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Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 27 September 2018 at 3.00 pm

Town Hall, Sheffield City Council

The Press and Public are Welcome to Attend

Membership

Councillor Chris Peace	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
Chief Superintendent Stuart Barton	South Yorkshire Police and Crime Commissioner
Jayne Brown	Sheffield Health & Social Care Trust
Nicki Doherty	Director of Delivery Care out of Hospital, Clinical Commissioning Group
Councillor Jackie Drayton	Cabinet Member for Children and Young People
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
Clare Mappin	The Burton Street Foundation
Dr Zak McMurray	Clinical Director, 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.

So that we can make a difference in Sheffield, the Board has a formal public meeting at least four times per year, interspersed with engagement events and private strategy meetings.

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 Sarah Cottam on 0114 273 5033 or email sarah.cottam@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 SEPTEMBER 2018

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. Better Care Fund Update (Pages 5 - 16)
Report of Jayne Ludlam, Executive Director, People, Sheffield City Council and Nicki Doherty, Director of Delivery, NHS Sheffield CCG.

5. CQC System Review
Report to follow.

6. Health and Wellbeing Strategy (Pages 17 - 68)
Report of Greg Fell, Director of Public Health, Sheffield City Council and Becky Joyce, Accountable Care Partnership Programme Director for Sheffield.

7. Health and Wellbeing Board Future Meeting Arrangements (Pages 69 - 74)
Report of Greg Fell, Director of Public Health, Sheffield City Council and Becky Joyce, Accountable Care Partnership Programme Director for Sheffield.

8. Minutes of the Previous Meeting (Pages 75 - 84)
Minutes of the meeting of the board held on 29 March 2018.

9. Date and Time of Next Meeting

NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 13 December 2018 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 Ludlam, Executive Director People, Sheffield City Council Nicki Doherty, Director of Delivery, NHS Sheffield CCG
Date:	27th Sept 2018
Subject:	Sheffield's Better Care Fund - Delivery and Transformation update
Author of Report:	Jennie Milner, Better Care Fund Programme Manager

Summary:

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

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

Health and Wellbeing Boards are expected to continue to oversee the strategic direction of the Better Care Fund and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners[1]. Given they are a committee of the Local Authority, Health and Wellbeing Boards are accountable to elected members and ultimately to the electorate.

[1] Section 195 of the Health and Social Care Act 2012

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

In 2017 Sheffield developed a fully pooled budget (£101m) for mental health services within the overarching BCF arrangements. That brought the current overall total of the Better Care Fund budget to £352m for 2017/18 and £380M for 2018/19. Our main areas of focus continue to be on adult admissions to hospital, active support and recovery, people keeping well, ongoing care, independent living solutions and capital expenditure.

Additional national funding under the Improved Better Care Fund (iBCF) was added in July 2017, plans for expenditure were approved by the Health and Wellbeing board. An update in March 2018 confirmed our continued intentions to deliver the Place Based Plan, working on a large scale on an integrated agenda, to have a significant impact on the people of Sheffield, delivering a whole system shift to prevention.
Health & Wellbeing Board is asked to receive this update, consider progress against our ambitions and support the key next steps in relation to integrated commissioning.

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?
- How can the Health and Wellbeing board contribute to the development of priority areas and enablers to support transformation at pace and scale?

Recommendations for the Health and Wellbeing Board:

1. That the Health and Wellbeing Board formally approve continued delivery of the plans
2. That the Health and Wellbeing Board approves the proposed allocation of iBCF funding for 2018-19 as set out in this paper.
3. That the Health and Wellbeing Board delegates final approval of the Better Care Fund submission to Jayne Ludlam, Executive Director People (SCC) and Nicki Doherty, Director of Delivery (CCG).
4. That the Health and Wellbeing Board discusses in more detail how integration can support strategic priorities at a future meeting.

Background Papers:

- Sheffield Integration and Better Care Fund Narrative Plan 2017-19
- Integration and Better Care Fund Planning Requirements for 2017-19
- Better Care Fund Operating Guidance for 2017-19

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

1.0 Introduction

1.1 Sheffield's Better Care Fund is intended to improve outcomes for local people by ensuring they get the right support from the right person in the right place at the right time.

1.2 The table below presents the Better Care Fund KPIs as at July 2018 (most recently published), the reportable delays have deteriorated since then.

	Sheffield	England
Rate of A&E attendances per 100,000 population for area (65+)	10,821	10,534
Rate of emergency admissions per 100,000 population (65+) (**DH measure**)	28,437	25,009
% of admissions that last longer than 7 days (65+)	37.2%	32.0%
90th percentile length of stay for emergency admissions (65+) (**DH measure**)	26.0	20.0*
Rate of delayed transfers of care attributable to NHS per 100,000 population (18+)	11.3	7.4
Proportion of discharges (following emergency admissions) which occur at the weekend (65+) (**DH measure**)	18.1%	19.7%*
% of emergency readmissions within 30 days of discharge (65+)	22.2%	18.6%
Proportion of older people who receive reablement services following hospital discharge (65+) (**DH measure**)	6.3%	2.7%
Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (65+) (**DH measure**)	74.7%	82.5%

1.3 The table uses use of urgent and emergency care as a proxy measure for the success of the local system in enabling a shift to prevention and also helping Sheffield's older people maintain health, wellbeing and satisfaction for longer. This approach has been used by the Department of Health and Social Care alongside the Care Quality Commission in choosing challenged systems (including Sheffield) for Local Area Reviews.

1.4 Sheffield's performance can be seen as below the England average both in terms of people who find themselves needing to access acute hospital care (A&E attendances and emergency admissions), how long they have to stay in acute hospital care (length of stay, delayed transfers of care, weekend discharges) and how long they are at home after hospital care (readmissions, still at home after reablement).

1.5 Sheffield's performance supporting older people can also be seen as not entirely a matter of resources. For example, the table tells us older people in Sheffield are over

twice as likely to receive reablement or rehabilitation services to help them leave hospital than the England average. This suggests that at least some of the challenge is about getting existing resources to operate in the best possible way for local people.

1.6 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.

1.7 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.

1.8 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.

1.9 Health and Wellbeing Boards are expected to continue to oversee the strategic direction of the Better Care Fund and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners[2]. Given they are a committee of the Local Authority, Health and Wellbeing Boards are accountable to elected members and ultimately to the electorate.

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

[2] Section 195 of the Health and Social Care Act 2012

- 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 History and Recent Achievements

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. This has since been developed further as part of our Accountable Care Partnership Memorandum of Understanding.
- Sixteen neighbourhoods set up across the city made up of groups of GP practices, and forming stronger partnership working with community services the VCF and police partnerships to address specific local needs in their communities. The Health and Wellbeing Board will receive an update on this at its November 2018 meeting.
- 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.
- Our collective work on tackling social isolation in Sheffield through the Ageing Better programme has been highlighted as an example of 'inspirational practice' by the World Health Organisation in their report on creating supportive environments and resilient communities.
- 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.

- Trusted Assessor roles in Active Recovery, supporting the planned integration of the Community Integrated Care Service and the Short Term Intervention Team
- A truly pooled budget for Mental Health
- A Dance to Health programme, which is receiving national attention.
- A rebalanced intermediate care bed base to enable investment in other services

4.0 Our ongoing priorities for 18/19

4.1 The Better Care Fund works in alignment with our Sheffield Place Based Plan, and our programme of work continues to support the Accountable Care Partnership arrangements established to deliver the Place Based Plan. The Better Care Fund programme was set out as a five year programme of work and in year four they key priorities, as outlined above, remain valid. In addition, Mental Health has established a single integrated commissioning team that is delivering a transformation programme underpinned by the principles of joint delivery and joint accountability; a genuinely pooled budget offers significant opportunities

4.2 Progress the key actions and milestones as set out in section three of the BCF narrative which accompanies this paper.

4.3 Identify opportunities to continue to improve outcomes and deliver transformation at pace and scale through a single integrated voice, supported by integrated planning and contracting that fully realises the benefits of the transformational programmes.

4.4 Develop our approach to risk share with a view to Annex 1if the Operating Guidance in relation to budget associated with Non-Elective Admissions, where we have an opportunity to shift our investment to support the prevention and early intervention agenda. The CQC System Review identified lots of good practice in the form of pilots to support our transformation programme; the challenge to us was to invest in these at scale, with the Better Care Fund providing us with the mechanism to do so.

5.0 Improving Outcomes and Integrate Commissioning Intentions

5.1 Recognising the current financial pressures across the system, commissioners are currently developing an integrated commissioning approach that will provide a firm foundation and single commissioning voice to maximise the potential from within existing budgets.

5.2 These strategic commissioning intentions will identify mechanisms to shift investment to improving the health outcomes of individuals; a prevention and early intervention approach that will both prevent and reduce the duration of acute episodes of care.

5.3 System leaders across health and social care are developing priorities and enablers, that will identify any opportunities to deliver the ambitions of the place based plan through stronger integration and collaborative working.

5.4 The strengthened approach to integrated commissioning will include prioritisation of areas in the BCF work programme that have the greatest potential impact and benefits for the system.

5.5 This focus will identify opportunities to ensure reduced demand on hospital services and increasing the capacity of the primary and community sector. Key workstreams will include, extending the range of services accessible to everyone in a primary care environment, to prevent hospital attendances through the intermediate care response and to support individuals to maximise their independence. Being clear on the range of alternatives to hospital admission and ensuring they are accessible in the community is important.

5.6 This will be supported by a range of enabler programmes to overcome the potential barriers that programme leads have identified to implementing transformation at pace and scale. This will include workforce development and integration, IT integration, new contractual models and branding that gives a single commissioning voice.

6.0 iBCF Summary of proposals and update 2018-19

6.1 Overview

The table below sets out:

- The carry forward amounts from 2017-18
- The 2018-19 allocation as confirmed at Council Cabinet in July 2017
- The existing commitments to 2018-19 allocations.
- The remaining allocation in schemes 1, 2, 7 and 11 which are subject to further explanation below.

	2017/18 C/F £000	2018/19 Allocation £000	2018/19 Committed £000	2018/19 Remainder £000
Supporting whole system innovation				
1. Whole System Innovation - DTOC & Improved Outcomes	23	324	0	347
2. Workforce Development / OD	190	250	18	422
3. Increasing flow within STIT	0	69	69	0
4. Improving medication management for people at home	0	187	187	0
5. Rapid mental health support to custody suite	51	102	153	0
6. Improving life chances to young people reaching adulthood	94	188	282	0
Increasing resilience of care market				
7. Fee rates: Homecare, Supported Living, Care Homes	0	3,750	2,500	1,250
Supporting Existing Pressures				
8. Community Support Workers	0	0	0	0
9. Mental Health	0	0	0	0
10. Learning Disability including transitions	0	2,000	2,000	0
11. To maintain Social Worker Provision	0	170	401	-231

12. DoLs	170	0	170	0
Enabler Investment				
13. Improving systems & reducing bureaucracy	0	1,000	1,000	0
Total	528	8,040	6,780	1,788

6.2 Overall financial context

The iBCF funding is intended to help ensure the Council and NHS partners work together as a "whole system" to best serve Sheffield's population. This incorporates achieving the strategic shift to prevention that all partners see as the key change required to improve health and wellbeing as well as making the best use of available resources.

At present, Sheffield's whole system is not working in a very preventative way. As set out in 1.2 above, there are increasing amounts of resource being focused on expediting discharges from hospital, often after a long length of stay, and comparatively little resource focused on avoiding admission.

This means that significantly greater cost is being incurred that previously envisaged by the Council on community arrangements to support discharge from hospital. The in-year cost of additional Council activity to support NHS-related increases in demand for older people only in 2018-19 has been forecasted as £3.3m. This is significantly over and above the rate of demographic growth and illustrates a system in urgent need of fundamental reform.

To counterbalance this pressure within 2018-19, the Council has benefitted from a one-off allocation of £1.7m from the Ministry of Housing, Communities and Local Government. However this still leaves an unresolved pressure of £1.6m.

The Council has agreed a four year Improvement and Recovery Plan for adult social care of which 2018-19 is year two. The plan is designed to ensure a shift to prevention and a clear focus on quality via an appropriately supported workforce. This will deliver improvements in value for money. Even if the plan delivers everything expected from it in 2018-19, including the resolution of the £1.6m pressure referred to above, adult social care will still require c.£10m funding from Council reserves to balance. Not resolving the £1.6m pressure will create a significant sustainability issue for the Council's overall finances.

6.3 Summary of proposals for 2018-19

- Therefore the headline proposal is to deploy £1.6m from iBCF in 2018-19 to enable continued availability of adult social care capacity to support older people safely leaving hospital. This allocation will be taken from the £1.788m amount within the 2018-19 iBCF allocation that has not already been committed as set out in the Cabinet Report.
- This will provide the Council and NHS partners with a small breathing space to enact the longer-term resource shifts required to ensure a sustainable system that is focused on prevention.

- The Council in partnership with the CCG proposes to allocate the remaining £188k on joint workforce development in relation to NHS Continuing Healthcare and joint assessment processes. This was a significant quality concern that arose from the Care Quality Commission review.

7.0 Summary

7.1 The Health and Wellbeing Board has a statutory duty to encourage integrated commissioning, and therefore oversight of the Better Care Fund is important

7.2 The key areas of priority remain valid and we are now in year four of a five year programme.

7.3 There are plenty of examples of excellent transformation, one of which (Age Better) is internationally being recognised as exemplar, and many being recognised nationally as excellent (e.g. person centred care planning).

7.4 We have yet to sustainably invest in our transformation and the prevention and early intervention new models of care, this is our priority for 2018/19; we will strengthen our integrated commissioning mechanisms, focus initially on the areas with greatest opportunity and develop our risk share approach with specific ambitions around the Non-elective Admissions spend.

8.0 Questions for the Board:

8.1 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?

8.2 How can the Health and Wellbeing board contribute to the development of priority areas and enablers to support transformation at pace and scale?

9.0 Recommendations for the Health and Wellbeing Board:

9.1 That the Health and Wellbeing Board formally approve continued delivery of the plans

9.2 That the Health and Wellbeing Board delegates final approval of the Better Care Fund submission to Jayne Ludlam, Executive Director People (SCC) and Nicki Doherty, Director of Delivery (CCG).

9.3 That the Health and Wellbeing Board approves the proposed allocation of iBCF funding for 2018-19 as set out in this paper.

9.4 That the Health and Wellbeing Board discusses in more detail how integration can support strategic priorities at a future meeting.

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HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of: Phil Holmes, Director of Adult Services

Date: 27th September 2018

Subject: Making it Better: health and care partnership work to improve support to older people

Author of Report: Phil Holmes 0114 273 6622

Summary:

This agenda item provides a summary for Health and Wellbeing Board members of performance across the NHS and social care in supporting older people with health and wellbeing.

This is in the context of the Care Quality Commission's Local Area Review of Sheffield that focused on three key areas in order to assess how well older people move through the health and care "system":

1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down; return to usual place of residence or admission to new place of residence

The report sets out:

- How we are performing in Sheffield in relation to joined-up support for older people with their health and care needs
- The action plan agreed by partners to ensure continual improvement.

Questions for the Health and Wellbeing Board:

The Health and Wellbeing Board is being asked to:
Review the information provided and agree recommendations about the future role of the Board to ensure that older people in Sheffield experience the best possible health and wellbeing.

Recommendations for the Health and Wellbeing Board:

Health and Wellbeing Board members are asked to review the information provided in the presentation and appended documents and provide comments about plans for improvement as well as arrangements (including the future role of the Board) in ensuring improvements are maintained.

The specific recommendation with regard to the future focus of the Health and Wellbeing Board is that it ensures governance arrangements are robust to drive the right outcomes for older people, and it evaluates progress every six months to ensure a meaningful shift to prevention at scale that means a greater number of people are able to maintain health and wellbeing for longer.

Background Papers:

Appendix One: The Sheffield Care Quality Commission report
Appendix Two: The Sheffield Local System Review Action Plan

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

Outcome 4 – People get the help and support they need and feel is right for them

Outcome 5 – 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?

Rebecca Joyce, ACP Programme Director

Making it Better: health and care partnership work to improve support to older people

1.0 SUMMARY

1.1 It has been a national concern for quite some time that older people often find support with their health and care needs to be not well coordinated. Even though individual professionals are most often excellent and truly committed, the older person's experience of the overall "system" is nevertheless fragmented. They do not always receive the right support in the right place at the right time.

1.2 In recognition of this the Care Quality Commission (CQC) instituted a series of Local Area Reviews in different parts of the country in the winter of 2017 that had concluded across 20 areas by June 2018. Sheffield was one such area.

1.3 The focus of the reviews was on three areas of activity: maintaining the wellbeing of a person at home, responding in a crisis and helping people return home after a crisis. What CQC wanted to see was a preventative approach where older people had support to stay healthy and happy at home as long as possible and where any issues were dealt with quickly.

1.4 The Department of Health and Social Care (DHSC) used six measures adjusted for local population to decide which areas ought to receive a review.

- i How many people aged 65+ had to be admitted to hospital on an unplanned basis (Sheffield ranked 92nd out of 150 Local Authority areas using 2017-18 data)
- ii How long people aged 65+ had to stay in hospital (Sheffield ranked 140th)
- iii How long people aged 65+ had to wait in hospital even though they were medically ready to leave (Sheffield ranked 141st)
- iv How many people aged 65+ were able to go home from hospital at the weekend if they were ready to do so (Sheffield ranked 139th using 2016-17 data)
- v How many people aged 65+ were able to benefit from support with rehabilitation (sometimes known as reablement) once they had left hospital (Sheffield ranked 12th using 2016-17 data)
- vi How many people aged 65+ benefitted from this rehabilitation to the extent they were still at home 91 days later (Sheffield ranked 135th using 2016-17 data)

1.5 Although these measures look very focused on the hospital, they provide a good proxy for how well health and care is supporting older people overall. Measure (v) above suggests a significant amount of community capacity is available, yet in spite of this older people in Sheffield are more likely than most places to be admitted to hospital, much more likely to have to stay an extended time, and less likely to stay at

home in the longer term once they leave hospital. Other areas, by showing better performance on these measures, are in effect demonstrating better grip on prevention that means more capacity can be used to keep people healthy and well at home, and less is necessary to respond to crises which are managed effectively when they do occur.

1.6 It is important to note that Sheffield's front line staff, both in the NHS and social care, and in all sectors, work with skill and dedication. The following quotes from CQC's final report, attached in Appendix One, acknowledge this and also refer to other Sheffield strengths.

i "Frontline staff were dedicated to providing high-quality, person-centred care"

ii "We found strengthening relationships and a strong commitment to achieve the best outcomes for the people in Sheffield"

iii "In a crisis, there was a collaborative response to support system resilience and risk mitigation"

iv "There were good foundations for further development on a system-wide basis"

1.7 However the high level messages from CQC are firstly not just to respond well to crisis, but to prevent it occurring in the first place, and secondly to quickly build on Sheffield's strong foundations so that older people here experience better outcomes from a much more joined up approach.

1.8 CQC has just announced six more Local Area Reviews. Three are for areas where they have never been before, including Leeds. A further three are for areas which were visited in the first 20 reviews and where CQC want assurance of progress. Therefore it may well be that Sheffield is visited again soon, particularly if we cannot demonstrate quick progress.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

What the Care Quality Commission found and Sheffield's response

2.1 The CQC report is attached at Appendix One. There is considerable detail there and Sheffield's response (laid out in detail in Appendix Two) will be summarised below.

2.2 The CQC approach was to focus on the experience of older people in Sheffield, and also the experience of local staff in working within our health and care "system". They pursued this with focus and integrity. The final report could have been written more clearly, and there are sections where CQC could have done better in robustly linking particular assertions to substantiating evidence. Nevertheless the view of health and care organisations in Sheffield is that the conclusions drawn by the Care Quality Commission are essentially valid, and based on a thorough process of triangulating views and evidence not only from "system leaders" but much more importantly from the people who we serve and the front-line staff who almost always do an excellent job in extremely difficult circumstances.

2.3 The CQC challenge to Sheffield is that better local system leadership can improve these circumstances both for staff and local people. National constraints are a key factor and the Care Quality Commission have also challenged national bodies to help create better conditions for improvement, both in Sheffield and elsewhere. However there is also considerable local scope for improvement. The national report produced by CQC to sum up the learning for all twenty reviews carried out to date can be found here .

2.4 The key areas of improvement for Sheffield are set out in the Action Plan which is provided as Appendix Two. This plan was developed after considering CQC feedback (itself informed by feedback from local Sheffield people) and deciding on priorities in partnership with local statutory and voluntary organisations.

2.5 The most prominent issue was that Sheffield's health and care services did not seem to be designed with the needs and preferences of the older person at their very centre. This meant that although individual staff did all they could, people could get a bad experience as they travelled between different services. Therefore sections 1 and 2 of the plan set out actions to develop *a way of working that is built around acknowledging and improving older peoples' views and experiences and which drives a citywide vision.*

2.6 There was also a strong sense that Sheffield's system was not only difficult to navigate for older people but similarly so for staff. Sections 3 and 4 of the plan focus on a *shared citywide workforce strategy to support front-line staff in delivering this vision and in particular further develop multi-agency working.*

2.7 CQC felt that the above gaps could be addressed most robustly if organisations worked together more clearly and robustly in the interests of local people and of front-line staff. The Health and Wellbeing Board were regarded by CQC as the key place for the public to be able to hold organisations to account for operating in a joined up way to achieve the best outcomes for older people. Overview and Scrutiny was also felt to be an essential public function in this regard. More broadly CQC recognised that statutory organisations needed to involve and work with Voluntary, Community and Faith (VCF) organisations much more systematically and sustainably as their potential contribution to better lives for older people was in danger of being overlooked. Therefore sections 5 and 6 focus on *clearer governance arrangements to ensure stronger joint-working between organisations and greater involvement for our Voluntary, Community and Faith sector.*

2.8 While recognising a large amount of innovative NHS and social care work in Sheffield that was showing some good results, CQC noted that too much was operating on a restricted or "pilot" basis which was limiting its impact. There would only be fundamental change when arrangements were in place to ensure that what

worked well was “rolled out” to ensure consistency and the best possible outcomes for the highest number of people. This meant that funding organisations in Sheffield needed to come together to ensure money was used in the best possible way for the whole system. Joining up the money needed to be complemented by joining up technology. Sections 7 and 8 in the plan focus on a *meaningful shift to prevention at scale, supported by clear commissioning arrangements and digital interoperability*

2.9 Finally the plan needed to address the issues set out in paragraph 1.4, stopping older people becoming stuck in hospital for longer than they needed to be and preventing a “revolving door” situation where some people who left hospital returned relatively quickly. Section 9 in the plan sets out a s*trong system focus on enabling the right support from the right person in the right place at the right time, to give the best possible experience for older people and to ensure the best use of resources.*

2.10 In order to address these important areas the plan is wide ranging and complex. It is absolutely essential that progress is made and maintained. The next section will suggest a role for Scrutiny in this regard.

3.0 Ensuring progress against the plan

3.1 The Care Quality Commission expect that Sheffield’s Health and Wellbeing Board, which meets in public on a regular basis, will hold the city’s services to account for working together and improving the health and wellbeing of older people. Therefore progress on the action plan will periodically be reported here. Part of the purpose of this report is to agree the frequency and focus of this reporting.

3.2 The Health and Wellbeing Board is responsible for health and wellbeing across the city, for people of all ages and from all backgrounds. Therefore it is important to focus responsibilities so that as much impact is achieved as possible within the time available to Board members.

3.3 Overview and Scrutiny also has an important statutory role. Like Sheffield’s Health and Wellbeing Board, the Overview and Scrutiny function was regarded by CQC as in need of some clearer focus to ensure that it also held organisations to account effectively in improving outcomes for older people.

3.4 This creates the potential for duplication and confusion between the roles of the two bodies, both of which are already under pressure from their accountability to Sheffield’s whole population, not only older people, and the need to ensure the best possible outcomes for everybody.

3.5 It has been proposed that the particular focus that Overview and Scrutiny take in holding Sheffield partners to account lies in improving the lived experience of older people. If a clear and undiluted focus on improving the experience of older people is not maintained it will be very easy for the change programme to miss the point. Therefore it has been proposed that the Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee receive a six monthly report that

sets out, drawing directly upon the experience of older people in Sheffield, progress that has been made to increase their satisfaction across the three areas set out by the Care Quality Commission:

i Maintaining the wellbeing of a person at home
ii Responding in a crisis
iii Helping people return home after a crisis

3.6 To complement this it is proposed that the Health and Wellbeing Board focuses on improvement areas that are most in line with its strategic purpose and priorities. These are:

i. Ensuring clearer governance arrangements to support partnership working
ii. Ensuring a meaningful shift to prevention at scale

3.7 Clarifying governance arrangements is a "task and finish" responsibility which is being delivered within this calendar year. These actions are intended to be complete by the next Health and Wellbeing Board meeting.

3.8 Ensuring a meaningful shift to prevention at scale requires ongoing monitoring of the outcomes experienced by older people, with the aim of maximising the opportunity to maintain the wellbeing of a person at home in order to minimise the need to respond in a crisis. It is proposed that analysis is shared with the Health and Wellbeing Board on a six monthly basis to set out progress in this area.

3.9 There are workstreams within the Accountable Care Partnership to address the other actions within the plan, for example the need to develop our shared workforce. These are absolutely key actions and if they are not completed effectively will inhibit both the experience that older people describe (reported at Overview and Scrutiny) and the system's ability to help them maintain health and wellbeing (proposed to be reported at Health and Wellbeing Board). However they are enabling actions and it is not proposed that they are routinely reported at the Health and Wellbeing Board unless on an exception basis.

4.0 What does this report mean for the people of Sheffield?

4.1 This report sets out partnership efforts to improve the care and support for older people in Sheffield. This will not only positively affect older people themselves but also their family members and communities

5.0 Equality of opportunity

5.1 The Council has a duty under section 149 of the Equality Act 2010 (the public sector equality duty) in the exercise of its functions to have regard to the need to:
a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.2 Although an Equality Impact Assessment (EIA) has not been undertaken for the production of the report, this duty has been taken into account during consideration of key change activities detailed in the report.

6.0 QUESTIONS FOR THE BOARD

The Health and Wellbeing Board is being asked to:
Review the information provided and agree recommendations about the future role of the Board to ensure that older people in Sheffield experience the best possible health and wellbeing.

7.0 RECOMMENDATIONS

7.1 Health and Wellbeing Board members are asked to review the information provided in the presentation and appended documents and provide comments about plans for improvement as well as arrangements (including the future role of the Board) in ensuring improvements are maintained.

7.2 The specific recommendation with regard to the future focus of the Health and Wellbeing Board is that it ensures governance arrangements are robust to drive the right outcomes for older people, and it evaluates progress every six months to ensure a meaningful shift to prevention at scale that means a greater number of people are able to maintain health and wellbeing for longer.

Sheffield Teaching Hospitals NHS Foundation Trust | NHS Sheffield Clinical Commissioning Group | Primary Care Sheffield | Sheffield City Council | Sheffield Health and Social Care NHS Foundation Trust | healthwatch Sheffield

Making it better

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Sheffield's Action Plan
Health and Care for Older People
2018-19

Background

This action plan sets out the priorities for continually improving the experience that older people have when they encounter Sheffield's health and care services. The plan pulls together a wide range of work that will be carried out by Sheffield organisations in partnership. It is in response to The Local Area Review of Sheffield's health and care support for older people that was carried out by the Care Quality Commission (CQC) in the spring of 2018.

The Local Area Review used an approach that focused on three areas for older people in Sheffield. CQC looked at how health and care organisations worked together to:

1. Ensure wellbeing so older people could live happily and healthily at home for as long as possible
2. Respond to crisis, for example in the event of illness or injury that created a sudden need for treatment, care and support
3. Help older people recover after crisis

Sheffield was one of twenty areas chosen by CQC for a Local Area Review because performance was not as good as many other parts of the country on a number of measures, including:

- Higher than average numbers of older people being admitted to hospital
- Once there, many older people having to wait a longer time than should be expected before returning home
- Where they needed support in their own home to be able to leave hospital, it too often took significant time to arrange this
- When they received support at home to help them recover after being in hospital, after 3 months had passed they were more likely than older people in many other areas to be back in hospital, or perhaps having to be supported in a care home.

The Care Quality Commission took Sheffield's recent performance against these national measures to be a strong sign that more could be done to improve the three areas above. Health and care organisations in Sheffield agree that these are absolutely key indicators of successful outcomes for older people and will continue to monitor them. Improvements in these measures will be driven by:

- A stronger grip on community prevention and wellbeing that reduces avoidable admissions to hospital
- Better planning and coordination inside and outside hospital to ensure older people are able to return home as soon as their hospital treatment is complete
- Community support that helps older people leave hospital quickly, supports them to stay in their own home and keeps them safe, well and independent for as long as possible.

Priorities

The CQC Local Area Review has helped identify the areas of focus that will drive the necessary improvements. Key actions for each of these priorities are set out over the next few pages. In summary these are:

1. A way of working that is built around acknowledging and improving older people's views and experiences and which drives a citywide vision (sections 1 and 2)
2. A shared citywide workforce strategy to support front-line staff in delivering this vision and in particular further develops multi-agency working (3 and 4)
3. Clearer governance arrangements to ensure stronger joint-working between organisations and greater involvement for our Voluntary, Community and Faith sector (5 and 6)
4. A meaningful shift to prevention at scale, supported by clear commissioning arrangements and digital interoperability (7 and 8)
5. Strong system focus on enabling the right support from the right person in the right place at the right time, to give the best possible experience for older people and to ensure the best use of resources (section 9)

Oversight

This plan will require coordinated work from partnership organisations across the city. The plan covers 2018-19 only and focuses a lot of actions in the autumn to avoid progress being overtaken by operational pressures in the winter.

The overall shared responsibility for the health and wellbeing of older people in Sheffield lies with the city's Health and Wellbeing Board. The Health and Wellbeing Board have been consulted about this plan and will hold partners to account for delivery of improved outcomes for older people. A strong start to this plan is vital and monitoring of improved outcomes will begin by October 2018.

The Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee also has an essential role in holding partners to account using the mandate of local elected Councillors. The delivery of the plan and the improvement of outcomes for older people is part of the Scrutiny work programme and progress will be reviewed on a six monthly basis.

Sheffield's Accountable Care Partnership (ACP) is the group of health and care organisations responsible for enabling and delivering this plan. As such, the ACP and its constituent organisations will be directly accountable for progress made.

What we will do	The difference we will make	What we will check	The key actions	Who will coordinate	By when in 2018-19			
					Q1	Q2	Q3	Q4
1 **A shared city wide vision** for older people's care, developed and shared between service users, carers and families, the wider population and frontline staff across the NHS, Council and voluntary sector.	Co-production of the vision and approach to delivery. Improved sense of a shared direction. Stronger prevention through greater emphasis on helping older people stay healthy and valuing the contribution they make.	The delivery of our overall programme of work for older people. Evaluation of events and shared understanding between frontline staff and strategic leadership.	1.1 Articulate, share and develop the vision for older people across the city and hold a series of workshops to further develop this and a high level delivery plan to support the work. This will focus on older people as well as other key work streams. The workshops will include older people and carers and staff. The approach will be discussed and agreed with Union partners across Sheffield.	ACP Programme Director			X	

What we will do	The difference we will make	What we will check	The key actions	Who will coordinate	By when in 2018-19			
					Q1	Q2	Q3	Q4
2 Ensuring **older people's views and experiences** become integral to our approach.	Improvement in self-reported satisfaction from older people and family carers in receipt of health or social care support.	Self-reported satisfaction of older people who use health and care services. Self-reported satisfaction of family carers. Evaluation measures to be built into Person Centred initiatives to ensure individuals feel their individual needs and goals are met. Ongoing collation of staff, user and carer feedback to help us shape our improvements.	2.1 Working with communities and system representatives to develop a comprehensive approach to becoming a Person Centred city across our health and care system across Sheffield. This will focus on "What Matters To Me" and bring together linked work such as Health Conversations, For Pete's Sake and the Alzheimer's society "This is Me" tool to identify the personalised needs of older people. These initiatives are gaining momentum across Health and Social Care in Sheffield & we need to build on this. Steps will be - Strategic agreement to scaling up work and a tangible plan at July 2018 EDG - Developing joined up training plans to scale up this work and techniques - Working in partnership with the voluntary sector to benefit from their considerable expertise in this area	Executive Delivery Group, Accountable Care Partnership (ACP).			X	

What we will do	The difference we will make	What we will check	The key actions	Who will coordinate	By when in 2018-19			
					Q1	Q2	Q3	Q4
		.	2.2 Take a set of individual patient case studies and review end to end experience of our health and care system. Consider what could be better, does our action plan sufficiently address these cases and agree any additional actions. Use feedback received from CQC Review as our starting point. Repeat on a 6 monthly cycle to assess whether our plan is making a difference.	Patient experience leads (co-ordinated by Head of Patient and Healthcare Governance, STHFT) This will work with voluntary sector and carers to capture their knowledge of individual experience too			X	
			2.3 Agree and implement an approach to engagement and co-design with Healthwatch and Voluntary Sector that builds on good examples within the city (i.e. Testbeds, MSK) and build capability and capacity across local health and care services to effectively involve local people.	Programme Director, ACP, CEO Healthwatch		X		
			2.4 Develop regular mechanisms to systematically share and learn continuously from older people's "end to end" feedback as part of our evaluation and monitoring mechanisms in relation to capturing and responding to system-wide patient experience. This will be facilitated by vibrant quality improvement approaches across the system.	Patient experience leads (co-ordinated by Head of Patient and Healthcare Governance, STHFT) This will work with voluntary sector and carers to capture their knowledge of individual experience too			X	
			2.5 Ensure system themes from older people's feedback is shared with, and built into, training and development plans for our workforce to ensure a tailored and responsive approach.	HR OD Director, SCC, part of Workforce ACP Work Stream			X	

What we will do	The difference we will make	What we will check	The key actions	Who will coordinate	By when in 2018-19			
					Q1	Q2	Q3	Q4
3 Develop a joined up city-wide strategy for the **workforce** across NHS, SCC, VCSE, and private sector that makes progress on shared strategic workforce issues, delivers a great staff and user experience and ensures stronger engagement with the front-line	A joined up approach to ensure that Sheffield is an attractive place to work in health and care. A joined up approach to tackling some of the shared recruitment and retention challenges within the older people's workforce. A joint approach to improving quality so that staff working across health and care have the tools they need to put "What Matters to You?" into action. A joined up vibrant training programme to support and develop a compassionate workforce.	Self-reported satisfaction of staff who work in health and care services. Turnover and vacancy rates, particularly in job roles that are difficult to fill. Improved experience of our older patients.	3.1 Establishment of a workforce oversight group to steer the development of a strategy, to be co-designed with frontline staff across the city. The approach will use a national workforce planning tool and 12 week rapid improvement approach. This will involve 3 workshops, the gathering of data and activity to help prompt shared discussion amongst frontline staff to generate strategic workforce plans and ideas to redesign and reshape the workforce.	CEO Sponsor of ACP Workforce Work Stream (SHSC CEO)			X	
			3.2 Analysis of workforce data and planning of engagement workshops.				X	
			3.3 Workshops to develop strategy using data, input of front-line staff, and views of local older people.				X	
			3.4 Publication of overall city-wide strategy for workforce, with a focus on older people that is co-designed and connects the frontline and the strategic vision. This needs to incorporate the private sector, voluntary and community sector as well as the statutory organisations. We will involve the unions across Sheffield in our approach. .					X

What we will do	The difference we will make	What we will check	The key actions	Who will coordinate	By when in 2018-19			
					Q1	Q2	Q3	Q4
			3.5 Progress the key workforce initiatives identified in the Place Based Plan, including: - a workforce passport that enables seamless working across organisational boundaries - working in partnership with the universities and colleges to develop skills across multidisciplinary teams to support new roles and delivery on new models of care (with a focus on mental health and communications skills).	CEO Sponsor of ACP Workforce Work Stream (SHSC CEO)			X	X
			3.6 Work with provider, voluntary, and education partners to embed a training module on person-centred care as part of the What Matters to You initiative.	Executive Director for Care Outside of Hospital, CCG			x	

What we will do	The difference we will make	What we will check	The key actions	Who will coordinate	By when in 2018-19			
					Q1	Q2	Q3	Q4
4 A city-wide **organisational development approach** to improve multi-agency integrated working at the front line and develop greater system leadership skills throughout the city	Improved multi-agency working for older people Improved pathways and communication between different services and parts of the systems More seamless care for older people Higher job satisfaction Better service user experience Development of a workforce that works across boundaries and has the skills to continuously improve	Self-reported satisfaction of people who use health and care services. Measures of quality of team work amongst frontline agency staff. Measures of self-reported working relationships between system partners.	4.1 Develop organisational development interventions to support and improve multi-agency working between frontline inter-agency teams.	AO, Sheffield CCG (CEO Sponsor of Organisational Development Group			X	
			4.2 Develop improved system leadership, behaviours and attitudes at all levels to develop collective leadership approaches across the city. The first stage will to be build a plan, as agreed by the Organisational Development ACP Workstream. This will build on the Liminal Leadership pilot delivered in Q1 2018/19.				X	
			4.3 Working towards a single Quality Improvement approach across health and social care organisations.				X	
			4.4 Build on and accelerate specific system wide improvement programmes for pathways within the ACP requiring improvement including A. Continuing healthcare processes B. End of Life care	CCG Chief Nurse / STH Chief Nurses/ Director of People Services SCC		X		
			4.5 Develop a learning culture, with the first step a process that shares and reviews incidents, risks, complaints and patient, family and carer experience across the system and routinely undertakes joined up system-wide analyses and investigations, including root cause analysis, where appropriate.	Clinical Governance Leads (coordinated by Head of Patient and Healthcare Governance, STHFT)		X		

What we will do	The difference we will make	What we will check	The key actions	By who	By when in 2018-19			
					Q1	Q2	Q3	Q4
5 Strengthening our **strategic partnership with the Voluntary, Community and Faith Sectors**	More seamless joint working for older people	Measures of self-reported working relationships at strategic level between system partners Develop what else we will check (as part of defining our new strategic working relationship with the VCF sector)	5.1 Define new strategic working relationship with Voluntary, Community and Faith (VCF) sector and consider how we create a mind-set shift to this relationship across the city.	Joint-chairs of ACP Board		X	X	
			5.2 Recognise the contribution of the VCF to health and care across the city through formal invitation to be a 7th formal full member of the ACP.		X			
			5.3 Develop clear plan about how this will be different and how the ACP will enable the VCF to have capacity to provide strategic leadership to the ACP and be a full partner. First steps will be - Discussion at ACP Executive Delivery Group (following strategic agreement from June ACP Board decision) - A discussion to understand and consider the sustainability of the sector for the future. - Agree what we will check to ensure ongoing improvement in the strategic partnership between health and social care and the VCF	CEO Voluntary Action Sheffield and ACP Programme Director			X	

What we will do	The difference we will make	What we will check	The key actions	By who	By when in 2018-19			
					Q1	Q2	Q3	Q4
6 Strengthening our supporting **governance** to turn vision into timely action	Review how housing links into services for older people at operational and strategic level. Clear definition of key respective roles for Health and Wellbeing Board (understanding needs and driving priorities at city-wide level), Accountable Care Partnership (driving actions to help achieve those priorities), Overview and Scrutiny Committee (ensuring accountability to local people both to work in partnership with them and to achieve good quality outcomes). Timely decision-making via clear governance. Shared understanding of progress and pitfalls.	Overview of other measures referred to in this plan: citizen and staff satisfaction, outcomes, responsiveness, use of resources. Work ongoing to establish measures for Active Support and Recovery work.	6.1 Hold a public session of the ACP Board with additional members of Healthwatch and VCSE as a first step to improving transparency.	Accountable Care Partnership Board Chairs	X			
			6.2 Establishment of 6 monthly monitoring of partnership delivery at Overview and Scrutiny.	Overview and Scrutiny Board, SCC	X			
			6.3 Review relationship and operation of Health and Wellbeing Board and ACP. This will include: - Active review of practice by other Health and Well-Being boards - Review of membership	Chairs of Health and Wellbeing Board and ACP Board			X	
			6.4 Review and strengthening of relationship with housing in operational, governance and strategic inter-agency working for older people	Director of Adult Services, SCC and Director of Commissioning, SCC		X		
			6.5 A clear programme ACP delivery plan with milestones informed by the plans for each of the work streams; this will require the partnership to identify and secure the resource to coordinate, communicate and drive each of the programmes	Programme Director, ACP			X	

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What we will do	The difference we will make	What we will check	The key actions	By who	By when in 2018-19 Q1	Q2	Q3	Q4
7 Scaling up pilots into sustainable, large scale change to ensure a meaningful shift to prevention	Focusing available resources on the support that has most impact for local people in helping them stay safe and well, and preventing avoidable deterioration.	Higher physical and mental health and wellbeing for older people, particularly in the most deprived parts of the city. A higher proportion of older people supported safely to stay at home. Older people getting back home more quickly after hospital admission.	7.1 Agree priorities for any short-term funding available to alleviate winter pressures.	Urgent and Emergency Care Transformation and Delivery Board, ACP		X		
			7.2 Evaluate successful pilots and assess scale up and implement on a city wide basis. This will include a review of Better Care Fund schemes.	ACP Executive Delivery Board CCG Director for Out of Hospital Services			X	
			7.3 Make recommendations about longer-term system reshaping of investment priorities to develop new models of care and support (i.e. facilitated through the Sheffield Outcomes Fund etc.). This will include a collated review of evidence from voluntary sector, health and social care about evaluation of models and recommendations for decisions and a reshaping of investment to be considered by the ACP Executive Delivery Group on a city-wide basis, based on evidence.	ACP Executive Delivery Group			X	
			7.4. Mobilisation of new models of care and support, through collaborative working which focus on multi-disciplinary multi-agency working and single inter-disciplinary care planning and records. These models must approach both the physical and mental health and well-being of older people building on approaches such as IAPT and other models across the city.	Commissioning leads – SCC and CCG				X

What we will do	The difference we will make	What we will check	The key actions	By who	By when in 2018-19			
					Q1	Q2	Q3	Q4
8 Review key supporting strategic and functional **enablers to improve effectiveness**	Focusing available resources on the support that is has most impact for local people in helping them stay safe and well, and preventing avoidable deterioration. More seamless joint working for older people	Self-assessment of key areas, e.g. data maturity	8.1 Review of digital inter-operability and ability to share care information across boundaries.	IT Leads coordinated by Programme Director, ACP		X		
			8.2 Work towards a joint commissioning strategy across health and social care that includes a commitment to creating stability in the parts of the market that we wish to develop and strengthen as part of our new models of care. We will avoid successive short term funding initiatives with smaller out of hospital providers/partners - Recommend an Integrated Commissioning Strategy - Develop an Integrated Commissioning Infrastructure - Complete mapping of provision/services across life stages and levels of intervention - Identify and agree priority areas for integrated commissioning	Accountable Officer, CCG Executive Director of People, SCC		X	X	X

What we will do	The difference we will make	What we will check	The key actions	By who	By when in 2018-19			
					Q1	Q2	Q3	Q4
9 Ensure **flow and best use of system capacity** so older people get timely support from the right person in the right place	Older people being able to return home as soon as their hospital care is complete, ensuring quickest possible recovery. Enabled by: - What Matters To You conversations engaging with carers and professionals who know the older person in the community and can help make decisions in the context of their whole life. - Linked approach between physical and Mental Health. The evidence is clear that effective MH Liaison can improve flow. - Timely in-patient discharge planning ensuring all time in hospital adds value for the older person. - Simplified "three routes out" with a focus on discharge to assess to enable return home. - Integration of community intermediate care including using "trusted assessor" principles. - Improved organisation of independent sector homecare capacity.	The experience of older people and those who care for them. A higher proportion of older people supported safely to stay at home. Older people getting back home more quickly after hospital admission A step change in both of the above measures ahead of winter 2018-19.	9.1 Ensure that the voice of the older person and those who care for them in their home is heard and listened to relation to getting them home. This will help to provide the right support, and minimise the risk of the provision of non-value adding interventions which introduce waste and do not benefit the individual.	Deputy Chief Nurse, STHFT		X		
			9.2 Refresh of independent sector homecare "Primary Providers".	Director of Adult Services, SCC			X	
			9.3 Development of outcome-based independent sector homecare.					X
			9.4 Joint commissioning and quality assurance of homecare and care homes between Council and CCG.	Director of Adult Services, SCC Chief Nurse, CCG				X
			9.5 Agreement and joint commissioning of non-home, non-acute bed capacity.	Clinical Director, CCG		X		
			9.6 Gold Level Board Rounds on all wards with high DTOC levels. 9.7 Continued roll-out across STH of the 'SAFER' patent flow bundle (which incorporates daily **S**enior medical review, **A**ll patients having a planned discharge date, **F**low of patients beginning **E**arly in the day, and all patients with a long length of stay being frequently **R**eviewed). All these actions are of vital importance in ensuring that patients receive timely and safe care in the most appropriate location.	Deputy Clinical Director, STH		X		

What we will do	The difference we will make	What we will check	The key actions	By who	By when in 2018-19			
					Q1	Q2	Q3	Q4
			9.8 Initial evaluation of "Red to Green" work to speed hospital decision making and discharge actions.	Deputy Medical Director, STH		X		
			9.9 Physio and OT assessment in acute setting within 24 hours.			X		
			9.10 Therapy Core Assessment and Triage Tool rolled out to all wards.			X		
			9.11 Streamlined handover from hospital and community to single point of access for community services.	Operations Director, STH Head of Access and Prevention, SCC		X		
			9.12 Integration of Active Recovery services provided by Council and STH: common assessment, trusted assessors, single rostering system.				X	

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Sheffield

Local system review report
Health and Wellbeing Board

Date of review:
5 – 9 March 2018

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Social care, and for Housing, Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:
- Delivery Lead: Ann Ford, CQC
- Lead reviewer: Karmon Hawley

The team included:
- One CQC Reviewers,
- Three CQC Inspectors,
- One Chief inspector

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- One Deputy Chief inspector
- One CQC Expert by Experience; and
- Three Specialist Advisors, two with local authority backgrounds and one with a health governance background.

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system was functioning within and across three key areas:
1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we asked the questions:
- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We then looked across the system to ask:
- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into

adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Sheffield City Council (the local authority), Sheffield Clinical Commissioning Group (the CCG), Sheffield Teaching Hospitals NHS Foundation Trust (STHFT), , Sheffield Health and Social Care NHS Foundation Trust, Primary Care Sheffield, Yorkshire Ambulance Service NHS Trust, Sheffield Health and Wellbeing Board and Healthwatch Sheffield.
- Health and social care professionals including care home and domiciliary agency staff, social workers, GPs, urgent care staff, reablement teams and health and social care provider representatives.
- Voluntary, community and social enterprise (VCSE) sector representatives.
- People using services, their families and carers during our visits to day centres and support groups and in focus groups.

We reviewed 18 care and treatment records and visited services in the local area including STHFT sites, intermediate care facilities, care homes, a domiciliary care agency, GP practices, out-of-hours services and the urgent care centre.

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The Sheffield context

Demographics

- 16% of the population is aged 65 and over.
- 84% of the population identifies as White.
- Sheffield is in the 20-40% bracket of most deprived local authorities in England.

Adult social care

- 72 active residential care homes:
  - 60 rated good
  - Eight rated requires improvement
  - One rated inadequate
  - Three currently unrated
- 47 active nursing care homes:
  - One rated outstanding
  - 25 rated good
  - 16 rated requires improvement
  - One rated inadequate
  - Four currently unrated
- 93 active domiciliary care agencies:
  - 42 rated good
  - 17 rated requires improvement
  - One rated inadequate
  - 33 currently unrated

Acute and community healthcare

Hospital admissions (elective and non-elective) of people living in Sheffield are mainly to:

- Sheffield Teaching Hospitals NHS Foundation Trust
  - Received 96% of admissions of people living in Sheffield
  - Admissions from Sheffield make up 71% of the trust's total admission activity
  - Rated good overall

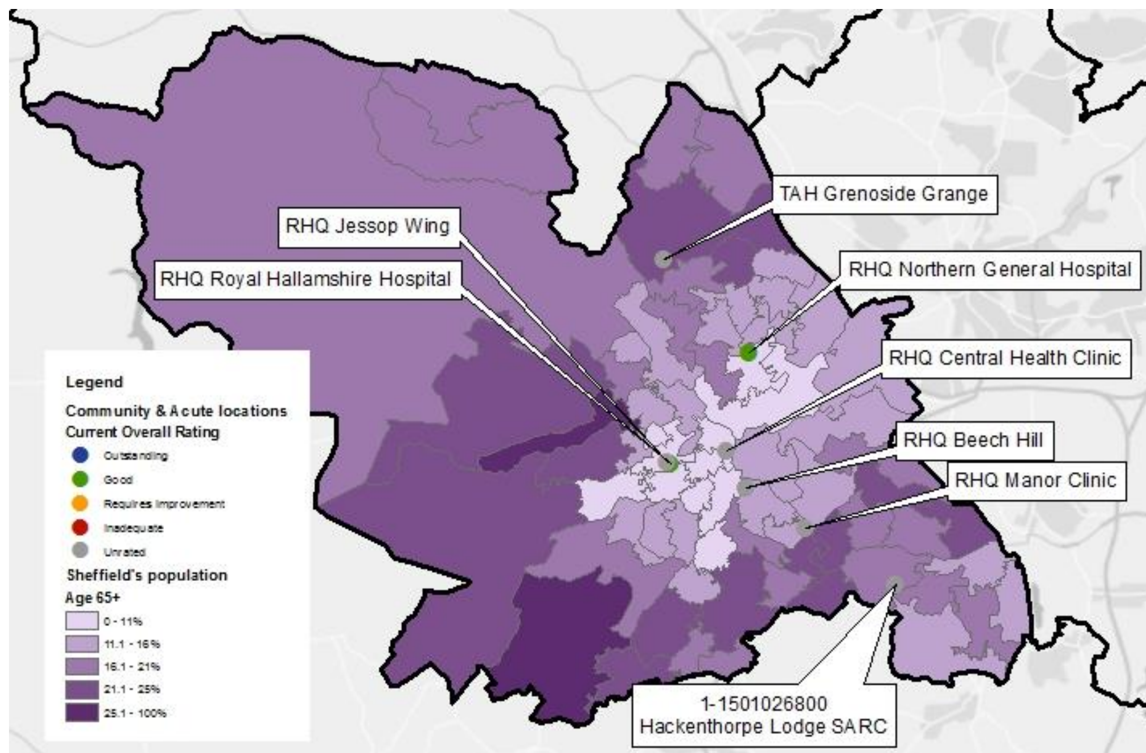
Community services are provided by:

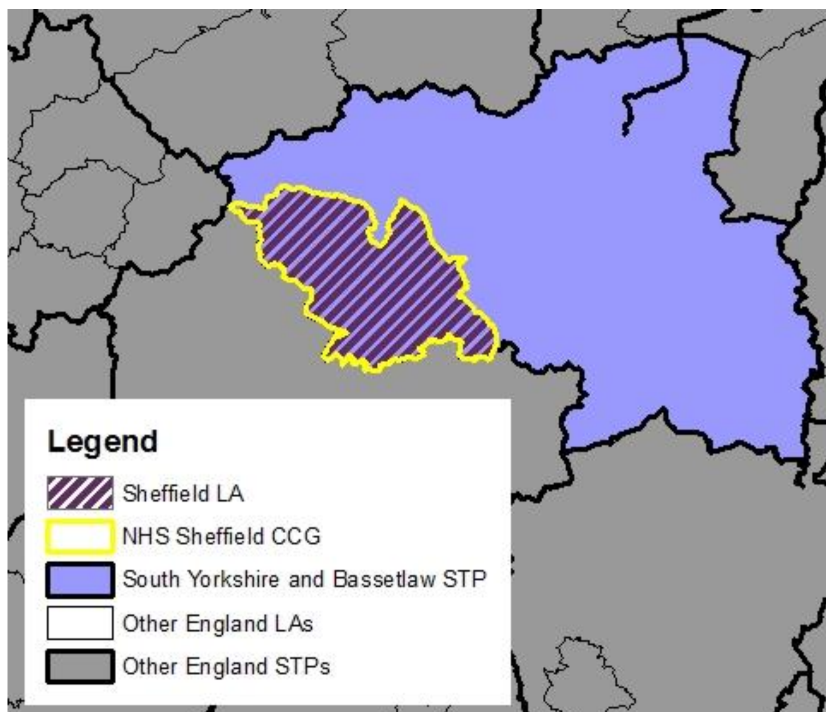
- Sheffield Health & Social Care NHS Foundation Trust
  - Rated good overall

GP practices

- 88 active locations
  - 78 rated good
  - One rated requires improvement
  - Two rated inadequate
  - Seven currently unrated

All location ratings as at 08/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.





Map 1 (above): Population of Sheffield shaded by proportion aged 65+. Also, location and current ratings of acute and community NHS healthcare organisations serving Sheffield.

Map 2 (left): Location of Sheffield LA within South Yorkshire and Bassetlaw STP. NHS Sheffield CCG is also highlighted.

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Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- The Health and Wellbeing Board (HWB) had previously been ineffective in driving system delivery and transformation. System leaders had acknowledged this and responded with a refresh of the purpose and focus of the board. The 'Shaping Sheffield' plan and the accountable care partnership (ACP) were reflective of the wider aspirations and work programmes of the system; however a lack of alignment of these strategies prevented a clear overarching system vision. It was anticipated that the restructure of the HWB would align strategies and drive the vision for integrated services and drive the transformation programme through the ACP. This would present a good opportunity to give assurances that system leaders were focusing on the right areas and involving the right people in developing and progressing service transformation.

- System leaders had developed a Joint Strategic Needs Assessment (JSNA) according to the needs of the population but this was due to expire in June 2018. The JSNA and the Health and Wellbeing Strategy was being refreshed and developed. This was in order to underpin the needs of the local population and to bring about the necessary changes to deliver on the work programmes and outcomes in line with the ACP.

- This work had resulted in a vision among system leaders for the transformation and delivery of services in Sheffield. However, this had not yet been clearly articulated as a strategy that was understood across all partners in the system. At an operational level, staff understood that there was a desire to move towards a preventative approach but were not clear on the plans for achieving this. This lack of clarity had an impact upon the pace of the system journey and the interagency working between health and social care.

- Sheffield is part of a sustainability and transformation partnership (STP) called the South Yorkshire and Bassetlaw Integrated Care System (ICS) which covered South Yorkshire and Bassetlaw. This had little influence on the Sheffield system as Sheffield had developed its own vision and strategies based on the assessed needs of the local population. However the partnerships and strategies in place in Sheffield were reflective of the wider aspirations and work programmes of the ICS.

- There were opportunities for increasing the scale of positive innovations being tested, such as the virtual ward. However; the desire to scale up innovations was compromised by weakness in the system's approach to evaluation and clearly evidencing the impact of pilot

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and test projects. As a result, commissioning decisions were not being supported by robust evaluation.

- We found strengthening relationships and a strong commitment to achieve the best outcomes for the people in Sheffield. We heard that Sheffield was "at its best when facing a crisis" and the system worked well together to address related challenges. However in making positive tactical responses to system pressures and crises, this had sometimes diverted attention from looking at the bigger picture and in particular, delivering the transformation required to meet the needs of people using services in a holistic way.

- System leaders acknowledged that relationships had improved over the twelve months prior to our review and they were working collectively. Engagement from NHS England and support from external consultants had helped the system move away from a perceived blame culture through constructive conversations and agreeing "a single version of the truth" regarding data . System leaders felt that = cultural change was "filtering through", however some comments received in response to our relational audit suggest there is still a perception of a blame culture; so further work is needed to fully embed and sustain positive perceptions about the emerging culture for all staff.

- Workforce challenges and the maintenance of a skilled and sustainable workforce was recognised as an ongoing challenge for Sheffield. Partners had developed organisational-based workforce strategies and system leaders were working to develop the workforce through a range of initiatives. However workforce leads were not collaborating to develop an overarching system workforce strategy or approach.

Is there a clear framework for interagency collaboration?

- The Joint Health and Wellbeing Strategy and the ACP provided a framework for interagency collaboration with an agreed memorandum of understanding setting out the relationship between the ACP Board and the Better Care Fund (BCF). System leaders felt this was providing a stronger framework for delivering the Shaping Sheffield Plan and BCF aims. A programme director had recently been appointed to oversee the delivery of the ACP work streams.

- Each work stream being delivered under the ACP had senior level sponsorship and brought together systems partners to share risk and delivery. The Active Support and Recovery work stream within the Accountable Care Partnership had a primary focus on older people.

How are interagency processes delivered?

- The delivery of interagency processes was based around localities referred to as

"neighbourhoods" serving areas of between 30,000 and 50,000 people. In parts of the city there are differences in the geographical boundaries used by health and social care organisations which resulted in some challenges to the delivery of interagency working in these neighbourhoods.

- A lack of integrated working and co-location impacted on service delivery and the ability of staff to be aware of changes across the system.

- There was a lack of joint plans to deliver services but some examples of shared agreements and approaches, such as the Active Recovery integration project under the ACP and the joint NHS and local authority community intermediate care services (CICS) were having positive outcomes on people's experiences.

- The VCSE sector did not feel integrated with statutory service delivery. There were a number of forums for the VCSE sector organisations to meet, form relationships and improve joint working. VCSE sector organisations felt that links between them and system partners were underdeveloped this lack of inclusion meant they were unable to influence the strategic direction of the local system based on their understanding of the needs of people who use services.

- Although there had been improvements in information sharing and joint working, most social care providers felt that they were not meaningfully involved or included in market shaping or service development.

- Health and social care integration was being driven with a top down approach and system leaders recognised that this had not filtered down to all staff. System leaders needed to continue building cross-system relationships, and develop and embed shared governance arrangements and jointly agreed performance criteria to provide staff with clarity regarding expectations.

What are the experiences of frontline staff?

- Some staff reported disconnection between health and social care services and told us that the leadership strategy was very different to the frontline reality. These kinds of sentiments were echoed in responses to our relational audit with some respondents describing feeling that social care and VCSE sectors were undervalued within the system, which has led to the health sector monopolising joint working decision-making. Frontline staff were dedicated to providing high-quality, person-centred care. However they reported heavy workloads and recruitment challenges that did not support seamless care delivery.

- The incompatibility of IT systems was a common problem and frontline staff faced challenges when sharing information which impacted on the ability of staff to support people effectively.

- System leaders and senior managerial staff were visible and accessible. However some operational and frontline staff felt more effective conversations and engagement opportunities were needed for them to feel part of the vision and able to influence and shape service design and delivery.

What are the experiences of people receiving services?

- Most people were treated with kindness and the majority of frontline staff provided person centred care, going the extra mile for people they cared for. Most people were positive about individual staff and their kindness and compassion.

- Some people who use services, their families and carers told us that they did not always feel well cared for and involved in making decisions about their care, support and treatment when moving through the health and social care system. Some people we spoke with reported a lack of trust in the system with a lack of transparency, openness and engagement. Specific concerns were raised in relation to the bullying and oppressive nature of some staff towards people using services and carers when they were in vulnerable circumstances.

- Some older people were not always seen in the right place, at the right time, by the right person. People using services, their families and carers reported multiple points of access and a fragmented approach to service provision. This resulted in people having to tell their story multiple times and on occasion with a lack of privacy and dignity. The system could do more to ensure that activities and services were easier to navigate and easier for people to find out about; this would improve access and use.

- Multiple concerns were raised in respect of the continuing healthcare (CHC) process and the timeliness and accuracy of social work assessments. This resulted in a lack of support to carers, inappropriate placements, placement breakdowns, hospital admissions and risks to people using services.

- People were not always communicated with effectively when there were delays in their care and treatment and they didn’t always experience a seamless and safe discharge to their usual place of residence. Decisions were sometimes made without consulting people, their spouse and/or family members. Also because of the quality of discharge information, GPs were not always notified of the need for follow up appointments which impacted on people’s follow up care.

- People faced delays when waiting for a long term care package on discharge from hospital, especially if they required complex support.
- The proportion of older people receiving reablement or rehabilitation upon discharge from hospital in Sheffield was significantly higher than the England average in both 2015/16 and 2016/17. However, the effectiveness of these services, as measured by the proportion of people still in their own homes 91 days later, had decreased in recent years and in 2016/17 was below both the comparator and England averages.
- Carers felt that they did not always receive the help and support they needed. Adult Social Care Outcomes Framework (ASCOF) data for 2016/17 showed the percentage of carers (of all ages and those aged 65 and over) in Sheffield who were satisfied with their experience of care and support was below the England average.

Are services in Sheffield well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

The Health and Wellbeing Board (HWB) had previously not been fully effective in its function and had not supported a clear shared strategic vision for the future of health and social care services in Sheffield. It was anticipated that the restructure of the HWB would align strategies and drive the vision for integrated services and the transformation programme through the ACP. The 'Shaping Sheffield' plan and the ACP were reflective of the wider aspirations and work programmes of the ICS however the ICS did not directly influence the system transformation programme.

Relationships across the system had not previously been productive however there was recognition that these had developed in recent years resulting in greater maturity between system leaders to enable change. While there was a shared commitment among system leaders to tackle challenges jointly this was not always translated into action at an operational level. There were missed opportunities to improve the system through lessons learned.

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There was a need for stronger engagement and coproduction with people who use services, their families and carers in the development of strategic priorities.

Strategy, vision and partnership working

- The Sheffield Health and Wellbeing Board did not at the time of our review appear to be effective, as key decisions were not being made to support the strategic approach. It was not driving transformation nor did it undertake robust scrutiny. This was recognised by the new HWB chair who was working to get the right stakeholders to the board. However the recent change in leadership and the refresh of the HWB was enabling system partners to work with a stronger focus on wellbeing and prevention, and shift investment to medium and long term care, working alongside the ACP.

- System leaders had developed a JSNA which although due to expire in June 2018 was in the process of being refreshed. The Health and Wellbeing Strategy had also recently been refreshed to reflect the needs of the local population. Alongside this was the ACP and the Shaping Sheffield plans, which while similar, need to be aligned to represent the vision that system leaders want to achieve in their transformation and delivery programmes.

- 'Shaping Sheffield' was the city's commitment to a single plan for improving health and wellbeing in the city. Although this plan linked into the Health and Wellbeing Strategy, the Better Care Fund (BCF) and Sheffield Accountable Care Partnership (ACP), the system was at the beginning of its journey and this vision and strategy needed to be fully aligned and embedded to become a reality. This presented a further opportunity to drive change using co-production with health and social care professionals and with people using services, their families and carers.

- Because the Health and Wellbeing Strategy, Shaping Sheffield and the ACP were not fully aligned the joint overarching strategic vision was not clear. It was not well understood by all frontline and operational staff which impacted on the culture of the wider system and interagency working between health and social care.

- There was an increased ambition to work together as a system, face system challenges and formalise ambitions through a joint strategic approach. Leaders within Sheffield were developing an ACP to provide a whole system strategic planning and commissioning approach across system partners. This offered a shared approach for the design and delivery of services however; this was not yet fully aligned or embedded or translated into actions which would provide clarity for staff in all organisations and people who used services about how the transformation of integrated services would be delivered.

- Sheffield was part of an STP called the South Yorkshire and Bassetlaw Integrated Care System (ICS), covering South Yorkshire and Bassetlaw. The ICS appeared to have had little influence on the Sheffield system as Sheffield had developed its own vision and strategies based on the assessed needs of the local population. However the partnerships and strategies in place in Sheffield did reflect the wider aspirations and work programmes of the ICS.

- The need to develop individual organisations had led to delayed transformation and delivery of integrated services. This led to a fragmented system where there was duplication of effort and, at times, a reactive tactical response to entrenched performance issues such as delayed transfers of care (DTOC).

- Historical relationships between system leaders were described as "tense" by system leaders, however there was consensus that these had improved through the development of the Shaping Sheffield strategy and a wider commitment to system-level working. Despite improvements it was evident that not all system partners were working together as effectively as they could, and this was recognised by system leaders.

- We received 230 responses to our online relational feedback tool. Although the 98 free text comments supplied as part of this feedback were mixed, various respondents described an increase in partnership working, and a will to work collaboratively to improve care for older people in a person-centred way. However, a few respondents noted that some cultural issues remained including the perception of a blame culture and social care and voluntary sectors feeling less valued than the health sector. Organisational development was required to address these barriers and create the required culture to enable better collaboration and service integration.

Involvement of service users, families and carers in the development of strategy and services

- The engagement and inclusion of people using services, their families and carers was not consistent across the system. Although there were mechanisms in place, the strategic approach to co-producing services was underdeveloped and people felt they had limited influence on the design and delivery of services.

- People who use services, their families and carers felt that there was a lack of dialogue and consultation between themselves, providers and commissioners when making decisions about service delivery. People did not feel listened to despite public consultation which caused them concern and anxiety. For example, people felt a decision had been made to close an Urgent Care Centre before a formal consultation had been undertaken.

- System leaders recognised there was more to do in respect of listening and using people's views and aspirations in the development of services and were keen to improve people's inclusion and engagement. Leaders also acknowledged there was an opportunity to work more closely with the VCSE sector to explore positive involvement and use the learning to develop a more inclusive approach.

- There were some examples where co-production had worked well, such as the Sheffield Young Carer, Parent and Adult Carer Strategy, the Dementia Care Pathway Review and the first point of contact with social services. All were developed in consultation with people who used services to determine what would meet people's needs.

- Feedback from people who use services had been used to assess the impact and developmental needs of the 5Q process (this is a person-centred process asking five questions to assess what is better for the individual), which was currently under evaluation. An example of where public involvement and feedback had resulted in change was the 15 Step Challenge undertaken in response to Friends and Family Test for community services. This improved the quality and quantity of feedback received from local people and a short video for staff was produced to encourage staff to respond to people's wishes and feelings.

- Although there were good levels multidisciplinary working within organisational boundaries these did not always translate across the system. System leaders and operational staff recognised the need to improve interagency and multidisciplinary working at pace.

- The external review commissioned by the Better Care Fund to explore the challenges in DTOC had encouraged system developments to improve relationships and promote the culture of interagency and multidisciplinary working. However the system still faced key challenges to resolve those issues. There were multiple first points of contact which were not fully understood by some professionals and resulted in some staff being detached from the overall system vision and how this influenced their work, making it difficult for everyone to work together in a unified way. The restructuring of social care, the reduction in resourcing of operational groups and a disconnect in discharge planning between frontline acute and social care staff had led to disjointed relationships between some health and social care partners. However, system leaders told us that social care staff were consistently involved in all discharge meetings which included the task group meeting (daily), flow meeting (weekly), and director level escalation meeting (twice weekly).

- New initiatives were being developed, sometimes without a shared approach, which resulted in silo working and potential duplication of effort. Staff at all levels acknowledged

that there was a lack of joined up working between health and social care and there had been issues in the past which had negatively affected relationships.

- We found that the lack of coterminosity between organisations and systems was a barrier to integration, particularly between social care and primary medical care services, where there was a lack of multidisciplinary team discussions and the existing referral systems. The alignment of the workforce across different sectors and around smaller locality-based population bases was also recognised as a system wide challenge. The advent of the ACP presented leaders with an opportunity to address these challenges in a coordinated and collaborative way.

- The local authority and the CCG were not working as effectively with social care providers as they could. Social care providers did not feel they were considered as system partners or involved in service design and delivery in a meaningful way.

- Although jointly commissioned services were limited, there were some examples of good individual services in health and social care working together. For example, the Short Term Intervention Service Team (STIT) and the Community Intermediate Care Service (CICS) were developing joint rostering and management approaches to improve shared use of resources.

- Yorkshire Ambulance Service NHS Trust works flexibly with primary and secondary care partners, using paramedic capacity to avoid transfers to hospital and facilitate A&E handovers at periods of peak demand.

- In a crisis, there was a collaborative response to support system resilience and risk mitigation. However, this was indicative of a reactive culture and further development was needed to plan effectively for the longer-term.

- There were good foundations for further development on a system-wide basis as some relationships and joint working were strong across and between the different organisations.

Learning and improvement across the system

- Learning worked well at operational level, as learning outcomes from pilots and projects were shared; however there was limited shared learning outside of organisational boundaries. There were some good pilot initiatives but there was a lack of appropriate strategic oversight, monitoring or in depth evaluation of these, which meant opportunities to influence commissioning and strategic development were missed. A more coordinated approach to developing pilot schemes and innovations is required to ensure they will

support strategic planning and commissioning. The First Contact service had been developed and implemented with clear aims and measurable indicators for delivering improvements, so this may be a good practice example for considering how other innovations and pilots could be evaluated and rolled out.

- Each organisation had sight of their own incident management but there was no single, co-ordinated approach to ensure lessons were shared widely across the health and social care interface. Despite the external review and improvements made to DTOC, the system had not been able to sustain this. The system was frequently in escalation which had resulted in sub-optimal performance being accepted as a consequence of a pressured system. There needed to be more evaluation of the contributing factors to the escalation and de-escalation processes so lessons could be learned, continuous improvements made and shared across the system.

- There were mixed views regarding how well the system was learning and improving. Concerns were expressed by some frontline staff that they didn't feel they had a voice and when they expressed concerns these were not always acted upon.

- There were examples of ambition to learn from best practice and develop systems and processes within individual organisations. For example, staff in A&E had recently been researching successful care plan methods which reduced people having to tell their story more than once.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

The Health and Wellbeing Board was responsible for overseeing the delivery of the transformation programme through the ACP which was responsible for the delivery of individual work streams identified by the HWB. Due to structural changes and new developments, more work was needed to strengthen and drive the collaborative delivery of health and social care services in Sheffield through the ACP board.

The newly formed ACP was the key governance arrangement in overseeing the delivery of the transformation work streams, driving collaborative working across the system. The HWB and the ACP shared the same joint chairs which provided consistency; however this arrangement meant that scrutiny of decision making may not always have been objective.

The lack of integration and continued silo working made it difficult for the system to analyse and assess the impact of services at a system level.

Overarching governance arrangements

- The HWB was designated to provide the strategic oversight for the delivery of health and social care services in the city. At the time of our review the Health and Wellbeing Strategy had been refreshed but structural changes and governance arrangements were being made to the HWB. Previous arrangements had not fully supported partners to collaboratively drive and support quality care across the health and social care interface.

- There was recognition by system leaders that the HWB required reconfiguration and a stronger sense of purpose. The HWB had recently been restructured with an aim to fulfilling its statutory functions and holding leaders to account as to how the system was working in the interests of the people of Sheffield.

- The ACP had recently been established to deliver the strategic vision and outcomes for the city, defined by the HWB through seven work streams. The ACP was in its infancy but was the key governance arrangement across the system to support collaborative working and to promote integration.

- The HWB was responsible for overseeing the ACP, however the HWB and the ACP were co-chaired by the same people – this was not a clean governance arrangement and it did not necessarily allow for true scrutiny of process and accountability. At the time of our review the governance arrangements between the HWB and ACP were still to be clarified and scrutiny arrangements finalised to ensure accountability and responsibilities were defined appropriately.

- A lack of scrutiny of decision making was also evident in the governance of the Healthier Communities and Adult Social Care Scrutiny Committee. The Committee was not sighted on discussions at the Health and Wellbeing Board and was therefore unable to provide any scrutiny to decision making.

- A Programme Director had been recruited to oversee the delivery of the seven transformation work streams of the ACP, each supported and sponsored by a Chief Executive and Chair. Progress of the work streams is to be reported into the HWB.

- The Sheffield Better Care Fund (BCF) was one of the largest in the UK with a combined budget of £364m. The BCF was steered by an Executive Management Group that included

leads from the CCG and the local authority focused on developing a joint commissioning approach to support the ACP.

- As part of Sheffield's BCF plan, there was focus on the delivery of initiatives jointly agreed between providers and commissioners. This promoted and had developed joint decision making and risk sharing arrangements to establish effective shared responsibility and governance of the pooled budget. All risks within the BCF were considered to be shared risks and while leaders were able to articulate how the system had responded to specific issues or pressure points, this approach was sometimes reactive and Sheffield was frequently responding to escalated risk.

- The lack of integration and continued silo working made it difficult for the system to analyse and assess the impact of services at a system level. For example, The End of Life Strategy was not integrated into the system governance arrangements. In addition there were no formal mechanisms for end of life professionals to report to the wider system the impact of this important service and consequently include end of life care in system wide planning.

Information governance arrangements across the system

- Use of, and access to IT systems was fragmented and varied both between and within organisations. There was a need for a clear centralised information plan the arrangements in place did not allow the seamless transfer of people's information. The information systems were not integrated, and were not allowing for the complete sharing of information; system partners were not able to access and see records across sectors. For example, health staff from the Active Recovery service and Integrated Care Therapy (ICT) could not access social care records which impacted upon assessment and meeting people's needs.

- There was a lack of digital interoperability. Frontline staff told us the IT systems were not fully effective in supporting communication and information sharing which impacted on the discharge process. For example, use of PharmOutcomes (an online system) to transfer discharge information was very low. Since the platform was launched last year there had been 18 referrals to community pharmacies, three from STHFT and 15 from community services. Frontline staff told us that this system was duplicating work and was time consuming to use. This could be improved if the referral system was integrated with the hospital system so that sending the information to community pharmacies became routine practice.

- Sheffield Hospice and other VCSE organisations developed their own Sheffield Palliative Care Communication System, it was hoped that this would develop into something that would support coordination with other services, but again, there were issues with different

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systems collaborating. Sheffield Hospice was developing a system for regularly assessing people and feeding information through to the Single Point of Assessment system to enable greater oversight of a person's health in their usual place of residence

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system was working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

Sheffield was particularly challenged by workforce issues in the acute and community sectors and a number of concerns were raised during our review. There was not a strategic plan at system level to align the workforce to future demand. Collaborative work had not taken place to tackle recruitment issues or to develop a single recruitment pathway. The workforce challenges resulted in heavy workloads for staff and impacted upon the delivery of care and integration of services.

There were some examples of innovative approaches to responding to workforce capacity and skill set, with workforce leads exploring new roles and models of care.

System level workforce planning

- Although there was recognition of pressures in each sector, there was no overarching workforce strategy that covered all of the systems in Sheffield. There was limited strategic oversight, an underdeveloped approach to joint workforce and limited future planning across the system. Frontline and operational staff were concerned that services were trying to recruit from the same pool of staff and this impacted on recruitment and retention of staff.

- There were staff shortages across the system and staff told us workloads were heavy which impacted upon the delivery of care and integration of services. Workforce challenges and the maintenance of a skilled and sustainable workforce were high on the agenda for Sheffield and there was recognition of the need to develop more proactive approach to recruitment and retention of staff. The system had invested more in secondary care because of the pressures of reactive work; however there were plans to invest in the community workforce to build preventative capacity.

- Electronic Staff Record data from July 2016 to June 2017 showed that the staff turnover rate at STHFT was lower than the national average across all staff groups. However the workforce in adult social care was less stable as estimates from Skills for Care showed that staff turnover rates had been rising year-on-year and in 2016/17 were above the England

and comparator average. Nevertheless, while estimates for adult social care staff vacancy rates in Sheffield have fluctuated in recent years but they have remained below the England average.

- Although there was no joint workforce strategy there were a number of separate workforce development plans including a primary care workforce strategy to address the potential shortages of GPs. STHFT were hosting training placements for physician associates to integrate into GP services.

- The local authority was producing a Workforce Development Strategy, operational from April 2018 and South Yorkshire Region Excellent Centre (SYREC) was supporting an educational initiative to reach the people working in care homes and within domiciliary care services in Sheffield. The ACP also had a specific workforce development stream and this should provide opportunities to better consider workforce planning and new employment models.

Developing a skilled and sustainable workforce

- Although there was a lack of strategic workforce plans that brought all the individual organisational work streams together, system leaders had been looking at capabilities and the competencies of the workforce within their own sectors For example, in primary care, GP practices were employing nurse practitioners and paramedics to undertake home visits.

- Workforce leads in the CCG had also been looking at moving on from traditional roles between the acute and community settings. STHFT had responded to system challenges in the A&E department to match flow, staffing numbers and skill mix, restructuring staffing to make sure they had the optimum staff working at the right times.

- The virtual ward brought together a multidisciplinary skilled team that were working together effectively to meet the needs of neighbourhood population groups. The virtual ward was having a positive impact on maintaining people’s wellbeing in their usual place of residence and preventing unnecessary admissions to secondary care. While staff in health services and the VCSE sector were working well and collaborating effectively, social care representation was absent from the team.

- There was a positive emphasis on training for staff across all sectors and there was evidence of joint training events taking place. However, workforce leads told us that the Developing People Improving Care framework did not involve social care and there was a gap in primary care. The Hospice had provided CCG funded sessions to educate the public, primary care professionals and other health and social care professionals about end of life

care. The Hospice also ran Project ECCO, which provided tele-mentoring to support practice and learning communities within 20 nursing homes.

- There was extended use of Community Matrons, Clinical Pharmacists and Physiotherapists in general practice to support with medical staff vacancies. Other roles including Care Navigators, Advanced Clinical Practitioners, Physicians Associates, Nursing Associates, Assistant Practitioners, were also being developed.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners were providing a diverse and sustainable market in the commissioning of health and social care services.

Commissioning strategies, underpinned by the JSNA, had supported a joint approach in managing and commissioning services. The JSNA had provided a platform to move forward with new models of care and service integration; however transformation strategies were not fully aligned. . Sheffield faced significant social care market issues, including in extra care housing capacity; the system needs to make sure there is sufficient capacity and resilience to cope with an anticipated increase in demand. The system had developed an integrated commissioning function with a pooled budget based around areas of need but there was little evidence that much more shared working was planned.

Strategic approach to commissioning

- The JSNA informed the Health and Wellbeing Strategy, the Shaping Sheffield plan and the ACP plan and defined what the system wanted to achieve for Sheffield, however these plans were not fully aligned to bring about the necessary changes to deliver on work programmes and resulting outcomes.

- At the time of our review the system had submitted a bid for an £80 million innovation fund to direct additional resources towards supporting frail older people and older people with long term conditions. In line with the Health and Wellbeing Strategy, it was intended that funding would be used to increase provision in preventative services.

- An executive management development group had been tasked with looking at what preventative services worked best. There was consensus among system leaders about what was working in terms of preventative services and keeping well, some of which

underpinned how long term conditions were managed. However some of these services, were not well managed, and there was a lack of integration. Commissioning leads were unable to articulate what the impact of individual services would mean in terms of outcomes for local people and there was limited oversight and evaluation of pilots and initiatives which meant that commissioners did not have extensive information to inform commissioning decisions.

- The BCF steered by an Executive Management Group included leads from the CCG and the local authority. There was also a Deputy Director overseeing the pooled budgets. There was commitment from leaders of STHFT to move towards more integrated commissioning with the local authority and the CCG, who were responsible for joint commissioning under the ACP. Some positive work had been undertaken to pool resources around the dementia pathway.

- Commissioners reported pressures as boards were still held to account for the financial position of the individual organisations but the ACP and Shaping Sheffield had provided them with a mandate for managing finances to meet the expectations of these system strategies. Despite being a large joint fund, integrated commissioning arrangements were not well developed. In 2013 the system agreed a single budget for health and social care but in reality they were not operating a single budget, although they were working towards a total resource model for 2020.

- The independent sector was vulnerable owing to financial and workforce challenges, although these had improved following a recent cost of care exercise which resulted in an uplift in fees to give fair price for care, and increase capacity in homecare. Social care providers needed to be more involved in strategic conversations and a number of issues still needed to be resolved in order to benefit from a unified commissioning strategy and workforce plan.

- The system had begun commissioning services through a neighbourhood working approach, based on analysis of the needs of the populations of the local area; there were varied levels of health needs identified in different parts of the city. Commissioning through neighbourhood working should bring together multidisciplinary team working, however concerns were raised in respect of the geography and staffing resources.

- Sheffield Integrated Commissioning Programme (April 2015) presented an overview of the redesign of the health and social care system, aimed at reducing reliance on hospital and long term care. It was evident that although there had been challenges, progress had been made in respect of the some of the work streams such as Active Support and Recovery.

Sheffield Integrated Commissioning Programme acknowledged that more detailed design was needed in regard to models of care, as well as addressing provider sustainability, efficiency and mixed economy provision.

Market shaping

- System leaders had a good understanding of the social care market but further work was needed to address the continued challenges the system faced owing to financial and workforce pressures.

- Sheffield had a Market Position Statement. It had recently been refreshed and was due to be presented to Sheffield City Council's cabinet shortly after our review. This had set out the ambition for the type and volume of care provided to support the overriding strategy of their three sphere model; keeping people at home, at home with enhanced support, or to another place for assessment.

- There was a commitment to prevention and building family resilience to enable people to stay at home with care wrapped around them. However, there were concerns in respect of the decision to map commissioning strategies to the three sphere model, rather than undertaking an in-depth evaluation of the market position to influence commissioning or strategic development.

- Care home bed modelling had been carried out to inform future commissioning; taking account of the growth in service demand, population needs and forecasted available supply of care beds. To support people being cared for at home, system leaders decided to expand the domiciliary care market and fee rates were increased by 8% in 2017/18 to support providers to increase their capacity. There was also planned investment in residential care through the introduction of a fair fee rate in April 2018. However system leaders were aware that there was much more work to do to ensure future sustainability and sufficient supply to meet demand.

- Our analysis showed that at September 2017 there were fewer residential care home beds per population aged 65+ in Sheffield (1848) compared the average across comparator areas (2215) and the England average (2223) and this number had decreased by 8% over the preceding two years. However, there had been a 3% increase in the number of nursing home beds over the same period and there were more nursing beds per population aged 65+ in Sheffield compared to comparator areas and the England average (2669 in Sheffield compared to 2200 across comparator areas and 2075 across England). The number of domiciliary care provider locations per population aged 65+ in Sheffield had increased by 5% and was higher than the comparator and England averages (89 compared to 86 and 79

respectively). Despite this there were specific challenges in commissioning non-bedded social care and care services such as extra care housing.

- We saw limited engagement with housing services at a strategic level; there seemed to be no direct link to the HWB and we saw little evidence of alignment of Planning Policy and Housing Policy with the Shaping Sheffield Plan, the Health and Wellbeing Strategy, or the ICS. There was a very limited amount of extra care housing for a city of Sheffield's size and no mention of housing based services for intermediate care (step up or step down). Housing services and the support from housing professionals was talked about favourably and well regarded by primary care and those involved in social prescribing. Housing staff and services were sometimes involved in discharge arrangements but housing services still thought there was more they could do and were keen to be more involved.

Commissioning the right support services to improve the interface between health and social care

- Through the development of Shaping Sheffield and the ACP there was a shared vision and strategy. While senior leaders knew what they wanted the system to achieve, strategies were not fully aligned, understood and owned by all organisational staff. The local authority and the CCG were responsible for joint commissioning under the ACP. Senior leaders in the CCG and local authority met and discussed plans and there was buy-in from STHFT to move towards more integrated commissioning.

- The local authority's housing service had changed its operating model to create a single point of contact; housing staff are aligned to and working within designated neighbourhoods to improve collaboration with health and social care partners. The housing strategy was developed with a good level of strategic interaction with health and social care and was informed by modelling to understand how services need to evolve to meet the changing needs of the population.

- The VCSE sector provided a range of services that were valued by people who used them, however these were underutilised and concerns were expressed by the sector in regard to the sustainability of some of their services, for example the advocacy support and advice provided to people claiming direct payments.

Contract oversight

- STHFT is rated as good by CQC. CQC data from December 2017 showed that 96% of GP practices in the area were rated good, none were rated outstanding and two practices were rated inadequate. Adult social care locations across Sheffield were more poorly rated than average. Although residential care homes in Sheffield were rated similarly to comparator

areas, a higher percentage (34%) were rated requires Improvement than the national average (25%). Nursing homes were performing well in their ratings, with 83% rated good compared to 74% and 75% across comparators and England respectively; however a higher percentage of domiciliary care and other community adult social care services were rated requires improvement in Sheffield compared to comparators and nationally.

- Where services had been re-inspected a higher percentage of adult social care services had improved in Sheffield compared to comparator areas and the England average (40% compared to 36% and 37% respectively), higher percentage of GP practices had kept the same rating (79% compared to 64% and 56%).

- The local authority and the CCG had started to jointly commission to better manage the quality of the care market and improve market management. Care home bed modelling had been carried out to inform future commissioning; taking account of the growth in service demand, population needs and forecasted available supply of care beds.

- Enhanced health care was one of the initiatives that had worked well and rationalised health care across the city. However the system encountered problems with this due to the ever increasing number of care homes and also those care homes which had been rated poorly by CQC. This had resulted in a mixed economy; some care homes were not receiving enhanced health care and the number continued to decline. Concerns were expressed in regard to the financial impact of this service and the benefits as there had been no uplift in fees for eight years.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how the system assures itself that resources are being used to achieve sustainable high quality care and promote people's independence.

There had been a long history of collaborative approaches and risk sharing arrangements. System leaders were committed to joining up their commissioning and using resources flexibly for the benefit of people who needed health and/or social care. Resource leads across the system collaborated well in times of crisis. However there wasn't a good understanding of what worked well and a lack of evaluation and oversight meant that we could not be assured about the impact of resources.

- The HWB which was responsible for ensuring services met the needs of the population was being refreshed and we heard the Overview and Scrutiny Committee (OSC) had recently

also been refreshed. The OSC had oversight of system challenges, but we heard it was not fully performing the scrutiny aspect of its role and gaining assurance that there was effective use of cost and quality information to identify priority areas and focus for improvement.

- We noted the ACP was being developed to take on more responsibility and oversight across health and social care in Sheffield but this was more strategic at the time of our review and still in development.

- As part of Sheffield's BCF Plan, there was focus on the delivery of initiatives jointly agreed between providers and commissioners to promote and develop joint decision making. There were risk sharing arrangements to establish effective shared responsibility and governance of the pooled budget. Finance leads had developed strong relationships and worked together to balance the system's finances and had developed a strong understanding of each other's' financial issues.

- There was evidence that BCF monies had been spent on solutions to target improvements against DTOC and support the social care market to enhance capacity. However it was not clear that this spend was part of an overarching strategy to improve performance in the medium to long term. Although there was evidence of financial risk sharing arrangements between the CCG and the local authority, there was less evidence of how these arrangements would be used to improve system integration.

- Although relationships were strong, there was not a shared understanding about what their priority areas were for funding prevention services at scale. Finance leads did not have collective oversight of what was working and how they would prioritise resources for particular services. However there were strong links from finance departments across the local authority, the CCG and STHFT into all of the accountable care work streams. The BCF budget was steered by a system leads' Executive Management Group focussed on developing a joint commissioning approach to support the newly developed ACP. To give better oversight, system leaders told us there had been improved joint working through the development of pooled budgets and fully integrated commissioning was beginning to gather pace. The BCF pooled budget for 2017/18 had been reviewed and brought together key budgets in relation to themes such as people keeping well, Active Support and Recovery and Independent Living Solutions.

- There was joint agreement between the CCG and the local authority to use additional social care funding made available from the iBCF to support the provider market. There had been a bid to the National Life Chance Fund, which had been successful in the first stage, which had a significant focus on frailty and long term conditions for older people.

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Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Sheffield safe?

The system was committed to supporting older people to remain well and to live independently at home. However preventative services were underdeveloped and some people expressed concerns in regard to social care assessments. Systems and practices were not working well for the majority of people we spoke with. More was needed to ensure there was a shared view of who in Sheffield was at risk of hospital admission and that pilot initiatives were fully evaluated and embedded.

- People who were frail, had complex needs or were at high risk of deterioration in their health or social situation were not always safeguarded from harm as systems, processes and practice across the health and social care interface were not fully established and embedded. Although system leaders saw admission avoidance as part of the prevention strategy, admission avoidance services were under developed and there was a lack of integration of health and social care. People at risk of deterioration were falling through the gaps and they reported not being listened to and experiencing a crisis before they received the support they needed.

- Some people were not effectively supported to stay in their usual place of residence. Not all of the care and nursing homes had access to enhanced GP support. There had been a plan in place to support all care homes but as the number of care homes had increased this had not been expanded and GPs had reduced their support due to the extra resources needed to invest in these services, especially in poorer rated care homes. This resulted in a lack of focus on early intervention, prevention and improving quality of life in a number of care homes. The previous impact this had on reducing hospital admissions had been apparent and recognised by the Local Medical Committee. To further support care home staff, formal teaching sessions from the system were offered to care homes focussing on subjects such as recognising deterioration, falls prevention and prevention of dehydration.

- System leaders were aware that the preventative agenda was underdeveloped and they were responding to this with development work; for example, with risk stratification and case management in primary care and the digital care home project. Risk stratification and case management promoted the early identification of the frailest people within GP practices who would benefit from an enhanced approach to care. The digital care home

project was using a range of digital devices to help individuals or their carers to keep a regular check on their health. The data was then sent live to the health Single Point of Access (SPA, an interface with a focus on admission avoidance) which identified any irregularities and followed up on potential concerns enabling preventative measures to be put in place earlier.

- Some people were exposed to risk of harm due to inaccurate and delayed social care assessments. We were told of examples where people's complex needs had not been identified, resulting in hospital admissions, inappropriate placements, a lack of support and removal of care packages. Missed reviews meant that people's changing needs were not always being identified. For example, a lack of timeliness and communication in a social care assessment resulted in a domiciliary care provider not being able to respond with the immediate change to the care package. This resulted in the person's health and wellbeing being compromised and ultimately a change in their social situation and usual place of residence.

- People using services, carers and frontline staff experienced multiple confusing access points as there was a lack of effective signposting to services and no comprehensive single point of access. Although there was a SPA for health and the First Contact team for social care, we received varied feedback about the effectiveness of these services from people using services, carers, and multiple professionals.

- The Active Recovery scheme reduced people's reliance on hospital and long term care and prevented people from going into hospital by responding rapidly to individual needs and undertaking assessments to provide the necessary support for a short period of time across seven days a week. If a GP felt that someone was at risk they could contact the team for support.

- Medicine optimisation took place as part of the Active Recovery scheme and there was also CCG-led support for social care providers which included education and training. However there was no formal, joined-up approach to support medicine optimisation and concerns were expressed in regard to the lack of oversight in regard to de-prescribing as part of routine practice.

- Our analysis of quarterly A&E attendance rates between 2014/15 and 2016/17 showed that A&E attendances of older people in Sheffield had reduced slightly but were still above the national average, although not significantly so. In the last quarter of 2016/17 there were 10,821 A&E attendances of older people per 100,000 in Sheffield compared to 10,534 nationally. The A&E attendance rate of older people living in care homes was also just above the England average.

Are services in Sheffield effective?

People did not always receive a multidisciplinary approach when requiring additional support due to fragmentation and silo working within the system. There were multiple and complex access points which caused confusion for people using services, carers and some frontline staff. There was some success with admission avoidance projects; however these had not been fully evaluated to measure success. There were widespread workforce issues across the majority of the system, which were impacting on service delivery and staff workloads. Staff reported concerns with IT systems not communicating effectively which reduced efficiency as key information about people's care and treatment was not always available.

- ASCOF data showed an increasing trend of older people being admitted to residential and nursing homes for long-term support in Sheffield. In 2015/16 the rate of admissions of older people to care homes in Sheffield was significantly higher at 988 per 100,000 compared to the comparator average of 772 and England average of 628. Care home admissions reduced in Sheffield in 2016/17 to 824 per 100,000 but remained above both the comparator and England average.

- People were not fully supported to maintain their health and wellbeing in their normal place of residence due to under-established preventative services. This had resulted in silo working and a lack of adequate community and primary care services. System leaders told us they were focussed as a collective on proactively supporting older people to remain well and live independently at home. To do so they had commissioned services and pilot initiatives around prevention, however these were early in inception and there wasn't a shared, evidence-based understanding of what prevention services worked best, or consistent evaluation of impact.

- People using services were at risk of not receiving consistent enhanced health care. Although there had been an evaluation report for community-based support in July 2017, this evaluation only looked at the effectiveness of one component of the People Keeping Well Programme. Furthermore, the people keeping well outcomes framework identified the function and outcome indicators but lacked key information in regards to how this would be fully achieved, monitored and measured.

- The enhanced health care in care homes (EHCH) implementation plan identified that Sheffield had successfully implemented some of the care model elements from the EHCH framework and were in the process of implementing others. It offered a number of initiatives such as medicine optimisation, providing intravenous antibiotic therapy at home and a range of training such as end of life care. The plan stated that all residential and nursing

homes in Sheffield were covered through the Locally Commissioned Service apart from four care homes. When we spoke with social care providers, GPs and the LMC, it was apparent that the reality did not reflect what was stated in the plan as they all expressed concerns in regard to the management, availability, sustainability and effectiveness of the service. More work needed to take place with social care providers with regards to the preventative agenda, focussing on early intervention, prevention and improving quality of life.

- The system had begun commissioning services through a neighbourhood working approach, based on analysis of the needs of the populations of the local area. It was anticipated that this approach would bring together multidisciplinary teams and integrated models of care. An example of this was the pilot called The Virtual Ward which covered four neighbourhoods. This was testing out an integrated approach to supporting people in their own home and reducing the need for hospital admissions and preventing unnecessary delays in hospitals. This model brought together community health professionals and the VCSE sector, to work in a person-centred and holistic way, although social care staff were not involved. Positive feedback was received about the service and the impact this was having on people's health and wellbeing. However the future of this initiative was unclear as there was the potential for the funding for the pilot being removed.

- People remained at risk of not receiving consistent care due to a lack of integrated working between health and social care. For example, frontline community health care staff told us they had become less integrated with social care and found this difficult to access, especially as social workers were not often assigned to people. This impacted upon relationships and information gathering about people they were providing care for. Furthermore, community health professionals found interacting with some social care providers challenging as they did not always know who to contact. This was highlighted as particularly problematic when helping people to remain at home towards the end of their lives.

- There was an agreement in the BCF return for the delivery of a seven day service across the health and social care system. Primary care access had been extended through a hub working approach and extended access, with GPs working collaboratively to provide services to people at the evenings and weekends. Data collected in March 2017 showed the provision of GP extended access was significantly greater in Sheffield than across comparator areas and the England average, with only 4% of the 82 GP practices surveyed in Sheffield offering no provision of extended access. The GP collaborative also supported GP surgeries and the A&E department out-of-hours so that there was 24 hour access to a GP if required. While this had yet to be fully stress tested, it enabled greater resilience and flexibility within the system and extended people's access to appointments and other

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professionals such as physiotherapy. Positive feedback was provided about the extended access services.

- As the NHS England Five Year Forward View promotes a diversified skill mix in practices, some GPs were looking at different ways to meet people's needs, such employing advanced practitioners and using social prescribing. Frontline staff told us that people's understanding of their own health was improved and they were enabled to engage in activities to promote their health and wellbeing through the social prescribing. This supported the preventative agenda, however dementia was not considered an ongoing health need and therefore people with very complex needs were being managed by social services and independent care providers.

- Services designed to improve flow through the system and keep people well at home were fragmented, with multiple interfaces. This increased the risk of delays in accessing services and confusion for people, carers and professionals; they reported it was difficult for them to navigate the system and understand the services on offer. They didn't feel listened to or supported in the way they the needed.

- Frontline and operational staff felt the SPA was pivotal to frontline services. There had been improvements in the way the SPA and First Contact worked over the preceding 12 months but it was more difficult to respond to demands out-of-hours when social care was involved, and concerns were raised from operational staff in respect of information sharing between health and social care. There was evidence that the SPA was dealing with and responding to calls and making the necessary referrals to other services but data also showed that there were some abandoned and inappropriate calls made to the SPA. There was a strong argument to make the single point of access more comprehensive and integrated to combine health and social care to reduce the risk of an inconsistent multidisciplinary approach that was complex and disjointed.

- There were time consuming layers to access step up services to avoid hospital admission. Social workers could not access the Active Recovery team or dementia rapid response team and they had to go through GPs who were not always aware of the pathways. There were missed opportunities to integrate these services to provide joint up care with more effective outcomes for people.

- System leaders and frontline staff reported widespread issues in respect of recruitment and retention of staff across the system and staff in the acute healthcare and community health and social care settings continued to report heavy workloads with additional pressures of meeting targets. Although there was no system-wide workforce strategy in place there had

been focus on job and career prospects and investment in additional long term staffing to manage and support the intermediate and acute care system. Initial discussions had also taken place with Skills for Care and Skills for Health which has highlighted that significant work was required. A project lead had been appointed who would pick this up as a priority for the 12 months following our review.

- To some extent, staff were able to use computer systems or software to exchange and make use of information within the system; however these were not always effective, which impacted on the ability of staff to share information, especially between organisations. BCF returns for 2016/17 showed that the NHS number was not being used as the consistent identifier for health and care services.

Are services in Sheffield caring?

People living in Sheffield were not always involved in discussions about their care and treatment. There was not always enough information and support provided to people and their carers. A commitment to personalisation was articulated in the BCF plan and the future strategic vision and staff at all levels demonstrated commitment to providing person centred care.

- System partners had committed to taking forward a city-wide commitment to person centred care and coordination. BCF plans supported personalisation and choice through development of alternative models of care and investment in more flexible budgets. Examples of this commitment were the five year programme in primary care; 'Specification Person Centred Care Planning', as well as a local authority programme, 'Three Conversations', and the ACP work streams. The aims of these services were to spend more time listening to people to understand their strengths and goals, improve outcomes for people, and empower staff to feel more confident about the advice and support they give; ultimately helping to avoid unnecessary unplanned admissions.

- However, most people, their family and carers told us that they felt neither listened to nor empowered to be involved in their assessment of care, support and treatment. At times they did not feel well cared for. This resulted in some very poor experiences; for example, one person described the inadequate support they had received to help them remain well and independent, which resulted in them experiencing an acute crisis and a subsequent long period of recovery in hospital and a reablement service.

- Analysis of GP survey data between 2011/12 and 2016/17 showed that the percentage of people who felt supported to manage their long term conditions was similar in Sheffield to the national average and average of its comparator areas. However, the health related quality of life score for people with long term conditions had been consistently below the national average over the same time period.

- Despite the poor experiences that people shared with us, most told us that individual staff were kind and caring when encountered. Frontline staff were dedicated to providing the best service they could for people.

- People were supported to remain socially included and connected through community support workers, carers' groups and social groups within the community. People valued these groups and the way in which they enriched their lives and helped them remain in contact with people.

- Carers we spoke with felt there was a lack of effective support. Most carers we spoke with were not aware of the support that was available for them and told us that during difficult times, there was a lack of communication and that their needs were not always considered. ASCOF data for 2016/17 showed only 30% of carers surveyed in Sheffield were satisfied with their experience of care and support compared to 39% nationally.

- The local authority and NHS partners', Young Carer, Parent and Adult Carer Strategy (2016-2020) set out six "carer principles" which defined the key actions and services that were required to improve carers' lives, which included ensuring that carers were identified. GPs were trying to encourage people to identify if they are a carer.

- Healthwatch Sheffield and VCSE organisations had methods to provide people with access to networking and keeping up to date with what was happening in the health and social care sector. However the VCSE sector felt they were underutilised and undervalued and they could offer more support to people, their families and carers.

Are services in Sheffield responsive?
System leaders and frontline staff had a shared vision that a person's own home was the best place for them, articulated as "Why not home, why not today?" We found some good work in place around admission avoidance but some projects were being developed in silos rather than strategically across the system, detracting from the effectiveness of services. There was an urgent need to review all services offered and arrive at a coordinated strategy for service design, delivery and outcomes.

- Social care providers reported variable experiences and outcomes with enhanced health care support, resulting in a lack of focus on early intervention, prevention and improving quality of life in a number of care homes. However the Virtual Ward project set up and running since 2016 within four neighbourhoods in central Sheffield was described by system leaders, operational and frontline staff as having a positive impact on the early

detection of deterioration and admission avoidance; data provided by the system confirmed this. However the evaluation of the Virtual Ward had not been fully completed to establish its full effectiveness. Frustration was expressed by some frontline staff and system leaders that this had not been rolled out to other localities as MDT work would have supported admission avoidance. This project brought together staff from primary care, district nurses and the voluntary sector and enabled a MDT approach. Despite this joined up approach, there were missed opportunities as there was no representation from the social care sector to ensure truly integrated working.

- GPs could access timely support from hospital consultants via the SPA to determine if hospital admission was required. This promoted conversations to determine appropriate care and treatment with a view to supporting people at home when previously this had not been possible. Frontline staff spoke positively with regards to the effectiveness of the SPA and the advice and clinical guidance they were able to gain. However concerns were expressed about the two-phased response before being passed to the appropriate person; frontline staff felt this was frustratingly long and that the process could be streamlined.

- Our analysis of hospital admissions from care home postcodes for a range of conditions deemed to be avoidable between October 2015 and September 2016 indicated that Sheffield had higher admission rates for pneumonia, pneumonitis and other lower respiratory tract infections compared to comparator areas and the national average.

- People using services told us that accessing the system was confusing and it was difficult to get non-urgent access to GPs. However, the GP hub working and extended access was being embedded with an aim to maintain people in their normal place of residence and keep them out of hospital by use of various initiatives such as early visiting services. The GP collaborative supported GPs out-of-hours and were able to make referrals between A&E and hospital wards to promote a more streamlined process and making sure people were seen at the right time, by the right people in the right place. Frontline and operational staff told us this system was working well and had resulted in better use of resources. Although not the only solution and professionals who may be able to help, this may address the concerns that people identified with access.

- Out-of-hours and minor injuries offered an accessible, community-based first aid unit and signposted people to available services or advice where needed.

- Hospital admission avoidance was in part achieved by initiatives such as the Clinical Decision Unit, Medical Assessment Care (MAC), ambulatory assessment units, front door frailty response team (FDFRT), the community Care Coordinator and the Active Recovery

service. Case files we reviewed demonstrated these services were effective and admissions had been avoided through the use of these services. Frontline staff and system leaders spoke positively of these initiatives.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Sheffield safe?

Although there was a shared view of risk taking which was monitored closely, the escalation processes in the acute setting had to be used frequently. The handover times for ambulances in the A&E department impacted on the service's ability to respond to emergency calls. People were not always seen in a timely way once they had entered the A&E department, which meant longer waits for treatment.

- People using services were not always seen in a timely way and they sometimes had to wait for treatment. However the system was responsive to surges in demand and there were some solid examples of when the system had rallied to maintain capacity. Senior leaders had been responsive to system flow. Within the acute setting they had begun to look at flow of people in the context of providing assurance that internal resources were being effectively maximised during periods of escalation and pressure. Senior operational staff had also begun developing and using alternative pathways for specific conditions to promote a seamless transfer, rapid assessment and treatment.

- People experiencing a social care crisis rather than a health crisis were not always supported to remain safe and well. Part of the difficulty was the lack of step up beds. Although the Active Recovery service team told us they tried to support in these instances and data provide by the system was reflective of this, there were no specifically commissioned services for this requirement. Frontline and operational staff confirmed it was difficult to access this type of service and this impacted upon admissions to hospital.

- Some residential homes provided some block contract beds for emergency respite to support carers in a crisis. However carers and the VCSE sector reported a need for more respite beds and that there was a lack of crisis plans for carers of older adults with learning disabilities.

- Some people using services reported poor experiences of emergency services and

treatment. Staff did not always have a good knowledge of people's needs, due to insufficient staff resources and at times insufficient communication. This resulted in inconsistent and at times unsafe support.

- People were able to access effective frailty assessments via the A&E department or GP collaborative and where possible supported to return home when appropriate and safe to do so.

- Sheffield had a predictive risk and analytics system which informed direct care and planning by primary care, community care and social care services. There were plans in place to extend e-record sharing as part of the predictive risk system under which care providers, gated by role-based access controls, would be able to access named excerpts from NHS and social care records.

- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. This enabled a shared view of risks to delivering services to people in crisis and was monitored closely. Dashboards regarding flow were provided daily to system leaders and frontline staff who told us these helped with managing escalation and staffing. In the acute setting, clinicians could refer to assessment units and the system portal for urgent advice, preventing admissions if possible. Frontline staff in the acute setting told us they had to use escalation procedures frequently due to system pressures but these processes worked well at times of extreme pressure and that they were listened to. Systems such as the Hospital Ambulance Liaison Officer (HALO) roles, reducing handover delays for the ambulance service and improving patient care during handover processes could be activated to support the A&E and system flow at these times.

- The handover times for ambulances in the A&E department impacted on the service's ability to respond to emergency calls. People were not always seen in a timely way once they had entered the A&E department, which meant longer waits for treatment. Our analysis of A&E waiting times showed that during 2016/17 only 86.9% of people attending A&E were seen within four hours, below the England average of 89.1% and the target of 95%. Data supplied by the system for the 15 minute handover times, showed during the period from 1 January 2018 until 19 March 2018 the department did not achieve 100% on any day. During this period, there were only eight days where more than 50% of the target was achieved and 70 days were below 50% of the target. The lowest figure achieved on one day was 15%, but on this day the 30 minute handover time was 21.8%, which meant that 67.2% of people waited less than 30 minutes for handover over to the department. Trolley waits in A&E for the same period of time showed that there was only one day where

everyone waiting on a trolley was seen within four hours. On seven days 25% of people waited over four hours and on five days 50% of people waited over four hours.

Are services in Sheffield effective?

Some people had poor experiences at the time of crisis and felt that the pressures of the system impacted upon the quality and effectiveness of the service they received. Admission avoidance systems had been invested in to try and prevent unnecessary admission to hospital. However high numbers of people were admitted to hospital in an emergency and they experienced longer lengths of stay. There were multiple pathways and access points, provided by different staffing groups to increase flow; however the criteria for some of these pathways would benefit from being redefined.

- Sheffield performed worse than all but two of its fifteen comparator areas for the Department of Health and Social Care measure looking at the 90th percentile length of stay for emergency admissions of older people between September 2016 and August 2017. Our analysis showed that, throughout 2014/15 to 20161/7, Sheffield consistently had a higher percentage of older people admitted as emergencies staying in hospital for more than a week, compared to both national and comparator averages. In several quarters, Sheffield's performance was significantly higher than the national average. In the last quarter of 2016/17 for example, 37% of older people admitted to hospital as emergencies in Sheffield stayed in hospital for more than a week; this was significantly higher than the national average of 32%.

- Some people shared significant concerns about their perception of the quality and range of services available to them at a time of crisis and felt that the pressure in the system affected their experiences.

- Our analysis showed that between August 2016 and July 2017 the percentage of 999 calls resolved by Yorkshire Ambulance Service NHS Trust (YAS) with telephone advice and the percentage of 999 calls attended and managed by YAS without transferring to hospital was consistently below the England average. In July 2017, only 9% of emergency calls received by YAS were resolved with telephone advice (below the England average of 10%), while 31% of calls attended by YAS were managed without transferring to hospital (below the England average of 38%). This impacted upon the number of people using alternative services and attending the A&E department.

- Ambulance handover times at A&E did not always meet their targets which impacted upon turnaround times to respond to other emergency calls. This had been recognised and over the three months prior to our review there had been a change in practice and a new rapid

assessment process to enable smoother and more effective triage. Frontline staff told us that relationships between the ambulance crew and A&E staff were building so they could work on the "fit to sit" handovers, which in turn would improve handover times.

- Analysis of quarterly overnight bed occupancy figures showed that STHFT had bed occupancy figures consistently higher than 90% throughout 2016/17 which was also higher than the England average. In the first quarter of 2017/18, bed occupancy was at 95% while the England average was 87%. National guidance suggests that optimal bed occupancy levels in hospital are around 85%. Hospitals with an average bed occupancy above 85% risk facing regular bed shortages, periodic bed crises and potential increased numbers of hospital acquired infections. The hospital flexed its bed base according to demand, opening and closing surge capacity as required. System leaders told us the apparent high occupancy levels were owing to their approach of staffing occupied beds well, rather than keeping open capacity which is not in use.

- Investment had been made in admission avoidance systems to prevent unnecessary admissions to hospital with the intention that people are treated quickly and returned home. Multidisciplinary working in the A&E department promoted integrated working. For example, there was mental health care support twenty four hours a day in the A&E and EAU, however capacity for this service was sometimes an issue. Staff in the FDFRT had undertaken core competencies in other roles to offer consistent care and reduce the need for people having to tell their story more than once. The FDFRT were effective in reducing hospital admissions as this helped with the assessment process and getting people home quickly and safely. However the system could be more streamlined if the system alerted the team to people suitable for this service, rather than staff needing to check the system and departments to see if there was anyone suitable for the service. Data supplied by the system showed that between 19 February and 4 March 2018, the team received 145 referrals from urgent care services; 91% of these referrals were processed for discharge, of which 75% were discharged on the same day.

- Services designed to improve flow through the health and social care system were evidence based. However, there were multiple pathways and access points, provided by different staffing groups, such as the MAC, Emergency Assessment Unit, the frailty unit and ambulatory care and there was an opportunity to redefine the criteria of the MAC unit. Although the multiple assessment units allowed a quicker turnaround time the multiple pathways created capacity and flow issues. System leaders and frontline staff were aware of this and were trying to make improvements at operational level. Some frontline staff reported concerns about the length of stay and the impact this had on people's health and wellbeing, with reports of people becoming more unwell and staff requiring different skills mixes to support them.

- People's experiences were impacted by capacity issues and the number of pathways. This resulted in some people moving departments and wards numerous times, including during the night.

- There was some interoperability between health and social care to allow staff to share information across the services. However concerns had been expressed by some frontline staff about accessibility to information at the point of crisis. There were a number of meetings which enabled effective communication and information sharing at strategic and operational levels.

Are services in Sheffield caring?
Frontline staff understood the importance of involving people and their families in decisions about their care. People's experiences at the time of crisis did not always promote their health and wellbeing or protect their privacy and dignity. Carers sometimes required more support at the time of crisis.

- Generally people were positive about the care and treatment they received but their experiences varied depending upon the complexity of their needs and the service they were using. For example, one person shared their experience of waiting in a corridor in A&E and said, "It is very distressing to be asked the same thing over and over again; you question if people know what they are doing, they asked for the same information five times and this was in front of people; there was no privacy." And a relative caring for their spouse told us frontline staff were not considerate of their needs as they wouldn't allow them to travel to the hospital with their spouse. This resulted in them not being with their spouse at the time of their death.

- People had to tell their story more than once because of multiple assessments. Carers and relatives were not always involved in the assessment process and their views and opinions were not always taken into account. This caused people and carers distress and impacted upon their confidence in the system to deliver care and support to them appropriately.

- People's health and wellbeing was not always promoted due to inconsistency in communication and the attitude of some staff. We were told of dismissive and patronising staff, contributions not being valued during consultations, and not being listened to. This was supported by frontline social care staff who reported a lack of sensitivity and understanding of needs of people living with dementia and gave examples of derogatory language being used by paramedics attending the service.

- Staff in STHFT were responsive to the needs of people living with dementia, and there was a quiet space allocated in A&E which promoted a calmer environment, and the frailty ward had a dementia friendly environment.

- People at the end of their lives were supported by collaborative working to die in their preferred place wherever possible. Systems and processes were in place to support this.

Are services in Sheffield responsive?
People living in Sheffield experienced multiple confusing access points and experienced long waits for treatment. Triaging took place on arrival to A&E and there were some responsive services which people were referred to if required which reduced some of the pressures on the system.

- People told us of long waiting times for ambulance transport and being treated in A&E which impacted upon their health and wellbeing. There had been some new initiatives in A&E where specific pathways had been defined for a number of conditions to achieve better outcomes for people, and staff were working on making pathways more person-centred.

- Ambulance turnaround times were not always responsive as hand over times in A&E sometimes exceeded an hour, which impacted upon the department and ambulance crew. In response to this there had been a recent change in practice and a new rapid assessment process had been implemented which enabled a more effective triage system. There was also a self-handover for people who had been assessed as "fit to sit2 to make handover time more effective and responsive.

- System leaders and frontline staff shared a vision of "why not home, why not today?" There were some systems in place to support collaborative working and prevent people being admitted to hospital, such as, the GP collaborative, Active Recovery service and the FDFRT. The SPA and First Contact team were also making referrals to other services to ensure correct streaming, advice and support was given. However there was a lack of step up beds and community based beds for people to use if they needed which impacted upon lengths of stay in hospital.

CareQuality Commission

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Sheffield safe?

The majority of people had poor experiences on discharge home from hospital which impacted upon their health, safety and wellbeing. There were low levels of trust in the discharge process due to widespread concerns about its quality and timeliness.

- People did not always experience safe discharges to their usual place of residence because of a lack of communication and coordination, adequate assessment and provision of services. Significant concerns were raised by people using services, carers, social care providers and the VCSE sector. For example, we were told that some people were being discharged home late at night from the wards and the A&E department between 02:00 and 03:00. System leaders told us this was infrequent it was a matter of responding appropriately to the individual needs and wishes of each person. People would not be discharged between these hours without having been appropriately assessed and unless they wished to go home. We also heard of an example of a person who was discharged from hospital and left at home sitting in a wheelchair without any support. Owing to transport and communication issues, domiciliary care agency staff were not at the person's home when they arrived home at 9pm. It wasn't until the following day that this person was found by their neighbour; they had been left sitting in the wheelchair all night.

- There were also widespread concerns regarding the quality and accuracy of discharge information, or about not getting any discharge information at all. This sometimes resulted in a lack of risk sharing and responsibility and at times resulted in placement breakdown as people required more significant care than the service provider had been led to believe.

- We received 16 responses from registered managers of adult social care services in Sheffield to our discharge information flow feedback tool. Responses were polarised with regards to whether or not services received discharge summaries from secondary healthcare services, with domiciliary care services rarely receiving them while care homes more commonly receiving them. Responses were mixed in regards to the timeliness, accuracy and comprehensiveness of discharge summaries. Eight respondents supplied free text comments in which the most common themes were having to chase for information, and receiving incomplete or incorrect information. One respondent noted how this could impact on service delivery and lead to readmissions. Other issues noted included poor discharge planning and processes, unsafe discharges at weekends, medication errors and

a lack of trust in assessments. One respondent noted that they felt the discharge process had deteriorated over the preceding six to 12 months.

- Analysis of weekend hospital discharges between April 2016 and March 2017 undertaken by the Department of Health and Social Care showed that Sheffield was among the lowest of its comparators for the percentage of people discharged at the weekend, at just 18%.

- On discharge from hospital people did not always get the adequate follow up care they required to remain safe. For example, a carer described their experience of intermediate care and the lack of support received prior to discharge under the 5Q process. This resulted in the person not being safe for discharge home, despite the process being started.

- On discharge from hospital, people's medicine information was not always correct resulting in risks of contraindications and potential ill health. There were opportunities for community pharmacists to be involved in planned hospital admissions and the discharge process which would help to reduce such incidents, and prevent readmission to hospital as a result.

- Most people were able to obtain equipment and adaptations before care packages started. The VCSE sector could support safe discharge home from hospital by taking referrals for emergency discharge equipment from the occupational therapists, STIT, community matrons and support workers.

- Our analysis showed that emergency readmission rates for older people were consistently higher than the England and comparator averages in each quarter between 2014/15 and 2016/17. In the last quarter of 2016/17 the percentage of older people in Sheffield requiring emergency readmission within 30 days of discharge from hospital was 22% compared to the England and comparator averages which were both 19%. Emergency readmissions to hospital for people living in care homes had broadly been more in line with the comparator group average, but above the national average.

Are services in Sheffield effective?

Although there had been considerable drive at a system level to address the issues of performance in relation to delayed transfers of care, the system had not been able to sustain this due to pressures over the winter period. People had poor experiences throughout the discharge process and experienced delays. To address DTOC there had been a greater focus on discharge to assess which had led to more people accessing reablement services. The drive to reduce DTOC had meant people were perhaps leaving reablement services too soon, which was why there was such a high number of people being readmitted.

- People experienced delays being discharged from hospital especially at weekends, due to waiting for medicines, availability of staff and transport issues. They also experienced inappropriate discharges. We were told of examples where people were discharged without care packages, medicines and equipment and to inappropriate settings. We received reports of poor joint working with a lack of communication with and involvement of the people, their carers, families and care home providers.

- Medicine data supplied in relation to STHFT demonstrated the mean turnaround time of take home medicines from September 2017 to February 2018 were in line with the expected 60 minutes. The percentage of take home medicines completed in less than 120 minutes had a target of 95% and the system was achieving above 90%. However, the process of monitoring medicine turnaround times was not consistent across the system, which impacted upon each individual organisation being able to integrate performance data and make any improvements if needed.

- There was a lack of strategic oversight of the discharge from hospital process and discharge dates were not being discussed early enough. Case files we reviewed demonstrated that the point at which discharge planning began varied and the level of detail was inconsistent. Frontline staff had differing views about when the discharge process would start and told us that although discharge information was discussed frequently it would not always be recorded due to work constraints.

- System leaders were aware of the DTOC challenges the system faced; following an external review recommendations were made. The system adopted a “single version of the truth”, held three joint summits to engage staff and stop a blame culture and developed and agreed the “Why not home, why not today?” approach. System leaders acknowledged these changes had not been fully embedded due to the winter pressures and that they needed to evaluate their effectiveness once the winter pressures had settled. This would present an opportunity to review the current pathways and discharge process, evaluate their effectiveness and gather feedback from people using services and their carers in order to embed and communicate a comprehensive and structured discharge process.

- The system had focussed on reacting to extreme pressures over winter rather than planning ahead, however efforts were being made to improve system flow and reduce DTOC. For example, the senior leaders held weekly meetings to discuss issues with system flow, stranded patients, and lengths of stay and provided oversight of bed capacity. There were also daily DTOC meetings to discuss transfers of care where ongoing support was required. The attendees for these meetings could be tailored to make it a more solution focussed meeting, for example by having the Active Recovery service team present.

- The discharge process was confusing, ineffective and unclear to some staff, and the 5Q process could not be clearly and consistently articulated. The 5Q discharge process was in the pilot phase and midway point reviews were showing a third of people were going home as first port of call with wrap around support and social intervention. The pilot has been extended until the end of March 2018 to obtain further data. Comments in our relational audit cited a lack of consultation between staff and decision-makers in regards to the creation and implementation of the 5Q process. They described the 5Q process as being poorly considered, and that a lack of communication had continued following implementation of the pilot.

- The trusted assessor model would complement the discharge to assess and 5Q processes but this was not currently functioning well which was impacting upon this being individualised for the person. The development of this model is essential to facilitating timely discharge from hospital.

- There were constraints with the discharge process such as a lack of choice and people waiting for placements, for example, when there was no capacity in social care, intermediate beds and the active recovery team. There were also issues in respect of capacity to undertake CHC assessments. This made the discharge process more difficult for staff in the acute setting as they were not able to determine how long a person would be waiting. There was a divide between health and social care and some therapy teams worked in isolation which impacted upon proper coordination of those agencies involved in the discharge process. This resulted in people receiving inconsistent support on leaving hospital. For example, one person told us they had no support to find their relative long term residential care upon discharge from hospital, in contrast they said that when their relative needed nursing care the NHS were more helpful and supportive. They felt this was due to a divide between health and social care. Frontline reablement and intermediate care teams felt that acute hospital staff needed more knowledge of the different criteria and pathways of where to discharge people to, to support the process.

- There was a lack of joined up assessments and information systems with different services carrying out their own assessments. Community frontline staff told us that this resulted in people having to repeatedly tell their story and this was not the best use of resources as it was duplication in work. However the information systems in use meant that it was hard to get a complete picture or chronology of people.

- Capacity issues also caused delays in discharging people from intermediate care and consequently accepting people from hospital. Frontline staff told us they were behind the

principle of getting people home but there were delays in people's onward journeys e.g. three week waits for STIT services.

- Analysis of ASCOF data showed that the percentage of older people receiving reablement services following discharge from hospital had risen over recent years in Sheffield (in contrast to the national trend) and was significantly higher than the England average in 2016/17 with Sheffield at 6.3% against the England average of 2.7%. While a higher percentage of older people were receiving reablement in Sheffield, the percentage who received reablement and were still at home 91 days after discharge from hospital was below both the comparator average and England average at 74.7% compared to the comparator average of 83.3% and the national average of 82.5%. Sheffield's performance on this measure had declined in recent years.

- In June 2017 the CHC process changed and no CHC assessments were to be undertaken in hospital. People would be transferred to an interim care bed where the assessment would take place; this was to reduce the length of stay. Some people using services, carers, social care providers and frontline staff told us the discharge process impacted upon CHC assessments and the quality and accountability of this process with concerns about it not being person-centred. Specific issues were raised regarding reassessment and withdrawal of CHC funding for some individuals at specialist dementia nursing homes.

- People did not always receive effective support after leaving hospital and there was inconsistent and insufficient access to rehabilitation. Some people experienced difficulties finding care for their complex needs which resulted in failed placements. Carers and social care providers told us this sometimes led to readmission to hospital. The trusted assessor workforce and project team were looking at the development of pathways when a person was discharged from hospital and referred to the Active Recovery service to promote a seamless transition.

- Despite these challenges, some people had some good experiences of support from the GP, community health teams and social care providers to enable them to rehabilitate. These services provided care, help and advice with a practical approach, for example the community physiotherapist, twice managed to get a person walking in their own home after being left in bed during two hospital admissions.

Are services in Sheffield caring?

People who use services, their families and carers were not always involved in the discharge process or involved early enough. Sometimes there was insufficient coordination and communication which resulted in a lack of continuity of care. Support services were available for people without family or friends available at the time they were ready to leave hospital.

- People and their carers were not always involved in the discharge process, or if they were, this was not always timely. For example, one carer told us they felt the hospital had forced them into taking their family member home when they felt their relative was not well enough to go home alone. Soon after discharge they returned to hospital. The carer stated the doctor was angry with them for returning to the hospital but the carer managed to convince the hospital staff they were not fit for discharge and they were readmitted.

- Our review of case files showed a person-centred approach was adopted at the point of discharge from hospital and wherever possible people's preferences were documented and the right people were involved in conversations about their care. However, some records showed these discussions were not always started early enough and this had impacted upon their discharge and length of stay.

- Sheffield Churches Council for Community Care, a charity working in partnership with STHFT, the local authority and the CCG, delivered a highly personal service to support people on their return from hospital. They provided a rapid response to support those people without family or friends available at the time they are ready to leave hospital. We received positive feedback about this service.

- Some people had poor experiences in respect of discharge from hospital or follow on services due to a lack of continuity in care and a lack of an individual approach. For example, one person who used the Active Recovery discharge to assess service felt that the team was so large there was very little continuity of care. Despite raising concerns about this, continuity of care was never provided. This person and their relatives found the whole process stressful rather than helping their recovery, which did not improve until they got continuity of care through a different care service.

- The 5Q discharge process was not well understood and had not been effectively embedded. This resulted in several failings relating to a lack of choice and control, multiple assessments and inappropriate placements resulting in placement breakdown. These failings were substantiated by the experiences of people using services and carers and some frontline and operational staff. Comments in our relational audit specifically noted that the 5Q process was not person-centred, with one respondent describing the process as "undignified".

- Staff across the system were not aware of a choice policy and told us they would try to negotiate with people and carers wherever possible but this was not always successful. An up to date choice policy would support this process and ensure that the system's vision of person centeredness was more fully recognised.

Are services in Sheffield responsive?
There were multiple pathways to facilitate discharge from the acute setting which caused some confusion for people using service, carers and frontline staff. People experienced a high number of delayed transfers of care. Data showed a higher number of CHC assessments were undertaken in an acute setting which could lead to delays and this needs addressing as a matter of urgency.

- Some people experienced delayed transfers of care and there was evidence within records we pathway tracked that discharge planning was not always starting early enough. Frontline staff had differing views as to when the discharge process would start and who would take the lead and responsibility for this.

- System leaders recognised the improvements needed in regard to DTOC and had begun to implement changes following an external review by Newton Europe. An operational multidisciplinary task team was developed. As the team had become embedded the size of the team had reduced but its scope remained the same. Changes had been made to systems and processes, however, there had been insufficient time to embed these changes before the winter period. This impacted upon the sustainability of these new processes and DTOC increased again. It was acknowledged that system pressures had been very significant and this had affected multidisciplinary working as teams did not work as well in sustained pressure. An analysis of this had taken place so the system could begin to address some of the issues. As a next step the system needs a focussed capacity plan which is planned over the longer term.

- STHFT had invested in predictive analytics hour-by-hour systems, for winter predicted admissions and discharges on a day-by-day basis and fed this information back into the system. It was evident that staff were utilising this information and it was being discussed in the MDT and bed management meetings across the system.

- Staff were aware that there had been a focus on reducing delays and felt there had been some small improvements, mostly communication between services and systems to make sure the relevant stakeholders were engaged in the process especially in regard to equipment and housing.

- As part of the home first principle, emphasis had been place on simplifying multiple discharge routes to three pathways. System leaders told us this had improved hospital discharge rates but acknowledged that more needed to be done to mapping and cascading this across STHFT. As there was a lack of clarity and focus around the discharge process

and the trusted assessor model was still evolving, this had resulted in the three routes to discharge not being fully embedded and utilised across the system. The system needs to make better use of the discharge to assess model and also assess weekend discharges to see if there are any themes and trends which are impacting upon this.

- Our analysis of the average daily rate of delayed transfer days per 100,000 population aged 18+ in each month between June 2015 and November 2017 showed that Sheffield's rate of delayed transfers increased sharply at the beginning of 2016 and remained much higher than the national average throughout the year, but then steadily reduced from a significantly high rate of 34.7 average delayed days in March 2017 to be much more in line with comparator and England averages by September 2017 with an average of 14.3 delayed days. Delayed transfers were also in line with national and comparator rates in October and November 2017. However data for December 2017 and January 2018 showed the rate of delayed transfer days increased again demonstrating that some improvements had not been sustained. The system has acknowledged that while its capacity to manage complex discharges improved significantly during 2017/18 these improvements were not able to keep pace with demand levels in December and January.

- Between July 2017 and September 2017 the NHS accounted for more delays than social care, with an average of 11.3 daily delayed days per 100,000 population aged 18+, compared to 5.2 days attributed to social care (a further 1.3 delayed days were attributed to both). By far, the main reason reported for delayed transfers of care in Sheffield over this time period was "awaiting care package in home", accounting for an average daily rate of 7.3 delayed days per 100,000 population aged 18+. Awaiting completion of assessment was also a more common reason for delay reported in Sheffield than across comparator area or England.

- There were differing views in regard to the availability of a domiciliary care packages, and the length of time to set these up. There was increased social care capacity but this was not always being used as well as it could be.

- The CHC assessment process was not always person-centred and there were issues with the quality of assessments and a lack of accountability for who would lead on this process. Some people reported concerns about not being listened to and bullying approaches with a lack of choice and control. Data from the first quarter of 2017/18 showed that more than half of decision support tools were completed in an acute setting (compared to 27% nationally), which could be contributing to delays. However following the introduction of the 5Q process the number of assessments completed in an acute setting fell to 0% in Q3 and Q4 of 2017/18.

- Based on data for the first quarter of 2016/17, Sheffield CCG had high rate of people receiving personal health budgets and direct payments for NHS CHC. ASCOF data for 2016/17 also showed that a comparatively high proportion of older people in Sheffield who were accessing social care services were also receiving direct payments (20.2% compared to 17.6% nationally and 14.5% across comparator areas).

- Patient transport accessibility also impacted on people's experiences and resulted in people being delayed in leaving hospital on the day of their discharge. A number of these issues were caused by the discharge planning process and the timeliness of discharge from hospital, use of resources and medicines. Ambulance discharge performance data supplied by the CCG on 22 March 2018 showed that patient transport services were consistently missing the target levels for all transfers definitions. The lowest performing being people collected no more than 60 minutes after Ready Time which was significantly below the target between September 2017 and February 2018.

- There were capacity issues with reablement and stepdown services and a lack of restrictive access criteria in regards to who would benefit from these services. At times this resulted in delayed transfers of care. These staff felt that they could do more to aid flow if they had more capacity and staff.

CareQuality Commission

Maturity of the system

What is the maturity of the system to secure improvement for the people of Sheffield?

- The system has been in a period of transformation over the last 12 months. Although this had enabled better joint working, more coordination of system changes and service delivery was needed.
- The roles of the HWB and the ACP were developing but further development is needed to ensure the HWB undertakes its statutory responsibilities and drives the system transformation programme alongside through the ACP.
- Relationships have improved and there is evidence of more collaboration but this is not mature and embedded to improve outcomes for the people of Sheffield.
- The ICS had little influence on the Sheffield system as Sheffield had developed its own vision and strategies based on the assessed needs of the local population.
- Whole system strategic planning and commissioning was developing with the Shaping Sheffield plan and the ACP. Although this provided a vision for the design and delivery of services, this need to be further embedded to ensure complete alignment and success of integration. More effective communication with staff at all levels and people using services was needed to make the vision a reality and improve outcomes for people using services.
- System leaders were attempting to align services to scale up integrated working and implement new models of care through transformation plans. This was being addressed through the ACP work streams and was in the early days of implementation.
- There were some positive examples of joint working and collaboration in the interests of the population's defined needs. However, overarching strategies had yet to be defined and co-production with local population needed further development.
- There was some evidence of system-wide multidisciplinary team working for effective outcomes; the virtual ward and community services, but there was little evidence of pathways across primary, community and secondary care that supported the wider objectives of health and wellbeing maintenance. There was a vision for full integration, but there was a long way to go to actualise this.

- A large proportion of decision making sat separately within individual organisations but there was evidence of system-wide approaches in respect of managing particular issues and challenges such as DTOC. In these instances there were shared metrics and systems for the oversight of performance and delivery.

- Relationships between leaders across the system had continued to develop over the previous two years with a move away from a blame culture. Although these were developing positively the relational audit demonstrated that work was still needed address longstanding cultural and communication issues.

- Sheffield was particularly challenged by workforce issues across the system. There were workforce plans at organisational level but no agreement to trial a combined recruitment campaign and develop a single recruitment pathway.

- System leaders acknowledged that incompatible information sharing systems were a barrier to seamless working across agencies but were committed to providing integrated care records and shared access wherever possible.

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Areas for improvement

We suggest the following areas of focus for the system to secure improvement

Strategic Priorities

- System leaders must continue to engage with people who use services, families and carers and undertake a review of people's experiences to target improvements, bringing people back to the forefront of service delivery.

- System leaders must work together to create the required culture and conditions to support integrated care delivery.

- Health and social care leaders across Sheffield should work together to align their transformation delivery programmes and strategies. Health and social care be must equal partners in the system transformation programme and strategic direction.

- System leaders should undertake evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement.

- System leaders should plan more effectively for winter and demand pressures throughout the year, ensuring lessons are learned and applied when planning for increased periods of demand.

- System leaders should continue to implement the recommendations of the Newton Europe review and evaluate their effectiveness. This needs to inform strategic planning and delivery.

- System leaders should develop a more proactive approach to market management in adult social care. They should continue to focus on domiciliary care to ensure that the proposed changes are effective. Strategic conversations must take place with people delivering services when these services are being recommissioned to establish the impact on service delivery.

- System leaders should develop a workforce strategy across health and social care and include providers in the VCSE sector to ensure a competent, capable and sustainable workforce.

- To ensure there is robust evaluation supported by data to inform commissioning decisions, system leaders should have a more coordinated approach to running pilots and developing innovations; it should be clear how they will fit in with the wider strategic plan and how quality information will be used to evaluate them against identified focuses for improvement.

- The discharge process should be evaluated incorporating the views and experiences of people using services, their families and carers. During this process system leaders must consider the multidisciplinary approach, clarity of the process, the three routes to discharge from hospital, the choice policy and the quality and consistency of the information provided. Following this evaluation, revised processes must be implemented and evaluated.

Operational Priorities

- There must be a review how people flow through the health and social care system, including a review of pathways so that there are not multiple and confusing points of access. Specific focus should be given to prevention, crisis and return. Pathways should be well defined, communicated and understood across the system.

- There must be an evaluation of health and social care professionals' skills in communication and interaction with people to establish where improvements are needed.

- Housing support services should be included within multidisciplinary working, especially in relation to admission to, and discharge from, hospital, to enable early identification of need and referrals.

- There should be a review of commissioned services to consider outcomes, design and delivery to improve the effectiveness of social care and CHC assessments.

- There should be a review of the methods used to identify carers eligible for support so that they are assured that carers are receiving the necessary support and have access to services.

- The trusted assessor model should continue to be embedded.

- The criteria for the reablement services should be evaluated and reviewed.

- There should be a specific focus to bridging the gap between the single point of access and First Contact, community and acute preventative services and rehabilitation. Social care providers should also be part of this process to align services and develop collaboration between all system partners.

- Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation.

HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	27th September 2018
Subject:	Health & Wellbeing Strategy – Proposed Approach
Author of Report:	Dan Spicer

Summary:

This paper sets out a proposed approach and timescale for producing a new Health & Wellbeing Strategy for Sheffield, and asks the Board questions to help guide its development.

Questions for the Health and Wellbeing Board:

How tightly drawn should the ambitions be within the Where we live and How we live sections of the Strategy, and where should the focus be?

Recommendations for the Health and Wellbeing Board:

It is recommended that the Board:

- Agree the proposed approach to developing the updated Health & Wellbeing Strategy
- Agree to receive drafts of the Strategy at their October private strategy session and December public meeting
- Agree to work towards signing off a final version of the Strategy at their March 2019 public meeting

Agree to discuss in further detail how successful implementation of the strategy will be delivered

Background Papers:

- *Sheffield Joint Health & Wellbeing Strategy 2013-18*

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

All outcomes

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

Greg Fell – Director of Public Health, Sheffield City Council

Becky Joyce – Accountable Care Partnership Programme Director for Sheffield

HEALTH & WELLBEING STRATEGY – PROPOSED APPROACH

1.0 SUMMARY

1.1 This paper sets out a proposed approach and timescale for producing a new Health & Wellbeing Strategy for Sheffield, and asks the Board questions to help guide its development.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 The Health & Wellbeing Strategy is the Health & Wellbeing Board's view, based in the Joint Strategic Needs Assessment and other evidence, of the things it can best focus on to improve the health of Sheffield's population, over the short and long term.

2.2 The people of Sheffield are a critical part of getting this right: the strategy needs to speak to what matters to them in terms of good health and wellbeing.

3.0 REFLECTIONS ON THE CURRENT STRATEGY

3.1 Discussions across a range of contexts suggest that there continues to be agreement that the issues identified by the current strategy are important and relevant, and that they remain so five years after it was approved.

3.2 However, there is also a view that it is very broad document, and that this makes it hard to see precisely whether and how it has driven change, and conversely easy to connect a wide range of pieces of work to at least one of its objectives.

3.3 The specific work programmes described in the strategy do not appear to have progressed as intended; this is partly a reflection of resource constraints, with the Board lacking its own delivery function.

3.4 The Strategy proposed a dashboard of measures to provide an overview of health and wellbeing in Sheffield. This has been kept up to date, and the current iteration is attached as an appendix of this paper. However, although it allows us to track trends over time, it is of limited use when assessing the success of the strategy. Critically, it does not facilitate judgement of the prevailing context in which those changes happened, and the context of the last five years has been extremely challenging for Sheffield and a lot of its residents.

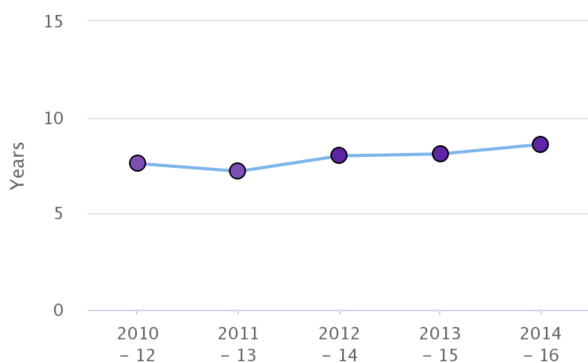
4.0 DEVELOPMENTS SINCE 2013

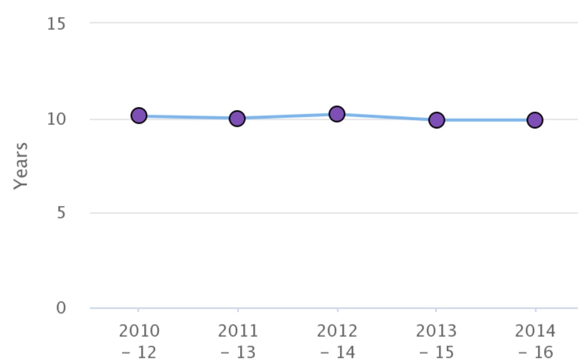
4.1 In addition to the weaknesses in the existing strategy identified above, it is also important to note that there have been a range of developments since it was published.

4.2 In particular, and while acknowledging it was one of the five outcomes set out in the strategy, there has been an increasing focus on and concern around health inequalities

in Sheffield, including the development of a specific Health Inequalities Action Plan in June 2014.

4.3 Health inequalities have remained broadly static over recent years, as shown in the following charts. None of the variations shown are statistically significant. It is important to note the background context of continued austerity, which is likely affecting some places more than others. Thus health inequities not getting worse in a challenging context is an important way to frame the overall message.





Source: Public Health Outcomes Framework: https://fingertips.phe.org.uk/ The charts show the gap in life expectancy between the most and least deprived people in Sheffield over a period of 6 years, with females on the left and males on the right.

4.4 In June 2016, the Health & Wellbeing Board agreed to refresh the city approach to health inequalities.

4.5 Following this, the Board held a facilitated workshop in February 2018 to consider further the response to health inequalities in Sheffield.

4.6 This reaffirmed the Board's commitment to and focus on reducing health inequalities in Sheffield, and also its commitment to consideration of both short- and long-term impacts and changes, with both seen as important and requiring consideration together.

4.7 As part of this session, the Board discussed the value of clear, easily articulable propositions or ambitions as a tool for the system to unite around, and to campaign around.

4.8 The discussion in the session also noted the need to refresh the Health & Wellbeing Strategy, as it expires at the end of 2018, and the potential benefits of drawing the two more closely together.

5.0 THE NEW STRATEGY – STRUCTURE AND APPROACH

5.1 Following the February workshop, the Board have held a number of conversations around the development of a new Health & Wellbeing Strategy. These have iteratively developed a proposed approach to the new document, reflecting the following key points of concern.

5.2 Firstly, that health inequalities should be front and centre, with the strategy making a clear statement that this is the focus of the Board and the lens through which it will examine everything.

5.3 Secondly, that it should actively avoid replicating existing strategies and focus on areas where the Board can add value. For example, in February 2017 Sheffield City Council approved a Tobacco Control Strategy up to 2022; the Board remains interested in the success of this and is clear that reducing smoking will benefit the health of the Sheffield population, but sees that it can add little value to this beyond ensuring its delivery. Its focus need to go beyond this and similar strategies. Similarly, there is an agreed strategy for the city on Air Quality, with no need to rewrite this. The focus of the Board and Strategy in this space should be to accelerate and coordinate implementation and ensure all sectors are involved.

5.4 Thirdly, it is now well understood that only around 20% of health outcomes are due to health and care service inputs. If this is to be a Health & Wellbeing Strategy, it will need to put the focus on the whole 100%.

5.5 Fourthly, that the Strategy should consider impacts and actions over both short- and long-term timescales, and they can support and reinforce each other.

5.6 With these in mind, the following is proposed for the new Strategy.

5.7 Health inequalities should be the single headline focus of the Strategy, with a central aim that

> **"Health inequalities in Sheffield are reducing, because the health and wellbeing of the poorest is improving the fastest."**

5.8 The Strategy will take a life-course approach, allowing for a range of short and long term activity and focus.

5.9 This will be done by breaking the Strategy down into three sections:

- Starting & Developing Well;
- Living & Working Well; and
- Ageing & Dying Well.

5.10 Within each of these, to reflect the Board's interest in clearly articulable ambitions of propositions, there will be three ambition areas as follows:

5.11 Starting & Developing Well:

- School Readiness: an ambition that all children in Sheffield are able to take full advantage of their educational opportunities from the start;
- Inclusion in Education: an ambition that all children and young people in Sheffield have the opportunity for a full and rounded education;
- Post-16 Destinations: an ambition that education leads to a productive outcome in terms of employment, further education or training.

5.12 Living & Working Well:

- Where we live: an ambition that everyone in Sheffield has access to a home, neighbourhood and community that supports their health;
- How we live: an ambition that everyone in Sheffield has a fulfilling occupation and the resources to support themselves;
- How we move: an ambition that the Sheffield environment supports everyone to have an active lifestyle.

5.13 Ageing & Dying Well:

- Multiple morbidity: an ambition that resources are shifted from acute hospital settings to primary care to respond to the increasing importance and early onset of multiple morbidity;
- Loneliness and isolation: an ambition that no-one in Sheffield suffers from loneliness or isolation, recognising it both as a health issue for all ages, and a particular risk factor for older people;
- End of life: an ambition that everyone in Sheffield lives the end of life with dignity, as independently as possible, in the place of their choosing, and with the support they and their family need.

5.14 The intention of this structure is to describe the critical staging posts of a healthy life from cradle to grave.

5.15 Discussions within Board to get to this point have produced clarity on ambition areas within Starting & Developing Well and Ageing & Dying Well; these are well defined and clear to articulate, though precise measures are yet to be identified

5.16 In relation to Living & Working, discussions within the Board have been less clear. In relation to Where we live, some Board members have expressed a desire to focus on housing and how it supports health, while others feel the strategy should look beyond this to include an interest in community and social infrastructure.

5.17 Similarly, in relation to How we live, the Board's original focus was on good employment, but discussion within the Board has raised concerns that this would omit a portion of the population who most suffer from the impacts of health inequalities, such as unpaid carers, those on welfare, or volunteer workers.

5.18 This is not the case in relation to How we move, where there is a degree of consensus within the Board that a focus on creating more active and accessible environments is appropriate.

5.19 This paper does not make a recommendation either way on these two ambition areas, but does note that they currently do not meet the Board's stated desire to have tight, focused, clearly articulable ambitions to work towards. It would be helpful for the Board to achieve clearer consensus on what it wishes to see in order to guide development of the strategy more clearly.

6.0 MEASURING SUCCESS

6.1 This paper has already identified the difficulty of determining whether the existing strategy has been successful or not. In light of this, it is sensible for the Board to consider exactly how this challenge could be addressed in the production of the new strategy.

6.2 Two points are particularly important in this. Firstly, that a population shift in health inequalities will only happen over generational timescales; we cannot expect to make a major difference within the timescale of this strategy alone.

6.3 Secondly, that the changing context within which the Strategy operates is critical, and that we can only judge success once this has been accounted for and incorporated into our understanding. Whatever measure of success we use, we need to be able to judge fairly against changing circumstance.

6.4 One suggestion could be to model what the expected trajectory is in each of the ambition areas, based on assumptions about prevailing conditions, with success seen as bending the curve of that trajectory. This would allow us to judge success incorporating how those assumptions have held up, allowing for some degree of assessment of the context in understanding the level of progress made.

6.5 It should be noted that long-term nature of changes in health inequalities raises other questions around commitment to that target beyond the life of this strategy. It may be that the Board should consider making a longer term commitment to a focus on health inequalities, with subsequent reviews of the Strategy focusing on the ambition areas rather than the headline target.

7.0 PRODUCING THE NEW STRATEGY

7.1 A partnership strategy needs to be produced **by** its partners and should not be imposed. With this in mind, lead authors for each chapter both from within the Board and beyond it have been recruited to ensure that the content of the strategy is owned by system leaders.

7.2 There remains a need to go beyond this to ensure the content is owned and understood by as many actors in the system as possible, we are seeking to involve the whole system in developing the strategy, under the auspices of those lead authors.

7.3 To this end it is proposed that the Board work with Healthwatch and VAS to run a range of engagement and consultation activity during the development of the strategy to reach out to different parts of the system and get their input, particularly including the population who the strategy is ultimately for, and voices that are not usually heard.

7.4 In relation to this, it is noted that the Accountable Care Partnership is planning to refresh the Sheffield Place Based Plan at the same time. These two documents need

to be synchronised, and will be seeking to engage similar groups in their development, so it is recommended that this work be developed and carried out in tandem.

7.5 Properly incorporating a wide range of voices beyond the Board and across the system means taking an iterative approach to developing the strategy, to enable a balance to be made between the Board's intentions as described above and the response received through engagement and consultation.

7.6 This needs time to get right, and with this in mind the following schedule is proposed:

- A rough first draft of the Strategy to be brought to the Board's strategy development session on 25th October for discussion
- Incorporating feedback from that session, this draft to be used as the basis for engagement with the system through November and December to produce a public first draft
- This public first draft to be presented to the Board at its formal public meeting on 13th December for discussion and comment
- More formal consultation on this draft to take place in January and February 2019, leading to development of the final Strategy
- The final Strategy to be presented to the Board for agreement at its formal public meeting on 28th March 2019.

8.0 DELIVERY AND IMPLEMENTATION

8.1 As noted above, the Board has extremely limited resources of its own, and these are insufficient for it to direct delivery programmes independently.

8.2 Instead, it will need to work with the wider system to deliver the Strategy collectively, starting by setting aspirations and ambitions for health and wellbeing improvements, as the proposed Strategy aims to do.

8.3 No proposals for how this should be achieved are made here, other than to note that the iterative, collaborative approach to developing the strategy described above should be supportive of this.

8.4 Beyond this, the Board does need to recognise that this challenge needs thinking through carefully, especially if the Board is to avoid the difficulties in evidencing impact in relation to the existing Strategy.

8.5 With this in mind it is suggested that the Board commit time to considering their approach to delivery carefully at an upcoming strategy development session.

9.0 QUESTIONS FOR THE BOARD

9.1 How tightly drawn should the ambitions be within the Where we live and How we live sections of the Strategy, and where should the focus be?

10.0 RECOMMENDATIONS

10.1 It is recommended that the Board:

- Agree the proposed approach to developing the updated Health & Wellbeing Strategy
- Agree to receive drafts of the Strategy at their October private strategy session and December public meeting
- Agree to work towards signing off a final version of the Strategy at their March 2019 public meeting
- Agree to discuss in further detail how successful implementation of the strategy will be delivered and evaluated

APPENDIX A – HEALTH & WELLBEING STRATEGY DASHBOARD

[To be inserted]

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Sheffield Outcomes Framework for Joint Health and Wellbeing Strategy

The table and chart below shows how the health of people for Sheffield compares with England. The average rate for England is shown as the vertical black line, which is always at the centre of the chart. The confidence intervals for England are shown in grey where they are available / applicable.

A red circle implies that Sheffield is significantly worse than England for that indicator; a green circle indicates that it is significantly better. A white circle is shown where confidence intervals were not available but may still indicate an important health problem.

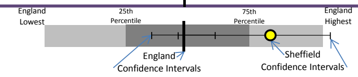
- Confidence intervals not available
- Sheffield is statistically WORSE than England
- " " " THE SAME as "
- " " " BETTER than "

Outcome		Indicator	Date of Data	England	Sheffield	England Worst	England Best
Healthy and Successful City	1	Percentage Children in Poverty (HMRC) (all dependent children under 20)	2015	16.60	21.60	30.60	2.80
	2	Gross income (annual) (£)	2017	23,743	21,907	17,415	38,110
	3	Percentage 16-64 who are long term unemployed	2018	0.40	0.70	2.20	0.00
	4	Percentage of 16-18 year olds not in education, employment or training (NEETS)	2016	6.00	5.30	44.76	0.00
	5	Percentage of children achieving good level of development at end of Reception	2016/17	70.70	69.80	3.78	78.90
	6	*Percentage of young people achieving GCSE 5A*-C inc. Eng. & Maths*	2015/16	53.5	53.7	36.4	75.7
	7	Homelessness Acceptances per 1000 households (unintentionally homeless and not in priority need)	2016/17	0.84	1.97	9.58	0.04
	8	Percentage mortality attributable to particulate air pollution	2016	5.29	4.58	6.94	2.62
Health and Wellbeing Improving	9	Life Expectancy at Birth Male, years	2014-2016	79.5	79.0	74.2	83.7
	10	Life Expectancy at Birth Female, years	2014-2016	83.1	82.6	79.4	86.8
	11	Mortality from causes considered preventable, per 100,000 population	2014-2016	334	351	546	218
	12	Infant Mortality (three year) per 1000 live births	2014-2016	3.88	5.23	7.88	1.59
	13	Percentage of Adults (18+) with Depression	2016/17	9.10	8.92	14.10	4.52
	14	Percentage of Adults (18+) smoking	2017	14.87	16.98	23.07	8.13
	15	Percentage of Children in Year 6 (age 10-11) Overweight and obese	2016/17	34.2	35.6	43.9	21.2
	16	Alcohol attributable hospital admissions, per 100,000 population	2016/17	636	695	1,151	388
	17	Percentage of children Breastfed at 6-8 weeks after birth	2016/17	44.4	50.5	19.3	75.6
Health Inequalities	18	Slope Index of Inequality for Life Expectancy Male, years of life	2014 - 16	8.20	9.90	14.90	1.10
	19	Slope of Index Inequality for Life Expectancy Female, years of life	2014 - 16	6.40	8.60	13.90	1.10
	20	Percentage Excess Winter Deaths Index (3 years, all ages)	Aug 2013 - Jul 2016	17.86	16.36	28.94	6.20
	21	Excess Under 75 year old mortality in Adults with Serious Mental Illness, per 100,000 population	2014/15	370	374	570	165
Care and Support When Needed	22	Percentage of people reporting a 'very good' or 'fairly good' experience of their GP surgery	2016/17	84.8	84.4	73.5	97.8
	23	Potential years of life lost from causes considered amenable to healthcare per 100,000 population	2014	2,817	2,641	4,684	1,517
	24	Emergency admission for acute conditions that should not usually require hospital admission per 100,000 population	2016/17	1,359.3	1,298.3	2,303.0	79.9
	25	Percentage one-year survival from breast, lung and colorectal cancer (nb data date = diagnosis year)	2015	72.6	74.1	65.7	77.9
	26	Percentage of people using social care who receive self directed support	2016/17	89.4	88.0	48.5	100.0
	27	Percentage of people using adult social care who have control over their daily life	2016/17	77.7	72.6	61.2	89.6
	28	Percentage of older people (65+) still at home 91 days after discharge from hospital into re-ablement/rehabilitation services	2016/17	82.50	74.70	0.00	97.20
	29	Permanent Admission to nursing/residential care (65+), per 100,000 population	2016/17	611	824	1,688	126
	30	Delayed transfers of care from hospital, per 100,000 population	2016/17	14.90	30.10	46.10	0.00

Columns "Change from previous period", "Overall Trend" and "Spine Chart" are shown graphically.

Note: indicator 6 is under review as it no longer matches national reporting of attainment at KS4.

Sheffield value is WORSE than previous time period
" " " BETTER " " " "
" " " the SAME as " " " "



See page 2 for definitions of indicators

v0.6, 12th May 2015

Outcome		Indicator Definitions
Healthy and Successful City	1	**Percentage Children in Poverty (HMRC) (all dependent children under 20)** PHOF Indicator 1.1. % of Children in "Poverty": The proportion of children living in families in receipt of out of work benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income. Dependent children are defined as all children aged <16 and those aged 16-19 not married or in a civil partnership, living with parents and in full-time non-advanced education or unwaged government training. Denominator is the total number of children receiving Child Benefit. NOTE: the local authority definition is slightly different to the national level definition of % children in relative poverty (living in households where income is less than 60% of median household income before housing costs). Used to be National indicator 116.
	2	**Gross income (annual) (£)** ASHE. Average gross annual income of employees on adult rates who have been in the same job for more than a year.
	3	**Percentage 16-64 who are long term unemployed** The percentage of 16-64 year olds who are claiming JSA for longer than 12 months. As measured by ONS in March of each year.
	4	**Percentage of 16-18 year olds not in education, employment or training (NEETS)** PHOF Indicator 1.5. The percentage of 16 to 18 year olds who are not in education, employment or training (NEET). The estimated number of 16-18 year olds not in education, employment or training divided by the total number of 16-18 year olds known to the local authority whose activity is either not in education, employment or training (NEET), or in education, employment or training (EET). This uses the average proportion of 16-18 year olds NEET between November and January each year. These figures are collected by local authorities, and cannot be compared with the DfE estimate of young people NEET which uses different definitions.
	5	**Percentage of children achieving good level of development at end of Reception** PHOF 1.02 Children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children
	6	**Percentage of young people achieving GCSE 5A*-C inc. Eng. & Maths** Percentage of pupils at the end of Key Stage 4 in LEA maintained schools at the end of the academic year achieving 5 or more GCSEs at grades A*-C or equivalent including English and maths, at end of Key Stage 4. Sourced from the Local Area Interactive Tool - provides access tp a uniform set of performance data on education and childrens services
	7	**Homelessness Acceptances per 1000 households (unintentionally homeless and not in priority need)** PHOF Indicator 1.15i - Statutory homelessness - Eligible Homeless People Not In Priority need per 1,000 households
	8	**Percentage mortality attributable to particulate air pollution** PHOF Indicator 3.1. The indicator is an estimated proportion. It represents the estimated annual mortality attributable to air pollution in the population aged 30+, as a proportion of total deaths of those aged 30+. Mortality burden associated with long-term exposure to anthropogenic (human-made)particulate air pollution (measured as fine particulate matter, PM2.5) at current levels.
Health and Wellbeing Improving	9	**Life Expectancy at Birth Male, years** PHOF Indicator 0.1i. Life expectancy at birth. Calculated using deaths at all ages, from all causes, registered in the respective calendar years.
	10	**Life Expectancy at Birth Female, years** PHOF Indicator 0.1i. Life expectancy at birth. Calculated using deaths at all ages, from all causes, registered in the respective calendar years.
	11	**Mortality from causes considered preventable, per 100,000 population** PHOF Indicator 4.03 Age-standardised mortality rate from causes considered preventable per 100,000 population
	12	**Infant Mortality (three year) per 1000 live births** PHOF Indicator 3.1. Crude mortality rate of infants aged under 1 year per 1000 live births. By date of death.
	13	**Percentage of Adults (18+) with Depression** Depression % of patients (18+) with depression on the GP practice register. QOF Indicator.
	14	**Percentage of Adults (18+) smoking** PHOF Indicator 2.14. Prevalence of smoking among persons aged 18 years and over from the Annual Population Survey (APS).
	15	**Percentage of Children in Year 6 (age 10-11) Overweight and obese** PHOF Indicator 2.6ii. Proportion of children aged 10-11 (Year 6) classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
	16	**Alcohol attributable hospital admissions, per 100,000 population** PHOF 2.18. Hospital Admission episodes for alcohol-attributable conditions (previously NI39): All ages, Directly age standarised rates per 100,000 population
	17	**Percentage of children Breastfed at 6-8 weeks after birth** PHOF Indicator 2.2 ii. Percentage of infants who are totally or partially breastfed at 6-8 week check. Babies with unknown feeding status at 6-8 weeks are excluded from the numerator and denominator.
Health Inequalities are Reducing	18	**Slope Index of Inequality for Life Expectancy Male, years of life** PHOF Indicator 0.2 (iii)m. The Slope Index of Inequality (SII) of life expectancy at birth within each English upper tier local authority based on local deprivation deciles of LSOA (LA level). The SII is a deprivation-based inequalities measure that can be applied to any indicator and has been approved by the NHS Sheffield Director of Public Health as the standard inequalities measure to be used for Public Health indicators. It represents the gap in indicator values between the most deprived and least deprived people in a given area. Sourced from London Health Observatories.
	19	**Slope of Index Inequality for Life Expectancy Female, years of life** PHOF Indicator 0.2 (iii)f. The Slope Index of Inequality (SII) of life expectancy at birth within each English upper tier local authority based on local deprivation deciles of LSOA (LA level). The SII is a deprivation-based inequalities measure that can be applied to any indicator and has been approved by the NHS Sheffield Director of Public Health as the standard inequalities measure to be used for Public Health indicators. It represents the gap in indicator values between the most deprived and least deprived people in a given area. Sourced from London Health Observatories.
	20	**Percentage Excess Winter Deaths Index (3 years, all ages)** PHOF Indicator 4.15. This indicator measures excess winter deaths expressed as the EWD Index, in order that comparisons can be made easily between different geographies. It indicates whether there are higher than expected deaths in the winter compared to the rest of the year. The year runs from August to July. Winter months are December to March, Non-Winter months are August to November and April to July. The ratio (5) of extra deaths from all causes that occur in the winter months compared to the average of the number of non-winter deaths of the same period.
	21	**Excess Under 75 year old mortality in Adults with Serious Mental Illness, per 100,000 population** PHOF Indicator 4.9 and NHSOF Indicator 4.5. The mortality rate in the mental health population is directly standardised to the national population. This is then compared to the national rate. The mental health population is defined as anyone who has been in contact with the secondary mental care services in the current financial year or in ether of the two previous financial years who is alive at the beginning of the current financial year. The mental health rate is directly standardised by age and sex to the England population.
Care and Support When Needed	22	**Percentage of people reporting a 'very good' or 'fairly good' experience of their GP surgery** NSHOF 4a.i This indicator aims to capture the experience of patients of their GP. The vast majority of the population visit their GP each year and often it is the experience people have of primary care that determines their overall view of the NHS.
	23	**Potential years of life lost from causes considered amenable to healthcare per 100,000 population** To ensure that the NHS is held to account for doing all that it can to prevent amenable deaths. Deaths from causes considered 'amenable' to healthcare are premature deaths that should not occur in the presence of timely and effective healthcare. The number of years of life lost by every 100,000 persons dying from a condition which is usually treatable, measured in a way which allows for comparisons between populations with different age profiles and over time.
	24	**Emergency admission for acute conditions that should not usually require hospital admission per 100,000 population** NHSOF 3a - This indicator aims to measure the reduction in emergency admissions for conditions that should usually be managed outside hospital. Where an individual has been admitted for one of these conditions, it may indicate that they have deteriorated more than should have been allowed by the adequate provision of healthcare in primary care or as a hospital outpatient. The indicator measures the number of emergency admissions to hospital in England for acute conditions such as ear/nose/throat infections, kidney/urinary tract infections and heart failure, among others, that could potentially have been avoided if the patient had been better managed in primary care.
	25	**Percentage one-year survival from breast, lung and colorectal cancer (nb data date = diagnosis year)** This indicator attempts to capture the success of the NHS in preventing people from dying once they have been diagnosed with breast, lung or colorectal cancer. A measure of the number of adults diagnosed with breast, lung or colorectal cancer in a year who are still alive one year after diagnosis. % net survival in people aed 15-99 years
	26	**Percentage of people using social care who receive self directed support** ASCOF Indicator 1C part 1. This measure reflects the success of councils in delivering personalised services, through self-directed support, including direct payments. Proportion of people using social care who receive self-directed support, and those receiving direct
	27	**Percentage of people using adult social care who have control over their daily life** ASCOF Measure 1B uses responses to question 3a in the Adult Social Care Survey which asks service users how much control they have over their daily lives. The measure is calculated as the proportion of respondents who say they have as much control as they want or adequate control, or who respond that they can make all the choices they want in response to the easy read version of the question which asks how much control the service user has in their life. It is expressed as a percentage of all service users who gave a valid response to question 3a.
	28	**Percentage of older people (65+) still at home 91 days after discharge from hospital into re-ablement/rehabilitation services** ASCOF Measure 2B part 1. NHSOF Indicator 3.6.i . The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. Those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months are not reported in the numerator.
	29	**Permanent Admission to nursing/residential care (65+), per 100,000 population** ASCOF Measure 2A part 2. People counted as a permanent admission should include: Residents where the local authority makes any contribution to the costs of care, no matter how trivial the amount and irrespective of how the balance of these costs are met; Supported residents in: Local authority staffed care homes for residential care; Independent sector care homes for residential care; and, Registered care homes for nursing care. Residential or nursing care which is of a permanent nature and where the intention is that the spell of care should not be ended by a set date. For people classified as permanent residents, the care home would be regarded as their normal place of residence. Where a person who is normally resident in a care home is temporarily absent (e.g. through temporary hospitalisation) and the local authority is still providing financial support for that placement, the person should be included in the numerator. Trial periods in residential or nursing care homes where the intention is that the stay will become permanent should be counted as permanent. Whether a resident or admission is counted as permanent or temporary depends on the intention of the authority making the placement.
	30	**Delayed transfers of care from hospital, per 100,000 population** ASCOF Measure 2C part 1. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer.

Sheffield Outcomes Framework for Joint Health and Wellbeing Strategy, Public Health Intelligence Team, SCC. v0.6, 12th May 2015

PHOF = Public Health Outcome Framework
NHSOF = NHS Outcome Framework
ASCOF = Adults Social Care Outcomes Framework
CCG = Clinical Commisioning Group

Sheffield Health and Wellbeing Board

Sheffield Joint Health and Wellbeing Strategy 2013-18

NHS England

NHS Sheffield Clinical Commissioning Group

healthwatch Sheffield

Sheffield City Council

Sheffield Joint Health and Wellbeing Strategy 2013-18

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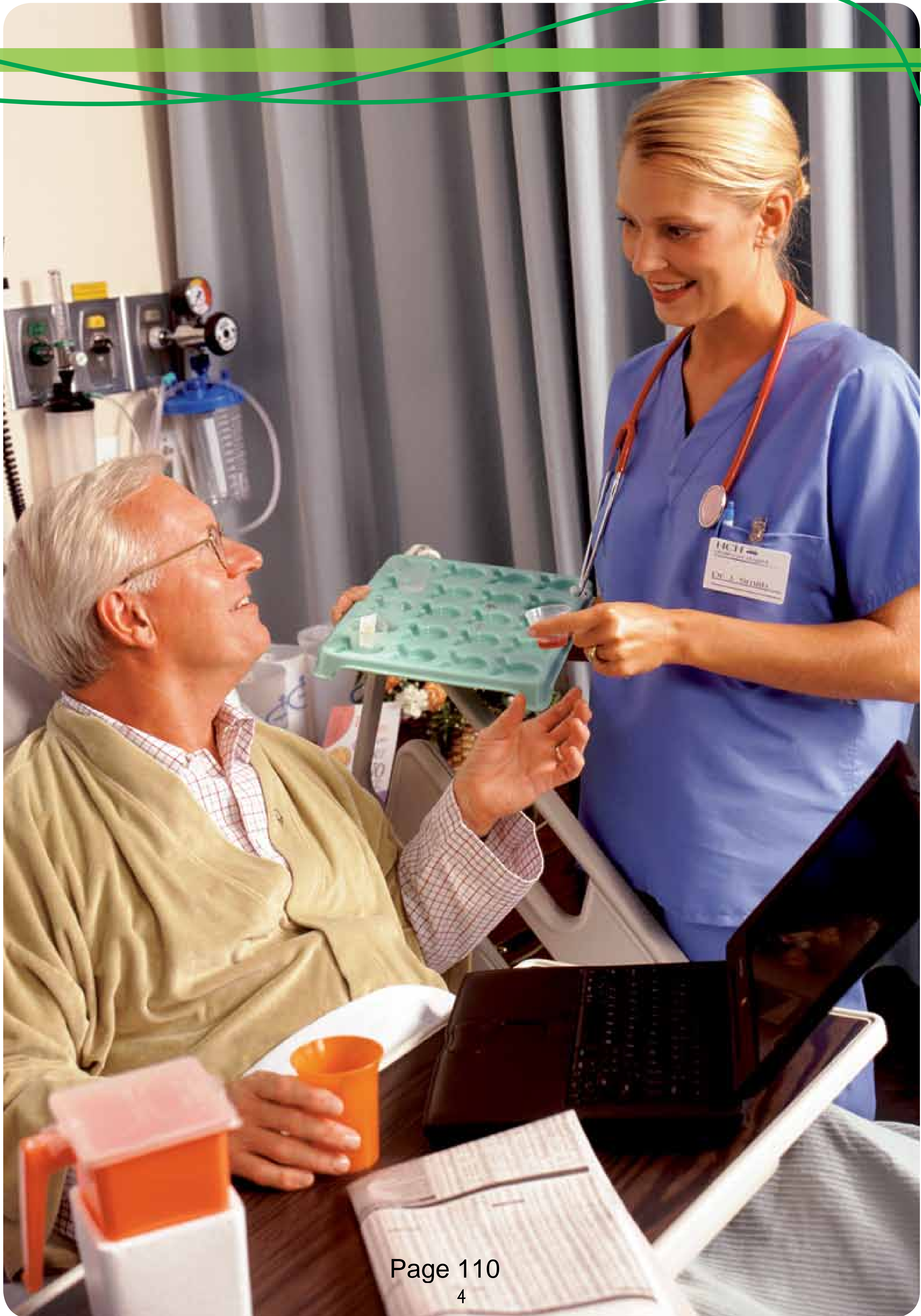


1 Foreword

Health and wellbeing matters to everyone. Being as healthy and well as we can be helps us to do the things we want to do and means that we can play an active role in our families, our communities and our city. Health and wellbeing is not just about being free from disease: it's about feeling physically, mentally and socially well, and socially engaged.

Health in Sheffield has improved considerably over the last few decades but our city is still blighted by inequalities and so we need to take a new approach. The city's new Health and Wellbeing Board is a big opportunity to stand up for Sheffield and start to make a real difference to the health and wellbeing of Sheffield people of all ages.

Sheffield's Health and Wellbeing Board has for the first time brought together the city's GPs, the City Council, a national perspective from NHS England, and an effective consumer voice through Healthwatch Sheffield into a strong partnership which has a shared strategy and a shared ambition. It is an opportunity to tackle the health and wellbeing problems that have affected Sheffield for generations by using our shared financial resources to invest in the things that make the biggest difference to people's health and wellbeing in the city. The Health and Wellbeing Board will challenge Sheffield people, businesses, public services and community organisations to work with us and share the responsibility for making Sheffield a healthier, successful city.

We know that health and wellbeing can be affected by poverty, aspiration, education, employment and the physical environment as well as by individual genetics. Our mission therefore is to tackle the main reasons why people become ill or suffer health inequalities in the first place, as well as to work with and empower people to improve their health and wellbeing today. Sheffield is an ambitious city and we know there are things we can do together to be a healthier and more successful place to live. But we acknowledge that we are living through financially tough times and we need to do what we can to stop the improvements in health and wellbeing over recent years being reversed.

In this, our Joint Health and Wellbeing Strategy, we have identified some of the things we need to do to make Sheffield a healthy, successful city. These can't be achieved by the NHS, Council or the public services on their own, and people have told us that they want and can take greater responsibility for their own wellbeing. Therefore, everyone has a role in making Sheffield a healthier place to live, work, grow up and grow older.

After listening carefully to what Sheffield people have told us and the evidence set out in our Joint Strategic Needs Assessment, we've set out in this Strategy what we believe we need to do to improve health and wellbeing in the city. It is a clear statement of intent for the coming years and we have taken the time to develop it and to frame it with your help. Everyone in Sheffield has a role in making our city a successful, healthier, better place to live and that is why your views and your involvement matter.

Councillor Julie Dore

Doctor Tim Moorhead

Co-Chairs, Sheffield Health and Wellbeing Board, October 2013

2 Introduction

1. Sheffield's Health and Wellbeing Board

The establishment of Sheffield's Health and Wellbeing Board presents an unprecedented opportunity to transform health and wellbeing in the city. The Board brings together GPs who are responsible for commissioning £700m of health services every year and Sheffield City Council who are responsible for £1.4bn of local government services every year and who have influence over many other services in the city. NHS England has a key seat in representing the national NHS picture, while Healthwatch Sheffield's role is to bring the views and experiences of Sheffield people.

Sheffield's Health and Wellbeing Board is focussed on what the Board can uniquely do to improve health and wellbeing in Sheffield. It therefore does not replace work going on in other areas and organisations, but seeks to add value and a system-wide partnership perspective.

The Health and Wellbeing Board's mission is to:

- Tackle the main reasons why people become ill or unwell and in doing so reduce health inequalities in the city.
- Focus on people – the people of Sheffield are the city's biggest asset. We want people to take greater responsibility for their own wellbeing by making good choices. Services will work together with Sheffield people to design and deliver services which best meet the needs of an individual.
- Value independence – stronger primary care, community based services and community health interventions will help people remain independent and stay at or close to home.
- Ensure that all services are high quality and value for money.

2. Sheffield's Joint Health and Wellbeing Strategy

This Joint Health and Wellbeing Strategy is a plan to improve the health and wellbeing of Sheffield people. It identifies things that will directly make a difference to people's health and wellbeing, such as investing in cancer services or tobacco control, but it also looks at the health and wellbeing system in Sheffield and its ways of working.

The Strategy is divided into ten principles and five outcomes, and is supported by five work programmes.

We know that this Strategy is aspirational and that we are operating in a difficult economic situation. We also know that national priorities within the fields of health and wellbeing may change and develop over time, which may affect our Strategy. However, we also believe that this is an opportunity for change and a redefinition of priorities. We want to be clear about what we want to achieve but will be flexible about how this will be done depending on capacity, demands and pressures that we may face. We know things may need to change and that organisations need to adapt to ensure the money spent in this challenging financial climate is making the biggest difference to health and wellbeing in Sheffield.

Sheffield's Health and Wellbeing Board in session

The Health and Wellbeing Board cannot do everything, but it can make a difference in some key areas. This Strategy therefore does not cover every health and wellbeing service provided in Sheffield, but instead seeks to set out the biggest things that the Board would like to see happen and which the Board believes would make the biggest difference to health and wellbeing.

In some cases this will require the Health and Wellbeing Board to do something new. In other cases it will require the Board to support initiatives that are already in place, and ensure such initiatives are geared up to improve health and wellbeing in Sheffield and aligned to the work of the Board.

3. Our process for writing and agreeing this Joint Health and Wellbeing Strategy

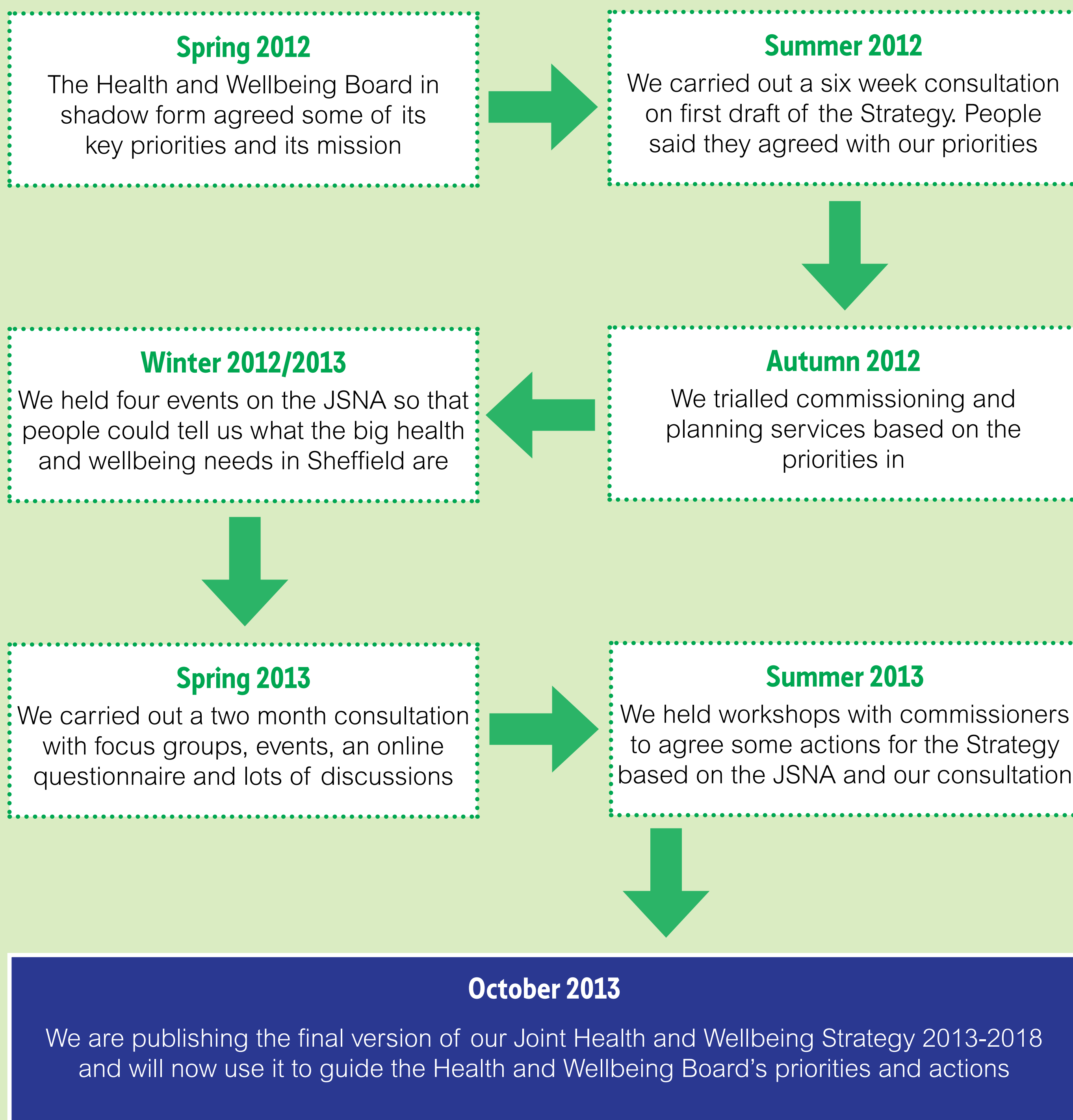
We have spent a considerable amount of time researching and refining this Strategy, talking to people around the city, to make sure that it is the right Strategy containing the elements that will make the biggest impact.

The evidence base used as the basis for this Strategy has been the Joint Strategic Needs Assessment. A Joint Strategic Needs Assessment (JSNA) is the means by which we assess the current and future health and wellbeing needs of the Sheffield population. It is joint because it involves working with a range of partners; it is strategic as it influences the Joint Health and Wellbeing Strategy and commissioning plans; and it is a needs assessment because it analyses and interprets health and wellbeing need in the city. A new JSNA for Sheffield was produced and published in June 2013. This followed a series of events held in January-March 2013 which were open to members of the public, providers and commissioners, all of whom attended to discuss the key needs of Sheffield people and to bring forward evidence.

The Health and Wellbeing Board put a key emphasis on working with members of the public and finding out what is important to them and what would make a big difference to their health and wellbeing. An initial consultation on this Joint Health and Wellbeing Strategy was carried out in summer 2012. A second consultation, which focussed on specific themes, was carried out in spring 2013. This was based firmly on the principles of co-production, and Sheffield citizens were very involved in shaping the consultation and the questions asked. A report about this consultation was produced and published in July 2013.

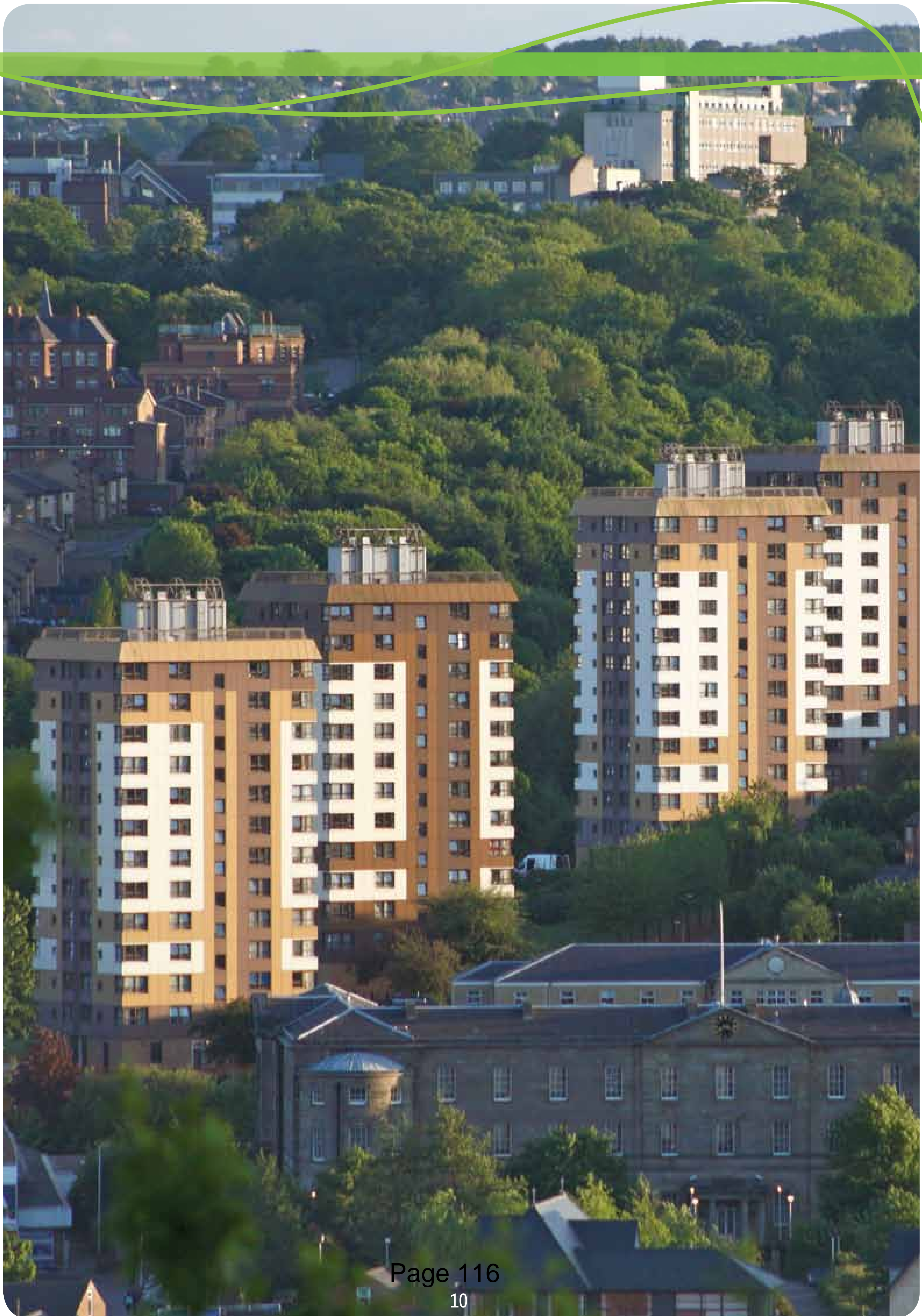
Through this consultation process and the work done to develop the JSNA, Sheffield's Health and Wellbeing Board can be sure that it has spoken to a range of Sheffield people and collected their views and opinions. This makes the Joint Health and Wellbeing Strategy all the more focussed and supported by the wider Sheffield community. We look forward to working with Healthwatch Sheffield to continue to speak to and hear the views of Sheffield people.

We have set out what we have done and who we have talked to below:



October 2013

We are publishing the final version of our Joint Health and Wellbeing Strategy 2013-2018 and will now use it to guide the Health and Wellbeing Board's priorities and actions



3 Ten Principles

We have ten principles which will guide all the decisions we make about the health and wellbeing services we pay for, deliver and support as a city. The application of these principles should shape the commissioning strategies of partner organisations across the city and the shape of future services.

1. **Valuing the people of Sheffield** - we want the best for Sheffield and Sheffield people will be at the heart of everything we do. People will be able to make informed choices about their wellbeing, be resilient and informed about short and long term health and wellbeing issues, be supported to take charge of their lives, and able to make decisions about the services they choose to access.

2. **Fairness and tackling inequality** - everyone should get a fair chance to succeed in Sheffield. Some people and families need extra help to reach their full potential, particularly when they face multiple challenges and significant deprivation. Tackling inequality is crucial to increasing fairness and social cohesion, reducing health problems, and helping people to have independence and control over their lives. Fairness and tackling inequalities will underpin all that we do.

3. **Tackling the wider determinants of health** - to become a healthier Sheffield, health and wellbeing must be everyone's responsibility. We cannot improve health and wellbeing alone so we will encourage people and organisations in the city to focus on improving wellbeing and tackling the root causes of ill health.

4. **Evidence based commissioning** - we will use local and national research and evidence of what works to ensure Sheffield's services are efficient, effective and meet the needs of people.

5. **Partnership** - we will work in partnership with people, communities and all public, private and voluntary, community and faith sector organisations to get the right services provided for the needs of people in Sheffield. We will work to join up health, social care, education, children's services, housing and other local government services to make a fundamental change to the city's health, wellbeing and quality of life.

6. **Prevention and early intervention throughout life** - we will prioritise upstream activity, support early intervention and prevent issues escalating at the earliest opportunity. A focus on prevention and early intervention is the key means of making Sheffield's health and social care system sustainable and affordable for future generations. Risk stratification and targeting will be crucial in making sure services and effective interventions reach the people who need them most.

7. **Independence** - we will help people maintain and improve their quality of life throughout their lives and increase individual, family and community resilience. Where people need support from health and social care services, those services will be tailored to individual needs and help people and their support networks to maintain or regain the greatest level of independence.

8. **Breaking the cycle** - we want to improve the life chances of each new generation by tackling the way in which poverty and inequality is passed through generations. We also want to stop the cycle of poverty, low aspiration, poor educational attainment, low income, unemployment, ill health and in some cases, homelessness, crime, alcohol, drug misuse, and domestic and sexual abuse, which undermine the health and wellbeing of some people in Sheffield.

9. **A health and wellbeing system designed and delivered with the people of Sheffield** - we will uphold the principles and values set out in the NHS Constitution and will design and deliver health, social care, children's, housing and other services which are co-produced with the people of Sheffield. We will work to ensure active participation and engagement of all ages with Healthwatch Sheffield.

10. **Quality and innovation** - we will ensure that the health, social care, children's and housing services provided in Sheffield are high quality and innovative in meeting people's needs. We will improve quality and stimulate innovation in the provision of health and wellbeing services in the city.

4 Five outcomes

The following pages are the heart of our Joint Health and Wellbeing Strategy. We have designed our Strategy so that all our aims and actions come under five outcomes which represent what we want to achieve for the people of Sheffield. We have included our vision for each outcome below:

OUTCOME 1 SHEFFIELD IS A HEALTHY AND SUCCESSFUL CITY

- Partners and organisations across the city to actively look to improve health and wellbeing through all areas, even those not traditionally seen as being about health and wellbeing.
- Housing across the city to be of a good quality, well–insulated with affordable bills and healthy and safe facilities.
- Sheffield people to be well-trained and able to access a range of fairly paid employment opportunities irrespective of disability, and for the city's economy to grow supporting the health and wellbeing of the people of Sheffield.
- Poverty, such as income poverty, fuel poverty and food poverty, to reduce, and that those affected by poverty are supported and encouraged to lead healthy lives.

OUTCOME 2 HEALTH AND WELLBEING IS IMPROVING

- Sheffield children, young people, families adults to be emotionally strong and resilient, and for emotional wellbeing to be promoted across the city.
- Sheffield children, young people and adults to be living healthily – exercising, eating well, not smoking nor drinking too much alcohol – so that they are able to live long and healthy lives.

OUTCOME 3 HEALTH INEQUALITIES ARE REDUCING

- Data about health inequalities in Sheffield to be excellent so that commissioners can be well-informed in tackling the issues.
- Sheffield's communities to be strong, connected and resilient, able to withstand crises and to support members of the community to live whole and healthy lives.
- Those groups especially impacted by health inequalities to have sensitive and appropriate services that meet their needs and improve their health and wellbeing.

OUTCOME 4 PEOPLE GET THE HELP AND SUPPORT THEY NEED AND FEEL IS RIGHT FOR THEM

- Sheffield people to receive excellent services which support their unique needs.
- Clear availability of information and support about health and wellbeing so that Sheffield people are able to help themselves.
- Patients and service users involved in decisions and their opinions valued.

OUTCOME 5 THE HEALTH AND WELLBEING SYSTEM IS INNOVATIVE, AFFORDABLE AND PROVIDES GOOD VALUE FOR MONEY

- Sheffield people at the centre of the Sheffield health and wellbeing system, underpinned by strong working relationships between commissioners with a clear methodology for joint working and pooled budgets underpinned by an innovative and affordable health and wellbeing system fit for the twenty-first century.
- A preventative system that seeks to help and identify people before they are really sick, enabling Sheffield people to stay healthy and well for longer.
- Frontline workers aware of health and wellbeing needs and able to signpost and support service users in obtaining the help they need.

We will measure the impact of our actions on the health and wellbeing of the people of Sheffield through indicators laid out in section 7.

Outcome 1 Sheffield is a healthy and successful city

What's this about?

This outcome is about making health and wellbeing part of everything the city does, recognising that the city needs to be healthy to be successful and successful to be healthy. The wider determinants of health are often described as the 'causes of the causes' of ill health. These wider determinants include issues such as: employment, education and skills, housing, the environment and crime, and all of them impact upon our health in one way or another. These factors are often inter-related and outside of an individual's control. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet their needs and deal with changes to their circumstances. Tackling the 'wider determinants of health' will not happen overnight so this must be a long-term aim for the city over the next 30 years.

Where are we now? What the JSNA and consultations have told us	What do we want to achieve	How will we achieve it?
	City-Wide Influence	
• How we feel about our environment has a real impact on our health and wellbeing. Sheffield's green spaces are an asset for the city, and it is crucial this land is well maintained and used to its full advantage. • Air pollution is an issue and the 'Air Quality Action Plan' should be delivered comprehensively across the City. • Making public transport accessible is crucial if we are to reduce isolation and enable people to have more control over their own lives.	**Partners and organisations across the city to actively look to improve health and wellbeing through all areas, even those not traditionally seen as being about health and wellbeing,** such as employment, education and skills, transport, housing, the environment, crime and criminal justice, business, leisure, economic growth.	1.1 Influence partners and organisations across Sheffield to consider and demonstrate the positive health and wellbeing impacts of policies, encouraging all organisations to make health and wellbeing a part of what they do.
	Housing	
• The poor condition of properties in the private rented sector is a big challenge facing the Council in the future, especially given the significant cuts to government funding in this area.	**Housing across the city to be of a good quality, well–insulated with affordable bills and healthy and safe facilities.**	1.2 Commission a plan to improve the standard of private rented sector housing in the city with a focus on the key impacts of poor housing on health and wellbeing.

Health and Employment		
• The long term unemployment trajectory and the issue of youth unemployment have significant implications for the health and wellbeing of the city. The quality of work is important for our health and steps should be taken to try and measure this and to increase awareness of the issue. • Sheffield must continue to improve its Key Stage 2 and Key Stage 4 results to narrow the gap with the national average. The focus must be on school age education and lifelong learning. • Poor quality underpaid work and a lack of opportunities affect healthy living and wellbeing.	**Sheffield people to be well-trained and able to access a range of fairly paid employment opportunities irrespective of disability, and for the city's economy to grow supporting the health and wellbeing of the people of Sheffield.**	1.3 Support activity and actions with schools, colleges and employers (as set out in the city's Economic Strategy) that increases educational and skills attainment for all ages. 1.4 Work with employers to create employment pathways for young people, and emphasise the role of health and wellbeing amongst all employers in the city. 1.5 Recognise that a Living Wage has positive health and wellbeing impacts for everyone, and emphasise to statutory, private and voluntary sectors working in health and wellbeing the Fairness Commission's aspiration that all employees should receive a Living Wage by 2023. 1.6 Support the Health, Disability and Work Plan and further work to understand and evaluate the costs of poor health to employment. 1.7 Pursue the development of broader approaches to health and the economy both with the Core Cities and in Sheffield City Region.
Poverty		
• Over one fifth of households in Sheffield are living in poverty, and food and fuel poverty are growing concerns. • Welfare reforms will impact negatively on health and affect the poorest and more vulnerable members of the community disproportionately. There is the potential of a 'double negative' impact for families with children under five, families with two or more children and lone parent families.	**Poverty, such as income poverty, fuel poverty and food poverty, to reduce, and that those affected by poverty are supported and encouraged to lead healthy lives.**	1.8 Support the actions set out in the Child Poverty Strategy and the recommendations of the Fairness Commission, especially recognising the importance of actions to mitigate the increasing impact of 'in work' poverty upon families in the city. 1.9 Support the creation and implementation of a city-wide fuel poverty strategy.

Outcome 2 Health and wellbeing is improving

What's this about?

This outcome focusses on specific aspects of children's and adults' health and social care and the wider determinants of health to improve health and wellbeing in Sheffield. Health in Sheffield has improved significantly in the past few decades. People in all parts of the city are living longer and deaths from major illnesses, especially heart disease and cancer, have reduced. However, there are a number of areas of concern, such as infant mortality rates, unhealthy lifestyles and poor mental health and wellbeing that will require concerted action over the coming years if this trend in improving health and wellbeing is to be maintained.

Unlike Outcome 1, this is focused on the ongoing, shorter term improvements in health and wellbeing which we need to be a well and healthy city in the long-term.

Where are we now? What the JSNA and consultations have told us	What do we want to achieve	How will we achieve it?
	Emotional wellbeing	
• 1 in 4 people will experience a mental health problem at some point in their life. Half of adults with mental health problems first experienced symptoms before the age of 14. In terms of severe mental health problems, Sheffield has a higher excess premature mortality rate for people with a severe mental illness than England as a whole and may also experience poorer levels of wellbeing. Promoting mental health and wellbeing for all is crucial to achieving health and wellbeing outcomes across the board. • It is important to get things right from an early age for children. • The 'Five Ways to Wellbeing' were well known by the consultation's respondents, but it was felt that more work was needed to enable communities to connect.	**Sheffield children, young people and adults to be emotionally strong and resilient, and for emotional wellbeing to be promoted across the city.** **Parenting is essential to ensure healthy living and wellbeing in children and young people.**	2.1 Promote a city-wide approach to emotional wellbeing and mental health, focusing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans. 2.2 Commission a needs-led response to support children and young people's emotional development to enable them to develop personal resilience and manage transition from childhood to adulthood. 2.3 Support the implementation of the new city Parenting Strategy which focuses on positive parenting and developing resilient families and communities so that all children have a stable and enriching environment in which they will thrive.

Living Longer

- Life expectancy is currently 78.1 years for men and 81.8 years for women. Whilst this represents a longstanding trend of year on year improvements, both remain lower than the national average of 78.58 years for men and 82.57 years for women.
- In terms of the major killers, cancer and cardiovascular disease account for around 60% of premature deaths in Sheffield, consistent with the national picture. For both the premature mortality rate from all cancers and cardiovascular disease, Sheffield has the lowest rates amongst the Core Cities but figures remain higher than the national average. We are detecting a worrying upward trend in both ill health and mortality linked to liver disease.
- We currently have around 6,400 people living with dementia in the City, and this is expected to rise to over 7,300 by 2020 and over 9,300 by 2030. Early diagnosis and intervention improves quality of life and can delay or prevent premature and unnecessary admission to care homes.
- The infant mortality rate in Sheffield is 5.2 per 1,000 live and still births (2011) compared with a national rate of 4.3 per 1,000. Infant mortality has been slowly rising, widening the gap with national outcomes.
- Smoking remains the single largest, reversible cause of ill health and early death in Sheffield. Continued action is required here and across a range of unhealthy or risky lifestyle issues in Sheffield including alcohol consumption, drug use, levels of child and adult obesity, diet and nutrition, physical activity and sexual health.
- People in Sheffield know that a healthy lifestyle can be achieved by eating more healthily and doing more exercise. However, many said it was not a priority due to other pressures in their lives. Others felt safe or affordable places to exercise were declining, and that unhealthy food was too easily accessible – and healthy food too expensive.
- Children and young people were motivated to do exercise when it was fun. Some did not like healthy food and the healthier school meal option.
- Schools have a crucial role to play in tackling obesity and combatting other unhealthy lifestyle choices.

Sheffield children, young people and adults to be living healthily – exercising, eating well, not smoking nor drinking too much alcohol – so that they are able to live long and healthy lives.

2.4 Support the 'Move More' initiative to encourage people to be more physically active as part of their daily lives.

2.5 Implement an integrated approach to reducing levels of tobacco use through integrating work on: smoke-free environments; helping people to stop smoking; using mass media by reducing the promotion of tobacco; regulating tobacco products; reducing the affordability of tobacco; and substance misuse services.

2.6 Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.

2.7 Commission a joint plan and integrated pathway across the city including schools and the commercial sector to act preventatively and with lower-tier interventions to tackle obesity, providing accessible information.

2.8 Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.

Outcome 3 Health inequalities are reducing

What's this about?

This outcome focusses on those people and communities who experience the poorest health and wellbeing. We need to address those communities who experience the worst health and wellbeing inequalities. Sheffield is characterised by stark inequalities between different groups of people and between different geographical communities. People in the most deprived parts of the city still experience a greater burden of ill-health and early death than people in less deprived areas, demonstrating that inequalities in health and wellbeing are linked to wider social, cultural and economic issues. It is acknowledged that putting additional support into the most disadvantaged areas and raising standards there will have a beneficial effect on the whole community. Groups such as Looked After Children, children with learning difficulties and disabilities, some BME communities, migrant and asylum communities, homeless people, victims of domestic and sexual abuse, carers and lesbian, gay, bisexual and transgender people, are all reported nationally to have below average health.

The focus for this outcome is over the next 10 years.

Where are we now? What the JSNA and consultations have told us	What do we want to achieve	How will we achieve it?
Address the root causes of health inequalities – improve data about health inequalities		
• There are large inequalities in life expectancy. For males, the gap between the lowest and highest life expectancy is 8.6 years, whereas for females, the gap is 8.2 years. These gaps in life expectancy have not remained static. Whilst inequality in life expectancy has decreased for males, it has increased for females.	**Data about health inequalities in Sheffield to be excellent so that commissioners can be well-informed in tackling the issues.**	3.1 Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them.
Address the root causes of health inequalities – build and develop communities		
• Social networks are absolutely crucial, and social isolation is a risk for all age groups. • More work needs to be undertaken to understand the extent of isolation in the city, the way in which it impacts on health and wellbeing and the health benefits of interventions that enable people to meet new people and develop social networks (such as lunch clubs for older people). • There is a lack of knowledge about community activities and community support, which can lead to social isolation and loneliness.	**Sheffield's communities to be strong, connected and resilient, able to withstand crises and to support members of the community to live whole and healthy lives.**	3.2 Work with partners to agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities and exploiting community assets, and which supports community-based organisations. 3.3 Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined-up city localities.

- Well-connected cities and localities with good links enable people to live healthy lives.

Address poor health in specific populations

- The people who are most in need of health services are often least likely to receive or access them.
- Whilst children and young people growing up in Sheffield today are generally healthier than ever, there are wide variations. For example, between the most and least deprived wards in the city there is a four-fold difference in infant mortality rates. Health and wellbeing outcomes for Looked After Children require particular attention.
- Demographic changes of an increasing population of under 5s and over 75s, an increasing proportion of population, especially in the younger age groups from Black and minority ethnic population, and new arrivals all present significant challenges for health, education social care and housing sectors in the city.
- Sheffield has longer waiting times for social care assessments than the national average, performs poorly in terms of the self-reported quality of life of people receiving adult social care, and its record on helping working age adults with on-going care and support needs into paid employment is weak.
- A need for more cultural understanding and language support, including sign language, in accessing services.
- Not everyone is able to access the internet.
- Health inequalities will grow as welfare reform impacts on certain groups.

Those groups especially impacted by health inequalities to have early support and sensitive and appropriate services that meet their needs and improve their health and wellbeing.

3.4 Identify which groups are least able to access services and establish reasons for difficulties and the health consequences of this. Work to improve access, prioritise those areas where the difficulties in access have significant health consequences, and simplify how people access care.

3.5 Ensure every child has the best possible start in life, including: focused action with the most deprived areas and groups, reducing infant mortality, developing strategies that improve parent/child attunement in early years, increasing the uptake of childhood immunisations, reducing the number of under 5s A&E attendances, reducing smoking rates in expectant mothers, improving children's dental health, increasing the rate of breastfeeding, reducing teenage conceptions, reducing obesity in children and young people.

3.6 Recognising that the city has growing numbers of new arrivals, including Roma, develop appropriate strategies to ensure families are appropriately accessing health, social care and education services.

3.7 Commission disease-specific interventions to tackle poor health in population groups that have worse health, including a programme to improve the physical health of the severely mentally ill or those with a learning disability.

3.8 Support quality and dignity champions to ensure services meet needs and provide support.

3.9 Work to remove health barriers to employment through the Health, Disability and Employment Plan.

Outcome 4 People get the help and support they need and feel is right for them

What's this about?

This outcome is about how people of all ages should experience services in Sheffield. This is about Sheffield's health and wellbeing system working better based on the needs of people in the city. It is important to focus not only on outcomes for people, but to consider people's knowledge of, access to, and experience of services. Currently, these are not all accurately measured but are important and must be given greater emphasis.

We need to make these changes now to support the achievement of outcomes 1, 2, and 3.

Where are we now? What the JSNA and consultations have told us	What do we want to achieve	How will we achieve it?
Person-centred care and support		
• Whilst the level of emergency hospital admissions in Sheffield is broadly in line with the national and regional averages, the average length of stay in hospital following an emergency admission in Sheffield is 28% higher than the national average and the joint highest nationally. • Services for children with speech, language and communication needs, new-borns, and 16/17 year olds with mental health needs require attention and particular consideration should be given to the ability of services in the city to meet the needs of these three groups. • Sheffield is just above the national average for helping people to stay living at home but has reduced permanent admissions to residential and nursing care homes at a faster rate than the national average. • There are often long waits for GP appointments and that the opening hours can cause difficulty for the working population. • People felt they had to wait a long time to get a referral to a specialist, which often led to a worsening of illness.	**SSheffield people to receive excellent services which support their unique needs.**	4.1 Continue to work with providers in the city to integrate the health, social care, education and housing support and care that is available, to establish a person centred approach to care. 4.2 Commit to implementing the statutory requirements of the Children and Families Act supporting the integration of planning for children with complex needs and disabilities. 4.3 Ensure the experience of transition from child to adult services supports and promotes health and wellbeing. 4.4 Work with GP practices to improve the ways people can access their services. 4.5 Ensure equality of access to services. 4.6 Commit to reducing waiting times to at least national standards/averages for health and social care.

• Quality of care, perhaps especially for older people, was seen as being an issue. • It is important that services are accessible for those who do not speak English as a first language, or who are blind, deaf or have some other sensory impairment. Advocacy services are important. • Administering personal budgets can be very difficult. • Young people in the transition phase to adulthood find services do not meet their needs. • Ex-armed forces personnel have told us that services do not take account of their needs.		4.7 Commit to: providing care closer to home; keeping hospital and short term care as effective as possible; and providing rehabilitation to help people stay independent for as long as possible.
Self-help		
• It is sometimes hard to know what services exist and how to access them. • It is important to help people with simple messages and tools so they can make the changes they want to make in their lives. • GPs and other health professionals also need to be aware of the services and support that is available.	**Clear availability of information and support about health and wellbeing so that Sheffield people are able to help themselves.**	4.8 Encourage an integrated 'Sheffield offer' on the help, care and support available to people so that they can access guidance, advice, signposting, advocacy and self-assessment tools themselves. 4.9 Commit to working with partners on a model of active citizenship that promotes health literacy and supports people to look after themselves as well as possible.
Engagement and Participation		
• Patient experience is a critical measure of performance and there are already significant efforts being made locally and nationally to enhance mechanisms for collecting, analysing and interpreting this on a systematic basis. • It is really important to involve people from all walks of life.	**Patients and service users involved in decisions and their opinions valued.**	4.10 Require both commissioners and providers to have effective engagement processes in place that take what service users think into account in all decisions. 4.11 Use patient/service user experience as a significant measure of quality.

Outcome 5 The health and wellbeing system in Sheffield is innovative, affordable and provides good value for money

What's this about?

This outcome is about how Sheffield's commissioners and service providers will deliver services. **As with outcome 4, it is our intention to make the changes to the way the health and wellbeing system works in Sheffield over the next 5 years to make the system sustainable and affordable in the long term.** The city's population is rising as a result of an increasing birth rate, inward migration and people living longer. Over the next 10 to 20 years there will be an increase in the number of older people in Sheffield alongside increasing numbers of children and working age adults with disabilities and complex needs. We know that this population change is likely to place a significant and increasing demand on health, social care, children's and housing resources.

In Sheffield we have developed an 'investment profile' of the city's NHS and Council budgets using a model that apportions budgets to the following categories: promoting lifelong health and wellbeing; early, short-term or one-off interventions designed to promote recovery and independence; and medium to long term support focused on stability and maintaining quality of life. This profile indicates that around 80% of all the money invested in health and wellbeing services in Sheffield in 2012/13 went into acute hospital care and medium to long term care and support services. The growth in our population and the economic situation mean that this balance of investment is unsustainable and greater emphasis should be placed on promoting lifelong health and wellbeing, recovery and independence.

Where are we now? What the JSNA and consultations have told us	What do we want to achieve	How will we achieve it?
Joint commissioning and whole-system transformation		
• Frustration with the at times lack of communication between health and social care services, with people feeling like they are passed 'from pillar to post'.	**Sheffield people at the centre of the Sheffield health and wellbeing system, underpinned by strong working relationships between commissioners with a clear methodology for joint working and pooled budgets underpinned by an innovative and affordable health and wellbeing system fit for the twenty-first century.**	5.1 Build on existing joint working to establish a clear joint commissioning methodology, including the consideration of pooled budgets in areas such as the health and social care budget for older people with long term conditions and children with complex needs. The joint commissioning methodology will include a commitment to the co-production of strategic plans to ensure services are delivered in the most effective way for the benefit of all.

		5.2 Address city-wide causes of high hospital use by promoting innovative ideas and models for whole system change. This will include working with providers to find the best way to redesign systems upstream, and engagement to build awareness of appropriate access to services.
Prevention and early intervention		
• Around 80% of all the money invested in health and wellbeing services in Sheffield is in acute hospital services, and in medium to long term care and support services. The growth in demand for services from an ageing and growing population, and the current economic situation, mean we need to find different ways of meeting people's needs. • Preventing problems from arising and intervening early can be better for people and more cost effective than the traditional reactive approach to problems. More schemes that emphasise prevention and early action, that reduce demand for acute and long term care, are needed. Health care needs to be better integrated with social and community care if we are to reduce dependency on hospitals and provide higher quality care. • Prevention is really important and needs more resources. One way of doing this is ensuring carers have access to all the information they need.	**A preventative system that seeks to help and identify people before they are really sick, enabling Sheffield people to stay health and well for longer.**	5.3 Establish more preventative and targeted approaches to the provision of health and social care by extending the application of population risk profiling (predicted risk of future health crisis) to enable a closer alignment between services and people's needs. This should inform the development of integrated care and reablement services to help people stay at home, be healthy for longer and avoid hospital and long-term care. 5.4 Make best use of available and emerging technology to support early and local intervention.
Health and wellbeing workforce		
• It is important to ensure that community-based work can flourish and dedicated commitment, time and resource should be made available to support the Voluntary, Community and Faith sector.	**Frontline workers aware of health and wellbeing needs and able to signpost and support service users in obtaining the help they need.**	5.5 Commission a basic training programme for all frontline workers that raises the profile of public health, mental health and safeguarding issues and ensures an understanding of services and tools available to make 'Every Contact Count'. 5.6 Commit to working with VCF organisations to find the best way of meeting people's needs locally and ensuring we benefit from the added value VCF organisations can bring. 5.7 Continue to seek greater efficiency from providers, without putting service users' safety or experience at risk.

5 Five work programmes

Some of the actions benefit from being joined up and the Health and Wellbeing Board has therefore created five work programmes. These will be commissioned from partner organisations and the Board will oversee the delivery of the outcomes. These work programmes will feed in on an annual basis to the Board.

Work programme 1 - A Good Start in Life

The foundations for lifelong social, emotional and physical health, and educational and economic achievement, are laid in early childhood. Nutrition (including in pregnancy), speech and language development, the family learning environment and most importantly the quality of the parent/care giver and child relationship in the first 2-3 years are powerful determinants of outcomes in childhood and later life. Investment in early years preventative and early intervention services can be not only cost saving but also the key to achieving better health and wellbeing and reduced inequalities in the whole population. This can impact a family environment and issues such as parenting, diet and obesity, foundation stage attainment and hospital admissions and attendances at A&E.

Work programme 2 - Building Mental Wellbeing and Emotional Resilience

Mental wellbeing can positively affect almost every area of a person's life - education, employment and relationships. It can help people achieve their potential, realise their ambitions, cope with adversity, work productively and contribute to their community and society. Promoting mental wellbeing for all has multiple benefits. It improves health outcomes, life expectancy, productivity and educational and economic outcomes and reduces violence, crime and drug and alcohol use. One in four people will experience mental illness at some point in their lives. Mental health problems are more common in the most deprived parts of Sheffield, and in the current economic climate problems such as anxiety and depression are expected to increase.

Work programme 3 - Food, Physical Activity and Active Lifestyles

Food has a big impact on many parts of our lives. It gives us pleasure and connects us to our environment and our culture as well as giving us the energy to function. A nutritious and healthy diet can contribute to better wellbeing for people of all ages but we know that for many people in Sheffield, access to a healthy diet is a major problem. A lack of food or poor quality food reduces people's ability to go about their daily lives (such as a lack of energy, lack of concentration) but also undermines long-term health, contributing to conditions such as diabetes, heart disease and cancer. Physical activity has a positive impact on physical and mental wellbeing, improving self-esteem and reducing stress. Although Sheffield has high quality sports facilities and open spaces, not everyone in the city is able to access or take advantage of these.

Work programme 4 - Health, Disability and Employment

Employment is important for improving health as being in work, job security and attaining 'better' jobs has a positive effect on the way people live and feel, and the choices they make with respect to their health. Being out of work has negative effects on an individual's health, reducing household incomes, increasing social isolation and increasing stress and depression. Most health risks associated with unemployment get worse over the time a person is out of work. Mental health issues and musculoskeletal problems are the largest causes of workplace absence, and developing a Long Term Condition can be a significant barrier to work. It is important to support those with these health problems to stay in work, thereby reducing the impact of their conditions and aiding recovery.

Work programme 5 - Supporting People At or Closer to Home

Care still relies too heavily on individual expertise and expensive professional input; 'patients' and service users want to play a much more active role in their own care and treatment. We want to reduce the dependency in Sheffield on high level or 'acute' hospital and residential care support. Not only is it expensive (and will become more so as more and more people live longer), it isn't what people tell us they want and doesn't always improve people's health and wellbeing in the longer term. Supporting patients to self-care can change people's attitudes and behaviours, improve quality of life, clinical outcomes and health service use including reducing avoidable hospital admissions. We need to make sure that, as far as possible, people can get on with their lives and have the right support in place to help them live independently and happily in the place they feel most comfortable.

6 Action

1. How will the Joint Health and Wellbeing Strategy be implemented?

Of course, one of the most important parts of any strategy is what happens as a result of it. For this Joint Health and Wellbeing Strategy, it is perhaps most useful to see the Health and Wellbeing Board's role as that of a strategic overseer.

The actions of this Joint Health and Wellbeing Strategy will be delivered in several different ways. The Health and Wellbeing Board will work together in partnership to:

- **Approve the annual commissioning plans of Sheffield City Council and NHS Sheffield Clinical Commissioning Group.**

  Sheffield City Council, NHS Sheffield Clinical Commissioning Group and NHS England all directly commission health and wellbeing services in Sheffield. The Health and Wellbeing Board will oversee all of these commissioning plans, and although it will not take a direct or detailed role in creating the plans, it will expect the organisations represented on the Board to take the Strategy's actions and goals forward. In some cases the actions in the Strategy will require something to be directly commissioned, and the Board will take a particular interest in the commissioning of these actions, although the actions will not be commissioned directly by the Board.

  At the start of each financial year, the Health and Wellbeing Board will agree their objectives for the year ahead based in part on the commissioning plans.

- **Support and influence the work of NHS England.**

  NHS England plays a key role on the Health and Wellbeing Board in Sheffield. As commissioners of GPs and other services in Sheffield and across the region and country, NHS England makes crucial decisions affecting Sheffield people. We will work with NHS England to connect priorities and commissioning intentions and influence how services are delivered in Sheffield.

- **Work with Healthwatch Sheffield to actively engage with the people of Sheffield.**

  Healthwatch Sheffield's role is to represent service user and citizen voice and experiences. The Health and Wellbeing Board will welcome Healthwatch Sheffield's role in bringing the views of children, young people and adults, framing the Board's agendas and way of thinking. We will work with Healthwatch Sheffield to ensure our engagement events, held several times a year, are representative and properly reflect and welcome different viewpoints and perspectives.

- **Hold partners and providers to account if issues are identified which do not support the outcomes of the Strategy.**

  If there is evidence that the Strategy's outcomes are not being achieved, the Health and Wellbeing Board will hold commissioners and providers to account. This may be in a formal Board meeting, particularly if it concerns Sheffield City Council, NHS Sheffield Clinical Commissioning Group and NHS England.

  The Health and Wellbeing Board also advocates a strong role for the city's scrutiny committees. If required, the Board will suggest issues for scrutiny committees to investigate. However, the Board will not play a detailed role in the management of specific contracts. This will be done by the organisations represented on the Board.

- **Seek to influence local partners and providers to act in a positive way for the health and wellbeing of the people of Sheffield, valuing the Sheffield community of professionals who work in health and wellbeing and/or have an interest or connection to it.**

  A key role of the Health and Wellbeing Board is to be a city leader, influencing others to act in the interest of improving health and wellbeing in the city. Not every action of this Strategy has financial implications. Some, instead, require the Board to work with others to bring about whole-system change. The Board will consider issues escalated to it requiring a city level response and will ensure that essential links are made across work programmes and initiatives.

  The Sheffield Executive Board is chaired by the Health and Wellbeing Board's co-chair, Councillor Julie Dore, and the Board will work with the Sheffield Executive Board to promote health and wellbeing messages across Sheffield and amongst a range of organisations and providers.

  In addition, the Health and Wellbeing Board has its own regular events for professionals and providers who work in health and wellbeing, and uses a range of communications tools to facilitate information and networking. This means that professionals and providers are linked to the work of the Board and are able to influence the Board's priorities and direction.

- **Support further consultation and development of the Joint Strategic Needs Assessment when required.**

  The Joint Strategic Needs Assessment is a key process to understand and define the health and wellbeing needs of Sheffield people. This will continue to develop and expand, documented at http://www.sheffield.gov.uk/jsna.

- **Monitor the health and wellbeing of Sheffield people on an annual basis in accordance with the measures outlined in this Strategy.**

  A set of outcome indicators are set out in section 7. These are our way of monitoring and finding out if the health and wellbeing, and the experiences of Sheffield people using health and wellbeing services, are improving. We will review and publish these annually.

- **Advocate for Sheffield on a national level when it is needed and appropriate.**

  Sometimes change is required on a national level, and as system leader for health and wellbeing in Sheffield it is appropriate that the Health and Wellbeing Board plays a national role when required.

2. How will the Health and Wellbeing Board be held accountable?

There are three main ways that the Health and Wellbeing Board will be held accountable:

- **By scrutiny committees and other statutory committees and organisations holding us to account.**

  The scrutiny committees of Sheffield City Council have the power to scrutinise not only the delivery of the Strategy but also the health service providers in the city. The committees will challenge organisations to make sure they are delivering the things set out in the Strategy. Healthwatch Sheffield representatives sit on the scrutiny committees and play a key role on them.

  Throughout the Strategy, we have made clear the importance of a good start in life for children and young people and supporting vulnerable people in Sheffield. We will work in close collaboration with Sheffield's Safeguarding Children Board and Adult Safeguarding Partnership to promote and protect the welfare of vulnerable people in the city.

  Sheffield's health and wellbeing system will also be held to account nationally and we are expected to make progress against the Government's new outcome frameworks for NHS, adults' and children's social care and public health. Performance against these frameworks will also be available online. In addition, independent organisations such as the Care Quality Commission, Monitor and OFSTED will have a vital role in assessing the quality of the health, social care and wider wellbeing services provided in the city.

- **By Healthwatch Sheffield consistently presenting the views of service users and Sheffield people.**

  Healthwatch Sheffield is the main channel into the Health and Wellbeing Board for Sheffield children, young people and adults to contribute their voice and influence. Healthwatch Sheffield will enable local people to shape decisions and will provide a direct link for the people of Sheffield to the Board, ensuring that issues with local health and wellbeing services are known and responded to by the Board.

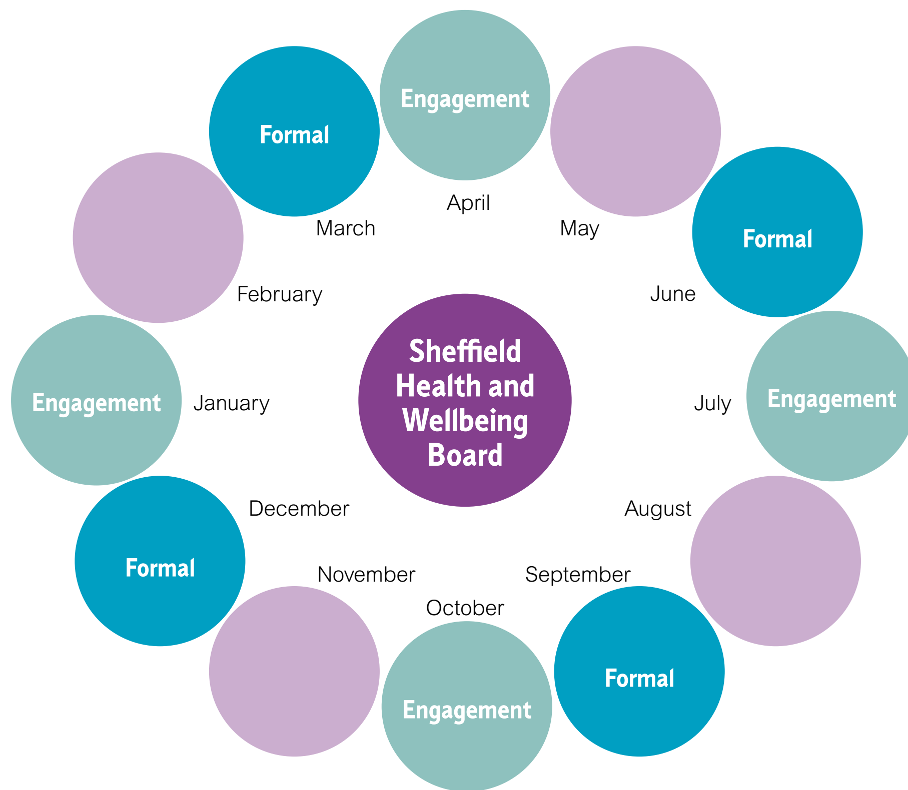
  Healthwatch Sheffield will also play a role in developing the work that underpins the Strategy, and shaping the Strategy's delivery.

- **By members of the public attending our meetings and getting involved.**

  As a Health and Wellbeing Board we hold regular events to hear the views of members of the public, service users and providers. We will engage with health, social care and wider service providers to ensure that the Board's work is informed by best practice in service delivery. We will make full use of Sheffield's existing strong partnerships to ensure that organisations in the city are fully involved in working to improve Sheffield's health and wellbeing.

  The Health and Wellbeing Board meets formally every quarter in public where there is an opportunity to ask questions and receive answers. All agendas, papers and minutes from these meetings are available to members of the public on the Board's website. The Board will also hold engagement events every few months, usually the month after each formal meeting.

The diagram below shows our yearly meeting cycle, with many things happening between meetings:



3. What is the organisational structure around the Health and Wellbeing Board?

Sheffield's Health and Wellbeing Board is at its heart a partnership: between the NHS, Healthwatch Sheffield and the local authority; between statutory organisations and members of the public; and between the Board itself and its providers, interest groups and the people of Sheffield. The partnership between GPs and councillors is perhaps particularly interesting, with both sets of people on the frontline, meeting Sheffield people on a daily basis.

No structure diagram fully conveys the intricacies of relationships between different organisations. Sometimes, partnership working makes governance structures confusing and hard to work out. We have produced the diagram below to show you some of the different organisations involved with health and wellbeing in Sheffield. It has deliberately not been shown as a hierarchy of organisations.

Sheffield's Health and Wellbeing Board is in purple at the centre.

In blue are the organisations which make up the Health and Wellbeing Board.

In green are selected meetings which take place regularly in NHS Sheffield Clinical Commissioning Group and Sheffield City Council. More detailed commissioning decisions will be made in these meetings.

In pink are the organisations that might want to feed into or monitor the Health and Wellbeing Board and who have an interest in strategic and commissioning decisions.

Above all of these are the people of Sheffield.

7 How we will measure health and wellbeing

The Health and Wellbeing Board will monitor this set of indicators annually to assess the progress and development of health and wellbeing in Sheffield. These are not measures designed to analyse the performance of the Board, or of specific services, but are instead intended as a way of seeing how healthy and well Sheffield people are overall.

	Outcome	Indicator
1	HWBO1	Child Poverty – Children (under 16) living in families in receipt of Child Tax Credit (CTC) whose reported income is less than 60 per cent of the median income or are in receipt of income support (IS) or Income-Based Jobseeker Allowance (JSA), as a proportion of the total number of children in the area.
2	HWBO1	Average gross annual income – of employees on adult rates who have been in the same job for more than one year.
3	HWBO1	Long term unemployment – percentage of the working age population claiming job seekers allowance for more than 12 months.
4	HWBO1	The proportion of 16-18 year olds not in education, employment or training.
5	HWBO1	Good level of development at age five - Foundation Stage Profile Attainment: Proportion achieving 78+ points.
6	HWBO1	Proportion of 15/16 year olds at Key Stage 4 achieving 5 A*-C GCSE grades including in English & Maths.
7	HWBO1	Homelessness Acceptances (unintentionally homeless and in priority need) - per 1,000 households.
8	HWBO1	Air pollution – estimated proportion of annual all-cause adult mortality attributable to anthropogenic (human-made) particulate air pollution.
9	HWBO2	Life expectancy at birth – Males.
10	HWBO2	Life expectancy at birth – Females.
11	HWBO2	Under 75 all-cause mortality rate per 100,000 population.
12	HWBO2	Infant mortality rate (3 year rate) per 1,000 live births.
13	HWBO2	Prevalence of mental health problems – percentage of GP registered patients with a mental health condition (Adults).
14	HWBO2	Prevalence of smoking among persons aged 18 years and over.
15	HWBO2	Proportion of children aged 10-11 (Y6) classified as overweight or obese.
16	HWBO2	Admission episodes for alcohol attributable conditions, rate per 1,000.
17	HWBO2	Percentage of infants that are totally or partially breastfed at age 6-8 weeks after delivery.
18	HWBO3	Gap in life expectancy (Males) – as measured by the slope index of inequality.
19	HWBO3	Gap in life expectancy (Females) – as measured by the slope index of inequality.
20	HWBO3	Excess winter deaths – ratio of excess winter deaths to average non-winter deaths.
21	HWBO3	Excess premature mortality in people with serious mental health problems per 100,000 population.
22	HWBO4/5	Access to GP services – proportion of patients able to get an appointment last time they tried.
23	HWBO4/5	A&E attendance rate (all ages) per 1,000.
24	HWBO4/5	Emergency admission rate for conditions usually managed within primary care per 100,000 population.
25	HWBO4/5	Antenatal assessment under 13 weeks - Proportion of women who have seen a midwife or maternity healthcare professional by 12 weeks and 6 days of pregnancy.
26	HWBO4/5	Proportion of people using adult social care who receive self-directed support.
27	HWBO4/5	Proportion of people using adult social care who reported they have control over their life.
28	HWBO4/5	Proportion of older people (65+) still at home 91 days after discharge from hospital into reablement/rehabilitation service.
29	HWBO4/5	Permanent admissions to residential/nursing care per 100,000 population.
30	HWBO4/5	Delayed transfers of care from hospital per 100,000 population.

8 Get involved

The Health and Wellbeing Board in Sheffield is keen to be open, transparent and honest about how it is working and how it is delivering its Joint Health and Wellbeing Strategy. We know that we will not have thought of or covered everything, and therefore want people to get involved. There are two main areas where you can get involved:

1. Get involved with and find out about the work of the Health and Wellbeing Board
You can:

- **Come to our Board meetings.**

We have formal Board meetings every three months where there will be the opportunity to ask questions. All agendas, papers and minutes of these Board meetings are published **online** and are available in print on request.

- **Come to our events and get involved in our consultations.**

There will usually be at least one event every three months. All information is **published online** and sent out through our networks.

- **Stay informed.**

The best way you can do this is by **signing up to receive our e-newsletter**. We also have a regularly updated website:
www.sheffield.gov.uk/healthwellbeingboard.

- **Get connected with others.**

Improving health and wellbeing is a task for all of us, as individuals and as organisations. You can share with others in lots of ways, for example using our **LinkedIn group** (if you're a provider) or follow us on **Twitter.** All of our events include opportunities to get to know other people in the city.

2. Tell Healthwatch Sheffield what you think about the services you receive
Healthwatch Sheffield has a key seat on the Health and Wellbeing Board, and its main role is to be a champion for the views of service users and Sheffield people. You can:

- **Visit Healthwatch Sheffield's hub.**

Healthwatch Sheffield has a ground-floor information hub, open during office hours at The Circle, 33 Rockingham Lane, Sheffield, S1 4FW.

- **Attend meetings and events run or supported by Healthwatch Sheffield.**

You can find out about these **online** or by calling 0114 253 6688.

- **Stay informed.**

The best way you can do this is by **signing up to receive Healthwatch Sheffield's e-newsletter and other information**.

- **Get advice and support.**

Healthwatch Sheffield wants to support you in using services in Sheffield and in managing your own health and wellbeing. You can find out about services online or by calling 0114 205 5055.

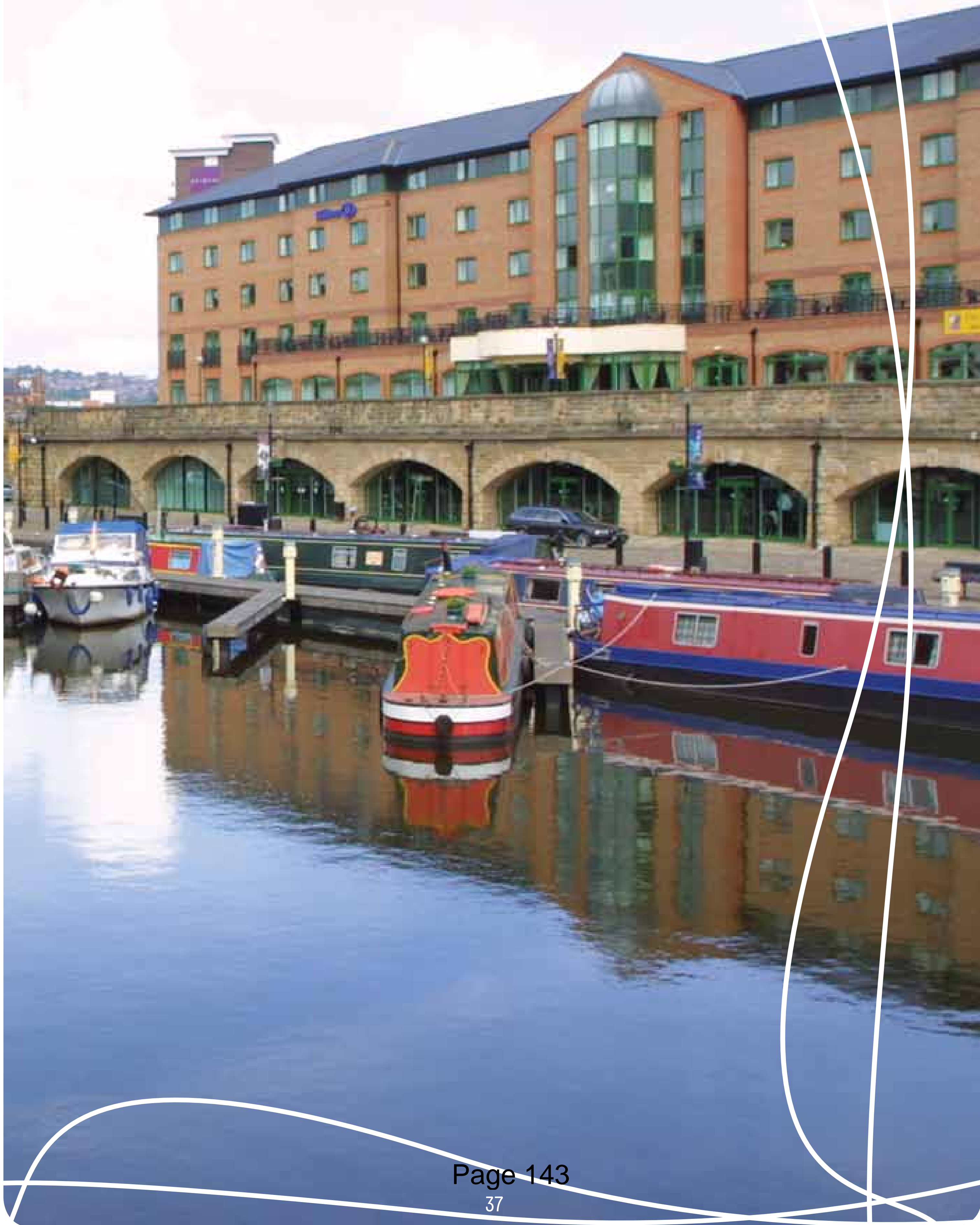
9 Linked documents

The Joint Health and Wellbeing Strategy does not mean that all other existing plans and strategies in the city need to be rewritten. Organisations and service providers are already doing things which will make a significant contribution to achieving the outcomes set out in this Strategy. This Strategy is primarily about beginning a social, organisational and cultural change in Sheffield so that long term health and wellbeing is an important consideration in everything we do. Clearly, there are some key documents which are linked to tackling the wider determinants of health in Sheffield and the Health and Wellbeing Board will contribute to the delivery of other strategies to ensure that there is a strong wellbeing focus and a coherent link with the Joint Health and Wellbeing Strategy. Some of these key documents and strategies that underpin the Joint Health and Wellbeing Strategy are:

- **CCG prospectus 2012**.
- **Fairness Commission Report 2013**.
- **Joint Strategic Needs Assessment 2013**.
- **Joint Health and Wellbeing Strategy Consultation Reports 2012 and 2013**.
- **Sheffield City Council Corporate Plan Standing Up for Sheffield 2011-2014**.

10 Glossary

Clinical Commissioning Group (CCG)	Clinical Commissioning Groups are groups of GPs that from April 2013 have been responsible for commissioning local health services in England. They will do this by working in partnership with local communities, local authorities; patients and professionals.
Commissioning	Commissioning is the process by which the health and social care needs of local people are identified, priorities determined and appropriate services purchased.
Health and Wellbeing Board (HWB)	Health and Wellbeing Boards exist in every upper tier local authority to improve services and the health and wellbeing of local people. They bring together the key commissioners in an area, including representatives of GPs, directors of public health, children's services, and adult social services, with at least one democratically elected councillor and a representative of Healthwatch. The boards assess local needs and develop a shared strategy to address them, providing a framework for individual commissioners' plans.
Joint Health and Wellbeing Strategy (JHWS)	The Joint Health and Wellbeing Strategy is the way of addressing the needs identified in the Joint Strategic Needs Assessment and to set out agreed priorities for action.
Joint Strategic Needs Assessment (JSNA)	The Joint Strategic Needs Assessment identifies the health and wellbeing needs of the local population to create a shared evidence base for planning and commissioning services.
Healthwatch Sheffield	Healthwatch Sheffield is the consumer champion for both health and adult's and children's social care. Healthwatch England exists at a national level.
NHS England (NHSE)	NHS England sits at arm's length from the government and will oversee local GPs. It makes sure that CCGs have the capacity and capability to commission successfully and meet their financial responsibilities. It will also commission some services directly.
Outcome	'Outcome' means 'result', 'goal' or 'aim'.
Sheffield City Council (SCC)	Local authorities play a crucial role in ensuring that day to day services of their communities are efficient and effective, offer good value for money and deliver what people need. Sheffield City Council provides many services that are related to health and wellbeing. It is largely independent of central government and is directly accountable to the people of Sheffield when they elect their councillors.
Voluntary, Community and Faith Sector (VCF)	The voluntary, community and faith sector, also referred to as 'the third sector', is made up of groups that are independent of government and constitutionally self governing, usually with an unpaid voluntary management committee. They exist for the good of the community, to promote social, environmental, health, cultural or other objectives.



We would like to thank all those who have been part of developing this Strategy: who came to our events, to provide us with information, who helped us identify the key actions - and who will help us implement this Strategy to make Sheffield a healthy and successful city.

A summary version and an easy read version of this Strategy are available on our website.

To request a printed copy of this Strategy, or if you have a query, contact:

Email: healthandwellbeingboard@sheffield.gov.uk
Website: www.sheffield.gov.uk/healthwellbeingboard
Phone: 0114 273 4567

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Sheffield S1 2HH

www.sheffield.gov.uk
www.sheffieldccg.nhs.uk
www.healthwatchsheffield.co.uk
www.england.nhs.uk

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HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of: Greg Fell & Rebecca Joyce

Date: 27th September 2018

Subject: Health & Wellbeing Board – Future Meeting Arrangements

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Author of Report: Dan Spicer – 0114 27 34554

Summary:

This paper sets out proposals to improve openness and transparency around the Health & Wellbeing Board's work and asks the Board to approve them. It also builds on Board discussions around the CQC System Review and the Health & Wellbeing Strategy to propose a broader review of Board membership, and of the relationship between the Health & Wellbeing Board and the Accountable Care Partnership Board, to be completed in time for discussion at the next public meeting in December 2018.

Questions for the Health and Wellbeing Board:

N/A

Recommendations for the Health and Wellbeing Board:

The Board are asked to:

- Agree to the proposal to implement quarterly formal public meetings, open strategy development sessions to the public, and publish agendas and minutes of these sessions online
- Agree to receive recommendations from reviews of ACP governance, and HWB terms of reference, at their December 2018 formal public meeting

Background Papers:

N/A

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

This aligns with all outcomes of the Joint Health & Wellbeing Strategy.

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

Greg Fell – Director of Public Health

Becky Joyce – Accountable Care Partnership Programme Director for Sheffield

HEALTH & WELLBEING BOARD – FUTURE MEETING ARRANGEMENTS

1.0 SUMMARY

1.1 This paper sets out proposals to improve openness and transparency around the Health & Wellbeing Board's work and asks the Board to approve them. It also builds on Board discussions around the CQC System Review and the Health & Wellbeing Strategy to propose a review of the terms of reference of the Health and Wellbeing Board (as is indicated in the current TOR), and secondly of the relationship between the Health & Wellbeing Board and the Accountable Care Partnership Board. This should be completed in time for discussion at the next public meeting in December 2018.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 Greater openness and transparency around the Board's work will increase democratic accountability to citizens of Sheffield. A review of the Board's membership, alongside a review of relationships between the Health & Wellbeing Board and the Accountable Care Partnership Board, will ensure that the right voices are round the table, and that the right governance arrangements are in place to support the improvement of health & wellbeing in Sheffield.

3.0 OPENNESS AND TRANSPARENCY

3.1 Since the Review of the Health & Wellbeing Board undertaken across the end of 2016 and start of 2017, the Board has had two formal public meetings per year, in March and September, with private, informal strategy development sessions scheduled for the remaining months of the year, excepting August.

3.2 Discussions within the Board since the finalising of that review, and externally, have raised concerns about the impact these changes have had on openness and transparency, and thus on democratic accountability.

3.3 These are legitimate concerns, though the benefits of the private strategy development sessions as a "safe space" for challenging discussions to take place are also acknowledged.

3.4 On balance, discussions have tipped in favour of greater openness and transparency, and with this in mind the following changes to meeting arrangements are proposed:

- Increase in frequency of formal public meetings from every six months to quarterly;
- Strategy development sessions to become open to the public;
- Agendas and minutes of strategy development sessions to be published; and

- Papers and presentations for strategy development sessions to remain private to ensure frank advice continues to be received.

3.5 It is suggested that these changes take effect immediately, and are incorporated formally into the Board's Terms of Reference at the next annual review of these.

4.0 HEALTH & WELLBEING BOARD AND ACCOUNTABLE CARE PARTNERSHIP BOARD

4.1 Following the publication of the NHS Five Year Forward View, additional structures have been created around the integration of NHS and social care services in Sheffield and the wider area, in the form of the South Yorkshire & Bassetlaw ICS, and the Sheffield Accountable Care Partnership.

4.2 As these developed, there were clear overlaps identified with the Health & Wellbeing Board's statutory duty to encourage integrated working between the NHS and social care. It was therefore important to ensure that the HWBB and ACP Board worked effectively together.

4.3 In response to this, it was agreed that that co-Chairs of the Health & Wellbeing Board should also be the co-Chairs of the Accountable Care Partnership Board, to ensure shared direction and commonality of purpose.

4.4 Concerns have been raised about this from a good governance point of view, particularly in the recent CQC System Review, and with reference to the Health & Wellbeing Board's role in holding the ACP to account for its work. It is proposed that this arrangement should be reviewed, as part of a wider review of governance around the ACP.

4.5 Concerns have also been raised about the comparative membership of the ACP Board and the Health Well-Being Board and whether this truly allowed the ACP Board to be held to account by the Health and Well Being Board in relation to the CQC Local System Plan, in the way that the CQC envisaged. In some cases, individuals on the Health and Well-Being Board report to colleagues on the ACP Board.

4.6 In addition, recent discussions at Health & Wellbeing Board strategy development sessions have raised concerns that not all the right voices are round the table for the discussions the Board wants to undertake.

4.7 In particular there is an absence of representation from place-focused services, an area the Board increasingly views as critical to improving the health and wellbeing of Sheffield, as reflected in the proposals for the refreshed Health & Wellbeing Strategy.

4.8 It may be beneficial to recruit members to the Board from this policy space. However this needs to be considered in light of:

- The Board's previously expressed desire to limit the number of members to better enable genuine discussion and debate;

- The Board's previous commitment to maintaining even membership between Sheffield City Council and NHS Sheffield Clinical Commissioning Group as a reflection of the Board's status as a partnership.

4.9 As a result, any decision to recruit additional members is not completely straightforward, as at the least it will require reconsideration of other areas of membership, and/or one of the Board's founding principles.

4.10 As a result it is suggested that there be a formal review of the Board's terms of reference over the remaining months of 2018, with recommendations to be presented to the December 2018 formal public meeting. This can be conducted alongside the review of ACP and HWB governance described above.

4.11 A first step of the review will be to survey all members of the HWB Board and ACP Board to get individual views on what improvements can be made.

4.12 Officers will also seek information from other health and care economies in the UK to understand different approaches to these governance questions and the relationship between the HWB and ACP.

5.0 RECOMMENDATIONS

5.1 The Board are asked to:

- Agree to the proposal to implement quarterly formal public meetings, open strategy development sessions to the public, and publish agendas and minutes of these sessions online
- Agree to participate in the governance review to ensure all views are considered.
- Agree to receive recommendations from reviews of ACP governance, and HWB membership, at their December 2018 formal public meeting

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 29 March 2018

PRESENT: Councillor Cate McDonald (Chair), Cabinet Member for Health and Social Care

Dr Tim Moorhead, Chair of the Clinical Commissioning Group

Dr Alan Billings, South Yorkshire Police and Crime Commissioner

Jayne Brown, Sheffield Health and Social Care Trust

Nicki Doherty, Director of Delivery Care out of Hospital, Clinical Commissioning Group

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

Greg Fell, Director of Public Health

Phil Holmes, Director of Adult Services, Sheffield City Council

Judy Robinson, Sheffield Healthwatch

Alison Knowles, Locality Director, NHS England

Clare Mappin, The Burton Street Foundation

John Mothersole, Chief Executive, Sheffield City Council

Professor Chris Newman, University of Sheffield

Dr David Throssell, Sheffield Teaching Hospitals NHS Foundation Trust

In Attendance:

Rebecca Joyce – Accountable Care Partnership Programme Director

Chief Superintendent Stuart Barton – South Yorkshire Police

Dr Anthony Gore – Woodseats Medical Centre

Ian Drayton – Partnership Manager, SOAR Community

Nicky Normington – NHS Sheffield CCG North Locality Manager

Helen Kay – Operations Director, Sheffield Teaching Hospitals NHS Foundation Trust

Sarah Burt – Interim Deputy Director of Delivery-Care out of Hospital, Clinical Commissioning Group

John Doyle – Director of Business Strategy, Sheffield City Council

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Jayne Ludlam, Dr Zak McMurray,

Professor Laura Serrent and Maddy Ruff.

2. DECLARATIONS OF INTEREST

There were no declarations of interest from members of the Health and Wellbeing Board.

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3. PUBLIC QUESTIONS

3.1 Public Questions from Save Our NHS

3.1.1 Mike Simpkin asked the following questions regarding the Health and Wellbeing Board, the Accountable Care Partnership and cuts to NHS Pharmacy budgets.

1) The Health and Wellbeing Board is the statutory lead for health strategy in the city. Why has it not met in public for nine months? Has it been holding meetings in private?

2) The paper entitled Better Care Fund Update, para 2.1 refers to the establishment of the Sheffield Accountable Care Partnership Board.

   a) What is the present and future status of the ACP Board?
   b) Who are its members?
   c) What powers does it or will it have, delegated or otherwise?
   d) If the ACP Board is a shadow board, what is it a shadow of?
   e) What is its relationship to the Health and Wellbeing Board and how does it differ?
   f) What is the relationship of the City Council to the Accountable Care Partnership Board?
   g) What is the relationship of the Accountable Care Partnership Board to the South Yorkshire and Bassetlaw Integrated Care System?
   h) Various promises have been made in Council and CCG meetings that the ACP board will begin to meet in public. When will this happen?

3) Have there been any effects in Sheffield of the 2017, 7.5% national cut to the NHS pharmacy budget? For example it was forecast that some pharmacies might no longer have sufficient staff to run the advice services which are essential components of local strategies such as the Primary Care Strategy while nationally large chains such as Lloyds have been closing practices. Did any Sheffield pharmacies qualify for special assistance? Have there been any pharmacy closures in Sheffield?

Mr Simpkin also asked an additional question-

4) What is the point of the Better Care Fund if it cannot prevent incidents like the threatened eviction of the long-term residents from Birch Avenue Care Home and disputes over eligibility and entitlement between the CCG and the Council? The

CCG's re-assessments of Continuing Care both residential and community-based have landed it in a lot of discredit.

3.1.3 Councillor Cate McDonald (Co-Chair) advised that not all meetings were held in public, it is stated in the terms of reference that the board would meet in public at least twice a year. It had been unfortunate recently that some of the meetings has been cancelled due to a range of reasons beyond control.

3.1.4 The Accountable Care Partnership Board was a partnership board with no statutory role. The members who sat on the board were Chairs and Chief Executives of the partners to the Sheffield ACP. This included Primary Care Sheffield, Sheffield City Council, Sheffield Clinical Commissioning Group, Sheffield Teaching Hospitals, leads from the Integrated Community Service, the Partnership Programme Director and the Director of Public Health. The Board had no powers, delegated or otherwise and was not a shadow board. Councillor Cate McDonald (Co-Chair) advised that the board has an aspiration to have a greater impact In the future.

3.1.5 The Accountable Care Partnership Board's relationship with the Health and Wellbeing Board was fluid and developmental at the moment. The board had a developing role alongside the other Boards. It was advised that more information would be available once the findings from a recent CQC review were known. Regarding the Board's relationship with the City Council; the City Council was a member of the Board.

3.1.6 The Accountable Care Partnership Board's relationship with the South Yorkshire and Bassetlaw Integrated Care System was that both were partners of the NHS. The ACP Board had a focus on Place and what was happening at a local level.

3.1.7 Councillor Cate McDonald (Co-Chair) confirmed that a meeting of the ACP board had taken place today and it had been agreed at this meeting that the Board to meet in public on a quarterly basis. Agenda's and minutes for the meeting will be published online. Rebecca Joyce, Accountable Care Partnership Programme Director expected that the next public meeting of the Board would be held at the end of June.

3.1.8 With regards to the question on national cuts to the NHS Pharmacy budget, it was confirmed that there had been no closures of pharmacies in Sheffield and there was no indication of any impact upon pharmacies in Sheffield. It was advised that just recently two additional pharmacy licences had been granted in Sheffield.

3.1.9 In relation to the final question, Councillor Cate McDonald (Co-Chair) advised that the Better Care Fund was an ongoing programme; there was an item on the agenda which included a presentation around the Better Care Fund which may provide answers to the question if Mr Simpkin wished to remain in the meeting for this item.

Nicki Doherty, Director of Delivery – Care out of Hospital did however advise that the presentation only covered an element of the Better Care Fund and may not cover the information that Mr Simpkin sought.

Phil Holmes, Director of Adult Services recognised the challenges around Birch Avenue Care Home, but felt that arguments between the Council and CCG would not contribute to resolving this

Dr Tim Moorhead advised that members of the Health and Wellbeing Board were unable to provide a full answer to the question around the Better Care Fund and the closure of Birch Avenue Care Home at the meeting, so a full written response would be provided to Mr Simpkin in due course.

4. PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, Sheffield City Council which provided a background summary of the Pharmaceutical Needs Assessment (PNA) for 2018-2021.

The PNA was an assessment of the need for pharmaceutical services for a specific population and was the tool by which the Health and Wellbeing Board ensured people had access to the right NHS pharmaceutical services, at the right time, in the right place.

The main findings of the PNA for 2018-2021 were Sheffield was well- served by its pharmacies and dispensing doctors with good coverage and choice across the different areas of the City, with good availability and access arrangements, including out of hours, high levels of patient satisfaction and no gaps in provision.

Pharmacies in the City had good links with NHS services both in relation to primary care and acute hospital services. However it was recognised there was potential to develop this much further, particularly in the context of developing integrated primary care services.

Jayne Brown, Sheffield Health and Social Care Trust found the document very comprehensive, and asked if it was felt we were doing enough to support pharmacies?

Greg Fell, Director of Public Health, Sheffield City Council advised that pharmacists were very skilled and carried out an enormous range of services, but there was always more that could be done.

Local pharmacies were already contributing extensively to raising awareness and understanding of health risks, promoting healthy lifestyles, providing advice and signposting to treatment and providing services, often in more accessible and acceptable settings.

Councillor Jackie Drayton felt encouraged by the community pharmacies being innovative in supporting Children and Young People and the Sexual Health Services.

The Board were advised that demographic and cost pressures from patients with long-term conditions was only likely to increase in the coming years and pharmacy's continued role in helping to meet the need was acknowledged.

Future known developments were unlikely to generate significant need for additional provision over the lifetime of the PNA.

RESOLVED that the board;

1) approve the Pharmaceutical Needs Assessment 2018-2021 and;

2) agree that the Pharmaceutical Needs Assessment 2018-2021 be published on the Council's website by 1st April 2018 together with a map of pharmacies in Sheffield.

5. PRIMARY CARE STRATEGY

The Board considered a report of the Director of Delivery Care out of Hospital on the Primary Care Strategy for Sheffield.

A presentation was also provided to the Board which gave an overview of the strategy and what had been achieved; the presentation also outlined the achievements so far and what was hoped for the future.

It was imperative that the strategy for primary care was of a consistent standard and quality was engaging and be accessible to anyone, regardless of their social circumstances and it would offer the same level of service to people with mental ill health and disability as was available to the rest of the population.

Creating better equality in health outcomes for people living in Sheffield would mean improving how people manage their own health and ill health and make sure they had equal access to the support needed, regardless of their social circumstances.

Dr Anthony Gore, Woodseats Medical Centre and Nicky Normington, NHS Sheffield CCG North Locality Manager advised that a lot of work was going on out in the community about embedding resilience into practices and upskilling practice managers.

Nicky spoke of getting GP's to work collaboratively to share space and services to ensure that patients received the same services at all practices in the City. GP's had worked with children to create a new superhero to combat people not turning up for their GP appointments called 'DNA Man'. Chapelgreen GP Practice had worked with Ecclesfield School to create the superhero figurehead for the campaign which was now being rolled out across their neighbouring practices.

The Board were advised that when people do not turn up for GP appointments it costs the NHS money and drives up waiting times for other patients. All practices had problems with people not attending appointments from time to time, so sharing the DNA Man campaign to tackle these challenges together would save money.

Nicky advised the Board that they were working hard to try and pull in the bigger services; however patient input didn't seem to be there especially in the North of the City.

Greg Fell, Director of Public Health, Sheffield City Council asked how staff would know when the practices were at a point where they were satisfied with the services provided to patients and what were the deal breakers?

In response it was advised that the practices had started pooling resources and the next steps were to input this into the daily working of the GP's. A sense of achievement would be felt when the patients accessed the most services and when staff said it felt better and the services provided appeared more joined up.

Alison Knowles, Locality Director, NHS England asked if it was a plan for staff to have the same localities?

In response it was advised that stronger relationships were needed through more work with mental health workers, social workers and health workers and also links needed to be made with the Police. The work taking place was about improving services, not trying to align boundaries.

Dr Alan Billings, Police and Crime Commissioner commented that the police would welcome more regular discussions with the CCG going forward with regards to more collaborative work between health professionals and the police. It was advised that the police were trying to get back to more community policing and hopes that links can be made.

The Police had buildings that could be utilised by different services and this could form part of the discussions for collaborative working going forward.

Nicki Doherty, Director of Care-Out of Hospital advised of the Strategic Estate Group, on which it was suggested that the Police be involved in.

Councillor Jackie Drayton commented that the strategy was very adult focussed and this could be a good opportunity going forward to establish links with other services such as Sexual Health Services and Domestic Violence Services.

Councillor Drayton also asked what the strategy could do to ensure people were visiting the doctors.

In response Dr Tim Moorhead advised that practices were raising the same issues and these needed to be addressed closely with the ACP.

Practices were seeing mainly children and the elderly, with a priority to see children on the day. Addressing patients' needs in different areas needed to be done sensitively and dealt with by teams.

Councillor Cate McDonald (Co-Chair) summarised the discussion and felt that the strategy was going in the right direction, but there was still a lot of work to do. Primary Care was central to the transformation of the NHS and inequality needed to be addressed in practice and across the board.

RESOLVED; that the board notes the primary care strategy update and presentation.

6. BETTER CARE FUND UPDATE

The Board considered a report of the Director of Delivery Care out of Hospital on the progress and challenges of the Better Care fund and its future strategic objectives.

A presentation was also provided to explain what had been achieved, how it feels now in Community Services and what was hoped for in the future.

The Better Care Fund was a term to describe the pooling of health and care commissioning budgets across Sheffield Clinical Commissioning Group and Sheffield City Council and had been in operation for over three years.

It was the key enabler to bring about parts of the transformation of the NHS, the Local Authority and local communities via Shaping and Sharing Sheffield as articulated in the Sheffield Place Based Plan.

The Better Care Fund covered transformational programmes and business in the following workstreams;

- People Keeping Well;
- Active Support and Recovery;
- Ongoing Care;
- Independent Living Solutions;
- Mental Health;
- Urgent Inpatient Admissions;
- Disabilities Grant.

The Board were advised that the funding received in Sheffield to buy services had flat lined and cut, so it was increasingly difficult to buy all the services needed for the increase in demand. The CCG and SCC looked at what was currently spent and found that there was a lot of duplication across the services that were commissioned, if this was done jointly it could reduce the duplication. There was emerging evidence that it would be better to shift some funding which was spent on unnecessary high cost care and better use it on preventing people or reducing the need for high cost care.

People of Sheffield had also said that they wanted more joined up care, wished to be more in control of their care and did not want to be in hospital unnecessarily.

Sarah Burt, Interim Deputy Director of Delivery - Care Outside of Hospital, Sheffield CCG and Helen Kay, Operations Director, Sheffield Teaching Hospitals NHS Foundation Trust outlined some of the achievements through the Better Care Fund.

There had been a development of a new model for wound care in communities with collaborative working with the community nurses, tissue viability experts, primary care representatives and CCG colleagues to use local patient and staff experience and national guidance to design a model which would provide a more effective and sustainable model of care.

The Active Recovery Service which had both admissions avoidance and facilitated return to home function was currently undergoing a redesign process. The service had, had a separate health and local authority employed support worker workforce for many years, with the local authority team taking over from health once patients were at the point of just needing the usual treatment care.

It was recognised that this caused duplication and handovers which were unnecessary and difficult for elderly people, and over the past nine months the project team were working hand in hand from the consultation phase to arranging workshops and meetings to develop the recommendations for change and begin implementation.

The creation of a multidisciplinary community hub, to enable simple referrals to extra support if needed after discharge from hospital, was being discussed.

Elsewhere in the city a huge amount of work was ongoing to support person centred care planning. There were strong links with social prescribing services in practices, and in some areas of the city the health and wellbeing partnerships were providing a good range of services which primary care could directly access or access via social prescribing signposting.

Other targeted work going on in the Community was the ‘Okay to Stay’ and ‘Virtual Ward’ which helped people with long term conditions stay safely at home.

In addition to what was expected of the local authority and CCG, the services worked within a very challenging financial situation and the populations needs were increasing, so the aim was to utilise all the resources better and smarter and shift the focus on avoiding or reducing high cost care by doing much more, closer to or in people’s communities/homes.

There was a consensus amongst the board members that the programme needed to be improved and the Board should set out more clearly what it expects of the Better Care Fund. Dr Tim Moorhead advised that moving money was difficult, so

it would not be easy to set a target on this, wider conversations would be needed around what budgets were set for different services and reflect on how the money was being spent.

Councillor Cate McDonald (Co-Chair) suggested that the points raised in today's discussion be taken forward to a further meeting to be arranged, after the feedback from the recent CQC review was available.

RESOLVED that the board;

1) discussed the opportunities for 2018/19 and noted the progress so far;
2) requests that the points raised be included in discussions at a further meeting to be arranged, after the feedback from the recent CQC review was available; and
3) agrees to receive a further report in November 2018.

7. MINUTES OF THE PREVIOUS MEETING

It was RESOLVED that the minutes of the meeting of the Board held on 27 July 2017 be approved as a correct record.

8. DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Wellbeing Board would be held on Thursday 27 September 2018, starting at 3.00pm.

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