is supported by the Next Steps on the Five Forward View which state that ACSs may evolve into accountable care organisations over number of years.

4. OUR AMBITION: WHAT ARE WE TRYING TO ACHIEVE AND WHY?

Our current delivery arrangements across LLR are not enabling us to make the progress we need in terms of service quality, safety and value for money for people who live in LLR in a number of ways. The care they receive both in the community and in hospital is of variable quality – some is excellent but some is not of the standard we would want for us or our family. There are also marked inequalities in health outcomes. The current way we are working costs too much in terms of organisational overhead, leads to significant duplication and other inefficiencies, and provides a disjointed experience – especially when people move from one care setting to another.

The partners have collectively agreed that a new approach is needed through our Better Care Together Plan. The starting place for this endeavor is creating a common vision and purpose that we all share. This vision describes our final destination and the purpose outlines our overarching objectives. Both are underpinned by a common set of values and guiding principles that will shape the way we work together.

Work on shaping our vision, principles and outcomes has been led by the Clinical Leadership Group and shared with the LLR system at the recent Clinical Leadership event. Further work is required to refine these but the latest version is detailed below.



5. WHAT MIGHT ESTABLISHING THE FIRST PHASE OF AN ACS IN LLR LOOK LIKE?

Looking comparatively at existing ACS arrangements internationally, and the national accelerator sites in the UK, suggests that we would need to evolve our operating model in LLR at three linked levels:

I. **System** – this would be about working across organisations as "one team", focused on the same common goals and with aligned financial incentives and joint decision making. This is not about organisational mergers but would be about creating the right environment and conditions that would enable and empower our clinical and operational staff to work together in a more integrated way focused on doing the right thing for LLR patient and the NHS pound in LLR.

II. **Network** – this would be about establishing a set of clinical/service networks that cover the whole of LLR and bring commissioners and providers together to jointly agree service models, care pathways and service investment. This would build on some of the more developed/mature examples of current clinical workstreams like urgent care, but the significant difference is each network would take responsibility for looking across a portfolio of linked services and the resource investment associated with these. The focus would be on improving quality, safety and outcomes across settings of care and driving down operating cost.

III. **Locality** – this would be about building on the current integrated locality team working and GP federation/at scale arrangements but making a major step towards fully integrated local MCP/ACO new care models. This would bring community health and social care services together wrapped around hubs of GP practices serving geographically defined local populations. The focus would be on proactively managing local population health, care planning and co-ordination. This would require teams from across different organisations to work together under shared clinical and managerial leadership – effectively forming a locality clinical 'division'. It would also require a move to local place based budgets, new contracting arrangements and an element of devolved decision making.

To work successfully as an ACS across LLR will require each of these three elements to be in place. Their relationship would not be a hierarchical one – each is necessary but would play a specific role within the system that taken together offers the prospect of constructing a far more effective set of delivery arrangements than our current organisation centric model. The following paragraphs expand on the potential elements and implications of moving in this direction across the three levels:

SYSTEM - LLR Health Partners "working as one team"

- Creating the environment focused on integration and collaboration, not competition and organisational autonomy and interest.
- Evolve the System Leadership Team, (SLT) into a ACS Leadership Team.
- Reformed as single 'system executive team' for LLR, with clinical and executive director roles for key portfolios. This could either build on the existing model of chief officer leads for each workstream, or move to more of a clinical director type model for system workstreams with chief officers retaining overall oversight.
- Based around portfolio roles not organisational positions and working to collectively manage a system financial control total.
- Formally recognise difference between 'parties' to the LLR ACS agreement (CCGs, UHL and LPT) and those who would be 'partners' to it (LAs, EMAS, DHU). This would clarify the relationship between local government and the NHS/STP as focused on operational and service working not structural, governance or financial integration.
- Strengthen role of Chairs and Non-Executive Directors/lay-member in more formal oversight and assurance group. This could involve moving the current informal chairs meeting into a more formal quarterly oversight group with CCG lay member rather than clinical input to maintain a level of independence.
- Supported managerially by a re-booted set of programme management functions. These could either build on the current separate PMO arrangement or look to embed support functions within mainstream CCG capacity and/or Commissioning Support Unit services.
- The three LLR CCGs moving towards closer collaboration and greater joint working. The focus will be on increasingly working as one commissioning team across LLR serving the three statutory bodies. To support this the three CCGs will formalise their joint decision making arrangements by setting up a joint-committee that will enable a wider range of common decisions to be taken once, in the same place.
- Move functions across NHS organisations (commissioner and provider) to more of a 'shared' mindset (e.g. finance, communications, safety) focused on working together as virtual teams seeking to deliver the same goals from their respective parts of the system. This would be not be about outsourcing but collaboration and shared service.

- Work with NHSE/I to streamline oversight and assurance arrangements into a single accountability framework across commissioners and providers. This would need to be progressed and formalized through the development of a memorandum of understanding setting out how the LLR ACS arrangements would operate and be overseen. Copies of example MOUs from other areas are attached in Appendix 1.

NETWORK: vertically integrating care pathways across LLR

- Take existing BCT workstreams a step on to work as managed care networks, vertically integrating specialist and generalist care across pathways, each led by a 'clinical director' and executive level sponsor.
- Each network 'blurring' commissioner and provider roles with responsibility both for service planning, redesign and operational delivery across different care settings.
- Each network taking a place based approach to the total healthcare funding available to support delivery and the operational cost and spend.
- And accountable for delivery of local outcomes, national standards and impact on activity and use of resources.
- Consolidate current BCT workstreams into a smaller number of strategic priority areas with more direct link to national NHS delivery priorities e.g.:
    - Urgent and Emergency Care
    - General Practice
    - Mental Health and Learning Disabilities (including Dementia and CAMHS?)
    - Planned Care and Cancer
    - Integrated Teams (including Long Term Conditions; Prevention; End of Life Care; Falls)
    - Home First (including Step Up; Step Down; Reablement; Rehabilitation; Recovery; Care Homes; Single Point of Access; Community Hospitals; Carers)
    - Children and maternity
- And bring together the various enabling and foundation workstreams under a single focus on creating a common platform e.g.:
    - Financial framework (LLR wide system control total distributed on an allocative and aligned incentive basis)
    - OD and clinical leadership – commit to single LLR Way
    - Business intelligence and population health segmentation
    - IM&T
    - Estates
    - Workforce
- CCG (and elements of NHSE/clinical networks) management and clinical resource working together as a virtual LLR-wide team aligned to delivery of STP system priorities.

- NHS provider managerial and clinical lead recourse aligned to work within and lead care network model.

LOCALITY: local horizontally integrated multi-disciplinary community provision

- Building on the Integrated Teams work, creating a stronger local delivery model for our 11 localities (which in the step up phase could work together in 3 groups/clusters).
- Effectively operating as place based leadership teams and service directorates for each patch across a number of service areas delivered on an out of acute hospital basis.
- Builds on GP federations, primary care home and neighborhood hub and spoke models already being supported in each CCG area working with their Member Practices.
- Taking devolved responsibility for delivery of a set of services within a delegate budget (shadow initially) to their local population to agreed health outcome metrics.
- Could for example include primary care at scale delivery, urgent care, community nursing services, social care, community mental health and specialist acute outreach team input.
- Some CCG functions aligned and embedded and delegated to support locality delivery with their Member Practices (e.g. medicines management, primary care and locality development).
- Would also impact on provider contracting arrangements, with each locality managing service and resource decisions against a strategic outcomes framework (i.e. not detailed commissioner service specifications).
- In time could progress to new Multispecialty Community Provider (MCP) / ACO contractual forms.
- Recognising the different starting positions of each of the three CCG areas, the early phase of development may require CCG specific oversight boards which may also have a longer life as ‘clusters’ of localities working together (e.g. the four federations working together across West Leicestershire). This would enable a strong localism reflecting population and service provision differences within a common LLR wide framework.

6. POTENTIAL NEXT STEPS

Developing the ACS will be an iterative process with phased development over the next few years. The first phase would concentrate on the governance, financial terms of trade, setting out what we want to achieve as a system, developing a Memorandum of Understanding and resources and would consist of the following elements:

Phase One September 2017 to March 2018

Action	Timescale
Organisational support for the direction of travel	September 2017
Development of a Memorandum of Understanding to set out how the system will work together in a ACS	October to November 2017
Approval of MOU by individual organizations	December/January 2018
Finalise system vision, mission, principles, values and outcomes	September to November 2017
Reform System Leadership Team into the ACS Leadership Team	September to November 2017
Consider how to formalise Chair, non-executive and lay member involvement in ACS governance oversight	September to November 2017
Formalise the Chief Finance Officers Meeting as a part of the formal governance structure	September to November 2017
CCGs to move to a formal joint committee arrangement to improve decision making process	September to November 2017
CCGs to consider areas of collaboration to reduce duplication and improve implementation	Ongoing
Agree and implement new arrangements for PMO functions	September to October 2017
Develop and agree approach to contracting for 2018/19 and system control total	September to December 2017

It should be clearly stated that Phase 1 does not by default commit partners to any next stage in development. There would be clearly identified milestones and gateways set out in a work programme for the ACS at which Boards and Partners would need to give due consideration about movement to the next stage. This would include specific agreement about any formal ceding of sovereignty and formal delegation of responsibilities. A MoU which is operational for Phase 1 would then need to be refined and agreed by Partners to reflect any future changes.

All organisations Boards are asked to consider this document in September 2017 with particular emphasis on the following questions:

1. Are you supportive of moving towards the creation of an ACS model across LLR?
2. Do you think this should be done in a phased approach?
3. What issues would need to be worked through in establishing the new model across the three different levels?
4. Are there other issues that impact on integrated/collaborative working that this proposal does not appear to address?
5. Does the Next Steps capture the key actions required to establish the ACS?

Appendix One:

Example of MOUs


Bay Health Care Partners.pdf


South Yrokshire.pdf

BAY HEALTH PARTNERS

"*Developing a Memorandum of Understanding for Accountable Care in the Bay Area*"

Draft Memorandum of Understanding (MoU) for a shadow Accountable Care System in the Bay Area

Version 5, 7th March 2016

Submitted for BCT Programme Board 10 March 2016

CONTENTS **PAGE tbc**

Appendix 1 – Shared Mandate tbc

Introduction

Major challenges around health inequalities, patient safety, financial and workforce sustainability, have led all statutory health and care partners in the Morecambe Bay area to work together on an ambitious programme of service redesign for the past three years. The overarching aim is to create an integrated health and care system for our population, which is sustainable for the long term.

This work has been brought together within a shared system strategy 'Better Care Together', which sets out the future for health and care services in Morecambe Bay through a population health approach and the creation of innovative new care models. The programme has been awarded Vanguard status in order to support the acceleration of our aspirations.

Since Vanguard status was awarded, although significant strides have been made to improve quality and safety in most services, and building capacity within our programme of integration, the financial position across the system has deteriorated. Within this changing context, the original Better Care Together Strategy, whilst still contributing significantly to our collective vision, now needs to be enhanced and supplemented by a fuller consideration of what else can be done to address the full scope of system challenges.

Furthermore, the national context now requires us to develop a Sustainability and Transformation Plan with our partners across Lancashire and South Cumbria, which will cover the next 3-5 years. Our updated *Better Care Together* strategy will become a key component of this wider STP.

As part of the work to consider how we could accelerate and expand the impact of our collaboration, partners have been exploring the development of an Accountable Care System. This is seen as a potentially helpful and necessary vehicle to cement our partnership working and provide a framework to mobilise our effort; and remove the barriers to integration necessary to achieve our aspirations. Agreement was given in principle by partner organisation's governing bodies to establish a 'shadow' Accountable Care System (ACS) from April 2016 (operating under the collective description of *Bay Health Partners*) subject to agreement of a supporting Memorandum of Agreement (MoU).

This paper sets out a Memorandum of Understanding (MoU) to build the foundation for, and define, our next phase of development during the shadow period. It is intended to provide a clear signal of intent for our direction of travel and the work programme to support this. It also sets out the high level implications for leadership, decision making and governance during the 'shadow' period.

The MoU does not set out the detailed arrangements that would be necessary under a fully operating Accountable Care System. The distinction between what we are proposing is in place from 1st April during the 'shadow' phase and what we might over time move to, is set out, with the work programme necessary to support this. The work programme builds in a number of 'gateways' where further Board approval would be needed to enable movement to the next phase. This will require ongoing refinement and consideration of the MoU as we mature and develop our shared approach.

This version of the MoU, therefore, is intended to be 'light touch'. It is seeking commitment and sign up from partner organisations to the next phase of work and how we work with each other over the next year, rather than a formal binding agreement. It has no legal status.

1. The Memorandum of Understanding (MoU)

1.1 Purpose of the MoU

The purpose of this MoU is to set out how the Bay Health Partners will work together over the next year within a 'shadow' Accountable Care System (ACS). The MoU seeks to describe:

- Our ambition – what we are trying to achieve and why;
- What a ***'shadow'*** ACS is and its scope and purpose;
- The governance that will be in place from the 1st April and implications for accountability to individual partner Boards;
- A summary of our collective work programme including a proposed timetable for the further development and implementation of the ACS arrangements. This includes work to scope the options for future organisational delivery vehicles;
- How we develop our joint leadership arrangements in support of the delivery of our shared programme of work, and a proposed framework for considering this.

This MoU is not exhaustive and is not intended to be legally binding between any of the parties. Accountability during the shadow period remains with partner organisations and will be discharged through the Accountable Officers of partner organisations on the shadow ACS Board supported by a shared Mandate set out within the MoU. Any further changes to the governance will need to be approved by Boards and supported by a refinement of the MoU and a supplementary scheme of delegation. To support shared decision making a Mandate is attached as Appendix 1 which sets out a framework by which partners can do this with support from their Boards.

All Partners to the current Better Care Together programme are encouraged to sign up to the MoU at this stage. At the point that formal delegation of responsibilities to a joint ACS Board from sovereign organisations is proposed, it is recognised there may be a distinction in the level to which partners are able to commit. The criteria to define this next step will form part of the work programme of the shadow ACS.

The MoU provides a framework to describe the changes that are necessary to all elements of the system including both provision and commissioning in order to establish an Accountable Care System.

1.2 Parties to the MoU

The following bodies are party to this agreement:

- Blackpool Teaching Hospitals NHS Foundation Trust (BTHFT)
- Cumbria Clinical Commissioning Group (CCCG)
- Cumbria County Council (CCC)
- Cumbria Partnership NHS Foundation Trust (CPFT)
- Lancashire Care NHS Foundation Trust (LCFT)
- Lancashire County Council (LCC)
- Lancashire North Clinical Commissioning Group (LNCCG)
- North Lancashire Medical Services (GP Federation)
- North West Ambulance Service (NWAS)
- South Cumbria Primary Care Collaborative (GP Federation)
- University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)

2. Our ambition: What are we trying to achieve and why?

2.1 Shared Vision, Values and Guiding Principles

We are currently failing people who live in the Morecambe Bay area in a number of ways. The care they receive both in the community and in hospital is of variable quality – some is excellent but some is not of the standard we would want for ourselves. There are also marked inequalities in health outcomes across the Bay, and again this is not good enough. The current way we are working costs too much, leads to significant duplication and other inefficiencies, and provides a disjointed experience – especially when people move from one care setting to another.

The parties subject to this MoU have collectively agreed that a new approach is needed. The starting place for this endeavour is creating a common vision and purpose that we all share. This vision describes our final destination and the purpose outlines our overarching objectives. Both are underpinned by a common set of values and guiding principles that will shape the way we work together.

Our **vision** is to see a network of communities within the Bay area enjoying great physical, mental, and emotional wellbeing, supported by a health and care system providing care that is recognised as being as good as it gets.

To achieve this, we will:

- Support the mobilisation of communities to improve their health and wellbeing, for example through self-management and co-production of care;
- Deliver high quality, continuously improving and compassionate care to everyone using our services; and
- Do this in a way that is sustainable in the long term.

In other words: ***Better Health, Better Care, Delivered Sustainably***

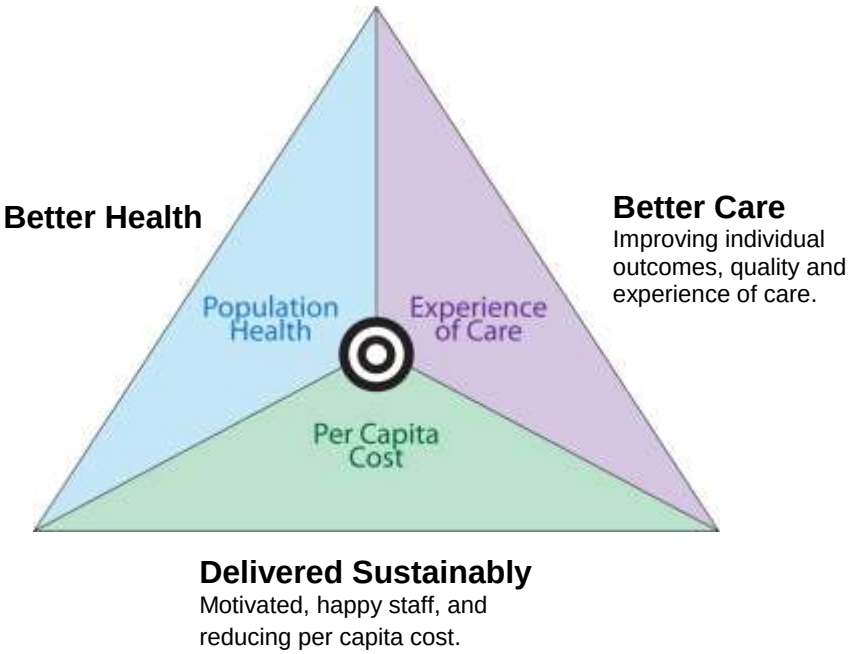
All Parties have agreed a **purpose** for our work together consisting of a clear set of overarching objectives for the programme. We have agreed that together we will:

- Understand our population's health and care needs and act positively on that understanding;
- Work with local people and our diverse communities to improve their health and wellbeing;
- Deliver safe, effective, and high quality health and care services, either from within the parties subject to this MoU or from other statutory and non-statutory providers;
- Support and develop our teams and individual staff members, and foster a shared culture of continuous improvement;
- Live within the financial resources available to us and create a sustainable health and care system.

… in order to deliver the *Triple Aim (*our 'compass*')* of:

- *Better Health* - improving population health;
- *Better Care* - improving individual outcomes, quality and experience of care;
- *Delivered Sustainably* – motivated, happy staff and reducing per capita cost.

Fig. 2.1 The Triple Aim (adapted from the Institute of Healthcare Improvement)



We will work to the following set of **values** which will guide how we work with each other and our partners:

Humility:	we listen first, reflect and then act;
Compassion:	we always remember we are here for the people we serve;
Fairness:	we are accountable, honest and inclusive;
Curiosity:	we never stop learning;
Ambition:	we never stop improving; and
Spirit:	we are energetic, resourceful and determined.

We have also agreed a small number of **guiding principles** that will underpin our work together:

- *A population focus* - we will work to promote wellbeing and reduce inequalities across our population that goes beyond preventing disease and delivering services;
- *A system built on trust* - we will build trusting relationships with local people and communities, and with each other, as the starting point for all that we do;
- *What is right for our users is right for the system* - the right care and support, in the right place, at the right time, by the right person;
- *Everyone's contribution matters* – from frontline clinical teams, to backroom staff, volunteers, senior leaders and Board members;
- *One system, one budget* - we are moving from fragmented to integrated care, with the needs of the system coming before those of individual organisations.

2.2 Our Outcomes

The parties within the ACS will be jointly held accountable for achieving the triple aim of our aspiration. The table below sets out the anticipated outcomes of successful delivery:

Table 2.1: Triple Aim successful delivery outcomes

Triple Aim	Proposed Outcomes
***Better Health* - improving population health**	✓ Outcomes aligned to published NHS/Public Health/Social Care outcome frameworks ✓ Reductions in health inequalities
***Better Care* - improving individual outcomes, quality and experience**	✓ Reduction in harm to patients – including zero 'never events' ✓ Upper quartile patient survey results ✓ Good or Outstanding inspection outcomes
***Delivered Sustainably* - motivated, happy staff, and reducing cost per capita**	✓ Upper quartile measures of staff engagement and satisfaction ✓ Reduction/Removal of system financial deficit ✓ Upper quartile efficiency measures

We have created a small number of overarching metrics, fully aligned with our purpose and guiding principles, which when taken together will inform us we are moving in the right direction – our 'True North' metrics. These metrics are intended to provide as near as possible 'real time' feedback on our progress.

Better Health *– improving population health*

- Increasing healthy behaviours by measuring the number of people - not smoking, drinking sensibly, taking regular exercise, eating healthily ('five a day').

Better Care *- improving individual outcomes, quality & experience*

- Reducing time spent waiting – days waiting at home for appointments, tests, procedures, and days/hours/minutes spent waiting in healthcare facilities for consultations, tests, procedures;

- Reducing miles travelled to receive healthcare.

- Reducing the number of defects in the system – safety, quality and effectiveness:
  - Reduce and eliminate preventable deaths;
  - Reduce and eliminate "failed" handovers between clinical teams;
  - Reduce readmissions;
  - Reduce and eliminate preventable infections;
  - Reduce late cancer diagnoses;
  - Reduce unwarranted variation in clinical care.

- Improving *Friends and Family Test* feedback.

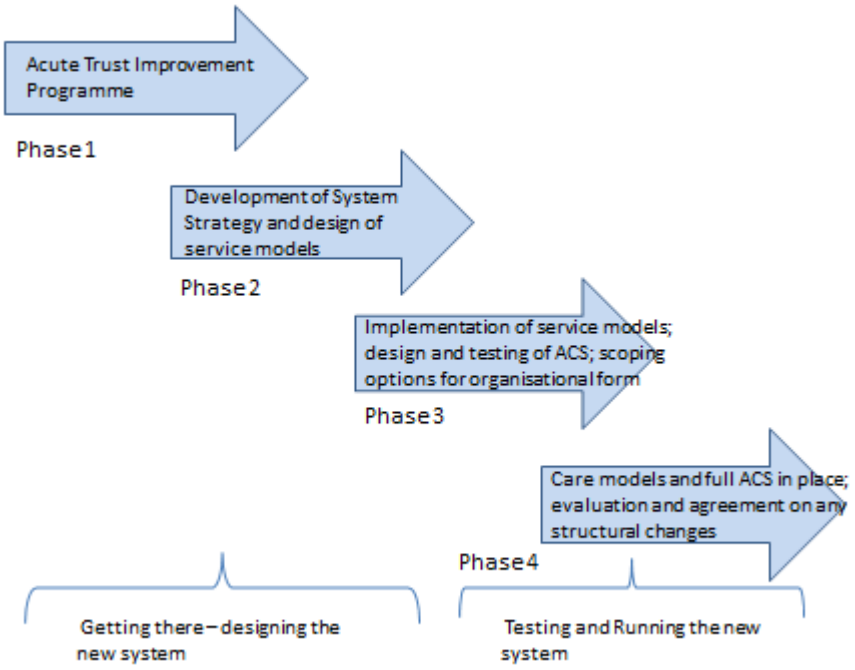
Delivered Sustainably *– motivated, happy staff and reducing per capita health & care spend*

- Increasing the number of improvement ideas implemented per staff member each month;

- Reducing cost per capita for our 365,000 population (£ spent per person*)*

3. Better Care Together Programme for 2016/17

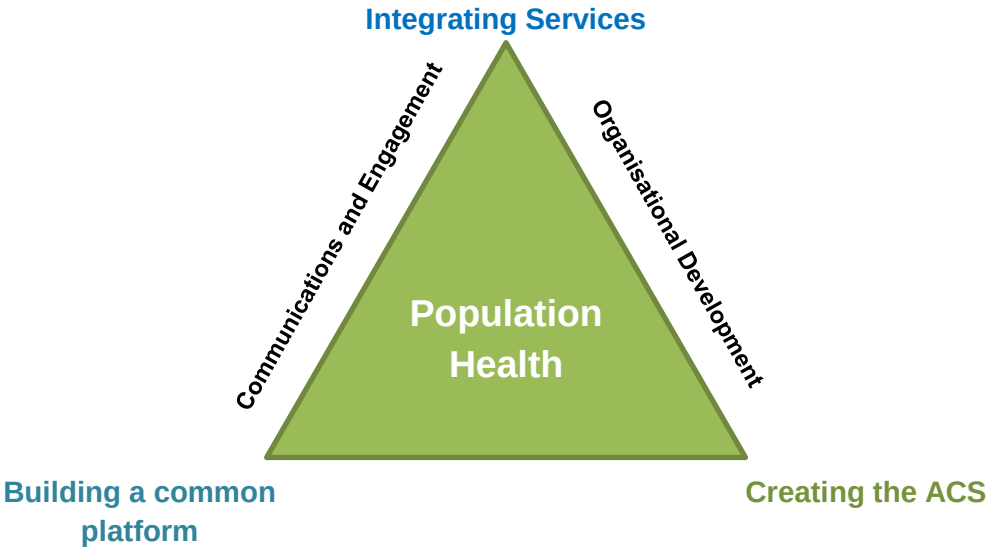
The diagram below outlines the phased approach that Better Care Together has been through over the last three years as it has transitioned from a programme to address the acute Trust's problems to the development of an Accountable Care System.



As we transition into the next phase, with a greater focus on implementing agreed service models and designing and implementing the Accountable Care System, consideration has been given to the design of the Programme going forward.

Figure 3.1below describes the three elements of the programme that will be overseen by the shadow ACS.

Figure 3.1: The three key elements of the Better Care Together Programme



Our Programme for 2016/17 has been built around these three elements and will be achieved as follows:

Table 3.1: The Better Care Together Programme 2016/17

Programme elements	Achieved through
Integrating services	Delivering Integrated Care Models (ICC), enabling self-care/ patient activation and integrating community, secondary and physical/ mental health.
Creating the ACS	Agreeing the vision and values, the MoU, the governance framework, and leadership team.
Building a common platform	Integrating clinical informatics, workforce, estates, finances and development of a shared improvement 'hub'.
Underpinned by effective communication and engagement, and whole scale organisational development.	

3.1 Integrating services

Integrating Services by delivering Integrated Care Communities and other integrated care models, enabling self-care/patient activation and integrating community, secondary and physical/mental health.

We believe that there are clear benefits to integrating care. We are confident that integrated systems of care offer both short and long term solutions to the challenges facing the NHS.

In the short term they provide a way for local health services to work together to tackle the immediate financial and service pressure that are universally faced across the country.
In the longer term, and more fundamentally; they provide a platform for implementing radically new models of care across local areas with the aim of improving population health and well-being.

The outline below summarise the key elements of our model for integration. The model thus far has been clinically led and 'driven'. It is our ambition as we build on the model further in 2016/17 that this continues to be the case.

Table 3.2: The Better Care Together Clinical Model

- **Integration of services across primary, community, mental health, social and secondary care.**
- **Co-production of care with patients and communities, with a strong focus on self-management, care planning and health improvement to keep people fit, well and independent for longer.**
- **A radically new out of hospital model, with the development of 12 multi-disciplinary, integrated care teams working in 12 natural communities, supporting those with long term conditions, frail older people and others at risk of admission.**
- **Urgent care rapid response teams and a care coordination centre ('air traffic control system' for clinicians) to be available for short term crisis intervention care when patients cannot be managed by the integrated care teams. The response team and coordination centre will form the bridge between community and hospital urgent care, helping patient move seamlessly and as quickly as clinically necessary, in and out of hospital (e.g. for diagnostics or short term acute care) drastically reducing hospital admissions and mortality.**
- **Integrated children's services working to the same model as adults services and integrated with the locality-based clinical teams.**
- **Smaller and safer hospitals, more responsive to the needs of the people using them and the requirements of the community based teams they are supporting; but still providing essential services where needed (such as Accident and Emergency and Maternity Services). Increasingly, hospital clinicians will work within the community based teams fostering a shared approach to staff development and improving pathways of care.**
- **Transformed primary care, moving away from the traditional 'corner shop' model to working both at scale and as part of integrated community based teams. The challenge is to achieve this in such a way that patients still feel they are looked after by GPs and teams who know and understand them.**
- **Integrated pathways of care across the system, with specialists working in the community providing education and skills enhancement and advice for complex cases; radically different ways of undertaking outpatient follow ups (such as patient initiated follow up); and referral management processes that support primary and community clinicians to improve decision making (e.g. through enhanced advice and guidance arrangements).**

Moving forward and beginning in 2016/17, there will be four key care streams supporting our programme of integration:

i. **LTC; Frail elderly; Urgent Care** – this builds on the work of the two existing place based streams of work called 'Out of Hospital' and includes the work to develop self-care and mobilised communities; the development of 12 integrated care communities (ICCs), and locality based clinical networks. It is proposed this is led and developed at a Bay level to ensure oversight and consistency within a single framework, but with clear supporting leadership at a locality based level (South Cumbria and North Lancashire) to support local adaption and development within ICCs and the three clinical networks.

ii. **Elective/planned care** – this includes the redesign of hospital based out-patients and elective surgery; and the development of specialist community services such as Neurology.

iii. **Mental Health and Learning Disabilities** – this includes work to redesign primary, community and secondary mental health services in line with the Cumbria and Pan Lancashire Strategies. It covers adult and older adult mental health and learning

disabilities. It includes contributing to the development of ICCs and integration of physical and mental health.

iv. **Children and Families** – this covers health and emotional well-being; community and hospital children's health services; Maternity; and CAMHS.

It is clear there are strong interfaces between all these care streams and so the operational leadership team should be drawn from the managers and clinicians leading this work, together with representation from the place based leadership teams.

3.2 Building a common platform

Building a common platform by integrating clinical informatics, workforce, estates, finances and development of a shared Improvement Hub.

There will be clear mandates from the ACS Board to enable the 'Common Platform' work stream to be successful. The areas of focus will be:

- *Estates management and capital investment*
- *IT and information provision*
- *Bay-wide procurement*
- *Back office functions support*
- *Building a shared Learning and Improvement collaborative for the Bay*

3.2.1 Estates management and capital investment

- Conduct a Bay wide audit of all land, buildings and equipment "owned" by the ACS;
- Conduct a risk profile;
- Develop a shared view of individual ACS partners' capital investment plans to be brought together;
- A framework for decision making on investment priorities / risk management to be developed;
- Work on rationalisation / maximising the ACS estate to be commissioned.

3.2.2 IT and Information Provision

- Conduct a Bay Wide audit of all of the hardware/infrastructure and systems currently in use across the Bay;
- This should include an assessment of annual costs, contract terms and exit points/ costs;
- Objective should be to rationalise systems/suppliers and - where possible - move to one "system" to use across the Bay over time;
- Agree an information sharing protocol to allow the transfer of patient information across providers;
- Explore opportunities for maximising IT enabled benefits as a core part of our programme to close our residual financial gap;
- Establish a Bay Wide IM&T Programme Management infrastructure, including a Bay Wide IM&T Director or similar.

3.2.3 Bay Wide procurement

- Conduct a Bay Wide audit looking at total Bay spend, current contract arrangements, numbers of suppliers, numbers of products, price ranges etc;

- Develop a Bay Wide Procurement Strategy to rationalise the above and reduce expenditure - part of the Residual Gap programme;
- Design and implement a single procurement approach for The Bay aligned to best practice principles laid out in the CIPS guidance. This will include infrastructure to reduce clinical variation and clinically led supplier management;
- Explore the opportunities included in the recent Carter report to identify where these can be scaled up / replicated across Bay partners;
- Work with IM&T colleagues to rationalise procurement systems and improve performance monitoring / reporting in relation to Bay Wide spend.

3.2.4 Back Office functions

- Explore the opportunities for rationalisation and consolidation of the back office functions.

3.2.5 The Bay Learning and Improvement Collaborative (BLIC)

The Accountable Care System (ACS) will be built on core values and beliefs to deliver the triple aim and it is essential that the system will be underpinned by an organisational development philosophy based on the principles of an integrated learning and improvement system, collective and distributed leadership and appreciative enquiry.

The ACS provides a platform to effectively pool existing resource and expertise across organisations to build the skills, improvement knowledge and leadership in our teams and communities to deliver better care together.

The Bay Learning and Improvement Collaborative will:

- Create high-performing, effective teams;
- Develop the skills to transform systems and services from a patient perspective;
- Support us in working differently together;
- Create commitment and energy for system improvement;
- Engage with all stakeholders (our employees and our citizens);
- Drive partnerships and collaboration (with employees and citizens);
- Build trust and confidence between partners and stakeholders;
- Embed a common culture of empowerment;
- Ensure measurable improvements against the “triple aim”.

The initial step will be to create a virtual team drawn from UHMBFT and CPFT, aligned to the Cumbria Learning and Improvement Collaborative, and utilising external resources and partners as required. Initial priorities will be to develop:

- Behavioural alignment across the system;
- Effective local teams (responsible for improvement, management and engagement);
- Clinical leadership capability;
- Improvement methodology and science.

3.2.6 Workforce

Better Care Together is about delivering an ambition to deliver a modern clinical strategy that will lead to improvements in outcomes, more efficient delivery of care and better patient experience. Better Care Together requires a very different ethos to ensure that patients are able to access “the right care, at the right time, in the right place” – to deliver this requires “right people, right place, right skills, right attitude”. It requires a

workforce that are fully equipped with the requisite skills, attitudes and behaviours, that are deployed effectively to give care and advice in the most appropriate setting and are fully supportive of the underpinning philosophy, vision and values of Better Care Together.

It is a clear imperative for Bay Health Partners to have in place a clear Workforce & OD strategy that seeks to support our staff during this time of change and uncertainty by:

- Providing the training and development necessary to deliver new roles and care models;
- Supporting effective leadership, team working and continuous improvement; and
- Developing a performance driven culture focussed on safety and quality

All BCT partners are committed to avoiding compulsory redundancies and to retraining staff for new roles as the care models are implemented.

3.2.7 Communications

Bay Health Partners will develop a Communications and Engagement Strategy for 2016/17 and beyond. As the service models develop and as teams from individual partners organisation work together, the need for a joined up and collective means of communicating and engaging is greater.

3.3 Development of an Accountable Care System

To achieve our ambition we need to work differently within the system. Through the BCT strategy we now have a clinical model which aims to radically transform the way we deliver care.

We have been granted Vanguard status to accelerate delivery of the BCT clinical model. We now need to go beyond this to support the mobilisations of our communities and delivery of integrated care across different teams and organisations through an Accountable Care System. And in the context of our worsening financial position, to explore shared approaches to back office and clinical support functions and different ways of working that are more efficient.

We believe the development of an accountable care approach is essential to deliver the BCT clinical model and population health focus. The current system is trapped in a regime of annual contracting cycles, organisational rather than system regulation, and payment models which do not create incentives for the outcomes our residents deserve. Our clinicians do not have access to shared records and our staff have different objectives and priorities. These barriers will need to be overcome if we are to stand a chance of achieving our desired outcomes.

The basic concept of an ACS in the Bay area is that the Bay Health Partners will take responsibility for delivery of all health and care for the population of 365,000 people for a defined period of time under a contractual agreement with a strategic commissioner.

The Accountable Care System will see Bay Health Partners working together and potentially over time ceding some individual sovereignty for the current responsibilities they have within the Bay area into a joint endeavour. Ultimately, this could include all of these aspects:

- Working to a common purpose, vision and values
- A single system plan, objectives, initiatives and metrics
- A single capitated budget
- Single leadership teams (at place-based, network and Bay-wide levels)

- A common platform covering: ICT; improvement tools, methodologies and approaches
- Common regulation and governance

The ACS will either "make or buy" (provide directly or commission) health and care services for the Bay population – a hybrid of commissioning and provider functions. With a focus on population health, there needs to be a strong public health focus as well as support to enable communities to take responsibility for their own health and wellbeing.

At this stage, however, the MoU sets out the agreements necessary to establish a ***shadow*** ACS as the first step in this journey. It should be clearly stated that the establishment of shadow arrangements does not by default commit partners to any next stage in development. There are clearly identified milestones and gateways set out in the work programme for the ACS at which Boards and Partners would need to give due consideration about movement to the next stage. This would include specific agreement about any formal ceding of sovereignty and formal delegation of responsibilities. This MoU which is operational for the shadow period would then need to be refined and agreed by Partners to reflect any future changes.

4. The shadow Accountable Care System (ACS)

This Memorandum of Understanding (MoU) sets out the framework for how the shadow ACS will operate.

4.1 Scope and purpose

The ambition of the Bay Health Partners is to create a population health system – one in which we move beyond the delivery of services to improving the health and wellbeing of the population. In so doing, we expect to implement the new care models set out in the Better Care Together strategy.

Accountable care for us means three things:

i. Being accountable for improving the health of the whole population not just those who present for care;
ii. Being accountable to the system not just our own organisations;
iii. Rebalancing accountability away from looking inwards and upwards through the multiple layers of the NHS to looking outwards towards the public we serve.

The shadow ACS will have delegated responsibility through the Accountable Officers on the shadow Board for the delivery of the BCT Programme for 16/17 based on the three streams of work outlined above to deliver our shared ambition and objectives. A sub-section of this will be the Value Proposition for 16/17 which will outline the key deliverables by which Bay Health Partners will draw down central resources in support of the programme.

A designated shadow ACS Leadership Team (key senior clinical and executive leaders drawn from partners) will be established that is responsible for supporting the Board and ensuring the delivery of the BCT Programme for 16/17 and ensuring progress against the key streams of work and agreed outcomes.

The Shadow Accountable Care System Leadership Team will be accountable to a reconstituted Bay Health Partners shadow ACS Board. This team will operate as an equivalent ‘Executive Team’ for the Programme. It will be supported by an operational delivery team consisting of managerial and clinical leaders heading up our care streams and place based work.

Table 4.1: The purpose of the shadow ACS Board

The Shadow ACS will:	The Shadow ACS is not intended to:
Provide strategic leadership and oversight to support achievement of our shared vision and objectives through delivery of the BCT Programme of the three streams of: • Integrating Services; • Building a common platform; • Creating the ACS.	Be the place where 'normal' day to day work of the partners is led or managed. Although it can provide a place for consideration of difficult system issues, such as system resilience.
Discharge its collective accountability for delivery to respective partner organisations through representation of appropriate Accountable Officers on the Board.	Take on any formal delegation from partners at this stage.
Make decisions in the context of the shared vision and outcomes framework but within the parameters of the shared Mandate (Appendix 1).	Replace local organisational decision making. However, the Board and its supporting leadership will need to work through what this means in practice as and when difficult situations arise.
Consider investment decisions collectively and agree the use of any nationally drawn down monies such as Vanguard funding.	Partner organisations will not incur liability for their share of the deficit out-with any further formal risk and benefit agreement. GPs will not incur personal liability for a share of a deficit on the ACS budget.
Negotiate potential conflicts of interest between system needs and priorities and individual/organisational needs and priorities.	Take a leadership role in the management of contracts with individual providers, for example, GMS contracts.
Operate through an informal shared leadership structure for this phase of development. The Board will support the development of leadership and devolved decision making through the ICCs and Clinical Networks to establish a more formal leadership structure in the next phase of development.	Make any changes to current contractual arrangements for GPs. GPs will remain within their existing contractual framework, with contracts held with NHSE and any changes to GP practice contract income will only be via their existing contractual framework.

4.2 Accountable Care System Governance Framework Development

2016-17 in the context of formation of the ACS/ACO is a year of transition. As we look to deliver healthcare in a more integrated and more sustainable way, there are a number of important questions we face.

A significant and early leadership challenge will be to consider how Boards of Directors and Governors can exercise control over services for which they are accountable, but do not necessarily deliver directly through their own organisations. At present, there is no strong evidence about a 'right way' to ensure good governance between organisations when working together through partnerships, joint ventures or other organisation forms.

The leaders of partner organisations have held a number of workshops to discuss the early thinking on governance and are clear that it is the quality of relationships that plays a crucial role in delivering good governance.

Good corporate governance requires strong leadership and direction to set strategy and organisational culture and context, to ensure the effective management of risks to the delivery of that strategy.

At this stage, we are not putting into place legally binding 'contracts' between partners or proposing a new delivery vehicle. However, we are clear that over the next 6-12 months, these will need to be explored.

Partners understand they are setting up a new 'entity' that over time will develop its own culture, its own strategies and ambitions. The emerging leadership structure will require the process for the 'owner' organisations to nominate Directors. This will ensure partner organisations retain oversight and ability to have control in the short to medium term.

In the short term, we will put in place interim leadership structures at system, network and Integrated Care Community level across the Bay. We will set clear objectives and measures of progress and we will commit programme resource to maintain momentum on delivery.

During 2016/17, the Board and Governing bodies of the individual partners will continue to provide assurance oversight through their own board assurance frameworks and governance processes. We will also work with the Good Governance Institute (GGI) to develop the detailed governance arrangements required to support a more formal approach. We envisage the outputs from the work will presented to Bay Health Partner Boards and Governing Bodies around September 2016.

Note:
The GGI is one of the leading providers of governance and leadership development expertise for the NHS and independent providers. They are the largest specialist organisation working in this field. GGI's work is well known to the regulators and within the NHS. GGI will be the preferred 'governance development' partner for Bay Health Partners in 2016/17.

4.3 Shadow ACS Leadership Structure and Development

4.4.1 Current leadership arrangements and the leadership challenge moving forward

The current leadership arrangements have been set up around the structure of the existing Better Care Together programme, with a strong programme management approach. Strategic oversight has been provided by a Programme Board which is chaired by the Senior Responsible Officer (SRO) for the Programme, the CEO of North Lancashire Clinical Commissioning Group. Leadership at the Programme Board is discharged through the CEOs of partner organisations and key clinical leaders, with supporting financial and managerial representation.

The Programme Board is supported by an operational Delivery Group consisting mainly of the SROs from the Steering Groups for each of the Programme's work streams. The SRO roles have mainly been undertaken by managers from the two Clinical Commissioning Groups with clinical and managerial representation on the groups drawn from across partner organisations and other key stakeholders.

Underpinning this approach has been a central Project Management Office that has provided the necessary support and resource to develop and deliver the various elements of the programme. This has been led by an interim Director and has included setting up project management and reporting requirements with the objective of establishing a rigorous process that would oversee the development of the constituent parts of the programme. The PMO is still in place and providing valuable support to the Better Care Together programme and will do so for as long as it is required. The majority of this support has been secured through the use of interim project managers commissioned externally.

Whilst these governance and leadership arrangements have been effective to date it is recognised there is now a need to evolve our approach to leadership as our partnership matures. As the programme fully transitions from phase 2 – strategic planning and design of services models into phase 3 and phase 4 – implementation of service models, and design and delivery of the ACS, there are a number of key challenges:

- **Capacity** - how do we enable our clinical and operational managers to take on stronger leadership roles and create the capacity that enables this, given the many competing demands on people's time?

- **Leadership roles during transition** - how do we create a leadership structure with the right skills and competencies for both: the process of change management as we implement new ways of working AND delivering the new care models in the future?

- **Supporting people to work differently** – how do we equip our leaders with the skills and competencies for system leadership rather than organisational leadership and to enable a population health approach rather than a traditional medical model?

In creating the detailed structure required to operationalise this leadership framework, priority is being given to the development of:

- A Shadow system ACS leadership team – that will be accountable to the ACS Board for the delivery of the agreed Programme
- Place based leadership teams – this includes Bay-wide; Clinical Network and Integrated Care Communities
- Care Stream leadership – leadership for the four areas outlined previously in section 4

4.4.2 Shadow system ACS leadership team

Shadow system leadership arrangements are proposed in order to develop an Accountable Care System in Morecambe Bay which can focus on population health improvement, deliver high quality services and reduce the per capita costs in the current system.

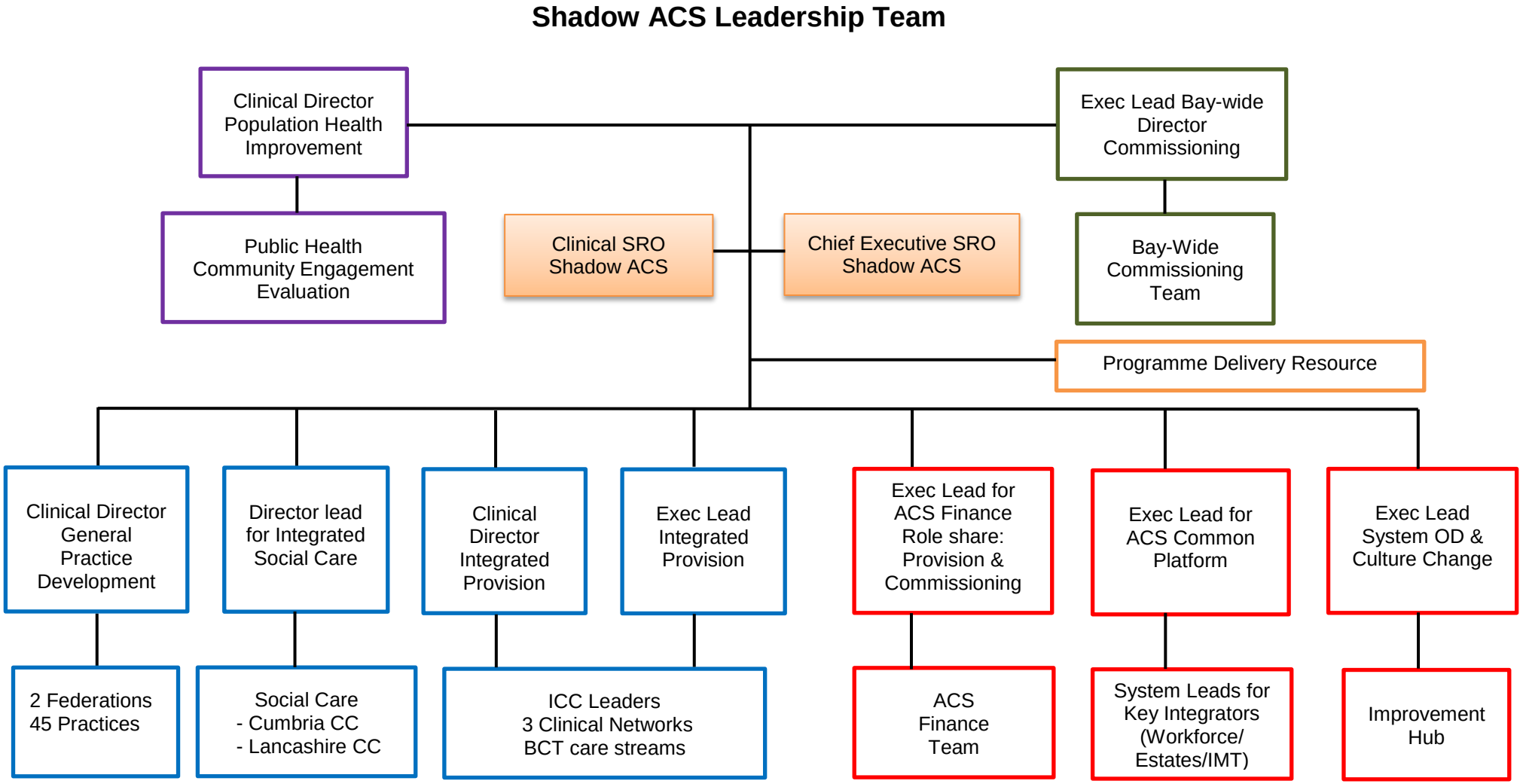
In 2016/17, this will mean taking responsibility for:

- Integrating Services – accelerating the delivery of the new care models set out in the BCT strategy and supported via our Vanguard Value Proposition;
- Building a Common Platform – taking action on a small number of key integrators to support our new care model, improving outcomes and clinical care and removing inefficiencies in the system;
- Creating an Accountable Care System in which the BCT partners agree how they will work together to deliver the population health system for all the communities in Morecambe Bay

It is proposed that the ACS is established with a clinical, as opposed to corporate model of leadership and this should be reflected in the make-up of the shadow ACS Leadership team and shadow ACS Programme Board. In so doing, clinical leaders would share accountability with, and be supported by senior managers for the strategic direction and outcomes of the ACS. They will also take a direct lead in involving the local communities of Morecambe Bay to become “fully engaged” in their own health and care.

The structure on the following page (figure 4.2) details the leadership roles within the Shadow ACS.

Fig: 4.2 Structure of the Shadow ACS



4.4.3 Place based leadership (including Bay-wide; Network and Integrated Care Communities)

Our leadership will need to reflect the requirement to operate and lead service development and delivery at these three place based levels. And, increasingly, enable our front line clinical and operational leaders to take on more active responsibility for joint management across organisational boundaries.

We will support the development of clearly identified leadership within our 12 local Integrated Care Communities and for network and Bay-wide services where appropriate. It is essential that a mixture of acute, community, mental health and primary care representation is available as part of the place-based leadership model.

It is proposed that each of the twelve Integrated Care Communities will have its own leadership team. It is recognised that a number of services that are configured at a network or Bay level, such as Rapid Response teams and Community Mental Health services, will continue to be managed at this level whilst playing strongly into Integrated Care Communities.

4.4.4 Care Stream leadership

As outlined in section 3.2, to promote the delivery of our model of integrated services, four care streams are being set up in 2016/17. These will be system wide streams of work and a key task of the leadership teams will be to ensure there is a clear strategic framework for each care area that promotes consistency of outcomes and standards, within which implementation can then be driven by place based teams.

4.5 Shadow ACS Programme Board

It is proposed to create a new Programme Board for the shadow ACS to replace the existing Better Care Together Programme Board. The Programme Board will ensure representation from all of the Bay Health partners who have committed to the MOU in March 2016.

The Programme Board will be chaired by the Clinical SRO.

Full membership would therefore be proposed to include the shadow ACS Leadership team, together with a senior representative from each partner organisation, if that partner organisation is not represented within the ACS Leadership team. The makeup of the Board would thus be:

Shadow ACS Leadership Team:

- Clinical SRO for Shadow ACS (Chair)
- Lead AO/SRO Shadow ACS
- Lead Director Integrated Social Care
- Clinical Director Integrated Provision
- Executive Lead Integrated Provision
- Clinical Director General Practice Development
- Clinical Director Population Health Improvement
- Executive Lead Bay-wide Commissioning
- Executive Lead for ACS Finance (Role share): Provision and Commissioning
- Executive Lead for the ACS Common platform & ACS development
- Executive Lead System OD and Culture Change

Partner Representatives (where organisations do not have representatives with a role in the ACS Leadership Team):

- Clinical Lead – North Lancashire/South Cumbria GP federation

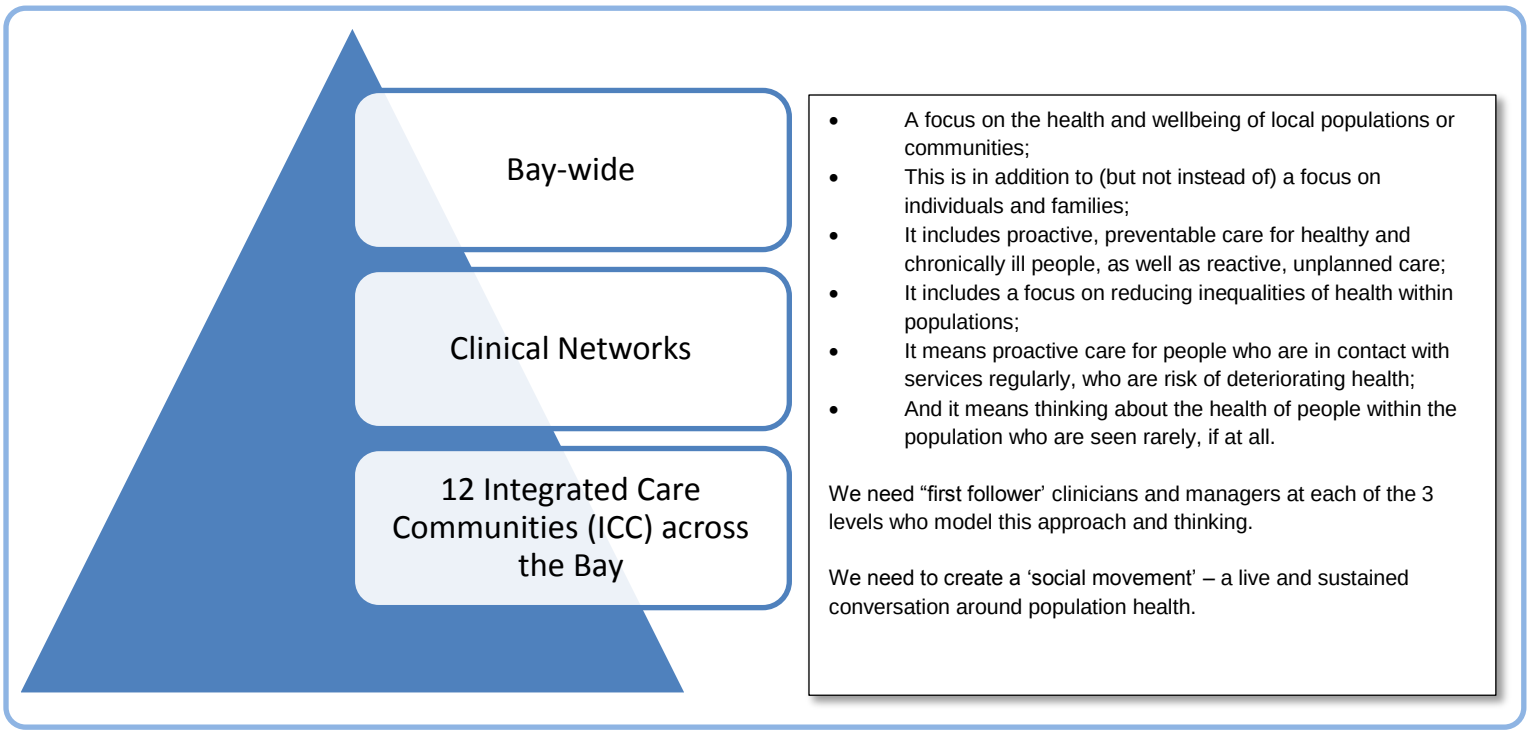
- AO or representative from statutory health partners
- Director – Lancashire County Council/Cumbria County Council
- Clinical Commissioning Leads - Lancashire North CCG/South Cumbria (CCG)

4.6 The role of leaders within our structure

To achieve the changes aspired to within the ACS, we need to shift from an organisational 'fortress' mentality to an emergent ACS leadership underpinned by building real teams at all levels.

This requires a radical shift in the mind-set of all concerned but will be reliant on leadership to guide and show the way forward.

Figure 4.3: What needs to be different? Modelling leadership for population health at each level



We are **transitioning from organisational to system leadership** - the 'zero sum game' (where if one part of the system gains another part loses) will coexist with an emergent system approach. The single organisational regulatory approaches will try and pull us in the opposite direction. Undoubtedly, this will be one of our greatest leadership challenges. However, **our overall leadership focus should be on delivering the triple aim.** It is not to deliver any particular structural change although this could follow over time. We believe this system approach is right but we will need to learn and adapt as we go.

4.7 Leadership development

Sally Baines is writing this section based on the 'offer' she is procuring currently.

4.8 Collaborative commissioning

The two Clinical Commissioning Groups have set out their intention to establish a joint strategic commissioning decision making group and a commitment to a new financial model. The joint decision making group will provide a Service and Finance Plan that will set out the Commissioner intentions and funding available to support the priorities within Better Care Together.

In the first phase the joint decision making group this will focus on acute and community services. The second stage will be other CCG commissioned responsibilities with named exceptions where there is an identifiable risk to the programme. Beyond that will be co-commissioning of primary care

5 Road Map and key dates for shadow Accountable Care System in 2016/17

A significant amount of work has been completed during 2015/16. A clear Road Map and supporting delivery plan will be developed and agreed with all parties with the objective of achieving a Shadow ACS from April 2016. The Road Map will include stepped increases in integration and the transfer of responsibilities and delegated authority, underpinned by a clear set of financial and performance milestones and checkpoints and gateways, robust risk and benefit share arrangements and aligned development of governance arrangements. It will specifically enable regular reviews of progress against the key milestones drawn from the agreed aims and achievements.

- **February 2016**
  - Creating an MOU between all partners.

- **March 2016**
  - "sign off" of MOU by all Boards and governing bodies.

- **March 2016**
  - Shadow ACS Leadership Team agreed.

- **March 2016**
  - Approval of outline system Business Case to support shadow ACS deliverables by NHSE and NHSE.
  - Provide investment strategy and key deliverables to 2020 and beyond.

  (Gateway 1 – requiring approval by Partner Boards)

- **April 2016**
  - Establishment of shadow ACS.
  - Senior leadership team in place.
  - Objectives for 2016/17 agreed.
  - PMO and Vanguard resource agreed.
  - Road Map for 2016/17.

- **April 2016**
  - Single approach to commissioning hospital and community services from April 2016 and other services from October 2016.

- **October 2016**
  - Proposal for next phase of ACS including;
  - Proposal to develop ACS/ACO from 2017.
  - Service model strategy 2017-2020.
  - Financial proposal for sustainability.

  (Gateway 2 – requiring approval by Partner Boards)

- **April 2017**
  - Next steps.

APPENDIX 1

This mandate has been established to provide clarity for Executive action within the NHS Success Regime and BCT programmes. It has already been endorsed within the Success Regime Programme Board

The framework is based on;

White lines – Areas where a Board has already agreed direction through the agreement of our "system" based 5 year plan.

Grey lines - Areas where a Board will need to have credible and strong cases made in order to support. Clear intentions and implementation plans to be set out in ways that give a strong sense of the benefits gained being greater than the risks involved across all the options available.

Red lines – Areas where a Board has positively asserted they have no appetite to proceed.

Principles;

- Boards will utilise this mandate to delegate as much as possible whilst clearly retaining Board level "call in" on matters this mandate identifies.
- Boards expects the system transformation programmes to ensure the right flow of resources representing patients flow across the whole system.
- That the decisions taken within this mandate will have clear risk assessment and visibility of risks reported to the Board.
- That organisational change will be minimised to only that necessary to achieve clear benefits (not in an end in itself).
- That fragmentation of services is reduced by effective service integration.
- That wherever possible likely decisions considered/taken within this mandate will be reported in advance or a soon as possible thereafter to the Board.
- That individual organisations will be pro-active in putting forward proposals to the system transformation programmes (not waiting for the programmes to define the agenda).

Collaboration Framework

	Strategic Intentions **What we want to achieve**	**Key areas**	
White Lines **(Our Boards have already agreed direction towards these)**	Successful "BCT" process to create stability and sustainability. Common clinical models/strategies that are cohesive and make the best use of skills/resources with the best outcomes for patients and staff. Common approaches to common issues to achieve the most critical mass and efficient/economic approach. Strong and effective mechanisms for partnership working. Getting more for the Cumbria £ overall. A positive culture as defined by the "Berwick Report". Quick improvement on key immediate imperatives (eg. urgent care).	Integrated care pathways and the skills/workforce to deliver these. Ability to demonstrate quality outcomes across integrated services. Shared collaborative leadership arrangements to lead integrated services. A flexible workforce able to deploy across organisational boundaries. Joint resource plans – setting our overall system sustainability. Joined up and cohesive engagement with the public about their health and health services. Reputational risks being managed together where appropriate. Shared information sets so that the whole system's performance is visible to all.	Shared skills/leadership development a more integrated future workforce. Shared premises use and "total place" Design and adoption of improved cont funding arrangements. Joint cases for investment and better u working together. Joint workforce planning and OD (eg.C Joint working with staff side groups th collective workforce. Communications being consistent or c common stakeholders. Coordinated urgent measures to suppo
Grey Lines **These issues need strong cases to be made in order to gain Board support**	• A move away from a Cumbria footprint for services currently serving the county population – unless proven for patients and/or staff and the public overall and is without adverse impact – eg. Mental H Specialist Community Services. • Resource pooling, joint effort, risk pooling – where the arrangements are agreed clearly by all partie • Commitment of Trust resources to address system rather than organisational imperatives – ensuring its agreed business plan without diversion unless this is approved by the Board. • Organisational form changes - unless the case is strong with clear benefits for patients and/or staff & evidenced. • Placing short term gains above true longer term sustainability (patching rather than fixing).		
Red Lines	• Changes that do not carry the confidence of our clinicians and wider staff. • Unilateral changes to significant patient pathways without system wide discussion/consultation. • Issues that evidently or potentially will worsen health outcomes or equality of health outcomes from • Risks transferring between organisations without agreed mitigations. • Change management that does not demonstrate our key values. • Worsening of an individual Trust's position (either Quality or Financial) as a vital local public service		

South Yorkshire and Bassetlaw Accountable Care System
PMO Office: 722 Prince of Wales Road
Sheffield
S9 4EU
0114 305 4487

23 June 2017

Letter to: South Yorkshire and Bassetlaw Accountable Care System Chief Executives

Dear Colleague

Re: South Yorkshire and Bassetlaw Memorandum of Understanding

Following discussions at our boards, governing bodies and in council meetings on the draft Memorandum of Understanding (MoU) for South Yorkshire and Bassetlaw (SYB), I am pleased to attach the revised, final document.

The final version takes into account your comments and feedback and reflects the changes you requested. In addition to the changes, you also raised questions about some of the detail in the MoU and involvement of your organisation and Place in how the processes might develop. These are now incorporated in a separate document which will be shared with you and we will be working through these important questions in the next phase and as our Accountable Care System (ACS) matures.

If we are to achieve our ambitions, then we must always start with Place, allowing local areas to flourish as we collectively take on the challenges across our System. I would like to reiterate that the MoU does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it. I would also draw your attention to your role within the Agreement.

As a core partner, you are a 'party to' the Agreement

'Parties to' have majority relationships (patient flows and contracts) within and across SYB and you are signing the agreement to be part of the emerging ACS in SYB. You will be subject to delegated NHS powers and a new relationship with other Parties, with both of the NHS regulators and are assured a package of support to transform health and care.

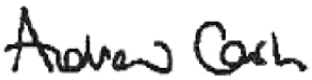
Your feedback and questions have been extremely valuable and as well as strengthening the document, will continue to shape our direction. I would like to thank you and your executive, non executive, lay colleagues and members for getting us to this point.

The documents reflects a point in time. We are still in negotiation with NHS England and NHS Improvement and the Arms Length Bodies on our MoU and are looking to take it to the 12 July Collaborative Partnership Board with a view to having support by the end of July.

The nature of our collective governance cycle means that it has taken us some weeks to get to this milestone but I am sure you will agree that it has been a thorough and valuable process. Our success to date is undoubtedly down to the strong relationships that exist between us and a proven history of working together. As we continue on our journey, we are building on very strong foundations and I look forward to working with you as we strengthen our position to bring about better health, care and life chances for the people of South Yorkshire and Bassetlaw.

We will be communicating about the ACS and our plans more widely in September and so the ask is that you now seek support for the direction of travel with your board, governing body and council meetings by the end of July.

Yours sincerely,



Sir Andrew Cash
ACS Lead

Health and Care Working Together

South Yorkshire & Bassetlaw Accountable Care System

Memorandum of Understanding 'Agreement'

June 2017

Title	Memorandum of Understanding for South Yorkshire and Bassetlaw Sustainability and Transformation Partnership		
Drafting coordinator	Will Cleary-Gray		
Target Audience	SYB Collaborative Partnership Board Membership, Place Partnership and Boards, statutory organisation Boards, Governing Bodies, Councils, NHS England, NHS Improvement and the ALBs and the Department of Health		
Version	V 0.3		
Created Date	10 April 2017		
Date of Issue			
Document Status	Final Draft for adoption by local governance		
To be read in conjunction with	Health and Care Plan Submission, November 2016, 5 Place Plans, individual statutory organisational plans and 5YFV Delivery Plan – next steps		
Document History:			
Date	**Version**	**Coordinating Author (s)**	**Details**
10 April 2017	0.1	Will Cleary-Gray	Creation of document
28 April	0.2	Will Cleary-Gray	Updated following CEO / AO Timeout on 28th April 2017
15 June	0.3	Will Cleary-Gray	Updated following feedback from Boards, Governing Bodies and Councils Foreword from STP lead
23rd June	0.4	Will Cleary-Gray	Initial feedback from CPB members
Approval by:			

Foreword

This document has been developed with South Yorkshire and Bassetlaw Health and Care partners. It is not a plan or a legal contract. We have already published our Plans across the five local Places and system in South Yorkshire and Bassetlaw. At the same time, each of our individual organisations has contracts in place.

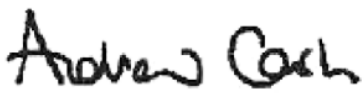
It does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it. This document recognises the complexity of how health and care organisations currently work and interact together to provide the best possible care and services. It is also mindful of how health and care organisations are coming together to form partnerships locally in place; integrating health and care, commissioning and providing, including voluntary, community, GP, mental health and hospital services. At the same time, some of those same organisations have formed partnerships and are coming together across South Yorkshire and Bassetlaw to plan and commission strategically to ensure safe, sustainable and equitable acute services. In short, we are seeing increased collaboration, joint planning and integration of services that are focused entirely on bringing the greatest benefits to our population.

It is a complex picture and one which we must work through together as we continue to focus on what matters – the people in the populations we serve. This means constantly reviewing our approach, together with our staff, patients and citizens. We will also continue to build trust between us, working through what is best for our populations while using best practice where it exists and national guidance and support where we need it.

This document summarises and sets out our shared commitment to continue to work together on improving health and care for the people of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield and collectively South Yorkshire and Bassetlaw. We still have much to work through and our plans and our approaches to delivering them continue to evolve.

This is our best assessment for 2017-19 on how we will work together, what we will work on and what we need to accelerate our vision and plans – the 'Give' and 'Get' which lies at the core of this MoU.

As we are in transition it is helpful to clarify how we are using terminology and acronyms for the purposes of this document. Sustainability and Transformation Plan (STP), Accountable Care System (ACS) and South Yorkshire and Bassetlaw Health and Care Partnership (SYB) are used throughout and they refer to the same thing – our SYB Partnership and our collaborative approach.



Sir Andrew Cash, ACS Lead

Contents

1. Introduction and context

1.1. This document has been developed with South Yorkshire and Bassetlaw Health and Care partners. It is not a plan or a legal contract. We have already published our Plans across the five local Places and system in South Yorkshire and Bassetlaw. At the same time, each of our individual organisations has contracts in place.

1.2. It does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it, setting out the framework within which our organisations will come together to establish how we will develop as an Accountable Care System.

1.3. South Yorkshire and Bassetlaw has five strong health and social care communities of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield which have a long history of working together in each local Place and across South Yorkshire and Bassetlaw (SYB) to achieve positive change and improvements for local people.

1.4. The links between poverty and ill health are well established and are the driving force behind our joint working. Creating jobs, ensuring availability of affordable, good quality housing and targeting resources towards areas of greatest need and reducing inequalities are all important to reduce poverty and improve our health and wellbeing.

1.5. Our collective and collaborative approach is increasingly focused therefore on prevention, integration, physical and mental health and crucially, co-production with citizens and communities; addressing the wider determinants of health together. These are inextricably linked and include:

- Employment, opportunity and business
- Adult and child health and social care, enabling independence
- Raising levels of education and skills to improve opportunity
- Safe, clean and green environment
- Life chances for all

1.6. Each health and social care organisation in each Place already has plans which have been developed in partnership and in some cases, for example the Better Care Fund Plan, these plans are jointly owned between health and social care.

1.7. There is a shared view that in order to transform our services to the degree required to achieve excellent and sustainable services in the future, we need to have a single shared vision and single shared plan both for each Place and for South Yorkshire and Bassetlaw. For this reason, leaders from across health and social care in each Place have come together to develop a single shared vision and single shared plan which has resulted in Place Plans and the SYB Plan.

1.8. South Yorkshire and Bassetlaw is therefore in a good position with a single shared vision and plan in each Place. This is made possible by the commitment and significant contributions of each constituent organisation.

1.9. This puts each of our localities, and system as a whole, in a strong position to develop and realise an ambitious set of health and social care services for our patients and service users; ensuring the best possible quality of care within available resources.

1.10. In developing a joint vision and plans in each Place, we intend to maximise the value of our collective action and, through our joined up efforts, accelerate our ability to transform the way we deliver services. Our Plans are not starting from scratch or replacing individual partners' plans- they build on existing plans, taking a common view and identifying areas where it makes sense for us to work together and collaborate.

1.11. Central to these ambitions is developing different relationships with each other in Place, across the system and with those that assure and regulate our health services. This will enable us to focus on integrating health and social care services and ensuring safe, sustainable and equitable hospital services for everyone.

1.12. We are committed to ensuring citizens and staff have the opportunity to be involved in conversations to help shape the direction of travel in the ACS and in Place. This ranges from their role in wellness, prevention and self-care; identifying what's important to the them in the delivery of services; as well as more specific consultation about service changes; and on the ongoing transparency and opportunity for them to hold us to account for delivery.

1.13. A key test of our new relationships will be the extent to which we adopt, as a first principle, an altruistic approach to each other as partners 'working as one'. How we respond as partners in times of need will be crucial and we must always put the needs of individuals, patients and the public first.

1.14. This document sets out how we propose to organise ourselves to provide the best health and care, ensuring that decisions are always taken in the interest of the patients we serve. It allows us to push even further beyond organisational need and allows us to build on working together in each Place *and* working together across SYB - to take collective strategic decisions across the whole of South Yorkshire and Bassetlaw to lift the standard of care no matter where people live or the organisation charged with planning or delivering care.

1.15. South Yorkshire and Bassetlaw set out its strategic ambition and priorities to improve health and wellbeing for all local populations in the Health and Care plan published in November 2016, together with how this will be implemented in each of the five Place Plans across Bassetlaw, Barnsley, Doncaster, Rotherham and Sheffield.

1.16. Following publication of the Next Steps in the Five Year Forward View, South Yorkshire and Bassetlaw has been confirmed as a high performing system and named as one of the eight Accountable Care Systems nationally. This means being supported centrally with additional funding, capacity and capability to be able to have more local control over health and care resources and in the delivery of transformational changes to services for people of South Yorkshire and Bassetlaw. This ability to have more local control is mainly reflective of the potential devolved responsibilities from health, its regulatory and assurance framework and health funding and resources.

1.17. This 'Agreement' sets out the framework within which our partner organisations, including NHS England and NHS Improvement will come together 'working as one', in 2017/18 to establish how South Yorkshire and Bassetlaw will develop as an Accountable Care System. We will agree together the delegated powers and new relationships we adopt between partner organisations, health regulators and health assurers to better achieve ambitions set out in the Plan and five Place plans.

1.18. The MoU sets out the approach to collaborative working and ambition to work as a shadow Accountable Care System in 2017/18, together with key milestones to move to a full ACS in 2018/19. SYB will engage with NHS England centrally, the Department of Health and the national Arm's Length Bodies (ALBs) to work through in 2017/18 *how* and *what* devolved NHS powers it will receive in 2018 as an Accountable Care System and which will be reflected in and subject to separate and specific agreements both with NHS England and local statutory organisations. Throughout this process we will be mindful of the legal duties placed on each partner organisation.

1.19. This 'Agreement' should be read in conjunction with the Plan, published in November 2016 and the five local Place plans across South Yorkshire and Bassetlaw. It should be viewed as a framework to enable collaborative working, secure central funding and support new

relationships with Arms Length Bodies (ALBs) in the pursuit of becoming an ACS to better deliver improved health and care for the population of South Yorkshire and Bassetlaw.

1.20. This 'Agreement' recognises the importance of integration of health and social care in each *Place* and that this will be an important factor in working through how the emerging Accountable Care Partnerships - which are being developed in each Place across partners and complement the ACS - develop to deliver improved care.

2. Parties to and partners in the Agreement

2.1. In developing this Agreement consideration has been given to the different relationships with constituent member organisations within the SYB ACS and the different relationship that organisations may wish to have with it. There are many partners working together - NHS and non NHS including local authorities and the voluntary sector each have respective governance, accountabilities and in many cases regulation responsibilities.

2.2. It is accepted that not all partners would want to be subject to many aspects of this agreement or indeed it would not be appropriate. NHS England and NHS Improvement have assisted SYB to establish clarity on which organisations should be ***Parties*** to and which might be ***Partners*** in this Agreement in context of NHS governance, accountability, regulation and assurance. For clarity, collectively, Parties to and Partners in are all members of the SYB Collaborative and its associated Partnership Board.

2.3. STP geographies were, in the large part, nationally defined. Core and associate partner terminology has been established over the course of developing the Plan to describe different partners and to support a wide and diverse partnership and to enable cross geographical boundary relationships and working.

2.3.1. For the purposes of this MoU core partners ('Parties to' the MoU) are NHS partners who have the majority relationships (patient flows and contracts) within and across SYB while Associate partners ('Partners in' the MoU) have majority relationships (patient flows and contracts) as core members of neighboring STPs, and relationships in SYB generally confined to a *Place* or Accountable Care Partnership (ACP). Associate partners are also likely to be subject to collaborative agreements in neighboring STPs or local ACP and receive support consistent with respective STPs. For clarity, collectively, 'Parties to' and 'Partners in' are all members of the SYB Collaborative and its associated Partnership Board

2.3.1. In the case of Chesterfield Royal Hospital NHS Foundation Trust, the trust became a core member in the partnership on the basis of its strong history of clinical networks within and across South Yorkshire and Bassetlaw including the Cancer Network and more recently the Cancer Alliance and its history of collaboration with acute trusts as part of the Acute Vanguard, resulting in significant acute flows into SYB. Early on in the plan development process, formal representation was made to NHS England and NHS Improvement jointly between the Partnership and Chesterfield Royal Hospital NHS FT for it to become a full partner in SYB which was supported.

2.3.1. It is recognised that Chesterfield sits within a neighboring STP and likely that it may be subject to agreements with the neighboring STP which will need to be worked through to establish the medium and longer term relationships with SYB ACS which may change. There may also be changes to the way other oragnisation engage in the MoU as we develop and mature as an ACS. This also applies to emerging organisations, federations and legal partnership including primary care federations and therefore we will need to review as we develop.

2.4. It is anticipated that Parties 'to' will sign the agreement as an emerging ACS in SYB, be subject to delegated NHS powers and a new relationship with each other, with both NHS regulators and assures and package of support to transform health and care.

2.5. It is anticipated that Partners 'in' will support the direction of travel and work in partnership with SYB ACS. In some cases they may be subject to separate agreements in neighboring ACS and aligned agreements in ACP in Place within SYB.

2.6. The Parties to this agreement are:

2.6.1. Commissioners

- NHS Bassetlaw Clinical Commissioning Group
- NHS Barnsley Clinical Commissioning Group
- NHS England
- NHS Doncaster Clinical Commissioning Group
- NHS Rotherham Clinical Commissioning Group
- NHS Sheffield Clinical Commissioning Group

2.6.2. Healthcare Providers

- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- Sheffield Children's Hospital NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Rotherham, Doncaster, South Humber NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

2.6.3. Heath Regulator, Assurer, Education and Training

- NHS England
- NHS Improvement
- Health Education England
- Public Health England

2.7. The Partners in this agreement are:

2.7.1. Local Authority partners

- Barnsley Metropolitan Borough Council
- Doncaster Metropolitan Borough Council
- Nottinghamshire County Council / Bassetlaw District Council
- Rotherham Metropolitan Borough Council
- Sheffield City Council

2.7.2. Provider partners

- Nottinghamshire Healthcare NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- East Midland Ambulance Service NHS Trust
- Doncaster Children's Services Trust

3. Scope

3.1. The scope of South Yorkshire and Bassetlaw's transformational plan covers all aspects of health and care, specifically:

- Public health
- Social care
- Primary care (including GP contracts)

- Community services
- Dental and screening services
- Mental health services
- Acute services
- Specialised services
- Research and development
- Health education and innovation
- Governance
- Assurance
- Regulation
- Resources and finance
- Capital and estate
- Information sharing and digital integration
- Workforce
- Communication and engagement

3.2. Key enablers to include:

- Appropriate governance and regulation
- Delegation of resources from relevant national partners in line with the delegation of statutory functions
- Access to fiscal and regulatory levers that enable the improvement of health and wellbeing outcomes through wider determinants e.g. education, employment etc.
- Empowered system leadership, supported by effective governance and accountability arrangements
- A shared strategic approach to capital and estates planning
- A shared strategic approach to communications and engagement
- A shared strategic approach to workforce planning (clinical and non-clinical)
- Development of new payment mechanisms that remove perverse incentives and encourage/ support new models of care
- Development of new information sharing system/ processes

3.3. Operating as a shadow ACS through 17/18, will require flexibility in terms of ways of working. As a result, it is expected that the scope will remain fluid over this time period, to allow arrangements to be tested and amended as required to secure the optimal outcomes.

4. System objectives

4.1. In our STP submission we set out the objectives for the SYB systems aligned to the dimensions of the triple aims of the STP. These are summarised below:

4.2. The parties share the following system objectives

4.3 Care and quality

- Joined up, high quality services across hospitals, care homes, general practices, community and other services
- Easy and convenient access to services across settings and times of day
- Greater availability of services closer to home
- Better quality, more specialised hospital based care
- Greater availability and variety of non-health services that enhance people's health

4.4 Health and wellbeing

- Better support for individuals in relation to physical and mental wellness and prevention
- A wider variety of healthy living schemes aimed at all communities within the population
- Active networks and links that connect people across communities and provide support
- Greater collaboration across the public sector relevant to the wider determinants of health

4.5 Finance and sustainability

- High quality, efficient services which provide good value for money for tax payers
- Reduced waste and greater efficiency in service delivery
- Greater use of available funding in enabling individuals to stay well and providing care closer to their homes
- A workforce and service that works flexibly to respond to individual needs and how people live locally, ensuring that the right skills and services are present in the right place and the right time

4.6 The NHS Constitution and Mandate sets out clearly what patients, the public and staff can expect from the NHS. SYB wants to build upon the rights and pledges of the Constitution and provide further opportunities for patients and the public to be involved in the future of their NHS - building on the Plan and the early conversations we have had with the citizens, patients and staff on these ambitions during February and March 2017.

4.7. The NHS Next Steps on the Five Year Forward View articulates why change is urgently needed, what that change might look like and how it can be achieved. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. It sets out the development of new models and SYB is committed to being an early implementer and a test bed for new, innovative approaches of:

a. An Accountable Care System across SYB, with devolved freedoms, accountabilities and responsibilities and new relationships with member organisations, including NHS England, NHS Improvement and the ALBs
b. A closer relationship between commissioning and providing, integrating and aligning approaches to strategic planning and transformation of services
c. Accountable Care Partnerships with providers across SYB, delivering new models of acute and specialist care
d. New models of commissioning at system level for acute services, reducing variation and duplication and minimising transactional activity
e. Operating and managing a system control total for health
f. Accountable Care Partnerships in each local Place delivering integrated health and social care aligned to an overall SYB ACS

4.8. SYB needs to develop different relationships and have freedoms and responsibilities to optimise its potential. This Agreement builds the collaborative partnership established to develop the Plan, creates the platform for SYB to build on these to implement its ambitions through the invitation to SYB commissioners and providers to develop an emerging ACS.

5. Overarching principles

5.1. In the documents that were submitted as part of the STP submission on 21 October 2016, STP partners made a commitment to upholding the principles summarised below:

- Improving quality and outcomes - As a system, partners will work collectively to improve quality and population outcomes for people and reduce health inequalities for all of our local populations.
- 'No worse off' principle – Decision making will be focused on the interests of people in SYB and our collaborative partnership will work to ensure those interests are served. We will ensure that our collective working and decisions do not lead to increased health inequalities or a worsening of health outcomes for any of our populations across SYB
- Inclusiveness - All stakeholders (including commissioners, providers, patients, carers and partners) will be included in decision making and empowered to shape the system as it continues to develop. This will require active and sustained communications and engagement, informing and involving people early and in ways that allow them to get involved and help shape the direction of travel as we tackle the challenges
- Participation - SYB will be involved in all decisions that materially impact on the health and care provided to its population or by its local partners
- Integration - Partners will work to support improvements in outcomes through increased integration
- Subsidiarity - Partners will work to support delegation of decision making to the most appropriate level, subject to robust governance and accountability mechanisms
- In the NHS family - Healthcare services in SYB will remain part of the NHS. All the commitments described in this Agreement aim to (i) strengthen health and care in SYB and (ii) uphold the NHS values and standards
- Transparency - Decision making will be underpinned by transparency and open information sharing between and amongst local and national partners
- Co-production - National partners will take a co-production approach with SYB, in which decision making is facilitated by national partners to devolve and by local partners to 'receive' and deliver delegated functions
- Form aligned to function - the delivery of shared outcomes will drive changes to organisational form where appropriate
- Wider system (NHS) focused - Further delegation decisions will continue to be subject to consideration by national partners.
    - Local partners commit to working with national partners to ensure alignment between national policy objectives and the strategic direction taken locally.
    - Local partners will continue work to support nationally agreed priorities, including those set out in the Five Year Forward View.
- Accountability - All organisations will retain their current statutory accountabilities for health and social care and any commitments made will remain subject to organisations' continuing ability to meet these accountabilities.

6. Direction of travel and key milestones

6.1. This document outlines our desire, individually and collectively, to achieve our vision of health and care in SYB. A significant amount of work has been delivered through working together locally to progress the system to its current state. However, we know that more work remains to be done and that a clear roadmap, agreed with all parties, will provide a clear and transparent way forward. We will continue to work together as local partners and with national colleagues to define the specific mechanisms and timescales associated with any further delegation of responsibilities and associated funding. Delegation of functions

from national partners to local partners on behalf of the "system" will take place in a series of agreed steps, the speed and scale of which will likely be determined by:

- The achievement of assurance criteria determined by national partners
- Demonstrated capability
- The strength/ appropriateness of governance arrangements
- The clarity of the delivery plan
- Suitability of gateway milestones

6.2. This approach will ensure that the system will only take on greater responsibilities and powers when it has the capability and resources to manage them appropriately.

Key milestones in the process include:

- By end July 2017, an MoU Agreement between SYB Parties giving the Framework by which SYB will 'work as one' to develop as an Accountable Care System and implement its Plan.
- By September 2017, taking staff and public feedback into account, we will refresh and rebrand the STP from a communications and engagement perspective to reflect becoming an ACS and what this means for the future of health and care
- By September 2017 we will agree a delivery plan for 2017/19 for SYB 'working as one' to include priority areas including urgent and emergency care, primary care, mental health and learning disabilities and cancer to demonstrate delivery and enable testing of key ACS objectives outlines in 4.7.
- By September 2017, governance and an approach for agreeing and monitoring investment decisions within the ACS will be agreed
- By the end of October 2017, with capital and transformation funding, we will agree how we will operate a system control total for health in 18/19
- By end October 2017, we will agree a new NHS single oversight and assurance framework for SYB to be operational by April 2018 with aligned resources to support an integrated SYB ACS oversight and assurance function which will work with streamlined regional and national oversight arrangements.
- By end of October 2017, we will agree system and place commissioning responsibilities for agreed functions and services to enable alignment for ACPs to focus on new ways of contracting and allocating resources including population budgets, population health management and segmentation approaches for Place tier 0 - 1 and a system commissioning function for tier 2 and 3 services (all to be agreed).
- By April 2018, we will agree governance and approach for delivery of tier 2 services following the hospital services review outcome to support a horizontally integrated accountable network of hospital based services.
- Each of the five Places has confirmed they wish to continue to develop their Accountable Care arrangements and it is anticipated that these will be in shadow form in 2017/18.
- By October 2017, SYB ACS will be 'working as one' with NHS England and NHS Improvement and working with ACPs in shadow form to provide support so that they will be legally constituted partnerships by April 2018 (at the latest).

7. Governance, accountability and assurance

7.0.1. This MoU does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it. It recognises the complexity of how health and care organisations currently work and interact with each other to provide the best possible care and services.

7.0.2. Our health and care organisations are already coming together to form partnerships in Place; integrating health and care, commissioning and providing, including voluntary, community, GP, mental health and hospital services. These are taking varying forms and the governance and how this best supported in an overall ACS will be a key priority in 2017/18 and will be an area for which we will receive national guidance and support.

7.0.3. At the same time, some of these same organisations are forming necessary partnerships and coming together across South Yorkshire and Bassetlaw, either our hospitals, to ensure safe, sustainable and equitable acute services as a 'group of hospitals' or our health commissioners to make consistent strategic planning and commissioning decisions as a system commissioner. In all of this, how the traditional separation between health commissioning and providing and the focus on competition is giving way to a focus on collaboration and integration.

7.0.4. All of this 'pushes' at the boundaries of the existing legal frameworks but other systems have found ways to work where there is evidence that it better serves to make improvement to the populations we serve.

7.0.5. Current statutory requirements for CCG assurance

7.0.5.1 NHS England has a duty under the NHS Act 2006 (as amended by the 2012 act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce healthy qualities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

7.0.5.2 NHS England must publish a report each year which summarises the results of each CCG's assessment. The detail of the CCG assurance framework which underpins the publication is NHS England policy rather than set in statute or regulation.

7.0.6. Current statutory requirements for Foundation Trust oversight

7.0.6.1. NHS Improvement (NHSI - the operational name which brought together Monitor and the Trust Development Authority (TDA) and their associated teams on 1 April 2016) has a duty under the NHS Act 2012 to ensure the operation of a licensing regime for Foundation Trusts (and other providers of NHS services). The licensing regime covers requirements on FTs in relation to: general conditions; pricing; choice and competition; integrated care; continuity of services; and governance. The 2012 Act provides powers for NHS improvement to enforce or set conditions on a provider's license.

7.0.6.2. The licensing regime is underpinned by the NHS Improvement Single Operating Framework which aims to help providers attain and maintain CQC ratings of good or outstanding. The framework is NHS Improvement policy rather than set in statute regulations.

7.1 Principles and underpinning assumptions

7.1.1. The Agreement is drafted by all *Parties* including NHS England, NHS Improvement and the ALBs where this is appropriate. The Agreement is intended to be flexible to achieve the right balance of '*Give*' and '*Get*' - financial, capacity, capability or devolved freedoms and flexibilities in return for improved delivery, operational, financial, quality, and transformational change.

7.1.2. There will be continual engagement and consultation with Boards, Governing Bodies and Councils throughout development. ACSs are not statutory bodies - they supplement accountabilities of individual statutory organisations. 2017/18 will be the first phase of SYB ACS and statutory organisations will continue with statutory accountabilities and relationships with NHS England and NHS Improvement, which will retain legal responsibility for CCG assurance and FT oversight respectively.

7.1.3. From September 2017, SYB Health and Care Partnership will adopt the 'Working Together' brand and as such will continue to deliver NHS Constitution and Mandate commitments in full and remain part of the wider NHS System. The Health and Care Working Together Partnership will deliver the FYFV ambitions through the development of an Accountable Care System with five constituent Accountable Care Partnerships and implementation of its Health and Care Working Together Plan (October 2016, revised April 2017) and five Place Plans.

7.1.4. The development of the Accountable Care System during 2017/18 will establish how individual organisations will be held to account for their contribution to the delivery of NHS Constitution and Mandate and the Health and Care Working Together Plan. Each of the five Places has confirmed they wish to continue to develop their Accountable Care arrangements and it is anticipated that these will be in shadow form in 2017/18. What constitutes 'shadow' is to be worked through and to be discussed and agreed with statutory organisations. SYB ACS 'working as one' with NHS England and NHS Improvement will work with ACPs providing support where required, especially where ACPs look to move to legal forms.

7.1.5. Operational management of the assurance and oversight processes will be through SYB working together and we will deliver the principles of the two national frameworks with a locally developed model with an integrated single oversight and assurance process within the ACS.

7.1.6. SYB will be assured once, as a place, for delivery of the NHS constitution and mandate, financial and operational control and quality.

7.2. NHS assurance, regulation and accountability

7.2.1. We would expect to move to a SYB relationship with NHSI and NHSE providing a single 'one stop shop' regulatory relationship with NHSE and NHSI in the form of streamlined oversight arrangements. An integrated CCG Improvement Assessment Framework (IAF) and Trust single oversight framework. CCGs will still require an annual review with NHSE. This will be in place from April 2018.

7.2.2. Single Accountability Framework

Within 2017/18, SYB working with NHS England and NHS Improvement will establish a Single Accountability Framework (SAF) which brings together the NHS England CCG Assurance

Framework and the NHS Improvement Single Operating Framework at a local level. The SAF will be implemented from 1 April 2018 and will set out:

- The roles and responsibilities of the parties to this Agreement (CCGs, providers, NHS England and NHS Improvement)
- The scope of the SAF including NHS constitutional commitments, national targets, quality indicators and productivity measures
- The internal governance, assurance and reporting system within SYB to support delivery of the SAF
- The external assurance and reporting system for SYB to NHS England and NHS Improvement
- The agreed trigger points and process where NHS England and NHS Improvement may exercise their statutory responsibilities for intervention.

7.2.3. The Single Accountability Framework will operate in shadow form within 2017/18. In shadow form, its scope will reflect the priorities of SYB (for example, cancer and urgent & emergency care).

7.2.4. The scope of the SAF will widen as the ACS matures until it covers the full range of NHS responsibilities. The timeline for the development of the scope of the SAF will be agreed between the Parties to the Agreement.

7.2.5. In 17 / 18 we will align NHS England and NHS Improvement functions and resources to support delivery of the 'integrated within SYB ACS' element of the Single Accountability Framework.

7.3. Quality and safety

7.3.1. South Yorkshire and Bassetlaw has a well established quality and safety approach at, organisation, Place and System level. Very much of what is described in this MoU is about improving quality and safety. This is both through our organisations choosing to work together on common challenges and on those issues which are most in need of a different way of working or most likely to deliver improvements through our joint efforts.

7.3.2. We commit to reviewing our approaches in light of developing as an ACS in 2017/18 to ensure our quality and safety oversight and assurance best supports how we are coming together in Place, as emerging ACPs and across SYB as an overall ACS.

7.3.3. There is growing evidence that the improvements we are aiming to achieve within our plan will give measurable improvements in quality ahead of any financial efficiency improvements. We would therefore want to develop clear quality metrics for SYB to enable us to track these quality improvements.

7.4. Financial

7.4.1. There are a number of areas that the ACS wishes to develop in conjunction with NHS England and NHS Improvement to support robust governance, accountability and assurance. The proposals will be developed through the SYB Directors of Finance Steering Group and ultimately approved by the Collaborative Partnership Board. The areas to be considered are outlined below.

7.4.2 How a system control total would work across the ACS?

This would focus on the following areas:

- How to create in year flexibilities including the potential use of a contingency or other specific business rules?
- How to reflect the impact of an agreed transformational scheme which differentially impacts organisational financial performance?
- Consideration of Place based control totals?
- Consideration of monitoring, management and reporting arrangements?
- Whether a set of efficiency indicators could be used to inform the application of a system wide control total?

7.4.3 Consideration of moving to a risk based approach to contracts?

Consideration will be given to developing a risk based approach to contracts where risks are identified and aligned to the organisation best placed to manage the risk and which supports the development of a system wide solution.

7.4.4 Investment decisions and business case development?

Agreeing a process to ensure investment decisions are optimal for the ACS footprint and are consistent with the ACS strategy. This will include a process on how any additional capital, transformation and any other external funding can be best deployed across the ACS. Developing a process to agree financial principles and assumptions to be used in ACS business cases

7.4.4 Agreeing a process for business planning, financial reporting and performance

To develop an ACS business planning process including agreement to a consistent set of planning assumptions, where appropriate, and taking into account national guidance. To develop in partnership with NHS England and NHS Improvement a monthly ACS report which covers both financial performance and performance against key operational targets.

7.5. Operational

7.5.1. In 2017/18 and as part of our approach to developing an integrated single oversight and assurance approach within SYB, we will review operational assurance and oversight including our approach to planning and delivery assurance so that it is integrated within SYB. We will also align NHS England and NHS Improvement functions and resources.

7.6. Shadow Accountable Care System

7.6.1. In 2017/18, SYB will develop as an Accountable Care System. This will include collective decision making, governance and a single accountability framework which will align the individual statutory responsibilities of Parties to the Agreement to the delivery of the Health and care Plan (November 2016).

7.6.2. Where it serves to improve population health outcomes and to meet the needs of patients, we will develop integrated working between commissioners and providers to transform services and reduce transactional costs in the system.

7.6.2. Each of the five Places will develop an Accountable Care Partnership (ACP) to deliver the ambition set out in its Place Plan and the wider Health and Care Plan (2016). The five ACPs will operate in shadow form within 2017/18 and will be legally constituted partnership by 1 April 2018, at the latest.

7.6.3. The five ACPs will bring together health and care services from statutory and non-statutory organisations to create a vertically integrated care system in each Place. This will include hospital services from tier 1.

7.6.4. Each of the five Places will explore new ways of contracting and allocating resources to its ACP including population budgets, population health management and segmentation approaches.

7.6.5. The five ACPs will connect between the five Places and with a horizontally integrated network of hospital based care (tiers 2 and 3) to support seamless care for patients and to create the overall accountable care system (ACS) for South Yorkshire and Bassetlaw.

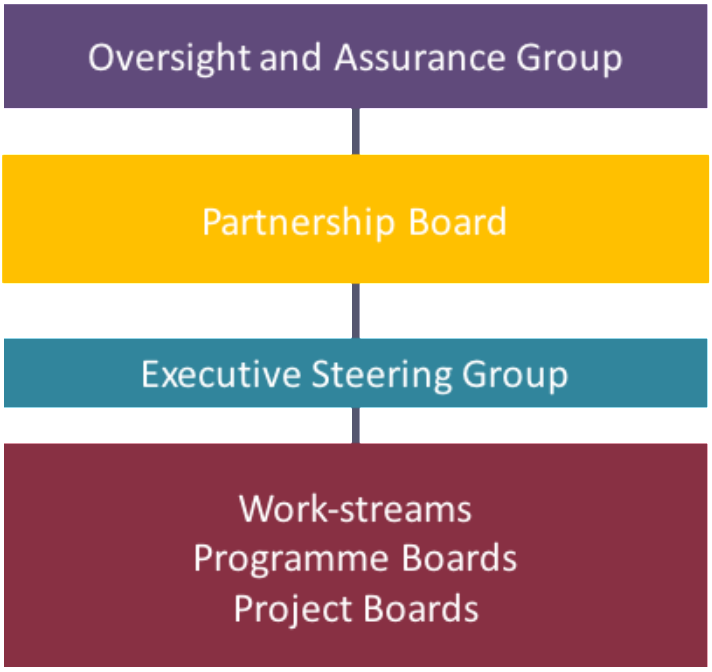
7.6.6. A system wide commissioning function will be in place within 2017/18 which will result from a reform of commissioning. We will build on approaches we have established in SYB, integrating approaches to planning and transformation and explore new ways of contracting and allocating resources to network of hospital based care. From April 2018, we will start to test the 'contract once' with the 'network of provider' to support sustainable services and drive improved outcomes for patients.

7.7. ACS governance

7.7.1. South Yorkshire and Bassetlaw has established collaborative governance. This governance recognises statutory governance of member organisations and where statutory organisations have come together to formally delegate to a joint committee or Committees in Common. It serves to support and supplement where agreed and appropriate, statutory governance and is the basis from which we will develop as an ACS.

7.7.2. A summary of SYB governance includes an Oversight and Assurance Group, a Collaborative Partnership Board, an Executive Steering Group and a range of programme Boards and project Boards.

Summary schematic - *South Yorkshire & Bassetlaw Health and Care Working Together Partnership Governance*



7.7.2.1. Oversight and Assurance Group: membership includes chairs from constituent statutory bodies including providers, commissioners, and Health and Wellbeing Boards with chief executives (CEOs) and accountable officers (AOs) in attendance.

7.7.2.2. Collaborative Partnership Board: membership includes CEOs and AOs from partner organisations including mental health and primary care, commissioning and local authority organisations, voluntary action groups, Healthwatch, NHS England and the ALBs. We also have clinical membership from primary and acute care. We plan to strengthen our Collaborative Partnership Board and review primary care input and wider clinical input and with lay membership.

7.7.2.3. Executive Steering Group: this group combines both the former STP executive steering group and the former finance oversight committee. Membership includes CEO and AO representation, together with directors of strategy, transformation and delivery and directors of finance.

7.7.2.4. Programme Boards: we have a range of programme boards delivering key priorities which are all led by a CEO and AO senior responsible officer (SRO). Each has a director of finance lead and a programme manager supporting.

7.7.3. This governance will remain in place for 2017/18 and during this time SYB will work with the Department of Health, NHS England, NHS Improvement and the ALBs as an ACS to review and establish governance that will best support us. This will be in place for 1 April 2018.

7.8. Joint Committees and Committees in Common

7.8.1. SYB CCGs, in partnership with North Derbyshire and Wakefield CCGs, have already established a joint committee and CCG governing bodies have delegated authority for the review of children's surgery and hyper acute stroke services. The membership includes accountable officers, clinicians and lay members. During 2017/18, we will review the scope of delegation to reflect the outcomes of the Hospital Services Review and the Commissioning Review so that formal governance arrangements are in place by 1 April 2018.

7.8.2. SYB acute providers, in partnership with Chesterfield Royal Hospital NHS Foundation Trust and Mid Yorkshire Hospital NHS Trust, have established a Committees in Common (*CiC*) to better support collaborative working between trusts including streamlining decision making. The collaboration has already supported changes in a number of programme areas including support services (back office functions) and a number have been joint with commissioners working together across the same geographical area.

7.8.3. During 2017/18, we will review the scope of delegation to reflect outcomes of the Hospital Services Review and Commissioning Review so that governance arrangements are in place by 1 April 2018. At this stage, the wider acute provider partnership includes both acute providers and community mental health providers. However the CiC does not currently extend to community mental health providers

7.8.4. The two programme offices and teams supporting commissioning and provider collaborations have now co-located to provide a joined up approach to planning and transformation delivery of acute services across SYB.

7.9. Place and accountable care development

7.9.1. CCGs and local authorities will continue to receive their respective health and care funding and to be statutorily accountable for their allocation.

7.9.2. Within 2017/18 each CCG will agree with its corresponding local authority the integrated governance structure which will support the allocation of resources to their ACP based on delivery of their agreed Place plan, wider Health and Care plan and agreed local outcomes.

8. Delivery improvement 2017/18-19

8.0.1. South Yorkshire and Bassetlaw has developed a number of priorities to support delivery of its Plan. These are led by chief executives and accountable officers with strong input from senior clinicians, public health, senior finance and operational colleagues from member organisations.

8.0.2. Transformation priority workstreams include:

- Urgent and emergency care
- Cancer
- Healthy lives, living well and prevention
- Primary care
- Mental health and learning disabilities
- Elective care and diagnostics
- Maternity and children's

8.0.2.1. Enabler workstreams

- Workforce
- Digital and IT
- Carter, estates and shared services
- Finance
- Communications and engagement

8.0.3. For 2017/18 – 19 South Yorkshire and Bassetlaw has identified a focused number of key priorities for delivery improvement 'working as one'. We will align resources and priority workstreams to support delivery of these key priorities at all levels within the emerging Accountable Care System and we will use these priorities to test new ways of working together and with NHS England and NHS Improvement to show additional benefits to patient and service delivery:

1. at organisational level
2. at Place (ACP) level
3. at System (ACS) level

8.0.4. Catalyst for change – in 2017/18 we will focus delivery improvements in urgent and emergency care, primary care, mental health and learning disabilities and cancer (or subsets of these priority areas) where we plan to make tangible improvements which will serve as a real catalyst for change across SYB. Each of our transformational workstreams has taken a unique perspective on how best they can contribute to delivering the 'key improvements' set out in the Next Steps on the Five Year Forward View. We will also take a unified approach to tackle efficiency improvement 'working as one' where this makes sense to do so.

8.1. Efficiency programmes, back office, Carter, Naylor

8.1.1. The efficiency programmes agenda is being addressed through two workstreams.

8.1.2. Firstly; The Provider Efficiency Group, which is responsible for the oversight of the acute and mental health trust providers programme and is addressing the eight nationally defined corporate service areas to ensure that collaborative opportunities are identified and maximised, including consolidation where appropriate. Its strategic objective is to develop systems that capture and optimise the cost effectiveness of corporate services so that services are assessed not only on direct costs and non financial quality indicators, but in relation to professional influence in driving efficiencies across trust systems, policies and processes. Its key aim is to reduce service costs with the summary data for showing the SYB position as 27/44, with potential savings of £4.4m to £10m, taking into account the national median and upper quartile benchmarking data from 2015/16. This is in line with estimated savings contained in the case for change submission October 2016.

8.1.3. The workstream's immediate priority is to achieve efficiency savings that will help to reduce the financial gap and, in particular, focus on savings and innovations that can be delivered during 2017/18. To enable effective oversight and delivery of collective solutions, a phased approach has been agreed on the key service areas that have shown, through the benchmarking data, the greatest saving opportunities, and which take into account the synergies and dependencies between these service areas. These are HR services, finance including payroll, and procurement.

8.1.4 . The ambition and commitment is to have regional networked arrangements using the same financial, HR and procurement solutions that will use consolidation and integration of transactional services as an enabler for common standardisation and streamlining of e-processes across all trusts to make efficiencies. Where and when appropriate, market testing may be undertaken.

8.1.5. The focus is therefore not just on changes to operating models but where with the use of technology and removal of transactional activity, significant efficiencies could be made. This is also reflected through formal HR streamlining and standardisation of priorities that target reduction of unwarranted variation and duplication across: workforce systems and compliance (including collaborative commercial relationships); general recruitment; bank and agency management (phase one focusing on medical agency including case for collaborative bank); occupational health/absence management; mandatory and statutory training; common bandings/gradings.

8.1.6. Secondly; there is a system wide Strategic Estates Group, the role of which is to provide strategic oversight, planning and direction to SYB clinical workstreams and the CCG Local Estate Forums (LEFs), enabling the delivery of more effective, Place based health facilities, property assets and health/public land across South Yorkshire and Bassetlaw. This workstream will support the implementation of a sustainable estate strategy that will help to deliver those objectives and also consider the findings of the Hospital Services Review and support the development and implementation of estates strategies arising from it. This will ensure a more integrated approach through the delivery of a smaller, more cost effective and efficient estate which is aligned more closely with the delivery of frontline public services.

8.1.7. The Strategic Estates Group brings together organisations which own health facilities, property assets and health/public land to facilitate the better use of all health and public

sector estate and will review principles for collaborative use of built assets. Its immediate priorities for 2017/18 – 2018/19 are based on three themes: strategic estates planning; aligning investment and disinvestment; and estates intelligence and spatial mapping.

8.1.8. Key outcomes are the production of a strategic estates plan and accompanying action plan, which sets out clear priorities for the delivery of better use of all local public land and property assets within respective geographical areas to deliver the estate objectives highlighted within the Health and Care Plan . It will also review the findings of the Naylor Review of surplus land and challenge partner organisations to address any recommendations, which will support the development of affordable estates and infrastructure plans and associated capital strategy

8.2. Managing demand and optimising care

8.2.1. The elective and diagnostic care workstream will be responsible for the planning, oversight and governance of a regional or sub regional elective and diagnostic care system. Closing the elective workstream's gap will be achieved by focusing on two priorities: reducing system demand and improving efficiencies in how we deliver our services. These themes will be delivered at Place and System levels through eight interventions; however, immediate priorities for 2017-2019 are described below.

8.2.2. Correct referral pathway – we will implement best practice demand management approaches that will reduce unnecessary or inappropriate referrals and ensure patients reach their most appropriate treatment first time. This will be achieved by piloting local solutions to advice and guidance and referral support with consideration to developing a regional solution. We will undertake local place based reviews of clinical pathways to reduce demand and attendance in hospital by developing community based services. We will support local organisations to improve utilisation of non face-to-face clinic delivery, alternative workforce models to drive efficiency and ensure effective access and discharge policies are in place to reduce unnecessary follow up appointments.

8.2.3. Procedures of low clinical value and clinical thresholds – we will develop a SYB policy for effective commissioning including a common set of controls and clinical thresholds for procedures to ensure adherence to best practice guidance.

8.2.4. Diagnostics – we will implement workforce and IT solutions that will reduce the demand and capacity gap in radiology reporting. We will work with the cancer workstream to develop diagnostic solutions that support early diagnosis.

8.2.5. Clinical efficiency – we will use benchmarking analysis (Getting It Right First Time) to identify and target variation along clinical pathways in order to deliver efficiencies. We will ensure our surgical activity is aligned to the appropriate setting and we will identify and transfer activity that can be delivered closer to home in the community.

8.3. General practice and primary care

8.3.1. Supporting and investing in general practice and primary care is a national priority mirrored by key priorities for all of our local Places. During the course of 2017 -19 we will deliver extended access to general practice for 100% of the local population by March 2019 and where possible, take steps locally to boost GP numbers including improving retention.

8.3.2. Expand multidisciplinary care including clinical pharmacists, mental health therapists, physician associates and increase the number of nurses in general practice.

8.3.3. Ensure 100% of GP practices are working together in hubs or networks by March 2019 that offer a greater scope of services which are increasingly capable of taking on population health responsibilities.

8.3.4. Expand multi-disciplinary care by deploying SYB's share of 1300 clinical pharmacists and 1500 mental health therapists, as well as physicians' associates and increase the number of nurses in general practice.

8.4. Urgent and emergency care (UEC)

8.4.1. We will continue to develop and strengthen the urgent and emergency care networks and partnership working through the UEC Steering Board, which builds upon the UEC Network established in 2015. A programme of work is currently being developed to take account of national requirements and the case for change described in the Health and Care Plan, with delivery models developed at place with a joint focus on redesigning the urgent and emergency care system and developing out of hospital services to reduce demand on A&E and acute beds.

8.4.2. The Five Year Forward View identified seven UEC priorities which will be included in the work programme. Specific priorities for 2017/18 include;

- We will work within Place and collectively across the System to ensure delivery of the four hour A&E standard and we will work as one with NHSE/I to agree improvement trajectories at System level with oversight on place delivery.
- We will work with Place to ensure the implementation of primary care streaming for each emergency department and with NHSE/I to agree at system level targets for activity flows through primary care streaming.
- We will work with Place to develop and identify the requirements for a clinical advisory service at three levels, 1) Place, 2) System 3) Regional to develop a hub and spoke arrangement to clinical advice using local clinicians/services where possible and scaling to system level where it is more efficient to do so.
- We will work as one with NHSE/I to agree at System level a realistic improvement trajectory to increase the volume of calls transferred from 111 to a clinician, working with providers of 111, out of hours and with place to deliver the ambition of 50% by March 2018 ensuring that NHS 111 connects into the appropriate clinical services and patients are directed to the most appropriate clinician/service.
- We will express an interest in becoming a pilot at system level for NHS 111 online in 2017/18 subject to the national roll out plan.
- We will work with Place to develop a plan to have at least one designated urgent treatment centre established by March 2018, which will include a review of existing urgent care centres, minor injury and walk in services to establish the baseline position and develop a plan to have a model for urgent treatment centres across the System in place by 2019.
- We will work with ambulance providers to implement the ambulance response programme and work as one with NHSE/I to develop realistic implementation plans. This will include working with Place to develop consistent offers on alternative pathways to conveyance to A&E.

- We will work with Place to improve patient discharges and flow through hospitals, including the establishment of a pilot to roll out the use of care home electronic bed states.
- We will work with Place to establish a common and shared approach to escalation management developing a plan to roll out a single system for better connections between Place and allow System level oversight of pressures in the UEC system.
- *We will work as one with NHSI and NHSE to align differential standards to secure delivery of integrated urgent care between 111 and out of hours providers.*

8.5. Mental health and learning disabilities (MHLD)

8.5.1 A number of priorities for the MHLD workstream have been identified, reflecting the requirements set out in *Implementing the Five Year Forward View for Mental Health* and identifying where and how a System level approach offers opportunities for improvements in service development and delivery. Key objectives for the workstream are:

- Development of core 24 liaison mental health services in all acute hospitals to support a reduction in pressure on the urgent and emergency care system, including reducing emergency admissions and length of stay for people with mental health problems.
- Providing support across all areas to develop integrated improving access to psychological therapies (IAPT) to ensure that people with long term conditions have their mental health needs met, reduce presentations for people with medically unexplained symptoms and improve patients' ability to self manage to reduce reliance on healthcare services.
- Taking a collaborative approach to developing perinatal mental health pathways and services.
- Working with specialised commissioning on specialist beds and community alternatives across children and young people's and secure mental health services.
- Improving the management of people with complex dementia needs, as part of moving care closer to home across the mental health and learning disabilities health and social care system.

8.5.2 In addition to supporting delivery of national objectives, the workstream is proactively addressing local issues, including gaps in services for adults with autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) and workforce issues. It will also work closely with the healthy lives, living well and prevention workstream to roll out innovations around social prescribing and employment support.

8.5.3 SYB will also oversee and support delivery of national objectives around access to services, including increasing access to psychological therapies, delivery of the 18 week referral to treatment target, and access to physical health checks for people with severe mental illnesses.

8.5.4 The workstream is also looking to explore opportunities for alternative commissioning and provider models where these will improve outcomes for patients, secure efficiency savings and secure service capacity and quality across SYB; including provider alliances and system commissioning.

8.6. Cancer

8.6.1. We will strengthen the newly formed Cancer Alliance by working with member organisations and at Place across the Cancer Alliance footprint; South Yorkshire, Bassetlaw and North Derbyshire. Our mandate and deliverables are explicitly articulated through the

Next Steps on the Five Year Forward View, the Cancer Taskforce strategy and our own Cancer Alliance Delivery Plan. Immediate priorities are outlined below:

- We will work to deliver the 62 day referral to treatment standard at System level as a single measure across our provider organisations by March 2018. This will create capacity to focus not only on the target but also enable us to focus on measures which hold the greatest significance to people affected by cancer such as quality of life, whilst also working to improve inter provider transfers within 38 days and improve earlier diagnosis.

- We will work with Place to implement interventions to achieve earlier diagnosis of cancer through raising awareness of signs and symptoms and maximising uptake in screening. We will understand capacity and demand across our diagnostics services, priorities in access to diagnostics and explore new models of access to diagnostics.

- We will support the delivery, through the local Cancer Alliance, of the strategic priorities to improve early diagnosis, services and outcomes for cancer patients as per the Cancer Taskforce report and facilitate the introduction of bowel cancer screening and primary HPV testing for cervical screening.

- We will continue to work with Place to fully deliver person centered care for people affected by cancer by implementing the living with and beyond cancer (LWABC) model of care.

- We have established an 'advisory board' of people affected by cancer to support decision making as part of our Living With and Beyond Cancer programme, one of our four Cancer Alliance workstreams. The Cancer Alliance board will also access this group on a topic by topic basis to support decision making on a range of issues such as performance.

8.7 Children's and maternity care

8.7.1 We have established a Children's and Maternity Delivery Board to support system transformation across three initial priority areas:-

1. Following public consultation, to reconfigure children's surgery and anaesthesia, developing new models of care with consistent management across providers, with sustainable care pathways that meet the newly specified standards of care.

2. For the acutely ill child, there is variation in the provision of care, and local assessment (in line with the national picture) identifies the current models are not sustainable, particularly in terms of workforce sustainability and coordinated care pathways. Therefore, there is a need to plan across a larger footprint and network provision. The immediate priority is to work together to develop sustainable new models of care for acute paediatrics, ensuring equity for children right across the SYB area through the adoption of a consistent 'blueprint' for services in each Place. This will be supported by a managed clinical network (MCN), ensuring a strong clinical input throughout. The blueprint will include paediatric acute services and consistent management across hospital settings, promoting demand management and supported discharge models in community settings, and the use of short stay assessment models.

3. For maternity services, we will work together to review the current offer and develop a single implementation plan for maternity care across SYB proposing changes in line with the implementing better births, through our Local Maternity Systems (LMS).

8.8. Workforce

8.8.1. The Local Workforce Action Board (LWAB) is the main vehicle for driving and managing the workforce work stream. There is an overarching aim and ambition to make SYB an attractive place to work to both attract and retain staff.

The LWAB is focusing on three initial priorities:

- Development of the South Yorkshire and Bassetlaw region excellence centre (1 of 7 in England) which aims to raise the standard for support staff by promoting vocational education including focusing on apprenticeships, sharing resources and acting as a vehicle for innovation.
- Creation of a faculty of advanced clinical practice for the region which aims to ensure consistent practice standards and secure resources for advanced clinical practitioners (ACPs) and physician associates (PAs).
- Sustainable primary care; plans include an increase in GP, practice nurse and clinical support worker numbers, plus further development of physician associates, AHP practitioners, care navigators and clinical pharmacists.

8.8.2. As an enabling work stream, the LWAB is committed to supporting the SYB workstreams to identify their workforce requirements and transform their services.

8.9 Digital and IT

8.9.1. We will be relentless in focusing on the needs of our citizens and our patients and will seek opportunities for technology to improve the ability of our staff and our partners to meet those needs. Therefore, on the journey towards achieving our vision we will:

- Directly support and influence the work of the SYB priority and enabling workstreams to ensure they are able to maximise the benefit of digital solutions.
- Transform the way in which we engage with patients and citizens, supporting them to maintain their own health and wellbeing through digital solutions.
- Improve the way in which health and care providers engage at all levels to ensure an integrated approach to digital transformation.
- Accelerate mechanisms that promote record and data sharing as more care is delivered outside a hospital environment, enabling clinicians to provide the best care in all settings, particularly via the use of mobile technology.
- Exploit big data analytics to inform frontline clinical decision making, provide real time system level management information and better targeting of prevention initiatives.
- Support and empower our staff, patients and citizens so they can maximise the potential of new technologies as they become available to them.
- Invest in interoperability and infrastructure to enable change

8.9.2. Focus areas from a recent development workshop (and a draft programme of interventions) are:

- Digital inclusion
- Self help connect
- Wellbeing and recovery
- Healthcare co-ordination

- Sharing data, predictive analytics
- Shared services and information governance
- Technical interoperability
- Digital health innovation

8.10 Development of accountable care in Place and System

8.10.1. In 2017/18, SYB will develop as an Accountable Care System. This will include collective decision making, governance and a single accountability framework which will align the individual statutory responsibilities of Parties to the MoU to the delivery of the Health and Care Plan (November 2016).

8.10.2. Where it serves to improve population health outcomes and to meet the needs of patients, we will develop integrated working between commissioners and providers to transform services and reduce transactional costs in the system.

8.10.3. Each of the five Places will develop an Accountable Care Partnership (ACP) to deliver the ambition set out in its Place Plan and the wider Health and Care Plan (2016). The five ACPs will operate in shadow form within 2017/18 and will be legally constituted by 1 April 2018, at the latest.

8.10.4. The five ACPs will bring together health and care services from statutory and non statutory organisations to create an integrated care system in each Place. This will include hospital services from tier 1 (to be determined).

8.10.5. Each of the five Places will explore new ways of contracting and allocating resources to its ACP including population budgets, population health management and segmentation approaches.

8.10.6. The five ACPs will connect between the five Places and with a horizontally integrated network of hospital based care (Tiers 2 and 3 to be determined) to support seamless care for patients and to create the overall accountable care system (ACS) for South Yorkshire and Bassetlaw.

8.10.7. A system wide commissioning function will be in place within 2017/18 which will result from a reform of commissioning. We will build on approaches we have established in the STP, integrating approaches to planning and transformation and we will explore new ways of contracting and allocating resources to the integrated network of hospital based care.

8.11. Commissioning reform

8.11.1. During 2017/18, we will undertake a review of commissioning as part of our system reform. This will consider the development of ACP in Place and the developing ACS and will need to influence and respond to:

a. The five ACPs bringing together health and care services from statutory and non statutory organisations to create a vertical and horizontal integrated care system in each Place, include hospital services from tier 1 (to be determined).

b. Developing new ways of contracting and allocating resources to its ACP including population budgets, population health management and segmentation approaches.

c. Connect between the five Places and with a horizontally integrated network of hospital based care (tiers 2 and 3 determined by the hospital services review and

delivery of safe and sustainable services) to support seamless care for patients and to create the overall Accountable Care System (ACS) for South Yorkshire and Bassetlaw.

d. Having a system wide commissioning function in place within 2017/18 with new ways of contracting and allocating resources to the integrated network of hospital based care. From April 2018, contracting once for a range of agreed services with the network to support sustainable services and drive improved outcomes for patients.

Organisations have agreed to fully engage in the review to support the objectives and also to support implementation of the review recommendations.

8.12. Specialised services

8.12.1. In many clinical areas, including cancer, mental health and learning disabilities, the commissioning of services is often split across a number of different organisations, which makes it much more difficult to plan the provision of integrated care. Different sets of commissioners make separate decisions about areas of provision which – for the patient – combine to form their whole patient journey. In children and young people's mental health, for example, young people move between types of provision that are commissioned and provided by separate organisations.

8.12.2. Whilst commissioning responsibilities have become more dispersed over recent years, our collective responsibility is to ensure that any differentiation in the commissioning of services does not manifest itself in fragmented services for patients. The development of the ACS gives the opportunity for specialised commissioners to work with local systems to ensure that joined up pathways are both commissioned and delivered across multiple health and social care settings and that the transitions between services are explicitly supported.

8.12.3. Commissioning specialised services across SYB helps remove some of the structural barriers that reinforce the separation between different elements of provision. It means that integration – for example between inpatient services and community services in mental health, or between chemotherapy and follow-up care in cancer – is 'designed-in' to local NHS services by joining up the commissioning processes across specialised and non specialised services, and across NHS and local authority care. Decision making is shifted as far as possible from the national to the local, to ensure it is based on the specific requirements of that geographical locality, giving local systems more say on how specialised budgets are spent in their area, making use of their deep understanding of their local population and giving them a voice in how resources are used locally in line with the established national service specifications.

8.12.4. The specialised services commissioned by NHS England include a diverse range of services, from the rare and highly specialised to more common/higher volume services. It follows that the most appropriate footprint for planning these services also varies (depending on a range of factors such as: patient numbers, shape of provision, financial risk, service specifications, strategy). NHS England has worked with its regional teams to undertake an initial segmentation of the services. This has resulted in developing a list of 20 services that are suitable for planning at populations up to 2.5m and thus at SYB level. During 17/18, work will take place with SYB and specialised commissioners to explore areas of focus that would be most relevant to work towards being part of the ACS.

8.12.5. Milestones:

- Areas of focus for specialised services to be planned at an SYB level agreed - Mar 18
- Shadow run budget for areas of focus for specialised services agreed - from Apr 18

- Ensure that for areas of focus agreed, any decisions on changes to services is made in partnership with SYB – from Apr 18
- 18/19 – work towards integration of services within ACS.

Further work is still required to understand the staff resource implications of this work and this will be explored during 17/18.

8.13. Hospital services review

8.13.1. Both commissioners and acute providers across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield have all committed to support an independent review of hospital services. The review will be completed in 2017/18. The terms of reference have been established and include the following key review objectives:

a) Define and agree a set of criteria for what constitutes 'Sustainable hospital services' for each Place and for South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire (in the context of South Yorkshire and Bassetlaw).

b) Identify any services that are unsustainable and not resilient against these criteria, in the short, medium and long-term, including tertiary services delivered within and beyond SYB.

c) Put forward a future service delivery model or models which will deliver sustainable hospital services.

d) Consider the future role of a district general hospital in best meeting patient needs in the context of the aspirations outlined in the South Yorkshire and Bassetlaw Health and Care Plan and emergent models of sustainable service provision.

9. National and regional support from the Department of Health, NHS England, NHS Improvement and the Arms Length Bodies

9.1. Capacity and capability

9.1.1. To support SYB ACS development there will be a process of aligning resources from ALBs to support delivery and establishing ACS integrated single assurance and regulation approach.

9.1.2. National capability and capacity will be available to support SYB from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

9.2. Financial including transformation and capital funding

9.2.1. In year one, an allocation of central funding has been ring fenced for the eight accelerating ACSs only.

9.2.2. SYB will therefore receive a share of the £450 million transformational funding allocated for the eight high performing systems and a share of the £325 million capital funding. How this funding is allocated to deliver our system plan is to be worked through and agreed.

9.2.3. Bespoke support to work through financial governance and operating a shared system control total and alternative payment models.

9.3. Nationally supported workstreams and peer support

9.3.1. National ACS workstreams/learning set have been established to work with and support the eight named Accountable Care Systems including:

- Communications and public engagement
- Leadership
- Scaling up primary care
- Urgent and emergency care
- Devolved transformation funding
- Spreading new care models and integrating care
- Capital funding
- Shared system control totals
- Alternative payment models
- System wide efficiency opportunities
- Governance
- Streamlining oversight
- Future of commissioning functions
- External partnerships to support population health.

10. Glossary of terms and acronyms

ACP	Accountable Care Partnership. The partnerships forming in each of the five local places of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.
or	Advanced Clinical Practitioner
ACS	Accountable Care System; here covering South Yorkshire and Bassetlaw with five constituent Places of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield
ALB	Arm's Length Body; see https://www.gov.uk/government/publications/arms-length-bodies/our-arms-length-bodies
AO	Accountable Officer at a Clinical Commissioning Group
Carter	Lord Carter's review: 'Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals' (2016)
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CiC	Committees in Common
CPB	Collaborative Partnership Board
CQC	Care Quality Commission, the independent regulator of all health and social care services in England
DoH	Department of Health
FT	Foundation Trust; a semi--autonomous organisational unit within the NHS
FYFV	Five Year Forward View; a strategy for the NHS (2014)
GB	Governing Body - governance of Clinical Commissioning Groups
GP	General Practitioner
GPFV	General Practice Forward View
HEE	Health Education England
HSR	Hospital Services Review
IAPT	Improving Access to Psychological Therapies
JC CCG	Joint Committee of Clinical Commissioning Groups - a statutory body where two or more CCGs come together to form a joint decision making forum. It has delegated commissioning functions.
LA	Local Authority, an administrative body in local government

LWAB	Local Workforce Action Board sub regional group within Health Education England
MCP	Multi-specialty community provider
MHLD	Mental Health and Learning Disabilities
MoU	Memorandum of Understanding; a formal agreement between two or more parties to establish official partnerships
Naylor Review	Sir Robert Naylor's review of NHS property and estates and how to make best use of the buildings and land (2017)
NHS	National Health Service
NHS 111	A national free to call single non-emergency number medical helpline
NHSE	NHS England
NHSI	NHS Improvement; operating name for Monitor, NHS Trust Development Authority and teams from 2016
PA	Physician's Associate
PACS	Primary and Acute Care System
Place(s)	One of five geographical subdivisions of SYB with the same footprint as the ACPs
SAF	Single Accountability Framework
SRO	Senior Responsible Officer, the visible owner of the overall business change, accountable for successful delivery
STP	Sustainability and Transformation Plans (2016); the NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
SYB	South Yorkshire and Bassetlaw
TBA	To be announced
TBC	To be confirmed
UEC	Urgent and emergency care
Vertical integration	FYFV delivery next steps: horizontally operating provider organisations simultaneously operating as vertically integrated care system, partnering with local GP practices formed into clinical hubs serving 30,0000 – 50,000 populations
Horizontally integrated	FYFV delivery next steps: Where provider organisations collaborate to form care systems. There are different forms; from virtual to actual mergers, for example, having 'one hospital on several sites' through clinically networked service delivery