Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 27 July 2017 at 9.30 am

Town Hall, Sheffield S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Cate McDonald	Cabinet Member for Health and Social Care
Dr Tim Moorhead	Chair of the Clinical Commissioning Group
Dr Nikki Bates	Governing Body Member, Clinical Commissioning Group
Dr Alan Billings	Police & Crime Commissioner
Jayne Brown	Sheffield Health & Social Care Trust
Councillor Jackie Drayton	Cabinet Member for Children, Young People and Families
Greg Fell	Director of Public Health, Sheffield City Council
Phil Holmes	Director of Adult Services, Sheffield City Council
Alison Knowles	Locality Director, NHS England
Jayne Ludlam	Executive Director, People Services Portfolio The Burton Street Foundation
Clare Mappin	
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group
Peter Moore	Director of Strategy and Integration, Clinical Commissioning Group
John Mothersole	Chief Executive, Sheffield City Council
Prof Chris Newman	University of Sheffield

Sheffield City Council

Judy Robinson	Chair, Healthwatch Sheffield
Maddy Ruff	Accountable Officer, Clinical Commissioning Group
Prof Laura Serrant	Sheffield Hallam University
Dr David Throssell	Sheffield Teaching Hospitals NHS Foundation Trust

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. http://www.sheffield.gov.uk/home/public-health/health-wellbeing-board

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

27 JULY 2017

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. Sheffield's 2017/18 and 18/19 Draft Better Care Fund Narrative Submission (Pages 5 - 58)
A joint report of the Executive Director People Services, Sheffield City Council and the Chief Officer, NHS Sheffield Clinical Commissioning Group.

5. Urgent Primary Care (Pages 59 - 68)
Report of the Director of Strategy and Integration, Clinical Commissioning Group.

6. Public Health Strategy (Pages 69 - 88)
Report of the Director of Public Health.

7. Sheffield Health and Wellbeing Board Terms of Reference (Pages 89 - 94)
To consider revised Terms of Reference for the Board.

8. Health and Wellbeing Board Forward Plan (Pages 95 - 96)
To consider the Health and Wellbeing Board's Forward Plan.

9. Minutes of the Previous Meeting (Pages 97 - 102)
Minutes of the meeting of the Board held on 30 March 2017.

NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Wednesday 27 September 2017 at 3.00 pm

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 Audit and 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 PAPER
FORMAL PUBLIC MEETING

Report of:	Jayne Ludlum, Executive Director Communities, Sheffield City Council Maddy Ruff, Chief Officer, NHS Sheffield CCG
Date:	13th July 2017
Subject:	Sheffield's 2017/18 and 18/19 Draft Better Care Fund Narrative Submission
Author of Report:	Peter Moore 0114 305 1575

Summary:

The Better Care Fund is a key enabler to bring about parts of the transformation the NHS, the Local Authority and local communities via Shaping and Sharing Sheffield have articulated in the Sheffield Place Based Plan. It is an ambitious plan to work at a large scale on an integrated agenda which would impact significantly on the people of Sheffield and improve their care.

Whilst the Better Care Fund has now operated for two full years, its' ambitions and remit are reviewed every year to ensure it reflects the priorities in Sheffield.

Locally, this year, for the first time, we have created a second fully pooled budget (£101m) for mental health services within the overarching BCF arrangements. This currently brings the overall total of the Better Care Fund budget to £352m for 2017/18. Our main areas of focus with the addition of mental health will continue to be on adult admissions to hospital, active, support and recovery, people keeping well, ongoing care, independent living solutions and capital expenditure. All of which are key themes with the Sheffield Place Based Plan.

Additional national funding under the Improved Better Care Fund (iBCF) was recently announced and this will be added into the pooled BCF budget arrangements following

consideration of the planned use of the funding by SCC's Cabinet in July. Key stakeholders have been consulted on the use of the funding and have input into current proposals.

Nationally, we are requested to provide a narrative of our plans for the next two years to NHS England. A complete set of national guidance is still to be issued. However, accompanying this paper is the draft narrative.

Health & Wellbeing Board is required to approve the narrative.

Questions for the Health and Wellbeing Board:

- Is Health and Wellbeing Board satisfied that these plans will 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, especially considering the emerging opportunities of commissioners and providers in Sheffield working together more formally as an Accountable Care Partnership to improve the health and wellbeing of Sheffield people?

Recommendations for the Health and Wellbeing Board:

- That the Health and Wellbeing Board formally approve these plans
- That the Health and Wellbeing Board delegates *final* approval of the Better Care Fund submission to NHS England to the lead executive officers in the Council and the CCG.
- That the Health and Wellbeing Board receives an update on progress at its November 2017 public meeting.

Background Papers:

- Sheffield's Better Care Fund draft submission 17/18 -18/19.

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

Sheffield is a health and successful city

Health and wellbeing is improving

Health inequalities are reducing

People get the help and support they need and feel is right for them

The health and wellbeing system is innovative, affordable and provides good value for money.

Who have you collaborated with in the writing of this paper?

Both the CCG and Local Authority have contributed to the production of this document via the Executive teams, Work-stream Leads and Executive Management Group – the joint committee with responsibility of the management of the Better Care Fund.

Sheffield's Better Care Fund 2017/18 and 2018/19

1.0 Summary

1.1 The Better Care Fund is a way of bringing together the NHS and Local Authority with local communities to focus on transforming and improving the health and wellbeing of Sheffield People. It includes ambitious plans as articulated in the Sheffield Place Based Plan, to work on a large scale an integrated agenda which would impact significantly on the people of Sheffield and improve their care.

1.2 The Fund was agreed in 15/16 and is now in its third year of operation. Whilst its original key priorities are still relevant, each year the CCG and Local Authority evaluates its priorities to ensure they are still relevant for the people of Sheffield. In addition to the priorities identified originally around a focus on people at risk of admission to hospital and those for whom there is the greatest opportunity for health outcomes improvement, starting in 17/18 the pooled budget also includes mental health. A truly integrated commissioning approach will offer more effective commissioning which should lead to better patient outcomes and value for money.

1.3 The health and care priorities listed in the Sheffield Plan are being delivered in part through the Better Care Fund. Sheffield is a leader in integration. As well as a substantial integrated commissioning budget, we have set up an Accountable Care Partnership Board to provide overall leadership represented by commissioners and providers. We also have leading organisations across the city signed up to a memorandum of understanding, across commissioners AND providers to enable closer working to deliver our priorities.

2.0 What does this mean for Sheffield people?

2.1 Sheffield people have told us:

- If things go wrong it's difficult to receive the care I might need quickly enough
- I find it hard to find my way around all the variety of services – or even to know if what I need is actually provided by someone
- We have to constantly repeat information from one person to another
- I have little control over the care I do or don't receive
- My psychological needs are not met as part of care for my physical needs
- Services often aren't available at night or weekends like they are during the week
- Why don't services plan in advance – surely they should know if I get unwell I'll struggle to cope but don't necessarily want or need to go into hospital
- Why can't I just have one care plan.

2.2 Integrated commissioning through the Better Care Fund gives us a real opportunity with all our partners in the city to work with citizens to answer what Sheffield people are saying. This includes improving outcomes:

- People will find it simpler to get round the care system and experience fewer delays
- We will build on and further develop, people's self care and health condition management skills, knowledge and abilities
- There will be improved quality of life for those in active care
- Services will be more equitable and accessible
- Services will be much more based in Sheffield's communities and closer to where people live, with staff working collaboratively to achieve the best outcomes for Sheffield People.

3.0 Introduction to the Better Care Fund

3.1 In 2013 NHS Sheffield Clinical Commissioning Group (CCG) and Sheffield City Council (SCC) agreed to work towards a single budget for health and social care. This agreement was developed through the Sheffield Executive Board and the Health and Wellbeing Board and both organisations jointly set ambitious targets. The ambition through integrated commissioning was to :

- Ensure people have a seamless, integrated experience of care, recognising that separate commissioning can be a block to providers establishing integrated services
- Achieve greater efficiency in the delivery of care by removing duplication in current services
- Be able to redesign the health and social care system, reducing reliance on hospital and long term care so that we can continue to provide the support people need within a reduced total budget for health and social care.

3.2 In 2015, in line with national guidance and direction and as part of the Health and Wellbeing Board strategy, the CCG and SCC entered into a section 75 Agreement covering the operation of the Better Care Fund. This agreement established a pooled budget and supported by formal governance arrangements to create flexibility between health and social care budgets, with a view to making the best use of the available resource within the city to address the needs of Sheffield People in a joined up approach.

3.3 The key priorities agreed at the time were to :

- Increase wellbeing of people at risk or emerging risk of declining health and loss of independence

- Support people to remain at home and avoid unnecessary admission, responding quickly when necessary.
- Minimising hospital stay and discharging with the appropriate support and maximising their recovery and independence
- Integrate assessments, placement and contract management of services looking after people needing ongoing care
- Reduce demand for admission

3.4 Successes to date include:

- A Sheffield system Memorandum of Understanding has been signed by major organisations. It provides a framework and process for collaborative working in Sheffield.
- Sixteen neighbourhoods set up across the city made up of groups of GP practices, and forming stronger partnership working with community services and the VCF to address specific local needs in their communities.
- The establishment of community partnerships across the city whereby larger and smaller VCF groups come together in partnership and identify any gaps in their services to meet the needs of their communities.
- The establishment of a clear way for services to refer people who need some additional low level support through a form of social prescribing.
- Further development of person-centred care planning, and developing an outcome measure to assess whether people feel more activated in the management of their own care.
- The introduction of technological schemes to improve the digital literacy of people and testing out new technology to help people manage their care in a more pro-active way.
- Discharge of patients at weekend is now supported by volumes of Planned Discharge Dates which are shared with transport providers enabling them to plan additional capacity when required to support the hospital at times of peak demand.
- Implementation of the Teaching Hospitals Excellence in Emergency Care – Assessment model in Admissions units:
- Implementation of planned approach to discharge management and themes of safer, better, faster.

4.0 Our priorities for 17/18 and 18/19

4.1 The Better Care Fund works in alignment with our Sheffield Place Based Plan. The work plan informed the Sheffield Place Based Plan which has in turn also informed our plans.

Our key themes as outlined above will remain our priorities. In addition, in 17/18 we have combined both CCG's and SCC's mental health budgets into one pooled budget of £101m which will give us the ability to commission whole pathways of care, establish a single integrated commissioning team, develop a single transformation programme, delivered jointly with our main provider of mental health services, underpinned by the principles of joint delivery and joint accountability.

4.2 In 17/18 we will continue to explore the possibility of incorporating the Childrens' services into the BCF arrangement from April 2018.

4.3 All of our priorities are listed in our key areas of work and delivery plan in section three of the BCF narrative which accompanies this paper.

4.4 We will also include in 17/18, capital expenditure grants to explore the potential of using the grants more strategically to help with Delayed Transfers of Care and Out of Hospital targets.

5.0 NHS England and H&WB Board Sign off process

5.1 The CCG and City Council are required to submit a plan to cover 2017-2019 which describes our plans and our targets. Health and Wellbeing Board need to approve the plan accompanying this paper. Final submission to NHS England is 11th September.

5.2 At the time of submitting this paper and accompanying plan to H&WB Board, not all of the guidance and requirements have been published. Health and Wellbeing Board need to be aware that because of timing, not all the financial details and targets are included in this paper. We will share this with HW&B Board later in the summer, once all the work is undertaken.

5.3 The Better Care Fund narrative which accompanies this paper describes the intentions for the next two years which are funded via the Better Care Fund.

6.0 Questions for the Board:

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

6.2 Where might there be further opportunities for integration and joint working, especially considering the emerging opportunities of commissioners and providers in Sheffield working together more formally as an Accountable Care Partnership to improve the health and wellbeing of Sheffield people?

7.0 Recommendations for the Health and Wellbeing Board:

7.1 That the Health and Wellbeing Board formally approve these plans

7.2 That the Health and Wellbeing Board delegates *final* approval of the Better Care Fund submission to NHS England to the lead executive officers in the Council and the CCG.

7.3 That the Health and Wellbeing Board receives an update on progress at its November 2017 public meeting.

Sheffield's Better Care Fund 2017/18 and 2018/19

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

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Contents

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1. Background

In 2013 NHS Sheffield Clinical Commissioning Group (CCG) and Sheffield City Council (SCC) agreed to work towards a single budget for health and social care. The ambition articulated through integrated commissioning of both health and social care was to:

- Ensure service users have a seamless, integrated experience of care, recognising that separate commissioning can be a block to providers establishing integrated services.
- Achieve greater efficiency in the delivery of care by removing duplication in current services.
- Be able to redesign the health and social care system, reducing reliance on hospital and long term care so that we can continue to provide the support people need within a reduced total budget for health and social care.

Our ambition is that we will, over the next few years, have a single budget for all health and social care in Sheffield, so that we make decisions about how we use our resource with a focus on what the people of Sheffield need, rather than on individual budgets. This will mean that we have a shared responsibility for the statutory responsibilities of both organisations. Of equal emphasis is an ambition to ensure that we commission jointly across health and social care which means using a broader range of skills in the procurement and commissioning process.

This year's plan

This Better Care Fund plan for 2017/18 and 2018/19 knits together more recent work on the Sustainability Transformation Plan for South Yorkshire and Bassetlaw, Sheffield's own Place-Based Plan, and the CCG's operational plans. It has an expanded number of areas for us to work jointly on. Our ambitions have been informed specifically by engagement work led by our Health and Wellbeing Board and by local and national public opinion on integration, and by the learning from our existing transformation programmes.

As part of our BCF Plan, we will focus on the delivery of initiatives jointly agreed between providers and commissioners and will develop joint decision making and risk sharing arrangements to establish effective shared responsibility and governance of the pooled budget. This will ensure that we make single, shared decisions on all aspects of care and expenditure within the remit of the pooled budget.

We believe that we will make better decisions about how we use the reducing resource for health and social care together, rather than separately. Together we will be able to use our resources to best effect, pooling health and social care money where business cases support that change, to provide the best care and support to our population. Working together, we avoid the risk that we make separate decisions that have an adverse effect on the services the other commissions, recognising that only savings and improvements to the whole system are helpful.

We are clear about both the potential benefits and the risks involved in our plans. Final sign off of our plans and associated budgets will be by SCC's Cabinet and by the CCG's Governing Body. Specifically, our organisations will be assured by a) our section 75 agreement, setting out the proposed approach to single decision making and to risk

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sharing, b) our financial plan for the pooled budget, and c) the business cases that will be required for the changes proposed in this document.

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2. Our vision and challenge

Our vision, as set out in our Place-Based Plan, is:

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.

Crucially:

- We believe that integrated commissioning is essential to the development of integrated services. The national and local evidence that integrated services result in better service user experience, increase efficiency and improve outcomes and the clear public message that services should be integrated.
- We believe that we will make better decisions about how we use the reducing resource for health and social care together, rather than separately. Together commissioning jointly we will be able to use our resources to best effect, shifting money from health to social care where business cases support that change, to provide the best care and support to our population. Working together, we avoid the risk that we make separate decisions that have an adverse effect on the services the other commissions, recognising that only savings and improvements to the whole system are helpful.
- There is also a huge benefit in working with wider cross-city partners through our Sheffield City Region Public Sector Transformation network.

Why do it?

We've set out our need to change in four challenge areas:[1]

The health and wellbeing challenge

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. The cost of inequalities is £30bn to the NHS (the financial challenge is £20bn).

[1] These are outlined in more detail in our Place-Based Plan Sheffield Place Based Plan and in our JSNA which is regularly being updated.

The care and quality challenge

Demand

•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
•Increasing number of children with complex health needs
•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
•People experiencing a crisis in their mental health need access to community based treatment 24/7

Value

•The Better Care Better Value Tool 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
•Access to children's services meets or exceeds national thresholds
•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
•Increase access to evidence based treatments for a range of mental health needs including psychological therapies (IAPT), perinatal, eating disorders, crisis care

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

The finance and efficiency challenge

By 2020-21 the combined health and care budget for Sheffield will be £1,390m. Whilst significant we have modelled that it could be £232m less than we will need if we don't change the way that we work or how services are provided. We want to provide Sheffield residents with the services that they need and this means that we need to ensure that we

get value (that delivers quality and benefit) for the Sheffield pound.
The culture and leadership challenge 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.

Addressing specific community needs and health inequalities

The city has a Health Inequalities Action plan, which was signed off by Health and Wellbeing Board in 2014. We are looking to do a refresh in December 2017.

We had a substantial discussion around this priority in May 2016 and reaffirmed the commitment to the principles agreed in the 2014 plan including:

- Continued commitment to an asset based community development based approach to Health and Wellbeing.
- Continued investment in and commitment to primary care and within this General Practice, especially in the most disadvantaged parts of the city.
- Continued commitment to the principle of implementing effort and change where greatest need is identified.
- Refocused effort on the link between employment and health
- Making the health choice the easiest and default choice.

We are currently in discussion how we will build commitment to interventions to address Health Inequalities more deeply into the totality of it's resource commitments, at both political and officer level. This will not be an easy task.

Our agenda around Health inequalities in our wider programme includes work on inclusive growth, fairness commission, and the city work on poverty.

The city is increasingly clear that the ongoing commitment to the policy of austerity is almost certainly making inequalities worse not better

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Examples of our commitment to engagement and health inequalities include:

The CCG and the local authority public health team have supported a development programme called the “Alliance of the Willing” that brings together GPs working in disadvantaged communities and their sister voluntary organisations who are also working in those communities. The programme builds on the experience of the Glasgow Deep End group - a network of GPs in Scotland who work in neighbourhoods with very high health inequalities. The Alliance of the Willing aims to capture good practice and influence key health strategies in the city.

On a wider scale, our new neighbourhoods which cover the whole city have the opportunity to work with local groups and the communities to identify what the needs are for their neighbourhood and how as neighbourhoods covering statutory and non-statutory organisations they can meet those needs and fill gaps. This could range from opportunities to bring more specific services and different access than what the city normally would offer to ensure services can be accessed by their communities to develop local plans to provide specific low level support to reduce social isolation.

We are committed to meeting our statutory obligations in relation to patient and public involvement. Our plans are continually being shaped by our citizens. In addition to the active participation in our workstreams, so far, this year we have sought views from our most vulnerable communities on access to health and care and is in relation to the Health and Social Care Act 2012, The Equality Act 2010, the NHS Constitution and the latest NHS England guidance. The most recent pre-consultation engagement activity also demonstrates our commitment to the Gunning Principals, particularly ‘engaging when proposals are still in their formative stage’. In order to inform development of options, it was important to utilise public health data to recognise groups who hadn’t been given specific opportunities to share their experience or usage of services in the previous two engagement activities on urgent care in 2015 and 2016. In the month of March 2017, the following groups were identified, approached and asked for their views:

- Homeless community
- Substance misuse community
- Asylum seekers and those living in temporary accommodation
- Communities with greatest deprivation
- Students
- City workers

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3. Our key areas of work

Theme objectives

The aims and outcomes of each theme have been refreshed to reflect current priorities.

Theme	Strategic Objectives
Theme 1 - People Keeping Well	The Strategic Objective of this scheme is to increase the wellbeing of people at greatest risk of declining health and loss of independence – reducing demand and dependency on the formal health and social care system. This will involve local information and advice to support self- care; community interventions to enable people to remain independent, and GP led care planning. As a result patients at medium to high risk of admission to hospital will be better motivated and supported to self-care, will have improved health and reduced reliance on health and social care services
Theme 2 - Active Support and Recovery	AS&R is the commissioner term that has been given to the range of services, predominantly community based, which supports the public, patients and clients in their own homes to remain as independent as possible despite the fact that they may have multiple health and care needs. These services do not consistently meet individual needs in a coherent and co-ordinated way. The commissioners require that in addressing these services options should be developed that: • support people to remain at home and avoid unnecessary admissions • respond quickly to the additional needs of people in this cohort and support them to remain out of hospital • make sure that people are discharged home with the appropriate support, minimising their hospital stay and maximising their recovery and level of independence
Theme 3 - Independent Living Solutions	The Strategic Objective of this scheme is to develop and promote the provision of independent living solutions in Sheffield so that more people can maintain and build their wellbeing and independence
Theme 4 - Ongoing Care	The overall aim is to integrate the assessment, placement and contract management functions related to ongoing care to improve quality, outcomes and process.
Theme 5 Adult inpatient Emergency Admissions	The overall aim is to undertake activity to reduce demand for admissions and to ensure that the patient stay whilst in hospital is as short and effective as possible. Additionally it allows monitoring of the impact of other BCF activity to reduce demand for hospital

DRAFT

	emergency admissions.
Theme 6 - Mental Health	The aim is to deliver a truly integrated commissioning approach which will offer more effective joined up commissioning (and therefore care), leading to better patient outcomes which will, by default, deliver better value for money.
Theme 7 - Capital Expenditure	The scheme will deliver home adaptations funded from the Disabled Facilities Grant to enable people to remain in their own homes and live independent lives reducing their need for organised care. Other Capital Grants will be used to deliver better systems to administer ongoing care.

Our Better Care Fund has 7 formal areas of work with Children and Young People added almost as a shadow run for full inclusion into the pooled budget from April 2018. We actively review the areas which the Better Care Fund cover, the following demonstrates how we are evolving.

In the 2016/17 BCF					
People Keeping Well	**Urgent Care (reducing emergency admissions)**	**Independent Living Solutions**	**Active Support and Recovery**	**Ongoing Care**	**Capital**
New to the BCF 17/18					
Mental health					
New to the BCF 18/19					
Childrens and Young People					

This section sets out in more detail what these areas of work are. Later sections of this BCF document talk about how we will measure these areas and what the financial plan for each is.

What will change?

Our plan will set out change in a number of areas which are building on our past Better Care Fund plans. Sections three of this document will set out what will change in each area.

Our Place-Based Plan sets out a range of things that we will be doing in the preventative space, which are not part of this BCF Plan. This includes:

- Our Heart of Sheffield programme: a radical upgrade in prevention

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- Our Work and Health programme: supporting people moving into meaningful economic activity or meaningful employment.[2]

The changes we plan should mean that, by 2020:

- More people, including children, young people and adults, will be getting the right care, at the right time and in the right place.
- People and their communities will be supporting each other to a greater extent and we will have improved and maintained their safety, wellbeing and greater levels of independence.
- Organisations will work together to a greater extent to help people and their communities to build and strengthen the support they provide to each other.
- More expert support will be available to help people to take control of their own care so that it is genuinely person-centered and complements and builds on the assets they already have.

Health and care services will be more focused on a person's needs and organisational boundaries will not get in the way

DRAFT

[2] There are currently 85,000 people across Sheffield City Region unemployed due to low level mental health or Musculo skeletal conditions. The health and employment system do not work together and those 85,000 people are all witnesses to this poor 'system connectivity'. We have recently had approved an operating model for a trial study to overcome/ reduce poor connectivity. The basis of the study is a pilot delivering Individual Placement and Support-based employment support. It will be a randomised control trial, receiving 7,500 referrals from the health system across the region (mainly primary care) over the course of the next 18months- 2 years. It will be integrated into an increased number of employment advisors within IAPT service across the region.

3.1 People Keeping Well

Lead director: Nicki Doherty Sheffield CCG/ Dawn Walton Sheffield City Council

3.1.1 What will this area of work do and what will change as a result?

- There is growing recognition that by ensuring people are connected to and feel part of their local community we can help them stay independent and well for longer and increase quality of life
- Social prescribing is a way of linking people with sources of support within the community. It provides a non-medical referral option that can support people to improve health and wellbeing
- Alignment of locality working including Asset Based Community Development, Housing Plus offer to tenants
- Supporting demand management activity for ASC and primary care

3.1.2 What will happen in 2017/18 and 2018/19?

- Implement a social prescribing model in all areas of the City
- Develop central referral hub
- Clear and consistent approach to management information and measuring impact
- Workforce development to have empowering conversations with people
- Integrate access to Social Prescribing model in all referral and assessment pathways
- Risk Stratification needs developing to include social indicators as well as health and to get ownership and sign up by all stakeholders
- Alignment of approach with CYPF locality based provision

Deliverables:

1. Develop the financial plan and further funding mechanism for the PKW partnerships and CSW's
2. Review SCC/CCG funded key workers in relation to delivery of PKW SP and demand management to determine future need
3. Identify long term funding for PKW
4. Tender community dementia monies
5. Tender community carer monies
6. Continue to support partnership development

3.1.3 What are the main benefits of this area of work?

The Key Benefits of this approach are;

- for the individual – improved health, greater independence, less social isolation, a route to building social capital and resilient communities, enabling and supporting individuals to manage their condition.
- For the system - Demand Management – shifting from reactive to proactive approaches means we reach people earlier and begin to develop a "self-management" culture within the organisation and in communities
- Financial efficiencies - anecdotal evidence from community support workers and local GP practices is that it has reduced demand on services but this is difficult to quantify

DRAFT

For the system – financial efficiencies which could lead to public sector cost reduction and/or releasing capacity to better manage demand; making best use of health and care practitioners' time; and a means of promoting a shift to preventative interventions.
For the community – making optimum use of local community support, and stimulating improvements in the quality and effectiveness of the VCS community offer.

Metrics:

- 75% of partnerships with social prescribing monies have a success matrix rating of 4 (good / minimal issues) for their partnership
- 75% of partnerships with social prescribing monies have a social prescribing process

3.1.4 What are the main risks and issues?

Risks

- Lack of long term financial investment means it is difficult to plan
- CBA is unable to prove categorically that the PKW model is saving the Health and Social Care System money
- CBA proves savings in secondary health services and social care but no agreed mechanism in place to release funds for reinvestment in PKW

Issues

- Need to invest in management information systems and workforce development but have little resource and an uncertain future
- Currently commissioning activity is Via SCC.
- Sign off for the strategic approach is confused as decisions have to be agreed in more than one place

3.1.5 What are the governance arrangements for this area of work?

- People Keeping well currently reports to the Active Support and Recovery Programme Board.

3.1.6 What consultation has been carried out?

- Significant consultation with providers as the framework, outcomes and principles of PKW was developed
- Co-production is at the heart of all PKW Commissioned services. All Community Partnerships have had to evidence their approach to co-production to ensure local people have had the opportunity to engage fully
- Partnerships working with local residents

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3.2 Independent Living Solutions

Lead director: Penny Brooks Sheffield CCG/Phil Holmes Sheffield City Council

3.2.1 What will this area of work do and what will change as a result?

This jointly procured contract was awarded in July 2015 and runs for up to 5 years. It is paid for from a true pooled budget into which the CCG pays around 2/3 of the total and SCC the remaining 1/3.

3.2.2 What will happen in 2017/18 and 2018/19?

British Red Cross (BRC) accept referrals from over 2000 health and social care workers for people needing equipment in their homes to enable them to continue living independently. They deliver the equipment from their warehouse in Darnall and then maintain and service the equipment before collecting it again when it is no longer required.

3.2.3 What's changed since the last BCF submission?

No changes to the service since last year. It is proposed to create a new social care capital scheme to separately capture the costs of high value community equipment. These tend to be more specialist items of equipment that are capital in nature.

What are the main benefits of this area of work?

The service is demand driven. Equipment is delivered within the timescales required by prescribers – ranging from same day delivery in urgent cases to 5 day delivery in routine cases. BRC consistently meet KPI targets and very few deliveries miss their target timescale.

- A large proportion of the equipment is loaned to people who have recently been discharged from hospital, thereby facilitating discharge. If the equipment is on the standard catalogue, it can be in place very quickly to allow the person to return home on the planned date.
- When a person is assessed in their home, equipment can be provided to enable them to retain independence from services and to remain at home for as long as possible.
- Where a person does have care needs, the appropriate equipment can be loaned to assist carers and in many cases reduce the amount of service needed (e.g. single handed calls as opposed to double handed)
- Because the equipment service is now funded through a true pooled budget, there is no longer any need for time consuming debates about who is responsible for payment.

3.2.4 What are the main risks and issues?

Risks

Financial risk – Although measures are in place and new ones being developed to contain unnecessary spend, it is highly likely that spend in 17/18 will not be any lower than in 16/17. In fact demand is expected to increase in line with increased use of other health and social care services. The measures being put in place in conjunction with implementation of a new

DRAFT

capital project to bear the costs of high value items are hoped to address some of the total pressures on this service which currently amount to £600k.

Issues

Whilst there is a continued financial pressure in this service it is an area that has so far been shielded from large scale budget cuts.

3.2.5 What are the governance arrangements for this area of work?

The service is governed by a Board co-chaired quarterly by Directors from SCC and CCG.

3.2.6 What consultation has been carried out?

Consultation has taken place about the service quality and performance with prescribers for the service in partner organisations and patients/service users. An annual report will be produced summarising these views together with the overall performance data.

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3.3 Active Support and Recovery

Lead director: Nicki Doherty Sheffield CCG/Phil Holmes Sheffield City Council

3.3.1 What will this area of work do and what will change as a result?

Our vision is to: “To provide accessible, person centred and fully integrated services in the heart of each community in Sheffield, preventing avoidable hospital and long term care admissions, and enabling those patients with ongoing complex needs to maximise their independence.”

The aim is to develop and redesign out of hospital services, to:

- Support people to remain at home and avoid unnecessary admissions
- Respond quickly to the additional needs of people in this cohort and support them to remain out of hospital
- Make sure that people are discharged home with the appropriate support, minimising their hospital stay and maximising their recovery and level of independence

The programme will potentially benefit all patients within the Sheffield area who are at risk of a hospital admission, with an emphasis on the proactive identification of those patients whose health is deteriorating.

The programme will have the following key components:

- Developing integrated, out of hospital care across Sheffield, delivered through a range of services both from within Neighbourhoods and those provided City wide.
- Has clear links with other key strategies such as primary care, urgent care, long term conditions and mental health.
- Has the provision of Care Closer to Home and person-centred care as its primary objectives.
- Is principally aimed at those patients with one or more long term conditions and aimed at helping them to maximise their independence in their own home.

To be clear, the Active Support and Recovery Programme will transform the way in which our reactive services are delivered (Intermediate Care, Rapid Response (STIT/ CICS), Community Nursing, Falls, SPA etc.). It will rebalance our resources by correcting the investment in less acute interventions that will allow a redistribution of activity from high cost interventions that are not needed to better value interventions that support, develop and promote independence. At the same time as increasing spend in less acute interventions the redesigned services will also release system savings.

3.3.2 What will happen in 2017/18 and 2018/19?

The following high-level activities are planned for the coming period:

- Social Prescribing: full roll-out of social prescribing to all neighbourhoods and an action plan for each that develops them along a maturity index; continuing embedding the community support workers. Purpose to optimise community support and intervention, support increased person activation and self-care and to increase access to the benefits and support packages that Sheffielders are entitled to

- Person Centred Care: develop a self-care strategy for Sheffield and an implementation plan , continued Care Planning LCS with introduction of PAM improvement metric, linking to self-care strategy develop Behaviour Change Academy as a partnership approach for Sheffield
- Rapid Response: implement revised rapid response service that addresses the current system limitations (needs to link to Independent Sector and Domiciliary Care solutions)
- End of Life (EoL): progress EPACCS, implementation of One Chance to Get it Right (last few days), increase number of people who die in their place of choice, increased support to care homes for EoL pathways
- Carer Support: support to carers to enable respite or temporary support whilst in hospital to keep people at home when carers cannot look after them
- Care Homes: increase nursing support to care homes to help meet increasing needs outside of hospital
- Virtual Ward: review evidence for virtual ward pilot in GPA1 and consider best model for citywide approach (links to urgent care programme)
- Case Management/Care coordination and navigation: people at increased risk of admission receiving case management support and where care needs are increased there is a coordinated response that ensure the most appropriate service provides the response
- Intermediate Care beds: re-profiling of intermediate care beds in response of increased community offer, will require shorter programmed length of stay with measureable outcomes, will also include step-up removing the need to admit in order to access this level of intervention
- Community IV: IV delivered at home and either removing the need for admission or where admission is required reducing the associated length of stay

3.3.3 What's changed since the last BCF submission?

- All 16 neighbourhoods in Sheffield are in place and are working on a development plan for 17/18
- Primary care and community care practitioners are working together to improve patient care / experience e.g. district nurses and practice nurses working together on wound care
- Further development of person-centred care including care planning, PAM embedded as outcome measure
- Roll out of Virtual Ward pilot to City Centre Neighbourhood incorporating 21 Practices – June
- Alignment with Test Bed technologies development
- Intermediate Care Beds re-profiled and reduced
- Digital Literacy pilot established in two Neighbourhoods (Porter Valley and South Sheffield Health Group) to support people with LTC/complex needs
- Revised and strengthened programme Governance
- Initiation of Virtual Ward / Enhanced Case Management pilot across Central Locality
- Digital Literacy projects in place in 2 Sheffield neighbourhoods in partnership with the Good Things Foundation
- Initiation of falls prevention pilot in Sheffield in partnership with Aesop and Yorkshire Dance

DRAFT

- Initiation of work on Active Recovery service to deliver greater efficiency through integration
- Business case in development to support community IV

3.3.4 What are the main benefits of this area of work?

Standard KPIS include:

- Reduction in non-elective admissions
- Reduction in permanent admissions to long term care (ASCOF 2a2)
- Reduction in delayed transfers of care (ASCOF 2ci)
- Improvement in the number of patients still at home 91 days post admission (ASCOF 2bi)
- Improvement in the proportion of older people (aged >65) who received reablement/rehab after discharge from hospital (ASCOF 2b2)
- Improvement in the overall satisfaction of people who use services with their care and support (ASCOF 3a)
- Delivery of financial savings equating to £4.6mm in 2017/18

3.3.5 What are the main risks and issues?

- Project Management Resource: successful service redesign in key project areas
- Neighbourhood maturity
- Collaboration between neighbourhoods
- Availability of business intelligence resource to model data necessary for service redesign
- Contractual solutions to new models of care in an accountable care partnership
- Ability to reinvest resource as per the Sheffield Memorandum of Understanding
- Reactive solutions to current demand and capacity in existing service models e.g. STIT
- Contractual issues with Intermediate Care beds
- Primary Care Sustainability and Resilience
- Transformational Funding to pump prime the redesign in order to release the savings

3.3.6 What are the governance arrangements for this area of work?

The AS&R Board will oversee this programme of work, reporting to Transforming Sheffield Board. The AS&R delivery group owns development and delivery of the plan.

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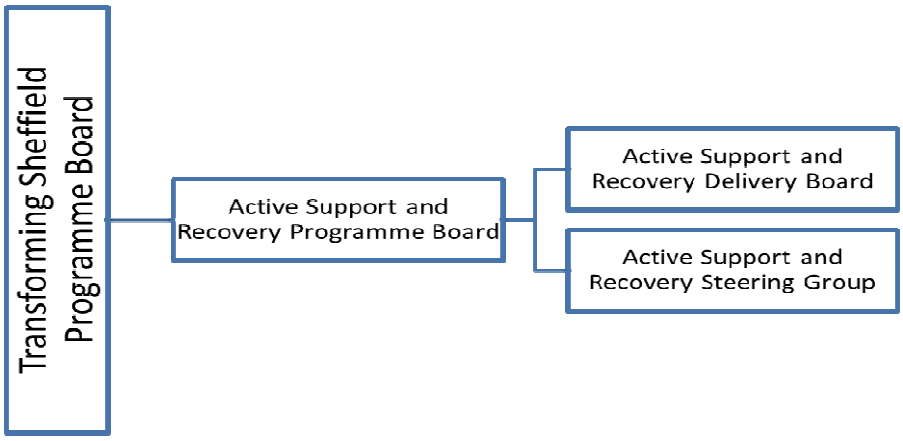

3.3.7 What consultation has been carried out?

The projects of work haven't progressed to a point where a consultation is required. However there has been active discussion with provider partners through Active Support and Recovery Workshops, Active Support and Recovery Delivery Board, and Active Support and Recovery Programme Board, Locality Meetings. Public engagement has happened through multiple avenues including the 2020 Vision, urgent care (which covers the same ground), and the citizen's reference group.

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3.4 Ongoing Care

Lead directors: Penny Brooks Sheffield CCG/Phil Holmes Sheffield City Council

3.4.1 What will this area of work do and what will change as a result?

Ongoing Care programme is redesigning and integrating Continuing Health Care and adult social care to achieve a single integrated assessment, with shared market management function and integrated group decision making on funding decisions s. With a focus on planning and delivery of support to meet the ongoing care needs using a joined-up approach from the Clinical Commissioning Group (CCG) and Sheffield City Council (SCC), and commissioning and contracting relevant services in the long term.

The Ongoing Care programme in partnership with CCG and SCC has been working through solutions to improve quality, process, and outcomes within a financial envelope. By establishing the right care, the right package, there are opportunities for savings, and the patient and carer experience should be measurable improved.

Sheffield citizens will experience:

- Improved patient experience through streamlined patient pathways through a joined up approach from the CCG and SCC, in relation to the determination of their care needs, and the planning and deliver of support to meet these needs
- Well-trained and supportive staff who are confident of providing robust and lawful advice, assessment and support
- A clear approach to charging for care including care provided free at the point of use where Primary Health Needs are identified
- Access to clinical leadership and support that is appropriate to their situation
- Access to information, advice and early intervention that will prevent avoidable deterioration in physical and / or mental health
- Being supported to leave acute beds as soon as they have no further need of treatment in that setting
- More emphasis upon support at home and less likelihood of having to move into care home
- Care and support arrangements that will best meet their needs

Sheffield's care providers will experience:

- A consistent approach with respect to fee rates, payment and contract management
- A consistent approach with respect to quality improvement and safeguarding
- A collaborative commissioning approach that builds good relationships, celebrates innovation and enables early problem solving

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Attached CCG and SCC staff will experience:

- Practice configured around the person rather than the organisation
- Reduced bureaucracy and streamlined decision-making
- Greater trust and joint working, including emphasis on early intervention and problem solving
- Encourage professional development

3.4.2 What will happen in 2017/18 and 2018/19?

Single integrated assessment and care management pathway

- Review the current pathway and processes
- Reduce bureaucracy and streamline processes
- Gap analysis of workforce
- Review of all high cost CHC and Social Care packages to ensure clients are receiving appropriate and cost effective care.
- Exploring scoping options of shared Information Technology system

Engagement and Stakeholder involvement

- Engagement workshops with carers to develop joint practice principles for short breaks allocation
- NHS England commissioning a video to support 'For Pete's sake!` initiative to develop culture across the whole system
- Shared workforce training across CCG and SCC

Improved contracting and market management

- New commissioning arrangements for homecare and Supported Living (by October 2017)
- Review of commissioning arrangements for care home placements locally(TBC)
- Discussions across STP/ACP for equity and economies of scale
- Review of commissioning arrangements for Direct Payments and Personal Health Budgets (timescale TBC)
- Integration of CCG and Council contracting and market management functions with respect to registered care settings and Direct Payment / Personal Health Budget markets (by April 2018)

Reduction in Delayed Transfers of Care and Rates of Readmission

- Pilot home first (5Q) approach to ensure long-term needs are not assessed in acute beds (by September 2017)
- Review the outcome from the 5Q pilot with a view to rolling out if pilot successful

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- Work with AS&R to review and plan step down intermediate care capacity to provide discharge to assess to commission step-down intermediate care capacity to provide a “Plan B” where D2A cannot be provided at person’s own home (by September 2017)
- Formal arrangements for integrated assessment and support planning underpinned by appropriate alignment of budgets and processes (timescales TBC) to support
    - 0-25 inclusion programme
    - Mental Health and Transforming Care programmes
    - Active Support and Recovery & Urgent Care programmes

3.4.3 What are the main benefits of this area of work?

- Reduction in bed days for patients in scope at both STH and SHSC, including reduction in DTOC
- 85% of Decision Support tools (DST) to be completed outside of hospitals
- 80% of DST’s completed within 28 days
- Reduction in care home placements
- Increase in uptake of Personal Health Budgets
- Patients receive appropriate and value for money care.

3.4.4 What are the main risks and issues?

- Release savings from redesign to other parts of the system
- Need to invest in shared information systems but limited resource
- Meeting assurance frameworks and timeframe
- Capacity and demand on resources and growth internally and across the system

3.4.5 What are the governance arrangements for this area of work?

The Ongoing Care Steering Board is responsible for the ownership and implementation of the Ongoing Care Delivery Plan. This board is in now in place.

An Ongoing Care Integration group is established to take forward the Ongoing Care Delivery Plan, and provide a forum where all issues related to work streams can be managed. Accountability for these work streams will be provided by the Ongoing Care Integration group, who will feed back regularly to the Ongoing Care Steering Board.

The Ongoing Care Integration group reports directly to the Ongoing Care Steering Board, which in turn is accountable to EMG. EMG acts as the overall accountable group for the delivery of Sheffield-wide health and care transformation as defined within the Sheffield place-based plan and the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

The chart below details the Ongoing Care programme and individual work streams. All of which are governed by the Ongoing Care Steering Board.

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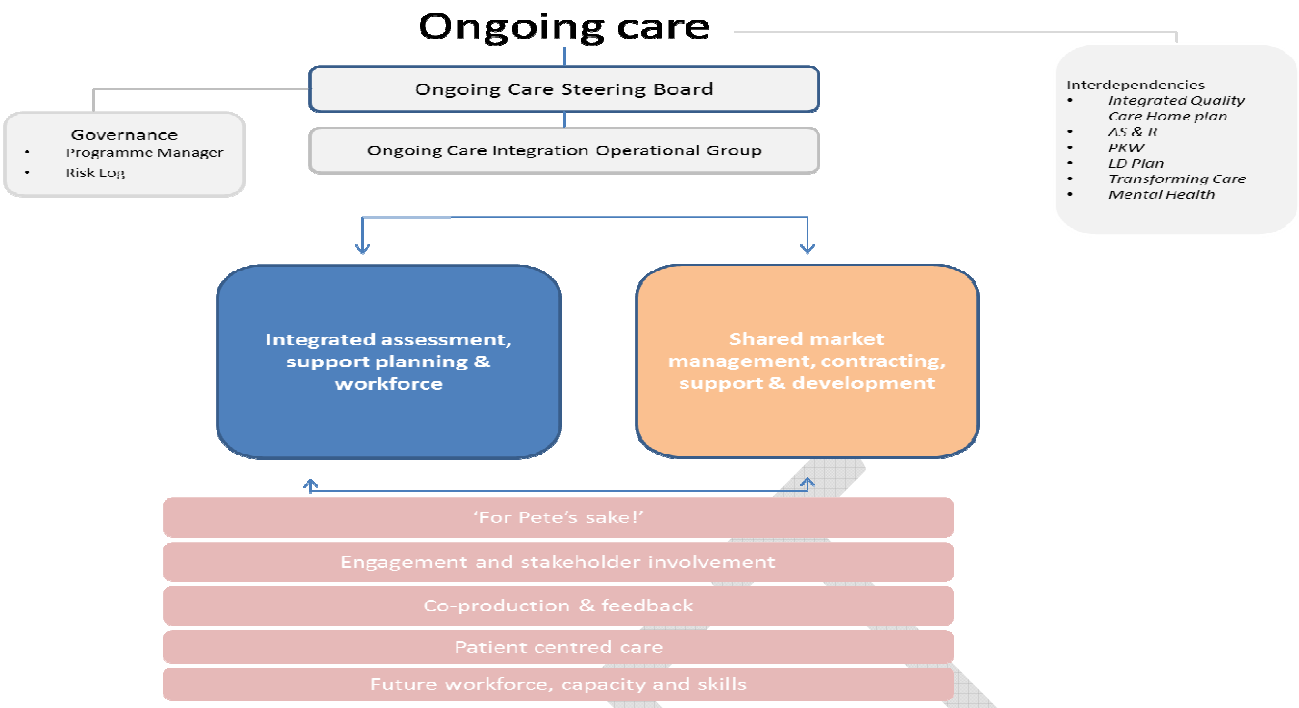

3.4.6 What consultation has been carried out?

A number of engagement **workshops have been** held with patients, carers and stakeholders to help shape, and identify the key priorities for the Ongoing Care programme. Consultation will be taking place with the development of the short practice principles guidance for short breaks allocation in the next few months.

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3.5 Urgent Care

Lead director: Peter Moore Sheffield CCG/Phil Holmes Sheffield City Council

3.5.1 What will this area of work do and what will change as a result?

This programme will deliver:

- A change in the offer for urgent and same day care in primary care
- Assessment and reduction in non-elective admissions
- Reduction in delayed transfers of care (DTOCs)

3.5.2 What will happen in 2017/18 and 2018/19?

- Review and redesign of the Urgent care in primary care system in Sheffield with implementation of some aspects having commenced
- Further improvements will be made to the assessment and step up facilities when patients' needs can no longer be met in Primary Care
- Patient flow through hospitals will be improved with care optimised and discharges planned on admissions.

3.5.3 What's changed since the last BCF submission?

- The review and redesign of Urgent care in primary has commenced
- Implementation of STH Excellence in Emergency Care – revised assessment models have been implemented in the Admissions units; implementation of the planned approach to discharge management has commenced and themes of safer, better, faster have been adopted.
- A taskforce has been established to reduce the number of DTOCs in the city

Key developments/successes in the last year:

SCH:

- The children's hospital continues to be one of the top three highest performing A&Es in England

STH:

- Conveyance rates by ambulance to A&E where patients then receive no treatment or diagnostic (or walk out before seeing a clinician) have reduced by 50% this year compared to last which is approximately 2000 less patients.
- There has been a step change in reducing the numbers of patients regularly attending A&E. Data from STH suggests a more than 10% reduction and a continuing downward trend.
- Following the relocation of the GP collaborative to effectively co-locate it with A&E there has been a steady improvement in the number of patients who are redirected there from A&E with 15-20 patients redirected every weekend day.

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- Pathway protocols for assessment pathways for GP urgent referrals have been strengthened via the SPA. Patients are now actively encouraged wherever possible to self-convey to hospital when accessing assessment pathways. This reduced travel time to 45 minutes (as opposed to 2-4 hours) greatly increases the opportunity for patients to return to their own home that day (and access other supporting services in the community) rather than being admitted.
- 35-40% of GP referred patients attending the reconfigured Medical Assessment Unit (MAU) are now being discharged rather than being admitted into the core hospital as in the past.
- 25-30% of patients attending the Acute Medical Unit (AMU) from A&E are also now being discharged rather than being admitted into the core hospital as in the past.
- Discharge of patients at weekends is now supported by volumes of Planned Discharge Dates (PDDs) which are shared with transport providers enabling them to plan additional capacity when required to support the hospital at times of peak demand.

3.5.4 What are the main benefits of this area of work?

- Patients requiring urgent primary care being seen in the most appropriate setting
- Reduction in conveyances to hospital which do not result in provision of significant care or diagnostics
- Reduction in non-elective admissions
- Reduction in DTOCs

3.5.5 What are the main risks and issues?

That system wide flow issues (particularly with regard to patients requiring short term reablement support) leading to high levels of DTOC are not resolved, leading to high levels of DTOC.

3.5.6 What are the governance arrangements for this area of work?

- Urgent care and same day care in primary care programme board
- A&E Delivery Board
- Weekly meetings – citywide CEOs

3.5.7 What consultation has been carried out?

- Urgent care in primary care – broad community engagement to develop the Urgent Care Strategy with further specific engagement with vulnerable groups on Urgent care in primary care. Additional engagement with local and potential providers to develop options for the future.. A formal public consultation will be undertaken September – December 2017..
- Discussions at A&E Delivery Board and elsewhere around assessment model and non-elective admissions.
- Taskforce joint working across STH/SCC/CCG.

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3.6 Mental Health

Lead directors: Peter Moore Sheffield CCG/Dawn Walton Sheffield City Council

Developing our approach to transforming Mental Health Services requires us to focus on prevention, improved access to early support and help and to better support those with complex and crisis needs. Our plan requires a move towards an all age approach and therefore integration between Children's, Young People's and Adult Mental Health Services.

3.6.1 What will this area of work do and what will change as a result?

The aims of this piece of work are to ensure:

- Pooled commissioning budget;
- Single/integrated commissioning team;
- Single vision for mental health services across Sheffield;
- Ability to commission whole pathways of care;
- Development of single transformation programme; delivered jointly with main provider; and
- Begin to instil Accountable Care Organisation (ACO) principles; joint delivery and joint accountability.
- Integrated transition between Children's and Adults

This area of work links to the Five Year Forward View for Mental Health and Implementing the Five Year Forward View for Mental Health.

3.6.2 What will happen in 2017/18 and 2018/19?

Initiation of large scale transformational programme including:

- Full review of dementia care pathway;
- Development of primary care mental health service;
- Implementation of Core 24 Liaison Mental Health Service (which starts outside of hospital);
- Development of neighbourhood based 'low level' provision (social prescribing); Early Help
- Maximising our range of prevention and early help services
- Review of long term nursing and residential care;
- Better access to step-up and step-down provision;
- Better integration between physical and mental health provision (parity of esteem); and
- Reduction in long term high cost out-of-city packages through targeted investment in local community based services.
- Improved access to training and employment
-

3.6.3 What are the main benefits of this area of work?

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Key Benefits

- Greater focus on early intervention; reducing severity and complexity by tackling illness earlier;
- Greater choice and personalised care;
- Delivery of care closer to home, adopting least restrictive principles;
- Better integration of physical and mental health care, delivery of holistic services;
- Driving efficiency through the delivery of less resource intensive services tailored to the needs of each individual.
- Improved access to training and employment
- Reduced pressure on crisis services across Social Care and Police

Metrics

- Better patient feedback and satisfaction scores;
- Reduction in overall mental health spend;
- Less activity delivered by secondary care mental health services;
- Reduction in acute hospital lengths of stay, outpatient attendances and accident and emergency presentations for those with a comorbid mental health diagnosis;
- Reduction in mortality gap between those with and those without a mental health diagnosis;
- Reduction in long-term nursing and residential care;
- Reduction in out-of-city placements; and
- Development of robust neighbourhood based portfolio of services; evidenced through increase in social prescribing.

3.6.4 What are the main risks and issues?

- Delivery of transformational programme is reliant of all parties working collaboratively and jointly. There is not statutory requirement for them to do this.
- Transformation programme does not deliver efficiencies within required timescales; this may therefore generate financial instability.
- Transformation programme is very ambitious and will require dedicated resource to ensure full delivery. Although a joint post has been created and has been filled, working across all three organisations, the delivery of each respective programme area is being undertaken on top of a number of individual's current roles. This will need to be reviewed regularly; joint working is being underpinned by the need to address system wide financial challenges; not through a formally constituted mechanism.

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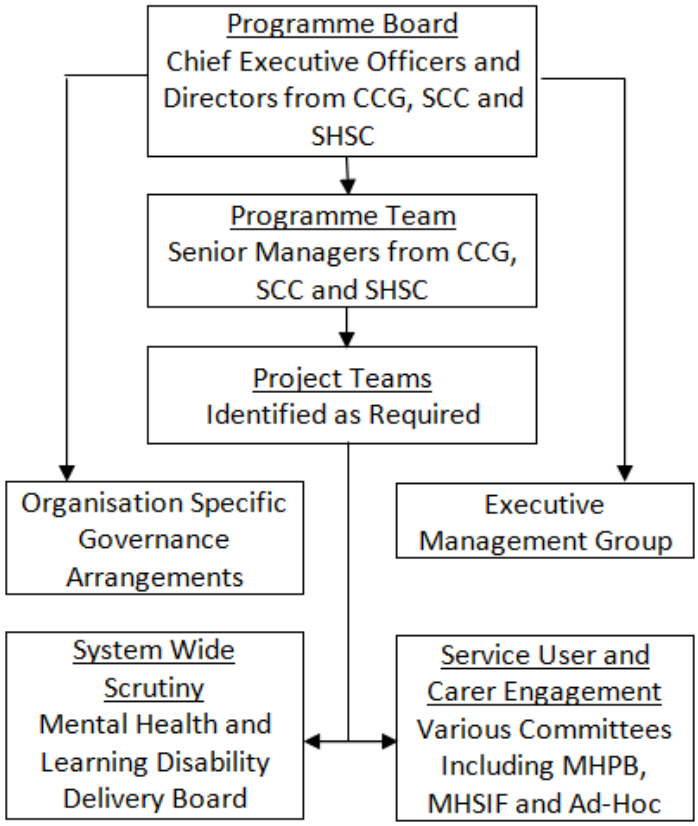
3.6.5 What are the governance arrangements for this area of work?



3.6.6 What consultation has been carried out?

- Service User and Public consultation will form a key element of individual project delivery plans.
- Engagement with providers has already been undertaken, in part, through the Mental Health and Learning Disability Delivery Board. This forum will continue to be used for wider engagement as well as ad-hoc engagement as required.

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3.7 Children and Young People

Lead director: Peter Moore Sheffield CCG/Dawn Walton Sheffield City Council

There is a growing need to develop an all age life cycle approach to our services ensuring long term plans to complex care needs are addressed

3.7.1 What will this area of work do and what will change as a result?

- **Future in Mind:** Children's Emotional Wellbeing and Mental Health work stream – Improving Access to Emotional Wellbeing and Mental Health, providing more early intervention, provide new models of care across that meets need.
- **Community Health:** Joining up Children's Primary and Secondary Care, Children's Education, Social Care and Family Support Services to ensure families get early help and care close to home.
- **Maternity and Best Start:** Improving the health and wellbeing of women and babies by ensuring we plan together between health and public health and provide evidence based models of care that ensure every child has the best start in life. Revise the local offer of Maternity care within localities.
- **Children with Complex Needs:** Increase personalisation of care between health, social care and education. Develop new provision to meet future need.
- Locality based working to improve access to Early Help Services through schools and primary care

3.7.2 What will happen in 2017/18 and 2018/19?

Inclusion in the BCF

- The main activity in 2017/18 will be to understand which areas of Children's expenditure will benefit the most from integrated working. It is proposed to formally add Children's activity to the BCF in 2018/19.
- Mental Health and SEND

Future in Mind

- Improve access by providing a crisis café and dedicated section 136 suite for young people
- Improve access to community mental health specialist services by reducing waiting times, and embedding evidence based treatment pathways Provide healthy minds support in more schools
- Provide a one stop shop for young people in need of emotional wellbeing support in the city centre.

Community Health

- Link primary care and secondary care within localities in Sheffield, and ensure rapid access to specialist healthcare when needed.
- Develop the skills of primary care and local communities in making sure children stay well and managing minor ailments, by working with GPs, schools and parenting practitioners.

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- Link Children's and Families support services and health within localities into one integrated local offer
- Redesign community nursing so that children with Long Term Conditions can be cared for at home instead of in hospital.

Maternity and Best Start

- Consult with women to find out how we should provide care for them.
- Work with the Local Maternity System across South Yorkshire and Bassetlaw to improve maternity care.
- Increase the personalisation of maternity care
- Ensure access to support is available to women as near to their home as possible to ensure they have a healthiest pregnancy possible.
- Develop atonement and attachment between infants and families
- Improve the pathway of maternal mental health

Children with Complex Needs

- Join up assessment and review between health and care for children with complex needs and SEND
- Provide support earlier when families are struggling and support children to be within their communities
- Joint agreements to placements of children in Health, Education and Social Care settings

3.7.3 What are the main benefits of this area of work?

- Future in Mind – increase in access and reduction in waiting times. Reduction in admissions
- Community Health –Reduced attendances and admissions
- Maternity and Best start – Reduced complexity and intervention, increase in midwifery lead care.
- Children with complex needs – Reduction in placements out of area.

3.7.4 What are the main risks and issues?

- Lack of engagement from clinical staff
- Diversion in approach and methodology with providers/ SCC/CCG
- Other agendas and initiatives such as in adult services with competing priorities on resource and direction of travel
- Demand on resources and growth in need could delay implementation of early help and early intervention and prevention models
- Public health resources being challenged which could impact on need
- Statutory duties still being met through changes in pathways and shared governance and accountability framework
- Meeting assurance frameworks and timeframe for mobilising new models of care
- Resources to deliver the changes needed within timescales needed.
- Clinical engagement and leadership

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3.7.5 What are the governance arrangements for this area of work?

Children's Transformation Board

3.7.6 What consultation has been carried out?

- Co - production in place with young people
- Joint programme planning in place with providers
- Consultation with local users of maternity care services being undertaken
- joint programme planning in place with health watch and VAS

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3.8 Capital

Lead director: Penny Brooks Sheffield CCG/Phil Holmes Sheffield City Council

3.8.1 What will this area of work do and what will change as a result?

With DFG work has started to see if there is potential to use some of the money more strategically to help with Delayed Transfers of Care and Out of Hospital Targets. There are strict rules on how the money must be spent and so it will take some time during 17/18 to scope out what is possible. The first potential new strategic capital proposal for DFG is the use for high value community equipment which is discussed above. If further scoping is successful then some additional capital funding may be available to support other health and social care capital initiatives.

The social care capital grant is being rolled forward into 2017/18. This grant will be used to help fund the cost of the replacement of the Care First – Sheffield City Council's social care case management system.

3.8.2 What will happen in 2017/18 and 2018/19?

- DFG scoping to identify strategic opportunities for capital investment
- Maximise the increased grant value by further promoting the service.
- Replacement of Care First

3.8.3 What are the main benefits of this area of work?

- The DFG currently funds (subject to eligibility) work to provide safe access into and around a person's home so that they and their carers can remain living there as comfortably as possible. Works that can be funded include large equipment such as stair lifts, hoists, through floor lifts and ramps and major adaptations such as level access showers. For more complex needs structural alterations and extensions can be funded.
- Need is assessed by Occupational Therapists and clients are further assisted through the financial and construction process by officers in the Adaptations Housing and Health (AHH) Team. The AAH team work closely with clients to help them achieve adaptations that are appropriate to their personal circumstances, offering to support them to carry out alternative works to meet their personal aspirations where possible. Around 400 people per year benefit from these grants.
- DFG strategic scoping is a new area of work for 17/18 which will consider if there are other ways this grant can be used for the benefit of patients.
- The replacement of Care First will improve the efficiency of the system leading to better service to patients. The project will also help in improving the integration of systems between Health and Social Care.

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3.8.4 What are the main risks and issues?

- DFG may provide some strategic capital investment opportunities, but there is no additional revenue funding to support these initiatives. The scoping may not find any meaningful projects to support.

3.8.5 What are the governance arrangements for this area of work?

- Care First Replacement is a large and complicated project which will be governed within SCC under normal project management processes.
- The DFG scoping will take place within Sheffield City Council and will be discussed at EMG if some opportunities are identified.

3.8.6 What consultation has been carried out?

- For Care First this will be covered within the project
- For DFG scoping this will be uncovered as the work progresses.

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3.9 The Improved Better Care Fund (iBCF) Direct Grant

3.9.1. The Government announced as part of the last budget an additional £2 billion to councils in England over the next 3 years to spend on adult social care services. Sheffield is to receive £24m of non-recurrent funding in total over the 3 years.

- The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

- In terms of the wider context, the funding is also intended to support councils to continue to focus on core services, including to help cover the costs of the National Living Wage, which is expected to benefit up to 900,000 care workers. This includes maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services, such as those which support best practice in managing transfers of care.

3.9.2 The Government had made a previous commitment to provide funding to Local Authorities as part of the Better Care Fund (BCF) arrangements on top of the funding which already flows through CCGs. Sheffield is to receive additional funding of £2.2m in 2017/18 building up to a recurrent figure of £21.9m in 2019/20. The table below provides the detailed breakdown.

Year	Annual £000 BCF	Cumulative £000 BCF	Annual Additional Investment £000	Cumulative Additional Investment £000	Total Annual £000	Total Cumulative £000
2017/18	2,200	2,200	12,500	12,500	14,700	14,700
2018/19	10,400	12,600	7,700	20,200	18,100	32,800
2019/20	9,300	21,900	3,800	24,000	13,100	45,900
Total	**21,900**		**24,000**		**45,900**	

3.9.2 As can be seen from above the impact of the additional funding is twofold:

- A much greater level of funding is available for 2017/18 than originally envisaged; and
- The overall amount of the BCF monies is effectively doubled over the three year period.

3.9.3 It is important to note, however, that the original Better Care Fund investment over the next three years is effectively cancelled out by continued reductions in the Revenue Support Grant (RSG) and hence needs to be used to maintain care budgets at existing levels.

3.9.4 The £24m additional funding must either be used on a one-off, non-recurrent basis, or be used to lever change that enables savings in other parts of the health and care system which can then be “recycled” to maintain agreed initiatives. At the time of writing this report, Sheffield’s proposals which have been discussed with key partners across the city, are currently being finalised with a paper to SCC’s Cabinet in July.

3.9.5 The government will also invest £325 million over the next three years to support the local proposals included within STPs for capital investment where there is the strongest case to deliver real improvements for patients and to ensure a sustainable financial position for the health service. In the autumn, a further round

of local proposals will be considered, subject to the same rigorous value for money tests. Investment decisions will also consider whether the local NHS area is playing its part in raising proceeds from unused land, to reinvest in the health service. It is anticipated that this funding will be allocated through CCGs at the local level.

Challenges for Adult Social Care

3.9.7 Challenges for adult social care can be split into three categories. These are listed below.

- The need to build the sustainability and resilience of key services so that capacity is there to support the whole health and social care system, particularly in times of high external demand
- The need to ensure that adult social care needs can still be statutorily met where there is significant financial constraint that might otherwise result in a service reduction.
- The need to invest in the infrastructure of adult social care so that services are effective, efficient and make best use of resources, ensuring that adult social care capacity continues to grow in the longer term.

3.9.8 Areas of potential investment that would help address the challenges are set out below:

- Improving medication management for people who receive care at home.
- Greater efficiency within the Short Term Intervention Team (STIT)
- Further whole system innovation to reduce Delayed Transfers of Care and improve outcomes for Sheffield people after their hospital stay.
- Improving life chances for young people moving into adulthood.
- Improving partnership working between specialist mental health services and the police.
- The need to improve systems and reduce bureaucracy in the delivery of adult social care
- The need to develop the social care workforce to support delivery
- Sustainability of the social care provider market supporting older people.
- The need to improve outcomes and use of resources for people with learning disabilities and people with mental health problems
- Support the high number of people who require assessment under Deprivation of Liberty Safeguards (DoLS)
- The need to maintain social work capacity until improvements are in place that increase productivity

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- The need to maintain Community Support Worker capacity while their preventative impact is evaluated.

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3.10 Delayed Transfers of Care

As a national outlier in Delayed Transfers of Care(DTOC), the CCG, Sheffield Teaching Hospitals and the Local Authority agreed to bring in the expertise of Newton Europe, a specialist in working with whole systems to work together to get to the root of why our delayed transfers of care remain a challenge, and to work with us to develop an action plan ready for delivery for this winter.

The work was launched at a city summit on the 23rd May to which all stakeholders were invited to learn of the outcomes of the two week diagnostic which Newton Europe had undertaken, to identify the underlying problems and then facilitated by Newton Europe, work together to identify how we can improve our discharge services for patients.

What was recognised in the first instance was what we do well,

- we all have a common purpose to always put the patient first
- Some outstanding best practice
- Significant progress made to increase reablement capacity
- Common view of the behaviours needed in a good system
- Unanimous high desire to improve.

Key facts on delayed transfers over the last 12 months which Newton Europe had highlighted in their diagnostic:

- People in Sheffield have spent **72,000** more days in Hospital over the last year than they needed to.
- 32% of those impacted on DTOC are waiting for a pathway to be allocated to them
- 30% of those impacted by DTOC are on a pathway to either intermediate, nursing and residential care
- 31% of those impacted by DTOC are waiting to go home with some extra support.

The key wokstreams agreed at the Summit were to:

- Get people home
- Rapid Community care
- Assessment at Home.

Current Position

Based on the work and outcomes of the summit, STH, the Local Authority and the CCG have worked together to develop the plans for the next stages of the programme. These have been presented to Chief Executives of the Council, CCG and STH who supported the plans. Our agreed reduction of numbers of DTOCs is to 50 with locally managed stretch targets.

In summary, we agreed that we will work towards developing only three routes out of hospital (replacing the myriad of current pathways), these being:

1. People who just need to go back to what they had before (ie no D2A)
2. People who might need more and should be assessed at home to determine what that might be (D2A at home)
3. People who might need more but MDT are anxious about them returning straight home so they go to step down for assessment (D2A in stepdown which would include Intermediate Care beds)

To develop these routes, we are establishing three workstreams:

1. Work in hospital to navigate people into one of these 3 routes as quickly as possible on admission .
2. Work in community to ensure rapid response community services are there to enable D2A
3. Work in community to ensure rapid capacity and response assessment is there to enable D2A

Our improved service model will be underpinned by the Improved Better Care Fund Direct Grant as described in section 4.

Key activities to help deliver the above workstreams will include –

- Understanding the perceived barriers to discharge.
- Increase support to therapists to develop a more holistic risk conversation with patients
- Integrate active recovery to provide a seamless service to patients to improve outcomes and productivity
- Increase resilience of Independent Sector Homecare
- Improve outcomes and productivity in regards to intermediate care beds
- Increase complex discharges via discharge to assess/more home based assessments.

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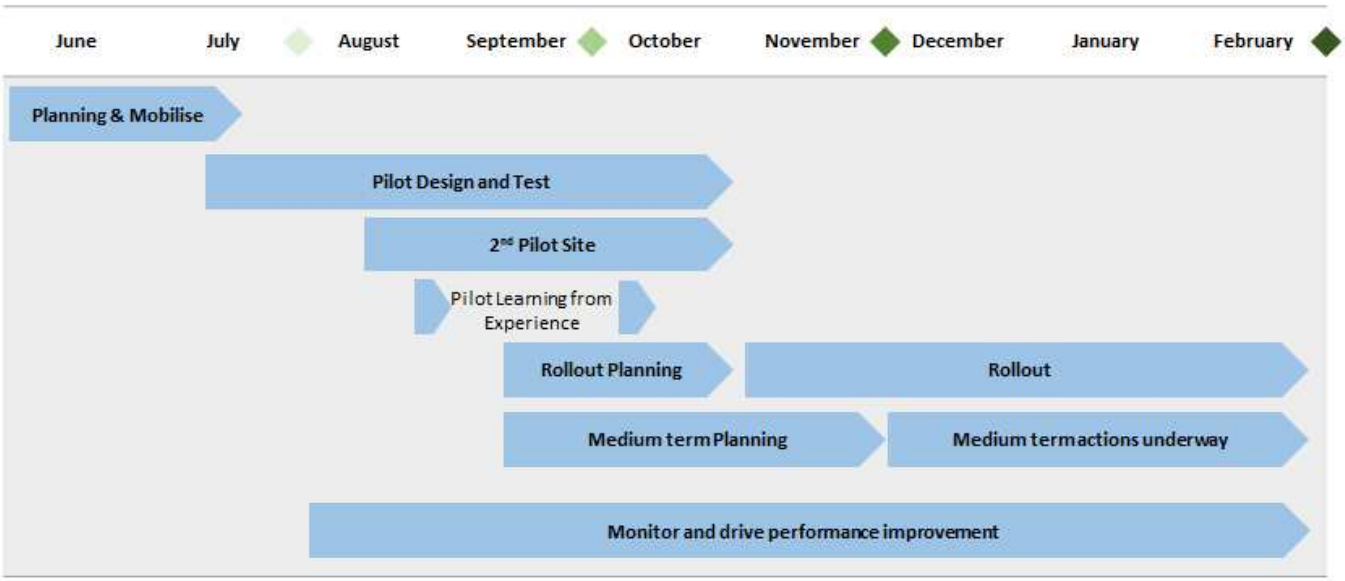
This will be underpinned by robust metrics and governance. Our main action plan

DTOC
A CLOSER LOOK

Sheffield Teaching Hospitals NHS
NHS Foundation Trust
NHS Sheffield
Clinical Commissioning Group
Sheffield City Council

PLAN



Use of the High Impact Change Model

Sheffield's approach will explicitly incorporate the High Impact Change Model to enable maximum benefits to be delivered in shortest possible time.

Workstream 1, Work in hospital to navigate people into one of the 3 discharge routes as quickly as possible on admission, will focus on mainstreaming Changes 1, 2, 3 and 7.

Change 1 : Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be setwithin 48 hours.

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services aroundthe individual.

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Workstreams 2 and 3, providing rapid response community assessment and services will focus on mainstreaming Changes 4, 6 and 8.

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

All three workstreams will be mindful of Change 5 to ensure that both discharge planning and community capacity is geared to support optimal flow all seven days a week.

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

4. Our financial plan

Overview

The Sheffield Better Care Fund recurrent Pooled Budget was £272m in 2016/17 and the current budget for 2017/18 is £352m. The respective contributions of Sheffield NHS CCG and Sheffield City Council are shown below. These figures are the initial budgets as agreed by the Executive Management Group on 15th May 2017.

The biggest proposed change to the BCF in 2017/18 is the addition of a new Theme in relation to Mental Health which is the main reason for the c£79m increase in value of the BCF budget. Sheffield NHS CCG and Sheffield City Council have agreed to pool their mental health budgets and to risk share the combined financial position.

A truly integrated commissioning approach for Mental Health will offer more effective joined up commissioning (and therefore care), leading to better patient outcomes which will, by default, deliver better value for money.

The initial BCF budget shown below currently excludes the £12.5m iBCF additional government funding announced in the Spring Budget but resources will be added to relevant budget lines as a formal variation once the proposals have been signed off by SCC's Cabinet in July. The £2.2m original increase in BCF funding for Sheffield has been added to the BCF, but this has been offset by an equal and opposite adjustment to recognise the impact of the reduction to the revenue support grant to the funding of SCC services.

The tables and narrative below cover the plans for 2017/18. Work is underway on finalising both the targets and financial plan for 2018/19 which will be reported at a later date

Allocation of Resources

The Sheffield BCF is structured around the key areas (themes) of activity.

Budget Overview	**2016/17 Recurrent Budget £000**	**2017/18 Initial Budget £000**	**2017/18 Change £000**
Theme 1 - People Keeping Well	8,130	8,262	132
Theme 2 - Active Support and Recovery	50,321	49,807	(515)
Theme 3 - Independent Living Solutions	3,879	3,864	(15)
Theme 4 - Ongoing Care	151,892	127,186	(24,705)
Theme 5 Adult inpatient Emergency Admissions	54,565	56,505	1,940
Theme 6 - Mental Health	0	100,772	100,772
Sub total - Revenue	**268,788**	**346,397**	**77,608**
Theme 7- Capital Expenditure	3,509	5,537	2,028
Total	**272,297**	**351,934**	**79,636**

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Note - the reduction in ongoing care is predominantly a transfer of Mental Health purchasing costs into the new Theme for Mental Health.

The 2017/18 financial position has been constructed based on joint planning between the CCG and Local Authority. Joint working formed part of the budget setting process of both organisations and was led through discussions at the Executive Management Group. In this way the impact of changes was considered across the whole health and social care system.

Management of the Pooled Budget

Work has started to draft the amendments to the S75 agreement for 2017/18 which should be finalised in July.

The Community Equipment Service (budget £2.8m) and Mental Health (Budget £101m) are jointly managed schemes with a risk share arrangement for any over or underspends. These schemes represent around 30% of expenditure lines within the BCF, with the balance being solely managed or jointly managed schemes that are funded solely by the partner responsible for that scheme.

The Section 75 agreement clearly sets out the process for dealing with over and underspends from all scheme types, and has worked well during 2015/16 and 2016/17. Work will continue in year to explore whether there are more services which would benefit from alternative mechanisms for the organisations to share risk when implementing integrated activities.

At present there is no agreement to implement a risk share arrangement for non-elective admissions. Both the council and the CCG are creating contingency plans to ensure that the expenditure in out of hospital services can be protected if the reduction in non-elective admissions, or other QIPP plans or efficiency savings cannot be met.

Protection of Social Care Services

One of the national conditions of the BCF in 2017/18 is to maintain real terms funding from Health to support social care services. Sheffield NHS CCG is committed to meeting the funding conditions attached to the BCF. There has been an increase in CCG funding for social care to satisfy the mandatory minimum contribution, and a significant additional contribution primarily due to the inclusion of mental health activity. The CCG total investment in the BCF increases to £244.4m in 2017/18, some £206m more than the mandatory minimum. In addition, investment in out of hospital services has been maintained.

Sheffield City Council is investing £107.5m in the BCF in 2017/18 which represents an increase of £7.8m mainly in adult social care.

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BCF Funding Sources	2016/17 Recurrent Budget	2017/18 Initial Budget	2017/18 Change
Funding Sources	**£000**	**£000**	**£000**
Sheffield Local Authority	95,103	101,975	6,872
Sheffield Local Authority - Disabled Facilities Grant (Capital)	3,058	4,031	973
Sheffield Local Authority - Other Capital	1,506	1,506	0
Sub Total Local Authority	**99,667**	**107,512**	**7,845**
Sheffield NHS CCG minimum contribution	37,657	38,331	674
Sheffield NHS CCG additional contribution	134,973	206,090	71,117
Sub Total CCG	**172,630**	**244,421**	**71,791**
Grand Total	**272,297**	**351,934**	**79,636**

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This increased spend on social care is predominantly to satisfy demographic and national living wage pressures, but there is also allowance for an increase in home care rates to improve the resilience of the independent sector and to support hospital discharge processes.

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5. Targets for 2017/18 and 2018/19

The number of mandatory BCF targets has been reduced in 2017/18. An overview of the mandatory targets is shown below.

	Actual 14/15	Actual 15/16	Target 16/17	Actual 16/17	Target 17/18
BCF Target Summary					
Mandatory BCF Targets	**No.**	**No.**	**No.**	**No.**	**No.**
Delayed transfers of Care					
Delayed transfers of Care (Delayed days)	24,138	23,411	19,000	48,969	21,203
DTOC (Delayed Days) rate per 100,000 of population (BCF Me	5,324	5,152	4,146	10,686	4,601
DTOC (patients) per 100,000 of population (ASCOF 2C1)	15.2	15.7	n/a	29.1	14.1
Non Elective Admissions	58,665	55,075	54,335	53,631	48,021
Admissions to residential and nursing care					
Admissions to residential and nursing care homes (Age 65+), per 100,000 population	820	987	824	816	768
Admissions to residential and nursing care (absolute number)	748	909	763	756	717
Reablement					
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement /	77%	77%	85%	75%	80%

Delayed transfers of care are monitored on three measures and have risen sharply in 2016/17. The target for 2017/18 assumes a 10% reduction on 2015/16 levels which is consistent with the Sheffield City Council ASCOF (Adult Social Care Framework) targets.

Non Elective Admissions

Non Elective admissions performed better than target in 2016/17. The cost of non-elective admissions was higher than budget in 2016/17, but this was predominantly due to excess bed day costs associated with a higher level of delayed transfers of care. The target for 2017/18 is based on reductions delivered primarily from activities within AS&R and urgent care

Admissions to residential and nursing care

The number of admissions in 2016/17 has fallen 17% compared to 2015/16, and achieved target. The target for 2017/18 is based on the ASCOF submission and assumes a 6% reduction in admissions compared to 2016/17. This will primarily be achieved via the implementation of the discharge to assess process.

Reablement

The proportion of older people still at home 91 days after discharge is forecast to increase to 80% in 2017/18. The final position for Q4 2016/17 was 75% which was affected by a higher number of deaths than in the prior year. The target for 2017/18 is based on the ASCOF submission is 80%.

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6. Our delivery plan and approach to risk

The strategic leadership and delivery assurance of the Better Care Fund is undertaken by our Executive Management Group (separate groups managing strategy and delivery). The Executive Management Group includes representation from Executive Directors and Directors leading the workstreams from both CCG and Local Authority.

The group was originally constituted as part of the integrated work between Sheffield CCG and the Local authority three years ago when the provider landscape, national direction and financial challenges were different. The focus has changed now following the Five year forward view, to more of a partnership approach for commissioners and providers together. Sheffield now has a broader plan as demonstrated in the Sheffield Plan, works in a South Yorkshire and Bassetlaw accountable care system, and the Better Care Fund and its governance needs to ensure it remains fit for purpose going forward to deliver all of our ambitions.

With this in mind, the group is reviewing its governance, roles and responsibilities to ensure it can:

- Work seamlessly within a joint commissioner/provider partnership
- That due to the ambitious savings plans, it can take responsibility to project manage progress, manage risks and inter-dependencies across all our workstreams.
- It uses resources smartly and does not duplicate any existing functions.

Programme Management

We understand that if we do not manage risk and focus on realising our benefits, we are at risk of not succeeding. We are therefore reviewing our programme management function across our workstreams to ensure that there is a system overview.

It has acknowledged that because of the huge savings needed in Sheffield it is reviewing its cross system assurance process to ensure all workstreams are on track and will ensure success and realise our benefits.

We are putting in place more systematic reporting processes to ensure that the system leaders are assured that all the workstreams are on plan to deliver. We are planning to put this in place over the next three months. All the risks have been mentioned in each of the workstreams and are being managed within each of their own governance arrangements and highlighted to Executive Management Group on an exception basis.

It is also mindful of wider programmes of work, such as the Public Sector Reform programme which will include health and care initiatives as well as the wider social value elements including employment, education and the economy.

As well as reviewing its roles and responsibilities, the Executive Management Group is also reviewing its scope, terms of reference and membership.

We are developing a wide range of outcomes, to meet our wide ranging objectives. Some are specific to each of the workstreams but it has been acknowledged that it is difficult to

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develop outcomes which can also be evidenced as been achieved, given our strong emphasis on prevention initiatives.

We are part of the national pioneer network and we share as well as learn from our partners across the network.

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HEALTH AND WELLBEING BOARD PAPER

STRATEGY MEETING

Report of:	**Peter Moore, Director of Strategy and Integration**
Date:	27th July 2017
Subject:	**Urgent Primary Care**
Author of Report:	**Kate Gleave, 0114 3051183**

Summary:

NHS Sheffield CCG's Strategy for Urgent Care articulated a need to improve Urgent Care services in recognition of the national policy to improve access and because Sheffield residents find the current service arrangements confusing and difficult to use appropriately. In order to achieve this, the Strategy recognised that local urgent primary care and services need to be reorganised.

The CCG has spent recent months considering how this might be achieved with a view to agreeing a set of options for the delivery of services to take to formal consultation in September 2017 with the public.

The purpose of this briefing paper is to summarise the Case for Change and the principles upon which the options have been based and to outline the timescales involved.

Questions for the Health and Wellbeing Board:

- Can the Board confirm that the objectives of the Urgent Primary Care review and redesign are in line with those of the Health and Wellbeing Board?
- Can the Board support and inform the formal public consultation?
- Would the Board support disproportionate re-investment into the areas of greatest need?

Background Papers:

Urgent Care Strategy (Appendix 1)

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

- Health and wellbeing is improving
- Health inequalities are reducing
- People getting the help and support they need and feel is right for them
- The health and wellbeing system is innovative, affordable and provides good value for money

Who have you collaborated with in the writing of this paper?

The work described within this paper has been informed by meetings with existing Sheffield providers, potential providers from outside the city and the engagement undertaken with the Sheffield public and specific deprived communities.

Urgent Primary Care Review and Redesign

1.0 SUMMARY

1.1 In May 2016 NHS Sheffield CCG approved the revised Strategy for Urgent Care (see Appendix 1). This articulated a need to improve Urgent Care services in recognition of the national policy to improve access and because Sheffield residents find the current service arrangements confusing and difficult to use appropriately. The Strategy set out the organisation's vision to ensure that the new model of urgent care will provide care where needed in the most appropriate setting that is easy to understand and to access for both patients and clinicians.

1.2 For patients with urgent but non-life threatening needs, highly response, effective and personalised services need to be provided outside hospital and care should be delivered in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. In order to achieve this, the Strategy recognised that local urgent primary care and services need to be reorganised.

1.3 The CCG has spent recent months considering how this might be achieved with a view to agreeing a set of options for the delivery of services to take to formal consultation in September 2017 with the public.

1.4 The purpose of this briefing paper is to summarise the Case for Change and the principles upon which the options have been based and to outline the timescales involved.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

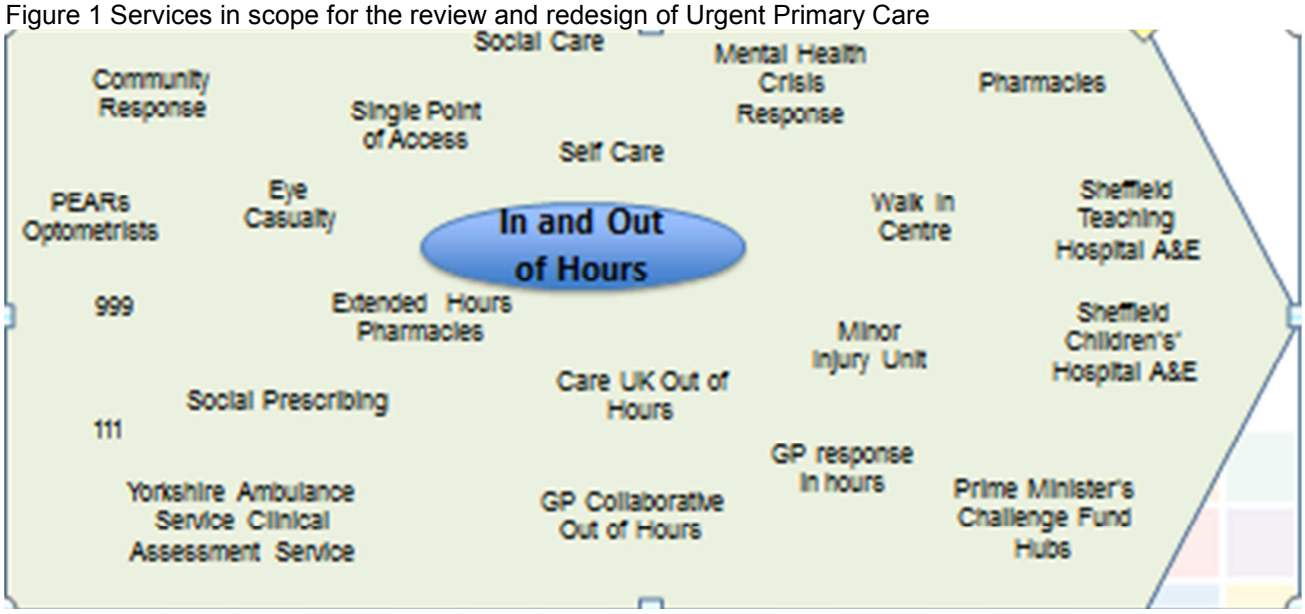
2.1 It is anticipated that by April 2020 Sheffield patients will be able to access highly responsive, effective and personalised urgent primary care with ease.

3.0 Definition and Scope

3.1 Urgent Primary Care has been defined as
'any patient contact requiring an appointment within 24 hours with a GP or Community service as defined by the patient'.
This includes care for mental as well as physical health and minor injuries as well as minor illness.

3.2 The scope of the service reorganisation is all of the services that provide first line urgent care in and out of hours. This includes all of the services listed below.

Figure 1 Services in scope for the review and redesign of Urgent Primary Care



3.3 It should be noted that only the urgent primary care activity seen within the adult and paediatric A&E Departments is included within scope. Emergency activity (defined as serious or life threatening or needing an immediate response) is outside the scope of this reorganisation. Dental care has also been excluded from the scope of the review. This is because NHS England (who commission all dental care) are currently undertaking a review of urgent dental care across South Yorkshire. The SCCG team are in dialogue with NHS England colleagues to make sure that each organisation is sighted on the potential impact and outcome of the other organisation's work.

4. Summary of the Strategic Context

4.1 The Keogh review of urgent and emergency care aimed to ensure that patients nationally have access to integrated 24/7 urgent care services. The Urgent and Emergency Care Delivery Plan (April 2017) set out a number of components that all Urgent and Emergency Care Systems must implement over the next 2 years.

4.2 Several of these requirements (listed below) impact on the design of the revised urgent primary care part of the system. NHS Sheffield CCG has considered what services and configurations are best for Sheffield and then incorporated the national requirements into these.

- The need to standardise walk in centres, minor injury units and urgent care centres into Urgent Treatment Centres which offer consistent high quality services and are less confusing for patients to access.
- Fully integrate urgent care services combining NHS 111 and GP out of hours services to deliver high quality clinical assessment, advice and treatment with shared standards and processes.
- The requirement to implement front door clinical streaming at Emergency Departments. Patients presenting at Emergency Departments with Urgent Primary Care needs will be diverted from the Emergency Department to a primary care service located on the same physical site.

- Deliver the requirements of the GP Forward View with regard to rolling out pre-bookable and same day evening and weekend GP appointments.

4.3 Several of the other components will support the urgent primary care part of the system but can be considered as peripheral enablers rather than part of the reorganisation consultation e.g. the Ambulance Recovery Programme which changes the way ambulance staff respond to particular types of calls.

4.4 Urgent care is highlighted as a priority within the local Sustainability and Transformation Plan with the overarching aim of simplifying urgent and emergency care and making it easier or patients to access the right services closer to home. This is supported by the local UECN and West Yorkshire Emergency Care Network Vanguard which are focussed on delivering the key elements of the national strategy at pace.

5. Summary of the patient engagement feedback

5.1 The team undertook significant amounts of engagement with the public whilst developing the Strategy for Urgent Care. Further work has just been completed with vulnerable groups to understand whether their needs and views vary from that of the wider population. The key findings from all of this engagement can be summarised as:

- Access to and variability of GP services across the city
- Patients confused as to what services to use and when and need education/ signposting
- System not working cohesively or communicating. Needs to be joined up and integrated across health and social care
- Inequalities – differing experience and knowledge of services depending on where you live in Sheffield
- Desire for alternative services available in the community/closer to home – transport is an issue
- Senior staff members working with vulnerable communities are finding a way to make the system work to meet people's needs, sometimes using creative ways to ensure people receive care.
- The cost of travel on public transport is a barrier, as are language issues.
- Anecdotally, access to mobile phones is an issue. For those people who do own a phone, they may not be able to afford credit.
- Specialised services for vulnerable people tend to be based in the city centre, and are offered on a drop-in basis.
- People are unlikely to arrive at other services (including the WIC, pharmacies, Minor Injuries, etc.) unless they have been told to attend by a person in authority (including case/project workers, receptionists, etc.).

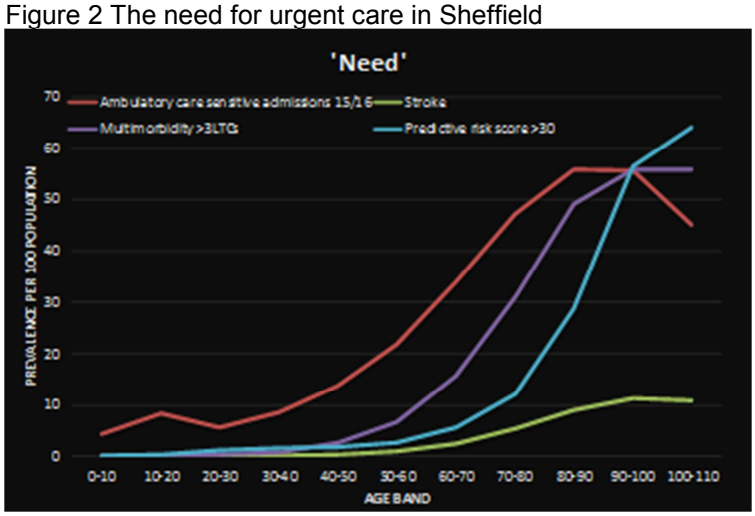
6. Summary of Need, Demand and Activity

6.1 Analysis of urgent care need and demand has been undertaken by Public Health colleagues. This indicates that different services within the city are currently serving

very different population constituencies and that there are inequalities of access based on levels of deprivation.

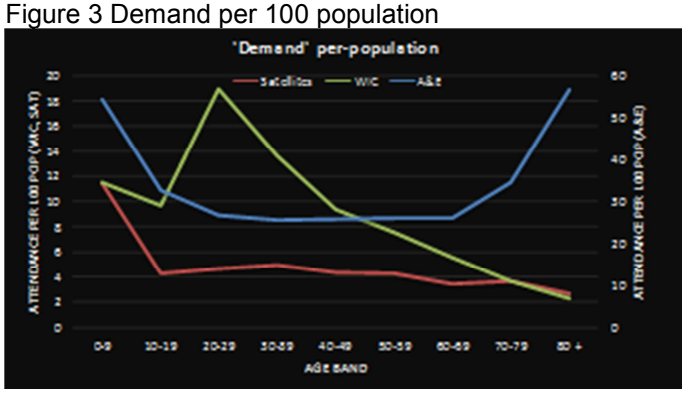
6.2 The need for urgent care is hard to quantify, but when considering the number and age band of patients with multiple long term conditions, ambulatory sensitive care conditions and the risk of being admitted to hospital, it is clear that the older the population is, the greater the need for urgent care.

Figure 2 The need for urgent care in Sheffield



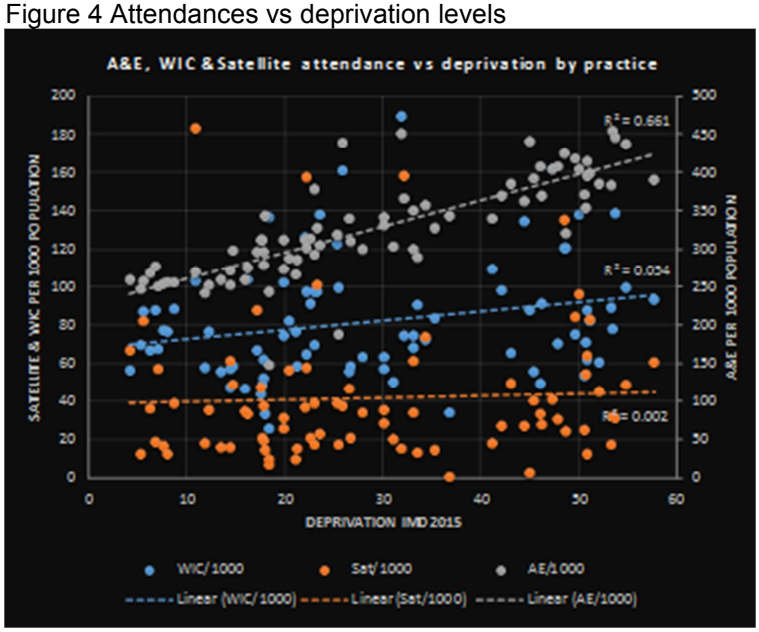
6.3 The demand for urgent care does not however follow the same pattern. The highest level of demand is generated by those under 9 and over 80 attending the Emergency Departments with between 50 and 60 attendances per 100 population. This is followed by the 20-29 age group attending the Walk In Centre with 20 attendances per 100 population and the under 9s attending the Prime Minister's Challenge Fund hubs (satellites) and the Walk In Centre with 9 attendances per 100 population.

Figure 3 Demand per 100 population



6.4 The rate of attendance only varies depending on level of deprivation at the Emergency Departments. This suggest that the most deprived populations in Sheffield who are likely to be in more need of urgent care because their health is likely to be worse are not accessing urgent care at the same rate as other parts of the population. This is supported by the geospatial distribution modelling undertaken by the Public Health team. This identified that the greatest volume of attendances at the Prime Minister's Challenge Hubs came from the Townships II Neighbourhood (South east of the city around Woodhouse) area which does not correlate with the most deprived areas of the city.

Figure 4 Attendances vs deprivation levels



7. Summary of the objectives of the reorganisation of Urgent Primary Care

7.1 The review of the strategic context, patient feedback and analysis of patient need, demand and activity indicates that in order to achieve the vision for urgent care, the reorganisation of Urgent Primary Care needs to achieve a number of objectives. These are:

Table 5 Objectives of Urgent Primary Care Review and Redesign

Objective	Rationale
Reduce duplication and simplify access	Patient feedback from Urgent Care Strategy and Vulnerable Groups engagement said this was key as current system is confusing and hard to navigate
Reduce inequalities	Patients are not accessing the current services based on levels of need. Some groups of patients are encountering barriers to access e.g. cost of public transport, access to a phone, interpreter requirements
Improve access to Primary Care services	Several primary care services are currently provided within secondary care. The range of primary care services also creates confusion and duplication
Improve access to urgent care provided by GP practices (without detrimentally affecting waiting times for planned care)	Access to urgent appointments within practices varies significantly across Sheffield, as does the length of wait for a planned appointment. This creates further inequalities across the city.
Support a sustainably resourced primary care	Primary Care within Sheffield needs further investment in order to provide a sustained service. This involves sustaining both the workforce and financial investment into practices
Encourage and support self care	Empowering patients to self care where appropriate encourages them to take responsibility and positive action for their health and wellbeing and reduces

	unnecessary interactions with urgent care services
Provide value for money	The CCG has a duty to ensure that it commissions services which provide value for money (spending less, spending well and spending wisely)
Deliver care locally and appropriately	Patient feedback had indicated that being able to access care locally is important but this has to be balanced to ensure that care is also appropriate for the population
Reduce pressure in Emergency Departments	Over the last year, STHFT have struggled to achieve the four hour A&E target. This is in part because of the volume of attendances, a proportion of which could have been managed within primary care
Contribute to or enable delivery of the national requirements	As stated in section 4 above, the system has to incorporate a number of national requirements into the services provided within Sheffield

7.2 As well as seeking to meet these objectives, the review and redesign has identified several key principles that need to be adhered to.

Table 6 Principles

Consistency of offer	Patients will receive a consistent service offer across the city in relation to the signposting and access to urgent care services. How services are delivered may vary by neighbourhood based on the needs of each population group but what services are delivered and how quickly these can be accessed will be the same
Moving money around the system, not reducing or increasing overall spend	The CCG believes that it can obtain greater value for money by investing appropriately in primary care. This will mean reducing investment in secondary care and/or duplicated services and reinvesting this into primary care, potentially with disproportionate levels of investment based on health inequalities
Continuity of Care	The CCG believes that providing patients with continuity of care is important when this continuity can positively impact on outcomes. Where this is not the case, patients will be seen by the most appropriate clinician for their condition

8. Timescales for development of the proposed options for consultation and implementation

8.1 The timescales for the development of the proposed options and the formal consultation were delayed as a result of the purdah caused by the General Election. The revised timescales are set out below.

Action	**Timescale**

Urgent Care Strategy published	25th May 2016
Urgent Primary Care potential options developed	November 2016 – August 2017
NHS Sheffield Governing Body decision to proceed to formal consultation	7th September 2017
Formal Consultation	8th September – 1st December 2017
NHS Sheffield Governing Body decision to implement the preferred option	2nd February 2018
Mobilisation phase	3rd February 2018 onwards

8.2 It is anticipated that the revised service offer will be fully implemented across Sheffield by the end of March 2020.

9.0 QUESTIONS FOR THE BOARD

9.1 It would be helpful if the Board can address the following questions:

- Can the Board confirm that the objectives of the Urgent Primary Care review and redesign are in line with those of the Health and Wellbeing Board?
- Can the Board support and inform the formal public consultation?
- Would the Board support disproportionate re-investment into the areas of greatest need?

Appendix 1 Urgent Care Strategy

http://www.sheffieldccg.nhs.uk/Downloads/CCG%20Governing%20Body%20Papers/2016/May%2026%202016/PAPER%20E%20Strategy%20for%20Urgent%20Care.pdf

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HEALTH AND WELLBEING BOARD PAPER

STRATEGY MEETING

Report of:	Greg Fell
Date:	27th July 2017
Subject:	Public Health Strategy
Author of Report:	Greg Fell

Summary:

Sheffield CC Cabinet have agreed a Public Health Strategy, which aims to describe the ambition of SCC to redress the 25 year difference in healthy life expectancy through the totality of SCC's functions (not just the Public Health Grant). A key feature of the strategy is focused on the concept of Health in All Policies, which considers how to maximise the health gain from policies and service areas that are not traditionally considered as "health" related. The acid test of adoption of a principle of Health in All Policies will be that all areas of decision making and resource commitment systematically consider health and wellbeing outcomes, and inequalities, across all decision making processes. To truly deliver a Health in All Policies approach it will be necessary to change the way the organisation thinks and does its business. The Committee are asked to consider how this approach can best be further developed.

Questions for the Health and Wellbeing Board:

- Are the priority areas identified in the strategy the right areas to be focusing on, and are there any of these that are of more immediate interest?
- Are there other areas we should be looking at too?
- What role could the Health & Wellbeing Board play in maximising the impact of the strategy?
- How could the Health and Wellbeing system in Sheffield build upon this direction to improve wellbeing in the city?
- How could the Health & Wellbeing Board work with the Council's Scrutiny function to support the delivery of the Strategy?

Background Papers:

Public Health Strategy

PUBLIC HEALTH STRATEGY

1. Introduction/Context

1.1. On 15th March Sheffield City Council's Cabinet agreed a Public Health Strategy.

1.2. In developing this, the original ask of the Leader of the Council and Chief Executive was to describe what SCC as a "public health organization" would look like, to transform 'public health' from an NHS facing model to a local government facing one, and to set out a strategy that described the ambition of SCC to redress the 25 year difference in healthy life expectancy between the most and least deprived areas of the city, through the totality of SCC's functions (not just the Public Health Grant).

1.3. The strategy is now agreed and published. Some further work will be done to turn this into a public facing document. As a Council Strategy, this paper principally describes the intended impact on SCC, but also highlights the potential for enacting this approach across the whole health and wellbeing system in Sheffield.

1.4. SCC is clear that the scope of "public health" is not confined to the services and activities funded from the Public Health Grant.

1.5. The approach taken in the strategy is, deliberately, tipped away from an NHS centric model of public health, though the importance of the NHS is not underestimated. This is an effort to redress the balance in approach to "public health", while being mindful of the large gravitational pull of the NHS and the potential in terms of the staff that work in it. The strategy therefore makes a concerted effect to shift the balance of the discussion and narrative on health away from healthcare and more towards other issues.

1.6. A key feature of the strategy is a focus on the concept of Health in All Policies. Health in All Policies is a mechanism to 1) make explicit, and 2) increase (rather than describe the current), health gain from policies and service areas that are not traditionally considered as "health" related. One of the aims is to ensure the health and inequalities impact is on the balance sheet in a visible and tangible way , in order to challenge the way existing resources are committed. The point of such approaches is to challenge existing resource commitments with a view to delivering more health return with them than is currently the case. Many of the processes in place will continue to happen; the challenge and opportunity is to maximise the wellbeing generated by those processes above what might have otherwise been the case.

1.7. In this way the intention is to seek to create health & wellbeing, something at least as sensible and as practical as simply avoiding disease.

1.8. Health in All Policies is not the only feature of the strategy, there is still an expectation that business as usual will continue – the services funded through the PH Grant, a focus on

lifestyles and a focus on health protection. In addition the first aim is to continually refresh our approach to health inequalities, arguably the hardest challenge of all.

2. Implementation

2.1. There is no intention to write a detailed action plan; indeed a detailed action plan may actually be a barrier to success, opportunism is likely to be strategy critical element of a successful approach. Implementing Health in All Policies will take many forms and there isn't a single idea or policy option that will achieve the goal.

2.2. The specific 10 areas highlighted in the strategy are one place to start, and focused on obvious opportunities, easy wins – in terms of where health gains can be made with limited changes to existing arrangements, and areas with significant gain potential. SCC expects to refresh or revise our strategy in these areas over the coming years. These are listed below:

1. **Best Start** – pre birth to primary school education (The first 1001 days);
2. A comprehensive **Work and Health** strategy;
3. The potential for **sustainable economic growth** to improve better health outcomes and redresses inequalities.
4. The **City for All Ages Strategy** and a refreshed approach to healthy ageing.
5. Optimising the health & wellbeing opportunities around **land use planning; population density and mix, transport planning including active travel**;
6. Development of an **Air Quality Strategy** for Sheffield.
7. Supporting the **NHS with the reform and transformation** agenda as articulated in the Sheffield Place Based Plan.
8. Reviewing and redeveloping the **Sheffield strategy for open space and green space,** bringing together our approach to the **Outdoor City, parks, Move More** and other agendas;
9. Maximising the health and wellbeing opportunities in our **housing strategy**, and development in the housing sector more broadly;
10. Developing a strategy for **mental wellbeing,** building on, and complementing the Mental Health Strategy.

Some of these target areas are wholly within the purview of SCC, but all would at a minimum benefit from a wider system view, some would be significantly enhanced by involvement from the wider system, and some are explicitly cross-organisational.

2.2. As per above, it should be emphasised these are only areas of obvious opportunity. Obviously where opportunities naturally arise on account of external or internal events these will be taken; it may also be possible to engineer opportunities. ‘Policy windows’ may only be open for a short time and may revolve on an unexpected crisis, budget process, and community demands, so an opportunistic approach will be important. Continued austerity represents a threat to progress for a number of reasons.

2.3. Gaining traction on the way that large resource commitments influence long term wellbeing and inequality outcomes, in the face of immediate demand led pressures, and reconsideration of core statutory duties is the key resource challenge. There may also be a belief gap to address.

2.4. There is a need to ensure the right machinery to make change happen. Arguably that may become a little bureaucratic but without machinery the strategy may never get beyond bold words. Eight ideas to develop implementation where it may be possible to demonstrate progress through a Health in All Policies approach are set out below:

- **Build health impact assessment into planning processes and developments in a practical way**, based on best practice. Linked to this, develop common monitoring and evaluation tools.
- **Ownership** – it only matters if others share the vision and general approach. Ownership of challenges by a large group of stakeholders matters. Persistence and presence across all parts of organisations will be needed, and potentially between organisations.
- **There may be merit in reconsidering the purpose of "commissioning" in some areas,** including what outcomes are desired and whether there are more strategic uses of resources to get those outcomes.
- **Be clear about expectations** - should key policy or service areas set and publish health and wellbeing objectives, take reasonable steps to meet objectives, and write an annual statement in which if objectives are not met reasons are given.
- **In some areas it may be necessary to change how success is measured in big systems, how Return On Investment is considered and what lessons can be learned from elsewhere in the world or other relevant sectors**. An example of this might be reconsidering how “success” is measured in transport policy, and the incorporation of health impact into economic success measures and evaluation models. A second example would be the consideration of the long term health impact of economic policies. The RSA Inclusive Growth report (among others) has noted that a healthy population is core to economic productivity, but is often missing from calculations.

- **Engaging citizens in this agenda is important, and could be done better.** There is a need to think through how to better engage individuals in the factors that influence their health. Health is NOT solely the product of our own choices, but individuals can influence these decisions as voters, consumers, employees and shareholders if they understand the problem. How can citizens be equipped to be just as (or perhaps more?) prepared to lobby their politicians over the levels of nitrous oxides on their local streets or the lack of street level activity in their housing estates, as the closure of an A&E department?
- **Supporting community based co-design to define and solve "problems". Starting with the problems as defined by communities themselves, rather than the problem as perceived by the authorities.** The five a day message will have little traction in a food desert: improving access to health services for depression and anxiety is necessary but if for instance, the root cause of people's anxiety is lack of housing security, a pill or talking therapies isn't going to solve it.
- **Aligning wider policies with improving health**. There is consensus that the decisions that influence job supply, housing quality, or the ability for people to lead active lives are going to have more impact on health than whether services fund a new treatment or build a new hospital.

3. What does this mean for the people of Sheffield?

3.1. The acid test of adoption of a principle of Health in All Policies will be that all areas of decision making and resource commitment systematically consider health and wellbeing outcomes, and inequalities, across all decision making processes.

3.2. For example, the expectation would be that transport policy and investments in this area will deliver health gain (and vice versa) and that should be led from within that part of the council.

3.3. Using this example further: developing a win/win approach is important. Success should be defined as both "how can health support successful transport policy" AND "how can transport policy deliver health outcomes". The language used may be important: the use of "health" language usually defaults to health care services, so we could consider using "wellbeing instead" as that is an outcome that is universally accepted.

3.4. Similarly the work of the planning or licensing committee should consider the possible health gain, or loss, associated with decision making. In this way "health" becomes business as usual for the council. This is a long term project and the difficulty shouldn't be under estimated. Success involves changing cultures, standard operating procedures for a city and challenging the status quo. There are obviously trade-offs and compromises are always necessary.

3.5. The focus of the strategy is on Council activity, but a Health in All Policies approach could clearly be applied beyond SCC; it is not hard to imagine that there is potential for significant

gains across the system in the context of the greater coordination involved in accountable care approaches. Irrespective of developments in this area, it should be expected that there will be opportunities for investing differently across the system to help deliver a healthier population.

3.6. It is of note that Government have attempted this in the past with a Cabinet Office led approach to health policy, but over time this defaulted to a DH led approach. Similar was seen in South Australia where "better health" was a prime concern of the Premier. Similarly here we should be mindful that the responsibility is organisational (and potentially multi-organisational), not solely that of the DPH.

4. Recent developments

4.1. Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee discussed the Public Health Strategy on 12th April. The Committee expressed strong support for the strategy and broad agreement for the ten early target areas outlined in the strategy, with some additional comments:

- There was a desire to see the strategy focus on young people of all ages, rather than just pre-school years;
- The Committee want to see consideration of sports clubs as a setting for health gain, looking beyond physical activity to linked social activities;
- The Committee were most interested in the following five priorities: Work and Health, Inclusive Growth, Healthy Planning, Air Quality, and Housing & Health;
- There was a suggestion that business cases for each of these be developed, covering: the range of outcomes to be achieved; how competing/conflicting outcomes are dealt with; and realistic estimates of what can and should be achieved (rather than hypothetical).

4.2. The Committee also reflected on the mechanisms for enacting a Health in All Policies approach. In relation to the Council's policy development processes, there was discussion that major reports and decisions should include consideration of impacts on health/health gain; this should not be a tick-box exercise, but an approach that ensures all policies, proposals etc. build 'public health' into their design.

4.3. In their discussions, the Scrutiny Committee recognized the potential impact they could have in this space, with appropriate training, development and awareness for the relevant members and officers. In particular they were supportive of the idea of calling in other portfolio areas (non-traditional health) to see what they are doing to maximise health gain. It was also noted that they are about to agree their work programme for 2017-18 so would want to consider relevant topics in this.

5. Questions for the Board

5.1. The Board is asked:

- Are the priority areas identified in the strategy the right areas to be focusing on, and are there any of these that are of more immediate interest?
- Are there other areas we should be looking at too?
- What role could the Health & Wellbeing Board play in maximising the impact of the strategy?
- How could the Health and Wellbeing system in Sheffield build upon this direction to improve wellbeing in the city?
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Appendix

Sheffield City Council

Public Health Strategy

April 2017 – March 2019

Suggested foreword

Responsibility for Public Health transferred from the NHS to local government in 2013. In reality responsibility for public health has rested with local government for over a century. Sheffield City Council has a stated aim of being a “public health organisation”, the aim of this strategy is to try to define what that actually means.

This strategy sets out an an ambitious agenda to reframe “public health” as a civic responsibility for local authorities, move away from some of the less successful approaches of the past and to influence the way a city works for health. The critical question is if we were redesigning a city for about 570,000 people where improved health and reduced inequality in health outcomes was a key criterion of success, what would this look like, and I had a budget of £14bn what would it look like.

Our strategy aims to take what could be defined as a healthy cities approach and implement this across the totality of responsibilities of the City Council. Our challenge is to institutionalise the focus across all our functions and decision making processes. Our view is the resources to be influence are the totality of the cities resources, not just “the public health grant”.

It is a two year strategy – April 2017 to March 2019. We are aware that many of the actions have a long term pay off. We also accept some of our ambition may be tempered by changes in national policy outside local control, but this doesn’t dampen our ambition. We will review progress in two years.

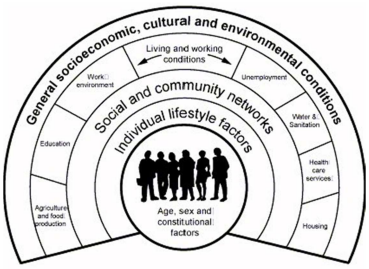
Cllr Cate McDonald, Cabinet Member for Health and Social Care.
John Mothersole, Chief Executive.

Contents

1 introduction

a) Our approach to health and well being, and inequalities in Sheffield.

SCC has agreed to adopt a social model of health[i] [ii]. This focuses the attention and locus on the upstream social and economic determinants of health.



A medically- and a socially-focused approach to health are not mutually exclusive, and different stakeholders may put different emphasis on one approach or the other. There are a number of balances to be struck between different approaches, for example: the balance between areas of activity, for example the balances between

- social issues (jobs and poverty) and lifestyle issues (tobacco and physical activity),
- service provision and structural / policy solutions
- "treatment of here and now issues" and "prevention by going upstream"

Our approach is deliberately different to the health service model of public health of the recent past. This is not to say that the health service doesn't have an important role in improving the health of the public, however our approach reflects the responsibilities of local government.

Inequality and social injustice in itself is a risk to health. Inequality affects how you see those around you and your level of happiness. People in less equal societies are less likely to trust each other, less likely to engage in social or civic participation, and less likely to say they're happy. Living in an unequal society causes stress and status anxiety, which may damage health. In more equal societies people live longer, are less likely to be mentally ill or obese and there are lower rates of infant mortality[iii].

4. b) The health of the people that live in the city, what are the key issues in Sheffield.

A wide selection of data and feedback from the public tells us a consistent story about the key themes for public health priorities.

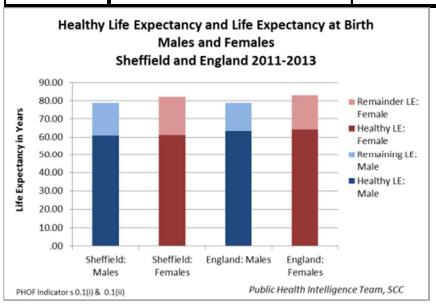
Good health and well being is obviously important in its own right as a fundamental human need. The Sheffield Joint Strategic Needs Assessment, the Public Health Outcomes Framework & the 2015 **Marmot Profile** for **Sheffield** gives good insight and high level indicators into some of the key issues, on the wider determinants of health, health improvement, health protection, premature mortality.

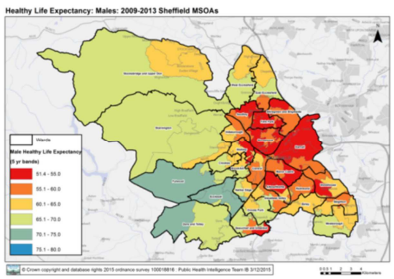
Our JSNA shows that the health priorities for Sheffield are largely the same as anywhere else; good mental health and wellbeing underpins all success; poor physical health is linked to lifestyle behaviours; health inequalities result from social and income inequality; healthier futures are built on good employment and decent homes. But the way these priorities distribute across our population is more unusual than many other similar large and diverse cities. Sheffield is characterised by extremes in the population; in terms of socio-economic status, health outcomes, environment and economic prosperity. But these extremes are often masked when we look at averages, meaning that the Public Health Outcomes for Sheffield can seem on a par with the rest of England when for large parts of the City the reality is significantly and enduringly worse. It's why we have to maintain a focus on small area variation in outcomes and develop our indicators and targets accordingly (see the ward and neighbourhood quilts[iv].

Healthy life expectancy is not improving and inequality persists

Healthy Life Expectancy is a metric that incorporates the length of life, but also the number of years lived with illness. For example, the graph below shows that for women in Sheffield average life expectancy is 82, but approximately 20 of those years are lived with poorer than optimal health. Recent research[v] has highlighted that one in eight people are too ill or disabled to work by state pension age. This is obviously important from a wide range of viewpoints, it is also a solvable problem. There is a 20-25 year gap between most and least deprived people in Healthy Life Expectancy, as indicated below, this is not just a geographic phenomena.

	Sheffield HLE Female	England HLE Female	Sheffield HLE Male	England HLE Male
2009-11	61.2	64.2	59.3	63.2
2010-12	61.4	64.1	60.6	63.4
2011-13	59.1	63.9	60.8	63.3





There are worrying signals that the long term, historic trend in the improvement of life expectancy has slowed significantly in recent years. This is happening in England and in Sheffield. The reasons for this are not yet known, but it is a significant issue that warrants significant attention.

5.

6. **2 Aims and objectives**

a) Why this strategy

Sheffield City Council has made a commitment to becoming an organisation oriented around prevention and to be a public health organisation. The challenge is therefore to optimise the use of its budget, associated purchasing power, and policy making process to improve health and address inequality.

This is a strategy for Sheffield City Council. It is intended to enable the public to hold the council to account in it's commitment to becoming a public health organisation. The **purpose of this strategy is to define the role of SCC as "a public health organisation" to set out a statement of ambition and to establish some priority areas** and strategically important issues.

This strategy aims to state the level of ambition contained within this commitment and set out a vision for the Council as an organisation focused on improving health outcomes and reducing inequalities

The strategy is not intended to replace existing plans and strategies, but to boost their implementation, to signal opportunities to further enhance progress against our priorities, and a tool to provoke debate on where more ambitious/radical approaches need exploring. This strategy will also be a tool to change the debate about "health" to something that is considerably wider than "health services" and considerably further upstream than the current debate. There is an obvious interface with other plans, including the Health and Well Being Strategy, the 2014 Health Inequalities strategy, the

Sheffield Place Based plan, the SCC Corporate Plan, the Best Start Strategy and existing service plans in many services and portfolios that will contain significant services and policy areas that impact on health.

The strategy is considerably broader than “service provision”, and includes policies and supportive environments can enable health. Large chunks of NHS and social care resource are used “buying back” health that we've already lost via policy choices in other policy spaces. Over time we may move away from “services” towards investments and outcomes.

b) Aim – what outcome are we seeking to change

The overall vision is to improve healthy life expectancy, and to reduce inequality in healthy life expectancy between best and worst communities.

The aim of this strategy is to increase healthy life expectancy by 1 year over the next 10 years, explicitly focused on improving fastest in those with lowest healthy life expectancy. This will equate to significant number of years of illness and disability avoided. The benefits of this in terms of care costs avoided are obvious. It will also equate to making an impact on the productivity of the economy, and contribute to a broader social justice agenda.

Our focus is on giving people in Sheffield **the best start in life** to maximise their life chances, and taking a life course approach. We will consider the health dividend across all our work; and considering how we can best support people in Sheffield to live **longer and healthier lives, with an explicit focus on inequalities.**

A healthy population is seen as an investment for vibrant and just society and economy not a cost to health and social care system. That investment will have positive consequences on downstream health and care costs, and broader social and economic impacts. For each of these interactions there is a two way relationship, The identified early priorities below are a combination of easy wins, big gain areas and strategically important issues.

The obvious challenge is being explicit about “well being” on the balance sheet and ensuring it is being considered with the same gravity as finance and economic growth. We will work towards quantifying the gain from changed life trajectories from past and current investments and policy decisions. ..

c) Objectives

We have set 4 objectives – focusing our attention on **health inequalities**, **health in all policies**, **health protection** and **healthy lifestyles**. The actions set out in the strategy are clearly focused on a clearly stated issue of avoidable illness and early death, and the consequences of both in terms of lost quality of life, lost economically productive years and pressure on health and social care services.

Objective 1- we will refresh and revise the Sheffield approach to health inequalities.

Sheffield City Council accepts this as one of its most important priorities. It also accepts there are no simple easy solutions. Through the Health & Well Being Board, the council has agreed five areas of focus reflect a need for interventions with a short and long term return and has agreed to refresh the city’s strategy for health inequalities with initial priorities:

- **Continued commitment to a community development based approach** to health and well being. We don’t underestimate the difficulty of this in an era of shrinking resources. We will build on and reflect the strengths which communities have, developing resilience and promoting greater community spirit.
- **Continued investment in and commitment to community and primary care, especially in the most disadvantaged parts of the city.** In particular we should focus on targeted cardiovascular risk management and an approach to healthy

lifestyles as part of treatment and prevention. We will also focus developing the model of, and maximising the impact of social prescribing.

- **Continued commitment to the principle of implementing effort and change where greatest need is identified**; this is building on the key recommendation of Professor Sir Michael Marmot of proportionate universality – a universal offer for all, but focused approaches where need is highest. Though this will require further debate there is a case to consider the concept of disproportionate universality.
- **Refocused effort on the link between employment and health**, through the development of a comprehensive strategy for work and health. This will focus on finding new ways to help people get back into work, and stay healthy at work.
- **When we are looking at the issue of healthy lifestyles we need to focus on the environment and make the healthy choice the easiest and default choice**. This may need some difficult conversations about policies and a shift away from "lifestyles" being about individual level actions and services.

We also agree that specific population groups required additional focus, for example children and young people, BME groups, those with learning and physical disabilities and those experiencing mental health problems. The **advantage of a double and layered approach is that it will allow for multiple inequalities to be handled at the same time.** The Council accepts these five issues aren't the only answer to the difficult issue of health inequalities, they are the issues we will focus on first. The council will also will also facilitate a number of public engagement events on this issue as a way of developing a broader debate.

Objective 2 – We will adopt a principle of Health in All Policies & systematically consider health and well being outcomes, and inequalities across all of the decisions we make

There is renewed interest in the concept of Health in All Policies, and there is currently an openness to new ways of working and innovative approaches. This gives us an opportunity to prioritise health and wellbeing across the totality of SCC resource commitments and areas of policy responsibility.

A Health in All Policies (HiAP) approach is strongly advocated by WHO and is being adopted worldwide. We will seek to work across sectors and systematically takes into account the health implications of decisions, seek synergies, and avoids harmful health impacts in order to improve population health and health equity.

Health in All Policies is mechanism to make explicit, **and increase** (*rather than describe* the current), the health gain from policies and programme areas that have not been considered as "health" related. One of the aims is to ensure the health and inequalities impact is on the balance sheet in a visible and tangible way. In this way we will challenge the way the existing resources are committed.

For example the expectation would be that transport policy and investments in this area will deliver health gain and that should be led from within that part of the council. The same may be said about licencing process, or the build environment planning process. In this way "health" becomes business as usual for the council.

The challenge remains to build this into the fabric of the organisation and the standard operating protocol so it is considered unconsciously. We will pursue an approach based on, but more ambitious than, the healthy cities model.

Objective 3 – we will maintain and develop a robust system to protect the population from preventable infections and environmental hazards

Protecting the population of Sheffield from preventable infections and environmental hazards remains a critical aspect of preventative work.

- **We will continue to ensure we have strong health protection arrangements by working through the Health Protection Committee** to provide leadership and strengthen assurance arrangements for preventing and responding to health protection incidents and communicable disease outbreaks.
- **We will continue to reduce risks to the health of the population through vaccination and screening programmes** and seek opportunities through targeted work to protect the health of those most at risk of infections and environmental hazards, including TB, sexually transmitted infections and HIV.

Objective 4 – we will develop ambitious policy and service based approaches to promote healthy lifestyles.

Reflecting that "healthy lifestyles" are in the context of the environment in which we live and make choices we will actively seek to encourage **an environment that is as healthy as it can be, to support the healthy choice being the easiest or default** option, using both behaviour change & behavioural insight techniques and policy focused approaches.

We will publish and implement detailed cross council and city strategies around

- **food – with a specific focus on sugar, salt and the fast food environment; food poverty, the local food economy.**
- **tobacco;**
- **alcohol and drugs**
- **physical activity;**

These strategies will link to other strategies focusing on public health priority areas for example oral health as an obvious inequalities challenge.
We will develop a "Heart of Sheffield" project to coordinate work in this area.

3 Implementation

It is not our intention to write a long action plan at this stage. Our aim is to use this strategy to influence the way the organisation works. Within our four broad objectives, there are ten areas of early focus where we would focus our attention first.

a) areas of early focus

We have not set out all the areas for detailed work on interventions beyond the headlines areas set out. The identified early priorities below are a combination of easy wins, big gain areas and strategically important issues where we feel we can make quick impacts. There are many other areas that are not included here, that remain important. There isn't a single big intervention that will resolve the challenges of the city in this area. An approach based on a range of interventions including education, service provision, regulation and structural and policy initiatives will be needed. Also we will seek to balance initiatives with a short, medium and long term pay off but all focused on reducing demand for downstream services.

There are a number of specific areas we propose to prioritise initially. These are set out below.

11. **We will renew and increase SCC's commitment to best start – pre birth to primary school education. The first 1001 days.** Building on this we will refocus our effort on Adverse Childhood Experiences and inequalities in educational attainment as a determinant of health. We will also refocus our approach to healthy schools agenda. This is underpinned by the evidence that proactive early interventions in early years, and with families, represents the best value investment for improving the health of future generations, and achieving short term gains. Ignoring this sets up future demand and avoidable poor outcomes.
12. **We will develop a comprehensive work and health strategy, focusing on delivery of interventions to optimise the health of those not in work due to ill health.** There are multiple other strands to this that need to be brought together into a coherent strategy; it also includes interventions to optimise the well being of those in work. This obviously reflects the two way relationship between health and the economy. We will also ensure that the skills system is a part of this work
13. **We will seek to maximise the potential for sustainable economic growth to improve better health outcomes and redresses inequalities**. There are many opportunities here around economic growth, the public and the social economy and inclusive growth to address health directly, but also the determinants of health such as poverty.
14. **We will refresh and redevelop the City for All Ages Strategy and refresh our approach to healthy ageing**.
15. **We will optimise the health & well being opportunities around land use planning; population density and mix, transport planning including active travel by adopting a healthy town framework**. We will seek to build health impact assessment into planning processes and developments in a way that is practical, pragmatic and supportive. There may be significant opportunities to learn from other European Cities on spatial planning.
16. **We will redevelop an Air Quality Strategy for Sheffield**. This will reflect the emerging evidence base about effective and cost effective interventions. Linked to this, **ensure that the developing Transport strategy fully engages with the opportunities to improve health and redress health inequality**. This will need to encompass the Streets Ahead programme but also incorporate close links with public transport planning and other aspects of transport.

17. **We will support the NHS with the reform and transformation agenda as articulated in the Sheffield Place Based Plan.** This will particularly focus on achieving the radical upgrade in prevention and the transformation of the delivery model to move the health and care system towards a place based population focused model based around "wellness". In addition we will focus on supporting the development of primary care, person centred care and capitalising on the potential of up scaling the implementation of behaviour change techniques.

18. **We will review and redevelop the Sheffield strategy for open space and green space, bringing together our approach to the Outdoor City, parks, Move More and other agendas**

19. **We will maximise the health and well being opportunities though the our housing strategy, and development in the housing sector more broadly.** This will include issues picked out in the Housing Hazard Rating System NICE Guidance 6, including - fuel poverty, slips and fall hazards, housing quality, supported housing, social housing and standards for new build and environmental hazards in homes.

20. **We will develop a strategy for mental well being**, building on, and complementing the mental health strategy.

b) Risks and enablers

Realising a health in all policies approach is dependent on a number of factors; **and success will happen if the approach is institutionalised. To truly deliver a health in all policies approach it will be necessary to change the way the organization thinks and does its business.**

This is a long term project and the difficulty shouldn't be under estimated. It involves changing cultures, standard operating procedures for a city and challenging the status quo. Gaining traction in the way that large resource commitments influence long term well being and inequality outcomes, in the face of immediate demand led pressures, and reconsideration of core statutory duties is the key resource challenge. It is accepted trade offs are often necessary. Often the execution of "public health" has been about challenging vested interests and as ever the demands of the short term thinking dominates agendas and resources. These are not easy challenges, as history has demonstrated in both the NHS and Social Care.

We will seek to build health impact assessment into planning processes and developments in a practical way, based on best practice. This will be prospective and undertaken in a way so as to influence policy at an early stage, not retrospectively measuring when a decision has been made. There is a danger that this becomes a technical diversion away from the real decision making process, we will assess that on a case by case basis.

On occasion asking challenging questions of what we commission and relook at the purpose of commissioning. We may consider the question of the purpose of "commissioning", what outcomes do we want to achieve and whether there are more strategic uses of resources to get the outcomes we want.

In some areas it may be necessary to change how success is measured in big systems, how ROI is considered and what lessons can be learned from elsewhere in the world or other relevant sectors. An example of this might be reconsidering how "success" is measured in transport policy, and the incorporation of health impact into

success measures and evaluation models. A second example would be the consideration of the long term health impact of economic policies.
We acknowledge that we need to continue the current path of establishing community and neighbourhood approaches as the key delivery mechanism; especially focused on an explicit community development approach. We will seek to work with people and communities by using a co-production approach wherever possible. And focus on building on existing assets and strengths in individual people and communities.
We also acknowledge we need to maximise the potential of citizen contact with public services to improve health through making every contact count and similar approaches. We have a strong training and development function both for SCC staff and within our communities that enables this to happen.

c) Indicators

Inequalities in healthy life expectancy is the key indicator of the success of this strategy. Obviously this is not something that is easy to see change in, or easy to change. As set out above the desired outcome is a 1 year improvement in healthy life expectancy over the next decade. This will be achieved achieved by focusing on inequality and areas or populations where healthy life expectancy is lowest.
We will use the established health and well being board indicator framework to measure progress; and we each programme and project will have its own indicator framework.
If successful we will see a changed direction of the resource commitment towards prevention being the norm and focused effort across the council on achieving the aim of the strategy – that being improving healthy life expectancy and reduction of the gap between best and worst.

d) Involving other stakeholders

Improving the health of the public is far from only being the business of “public health”. We encourage new partnerships and new stakeholders to be involved in the pursuit of improved health and wellbeing in the city that may not have been explicitly involved in the past. These include, but are obviously not limited to communities, the fire service, the police, trade unions, business leaders, better incorporating the knowledge that rests within the universities and higher education sectors.
This is a strategy for SCC. Sheffield city council cant, by itself, solve the problem of health inequalities. Our ambition is to engage a wider set of stakeholders into “public health”. We will obviously reflect the ambition for 'public health' across the totality of the system, there should be contributions from the NHS, VCS, Public Health England, the universities both as major employers and in terms of knowledge transfer, schools and many others.

We will also invite expertise from outside Sheffield to help us think through difficult problems from a range of new perspectives.

7. **e) Resources**. **The “public health budget”.**

Public health is an organisational responsibility not a line in a budget. The “Public Health Grant” cannot by itself address the public health challenges of the city. The purpose of the public health grant is to leverage change and to enable fresh and challenging approaches to be tested and applied.
Sheffield City Council has set out its ambition to be a public health organisation, so the challenge is therefore to optimise the use of its £1.4bn budget, and associated purchasing power, to best improve health and address inequality. This is best framed as not about “new resources” but as about maximising benefits from existing commitments, and then changing the nature and shape of those commitments over time to optimise outcomes.
Thus the question on “the public health budget” is best framed as “is SCC using its power to

best improve the trajectory of health and wellbeing indicators, to redress health inequality and to optimise the health dividend (or the health return on investment) through the right interventions".

The task is one of reimagining health in a city, setting out from a health perspective what sort of city we want in 1, 2, 5, 10 and 20 years, and what investments and changes we need to make now to achieve this.

f) Who has what responsibility and accountability

Leadership of public health is currently a shared responsibility with a number of individuals and groups playing a part. There isn't a hierarchy, one concept isn't subservient to another. Improving health and well being is a key function of all aspects of the councils business.

Councillors have a role to set the policy direction, provide political leadership and engage communities in understanding and addressing challenges, and taking opportunities when they arise.

The Council also has a significant role in terms of wider influence outside Sheffield, for example in Sheffield City Region and advocating for where we want to see change at a national policy level through influencing government.

Where change requires a national legislative or policy change there is an important role of **SCC Members in advocacy for national change**.

SCC Cabinet has a responsibility for agreeing the overall strategy and detailed implementation plans and to realise the vision.

It is important to be clear that the council can't direct and control all aspects of this agenda, nor should they try to. Similarly the council doesn't have "the answer" to the problem; the role is to set a framework and a culture and to orchestrate the right response to the challenge.

The Health and Well Being Board has a critical role for the city in improving the health of residents and tackling inequality, and the council will work though the Board to influence agendas it cannot influence alone.

Scrutiny also has an important role In developing rounded policy and scrutinising implementation.

The role of the DPH should be to champion new ideas, to influence resource commitments so they better improve well being and health inequalities and support the council to achieve its potential. The Annual DPH report will consider progress in implementation of this strategy.

Implementing Health in All Policies requires a level of technical skill and sustained committed leadership. The LGA guidance[1] made a number of helpful suggestions about "backbone staff". The Council will consider how best to enable this through the skill sets we have and what we need to develop. Despite immediate budget pressures the support staff to enable strategic change to happen are not seen as an expensive luxury.

4 Conclusion

The task and ambition of this strategy is one of helping, supporting, injecting new ideas and fresh approaches to core SCC business to enable each and all of those systems to give us better health and wellbeing outcomes. This may, however, imply using expertise to ask challenging questions of current models and testing whether current commitments really deliver improved outcomes and value. There is also a role to connect systems together in a way they may not have been historically connected.

The realisation of a "health in all policies" approach, and the challenge for this strategy is that it must change the way we commit mainstream resources. The point of such approaches is using such frameworks to challenge resource commitments and improve

outcomes with a view to delivering more health return with them than is currently the case. The difficulty of moving some of these debates forward is not underestimated.
This is an ambitious agenda to reframe “public health” as a civic responsibility for local authorities, move away from some of the less successful approaches of the past and to influence the way a city works for health. We accept some of our ambition may be tempered by changes in national policy outside local control, but this doesn’t dampen our ambition. We will review progress in two years.

[i] http://sheffielddemocracy.moderngov.co.uk/Data/Cabinet/20120125/Agenda/11%20New%20Arrangements%20for%20Public%20Health%20in%20Sheffield.pdf
[ii] http://sheffielddemocracy.moderngov.co.uk/documents/s9992/Social%20Model%20of%20Public%20Health.pdf
[iii] https://www.equalitytrust.org.uk/about-inequality/impacts
[iv] https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report.html
[v] https://www.tuc.org.uk/equality-issues/age-equality/one-eight-people-are-too-ill-or-disabled-work-state-pension-age-says

Sheffield Health and Wellbeing Board

Terms of Reference

Revised February 2017

1. Role and Function of the Health and Wellbeing Board

1.1 The Sheffield Health and Wellbeing Board (the Board) is established under the Health and Social Care Act 2012 as a statutory committee of Sheffield City Council (the Council) from 1 April 2013. However, it will operate as a multi-agency board of equal partners.

1.2 The Board will develop and maintain a vision for a city free from inequalities in health and wellbeing, taking a view of the whole population from pre-birth to end of life.

1.3 The Board will be the system leader for health & wellbeing, acting as a strong and effective partnership to improve the commissioning and delivery of services across the NHS and the Council, leading in turn to improved health and wellbeing outcomes and reduced health inequalities for the people of Sheffield.

1.4 In doing this, the Board will take an interest in all the determinants of health and wellbeing in Sheffield and will work across organisational boundaries in pursuit of this.

1.5 The Board will be ambitious for Sheffield and hold organisations in Sheffield to account for the delivery of the Board's vision for the city. It should enable organisations to work in an integrated way, for the purpose of advancing the health and wellbeing of people in Sheffield.

1.6 The Board is statutorily required to carry out the following functions:

- To undertake a Joint Strategic Needs Assessment (JSNA)[1];
- To undertake a Pharmaceutical Needs Assessment (PNA)[2];
- To develop and publish a Joint Health and Wellbeing Strategy (JHWS) for Sheffield[3]
- To provide an opinion on whether the Council is discharging its duty to have regard to the JSNA, and the JHWS, in the exercise of its functions[4];
- To review the extent to which the Clinical Commissioning Group (CCG) has contributed to the delivery of the JHWS[5]; to provide an opinion to the CCG on whether their draft commissioning plan takes proper account of the JHWS[6]; and, to

[1] Section 116 Local Government and Public Involvement in Health Act 2007 (the LGPIHA 2007)
[2] Section 128A National Health Service Act 2006 (the NHSA 2006).
[3] Under Section 116A LGPIHA 2007
[4] Under Section 116B LGPIHA 2007
[5] Under Section 14Z15(3) and Section 14Z16 NHSA 2006
[6] Section 14Z13(5) NHSA 2006

provide an opinion to NHS England on whether a commissioning plan published by the CCG takes proper account of the JHWS[7];

- To support joint commissioning and encourage integrated working and pooled budget arrangements[8] in relation to arrangements for providing health, health-related or social care services;
- To discharge all functions relating to the Better Care Fund that are required or permitted by law to be exercised by the Board; and
- To receive and approve any other plans or strategies that are required either as a matter of law or policy to be approved by the Board.

1.7 In addition to these the Board will also take an interest in how all organisations in Sheffield function together to deliver on the Joint Health & Wellbeing Strategy.

1.8 The Board will own and oversee strategic planning for the health and care system in Sheffield, hold all organisations to account for delivering against it and take an interest in all associated strategies and plans.

2. Membership

2.1 The membership of the Board is as follows:

- Sheffield City Council:
  - Cabinet Member for Health & Social Care
  - Cabinet Member for Children, Young People & Families
  - Chief Executive
  - Director of Adult Social Services
  - Director of Children's Services
- Sheffield NHS Clinical Commissioning Group
  - Governing Body Chair
  - One other Governing Body GP
  - Accountable Officer
  - Medical Director
  - Director of Strategy
- Other Commissioners
  - Senior Representative from NHS England
- Providers
  - NHS Provider – Clinical Representative
  - NHS Provider – Non-Executive Representative
  - VCF Provider
  - Blue Light Service
  - Housing Association

[7] Section 14Z14 NHSA 2006

[8] In accordance with Section 195 Health and Social Care Act 2012. This includes encouraging arrangements under Section 75 NHSA 2006.

- Independent Voice
    - Chair of Healthwatch Sheffield
    - Director of Public Health
    - Academic

2.2 Other representatives from the wider health and wellbeing community in Sheffield may be invited to attend the Board from time to time to contribute to discussion of specific issues.

2.3 Any changes to personnel will be approved through Full Council on an annual basis.

3. Governance

3.1 **Chair:** The Board will be co-chaired by the Council Cabinet Member for Health & Social Care and the Chair of the CCG, with chairing of meetings generally alternating between them.

3.2 **Attendance at meetings and deputies:** In order to maintain consistency it is assumed that Board members will attend all meetings. Each member may name 1 deputy, one of whom may attend a meeting and vote in place of the member.

3.3 **Quorum:** 1 Elected Member of the Council & 1 other Council Representative, 1 CCG Governing Body GP and 1 other CCG Representative, 1 Provider Representative, and 1 Independent Voice Representative, with an in-meeting majority for Commissioners.

3.4 **Decision-making and voting:** The Board will operate on a consensus basis. Where consensus cannot be achieved the matter will be put to a vote. Decisions will be made by simple majority: the Chair for the meeting at which the vote is taken will have the casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chair.

3.5 **Authority of representatives:** It is accepted that some decisions will need to be made in accordance with the governance procedures of the organisations represented on the Board: however, representatives should have sufficient authority to speak for their organisations and make decisions within their own delegations

3.6 **Accountability and scrutiny:** As a Council committee, the Board will be formally accountable to the Council. Its work may be subject to scrutiny by any of the Council's relevant scrutiny committees

3.7 **Relationship to other groups:** The Board has formally agreed a protocol with the city's Safeguarding Boards and will develop relationships with other bodies in the city such as the Council's scrutiny committees, and other partnership and commissioning boards.

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4. Meetings, agendas and papers

4.1 The Board will normally meet every six months in public, interspersed with engagement events and private strategy development meetings. There will be no fewer than 2 meetings per financial year, with a maximum of 32 weeks between meetings.

4.2 Dates, venues, agendas and papers for public meetings will be published in advance on the Council's website.

4.3 The co-Chairs will agree the agenda for each meeting, supported by an officer subgroup

4.4 Agendas and papers will be circulated to all members and be available on the Council's website 7 days in advance of the meeting

4.5 Minutes will be circulated to all members, and published on the Council's website as soon as possible after the meeting

4.6 It is expected that those who write papers will work collaboratively with others to provide a city-wide perspective on any given issue.

5. Role of a Health and Wellbeing Board member

5.1 All members of the Board, as a statutory committee of the Council, must observe the Council's code of conduct for members and co-opted members. Other responsibilities include:

- Attending Board meetings and fully and positively contributing to discussions, reading and digesting any documents and information provided prior to meetings
- The membership of the Health & Wellbeing Board is constructed to provide a broad range of perspectives on the development of strategy. With this in mind, members are asked to bring the insight, knowledge, perspective and strategic capacity they have as a consequence of their everyday role, but must not act simply as a representative of their organisation, but with the interests of the whole city and its residents at heart.
- Fully and effectively communicating outcomes and key decisions of the Board to their own organisations, acting as ambassadors for the work of the Board, and participating where appropriate in communications/marketing and stakeholder engagement activity to support the objectives of the Board, including working with the media
- Contributing to the development of the JSNA and JHWS
- Ensuring that commissioning is in line with the requirements of the JHWS and working to deliver improvements in performance against measures within the public health, NHS and adult social care outcomes frameworks

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- Declaring any conflict of interest, particularly in the event of a vote being required and in relation to the providing of services
- Acting in a respectful, inclusive and open manner with all colleagues to encourage debate and challenge.

6. Engagement with the public and providers

6.1 Healthwatch Sheffield is the Board's lead for involving Sheffield people in decision-making around health and social care. It is expected that the Healthwatch Sheffield representative(s) will clearly ensure Sheffield people's views are included in all Board discussions, with Elected Members, and other Independent Voice members also having a role in this regard.

6.2 Formal public meetings will be held twice a year and will be preceded/followed by a discussion forum on a particular issue. In addition, members of the public are invited to ask questions at the formal public meetings. An answer may take the form of:

- An oral answer
- A written answer to the member of the public, circulated to the Board and placed on the Council's website
- Where the desired information is contained in a publication, a reference to that publication.

The Board's chairs retain the right to restrict the length of time given to answering public questions at any meetings held.

6.3 The Board will hold a range of engagement events every year, open to the public and/or providers. These events will be in addition to the formal, public meetings of the Board and will be a means of:

- Providing an avenue for members of the public to impact on the Board's discussions and work;
- Engaging the public and/or providers in the development of the JHWS;
- Developing the Board's understanding of local people's and providers' experiences and priorities for health and wellbeing;
- Communicating the work of the Board in shaping health and wellbeing in Sheffield;
- Developing a shared perspective of the ways in which providers can contribute to the Board's delivery.

6.4 The Board will maintain a website with up-to-date information about its work and send out regular newsletters.

7. Review

7.1 These Terms of Reference will be reviewed annually.

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Health and Wellbeing Board - Forward Plan

Month	Date	Type	Topics	Topic Leads	Additional invitees and notes
July	27/07/17	Public	Public Health Strategy	Greg Fell	
			Better Care Fund	Peter Moore	
			urgent care and interface with primary care	Peter Moore	
			Terms of Reference	Greg Fell	
August	No meeting				
September	27/09/17	Public	Accountable Care System Update	Will Cleary-Grey	
			Accountable Care Partnership - moved from m	Greg Fell/Peter Moore	
October	05/10/17	Strategy	JSNA/DPH Report	Greg Fell	
			Children's Services - scope to include emotiona	Jayne Ludlam	
			Primary Care	Katrina Cleary	
November	09/11/17	Strategy	Development Session	LGA Facilitators	
December	*TBC*	Strategy	health inequalities	Greg Fell	

Priorities for following 6 months	Topic Longlist		
	Public Services	**Board Reflection**	**Wider Determinants**
Urgent Care Review	Dementia Strategy	Citizen Voice on the Board	Adverse Childhood Experiences
Primary Care	Developing engagement across systems	HWB Outcome Framework	Air Quality, Transport & Health
Accountable Care Partnership	IV Drugs - learning from other cities	JHWBS Review	Community contribution to Wellbeing
Health & Wellbeing Inequalities	Moving towards a preventative approach		Employment & Health
Hospital Services	Public Service Reform		Housing Strategy
Mental Health Services	Sexual Health		Immigration Act
Public Engagement	Social Prescribing		Inclusive Growth
	Transitions from YP to Adult Services		Local Plan & HWB Outcomes
			Poverty & HWB Outcomes

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 30 March 2017

PRESENT: Councillor Cate McDonald (Chair), Cabinet Member for Health & Social Care, Sheffield City Council

Dr Tim Moorhead (Co-Chair), Chair of the Sheffield Clinical Commissioning Group

Dr Nikki Bates, Governing Body Member, Sheffield Clinical Commissioning Group

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

Greg Fell, Director of Public Health, Sheffield City Council

Sue James, Healthwatch Sheffield

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

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

Dr Zak McMurray, Clinical Director, Clinical Commissioning Group

Peter Moore, Director of Strategy and Integration, Sheffield Clinical Commissioning Group

Maddy Ruff, Accountable Officer, Sheffield Clinical Commissioning Group

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from John Mothersole, Sheffield City Council and Judy Robinson, Healthwatch Sheffield.

2. DECLARATIONS OF INTEREST

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

3. PUBLIC QUESTIONS

There were no questions from members of the public.

4. UPDATING THE JOINT STRATEGIC NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health concerning the Joint Strategic Needs Assessment (JSNA). The report outlined the progress made

with the implementation of changes, updating and using the JSNA, as agreed by the Board at its meeting on 31 March 2016.

There were two key actions which had been progressed in 2016-17. Firstly, the inclusion in the Director of Public Health Annual Report 2016 of a chapter relating to intelligence from the JSNA. Secondly, an online resource, using the Council's Open Data platform was created, which covered a range of subjects, including: population, communities of interest, economic, social and environmental determinants of health, child, maternal and reproductive health, disease and disability, mental health and wellbeing; and commercial determinants of health.

The report set out further areas of work which would need to be done relating to the JSNA. The Board was requested to comment or raise questions about the design, usage or content of the JSNA online resource; to identify specific topics for inclusion, in addition to those listed at Appendix A to the report; and suggest changes or improvements to the resource.

Members of the Board asked questions and commented in relation to the JSNA, as summarised below:

There was need for an analytical view of disability in relation to children to enable anticipation and forecasting which would inform such areas as school places, health and social care. There was currently a recommissioning of programmes of work. It was difficult to determine which particular services had the greatest impact on health and population need and the addition of outcome metrics would be welcomed. It was agreed that there should be greater alignment of need with performance and outcomes.

Within the list of topics for inclusion in the online resource contained in the appendix to the report, there was a section on economic, social and environmental determinants of health and specific reference to fuel poverty and it was suggested that this should also refer to poverty in more general terms. There was evidence regarding the numbers of children living in households with material deprivation and those living in poverty and in circumstances where at least one adult in the household was working. Reference was made to the effect of benefit changes on disabled people and those with ill health conditions in later years. It was agreed that the broader issue of poverty and benefits would be included in the online resource.

The resource might also include people receiving social care services and where there was need and the demand was not met. Childhood experiences were also a factor in relation to young people who had been in care and care leavers. In addition, account might be taken of different types of employment, such as zero hours contracts and changes to employment. The Board was informed that the information in the online resource could be broken down onto parts, for example the number and nature of jobs. Whilst it was an important issue, relatively little was known in terms of data, relating to childhood experiences.

Some assurance was needed that services were matched to need and a question was asked about the extent to which the JSNA was the most appropriate

mechanism in relation to which the Board could come to a view about how well services matched need. This was potentially a separate and large piece of work. It was agreed that, whilst the JSNA was a key first step, consideration of services and need would be a separate piece of work to the JSNA and might also include a health equity audit. It was noted that the pharmaceutical needs assessment would be submitted to the Board in the summer.

In relation to health inequality, the issue was how a more equitable spread of resource might be created. The Board should also give consideration to priorities in relation to the JSNA and ask what its plans were addressing within the JSNA. Consideration should also be given, as part of the online resource, to communities of interest. These might include the City's student population. Other areas might include young people, mental health and transitions from childhood, adolescence and to adulthood.

Thought should be given as to how people accessed the JSNA information online if they did not already have the link to the site, including users such as community groups. It was considered that this was a good resource and the information therein should be as accessible as possible.

RESOLVED: That the Health and Wellbeing Board:

1. Endorses that work continues to complete all sections of the JSNA online resource by June 2017, subject to any amendments;

2. Requests that a summary of 'what the (updated) JSNA is telling us' is incorporated into the Director of Public Health Report 2017; and

3. Requests that proposals for further development of the online resource are presented to a meeting of the Board later in the year.

5. BETTER CARE FUND

5.1 The Board considered an update on the Better Care Fund from Peter Moore Director of Strategy and Integration, Clinical Commissioning Group. The presentation included the principles of the Better Care Fund; the achievements of joint work between organisations in the past year and learning during that time. The themes and plans for the forthcoming year were also outlined, as summarized below:

5.2
- Implement a new model of Active Recovery
- Redesign the discharge process and reduce delayed transfers of care
- Optimise the use of the Disabled Facilities Grant
- Integrate care home market management functions
- Join up long-term support adults' assessments
- Join up assessment and review between health and care for children with

complex needs and SEND (Special Educational Needs and Disabilities)
- Implement an assess to admit model to reduce non-elective admissions
- Prepare business cases for key areas of mental health transformation
- Continue to implement our approach to social prescribing
- Improve access to children and young people's mental health services
- Increase the personalisation of maternity care

5.3 Members of the Board discussed the issues raised in the presentation, as summarised below:

5.4 There were issues to be overcome relating to the use of funding and the relevant framework to enable this and it was not clear whether some of the problems relating to the Better Care Fund were a matter of national policy or local detail. However, there was a partnership approach whereby plans were owned jointly between health and social care. It was hoped that the development of Accountable Care Partnerships would assist the process of delivery of improvement as set out in place based plans. This approach would include commissioners and providers.

5.5 Ambitious plans were in place and there were challenges to overcome, including organisational boundaries and budget cycles. Whilst the involvement of more organisations was something to be welcomed, effective decision making was also required. The internal market which had been introduced in health in the past two decades had resulted in both successes and failures and one problem was that it created a fragmented system with artificial boundaries, which would need to be removed if a more integrated model was to be successful. The links to the JSNA also needed to be recognised.

5.6 **RESOLVED:** that the presentation is noted and to request that the relevant plans relating to the Better Care Fund are submitted for approval to a meeting of the Board in May 2017.

6. HEALTH AND WELLBEING BOARD FORWARD PLAN

6.1 The Board considered a report outlining its work plan for the year and discussed priority areas of work.

6.2 An additional area which might be included in the Board's priorities was immigration legislation and the implications for health, the voluntary and community sector and the local authority.

6.3 The Primary Care review item, planned for 8 June would be rescheduled. The Board indicated its support for a bespoke development programme for the Board, arranged through the Local Government Association (LGA).

6.4 **RESOLVED:** that the Board agrees the forward plan to the end of August 2017 subject to the addition of issues relating to immigration and refugees and the rescheduling of the Primary Care review item.

7. MINUTES OF THE PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Health and Wellbeing Board held on 29 September 2016 be approved as a correct record.

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