Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 27 March 2014 at 2.00 pm

Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Julie Dore	Leader of the Council
Dr Tim Moorhead	Clinical Commissioning Group
Dr Amir Afzal	Clinical Commissioning Group
Ian Atkinson	Clinical Commissioning Group
Councillor Jackie Drayton	Cabinet Member for Children, Young People and Families
Pam Enderby	Healthwatch Sheffield
Councillor Harry Harpham	Deputy Leader/Cabinet Member for Homes & Neighbourhoods
Margaret Kitching	South Yorkshire and Bassetlaw Cluster
Councillor Mary Lea	Cabinet Member for Health Care and Independent Living
Jayne Ludlam	Executive Director, Children, Young People & Families
Laraine Manley	Executive Director, Communities
Dr Zak McMurray	Sheffield Clinical Commissioning Group
John Mothersole	Chief Executive
Dr Ted Turner	Clinical Commissioning Group
Dr Jeremy Wight	Director of Public Health

Sheffield City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

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

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

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

PUBLIC ACCESS TO THE MEETING

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

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

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

FACILITIES

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

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

27 MARCH 2014

Order of Business

1. Apologies for Absence

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

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

4. Health and Wellbeing Plans for Sheffield in 2014-15 (Pages 5 - 74)
Joint report of the Leader of Sheffield City Council, the Chair of NHS Sheffield Clinical Commissioning Group and the Director of Quality and Nursing, NHS England (South Yorkshire and Bassetlaw).

5. Joint Strategic Needs Assessment Annual Report 2013-14 (Pages 75 - 84)
Report of the Director of Public Health.

6. Joint Health and Wellbeing Strategy Work Programmes
To receive presentations regarding the five Work Programmes:

a. A Good Start in Life
b. Building Mental Wellbeing and Emotional Resilience
c. Food, Physical Activity and Active Lifestyles
d. Health, Disability and Employment
e. Supporting People At or Closer to Home

7. Minutes of the Previous Meeting (Pages 85 - 92)
To approve the minutes of the meeting held on 12 December 2013.

8. Date and Time of Next Meeting
The next meeting is on Thursday 26 June 2014 at 2.00pm, at the Town Hall Sheffield

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

New standards arrangements were introduced by the Localism Act 2011. The new regime made changes to the way that members' interests are registered and declared.

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, and has been published on the Council's website as a downloadable document at -http://councillors.sheffield.gov.uk/councillors/register-of-councillors-interests

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

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

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

Further advice can be obtained from Lynne Bird, Director of Legal Services on 0114 2734018 or email **lynne.bird@sheffield.gov.uk**

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Councillor Julie Dore, Leader of Sheffield City Council Dr Tim Moorhead, Chair of NHS Sheffield Clinical Commissioning Group Margaret Kitching, Director of Quality and Nursing, NHS England (South Yorkshire and Bassetlaw)
Date:	27th March 2014
Subject:	Health and Wellbeing Plans for Sheffield in 2014-15: Plans from Sheffield City Council, NHS Sheffield Clinical Commissioning Group and NHS England (South Yorkshire and Bassetlaw)
Author of Report:	Louisa Willoughby, 0114 205 7143

Summary:

Sheffield's Health and Wellbeing Board exists to bring together the many elements of the health and wellbeing system in Sheffield and provide a joint strategy and structure for making decisions that benefit the health and wellbeing of Sheffield people. The Board is built on positive and fruitful relationships and partnership between the organisations that commission health and wellbeing services across the city.

This paper presents the Health and Wellbeing Board's priorities for 2014-15. It also presents the plans for the different organisations on the Health and Wellbeing Board, which are shaped by the Health and Wellbeing Board's Joint Health and Wellbeing Strategy, service users' needs and budget considerations.

In addition, the paper presents the Board's ambitious plans for integrating health and social care over 2014-15 and beyond. This includes the Board's plans for the use of the Better Care Fund.

Questions for the Health and Wellbeing Board:

- Do the plans contribute enough to delivering the Joint Health and Wellbeing Strategy?
- Are there areas for greater joint working between the four organisations on the Health and Wellbeing Board (and others) in 2014-15 and looking to the 2015-16 budget setting process?
- Does the Board have any specific comments to make regarding any of the organisations' plans (Appendices A-C)?
- What role is there for Healthwatch Sheffield over the coming year in assisting with the implementation of these plans?

Recommendations for the Health and Wellbeing Board:

- That the Board formally approves the plan for the Better Care Fund (Appendix D).
- That Board members and the Board's organisations commit to working together in an integrated way over the coming year.

Background Papers and Appendices:

- Health and Wellbeing Board Joint Health and Wellbeing Strategy: available online at https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html.
- Sheffield City Council Budget 2014-15: summarised in Appendix A with more detail online at https://www.sheffield.gov.uk/your-city-council/finance/how-we-spend-budget.html.
- NHS Sheffield Clinical Commissioning Group Commissioning Intentions 2014-19: set out in Appendix B.
- NHS England (South Yorkshire and Bassetlaw) Commissioning Intentions 2014-15: set out in Appendix C.
- Sheffield Health and Wellbeing Board's plans for the integrated commissioning (including the Better Care Fund): set out in Appendix D and available online at https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/integration.html.
- Health and Wellbeing Board Forward Plan for 2014-15: set out in Appendix E.

HEALTH AND WELLBEING PLANS FOR SHEFFIELD IN 2014-15: PLANS FROM SHEFFIELD CITY COUNCIL, NHS SHEFFIELD CLINICAL COMMISSIONING GROUP AND NHS ENGLAND (SOUTH YORKSHIRE AND BASSETLAW)

1.0 SUMMARY

Sheffield's Health and Wellbeing Board exists to bring together the many elements of the health and wellbeing system in Sheffield and provide a joint strategy and structure for making decisions that benefit the health and wellbeing of Sheffield people. The Board is built on positive and fruitful relationships and partnership between the organisations that commission health and wellbeing services across the city.

This paper presents the Health and Wellbeing Board's priorities for 2014-15. It also presents the plans for the different organisations on the Health and Wellbeing Board, which are shaped by the Health and Wellbeing Board's Joint Health and Wellbeing Strategy, service users' needs and budget considerations.

In addition, the paper presents the Board's ambitious plans for integrating health and social care over 2014-15 and beyond. This includes the Board's plans for the use of the Better Care Fund.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

The Health and Wellbeing Board's Joint Health and Wellbeing Strategy recognises that good health and wellbeing is a matter for every service area, and that people are healthy and well not just because of the health and social care they receive, but also because of the nature of the housing, environment, communities, amenities, activities and economy surrounding them. The Board's Strategy focuses therefore not just on specific interventions to improve health and social care, but also on the 'wider determinants' of health. This means that the Health and Wellbeing Board aims for *all* Sheffield people to be *positively* affected by its plans to improve health and wellbeing in Sheffield.

Of course, the Health and Wellbeing Board cannot prevent all sickness and ill health, but this paper sets out plans to best support and maintain Sheffield peoples' health and wellbeing in 2014-15. The plans of the organisations which make up the Health and Wellbeing Board also have a preventative focus, working to delay people's need for long term help, care and support.

In creating its Joint Health and Wellbeing Strategy, the Health and Wellbeing Board has been careful to engage closely with Sheffield people and service users, providers and members of the public. The Board can be confident that its Strategy, and therefore its plans, reflect the needs and concerns of Sheffield people. Services will work together with Sheffield people to design and deliver services which best meet the needs of an individual.

3.0 HEALTH AND WELLBEING COMMISSIONING IN SHEFFIELD

3.1 A review of the Health and Wellbeing Board in 2013-14

Sheffield's Health and Wellbeing Board has existed as a statutory body since April 2013, and therefore from April 2014 will be entering its second year. 2013-14 was an effective year in which:

- A Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy were approved, following consultation with over 1,500 citizens.
- The Board's work on the integration of health and social care began in earnest with two engagement events in July and October 2013, followed by further engagement. This paper and its appendices set out some of the practical implications following on from this engagement work.
- Work continued in each of the Board's five work programmes, including strategies for Food and Physical Activity in the city and continued work on giving children the best start in life.
- The Board heard about and responded to a range of issues, including the Dublin Declaration for Age-Friendly Cities and Communities, the Prime Minister's Challenge on dementia, the inquiries into Winterbourne View and Mid-Staffordshire, the Fairness Commission, and the Director of Public Health's Report.
- The Board was shortlisted in the Health Service Journal Awards for its partnership between the NHS and local government.
- Healthwatch Sheffield was formally established and became a full member of the Board.

3.2 An explanation of the different commissioning arrangements and responsibilities for improving health and wellbeing in Sheffield

'Commissioning' is the identification of needs and the buying of services to meet those needs. As the King's Fund's 'Alternative Guide to the NHS in England' demonstrates,[1] there is no simple commissioner of health and wellbeing services in Sheffield, and there is no simple way of identifying how much money is available and spent to improve health and wellbeing and to provide the vital services that people need to stay healthy and well.

In addition, as the Health and Wellbeing Board's Joint Health and Wellbeing Strategy recognises, health and wellbeing is supported by a number of things, not just direct GP, hospital or social care provision. It is therefore equally difficult to provide a full account of where resources are being deployed which will have an impact on health and wellbeing.

However, roughly speaking, in Sheffield the following organisations are responsible for commissioning and procuring health and wellbeing services:

- **Sheffield City Council** is responsible for a whole range of services and support for Sheffield people. Most explicitly in health and wellbeing terms it is responsible for: adult

[1] For more information: http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england.

social care, children's social care, public health and support for local communities. It is also responsible for some of the 'wider determinants' of health, such as education, employment and skills, economic development, libraries, town planning and housing, countryside and environment, and much more. In some areas the Council also provides the services people need as well as pays for them.

- **NHS Sheffield Clinical Commissioning Group** is responsible for commissioning a good proportion of NHS services in the city. It does not itself provide the services (this is done, mostly, by the main NHS providers in the city[2] and the independent and voluntary, community and faith sectors). The Clinical Commissioning Group is GP-led, ensuring clinical expertise is at the heart of decision-making.

- **NHS England South Yorkshire and Bassetlaw** is responsible for areas of commissioning that benefit from a *regional* perspective, such as specialised NHS services (like heart surgery and many areas of paediatric medicine and surgery) and some public health services (such as cancer screening and immunisation programmes). NHS England South Yorkshire and Bassetlaw is also responsible for funding Sheffield's GPs and other elements of primary care, such as dentistry, pharmacy and optometry.[3]

- Health and wellbeing services are commissioned and provided in Sheffield by other organisations, such as national charities or the Big Lottery Fund.[4] However, while being able and willing to fully support such initiatives, the Health and Wellbeing Board has little direct control over where the money is spent.

Sheffield's Health and Wellbeing Board is in a unique position to bring together the different organisations which commission health and wellbeing services in the city. Board members[5] come from a variety of backgrounds and from all of the three main commissioning organisations listed above, supported by Healthwatch Sheffield as the voice of Sheffield people.

It is important to note that the organisations listed above operate to different commissioning models and timeframes. As a national organisation, NHS England has to consult with a range of organisations and stakeholders; whereas the local authority and Clinical Commissioning Group are able to be much more driven by local priorities. However, while the local authority sets an annual budget in March of each year, the Clinical Commissioning Group sets out what it wishes to change over the coming year rather than setting out specific spending (and saving) plans. The differences in approach do not mean that sharing priorities and having joined-up, coordinated plans is impossible; however, it does mean that continuous effort is required to act in an integrated way between partners. This is one of the roles of Sheffield's Health and Wellbeing Board.

Section 4 below sets out the Health and Wellbeing Board's strategy and priorities for improving health and wellbeing in Sheffield in 2014-15 and section 5 details the plans of the partners on the Health and Wellbeing Board. Section 6 below sets out one of the main ways

[2] Namely, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Children's Hospital NHS Foundation Trust and the Sheffield Health and Social Care NHS Foundation Trust.
[3] See paper setting out the developing strategy for primary care in Appendix C.
[4] The Health and Wellbeing Board fully supports ongoing bids from partnerships in Sheffield to the Big Lottery as part of its Fulfilling Lives Programme: A Better Start and Ageing Better.
[5] For more information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/board.html.

that the Health and Wellbeing Board is bringing the three commissioning organisations together to improve health and wellbeing in the city this year.

4.0 THE HEALTH AND WELLBEING BOARD'S PRIORITIES

4.1 The Health and Wellbeing Board's Strategy

Sheffield's Health and Wellbeing Board formally agreed in September 2013 a Joint Health and Wellbeing Strategy.[6] This was based on the evidence of the Joint Strategic Needs Assessment.[7] Both documents were agreed following extensive consultation with Sheffield people and with professionals who work in the fields of health and wellbeing.[8]

At the heart of the Strategy are five outcomes, listed below with the vision for each outcome:

1. **Sheffield is a healthy and successful city.**

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

2. **Health and wellbeing is improving.**

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

3. **Health inequalities are reducing.**

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

[6] For more information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html.
[7] For more information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA.html.
[8] For more information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/strategy-consultation.html.

4. **People get the help and support they need and is right for them.**

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

5. **Services are innovative, affordable, and deliver value for money.**

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

4.2 The Health and Wellbeing Board's priorities for 2014-15

It is in the context of the vision set out in the Joint Health and Wellbeing Strategy that the Health and Wellbeing Board's priorities for 2014-15 have been formulated. These are as follows:

1. **Integration and health inequalities**. Board members have agreed two main areas of focus for 2014-15: integrating health and social care and tackling health inequalities in the city. More information about integrating health and social care is set out in section 6.0 and Appendix D.

2. **The Joint Health and Wellbeing Strategy**.[9] Over 2014-15, the Health and Wellbeing Board will monitor:

    a. The Joint Health and Wellbeing Strategy's *outcomes*. Each outcome will be considered over the course of the year (see Appendix E).

    b. The Joint Health and Wellbeing Strategy's *indicators of progress*. These will be considered in September 2014.

    c. The Joint Health and Wellbeing Strategy's *work programmes*.[10] These will be considered in March 2014 and March 2015.

    d. The *evidence base* for the Joint Health and Wellbeing Strategy. This is called the Joint Strategic Needs Assessment.[11] Updates will be provided as appropriate.

[9] For more information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html.
[10] For more information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy/work-programmes.html.
[11] For more information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA.html.

3. **Commissioning by the organisations seated on the Board**. Health and Wellbeing Board partners have been involving one another in developing their plans for 2014-15 (see section 5.0 of this paper and appendices). Over the coming year, Board members will assist one another in delivering and formulating plans.

4. **Influencing and involving others**. As the key strategic lead for health and wellbeing in Sheffield, the Health and Wellbeing Board has a role to play in influencing partners and engaging with members of the public. It will do this through events and communications. The Board sends out a monthly e-newsletter which over 1,500 people receive and which publicises information about meetings, events and consultations, enabling individuals and organisations to get involved. Other tools are used to ensure that the Board's work is communicated across the city.[12]

Board meetings will consider all of these issues, and any upcoming and new issues, over the course of 2014-15. Individuals and organisations are invited to attend meetings, ask questions, and get involved in the agenda of the Board in 2014-15.

5.0 THE HEALTH AND WELLBEING BOARD'S PARTNERS' PLANS

The Health and Wellbeing Board has a role to play in commenting on and influencing the different plans of the Board's key partners. These are set out in brief below, and in detail in the Appendices:

- **Sheffield City Council**'s plans cover a wider range of areas, based on the outcomes set out in the Council's Corporate Plan.[13] Under the Council's Better Health and Wellbeing Strategic Outcome,[14] the following four priorities have been set out:
    - Doing what we can to help people stay independent, safe and well.
    - Targeting our support on those that need it most, to reduce health inequalities.
    - Making sure services in this area are as efficient and effective as possible.
    - Working more closely with health services so that people get better coordinated help and support.
- **NHS Sheffield Clinical Commissioning Group**[15] has identified the following ambitions as part of its five-year plan:
    - All those who are identified to have emerging risk of admission through risk stratification, are offered a care plan, agreed between them and their clinicians (potentially 15,000 people).
    - To have integrated primary and community based health and social care services underpinned by care planning and a holistic approach to long-term conditions

[12] More information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board.html.
[13] Sheffield City Council Budget 2014-15 is available online at http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=154&MId=5373&Ver=4 with supporting detail at https://www.sheffield.gov.uk/your-city-council/finance.html.
[14] For more information: https://www.sheffield.gov.uk/your-city-council/finance/2014-2015-budget.html.
[15] See plans set out in Appendix A.

management to support people living independently at home, reducing emergency hospital admissions by up to 20% and emergency department attendances by up to 40%.

- Care requiring a specialist clinician will be brought closer to home, changing the place or method of delivery for a significant proportion of current hospital attendances.
- We will reduce the number of excess early deaths in adults with serious mental illness to be in line with the average of the best three core cities in England, and achieve similar improvements in life expectancy for people with learning disabilities.
- We will have put in place support and services that will help all children have the best possible start in life.

- **NHS England South Yorkshire and Bassetlaw**[16] has identified a range of objectives for the three areas of specialised work it commissions. These include:
  - Commission high quality services.
  - Reduce health inequalities and the variation in the uptake of services.
  - Concentrate services in centres of excellence.
  - Role of primary care services maximised in prevention of ill health and promotion of health and wellbeing.
  - Patient/user experience improves measurably.

6.0 INTEGRATED COMMISSIONING

Sheffield's Health and Wellbeing Board has a role to bring together and to coordinate the different areas of investment in health and wellbeing in Sheffield into a single approach and a shared vision that benefits Sheffield people and spends money effectively. This is one of the main purposes for and benefits of having a Health and Wellbeing Board, and Sheffield's Board takes this opportunity seriously.

In some areas, this calls for full integration of health and social care; that is, a removal of organisational barriers, budgets and perspectives to focus on the individual. The Board's Joint Health and Wellbeing Strategy consultation demonstrated that members of the public did not want to be passed from 'pillar to post' in the system, but wanted to receive excellent, individualised care.[17] Integrated, joined-up care that brings together NHS, social care, and other forms of care and support provided in people's homes and communities is massively important in improving people's health and wellbeing.

The four partners on the Health and Wellbeing Board will be working together to make changes to ensure they work and commission in a more integrated way to improve Sheffield

[16] See plans set out in Appendix B.
[17] For more information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/strategy-consultation.html.

peoples' experience. Explicitly, this will involve more direct sharing of budgets, risk, personnel and decision-making between organisations.

The Health and Wellbeing Board will be developing its plans for integration in a range of areas in 2014-15, ready for 2015-16 budgets. The plans include the Better Care Fund, which is a reallocation of £3.8billion[18] across the country to bring about a transformation in the way the NHS and local authorities work together and with local communities. This money needs to be spent in 2015-16, but local Health and Wellbeing Boards need to plan *now* to ensure the money can be spent in a year's time.

Sheffield's Better Care Fund plan,[19] which the Health and Wellbeing Board has a responsibility to approve in March 2014, sets out the following vision for integrated care:[20]

We want to integrate health and social care so that:

- People – including *children, young people and adults* – get the right care, at the right time and in the right place.
- People and their communities in Sheffield support each other to improve and maintain their wellbeing and independence.
- Organisations in Sheffield work together to help people and their communities to build and strengthen the support they provide to each other.
- Expert help is available to help people to take control of their own care so that it is genuinely person-centred, and complements and builds on the assets they have.
- Health and care services are focussed on a person's needs - organisational boundaries do not get in the way.

The Health and Wellbeing Board's work in 2014-15 will be focussed on four main areas, all areas that are in keeping with the ambitions set out in the Joint Health and Wellbeing Strategy:

1. Keeping people well in their local community.
2. Intermediate care.
3. Community equipment.
4. Long-term high support.

The Board is committed to working with members of the public and providers on this work in 2014-15. It is an exciting opportunity to remodel sand redesign some areas of the health and wellbeing system so as to achieve better outcomes for Sheffield people.[21]

[18] For more information: http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE.
[19] See Appendix D and https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/integration.html.
[20] This vision built on the engagement events the Health and Wellbeing Board ran in 2013. For more information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/engagementevent.html.
[21] To register your interest in being involved, go to https://www.surveymonkey.com/s/GDP7XX9.

6.0 QUESTIONS FOR THE BOARD

- Do the plans contribute enough to delivering the Joint Health and Wellbeing Strategy?
- Are there areas for greater joint working between the four organisations on the Health and Wellbeing Board (and others) in 2014-15 and looking to the 2015-16 budget setting process?
- Does the Board have any specific comments to make regarding any of the organisations' plans (Appendices A-C)?
- What role is there for Healthwatch Sheffield over the coming year in assisting with the implementation of these plans?

7.0 RECOMMENDATIONS FOR THE BOARD

- That the Board formally approves the plan for the Better Care Fund.
- That Board members and the Board's organisations commit to working together in an integrated way over the coming year.

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Sheffield City Council

Health and Wellbeing Budget Plans 2014-15

1. Introduction

Sheffield City Council is responsible for a whole range of services and support for Sheffield people. Most explicitly in health and wellbeing terms it is responsible for: adult social care, children's social care, public health and support for local communities. It is also responsible for some of the 'wider determinants' of health, such as education, employment and skills, economic development, libraries, town planning and housing, countryside and environment, and much more.

This paper sets out the Council's main spending priorities and intentions for 2014-15. This are set out in more detail in the budget document that is available on the Council's website.[1] The Council has made its plans firmly in line with the aspirations set out in the Health and Wellbeing Board's Joint Health and Wellbeing Strategy.[2]

2. Services for adults

We spend around £150 million each year helping adults across Sheffield stay healthy and well. This is our second biggest area of our spending, behind education. Most of our money goes on Adult Social Care – helping thousands of people who need extra help and support to stay independent, safe and well. This includes paying for more than one million hours of home care every year and spending £1.5 million *every week* on accommodation for people who are not able to live independently at home.

This area also includes our Housing Service. We are the landlord for 41,000 properties and responsible for 2,100 leasehold properties in Sheffield. The rent we collect from tenants pays for the cost of our Housing Service and the work they do to support tenants and keep properties in good condition. We know that good quality housing can make a difference to people's health and wellbeing.

In previous years, we have been able to protect most of our spending on adult social care by finding most of the savings needed from other service areas. The scale of the Government funding cuts means that we can no longer protect our adult social care budgets – the severity of the cuts to other services would be unacceptable to us and the public. We expect therefore to reduce our adult social care spending by around £40 million over the next two years. This means significant reductions in spending over a short period of time. At the same time, there are changes planned to national legislation about how

[1] https://www.sheffield.gov.uk/your-city-council/finance/how-we-spend-budget.html.
[2] https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html.

people will pay for their care in future. This means that adult social care will be a challenging area for some time and that we will have to make changes to ensure that services are as effective and efficient as they can be, ahead of these national changes which are expected to be introduced after the next general election.

We are committed to ensuring Sheffield people can stay healthy, stay out of hospital, and live independently at home for as long as possible. We will therefore focus our spending in this area on:

- Doing what we can to help people stay independent, safe and well.
- Targeting our support on those that need it most, to reduce health inequalities.
- Making sure services in this area are as efficient and effective as possible.
- Working more closely with health services so that people get better coordinated help and support.

We are working hard to make services more joined-up and efficient. However, the scale of the continued Government cuts to our funding means that we have to make difficult decisions. Our principles for reducing costs include:

- Providing information, advice and signposting about services available in the community which people can access directly to support their independence and wellbeing.
- Only funding services that meet unmet eligible social care needs in the most cost effective way.
- We remain committed to giving people choice or control over how their needs are met, but we will be more mindful of value for money. For example, we won't pay a higher price for someone's personal care if a good quality alternative provider can meet these needs for less. If someone wants to use a more expensive provider then they will have to pay the extra cost themselves.
- We will continue to offer people Direct Payments so that they can arrange and pay for their own care if that is their wish. However, we need to make sure that everyone who receives a Direct Payment is able to manage it, and that the arrangements meet their care needs. We will review people's Direct Payments at least every year.
- We will help more people get the financial support they are entitled to from Government.
- We will not meet the cost of care and support services that are already funded elsewhere.
- We will develop new types of accommodation that help people stay independent, safe and well at a lower cost than traditional alternatives.
- We will help more people to help themselves by offering professional support, physical therapies, and more innovative equipment and technology.

- We will encourage providers of innovative, more cost effective care and support services to increase the amount of people they can support.

Spending plans

Therefore, our spending on adult social care and other elements over 2014-15 will amount to roughly the following:[3]

	Page Ref	Gross Expenditure £000	Gross Income £000	Net Expenditure £000
BUSINESS STRATEGY				
Improvement and Development	138	1,296	170	1,126
Quality and Safeguarding	140	2,072	877	1,195
Executive and Portfolio-wide Services	142	1,137	1,456	-319
		4,505	2,503	2,002
CARE AND SUPPORT				
Joint Learning Disability Service	144	55,595	2,681	52,914
Assessment and Care Management	149	78,883	2,830	76,053
Provider Services	154	14,761	2,840	11,922
Housing Related Services	158	5,555	2,924	2,630
Contributions to Care	160	1,632	32,754	-31,121
		156,426	44,029	112,398
COMMISSIONING				
Housing Commissioning	162	22,245	5,512	16,734
Mental Health Commissioning	165	13,913	1,425	12,488
Social Care Commissioning	168	5,480	1,499	3,981
		41,638	8,436	33,203
COMMUNITY SERVICES				
Community Safety	170	507	66	441
Libraries	172	6,426	1,246	5,180
Locality Management	174	3,183	110	3,073
Public Health	176	12,062	11,633	429
		22,178	13,055	9,123
		224,747	68,023	156,726

[3] This table has been taken from the Council's annual budget for the *Communities Portfolio* which is available online at https://www.sheffield.gov.uk/your-city-council/finance/how-we-spend-budget.html. The *Communities* budget does not just cover adult social care. The figures for public health on this table represent those elements of the public health grant spend that are allocated to this portfolio.

3. Services for children and young people

Outcomes for children in Sheffield are the best they have ever been however we know there is more to do to ensure all children and young people get a great education, are safe and healthy. We spend about £80 million on services for children, young people and their families – about 16% of our net revenue budget - and just over £360 million is spent on education by schools, including Academies, in the city.

Our ambition for Sheffield is that "every child, young person and family achieves their full potential by raising expectations and attainment and enabling enriching experiences". To help us achieve this vision our £80 million is spent in three main areas.

- Keeping children, young people and families safe, healthy and thriving and giving every child a great start in life. Children's social care will always be a priority for us and this is where we spend the majority of our £80 million. This includes residential care, our fostering and adoption services and support for those children and families who live in difficult circumstances and where there is a risk to children and young people's safety. We believe spending money on prevention is an effective and efficient use of our resources, so this includes money spent on helping families before crises hit.
- Developing skills for life & work and encouraging active, informed and engaged young people into further education, employment or training. Increasingly we are spending our limited resources in a targeted way, supporting young people and helping those who are most at risk of not being in education, employment or training (NEET) when they leave school. This is an area we are leading the way in nationally: we've agreed a deal with Government whereby we have control of the funding and are redesigning and improving the skills system. We're putting much more power in the hands of employers and local businesses, and with other local authorities, agreed to deliver 4,000 new apprenticeships and 2,000 upskilled employees by 2016
- Supporting schools and children and young people's education being the advocate and champion for Children, Young People and Families and improving the quality of learning outcomes and attainment for all. The Council's role with schools is changing because all schools and particularly Academy schools are increasingly free to make their decisions about how they are run. Although we don't run schools, and haven't for many years, we do still have an important job to do and our statutory responsibilities haven't changed.

We work in partnership with schools and other education providers on the key educational issues affecting the whole city such as school places or support for vulnerable learners. We challenge schools where their performance is not good enough and support them to improve. We provide a number of services to schools for their children and young people, and schools buy many of these services from us, for example school music service, transport for some children with Special Education Needs and some administrative support.

Within this area of spending, we've made a lot of changes to how we deliver and pay for services – increasingly working in partnership with others, including schools. We have found savings on management, premises and admin costs whilst protecting as much as we can services to children and families.

Next year we need to find further cuts of about £10 million from our current spending on Successful Young People and Families and a further £4 million to address cost pressures. Our challenge is that we have to quickly reduce how much we spend, whilst focusing on the ambitions we want to achieve for the City and ensuring we keep a close eye on the impact of any changes we make, in particular the risks, especially on any particularly affected groups of people and the City in general.

Our approach to address this budget challenge will be to continue to:

- Keep children and young people safe. We will invest in prevention and early intervention, making sure that we do as much as we can to support children and their families before a crisis hits. We have worked hard over recent years to make sure there are better options for children and young people than residential care – such as fostering and adoption placements with families and in community settings. This means we need to purchase less residential care.

- Support young people into further education, employment or training. We will continue our approach of increasingly targeting resources to those who most need our help and where we can have the biggest impact. We propose to focus our spending on those young people who most need our help. This is an area where we have prioritised investment and have developed innovative proposals to provide opportunities for young people and which match the training that young people receive with the needs of local employers. As our funding reduces, we will be less able to provide funding for activities for young people so we will be working to encourage and support community organisations to provide these activities, to focus on young people most in need of our help.

- Give responsibility to schools wherever possible. We will work in partnership with schools, through the City Wide Learning Body, to give responsibility to schools wherever possible. We will increase the scope of our arrangements with schools, exploring ways to look at increasing services traded with and delivered in partnership with schools. We will continue to ensure that funding for services for those most vulnerable children and young people is prioritised and make sure that any funding retained by the Council is spent on key services which support children and young people's education.

Meanwhile, we will continue to be as efficient as possible across all our services. Within this overall approach, we have a number of specific savings proposals, and will be consulting with service users and other interested people and organisations on these and other proposals over the next few months.

In the medium term, we are working to develop (with adult services and the NHS) an all age disabilities service from birth to old age, to support individuals to lead independent lives. We are also exploring what opportunities exist to bring together our children and adult safeguarding services. We are investigating whether there are other funding models that might be appropriate for paying for social care services and have been shortlisted for a substantial grant to work with partner organisations to give children the best possible start in life.

Spending plans

Therefore, our spending on children's services and other elements over 2014-15 will amount to roughly the following:[4]

	Page	Gross Expenditure £000	Gross Income £000	Net Expenditure £000
BUSINESS STRATEGY				
Capacity Planning and Development	79	2,873	2,873	0
Organisational Development	80	3,689	461	3,228
Strategic Support Services	81	253,755	262,682	-8,927
Information Systems	83	4,802	5,017	-215
Contract Services	85	16,385	14,529	1,856
Resources Support Services	87	24,923	24,487	436
Children's Commissioning	90	2,884	2,395	489
Children's Public Health	91	15,039	15,039	0
		324,350	327,483	-3,133
CHILDREN & FAMILIES				
Prevention and Early Intervention	93	9,803	7,069	2,734
Fieldwork Services	96	17,105	874	16,231
Health Strategy	101	3,951	1,075	2,876
Learning Difficulties and Disabilities	103	1,623	130	1,493
Policy and Service Improvement	104	317	42	275
Provider Services	106	22,764	4,907	17,857
Safeguarding Children	111	2,637	1,321	1,316
Placements	113	14,702	2,061	12,641
Early Years	116	6,263	1,293	4,970
		79,165	18,772	60,393
INCLUSION & LEARNING SERVICES				
Access & Pupil Services	118	6,215	5,263	952
Learning & Achievement Services	121	2,047	906	1,141
Inclusion & Targeted Services	123	13,716	12,030	1,686
		21,978	18,199	3,779
LIFELONG LEARNING SKILLS & COMMUNITIES				
Employment and Skills	125	6,310	3,817	2,493
Family and Community Learning	127	9,452	9,377	75
Performance & Partnerships	130	1,189	634	555
14-19 Partnership	131	2,809	2,763	46
Strategic Support	132	1,592	724	868
Youth	134	6,816	1,280	5,536
		28,168	18,595	9,573
		453,661	383,049	70,612

[4] This table has been taken from the Council's annual budget for the *Children, Young People and Families Portfolio* which is available online at https://www.sheffield.gov.uk/your-city-council/finance/how-we-spend-budget.html. The figures for public health on this table represent those elements of the public health grant spend that are allocated to this portfolio.

4. Public health services

Public health responsibilities transferred from the NHS to local government in April 2013. At the same time, funding was transferred from the NHS to local authorities in the form of the Public Health Grant, in order to ensure that those authorities had the resources necessary to fulfil their new responsibilities. The public health Grant is ring-fenced for public health purposes

Planned use of the Grant

The Public Health Grant will increase from £29.665M in 2013/14 to £30.748M in 2014/15, an increase of £1.083M. It has been assumed that external income to support specific PH Programmes will continue at the same level in 2014/15 as in 2013/14. If this is not the case, the funding available for those specific programmes will have to be reduced on a pound for pound basis. Overall, the total amount assumed to be available to spend on PH Programmes, made up of the Grant and external income, in 14/15 is £31.721M.

Use of the Grant

Overall, approximately £23.5M is to be spent on programmes continuing from this year, though the actual amount spent on each programme will not necessarily remain the same. An additional £2.1M is to be spent in CYPF and Communities on programmes which prior to April 2013 were funded by the Portfolios themselves, bringing the total up to approximately £4.2M.

Approximately £1.1M is to be spent on a number of new programmes aimed at addressing the root causes of ill health, consistent with the social model of health adopted by Cabinet. If the additional investment in existing programmes is added to this, it gives a total of approximately £1.3M worth of new activity. This represents the beginning of a re-shaping of the overall public health programme, consistent with the Council's ambition to 'do things differently' and become a public health driven organisation, whilst maintaining our efforts to improve the Public Health Outcomes Framework indicators and thus mitigate the risk of loss of PH Grant value in future years.

Programmes continuing from previous years

Programme	Portfolio	£K	Notes
Sexual health services	CYPF	5,337	Statutory
SH - enhanced services	CYPF	200	Statutory
GUM and contraceptive services outside Sheffield	CYPF	170	Statutory
SH and contraceptive prescribing	CYPF	270	Statutory
CYP substance misuse services	CYPF	383	
Sexual Health outreach (SWWOP)	CYPF	56	

Support to Young Carers	CYPF	55	
School nursing	CYPF	1831	Includes statutory National Child Weighing and Measuring (NCMP) programme
Family Nurse Partnership	CYPF	160	
Community genetics awareness	CYPF	35	
Subtotal		**8,497**	
Tobacco control	Place	1,480	Contracts to be let for 3 yrs from April '14
Adult weight management	Place	685	Being re-specified and retendered during 14/15 with 3 year contracts
Children's weight management	Place	224	Being re-specified and retendered during 14/15 with 3 year contracts
Activity Sheffield	Place	400	Second year of two year commitment (13/14 & 14/15)
Upperthorpe Healthy Living Centre (food work)	Place	70	
Air quality monitoring (East End Quality of Life)	Place	55	
Subtotal		**2,914**	
DACT drug treatments	Comms	4,836	Programmes being retendered during the course of the year
DACT alcohol treatment	Comms	737	Programmes being retendered during the course of the year
DACT - Community pharmacies	Comms	321	
DACT - Police team for Drugs Intervention Programme	Comms	149	
Drug interventions programme	Comms	1,410	Contribution of £551K from Police and Crime Commissioner to this
Healthy Communities	Comms	273	
Social Capital'	Comms	290	
Health trainers	Comms	308	Contribution of £200K from Clinical Commissioning Group for this
Health champions	Comms	185	
Carers' support	Comms	210	Contracts let to Sept '15
Carers' respite	Comms	110	Contracts let to Sept '15

Substance misuse (residential rehabilitation)	Comms	350	
Hidden Harm - Safeguarding	Comms	40	
Mental ill health prevention	Comms	125	
Find and Stay in Employment - Bridge	Comms	50	
Employment Support - MH Problems – First step trust	Comms	106	
Mental Health Support to the Somali Community	Comms	73	
Support to Chinese Community – Kin Hom	Comms	55	
Magazine for Mental Health Service Users	Comms	20	
Advocacy for Older People with Mental Health Problems	Comms	34	
Infrastructure support to Third sector	Comms	61	
Private housing standards initiative	Comms	500	£175K increase over current budget
Subtotal		**10,243**	
Health Checks	DPHO	500	Statutory
Community infection prevention and control service	DPHO	90	Statutory
Occupational Health - SOHAS	DPHO	102	
Oral health promotion	DPHO	150	
Subtotal		**842**	
Subtotal, continuing activity		**22,496**	

Funding of programmes previously funded by Portfolios using mainstream revenue grant (with some contribution from PHG)

Early years	CYPF	1950	£554K increase
Floating support	Comms	2375	£1,660K increase

New investment to address root causes of ill health, consistent with the 'social model'

Early intervention and prevention (mental health and wellbeing)	CYPF	400	
CAMHS training capacity	CYPF	50	

Cycling opportunities	Place	50	
Move more	Place	55	
Cheap and illicit tobacco and alcohol enforcement activity	Place	97	
Eat well campaign	Place	100	
HENRY (Healthy Eating and Nutrition for the Really Young)	Place	60	
Employment and health work with young people	DPHO	200	
Employment and disability initiative	DPHO	80	
Subtotal new investment		**1092**	

5. Wider health and wellbeing services

The following are some areas where the Council spends money, which may not *necessarily* be perceived as being directly to do with health and wellbeing but which the Health and Wellbeing Board very much sees as contributing to it.[5]

Area	Net expenditure
Community safety	£441,000
Libraries	£5,180,000
Employment and skills	£2,493,000
Culture and environment (includes parks)	£17,178,000
Business strategy and regulation (includes environmental health)	£28,270,000
Regeneration and development	£50,620,000

[5] This is a summary of some of the other elements of the Council's annual budget. More information is available online at https://www.sheffield.gov.uk/your-city-council/finance/how-we-spend-budget.html.

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Commissioning Intentions 2014-19

Draft

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Executive Summary

This plan sets out our ambition for the next five years (2014-19) and our actions for the years 2014-16 towards those aims. These are based on the aims set out in our prospectus and the outcomes that Sheffield's Health and Wellbeing Strategy intends to achieve.

Prospectus Aims

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in Sheffield
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
- To ensure there is a sustainable, affordable healthcare system in Sheffield

The outcomes set out in the Joint Health and Wellbeing Strategy

- Sheffield is a healthy and successful city
- Health and Wellbeing is improving
- Health inequalities are reducing
- People get the help and support they need
- Services are affordable, innovative and deliver value for money.

Our Ambitions for 2019

- All those who are identified to have an emerging risk of hospital admission are offered a care plan.
- To have an integrated primary and community based health and social care services approach to long-term conditions management to support people living independently at home, reducing emergency hospital admissions by up to 20%.
- Care requiring a specialist clinician will be brought closer to home.
- Reduce the number of excess early deaths in adults with serious mental illness and achieve similar improvements in life expectancy for people with learning disabilities.
- To put in place support and services that will help all children have the best possible start in life

We have identified 65 projects for the next two years, including:

- Extending care planning and commissioning Integrated Community Teams
- Changing and simplifying access to urgent care services and establishing an urgent primary care centre
- Specifying and procuring integrated intermediate care services
- Working with consultants to transform outpatient services
- Commissioning for outcomes and value, initially in Musculoskeletal services
- Ensuring equality of access for all to all services

To achieve these aims, we will develop a Commissioning for Quality strategy, support the development of primary care providers, put in place integrated commissioning of health and social care with Sheffield City Council, and significantly strengthen our public and patient engagement.

1. Introduction and Context

We published our Prospectus in January 2012, in the early stages of the development of the Clinical Commissioning Group in shadow form, and renewed it in April 2013, as an established statutory body. Our four Prospectus aims are unaltered and remain at the heart of our ambition:

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in Sheffield
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
- To ensure there is a sustainable, affordable healthcare system in Sheffield

The Health and Wellbeing Board in Sheffield, which works as a strategic commissioning partnership between the CCG and the City Council, published its strategy in 2013. We are committed to working with partners to achieve the outcomes set out in the Joint Health and Wellbeing Strategy

- Sheffield is a healthy and successful city
- Health and Wellbeing is improving
- Health inequalities are reducing
- People get the help and support they need
- Services are affordable, innovative and deliver value for money.

1st April 2014 is the beginning of the second year of operation for the CCG. We expect in our first annual report to demonstrate significant achievements for 2013/14 including delivery of the required 1% financial surplus, meeting the majority of NHS Constitution standards, delivering over three quarters of the 84 commissioning intentions we published for 2013/14, and making great progress in developing as an organisation, with strong clinical leadership and good management support.

In our second and subsequent years of operation, we intend to build on our work so far to achieve our aims, set out in our prospectus, recognising that most health services in Sheffield are seeing increased demand and our acute hospitals in particular remain under significant pressure, that we have not yet made a difference to health inequalities, and that change may seem marginal to many of our patients and our member practices.

We want to now make faster progress towards achieving our aims. To do that, we have set ourselves a number of ambitious objectives for the next five years, which will transform the way healthcare is delivered in Sheffield and improve the health and wellbeing of people in Sheffield, especially those population groups with the poorest health.

We are doing this in the context of some major challenges facing the NHS, including:

- Demography – ageing and changes in make-up of population
- National funding constraints; the CCG will see minimal increases in funding in real terms and need to deliver efficiencies in all areas of our spend
- Increasing public expectation and rising demand
- Cost of new drugs and procedures

The NHS "Call to Action" summarises these challenges in the diagram below, and can be found at
http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

More now than ever we need to work in partnership with other organisations that meet people's health and social care needs. We will be working with Sheffield City Council to join together our commissioning arrangements so that we can commission services that are integrated around people's needs, and so that we can make the best possible use of the resources available to support people in Sheffield. We are also strengthening our partnerships with the Foundation Trusts in Sheffield, so that our contractual relationships are set in the context of shared aims and objectives to ensure health services in Sheffield achieve the highest standards for our patients. The voluntary sector led partnership that has developed Sheffield's "Best Start" bid to the Big Lottery will be critical for us in achieving our aims for children and families in the city

Our five year vision for healthcare in Sheffield, and the commissioning plans for 2014/16 that it contains, will help us to achieve the aims we set out in our Prospectus and in the Health and Wellbeing Strategy.

This document describes our vision and ambitions, and our priorities for action in 2014/15 and 2015/16. Its primary purpose is to share our intentions with providers of healthcare, with partner organisations in the city, and with the public we serve. These intentions will inform our contract negotiations and our detailed business planning for the next two years.

2. Our Population's Health

The current population of Sheffield (based on ONS Mid-Year estimate for 2012) is 557,382 people of which 275,673 are males (49.5%) and 281,709 females (50.5%). This represents an increase in population of 8.6% since 2001. The population is projected to rise by a further 5.2% to around 586,500 in the year 2020. 0-4 year olds make up around 6% of the population (approximately 34,300) and 4.4% are 75 years and over (approximately 24,700). This older age group will increase by around 17% by the year 2020 to approximately 29,000 people.

Life Expectancy

Life expectancy for both men and women in Sheffield is improving year on year. For men average life expectancy at birth is 78.4 years and 82.1 years for women (2009-2011). Whilst this represents a longstanding trend of improvement, both remain lower than the national average of 78.9 years for men and 82.9 years for women.

A different picture of health emerges when we look at the gap in life expectancy between the most and least deprived people in Sheffield. This shows that the current (2009-2011) gap between the most and least deprived men in Sheffield is 8.69 years and 7.35 years for women. This compares with the 2001-2003 gap of 8.69 years for men and 7.10 years for women i.e. a significant and persistent health inequality in the City.

Preventable premature mortality

Cancer and cardiovascular disease account for around 60% of all premature deaths in Sheffield, consistent with the national picture. For both the premature mortality rate from all cancers and cardiovascular disease, Sheffield has among the lowest rates of the Core Cities but figures remain higher than the national average.

Over half of all premature deaths from cancer are considered preventable, which in Sheffield equates to approximately 350 deaths a year. Common preventable causes of cancer are smoking, poor diet and physical inactivity. A large number of cancer deaths may also be prevented through earlier detection and treatment of signs and symptoms.

Widespread changes in lifestyle, systematic identification of people at risk, and better treatment for cardiovascular disease has resulted in the premature mortality rate falling year on year in Sheffield, and at a faster pace than nationally. Nevertheless although the gap between Sheffield and rest of the country has narrowed, our rate remains significantly higher than the national average. Over two thirds of premature mortality associated with CVD is considered preventable. In Sheffield this equates to over 230 premature deaths per year. The NHS Health Check programme, together with the range of other actions to ensure timely prevention and early intervention in relation to chronic disease, supports improvements in this area.

We are detecting a worrying upward trend in both ill health and premature mortality linked to liver disease. Liver disease is the only major cause of premature death in Sheffield for which the rate is increasing. People are also dying from it at younger ages. Premature mortality from liver disease in Sheffield now accounts for just over 70

deaths in people under the age of 75 years per year. Over 90% of these deaths are considered preventable. The common avoidable causes of liver disease are alcohol consumption and obesity.

In Sheffield around 1,000 new cases of diabetes are diagnosed every year and prevalence is expected to continue to rise for the foreseeable future. In spite of the rate of increase there is evidence that diabetes care is improving in the City. For example, the proportion of diabetes patients with good control of their blood sugar level, according to their GP record, has improved from 63% in 2009 to 73% in 2012. This means that Sheffield has a favourable profile in terms of preventable morbidity and mortality outcomes and the individual disease contributions to that; especially so for a city population.

Mental Health and Dementia

There are currently around 6,400 people living with dementia in the City, and this is expected to rise to over 7,300 by 2020 and over 9,300 by 2030. Early diagnosis and intervention improves quality of life and can delay or prevent premature and unnecessary admission to care homes. Around one third of people with dementia currently live in (largely) private sector care homes, and the trend is towards entering care with more severe disease. If current policies remain in place, by 2025 the demand for this type of care home accommodation is predicted to increase by 55% with 71% of the increase coming from people aged 85 and over.

Mental health problems are common, with one in four people experiencing a mental health problem in their lifetime and around one in one hundred people suffering a severe mental health problem. In relation to common mental health problems, such as depression and anxiety, around 12.27% of Sheffield adults are estimated to have depression compared with 11.68% in England.

Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for individuals, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In terms of severe mental illness the latest figures for Sheffield (2011-12) suggest that the number of people with a psychosis (all ages) registered with a Sheffield GP practice was approximately 4,500. When considered as a percentage of all people registered with a Sheffield GP, this represents 0.80% which is on a par with the England average of 0.82%.

People with a severe mental illness have a threefold increased risk of premature death than those without such an illness and a reduced life expectancy of approximately 16 years for women and 20 years for men. The excess premature mortality rate in Sheffield people with a mental illness (988 per 100,000 population) is higher than that for England (921 per 100,000 population). The mortality rate from suicide and undetermined injury however, at 6.45 per 100,000 population (2009-2011) is much lower than the average for England (7.87 per 100,000 population). In the recent National Audit of Schizophrenia (2012) while Sheffield had the second best record nationally for avoiding prescribing more than one antipsychotic drug and the best for not exceeding recommended doses, it was ranked lowest in the sample of service users for having their weight monitored in the previous 12 months and was below the

national average for checking blood pressure, smoking status and alcohol intake, and general physical health monitoring.

Child and Maternal Health

There is now overwhelming evidence that conception through to the early years is a crucial phase of human development. The mental and physical health of mothers during and immediately after pregnancy can have lifelong impacts on the child.

A key priority for providing the best start in life for a child is breastfeeding. When compared with national, regional and peer city averages, Sheffield performs well in terms of the percentage of babies who continue to be breast fed at 6-8 weeks after birth. The latest figure for the period 2012-2013 puts this at 50.8%. However this has remained virtually unchanged over the last 4-5 years, and almost one third of all babies who are breast fed at birth are no longer breastfeeding 6 to 8 weeks later.

Whilst not as great in terms of overall numbers of deaths, infant mortality (deaths in babies under the age of 1 year) also impacts significantly on the overall average calculation of life expectancy. Currently the Sheffield rate is 5.2 per 1,000 live and still births (2011) compared with a national rate of 4.3 per 1,000 and is ranked fifth of the eight Core Cities. The rate in Sheffield has been rising slowly, widening the gap with national outcomes. The incidence of infant mortality (2009/2012) in the Asian & Asian British ethnic group (10 per 1,000 live births) in Sheffield is more than double the incidence for the White ethnic group (4.5 per 1,000 live births) as is the rate in the Black and Black British group (10.5 per 1,000 live births).

Other key issues for Sheffield include

- Maternal obesity is a factor in around 30% of still births or neonatal deaths (and approximately 35% of maternal deaths). The trend in the proportion of Sheffield women who are obese or morbidly obese is almost 22% and is increasing.
- The percentage of Sheffield mothers smoking at delivery was lowest in 2009-2010 (13.6% equivalent to around 860 mothers). Over the last three years this has increased to 14.1% (just over 900 mothers), counter to the national trend.
- Sheffield's teenage pregnancy rate has reduced significantly over the last few years and now stands at 35.2 per 1,000 births in girls aged 15-17 years (2011), but is above the national average of 30.7.
- A key strand of our infant mortality strategy, for example, is concerned with reducing infant deaths and severe disability related to consanguinity

Sexual Health

The consequences of poor sexual health can be serious including unplanned pregnancy, avoidable illness and mortality from sexually transmitted infections and HIV/AIDS. Sheffield is ranked 83 (out of 326 local authorities, first in the rank has the highest rates) in England for rates of STIs in 2011. 4350 acute STIs were diagnosed in Sheffield residents, a rate of 783.1 per 100,000 residents, and 64% of acute STIs were in young people aged 15-24 years old.

In 2011 the diagnosed HIV prevalence in Sheffield was 1.8 per 1,000 population aged 15-59 years compared to 2 per 1,000 in England. Between 2009-2011 48% of HIV diagnoses were made at late stage of infection compared to 50% in England. The

current chlamydia diagnosis rate is 1851 per 100,000 (aged 15-24 year olds) against a national target of 2300 per 100,000 (aged 15-24 year olds).

Marked inequalities exist in sexual and reproductive health in Sheffield. The burden of sexual ill health is not equally distributed among the population but concentrated amongst those who are the most vulnerable including men who have sex with men, young people and minority ethnic groups.

Vulnerable Children and Young People

Half of adult mental health problems start before the age of 14. Early intervention to support children and young people with mental health and emotional wellbeing issues is vital. The Sheffield Every Child Matters Survey (ECM 2012) identified that the number of Y10s (14 and 15 year olds) saying they feel sad or depressed 'most of the time' has increased from 9% in 2011 to 14% in 2012. Children who qualify for free school meals report high levels of sadness and lower levels of wellbeing than average. In addition, Looked after Children are particularly at risk of developing mental health problems.

Particularly vulnerable groups, such as young people living in poverty, those 'Not in Education, Employment or Training' (NEETs), or those who are homeless or in care, are more likely to suffer poor emotional health than other young people. They are also more likely to misuse alcohol and other substances.

Health Inequalities

There are significant health inequalities in Sheffield, despite the progress made in improving the health of the population over the last few years. These inequalities are described in detail in the reports of the Director of Public Health and the Joint Strategic Needs Assessment. Although they do not represent the full picture of health inequalities in Sheffield, the following give a clear indication of the scale of the issue.

- The difference in life expectancy at birth for males, as measured by the Slope Index of Inequality, is 8.7 years, ranging from 74.4 years in the most deprived areas of the City to 83.1 years in the least.
- The difference in life expectancy at birth for females, as measured by the Slope Index of Inequality, is 7.3 years, ranging from 78.7 years in the most deprived areas of the City to 86 years in the least.
- Infant mortality rates (per 1000 live births) in Sheffield are 5.5 for White British mothers, 10.9 for Black and Black British mothers, and 13.4 for Asian and Asian British mothers.
- Smoking in pregnancy is strongly related to socio-economic status and the prevalence of smoking around the time of delivery varies from 0% to 40% across Sheffield neighbourhoods
- The Confidential Inquiry into the premature deaths of people with learning disability (CIPOLD 2013) found that men with learning disabilities die on average 13 years and women with learning disability 20 years earlier than the general population.
- People with schizophrenia will on average die 14.6 years earlier than the general population.

3. What services will look like in five years' time and how we will improve health and outcomes for the people of Sheffield

To respond to the challenges the NHS faces, meet the expectations of our patients, and achieve the aims set out in our Prospectus, we want the way healthcare is delivered in Sheffield to have changed so that:

- Primary and community care will become the setting of choice for more services and as result patients in Sheffield will receive as much of their care as possible within a community setting.
- The care and services people receive will be of high quality delivered by fully supported clinicians, with seamless transfer to expert hospital-based secondary care when and if that is needed.
- Primary and secondary care clinicians will be enabled to work together with the patient, using a single patient record to support communication and ensure input is provided at the appropriate time, in the most appropriate setting and by the most appropriate professional for the patient.
- Patients will be supported in the self-management of their conditions where appropriate and we will seek to ensure technology is fully utilised in order to support patient care and monitoring without the need to travel to a hospital setting.
- Where appropriate services will be integrated to meet the needs of the patients and partners and co-commissioners will work collectively and collaboratively to achieve this.
- We use strong commissioning principles to deliver the best clinical outcomes for all our patients and we ensure services provide the highest quality of care while representing best value for money

To achieve this vision, we have set ourselves a number of ambitions for 2019:

- All those who are identified to have emerging risk of admission through risk stratification, are offered a care plan, agreed between them and their clinicians (potentially 15,000 people.)
- To have integrated primary and community based health and social care services underpinned by care planning and a holistic approach to long-term conditions management to support people living independently at home, reducing emergency hospital admissions by up to 20% and emergency department attendances by up to 40%.
- Care requiring a specialist clinician will be brought closer to home, changing the place or method of delivery for a significant proportion of current hospital attendances (numbers to be agreed in year)
- We will reduce the number of excess early deaths in adults with serious mental illness to be in line with the average of the best three core cities in England, and achieve similar improvements in life expectancy for people with learning disabilities.
- We will have put in place support and services that will help all children have the best possible start in life

How we will improve health and outcomes for the people of Sheffield

We need to change the way we work to achieve these ambitions, and will:

- Adopt a whole person approach to the identification and response to the needs of an individual and their carer
- Work with Sheffield City Council to plan, commission and where appropriate competitively procure services together to improve services and outcomes within the funding available
- Involve patients and the public in our decision making, to ensure the changes we plan meet their needs, and support people and communities to look after themselves and remain independent
- Work with providers to develop the capacity and skills to deliver many more services in local settings and develop contractual models to commission from primary care providers
- Aim to ensure equality of access for all to all services

We will adopt a strong programme management approach to delivery of our commissioning intentions, with arrangements in place to ensure that individual projects are aligned and with an enhanced focus on delivery and benefits realisation, to ensure that we achieve our aims and patients and clinicians can see the improvements in services and in health we make.

Our work will continue to be largely delivered by our clinical portfolios, each led by a GP member of our Commissioning Executive Team and a nominated Governing Body member, and supported by our commissioning managers, with our quality work led by our Chief Nurse. Our clinical portfolios are:

- Acute Elective care
- Acute Urgent care
- Long Term Conditions, Cancer and Older People
- Mental Health, Learning Disabilities and Dementia
- Children and Young People

Each portfolio has identified priorities for the next two years that will contribute to achieving our ambitions. These are set out in the following section. It should be noted that many of the projects will contribute to more than one of the five ambitions, but for brevity, for presentational purposes, each project appears only once, aligned with the ambition it most directly contributes to.

Key priorities for the next two years include:

- Extending care planning and commissioning Integrated Community Teams
- Changing and simplifying access to urgent care services or them and establishing an urgent primary care centre
- Specifying and procuring integrated intermediate care services
- Working with consultants to transform outpatient services
- Commissioning for outcomes and value, initially in Musculoskeletal services
- Ensuring equality of access for all to all services

Some of our projects will be delivered through integrated commissioning arrangements with Sheffield City Council, as set out in section 7.

4. Our portfolio projects and efficiency plans

We have identified the projects we intend to undertake in the next two years, to move towards achievement of our five year vision and to make the efficiency gains we require to meet our financial duties and support the service changes and improvements we would like to make.

The projects are firstly listed by the ambition they most contribute to (noting that many projects will help achieve more than one aim). There is then a table of the financial assumptions underpinning the projects, showing the net saving or expenditure expected from the projects and therefore how we expect to achieve the savings required. The full financial plan is shown in section 8.

4.1. All those who are identified to have emerging risk of admission through risk stratification, are offered a care plan, agreed between them and their clinicians (potentially 15,000 people.)

Project Title	Delivery
Long Term conditions, Cancer and Older People	
Complete the care planning evaluation, recommend any changes arising for the way care planning is delivered and develop a specification and commissioning plan to operate from October 2014	2014/15
Ensure the delivery of an integrated community nursing service that is responsive and delivers holistic, high quality care to those that need it, focussed on admission avoidance and upstream care management	2014/15
Develop a new outcome based specification for integrated community health and social care services to include nursing, adult social care, community geriatricians, therapy services, care home support team, and intermediate care	2015/16
Identify people with 5+ emergency admissions or A&E attendances and implement care plans jointly across primary and secondary care addressing physical and mental health care needs	2015/16
Improve community resilience to help keep people safe at home and enable them to return home following an inpatient episode providing practical support to help minimise avoidable readmissions.	2014/5 & 2015/16
Work with partners including Public Health colleagues and providers so that all health and social care staff will deliver the same health promoting messages	2014/15
Put a new model of domiciliary care for people at the end of life in place in one locality to improve care and reduce admissions	2014/15
Evaluate domiciliary care for people at the end of life to inform commissioning intentions for 16/17	2015/16
Implement use of Electronic Palliative Care Coordination Systems (EPaCCS) as a co-ordination system	2014/15
New EPaCCS in place across Sheffield and all relevant providers able to access shared care plans for EOLC patients. Lessons learned for extension to LTC patients and plans to extend system agreed.	2015/16
Develop a dashboard looking at key indicators across selected condition-specific pathways, to identify any under-diagnosis and under-treatment of those populations with a learning disability, a serious mental illness or those who are socially isolated and outcomes for the whole population with these diseases	2014/15
Ensure there are effective self-care programmes available to support people	2015/16
Commission services to ensure early detection and diagnosis of disease	2015/16
Work to implement opportunities within CVD and cancer to reduce potential years of life lost that are amenable to health interventions	2014/15

Implement Cancer Survivorship Programme underpinned by a service specification in contracts	2015/16

Acute Urgent Care

Ensure Flu, Pneumonia, Hep B and TB vaccinations for public and staff are at recommended levels. Put in place prophylactic prescribing of antibiotics for people at risk of developing infections e.g. COPD	2014/5-2018/9

Mental Health, Learning Disabilities and Dementia

Explore models of social prescribing and navigator/signposting service	2015/16
Ensure risk stratification and care planning include people with LD, SMI and dementia	2015/16

4.2 To have integrated primary and community based health and social care services underpinned by care planning and a holistic approach to long-term conditions management to support people living independently at home, reducing emergency admissions by up to 20% of and emergency department attendances by up to 40%.

Project Title	**Delivery**
Acute Urgent Care	
Evaluate current projects delivered through the Right First Time programme and determine which, if any, should continue	2014/15
Pilot an Urgent Primary Care Centre to manage around 52,000 minor illness and minor injury attendances and reduce Emergency Department attendances by 40% if fully implemented.	2014/15-2015/16
Consider application of the Urgent Primary Care Centre model to Sheffield Children's Hospital and develop Patient Pathways in conjunction with Primary Care Clinicians for the top 20 presenting minor illness conditions	2014/15-2015/16
In developing the expected full business case for the permanent model for the Urgent Primary Care Centre take into account .the future of the Minor Injuries Unit	2014/15-2015/16
Undertake a systematic review of major specialties with the highest numbers of patients admitted as emergencies – one specialty per year with review and pathway redesign in year 1 and impact in year 2. • Respiratory Medicine - 2014/15 - 2015/16 • General Surgery - 2015/16 - 2016/17 • Geriatric Medicine and Paediatrics - 2016/17 - 2017/18 • General Medicine - 2017/18 - 2018/19	2014/15-2018/19
Ensure constant and ongoing update to the Directory of Services, which supports the correct signposting of callers to 111 to available services, to minimise the risk of callers being inappropriately directed to a service which is not designed to meet their urgent or emergency care needs.	2014/15-2018/19
Make direct access to available NHS and Social Care services for people with a Mental Health or Learning Disabilities condition possible via NHS111. Develop interventions for people with a cognitive impairment to reduce the frequency of them attending the Emergency Department or being admitted as an emergency	2014/15
Develop the role of advanced paramedic and improved direct access for Ambulance Crews to rapid response services such as the Single Point of Access, GP In and Out of Hours Services, and Crisis Mental Health Teams to enable reduced conveyances to acute hospital from 65% to 50%.	2014/15-2018/19
Maximise the take up of the minor ailments scheme and the role of Pharmacists in providing advice on a range of minor illnesses by targeted communication and positive redirection from other parts of the urgent care system	2014/15

Ensure common specifications for the following are developed to inform contracting for 2015/6 for all Sheffield's Emergency, Urgent and GP Out of Hours services: • Major Trauma (in future Major Emergency Centres) • Emergency Department (in future Emergency Centres) • Minor Injuries • Minor Illness • Positive redirection of(of non-urgent cases)	2014/5

Long Term Conditions, Cancer and Older People

Work with Sheffield City Council to re-specify intermediate care services, focussing on step up and step down services, including admission avoidance, active recovery, bed based rehabilitation, assessment for long term care, incorporating the results of the Right First Time external evaluation	2014/15
Deliver a programme of redesign work on Ambulatory Care Sensitive Conditions, initially focussed on the frail older adult population, targeting falls and fracture prevention, the prevention and community based treatment of common infections and continence issues	2015/16

Mental Health, Learning Disabilities and Dementia

Explore opportunities for redesign of specialist MH/LD/dementia care pathways.	2014/15
Develop adult liaison psychiatry to ensure coordinated management of complex needs within acute care for adults aged 18-64	2014/15
Improve the out of hours crisis response for people with Mental Health problems or Learning Disabilities, working in collaboration with SY Police, and exploring better support for forensic health.	2015/16
Ensure the Acute Care Reconfiguration results in appropriate bed capacity with commensurate increase in community provision.	2015/16

4.3 Care requiring a specialist clinician will be brought closer to home, changing the place or method of delivery for a significant proportion of current hospital attendances

Project Title	**Delivery**
Acute Elective Care	
Commission for outcomes and value for citywide musculoskeletal services	2015/16
Commission management of stable glaucoma patients out of hospital	2014/15
Understand the opportunity for the development of community clinics to support transformation of outpatients, reviewing the suitability of existing community clinics (Gynaecology, ENT, Gastro, Respiratory) to be expanded citywide	2014/15
Identify services to be delivered in the community via the primary care basket of services	2014/15-2015/16
Continue to support development of new clinical pathways Implement findings from Referral Education Support evaluation	2014/15-2015/16
Identify opportunities to develop technology to support patient self-care and remote monitoring/increased non-face-to-face activity	2014/15-2015/16
Identify areas where GP direct laboratory requesting and joint partnership working supports patient care within a primary/community setting. Identify areas for GP education and training, to deliver new services	2014/15-2015/16
Utilise advice & guidance to support referrers	2014/15
Review community dermatology/minor surgery services	2014/15

Reduce (via contract) non-clinically value-adding activity using benchmarking in: • Colorectal surgery • Urology • Endocrinology • Rheumatology • Orthopaedics	2014/15
Implement agreed non face to face tariffs	2014/15-2015/16

Mental Health, Learning Disabilities and Dementia

Develop the model for primary care prevention and early intervention mental health services/LD/dementia services, enabling improved access to specialist advice and support within primary care, shifting resources from acute care to primary and community care	2015/16

Children, Young People and Families

Develop training for General Practice to increase confidence in the management of Paediatrics at a primary care level and reduce the need to attend hospital for Paediatric problems.	2015/16
Redesign services to ensure more teams are joined up within community settings and ensure that key community services that impact upon child health are targeted in the right local communities to reduce health inequalities, focusing on: • Maternity Care Pathways • Children's Urgent Care • Elective Care Pathways (Including Paediatrics, Community Paediatrics and Nursing, Dermatology and Continence Services) • Speech and Language Therapy Services	2015/16

4.4 We will reduce the number of excess early deaths in adults with serious mental illness to be in line with the average of the best three core cities in England, and achieve similar improvements in life expectancy for people with learning disabilities.

Project Title	**Delivery**
Mental Health, Learning Disabilities and Dementia	
Use Equality Impact Assessments to address the inequality faced by this population and ensure mainstream services make "reasonable adjustments" to their service delivery to ensure equitable access (working with contracts and all portfolios)	2014/15
Work as part of Right First Time to ensure the SMI population of Sheffield have annual physical health checks and to improve management of physical health in SHSC	2014/15-2015/16
Reduce out of city placements for people with LD or Dementia, in line with Winterbourne concordat actions	
Establish better coordination/case finding of people with complex health and cognitive impairments to target prevention and early interventions around physical and mental health needs	2014/15

NB. Many of the projects in the three areas above will also have a positive impact on this ambition, but are not listed here as well to avoid duplication. In total, around 40 of our projects will contribute.

4.5 We will have put in place support and services that will help all children have the best possible start in life

Project Title	Delivery
Children, Young People and Families	
Develop stronger partnerships for joint planning and commissioning through the Children's Health and Wellbeing Board and Children's Joint Commissioning Group.	2014/15
Ensure that all key stakeholders and providers are working to the same outcomes and success measures.	2014/15
For Children with Special Education Needs and Children with Complex Needs, identify new pathways for assessment of need, care planning and reviews to deliver the requirements of the Children and Families Bill.	2014/15
For these children we will also redesign and clarify the pathway for access to equipment within the community and the offer of respite care provision.	2014/15-2015/16
Develop Emotional Wellbeing and Mental Health Services by supporting the implementation of Children's IAPT	2014/15-2015/16
Develop the pathway for supporting Maternal Mental Health ensuring the specification for these services are clear.	2014/15-2015/16
Review and redesign Safeguarding pathways to ensure clarity of use and appropriate targeting of resources.	2014/15
Work with partners to achieve the aims of the "Best Start" bid to the Big Lottery fund	2014/15-2015/16
Redesign Looked After Children's Health services to provide better continuity of care for children placed out of area.	2014/15
Mental Health, Learning Disabilities and Dementia	
Ensure a seamless transition from children's to adult services and address the 16-18 transitional gap, commissioning a single service from one provider	2014/15

4.6 Portfolio Specific Projects

In addition, there are some important actions for the next two years that do not directly support achievement of the five ambitions, but are no less important, listed below.

Project Title	Delivery
Long Term Conditions, Cancer and Older People	
Implement changes to spirometry testing to bring about improvements in quality	2014/15
New sleep apnoea service in place**,** subject to business case	2014/15
Commission stroke 6 month review	2014/15
Mental Health, Learning Disabilities and Dementia	
Conduct an in depth review to develop a baseline of the cost and outcomes of current commissioned mental health, dementia and LD services.	2014/15
Ensure the reconfiguration of community mental health services for older adults & CLDT achieves the intended benefits	2014/15-2015/16
Explore opportunities for use of assistive technology to maximise recovery and independence	2014/15-2015/16

Seven Day Working

Sheffield's health and social care community is taking part in the early adopter Seven Day Services Improvement Programme. We want to move towards the provision of more responsive patient centred services, across the seven day week, to tackle apparent variation in outcomes for patients admitted to hospitals at the weekend across the NHS in England.

4.7 Achieving Efficiency Improvements

As noted at the beginning of this section, we need to make significant efficiency gains (i.e. savings) over and above those which accrue to the CCG through use of the national tariff (price) deflator for most of our contracts. These are required to be able to meet the challenges we face.

The table below sets out where the projects above are expected to deliver savings and the confirmed investments we will be making to help support delivery.

Summary of QIPP Plan 2014/15 to 2018/19

	Note	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	TOTAL £'000
Acute Elective	A	1,300	700	1,800	1,900	2,000	7,700
Acute Urgent Care	B	3,700	4,300	7,200	7,100	7,000	29,300
CHC	C	500	500	0	0	0	1,000
Prescribing	D	500	500	500	500	500	2,500
Total Gross Savings		6,000	6,000	9,500	9,500	9,500	40,500
Planned Investment	E	(1,000)					(1,000)
NET QIPP		5,000	6,000	9,500	9,500	9,500	39,500

Notes:

A) Acute elective care - savings to be a combination of outpatient reductions and other initiatives such as pathway changes and contracting efficiencies.

B) Acute urgent care – our plan is to reduce non elective admissions (including excess bed days) by 20% over 5 years, equating to £28m or around 28% in £'s terms. More of this saving will be in the latter part of the five year plan, as the services put in place to achieve this, such as care planning, will have an increasing impact over time.

C) CHC - modest savings targets in years 1 and 2 given underlying demand. From 2015/16 we expect CHC budget to be part of Better Care Fund arrangements and savings will therefore be within the pooled budget we will put in place.

D) Prescribing - budgets have been increased by 4.5% each year with expectation that this increase will be mitigated against by a continuing programme to maximise cost effective prescribing

E) There will be very modest investment in 2014/15 - with additional investment via the Call to Action Fund. Any investment from 2015/16 will have to be as a result of achieving additional efficiencies as a result of the BCF arrangements

Full details of the financial plan and the assumptions underpinning it are in section 8.

5. Commissioning for Quality: How we will improve the quality of services and patients' experience of healthcare

Our aim is to ensure that the CCG drives up the quality of care and treatment of services commissioned for the people of Sheffield, and that there continues to be a culture of continuous quality improvement.

We will develop a comprehensive and challenging CCG Commissioning for Quality Strategy and action plan that describes the CCG's aspiration to be an excellently performing organisation and clarifies its roles and responsibilities in relation to the new commissioning landscape and significant commissioning requirements. These requirements have arisen from a wealth of government and regulatory reviews during the last two years including:

- Government Response to Mid Staffordshire Public Inquiry and a number of other safety reviews (as detailed in 'Hard Truths' November 2013)
- Actions following the review of Winterbourne View, outlined in "Transforming Care"
- Recommendations arising out of Confidential Inquiry into the Premature Deaths of People with Learning Disability (CIPOLD) 2013
- Regulatory changes to CQC and Monitor
- Nursing review – the 6 C's

The CCG aspires to be a high performing CCG, demonstrating excellence in commissioning health care provision by having in place the following:

- Effective Internal Quality Governance
- Effective Partnership and Integration processes with all key stakeholders
- Excellent relationships with providers
- High performing providers and continuous quality improvement
- Robust Quality Assurance and Risk Management processes
- Effective Primary Care and care pathway development
- Research and Education

The Commissioning for Quality Strategy will set out actions to achieve these, including:

<u>Internal Quality Governance</u>

- Development of good clinical leadership via OD workshops and 1:1 development
- Effective internal CCG working relationships – Quality linked to all portfolios
- Raising the focus of Quality at Governing Body
- Systematically gaining, reviewing and acting on Patient experience feedback
- Transparency and duty of Candour – public reporting and website

<u>Partnership and Integration with all key stakeholders</u>

Continue to develop effective working and reporting relationships with the following:

- NHSE Area Team
- Local Authority – Care Home provision, Safeguarding, Public Health
- Police
- Clinical Networks
- Local Education and Training Boards
- Academic Health Science Network

- The Coroner
- Local Committees
- Quality and Professional regulators – CQC/NMC/GMC/AHP's
- Quality Surveillance Groups

Relationships with Providers

- Primary Care and Secondary Care – via care pathway development
- Executive level contact – 1:1's, Board to Board
- Specific Quality Work streams – Specialist contacts within each provider
- Contractual relationships – via the quality requirements of contracts

Quality Assurance and Risk Management processes

- Review provider monitoring data – information flows and data timing and quality
- Data analysis and triangulation of information – more provider focused monitoring
- Risk Profiling – at provider and health community level
- Improve collaboration with CQC to share data and manage provider performance
- Review assurance methodology - site visits / joint CQC/health watch to ensure it is evidence based
- Implement specific new initiatives relating to monitoring Trust Staffing Levels via the contracting process, new priorities for safeguarding to prevent/child sexual exploitation and development of seven day services and the impact on quality
- Review formal processes for managing failing services and Trusts
- Strengthen patient and staff experience assurance, e.g. through complaints and Friends and Family Test, and triangulate the data with other data
- Medicines Safety and Governance – continue to demonstrate compliance
- Care Home Quality – develop enhanced quality assurance with LA to care homes not previously included (LD homes) and review the monitoring of Community / Domiciliary services
- Continuing Health Care / IFR – ensure accountable systems of delivery for individual commissioned services with CHC and IFR.

High performing providers and continuous quality improvement

- Provider standards for quality embedded in contracts - National Quality Dashboards/Metrics/Quality Premium/NHS England assurance framework/CQC new standards
- Effective Benchmarking – timely national and local performance
- Implement Quality Incentive Schemes – CQUIN's and contract levers
- Continue joint working where appropriate – via the portfolios/infection control
- CHC & Section117 aftercare - implement contract frameworks

Primary Care - Membership Support and Provision

- Ensure continuous quality improvement - infection control/ safeguarding/ SI reporting/ audit and research in primary care
- Ensure effective working relationships with the Area Team to fulfil our membership duties for quality – via CCG MOU
- Joint care pathways and protocols – Evidence based, shared care protocols

- Develop quality assurance processes and outcome monitoring for Local Commissioned Services – GP Associations and other LCS's.
- Review Workforce with AT – Practice Nurses and GP's
- Improving Prescribing – support to prescribers / enhancement of GP clinical systems
- Develop the research capacity and capability within Primary Care

Primary Care - Commissioning for quality

- Effective GP engagement – Develop the role of the GP Quality Lead
- Effective communication and information sharing - Assurance Committee/intranet
- Continue GP involvement with quality incentive schemes – CQUINS
- Develop a quality improvement scheme for general practice that will complement the work of NHSE.

Research and Education

- Establish research credibility of CCG both locally and nationally
- Develop effective relationship with Health Education England, as Education commissioner ensuring educational needs of future are identified and met
- Establish effective working relationships with Sheffield Hallam University and University of Sheffield

Medicines Management - 2014/15 Key Areas of Work

Medicines Optimisation

The overarching area of work for the medicines management team in 2014/15 will be medicines optimisation. This is a patient focussed approach to ensuring the best use of NHS medicines, taking account of safety, clinical effectiveness and value for money. In Sheffield we will build upon success achieved to date and aim to secure improved patient outcomes via high levels of patient engagement and enhanced inter and intra professional collaboration.

Areas of work that will contribute to the delivery medicines optimisation and which will be prioritised in 14/15 include:

Medicines Safety

The team will continue to support implementation of MHRA alerts and recommendations at GP practices to ensure safe prescribing of medicines.

The team will undertake a programme of quality work to ensure that medicines are prescribed and/or monitored in accordance with guidelines. Proposals for 14/15 include:

- Review patients on amiodarone to ensure prescribing is in line with the shared care protocol
- Review patients with heart failure to ensure they are on appropriate treatment and stepped up accordingly, in line with NICE clinical guideline 108
- Continued review of dual therapy antiplatelet medication post MI to ensure that outcomes are optimised and balanced against the risks of bleeding

- Targeted medicines review e.g. recently discharged patients, care homes residents, patients receiving domiciliary care to reduce hospital admissions and where appropriate promote independent medicine taking.

Support to GP practices – including Clinical Systems development.
The team will continue to offer regular sessional assistance to every practice in the city to support high quality prescribing. In addition work to maximise the potential of clinical systems in practice will be progressed in order support medicines optimisation.

Medicines Quality
Working collaboratively with local stakeholders and under the auspices of the Area Prescribing Group the team will continue to maintain the Sheffield Formulary and Traffic Light System. Local guidelines and shared care protocols (SCPs) will be developed and updated according to need. This work will include updating the Amiodarone SCP, the Epilepsies in Children SCP and the Childhood and Adolescence ADHD SCP. Improved signposting of anticoagulation guidelines, including clarification of local options relating to warfarin and choice of recently introduced novel oral anticoagulants.

Community pharmacy
The team will continue to support community pharmacy:
- As part of the integrated unscheduled care strategy e.g. minor ailment scheme, assured availability of palliative care medicines, emergency supply of medicines;
- In embedding and promoting established successful services e.g. NHS flu immunisation;
- In expansion and development of the Healthy Living Pharmacy initiative;
- By developing responsive services to support public health priorities of Sheffield CCG;
- In maintaining good clinical governance via available resources;
- By ensuring community pharmacy integration in applicable care pathways and city-wide medicines related policies

Cost Efficiency and best use of resources
The team will implement a series of interventions, set out within the prescribing workstream plan, to deliver significant savings over the year and ensure that Sheffield prescribing continues to deliver value for money and benchmarks well.

6. Tackling Health Inequalities and Ensuring Equality of Access to Healthcare

Many of the interventions and actions required to reduce health inequalities address the wider determinants of health or are public health initiatives. NHS Sheffield CCG backs these actions and will work with Sheffield City Council in support of them, through the Health and Wellbeing Board. However, we are also clear that we, as clinical commissioners of healthcare, can take action ourselves, and have identified five themes for action:

1. Providing high profile clinical support for national and local actions that reduce health inequalities, including public health interventions
2. Supporting individuals to be aware of their own health and their health risks, and to take responsibility for their health
3. Ensuring equality of access to healthcare, targeting resources to areas and populations with the greatest need
4. Commissioning disease specific interventions that are known to help reduce health inequalities
5. Ensuring compliance with the Equality Act, taking action to eliminate any discrimination in the provision of healthcare in Sheffield.

As clinical commissioners, we will act through:

- Our contracts and relationships with the Foundation Trusts, VCF and private providers of healthcare to the people of Sheffield
- Our partnership with Sheffield City Council, including our role at the Health and Wellbeing Board, and with the NHS Commissioning Board (particularly with regard to implementing actions in primary care)
- As clinical leaders, influencing GPs and hospital clinicians, and advising patients and the public of Sheffield

We want to ensure there is equality of access and treatment for all people to the services that we commission, both as a matter of fairness and as an essential part of our drive to reduce health inequalities and increase the health and wellbeing of all our population.

We have set ourselves the following equality objectives:

- Ensuring equality is core commissioning business
- Improve the range of activity information we have about patients in protected groups and how this is being used
- Improve our understanding of patient experience of services, re E&D, and act upon instances of potential discrimination
- Developing strong and consistent leadership on equality issues
- Improving access to services i.e. contracting

We are ensuring that all our staff are embedding equality and diversity in all their work and through our contracts and partnerships with providers we are supporting them to tackle inequities and barriers to services for patients. We monitor the performance of all providers in Sheffield.

7. What we will do to enable this to happen

A. Primary care development

General Practice: GP Associations

General practice will need to consider how it best operates at a scale that can deal with the increasing demands placed on it, whilst retaining the highly valued local relationships with their patient groups. There is growing recognition that practices should move forward on establishing practice federations, and to bring isolated practices more formally into larger provider organisations or networks. General Practice in Sheffield is already well placed to move forward on this way of working via our GP Association (GPA) model.

Initially heralded via the Right First Time programme and to promote MDTs working together to plan and manage the health needs of patients with multiple co-morbidities, GPAs over the last 18 months have been forming and rising to this particular challenge with a range of positive outcomes.

The emerging GP Provider Assembly is developing in a way which will give general practice providers a voice within city wide fora, and beyond.

The Assembly should become well placed to move even further with the collaborative way of working started by the GPAs and, as a minimum could:

- Consider how the transition needed within the changing landscape of primary care, sharing learning and propagating developments across practices might be further;
- Work with the Right First Time (RFT) Programme to further integrated community team working;
- As the city-wide voice for general practice provides , offer services to commissioners at different levels – practice, GPA, Locality, City which deliver their objectives/priorities – which contribute to meeting the priorities outlined in our commissioning plans in a way which secures services for all relevant patients;

In short, The Assembly, working with other providers, could be a key vehicle to support the delivery of the services we wish to see provided closer to people's home and not in a hospital setting.

Pharmacy

Pharmacists are the third largest health profession, with community pharmacy in Sheffield acting as the gateway to health for around 16,000 people each day.

The pharmacy service supports the public to stay well, live healthier lives and to 'self-care': Sheffield is a pathfinder site for the "Healthy Living Pharmacy" initiative; pharmacy already plays a key role in the management of long term conditions; and pharmacists currently carry out Medicines Use Reviews (MURs) and provide the New Medicine Service (NMS) to patients newly prescribed certain medicines.

We intend to explore the areas in which pharmacy could contribute further, for example in providing a broader range of clinical and public health services that will deliver

improved health and offer consistently high quality to patients; having a stronger role in the management of long term conditions; working more closely with GPs and Associations in an integrated primary healthcare team approach, etc.

We intend to further explore the potential Pharmacy has to provide services that will contribute more to our plans for out of hospital care.

Optometry and Dentistry

Whilst less core to the delivery of our overall strategy than General Practice and Pharmacy we recognise that these two contractor groups still have much to offer in their field of expertise.

We intend to continue building on the positive working relationships we have nurtured in recent years with the Local Dental and Optical Committees to explore with them how their respective professions might further support the delivery of our commissioning intentions.

Responding to the Market

We urge the four contractor groups to consider how – as the CCG increasingly tests the market in specific service areas – they intend to develop the necessary skills, capacity and collaborative relationships to be able to respond accordingly. For our part the CCG will explore the extent to which we can support this work with a view to further stimulating the market.

B. Integration of Health and Social Care

We have developed a strong co-commissioning relationship with Sheffield City Council (SCC), building on the pre-existing relationships the Council had with the predecessor PCT and establishing the Health and Wellbeing Board as a genuine partnership of commissioners. We have published our Joint Health and Wellbeing Strategy and have agreed that we should integrate our commissioning wherever there is clear benefit to service users.

We have established a Joint Commissioning Executive Team, made up of Directors of SCC and the CCG, and have agreed to deliver some of our commissioning intentions jointly. We believe that this will lead to improved experience of services for our patients, stronger community support, increased ability to invest in keeping people well at home, and more efficient delivery of services.

Integrated commissioning should support Sheffield's current transformation programmes, Right First time and Future Shape Children's Health, both of which are partnerships between SCC, the CCG and provider organisations.

Our initial priorities for integrated commissioning are:

- Keeping people well at home – including community support, care planning and integrated community health teams
- Intermediate care– to provide more alternatives to hospital, closer to home, and improve discharge from hospital, so that more people can return to their own homes after a period of hospital care

- Community equipment – to bring together several elements of equipment provision in health and social care
- Long term high support to people – to integrate assessment, placement and quality assurance of long term care provided to people, removing as much as possible the distinction between health and social care, whilst maintaining eligibility rules to NHS and council funding.

We will use the Better Care Fund (previously known as the Integration Transformation Fund) to support integrated commissioning. We are proposing to establish a pooled budget in 2015/16 to cover at least the above areas, which will be well in excess of the Governments minimum requirements. We will publish further information about this during 2014/15 and will work together as integrated commissioners in 2014/15, as a "shadow" year of the pooled budget. This means that we will take decisions together on the areas above, and agree how we contract, manage performance and share risks and benefits between us as if we had a pooled budget.

C. Public and patient involvement (PPI)

The CCG's Governing Body agreed a communications and engagement strategy in June 2013 and endorsed the involvement plan which will deliver the engagement aspects of the strategy in November 2013.

The plan sets out how we should inform, involve, engage and enable the people of Sheffield. Key features of the plan include working with Healthwatch, establishing a database of people willing to be involved in our work, establishing a patient panel, supporting clinical portfolios to embed PPI in their work, and working with partners to support increased health literacy and strengthened community resilience.

We have established a PPI task and finish group to work with partners to develop a citywide approach to PPI, moving beyond the mechanics of good engagement in our decision making to working with communities to improve health and wellbeing.

We want to involve patients and the public in both the quality improvement and service change aspects of our work, and to support people in Sheffield to have a better understanding of health issues and be able to take control of their health. There are different mechanisms required for each of three main areas of work and our Public and Patient Involvement Plan, approved by Governing Body in November 2013, sets these out.
In brief, our plan is based on three levels of involvement:

- Informing – ensuring our patients and public know what we are doing
- Involving & Engaging – ensuring those who want to have opportunity to tell us what they think & establishing a real conversation with patients and the public about what we do
- Enabling – working in partnership to ensure that appropriate support is available for people to contribute

The main ways in which we will inform, involve and engage are:

- Using the Internet, social media and written documents
- Making sure that practice participation groups can be involved in CCG issues as well as issues about their own practice, if they wish to

- Setting up an involvement database so we know who wants to be involved, in what areas of work
- Establishing a patient panel
- Supporting our GPs and commissioning managers to inform, involve and engage patients and the public in their work,
- Working with Healthwatch
- Developing joint approaches with partner organisations

D. CCG development

2014/15 is only the second year of the CCG's statutory existence, and we will continue to work on the development of the CCG as a member organisation, focussing on the following areas.

<u>CCG Workforce</u>
- Structure
- CSS
- Ways of working including embedded staff
- Employer of choice – skills
- Systems / processes / policies
- Culture / style / shared values
- Commissioning capability and capacity

<u>Working with Partners</u>
- ALB / LA / Patients / CSS / NHSCB
- Providers including FTs and VCF organisations
- Engagement
- Strategy development
- Systems and structures

<u>Membership Organisation</u>
- Governing Body development
- Compliance and System development
- Governance and Assurance
- Member engagement
- Wider clinical engagement including succession planning
- CRG
- Portfolios
- Membership Office

E. Partnerships

To be added, covering partnership with neighbouring CCGs, with the wider NHS, and within the city (EG Best Start)

8. Five Year Financial plan: April 2014 to March 2019

All CCGs are being required to produce a five year financial plan with the first two years of the plan in more detail. The main purposes of our plan are twofold:

- To ensure we can deliver on CCG financial statutory duties and
- To support delivery of the CCG's Commissioning Intentions

To support CCGs in putting together a five year plan a range of national information, guidance and planning assumptions has been issued by NHS England and Monitor. This guidance continues to change and the plan included in this draft commissioning intentions document reflects our draft financial plan submission on 14 February 2014 and does not include certain additional potentially significant financial pressures for the years 2014/15 to 2016/17 as we (and other CCGs) are raising queries on these issues and suggesting alternative approaches. The final version of our plan to be submitted to NHS England on 4 April 2014 will incorporate the impact of these issues as appropriate.

The CCG's plan is also based on local intelligence and takes into account local priorities. Inevitably it has to be based on a whole series of assumptions which are discussed in more detail below and each year the plan will need to be flexed to deal with unexpected issues and a range of risks and challenges.

CCG Allocations

NHS England is responsible for allocating resources for commissioning NHS services, both for the services that it commissions directly as well as the resources to be allocated to CCGs. NHS England's Board met on 17 December 2013 to consider options for the CCG allocations formula and the level of cash uplift which each CCG should receive for the next two years in the light of the new formula.

Each CCG will receive an increase its baseline funding which as a minimum is in line with a national inflation measure. CCGs which are seeing significant population growth and which have actual baseline funding below their new "target" will receive additional growth funding. Sheffield's population is growing but at a slower rate than a number of other places in the country. The information on target allocations was published on 20 December 2013 and shows Sheffield CCG to be more than 5% "above target". **As a result, Sheffield CCG will receive the minimum uplift.** This puts us in the same position as around two thirds of CCGs. NHS England has subsequently provided further modelling on how individual CCG positions might change over years 3 to 5 and hence the growth funding which each might expect. On this modelling Sheffield CCG remains over 5% above target and would therefore receive the minimum growth. Details are set out in **Table A** below.

CCGs separately receive a Running Cost Allowance each year to fund the clinical engagement, staff, support services and other infrastructure costs to enable the CCG to undertake its commissioning role. The 2014/15 allowance at £14m shows a very small reduction from the current year and then all CCGs see a 10% reduction in their RCA (so budget becomes £12.6m for Sheffield). For the first 2 years of the plan we are looking to non recurrently underspend our RCA by £1.5m and £0.5m respectively to support commissioning spend.

Table A: Allocations

	2014/15 £'m	2015/16 £'m note 1	2016/17 £'m	2017/18 £'m	2018/19 £'m
Expected Recurrent Allocation	**694.6**	**718.8**	**731.8**	**744.2**	**756.9**
Target Allocation per NHSE agreed formula	657.1	682.2	Information not available (note 2)		
Distance ABOVE target	37.5	36.6	Information not available (note 2)		
as a % of actual allocation	+5.63%	+5.41%	Expected to remain over 5%		
Expected Growth in funding	14.6	11.8	12.9	12.4	12.7
as a % of prior year allocation	+2.14%	+1.70%	+1.80%	+1.70%	+1.70%
Note 1: In 15/16 and beyond actual and target allocation INCLUDES £12.4m which will be added to CCG allocation for transfer to Better Care Fund ex NHS England			*Note 2: NHS E have not published target allocations beyond 2015/16 but have provided assumptions on growth uplift - Sheffield to receive min growth meaning we are expected to stay more than 5% above target*		

Development of Financial Plan – Key Assumptions

The CCG's Governing Body has approved a set of planning assumptions for all 5 years of the plan but with a particular focus on the first two years as follows:

1. Delivery of 1% reported surplus:
   The CCG has a statutory duty of financial breakeven but NHS England guidance requires each CCG to plan for a 1% surplus which it will carry forward to future years. This is £7m in 2014/15 rising to £7.7m in 2018/19.

2. Retain % of baseline resources for NON recurrent expenditure
   In **2014/15** 1.5% of resources held back for non recurrent spend plus a 1% "call to action" fund in line with national guidance. Thus in total 2.5% (£17.3m). Governing Body has agreed the deployment of these resources on a range of issues such as continuing existing test of change projects (elective and Right First Time) until evaluation complete, piloting new initiatives, winter resilience and 18 week back log activity. It is envisaged that some of this funding will be made recurrent and incorporated into the Better Care Fund arrangements from 2015/16.

   From 2015/16 onwards the requirement is to hold a 1% fund (or around £7m), which will be used for similar purposes as those outlined for 2014/15.

3. Start each year with 0.5% (£3.5m in 2014/15) general contingency reserve
   The reserve is to help manage unexpected in year pressures such as those that can be created by exceptional winter conditions, flu pandemic, or of course as part of managing risk if planned QIPP savings are not fully delivered. Should such pressures not materialise the funding can be used for local priority investments in year.

4. Recurrent baseline opening budgets:
For each contract or service area an assessment of the recurrent baseline requirements has been made as a starting point for the next year's budget.

5. Inflation, Tariff efficiency and PbR changes:
The default position is the application of national guidance on these issues. Tariff (price) assumptions are shown in Table B below. However, Governing Body has agreed that there are a few areas of spend where the CCG may find it appropriate to not impose a cash releasing efficiency requirement such as certain community and primary care services where to impose the efficiency would probably reduce the quantity/level of service and would be counter to CCG strategic intentions. In such circumstances the CCG will be looking for improvements in outcomes.

GP prescribing is a major budget (£86m in 2014/15) where we have applied no price reduction as prices are set nationally through national negotiations or by individual suppliers and the CCG has no control over price setting.

6. Underlying/Technological led demand:
A critical element of the financial planning process is to understand the underlying demand due to population changes, new technologies and other factors influencing demand for health services. Modelling has been undertaken jointly via public health, information and contracting colleagues to identify possible cost pressures and these are summarised in table B below. They are stated before the impact of any efficiency (QIPP) savings.

7. Investment Priorities:
The plan contains a small number of specific investments outside of QIPP for the next 2 years and then a small reserve for new investments in years 3 to 5.

8. Efficiency Savings (QIPP)
The key driver for QIPP is to improve services to patients. We are looking to achieve a major shift in the setting in which patients receive services and reduce the need for acute interventions where appropriate. From a financial perspective the CCG needs to undertake QIPP for 2 reasons:

- To deliver the planned financial position where we need NET savings from QIPP to meet cost pressures as the cash uplift for the next 2 years will be insufficient to meet assessed pressures– ie primarily those set out in assumption 6 above.

- To allow the CCG to invest in new quality developments.

A high level summary of our plan can be found in section 4.7 above.

Summary of Plan

The CCG is focussing on how to best utilise our total allocation in each year (figures shown in Table A above.) We are also looking at the setting of care and are planning on increasing our spend on community based care and reducing spend on acute hospital care where appropriate. At this stage it is difficult to be precise on how our resources will move year on year as this will be influenced by the outcome of delivery of our efficiency (QIPP) programme, year on year contract negotiations and procurements

and whether our assumptions on underlying/other demand prove accurate. It will also be influenced by the level of funding we place into the Better Care Fund and the integrated commissioning arrangements with Sheffield City Council from 2015/16. The next iteration of our Commissioning Intentions will seek to provide more detail on how we envisage the distribution of our resources in 5 years' time compared to our spend in 2013/14.

Table B below, however, summarises how we expect our funding to increase over the next 5 years and how we might use that increase.

Table B Incremental Change in Funding and Spend 2014/15 - 2018/19

		2014/15 £'m	2015/16 £'m	2016/17 £'m	2017/18 £'m	2018/19 £'m
A	**Cash increase to CCG Recurrent Baseline Resources**					
	Cash Uplift - see table below for assumptions	**14.6**	**11.8**	**12.9**	**12.4**	**12.7**
B	**Impact of Tariff**					
	Inflation including CNST - cost to CCG - see below for %s	-14.7	-16.3	-17.7	-20.2	-20.3
	4% efficiency where applied in contracts – benefit to CCG	19.4	18.8	19.1	19.0	18.9
		4.7	**2.5**	**1.4**	**-1.2**	**-1.4**
C	**Cost Pressure/ Investments**					
1	High Cost Drugs - growth in demand / technological changes	-1.5	-1.5	-1.5	-1.0	-1.0
2	Activity pressures covering Acute/Community/Mental Health/Ambulance	-5.9	-6.2	-6.4	-5.6	-5.2
3	CHC est of underlying demand growth	-1.5	-1.5	-1.5	-1.0	-1.0
4	Prescribing - volume growth at 4.5% and price fluctuation	-3.9	-4.1	-4.2	-4.4	-4.6
5	Investment in local and national imperatives - estimates from 2015/16	-0.8	-1.1	-1.1	-0.6	-0.6
6	Adjustment to create correct non recurrent budget and correct underlying surplus to comply with national planning requirements	-6.7	4.6	-4.6	-3.4	-3.5
7	Assume most of £7m Call to Action Fund created in 2014/15 is deployed on initiatives which then recurrently become part of Better Care Fund arrangements, together with an estimate of new requirements		-6.5	-0.7	-0.7	-0.7
8	0.5% general contingency - national planning requirement - assume use each year so need to reinstate in each subsequent year	-3.5	-3.6	-3.8	-3.9	-4.0
9	Increase surplus so maintained at 1% minimum requirement	-0.3	-0.2	-0.2	-0.1	-0.1
		-24.1	**-20.1**	**-24.0**	**-20.7**	**-20.7**
D	**Efficiency (QIPP)**					
	Target Savings	6.0	6.0	9.5	9.5	9.5
	Planned Investment (From 15/16 via Better Care Fund arrangements)	-1.0	0.0	0.0	0.0	0.0
	MINIMUM NET QIPP	**5.0**	**6.0**	**9.5**	**9.5**	**9.5**
E	**Delivery of 1% surplus**					
	Return of prior year surplus	6.9	7.2	7.4	7.6	7.7
	In year increase/(decrease) to meet national requirement	0.3	0.2	0.2	0.1	0.1
		7.2	**7.4**	**7.6**	**7.7**	**7.8**

	CCG minimum cash uplift per planning guidance	2.14%	1.7%	1.8%	1.7%	1.7%
	Inflation rates - acute sector - includes 0.4% for service development in 14/15 and 0.3% for CNST all years	2.8%	3.2%	3.3%	3.7%	3.7%
	Inflation rates - mental health & community - allows 0.1% for service development in 14/15 and nil for CNST	2.2%	2.9%	3.0%	3.4%	3.4%
	Efficiency - all sectors unless CCG agrees to "waive"	-4.0%	-4.0%	-4.0%	-4.0%	-4.0%

9. What this means for our local providers of health care

The transformational changes we are planning will alter the way healthcare is delivered in Sheffield, with more emphasis on supporting people to keep well and more care and treatment in community settings, with less care delivered in hospitals.

This will be reflected in our contracts with our local Foundation Trusts, primary care providers, voluntary sector organisations and a wide range of other providers of acute and community healthcare. For some, it will mean significant change in how they deliver services and this will of course affect the clinicians delivering those services.

Most significantly we expect to see a reduction in non-elective admissions, a change in the way elective care is delivered, which will reduce hospital activity, and increase activity in community settings (including GP practices), and an increased level of community services intended to help keep people well at home. Taking into account the impact of demographic changes, technological changes, efficiency schemes (QIPP) and activity to ensure we meet NHS Constitution standards, our planned secondary care activity for the next five years is as summarised in the table below.

CCG Activity	Elective Admissions - Ordinary Admissions	Total Elective Admissions - Day Cases (FFCEs)	Total Elective FFCEs	GP Written Referrals (G&A)	Other referrals (G&A)	Total Referrals	Non-elective FFCEs	All First Outpatient Attendances	First Outpatient Attendances - following GP Referral	All Subsequent Outpatient Attendances (G&A)
2013/14 Forecast Outturn	15578	58665	74243	90943	110856	201799	58911	176951	78127	430017
Forecast growth in 2014/15	3.8%	3.7%	3.7%	2.5%	2.1%	2.3%	0.2%	2.8%	3.1%	2.5%
2014/15 Total	16163	60863	77026	93194	113231	206425	59019	181925	80526	440812
Forecast growth in 2015/16	1.4%	1.7%	1.6%	0.2%	3.8%	2.2%	-1.2%	0.8%	-0.1%	-0.1%
2015/16 Total	16393	61885	78278	93351	117539	210890	58324	183316	80412	440214
	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-	-
Forecast growth in 2016/17	1.6%	1.7%	1.7%	-1.9%	0.9%	-0.3%	-3.6%	-1.1%	-0.7%	-1.9%
2016/17 Total	16660	62928	79588	91536	118616	210152	56209	181307	79829	431693
Forecast growth in 2017/18	1.5%	1.6%	1.6%	-0.9%	-0.9%	-0.9%	-4.0%	-0.9%	-0.9%	-1.9%
2017/18 Total	16918	63956	80874	90714	117570	208284	53951	179693	79116	423516
Forecast growth in 2018/19	1.5%	1.6%	1.6%	-0.9%	-0.9%	-0.9%	-4.0%	-0.9%	-0.9%	-1.9%
2018/19 Total	17180	64965	82145	89881	116506	206387	51807	178055	78392	415500

Changes will include:

<u>Sheffield Teaching Hospitals NHS FT</u>

- Investment in activity to deliver NHS Constitution pledges such as treatment within 18 weeks
- Reducing hospital based outpatient activity in a number of areas
- Reducing emergency admissions and hence capacity requirements
- Development of commissioning for outcomes in MSK services initially
- Piloting of urgent primary care centre and responding to further commissioning plans on the redesign of urgent ambulatory care
- Establishment of integrated community teams
- Responding to new specifications and potentially competitive procurements for intermediate care services
- Amendment to maternity services specification and negotiation of activity and tariff for antenatal and post natal care

- Addressing recommendations of the Confidential enquiry into the premature deaths of people in hospital (CIPOLD)

Sheffield Health and Social Care NHS FT

- Ensuring acute care reconfiguration results in the right bed and community capacity
- Moving resources from secondary care to primary care, through a stepped model of care routed in prevention and early intervention
- Incentives to support action on out of city placements
- New model for 16-17 year old MH care
- Development of outcome focussed contracts

Sheffield Children's NHS FT

- Investment in activity to deliver NHS Constitution pledges such as treatment within 18 weeks
- New model for 16-17 year old MH care - an extension of the CAMHS specification
- Work on the development and delivery of the Urgent care plan
- Redesigned service pathways as indicated in this document

Primary Care Providers

- Extension of care planning (subject to evaluation)
- eReferral utilising C&B system
- Development of locality based urgent care
- Focus on primary prevention and earlier presentation from primary care

Voluntary Sector Providers

- Potential development of partnerships with primary care to keep people well at home

Others

- Assessment and care coordination to meet requirements of SEN reforms
- Ensuring all CHC-funded care is purchased under formally contracted arrangements

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NHS England - South Yorkshire & Bassetlaw Area Team
Direct Commissioning Plans, First Draft

For discussion at Sheffield Health & Well-Being Board on 27 March 2014

Introduction

NHS England was formally established on 1 April 2013. A national organization with 27 Area Teams, NHS England has a seat on each Health & Well-being Board (H&WB). South Yorkshire and Bassetlaw Area Team (SY&B AT) has a seat on 4 H&WBs in the patch; Doncaster, Rotherham, Sheffield and Barnsley respectively. In describing the relationship between NHS England and Health & Well-being Boards, a key point of reference is the publication "Putting Patients First – The NHS England Business Plan for 2013/14 – 2015/16". This describes the key priorities of NHS England, and it is clear that there are several of these that overlap with the aims of H&WBs, and indeed require the H&WB as a vehicle for effective delivery. Specifically the following NHS England priorities would seem most relevant to the H&WB agenda;

- Uphold NHS Constitution rights and pledges
- Deliver on the outcome framework domains
- Promote equality and reduce inequalities in health outcomes (a key vehicle for this is the delivery of the H&WB Strategy and the scrutiny of the JSNA – both of which are within the remit of the H&WBB)

For each of these priorities, NHS England acts in a dual capacity; firstly as a direct commissioner of healthcare services, and secondly as the assurer of the commissioning system, providing support to and development of CCGs where appropriate. This paper is concerned with the former role, and provides the very first draft of the South Yorkshire & Bassetlaw Area Team's direct commissioning plans from 2014-15 onwards. The purpose of bringing this information before the Board is to support the H&WB's proper and comprehensive understanding of the local health system, and allow members to influence and/or challenge the plans, particularly with regard to the areas of overlap with the H&WB's priorities.

NHS England's Directly Commissioned Services

Direct commissioning is one of the eight core work areas by which NHS England will deliver better outcomes for patients (Putting Patients First April 2013). Defining direct commissioning as one entity hides the breadth and complexity of the services which have an overall value of £25.4bn and include

- Specialised Services
- Primary Care
- Public Health
- Health and Justice
- Services for Armed Forces and their families

These services are commissioned locally by all or some of the Area Teams of NHS England through a number of single operating models. These models seek to improve population health, to address inequalities in access and outcomes across the country with a focus on commissioning for quality and patient safety.
Directly commissioned services need to join up with local services commissioned by CCGs and other partners to ensure that people experience seamless and integrated care.

Services Commissioned by South Yorkshire and Bassetlaw Area Team

SY&B Area team commission the following:

- Primary Care Services for South Yorkshire and Bassetlaw patients, including GP, dental, optometry and pharmacy care; these equate to £359 million
- Public Health Services for South Yorkshire and Bassetlaw patients, including health visiting, some screening services, and 0-5yr child health services; these services equate to £47 million
- Specialised Services from all the providers of these services in Yorkshire & Humber, for all the patients treated by those providers. The contract values total over £1 billion.

Services commissioned by other Area Teams in Yorkshire & Humber

Health and Justice services, and Services for Armed Forces and their families, are commissioned on a regional basis by West Yorkshire Area Team and North Yorkshire Area Team respectively. The Area Teams' plans for these services will be presented to the H&WB in due course, as by nature of their regional commissioning function, they are responsible for services provided within South Yorkshire and Bassetlaw.

Planning Guidance and Timescales

In December 2013, NHS England published "Everyone Counts; Planning for Patients 2014-15 to 2018-19". This document set out the need for strategic and operational plans from both CCGs and NHS England commissioners. A key emphasis of the document is the importance of integration across health and social care, and the requirement to structure planning processes to achieve this. In recognition of this, the South Yorkshire & Bassetlaw Area Team is presenting the very first draft of the plans for each of its three direct commissioning functions to H&WBs, which set out in headline terms the strategic direction of travel, with reference to some local priorities. The first cut of draft plans were submitted to NHS England on 14 February, and then further versions are due for submission on 4 April before the final version on 20 June 2014.

Recommendations:

H&WB Members are asked to

a) consider the content of the first draft commissioning plans for South Yorkshire & Bassetlaw Area team's direct commissioning responsibilities,
b) provide any comments or feedback to take into account in further iterations;
c) advise regarding any additional discussion that the Board would like to schedule regarding all or any of the plans in more detail

Paper prepared by:
Laura Sherburn
Assistant Director Clinical Strategy
January 2014

Specialised Commissioning in Yorkshire & Humber is a system comprised of partners from CCGs & Area Teams who have come together to agree, refine and implement the following vision:

To commission specialised services, concentrated in 15-30 centres, that are sustainable, high quality, innovative, and seamless

System Objective One

Concentrate services in centres of excellence

System Objective Two

Commission for outcomes with robust service user involvement

System Objective Three

Evidence-based services

System Objective Four

Clinically and financially sustainable network service models

System Objective Five

Collaborative commissioning with partners

Delivered through: Service Specifications

Assessment of compliance against the national service specifications will translate into a clear work programme for both providers and commissioners to take forward working closely with CCGs regarding the impact on future service configuration in each locality

Delivered through Consistent Pricing

Standardisation of local prices via national benchmarking and greater scrutiny of data; with particular focus on top 10 spend areas

Delivered through High Quality Data and Business intelligence

Access to and effective use of data and intelligence held regarding specialised services and population need, working closely with South and West Yorkshire CSU

Delivered through QIPP

Consistent application of the QIPP (quality, improvement, prevention, productivity) methodology to all commissioned services, to move us into the transformational agenda and achieve financial balance

Delivered through Shared Work Programme

- Determination of where/what the centres of excellence for each service are, and the relevant network footprints; agree the commissioner footprint for development work
- Developing sustainable models of care and clinical networks
- Alignment of work programmes with Yorkshire & Humber Strategic Clinical Networks and Operational Delivery Networks

Overseen through the following governance arrangements

- National – PMO in place to oversee construction and delivery of specialised services action plan, which includes oversight of business planning processes; national Specialised Commissioning Oversight Group in place, with Area Team Director membership;
- Regional – further oversight provided by Regional Specialised Commissioning Operational Group, and Regional Transformation Group; support in place through regional POC leads
- Local – 3 Area Teams regular meeting; CCG Collaboratives; Yorkshire & Humber Clinical Senate in place; "host" contractors of providers working with SY&B AT on managing quality performance

Measured using the following success criteria

- Reduction in variation
- Improvement in clinical outcomes
- Full provider compliance against national specifications and standards
- Comprehensive set of national clinical commissioning policies governing access and eligibility for services
- Specialised services evenly distributed across the country to ensure optimum access, designed on the basis of clear evidence
- Well-defined service models and patient pathways
- Reduced number of centres of excellence with clear catchment networks in place
- Sustainable workforce

System values and principles

- Patients and the public are at the heart of everything we do
- Commissioning initiatives must always be underpinned by a clear and robust evidence base
- Commissioners across the system will work together in pursuit of optimal patient outcomes and experience
- QIPP principles are applied consistently across commissioning
- Transparency in decision-making & clear accountability

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Appendix A: Direct Commissioning of Primary Care SY&B – Plan on a Page **DRAFT 14.2.2014**

General Practice, Community Pharmacy, Dental and Eye care providers to play a much stronger role at the heart of a more integrated system of community based services that improves outcomes for patients.

System Objective One Role of primary care services maximised in prevention of ill health and promotion of health & well being	**Delivered through** New models of holistic & proactive primary care that facilitate a developing provider landscape; Provider development/training opportunities identified and supported by Health Education England SYB partnership council work program; strong LPNs; Patients & their carers involved more fully in managing their own health.
System Objective Two Patient/user experience improves measurably	**Delivered through** Best practice models of patient access implemented across primary care that address variation in outcomes & access, particularly for frail older people & those with complex health needs; commissioning for excellent access and diversity (including language barriers); Increasing & responsive user engagement informs commissioning decisions;
System Objective Three Primary care services aligned to support local commissioning priorities of each community	**Delivered through** Alignment of strategies for out-of-hospital care with premises development and workforce strategies; improve utilisation of premises that are fit for purpose; commissioning decisions recognise interdependencies; Strong LPNs;
System Objective Four Integrated primary care services that deliver measurable change	**Delivered through** Work with HWBB to identify key contributions for primary care to integrate and deliver change; Co-commissioning with CCGs; innovative contracting mechanisms; cross sector accreditation frameworks; PMS contract reviews
System Objective Five Provider development facilitates skills & competencies that deliver challenging commissioning intentions	**Delivered through** Review of primary care workforce to identify risks & opportunities presented by workforce profile ; piloting new/joint primary care roles; innovative solutions to workforce recruitment retention and development; identify promote national capability & capacity programmes; create training opportunities for practice nurses & staff
System Objective Six Consistently high quality services that are safe and demonstrate value for money	**Delivered through** Proactive response to complaints and concerns; rapid action in response to safety risks, early intervention; develop and support mechanisms that promote continual learning;

Overseen through the following governance arrangements

- Shared system leadership overseeing implementation of the improvement interventions
- Individual organisations leading on specific projects
- Joint responsibility with CCGs to drive up all aspects of quality in primary care
- Strong LPNs delivering clinical leadership and driving innovation.

Measured using the following success criteria

- Delivery of the system objectives
- Reduction in variation
- No provider under enhanced regulatory scrutiny due to performance concerns
- Sustainable workforce
- Services developed at scale and deliver within available resources

System values and principles

- Primary care continues to be effective first point of contact for patients
- Common core offer of high quality, patient centred primary care
- Patient experience and clinical leadership drive the commissioning agenda securing higher quality services
- Reduction in health inequalities & continuous improvement in health outcomes across 5 of Outcomes Framework

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To commission the Section 7a public health programmes to secure good population health for the residents of South Yorkshire and Bassetlaw. We will commission - a Healthy Child programme for 0-5s and screening and immunisation programmes that drive improving and protecting the publics health, ensure the best possible start in life, reduce health inequalities and contribute to a sustainable public health care system. We will also commission a Child Health Data system that supports sustainable improvements in both the commissioning and delivery of the services.

System Objective One
Commission high quality seamless services

System Objective Two
Reduce health inequalities and variation in uptake

System Objective Three
Identify and mitigate against risk and learn from incidents

System Objective Four
Commission services which are clinically and financially sustainable and Valuefor money

System Objective Five
To ensure the safe transition of the commissioning responsibility of the healthy Child programme to the LA by October 2015

Delivered through: Service Specifications
Assessment of compliance against the national service specifications will translate into a clear work programme for both providers and commissioners to take forward
Delivered through: a framework of performance management and integrated commissioning with other key commissioners.
Delivered through: increases to services
Numbers of Health Visitors and FNP nurses to be increased in line with National Trajectories.

Delivered through High Quality Data and Business intelligence
Access to and effective use of data and intelligence held regarding services and population need.
To commission high Quality CHIS in line with national specifications to

Delivered through: Risk and Incident management
A systematic approach to risk assessment, incident notification, management and learning locally and nationally

Delivered through QIPP
Consistent application of the QIPP (quality, improvement, prevention, productivity) methodology to all commissioned services, to move us into the transformational agenda

Delivered through: Partnership working
To develop transitional shadow commissioning arrangements throughout 2014/15 to ensure the integration of the commissioning strategies with those of the LA .

Overseen through the following governance arrangements

1. National –Public Health Commissioning Oversight Group in place, with Area Team Director membership; National Health visiting Transition board
2. Regional –Regional Heads of Public Health Commissioning and Screening and Immunisation Leads Group, Regional Health Visiting Transition board.
3. Local (provider) –Local FNP Boards, local integrated Commissioning forum, a framework of Screening and immunisation programme boards which report into a AT wide Screening and immunisation Advisory Group.
4. A strong performance management structure of the Health Visiting Trajectory performance

Measured using the following success criteria

- Full provider compliance against national specifications and standards
- Well-defined service models and pathway
- Performance which is at or exceeding national targets
- Successful management and mitigation of risks in the system
- Services which are able to learn from incidents
- Reduction in variation of price for services between different providers
- Reduction in variation of uptake both geographically and across hard to reach groups

System values and principles

- Patients and the public are at the heart of everything we do
- Commissioning initiatives must always be underpinned by a clear and robust evidence base
- Commissioners across the system will work together in pursuit of optimal commissioning of Childrens services to maximise the quality improvement, efficiency of services and patient and Family experience.
- QIPP principles are applied consistently across commissioning
- Transparency in decision-making & clear accountability

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Sheffield's Plans for Integrated Commissioning of Health and Social Care

Information Document March 2014

Introduction to our plans to transform health and social care in Sheffield

The Sheffield Health and Wellbeing Board's Joint Health and Wellbeing Strategy consultation told us that members of the public did not want to be passed from 'pillar to post' in the system, but wanted to receive excellent, individualised care. **Integrated, joined-up care** that brings together NHS, social care, and other forms of care and support provided in people's homes and communities is massively important in improving people's health and wellbeing.

The four partners on the Health and Wellbeing Board, including Sheffield City Council and NHS Sheffield Clinical Commissioning Group, are working together to make changes to ensure we work and commission in a more integrated way to improve Sheffield peoples' experience.

We will be **developing our plans in a range of areas in 2014-15**, ready for our **2015-16 budgets**. Our plans include our priorities for spending the **Better Care Fund**, a pot of money which has been allocated to bring about a transformation in the way the NHS, local authorities and local communities work together across the country. This money needs to be spent in 2015-16, but local Health and Wellbeing Boards need to plan *now* to ensure the money can be spent in a year's time. **Read on to find out more.**

Our vision

Through our engagement with members of the public, providers, commissioners and other practitioners, we have developed a **shared vision for integrated care** in 2019 that covers **all ages**.

We want to integrate health and social care so that:

- People – including *children, young people and adults* – get the right care, at the right time and in the right place.
- People and their communities in Sheffield support each other to improve and maintain their wellbeing and independence.
- Organisations in Sheffield work together to help people and their communities to build and strengthen the support they provide to each other.
- Expert help is available to help people to take control of their own care so that it is genuinely person-centred, and complements and builds on the assets they have.
- Health and care services are focussed on a person's needs - organisational boundaries do not get in the way.
- We get the best services and support we can for Sheffield from our combined resources

Our priorities

We have agreed **four main areas** to start with, which we will work on scoping and developing in 2014-15 and launching in some form in 2015-16. This will build on past work developed by our established transformational change programmes and we may choose to extend the scope of our work further in 2015-16. Our plans for integrating health and social care sit within the wider ambitions of Sheffield's Joint Health and Wellbeing Strategy.

Services in the four main areas will be designed to be:

- Focussed around the needs of the individual.
- Efficient, with blockages that currently exist in and between organisations removed.
- Affordable, spending the money on schemes together, not as separate organisations, which will help us to manage demand appropriately and make savings where this is appropriate.

The schemes we are currently focusing our integration work on are:

1. Keeping people well in their local community

What do we think this might look like? A new and coordinated network of services to support people at most risk of needing health and social care, to help them stay independent and well in their local communities. Our ambition is to increase investment in keeping people well in their local community, funded from savings from reduced hospital admissions. This may include: a GP led process which works with patients to plan care for those at most risk of needing urgent hospital care; a revised model of identifying who is at risk, covering both health and social needs; a new specification for community teams who provide care; improved advice, information and low-level support; multidisciplinary team-working across a range of disciplines including housing; the involvement of local communities and community organisations in supporting people to keep well.

What will be the benefits for Sheffield people?

- Increased independence, health and wellbeing, and reduced loneliness and isolation.
- Improved accessibility to help, support and advice in people's local communities.
- Practical support and 'quick fixes' in the local community for those in need.
- Reduced demand for formal health and social care by working to prevent people's need to access it.
- Strong community organisations which work well together and with statutory organisations, supporting community activities that are better targeted at the needs of people at risk of declining health and wellbeing.

What happens next?

We will be developing an outcome-based specification for services that support people to keep well at home, doing the clinical and economic analysis to determine whether investment in such services will be cost effective (including evaluating the effectiveness of the care planning service currently commissioned from GPs), and then deciding how we will procure the service (if the business case demonstrates cost effectiveness). We will work with the Think Local Act Personal initiative to establish genuine engagement with Sheffield's communities as we develop our proposals.

2. Intermediate care

What do we think this might look like? We intend to develop new specifications for intermediate care services to establish a single service to support people after they have had a spell in hospital or social care, and to provide alternatives to going into hospital for people if they have a crisis, where it is possible to provide care and support in, or nearer to, home instead. We will define intermediate care in terms of outcomes for people, rather than specific interventions, and set contracts on that basis. Services to provide this support will include bed-based and home-based support, active management of admissions and hospital discharge, and a single point of access to respond to people's needs in a crisis. The new service will take account of people's mental health needs as well as their physical health. We would expect the current set of services (20+) to be simplified as a result, so it is easier for people and practitioners to access the right service.

What will be the benefits for Sheffield people?

- Hospital admissions are prevented where possible, as people are more likely to stay healthy for longer if they can avoid hospital.
- People leave hospital earlier and are supported quickly and easily at home
- More people get back home after hospital rather than entering long-term care.
- People get back on their feet as soon as possible.
- Mental health needs are addressed as well as and alongside physical health needs.
- Money is spent more effectively to support people's needs.
- Better support for people with dementia to live well at home.

What happens next?

We will be developing an outcome-based specification for services that at least provides the same level of support as the current set of services but which is focussed on achieving better outcomes for people. We will then determine how best to procure those services. We will continue to work with providers and public as we develop our proposals.

3. Community equipment

What might this look like? A new service for children, young people and adults to ensure that there is the right equipment to support people to live independently. This service would be quick and practical, reducing delays elsewhere in the system and avoiding disputes about which organisation should pay for the support.

What will be the benefits for Sheffield people?

- Quick and practical access to the adaptations people need.
- Improve independence and wellbeing so that people can live in their own homes and communities for longer.
- Crises prevented and need for long-term support reduced.

What happens next?

We will be developing a new specification for services and determining how best to procure those services. We will continue to work with providers and public as we develop our proposals.

4. Long-term high-support

What might this look like? A single approach to assessment, funding and management of long term intensive support offered to children, young people and adults with long-term health, social and specialist housing care needs or lifelong conditions who may require long-term health and social care support. This includes the care delivered in people's homes or in supported living accommodation through to residential and nursing care, both in and out of Sheffield. It will include long term care currently funded by the NHS (continuing health care) and the council. Eligibility rules for both NHS and council funding will continue to be applied. This will result in improved coordination of process, better focus on care, and more cost effective placements. It is likely to include a revised assessment process, improved care coordination, and single integrated teams of health and social care workers.

What will be the benefits for Sheffield people?

- Faster, coordinated assessment and decision-making about the support that people need.
- 'Personal Care and Independence Plans' which will enable those needing support to have influence over the support they need.
- Providing care and support across the length of a person's life, rather than separating it arbitrarily by age or condition.
- Building on and supporting people's self-care abilities and enabling family carers, who so wish, to continue to actively contribute.
- Retaining and building people's links with their local communities and their opportunities to contribute.

What happens next?

We will be working out the details of our approach to managing budgets and contracts together and working with staff to integrate our working practices. This represents a major change for staff working in this area and will require significant time, effort and support.

What our proposals might mean for our providers

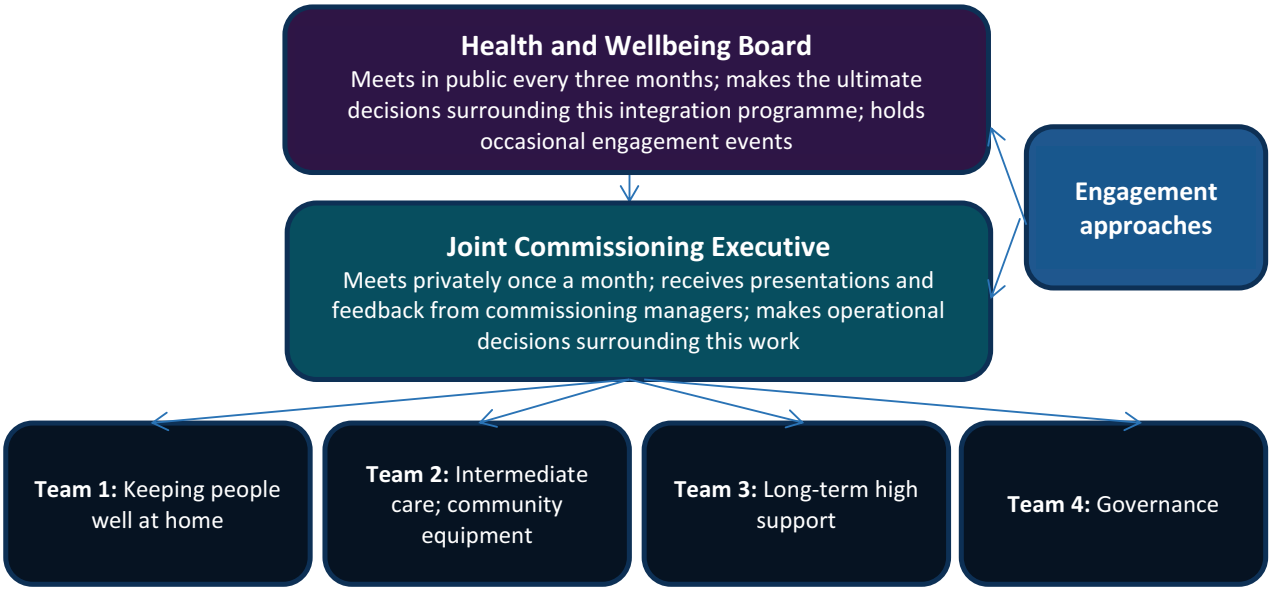
As a result of the establishment of a pooled budget for the areas described in this document (with the ultimate aim of establishing a single budget for health and social care in Sheffield) there will be a single fund and single decision-making on the commissioning of services covered. The implications of this for providers are likely to include:

- Changes to the way services are designed and delivered, with organisations needing to work together even more closely than they do now, to provide better and joined up care to service users. This may include possible changes to contractual arrangements to support the above.
- Changes to provider relationships with one another. We would expect our providers (acute and others) to have to work differently and potentially more collaboratively with one another.
- Stronger involvement of community-based organisations and people who use services and carers in the redesign of services, integrated pathways and changing the service delivery culture.
- Changes for frontline workers and operational delivery, with much greater multidisciplinary working and communication between teams.

How we will manage this programme of work

Our Health and Wellbeing Board is taking the lead in this integration work, and has set up a Joint Commissioning Executive, with Directors from both the City Council and the CCG, to oversee integrated commissioning work on behalf of the Health and Wellbeing Board.

Ensuring that our work programme has proper governance procedures has been and will continue to be a priority for us, and we have outlined our decision-making and team structure below.



How we will measure progress

The Joint Commissioning Executive will be agreeing specific objectives for our work, which will demonstrate improvement in service user experience and outcomes. These will include:

- Permanent admissions to residential and nursing care.
- Proportion of older people who were still at home 91 days after discharge from hospital.
- Delayed transfers of care.
- Avoidable emergency admissions.
- Patient experience.
- Proportion of people feeling supported to manage their long-term condition.

The Health and Wellbeing Board also monitors the health and wellbeing of Sheffield people as part of the Board's annual check on the progress of our Joint Health and Wellbeing Strategy.

What this means *now*, in 2014, and what it will mean for Sheffield people

2014-15 will be an important year for us as we prepare our plans for 2015-16 and beyond. Our work in 2014-15 will involve the following elements:

- **Single decision-making**: Senior managers and clinicians from the local authority and CCG, guided by the Health and Wellbeing Board, will make decisions together rather than as separate organisations.
- **Single commissioning**: Commissioners from both organisations will work together to produce single service specifications for the delivery of services funded from a single integrated budget.
- **Work with providers, including voluntary sector organisations and GP Practices**: We need to work together to develop our providers and engage with GPs in Sheffield's communities.
- **Engagement with Sheffield people**: We want to involve Sheffield people to shape services.
- **Investment in IT**: We know that to achieve some of our objectives we need to invest in systems that work and speak to each other across organisational boundaries.
- **Developing more meaningful measures of success**: We too often measure the success of organisations in the health and care system rather than whether we are working well together as a whole. We will work during 2014-15 on 'whole system' measures of success that will drive the integrated commissioning of services.

What does this mean for Sheffield people?

- Local communities in Sheffield are increasingly supported by strong links between GPs, schools, social workers and community organisations, which helps people like them to stay independent for longer.
- Older people who have come out of hospital are helped by to stay at home. Families and carers will not have to chase professionals or ask them to talk to each other.
- Children with a learning disability and their families and carers are supported in managing their needs and can trust that when they turn 18 they will continue to receive the support they need.

Sign up to get involved and receive regular updates

We have done lots of consultation up to this point to help us identify some of the priorities for our plans, but **over the next year we will need your help** – as members of the public, service users, patients and providers – to shape the plans so we are designing services that best meet people's needs.

- Find out more about how past consultation and engagement has informed our plans here.
- Register your interest in being involved in specific areas of work here.
- To receive regular updates about our work, sign up for our monthly e-newsletter.
- To find out more about Sheffield's Health and Wellbeing Board, please go to our website.
- To ask us a specific question, email us: healthandwellbeingboard@sheffield.gov.uk.

Sheffield Health and Wellbeing Board
Forward Plan 2014-15

Version: March 2014 – these plans are subject to change over the year.

Our priorities for 2014-15

The Health and Wellbeing Board will spend the next year focussing on the outcomes in its Joint Health and Wellbeing Strategy, making a difference in Sheffield by:

- Influencing others to prioritise health and wellbeing and work together.
- Commissioning programmes and services that meet the ambitions in our Strategy.[1]
- Working in particular areas through work programmes.[2]

We will also focus our work on two particular areas: health inequalities and integrating health and social care. These two topics, along with our Strategy, will form the basis of most of our discussions.[3]

As a Board it is important for us that we engage with members of the public, service users, patients and providers. This is at the heart of what we do, evidenced by Healthwatch Sheffield's role on the Board. We hold a number of events and use a number of communications tools to facilitate this.[4]

Our meeting cycle

Public meetings are formal Board meetings which any member of the public can attend. Formal papers are received and official decisions made at these meetings. Each public meeting will:

- Have a declaration of interests from members of the Board.
- Give members of the public the chance to ask questions.
- Provide genuine discussion between Board members on a range of papers.
- Make formal, public, minuted decisions if this is what is required.

Engagement meetings are opportunities for Board members and members of the public, providers and other stakeholders to meet, something there has been much demand for.[5] Each engagement meeting will:

- Provide opportunities for discussion and engagement with the wider Sheffield community.

[1] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html.
[2] https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy/work-programmes.html.
[3] We have published some criteria for topics that we would normally discuss at formal Board meetings which can be downloaded at: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/involved.html.
[4] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board.html for more.
[5] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events.html for events held in 2013.

- Be focussed on meaningful issues which are aligned to the priorities of the Joint Health and Wellbeing Strategy.
- Give attendees the opportunity to frame some of the topics for discussion.

Forward plan

Type of meeting	Date/month	Agenda items
Engagement	**29 May**	Health inequalities event
Board meeting	**26 June**	Outcome 3 of the Joint Health and Wellbeing Strategy Healthwatch Sheffield annual report
Engagement	**24 July**	Healthwatch Sheffield leading the event
Board meeting	**25 September**	Outcome 1 of the Joint Health and Wellbeing Strategy Update on health and wellbeing outcome indicators
Engagement	**30 October**	To be decided
Board meeting	**11 December**	Outcome 2 of the Joint Health and Wellbeing Strategy
Engagement	**29 January**	To be decided
Board meeting	**26 March**	Outcomes 4 and 5 of the Joint Health and Wellbeing Strategy Update on the work programmes Update on the Joint Strategic Needs Assessment

We plan on maintaining a strategic focus on integration and health inequalities, as we have identified these as being important for us as a Health and Wellbeing Board. This will include regular updates.

However, other topics we plan on covering in 2014-15 but have not allocated a particular agenda slot include:

- The Care Bill.
- The Children and Families Bill.
- The Director of Public Health Report 2014.
- Quality issues, including Francis Report and Winterbourne View Report.
- Adults' and Children's Safeguarding.
- Comment on CCG, Council and NHS England commissioning plans and intentions.
- Responding to feedback from our plans to establish a provider assembly.
- Topics that Healthwatch Sheffield brings to the Board as appropriate.

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of: Dr Jeremy Wight, Director of Public Health

Date: 27 March 2014

Subject: Joint Strategic Needs Assessment Annual Report 2013-14

Author of Report: Louise Brewins (0797 130 4428)

Summary:

The JSNA (2013) identified a number of health and wellbeing topics where more evidence was required about the local position. This report provides an update on the progress made in gathering this additional JSNA evidence as well as identifying a number of additional topics for further analysis in 2014-15. In addition the report sets out proposals for an approach to developing indicators for outcome 5 of the Joint Health and Wellbeing Strategy.

Questions for the Health and Wellbeing Board:

- Is the level of detail in the report sufficient and if not, should it be more or less detailed?
- Are there other aspects of JSNA work that it would be helpful to report on (e.g. JSNA online resource)?
- Is the proposed approach to the development of outcome 5 indicators acceptable?
- Are there other JSNA topics that should be explored further?

Recommendations:

The Board is asked to:

- Note the significant progress achieved to date.

- Identify which, if any of the topics discussed in the report, it would wish to receive a specific agenda item on for a future meeting.
- Agree that a paper outlining the proposed Health Equity programme be presented to a further meeting.
- Agree the proposed way forward for developing indicators for outcome 5 of the Joint Health and Wellbeing Strategy.
- Request a full update on all of the outcome indicators when the most up to date data are available.
- Agree the additional JSNA topics to be investigated further in 2014-15.

Reasons for the recommendations:

It is important that the Board shapes and agrees the JSNA process and related areas of work as this is the key means by which it obtains evidence to support development and evaluation of the Joint Health and Wellbeing Strategy.

Background papers:

- JSNA 2013 available at https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA.html.

Sheffield Joint Strategic Needs Assessment Annual Report to the Health and Wellbeing Board 27th March 2014

1. Background

1.1 The Board published its first Joint Strategic Needs Assessment (JSNA) in July 2013. This provided a range of information and intelligence about health and wellbeing in the City to support development of the Joint Health and Wellbeing Strategy. As an evidence base for the Strategy, the Board recognised that the JSNA needed to be more than just a document. Specifically, the JSNA should be considered as a continuous process of adding to our knowledge and understanding of health and wellbeing in Sheffield.

1.2 The JSNA report prioritised 15 health and wellbeing topics or 'knowledge gaps' where further detailed data collection, analysis, audit, evaluation or research was needed to enhance the local evidence base. In addition, the JSNA was used to develop a set of health and wellbeing indicators to help the Board evaluate achievement of its five strategic outcomes, as set out in the Joint Health and Wellbeing Strategy. Indicators were developed and agreed for the first four outcomes of the Strategy in October 2013. It was recognised however, that further work was needed to identify suitable indicators for the fifth outcome '*The health and wellbeing system is innovative, affordable and provides good value for money'*. Finally, over this same period, a number of other topics have emerged where further analysis and/or assessment would be helpful to determine inclusion within the JSNA.

1.3 The purpose of this report is therefore to: provide the Board with an update on the progress that has been made on responding to the JSNA knowledge gaps (section 3), set out a way forward for developing indicators for the fifth outcome of the Joint Health and Wellbeing Strategy (section 4) and identify the topics to be investigated further in 2014-15 (section 5).

2. What does this mean for Sheffield people?

The JSNA provides a wealth of information and evidence about the health and wellbeing needs of the Sheffield population. This information underpins the development of the Joint Health and Wellbeing Strategy which in turn influences relevant commissioning plans. It is therefore important that the JSNA is as comprehensive in its coverage of need as possible and, where there are gaps in this information, seeks to address them. The JSNA should also be kept up to date.

3. Progress as at March 2014

3.1 <u>Sensory impairments</u>

A Health Needs Assessment (HNA) has been produced and discussions are currently being held with Communities Portfolio (SCC) and the Clinical Commissioning Group (CCG) to agree appropriate commissioning priorities and actions in response to the HNA's recommendations. The HNA confirmed the JSNA finding that Sheffield is seeing a growing number of people experiencing problems with either their eyesight and/or

their hearing and that this is leading to a largely preventable increase in the burden of ill health and disability in the City. One of the key ways for addressing this problem, as recommended by the HNA, is to raise public awareness of eye health and the benefits of regular eye check-ups. Additional Public Health grant funding was secured in 2013-14 to support taking this recommendation forward.

3.2 Resilience

Our JSNA noted that places where people get along well together tend to be places where people feel safer, live longer and respond better to emergencies or unexpected events, including adverse weather events. Resilience was also a big issue at our JSNA consultation events. At the time however we did not have an agreed consistent definition of resilience, nor agreed, reliable and comparable measures and therefore lacked an agreed basis from which to work.

Following a series of one to one meetings with key strategic leaders, and discussion at a Sheffield Executive Board meeting in September 2013, key agencies agreed to commit to developing a whole city approach to building strong and resilient communities. This approach is being led through Sheffield Executive Board, working in partnership with the newly established Local Area Partnerships. The two key pieces of work being taken forward are the development of a shared definition of success (the key characteristics of a resilient community) and developing a jointly owned city approach based on evidence, local knowledge and best practice. The initial phase of work is due to complete in spring 2014.

3.3 Assets

As part of the development of the social model of public health in the Council and related community wellbeing programme, transfer of Sheffield Homes staff into the Council and development of the Housing+ service, creation of the Local Area Partnerships, and a number of examples of place-based working, there is now considerable scope for greater operational alignment of services that are capable of identifying and strengthening community assets. A clear link is being made as part of the work on resilience and in terms of taking forward place-based working on a more systematic basis but further discussion on the knowledge and evidence needs to support this is now required. One possible option being explored would be to conduct a population-based survey. This work is being led by the Communities Portfolio.

3.4 Autism

With around 6,000 adults with Autistic Spectrum Disorders (ASD) in Sheffield and in the knowledge that this represents one of the fastest growing areas of ‘primary need’ in the City, the JSNA identified the need for a more in-depth Health Needs Assessment (HNA) to be undertaken to provide information and evidence on current and future numbers, diagnosis, co-morbidity and key service issues to inform the work of the Autism

Strategy Implementation Group (ASIG). The HNA is due for completion in the spring and is focussing on adults, although information on children and young people with autism is included in the HNA on children with complex care needs (see section 3.7).

3.5 Older people's wellbeing in care homes

An HNA has been completed and its recommendations are being taken forward by the Quality in Care Homes Programme Board (SCC) as well as being shared with the CCG. The HNA makes a number of recommendations for improving the wellbeing of care home residents but its central recommendation is to characterise care homes as settings for the effective and efficient promotion of public health, akin to the 'Healthy Schools' approach. This approach has the potential to provide a systematic means by which to improve outcomes for older residents and thus make a significant contribution to improving health and wellbeing in the City overall.

3.6 Impact of welfare reform

In July 2013 a paper entitled 'The Impact of Welfare Reform on Sheffield's Residents' was taken to Scrutiny. Since that time, there have been further changes to welfare arrangements. A Welfare Reform Implementation Group has been established in the Council with one of the main work streams being concerned with measuring and assessing the impact of the reforms on the local population. The JSNA raised concern about the extent to which the outcomes of the Health and Wellbeing Strategy would be achievable in the context of such potentially negative impacts. Work has therefore been undertaken to begin to quantify the impacts of welfare reform, both in financial and health terms. More specialist support is needed however to develop this information further and discussions are currently being held with relevant academic partners for an 'integrated' health impact assessment.

3.7 Children with complex needs

A Health Needs Assessment (HNA) is due for completion at the end of March 2014 and will provide information and evidence on current and future needs, risk factors and service requirements. Recommendations will be taken forward under the auspices of the complex care work stream of the Children's Health and Wellbeing Partnership Board.

3.8 GP user experience and service access

Based on qualitative evidence gained at our consultation events, the JSNA identified the need to explore local evidence concerning access to GP practices services in more depth. In particular, this included issues such as contacting the surgery by telephone, waiting times for an appointment and seeing a GP at the weekend. The NHS England Area Team for South Yorkshire and Bassetlaw is currently preparing its primary care

strategy which will include its approach to access and quality of primary care services in the area. The key aim will therefore be to ensure local evidence is used to help inform the strategy. The work undertaken by Sheffield Healthwatch, in relation to the public's views on primary care access in Sheffield, will therefore provide this evidence, both in terms of informing the NHS England strategy and local CCG plans for work with practices.

3.9 Children and young people's emotional and mental health

An HNA is due for completion at the end of March 2014 and will provide relevant evidence to inform development of the Children Health and Wellbeing Board's strategy. The HNA is focusing on current and future numbers, risk/protective factors, high risk groups and service requirements.

3.10 Mental ill health and service use and access for physical health needs

The JSNA highlighted serious concerns regarding the physical health outcomes of people with mental health problems, especially people with serious mental illness. Although a national problem, the situation in Sheffield was identified as particularly worrying. Evidence was needed on 'what works'. This is being taken forward as a project within the Right First Time programme. The project is currently gathering evidence to support evaluation of a systematic approach to addressing the physical health needs of people with a serious mental illness. GP practices are core to this approach which is centred on the annual health check and use of community development workers linked with practices. Three GP practices are currently participating in the pilot. More detailed evidence from the evaluation is due in September 2014 and will include focus on issues such as acceptability (staff and patient), removal of barriers, take-up of the health check and, where available, changes in behaviours and choices. Subject to evaluation (and funding), the aim is to mainstream the approach in 2015.

3.11 Neurological conditions

The JSNA identified that nationally the number of people with neurological conditions is likely to grow sharply over the next two decades and that this would increase the impact on both health and social care services. However, it also identified that we needed comprehensive and up-to-date local data if we are to assess need accurately and determine where best to focus interventions for improvement. An initial briefing on the state of the local evidence has been prepared and will be taken to the Adult Joint Commissioning Group for consideration.

3.12 Lifestyle behaviours

The JSNA recognised that information about people's lifestyle behaviours, such as smoking, alcohol consumption, eating habits and levels of physical activity, was almost exclusively dependent on national surveys, making it difficult to assess and target work according to local variations and preferences. Actual data on smoking, alcohol consumption and weight, derived from GP practices, is now becoming available and this is being used to support effective targeting and provision of prevention and early intervention work. Initial analysis is focussing on developing a more accurate picture of prevalence and how this varies across Sheffield's communities and is being used to inform the long term conditions programme within the CCG and the Council's stop smoking service tender and specifications for the Weigh Ahead and Physical Activity contracts.

3.13 Pharmaceutical needs assessment

National guidance indicates the Pharmaceutical Needs Assessment (PNA) should be fully updated and published by April 2015. A steering group and delivery plan is being set up to take this forward in Sheffield. Meanwhile, the current PNA (published 2010) and live map continue to be updated as required and are made available to NHS England and industry on request. A more detailed briefing on producing the PNA for Sheffield was circulated to the Board in January 2014.

3.14 Equity of spend

It has long been acknowledged that putting additional support into the most disadvantaged communities of a population and raising standards there will have a beneficial effect on the whole population. In addition, the Fairness Commission recommended that the Health and Wellbeing Board should seek to ensure that spending across the City is more fairly utilised based on the relative needs of its communities. This includes making services more accessible and appropriate to groups who underuse them. The JSNA identified however that we lacked comprehensive enough evidence to judge whether the distribution of resources was linked to the distribution of need or not.

Analysing the extent of unwarranted variation in healthcare utilisation represents one way in which this JSNA knowledge gap could be considered. Looking at health (and social care) spend in total however would be a significant undertaking and probably unrealistic. The approach proposed therefore would be to establish a 'health equity programme' to be led by the healthcare public health team based in the CCG on behalf of the Health and Wellbeing Board. This programme would then be based on a prioritised set of topics or service areas and use a systematic approach to assessing equity and need. The programme is currently being scoped and it is therefore proposed that a separate paper on this is brought to the Board for approval.

3.15 Health needs of protected groups

Whilst the JSNA presented extensive information on health inequalities in the City by geography and socio-economic status, it was clear there was considerably less information on other axes of inequality such as disability, ethnicity and sexual orientation. It is important that in the future we develop, where practicable, our joint assessment of need within the context of our Equality Duty and related protected characteristics. A new Health Inequalities Action Plan for the City is currently under development, as part of implementation of the Joint Health and Wellbeing Strategy. The first actions in the plan will be to define the populations and communities of identity/interest and the aspects of health and wellbeing we wish to measure, and to then source and collect relevant data. A good start has been made with the production of a number of 'community knowledge profiles' (currently these cover ethnicity, gender and disability). These profiles will be further developed to cover other relevant communities.

4. Outcome 5 health and wellbeing indicators

4.1 In October 2013, the Board agreed a set of 30 indicators that it would use to help judge whether it was making progress towards its strategic outcomes. These indicators related to the first four outcomes of the Health and Wellbeing Strategy. The Board agreed however, that further work was needed to develop indicators suitable for evaluating the fifth outcome of the strategy - t*he health and wellbeing system is innovative, affordable and provides good value for money'*. The following sections set out some of this further thinking and identify potential way forward.

4.2 The first element of the outcome is concerned with the extent to which the local health and wellbeing system is ***innovative***. The most straightforward way to measure this would be to identify the number of new, evidence-based services commissioned to improve health and wellbeing in Sheffield i.e. services of a different nature rather than the same type of service commissioned from a different provider.

4.3 The second element concerns whether the health and wellbeing system is ***affordable***. There are a number of approaches that could be taken here. The most straightforward option would be to focus on whether the respective budgets of the Council and the CCG are in balance and achieving required savings. Another option would be to focus on local demand management priorities. There are already a number of 'demand management' indicators included under outcome 4 of the Strategy however (emergency admissions, admissions to care homes, delayed transfers of care and A&E attendances). The proposed way forward would therefore be to use these indicators to cover both outcomes 4 and 5 in addition to one or two budget/savings indicators including, potentially, affordability in future years.

4.4 The third element of the outcome, whether the health and wellbeing system provides good ***value for money***, is perhaps the most difficult to capture. Broadly the aim should be to combine spend, quality and outcome into one indicator. In the context of the NHS, it is proposed that the Department of Health's Spend and Outcome Tool (SPOT) be used to construct an indicator measuring the proportion of health programmes where

there is high spend and poor outcomes relative to Sheffield's statistical neighbours. For Adult Social Services and Children and Young People's services relevant benchmark indicators would be used. This could include development of unit price comparisons.

There is a fourth area of value however that should be considered. The Public Services (Social Value) Act 2012 became law on the 8th March 2012. The Act places a duty on public bodies to consider social value ahead of a procurement process for the provision of services, the provision of services together with the purchase or hire of goods, or the carrying out of works. Specifically the requirement is to consider how what is proposed to be procured might improve the economic, social and environmental well-being of the relevant area and how, in conducting the process of procurement, to secure that improvement. It is unclear at the moment how we would measure this objectively and it is therefore proposed that we explore this further.

5 New topics for the JSNA in 2014-15

5.1 Since the JSNA was published last year a number of other health and wellbeing topics have been raised for possible inclusion within the JSNA. It is proposed that these topics be considered in more detail in 2014-15 with recommendations made to the Health and Wellbeing Board as appropriate and relevant.

5.2 Climate change and adaptation

Changing weather patterns, more frequent extreme weather and rising temperatures have direct implications on our health and pose challenges to the way in which the NHS, public health and social care system operates. These impacts are extremely likely to be magnified in the future. One of the main ways in which we can respond to this is via 'adaptation' or, preventing avoidable impacts and health burdens through comprehensive preparation. Nationally a sustainable development strategy has been produced jointly by the Local Government Association, NHS England and Public Health England for the NHS, Public Health and Social Care system. The Environment Agency has recently produced a toolkit to support Health and Wellbeing Boards, as part of their JSNA, to identify the adaptation measures available at the local level and the opportunities to improve people's health and save money through action on this agenda. It is proposed that the toolkit is used to undertake this local assessment.

5.3 Other topics

As a result of Freedom of Information requests and general enquiries a number of other health and wellbeing issues have been raised for further investigation. These are:

- Adults with complex care needs
- People with HIV/AIDs and experience of poverty
- Epilepsy
- Offender health
- End of life care

It is proposed that each topic be considered in more depth with recommendations made to the Board as required.

6. Questions for the Board

- Is the level of detail in this 'annual' report sufficient? If not, should there be more or less detail?
- Are there other aspects of JSNA work that it would be helpful to report on (e.g. JSNA online resource)?
- Is the proposed approach to the development of outcome 5 indicators acceptable?
- Are there other JSNA topics that should be explored?

7. Recommendations

The Board is asked to:

- Note the significant progress achieved to date.
- Identify which, if any of the topics discussed in the report, it would wish to receive an agenda item on for a future meeting.
- Agree that a paper outlining the proposed Health Equity programme be presented to a future Board meeting
- Agree the proposed way forward for developing indicators for outcome 5 of the Joint Health and Wellbeing Strategy.
- Request a full update on all the outcome indicators when the most up to date data are available (likely to be September 2014)
- Agree the additional JSNA topics to be investigated in 2014-15.

8. Reasons for the recommendations

It is important that the Board shapes and agrees the JSNA process and related areas of work as this is the key means by which it obtains evidence to support development and evaluation of its Strategy.

Louise Brewins

Sheffield City Council

27th March 2014

SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 12 December 2013

PRESENT: Dr Tim Moorhead (in the Chair), Clinical Commissioning Group
Councillor Julie Dore (Co-Chair), Leader of the Council
Dr Amir Afzal, Clinical Commissioning Group
Jason Bennett, Healthwatch Sheffield
Councillor Jackie Drayton, Cabinet Member for Children, Young People and Families
Margaret Kitching, South Yorkshire and Bassetlaw Cluster
Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living
Jayne Ludlam, Executive Director, Children, Young People and Families
Dr Zak McMurray, Clinical Commissioning Group
Dr Ted Turner, Clinical Commissioning Group
Richard Webb, Executive Director, Communities
Dr Jeremy Wight, Director of Public Health

IN ATTENDANCE: Rt Hon. Andy Burnham MP
Heather Burns – Senior Commissioning Manager, Clinical Commissioning Group
Joe Fowler – Director of Commissioning, Sheffield City Council
Tim Furness – Director of Business Planning and Partnerships, Clinical Commissioning Group
Professor Alan Walker – Chair of the Sheffield Fairness Commission

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Ian Atkinson (Clinical Commissioning Group), Pam Enderby (Healthwatch Sheffield), Councillor Harry Harpham (Cabinet Member for Homes and Neighbourhoods) and John Mothersole (Chief Executive, Sheffield City Council).

2. DECLARATIONS OF INTEREST

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

3. HEALTH INEQUALITIES IN SHEFFIELD

Councillor Julie Dore, Co-Chair of the Board, introduced a discussion paper entitled *Tackling Health Inequalities in Sheffield*, which set out what each of the constituent organisations on the Health and Wellbeing Board was doing to address health inequalities. She outlined the work of the Fairness Commission in relation to inequalities and the Commission's recommendations to address inequalities.

The Health and Wellbeing Board was asked in this, the first of two discussions on health inequalities, to consider each of its constituent organisations' responses to health inequalities and to identify additional action as appropriate.

Councillor Dore introduced Professor Alan Walker, the Chair of the Fairness Commission, who gave a presentation concerning the first annual review of the impact which the Fairness Commission had made.

Professor Walker stated that the stance which the Commission had taken was particularly bold – to make Sheffield the 'fairest city'. There were 4 targets specific to the remit of the Health and Wellbeing Board and a wider set of targets relating to mental health and wellbeing and carers. He outlined the responses of all the relevant organisations, those matters which were outstanding and the related principles. Professor Walker outlined the challenges to the Health and Wellbeing Board, namely (i) a need to tackle premature deaths of people with learning disabilities and severe disabilities; (ii) to develop a life course strategy, to embed prevention including health care and quality of life. He stated that mental illness was responsible for causing early deaths (of up to 20 years earlier) and also increased the risk of a person suffering from one of the top five health related killers. It was important, he said, to be ambitious about tackling inequalities.

The Board discussed matters raised by Professor Walker and in relation to health inequalities, as summarised below:

A major discussion was required to respond to these challenges and as to how organisations can pull together in taking actions which reduce inequality. Reducing inequalities was a strand which ran through the City Council's strategies, including in the Corporate Plan and the budget and the food and physical activity strategies.

The mental health of adolescents was important as was the impact on children and young people who were living in households which included people with poor mental health or with a mental illness.

The shortened life expectancy for people with a mental illness was particularly stark. There was a role for GPs in providing health checks and for health and social care in the way that personal budgets were applied to a person's recovery or in helping them to manage mental illness and physical health.

The Rt Hon Andy Burnham MP, having attended the meeting for this item of business, stated that it was a privilege to hear the quality of the conversation and the level of challenge in the Board's discussion. He referred to the concept of a social model of support encompassing the whole person and observed that mental health should be moved to the centre of the health and social care system. At present, Child and Adolescent Mental Health Services (CAMHS) received only a small proportion of the total funding available to the NHS and Local Authority and there was a shortage of crisis prevention services. There was a shortened life expectancy of up to 20 years for people with mental illness. He encouraged the Board to make representations with regard to the weighting

of health funding to areas with greatest need and health inequalities. He stated that Labour was developing policy around full integration and commissioning and was beginning discussions in this regard. He referred to the forthcoming report by John Oldham on whole person care, due to be published in February 2014.

The Chair, Dr Tim Moorhead, clarified that the Board had made representations on this issue and had briefed two of the City's local MPs, David Blunkett and Clive Betts in this regard. He stated that the NHS also had a duty to take action with regard health inequalities. In reference to the report on whole person care, Dr Moorhead stated that the Board would like to engage with this work.

Comments were made by other members of the Board as follows:

The City Wide Learning Body was developing a project on young people's mental health and the transition from child to adult services and support which supported the notion of a life-course strategy.

Whilst infant mortality was reducing, there were inequalities within that overall reduction, in such areas as maternal smoking. Breastfeeding was an area in which there had been successful improvement in performance and the question was how improvement could be sustained and problems arising from the widening funding gaps could be mitigated.

The Fairness Commission viewed the Health and Wellbeing Board as the strategic lead on the issue of health inequalities and the translation of strategy into next steps. The tasks were to turn around inequalities and to bring about prevention in future generations, which required a joined-up perspective.

Systemic change would need a long term vision and there were already changes to the role of GPs, for example. Action such as health risk assessments for those people who might not have previously been identified as 'at risk' was being encouraged by GPs as commissioners. However, there was always a time lag in implementing change and seeing its full effect.

Healthwatch Sheffield was in a position to rapidly identify health inequalities by asking people and listening to them.

Health inequalities were the consequence of socio-economic factors and the Board should be realistic about what it could achieve. Much could be done to mitigate the effects of inequalities on health, although these might not equate to a coherent set of actions, a fact of which Professor Walker had reminded the Board. There were short, medium and long term actions necessary. In the short term, action should be taken for people who may die in the next 5 years. In the medium term, things should be done to stop people from developing illnesses, which might include lifestyle and in the longer term, the root causes of ill health needed to be addressed.

We should be mindful of the scale of effort required to bring about health improvement. For example, the prevention of heart disease required a city wide

initiative, encouraging GPs to identify those with a high risk of heart disease. With regard to mental health, it was recognised that many of the actions necessary had not taken place.

It would be helpful to turn the numerous strands of work into a coherent and powerful collection of actions, in relation to which all organisations played a role. Addressing the gap in provision for mental health and learning disabilities should be identified as an objective.

RESOLVED: That the Board (a) thanks Professor Alan Walker for his attendance and contribution; (b) requests the Director of Public Health to produce a Health Inequalities Action Plan; and (c) requests that a further paper on health inequalities be submitted to the Board in Spring 2014.

4. SHEFFIELD HEALTH AND WELLBEING BOARD'S PLANS FOR INTEGRATING HEALTH AND SOCIAL CARE

The Board received a presentation by Joe Fowler (Director of Commissioning, Sheffield City Council) and Tim Furness (Director of Business Planning and Partnerships, NHS Sheffield Clinical Commissioning Group) concerning the Board's plans for the integration of health and social care. The presentation made reference to formal and informal integration and the role of commissioners in achieving the best outcomes for citizens. The challenge was to undertake initiatives at the appropriate scale, learning from what happens in one area to inform the implementation of initiatives in other areas. The Joint Commissioning Executive Team had prioritised the development of plans for integrating in the areas of community prevention, intermediate care and re-ablement and long term high support and CAMHS would also be considered. Challenges included how organisations could pool resources and better manage funds both locally and nationally and how greater autonomy might be achieved for Sheffield. A further report would be submitted to the Board in March 2014.

Members of the Board made comments as summarised below:

The priority areas and general direction of travel were supported. The role of NHS England in supporting integration and the role for Healthwatch in engagement and (patient) voice was acknowledged. The focus upon outcomes was in contrast to previous attempts at health and social care integration, which had concentrated on structure.

The Board was responding to consultation on proposals collectively and it needed to make sure its voice was heard by all political parties in relation to integration and what works for the City.

There were developments with regard to opportunities within the Children and Families Bill, for example, in relation to special needs.

RESOLVED: That (a) the presentation concerning the integration of health and social care is noted; (b) the Board be kept regularly appraised of progress in relation to the integration of health and social care; and (c) a further report on the

integration of health and social care is submitted to the Board at its meeting in March 2014.

5. THE CONFIDENTIAL INQUIRY INTO PREMATURE DEATHS OF PEOPLE WITH LEARNING DISABILITIES (2013): ITS CRITICAL IMPLICATIONS FOR HEALTH AND HEALTH INEQUALITIES IN SHEFFIELD

The Board considered a report concerning the findings and recommendations of the national confidential inquiry into premature deaths of people with learning disabilities (2013). Heather Burns, Senior Commissioning Manager, NHS Sheffield Clinical Commissioning Group presented the report. The inquiry had made a number of findings, including that people with learning disabilities died much earlier than the general population of preventable causes and most commonly through problems and delays with health investigations and treatments.

There were inadequate reasonable adjustments made, a failure to follow the Mental Capacity Act, end of life care pathways and do not attempt cardiopulmonary resuscitation orders. There was a lack of proactive healthcare and planning in the cases reviewed.

The local responses to the Inquiry's various recommendations were summarised in the report.

Members of the Board made comments and asked questions to which responses were given, as summarised below:

The recommendations of the Confidential Inquiry should be embedded in practice and in the treatment of people with learning disabilities.

Was there a comparison or cross reference of the policies which protect and safeguard children with those for people with learning disabilities? There was concern that young people with learning disabilities were being pushed into independent living.

The law applying to children and to adults (e.g. people with disabilities) was different. The framework for people with learning disabilities was the Mental Capacity Act. The integration of services and the provision of holistic care were challenging issues involving hospitals and GPs. A whole-age approach needed to be taken for people with learning disabilities to provide a life pathway. It was noted that, at present, safeguarding was the responsibility of two separate bodies, namely the Children and Adult Safeguarding Boards respectively.

The recommendations of the Inquiry did not make specific reference to support for carers and this was an area that should be included in the Board's plans.

From a public health perspective, more could be done to improve matters for people with learning disabilities. In terms of public health intelligence, there should be an amount of caution exercised regarding expectations as it may be difficult to obtain data, which might not have been systematically recorded or may not be linked.

The framework was different for children and adult safeguarding. There needed to be work to improve awareness through the Mental Capacity Act and thought should be given to expectations regarding the standard of care and support for people with learning disabilities. There had been change in public policy with regard to equitable rights and citizenship, and whilst there was some good practice, the existence of choice allows for certain things not to be done. 'Reasonable adjustment' was partly dependent upon culture and attitude of service providers.

The health and social care self-assessment process mapped out the gaps in provision for people with learning disabilities.

There was a prioritisation process and the associated resource and expenditure implications were considered within that process. As such, was the Board expected to endorse the recommendations simply as principles? There was a notion that, if the right process was adopted for people with learning disabilities, then similarly, this would equally apply to other groups, including, for example, people suffering with dementia. The recommendations could be applied more widely and be linked to the action planning for health and social care assessments.

RESOLVED: That (a) the Board notes the recommendations of the Inquiry, and seeks assurance that local partners are taking all reasonable steps to ensure equal access to healthcare for people with learning disabilities in Sheffield.

(b) the Public Health Intelligence Team is invited through their core offer to Sheffield City Council and the Clinical Commissioning Group, to analyse and research outcomes for people with learning disabilities in Sheffield in respect of:

i. Recommendation 7 of the Inquiry *(People with learning disabilities to have access to the same investigations and treatments as anyone else, but acknowledging and accommodating that they may need to be delivered differently to achieve the same outcome);* and

ii. Recommendation 17 of the Inquiry (*Systems in place to ensure that local learning disability mortality data is analysed and published on population profiles and Joint Strategic Needs Assessments*).

Reasons for Decision:

The Confidential Inquiry is based on intensive research in the South-West of England. We do not really know if the situation is the same, better or worse in Sheffield. Understanding more about the health, healthcare, morbidity and deaths of people with learning disabilities in the City would enable us to take targeted action to improve access to healthcare and address serious health inequalities experienced by this population.

6. DIRECTOR OF PUBLIC HEALTH REPORT FOR SHEFFIELD 2013

The Board received a presentation concerning *New Opportunities*, the Director of Public Health Annual Report for Sheffield 2013 by Dr Jeremy Wight, the Director of Public Health. He outlined statistical information regarding life expectancy and the effect on life expectancy of factors including disability and inequality. The presentation also summarised the 11 recommendations for public health, which corresponded with the Health and Wellbeing Strategy.

In terms of the process by which the recommendations could be incorporated within the Health and Wellbeing Strategy, there was a fit with the Joint Strategic Needs Assessment (JSNA). The new aspects in the Director of Public Health's report could be included in the JSNA and the Health and Wellbeing Strategy adapted accordingly.

The recommendations in the report were focussed upon public health in the Council. It was noted that a presentation on the Annual Report had also been made to the City Council and the Clinical Commissioning Group.

RESOLVED: that the information contained in the Director of Public Health Report for Sheffield 2013 and, in particular, the eleven recommendations for improving public health, which are based on an analysis of the new opportunities that now exist as a result of the transfer of public health leadership to the Council, be noted.

Reasons for the decision:

1. It is good practice for Director of Public Health reports to contain recommendations aimed at improving the health of the population.
2. Recommendations have been made in areas where there is particular scope to improve the health of the people of Sheffield through combining public health expertise with the scale and outreach of the City Council.

7. BETTER OUTCOMES FOR CHILDREN AND YOUNG PEOPLE'S PLEDGE

The Board considered a report requesting that it sign up to the Better Health Outcomes for Children and Young People Pledge. The Children's Health and Wellbeing Partnership Board had committed to sign-up to working to achieve the ambitions outlined in the Pledge and requested that this Board also gives its endorsement.

Members of the Board commented, as follows:

The Looked After Children Pledge and the Better Health Outcomes for Children and Young People Pledge would benefit from being joined together.

That, whilst the ambitions and commitment sought might be supported, some consideration should also be given to the resource implications and performance metrics.

RESOLVED: that (i) the Executive Director, Children, Young People and Families is requested to produce a revised report concerning the Better Outcomes for Children and Young People Pledge and the Looked After Children Pledge to be submitted to the next meeting of the Board on 27th March 2014.

8. PUBLIC QUESTIONS

Public Question Concerning Care Planning

Mike Simpson referred to his local doctor's surgery patient participation group at which he was told that the Clinical Commissioning Group (CCG) had commissioned some form of care planning exercise from all practices. He stated that at that brief discussion, it was not clear what was meant by care planning. He asked what is the relationship of this exercise to the integration work described to the Health and Wellbeing Board?

In response, Dr Tim Moorhead, the Co-Chair of the Board, stated that the CCG had asked GP practices to implement a care planning approach, which describe an individual's range of illnesses and produced a plan, possibly with the involvement of a multi-disciplinary team, to support a person to self-care and address what should be done if there is an escalation in their health needs. For long-term conditions, the plan was subject to regular review.

Practices were asked to look at cases of moderate risk. If there was a care plan it was thought that this may reduce the likelihood of a patient's escalation to urgent care. It was not yet known how effective the approach will prove to be. Investment had been made into the care planning approach in this year and was intended for the next financial year. All of the GP practices in Sheffield had taken up the approach.

Tim Furness, the Director of Business, Planning and Partnerships, NHS Sheffield Clinical Commissioning Group, explained that in relation to integration, care planning was also part of the health and social care commissioning picture. It was acknowledged that care planning did have different meaning, depending upon the context.

9. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the Board held on 26th September 2013, were approved as a correct record.