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Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 29 September 2016 at 3.00 pm

Town Hall, Sheffield S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Julie Dore	Leader of the Council
Dr Tim Moorhead	Chair of the Clinical Commissioning Group
Dr Nikki Bates	Governing Body Member, Clinical Commissioning Group
Councillor Jackie Drayton	Cabinet Member for Children, Young People and Families
Greg Fell	Director of Public Health
Alison Knowles	NHS England
Jayne Ludlam	Executive Director, Children, Young People & Families
Laraine Manley	Executive Director, Communities
Councillor Cate McDonald	Cabinet Member for Health and Social Care
Dr Andrew McGinty	CCG Clinical Representative
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group
John Mothersole	Chief Executive, Sheffield City Council
Judy Robinson	Healthwatch Sheffield

Sheffield City Council

Maddy Ruff	Accountable Officer, Clinical Commissioning Group
Dr StJohn Livesey	CCG Clinical Representative
Dr Ted Turner	Governing Body Member, Clinical Commissioning Group

Sheffield City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

Sheffield's Health and Wellbeing Board started to meet in shadow form in January 2012 and became a statutory group in April 2013. The Health and Social Care Act 2012 states that every local authority needs a Health and Wellbeing Board. It is a group of local GPs, local councillors, a representative of Sheffield citizens, and senior managers in the NHS and the local authority, all of whom seek to make local government and local health services better for local people. Its terms of reference sets out how it will operate.

Sheffield's Health and Wellbeing Board has a formal public meeting every three months as well as a range of public events held at least once a quarter.

Sheffield's Health and Wellbeing Board has a website which tells you more about what we do. www.sheffield.gov.uk/healthwellbeingboard

PUBLIC ACCESS TO THE MEETING

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Meetings are normally open to the public but sometimes the Board may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information please contact Jason Dietsch on 0114 273 4117 or email jason.dietsch@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

29 SEPTEMBER 2016

Order of Business

1. Apologies for Absence

2. Declarations of Interest (Pages 1 - 4)
Members to declare any interests they have in the business to be considered at the meeting.

3. Public Questions
To receive any questions from members of the public.

4. Sustainability and Transformation Plans and Shaping Sheffield (Pages 5 - 84)
Joint report of the Director of Public Health and the Integrated Commissioning Programme Director, Sheffield Clinical Commissioning Group.

5. Minutes of the Previous Meeting (Pages 85 - 96)
Minutes of the meeting of the Board held on 31 March 2016.

6. Date and Time of Next Meeting
To note that the next meeting of the Board will be held on Thursday 30 March 2017 at 3.00 p.m. at the Town Hall Sheffield.

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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HEALTH AND WELLBEING BOARD MEETING

Report of: Greg Fell, Peter Moore

Date: 29 September 2016

Subject: Sustainability and Transformation Plans

Author of Report: Nicki Doherty

Summary: This paper summarises the latest position on the development of the South Yorkshire and Bassetlaw STP and the Sheffield Local STP, key next steps and points for discussion.

It sets out the content of the Sheffield Local STP, its case for change including some detail behind the current financial figures as derived from the STP calculations. And it describes the key things we will do based on the inputs and discussion to date.

It notes the work in progress to develop the detail within the plan, including work from Price Water House Cooper to develop our financial strategy and a further timeout session for the Transforming Sheffield Programme Board.

Key steps now are finalising the detail of what we are going to do alongside finalising our financial strategy. This will happen by the end of September to feed into the South Yorkshire and Bassetlaw STP in time for submission of the STP to NHS England on October 21st. Following that there will be a programme of work to take us to signing off contracts by 23rd December and then 17/18 delivery plans by early February.

The Health and Wellbeing Board needs to consider the current stage of progress in relation to both the South Yorkshire and Bassetlaw STP and the Sheffield STP and agree how it would like to be kept involved and informed in future shaping of the plan.

Questions for the Health and Wellbeing Board:

The board is asked:

- To note the context in which the STP is being developed, and the challenging timescales that have been set.
- To note that many of the constituent parts of the plan reflect plans that are already in train – both at South Yorkshire and Sheffield level.
- To note that the plan represents an opportunity to transform service provision in a way that better enables us to meet the three goals of improved heath & wellbeing, improved service quality, and improved efficiency.
- To consider whether there are improvements to the way the plan is being developed that will enable greater involvement and engagement of groups not currently involved.
- To consider whether there are elements of the plan or process that need to be made more visible and explicit

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Which outcome(s) of the Joint Health and Wellbeing Strategy does this align with?

All

1 Introduction

1.1 This paper builds on the previous Health and Wellbeing Board discussions and shares with Health and Wellbeing Board members both the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) and the Sheffield Place Based Plan as a component of the STP.

1.2 It is important to note that whilst the plans are nearing their final iterations there is still a significant amount of work to complete to:

a) Ensure that we have plans that are built upon robust assumptions we can have collective confidence in

b) We agree a set of clear priorities, that are signed up to by system, and that will deliver system wide impact

c) Recognise that the submission to NHS England represents a plan upon which a great deal of consultation can then be built. NHS England has recently published guidance on consultation and engagement specifically for STPs.

1.3 It is worth reminding the Board that these plans are based on the work we have been doing over previous years to work together to transform our services, both across South Yorkshire and Bassetlaw and locally in Sheffield. It pulls together our collective aims and works and sets out how we will work differently to ensure that we are in a position to deliver.

1.4 Within Sheffield, the components of the Place Based Plan are built on published strategies, including the Primary Care Strategy, the Urgent Care Strategy and the Out of Hospital Strategy. Within South Yorkshire, the Working Together Programme has been established for some time and has set out a number of change programmes for some services. These plans have been developed with a diverse set of stakeholders from across the city as described in the plans themselves.

2.1 South Yorkshire and Bassetlaw Sustainability and Transformation Plan: Key Messages and Timeline

2.1.1 The South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) is the local version of the national plan, the Five Year Forward View. Published in 2014, it set out a vision of a better NHS, the steps we should take to get us there, and how everyone involved need to work together.

2.1.2 The Five Year Forward View highlights three areas where there are growing gaps between where we are now and where we need to be in 2020/21. These gaps are:

- the health and wellbeing of the population
- the quality of care that is provided
- and finance and efficiency of NHS services

2.1.3 Both the South Yorkshire and Bassetlaw and Sheffield plans are written for, by, and with local people with the aim of ensuring we all receive better care, are healthier, and have an NHS that runs more efficiently by early 2021.

2.1.4 The South Yorkshire and Bassetlaw STP comprises a strong community of stakeholders, including many voluntary sector organisations, 208 GP practices, five local

authorities, five clinical commissioning groups, five acute hospitals, two of which are integrated with their community services, two associate acute hospital trusts, four mental health providers, five Healthwatch organisations and two ambulance services. It is also working closely with STP associate partners in North Derbyshire and Mid-Yorkshire. Across the region, the STP partners employ 74,000 staff across health and social care and administer £3.9bn public funds every year.

2.2 The health and wellbeing gap

2.2.1 In South Yorkshire and Bassetlaw, people are living longer, but there are high levels of deprivation, unhealthy lifestyles and too many people dying prematurely and from preventable diseases.

2.2.2 Whilst life expectancy is increasing, healthy life expectancy is not, and there are significant inequalities between best and worst. The inequality is not just a geographic issue as it affects people with a serious mental illness, those with a learning disability and others. The inequality can be expressed in terms of both physical and mental wellbeing.

2.2.4 Our health and care services want to support people more to do this – by making it easier to get expert advice and to access free healthy living schemes. We also want to support people to connect with and develop local links and networks in their neighbourhoods, building trust and understanding across communities. The simple fact is that a healthier population is a happier population – one which relies less on the NHS and other care services to treat problems that could have been prevented.

2.3 The quality gap

2.3.1 Across South Yorkshire and Bassetlaw, we know that quality, experience and outcomes can vary and we know that care can be disjointed from one service to another because our many organisations don't always work as closely as they should. We have some good Care Quality Commission feedback for our organisations but we also know there are some areas for improvement. And we also know that people want their health and care support and treatment in a place and at a time that is right for them. For many, this means care that is provided at home, or closer to home, and not in a hospital.

2.3.2 We want the same quality of service for people, as close to them as possible. Doing this jointly means a better solution for everyone – whether people live in Staveley, Shafton, Sharrow or Shireoaks.

2.4 The finance gap

2.4.1 Along with health and care services across the country, South Yorkshire and Bassetlaw faces financial pressures and our hospitals and other organisations are struggling to balance their books. There are a range of causes for this, including rising demand for care among our population and that many people now often have more complex health conditions, such as obesity and heart disease, which require more complex treatment.

2.4.2 Extra money has been provided for NHS organisations but we still estimate a gap of around £727 million across health and social care in South Yorkshire and Bassetlaw in the next four years. We believe there's more we can do to alleviate some of the financial pressures over the next four years. We need to find new and better ways to meet the needs of local people and do things more efficiently and with less waste. This doesn't

mean doing less for patients or reducing the quality of care. Rather, it means more preventative care, and bringing care out of hospitals and closer to home.

2.5 The thinking so far

2.5.1 Over the last few months, work has been taking place with patient groups, the voluntary sector, hospitals, GPs, local councils, commissioners of services and the universities to discuss what needs to happen in South Yorkshire and Bassetlaw. Conversations and planning are in the early stages of looking at addressing the challenges facing health and care services and improving the health of the population.

2.5.2 The coalition of partners has been led by STP lead Sir Andrew Cash and supported by the already established Commissioners and Providers Working Together programme management offices. Work to date has included:

- STP guiding coalition – two fully inclusive South Yorkshire and Bassetlaw system wide events shaping and consulting on the plan
- STP executive steering group – all chief executives (Local Authority and Trust) and accountable officers meeting fortnightly and also as part of a two day timeout
- STP executive coordinating group – STP lead, plus accountable officer representative from CCGs, chief executive representative from trusts and local authorities and the workstream leads meets weekly to drive the plan forward

2.5.3 The STP programme office has been working with 15 workstream leads (trust provider chief executives and CCG chief officers) to establish the main priorities and to show how South Yorkshire and Bassetlaw will create a long term sustainable health and care system for the population.

The workstreams are:

- CCG place based plans – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.
- Urgent and emergency care
- Maternity and children's
- Mental health and learning disabilities
- Cancer
- Elective and diagnostics
- Public sector reform
- Workforce
- Finance
- Digital and IT
- Carter, procurement and shared services

2.5.4 The South Yorkshire and Bassetlaw thinking is in line with Sheffield's; starting with where people live, in their neighbourhoods focusing on people staying well - introducing new services, improving co-ordination between those that exist, supporting people who are most at risk and adapt our workforce so that we are better meeting the health and care needs of people in their homes and clinics. We want care to flow seamlessly from one service to the next so people don't have to tell their story twice to the different people caring for them, and everyone is working on a shared plan for individual care.

2.5.5 At the same time, partners agree that everyone should have better access to high quality care in specialist centres and units and that, no matter where people live, they get the same standards, experience, and outcomes for their care and treatment. The STP will do this by working together more closely, by developing a networked approach to services.

2.5.6 The partners also believe that people with mental health and learning disabilities must be treated with the same respect and regard as those with physical health issues, and as well as committing to ensuring they have the same access to services, it wants to improve their life chances.

2.5.7 Developing and supporting staff is the only way to achieve these ambitions and partners envisage a flexible workforce that comes together in neighbourhood hubs and specialist centres to offer people the best and most appropriate care.

2.5.7 Appended is a paper that was recently discussed with the Sheffield Health Overview and Scrutiny Committee setting out some other aspects of the STP development.

3 The Sheffield Local Sustainability and Transformation Plan: Key Messages and Timeline

3.1 Overview

3.1.1 The latest iteration of the Sheffield Local STP (version 0.7) sets out the local Sheffield context, its vision and aims, the Sheffield case for change and what we will do and how we will do it.

3.1.2 It is important to note that this is still being further developed, in particular:

- Support from Price Water House Cooper in developing the Sheffield Financial Strategy (linking back into the South Yorkshire and Bassetlaw STP) and how the gear shift in where Sheffield spends its money will look over the course of the plan
- A further Transforming Sheffield Programme Board session to review the key messages and to fully agree our systems priorities based on where we will get the best impact
- Editing and formatting

3.2 Key Messages

3.2.1 Key messages from the plan are:

- There is a case for a radical upgrade in prevention, which we will need to find a way to support both by investment as well as building prevention into the way that we work
- The gaps around health and wellbeing are well known and rehearsed in particular with poorer outcomes for life expectancy, healthy life expectancy (a substantial gap), educational attainment unemployment and housing compared to the England average
- We have particular challenges around delayed transfers of care following admission and for people staying at home 91 days after leaving hospital; and access to hospital services are becoming increasingly challenged against national expectations (performance indicators like 18 week referral to treatment standards)
- We know that there are services that don't offer value for money and therefore need to be reviewed with a view to decommissioning or recommissioning differently

- We need to work differently as a system, developing strong and visible system leadership that builds the culture and capability required to deliver what we plan to

3.3 Finance

3.3.1 The Sheffield Local STP forecast deficit based on a do nothing scenario is -£235m, this figure is taken from the methodology used for the South Yorkshire and Bassetlaw STP financial calculations. Sheffield has commissioned a piece of work from Price Water House Cooper to secure a more detailed understanding of the Sheffield money and inform our Financial Strategy for managing our money across the system; this will map out and support investment as well as detail the shift in spend from hospitals into prevention, communities and primary care. The required investment will also set out how Sheffield will use any incoming transformational funds.

3.3.2 To help understand the STP calculations it is important to understand:

- That the STP process requires NHS organisations to calculate per national rule set:
    - CCGs – Compares our allocation with projected expenditure. Thus includes price and demand led cost pressures, together with investment to meet FYFV national priorities in primary care and mental health. Gap (or efficiency target) is derived by assuming we meet business rules e.g. 1% surplus each year as well as pressures/investment requirements.
    - Sheffield CCG has allocation uplift which is well below average in all years to 20/21 as adjudged to have existing funding more than 5% above “fair shares” target funding, which means our financial gap likely to be higher than average.
    - Trusts – Gap comprises any historic deficit plus the 2% efficiency requirement pa embedded in national NHS prices and as a result of expected loss of other non-activity based income e.g. national education & training grants.
    - Following new guidance ALL organisations are assumed to deliver 2016/17 control totals, and hence deliver QIPP/CIP (i.e. efficiency) programmes in full and recurrently. Hence the Gap now looks at 4 years from 2017/18.
    - No guidance on how Local Authorities calculate their Gap. Work to confirm the approach across the 4 South Yorkshire LAs covering adult & Children's social care and PH grant is being done currently.
    - No organisation able to assume any share of national STP funding. Sheffield Trusts should receive c£22m sustainability funding non-recurrently in 2016/17. Trusts will similarly receive non recurrent support in 2017/18 and 2018/19 but amounts to be confirmed. For 2020/21 the South Yorkshire and Bassetlaw STP area has an indicative allocation of £105m. The element which Sheffield might receive as part of this will play out as part of resolving SY&BL system wide STP plan.

- Solutions have to be mapped to NHS efficiency programme headings for STP but broadly fall into 3 categories:
    - Individual organisational business as usual (BaU) efficiencies – Trusts must deliver min 2% either through Carter workstreams e.g. rationalisation of back office functions and estates or other actions; for CCGs main area of BaU is GP prescribing; LAs to identify efficiency proposals
    - Reduction in demand in particular for acute hospital care (urgent and elective) but also long term nursing and social care. Modelling continues as to whether we can simply reduce the growth in activity or are actually able to reduce activity below 2016/17 levels. This is important particularly as the first avoids the need

to increase capacity etc. but the second requires a reduction in workforce, estate etc. and likely therefore modelling suggest can't expect to release 100% of costs in short-medium term. The Local health & social care Place Based Plans are seen as primary source of identifying solutions to reduce demand, including enhancing out of hospital capacity, self-care and prevention actions.

- Reconfiguration of acute services where these could lead to consolidation of the number of sites from which selected services are provided. This is to ensure resilience and quality of service as well as potentially reduce costs for providers. Costs for commissioners assumed to stay the same if volume of activity remains the same.

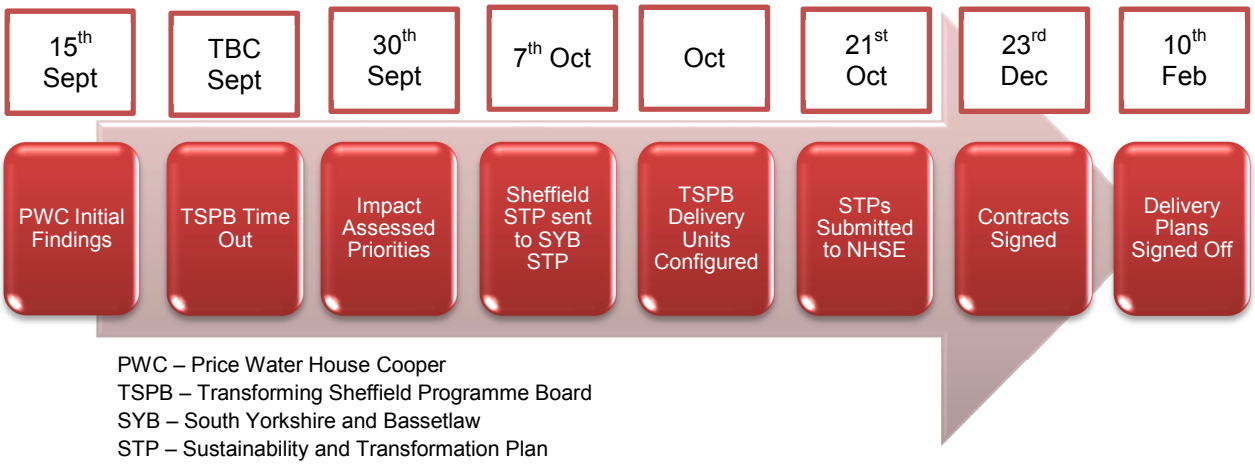
3.4 What we are going to do

3.4.1 The plan sets out programmes of work across each of the tiers of health (pages 19-24). These need to be prioritised to ensure that we are able to deliver them effectively and will require a staged approach that considers impact and phasing. This will be described fully by the end of September and will be informed by both the work that Price Water House Cooper is undertaking as well as the next Transforming Sheffield Programme Board session. Figure 1 below describes what the programmes over the next 5 years look like at this stage as well as year 1 priorities (the latter having been developed as part of the first Transforming Sheffield Programme Board timeout session).

Fig. 1 Sheffield Plan Programmes of Work and Year 1 Focus:

Programmes	***Year 1***
Early Years and Families	We will empower parents, families and carers to provide healthy, stable and nurturing family environments
Education and Aspiration	We will Implement a new Vulnerable Young People's Service We will Increase the proportion of school ready children
Heart of Sheffield	We will recognise the link between employment and physical and mental health and help more people into work
Helping More People into Work	
We Are The NHS (self-care and social prescribing)	We will agree a single risk stratification process for our population and agree how we use this so that we can then target our resources so we can help those most at risk
Strengthening Primary Care	
Care Planning and Person Activation	We will invest heavily into the development of neighbourhood working
Help to Stay at Home	We will work with our staff and teams to promote flexibility, to promote patient centred services and to promote a culture in Sheffield where staff across organisations are enabled to resolve difficult issues which impact on patients and communities
Accountable Care System with MCPs	
Referral and Pathway Coordination	We will tackle inequalities head on by making disproportionate investments in effort and resources into those communities with most need

3.5 Timeline



3.5.1 This timeline will develop in detail informed both by the final detail of the plan and priorities as well as the national NHS operational planning guidance expected during September.

4 Summary

4.1 This paper summarises the latest position on the development of the South Yorkshire and Bassetlaw STP and the Sheffield Local STP, key next steps and points for discussion.

4.2 It sets out the content of the Sheffield Local STP, its case for change including some detail behind the current financial figures as derived from the STP calculations. And it describes the key things we will do based on the inputs and discussion to date.

4.3 It notes the work in progress to develop the detail within the plan, including work from Price Water House Cooper to develop our financial strategy and a further timeout session for the Transforming Sheffield Programme Board.

4.4 Key steps now are finalising the detail of what we are going to do alongside finalising our financial strategy. This will happen by the end of September to feed into the South Yorkshire and Bassetlaw STP in time for submission of the STP on October 21st. Following that there will be a programme of work to take us to signing off contracts by 23rd December and then 17/18 delivery plans by early February.

4.5 The Health and Wellbeing Board needs to consider the current stage of progress in relation to both the South Yorkshire and Bassetlaw STP and the Sheffield STP and agree how it would like to be kept involved and informed in future shaping of the plan.

5 Questions for the Board

The board is asked:

- To note the context in which the STP is being developed, and the challenging timescales that have been set.
- To note that many of the constituent parts of the plan reflect plans that are already in train – both at South Yorkshire and Sheffield level.
- To note that the plan represents an opportunity to transform service provision in a way that better enables us to meet the three goals of improved heath & wellbeing, improved service quality, and improved efficiency.
- To consider whether there are improvements to the way the plan is being developed that will enable greater involvement and engagement of groups not currently involved.
- To consider whether there are elements of the plan or process that need to be made more visible and explicit

Author and Date

Nicki Doherty 19th September 2016

Appendices

1) Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee. 14th September 2016 on the SYB STP.
2) Slides used in this presentation with Scrutiny.
3) Sheffield Place Based Plan V0.7

Appendix 1

Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee 14th September 2016

Report of: Commissioners Working Together

Subject: Update on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Author of Report: Will Cleary-Gray, Programme Director

Summary:
This paper is to update the OSC on the developing South Yorkshire and Bassetlaw Sustainability and Transformation Plan and inform them of next steps for engagement.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	✓
Other	

The Scrutiny Committee is being asked to:
The Committee is asked to note the update and next steps

Background Papers:
N/A

Category of Report: OPEN

South Yorkshire and Bassetlaw Sustainability and Transformation Plan – an update

1. Introduction

1.1 In January 2016 health and care organisation across England were asked to come together to develop sustainability and transformation plans (STP) to take forward the Five Year Forward View strategy for England; building on existing work already taking place in local communities.

Led by Sir Andrew Cash, 17 of South Yorkshire and Bassetlaw's health and care, education and research organisations are working together to improve local services for our combined population.

2. South Yorkshire and Bassetlaw Sustainability and Transformation Plan

2.1 There have been some big improvements in health and social care in South Yorkshire and Bassetlaw in the last 15 years. People with cancer and heart conditions are experiencing better care and living longer, waits are shorter and people are more satisfied. We are proud of our local services and the huge progress we've made so far.

However, people's needs are changing, new treatments are emerging, the quality of care is variable, and preventable illness is widespread.

With this, and the need to develop a local STP, in mind, over the last few months, we've been working with patient groups, the voluntary sector, hospitals, GPs, local councils, commissioners of services and the universities to discuss what needs to happen in South Yorkshire and Bassetlaw.

We are in the very early stages of looking at how we can address the challenges facing our health and care services and improve the health of our population.

We have a strong community of stakeholders, including more than 10,000 voluntary sector organisations, 208 GP practices, five local authorities, five clinical commissioning groups, five acute hospitals, two of which are integrated with their community services, two associate acute hospital trusts, four mental health providers, five Healthwatch organisations and two ambulance services. We are also working closely with our STP associate partners in North Derbyshire and Mid-Yorkshire. We employ 74,000 staff across health and social care and administer £3.9bn public funds each year.

Our thinking starts with where people live, in their neighbourhoods focusing on people staying well. We want to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we are better meeting the health and care needs of people in their homes and clinics. We want care to flow seamlessly from one service to the next so people don't have to tell their story twice to the different people caring for them, and everyone is working on a shared plan for individual care.

At the same time, we agree that everyone should have better access to high quality care in specialist centres and units and that, no matter where people live, they get the same standards, experience, and outcomes for their care and treatment. We will do this by working together more closely, by developing a networked approach to services.

We also believe that people with mental health and learning disabilities must be treated with the same respect and regard as those with physical health issues, and as well as committing to ensuring they have the same access to services, we want to improve their life chances.

Developing and supporting our staff is the only way we will achieve these ambitions. We envisage a flexible workforce that comes together in neighbourhood hubs and specialist centres to offer people the best and most appropriate care.

2.2 **We want to improve the quality of care people receive**

We want to make sure that the care people receive is always high quality – regardless of where they live, which medical professional they see, and whether they are treated at a GP surgery, care home or elsewhere.

We know that quality, experience and outcomes can vary and we know that care can be disjointed from one service to another because our many organisations don't always work as closely as they should. We have some good Care Quality Commission feedback for our organisations but we also know there are some areas for improvement. And we also know that people want their health and care support and treatment in a place and at a time that is right for them. For many, this means care that is provided at home, or closer to home, and not in a hospital.

We want the same quality of service for people, as close to them as possible. Doing this jointly means a better solution for everyone – whether people live in Staveley, Shafton, Sharrow or Shireoaks.

2.3 **We want to improve health and wellbeing for everyone**

In South Yorkshire and Bassetlaw, people are living longer, but we have high levels of deprivation, unhealthy lifestyles and too many people dying prematurely and from preventable diseases.

Poor eating habits can lead to weight gain, which in turn can result in serious complications like type 2 diabetes. Smoking and alcohol consumption, which are particular issues in our region, are also harmful and can increase the risk of cancer. We also know that there are higher than average deaths in people under the age of 75 from cancer, heart disease and serious mental illness.

Our levels of childhood poverty are significantly higher than the national average and the gap is widening. We also have significant deprivation and inequalities, with a difference in healthy life expectancy of more than 20 years across our area – and we have higher than the national average of teenage conceptions and mums smoking during pregnancy.

Many of these can be prevented by different lifestyle choices and keeping a check on our health.

Our health and care services want to support people more to do this – by making it easier to get expert advice and to access free healthy living schemes. We also want to support people to connect with and develop local links and networks in their neighbourhoods, building trust and understanding across communities. The simple fact is that a healthier population is a happier population – one which relies less on the NHS and other care services to treat problems that could have been prevented.

2.4 **We want to ensure our services are efficient**

Along with health and care services across the country, we face financial pressures and our hospitals and other organisations are struggling to balance their books. There are a range of causes for this, including rising demand for care among our population and that many people now often have more complex health conditions, such as obesity and heart disease, which require more complex treatment.

Extra money has been provided for our NHS organisations but we still estimate a gap of around £727 million in the next four years. We believe there's more we can do to alleviate some of the financial pressures over the next four years. We need to find new and better ways to meet the needs of local people and do things more efficiently and with less waste. This doesn't mean doing less for patients or reducing the quality of care. Rather, it means more preventative care, and bringing care out of hospitals and closer to home.

2.5 **What next?**

We have been asked by NHS England to present a high level financial analysis of the gap in resources in mid-September. By mid-October, we expect local conversations with patient and voluntary groups and partners to have progressed across all our areas to a place where we have more detailed plans and our final submission will be on 21 October.

We then expect to pre-consult on the plan widely with the public in the New Year.

From October, we are starting formal consultation on proposals to hyper acute stroke services and children's surgery and anaesthesia services across our region. Both these proposals are based on reviews which showed that people have different experiences and receive different standards of care depending on where they live. Both theses reviews are examples of some of the work to improve services across South Yorkshire and Bassetlaw and will lead to more sustainable services for Stoke and Children's care.

3 What does this mean for the people of Sheffield?

3.1 We believe that to improve care for the people of Sheffield (and South Yorkshire and Bassetlaw as a whole), health and care services need to work more closely together, and in new ways.

By working in this way, we will also be able to contribute to the region's economic growth, helping people to get and stay in work. As well as supporting their health and wellbeing, this will help to keep South Yorkshire and Bassetlaw economically vibrant and successful.

4. Recommendation

4.1 The Committee is asked to note the update and next steps

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

An overview

September 2016

What is health and care like today in South Yorkshire and Bassetlaw?

Big improvements in the last 15 years

People with cancer and heart conditions are getting better care and living longer

Waits are shorter, people are more satisfied

We are proud of our local services and the huge progress we've made

However…

People's needs are changing

New treatments are emerging

The quality of care is variable

Preventable illness is widespread

We believe that to improve care for people, health and care services need to work more closely together, and in new ways

Working in this way, we will also be able to contribute to the region's economic growth, helping people to get and stay in work.

Local plans for better health and care are Sustainability and Transformation Plans (STPs)

They are the local version of the national plan, called the NHS Five Year Forward View

Our STP partners

74,000 staff across health and social care

10,000 voluntary sector organisations

208 GP practices

5 clinical commissioning groups

5 local authorities

5 foundation trusts

5 Healthwatch

4 mental health trusts

2 associate hospitals/ 2 ambulance services

We're in the very early stages of looking at how we can address the challenges facing our health and care services and improve the health of our population

We want to **improve health and wellbeing** for everyone

We have high levels of deprivation, unhealthy lifestyles and too many people dying prematurely and from preventable diseases

Smoking and alcohol consumption are issues for our region

We have higher than average deaths in people under 75 from cancer, heart disease and mental illness

Our childhood poverty levels are significantly higher than the national average

We want to support people to choose healthier lifestyles – by making it easier to get expert advice and access to free healthy living schemes. And to help them connect and develop local links and networks in their neighbourhoods

We want to **improve the quality of care people** receive

We know that quality, experience and outcomes can vary and be disjointed from one service to another

We have some good CQC feedback for our services, but we know there are areas for improvement

We know that people want their health and care support and treatment in a place and at a time that is right for them

This means care at home, or closer to home and not in a hospital

We want the same quality of service for people, as close to them as possible

We want to **ensure our services are efficient**

We face financial pressures and our hospitals and other organisations are struggling to balance the books

Rising demand for care, more people with complex conditions means they need more complex treatment

Extra money has been provided but we still estimate a significant gap in the next four years

We need to find new and better ways to meet the needs of local people

This doesn't mean doing less for patients or reducing the quality of care. Rather, it means more preventative care, bringing care out of hospitals and closer to home

Our thinking so far…

It starts with where people live, in their neighbourhoods focusing on people staying well

We want to introduce new services

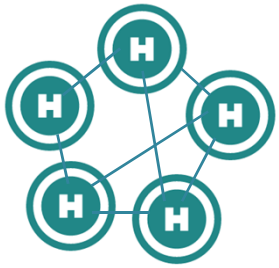
Improve co-ordination between services that exist

Support people most at risk

Adapt our workforce to better meet health and care needs of people in their homes and clinics

At the same time, everyone should have better access to high quality care in specialist centres and get the same standards, experience and outcomes

We will work together more closely



We will develop a networked approach to services

No matter where people live, they will get the same care and treatment

People with mental health and learning disabilities will be treated with respect and regard

We will treat them with the same respect and regard as those with physical health issues

They will have the same access to services

We will improve their life chances

We will develop and support our staff

We will create a flexible workforce

Coming together in neighbourhood hubs and specialist centres

Offering the best and most appropriate care

What next?

We will further develop our understanding of the three gaps including resources early- October

We expect local conversations with patients, voluntary groups and partners to have progressed by mid-October

NHS

We expect to develop our STP ambitions further by mid October

We expect to develop firm proposals and to share these more widely in the New Year

Contact us:

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Shaping Sheffield: The Plan

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Created By: Nicki Doherty
Illustrated by: Kate Woods

Shaping Sheffield: The Plan

Shaping Sheffield Stakeholders:

Burton Street Foundation
Carers' Centre
Cavendish Centre
Chesterfield Royal Hospital FT
Citizen's Advice
Common Purpose
Community Pharmacy Sheffield
Creative Pathways
Creative Sheffield
Darnall Wellbeing
Disability Sheffield
Equalities and Involvement
HealthWatch Sheffield
Heeley City Farm
Heeley Development Trust
Horizon Care
Imam Sheikh Mohammad Ismail
Inspire UK
Manor and Castle Development Trust
Meadowhall
Mixim
PACES
Primary Care Sheffield
Public Health
Reach South Sheffield
Sheffield 50+
Sheffield Age UK
Sheffield CCG
Sheffield Chambers of Commerce
Sheffield Children's Hospital FT
Sheffield Churches Council for Community Care
Sheffield City Council
Sheffield City Counsellors
Sheffield City Primary Care Localities
Sheffield Equality Hub
Sheffield Hallam University
Sheffield Health and Care Trust
Sheffield Health and Wellbeing Board
Sheffield International Venues
Sheffield Jesus Centre
Sheffield Local Medical Committee
Sheffield Mencap
Sheffield Mind
Sheffield Save Our NHS
Sheffield Teaching Hospitals FT
Sheffield Walk In Centre
Sheffield Young Carer's Project
Shipshape Community Health
SOAR
South Yorkshire Fire and Rescue
South Yorkshire Housing
South Yorkshire Passenger Transport Executive
South Yorkshire Police
St Luke's Hospice
St Mary's Community Centre
St Wilfred's Centre
Survivors of Depression in Transition
The Key Fund
The Rock Christian Centre
University of Sheffield
University Technical College (UTC)
Voluntary Action Sheffield
We Love Life and Recovery Enterprises
Yorkshire Ambulance Service
Zest Community

Contents

Foreword

The Sheffield Plan has been developed through partnership across public sector, commercial sector, voluntary sector organisations and members of our public.
It draws on inputs through the engagement and design of our health and care services as well the priorities set out in key documents including the Sheffield Health and Wellbeing Strategy, the Five Year Forward View, GP Forward View, Mental Health Forward View, Community Pharmacy Forward View, Facing the Future and National Cancer Strategy.
The development of the plan has been overseen and driven via the Transforming Sheffield Programme Board:

Insert quote from John Mothersole, CEO Sheffield City Council

Insert quote from Julie Dore, Chair Sheffield HWB

Insert quote from Maddy Ruff, AO Sheffield Clinical Commissioning Group

Insert quote from Tim Moorhead, Chair Sheffield HWB and SCCG

Insert quote from Sir Andrew Cash, CEO Sheffield Teaching Hospitals Foundation Trust

Insert quote from Greg Fell, Sheffield DPH

Insert quote from Dr Andy Hilton CEO Primary Care Sheffield

FIRE?

Insert quote from Kevan Taylor, CEO Sheffield Health and Social Care Trust

POLICE?

Insert quote from Simon Morritt CEO Sheffield Children's Hospital Foundation Trust

Healthwatch?

Plan on a Page

About Sheffield

- This city is confident about its future, but knows that it must also face up to and deal with its challenges for that future to be successful and fair.
- A record of and commitment to systems leadership
- A successful city with established record of partnership working
- A cultural city
- The UK's first National City of Sport
- Three hospitals offering specialist services
- Primary Care Sheffield: unifying primary care
- Two Universities
- Two University Technical Colleges

The Sheffield Challenge

- The people of Sheffield are not living lives that are as long and as healthy as they could be.
- Projections show that the money that we have to spend on supporting people when they become ill and to help them live long and healthy levels will not be enough to keep everything that we do now in place.
- If we can better help people to live longer healthy lives then there will be less ill-health, less demand for medical and care services and therefore more money for those services that will still be needed.
- There are inefficiencies in how money is currently spent,
- We need to find the money and actions that see people living longer and healthier lives

What We Are Going To Do

- Invest in our future generations: early years and families, education and building and supporting aspiration
- Invest in prevention, with a focus on cardiovascular disease and diabetes
- Help more people back to work, with stronger health and employment connectivity
- Strengthen Primary Care to meet todays needs and future needs
- Help more people to stay at home through self-care, support in the community, and pathway coordination
- Design an infrastructure that supports this that evolves in support of the way of working that we design

What Does Success Look Like?

- Fewer people going to hospital
- Reduced inequalities across the city
- Measureable improvement in health and wellbeing, including education and employment
- Improved experience, including good access to services when people need them
- Services that demonstrate value for Sheffield people
- Efficient use of estate and back office functions

Governance

We will have a structure that assures Sheffield that we will deliver what we have set out to.

- Shaping Sheffield will bring the city partners together to shape our direction as we transform and to align our work to support transforming
- Transforming Sheffield will deliver the programmes of work under the direction of the Chief Executives across Health and Care
- The Health and Wellbeing Board will have oversight of progress in delivering our Health and Wellbeing strategy
- Planning will be done collaboratively through a Strategic Planning Group responsible for a co-production agenda
- Significant service decision will have public consultation and go through the overview and scrutiny committee

The Sheffield Pound

- Single health and care account for Sheffield
- Payment mechanisms that incentivise the behaviours needed to make our transformation work
- Investing in prevention and primary care

Sheffield Now

'We have one of the greatest opportunities available to us to make Sheffield a person-centred, healthy and successful city'

Sheffield is a city and metropolitan borough in South Yorkshire. We have a strong track record for working in partnership across all public sectors through well established networks, for example the Working Together Programme. This partnership approach has been recently strengthened by the established Sustainability and Transformation Plan (STP) agenda.

With the Peak District on our doorstep, excellent culture through our theatres, museums, parks and activities, and nationally prominent organisations with a track record for success (Fig 1), and a wealth of national leaders across our public and voluntary sectors, we have one of the greatest opportunities available to us to make Sheffield a person-centred, healthy and successful city. Collectively we spend circa £1.2bn on health and care for the city.

In spite of this Sheffield has consistently lagged behind the England average for health and social care outcomes. We know that Sheffield has for the last ten years not delivered its potential to reduce the substantial gap in healthy life expectancy:

- Over 20 years between the most and least deprived men; 25 years for women; up to 20 years for people with serious mental illness or learning disability
- 40% of current illness in the city is either preventable or 'delay-able' and the financial benefit of reducing this matches the moral imperative to do so
- We know why; because no one organisation has it in its power to deliver this, it requires whole system solutions where every member understands their role.

The Sheffield Plan

This plan, under the umbrella of Shaping Sheffield and the Transforming Sheffield Programme addresses that. By developing our whole systems leadership at the most advanced level and by working with national partners and regulators we will ensure we deliver real change and close the gaps that we have previously been unable to fully address.

Fig 1. Sheffield Strengths

Co-terminus citywide council and CCG: citywide commissioning
A strong city council with a Devolution agenda
Two acute hospitals also providing specialist tertiary services to South Yorkshire and Bassetlaw and beyond
Sheffield Health and Social Care Trust
Primary Care Sheffield
Track record of strong partnership Transforming Sheffield Programme
Two major universities: training; research and development
Two University Technical Colleges, one for Health and Wellbeing
Shortlisted to be the first city designated as UK City of Culture
The UK's first National City of Sport
Innovation: Vanguards, Test Bed, Prime Minister's Challenge Fund
Meadowhall

The Sheffield Vision

Mission

The mission is simple. It is for the people of Sheffield to live long and healthy lives with affordable and quality support in place to help them do that.

Vision

To be recognised nationally and internationally as a person-centred city that has created a culture which drives population health and wellbeing, equality, and access to care and health interventions that are high quality and sustainable for future generations.

We will have a reputation for working in partnership to co-produce, improve outcomes, experience and inclusion and to influence national policy and regulation; this will be visible in our success.

Aims

- Develop Sheffield as a healthy and successful city
- Increase Health and Wellbeing
- Reduce Health Inequalities
- Provide people with the help, support and care they need and feel is right for them
- Design a Health and Wellbeing System that is innovative, affordable and offers good value for money
- Be employers of caring and cared for staff with the right skills , knowledge and experience and supported to work across organisational boundaries
- Deliver excellent research, innovation and education
- To develop and expand specialised services for children and adults across the region

Challenge

At one level, our challenge is clear. At present, and on average, the people of Sheffield are not living lives that are as long and as healthy as they could be. At the same time, projections show that the money that we have to spend on supporting people when they become ill and to help them live long and healthy levels will not be enough to keep everything that we do now in place. If we can better help people to live longer healthy lives then there will be less ill-health, less demand for medical and care services and therefore more money for those services that will still be needed.

We also know that there are inefficiencies in how money is currently spent, sometimes because we spend money on the symptom and not the cause and sometimes because we don't join-up enough to get the best value.

Our challenge now is to find the money and actions that see people living longer and healthier lives and also to change how we do things and what we do to get more out of what we spend, and to design this approach in a way that enables our communities to support the plan. We need to start doing this now and with a sense of urgency.

New Models of Care

'Increasingly we need to manage systems – networks of care – not just organisations' – NHS Five Year Forward View (FYFV)

Overview

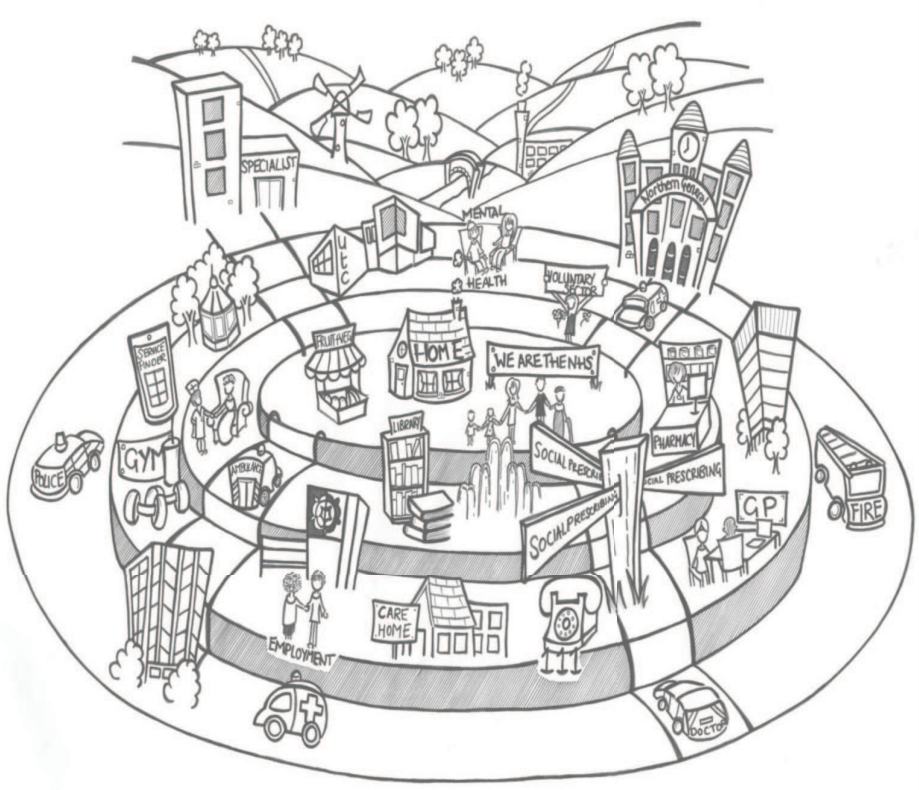
More care will be provided closer to home with services designed around the person and will work in levels depending on need. These levels are:

1. Person, Household, Family and Friends – for example care assessments, self-care
2. Neighbourhood (30k-50k population) – for example employment advice and support groups
3. Locality (120-150k population) – for example urgent care centres
4. City – for example the services provided in hospital
5. Beyond City – for example ambulance services

Each level requires increasing expertise/input and has less demand per head of population than for services in the levels below

How

In order for this to work existing providers will need to work differently, with workforce working flexibly across organisational boundaries and services being delivered collaboratively. An Accountable Care System model will be used to enable this, supported by the established Memorandum of Understanding. At locality level we will see Multispecialty Community Providers delivering services.



Shaping Sheffield

Overview

By using our collective strengths, resources and expertise we will work jointly to remove the barriers that have historically prevented us from realising the full benefits of our programmes. Success will be evidenced through measurably achieving our aims and ambitions.

Shaping Sheffield:

- Brings together the city with a shared goal to improve the Health and Wellbeing of our Sheffield citizens
- Listens to the city's voice using patients, citizens, business and service providers to shape the strategic direction and plans to deliver it
- Agrees key actions and jointly commits to making them happen; this is not just for health and care to solve

Click here for videos and packs for the Shaping Sheffield Programme

Transforming Sheffield Programme

The Transforming Sheffield Programme Board represents the Chief Executives of our Health and Social Care organisations . It has signed up to the principles below to secure our collective success in realising our vision, our aims and our ambitions.

Transforming Sheffield Programme Board Principles:

- Collectively committed to a single plan for Sheffield and for its successful delivery
- Transparency and openness about organisational challenges, risks and development
- No unilateral changes without understanding the wider system impact
- Solving system problems will be a collective responsibility
- Provide a collective and united front to external policy and regulation development
- Seek to be ambitious, learning from each other and our partners

South Yorkshire and Bassetlaw Sustainability and Transformation Programme (STP)

This plan is an regional plan that brings together opportunities for better ways of:

- The radical upgrade in prevention
- health and care services that increase quality in care (for example where the is specialist expertise required)
- services that offer greater value for every pound spent (for example back office functions)

This over arching STP sets out high level expectations for local service provision and therefore the Sheffield Plan, and in turn the Sheffield Plan sets out expectations of the STP

Why Sheffield Has to Change

Health and Wellbeing System Challenge

In Sheffield we have defined four key system challenges to improving population health and wellbeing and to providing high quality sustainable services to our population. This plan needs to address each of these four areas. We will specifically set out what each of theses challenges mean.

The scale of the challenge demands:

- a significant step change in the scale and pace in service transformation
- importantly the way we work in order that we are able to provide affordable and sustainable services

This will depend upon us working together as a city in a partnership of:

- Patients
- Public
- Voluntary sector
- Commercial sector
- Religious sector
- Public sector

The means planning for the future through:

- a radical upgrade in prevention
- streamlining and aligning services that work independently of organisational boundaries
- tackling the broader determinants of health and wellbeing.

The NHS Five Year Foreword View reinforces this approach and provides us with an opportunity to genuinely transform the way we work

The Case for a Radical Upgrade in Prevention

'If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.' Simon Stevens, FYFV

Why take prevention seriously?

- Illness is driving the growth in demand for services, not ageing
- Therefore prevention is the only long-term sustainable solution to:
  - reducing need of individuals for state-funded care; AND
  - reducing cost
- Our current models of health and social care are not meeting population health needs or delivering prevention
- Current incentives are misaligned – despite the Wanless Review recommendations in 2002, the investment in prevention has not moved beyond the 'slow uptake' scenario
- Continuing with this status quo is financially and clinically sub-optimal and harms future populations through avoidable illness and complications
- At least 40% of illness is preventable or 'delay-able' but only 5% of the total healthcare budget is spent on prevention
- Contrast this with the fact that the direct healthcare costs of treating diseases caused by smoking have been estimated at 6.5% of the total healthcare budget
- Prevention can contribute to reduced healthcare demand and costs in the short term e.g. reduction in smoking prevalence reduces hospital admissions for heart attacks and strokes over 5 years

What Does the Radical Upgrade in Prevention Do?

1. Improve life chances by expanding and developing employment pathways for people furthest from the labour market

2. Achieve healthier lives by developing a 'Heart of Sheffield' programme to deliver healthy public policies and services at scale

3. Enhance neighbourhood and GP services by developing comprehensive local services that support people to better manager their own health and stay well in their communities

The Health and Wellbeing Challenge

Overview

Over the last 10 years, Sheffield's position relative to the rest of the country has remained virtually unchanged for most health and wellbeing indicators.

Sheffield continues to lag behind the England average on most outcomes including life expectancy, healthy life expectancy, educational attainment, unemployment and housing.

The gap in healthy life expectancy in Sheffield is substantial: over 20 years between the most and least deprived men; 25 years for women; and up to 20 years for people with serious mental illness or learning disability.

Wider Determinants of Health

- Almost 23% of all Sheffield children live in poverty compared with 18.6% nationally.
- 69.9% of Sheffield children in Year 1 achieved the 'school readiness' standard compared to 74.2% for England. Children with free school meal status achieved only 57.1% in Sheffield compared to 61.3% for England
- 6.6% of Sheffield's 16-18 year olds were not in education, employment or training in 2013 compared with 5.3% for England
- 11.3% of households (26,604) in Sheffield experienced fuel poverty, compared with 10.4% in England
- 11.4% of Job Seekers Allowance claimants in Sheffield are long term claimants (greater than one year), compared to 7.1% for England

Health Improvement

- Smoking, physical inactivity, poor diet and alcohol misuse make up the four main health risk behaviours responsible for the four main causes of early death (cancer, cardiovascular disease, respiratory disease and liver disease)
- The proportion of Sheffield mothers smoking at the time of the birth of their baby is consistently higher than the national average (15.1% in 2014/2015)
- Despite an overall reduction in teen pregnancies, Sheffield's rate remains significantly higher than the national average (24.3 per 1000)
- The number of alcohol related hospital admissions is increasing and in 2012/2013 was 706 per 100,000 population, significantly higher than the England rate of 637

Health Protection

- Just over half of all patients newly diagnosed with HIV in Sheffield are diagnosed late (51%), which is significantly higher than the figure nationally (45%). Late diagnosis is associated with poorer patient outcomes and higher healthcare costs
- The incidence of TB in Sheffield has increased from 10.5 new cases per 100,000 population in the early 1980s to 16.7 per 100,000 in 2011-2013 (approximately 100 new cases per year); significantly higher than the England average

The Care and Quality Challenge

Demand

- Aging population with increased diagnosis of long term conditions as well as co-morbidity
- Increased patient expectation
- With more people working longer those able to care for their relatives are reducing, putting more pressure on care and support services
- Significantly high number of delayed transfers of care
- Variation in rates of cancer mortality across the city
- We have more long-term admissions to care homes per 100,000 population
- We have fewer people at home 91 days after leaving hospital

Value

- The Better Care Better Value Tool (Fig 1) identifies areas where there is an opportunity for us to redesign services to reduce hospital based activity that is either better provided in another setting or not at all:
  - Reducing length of stay
  - Reducing emergency readmission within 14 days
  - Managing the number of follow-up; appointments
  - Patients not attending appointments
- The Right Care tool identifies procedures that offer limited clinical value; these need review

Access

- Access to adult services, against national targets, is challenged (Fig 2)
- Access to children's services meets or exceeds national thresholds (Fig 2)
- The proportion of people receiving IAPT moving into recovery is a new measure and plans are in place to improve
- Cancer Screening coverage for the Sheffield population is above national average for all programmes

Experience

- Poor experience can happen when multiple agencies are involved
- Complaints feedback indicates themes including communication and values and behaviours.
- The Annual Healthwatch report also identifies themes including:
- Waiting too long for a service, or not getting help early enough
- Physical and mental needs treated separately

Fig 1. Better Care Better Value Tool: The Sheffield Opportunity

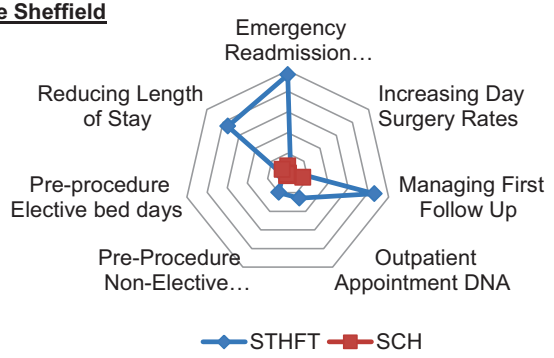
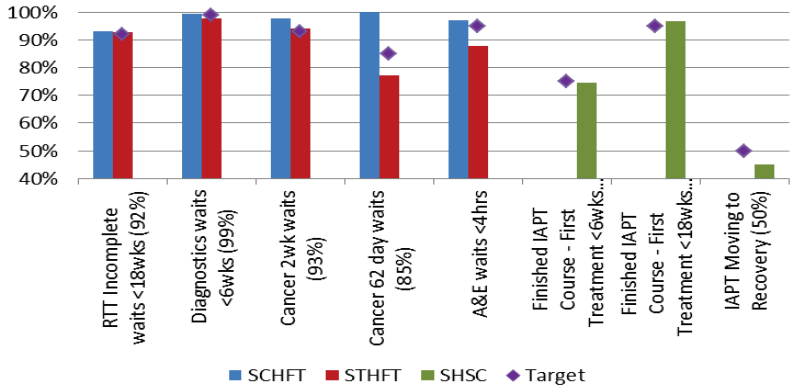


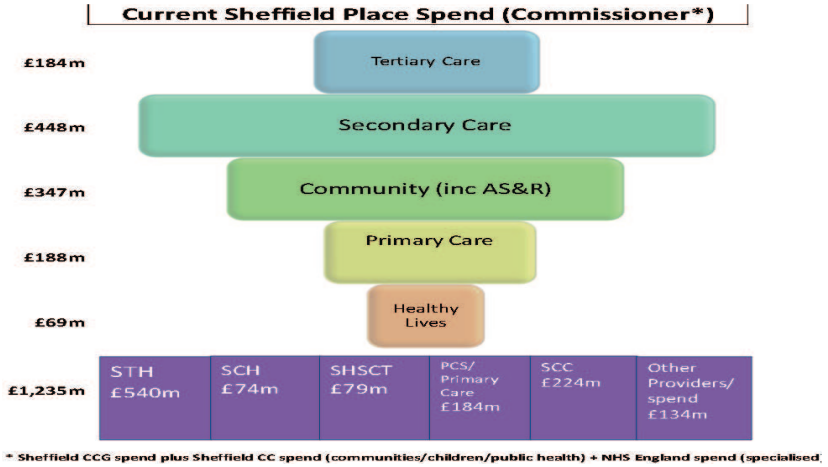
Fig 2. Sheffield Healthcare Provider Performance



The Finance and Efficiency Challenge

STP process requires NHS organisations to calculate per national rule set

- CCGs – Compares our allocation with projected expenditure.. Thus includes price and demand led cost pressures, together with investment to meet FYFV national priorities in primary care and mental health. Gap (or efficiency target) is derived by assuming we meet business rules eg 1% surplus each year as well as pressures/investment requirements.
- Sheffield CCG has allocation uplift which is well below average in all years to 20/21 as adjudged to have existing funding more than 5% above "fair shares" target funding, which means our financial gap likely to be higher than average.
- Trusts – Gap comprises any historic deficit plus the 2% efficiency requirement pa embedded in national NHS prices and as a result of expected loss of other non activity based income eg national education & training grants.
- Following new guidance ALL organisations are assumed to deliver 2016/17 control totals and hence deliver QIPP/CIP (ie efficiency) programmes in full and recurrently. Hence the Gap now looks at 4 years from 2017/18.
- No guidance on how Local Authorities calculate their Gap. Currently confirming approach across the 4 South Yorkshire LAs covering adult & Children's social care and PH grant
- No organisation able to assume any share of national STP funding. Sheffield Trusts should receive c£22m sustainability funding non recurrently in 2016/17. Trusts will similarly receive non recurrent support in 2017/18 and 2018/19 but amounts to be confirmed. For 2020/21 the South Yorkshire and Bassetlaw STP area has an indicative allocation of £105m. The element which Sheffield might receive as part of this will play out as part of resolving SY&BL system wide STP plan.



Solutions have to be mapped to NHS efficiency programme headings for STP but broadly fall into 3 categories:

- Individual organisational business as usual (BaU) efficiencies – Trusts must deliver min 2% either through Carter workstreams e.g. rationalisation of back office functions and estates or other actions; for CCGs main area of BaU is GP prescribing; LAs to identify efficiency proposals
- Reduction in demand in particular for acute hospital care (urgent and elective) but also long term nursing and social care. Modelling continues as to whether we can simply reduce the growth in activity or are actually able to reduce activity below 2016/17 levels. This is important particularly as the first avoids the need to increase capacity etc. but the second requires a reduction in workforce, estate etc and likely therefore modelling suggest can't expect to release 100% of costs in short-medium term. The Local health & social care Place Based Plans are seen as primary source of identifying solutions to reduce demand, including enhancing out of hospital capacity, self care and prevention actions.
- Reconfiguration of acute services where these could lead to consolidation of the number of sites from which selected services are provided. This is to ensure resilience and quality of service as well as potentially reduce costs for providers. Costs for commissioners assumed to stay the same if volume of activity remains the same.

Deficit Summary (Do Nothing)	2017-18	2018-19	2019-20	2020-21
	£m	£m	£m	£m
CCG	-£30	-£49	-£64	-£75
STH	-£36	-£53	-£68	-£85
SCH	-£6	-£10	-£14	-£18
SHSC	-£4	-£6	-£8	-£11
SCC	-£21	-£30	-£38	-£46
Headroom*				tbc
Total Health and Social Care	-£96	-£147	-£191	-£235

* additional savings targets to deliver prevention investment/allow for slippage

The Culture and Leadership Challenge

'Like the Hungarian soldiers, Academy participants found that having the 'map' (the theory of large scale change) and using it to guide their actions, made them more confident, competent and effective in their ability to achieve their goals for change'

— Helen Bevan; Leading Large Scale Change

Overview

- We often don't fully understand the pre-conditions needed in order to really make change happen
- By not defining causal links and behavioural drivers we often don't see the full benefit or impact of planned changes and therefore in spite of can feel like successful implementation of a transformational project we still face the same problem
- Often the timeframes we set ourselves for designing and implementing change are challenging and taking time to understanding the theory behind it is compromised
- We need to be clearer on how we get from where we are to where we plan to be (really be)

Leadership and Behaviours

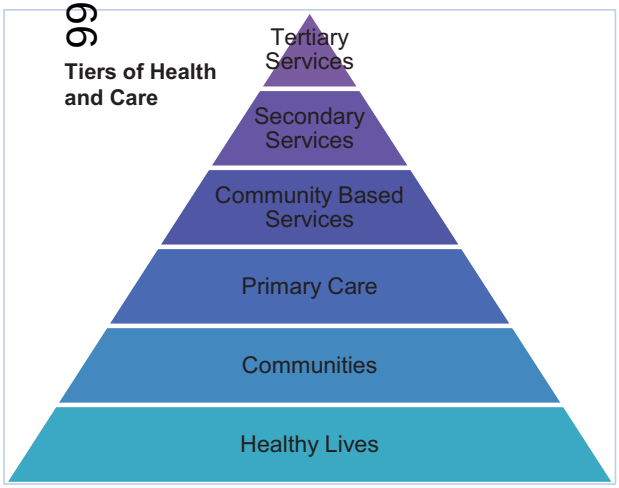
- To drive the innovation, creativity and socio-economic development required to close the health and wellbeing, care and quality and finance gaps we must first close our leadership gap
- As a system we have been experiencing significant and rapid change, and there is more ahead. This kind of changing environment requires the leadership capacity needed to adapt and succeed in the future.
- Our challenges are multi-dimensional as we face a range of complex needs.
- We need to develop strong and consistent leadership across our system using shared strategies and behaviours. This in turn will shape the behaviours across the system both in our workforce and in the Sheffield people
- The challenge to create the space to do this has never been greater

What Are We Going To Do?

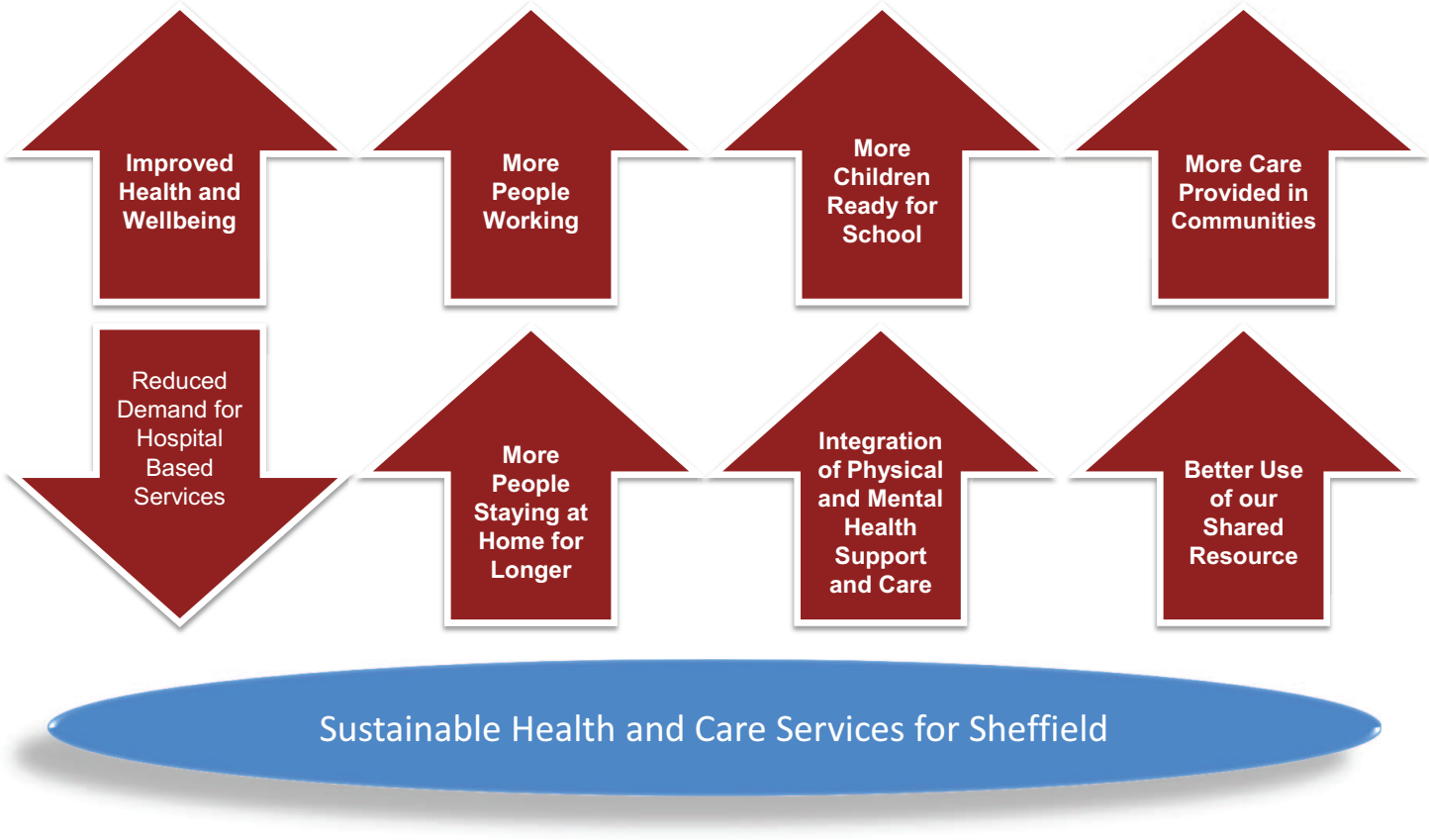
Overview

The plan draws together key programmes of work across the city that are focussed on improving health and wellbeing in a sustainable way. It uses tiers of health to set out how each of those programmes impacts across the system.

This page summarises the key programmes that Sheffield is committed to over the next 5 years. We then describes the timeframes and then how these look against each of the tiers of health (where there is also more detail about what sites within each programme. (See page 36 for detailed outcomes)



IMPACT



How Are We Going To Do It?

Overview

IN DEVELOPMENT

We have identified a number of programmes of work spanning the tiers of health that will deliver the impact/outcomes described on page 16.

Success requires prioritised programmes agreed and owned by the whole system. The Transforming Sheffield Programme Board has had a session working through the detail of the plan as it stands and will be convening again to agree what this needs to look like. Broadly the areas on the right are the programmes of work that the plan sets out, with year one describing the priorities identified as part of the first Transforming Sheffield Programme Board timeout.

Additionally PWC is doing a piece of work to develop the detail behind our financial strategy that includes investment and savings and a year by year outline of how we will shift spend from acute to community services. This will also contribute to informing where we focus our efforts to ensure maximum impact on shaping Sheffield in a way that transforms our services using models that are sustainably fit for the future.

Development timeline:

Programmes	*Year 1*
Early Years and Families	We will empower parents, families and carers to provide healthy, stable and nurturing family environments
Education and Aspiration	We will Implement a new Vulnerable Young People's Service We will Increase the proportion of school ready children
Heart of Sheffield	We will recognise the link between employment and physical and mental health and help more people into work
Helping More People into Work	
We Are The NHS (self-care and social prescribing)	We will agree a single risk stratification process for our population and agree how we use this so that we can then target our resources so we can help those most at risk
Strengthening Primary Care	We will invest heavily into the development of neighbourhood working
Care Planning and Person Activation	We will work with our staff and teams to promote flexibility, to promote patient centred services and to promote a culture in Sheffield where staff across organisations are enabled to resolve difficult issues which impact on patients and communities
Help to Stay at Home	
Accountable Care System with MCPs	
Referral and Pathway Coordination	We will tackle inequalities head on by making disproportionate investments in effort and resources into those communities with most need

Timeframes for Delivery

IN DEVELOPMENT

See commentary on page 17

1. People Living Healthy Lives

Why Is This A Priority?

The cost to Sheffield of avoidable illness and disease is in the region of £m.
The broader determinants of health and wellbeing need to be a key part of our plan as they will both reduced preventable illness and disease and close the inequalities gap. If left unaddressed the increasing demand for more expensive health and care interventions will continue with costs exceeding what we are publicly able to afford.
A radical upgrade in prevention is essential and the Sheffield Plan sets out strong ambitions for making this a reality.

What Does Feedback Tell Us?

"Sport activities/interests could be used for education and screening awareness in men. Different types of method need to be used for different communities."
"Work with other departments such as education, housing, transport, town planning, police etc. to work on the wider determinants of health. Security and safety are essential to good health."

Outcomes/Impact

- Reduced gap in healthy life expectancy from 20 to 15 years between best and worst off
- Children healthy and 'learning ready' at age 4 increase from 66% to 75%
- Fewer young people not in employment, education or training
- more people moving into economic activity or meaningful employment
- Reduced impact of social isolation

Heart of Sheffield

A radical upgrade in prevention. We will
- Scale up smoking and alcohol brief interventions at all points of patient/client interactions; done at scale. Includes National Diabetes Programme
- Implement a model of life style services that scales up an affordable level off support; targeting those groups that will benefit most
- Implement healthy public policy initiatives, making the healthy choice the default and easiest
- CVD risk factor management at scale

Helping More People Into Work

Supporting people moving into meaningful economic activity or meaningful employment. We will:
- Put in place new and expanded employment pathways will enable referrals from health into employment and from employment into health; keeping people well at work and helping people back into work
- Have mentally healthy workplaces through implement the Mindful Employer Programme across all organisations
- Support people in their return to work

Education and Aspiration

Supporting children and young people in education and to achieve their aspirations we will:
- Implement a new Vulnerable Young People's Service; targeted multi-agency early intervention and prevention ; improving key outcomes and life changes for c. 1000 teenagers and young adults per year
- Increase the proportion of school ready children through a programme of initiatives including targeted early learning initiatives and partnership development

"Insert a quote from one of TSPB/HWB/GB members"

People Being Well

Sheffield people will get support they need to stay well by:
- Promote Five Ways to Wellbeing to reduce the impact of social isolation on people with learning disabilities, mental ill-health, autism and dementia
- Single point of contact for health professionals to make patients' houses warmer
- Falls Preventions Service (reducing number of elderly fallers – top callers for ambulances

Working in Partnership

- Work with Age UK to reduce social isolation and loneliness in older people
- Work with voluntary and commercial partners to align prevention, health and wellbeing agendas and maximise impact through aligned priorities and work
- Feed into and draw upon the South Yorkshire and Bassetlaw Chief Fire Officers Health and Wellbeing Programme
- Improve the standard of private rented sector housin; focus on the key impacts of poor housing on health and wellbeing.

The Sheffield Pound

PWC bit
We will invest £x over the next x years to support these programmes
We will take opportunities through existing programmes by making every contact count and service contracts will include requirements to proactively promote the city's prevention and wellbeing agenda (MH EoLC)
Return on Investment:…
Commissioning for Social Value
SIBs/Commercial partnerships
Looking at portfolio of Social Investment to create a single sig. fund for Sheffield

2. Strengthening Communities

Why Is This A Priority?

Strong communities are essential to good health and wellbeing and building individual resilience and independence . By strengthening our communities we will improve physical, emotional and mental wellbeing, we will promote healthier lifestyles and we will provide clear and simple signposting to services and support that enables people to take control of their health. People will feel supported and able.

What Does Feedback Tell Us?

"Need to celebrate community/voluntary support as they take on more care responsibilities."
"Rural communities seem to have a stronger bond. How do we create that spirit in pockets of a city? Communities used to be built around churches or pubs, could health centres be made into community hubs."
" 'Walter' used to call 999 all the time and an ambulance would come and he would be admitted to hospital. He was supported by a Community Support Worker. Avoided 999 calls and hospital admittance. He was just a lonely man."

Outcomes/Impact

- Reduced demand on the secondary care system (elective and non-elective admissions and attendances)
- More People Cared for at Home
- Increased level of Person Activation
- Best Start metrics?

We Are The NHS

- Major shift to supporting people to take ownership and control of their own health and wellbeing - e,g, referral to info, advice, community activities and support.
- Peer support **will be an assertive first response** to presenting issues such as low level depression, obesity, aches and pains; a social prescribing approach.

People Keeping Well

- Radical upgrade to emotional and mental health wellbeing services (e.g. increased access to talking therapies and peer support groups, mental health services coordinated with other services at neighbourhood level)
- New Home Care support arrangements: local, responsive, flexible and personalised
- Improve Health Literacy In Sheffield
- Improve support to carers, reducing carer stress and ill-health

Early Years and Families

- Improve access to health and wellbeing initiatives for children and families
- Empower parents, families and carers to provide healthy, stable and nurturing family environments
- Engage families in local communities to influence and play a positive role in shaping activities and services
- Reach into our communities and ensure that service provision is accountable to local communities and response to community

"Insert a quote from one of TSPB/HWB/GB members"

Successful Young People

- **Successful Young People -** targeted support for 1,000 at risk teenagers and young adults though integrated, multi-agency teams combining youth and health workers, police officers and a range of advice and support services. Zero Tolerance approach to suicide prevention

Working in Partnership

- Working with Voluntary Sector, Religious Sector and Commercial Sector partners to align community and neighbourhood programmes giving a consistent message, consistent support and creating the greatest opportunities for communities to take full advantage of the support and activities available to them
- Linking across established programmes such as Learn Sheffield . Healthy Minds Framework and Move

Making the Money Work

PWC bit
We will invest £x over the next x years to support these programmes
We will take opportunities through existing programmes by making every contact count and service contracts will include requirements to proactively promote the city's prevention and wellbeing agenda
Return on Investment:…
Commissioning for Social Value

3. Primary Care For Now and For the Future

Why Is This A Priority?

General practice is under significant pressure. With more care moving to local primary and community settings both General Practice and Primary Care (including pharmacy, optometry, dentists) in general need to be redesigned to meet demand, provide the right services by the right professionals and support patients to manage their own health and wellbeing as well as more easily navigate the services available to them.

The GP Forward View sets out a case for practices working at scale, at a neighbourhood level. Additionally as we move more care into community settings, primary care services will need to be configured to respond to this; recognising that people with long term conditions need a more holistic approach.

What Does Feedback Tell Us?

"Health Centres should be designed as community hubs with newsagents, other services, libraries."
"Continuity of care and access to care for people with mental health problems and disabilities.."

Outcomes/Impact

- Strong and sustainable General Practice as part of Primary Care through access to services and that supports continuity
- Reduced demand on the secondary care system (elective and non-elective admissions and attendances)
- More People Cared for at Home
- Increased Access to Primary Care across the week
- Best Start metrics?

Primary Care Services

- Targeted and increased sexual health provision available and offered across primary care settings
- **Midwife led care in every community** – new family centres to support new mums and dads to make a healthy and happy start to family life. Strong focus on those at risk of struggling with family life
- Supporting self-care and independence through promoting healthy living and sign posting to community support
- Increased use of tele-health to support self-care
- Develop child and adult

A Multi-Disciplinary Approach

- Neighbourhoods working across health, social care, voluntary sector, police and housing to design and coordinate services that meet the needs of that neighbourhood
- Use of care plans for those with long term conditions, increasing patient confidence, knowledge and skills for them to manage their own health and wellbeing as well as providing informed and smooth handover of care over of care between partners.
- Increasing person activation in their own health using the Person Activation Measure (PAM) as a tool

A Consistent Offer

- A Sheffield-wide locally accepted model of care with agreed and followed pathways. For primary care this means referral guidelines, adhering to prescribing policy and reducing variation in clinical practice
- Access – extended access through 111 and local clinical hubs ,offering consistent access across all localities
- Clinical Assessment s, Services , Education and Support (CASES) will support GPs to manage patients in primary care

"Insert a quote from one of TSPB/HWB/GB members"

Estate and Infrastructure

- Greater use of technology to enhance patient care and experience (e.g. online booking and appointment management, online access to your healthcare record)
- Support practice development and Quality Improvement processes and expertise
- One Public Estate Programme
- A fit for purpose estate for now and in future for core and expanded services, aligned to practices working at scale
- Maximising void LIFT space

Working in Partnership

- Secondary care consultants support primary care to deliver strategic outcomes
- Working at scale: where demand is less services will be provided at neighbourhood or locality level
- Support practices to become key stakeholders in developing the neighbourhood working approach alongside all other health and social care providers and 3rd

Making the Money Work

PWC bit
We will invest £x over the next x years to support these programmes
We will take opportunities through existing programmes by making every contact count and service contracts will include requirements to proactively promote the city's prevention and wellbeing agenda
New funding models for local collaborations that release time for patients
Explore potential of local MCP approach as per contractual

4. Community Based Services Providing Care Closer to Home

Why Is This A Priority?

There is national and international recognition of the need to integrate services outside of hospital in order to provide safe, effective and efficient care for the increasing number of people living with multiple long term conditions. It would be unthinkable for numerous providers, with largely unconnected specifications, separate management arrangements with different objectives and plans and with different contractual arrangements, to be working within a single hospital. But health and social care services provided to the same communities, households and individuals outside of hospital are currently provided in this way.

What Does Feedback Tell Us?

"Rapid response care in people's homes/care settings instead of an ambulance taking someone to A&E because support services aren't in place."
"There should be a clear plan of what to do in a crisis."

Outcomes/Impact

- Reduced demand on the secondary care system (elective and non-elective admissions and attendances)
- More People Cared for at Home
- Reduced Readmissions
- Increase the number of people who are supported to die in their own home
- Reduce from 23 to 6 people with Learning Disability/Autism cared for in a specialist hospital

Care Planning and Coordination

- A single care plan for patients with long term conditions , at increased risk of admission or end of life that supports staying at home
- Core focus on person-centred care principles that increase and enable population level of activation across health and care
- Prevention approach to reduce incidence of common reasons for admission in frail elderly and people with dementia
- The GP will be the expert generalist and lead clinician for their patients regardless of the service providing care

Help to Stay at Home

- Primary Care supported step-up and step down provision: development of X beds and Y home support capacity to intensively support for short spells
- Model for step-up/down provision to include access to short stay Learn Disability and Mental Health placements (e.g. Section 136 beds/PDU/short breaks/respite/Intensive Home Support)

Multi-Disciplinary Working

- Multidisciplinary team working with patient centred care approach at neighbourhood level
- Multidisciplinary team meetings to agree interventions to provide support, keyworker and coordination, including links across adult, family and child services and across physical and mental health
- Where diagnostics are better provided in a community setting services will be set up accordingly
- An upgrade to psychiatric liaison services

"Insert a quote from one of TSPB/HWB/GB members"

Urgent and Planned Care in the Community

- Make more services available at community and neighbourhood level to support people remaining at home (e.g. community IV administration and diagnostic services)
- New Primary Care led Urgent Care Centre(s) to enable diversion from and demand reduction for secondary care, with one in front of A&E
- Develop "Assess to Admit" approach in the person's own home
- Emergency Care Practitioners providing in situ treatment

Signposting and Partnership

- 111 Clinical Advisory Service partnered with local clinical hubs managing care pathways; directly booking GP appointments
- Paramedic Pathfinder supporting alternatives to hospital
- The Single Point of Access will directly access all relevant services
- As well as education the CASES service will direct patients where onward referral is needed to the most appropriate services

Making the Money Work

PWC bit
We will invest £x over the next x years to support these programmes
We will take opportunities through existing programmes by making every contact count and service contracts will include requirements to proactively promote the city's prevention and wellbeing agenda
Return on Investment:…
Integrated Personal Commissioning
Personal Health Budgets

5. Hospital Based Services When Hospital is The Right Place

Why Is This A Priority?

We know that we have too many people receiving both planned and urgent care in a hospital setting. Whilst this is often the right thing there is a significant proportion of care that is either better provided in a community setting or not needed at all. We need to ensure that the hospital services work in harmony with community and primary care based services, enabling earlier discharge and a reduction in demand (new , follow-up and readmission) for hospital based services. By doing this our model of care will become affordable, people will receive care closer to their homes and we will be able to support hospital based delivery with the right workforce

What Does Feedback Tell Us?

"People are thrown off a cliff edge when they finish their treatment. There needs to be an intermediary."
"Links need to be made by the out of hours service with the relevant consultants in hospital which allows for the out of hours service to speak to the on call Registrar when they think one of their long term patients should be admitted to them directly."

Outcomes/Impact

- Reduction in follow-up
- Reduction in inpatient surgery
- Reduction in non-elective admissions
- Reduced Length of Stay
- Reduced morbidity
- Reduction in variation

Care Planning and Coordination

- Every patient admitted to have a clear plan for care and discharge from decision to admit
- Involvement of carers in assessment, care planning and care delivery
- Social prescribing infrastructure to be accessible from secondary care

Driving Value

- We will review services to ensure that they that offer value and quality. Where this is not found to be true we will work with the public to decide on which services need to be redesigned and which we should no longer provider. We will use tools such as Right Care to support this.
- Through internal and external benchmarking we will drive down unexplained variation in practice, supported by "whole journey" care pathways

Diagnostics

- Agreed "whole journey" care pathways for diagnostics and assessment, including direct access from primary care
- Radical upgrade to diagnostic access and turnaround times to reduce patient anxiety and improve outcomes through earlier intervention
- Results to be appropriately communicated directly to the patient
- **Where diagnostics (eg histopathology) are better provided on a regional STP footprint we work with partners and public to design them**

"Insert a quote from one of TSPB/HWB/GB members"

Doing Only What Hospitals Can Do Best

- Ambulatory Care Sensitive Conditions to be managed out of hospital, supported by clear pathways of care
- Increased self-care and patient initiated follow-up, supported by clear pathways and timeframes
- Pre-operative assessment outside of hospital unless clinically indicated
- Increased access to specialist advice through a range of approaches (telephone, video-call, face to face)
- Preparation before hospital attendance

Getting People Home

- Advanced surgical and enhanced recovery techniques
- Implement and embed the "Discharge to Assess" model; care needs assessed in an alternative setting to hospital
- Patients supplied with min. 7 days medications or discharge
- Electronic discharge summary sent to GP within 24 hours of A&E, Inpatient or Day case Care

Making the Money Work

PWC bit
We will invest £x over the next x years to support these programmes
We will take opportunities through existing programmes by making every contact count and service contracts will include requirements to proactively promote the city's prevention and wellbeing agenda
Return on Investment:…
Move away from payments like PbR that incentivise more rather than less hospital activity

6. Specialised Services

Why Is This A Priority?

What Does Feedback Tell Us?

"If we have to travel to go to a specialist place, then it wouldn't bother us, as long as they know what they are doing and get her better"

Outcomes/Impact

- Increased proportion of specialist activity in Sheffield
- Improved outcomes through increased expertise

Tiering of Services

Concentration of specialist elective care on sub-regional sites

Care Bundles

Ambulance

"Insert a quote from one of TSPB/HWB/GB members"

Sheffield as a Tertiary Centre

Working With Partners

- Associate STPs

Financial Strategy

PWC bit
We will invest £x over the next x years to support these programmes
We will take opportunities through existing programmes by making every contact count and service contracts will include requirements to proactively promote the city's prevention and wellbeing agenda
Return on Investment:…
Personalised Commissioning
Personal Health Budgets

Awaiting STP Plan Detail

What We Need to Make This Happen

Why Is This Important

The programme under each of our priorities will not deliver themselves. There are several enabling programmes that cut across each of the priorities and are fundamental to their success.. There are:

- Business Intelligence and Analytics
- Information Technology
- A Strategy for Estates
- Organisational Development (OD) and Workforce
- Research and Development
- Governance
- Our Digital Roadmap
- Communications and Engagement
- Finance and Resource

Investment/Financial Strategy

To be populated by PWC work??

Business Intelligence & Analytics

A single cross city Business Intelligence (BI) function that:

- optimises the BI expertise and resource
- supports 'a single version of the truth' to inform measurement, assessment and future planning

Information Governance and record sharing agreement

Information Technology

A single cross city IT function working collaboratively to:

- optimise the IT expertise and resource
- provide capacity to support implementation of the Digital Roadmap as well as providing responsive systems support to users
- implement the Digital Roadmap and Test Bed

Estates

Sheffield Public Sector Estate Vehicle

As part of the National One Public Estate Programme we will:

- Plan for integration and co-location of services where possible
- Purposefully create voids in LIFT assets, and positively relocate services to them ('Strategic Hubs'); using these to enable new service delivery models for care closer to home,
- Agree a strategy to accelerate and promote Agile Working across the Sheffield First strategic partnership members

OD and Workforce

- Task shifting: tasks moved where appropriate to less specialised workers
- Working in partnership with the universities and the colleges to develop skills across multi-disciplinary teams to support new roles and delivery of new models of care (particular focus on mental health and communications skills)
- A workforce passport that enables seamless working across organisational boundaries
- Leadership development (esp. primary care)
- Values based recruitment

Research & Development

- Development of risk stratification models for predicting health and social care use
- New contractual models that remove any perverse incentives to reducing use of medical interventions and support management of demand
- Combined models for personal health and care budgets
- New technology and treatments that improve patient outcomes and reduce spend in hospital settings
- Developing healthy public policy approach

Governance

- A single joined up communications and engagement plan to ensure a consistent and reliable message about plans and what they mean
- Clear citywide governance and leadership to oversee implementation, delivery and future planning
- A single income and expenditure account for the city

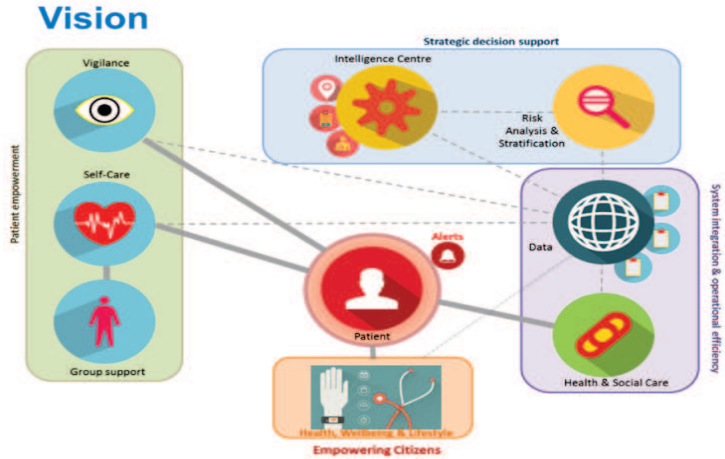
How Will Digital Technology Help?

Overview

Through the Test Bed and working collaboratively across our wider health and care region we will drive innovation and deliver cost effective digital and technology enabled solutions. Strategic infrastructure development, generating better inter-organisational interoperability and data sharing across our community, combined with innovation in patient focussed digital solutions will accelerate our ability to respond to local challenges and drive efficiencies in the delivery of high quality services to patients across our city and our region

Citizen and Patient Empowerment

Through the Test Bed and working collaboratively across our wider health and care region we will drive innovation and deliver cost effective digital and technology enabled solutions. Strategic infrastructure development, generating better inter-organisational interoperability and data sharing across our community, combined with innovation in patient focussed digital solutions will accelerate our ability to respond to local challenges and drive efficiencies in the delivery of high quality services to patients across our city and our region



System Integration and Operational Efficiency

The Sheffield health and care community have a shared commitment to achieve the 10 Universal Capabilities and 7 PF@PoC capabilities. Supplemented by shared governance arrangements this will rapidly result in system interoperability and integration. Key developments will include:

- Shared records (including N3 link to the Child Protection Information System))offering increased access to relevant, real time, information about a patient by health and care providers.
- Improved interoperability to enable more effective and efficient transfer of care across providers (e.g. through e-referral and discharge processes) supporting reduced waiting times and access to appropriate support
- Promote mobile working of practitioners through Wi-Fi accessibility and roll-out of remote working solutions for practitioners
- Promotion of remote monitoring, new forms of consultation (e.g. video, phone) and mobile health (mHealth) will also support care based in the citizen's own home, reducing the burden of routine care on patients, their carers and families, and health professionals
- Better tracking and scheduling of staff and resources will enhance operational efficiencies (e.g. via OrderComms, e-rostering, e-prescribing etc.)

Strategic Decision Support

- Use population data to help identify and provide evidence for best practice and quantitatively assess quality outcomes
- Ensure better informed clinical decisions enabling more appropriate cost effective and safe care (e.g. avoiding drug contra-indications) as well as support for safeguarding
- Increased reliance on validated risk stratification and population analytics will enable more efficient case finding and targeted intervention
- Digital solutions to measuring benefits and outcomes (e.g. collecting Patient Reported Outcomes Measures)
- Social prescribing referral system
- Improved data flows supporting more efficient resource deployment (e.g. care coordination hub)
- Population analytics to support supply/demand modelling in response to changes in population health and care needs

Communications and Engagement

IN DEVELOPMENT WITH SUPPORT OF COMMS and STP COMMS

- ***Tiers of Communication***
- ***Key Messages***

Available by 30th Sept

The Sheffield Pound

Our financial strategy IN DEVELOPMENT WITH SUPPORT OF PWC.

Available by 30th Sept

Governance and Delivery

Overview

We need a way of working that assures Sheffield that we will deliver what we have set out to.

•Shaping Sheffield will bring the city partners together to shape our direction as we transform and to align our work to support transforming

•Transforming Sheffield will deliver the programmes of work under the direction of the Chief Executives across Health and Care

•The Health and Wellbeing Board will have oversight of progress in delivering our Health and Wellbeing strategy

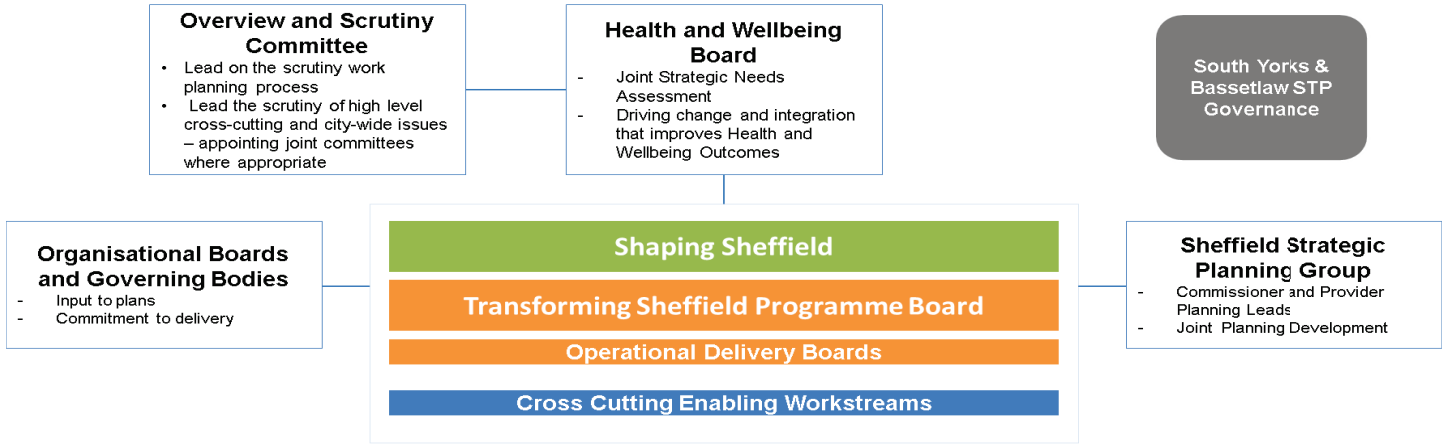
•Planning will be done collaboratively through a Strategic Planning Group responsible for a co-production agenda

•Significant service decision will have public consultation and go through the overview and scrutiny committee

Each of our priorities will have a series of robust delivery plans drawn up (where they do not already exist)

The Programme Management Offices will work in partnership to drive implementation

Governance



- Each of the delivery plans will have dashboards aligned to the outcomes described under measuring success
- These will be reviewed on a monthly basis to:

1. Measure implementation progress and map through any impact from faster or delayed implementation
2. Measure impact after implementation to provide assurance that our identified benefits are realised, make any adjustments or inform future transformation

Risks

Organisational Behaviour

Description: Each organisation has financial and delivery targets to deliver that system wide transformation may put at risk over the transformational period. Individual organisational approaches to managing that risk will potentially compromise the system wide delivery and Place Based Plan

Mitigation: Transforming Sheffield Programme Board ownership of and commitment to the plan with a risk share approach
Memorandum of Understanding in place to support development of services outside of hospital and based around neighbourhoods

Contractual and Payment Mechanisms

Description: Acute providers are currently paid by results using a tariff based system, this incentives acute activity (particularly with the hospital provider financial pressures) and therefore disincentives the intention within the Sheffield Plan to increase the proportion of care outside of hospital

Mitigation: Review of contractual and payment mechanisms with a move towards capitated budgets and a supply chain approach

Transformational Funding

Description: Funding is required that enables the investment that will be needed to deliver the transformation change before the longer term funding is available through savings made as a result of the new models of care

Mitigation: Develop Commercial Partnerships
Develop approach to using non-recurrent innovation and research funds through the Transforming Sheffield Programme Board to support transformational change.
External expertise and additional capacity from Price Waterhouse Cooper to support a robust financial mapping of investment and saving

Resource to Deliver

Description: This plan is ambitious and a real opportunity to genuinely transform the way we work in Sheffield to make a real impact for our population in a sustainable, affordable way; it will make real improvements to quality of care and health outcomes. This will not be achieved if we try and deliver it on top of "Business as Usual".

Mitigation: Develop and support a realistic and targeted resource plan that is aligned to the Sheffield Plan in a way that is responsive to 5 year delivery programme and that supports the Transforming Sheffield Programme governance structure

Regulation and Policy

Description: There will be regulations and nationally imposed policies that will not support new ways of working

Mitigation: Work with statutory and regulatory bodies to develop approaches that allow testing of the new ways of working and inform development of revised policy/regulation that support the new models of care.

Public Consultation

Description: The public response to the development and change to services required as part of this transformational approach may delay progress if not well managed. The public need to be part of the transformational work from the beginning.

Mitigation: Co-production of plans with the public
Using the collective communications and engagement resource to ensure a robust and well managed approach to co-production, engagement and consultation

Appendices

Commissioning Intentions 17/18, with provider job cards

Clinical Priorities as Described in the Forward View

The planning guidance " Delivering the Forward View" makes specific reference to delivering six clinical priorities. These are woven through each of our priority areas, but for ease we have drawn them out specifically in this section

Cancer

- Gap analysis against the National Cancer Strategy
- Active members of South Yorkshire Cancer Strategy Group and developing Cancer Alliance
- Optimise cancer screening programmes
- Implementation of the new NICE suspected cancer referral guidelines
- Suspected cancers will be diagnosed within 28 days of GP referral
- Risk stratified pathways and recovery packages for people living with and beyond cancer

Dementia

- Further develop the post diagnostic support offer in Sheffield
- Better support people with dementia and their carers to live well at home
- Maintain / continue to improve the diagnostic rate
- Dementia prevention programme
- Sheffield as a centre for dementia related research
- Improve experience of people with dementia (and their carers) at the end of life
- Develop new care pathways and services

Diabetes

- Sheffield has been selected as a first wave site to become one of the early deliverers of the National Diabetes prevention Programme
- We will deliver NHSE procured weight reduction, exercise and lifestyle change interventions targeted at people or are at risk of developing Type 2 diabetes
- There will also be joint action between the CCG and the City Council to reduce obesity in adults and children

Learning Disabilities

- Reduction in number of people requiring specialist hospital placement
- Integrated working to improve physical health of people with LD & SMI.
- Radical upgrade in psychiatric liaison.
- Set requirement for providers to have Easy Read documentation.
- Annual health checks for this population.
- Re-commission autism diagnostic and post diagnostic service with a new specification

Maternity

- Personal Health Budgets
- Clear service specification with aligned payment pathway for maternity care.
- Stimulate the market and consider the development of alternative providers of maternity care within community settings.
- Introduce new standards and reporting for improving outcomes of care within maternity services.
- Deliver the national care bundle and new quality schedule for maternity care services .

Mental Health

- Improved access for children, young people and adults to emotional and mental health wellbeing services; providing early intervention
- Expand method of access to mental health services through wider digital/IT opportunities and different talking therapy interventions being made available.
- Mindful employer programme
- Developing an integrated Primary Care Mental Health Service

What Success Looks Like

The plan sets Sheffield ambitious measureable 5 year goals as set out here. Though ambitious they are also tested and there is confidence across the system that by working in strong partnership to deliver the programmes set out they are achievable.

These are ambitious programmes of work, underpinning a commitment to measurably demonstrate achievement of our aims and ambitions through closing each of the four gaps set out in the Case for Change.
To do this each of our Transforming Sheffield programmes of work will have clear and defined metrics. These metrics will be used to assess impact as well as to feed into on-going transformation, adjusting programmes where the actions are not successful (learning from each other and our work as we go) and embedding them where they have clearly added value and had an impact.

Collectively these will achieve improved population health and wellbeing, improved patient access and experience (developing a consistent offer so that people know what to expect), and significant reductions in demand for acute services (through preventing ill health as well as providing more appropriate alternatives where hospital isn't the right care setting).

Fewer People Going to Hospital

- Increased average level of 'activation' for people with Long Term Conditions
- Fewer falls in the homes
- 5% reduction in births requiring intensive care
- Reduction from 23 to 6 people with Learning Disability/Autism requiring specialist hospital admission
- More people still at home 90 days after discharge
- 30% less non-elective admissions
- 20% less elective admissions
- 30% less new outpatient activity (adults)
- 35% less follow-up activity (adults)

Reduced Inequalities

- Overarching long term strategic outcome (20 year timescale): an improvement in overall healthy life expectancy, with greater and faster improvement n those with the poorest healthy life expectancy. Measured by reducing the gap in healthy life expectancy from 20 years to 15 years between best and worst off
- Fewer people not in employment, education or training by 2021
- 5000 more people who are currently long term unemployed moving into meaningful employment

Improved Health and Wellbeing

- Improve school readiness at the end of reception and entry into Year 1 at four: from 66% to 75%
- More people reaching national standards of physical activity
- Reduced conception rates in under 18s from 27.9 to 9 per 1000 females
- Full access for all cancer patients to all elements of the Living With and Beyond Cancer 'Recovery Package'

Driving Value

- Reduction in prescribing costs
- Greater proportion of Ambulatory Care Sensitive Conditions managed without admission
- Reduce volume of Delayed Transfers of Care to below national Benchmark
- Clinical services able to demonstrate clinical value

Experience

- More people who are mostly or completely satisfied with the health (National Wellbeing)
- More people who are satisfied with their life overall (National Wellbeing)
- Increase in average score reporting positive statements of feelings and thoughts (Short Warwick-Edinburgh Mental Well0Being Scale)
- Improved access as measured through the nationally set performance indicators
- More people supported to die in their own home

Back Office Efficiency

- Reduction in administrative and management overheads
- Reduction and more efficient use of public sector estate
- More efficient running of services across the South Yorkshire and Bassetlaw STP footprint in relation to procurement and diagnostics (e.g. pathology)

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 31 March 2016

PRESENT: Councillors Julie Dore (Chair), Leader of the Council

Councillor Jackie Drayton, Cabinet Member for Children, Young People and Families

Greg Fell, Director of Public Health, Sheffield City Council

Councillor Mazher Iqbal, Cabinet Member for Public Health and Equality

Alison Knowles, Locality Director, NHS England Yorkshire and the Humber

Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living

StJohn Livesey, Clinical Lead, NHS Sheffield Clinical Commissioning Group (CCG)

Jayne Ludlam, Executive Director, Children, Young People and Families, Sheffield City Council

Dr Andrew McGinty, Clinical Lead, NHS Sheffield CCG

Judy Robinson, Chair, Healthwatch Sheffield

Maddy Ruff, Accountable Officer, NHS Sheffield CCG
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IN ATTENDANCE Sue Fiennes, Independent Chair, Sheffield Safeguarding Children Board and Safeguarding Adults Board

Richard Parrott, Strategic Commissioning Manager, Sheffield City Council

Peter Moore, Integrated Commissioning Programme Director, NHS Sheffield CCG/Sheffield City Council

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Tim Moorhead, Dr Nikki Bates, Maggie Campbell, Laraine Manley, Dr Zak McMurray, John Mothersole and Dr Ted Turner.

2. DECLARATIONS OF INTEREST

There were no declarations of interest from Members of the Board.

3. PUBLIC QUESTIONS

3.1 Public Question Regarding Social Prescribing

Nicola Smith asked what the plans were in Sheffield as regards the introduction of social prescribing, so that people were best able to access support to stay well and have a lasting recovery if they had been unwell.

Dr St John Livesey responded that social prescribing was something which had to be made to work well and there was a good example of social prescribing working successfully in Rotherham. Third sector organisations were involved, through organisations such as Voluntary Action Sheffield. The Clinical Commissioning Group (CCG) and City Council lead on this matter was Peter Moore. This was part of the wider 'People Keeping Well' workstream and improving the co-ordination of referrals by primary care to services provided by the voluntary and community sector.

Councillor Mazher Iqbal stated that Voluntary Action Sheffield had hosted a Social Prescribing summit in 2015 and the Council was working with the CCG to produce a framework. A number of third sector organisations were part of the community wellbeing programme and it was acknowledged that there was need to improve the co-ordination of services.

Councillor Mary Lea said that social prescribing could be used to address the particular needs of individuals.

3.2 Public Questions Concerning People With Learning Disabilities and Employment

Adam Butcher asked how the Board would make sure that all members of the Learning Disabilities community and disabled community were able to gain employment, especially after a period out of the jobs market and how might they be supported with Work Capability Assessments undertaken by the Department for Work and Pensions.

Councillor Julie Dore stated that, in response to the Work Capability Assessments, local councillors did what they could to signpost people to help and the appeals process, in those cases when an individual believed an incorrect decision had been made or a decision was unfair.

Councillor Mazher Iqbal stated that the Council funded the Citizens' Advice Bureau, an organisation which collected data and carried out work in relation to benefits sanctions. There had also been a debate in Parliament concerning Work Capability Assessments in February 2016. Work was being done across Cabinet portfolios in relation to the re-design of support for people who had been away from the jobs market for a long period.

3.3 Public Questions Concerning the Better Care Fund

Mike Simpkin asked several questions relating to the following report submitted to the Board: *Sheffield's 2016/17 Draft Better Care Fund Submission,* as follows:

1) *In reference to governance*: How does the Board think its responsibilities and decision-making will be affected by the increasing number of sub-regional

structures appearing in the NHS, including the Working Together Partnerships, the new Testbed, and the Sustainability and Transformation Footprint for South Yorkshire and Bassetlaw?

2) What is the meaning of paragraph 8.1 in the Better Care Fund Draft Submission (p.27)? What is the accountability of the new Sheffield Transformation Board and to whom will it report?

3) Mr Simpkin stated that in reference to Para 4.2 of the report concerning a focus on those for whom there is the greatest opportunity for health outcomes improvement, there had been increasing concern that commissioning solely for health outcomes could be to the disadvantage of people with long term conditions for whom maintenance may be a more realistic ambition than improvement. He asked whether the Board was satisfied that the desired outcomes of the Better Care Fund reflect the full spectrum of patient need rather than organisational priorities and if they had been formulated with the full involvement of patients and service users.

Maddy Ruff stated that as part of planning and delivery of services, a broader footprint was being examined. The wider footprint of South Yorkshire and Bassetlaw had been covered by the Working Together Programme, although the footprint for the new Transformational Programme was not exactly the same. It was still relatively early in the process and the CCG and City Council were working with NHS England with regard to how plans would fit with the requirements of the Health and Wellbeing Board. Each CCG would produce a plan and the NHS and Sheffield City Council would work together, with that work being brought together through the Transforming Sheffield Programme Board. The governance arrangements relating to the Programme Board were being worked upon. It was positive that the commissioner and provider organisations were coming together to plan services.

Alison Knowles added that the basis of the footprint for NHS planning was the CCG, which was the accountable organisation for health services and a wider planning footprint was being looked at because of the savings required by the NHS to 2020. It was appropriate to have local planning in relation to primary care services, whereas, for some specialist services, such as stroke services, a wider planning footprint might be applicable.

Judy Robinson stated that there were good examples of working with the voluntary, community and faith sector.

Councillor Julie Dore stated that, in contrast to Manchester, Sheffield City Region chose not to deliver health and social care for the City region as a whole. The Health and Wellbeing Board would continue to look at its remit and focus in the light of emerging changes, including legislative change. With regards to Mr Simpkin's final question concerning patient need, Councillor Dore stated that the Board would consider that matter when it considered the *2016/17 Draft Better Care Fund Submission* later in the meeting.

3.4 Public Questions Concerning Adult Autism

Roger Guymer submitted questions in writing to the Board regarding the national strategy on adult autism as it affects Sheffield, as follows:

"1. I note that under Outcome 3 of your Sheffield's "Joint Health and Wellbeing Strategy - Report on Progress and Actions - September 2015", Health Needs Assessments are being undertaken or updated in relation to the following groups in Sheffield:

- Mental Health
- Learning Disabilities
- Carers
- Homeless
- Roma Slovak

Whilst I accept that attention to the needs of these various groups is commendable and highly desirable, why is there no mention of autism in Sheffield's Joint Health and Wellbeing Board's Strategy document or in the Board's Report on Progress and Actions of September 2015 (or, for that matter, in the Director of Public Health's 2015 report) when Sheffield's Joint Strategic Needs Assessment of 2013 says that *"There are as many as 6,000 adults with Autistic Spectrum Disorders (ASD) locally and we know this is the fastest growing area of 'primary need' in Sheffield"* ? And when the government's 2015 Statutory Guidance for Local Authorities and NHS organisations says that "*Health and Well-being Boards have a crucial role to play in overseeing implementation of the Adult Autism Strategy*" and that "*the Health and Well-being Board is central to ensuring the needs of people with autism are addressed locally*"?"

2. Why does Sheffield currently have no Autism Partnership Board when Sheffield does have a Learning Disability Partnership Board and a Mental Health Partnership Board, and when the Department of Health March 2015 Autism Statutory Guidance says that "*Local partners should already have a local autism partnership board in place, which brings together different organisations, services and stakeholders and adults with autism and their families to set a clear direction for improved services. Autism partnership boards have proved to be a highly effective means for stakeholders to shape and monitor local delivery of the strategy and statutory guidance. It is therefore essential for their partnership arrangements to be established in areas where they are not currently*"?

Councillor Julie Dore stated that responses would be given in writing to Mr Guymer, who was not in attendance at the meeting.

4. UPDATE FROM THE SAFEGUARDING BOARDS

The Board considered a report of the Independent Chair of the Safeguarding Children and Adults Boards, Sue Fiennes. The report provided an overview of Safeguarding activity in Sheffield and outlined priorities for 2016/17. The Annual Reports of the Safeguarding Children and Adults Boards for 2014-15 were appended to the report submitted to the Board.

The Board was asked to consider how Safeguarding related to the Board's current priorities and whether there were any developments the Board would want to see that would better align the work of the Safeguarding and Health and Wellbeing Boards.

Sue Fiennes stated that a governance review of the Safeguarding Adults Partnership had been completed and implemented in 2014/15. The leadership and governance of safeguarding was mature and enabled challenge and openness and there was a good basis for continuing improvement. It was also likely that the Child Death Overview panel would be taken out of the Safeguarding Board structure. With regard to adult safeguarding, Sheffield was at the forefront of issues concerning self-neglect and was well placed to develop this work. There were links between narrowing the health gap between communities in the City and keeping people safe. There was also recognition of diversity and the requirement to consider the needs of different communities and approach these in the appropriate way.

Members of the Board asked questions and made comments as summarised below:

It was important to make sure that as much as possible was being done in relation to safeguarding and it had to be a foremost priority to keep people safe.

There was a balance required of proactive and reactive approaches and the question was asked as to how this might be done better. In response, the Board was informed that as regards adult safeguarding, the Safe in Sheffield scheme had been well received by people with disabilities and a positive programme of prevention had been created. If progress was made in relation to health and wellbeing programmes, for example therapeutic support and suicide pathways, this might help to realise a more balanced approach.

As regards what needed to happen in order to make a difference, there was a significant challenge in relation to available resources and other approaches were being looked at. In relation to emotional wellbeing, resources could be pooled to provide support to people in need.

There was a need to train and support people who were the eyes and ears of the Board and respective organisations in relation to safeguarding, be they in services which required them to visit people's homes or other services such as licensing. They should be able to help recognise signs of issues relating to safeguarding and exemplar training was available to enable and support people in such roles to do so. Training should also be available for elected members.

The health gap was something that was recognised by the Board and the changing nature of the City's population and requirement for proactive measures in relation to safeguarding was also something to which the Board would need to give its attention.

Members thanked Sue Fiennes for her work for adults and children in respect of safeguarding and it was recognised that as Independent Chair, she had held

organisations to account, including the Council and health trusts in the City, and had provided challenge. There were initiatives including the Safe in Sheffield initiative that could contribute to adult safeguarding and helping people to keep well in the future.

The Health and Wellbeing Board needed to be able to respond quickly to new and emerging issues and policy changes. For example, the implications for safeguarding of the decision to make primary schools become academies. At present, local authorities had responsibility for the safeguarding of vulnerable children at primary school age.

Councillor Julie Dore, on behalf of the Board, expressed the Health and Wellbeing Board's best wishes and thanks and appreciation for the work that Sue Fiennes had contributed to safeguarding, especially in the most recent few years in relation to Child Sexual Exploitation and with regard to individual safeguarding cases.

RESOLVED: That the Health and Wellbeing Board:-

1. Endorses and supports the work of the Safeguarding Boards in Sheffield; and

2. Commits to continuing to work with the Safeguarding Boards to protect people at risk.

5. HEALTH AND WELLBEING PLANS FOR SHEFFIELD IN 2016/17

The Board considered a report of the Director of Commissioning, Sheffield City Council and Director of Health Care Reform, NHS Sheffield Clinical Commissioning Group, concerning Health and Wellbeing Plans for Sheffield in 2016/17. The report was presented by Richard Parrott, Strategic Commissioning Manager, Sheffield City Council.

The report outlined plans for 2016/17, based around 5 main actions and how the Health and Wellbeing Board and its partners would work together to address them. These were as follows:-

Action 1: Over 2016/17, the Health and Wellbeing Board will continue to communicate and engage with Sheffield people and organisations to ensure that the vision and plans we have are the right ones.

Action 2: The Health and Wellbeing Board will ensure that the JSNA will be fully refreshed and revised in 2016/17.

Action 3: Once the JSNA has been refreshed and revised, in 2016/17 the Health and Wellbeing Board will take the lead, with partners, in revising the Joint Health and Wellbeing Strategy.

Action 4: In 2016/17, the Health and Wellbeing Board will continue to ensure that the plans of the Board's main organisations – Sheffield City Council, NHS Sheffield Clinical Commissioning Group, NHS England, Healthwatch Sheffield – are coordinated and coherent.

Action 5: In 2016/17, the Health and Wellbeing Board will take a proactive and

assertive approach to ensure that partner organisations make progress with tackling health inequalities, transforming the health and care system, and delivering better outcomes for Sheffield people.

The Board was asked to consider the following issues:

- Does the Health and Wellbeing Board support the priorities proposed by the commissioning organisations?
- Are there areas for greater joint working between the organisations on the Health and Wellbeing Board (and others) in 2016/17?
- Does the Health and Wellbeing Board approve of the five actions outlined in the report?
- What role is there for Healthwatch Sheffield over the coming year in assisting with the implementation of these plans and ensuring that Sheffield people are appropriately involved, communicated with and engaged?

Members of the Board asked questions and commented upon the matters relevant to this item, as summarised below:-

Whilst tackling health inequalities was identified as a concern for the Board, the Commissioning Plans as appended to the report, did not say how inequalities would be addressed. The Director of Health Annual Report 2015 indicated that there had been little improvement in relation to health inequalities over the past 10 to 15 years. In response to this point, the Board was informed that there was a focus on reducing health inequalities and this was evident for particular groups, including people with learning disabilities. However, this might be made more explicit within the plans from Sheffield City Council and NHS Sheffield Clinical Commissioning Group (CCG).

It would be useful to identify a smaller number of priorities, on which effort could be directed and in relation to which progress could be made. Further discussion would take place with the Director of Public Health. It was also questioned as to whether the City Council and CCG plans were truly ambitious and bold rather than operational. The Board were informed that the appendix to the report brought together plans of both organisations and did represent a step forward.

The CCG in Liverpool for example had decided to contribute funding for physical activity, which could be allocated to programmes or initiatives involving physical activity. There were also areas of public health and inequalities which could be considered by having bold and ambitious plans. Community projects might be extended, where these had achieved good results, and other jointly delivered activity could also be considered.

Reducing health inequalities was a priority for the Board and should be a thread through the various aspects of its work, but it should also be explicit in asking questions about health inequalities in each decision that was made.

In refreshing plans for the CCG, health inequalities were one of the main priorities and the CCG was working jointly with the City Council. The CCG faced significant

challenges as regards its financial position and it was important to prioritise the use of resources. Physical activity and smoking cessation were two areas which made a difference to health.

Community assets could be considered alongside other resources and systems. Healthwatch Sheffield was keen to work with the City Council and the CCG on such issues. The recognition of people as potential assets as well as organisations was important and could also be included as part of the Joint Strategic Needs Assessment (JSNA). The People Keeping Well plan included the building of social capital and self-care.

People suffering with mental ill health and those with learning disabilities were known to have a comparatively shorter life expectancy and the City Council and CCG were in a position to try to address these issues together. However, new additional resources were not available. There was a role for social workers and health workers in referring people to services such as smoking cessation services.

It was important to get things right for children in their early years, which would set the conditions for later in life. Young Commissioners had been trained so they could participate in the process of discussing tenders and it was hoped that young people would continue to be engaged and they would have a voice in the commissioning of services. The CCG and City Council plans were evolving and would change where appropriate, with items being added or taken away.

RESOLVED: That:

1. the Health and Wellbeing Board supports and endorses the plans set out in this document and the actions proposed for the Board; and

2. Health and Wellbeing Board members and the Board's organisations commit to working together in an integrated way over the coming year.

6. UPDATE FROM THE JSNA

The Board considered a report of the Director of Public Health concerning the Joint Strategic Needs Assessment (JSNA), which set out the main findings of a review of the Sheffield JSNA conducted earlier in 2016 based on stakeholder interviews and literature. The report outlined actions, a timeline and resources required to develop an up to date JSNA by October 2016.

It was proposed to combine production of an up to date JSNA summary report with that of the 2016 Director of Public Health report, focused on the key actions and interventions that would improve outcomes and reduce health inequalities. The full redesign of the JSNA would then be developed as a phased programme of work starting later in the year.

Greg Fell, the Director of Public Health, stated that the JSNA had been defined differently by different local authorities. It was important that the document was both joint and focussed on need, rather than demand. There was also a duty to produce a Director of Public Health Annual Report. Public Health England

produced data packs and ward and neighbourhood profiles which would help to inform this work. During the review, stakeholders had expressed concerns regarding organisations working in silos between organisations and within them and in relation to age groups. There was also a desire to increase emphasis on prevention.

The Board was asked to consider the following questions:

- Is the proposal to combine the JSNA with this year's DPH report acceptable?
- Is the timescale of April to October 2016 acceptable?
- Are there any nominations for the editorial group?
- Is the broad approach to the report (i.e. based on starting well; living well; ageing well) acceptable?
- Are there any specific questions the report should seek to answer?

Members of the Board commented and asked questions on the matters raised by the report, as summarised below:-

Changes in the health of the population were gradual and it was accepted that for this year, an interim summary JSNA could be combined with the Director of Public Health's Annual Report. The timescale of April to October 2016 was agreed. The interim Director of Public Health had engaged with stakeholders as part of the JSNA review. An editorial group would be established to oversee this work. It was important to consider how data could be used to inform decisions on spending to bring about health improvement.

There were other issues which should also be considered in the report relating to all age mental and emotional health and wellbeing and young people's health. It was clarified that the Director of Public Report would continue to be produced annually.

RESOLVED: That the Health and Wellbeing Board:

1. Agrees the approach to developing a combined report as set out in section 4 of the report submitted;
2. Agrees the key actions and timescale set out in section 4 of the report; and
3. Requests the final report for approval in October 2016.

7. UPDATE FROM THE CHILDREN'S HEALTH AND WELLBEING BOARD

The Board considered a report of the Executive Director, Children, Young People and Families, Sheffield City Council, the Chief Officer, NHS Sheffield Clinical Commissioning Group and the Cabinet Member for Children, Young People and Families, Sheffield City Council. The report provided an update on activity of the Children's Health and Wellbeing Partnership Board and an overview of the Children's Health and Wellbeing Board work stream priorities and outlined the current work programme.

Jayne Ludlam, the Executive Director, Children, Young People and Families, introduced the report and stated that in the development of the Sheffield Children's Health and Wellbeing Programme Blueprint, the Partnership Board had reviewed the JSNA, public health profiles and variation in child health outcomes. The Partnership Board priorities were outlined and these workstreams were each led by an Executive Member of the Board.

Health and Wellbeing Board members would be given opportunity to hear how work on the Emotional Wellbeing and Mental Health work stream was progressing during the discussion forum which was to take place at the end of the Health and Wellbeing Board Meeting. The Board was asked whether it was in agreement with the priorities and workstreams which the Children's Health and Wellbeing Partnership Board had identified.

It was noted that the engagement and support of Sheffield Healthwatch and Young Healthwatch as regards priorities had been beneficial.

RESOLVED: That the Board:

1. Notes the work of the Children's Health and Wellbeing Partnership Board, the identification of the Board priorities and named Board sponsors;

2. Notes the development of the Children's Health and Wellbeing Programme (2015- 2020) Blueprint document;

3. Notes the impending review of governance structures and boards that exist across Children and Young People's services; and

4. Requests a future update and description of activity/progress from each of the work streams (and to note that the Emotional Wellbeing and Mental Health work stream will be providing an update on progress in the discussion forum at the end of the meeting on 31st March 2016).

8. UPDATE ON THE BETTER CARE FUND

The Board considered a report of the Chief Officer, NHS Sheffield Clinical Commissioning Group and the Executive Director Communities, Sheffield City Council. The report sought approval to Sheffield's 2016/17 Draft Better Care Fund Submission and the delegation of final approval of the Better Care Fund submission to the lead executive officers in the Council and the Clinical Commissioning Group. The draft submission for Sheffield's Better Care Fund 2016/17 was appended to the report. Peter Moore, NHS Sheffield Clinical Commissioning Group/Sheffield City Council, presented the report.

The Board was asked to consider the following questions:

- Is the Health and Wellbeing Board satisfied that these plans will help to progress the Board's ambition to transform the health and care landscape, reduce health inequalities and deliver better outcomes for Sheffield people?

- Where might there be further opportunities for integration and joint working?

Members of the Board asked questions and made comments, as summarised below:-

In the plans for the second year of the Better Care Fund, the report indicated that the planned pooled budget of £282m included current expenditure on four areas of need, focusing on those at risk of hospital admission and those for whom there is the greatest opportunity for health outcomes improvement. It was questioned whether attention was also being given to long term conditions and in response, the Board was informed that in relation to long term conditions, helping people with such conditions to maintain their health was important. A doctor's job was to see to people who were ill and dealing with those with long term conditions was a relatively new addition, which required a realignment of structures. There was a 20 year gap in people keeping well between people in the most and least deprived sections of the population. It was important that the ongoing care (which was one of four key areas in 2016/17) was provided to those with long term conditions.

Whilst adults were the main focus of the Better Care Fund, there was also an earlier indication that children and young people would be considered. For example, the target of reducing emergency admissions was focussed only on adults. In response it was agreed that this was a fair challenge, which should be given further consideration. A joined-up approach was required for a number of areas and it was important to make sure there was prevention activity at an early stage. A children's delivery board was to be established. There had also been discussion regarding the integration of activity relating to the Better Care Fund and children's services, especially with regard to the development of services in neighbourhoods. However, it was acknowledged that, at present, children and young people were an omission in relation to the Better Care Fund submission.

Other observations were made including that the 'need' statement did not follow through on actions and there was not an evaluation regarding outcomes; and that the Better Care Fund did not actually represent new money, although it was not the only financial resource for health and social care.

A question was asked as to whether health assessments were available for young people.

It was acknowledged that there were organisational, professional and cultural boundaries and some matters were affected by such boundaries. A flexible workforce was needed.

A question was asked as to whether there had been high level discussion regarding the Better Care Fund which had included the Executive Director, Children, Young People and Families.

RESOLVED: That the Health and Wellbeing Board:

1. Formally approves these plans;

2. Delegates final approval of the Better Care Fund submission to the lead executive officers in the Council and the Clinical Commissioning Group (CCG); and
3. Receives an update on progress at its September 2016 public meeting.

9. MINUTES OF THE PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Health and Wellbeing Board held on 24 September 2015 be approved as a correct record.

Note: At the conclusion of the meeting, a discussion forum took place concerning children and young people's wellbeing and mental health.