Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 26 September 2019 at 3.00 pm

Conference Room, Town Hall, Sheffield City Council

The Press and Public are Welcome to Attend

Membership

Chief Superintendent Stuart Barton	South Yorkshire Police
Dr Nikki Bates	Governing Body Member, Clinical Commissioning Group
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
Jane Ginniver	
Phil Holmes	Director of Adult Services, Sheffield City Council
Dr Terry Hudsen	NHS Sheffield CCG
David Hughes	Sheffield Teaching Hospitals NHS Foundation Trust
Alison Knowles	Locality Director, NHS England
Councillor George Lindars-Hammond	Cabinet Member for Health and Social Care

Sheffield City Council

Laraine Manley	Executive Director, Place
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
Judy Robinson	Chair, Healthwatch Sheffield
Councillor Paul Wood	Cabinet Member for Neighbourhoods and Community Safety

Sheffield City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

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

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

Sheffield's Health and Wellbeing Board has a website which tells you more about what we do. http://www.sheffield.gov.uk/home/public-health/health-wellbeing-board

PUBLIC ACCESS TO THE MEETING

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

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

If you require any further information please contact Abby Brownsword on 0114 273 5033 or email abby.brownsword@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

26 SEPTEMBER 2019

Order of Business

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:	Greg Fell
Date:	26th September 2019
Subject:	Towards an intelligence-led End of Life strategy for Sheffield
Author of Report:	Eleanor Rutter 07917 240200

Summary:

Questions for the Health and Wellbeing Board:

- Does the Health and Wellbeing Board accept that a comprehensive end of life approach, including community and civic elements is most likely to deliver best outcomes for Sheffield? If so, would the Board sponsor a workshop to consider whether Sheffield should become a 'Compassionate City' and how best to progress that?
- How will the Board help to engage and enable leaders from within communities and neighbourhoods?
- Can Board members give their individual organisational commitment to an integrated intelligence function to deliver this work?
- Does the Board support further development of a strategy based on the six national ambitions with the addition of a dynamic intelligence core?

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

Ageing and Dying Well: Everyone in Sheffield lives the end of their life with dignity in the place of their choice.

Who has contributed to this paper?

Dr Sam Kyerematen – St Luke's Hospice

Dr Anthony Gore – Sheffield CCG

John Soady – Sheffield City Council, Public Health

Louise Brewins – Sheffield City Council, Public Health

Towards an intelligence-led End of Life strategy for Sheffield

1.0 SUMMARY

This paper describes the importance of taking a holistic approach to the 'end of life' for all of Sheffield's citizens as opposed to a more narrow, medical view of 'end of life care'. Rather than discussing medical causes of death it explores the common elements of any life coming to an end. As such it suggests that if all people affected by a death are to have their physical, psychological, social and spiritual needs met in the most cost-effective way possible we must develop and integrate our specialist and generalist palliative care services alongside compassionate communities and a civic approach to support and improve the end of life experience.

The paper highlights how many important questions regarding the end of life are currently unanswerable in spite of the considerable time and effort put into collecting data in different organisations nationally and across the city. It describes how close we are to completing a comprehensive, joined up approach to intelligence which can drive forward the change that is needed in this area.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

Everybody dies regardless of social class, ethnicity, sexuality or any other defining characteristic. Not everybody can expect to have their needs met optimally by the current system in Sheffield. There is a mounting body of evidence that suggests that access to appropriate support at the end of life is dependent on clinical diagnosis, age, social class and ethnicity amongst other things. Not enough is yet understood about those inequalities in Sheffield.

By taking an intelligence-led approach to the change suggested in this paper, we will be better able to understand the inequities in the current system and how we can focus our efforts on reducing them.

Towards an intelligence-led End of Life strategy for Sheffield

1. Introduction

In December of 2018 Sheffield's Health and Wellbeing Board (H&WB) signed up to nine ambitions in its revised strategy. One of those ambitions was to ensure that everyone in Sheffield could live the end of their life with dignity in the place of their choice. This paper starts to explore how we might achieve that ambition. It focuses particularly on the concept of the 'end of life' (as opposed to 'end of life care'), includes the importance of that not just to the dying person, but to all of those involved and left behind, and describes how we might develop and use high-quality intelligence to transform Sheffield into a place where everyone involved in a death has the best possible experience.

1.1. What is the End of Life?

Around 1% of the population die each year. In Sheffield, in 2017, that equated to 4,991 people. Of equal importance to this paper is the fact that in excess of 577,789 Sheffield residents are on a pathway to death at any given time.

It could be said that dying is easy, "simply an out-breath … and no more in-breaths"[1] – the challenge comes in what happens around the terminal breath: in the time before and after that breath, and as experienced by the people around the dying person.

Whilst each death is unique, all have common factors. A better understanding of those common factors can help us to prepare optimally in order to get the best possible outcomes for individuals, the bereaved, care staff and the city.

1.2. What it isn't

Death is an emotive subject. The term 'End of Life' is likely to conjure up a clear image for most people: a palliative care nurse, a 'do not resuscitate' order or the death of a high-profile celebrity. The volume of charitable activity in relation to the end of life is testimony to how strongly people feel (but may also indicate how hard people find it to understand or deal with their own emotions in this area, preferring to channel their distress into something that feels positive).

These are all important elements of our current end of life care system, but do not encompass a whole-population approach to the end of life and can offer an unhelpful narrative by either conjuring up a complex, highly-medicalised image of the end of life or a sanitised version which fails to acknowledge and therefore prepare for some of the more challenging aspects.

2. Background

2.1. What we know

Many discussions about the end of life include a description of causes of death. This paper intentionally avoids that approach, as describing pathology can often, perhaps inevitably, draw the

[1] Sarah Malik. Specialist Information and Support Nurse. Haematology, Oncology, hospice care and helpline nursing.

reader into a medical model of thinking. That is not to deny the importance of medical interventions in some deaths, but if we are to develop a city-wide approach to preparing optimally for the end of every life, it is important to understand firstly the type of needs that arise around the 'edges' of that single, terminal breath.

2.1.1. The 'Edges'

The edges of a death can be viewed as having two dimensions; one is human, the other, time.

In the case of a predictable death, it can be seen clearly that a dying person will have physical, psychological, spiritual and social needs which all end at the point of death. What is less well documented is that there are layers of people around the dying person who will have similar needs which also continue in the immediate aftermath of the death and potentially, well into the future.

How great those needs are and how well they are met will determine the overall impact on the individual, the bereaved, the wider community, professional care staff and society. If that impact is the best possible, we can move beyond something which may be considered to be a good death to making Sheffield a good place to die.

2.1.2. Types of death

Whilst the cause of death can contribute to the experience of dying, it is perhaps more helpful to think of deaths within a few important categories:

- Sudden or predicted
- Adults, children or perinatal
- Physiological, pathological or traumatic (i.e. due to old-age, premature (and preventable) causes or accidents)

2.2. What is the problem?

2.2.1. The triple gap

The myriad of challenges currently facing the health and social care system are often characterised according to three, key gaps, namely: gaps between available and required financial resource, best possible health and wellbeing outcomes and those currently experienced and consistent, gold-standard care quality and the variable standards currently delivered. Nowhere exemplifies these three gaps better than the current end of life care system.

Whilst many people do have a good experience of death in Sheffield, some do not. Sometimes people's final stage of life is not lived in a way they may have hoped; that can often involve multiple hospital admissions in the twelve months before death. This puts them in one of the most expensive parts of the system where it can be most difficult to meet their needs, particularly social, psychological and spiritual. In 2017/18 there were 2,748 people on primary care, palliative care registers in Sheffield who experienced a total of 2,678 A&E attendances and 2,884 potentially avoidable hospital admissions, with an associated cost of £9.5m.This is not a financially sustainable model of care and the growing population only serves to increase that pressure.

Anecdotal evidence suggests that that some groups of people get a better experience of care and support at the end of life than others. This avoidable gap represents an inequality in both quality and sometimes even quantity of life.

Examples of poor care at the end of life are too common. People in Sheffield are not guaranteed to get the best possible experience. This can take many forms; one prominent example is the recent CQC report of care for older people which raised as an issue the poor integration of services to support people at the end of life. In addition to variation of quality within our current model of care, questions are being raised in the professional community about our fundamental approach to end of life care. 'Over-medicalisation' cannot only affect the quality of the end of a life detrimentally, it can actually shorten life and, perhaps more importantly, hide death away inside institutions thus removing the essential learning experience from the wider community that death is a normal part of life.

2.2.2. Leadership

There is great energy for change in Sheffield. Leadership, so far has tended to come from people working in the specialist, palliative care area, perhaps a reflection of the fact that it is they who are most comfortable talking about the end of life and how that might best be supported across the city.

The effort that has brought us to this place is immense. We must guard against discounting that because of the part of the system from where it has come. We have preconceived ideas about a 'spectrum' of care from community-based, self-care, through social care support and primary, medical care to specialist, bed-based, palliative care. It is easy to attach to that 'spectrum' the labels 'good and cheap' at one end and 'bad and expensive' at the other.

A city that offers a good end of life experience to all has no spectrum, but a fully integrated model (see figure 1 below) which recognises that different people will require different support and ensures their needs are appropriately met.

That said, if our aim is to enhance, support and integrate the more specialist services, with our community structures we need to identify experience and leaders from within communities and help them to engage others more broadly with the process and experience of dying. It could be suggested that the absence of community leaders from this current collaboration might indicate an absence of such people, but the volume of charitable activity that happens in this area would suggest that is not case. What is more likely is that our current medical-model of dying, and 'top-

down' approach to bringing about change, is excluding experienced and passionate leaders from within our communities.

2.2.3. The bereavement journey

Bereavement is associated with worse physical and mental health outcomes and increased use of medical services. Estimates in Scotland suggested it could add £23.3m per year in additional hospital bed days alone[2] and yet the primary need (often depression and loneliness) could better be described as failures in social support systems. Loss, the stresses and strains of caring and 'compassion fatigue' do not affect only one, key person, nor do they only begin at the time of death. The experience of caring and circumstances of a death can either worsen or mitigate the impact of suffering a bereavement.

Unlike death, which occurs only once, loss and bereavement is something most people experience multiple times in a lifetime. A good experience is not just a worthwhile end in itself, but prepares an individual for subsequent occasions and ultimately their own death.

In Sheffield, not enough is known about the experience of care and loss at the end of life and anecdote suggests too many people are impacted more negatively than would be the case if communities were better supported.

2.2.4. Over medicalisation

Many examples of really good end of life experiences come from hospices. That has led us, perhaps understandably, to assume that the frequency of poor care would lessen if more people had access to specialist palliative and/or hospice-based care.

Whilst all people need to have their physical, social, psychological and spiritual needs met as they approach the end of their lives, all people do not necessarily need a doctor, a specialist team or an in-patient bed in order to do that. The origin of even the best palliative care is from within our medical system and thus is built on a medical model of need. There is always a risk, therefore that medical solutions will be sought to problems which may potentially have different, and more effective, social solutions. Our increasingly medical approach to death has, over recent years moved it into medical spaces. This has itself had a negative impact by hiding death away, removing its 'normality' and making it something people don't understand. In turn people 'miss out' on the learning experience of watching elderly grandparents, family friends and perhaps neighbours die; all helpful preparation for when death comes even closer to them.

2.2.5. Intelligence

Strategic planning within the end of life system in Sheffield could be described as 'data rich, but intelligence poor'. That represents a 'lose-lose' situation whereby staff in single organisations can spend a great deal of time and energy collecting data, whilst at the same time system leaders are not able to answer the most basic questions, which are essential if the system is to be transformed. For example:

[2] Stephen AI, Macduff C, Petrie DJ, et al. The economic cost of bereavement in Scotland. Death stud 2015; 39: 151-7.

- How many people in Sheffield have a good death?
- Who gets a good death and is that fair?
- Could death be better if services were structured differently or if society viewed it differently?
- Can we make dying more cost-effective?
- What happens to those left behind after death?

These questions need to be answered if appropriate change is to be made. That requires appropriate resource to be committed to turning data into intelligence and in turn, high-quality decision making.

3. Where are we now?

3.1. National ambitions

The National Palliative and End of Life Care Partnership is a group of national organisations with experience of, and responsibility for, end of life care. They set out six national ambitions which formed a framework for local action to improve palliative and end of life care between 2015 and 2020.

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

These are unchallengeable in their intent and were signed up to by the H&WB as part of the refreshed strategy in December 2018. The next step is to make them a reality across Sheffield.

3.2. Good work in single organisations

Exemplary care can be found across Sheffield in health and social care, the voluntary sector and in private homes. Examples include the receipt of the Royal College of Nursing Emergency Nursing Award for 2019, by STHFT's Emergency Department End of Life Team and the success of St Luke's EnComPaSS project in which new technology based models of care were used by the community palliative care service resulting in over 800 fewer A&E admissions and 8,700 hospital bed days for end of life patients in Sheffield.

Improving care at the end of life is the subject of internal improvement plans in many Sheffield organisations which can only be a good thing. However, if we are to optimise the end of life experience for all of Sheffield's citizens care must be taken to ensure those organisations' plans are fully aligned to an integrated direction of travel across the city.

3.3. Integrated Care System (ICS) support

Within the South Yorkshire and Bassetlaw (SY&B) ICS the importance of improving care at the end of life in a consistent and cost-effective way that also prepares for the anticipated demographic increase in end of life need is recognised. The need to understand and address place based and regional variations, develop shared standards and best practice, and leverage shared resources has been acknowledged in a commitment to end of life care for citizens of all ages, dying from all causes in SY&B.

It is recognised that the solution lies not in a single, region-wide delivery plan, service or mandate, but in the synergistic development and implementation of place based end of life strategies. This recognises the strength of supporting development at place level against agreed ICS and national standards and sharing resources where appropriate. The aspiration to share best practice includes approaches to shared records and intelligence in which Sheffield is recognised to be a regional and potential, national leader.

3.4. Accountable Care Partnership (ACP) End of Life strategic group

Built out of recognition that we need to work in partnership to deliver better integrated care services for people at the end of their lives, this group brought together Sheffield Clinical Commissioning Group (SCCG), St. Luke's Hospice and Sheffield Teaching Hospitals NHS Foundation Trust (STHFT). Some good foundations have been laid, and four local priorities identified:

- Commitment to deliver high-quality end of life care to anyone affected by terminal illness in Sheffield in the last few months of life.
- Commitment to deliver high quality services which are continually monitored to improve care to enable as comfortable, dignified and individualised an experience as possible.
- Promotion of better end of life care through the culture that care of the dying is everyone's responsibility.
- Providing the skills and tools to enable staff to deliver high quality end of life care.

However, driven by experience rather than intelligence, its aims are neither broad nor ambitious enough to deliver the transformational change needed in Sheffield.

3.5. Data and analytics

Very significant added value is available from being able to link data from different organisations' care records to aid our understanding of personal, social and care needs as the end of life approaches. Arrangements are already in place to do this and we are on the cusp of completing the exercise. In this arrangement data from the care records of individual patients from all the statutory

organisations in the city involved in providing care at the end of life are being collated centrally (at SCCG) in such a way that the records can be linked, anonymously, in any combination. This comprises care record data from STHFT, St Luke's, primary care and social care. It will enable a level of analytical sophistication and detail that has not previously been available and indeed, not achieved elsewhere. This, of course, will be limited to a degree by the extent and quality of information available from care records; so some important questions, for example concerning the 'experience' of dying, would necessitate the collection of additional data not presently recorded.

Due to information governance and legal considerations, there are some constraints on how and the extent to which individual organisations can contribute to the analytical effort; some organisations may be restricted to handling only aggregate data rather than at the level of the individual. However, the data sharing permissions we have in place include the two Sheffield universities, so a collaborative approach across partners offers some unprecedented possibilities in this sphere.

3.6. Transformational change

In summary, Sheffield has the all the necessary components to bring about the transformational change that the people of Sheffield deserve. This is recognised by national leaders who have great expectations that Sheffield is able to lead the way in this important area. However, these components are not yet fully aligned and working to one, single, strategic agenda for the city.

4. Where do we want to get?

The change we need to see is about more than organisations working better together, it will require cultural change in both professionals and the citizens of Sheffield where success will drive greater ambition via the knock-on effect of 'normalising' the experience of approaching the end of life with greater confidence in homes and communities across the city.

Such ambitions cannot be realised overnight. Indeed it is hard to define exactly how long, a 'long-term' vision may take to realise. It is thus important that short and medium term aims are described in order that the immediate needs of people and organisations don't get overlooked.

4.1. Short term

Many people currently experience the best support Sheffield can offer at the end of life and experience what would be described as a good death, but that is not guaranteed across the board. Evidence suggest that non-cancer patients, ethnic minority community groups, older people and marginal groups (i.e. homeless populations) have less access to specialist palliative care services[3]. A short term priority must be to deliver access to good quality care equitably across Sheffield.

4.2. Medium term

Better integration of services and improvement of community care should go some way towards closing the triple gap described in 2.2.1 but medium term aims need to be met in a way consistent with longer term ones.

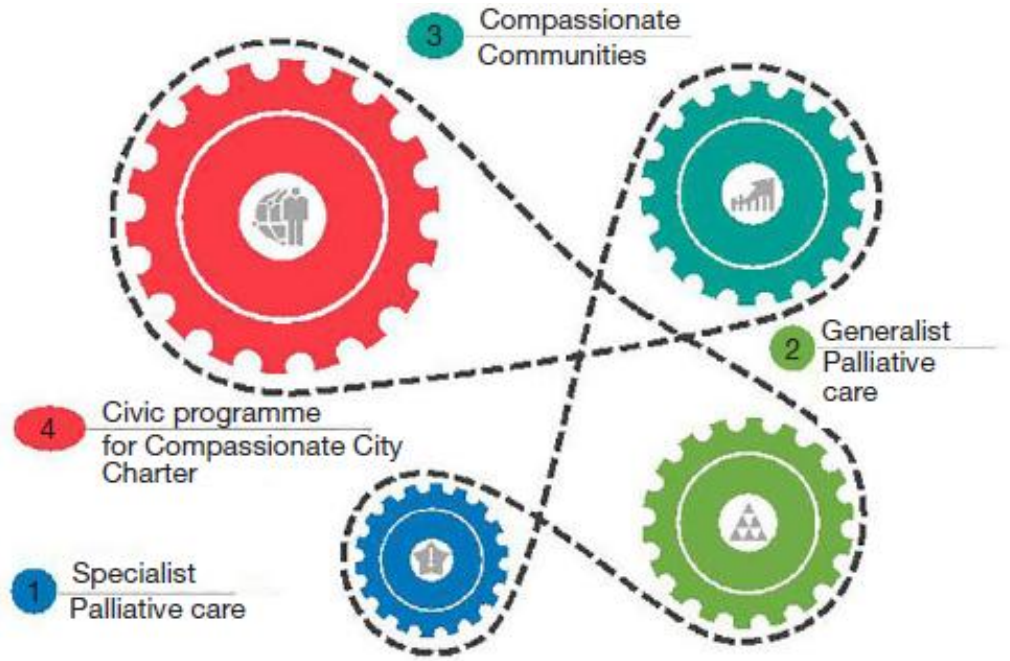
[3] Abel J, Kellehear A, Karapliagou A. Palliative Care – The New Essentials. Annals of Palliative Medicine 2018.

4.3. Long term

When we consider the multi-faceted nature of experience at the end of life, our long term ambition should be to go beyond focusing primarily on clinical care of terminal conditions (an approach that can lead to a reductionist focus on goals achievable within healthcare organisations) to a whole-city approach, aiming to meet people's needs holistically by bringing together effective elements within communities, civic institutions and clinical services.

This holistic approach to the end of life also enables the development of a model of practice that has the potential to support not only citizens affected by predictable terminal conditions (including extreme old age), but support more broadly, those affected by bereavement and sudden unpredictable death including deaths in maternity and children of all ages as well as transition.

Figure 1:



The model above represents an ambitious but achievable approach to supporting all people affected at the end of a life. The key to fulfilling the opportunities derived from this model are the integration of the processes and operations of its four components: Generalist Palliative Care, Specialist Palliative Care, Compassionate Communities and a civic approach to the end of life.

Compassionate Communities are naturally occurring networks of support in neighbourhoods and communities, surrounding those experiencing death, dying, caregiving, loss and bereavement.

The civic component of end-of-life care recognizes civic participation and co-operation from public sectors and institutions, as the basis upon which community care is based, and mobilises actions that support end-of-life care in public institutions. An example of a Charter of Actions for a Compassionate City is included at appendix 1.

Specialist and Generalist Palliative Care components of the model already form a recognised and valued part of end of life care delivery in Sheffield. However, the complexity of need and Generalist Palliative Care makes it difficult to describe absolutely the overlap between the two, and organise into concrete pathways and therapeutic practices. Given that access to Specialist Palliative Care is determined by referral from generalist services, these complexities potentially lead to inequity of access, which at present is hard to characterise and almost impossible to quantify. There needs to be a continuum of support between specialist, generalist, community and civic end-of-life care, so that support is offered at the most appropriate level and according to need.

There are many challenges in effectively implementing such a model: knowing to what extent the component parts play a role in supporting a good end of life experience in different contexts and understanding the impact, fairness and cost-effectiveness as we implement new practices form just a few. All however, illustrate the importance of system change being underpinned and driven by an ongoing, dynamic use of best available intelligence.

5. How do we get there?

5.1. Intelligence

We need to develop an intelligence (data) led approach to our work. This is because we need to be able to better understand and predict future end of life health and care needs, reduce health inequalities associated with the end of life and make better use of the resources available to us.

There are a number of datasets and data sources available to us in the city to support this work but they currently operate within individual organisational silos. We therefore need to be able to link these various data sets together. Linked data allows us to generate new insights at a system and population level. This facilitates development of interventions tailored to specific cohorts of people and specific types of outcomes. The key impacts of linked data are:

- Improved population level data about needs to drive planning and delivery of proactive care to achieve maximum impact.
- Segmentation and stratification modelling to identify local ‘at risk’ cohorts and to quantify effectiveness and cost effectiveness.
- Targeted interventions that improve outcomes for people and their families and reduce unwarranted variations in outcomes.

The IG and IT infrastructure and arrangements and appropriate workforce expertise exist locally to enable us to do this. Specifically though, with the support and endorsement of the H&WB, data sharing arrangements need to be maintained by relevant partners who also need to deploy elements of their IT and workforce to support this work.

5.2. Partnership

System-wide solutions are required, driven by population, rather than individual organisational, need. Thus it is imperative that we work in partnership to ensure our endeavours complement each

other, avoid duplication of our efforts and that our citizens experience seamless support to meet their physical, psychological, spiritual and social needs.

5.3. Whole city

Delivering this model would require engagement of partners well beyond the Health and Wellbeing Board including for example, workplaces, faith groups, recreational groups and the local media.

6. Questions for the board

- Does the Health and Wellbeing Board accept that a comprehensive end of life approach, including community and civic elements is most likely to deliver best outcomes for Sheffield? If so, would the Board sponsor a workshop to consider whether Sheffield should become a 'Compassionate City' and how best to progress that?

- How will the Board help to engage and enable leaders from within communities and neighbourhoods?

- Can Board members give their individual organisational commitment to an integrated intelligence function to deliver this work?

- Does the Board support further development of a strategy based on the six national ambitions with the addition of a dynamic intelligence core?

Appendix 1

THE COMPASSIONATE CITY [4]

- A CHARTER of ACTIONS -

Compassionate Cities are communities that recognize that all natural cycles of sickness and health, birth and death, and love and loss occur everyday within the orbits of its institutions and regular activities. A compassionate city is a community that recognizes that care for one another at times of crisis and loss is not simply a task solely for health and social services but is everyone's responsibility.

Compassionate Cities are communities that publicly encourage, facilitate, supports and celebrates care for one another during life's most testing moments and experiences, especially those pertaining to life-threatening and life-limiting illness, chronic disability, frail ageing and dementia, grief and bereavement, and the trials and burdens of long term care. Though local government strives to maintain and strengthen quality services for the most fragile and vulnerable in our midst, those persons are not the limits of our experience of fragility and vulnerability. Serious personal crises of illness, dying, death and loss may visit any us, at any time during the normal course our lives. A compassionate city is a community that squarely recognizes and addresses this social fact.

Through auspices of the Mayor's office a compassionate city will - by public marketing and advertising, by use of the cities network and influences, by dint of collaboration and co-operation, in partnership with social media and its own offices – develop and support the following 12 social changes to the cities key institutions and activities.

- Our schools will have annually reviewed policies or guidance documents for dying, death, loss and care

- Our workplaces will have annually reviewed policies or guidance documents for dying, death, loss and care

- Our trade unions will have annually reviewed policies or guidance documents for dying, death, loss and care

- Our churches and temples will have at least one dedicated group for end of life care support

- Our city's hospices and nursing homes will have a community development program involving local area citizens in end of life care activities and programs

- Our city's major museums and art galleries will hold annual exhibitions on the experiences of ageing, dying, death, loss or care

[4] From K.Wegleitner, K Heimerl, A. Kellehear (2016) Compassionate Communities: Case studies from Britain and Europe. Abingdon, Routledge, 2016, pp 80-82

- Our city will host an annual peacetime memorial parade representing the major sectors of human loss outside military campaigns – cancer, motor neuron disease, AIDS, child loss, suicide survivors, animal companion loss, widowhood, industrial and vehicle accidents, the loss of emergency workers and all end of life care personnel, etc.

- Our city will create an incentives scheme to celebrate and highlight the most creative compassionate organization, event, and individual/s. The scheme will take the form of an annual award administered by a committee drawn from the end of life care sector. A 'Mayors Prize' will recognize individual/s for that year those who most exemplify the city's values of compassionate care.

- Our city will publicly showcase, in print and in social media, our local government policies, services, funding opportunities, partnerships, and public events that address 'our compassionate concerns' with living with ageing, life-threatening and life-limiting illness, loss and bereavement, and long term caring. All end of life care-related services within the city limits will be encouraged to distribute this material or these web links including veterinarians and funeral organizations

- Our city will work with local social or print media to encourage an annual city-wide short story or art competition that helps raise awareness of ageing, dying, death, loss, or caring.

- All our compassionate policies and services, and in the policies and practices of our official compassionate partners and alliances, will demonstrate an understanding of how diversity shapes the experience of ageing, dying, death, loss and care – through ethnic, religious, gendered, and sexual identity and through the social experiences of poverty, inequality, and disenfranchisement.

- We will seek to encourage and to invite evidence that institutions for the homeless and the imprisoned have support plans in place for end of life care and loss and bereavement.

- Our city will establish and review these targets and goals in the first two years and thereafter will add one more sector annually to our action plans for a compassionate city – e.g. hospitals, further & higher education, charities, community & voluntary organizations, police & emergency services, and so on.

This charter represents a commitment by the city to embrace a view of health and wellbeing that embraces social empathy, reminding its inhabitants and all who would view us from beyond its borders that 'compassion' means to embrace mutual sharing. A city is not merely a place to work and access services but equally a place to enjoy support in the safety and protection of each other's company, even to the end of our days.

HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	John Macilwraith
Date:	26th September
Subject:	Autism Strategy Update
Author of Report:	Joel Hardwick

Summary:

Supporting autism should be considered as an area of all-age working.

A draft one year action plan for addressing the most urgent autism issues is in place.

The paper proposes a three step plan to address immediate issues and develop a more robust longer term plan.

Questions for the Health and Wellbeing Board:

1.1 Is this proposed plan appropriate?

1.2 Are there any areas of autism support that the Board wishes to flag to be considered as part of the action plan and spring review?

1.3 Are there any key changes would the Board like to see in Autism support over the next five years?

Recommendations for the Health and Wellbeing Board:

1.4 The proposed three step plan is approved by the Board.

1.5 A further update on this work area is presented in September 2020.

1.6 A member of the board is nominated as the key link for the Autism Partnership Board.

Background Papers:

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

- Every child achieves a level of development in their early years for the best start in life.
- Every child is included in their education and can access their local school.
- Everyone has access to a home that supports their health.
- Everyone has a fulfilling occupation and resources to support their needs.
- Everyone has equitable access to care and support shaped around them

Who has contributed to this paper?

Joel Hardwick

Dawn Walton

Sara Storey

AUTISM STRATEGY UPDATE

2.0 SUMMARY

2.1 Supporting autism should be considered as an area of all-age working.

2.2 A range of partners, including Sheffield City Council, the NHS, police, Department of Work & Pensions, the Universities, voluntary sector and others, must be involved in this area of work to ensure the greatest impact.

2.3 A draft one year action plan for addressing the most urgent autism issues is in place, and a Joint Strategic Needs Assessment has been completed recently.

2.4 The paper proposes a three step plan to address immediate issues and develop a more robust longer term plan for the development of an Autism strategy which aligns with other developments.

3.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

3.1 The one year action plan has been aimed at addressing urgent issues with supporting autism in Sheffield; this helps to address health inequalities.

4.0 MAIN BODY OF THE REPORT

4.1 An Autism Partnership Board is now in place with a broad range of organisations and those with lived experience. A children's focused group also exists, but this is solely for professionals.

4.2 Under the Partnership Board there is a draft one year action plan aimed at addressing the most urgent issues, this is linked to an Autism self-assessment undertaken by the Board.

4.3 A Joint Strategic Needs Assessment has recently been completed; this needs to be reviewed for implications for the Partnership Board.

4.4 There are a number of plans and strategies being developed or already in existence across the city. Any Autism Strategy would need to link effectively to these areas of work.

4.5 Examples of these plans and strategies include, the SEND & Inclusion Strategy (under development following the recent CQC/Ofsted Inspection), the all-age mental health strategy (under development), work being undertaken in the NHS to improve support for autism and wider developments such as the growth in retailers and football clubs taking steps to be more autism friendly.

4.6 In order to effectively develop work in this area, the following three step plan is proposed;

4.6.1 Autumn 2019: Complete the one year action plan under the Partnership Board and complete immediate actions, also review the recent Joint Strategic Needs Assessment and its implications.

4.6.2 Spring 2020: Review and take stock of other developments, such as the SEND & Inclusion Strategy, and gather cross-sector leaders to identify and propose a way forward.

4.6.3 Summer 2020: Develop a plan as agreed through the Spring 2020 review, this will potentially lead to the development of an Autism Strategy or a more robust longer term action plan.

5.0 WHAT NEEDS TO HAPPEN TO MAKE A DIFFERENCE IN THIS AREA?

5.1 Agreement through the Health and Wellbeing Board that the proposed way forward is the appropriate; this will provide officers with the mandate to approach this area in this way.

6.0 QUESTIONS FOR THE BOARD

6.1 Is this proposed plan appropriate?

6.2 Are there any areas of autism support that the Board wishes to flag to be considered as part of the action plan and spring review?

6.3 Are there any key changes would the Board like to see in Autism support over the next five years?

7.0 RECOMMENDATIONS

7.1 The proposed three step plan is approved by the Board.

7.2 A further update on this work area is presented in September 2020.

7.3 A member of the board is nominated as the key link for the Autism Partnership Board.

HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Jane Ginniver
Date:	17th September 2019
Subject:	Sheffield Accountable Care Partnership (ACP) Workforce Strategy
Author of Report:	Jane Ginniver

Summary:

This draft workforce strategy is presented for consultation prior to its planned presentation at the ACP Board for approval in October. Workforce has been identified by the ACP Board as its greatest priority, and we need to ensure that the implementation of this strategy drives the required changes across the system. This consultation period is therefore critical to ensure that all partners across Sheffield engage with and support the strategy, with the belief that it represents and addresses their workforce-related system priorities.

Questions for the Health and Wellbeing Board:

Does the Sheffield ACP Workforce Strategy cover all the most critical considerations around workforce for the city, either directly or through work with other bodies (eg the South Yorkshire and Bassetlaw ICS)?

Background Papers:

The Sheffield ACP Workforce Strategy

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

All aspects of the strategy

Who has contributed to this paper?

Staff and members of the public from across Sheffield have been involved in developing this strategy, from December 2018. The draft Workforce Strategy was available for consultation from 25th July to 6th September 2019. This was circulated widely for feedback to individuals and groups, including:

- those involved in workshops to develop the strategy
- members of partner executive or workforce-specific groups / committees
- staff-side union representatives
- the LMC
- members of ACP workstreams
- the ICS workforce hub

A large amount of feedback has been received, which was all constructive, overwhelmingly positive and in support of the strategy. Much of the feedback has been integrated within the revised strategy, which is attached to this paper.

Sheffield ACP Workforce Strategy

1.0 SUMMARY

1.1 This draft workforce strategy is presented for consultation prior to its planned presentation at the ACP Board for approval in October. Workforce has been identified by the ACP Board as its greatest priority, and we need to ensure that the implementation of this strategy drives the required changes across the system. This consultation period is therefore critical to ensure that all partners across Sheffield engage with and support the strategy, with the belief that it represents and addresses their workforce-related system priorities.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 This strategy is developed to underpin and enable the Shaping Sheffield Plan, which is driven by the need to address health inequalities in the city.

2.2 MAIN BODY OF THE REPORT

2.3 Extensive feedback through the formal consultation period has informed this version of the workforce strategy. The key feedback points made are highlighted in the table below.

Feedback:		**Changes Made:**
1.	That the importance of Primary **Care** as an ACP priority was not prominent enough within the document. In particular, while there are recruitment activities underway outside the Sheffield ACP that we do not want / need to duplicate, there is a requirement to ensure that we make Sheffield as attractive as possible for potential new recruits, to ensure that we maximise recruitment from the various initiatives underway elsewhere.	Incorporated an action around Primary Care into the 2019-20 priorities, specifically adding an action to develop a 'Brand Sheffield'; a shared narrative that all partners across the ACP are able to use to attract the best talent to Sheffield. The immediate priorities have also been re-drafted to be more operational with timescales attached.
		Added information about the Primary Care Strategy and the implications this will have on the Primary Care workforce.
2.	The priorities for 2019-20 were not specific enough around what we plan to do and when	Re-drafted all of these priorities to make more

	we plan to do it.	tangible.
3.	The parity of importance between children and adults was not appropriately represented.	Additional data on children has been sourced, and sections have been re-structured to follow a lifeline approach.
4.	The narrative often conflated the roles and contributions of Carers and volunteers.	Information about the Young Carers, Parent and Adult Carer Strategy has been included.
		Greater clarity has been provided to distinguish between Carers and volunteers.
5.	Feedback from various occupational groups, children, primary care and the voluntary sector that the strategy needed to be more specific about how it would support them.	Strengthened the wording in paragraph 5 to reinforce the concept that everything in this strategy is assumed to apply to all those who contribute to health and social care across Sheffield, and to capture that this is a whole workforce and cross system strategy. Particular groups / parts of the sector will only be mentioned by exception.
6.	Feedback that the themes outlined in Section Two should be re-ordered, as culture is critical in shaping the environment for all other actions to be successful.	Re-ordering of the themes within the implementation plan

3.0 QUESTIONS FOR THE BOARD

3.1 Does the Board feel that the amendments made to the strategy address the points raised?

3.2 Are there additional points that the Board feels need to be included in the strategy.

4.0 RECOMMENDATIONS

4.1 The Board is asked to support this system workforce strategy.

The Sheffield ACP Workforce Strategy:

Creating a flourishing and thriving Sheffield by developing our people in a joined up way to deliver holistic, person-centred and integrated care

2019-2024

Contents

1. Executive Summary & bring forward the importance of health inequalities

The workforce vision outlined in the Shaping Sheffield place-plan is *to create a flourishing and thriving Sheffield by developing our people in a joined up way to deliver holistic, person-centred and integrated care*'.

This workforce strategy seeks to identify how we will do this and where a place-based approach will have greatest impact. It should complement workforce strategies and plans at organisational, South Yorkshire and Bassetlaw Integrated Care System (ICS), regional and national levels.

Shaping Sheffield articulates our ambition to transform our population's health, care and well-being, improving outcomes for the people of all ages of Sheffield in the context of the inequitable distribution of poor health and wellbeing across the city. The implementation of this system workforce and development strategy will contribute directly to the vision of providing *prevention, well-being and great care together.*

Through a number of staff and public consultation events, 7 key priorities have emerged:

i. Culture
ii. Person-centred approaches
iii. Staff Wellbeing
iv. Valuing the Unpaid Workforce
v. New Ways of Working
vi. Recruitment and retention
vii. Learning and Development

Section One of this strategy describes the approach taken in its development; its interdependencies; the national, regional and local contexts; exclusions from the strategy; governance and next steps. Section Two is the implementation plan, which upon approval of the strategy from both ACP Board and Health and Wellbeing Board, will be developed into further detail concurrently with implementing the identified priorities for 2019-20.

These identified priorities are:

i. There is a national and international shortage of staff across almost all professions in the sector. The development of Primary Care Networks and the new roles being employed within them will exacerbate this problem. While there is work being undertaken nationally, across the ICS and in our universities to increase training places and student numbers, this will not be enough to address the full scale of the problem. We need to develop a strong 'Brand Sheffield' that is consistent across the ACP to promote the benefits of living and working in the city, with the intention of attracting new recruits to work here. This will be completed and in use by March 2020.

ii. Developing a person-centred city is central to the Shaping Sheffield strategy. We will develop a set of organisation development approaches to embed this way of working in our

frontline staff. This will focus on the practical application of the 'what matters to you'[1] approach, bringing together staff from across the system and embedding other key messages identified in this strategy and within Shaping Sheffield (such as the integration of physical and mental health, children's and adults). This development will be implemented by March 2020.

iii. Care home staff have the potential to make a significant contribution to reducing the numbers of urgent admissions to hospital. There are currently numerous pockets of support being targeted at care homes, running the risk of overburdening an already stretched workforce and forcing them to disengage from the wider system. We will pull all of this activity into a co-ordinated package of support for this section of our workforce by the end of December 2019.

iv. The impact of leadership and culture on our workforce cannot be under estimated. We will develop a strong community of capable, resilient leaders across the city and within Primary Care Networks, who are able to lead within and on behalf of organisations, systems and places. To do this, we will implement and embed system leadership and organisation development programmes to ensure that our workforce is motivated, empowered, capable and confident to provide '*prevention, well-being and great care together*'. This will include;

    a. further cohorts of 'Leading Sheffield', and

    b. the extension of 'Collaborate' across other Primary Care Networks, with the intention of coverage across at least 6 PCNs by December 2020

    c. the development of an ACP leadership community during 2020, bringing 'alumni' from multiple leadership programmes together to continue their development and to enable their contribution to strategic system priorities

v. There is a disparity in staff access across the system to good quality development – those employed by the large statutory organisations benefit from extensive organisational development programmes whereas those working in primary care, the voluntary sector, independent care homes or as Personal Assistants, do not have access to this level of support. The apprenticeship levy is one source of funding that will help to redistribute some of this development support across the system, and our statutory organisations will lose access to significant unspent apprenticeship levy monies in 2020. We will explore options for 'gifting' this to primary care, the voluntary sector etc to enable them to invest in staff development. An agreed process for developing this will be in place and widely communicated by March 2020, with the first apprenticeships in post by September 2020.

[1] https://www.whatmatterstoyou.scot/

2. Introduction

The health and social care sector in the UK is experiencing considerable turbulence, and this pace of change is unlikely to reduce within our context of political turmoil, a national and global ageing and growing population and increasing inequalities. This places pressure on our workforce, which is not growing to keep pace with demand. Place these issues alongside peoples' changing expectations from work; flexibility in hours, how and where work takes place and the type of work being completed; digital solutions which match the functionality they enjoy at home and reduced formalities and hierarchies; it is clear that our systems and structures are under pressure.

There is no expectation that additional funding will come into the system, and with parts of the sector already under serious pressure to break even, we need to start to work differently to ease the pressures of the system and of our workforce. A focus on prevention, moving care closer to a person's usual place of residence and developing a different psychological contract between the public and the sector, with person-centred approaches at its core, is critical. The impact this will have on our workforce though must not be underestimated; increasingly complex needs will be cared for out-of-hospital, staff will need to change the way they work and develop new skills and specialists will need to develop generalist approaches to support the growing number of people with multi-morbidities.

The Shaping Sheffield Plan (paragraph 10.3) outlines our commitment to our workforce and our vision. All ACP partners agree that a focus on workforce is currently our greatest priority, and critical if we are to achieve sustainable transformational change to address the challenges outlined above. This is consistent with messages contained within the NHS Long Term Plan and the NHS Interim People Plan. It is widely expected that the Social Care Green Paper will also have a focus on workforce and new models of care when it is published.

This strategy outlines the scale of the challenges facing our workforce and identifies the priorities that we will implement across the Sheffield Accountable Care Partnership. These priorities are designed to complement, not duplicate, workforce activity undertaken at organisational, ICS, regional and national level, thus ensuring that activity is scaled appropriately and that all sections of our workforce receive the support and focus required to achieve our vision.

3. Our Vision

To create a flourishing and thriving Sheffield by developing our people in a joined up way to deliver holistic, person-centred and integrated care'.

Sheffield's ACP partners employ a combined total of more than 38,000 staff – more than 10% of the city's working age population. Our workforce is therefore not separate from our public, patients or service users. Our workforce *is an integral part* of the population we serve. As employers we therefore need to role model good health and wellbeing practice, enabling and encouraging our staff to live the best lives they can. Our workforce is committed, passionate and compassionate. We need to care for, develop and enable the collective potential of all our people, particularly where they

meet and work together across organisational boundaries and harness their energy, ingenuity, talents, differences and shared sense of purpose.

4. **Purpose**

The purpose of this document is to set out the workforce strategy that will ensure we achieve this vision.

5. Key Concepts

Some core concepts underpin this strategy:

- When we refer to 'workforce', this is directed at anyone who contributes to health and social care in Sheffield. This includes all paid *and unpaid* staff, volunteers and carers working across the full spectrum of health and social care, the workforce in children's and adults' health and care, physical and mental health, primary and specialist care, and all professions. Where there are references to specific parts of the workforce (as opposed to an assumption that each recommendation automatically covers all of the above), these are named within this paper.

- This is a place-level workforce strategy. As such we have prioritised those areas that will have potential for the greatest impact at place and covers only those matters that sit across the whole system. This strategy and the ensuing plan should sit alongside and complement (not replace) individual organisational workforce strategies, as well as ICS, regional and national agendas.

- All ACP partners and members of the public have been fully engaged with the development of this strategy, through designated workshops, one-to-one meetings and group discussions. The key Themes for Change have been developed directly from the feedback received through the consultations.

- This strategy talks a lot about 'integration'. By this we mean working closely, often in multi-disciplinary teams, with people not employed by the same organisation; this could be employees of another organisation, carers, volunteers or other members of the public.

6. Exclusions

The following areas will not be covered within this strategy, although they are all critical in supporting the further development of our workforce and the achievement of the Shaping Sheffield ambitions. The primary reason for not including them within this strategy is because other groups / areas are already working on them – this is outlined under each paragraph. It is important that the

ACP's Workforce and Organisation Development Transformation Group has sight of progress in each of these areas, as they will impact on the ability to achieve the intentions of this strategy.

6.1 Capacity and Demand

It is acknowledged that we have limited useful (system level) data for workforce planning purposes. Current issues around capacity and lack of technological interoperability means that to collate meaningful local data would take at least 2 years and divert attention from implementing some of the changes outlined in this strategy. Data *is* being collated at a national and regional level, and while this is not perfectly applicable to us and will not take account of specific local innovations, it is still a good guide. Sheffield is broadly similar to comparable cities, so more generalised data does give us a good evidence base for our key workforce challenges.

In addition, while a new care model has been proposed (outlined below), there is still considerable work to do on this before all workforce implications are known. Investment in the collation of detailed local workforce data will have far greater impact when it can be clearly aligned with a new care model.

We are therefore not proposing that we spend time collecting workforce data at place level at this point in time, but that it is a core part of the ongoing work to develop and implement the new care model.

6.2 ICS / Regional / National Areas of Focus

As identified above, this strategy focuses on those workforce priorities that are best addressed at place. This primarily affects the training, attraction and recruitment of professional staffing groups, which are subject to much activity elsewhere in the health and care system. However, we do have a responsibility in the ACP for working with these wider bodies to ensure that Sheffield priorities are being appropriately and sufficiently addressed elsewhere and for influencing these broader agendas.

Paragraph 9.2 outlines the South Yorkshire and Bassetlaw ICS' workforce priorities, as these have the greatest direct impact on the Sheffield workforce.

6.3 Digital

Digital issues have been raised repeatedly by staff and the public throughout the development of this strategy. The single biggest issue raised was the lack of digital interoperability hindering integrated working across and between organisations. As this is currently the focus of the ACPs Digital Workstream, this will not be addressed within this strategy, although the link with workforce needs to be central to the plans emerging through the proposals of the Digital group and the Workforce and OD Transformation Group will remain sighted in the workforce elements of the Digital work.

6.4 Estates

Estates concerns were also raised through the consultation workshops. These were primarily recommendations from staff to increase the opportunities for co-location with other organisations across the system to facilitate integrated working. The development of a coherent system-wide Estates approach is currently being pursued through other groups (principally a cross-organisational Estates group overseen by the Sheffield CCG), and therefore this strategy will not incorporate proposals related to Estates.

7. **Production of this strategy**

This strategy has been developed by front line staff and members of the public.

This strategy was developed between December 2018 and July 2019. In addition to the specific workforce-focused engagement events and activities, the Shaping Sheffield consultation events also harnessed a lot of feedback related to workforce and culture, all relevant to this place-based plan.

We ran 3 workshops with more than 150 members of the public and front-line staff from across Health & Social Care in Sheffield. Healthwatch also conducted specific public consultation events, through formal workshops and individual one-to-one conversations. Including the Shaping Sheffield events and online questionnaire, this strategy incorporates the views of more than 600 members of the public and staff from all parts of the system.

A steering group comprised of members from all ACP partners has worked together to analyse the feedback, work with the partner organisations to secure appropriate engagement and contributed to the production of this workforce strategy.

This strategy has set the programme of work to address the most pressing workforce issues that Sheffield faces – and will be underpinned by detailed workforce planning in specific areas. The diagram below sets out the approach undertaken.

Following each draft of this strategy, further consultation has taken place across the ACP workstreams, organisational and voluntary sector leadership teams, specialist workforce personnel, the LMC, staff-side representatives, front-line staff and carers. All of this feedback has been consolidated to inform this version.

8. The National Context

8.1 Data

- Under current models of care and staffing, it is expected the need for health care workers in the NHS would increase to over 1.5 million FTE staff by 2030 but current trends in employment do not cover this
- A study into adult social care has shown that 21% of 20-55 year olds have considered a career in the sector but only 4% have gone on to apply. The 2 primary reasons for not pursuing this as a viable option have been cited as a lack of awareness of how to apply, and perceived unsuitability related to qualifications.
- Adult social care also experiences high levels of staff turnover with Skills for Care estimating that the staff turnover rate of directly employed staff working in the adult social care sector was 30.7%. This equates to approximately 390,000 people leaving jobs per annum. A large proportion of staff turnover is a result of people leaving jobs soon after joining.
- Life expectancy is projected to increase from 73.5 years in 2018 to 74.4 in 2022—bringing the number of people aged over 65 globally to more than 668 million, or 11.6% of the total global population[1].

- Long-term conditions are more prevalent in deprived groups; people in the poorest social class have a 60% higher prevalence than those in the richest social class[2]
- Half of all lifetime mental health illness can be diagnosed at the age of 14 so early intervention will alter the life chances of these young people *(NHSE)*
- Treatment and care for people with long-term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure[2]
- Ageing and growing populations, greater prevalence of chronic diseases, advances in innovative, but costly, digital technologies all increase demand and expenditures on health and care systems[3].
- With a growing proportion of older people in the UK there is growing number of people with long term comorbidities; 75% of 75 year olds in the UK have more than one long term condition, rising to 82% of 85 year olds
- This ageing workforce along with the rising demand for health care services drives shortages of appropriately skilled staff in both developed countries and developing economies[1].

8.2 National Drivers

The **NHS Long Term Plan** was published in January 2019 with a focus on prevention, population health and integration. Underpinning the plan is an emphasis on the "*triple integration of primary and specialist care, physical and mental health services, and health with social care*." Within the Long Term Plan, we see a greater focus on children and mental health. The plan has committed £4.5 billion more for primary medical and community health by 2023/24 and £2.3 billion for mental health.

The **NHS Interim People Plan** was published in June 2019, with a full people plan scheduled for release towards the end of the year. The interim plan outlines national NHS workforce plans, and commits to:

- Create a healthy inclusive and compassionate culture (including ensuring equality and diversity, tackling bullying and reducing violence)

[2] Department of Health (2012) Long-term conditions compendium of Information: 3rd edition. Available at https://www.gov.uk/government/news/third-edition-of-long-term-conditions-compendium-published

[3] Deloitte (2019) 2019 Global health care outlook - Shaping the future. Available online at https://www2.deloitte.com/global/en/pages/life-sciences-and-healthcare/articles/global-health-care-sector-outlook.html

- Enabling great development and fulfilling careers (including CPD and ensuring recognition of qualifications between employers)
- Ensuring everyone feels they have a voice, control and influence (including freedom to speak up, health and wellbeing and flexible working)
- Address entry routes into the profession building on the nurse apprenticeship and nurse associate routes
- Development of a *'blended learning nursing degree'* programme working with higher education providers
- Place a greater focus on primary and community nursing.

The plan says NHS leaders should have:

- *'A compassionate inclusive culture'* including senior leaders, clinical and non-clinical roles and the *'vital middle manager layer*.' Leadership priority areas are named as; system leadership; quality improvement; talent management; inclusion and diversity.

A balanced scorecard will be developed to assess organisations in these areas via the NHS Oversight Framework and the CQC Inspection Framework (Well Led Assessment). In addition, a newly developed ICS workforce 'maturity framework' will be used to assess the readiness of ICS to take on responsibilities including workforce planning.

You can access the full plan HERE.

The **Prevention Green Paper** was published in July 2019 and outlines the intent to:

- Embed genomics in routine healthcare, and improve screening services
- Remove the inequalities in healthcare through focused interventions for those living in deprived areas, and for groups such as those sleeping rough, care leavers and offenders
- Further action to tackle obesity, particularly in children
- An ambition to be 'smoke free' by 2030
- Embed strategies for preventing and supporting mental ill-health
- Improve available data to track the nation's health

We anticipate the **Social Care Green Paper** will further consolidate this focus on a preventative, person-centred, holistic and integrated care approach. The 7 guiding principles of the anticipated Social Care Green Paper are:

- A greater focus on prevention and primary and community services
- The development of *"genuinely integrated teams of GPs, community health and social care staff"*
- A move to a more home based model of care as an alternative to hospitalisation.
- A focus on reducing demand on the emergency pathway
- A greater focus on prevention programmes directed to areas of greater need.
- Greater focus on digital enablement of care for patients and carers
- The need to redesign workforce to better attract and retain staff and to develop integration

9. The Regional and ICS Context

9.1 Data

- From a total population of 1.5m, 72,000 people are employed in health and social care across South Yorkshire and Bassetlaw (SY&B).
- 30 Primary Care Networks across the system include one of the largest (Barnsley) and one of the smallest (Upper Don, Sheffield) in the country
- There are 6 acute hospitals (including Chesterfield as an 'Associate' hospital), 5 CCGS, 5 Local Authorities and 4 care / mental health trusts across SY&B.

9.2 ICS Workforce Priorities

The ICS infrastructure is poised to have increasing influence over workforce planning over the next 5 years: '*we are clear that over time, and within a national framework, ICSs will take on the leading role in developing and overseeing population-based workforce planning for local health services. This will mean that ICSs become responsible for some activities currently undertaken by national bodies, while recognising that some activities will always need to be carried out nationally*'[4].

The NHS IPP defines the workforce responsibilities at a national, regional and ICS level, although doesn't go down to place level. There is clearly a role however for the majority of local workforce activity to be driven through place arrangements. There are some activities that are much better positioned through our work across the ICS, and this strategy will not go into detail on these. The table below outlines these core ICS-level priorities, highlighting where this is a link with place-level plans.

[4] The NHS Interim People Plan p59

Priority	ICS Activity	Sheffield-specific Activity (ICS and ACP)
Education Training and Development *"To be the best place to develop health and social care careers"* • **Educational and Development using ECHO**[5] • **Leadership** • **Organisational Development Bespoke Capacity and Capability Offer (**Develop system leadership capability, equipping our emerging system leaders with the skills and confidence to identify and drive forward required changes).	*-850 staff to attend ECHO training by March 2020.* *-50% of nursing / Care Homes to access ECHO training by Mar 2020* *- Develop a Leadership strategy for approval by Sep 2019* *-Secure budget for system leadership development training by Sep 2019* *-Commence procurement of system leadership training by Dec 2019*	Childhood and Young Adult Asthma ECHO in September 2019. Engaging with SCC, SCH, PCS, Education, Public Health to deliver 5 sessions. Planning an 'unwell child ECHO for 2020) Care Homes ECHO in progress. Leading Sheffield 5 days training and development over 3 months 40 places, recruiting to cohort 2 July 2019. Collaborate – 20 places for community and 3rd sector staff Shadow Board 18 places Bespoke offer from partners to other organisations for OD support with cross system developments.
Supply *"Building a sustainable local supply of health and care talent"* • **Schools Engagement** • **Employability** • **Placements**	*-To increase number of career ambassadors by 50% by Mar 2020* *-70% of schools to have had a careers visit by Mar 2020* *- staff to be recruited through defined employability programmes by Mar 2020* *-Increase number of student nurses on university programmes* *-Ensure alignment of*	A Sheffield City Health and Social Care schools engagement event for 2020 STH Employability Scheme for people with Learning Disabilities and Autism in progress. Placement Pilot Project Sheffield Place Based Teams exploring and testing new models for placement provision in collaboration with HEI's.

[5] Collaborative digital learning software

	placements and supply across key new roles.	
New Roles *"Introduce new tested cross professional roles at scale that enhance patient care"* • **Apprenticeships** • **Assistant Practitioners** • **Nursing Associates** • **Advanced Clinical Practitioners** • **Physician's Associates**	*-To increase levy spend by 50% against baseline by Mar* 2020. *-Two Cohorts of TNA to commence in 2019* -89 ACPs planned for 2019/20 and development of First Contact MSK AHP Practitioners -40 PAs planned for 2019/20 -20 practice nurses GP Ready for 2019/20	Working across partners to explore levy transfer opportunities from CCG to a Care Home and or a GP practice/PCN 5 Practice Nurses on the Vocational Training Scheme (VTS) will be placed in Sheffield in 2020

In addition to the above, new routes into professions such as Psychiatry and Nursing are being explored to help address the talent pipeline shortage. The ICS is also in the early stages of developing a paediatric workforce strategy.

10.The Local Context

10.1 Local Data

- Sheffield broadly performs well as individual organisations, with pockets of good integrated practice
- The sector employs more than 38,000 staff in Sheffield – 10% of the city's working population
- In 2018 there were approximately 3,389 voluntary and community sector organisations with 51% of these providing health, welfare, and social care[6]
- The voluntary sector in 2018 had 29,500 paid staff, 97,325 volunteers and contributed £287m to the Sheffield economy[4]
- Sheffield acute care turnover and vacancy rates are lower than the England average
- Adult social care vacancy rates are lower than the national average, although turnover rates are higher[7].

[6] Harris, J., Rimmer, M. (2018) Sheffield State of the Voluntary and Community Sector 2018. School of Health and Related Research The University of Sheffield.

- In 2014/15 the percentage of individuals with a long-term illness, disability or medical condition diagnosed by a doctor at age 15 was 13.6% in Sheffield, which is similar to the national average of 14.1% *(fingertips).*

- Emergency admissions of children under the age of 19 in Sheffield for long term conditions are increasing or remain high:
    - For epilepsy were at 54.2 per 100,000 in 2016/17 this is an increase from the previous two years but is still lower than the peak rate of 76.3 per 100,000 in 2013/14[8]
    - For diabetes were at 55.0 per 100,000 in 2016/17 which has increased year on year for 4 years[8]
    - For asthma the rate has decreased for 4 years to 109.0 per 100,000 in 2017/18 but still remains higher than both epilepsy and diabetes[8]
    - The number of children with autism known to schools per 1000 has increased from 16.7 in 2015 to 22.4 in 2018 which is a more dramatic increase than the England average[8]

- There is an increasing and serious prevalence of childhood obesity. Overweight children are more likely to require more medical care, be absent from school, experience health-related limitations and have mental health problems. The risks of going on to develop Type 2 Diabetes are also higher *(NHSE).* In Sheffield the prevalence of obesity in year 6 children was at 21.1% as of 2017/18 compared to 15.5% in 2006/07[8]

- The principle driver of demand for healthcare illness is not age – it is increasing multi-morbidity

- The onset of multi-morbidity occurs 10-15 years earlier for people in the most deprived areas than those in the most affluent areas

- Sheffield is one of the 20% most deprived Local Authorities in the UK, whilst also containing some of the most affluent 1% of areas. 1 in 4 children live in poverty. Health outcomes match these extremes

- The rate of households in temporary accommodation (per 1,000 estimated total households) for Sheffield was 0.5 compared to the national average of 3.4. The number of households in temporary accommodation was 77 in 2016/17 but for 2017/18 this had increased to 116[9]

- The 2018 rough sleeping rate (per 10,000 households) for Sheffield was 1.1 compared to the national average of 2.0 (this accounts for an estimated 26 rough sleepers in 2018, a rise from 10 in 2014)[10]

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[7] CQC LA area data profile: older people's pathway July 2018

[8] https://fingertips.phe.org.uk/

[9] Public Health England (2019) Wider Determinants of Health - Statutory homelessness - households in temporary accommodation. Public Health Profiles.

- Domestic abuse-related incidents and crimes recorded by the police per thousand, were 31.3 in Sheffield compared to the national average of 25.1 in 2017/18. This is a slight increase from 2015/16 where it was 28.9[11]
- The number of emergency hospital admissions for violence (including sexual violence) per 100,000 population in Sheffield was 48.8 for 2015/16-2017/18 compared to the national average of 43.4. This figure has reduced year on year since 2011/12-13/14[12].

The system invests £1.1bn in the Sheffield care system – in an increasingly challenging context:

- 97% of this money is spent on treating illness, 3% on prevention
- In a context of increasing multi-morbidity, the challenge is to balance the gap between anticipated costs and the funding available
- By 2024 an additional 21% of funding will be required to simply keep pace with the current levels of demand.

10.2 Health and Wellbeing Strategy

Sheffield's Health and Wellbeing Board launched its new strategy in July 2019. Adopting a life course approach to tackle the inequitable distribution of health and wellbeing across the city, it contains 3 chapters:

i. *Starting Well:* laying the foundations for a healthy life

ii. *Living Well:* ensuring people have the opportunity to live a healthy life

iii. *Ageing Well:* considering the factors that help us age healthily throughout our lives

This workforce strategy aligns with the Health and Wellbeing strategy. The ACP workstreams and priorities outlined in 'Shaping Sheffield' have been mapped across the Health and Wellbeing Strategy's 3 chapters.

[10] Ministry of Housing, Communities & Local Government (2019) Live tables on homelessness - Rough sleeping statistics England autumn 2018: tables 1, 2a, 2b and 2c.

[11] Public Health England (2019) Wider Determinants of Health - Domestic abuse-related incidents and crimes - current method. Public Health Profiles.

[12] Public Health England (2019) Wider Determinants of Health - Violent crime (including sexual violence) - hospital admissions for violence. Public Health Profiles.

10.3 Shaping Sheffield

The workforce strategy is a key priority within the 2019-2024 Shaping Sheffield Strategic Plan. Our vision for workforce to '*create a flourishing and thriving Sheffield by developing our people in a joined up way to deliver holistic, person-centred and integrated care*' contributes directly to the overarching ACP vision of providing '*prevention, well-being and great care together*'.

The Shaping Sheffield Plan was developed following widespread consultation with ACP partner staff and members of the public during January and February 2019. Workforce and culture were recurring themes through all of the consultation events. All of the points raised have been considered and incorporated within this strategy, alongside the feedback from the workshops dedicated to securing staff and public input to the workforce strategy.

Our Shaping Sheffield Plan has identified six priorities; 1. Starting Well. 2. Neighbourhood Development. 3. All Age Mental Health 4. Reducing Smoking 5. Ageing Well. 6. Promoting Prevention. This workforce strategy will enable our plans.

The SEND and CQC Local System reviews highlighted a fragmented care system, inconsistent & confusing to access:

10.4 Joint Ofsted and CQC Local Area SEND Review

This review in November 2018 highlighted the following:

- The lack of a co-produced, coherent vision and strategy for SEND (Special Educational Needs and Disabilities) in Sheffield
- A lack of communication, clarity and consistency in the relationship between the local area leaders, parents, carers, children and young people
- Poor strategic oversight of SEND arrangements by the CCG, which results in unacceptable waiting times for access to specialist equipment and appropriate pre- and post-diagnosis support and children and young people's needs not being met
- Weaknesses in commissioning arrangements to remove variability and improve consistency in meeting the education, health and care needs of children and young people aged zero to 25 with SEND
- The quality and timeliness of Enhanced Health Care (EHC) plans
- Inconsistencies in identifying, assessing and meeting the needs of children and young people with SEND in mainstream primary and secondary schools
- Weaknesses in securing effective multi-agency transition arrangements for children and young people with SEND.

Our subsequent Statement of Action commits to us having '*a workforce that is equipped with the knowledge and skills to provide consistent support for children and young people'.* We will have:

- A citywide training offer for SEND, which will be published and delivered across all services that support children and young people. This will include but not be limited to training on:
    - Person centred practice, including communication
    - A graduated approach to meeting SEND needs
    - SEND statutory processes
    - The role of the Special Educational Needs Co-ordinator (SENCO)
    - Providing and implementing assessment information and support
- Training videos will be published on the local offer outlining a range of training areas that will support communication to parents and young people as well as practitioners. This will include around statutory processes and support

10.5 CQC Local System Review

In the spring of 2018, the Care Quality Commission carried out a Local System Review of Sheffield's health and care support for older people. Sheffield was one of twenty areas chosen by CQC for a Local System 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, and 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.

Our plan in response to the recommendations arising from the review identified key themes for action:

- A way of working that is built around acknowledging and improving older people's views and experiences and which drives a citywide vision
- A shared citywide workforce strategy to support front-line staff in delivering this vision and in particular further develops multi-agency working
- Clearer governance arrangements to ensure stronger joint-working between organisations and greater involvement for our Voluntary, Community and Faith sector

- A meaningful shift to prevention at scale, supported by clear commissioning arrangements and digital interoperability
- 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

Specifically related to workforce, we committed to:

'Develop a joined up city-wide strategy for the workforce across the 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'.

10.6 Joint Commissioning

In order to enable the ambition of more integrated working, commissioners from both health and social care are working together to develop a single commissioning plan for Sheffield. This builds on the Better Care Fund and Section 75 Agreements already in place in the city, strengthening how we make best use of the Sheffield pound, and designing integrated ways of working to reduce reliance on hospital and long term care.

This new commissioning approach has an aligned set of principles with the Shaping Sheffield Plan including reduction of inequalities; the development of preventative and person centred approaches; care closer to home and the provision of support through neighbourhoods and localities. Initial priorities identified by the Joint Commissioning Committee are frailty, SEND and mental health.

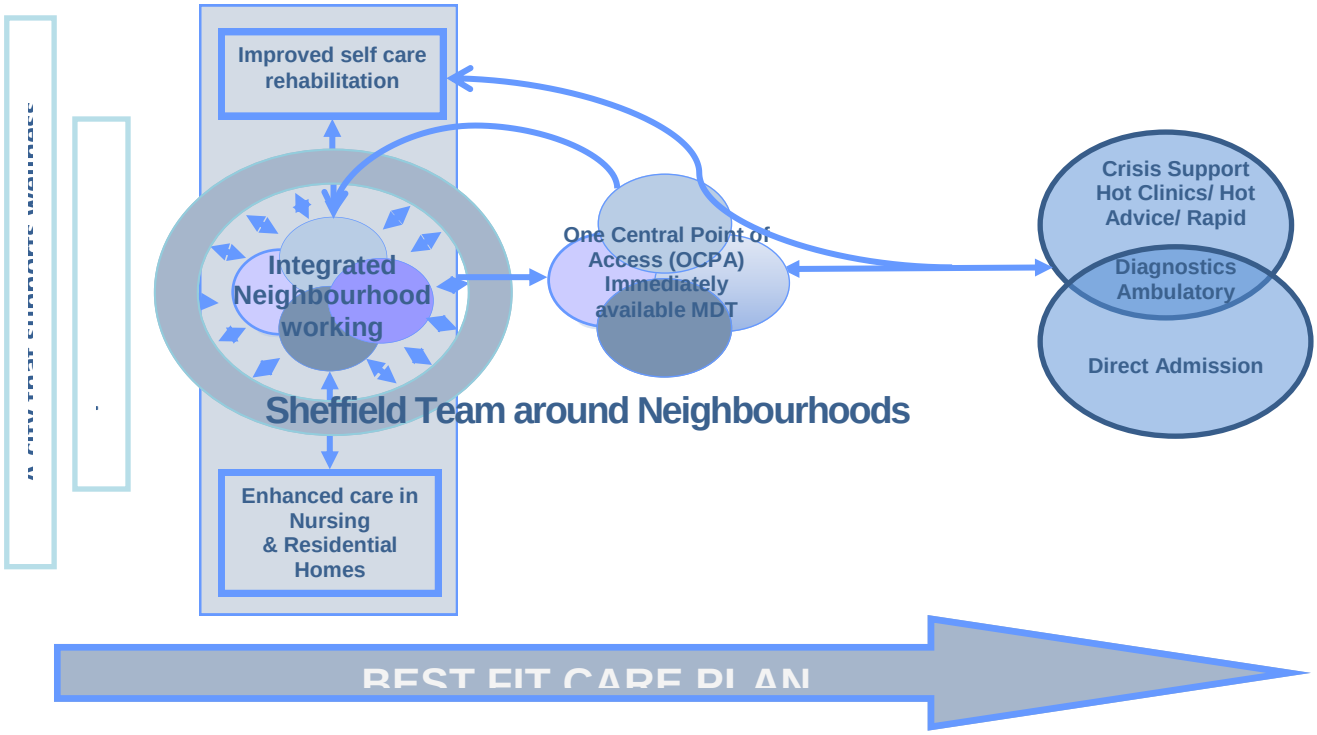
Payment reform was a recurrent theme within the consultation events held in the development of this strategy. There was a particular desire to see a move towards longer term contracts for staff and providers, to facilitate more sustainable impact from the investment.

10.7 A New Integrated Model of Care

We know that the non-elective pathway does not always provide the best experience for our citizens, as individual stories demonstrate and the CQC Local System Review patient experience data showed.

A new model for integrated care has been developed by senior clinicians across STH and the CCG. This work began with a focus on the primary, community and front-door processes to consider how the system can better keep people well and out of hospital. Inevitably the discussions strayed beyond physical health and the NHS to social care, mental health and the contribution of the VCSE. The model has been discussed by the ACP's Executive Delivery Group and wider conversations are taking place across the system to discuss how we can make this model a reality of practice.

This model supports the “Ageing Well” priority of Shaping Sheffield, one of our identified 5 priorities. Our workforce strategy will need to help enable this care model alongside the changes planned for dementia care, homecare and other areas of work affecting those living with frailty or at risk of becoming frail.



11. **Key Strategies and ACP Workstreams**

11.1 Sheffield Primary Care Strategy

In early 2019 the primary care strategy for Sheffield was refreshed to reflect the NHS Long Term Plan, which was published in January 2019.

As society develops and medicine advances to keep pace with the changing population and its evolving health needs, the NHS must transform in order to ensure the future services are responsive to their users and are sustainable in the longer term.

The Primary Care Strategy aims to ensure that the people of Sheffield have excellent local, joined up, sustainable primary and community support to enable them to live their lives to the full.

To do this, we will therefore shift the focus of care and support towards primary and community care. We will do this through the development of provision at the relevant scale including existing services, such as General Practices, mature neighbourhoods wrapped around Primary Care Networks and City-wide solutions.

This Primary Care Strategy therefore aims to:

- Have high quality, sustainable primary care services that are fit for purpose now and in the future
- See health, social and voluntary care services working collaboratively for the benefit of individuals with a key focus on neighbourhood development and population health outcomes
- Work with system partners to address the wider determinants of ill health by taking a positive approach to prevention and supporting neighbourhood development across Sheffield.

11.1.1. Primary Care Workforce:

There is a well-publicised workforce shortage across Primary Care with a training and employment gap in GPs and Practice Nurses nationally. Sheffield has already seen a wide-spread adoption of new roles including Nurse Practitioners, Clinical Pharmacists, Physicians Associates, First Point of Contact Physiotherapists and the recent recruitment of first point of contact mental health workers (as part of our neighbourhood transformation pilots). There are several schemes supporting this diversification of the GP workforce from Higher Education England (HEE) and NHS England, the largest of which is within the PCN Direct Enhanced Service (DES), which offers subsidies for:

- Clinical Pharmacists and Social Prescribing Link Workers from 2019
- Physiotherapists from 2020
- Physicians Associates from 2020, and
- Paramedics from 2021

One of the priorities for the Primary Care Delivery Board is developing a Primary Care Workforce strategy and workforce plan which interlinks directly to the Shaping Sheffield plan. The strategy will cover 3 main areas:

i. Sheffield's approach to the workforce requirements in maintaining current activity in Primary Care, replacing the natural turnover of staff and wherever possible increasing efficiencies and relieving demand pressures with appropriate diversification of staff.
ii. Sheffield's approach to the development, and implementation, of new roles across PCNs and Neighbourhoods. This will include consideration for the use of staff in multi-organisational, multi-professional teams.
iii. Sheffield's approach to the roles required in Primary Care to deliver any additional activity transferred from other settings.

Data is currently being collected to support this strategy and the strategy is being written in conjunction with the South Yorkshire Workforce Hub. It will be interlinked with the recently drafted Shaping Sheffield strategy.

The strategy will address specific issues in:

- Defining the training and OD requirements alongside the recruitment and development of staff.
- Considering the redevelopment of the GP role as a consultant generalist

- Completing accurate baselines for Primary Care in Sheffield and projecting retirement figures for the next 5 years. From this data, we intend to identify gaps in projected workforce and feed these into our plans.
- Developing career pathways
- Supporting the recruitment of additional roles and exploring international recruitment
- Understanding our recruitment and retention plan as a city
- Understanding how Sheffield interlinks strategically with neighbouring Health and Social Care economies, ICS, Health Education Yorkshire and Humber and education and training providers to identify all opportunities for developing the workforce required
- Working jointly with relevant partners to create placement and mentoring opportunities, create new roles and inform the development of training and education courses. We want to make Sheffield a place that people want to work in and stay working in.

11.2 Young Carer, Parent and Adult Carer Strategy

Sheffield has a joint multi-agency Young Carer, Parent and Adult Carers Strategy (2016-2020) which sets out the challenges that carers face, the impacts on their lives and a set of principles for providing support. The unpaid contribution of the city's 60,000 carers is a crucial element of the health and social care system, and is valued at around £1,186 million. One of the underpinning principles of the Carers Strategy is that 'Carers are respected as partners in the delivery of support, care and recovery' and are supported across the city by all organisations, so that they can continue to provide care.

11.3 Mental Health and Learning Disabilities

The ACP's Mental Health and Learning Disabilities (MHLD) workstream has established its own Workforce Development and Training Group, which is exploring how we can ensure that frontline workers/partners have the knowledge, skills and attitudes to deliver holistic care. This includes a consideration of new roles and ways of working that could deliver physical health checks, interventions and holistic action plans for person centred approaches and support. Key questions covered by the group are:

- How to ensure frontline workers/partners have the knowledge, skills and attitudes to deliver holistic care?
- What can be done to ensure frontline workers/partners are able to ensure people have their full physical health check each year including self-care?
- What needs to be available and how will we do this?

11.4 Pharmacy

The ACP Pharmacy Transformation Group is carrying out a mapping exercise of the pharmacy workforce in Sheffield to form part of a wider SYB ICS pharmacy workforce mapping process. A

group member is leading on work at ICS level to articulate the stocktake of the current situation, outline a vision for the pharmacy workforce and make recommendations for how the vision might be achieved. The paper to be delivered to the Local Workforce Action Board (LWAB) in September 2019 will focus particularly on the risks to the system and impact on patient health should the necessary workforce planning and transformation not take place. It will include illustrations about what might be achieved. The Group is also exploring potential for system-wide approaches to recruitment to the new NHSE pharmacist roles within Primary Care Networks and the provision of medicines experts across Sheffield in specialisms such as mental health, frail elderly and de-prescribing. It is also keen to establish system-wide training provision for pharmacy professionals, integrating across the ICS where applicable.

11.5 Dementia Strategy

A Dementia Strategy for the city was developed in 2018, which calls for local action to transform dementia care.

On average, a person can live with dementia for a further 10 to 15 years post diagnosis. Given the rise in the number of people living well into their seventies and eighties in the UK, this means dementia is an increasingly important factor in relation to healthy life expectancy.

It is therefore increasingly important that our workforce is skilled to recognise dementia and provide the care and support to people and their families living with the dementia. There are several specific commitments made in the dementia strategy that involve how our local workforce will need to develop, a few key examples are outlined below.

- All public sector employees in the city will receive the appropriate level of dementia training for their role
- Increased awareness about the risk factors and progression of dementia in health and social care staff
- Closer working between specialist dementia services and local communities.
- There will be an increased awareness across health and social care staff about the issues faced by carers and the importance of providing timely support
- Health and social care providers will be better skilled to facilitate those early conversations about advanced care planning.
- Care planning information will be shared better across organisational boundaries.
- Care homes will receive on-going specialist dementia training.

12. Themes for Change

Throughout the consultation, staff and members of the public were asked to identify both barriers facing the Sheffield health and social care workforce, as well as ideas for addressing these barriers. These have been consolidated into the following headings:

1. Culture
2. Person-Centred Approaches
3. Staff Wellbeing
4. Valuing the Unpaid Workforce
5. New Ways of Working
6. Recruitment and Retention
7. Learning and Development

Section 2 of this strategy, on pages 28 to 35 outlines the vision, challenge, priorities and intended benefits for each of these headings. There will be further development of this implementation plan into a tangible set of actions to implement this strategy upon the strategy's approval.

13. **Our 2019-20 Priorities**

The most pressing priorities for 2019/20 are:

i. There is a national and international shortage of staff across almost all professions in the sector. The development of Primary Care Networks and the new roles being employed within them will exacerbate this problem. While there is work being undertaken nationally, across the ICS and in our universities to increase training places and student numbers, this will not be enough to address the full scale of the problem. We need to develop a strong 'Brand Sheffield' that is consistent across the ACP to promote the benefits of living and working in the city, with the intention of attracting new recruits to work here. This will be completed and in use by March 2020.

ii. Developing a person-centred city is central to the Shaping Sheffield strategy. We will develop a set of organisation development approaches to embed this way of working in our frontline staff. This will focus on the practical application of the 'what matters to you'[13] approach, bringing together staff from across the system and embedding other key messages identified in this strategy and within Shaping Sheffield (such as the integration of physical and mental health, children's and adults). This development will be implemented by March 2020.

iii. Care home staff have the potential to make a significant contribution to reducing the numbers of urgent admissions to hospital. There are currently numerous pockets of support being targeted at care homes, running the risk of overburdening an already stretched workforce and forcing them to disengage from the wider system. We will pull all of this

[13] https://www.whatmatterstoyou.scot/

activity into a co-ordinated package of support for this section of our workforce by the end of December 2019.

iv. The impact of leadership and culture on our workforce cannot be under estimated. We will develop a strong community of capable, resilient leaders across the city and within Primary Care Networks, who are able to lead within and on behalf of organisations, systems and places. To do this, we will implement and embed system leadership and organisation development programmes to ensure that our workforce is motivated, empowered, capable and confident to provide '*prevention, well-being and great care together*'. This will include;

    a. further cohorts of 'Leading Sheffield', and

    b. the extension of 'Collaborate' across other Primary Care Networks, with the intention of coverage across at least 6 PCNs by December 2020

    c. the development of an ACP leadership community during 2020, bringing 'alumni' from multiple leadership programmes together to continue their development and to enable their contribution to strategic system priorities

v. There is a disparity in staff access across the system to good quality development – those employed by the large statutory organisations benefit from extensive organisational development programmes whereas those working in primary care, the voluntary sector, independent care homes or as Personal Assistants, do not have access to this level of support. The apprenticeship levy is one source of funding that will help to redistribute some of this development support across the system, and our statutory organisations will lose access to significant unspent apprenticeship levy monies in 2020. We will explore options for 'gifting' this to primary care, the voluntary sector etc to enable them to invest in staff development. An agreed process for developing this will be in place and widely communicated by March 2020, with the first apprenticeships in post by September 2020.

14. Next Steps

14.1 Consultation

All ACP partners, trade unions, representative bodies, members of the public, the South Yorkshire and Bassetlaw ICS and other organisations involved in health and social care across the city will have the opportunity to provide feedback on this draft strategy.

Governance arrangements, as outlined below, will be established during the consultation period to ensure swift progress with our identified priorities.

14.2 Governance

This strategy and the ensuing plan will be managed through the ACP's Workforce and OD Transformation Workstream, on behalf of the ACP Board.

Section 2

Implementation Plan

1. Culture:

We will develop a culture across health and care in Sheffield that embraces integration, builds trust across organisational boundaries, recognises the contribution of staff at all levels of the hierarchy and from all parts of the sector, and places the Sheffield citizen at its centre.

The Challenge:

- Culture is heavily reliant upon local working practices, in particular management and leadership capabilities. These are variable across the ACP
- Culture is currently closely aligned with organisational structures and individual management capability, with limited system culture or sense of belonging
- Members of the public, carers and the voluntary sector are not systematically involved in the development of new models of care or provision

Aims:

1. Develop a leadership culture at all levels of the system, linking organisational-specific development to ensure consistency of message and culture. Specifically, build on the early successes of 'Leading Sheffield' and 'Collaborate'
2. Develop a community of system leaders, providing the opportunity to share good practice, build cross-system understanding and relationships and develop system leadership capability
3. Ensure that managers at all levels have access to good quality management development
4. Develop a culture that embraces difference in its very widest sense; including going beyond protected characteristics to valuing different perspectives and building trust (links with Staff Wellbeing)
5. Embed executive system leadership development to develop trust and understanding between and across ACP partners
6. Senior teams to be more open and transparent to staff and public around decision-making, inviting the contribution of all at the earliest opportunity
7. Make best use of the assets we already have in the city; existing staff skills, plus knowledge and experience of the public.

Expected benefits:

- The development of excellent system leaders across the ACP will lead to integrated working being the accepted norm
- Consistent expectations and performance of all managers across the system will impact on staff wellbeing and performance and people's experiences
- Valuing, listening to and acting upon the contribution of staff and the public will create a stronger system that all are engaged with

2. Person-Centred Approaches:

'Enabling the people of Sheffield to live a life they value, and allow people and communities to have greater control over what matters to them'

The Challenge:

- Different interpretations of the meaning of the term 'person-centred' are made across the ACP, and a lack of clarity about how it applies to personal practice to facilitate consistency across all parts of the sector
- There are some excellent examples of where this works well in the city, but this is not consistent across all areas

Aims:

1. All staff to be educated in and to adopt the ethos of "what matters to you" and implement this in a way appropriate to the care setting
2. Provide staff with the tools and knowledge to enable them to implement Person-Centred approaches in every stage and aspect of the person's journey – not just at the point of care
3. Focus on the needs of service users, carers and communities rather than organisations, using an asset-based approach, empowering and enabling people to manage their own health
4. Implement integrated (cross sector) development for all staff
5. Identify all methods and opportunities to embed the approach into recruitment, training, appraisal, and everyday communications to staff. Different organisations may have different ways of disseminating this understanding across their organisations but the message will be consistent across the system
6. Working with neighbourhood teams, the voluntary sector and the public, develop the Link Worker roles to provide people with guidance about, and support to access additional, peripheral services that can improve their overall care experience and holistic wellbeing.

Expected benefits:

- Confidence and knowledge to advise and refer people to a range of services; enabling them to manage their own health and wellbeing
- People, including children, feel empowered to engage and influence their care provision
- A reduction in the numbers of preventable illnesses and the numbers of inappropriate appointments / A&E attendances
- Improved perceptions around fairness and equitability of service provision.
- Focus on people and their personal needs (this includes children) rather than on their illness or care needs in isolation
- Improved openness, transparency and access to available appropriate services and care provision.

3. Staff Wellbeing:

The ACP employs more than 38,000 staff across Sheffield. A focus on the health and wellbeing of these staff will have an impact beyond these individuals, and will have a significant impact on changing the culture of the system.

The Challenge:

- Long, busy shifts and staff shortages can make it difficult for staff to take sufficient breaks. This inhibits the ability of staff to eat healthily and exercise regularly, with a detrimental effect on their longer term health and wellbeing
- Staff shortages also place pressure on managers to fill gaps, sometimes at the expense of ensuring staff wellbeing
- In the 2018 NHS staff survey 27.7% of staff felt that their organisation took positive action on health and wellbeing (STH, SCH, SHSC average)
- Our BAME and LGBTQ+ staff are more likely to report bullying and feeling undervalued than other staff groups. In the 2018 NHS staff survey 17.3% of BME staff said they experienced at least one incident of bullying, harassment or abuse from other colleagues and 10.9% from managers, compared to 14.1% and 9.5% of white staff (STH, SCH, SHC averages). For LGBTQ+ staff this was 20.8% from colleagues and 13.8% from managers whereas for heterosexual staff this was 12.4% and 9.7% (STH, SHSC average).
- Variability of management and leadership capabilities has an impact on staff wellbeing, motivation and effectiveness
- As care is transferred to take place closer to home, community teams will face increasingly complex cases, which they may not have the resources to address and which could also impact on their own wellbeing

Aims:

1. All ACP organisations to develop health and wellbeing strategies, with consistent KPIs (linked with the ACP prevention priorities), narrative and available support
2. Address cultural and equality issues through developing consistent employment processes, policies and development activities to ensure that all our organisations embrace difference in all its guises
3. The identification of 'Centres of Excellence', where support is offered across and beyond organisational boundaries in areas such as management development and occupational health, ensuring that managers at all levels are included
4. Embed system leadership development at all levels
5. Develop consistently good approaches to supporting staff with their mental health to include regular, scheduled de-briefs for staff working in communities
6. Ensure that every organisation role models excellence in health and wellbeing for their staff

Expected benefits:

- More adaptable / flexible workforce available across the organisations
- Improved culture, accepting of difference in all its guises, will lead to improved staff retention and improved effectiveness
- System leadership development will foster culture change and enable staff at all levels to promote and drive transformational change
- Managers across the system will be competent and confident in supporting staff in identifying and dealing with mental health challenges, enabling all staff to be fully effective in work
- Improved quality of care and support from better motivated and supported staff will lead a reduction in complaints and an increase in compliments

4. Valuing the Unpaid Workforce:

Approximately 50,000 volunteers work across the sector in Sheffield, and 10% of Sheffield residents are unpaid carers. This work is typically under the radar and is not recognised as the significant contributor that it is (estimated to bring c. £700m into the Sheffield economy). The value of Carers to the health and social care sector in Sheffield is equivalent to £1,186,000,000 per annum (2015).

The Challenge:

- Every day, an additional 55 people in Sheffield take on caring responsibilities for the first time. There is excellent support from voluntary organisations, although they have direct knowledge of just a fraction of the number of carers in the city. Most carers cope alone or with support from wider families and neighbours. With enhanced support we could do much more to reduce urgent admissions to hospital, and ensure greater wellbeing of both the individual being cared for and the carer.
- Volunteers are a bedrock of the VCF community, which in turn provides invaluable support to people across Sheffield in health and care. Yet volunteers have access to very few of the opportunities that our staff have access to, eg development opportunities.

Aims:

1. All aspects of this workforce strategy will consider the inclusion of the unpaid workforce (including unpaid carers) across the system
2. Work closely with carers and the Sheffield Carers Centre to develop and implement support in line with (and where appropriate, integrated with) other workers in the sector
3. Build community independence through developing volunteers, opening up development opportunities that staff have access to, to those volunteering in the sector
4. Promote volunteering to all staff as a development opportunity
5. Offer work experience to service users within that service.

Expected benefits:

- Greater support for unpaid carers will reduce avoidable admissions to hospital, support the carers' wellbeing and reduce the risks of the carer's health deteriorating
- Raising the profile and value of the volunteer workforce will encourage people to stay and take up volunteering roles
- Developing more opportunities and support for volunteering will support talent attraction

5. New Ways of Working:

Emerging models of practice (eg neighbourhoods, OCPA) will require staff to develop new skills to deal with increasing complexity in caseloads, and adopt a more integrated and holistic approach.

The Challenge:

- As care is transferred closer to people's homes, community teams will face increasingly complex cases, which they may not have the resources to address and which could also impact on their own wellbeing
- The numbers of people with multi-morbidities is growing, and multi-morbidities are more common than uni-morbidities (section 8.1). This will require staff to implement new ways of working and develop new capabilities in order to embed person- and family-centred approaches
- Technological advances have the potential to transform the way our staff work. The digitisation agenda outlined in the Long Term Plan is ambitious, and we need to ensure that our staff are equipped with the capabilities and confidence to realise its potential impact
- New roles, many linked with the new Primary Care Networks (PCN), are developing at pace. System working and system leadership will be critical to ensure high value integrated working.

Aims:

- Working closely with the PCN Clinical Directors and People Keeping Well networks, develop and implement support plans for staff working within the new Primary Care Networks, to assist the shift to new ways of working and a shared understanding of everyone's roles. These could include, for example, the establishment of mentoring programmes between generalist and specialist clinicians
- Upskill staff to enable them to adopt a holistic physical / mental health approach in line with the dementia strategy and supporting the work of the Mental Health and Learning Disabilities workstream
- Develop cross-sector posts / secondments / job shadowing / learning and development opportunities between children's and adults' services, physical and mental health and statutory and non-statutory organisations
- Work with care homes and (paid and unpaid) carers to create a holistic approach to developing capability

Expected benefits:

- High impact integrated community teams will facilitate person-centred approaches, increased personal responsibility for own health and wellbeing, greater prevention of avoidable ill health and a delay in the onset of health conditions.
- Deeper understanding of everyone's roles across the system will lead to more effective working and improved care and support for individuals.

6. Recruitment and Retention:

Health and Social Care will be an aspirant sector for a wide variety of school leavers to work in, recognising the depth and breadth of career opportunities, which are aspirational to all of our communities. Staff will be proud to work across the sector, motivated and able to bring their whole self to work and take personal responsibility for creating better care and health for the Sheffield population.

The Challenge:

- Recruitment is currently conducted at an organisational level for almost all roles. Filling gaps in one organisation often means creating gaps in another part of the system. This problem will be exacerbated with the additional roles funded through Primary Care Networks with insufficient national planning for training a larger pipeline to fill the gaps those appointed will leave behind
- The range of job roles and opportunities on offer across the system is not recognised amongst school, college and university leavers
- Our workforce does not adequately represent the communities we serve. E.g. 14.6% of our workforce is BAME compared with 16% of the Sheffield population. BAME communities are not proportionately represented at all levels of our organisations.

Aims:

1. Develop a shared 'Brand Sheffield' narrative – selling Sheffield as a place to live and work
2. Develop system-wide recruitment and retention strategies, incorporating shared roles
3. Secure agreements from all partners on consistent application of employment processes and policies to facilitate cross-system working. This will include, but is not restricted to; Agenda for Change job matching, induction, mandatory training, appraisal and core line management processes
4. Embed core behaviours (eg a commitment to prevention) into all roles
5. Work with the ICS recruitment team to ensure sufficient emphasis is placed on Sheffield-based education leavers within their recruitment approach
6. Develop a diversity plan to ensure our workforce accurately represents the communities it works within
7. Develop new options for cross-system roles making use of the apprenticeship levy, sharing access to this across the ACP.

Expected benefits:

- The development of whole-system recruitment strategies and the development of career pathways will minimise the movement of gaps across the system and start to reduce the level of vacancies
- Greater efficiency in recruitment as organisations pool resources to eliminate duplication
- Better representation of our communities among our workforce will generate greater engagement from the public with health and social care

7. Learning and Development:

The ambition of this strategy is **to create a flourishing and thriving Sheffield by developing our people in a joined up way to deliver holistic, person-centred and integrated care**. Learning and development clearly plays a critical role in enabling this.

The Challenge:

- Some of the 38,000 workforce have access to excellent learning and development, but this is not consistent across the sector
- Rising complexity and multi-morbidity profiles, in addition to the development of new ways of working (eg the need for greater integration of physical and mental health support and the transfer of care closer to home) demand new skills from staff across all ACP partners
- The introduction of new roles, particularly in health, will require a change in the way that other traditional roles are conducted
- Support for care home staff has increased in recent years, but it is disjointed and its impact is unknown
- The voluntary sector and primary care do not have access to the same funds (eg apprenticeship levy) as our statutory organisations.

Aims:

1. Work with care homes and care home staff to develop appropriate development and career pathways, create consistency in support and focus on prevention activities
2. Develop an agreement and process to share unspent apprenticeship levy monies with organisations in the sector who do not have immediate access to the required funds, particularly the voluntary sector, primary care and care homes
3. Agree the core skills where a common approach and language would facilitate enhanced integrated and prevention-focused working. This should include Quality Improvement skills
4. Embed rotational practice and cross-system job shadowing within probation and induction for key roles
5. Work with the universities and the ICS workforce teams to integrate priorities from this strategy into the curricula for all health professionals
6. Extend access to development and resources (eg libraries and online development) to all relevant parties working across the health and social care system, this includes the voluntary sector, police, education, care home staff and unpaid carers: the Sheffield

Expected benefits:

- A raised profile of the value of front-line health and care roles, increasing motivation and applications from outside the sector
- The development of a common language will facilitate integrated working, removing some of the barriers currently faced by staff in system roles
- Creating shared development opportunities will help build relationships and trust across organisational boundaries, leading to smoother journeys for people across pathways.

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HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Jane Ginniver
Date:	17th September 2019
Subject:	CQC Local System Review Action Plan – Quarterly Update
Author of Report:	Steve Roney

Summary:

This report provides an update on progress against the CQC Local System Review submitted in July 2018.

This is the fifth quarterly update of progress, with the first considered in September 2018. This report has been considered by the ACP's Executive Delivery Group and other governance meetings in ACP partner organisations.

Alongside system ownership through the ACP's EDG, each organisation has identified an executive lead for their organisation. That individual is responsible for ensuring actions for each partner are appropriately governed within organisations.

Questions for the Health and Wellbeing Board:

Background Papers:

- The updated CQC LSR action plan and CQC metrics

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

Everyone has equitable access to care and support shaped around them

Everyone lives the end of their life with dignity in the place of their choice

Who has contributed to this paper?

The action plan is owned by all ACP partners, and everyone named within the action plan has submitted progress updates.

CQC Local System Review Quarterly Update, August 2019

1.0 SUMMARY

1.1 This report aims to provide an update on progress against the CQC Local System Review submitted in July 2018.

1.2 This is the fifth quarterly update of progress, with the first considered in September 2018.

1.3 This report has been considered by the ACP's Executive Delivery Group and other governance meetings in partner organisations.

1.4 Alongside system ownership through the ACP's EDG, each organisation has identified an executive lead for their organisation. That individual is responsible for ensuring actions for each partner are appropriately governed within organisations.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 The action plan emerging from the CQC Local System Review addresses health inequalities throughout, with the intention of changing the system to provide parity of access to care for Older People, regardless of individual circumstances.

3.0 MAIN BODY OF THE REPORT

3.1 In 2018, 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 delayed transfers of care.

3.2 The action plan focuses on improving and accelerating progress on the following themes:

A. 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 of the action plan).

B. A shared citywide workforce strategy to support front-line staff in delivering this vision and in particular further develops multi-agency working (sections 3 and 4 of the action plan).

C. Developing clearer governance arrangements to ensure stronger joint-working between organisations and greater involvement for our Voluntary, Community and Faith sector (sections 5 and 6 of the action plan).

D. A meaningful shift to prevention at scale, supported by clear commissioning arrangements and digital interoperability (sections 7 and 8 of the action plan).

E. A 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 (section 9 of the plan, covering the Why Not Home Why Not Today Work)

3.3 The CQC have indicated their intention to return to care economies to review whether their recommendations have been implemented and care has improved.

3.4 Two appendices accompany this report:

- Appendix 1 – Line by line progress report against CQC LSR Action Plan
- Appendix 2 - Why Not Home Why Not Today Dashboard

3.5 Areas of the Plan Progressing Well

A. The **Shaping Sheffield plan was endorsed** by the ACP Board in June 2019. The plan is now out for approval with each of the partner organisations and it is expected that approval will be received from each partner by the end of September. Following this the plan will be published on the ACP website which is under development and has a launch date of the end of August.

B. We have now developed a draft **integrated workforce strategy** which is currently out for consultation. This galvanises significant public and staff engagement, most recently from engagement workshops for children and hard to reach groups in July, and considerable work by a Steering Group comprising leads from across the system. This is a significant development. However, the mobilisation of this will be a major undertaking and needs full engagement of universities, schools and colleges, plus transformational workforce strategic leadership and capacity across the city. Hence the actions in the plan around this are marked amber to signal the significant implementation challenge.

C. Person centred care has been defined within the Shaping Sheffield plan and is stated as a core theme within the draft workforce strategy. Extensive development is planned for frontline staff through secured HEE funds.

D. Good work continues on DTOC through close collaborative working and efforts of all parties comprising the Why Not Home Why Not Today group. The WNHWNT metrics on DTOC performance show the number of delayed patients remained below the target of 45 for 6 weeks. However, the number of delayed patients has increased each week since 16th July and has been above target for 3 weeks.

3.6 Areas of Concern

The key areas of concern are:

A. We committed to a **new relationship with the voluntary sector** in our action plan (see tasks 5.1-5.3) but we have not yet reached agreement on what this looks like. ACP Board has now approved an initial investment of £50,000, which will create additional capacity to focus on some very specific outcomes over the next 12 months.

B. No further progress made on **developing new models of care and support**. 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. This work needs urgent focus on links with PCNs and mental health investment.

C. Reviewing **digital inter-operability** in the city remains behind schedule as set out in the action plan. The Digital Workstream has made significant progress in this area following some changes in leadership, however we are a long way from implementation and there are concerns around costs, including the ambiguity around where funding will be drawn from, among ACP partners.

3.7 A review of this action plan is intended to take place prior to the next quarterly review. This will consider:

- Whether the actions have had the desired impact
- Whether the identified actions remain fit-for-purpose, or require adjustment / change

3.8 Each organisational lead for this action plan will be asked to contribute to this review.

4 QUESTIONS FOR THE BOARD

4.1 We need to be sure this action plan is a vehicle for change, rather than a process we move through. In particular this requires bold action to tackle the areas of concern outlined.

4.2 You are asked to debate the points outlined and:

- Note the areas of good practice
- Outline any further points they wish to consider relating to how they are addressing the areas of concern.

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CQC Local Services Review Action Plan
Produced by Jane Ginniver
Dated: 12.8.2019

WBS	ID	Task Name	Description	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
1	**CQCLSR18.19-01**	**A Shared City Wide Vision**	**A Shared city wide vision for older peoples care, developed and shared between service users, carers and families, the wider population and frontline staff across the NHS, Council and voluntary sector**							
1.1	CQCLSR18.19-02	1.1 Vision for Older People Across the City	Articulate, share and develop the vision for older people across the city and hold a series of workshops to further develop this and a level delivery plan to support the work.	31/12/2018		June 2019	Closed		Jane Ginniver ACP	24/7/19: Shaping Sheffield endorsed by ACP Board June 2019. Draft all age workforce strategy out to consultation July 2019. 20/5/2019 Shaping Sheffield: The Plan - draft developed, reflecting vision for older people. Currently being consulted on. 25/1/2019 5 public and staff workshops planned 28/1/2019 - 8/2/2019. Developing overall strategy, Older People one of 5 key priorities. Further staff and partner events being organised. Older People workforce workshops completed - links to changing care model/ overall strategy.
2	**CQCLSR18.19-03**	**Ensuring Older Peoples 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**							
2.1	CQCLSR18.19-04	2.1 Develop a Comprehensive Approach to becoming Person Centred City	Working with communities and system representatives to develop a comphrehensive appraoch 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 Petes Sake, and the Alzheimers society - This is Me tool to identify the personalised needs of older people	31/12/2018			Open	Amber	Nicki Doherty, CCG/ Jane Ginniver, ACP / Susan Hird SCC	25/7/19 definition agreed within Shaping Sheffield, and core theme within draft workforce strategy, with extensive development planned for frontline staff through secured HEE funds 20/5/2019 draft definition included within the Shaping Sheffield Plan for agreement across the ACP. The development of person-centred approaches is integral to the draft workforce strategy, with development for front-line staff prioritised for 2019-20 using funds secured from HEE. Activities planned across the ACP to mark 'What Matters to You' day on 6-6-19.
2.1.1.	CQCLSR18.19-05	2.1.1 Strategic Agreement	Strategic Agreement to scaling up work and a tangible plan at July 2018 EDG	31/12/2018			Closed		Nicki Doherty, CCG/ Jane Ginniver, ACP / Susan Hird SCC	25/7/19 Plans agreed as described above 20/5/2019 update: plan has been developed, this pulls together and monitors activity from various groups across the ACP. Not yet been to EDG. Jan 19: Strategic commitment secured. Growing good practice - plan required.
2.1.2	CQCLSR18.19-06	2.1.2 Developing Joined Up Training Plans	Developing joined up training plans to scale up this work and techniques	31/12/2018			Open	Amber	Workforce & OD Transformation Group	25/7/19 Draft workforce strategy now out for consultation. On track for Autumn approval. 20/5/2019 workforce skills workstream will develop through the workforce strategy implementation work. Plan is to have this up and running by September '19 to progress at pace. 25.1.2019 Older People workforce strategy workshops completed. Joined up trained key theme. Strategy to be developed by April. Implementation plan will be critical - need clear vehicle to deliver plan.

WBS	ID	Task Name	Description	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
2.2	CQCLSR18.19-08	2.2 Individual Patient Case Studies & Review end to end studies	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 and does our action plan sufficiently address these cases and agree any additional actions.	31/12/2018			Open	Green	Sue Butler, STH	12/8/19 Looking into 'who' already in the system could conduct similar interviews with patients in the future. Next steps regarding gaining consent from selected interviewees to access their health and care records to be finalised. 20/5/2019 12 user interviews have been undertaken in a number of settings by Laura Cook from Health Watch as a pilot. Lessons learned and next steps discussed. LC drafting revise the interview schedule in light of findings and to agree next steps. Information sharing protocol agreed across partner organisations
2.4	CQCLSR18.19-10	2.4 Develop Regular Mechanisms	Develop regular mechanism to systematically share and learn continuously from older peoples end to end feedback as part of our evaluation and monitoring mechanism in relation to capturing and responding to system wide patient experience. This will be facilitated by vibrant quality improvement approaches across the system	31/12/2018			Closed		Rebecca Joyce ACP, Margaret Kilner, Healthwatch (Laura Cook)	25/7/19 work now embedded for continuous feedback from patients to record experience, and longer term funding agreed for continuation of this work. Older Peoples engagement group established. 20/5/2019 Interviews carried out about end to end experiences of older peopleand for Route 2 bed nursing homes. Interview findings have been shared with those involved in evaluating Route 2 beds, and will be presented at the WNHWNT Board on 13th May. 25.1.19 See above - advisory group and ongoing semi-structured interviews.
3	**CQCLSR18.19-12**	**Develop a Joined Up City-Wide Strategy for the Workforce**	**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 with the older peoples workforce. A Joint approach to improving quality so that staff working across health and care have the tools they need put "What Matters to You" into action. A Joined up vibrant training programme to support and**							
3.1	CQCLSR18.19-13	3.1 Establishment of a Workforce Oversight Group	Establishment of a workforce oversight group to steer the development of a strategy to be co-designed with frontline staff across the city.	31/12/2108			Open	Green	Workforce & OD Transformation Group	25/7/19 Draft workforce strategy now out for consultation 20/5/2019 see above re workforce skills group emerging from the workforce strategy. There will also be a group addressing identified recruitment and retention issues. 5/1/2019 Group steering 12 week process. 2 co-design workshops completed, rich outputs for strategy.
3.4	CQCLSR18.19-16	3.4 Publication of overall city wide strategy for workforce	Publication of overall city-wide strategy for workforce, with a focus on older people that is co-designed and connects the front line and the strategic vision. This needs to incorporate the private sector, voluntary and community sector as well as the statutory organisations. We will involve unions across Sheffield in the approach	31/03/2019			Open	Green	Workforce Group	25/7/19 Workforce strategy now developed into an all age strategy to ensure cohesion. Draft out for consultation. 20/5/2019 draft strategy now published with a view for final sign-off in September '19 25/1/2019 - see above. On track for April draft.
3.5	CQCLSR18.19-17	3.5 Key Work Force Initiatives identified in the Place Based Plan	Progress the key workforce initiatives identified in the Place Based Plan	31/03/2019			Open	Amber	Workforce & OD Transformation Group	25/7/19 Draft workforce strategy now out for consultation. 20/5/2019 draft workforce strategy now published with a view for sign-off in September '19 25/1/2019 No Further Update 31/10/2018 - Progress since July: Part of Wider Workforce Strategy Work - will be part of workforce strategy plan.
3.6	CQCLSR18.19-18	3.6 Embed a Training Module on Person Centred Care	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	31/12/2018			Open	Amber	Nicki Doherty, CCG/ Jane Ginniver, ACP / Susan Hird SCC	25/7/19 Identified in the draft strategy as a priority. Funds secured from HEE. 20/5/2019 plan outlined in the draft workforce strategy to develop this as a priority in 2019-20 25/1/2019 - implementation plan still needs to be determined - needs to be worked into strategy implementation approach.

WBS	ID	Task Name	Description	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
4	**CQCLSR18.19-19**	**A City Wide Organisational Development Approach**	**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** **High job satisfaction**							
4.1	CQCLSR18.19-20	4.1 Develop Organisation Development Interventions	Develop organisation development interventions to support and improve multi-agency working between frontline inter-agency teams	31/12/2018			Closed		Workforce & OD Transformation Group	25/7/19 OD interventions including Leading Sheffield, Collaborate, Shadow Board now developed and moving towards second cohorts. 20/5/2019 'Leading Sheffield' cohort launched in March 2019. 38 participants from across the system with the aim of developing system leadership capability and capacity, and expedite integrated working. First cohort due to conculde 22nd May, 2nd cohort planned to launch in September '19. 25/1/2019: Neighbourhood based "liminal leadership" cohort 2 to commence March. Promote MDT working.
4.3	CQCLSR18.19-22	4.3 A Single Quality Improvement Approach	Working towards a single quality improvement approach across health and social care	31/12/2018			Open	Amber	Mark Bennett SCC, Jane Ginniver ACP, Maddy Desforges VAS	25/7/19 Good feedback from SCC staff, some VCSE staff have attended introductory course with interest in wider training 20/5/2019 4 SCC staff currently being trained as MCA coaches. Inital conversations held with voluntary sector - capacity an issue - conversations ongoing. 25/1/2019 SCC and VCSE have committed to this but not yet happening.
4.4	CQCLSR18.19-23	4.4 Build on System Wide Improvement Programmes	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	30/09/2018			Open	Amber	Chief Nurses	30/7/2019 - CHC: Somewhere else to Assess (S2A) tender submission deadline 11.7.19 with seven bids received. S2A 'Team around the person' under development with lessons learnt from the model deployed in the Route 2 Beds |CHC Digital Transformation Business Case under development | PEG Project implemented 15.7.19 supported by the community investment fund, joint reporting to the LTC and Ongoing Care Programme Boards. 20/5/2019 - CHC: Care at Night successfully implemented. Values and behaviours workshops delivered with frontline workers with impacts starting to be seen in reduced complaints . High level Delivery Plan now being implemented with leadership & workstreams mobilised. Short Breaks approval rescheduled to July.
4.5	CQCLSR18.19-24	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	30/09/2018			Open	Green	Sue Butler, STH	30/7/2019 Comments have now been received in relation to the draft protocol and this now awaits final sign off across the city. Commenced collating the data for quarterly reporting, at STH we have added functionality to Datix to enable data collection routinely. 20/5/2019 2. A draft protocol for handling NHS/Social Services inter-agency complaints produced and awaiting comments from organisational Complainants Managers. A number of inter-agency complaints have been managed using the joint approach and lessons learned gathered. Complaints Managers sub-group to be asked to provide figures and feedback on a quarterly basis to the LSR Group.
5	**CQCLSR18.19-25**	**Strengthening our Strategic Partnership**	**strengthening our strategic partnership with the voluntary community and faith sectors to provide more seamless joint working for older people**	**31/12/2018**						

WBS	ID	Task Name	Description	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
5.1	CQCLSR18.19-26	5.1 Define New Strategic Working Relationship with VCF	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	31/12/2018			Open	Amber	ACP Board Chairs, Kathryn Robertshaw, Jane Ginniver	25/7/19 Initial funding agreed by ACP Board, with a view to progress to recruit in September 2019. To be reviewed after 12 months. Work ongoing to embed VCSE representstives on ACP workstreams. Conversations being held with the ICS about naitonal funding they have secured to invest in the VCSE 20/5/2019 CEOs have discussed and agreed importance of contracting differently and supporting sustainability of the sector. Proposal to EDG May 2019 and to ACP Board in June 2019. 25/1/2019 - Further consolidation of relationship throughout system required on ongoing basis.
5.3	CQCLSR18.19-28	5.3 How the ACP will enable the VCF to have the capacity to provide strategic leadership to the ACP	Develop a 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	31/12/2018			Open	Amber	Maddy Desforges, VAS, Kathryn Robertshaw, ACP	25/7/19 As above 20/5/2019 CEOs have discussed and agreed importance of contracting differently and supporting sustainability of the sector. Proposal to EDG May 2019 and to ACP Board in June 2019. 25/1/2019 - Plan presented at December EDG but conclusions not drawn about next steps. Ongoing.
6	**CQCLSR18.19-29**	**Strengthening our Supporting Governance**	**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 well-being board (understanding needs and driving priorities at city -wide level). ACP 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**				**Open**			
6.4	CQCLSR18.19-33	6.4 Review and Strengthening of Relationships	Review and strengthening of relationship with housing in operational, governance and strategic inter-agency working for older people	30/09/2018			Closed		Sara Storey, SCC	31/7/2019: There is a well-established Housing, Health and Care reference group in place and meeting regularly. 25/5/2019: Ongoing development of links between housing and care at SCC; capital requirements for housing being developed. Further work to do. 25/1/2019 - . Closer relationships housing/ ASC leading to better delivery of equipment adaptations - operational. Joint development of supported housing focusing on key schemes where health, housing and care can be better aligned. Adlington more sheltered independent living as new model of Homecare currently being developed. L 31/10/2018 - No changes since last update in July. Plan: Working in SCC to delivery a joined up approach to housing and social care to deliver a more targeted & effective approach to housing older people
6.5	CQCLSR18.19-34	6.5 ACP Delivery Plan	A clear programme ACP delivery plan with milestones informed by the plans for each of the work streams. This will require the partnerships to identify and secure the resource to co-ordinate, communicate and drive each of the programmes	31/12/2018			Open	Amber	Jane Ginniver, Kathryn Robertshaw, ACP	25/7/19 Shaping Sheffield endorsed by ACP Board and Health and Wellbeing Board. Workstreams met at 2-day TCSL course to progress plans more quickly. Focused action plans and visions to be agreed. 20/5/2019 Resources largely in place for delivery. Stronger delivery plan in place underpinning refreshed Shaping Sheffield plan (to be formally signed off June/ July 2019). 25/1/2019 - Overall plan developing, will be drafted for April following public and staff consultation process currently taking place.

WBS	ID	Task Name	Description	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
7	**CQCLSR18.19-35**	**Scaling up pilots, into sustanable, 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**							
7.2	CQCLSR18.19-37	7.2 Evaluate successful pilots and assess scale up	Evaluate successful pilots and assess scale up and implement on a city wide basis. This will include a review of Better Care Fund Schemes	31/12/2018			Open	Amber	Nicki Doherty, CCG	08/8/2019 Better care fund programmes reviewed and now drafting the 19/20 submission. 20/5/2019 Joint Commissioning Committee formally commencing April 2019. frailty one key priority. Provider/ commissioner conversations to be aligned with one shared narrative within refreshed Shaping Sheffield Plan.
7.3	CQCLSR18.19-38	7.3 Longer Term System Reshaping	Make recommendations about longer term system reshaping of investment priorities to develop new models of care and support (ie facilitated through the Sheffield Outcomes Fund etc)	31/12/2018			Open	Amber	EDG	20/5/2019 See above. 25.1.2019 - See above. Commissioner and provider discussions taking place on specific proposals. Needs to be brought together joint system approach.
7.4	CQCLSR18.19-39	7.4 New Models of care for mobilisation	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	31/03/2019			Open	Red	Commissioning Directors SCC, SCCG	25/7/19 no further progress made on developing new models of care. Needs urgent focus on links with PCNs and mental health investment 20/5/2019 remaining urgency to achieve system agreement and move into delivery 25/1/2019 - urgency to ensure decisions & actions to mobilise new model of care. This timescale is pressing challenging now.
8	**CQCLSR18.19-40**	**Review key supporting Strat & Funct Enablers to improve Effectiveness**	**Review key supporting Strat & Funct Enablers to improve Effectiveness focusing available resources on the support that has most impact for local people in helping them stay safe and well, and preventing avoidable deterioration.** **More seamless joint working for older people**							
8.1	CQCLSR18.19-41	8.1 Review of Digital Inter-Operability	Review of digital inter-operability and ability to share care information across boundaries	30/09/2018			Open	Amber	Sheffiedl CIOs	06/8/2019 Draft Strategic Outline Case (SOC) agreed by Chief Information Officers and being taken through organisations executive teams (or equivalents) for shaping over the summer. Final version to be presented to ACP EDG in October 2019 and Outline Business Case scheduled for completion December 2019. Delivery is expected to commence in 2020/21 and will be confirmed in the business cases when produced. 20/5/2019 Business case for end of June 2019. Behind plan on timescale but better CIO ownership and system support for approach.
8.2	CQCLSR18.19-42	8.2 Work towards a Joint Commissioning Strategy	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.	31/03/2019			Open	Amber	Maddy Ruff, CCG, John Mothersole, SCC	08/8/2019 July Joint Commissioning development session, reviewing the joint commissioning intentions for multi morbidity, with intent to prevent and reduce frailty. Plans to include securing a wide range of provision across neighbourhoods and localities to support new models of care and ensure stability in health and social care. Joint commissioning committee met in public on 24.6.19 and agreed terms of reference and priorities. 20/5/2019 Agreements now made, first Joint Commissioning Committee in April 2019. Frailty one of three priorities.

WBS	ID	Task Name	Description	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
9	**CQCLSR18.19-43**	**Ensure Flow & Best Use of System Capacity**	**Ensure Flow & Best Use of System Capacity so older people get timely support from the right person in the right place.**							
9.1	CQCLSR18.19-44	9.1 Ensure that the voice of the older person is heard	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	30/09/2018			Open	Green	Sue Butler, STH	30/7/2019 see 2.2, 2.3, 2.4 20/05/2019 see 2.2, 2.3, 2.4 25.1.2119 - see 2.2, 2.3, 2.4. Good progress. 31/12/2018 - Progress since July: see 2.2, 2.3, 2.4 co-ordination of patient experience across the system plus 2.3 wider work with strategic and operational partner to strengthen approach in ACP as a whole
9.2	CQCLSR18.19-45	9.2 Refresh of Independent Sector Homecare	Refresh of independent Sector Homecare "Primary Providers"	31/12/2018			Closed		Sara Storey SCC	31/7/2019: Action complete 21/5/2019: Independent sector much improved & outcomes on flow demonstrated in system DTOC position. Two actions - remodelled contracting and commissioning service to provide clearer focus on brokerage and quality assurance in independent sector, plus restructured team to better support. New longer term homecare models to sustain people in Sheffield. 25.1.2019 - Reorganisd primary home care provision to ensure greater provision for the city. Incentive schemes introduced to increase capacity in periods of peak demand mobilised and helping pts leave hosp quickly.
9.3	CQCLSR18.19-46	9.3 Development of Outcome based Independent Sector Homecare	Development of outcome-based independent sector home care	31/03/2018			Open	Amber	Sara Storey SCC	31/7/2019: Planning stage continues. Plan is still to start implementation phase in October. 21/5/2019: Draft propositions on outcome based homecare developed which will help develop a different longer term approach. 25/1/2019 - be clear about locality model in city by March for new home care model with implementation by Oct.
9.4	CQCLSR18.19-47	9.4 Joint Commissioning and Quality Assurance of Homecare and Care Homes between Council and CCG	Joint Commissioning and quality assurance of homecare and care homes between Council and CCG	31/03/2018			Open	Amber	Mandy Philbin, CCG, Sara Storey, SCC	31/7/2019: A jointly commissioned tender has been carried out and is I place for the care at night service. A jointly commissioned tender for somewhere else to assess beds has been carried out and awarded last week. 21/5/2019 - Improved infrastructure to support QA processes - further work to advance the proposal model with regards to Older People.
9.5	CQCLSR18.19-48	9.5 Agreement and Joint Commissioning of Non-home None-acute Bed Capacity	Agreement and joint commissioning of non-home, non acute bed capacity	30/09/2018			Open	Green	STH/ SCCG	08/8/2019 Discussion ongoing to confirm if offsite bed capacity will continue at the current level, be increased or decreased before winter 2019. 20/5/2019 Operational arrangements working well. Longer term plan and funding being discussed. 25/1/2019 Intermediate beds commissioned and working well, with good flow. Jointly managed across community team at STH/ Social Care
9.6	CQCLSR18.19-49	9.6 Gold Level Board Rounds on all wards with high DTOC levels	Gold Level Board Rounds on all wards with high DTOC levels	30/09/2018			Closed		Jennifer Hill, STH	08/8/2019 Gold board rounds are on all wards with high DTOC levels 20/5/2019 On track 25.1.2019 Largely in place, some risks around maintaining during operational pressures linked to Hadfield.

WBS	ID	Task Name	Description	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
9.7	CQCLSR18.19-50	9.7 Roll out across STH of the SAFER patient flow bundle	Continued roll-out across STH of the 'SAFER' patient flow bundle (which incorporates daily senior medical review. All patients having a planned discharge date, flow of patients beginning early in the day and all patients with a long length or stay being frequently reviewed). All these actions are of vital importance in ensuring that patients receive timely and safe care in the most appropriate location	30/09/2018			Open	Green	Jennifer Hill, STH	08/5/2019 SAFER is established across STH. While there is still work to do to re sustaining (roll out, adapt, secure buy in and bed down into practice) existing change and improvement approaches should sustain the work going forward. 09/5/2019 SAFER has achieved its transformational goals. Still work to do to re-sustaining (roll out, adapt, secure buy in and bed down into practice) existing change and improvement approaches should sustain the work going forward. Significant challenge maintaining SAFER on wards following Hadfield decant. STH Programme management office is continuing to provide support.
9.8	CQCLSR18.19-51	9.8 Initial Evaluation of 'Red to Green' work	Initial evaluation of RED to Green work to speed hospital decision making and discharge actions	30/09/2018			Open	Green	Jennifer Hill, STH	08/5/2019 No escalations to report 20/5/2019 Agreed that WNHWNT to receive quarterly reports or escalations for red to green going forward. No escalations to report for May. 25/1/2019 Roll out continuing, additional support from STH Organisational Development team during winter period.
9.9	CQCLSR18.19-52	9.9 Physio and OT Assessment in Acute Setting within 24 hrs	Physio and OT assessment in acute setting within 24 hours	30/09/2018			Open	Green	Jennifer Hill, STH	08/8/2019 No update 20/5/2019 Data from March 2019 – 98.03% of patients were assessed by PT and 95.99% by OT within KPI standard of 95% (part of hospital complete workstream) 25/1/2019 - HIghlight report outlines over 95% compliance with targets for therapy to support timely discharge.
9.10	CQCLSR18.19-53	9.10 Therapy Core Assessment and Triage Tool Roll Out	Therapy core assessment and triage tool rolled out to all wards	30/09/2018			Open	Green	Jennifer Hill, STH	08/8/2019 No update 20/5/2019 Progress remains on track for core assessment project with an aim to develop an electronic form on Lorenzo and only one profession needing to complete the initial assessment (part of hospital complete workstream)
9.11	CQCLSR18.19-54	9.11 Streamlined handover from hospital and community to single point of access	Streamlined handover from hospital and community to single point of access for community services	30/09/2018			Open	Amber	Sara Storey (SCC), Helen Kay (STH), Michelle Fearon (SHSC)	31/7/2019: No update. 20/5/2019 Ambitious proposal to integrate SPAs in Sheffield being explored. 25/1/2019 no update available at time of writing. 31/10/2018 - no updates since last report 26/09/2018 - Single Point of Access - Programme of work ongoing Plan: Detailed next steps TBC Capacity: SR Accountable body: UEC
9.12	CQCLSR18.19-55	9.12 Integration of Active Recover Services	Integration of Active Recovery Services provided by council and STH: common assessment, trusted assessors, single rostering system	31/12/2018			Open	Green	STH and SCC Leads. Sara Storey (SCC) and Helen Kay (STH)	31/7/2019: Work continues and the detailed program plan is on track. 21/5/2019: Work progressed - teams working jointly, joint systems, better alignment of teams. Tangible progress, opportuinity to consider potential further team integration. Opportunity to build on this further.

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Appendix 2

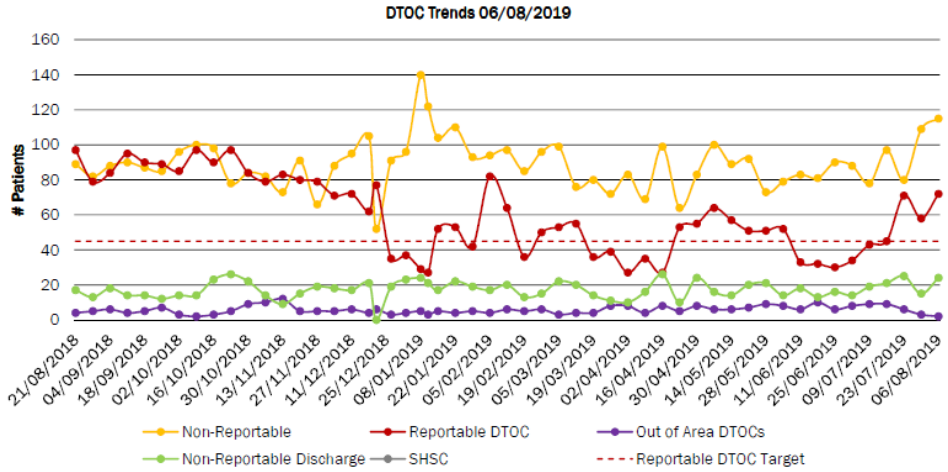
CQC Report: Why Not Home Why Not Today Metrics

The WNHWNT board has not met since the last CQC update report was produced on 20th May 2019. The data in this report is taken from the DTOC dashboard. Therefore we do not have the number of NHSE reported delays in days and the DTOC trend graphs are slightly different when compared to last months report.

Core metrics

- DTOC performance in early August shows the number of delayed patient has been above target for 3 weeks. Increases have continued to be effectively managed to ensure lower numbers than the same period last year overall.

Chart 1



Weekly reports generated to inform system wide operational management of all delays and focus upon 'delayed patients'. These reports allow a more immediate appreciation of performance and provide more granular data which in Chart 1 show an increase in the number of reportable delayed patients recently. The number of reportable delayed patients was below target from 11/06/19 for 5 weeks but sharply increased 23/07/19 and has been above the target of 45 since.

Chart 2

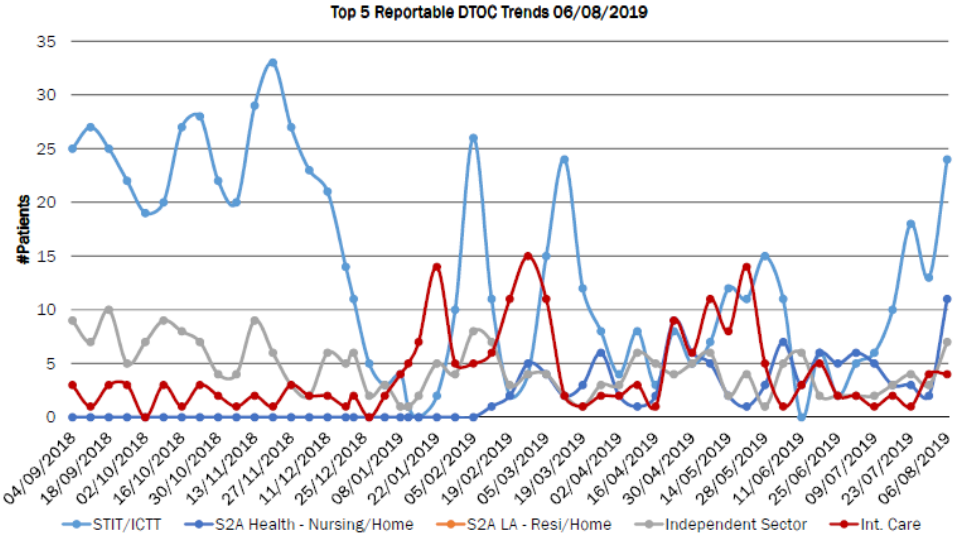


Chart 2 shows previously reduced queues within the Route 2 (home to assess) delay categories, although this has peaked at 06/08/19. A significant peak in demand for STIT/ICTT resulted in an increase in patients waiting in early February and in March. A similarly high peak has now been observed for August. Discussion with the operational teams has indicated that the rapid recovery in these peaks in demand have been achieved through flexibly switching between STIT and Offsite Community Beds (OCB) capacity. Future reports will show whether the peak in August is recovered as rapidly.

Route 2 Capacity Flexibility

Flexibility now provided by the Offsite Community Beds (OCBs) with the increased demand for Route 2 catered for via dovetailing STIT and OCB capacity to ensure delays are quickly tackled. Moreover, the OCBs and Intermediate Care Beds (ICBs) are now managed in tandem, teeming and ladling bed capacity between the two in order to provide a rapid response to changing demand patterns.

This flexible approach is co-ordinated via the weekly system 'Flow' meeting and informed by the daily TASK meetings.

Patient Experience

It is the intent of this report to include regular information on patient experience across the system. This report includes information provided by Laura Cook, Healthwatch.

Route 2 beds:

- Healthwatch Sheffield has interviewed three patients on Brearley 2 and completed two follow-up interviews with people in their own homes to capture experiences of returning home following a Route 2 bed stay.

- At the Older People Engagement Steering Group (OPESG) meeting on 30th July, members discussed 'who' already in the system could conduct similar interviews with patients in the future.

- Next steps regarding gaining consent from selected interviewees to access their health and care records to be finalised during the Route 2 interviews have been shared with CQC LSR Patient Experience meeting on 13/09/19. Route 2 patient case studies have been shared with the group.

Other work:

- 65+ Health and Care survey has been developed in partnership with the OPESG. The survey is currently live with a response deadline of 9th September. The findings aim to provide insight into what is and is not working well and captures respondent's demographic information to allow experiences of specific groups to be compared. Learning around partnership working to reach a diverse range of people will be captured.

- Healthwatch Sheffield is currently exploring the option of implementing an idea from the OPESG. The aim is to try out gathering patient and carer knowledge of local activities and groups for older people in GP surgery waiting rooms within a given neighbourhood area, to enable information to be collated and then shared within the same surgeries.

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 27 June 2019

PRESENT: **BOARD MEMBERS:**

Councillor George Lindars-Hammond (Chair) – Cabinet Member for Health and Social Care
Dr Tim Moorhead (Chair), Dr Nikki Bates, Barton, George Lindars-Hammond (Chair), Greg Fell, Mappin, John Mothersole and
Judy Robinson – Chair, Sheffield Healthwatch
Lesley Smith – Accountable Officer, Sheffield CCG
Kathryn Robertshaw – Joint Interim Accountable Care Partnership Director, Accountable Care Partnership
Maddy Desforges – Chief Executive Officer, Voluntary Action Sheffield

SUBSTITUTES IN ATTENDANCE:

Jennie Milner – Integration and Better Care Fund Lead, Sheffield Better Care Fund
Dawn Walton – Director of Commissioning, Inclusion and Learning, Sheffield City Council
Terry Hudson - GP Governing Body Member, Sheffield CCG

ALSO IN ATTENDANCE:

Dan Spicer – Policy and Improvement Officer, Sheffield City Council
Kay Kirk – Business Support to the Sheffield City Council Health and Wellbeing Board
Abby Brownsword, Principal Committee Secretary, Sheffield City Council

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Jackie Drayton, Councillor Paul Wood, Phil Holmes, Laraine Manley, Alison Knowles, Jane Ginniver, David Hughes, Jayne Brown, Alison Metcalfe, Chris Newman and Nicki Doherty.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest made.

3. PUBLIC QUESTIONS

3.1 There were no questions from members of the public.

4. CARE QUALITY COMMISSION SYSTEM REVIEW - ACTION PLAN UPDATE

4.1 Kathryn Robertshaw, Joint Interim Accountable Care Partnership Director, presented the CQC System Review Action Plan update. The position was more favourable than the previous quarter and good work had taken place regarding delayed transfer of care. There was now a draft integrated workforce strategy for Older People and a more holistic view was being taken of the user experience through the system. The Joint Commissioning Committee had now been established.

4.2 Areas of concern included: the new relationship with the voluntary sector, the commissioning focus on multi morbidity and reviewing digital inter-operability. There was a need to ensure that the correct names were associated with actions on an ongoing basis.

4.3 John Mothersole, Chief Executive, SCC, noted the importance of delivering actual change, rather than treating the Action Plan as a tick box exercise.

4.4 **RESOLVED:** That the areas of good practice be noted.

5. SHAPING SHEFFIELD - FINAL SIGN OFF

5.1 Kathryn Robertshaw, Joint Interim Accountable Care Partnership Director, presented the report which detailed the production of the Shaping Sheffield Plan. The plan was strategically rooted within the Health and Wellbeing Strategy and would be a dynamic document which would change as work-streams changed.

5.2 The plan had been updated to reflect feedback from the ACP, Executive Delivery Group (EDG) and Health and Wellbeing Board, feedback from all partner organisations, feedback from Healthwatch and the ACP Service User Advisory Group and contributions from individuals and teams across the system. It was now time to move to the delivery stage of the plan. The need for good communications was discussed.

5.3 Dr. Tim Moorhead welcomed the plan and noted that the Health and Wellbeing Strategy was looking for sponsors and there was a possibility that the two documents could be aligned. The next step was to consider how to take the plan forward.

5.4 The Chair asked whether any consultation had been carried out with Trade Unions and Kathryn Robertshaw explained that consultations had been carried out with all the main unions and a meeting with the GMB had taken place regarding their online learning resource.

5.5 The next step was to take the plan to all the ACP Boards and to look at how the plan could be implemented alongside the Health and Wellbeing Strategy.

5.6 **RESOLVED:** That:-

(a) Full partner support and ownership of the plan be confirmed and;

(b) The timetable for final sign off through system and partner boards, be noted as agreed by EDG and set out below:

ACP Board	21st June 2019
Health and Wellbeing Board	27th June 2019
Partner Boards	June/July Boards
ICS – For Information	Q2 Review Date

6. BETTER CARE FUND

6.1 Jennie Milner, Better Care Fund Programme Manager, presented the report which gave an update on:

- Progress on the Better Care Fund Programmes against the 17/19 narrative plan.
- Performance against the agreed Better Care Fund KPI's.
- The financial performance of the Better Care Fund pooled budget for 2018/19.
- Better Care Fund programme budget and high level plans for 2019/20.

6.2 The report also included details of system challenges within the year, the need to improve fragmented services and full details of the budget including overspend. The programme was in the best position for the last two years regarding delayed transfer of care, but the target on non elective admissions had not been met and it was felt that the target had been too ambitious and should be amended. Additional KPI's were also being proposed to measure performance.

6.3 John Mothersole, Chief Executive SCC, agreed that the target had been too ambitious, but that the figures were still heading in the wrong direction. It was hoped that the new Joint Commissioning Committee could help with issues such as this. He suggested that it may be useful to look at what would constitute a good distribution of resources would look like in 2021 to create a blueprint.

6.4 Sarah Burt, Sheffield CCG, welcomed the possibility of a blueprint of resources. Social investment provided a good opportunity to help manage pressures within the system.

6.5 The Chair stated that the report was a good representation of where we were now and it was hoped to spend the Better Care Fund more strategically in the future.

6.6 **RESOLVED**: That:-

(a) in considering the two questions set out in the report in relation to the Better Care Fund Update, the Board's answers be as follows:-

(1) *Is the progress to date on the way we work together sufficient?* The Health and Wellbeing Board noted that progress was ongoing.
(2) *Considering the latest joint Health and Wellbeing Strategy, feedback from*

the CQC Local System Review and the agreed action plan, does the Health and wellbeing Board require any additional information to the updates on the 2019/20 priorities? It was felt that the Health and Wellbeing Board had sufficient oversight.

(b) The update on the programme, be noted;

(c) The outturn budget for 2018/19, be noted;

(d) The establishment of the Joint Commissioning Committee and its alignment to the Accountable Care Partnership to add pace and scale to address the financial overspends, be noted;

(e) The delayed NHS England (NHSE) guidance and final template for the 2019/20 plan, be noted and;

(f) The proposed budget and priorities for 2019/20 be noted and final responsibility for approval be delegated to the Chair of the Health and Wellbeing Board, as it was subject to the published NHSE guidance and template.

7. TRANSITIONS AND SEND UPDATE

7.1 Dawn Walton, Director of Commissioning, Inclusion and Learning, SCC, presented the report which gave an update on transitions and SEND. This was the second update to the Board and lots of activity had taken place.

7.2 A Preparation for Adulthood project team had been established, the results from the Ofsted and CQC SEND inspection and the written statement of action had been approved and published.

7.3 Other actions included:

- Further work in early years services to ensure a child's additional needs are identified at the earliest opportunity and support put in place.
- Developing a package that supports the transition from nursery into primary school, with primary schools given details about their new SEN cohort in advance – to enable more effective planning/support to be put in place earlier on.
- Vulnerable Learner Reviews to more effectively identify the support children need in advance and during key transition stages – including the move from primary to secondary school and into adulthood – and for those at risk of exclusion.
- Developing the post-16 offer for young people with SEND, to include meaningful activities for those unlikely to move into employment.
- Greater involvement from health and social care at transition points.
- Developing clearer and smoother pathways from children's to adults services.

7.4 Greg Fell, Director of Public Health, SCC, noted that there was beginning to be a distinction between a principles approach and a service approach. Dawn Walton replied that work was still needed to change the culture, but the right mechanisms were in place.

7.5 Dr. Tim Moorhead asked how much engagement there had been with families. Dawn Walton felt that there had been a lot of engagement, including with the Parent and Carer Forum.

7.6 There was still a challenge between adhering to the statutory framework and being meaningful. All new plans were completed within the 20 week statutory timescale, but there was a need to ensure that the right provision was available.

7.7 **RESOLVED:** That the update be noted.

8. ACCOUNTABLE CARE PARTNERSHIP PROGRAMME DIRECTORS REPORT

8.1 Kathryn Robertshaw, Joint Interim Accountable Care Partnership Director, presented the report which provided an overview of the programme activities. The leadership of the ACP was going through some changes and a review of the chief executive sponsorship and workstreams was ongoing. The report also included details of the Risk Log.

8.2 A two day development session had given workstreams an opportunity to focus on developing delivery plans and to make connections between their areas of work.

8.3 The report gave an outline of the work in the following areas:

- Elective Care
- Urgent and Emergency Care
- Long Term Conditions and New Model of Care
- Mental Health and Learning Disabilities
- Primary Care and Population Health Management
- Childrens and Maternity
- Digital
- Workforce/Organisational Development
- Pharmacy Transformation
- Communications and Engagement
- Payment Reform

8.4 It was noted that all the ACP Boards needed to be better aligned and there was a need to ensure that reports to the Health and Wellbeing Board should be more strategic.

8.5 **RESOLVED:** That the following be noted:-

(a) Shaping Sheffield Plan had been developed with good cross system engagement and was now ready for final sign off by the ACP Board and Health and Wellbeing Board;

(b) Re-visioning work was underway for the LTC Board and;

(c) The Risk Log be noted.

9. MINUTES OF THE PREVIOUS MEETING

9.1 **RESOLVED**: That the minutes of the meeting of the Board held on 28th March 2019, be approved as a correct record.

9.2 Further to Minute No. 4, Greg Fell, Director of Public Health, SCC, reminded Board Members of the Health and Wellbeing Strategy launch event to take place next week.

10. DATE AND TIME OF NEXT MEETING

10.1 It was noted that the next meeting of the Health and Wellbeing Board would be held on Thursday 26th September 2019, starting at 3.00pm.