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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 23 July 2014 at 10.00 am

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Mick Rooney (Chair), Sue Alston (Deputy Chair), Jenny Armstrong, Olivia Blake, John Campbell, Katie Condliffe, Qurban Hussain, Anne Murphy, Denise Reaney, Jackie Satur, Brian Webster, Philip Wood and Joyce Wright

Healthwatch Sheffield
Helen Rowe and Alice Riddell (Observers)

Substitute Members
In accordance with the Constitution, Substitute Members may be provided for the above Committee Members as and when required.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Healthier Communities and Adult Social Care Scrutiny Committee exercises an overview and scrutiny function in respect of the planning, policy development and monitoring of service performance and related issues together with other general issues relating to adult and community care services, within the Neighbourhoods area of Council activity and Adult Education services. It also scrutinises as appropriate the various local Health Services functions, with particular reference to those relating to the care of adults.

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.

Members of the public have the right to ask questions or submit petitions to Scrutiny Committee meetings and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

Scrutiny Committee meetings are normally open to the public but sometimes the Committee 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 about this Scrutiny Committee, please contact Matthew Borland, Policy and Improvement Officer on 0114 27 35065 or email matthew.borland@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.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
23 JULY 2014

Order of Business

1.	**Welcome and Housekeeping Arrangements**	
2.	**Apologies for Absence**	
3.	**Exclusion of Public and Press** To identify items where resolutions may be moved to exclude the press and public	
4.	**Declarations of Interest** Members to declare any interests they have in the business to be considered at the meeting	(Pages 1 - 4)
5.	**Minutes of Previous Meetings** To approve the minutes of meetings of the Committee held on 19th March, 10th April and 4th June, 2014, and to note the attached Actions List	(Pages 5 - 22)
6.	**Public Questions and Petitions** To receive any questions or petitions from members of the public	
7.	**Sheffield Health and Wellbeing Board - Plans for 2014/15** Joint report of Ian Atkinson, Accountable Officer, NHS Sheffield Clinical Commissioning Group, and John Mothersole, Chief Executive, Sheffield City Council	(Pages 23 - 74)
8.	**Sheffield NHS Clinical Commissioning Group - Commissioning Intentions 2014/15** Report of Tim Furness, Director of Business Planning and Partnerships, Sheffield Clinical Commissioning Group	(Pages 75 - 116)
9.	**"How Did We Do?" - Sheffield's Local Account of Adult Social Services 2014** Report of Laraine Manley, Interim Executive Director, Communities	(Pages 117 - 148)
10.	**Nutrition and Hydration Working Group** Report of the Policy and Improvement Officer	(Pages 149 - 164)
11.	**Draft Work Programme 2014/15**	(Pages 165 - 170)

Report of the Policy and Improvement Officer

12. Sheffield Adult Safeguarding Partnership - 2014/15 Business Plan (Pages 171 - 180)

Report of Simon Richards, Head of Quality and Safeguarding, Sheffield City Council (Briefing Paper only)

13. Date of Next Meeting

The next meeting of the Committee will be held on Wednesday, 17th September, 2014, at 10.00 am, in the Town Hall

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

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

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 19 March 2014

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Janet Bragg, John Campbell, Roger Davison (Deputy Chair), Tony Downing, Adam Hurst, Martin Lawton, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright

Non-Council Members (Healthwatch Sheffield):-
Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Katie Condliffe.

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 15th January 2014, were approved as a correct record. The Committee also noted the Action Update attached to the minutes and, arising from their consideration, the Chair, Councillor Mick Rooney, reported, in connection with Hospice Care in Sheffield, that the Committee had received a letter of response from Ian Atkinson, Accountable Officer, NHS Sheffield Clinical Commissioning Group (CCG), a copy of which had been circulated to Committee Members, which confirmed that the CCG had extended their contract with St Luke's Hospice from one year to two years, effective from 1st April 2014, and proposing that, by the end of June 2014, the CCG would work with the Hospice to produce a joint Contingency Plan. The Committee considered that their concerns had been taken on board and were pleased with the steps that had been taken by the CCG.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 In response to a public question regarding dementia friendly training and links to Ward level plans, the Chair, Councillor Mick Rooney, stated that discussions were taking place with regard to piloting dementia friendly areas in the City and that he would find out more and send a written response to the questioner.

6. SHEFFIELD CHILDREN'S FOUNDATION TRUST ANNUAL QUALITY REPORT 2013/14

6.1 The Committee received a report of the Director of Nursing, Sheffield Children's Foundation Trust, to which was appended a draft of the Trust's Annual Quality Report 2013/14, which summarised the performance of the Trust in 2013/14 in relation to quality of care. It set out the quality priorities for 2014/15, which had been arrived at in consultation with user families, governors and agency partners.

6.2 As a preliminary, the Policy and Improvement Officer, indicated that, as there had been no formal feedback from Healthwatch Sheffield, the intention of this meeting was to discuss and capture comments on the draft Annual Quality Report and then delay a formal response until the consultation with Healthwatch Sheffield had been completed.

6.3 In attendance for this item was John Reid, Director of Nursing, Sheffield Children's Foundation Trust, who referred the Committee to the draft report, making particular reference to the fallout from the Mid Staffordshire Public Inquiry, Children's Psychiatry and the building of the new hospital wing. He added that a plain English version of the report would be produced when it had been finalised.

6.4 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- The 2014/15 priorities reflected comments from the Trust's governors, clinicians and surveys for improvements. Other priorities had stemmed from the recommendations of the Mid Staffordshire Public Inquiry and the fact that the Children's Psychiatry Service was overwhelmed.

- The outcomes of the actions relating to newborn screening in the Neonatal Surgical Unit were that the Children's Service received a handover communication which was reported on regularly and the results of a health visiting survey, which had been commissioned in January, would be placed on the Trust's website in March and reflected in the final Annual Quality Report.

- All complaints were regarded as valid and were used as a learning tool. They were all reviewed and responded to and this had resulted in an improved service. A Governors' Group examined a sample of anonymised complaints, which was a procedure set out by the National Patient's Association. It was also proposed to check that all responses were compassionate.

- Selection and training of staff included the potential to care and be part of a team.

- Psychological illness in children was difficult to define as they were in the process of development, but one major sign of this was when anxieties interfered with their normal life. From the ages of 8 to 9 upwards, attempts were made to treat children with psychological illnesses as outpatients but sometimes it was necessary to have them admitted. There had been an

upswing in eating disorders and self-harming and strategies were devised involving both therapy and exercise to address these conditions. The City had two units with a good success rate, but it should be appreciated that there was no quick fix. Referrals were usually made by GPs, schools or relatives.

- Attention Deficit Hyperactivity Disorder (ADHD) was measured by how much it prevented normal life, such as being unable to participate in education or becoming involved in the criminal justice system. The Trust tended to use talking therapies to address this condition, with the use of drugs being avoided unless absolutely necessary. In cases where drugs were used, physical monitoring took place to assess any side effects.

- In relation to psychological services, the Commissioners were anxious to ensure that nothing was missed in the transition from child and adolescent to adult services.

- In relation to prescribing antipsychotics for children and adolescents, it was proposed to explore the possibility of a joined up protocol with GPs.

- The friends and family test was a national one, with the question being directed to the parents of children under 8 and with children over 8 being asked directly.

- A contract had been agreed at the beginning of the year with NHS England in relation to payment for referrals to the Children and Adolescent Mental Health Service (CAMHS) at the Becton Centre from other parts of the country.

- In relation to the Patient Experience surveys, the Trust was looking at detail, with anything less than 'excellent' indicating a problem. Benchmarking was undertaken against other Trusts, with the Sheffield results comparing favourably.

- It was a truism to say that in all acute services there was a difference in service at weekends. Clinics were held on weekdays and at weekends it was emergencies which tended to be dealt with. Evening clinics were to be introduced and it had been noted that there was an upsurge in Accident and Emergency admissions during the week. On weekdays, there were different teams working, different diagnostic services available and different access to laboratories. There was a need to change to deal with changing public expectations and work-life balance, and it was intended to provide a different, but not worse, service at weekends.

- Difficulties were experienced in the week in relation to pharmacy waiting times at the Children's Hospital, as children preferred liquid medicines, which commercial pharmacies tended not to stock. The pharmacy at the Hospital had now introduced pagers to help reduce queues at the pharmacy counter.

- The Director of Nursing assessed the nursing established with a Senior Nurse twice a year and at the entrance to each ward there was a noticeboard giving details of staffing.

- In an attempt to reduce pharmacy waiting times for patients awaiting discharge, ward based pharmacists had been introduced who would write up prescriptions for such patients.

- Whilst there was only one formal complaint relating to car parking, it remained that this was the biggest source of feedback received. The main source of complaints relating to care and treatment were as a result of parents disagreeing with diagnosis and treatment. Generally though, the complaints rate in Sheffield was low in comparison to the number of interactions.

- The reason for the number of internet links in the Annual Quality Report was to make the detail behind it available. Printed copies of the report were made available in public areas and the easy read version contained only one link, which was to the full report.

6.5 RESOLVED: That the Committee:-

(a) thanks John Reid for his contribution to the meeting; and

(b) notes the contents of the report and the responses to questions.

7. PUBLIC HEALTH INVESTMENT 2014/15

7.1 The Committee received a report of the Director of Public Health which set out the proposed use of the Public Health Grant for 2014/15. The report was introduced by Jeremy Wight, Director of Public Health, who emphasised that the philosophy behind the spending proposals was to address the root causes of ill health.

7.2 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- Attempts were made to join up all services and Public Health staff were now working in different parts of the Council, using the distributed model across Portfolios. Many of these staff had worked together at the Primary Care Trust (PCT) and now liaised across the Council. In addition they had contact with colleagues in the NHS, e.g. health trainers, so that the trainers knew what support was available.

- £100,000 had been allocated to the Eat Well campaign to support the Food Strategy. This was led from the Place Portfolio and included work by officers in the Children, Young People and Families Portfolio. If it was felt that cook and eat classes would make a difference, then these would be organised. The Healthy Communities Programme had operated cook and eat classes, and the Healthy Schools Programme linked with the Children, Young People and Families Portfolio. It was accepted that child poverty and the welfare reforms were an issue with regard to healthy eating and obesity.

- The Food Plan had been considered at the Economic and Environmental Wellbeing Scrutiny and Policy Development Committee and the

implementation and effectiveness of the Food Strategy would be monitored.

- It was agreed that poverty was detrimental to public health, but the anti-poverty strategy was led elsewhere.

- Work was being undertaken with Job Centre Plus and GP Practices to remove barriers to employment caused by ill health, which appeared to predominately relate to mental health and musculoskeletal conditions.

- £400,000 was being invested in Activity Sheffield, with additional funding being allocated to the Move More strategy and cycling opportunities. The Healthy Walking sessions had been discontinued as they did not appear to be providing the biggest health return, with participants being people who were not usually inactive. Public Health staff in the Place Portfolio worked with the Council's Planners to encourage cycling and walking.

- The zero funding allocations shown in the report for 2014/15 were as a result of those programmes being commissioned by other organisations.

- To ensure that the Portfolio funding was used for public health benefit, the Council's Chief Executive was required to sign off a document confirming this for the Department of Health.

- The programmes invested in were monitored to ensure that funding was spent in the best manner possible, although in some cases, such as smoking cessation, it was not possible to obtain a full picture as some people would stop smoking without any support.

- It was not thought that there was any link between oral health promotion programmes and food banks.

- Finding employment opportunities for those with learning disabilities was a difficult area, and helping them to stay in employment more difficult still.

- Free school meals were seen as making a positive contribution to public health, as it meant that children and young people receiving them had at least one nutritious meal per day.

- E-cigarettes were less damaging than normal ones as they contained less tar and, if used in withdrawing from smoking normal cigarettes, were seen as a good thing. The danger with e-cigarettes though was that they tended to re-normalise smoking, particularly where young people were taking them up and they were proving to be a gateway to conventional smoking. New EU regulations were looking to control the use of e-cigarettes.

7.3 RESOLVED: That the Committee:-

(a) thanks Jeremy Wight for his contribution to the meeting;

(b) notes the contents of the report and the responses to questions;

(c) requests that:-

(i) it be kept informed of the performance of the Food Strategy; and

(ii) the Children, Young People and Family Support Scrutiny and Policy Development Committee considers how children and young people were being taught to cook and eat healthily at school; and

(d) requests the Director of Public Health to consider:-

(i) whether it could view the 2015/16 Public Health Budget prior to it being agreed, so Members could have an opportunity to comment on it;

(ii) the means by which details of where Public Health funding had been spent, together with confirmation that it had been spent appropriately, could be made publicly available;

(iii) the provision of a statistical analysis at the end of each year on the effectiveness of Public Health spending;

(iv) the establishment of a connection between Food Banks and the Oral Health Assessment Tool Programme; and

(v) the most appropriate route for dealing with the effect of e-cigarettes in the City.

8. DEVELOPING THE SOCIAL MODEL OF PUBLIC HEALTH

8.1 The Committee received a report of the Director of Public Health, which provided Members with an update on the development of a Social Model of Health/Health Communities Review, as requested at the Special Meeting of the Committee on 5th November 2013.

8.2 The report was introduced by Chris Shaw, Head of Health Improvement, who particularly referred Members to the four appendices attached to the report which covered an update on the Healthy Communities Review, a definition and examples paper on Social Capital, a summary delivery structure and a project delivery chart with timelines. He also emphasised that a full outcomes and measures document for Social Capital commissioning had not been provided as this had not yet been completed and that this would be commercially sensitive until the Commissioning Specification had been published.

8.3 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- The work undertaken so far on the Commissioning Specification was

included, but this had not been completed because of having to focus on the Managing Employee Reductions procedure.

- The intention was to develop a more focused approach to Social Capital in relation of Public Health, with a view to synchronising processes. It was hoped to have a plan in place by October 2014, by which time there could be more added value.

- The Healthy Communities Programme comprised 14 separate programmes and the proposal was to break this down into manageable pieces.

- It was hoped to see evidence of smaller providers being given opportunities and the Procurement Team were to hold training sessions with providers.

- The Council's Public Health officers had established links with the Right First Time initiative.

8.4 RESOLVED: That the Committee:-

(a) thanks Chris Shaw for his contribution to the meeting;

(b) notes the contents of the report and the responses to questions; and

(c) requests that a written update report on progress with the Social Model of Public Health/Healthy Communities Review be included on the agenda for each future meeting of the Committee.

9. UPDATE ON SELF DIRECTED SUPPORT AND PERSONALISATION

9.1 RESOLVED: That the Committee:-

(a) notes the contents of the Update Report on Self Directed Support and Personalisation; and

(b) requests the Policy and Improvement Officer to obtain a response to the questions put by Councillor Adam Hurst, from the Interim Director of Care and Support, and circulate the response to Committee Members.

10. UPDATE ON PROGRESS IN IMPLEMENTING PLANS FOR IMPROVING MAJOR TRAUMA WITHIN YORKSHIRE AND THE HUMBER

10.1 RESOLVED: That the Committee notes the contents of the very readable Update Report on Progress in Implementing Plans for Improving Major Trauma within Yorkshire and the Humber.

11. DATE OF NEXT MEETING

11.1 A special meeting of the Committee will be held on Thursday, 10th April 2014, at 12.00 noon in the Town Hall, to consider Quality Accounts.

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S H E F F I E L D C I T Y C O U N C I L

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 10 April 2014

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Janet Bragg, Roger Davison (Deputy Chair), Tony Downing, Adam Hurst, Diana Stimely, Joyce Wright and Denise Reaney (Substitute Member)

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors John Campbell, Katie Condliffe (Councillor Denise Reaney attended the meeting as the duly appointed substitute), Martin Lawton and Jackie Satur.

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 Councillor Mick Rooney declared a personal interest in Agenda Item 7 (Sheffield Health and Social Care NHS Foundation Trust – Quality Report 2013/14) as a Non-executive Member of the Sheffield Health and Social Care NHS Foundation Trust.

3.2 Councillor Roger Davison declared a personal interest in Agenda Item 7 (Sheffield Health and Social Care NHS Foundation Trust – Quality Report 2013/14) as a Governor of the Sheffield Health and Social Care NHS Foundation Trust.

3.3 Councillor Sue Alston declared a personal interest in Agenda Item 6 (Sheffield Teaching Hospitals NHS Foundation Trust – Quality Report 2013/14) as an employee of the Sheffield Teaching Hospitals NHS Foundation Trust.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 There were no questions raised or petitions submitted by members of the public.

5. SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST - QUALITY REPORT 2013/14

5.1 The Committee received a report of Dr David Throssell, Medical Director,

Sheffield Teaching Hospitals NHS Foundation Trust, which provided information on the quality of services delivered by the Sheffield Teaching Hospitals NHS Foundation Trust during 2013/14 and identified Quality Report Objectives for 2014/15. Appended to the report was a draft of the Quality Report 2013/14.

5.2 The report was supported by a presentation by Sandi Carman, Head of Patient and Healthcare Governance, and also in attendance for this item were Neil Reilly, Assistant Chief Executive, and Kirsten Major, Executive Director of Strategy and Operations, Sheffield Teaching Hospitals NHS Foundation Trust. The Committee noted Dr Throssell's apologies, due to him having to attend a meeting with the Secretary of State at short notice.

5.3 Members of the Committee raised questions and the following responses were provided:-

- The Trust took the issue of cancelled operations very seriously due to both the adverse effect on the patient and the inconvenience caused to friends and relatives. It was accepted that the target figure of 4% represented a significant challenge for the Trust, and a number of actions had been put in place in an attempt to ensure this target was reached. Although the target figure was not reached in 2013/14, the number of cancellations was less than in 2012/13. In terms of the top five reasons for cancellations, 'Operation Not Required' referred to those cases where the patient's clinical position had changed, such as if they had experienced some form of spontaneous improvement or a significant deterioration prior to the operation. 'Lack of Theatre Time' referred to those cases where previous operations or procedures had taken longer than expected, and when the shift of the staff involved had come to an end. The Trust accepted that there was a need to manage availability/theatre time better in order to overcome this.

- The Trust was also aware of the frustration and inconvenience caused by the delays in dispensing medication for patients discharged from hospital. It also presented the Trust with problems in that patients often waited on the wards, thereby preventing admissions. The procedure regarding the dispensing of medication involved a number of stages and there were delays in each stage. One action taken by the Trust had involved having a Pharmacy Technician in the Discharge Lounge, and this had helped to speed the procedure up.

- The objective in terms of the assessment of patients in Accident and Emergency in under four hours means that the patient will have been assessed, and a definitive point of care delivered, be that discharge, admission or in receipt of active treatment.

- Mortality rates in Sheffield were no higher at weekends than during the week, although it was acknowledged that such rates were higher in other parts of the Country.

- The Trust was making a considerable effort to improve its performance in terms of the reporting of, and dealing with, complaints or concerns raised by patients or their families. As part of this work, there were now a number of opportunities for people to provide feedback in terms of their treatment. The Trust also agreed with the issue raised regarding the requirement to log all complaints or concerns raised by patients or their families, however they were reported.

- Whilst communication between Accident and Emergency Units and GPs was still sent in paper form, the Trust had recently introduced a facility whereby feedback could be provided electronically, and it was the plan to move to the electric format only in the near future. The Trust's firewall would stop anyone without authority from accessing such information.

- All patients were coded for data purposes. This information is obtained from medical records and entered onto a database. The standard is 90% correct reporting of the primary diagnosis and procedure and 80% correct recording of secondary diagnosis and procedures. The incorrect items detailed in the Quality Report (8% to 23%) relate to the incorrect interpretation of the notes for coding purposes, and not clinical errors relating to a patient's care.

- Whilst waiting times were a national target, the Trust also wanted to review the impact of waiting times on the patient experience, specifically those patients waiting over 18 weeks for treatment, in order to capture how they were affected. The Trust would have dialogue with those patients who had not received treatment within specified waiting times, and this would be detailed in the next Quality Report.

5.4 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, the information reported as part of the presentation and the responses to the questions raised;

(b) requests the Policy and Improvement Officer to summarise the comments made, to be shared with the Chair, and then with the Committee, prior to being submitted to the Trust; and

(c) thanks Neil Reily, Sandi Carman and Kirsten Major for the presentation made and for responding to the questions raised.

6. SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST - QUALITY REPORT 2013/14

6.1 The Committee considered a report of Jason Rowlands, Director of Planning, Performance and Governance, Sheffield Health and Social Care NHS Foundation Trust, containing a draft of the Trust's Quality Report 2013/14. The Committee had been invited to review the draft report and provide comment to the Trust on its assessment of the quality of its services and the proposed priorities 2014/15. The report was supported by a presentation from Jason Rowlands and also in

attendance for this item, was Tanya Baxter, Head of Integrated Governance.

6.2 Members of the Committee raised questions and the following responses were provided:-

- The RESPECT Approach was introduced by the Trust around three years ago, and comprised an ethical approach to managing aggression and violence. Staff had been trained to deal with patients who expressed aggression and violence, in a safe and sensitive manner. The approach had resulted in an improved experience for service users and was recognised as a model of good practice.

- The significant increase in the use of seclusion during the last year was being monitored by the Board's Quality Sub-Committee. The reasons for the increased use were outlined in the report.

- There were plans to construct a new Psychiatric Intensive Care Unit (PICU) on the former Oakwood site at the Northern General Hospital, which would result in a bigger unit, with improved facilities, and a much more therapeutic ward environment. It had been accepted that the present facilities for patients who remained agitated and/or distressed for longer periods of time were limited and the new unit would address this area of concern. The plans in respect of the development of the unit would be shared with Healthwatch Sheffield.

- The Trust was expanding and improving how it understood the experiences of its service users and the Board had invested in a new Service User Experience Monitoring Unit. This would build on the previous Public and Patient Involvement work undertaken in the Trust, and would look to develop, over time, a range of approaches to understand experiences across the Trust's different services.

- Improvements in supporting people with developing memory problems were noted. More people were being seen than before, and services were reaching more people in Sheffield, compared to the rest of the country. Routine information wasn't produced to help understand if the physical health needs of people with dementia were being met within primary care, though there may be ways to understand this from the information collected by GPs. The Trust agreed to raise this, if possible, with the Clinical Commissioning Group (CCG).

- The Trust had been requested by the Board to look at the issue of waiting times in terms of diagnosing people with dementia. Whilst the above improvements were noted, unfortunately, there had been no progress made in terms of reducing such waiting times, but the Trust would continue to work towards a reduction. The Trust and the CCG had reported on developing plans to the Committee earlier in the year. The Trust was able to update that these plans had now been agreed and implementation would commence during the year.

- There were two acute wards at Nether Edge and two wards on the Northern General Hospital site.

- The Trust recognised that it needed to make further improvements in staff appraisal rates. To support this, new arrangements had been put in place to ensure that staff appraisals were undertaken during April, May and June.

- In terms of the incidents reported within the Trust, the reference to medication errors involved errors in the administering of medication by staff. A serious incident had resulted in a change in the policy in terms of the administering of medication, and which had been rolled out to all areas of the Trust.

- When patients were being considered for residency within a learning disability registered or supported living home, the Trust and the Housing Association would always look at the compatibility in terms of the existing residents. As part of this process, the Trust would attempt to ascertain the views of the tenants already living there. Generally, there were few issues with regard to compatibility, but issues may arise, for example, in those situations where people moved to a Unit as a matter of urgency, at very short notice.

6.3 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, the information reported as part of the presentation and the responses to the questions and comments raised;

(b) requests the Policy and Improvement Officer to summarise the comments made, to be shared with the Chair, and then the Committee, prior to being submitted to the Trust; and

(c) thanks Jason Rowlands and Tanya Baxter for attending the meeting and responding to the questions raised.

7. CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) WORKING GROUP REPORT

7.1 The Committee received a report of Councillor Mick Rooney, Chair of the Child and Adolescent Mental Health Service (CAMHS) Working Group on the outcome of a review undertaken by the Working Group of CAMHS in Sheffield. The Working Group had been established by the Scrutiny Committee in September 2012, and had used a range of techniques to undertake the review, which had included desktop research, meetings and interviews. The Committee also considered a draft combined response to the report, compiled by the City Council (Children, Young People and Families), the Sheffield Clinical Commissioning Group (CCG) and Sheffield Children's NHS Foundation Trust.

7.2 RESOLVED: That the Committee:-

(a) notes and approves the contents of the Child and Adolescent Mental Health Service (CAMHS) Working Group report now submitted, together with the draft combined response to the report compiled by the City Council (Children, Young People and Families), Sheffield CCGroup and Sheffield Children's NHS Foundation Trust; and

(b) agrees that (i) the subject of transitions within the CAMHS be included as part of the Committee's Work Programme 2014/15 and (ii) in the light of the tight timescales, the CAMHS Working Group approach the parents who had been involved in this piece of work, to invite them to a meeting to discuss the draft response to the report in more detail.

8. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (YORKSHIRE AND THE HUMBER)

8.1 The Committee received a report of James Henderson, Director of Policy, Performance and Communications, on the present position with regard to the Joint Committee, specifically in relation to the new Congenital Heart Disease Review. The report indicated that following the establishment of the Committee in March 2011, to consider and respond to the proposals arising from the Safe and Sustainable Review of Children's Congenital Cardiac Services in England, a number of concerns had been raised about the proposals, and the Secretary of State for Health had consequently accepted in full, the findings and recommendations of the Independent Reconfiguration Panel, and called a halt to the Safe and Sustainable Review process. NHS England had subsequently submitted proposals for undertaking a new review into the whole lifetime pathway of care for people with congenital heart disease. In the meantime, the Committee had continued to meet to maintain the momentum of its previous work and at its meeting held in December 2013, there was broad support to continue its work, and a revised Terms of Reference for the Committee, attached at Appendix 2 to the report now submitted, had been agreed.

8.2 On the basis that the Joint Committee would make recommendations to NHS England and other interested parties, which could include the Secretary of State for Health, the Committee felt it advisable that the 15 constituent authorities should reconfirm their commitment to the Committee, and agree the revised Terms of Reference.

8.3 The Policy and Improvement Officer, Diane Owens, referred to the addendum to the report, which had been circulated to Members of the Committee prior to the meeting, and which provided additional detail, following legal advice, in terms of the purpose of the report, together with a revised set of recommendations.

8.4 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the addendum to the report, circulated prior to the meeting; and

(b) recommends to Council that it:-

(i) reconfirms its commitment to the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation the new Congenital Heart Disease Review;

(ii) approves the Terms of Reference of the Joint Health Overview and Scrutiny Committee for the new Congenital Heart Disease Review as set out in Appendix 2 to the report now submitted;

(iii) requests this Committee to nominate a Member to sit on the Joint Health Overview and Scrutiny Committee in relation to the new Congenital Heart Disease Review and, upon nomination, agrees to appoint that Member to the Joint Scrutiny Committee in accordance with paragraph 7.3 of the Protocol for Yorkshire and the Humber Councils Joint Health Scrutiny Committees, as incorporated in Sheffield City Council's Constitution;

(iv) delegates the functions, set out in Appendix 1 to the report now submitted, that shall be exercisable by the Joint Health Overview and Scrutiny Committee, subject to the terms and conditions detailed in the Appendix; and

(v) approves amendments to the Protocol for Yorkshire and the Humber Councils Joint Health Scrutiny Committees so that the functions referred to in (b)(iv) above are incorporated.

(NOTE: In accordance with Council Procedure Rule 26 of the Council's Constitution and the provisions of Section 100B(4)(b) of the Local Government (Access to Information) Act 1985, the Chair decided that the above item be considered as a matter of urgency as it would need to be considered by Full Council, at its next meeting, in July 2014, although it had not been possible to give five clear days' notice that the matter was to be considered.)

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S H E F F I E L D C I T Y C O U N C I L

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 4 June 2014

PRESENT: Councillors Sue Alston, Jenny Armstrong, Olivia Blake, John Campbell, Katie Condliffe, Qurban Hussain, Anne Murphy, Denise Reaney, Mick Rooney, Jackie Satur, Brian Webster, Philip Wood and Joyce Wright

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1. APOLOGIES FOR ABSENCE

No apologies for absence were received.

2. APPOINTMENT OF CHAIR AND DEPUTY CHAIR

RESOLVED: That Councillor Mick Rooney be appointed Chair of the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee and Councillor Sue Alston be appointed Deputy Chair.

3. DAY AND TIME OF MEETING

RESOLVED: That meetings of the Committee be held on a bi-monthly basis, on dates and times to be determined by the Chair.

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Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee 23 July 2014

Report of: Ian Atkinson, Accountable Officer, NHS Sheffield Clinical Commissioning Group
John Mothersole, Chief Executive, Sheffield City Council

Subject: Sheffield Health and Wellbeing Board's Plans for 2014/15

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. This paper presents the Board's priorities for 2014/15, based on the Joint Health and Wellbeing Strategy.

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

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

The Scrutiny Committee is being asked to:
Consider the Health and Wellbeing Board's delivery plan for the Joint Health and Wellbeing Strategy over 2014/15, and to provide views, comments and recommendations.

Background Papers:
Appendix A – Public document detailing Sheffield's Plans for Integrated Commissioning 2014/15 and beyond.
Appendix B – Sheffield Joint Health and Wellbeing Strategy 2013-18.

Category of Report: OPEN

Report of Accountable Officer, NHS Sheffield Clinical Commissioning Group and Chief Executive, Sheffield City Council

Sheffield Health and Wellbeing Board's Plans 2014/15

1.0 BACKGROUND AND CONTEXT

1.1 What is the Health and Wellbeing Board?

Sheffield's Health and Wellbeing Board has existed as a statutory Board since April 2013. The Board is built on positive and fruitful relationships and partnership between the organisations that commission health and wellbeing services across the city, namely Sheffield City Council, NHS Sheffield Clinical Commissioning Group, and NHS England. Healthwatch Sheffield is also a member as a representative of Sheffield people.

The 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.[1]

1.2 Purpose of the paper[2]

This paper presents the Health and Wellbeing Board's priorities for 2014/15. In part these are based on 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, this paper presents the Board's ambitious plans for integrating health and social care over 2014/15 and beyond.

1.3 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.

In creating its Joint Health and Wellbeing Strategy, the Health and Wellbeing Board was 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. In addition, the Board's consultation on the

[1] The Board has a website with lots of information about its members, meetings and activities. See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board.html.

[2] An earlier version of this paper was submitted to the Health and Wellbeing Board in March 2014.

Strategy 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.[3] Therefore, the Board's role of bringing together the different organisations that commission care is massively important in improving people's health and wellbeing.

1.4 How does health and wellbeing commissioning operate in Sheffield?

'Commissioning' is the analysis of needs, the design of services to meet those needs, the procurement of services (where necessary), and the monitoring and ongoing review of whether needs are being met. There is no single commissioner of health and wellbeing services in Sheffield, and there is no simple way of identifying how much money is spent to improve health and wellbeing and to provide the vital services that people need to stay healthy and well.[4]

In addition, health and wellbeing is supported by a number of things, not just direct GP, hospital or social care provision. It is therefore 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 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[5] 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.

- Health and wellbeing services are commissioned and provided in Sheffield by other organisations, such as national charities or the Big Lottery Fund. However, while being

[3] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/strategy-consultation.html.
[4] See a useful guide to the NHS in England: http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england.
[5] Namely, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Children's Hospital NHS Foundation Trust and the Sheffield Health and Social Care NHS Foundation Trust.

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[6] come from a variety of backgrounds and from 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.

These 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.

2.0 A REVIEW OF THE HEALTH AND WELLBEING BOARD'S WORK IN 2013/14

The Health and Wellbeing Board has existed as a statutory body since April 2013. 2013/14 was an effective first year for the Board in which:

- A Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy were approved, following consultation with over 1,500 citizens.[7]
- 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 with smaller groups.[8]
- Work continued in each of the Board's five work programmes, including strategies for Food and Physical Activity in the city.[9]
- The Board heard about and responded to a range of issues, including the Dublin Declaration for Age-Friendly Cities and Communities,[10] the Prime Minister's Challenge on dementia,[11] the inquiries into Mid-Staffordshire[12] and Winterbourne View,[13] the Fairness Commission,[14] and the Director of Public Health's Report.[15]

[6] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/board.html.
[7] See http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5088&Ver=4 and http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5089&Ver=4.
[8] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/engagementevent.html.
[9] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy/work-programmes.html.
[10] The letter sent can be downloaded from: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/news.html.
[11] The letter sent can be downloaded from: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/news.html.

- 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.

3.0 THE HEALTH AND WELLBEING BOARD'S PRIORITIES FOR 2014/15

The Health and Wellbeing Board has identified the following priorities for 2014/15:

1. **Monitoring the Joint Health and Wellbeing Strategy**. Over 2014/15, the Health and Wellbeing Board will monitor the Strategy. See section 4.0 for more.
2. **Focus on integration and health inequalities**. Board members have agreed these areas as the two main areas of focus for 2014/15. More information about integrating health and social care is set out in section 5.0, while a popular event with a focus on tackling health inequalities was held in May 2014.
3. **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. One clear way it will do this through regular events and communications.[16]

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.

4.0 SPECIFIC FOCUS: MONITORING THE JOINT HEALTH AND WELLBEING STRATEGY

Sheffield's Health and Wellbeing Board formally agreed in September 2013 a Joint Health and Wellbeing Strategy.[17] This was based on the evidence of the Joint Strategic Needs Assessment.[18] Both documents were agreed following extensive consultation with Sheffield people and with professionals who work in the fields of health and wellbeing.[19]

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

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[12] See http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5088&Ver=4.
[13] See http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5089&Ver=4.
[14] See http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5088&Ver=4, http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5166&Ver=4 and http://www.slideshare.net/fullscreen/SheffieldHWB/professor-alan-walker/1.
[15] See http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5166&Ver=4.
[16] 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. See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board.html.
[17] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html.
[18] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA.html.
[19] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/strategy-consultation.html.

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.

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.

Over 2014/15, the Health and Wellbeing Board will monitor the Strategy's:

- *Outcomes*. Each outcome will be considered over the course of the year.
- *Indicators of progress*. These will be considered over the course of the year.
- *Work programmes*. These will be considered in March 2015.[20]
- *Evidence base*. Updates will be provided as appropriate.[21]
- *Commissioning*. The Health and Wellbeing Board's partners will commission according to the Strategy and have involved one another in developing their plans for 2014/15. Over the coming year, Board members will assist one another in delivering and formulating plans.[22] See section 5.0 for more information below about a specific area of commissioning.

5.0 SPECIFIC FOCUS: INTEGRATING HEALTH AND SOCIAL CARE (THE BETTER CARE FUND)

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.

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 wanted to receive excellent, individualised care.[23] 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 peoples' experience. Explicitly, this will involve more direct sharing of budgets, risk, personnel and decision-making between organisations.

The Health and Wellbeing Board's organisations 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 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.

[20] The last updates were received at the March 2014 Board meeting. View the presentations given: http://www.slideshare.net/sheffieldhwb.
[21] The last update was received at the March 2014 Board meeting. See http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5168&Ver=4.
[22] These plans were received at the March 2014 Board meeting. See http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5168&Ver=4.
[23] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/strategy-consultation.html.

Sheffield's Better Care Fund plan, which the Health and Wellbeing Board approved in March 2014, sets out the following vision for integrated care: [24]

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 aligned with the ambitions set out in the Joint Health and Wellbeing Strategy:

1. Keeping people well in their local community.
2. Intermediate care.
3. Independent living solutions (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 and beyond. It is an exciting opportunity to remodel and redesign areas of the health and wellbeing system so as to achieve better outcomes for Sheffield people.

6.0 RECOMMENDATIONS

Scrutiny is asked to:

- Provide views, comments and recommendations on the Health and Wellbeing Board's delivery plan for the Joint Health and Wellbeing Strategy over 2014/15 including its specific focuses on health inequalities and integration of health and social care.
- Advise on further information it needs and when it might want it.
- Receive a similar report in 2015 as part of ongoing dialogue with the Health and Wellbeing Board.

[24] See Appendix A and also http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE. This vision built on the engagement events the Health and Wellbeing Board ran in 2013. See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/engagementevent.html.

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

Information Document May 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 establishing and spending a pooled budget between us, building on the national **Better Care Fund** arrangements**.**

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, getting the most out of the combined resources of the partners.

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 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.

The Pooled Budget

We have agreed to establish a pooled budget in 2015/16 to fund the above areas of work. The total budget is likely to be around £278m, as set out in the table below.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
		£'000	£'000	£'000
NHS Sheffield Clinical Commissioning Group	TBC		37,783	187,394
Sheffield City Council	TBC	12,399	3,456	90,651
BCF Total		**12,399**	**41,239**	**278,045**

During 2014/15 we will develop the details of our pooled budget agreement, finalising which budgets will be included and setting out how we will make decisions and share benefit and risk from the pooled budget, whilst retaining our separate statutory responsibilities.

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, pathways and changing the service delivery culture.
- Changes for frontline workers and operational delivery, with much greater multidisciplinary working and communication between teams.

The establishment of a pooled budget and integrated commissioning strengthens commissioning of health and social care in Sheffield. However, our providers will still have a key role, as partners in the city, in working with us to design services, and in delivering those services. We hope to use our established partnership arrangements (Right First Time, Future Shape Children's Health) to continue to work with providers as we develop service specifications for the areas we have set out above. To be even more effective we need to involve primary care and voluntary sector providers in these partnerships.

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 a timetable and 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

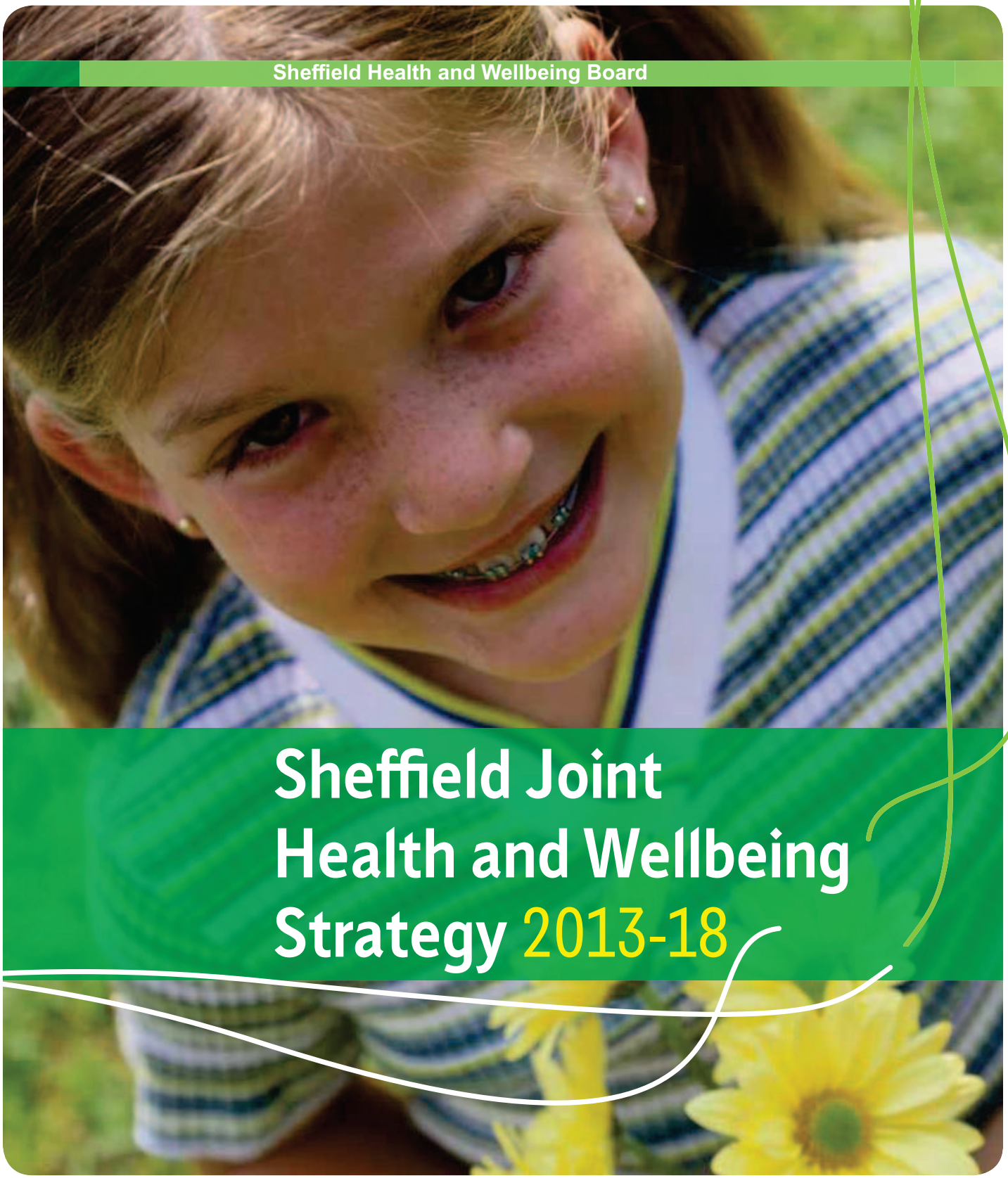
2014-15 will be an important year for us as we prepare our plans for 2015-16 and beyond. Our work in 2014-15 will involve the following elements:

- **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.

Sheffield Health and Wellbeing Board



Sheffield Joint Health and Wellbeing Strategy 2013-18

NHS England

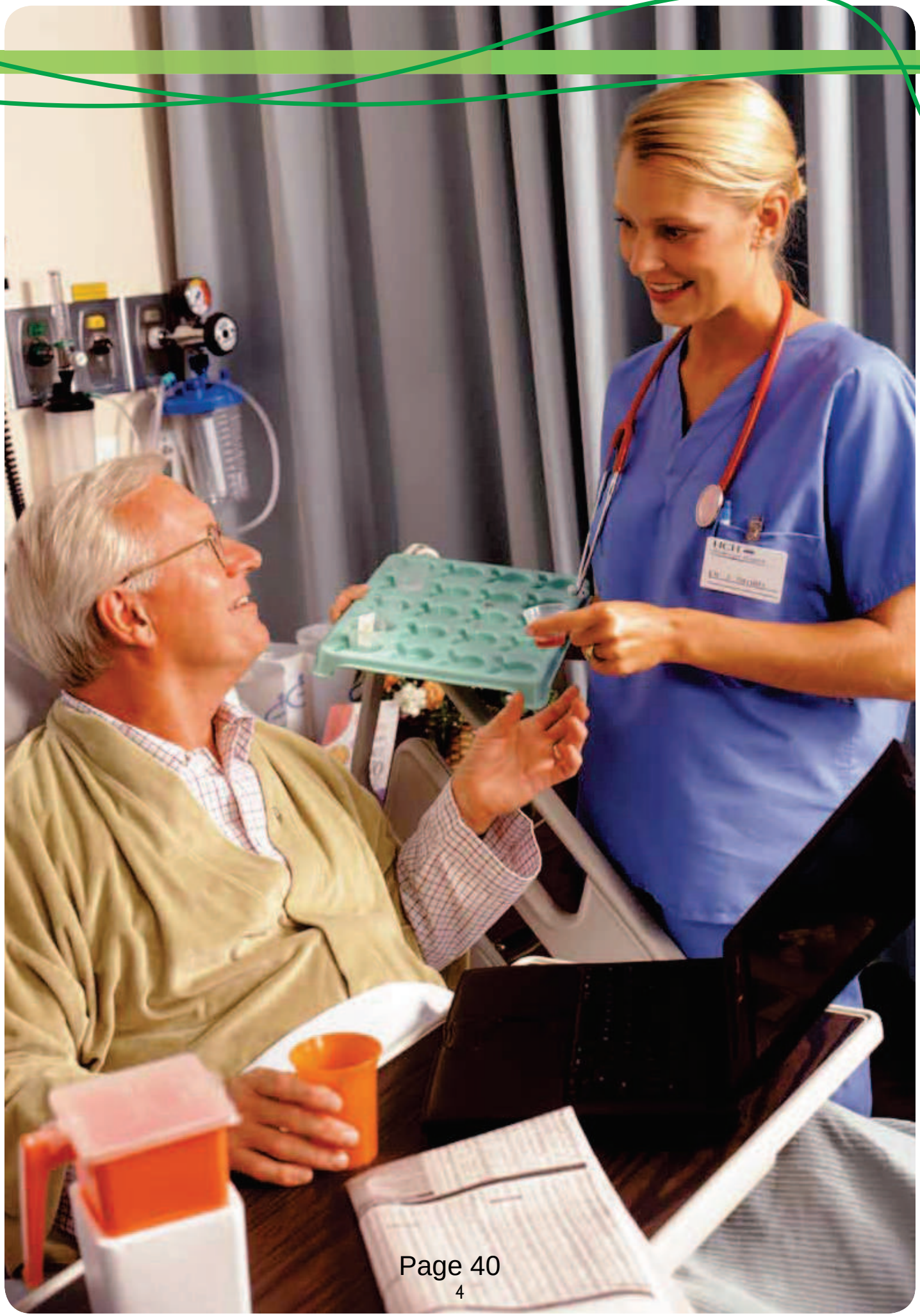
NHS Sheffield Clinical Commissioning Group

healthwatch Sheffield

Sheffield City Council

Sheffield Joint Health and Wellbeing Strategy 2013-18

Contents



1 Foreword

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

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

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

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

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

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

Councillor Julie Dore

Doctor Tim Moorhead

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

2 Introduction

1. Sheffield's Health and Wellbeing Board

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

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

The Health and Wellbeing Board's mission is to:

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

2. Sheffield's Joint Health and Wellbeing Strategy

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

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

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

Sheffield's Health and Wellbeing Board in session

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

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

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

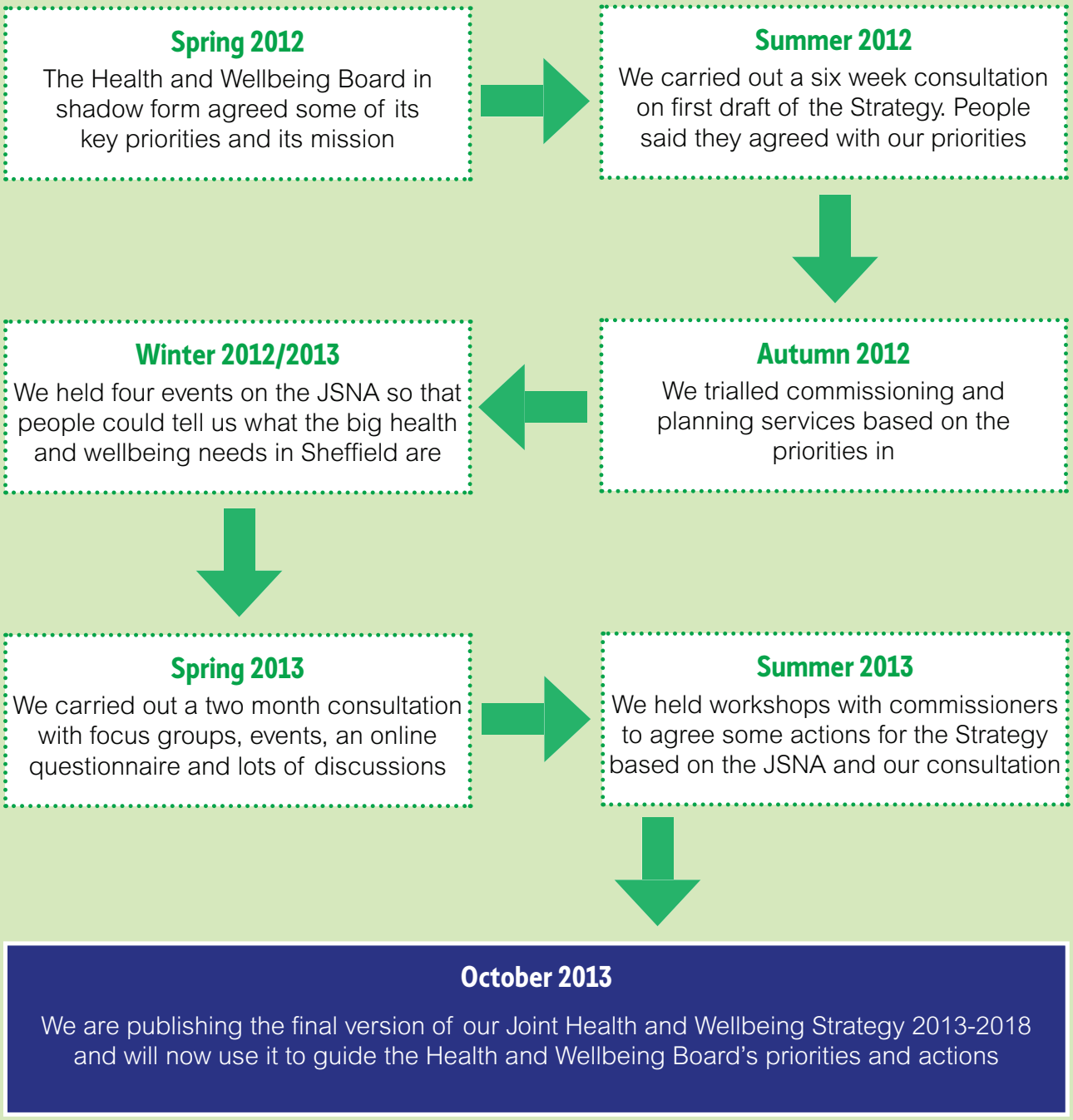
We have spent a considerable amount of time researching and refining this Strategy, talking to people around the city, to make sure that it is the right Strategy containing the elements that will make the biggest impact.

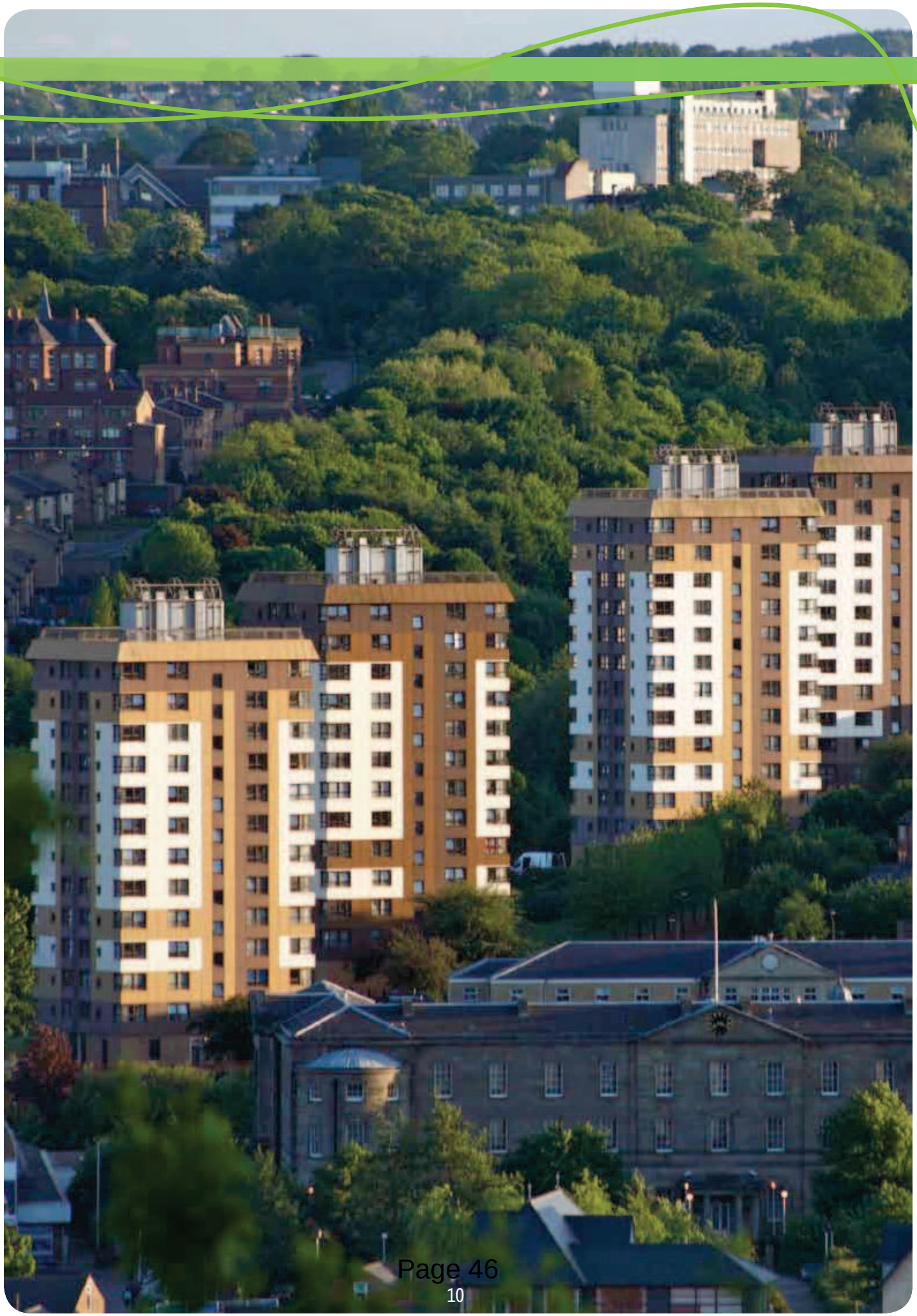
The evidence base used as the basis for this Strategy has been the Joint Strategic Needs Assessment. A Joint Strategic Needs Assessment (JSNA) is the means by which we assess the current and future health and wellbeing needs of the Sheffield population. It is joint because it involves working with a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

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

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

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





3 Ten Principles

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

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

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

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

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

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

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

7

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

8

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

9

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

10

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

4 Five outcomes

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

OUTCOME 1 SHEFFIELD IS A HEALTHY AND SUCCESSFUL CITY

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

OUTCOME 2 HEALTH AND WELLBEING IS IMPROVING

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

OUTCOME 3 HEALTH INEQUALITIES ARE REDUCING

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

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

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

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

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

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

Outcome 1 Sheffield is a healthy and successful city

What's this about?

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

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

Health and Employment

- The long term unemployment trajectory and the issue of youth unemployment have significant implications for the health and wellbeing of the city. The quality of work is important for our health and steps should be taken to try and measure this and to increase awareness of the issue.
- Sheffield must continue to improve its Key Stage 2 and Key Stage 4 results to narrow the gap with the national average. The focus must be on school age education and lifelong learning.
- Poor quality underpaid work and a lack of opportunities affect healthy living and wellbeing.

Sheffield people to be well-trained and able to access a range of fairly paid employment opportunities irrespective of disability, and for the city's economy to grow supporting the health and wellbeing of the people of Sheffield.

1.3 Support activity and actions with schools, colleges and employers (as set out in the city's Economic Strategy) that increases educational and skills attainment for all ages.

1.4 Work with employers to create employment pathways for young people, and emphasise the role of health and wellbeing amongst all employers in the city.

1.5 Recognise that a Living Wage has positive health and wellbeing impacts for everyone, and emphasise to statutory, private and voluntary sectors working in health and wellbeing the Fairness Commission's aspiration that all employees should receive a Living Wage by 2023.

1.6 Support the Health, Disability and Work Plan and further work to understand and evaluate the costs of poor health to employment.

1.7 Pursue the development of broader approaches to health and the economy both with the Core Cities and in Sheffield City Region.

Poverty

- Over one fifth of households in Sheffield are living in poverty, and food and fuel poverty are growing concerns.
- Welfare reforms will impact negatively on health and affect the poorest and more vulnerable members of the community disproportionately. There is the potential of a 'double negative' impact for families with children under five, families with two or more children and lone parent families.

Poverty, such as income poverty, fuel poverty and food poverty, to reduce, and that those affected by poverty are supported and encouraged to lead healthy lives.

1.8 Support the actions set out in the Child Poverty Strategy and the recommendations of the Fairness Commission, especially recognising the importance of actions to mitigate the increasing impact of 'in work' poverty upon families in the city.

1.9 Support the creation and implementation of a city-wide fuel poverty strategy.

Outcome 2 Health and wellbeing is improving

What's this about?

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

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

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

Living Longer

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

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

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

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

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

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

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

Outcome 3 Health inequalities are reducing

What's this about?

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

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

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

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

Address poor health in specific populations

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

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

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

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

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

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

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

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

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

What's this about?

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

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

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

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

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

What's this about?

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

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

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

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

5 Five work programmes

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

Work programme 1 - A Good Start in Life

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

Work programme 2 - Building Mental Wellbeing and Emotional Resilience

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

Work programme 3 - Food, Physical Activity and Active Lifestyles

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

Work programme 4 - Health, Disability and Employment

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

Work programme 5 - Supporting People At or Closer to Home

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

6 Action

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

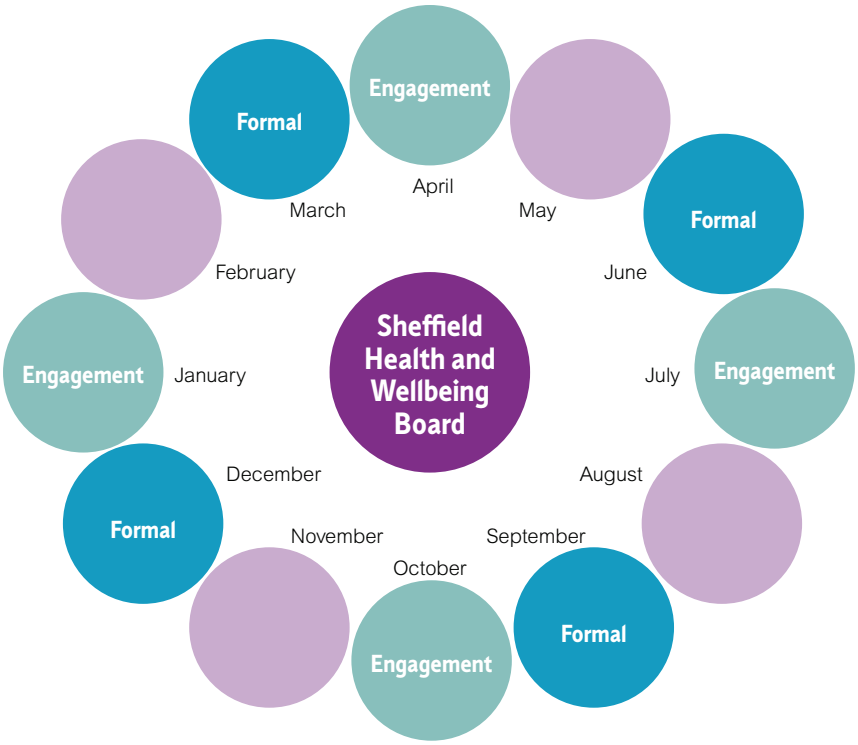
  Healthwatch Sheffield will also play a role in developing the work that underpins the Strategy, and shaping the Strategy's delivery.

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

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

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

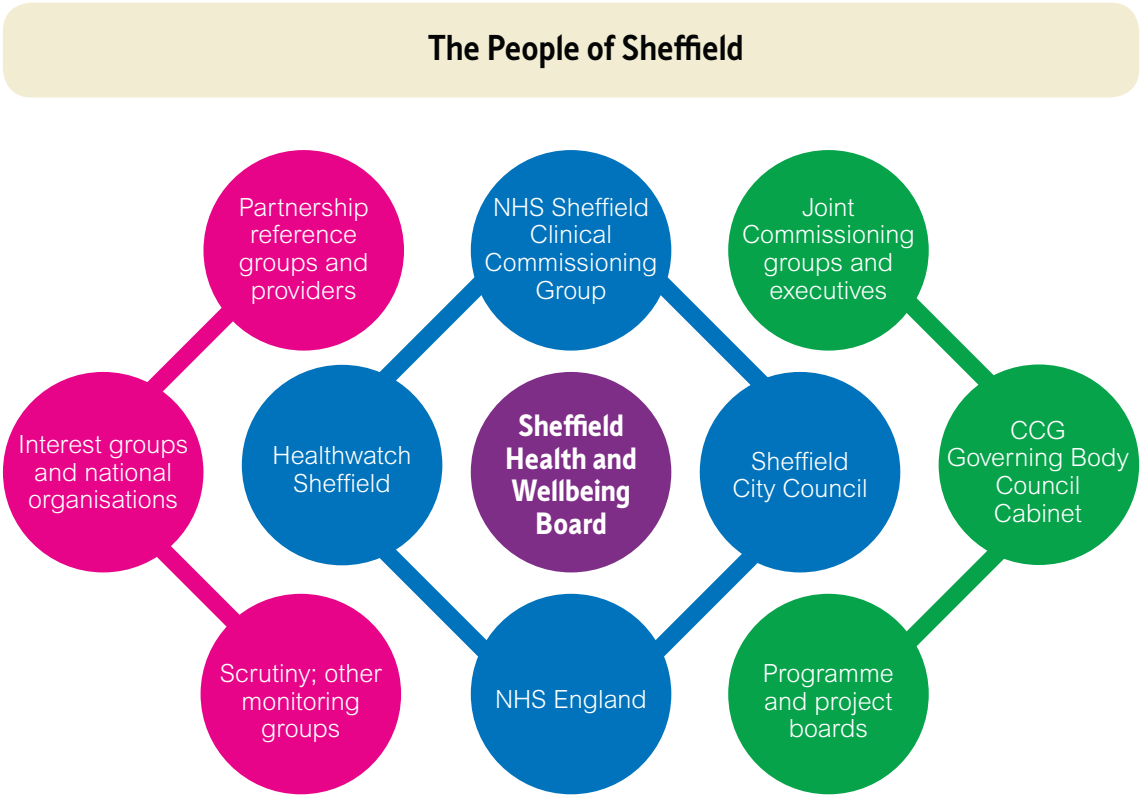
The diagram below shows our yearly meeting cycle, with many things happening between meetings:



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

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

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



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

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

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

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

Above all of these are the people of Sheffield.

7 How we will measure health and wellbeing

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

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

8 Get involved

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

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

- **Come to our Board meetings.**

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

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

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

- **Stay informed.**

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

- **Get connected with others.**

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

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

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

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

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

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

- **Stay informed.**

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

- **Get advice and support.**

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

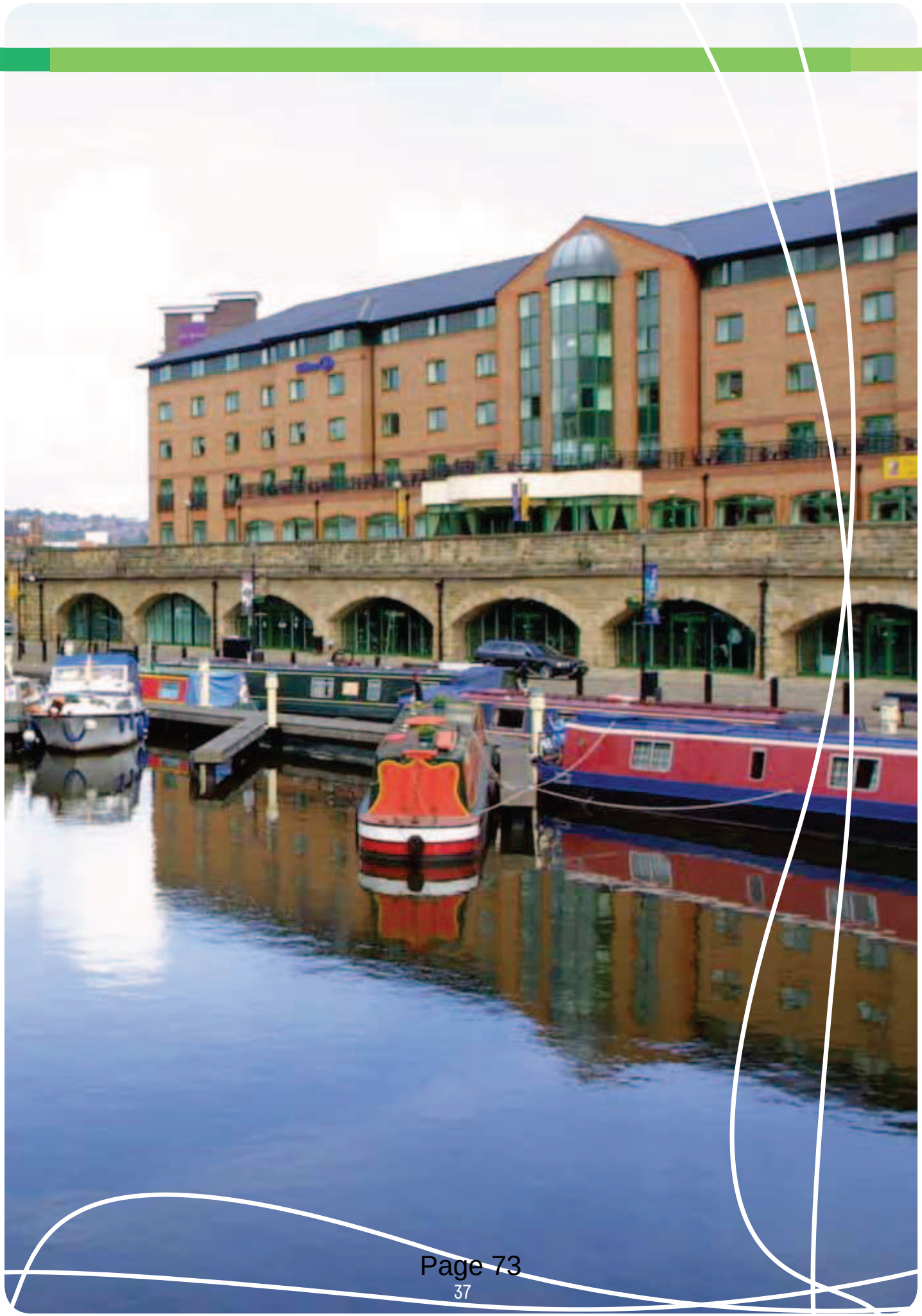
9 Linked documents

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

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

10 Glossary

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



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

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

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

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DP14000

Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee 23 July 2014

Report of: Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield CCG

Subject: CCG Commissioning Intentions

Author of Report: Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield CCG

Summary:
This report introduces the CCGs commissioning intentions for 2014/16, set in the context of our five year ambitions:

- 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

The document describes how these ambitions are set in the context of the joint health and wellbeing strategy and notes the importance of integrated commissioning with Sheffield City Council to achieving our shared ambitions. It also sets out how we have engaged the public in developing these plans.

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

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

The Scrutiny Committee is being asked to:
Consider the CCG's plans, in the context of the joint health and wellbeing strategy and integrated commissioning plans, and provide views and comments.

Background Papers:
Appendix 1 - NHS Sheffield CCG Commissioning Intentions

Category of Report: OPEN

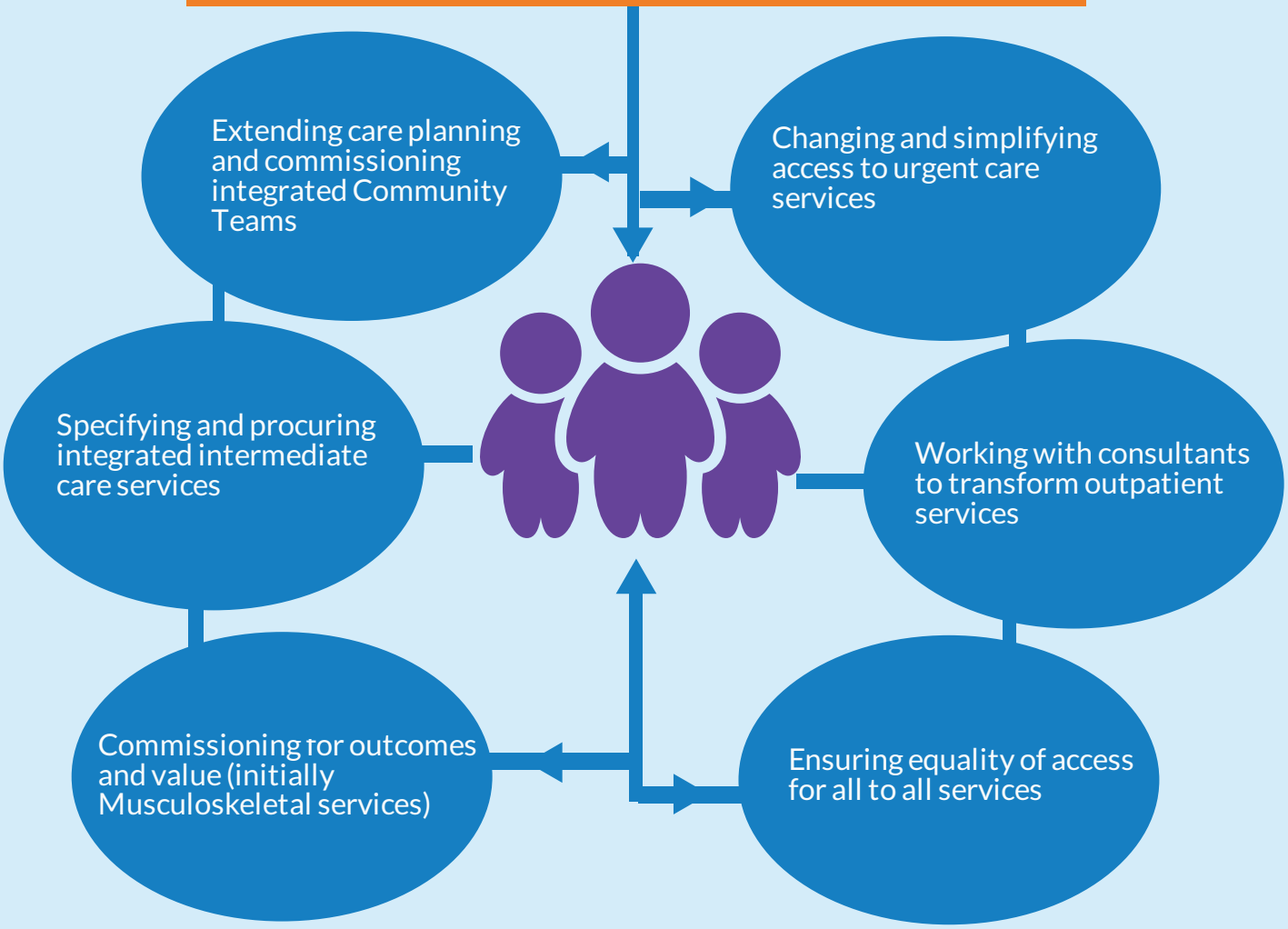
Commissioning Intentions 2014-19

Ambitions for 2014-2019

based on aims from our prospectus and the outcomes of Sheffield's Health and Wellbeing Strategy - see over

- Care plans offered to all those identified as having emerging risk of hospital admission
- Care requiring specialist clinician brought closer to home
- Support and services in place to help all children have the best possible start in life
- Services taking a more joined-up approach to managing long term conditions across primary and community based health and social care, to help reduce emergency hospital admissions by up to 20%
- Reduced excess early deaths in adults with serious mental illness and improvement in life expectancy for people with learning disabilities

Projects to ACHIEVE these ambitions include



Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Develop a Commissioning for Quality Strategy

Significantly strengthen our public and patient engagement

To achieve these ambitions we will also

Put in place integrated commissioning of health and social care with Sheffield City Council

Support the development of primary care providers

Intended outcomes of the Joint Health and Wellbeing Strategy

People get the help and support they need

Health inequalities are reducing

Sheffield is a healthy and successful city

Services are affordable, innovative and deliver value for money

Health and wellbeing is improving

CCG Prospectus aims

- Improve patient EXPERIENCE and ACCESS to care
- Improve QUALITY and EQUALITY of healthcare in Sheffield
- Work with Sheffield City Council to continue to REDUCE health INEQUALITIES in Sheffield
- Ensure there is a SUSTAINABLE and AFFORDABLE healthcare system in Sheffield

Commissioning Intentions 2014-19

Executive Summary – Plan on a Page

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.

This document sets out the actions we will take towards these ambitions in the next two years. Key projects include:

- 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.

This document has been discussed and endorsed by the Health and Wellbeing Board in Sheffield, as part of a discussion to ensure that all partner organisations' (the CCG, Sheffield City Council and NHS England) plans contribute to achieving the outcomes set out in our Health and Wellbeing Strategy.

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 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	3,350	3,100	2,500	10,950
Acute Urgent Care	B	3,700	4,300	5,650	5,900	6,500	25,050
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 £25m 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

We have established strong working partnerships with Sheffield City Council, with neighbouring CCGs, with our providers in the city and more broadly within the city. We need to continue to work with our partners, and strengthen those partnerships, to deliver our ambition.

Within Sheffield we will continue to be actively engaged in a range of partnerships to deliver improvement to health and wellbeing in the city. Much of this work will be led by the Health and Wellbeing Board, in which we are active partners with SCC, NHS England and Healthwatch. We will contribute to and support partnership initiatives that are established for specific aims.

Currently, these include the VCF sector led development of the Best Start bid to the Big Lottery, which if successful will bring significant resource in the city to improve the health of children in the city (starting with three of our most deprived wards); the MoveMore initiative to increase physical activity in the city, and the development of a Food strategy to tackle obesity.

With neighbouring CCGs and with providers across South Yorkshire and beyond, we are working on a collaborative programme work designed to ensure that health services across the area are of high quality and affordable in the future. This programme includes a number of areas of work, some of which CCGs will be actively involved in. The major themes are

- Sharing and adopting good practice in staff management and procurement – which is largely about how hospital services are managed.
- Ensuring all patients have access to safe, high quality clinical services 24 hours a day, seven days a week – which CCGs will collectively take a lead role in, as it is about how services are delivered to patients across the area.

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. The plan included in this document reflects our financial plan submission on 4 April 2014. In this submission we have highlighted that in line with other CCGs, we remain in discussion with NHS England on how the legacy issue of CHC retrospective costs should be funded, but have confirmed that the CCG has identified how it would flex its non recurrent investment in 2014/15 to fund its proposed share (£2.7m) of the £250m national risk pool, should this risk crystallise. For future years we have noted as a potential further risk. In our downside risk assessment we have shown the potential £7m pressure in 2016/17 for changes to national pension costs should the CCG have to fund providers through the tariff arrangements for these costs, without any equivalent increase in our funding. The Governing Body has discussed a range of potential mitigating actions to manage the pressure and further work on this downside scenario plan will continue over coming months.

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 looking at the setting of care and planning to increase our spend on community based care and reduce 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.

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.

Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee

Report of: Laraine Manley, Executive Director, Communities

Subject: **'How did we do?' – Sheffield's local account of adult social care services 2014**

Author of Report: Chris Blackburn, Development Officer, Business Strategy, Communities 2734972

Summary: This report provides an overview of the initial structure proposals for the 2014 Local account and to allow the committee to review the 2013 account and use this to give feedback and steer for the direction of the 2014 local account. A brief outline of the content has been included for review and comments.

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

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

The Scrutiny Committee is being asked to:

- Review and comment on the 2013 local account and give feedback as to how it could be improved or developed for 2014.
- Consider the suggested content in the table at 2.6.
- Suggest any other areas, issues or topical content for the 2014 local account to focus on.
- Consider further involvement in the development of the local account for 2014.

Background Papers:

Appendix 1 - How did we do? Sheffield's adult social care services 2013

Category of Report: OPEN

Report of the Executive Director of Communities – Laraine Manley

'How did we do?' – Sheffield's local account of adult social care services 2014

1. Introduction

1.1 Since 2012 all councils had to produce a local account of how their adult social care and support services are performing. This is essentially an annual report to the public, providing information on the performance of local social care services along with details about priorities and outcomes.

1.2 The local account forms part of the region's approach to sector led improvement, replacing the Care Quality Commission's (CQC's) annual performance assessments, the last of which was in 2010.

1.3 The format of local accounts is not prescribed as such but the Association of Directors of Adult Social Services (ADASS) has some agreed expectations about content.

1.4 Local accounts are produced with the help of service users and early drafts are shared with other councils for their comments. We intend to do the same this year, using feedback to improve the report, before it is published in December 2014.

1.5 Coming to Scrutiny early in the design process enables us to get a steer on structure and content. At this stage, we hope that the committee members will have ideas about content that they think is topical and is of interest to people in Sheffield.

2. Review of 2013 local account and planning for 2014

2.1 This will be the third local account produced by Sheffield City Council.

2.2 Customer comments on last year's local account acknowledged that it "seems an honest report, reporting both good and bad". We want to retain this balance, whilst ensuring that areas that are under-performing are clearly highlighted as a priority.

2.3 We are working with the Quality Improvement Network (QIN) readers group to review last year's report. The readers group has been invaluable in helping us present the content of the local account in a format that is easy to understand.

2.4 We have invited Healthwatch Sheffield to contribute to the local account. We have asked them for their views on areas of concern and relevance for content. They have also shown interest in producing their own section as they did last year.

2.5 Before publishing the local account we share a draft for review with colleagues in other councils in the region. This review process also involves students and customers to provide different perspectives.

2.6 We are proposing to develop the structure for the 2014 local account using last year's as a starting point. The following table shows this.

How did we do 2013 content	How did we do Suggested 2014 content
Introduction by Cabinet Member for Health, Care and Independent Living and Sheffield's nominated Director of Adult Social Services	**Introduction** by Cabinet Member for Health, Care and Independent Living and Sheffield's nominated Director of Adult Social Services ▪ Include how we have improved the local account based on feedback from the public and partners.
How we spend your money	**How we spend your money** ▪ Include reference to the Adult Social Care budget consultations.
	Looking to the future Overview of the upcoming challenges, and how these could affect services, including the Care Act.
Measuring our performance Explanation of the indicators used, how they are presented and how we compare.	**Measuring our performance** Explanation of the indicators used, how they are presented and how we compare.
Complaints	**Complaints and customer feedback** Complaints and other sources of feedback
What we did Using measures from the four outcomes in the Adult Social Care Outcomes Framework (ASCOF) and "I" statements from Making It Real.	**What we did** Split into ***How we compare*** and ***How this affects you*** for the four ASCOF outcomes and related "I" statements to ensure we look at performance from the customer perspective.
Incorporated in the above section would be work done by Healthwatch Sheffield, information regarding Equalities and Dignity in Care, Adults Safeguarding information and any relevant case studies.	
Last year we said we need to get better at... Review of the targets set in the previous year's local account and the work done to reach them.	**Last year we said...** Review of the targets set in the previous year's local account and the work done to reach them.
What we are doing to improve Overview of the work to improve services and performance.	**What we are doing to improve** Overview of the work to improve services and performance. ▪ Include reference to recent peer challenge and actions since.
Get involved and have your say	**Get involved and have your say**
	Useful links and contacts – Links to documents mentioned in the local account as well as essential contact information for readers.

3. Impact for Sheffield's public.

3.1 Sheffield local account is a report of performance in 2013/14 for Sheffield's adult social care services – as such, it may be of interest to many Sheffield residents, whether they currently use these services or not.

3.2 Service users of Sheffield's adult social care are likely to be interested in the performance of their services and how they compare with other councils. They will also be interested in the actions being taken to improve the services across the city.

3.3 The local account is a public document and will be promoted on the Sheffield City Council website. Alternative formats will also be available on request.

4. The Scrutiny Committee is asked to:

4.1 Review and comment on the 2013 local account and give feedback as to how it could be improved or developed for 2014.

4.2 Consider the suggested content in the table at 2.6.

4.3 Suggest any other areas, issues or topical content for the 2014 local account to focus on.

4.4 Consider further involvement in the development of the local account for 2014.

How did we do?

Sheffield's adult social care services 2013

Sheffield City Council

Introduction

This is our second 'local account' – the annual report of Sheffield's adult social care services. It tells you how we did last year (2012/13), how things have changed from the previous year and how we are performing compared to other councils. It also says what we plan to do in future to improve services across the city.

Last year's report was generally well received, but you had some ideas for making it better and we have tried to use those in this year's report. We hope you will find the information easy to find and understand, but we are always looking to improve so we would welcome your feedback for next year's report. Have a look at the 'Get involved and have your say' section for more information.

We are also looking for people who use services to help shape adult social care in Sheffield. For information about how to get involved, please see the section on page 27.

A range of people and organisations have helped us put this report together, including people who use our services and others involved in social care in Sheffield. The Council's Scrutiny Committee for Healthier Communities and Adult Social Care helped shape this report and the new independent consumer champion, Healthwatch, has written its first piece. We hope to build on this with even more involvement next year.

This report is part of a programme of improvement, which is led from within the adult social care sector. This report and our performance will be reviewed by other councils and independent organisations, to make sure we understand where we are doing well and where we need to improve.

This is a challenging time for adult social care services in Sheffield. More people need our services, and increasing costs and government cuts means that we are forced to make difficult decisions about how we support people in the city.

Above all, our aim is to make sure that funding is used fairly and consistently for people who are most in need of care and support.

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

Richard Webb
Executive Director, Communities

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How we spend your money

With increasing demand and a smaller budget, it is becoming harder to provide the care and support services we would like.

The challenges we are facing

9% increase in the number of people over 65 by 2020

Number of people over 65 with a long-term, limiting illness projected to rise by 2020. **+10%**

23% increase in the number of people with mental health needs requesting support in 2012/13 compared with the previous year.

increase in the number of patients referred to hospital teams in 2012/13 compared with the previous year **+17%**

+29% increase in the average cost of a support package in the last five years.

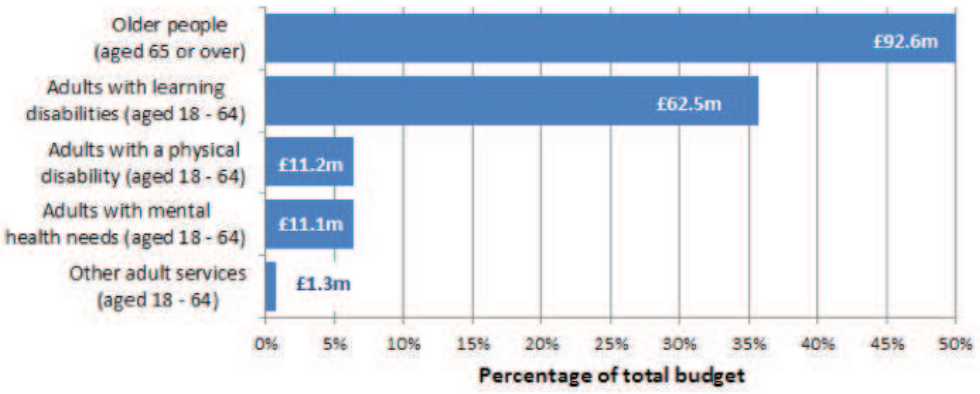
What we are doing

- Protecting frontline services as much as possible
- Providing the care and support that people need to stay safe and well
- Reviewing all spending and potential savings including administration costs
- Reducing staff costs
- Reviewing management processes
- Working with the NHS to support more people to live independently at home and to avoid unnecessary admissions to hospital and to care homes
- Making sure funding goes fairly and consistently to people who need assistance most

Spending in 2012/13

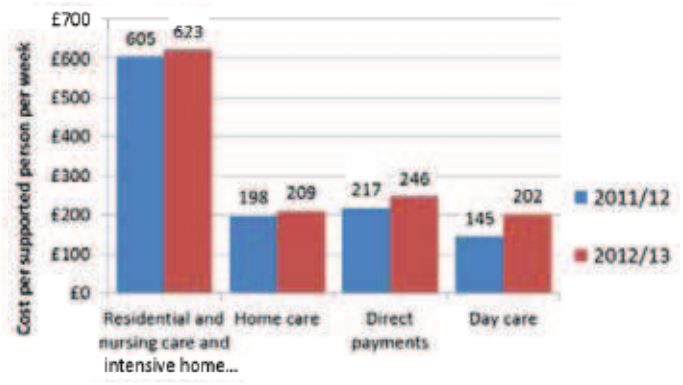
The graph below shows how much was spent on different groups of people last year and what proportion that was of the total budget. Caring for older people is half the total budget, at £92.6m, followed by Adults with Learning Disabilities, which costs the Council £62.5m.

Spending on adult social services by client group, 2012-13



We also calculate the average weekly cost of supporting each person. This cost has gone up slightly across social care services. The biggest increases in unit costs are in day care. This is due to a 15% fall in people using these services, with running costs not yet reduced.

The cost of providing adult social care in Sheffield over the past two years (pounds per person per week)



The average costs of supporting people in Sheffield are similar to the national average and other councils in our region. However, Sheffield spends more per person for direct payments. This is something that we are looking at to find out the reasons why.

Measuring our performance

All councils in England must regularly provide information about our services to the government. In this report you will see how Sheffield compares with the average results from the following groups of councils:

National - all the councils in England
Yorkshire and Humberside - all fifteen councils in our region

Throughout this report we use some symbols to show how our performance has changed since last year (the arrows) and how we compare to the other Yorkshire and Humberside councils (the colours). You can see these symbols with many of the graphs and tables.

	Sheffield is performing **above** the average of councils in our region
	Sheffield is performing **very close to or the same** as the average of councils in our region
	Sheffield is performing **below** the average of councils in our region

↑	Sheffield's performance is **better** than last year
⇔	Sheffield's performance is **very close to or the same** as last year
↓	Sheffield's performance is **worse** than last year
◎	Information collected for the **first time**, this year

By comparing ourselves with other councils, we can see where we need to improve. You can see if we improved the things we wanted to in “Last year we said…” on page 25.

We are generally doing well at…

- Offering reablement services to people being discharged from hospital
- Getting people back home without delay after being in hospital
- The number of people who have ‘self-directed support’

We need to get better at…

- Providing people with information about support services
- Increasing service users’ satisfaction with the care and support they receive
- Keeping carers informed and involving them in the organisation of services
- Helping people with learning disabilities find paid employment

Getting others to check our performance

Sheffield has worked with other councils in the region to come up with ways of checking how we are doing and making improvements. As part of this we have all agreed that we will let customers check our services – this is often called ‘mystery shopping’.

A group of customer inspectors from outside of Sheffield recently tested our services. They looked at how customers contact our services (in person, on the phone and on the internet).

Here’s some of what the customer inspectors found…

- “Reassured. Provided clear answers to questions that I was able to understand”
- “Not straightforward, difficult to find. Struggled to find or access information”
- “Easy to read and understand, layout good, lots of information”
- “Felt like I was wasting his time and he could not get rid of me quick enough”
- “The safeguarding page is excellent and includes everything you would need to know. The layout, pictures and text size are very good.”

Here's how they rated us, compared with last year…

Customer contact	2012 Rating	2013 Rating
Telephone	UNSATISFACTORY	GOOD
Website	UNSATISFACTORY	GOOD
Face to face	GOOD	GOOD
Reception	UNSATISFACTORY	GOOD
Out of hours service	FAIR	UNSATISFACTORY
Safeguarding access	Not tested in 2012	GOOD

The customer inspectors rated five of our contact types as being good but the 'out of hours' contact as unsatisfactory. Even though this rating is based on just one sample, we believe that every contact should be good, so we will investigate what went wrong on this occasion.

Complaints

There was a small fall in the number of complaints about adult social care in 2012/13. The time taken to resolve complaints and satisfaction with the process both improved.

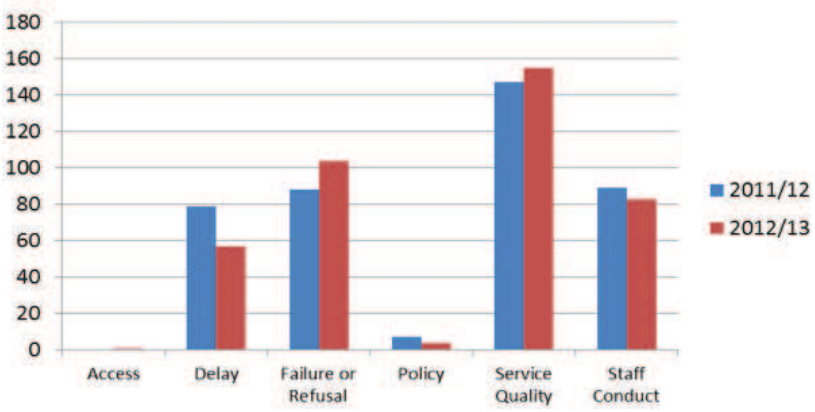
	2012/12	2012/13	
Number of complaints about adult social care	172	163	⇧
Proportion of complaints that were resolved within 6 months	84%	86%	⇧
Proportion of people who were satisfied with the complaints process (Target is 80%)	63%	69%	⇧
Average time taken to resolve (or respond to) a complaint	119 days	90 days	⇧

In last year's report, we said that we were going to focus on improving:

- The time taken to respond to complaints
- Taking action to minimise complaints about staff conduct

The table above shows we have reduced the average time taken to respond to a complaint by 29 days. The graph below shows we have also seen a small reduction in the number of complaints about staff conduct, but there is still more work to do in this area.

The number of complaints received in 2011/12 and 2012/13, by subject
Note that each separate complaint can include more than one subject

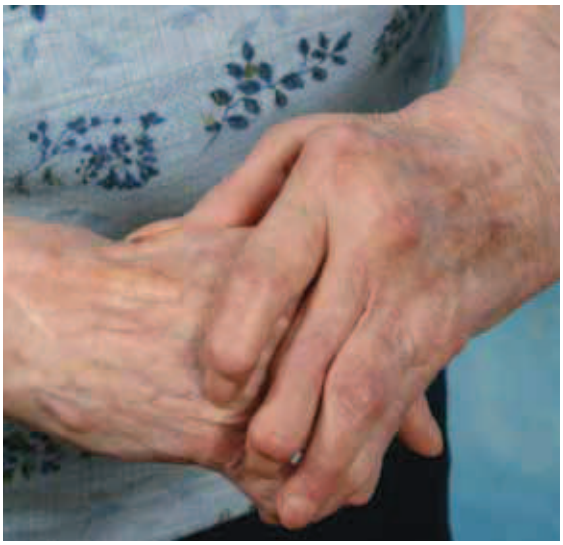


Comments and compliments

If you have a comment on a service please let us know. It helps us to improve our services and we use it to inform the planning for better services in the future. It is also important for us to know what works, as well as what doesn't, so we welcome any compliments too.

Complaints Team
FREEPOST NEA 5527
Town Hall
Sheffield S1 2ZZ

You can telephone the Complaints Team on 273 4660 or fax on 273 4652 or by email at: complaint@sheffield.gov.uk



What we did

Outcome One - Enhancing the quality of life for people with care and support needs

Choosing your support services

Self-directed support (SDS) enables people to choose the support to help meet their needs. Last year just over half of all service users self-directed their support. This has risen to nearly 70%, putting us well above the national and regional averages for self-directed support.

Money allocated to pay for someone's support is called their personal budget. This money can be paid directly to the service user for them to arrange some or all of their care.

Whilst self-directed support is important it has to have a purpose. The purpose for adult social care in Sheffield is about people being independent, safe and well, with services that are good quality, respond to customers and are affordable.

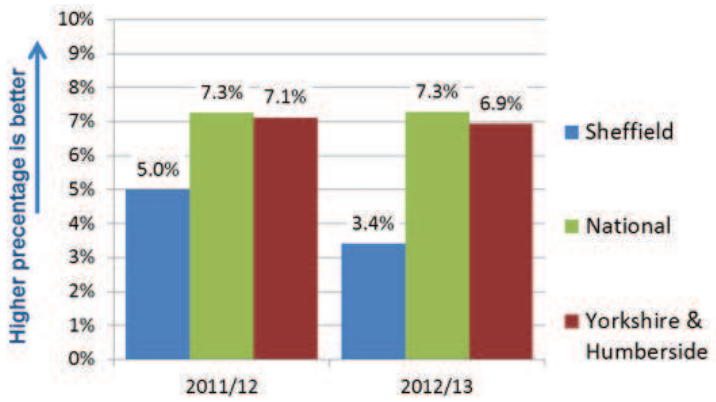
Finding paid employment

There is a strong link between employment and quality of life for people with a learning disability or with mental health problems. We aim to support people wherever we can to help them find work. In 2011/12, 5% of people with a learning disability were in paid employment. In 2012/13, this fell to 3.4%, which is under half the national and regional averages.

There have been some improvements since the end of the year, but the budget pressures mean we are unlikely to improve our performance in this area.

There is a similar picture with adults using mental health services. 5.1% of these service users are in paid employment, compared to a regional average of 8.6%.

The proportion of adults with learning disabilities who are in paid employment



Living in a settled home

People's quality of life is greatly affected by where they live. For people with a learning disability it can have a huge impact on their safety and their feelings of being socially included. People benefit from living in a settled home, either independently or with their family, as opposed to less settled places such as temporary accommodation, care homes or staying as a short-term guest with family or friends.

There has been a 10% increase in the number of adults with a learning disability living in settled accommodation, bringing it to 78%. This is higher than the national average and the same as the average in our region.

What you have told us

This year we sent out the third annual Adult Social Care Survey to a random sample of people using care services. All councils in England do this survey, so we can compare the experiences of people in Sheffield with those across the country.

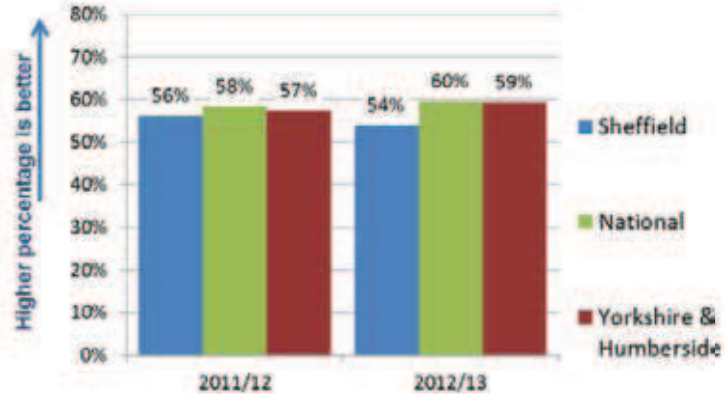
'I have the information and support I need in order to remain as independent as possible'

These sections of the report, called "What you have told us", use some 'I statements', written by people who use services to show what they expect from a high quality service.

How you rate your quality of life

One of the questions asks how people feel about their lives in general. When compared with the national and regional averages, fewer people in Sheffield said that they felt either “good” or “very good” about their lives. The result is also a little lower than before.

Proportion of people using social care who receive direct payments



Meeting basic needs

Our annual survey asks about some of the basic things that many people take for granted, like keeping clean and presentable, getting enough food and drink and keeping their home clean and comfortable. Despite a small increase in the number of people who feel their homes are adequately clean and comfortable, Sheffield scored slightly below the national average and there are improvements to be made. We will report back on our progress in next year’s report.

Feeling in control

Feeling in control is also an important factor in ‘quality of life’. 76% of people who responded to the survey felt that they had enough control over their daily lives. This is slightly lower than last year, but is similar to the national and regional averages.

Carers’ views

This year we also surveyed carers for the first time, to ask how caring for someone impacts on their lives. A ‘quality of life’ score showed that carers in Sheffield scored the same as the national average and slightly lower than the average in our region.

Working with William

The Woodcraft Project started out as a day service for adults with a learning disability. It is now a thriving social enterprise. It has a workshop at Graves Park where members of the project make wood products such as garden benches, rabbit hutches and planters.

Products are sold by those involved in the project at the shop based at the animal farm on the other side of the park.

William Calvert, one of the workers, told us about his work in the shop, which he loves. He said about the social enterprise, “It’s helping people go out and get a job in a shop”.

Talking about the support workers at the project, William said, “Derek and them help me. In case I make a mistake in the till. It works well. I’ve learnt a lot”.

We talked a bit about the shop and how it’s been doing since it opened last year. William said, “It’s been doing a lot. It’s busiest at school holidays and while kids come in”.

They are in the process of looking for a bigger workshop so they can expand to meet the increasing demand for their products.

Dignity in care

No one chooses to be in a situation where they need help with everyday tasks, such as eating, bathing and dressing. Where people do need help, it should be given in a way that makes them feel respected and valued, with as much independence and privacy as possible.

Sheffield City Council believes that dignity should be at the heart of services. Last year, we set up the Dignity Champions Network, for anyone who provides care and support in the city. Members receive news and information, meet to share good practice and talk about any problems they have had.

The Sheffield Dignity Code

- Dignity is to be recognised as a basic human right not an optional extra.
- When providing services all staff should show respect and value each customer/service user as a unique individual.
- Services are to respect the privacy of their users and provide the services supporting this.
- Services will enable their users to have their say, value their contribution and actively involve the users in all decisions about the services they receive without the fear that expressing their opinions will be held against them.
- Our aim is for the people of Sheffield to lead a life of dignity, maintain independence and be able to choose how they participate in the social and cultural aspects of their community.

Recognising good practice

As part of the Sheffield Dignity Champions Network, awards are presented to people and organisations that have been outstanding in providing care with dignity and respect:

- **Individual award winner** - Michael Madden, Night Care Assistance, Eagle House
- **Team award winner** - Darnall Dementia
- **Large (national) organisation award winner** - Emmaus, Sheffield
- **Small organisation award winner** - The Burton Street Foundation
- **Practice award winner** - Lynne Allen and Donna Coe, East Bank Care Home, Sheffield Health and Social Care NHS Foundation Trust
- **Innovation award winner** - Eagle House Catering Team

Information on how to nominate someone for next year's awards will be available in early 2014. All nominations, particularly from service users are very welcome.

For further information, please contact DignityNetwork@sheffield.gov.uk

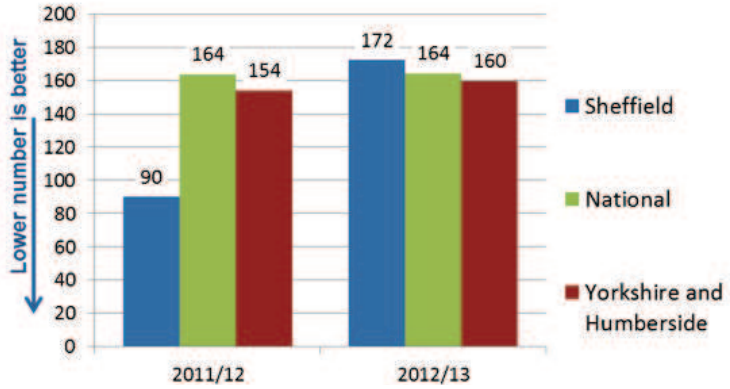
Michael Madden, winner of the Individual award, nominated by colleagues for his compassion, individual attention and high standards of professional care.

Outcome Two - Delaying and reducing the need for care and support

How many people are moving into care homes?

We aim to support people to stay in their own home for as long as they can. Some people eventually need to move into a care home, but ideally this should be as few as possible. The graph below shows that the rate of admissions to care homes almost doubled in Sheffield in the past year and our performance deteriorated significantly compared to other councils.

The number of permanent admissions to care homes per 100,000 population

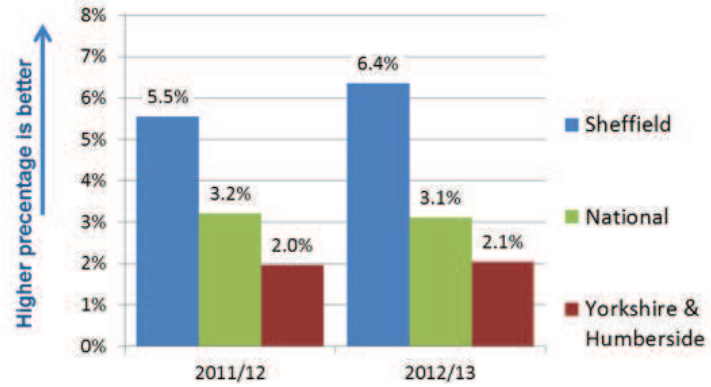


This very large increase was due to problems with an initiative to speed up people's return to independent living after a stay in hospital. Too many patients were being discharged into care homes. A new way has now been introduced and early results show that the number of admissions has already dropped by almost 40% in the first three months of 2013/14. This is in line with our target for the year. We expect to have better results next year.

Being able to live at home after being in hospital

Older people leaving hospital often need short-term help to regain their confidence and live as independently as possible in their own homes. The services that provide this are called 'reablement' or 'rehabilitation' services. In the last year, we offered these services to 6.4% of older people leaving hospital, which is an increase of 1.1% on the previous year and more than double the national average.

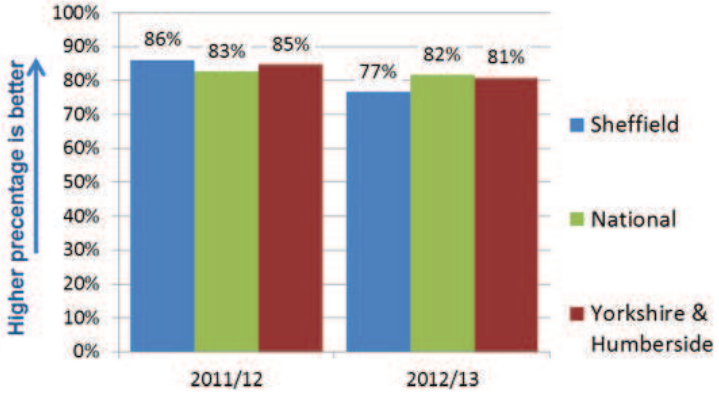
The proportion of older people (65 and over) who were offered reablement services after leaving hospital



We check how many people, who were referred to these services, are still living at home 91 days after leaving hospital. Sheffield's success rate in this area dropped in the last year and we are now below the national average and other councils in our region.

This decrease is also a result of the same problems we had with the permanent admissions to care homes and is expected to improve in 2013/14. Sheffield's numbers are still likely to be higher than average, due to the wider range of people offered reablement in the city.

The proportion of older people (65 and over) who were still at home 91 days after leaving hospital and going into reablement/rehabilitation services

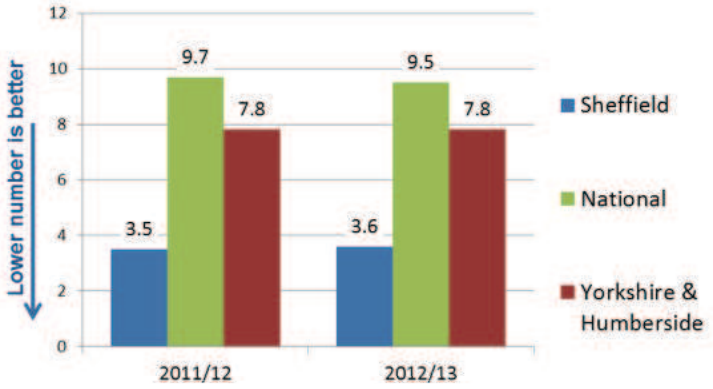


Getting back home from hospital without delay

People usually want to leave hospital and get back home as soon as it is safe to do so. Any delays in getting the right care services organised mean an unnecessarily long stay in hospital.

Sheffield performed well, with delays well below the national average and the third lowest in the region.

Number of delayed beds in hospital per 100,000 population



Helping people avoid the need for ongoing support services

Our reablement service works with people to help them regain their independence after an illness or injury, giving people the small amount of help they need now before things get too difficult for them to manage themselves.

Helping Mr G to be independent

Mr G has cerebral palsy and serious mobility problems. His doctor was concerned that he was becoming socially isolated. Mr G lives in an old, poorly heated property and is prone to falls.

A Community Support Worker worked with him to access the support and services that could help him, including insulation for his home, an emergency alarm and physiotherapy to help him with his problem with falls.

What you have told us

'I have access to a range of support that helps me to live the life I want and remain a contributing member of my community'

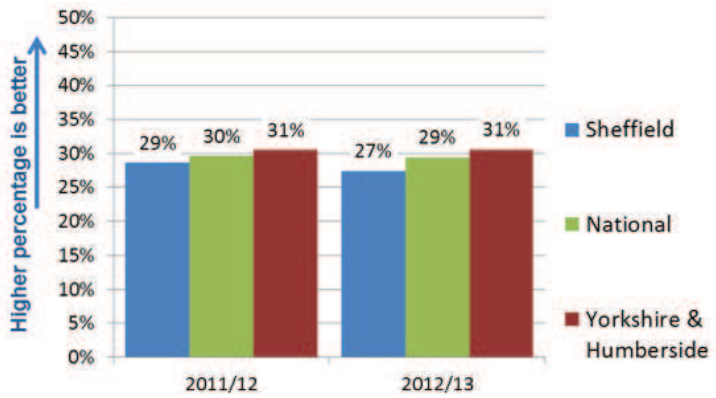
Keeping in touch

To feel part of a community it is important to have contact with the people you like. 45% of people who responded to our survey said they felt able to do this, which is broadly in line with the national and regional averages and a small improvement on last year.

Getting out and about

Being active in the community means being able to get around your local area. Of the people we asked, only 27% said they can get to all the places they want to. This is slightly lower than last year and lower than the average for our region.

When we asked: Thinking about getting around outside your home, which statement best describes your present situation? (People who answered "I can get to all the places in my area that I want")



Outcome Three - Ensuring people have a positive experience of care and support

What you have told us

'I have care and support that is directed by me and responsive to my needs'

Satisfaction with services

We asked what people think of their overall care and support. Sheffield has done less well than last year, with only 56% of people saying they are "extremely satisfied" or "very satisfied".

Carers in the city also have a below average view of the services received by the person they care for. We are not performing as well as most other councils in our region, with only 39% of carers saying they are either "extremely satisfied" or "very satisfied" with services.

Finding information and advice

It is important for people to easily find information and advice about care and support. In the past year, 66% said information was easy to find. This is a little lower than last year and the lowest in our region, so we need to improve. We are reviewing our guidance on adult social care services - simplifying things in line with customers' views. We will put new information on our website about how to access services and how to keep people independent, safe and well.

Feeling included in decisions

Decisions made in planning care for someone can also have a huge impact on the lives of those who care for that person, so carers should feel consulted when support is planned.

Of the carers responding to our survey, 71% said they "always" or "usually" felt involved or consulted. This is the lowest result in our region so we are looking to improve this.

healthwatch Sheffield

What is Healthwatch Sheffield?

Healthwatch Sheffield is a new independent voice for the people of Sheffield, helping to shape, challenge and improve local health and social care services. We work with local people to improve services and help you to get the best out of those services.

Sheffield City Council is providing the funding for Healthwatch Sheffield but it is a new independent organisation set up by a consortium of three local voluntary organisations, which is led by Voluntary Action Sheffield.

How can Healthwatch Sheffield help you?

We can help you by:

- Providing advice and information about local services that might be useful for you, a relative or friend.
- Getting your views on health and social care heard in the city, so you can help to make improvements.
- Ensuring that everybody in the city is able to be involved, by building a wide range of networks and activities, which include adults, children and young people.

Looking for information and advice?

We have a self-help section online at: **www.advicesheffield.org.uk/self-help/**

If you would like to speak to an adviser, who can help you to find the information and support you need, please call: **Sheffield Adviceline (0114) 205 5055** (Lines open Monday to Friday 10am-4pm)

What's your experience of using social care services?

We want to hear about your experiences (good and bad) of health and social care services in Sheffield. We can use your views to influence, challenge and make a difference to the way services are delivered. You can telephone, email or write to tell us about your experience.

Are you interested in getting involved?

We have a regular newsletter with updates on our work and we are developing a range of volunteering opportunities.

Please contact us to sign up for the mailing list or to register your interest in volunteering. Let's work together to help improve your local health and social care services.

Contact Us

Healthwatch Sheffield
33 Rockingham Lane, Sheffield, S1 4FW
Tel: (0114) 253 6688
Email: info@healthwatchsheffield.co.uk **Twitter:** @HWSheffield
www.healthwatchsheffield.co.uk

Outcome Four - Safeguarding people whose circumstances make them vulnerable and protecting them from avoidable harm

What you have told us

'I feel safe, I can live the life I want and I am supported to manage any risks'

Feeling safe

Our survey asked people who receive services, how safe they feel. Two thirds said they felt as safe as they want to be – similar to results across the country and in similar big cities.

We also asked people if the services they get help them feel safe and secure. 78% said they did, which is better than last year and about the same as national and regional averages.

Safeguarding Adults

Sheffield's Safeguarding Adults Partnership, is made up of a number of organisations responsible for protecting vulnerable adults at risk of harm. They work together to:

- Help promote awareness and understanding of adult abuse
- Involve services in the development of our policies and services
- Make sure lessons are learned from the worst cases of abuse

Contact and information
To get in touch or for more information, please write to:
Sheffield Safeguarding Adults Office, Redvers House, Union Street, Sheffield, S1 2JQ

Or go to: www.sheffield.gov.uk/caresupport/adult/adult-abuse/partnership

Peace of mind for Mr H

Mr H has Motor Neurone disease and is unable to use his arms, so could not use an ordinary care alarm button. He was concerned about needing help when nobody is close by.

City Wide Care Alarms staff identified two new solutions. With a voice activated unit in his bedroom at the side of the bed, a 'touch it' (which only needs the touch of skin, not actual pressure) in the living room and one in the hallway at floor level, he can raise an alarm from his chair or if he falls. The equipment has been in place for some months now. Mr H has not needed to raise an alarm in this time, but he and his family feel he is much safer, now he can get help if needed.

Care alarms on show

Thanks to a new site at the Wicker Mobility Shop, people can now try out different City Wide Care Alarms (CWCA) to see if any would be useful in their homes.

Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, said: "When Wicker Mobility Shop offered space in their showroom, it was a great opportunity for people to see the range first hand. Customers get completely impartial information and are free to take up the service or not as they wish".

Ellie Bennett, Operations Manager at Wicker Mobility Shop, said: "We are delighted to link with the Council on this. Not only do we have the general CWCA equipment – we can also show some of the sensors available to help people at risk of falling or with memory problems".

Councillor Jenny Armstrong, Cabinet Assistant for Health, Care and Independent Living, said "As CWCA is the only service to provide their own trained staff to assist in an emergency, this can be a real help in taking some of the pressure off carers".

For more information, please contact:
City Wide Care Alarms, Priory Office, Station Road, Darnall, Sheffield S9 4JT
Telephone: 0800 013 0980
Email: citywidecarealarms@sheffield.gov.uk

Councillor Jenny Armstrong (left) and Ellie Bennett at the official opening of the new CWCA denonstration site

Last year we said we need to get better at…

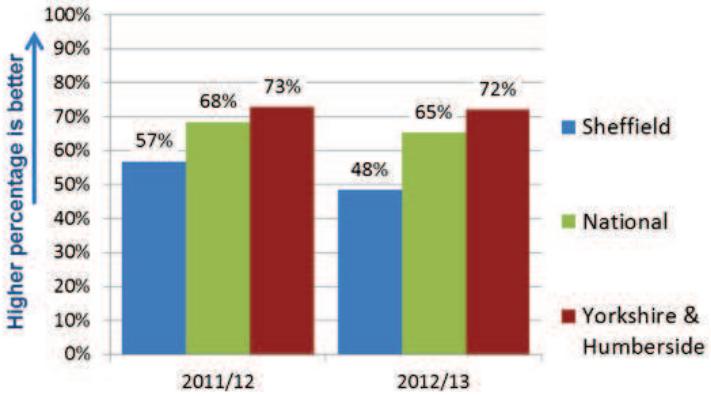
- Making sure that everybody has an annual review of their needs
- The time it takes to complete assessments for support
- The time is takes to receive services after an assessment
- The time it takes to respond to complaints
- People's satisfaction with the complaints process

Here's how we are doing…

Making sure that everybody has an annual review of their needs

In 2012-13, the proportion of people having an annual review fell to 48% compared to 57% the year before. We don't expect to review 100% (those who have only recently taken up a service will not need a review until next year) but it is a priority for us to improve. We are developing quicker, fairer processes to review and reassess people's needs and we have set a target to meet the Yorkshire & Humberside average

The proportion of people receiving a service who had a review of those services in 2012/13



The time it takes to complete assessments

All people new to social care services must be assessed for their level of need. It is important this happens as quickly as possible, so people get the care and support they need. In 2011/12, it took an average of 88 days to do these assessments, from the point that we first had contact with the person. Last year, that time increased slightly to 90 days.

Thanks to some changes we have made, things are now starting to improve and we aim to bring the average waiting time down to 28 days within the next two years.

The time it takes to complete assessments

Support plans include all the care and support services someone is going to have. In 2011/12, it took an average of 74 days from the assessment to the finished support plan. Last year, we reduced it to 48 days. Improvements to the process will help make it even quicker.

The time it takes to respond to complaints

This is the time taken from the complaint being made to the point it is resolved. In 2011/12 the average time taken was 119 days. In 2012/13, this fell to 90 days, so it is improving.

People's satisfaction with the complaints process

After a complaint has been resolved, we ask people how satisfied they were with the process. We have set ourselves a target of 80% of people saying that they are satisfied. We have not yet met that target but we have improved, with satisfaction rising from 63% in 2011/12 to 69% in 2012/13. We hope to improve more next year to get us closer to our target.

What we are doing to improve…

We will do some extra work on those things that are not improving and where we are not doing as well as other councils. We are inviting representatives from other councils to look at how we do things and to challenge the way we work. We will also be looking at what we can learn from others. In next year's report, we will tell you what we have learned and how we are using this to improve.

Get involved and have your say

If you are a service user or carer, we welcome your views about the quality of our services. You can use your own experiences to help us improve services. The Quality Improvement Network provides a variety of ways for people who use adult social care services to get involved.

If you'd like to get involved, we will talk with you about your interests and how much time you have available to find a way of being involved that suits you. To find our more please contact:

Support

If you come to meetings with us, we'll make sure they are always held in an accessible, city centre venue. We'll ask you if you have any support needs or need any adjustments so that you can take part. We will always reimburse you for any travel or Personal Assistant expenses you incur on the day.

The Quality Team, Redvers House (Floor 8),
Union Street, Sheffield, S1 2JQ

Email: PracticeDevelop@sheffield.gov.uk
Telephone: 0114 273 4119

Feedback

We would really like you to tell us what you think about this report, to help us improve it next year. Please contact:

Howard Middleton - Development Manager
Email: howard.middleton@sheffield.gov.uk

Planning and Performance,
Redvers House (Floor 8), Union Street, Sheffield, S1 2JQ

Thank you

The Care and Support Readers group, Healthwatch, the Healthier Communities and Adult Social Care Scrutiny Committee and everyone who helped to produce this report.

This document can be supplied in alternative formats,
please contact 0114 273 4825

Sheffield City Council
www.sheffield.gov.uk

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
23rd July 2014

Report of: Nutrition & Hydration Working Group

Subject: Nutrition & Hydration Working Group: Phase 2– Draft Reports & Recommendations

Author of Report: Diane Owens, 0114 27 35065, diane.owens@sheffield.gov.uk

Summary:

In November 2012, this Committee established the Nutrition and Hydration in Hospitals Working Group, to look at the quality of food in Sheffield's hospitals, as well as the support that people get to eat and drink whilst they are in hospital. The Committee agreed that the focus of this work would be on adults.

The first phase of the work focussed on the Northern General Hospital and a report was subsequently produced and shared with the Trust.

In November 2013 the Committee agreed to extend the piece of work to include observation visits to Weston Park, Royal Hallamshire including the Jessops Wing and the Sheffield Children's Hospital (on behalf of the Children, Young People & Family Support Scrutiny Committee). This report covers this second phase of the work undertaken by the group and includes the full draft reports from the visits (Appendix A & B).

The Working Group would like to present the final draft reports to this Scrutiny Committee for approval along with the group's recommendations.

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

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other: Working Group - draft Report and recommendations	**X**

The Scrutiny Committee is being asked to:

- Approve the two Reports which have been produced by the Nutrition & Hydration Working Group (Appendix A & Appendix B)
- Agree to formally share the Reports with the respective Trusts and request a response.

Background Papers:
n/a

Category of Report: OPEN

Most reports to Scrutiny Committees should be openly available to the public. If a report is deemed to be 'closed', please add: **'Not for publication because it contains exempt information under Paragraph xx of Schedule 12A of the Local Government Act 1972 (as amended).'**

Nutrition & Hydration Working Group – Draft Report & Scrutiny Recommendations

1. Introduction/Context

1.0 The Nutrition & Hydration Task & Finish Group is a sub group of the Healthier Communities & Adult Social Care Scrutiny Committee.

1.1 A public question was put to the Scrutiny Committee at its meeting on the 17th October 2012, raising concerns about the quality of hospital food in Sheffield. The Committee subsequently agreed to establish a Working Group to look at the quality of food as well as the support that people get to eat and drink whilst they are in hospital.

1.2 The original piece of work focussed on the Northern General Hospital, following which a report was produced and shared with the Trust. This report is available at www.sheffield.gov.uk/scrutiny

1.3 In November 2013 the Committee agreed to extend the piece of work to include observation visits to Weston Park, Royal Hallamshire including the Jessops Wing and the Sheffield Children's Hospital (on behalf of the Children, Young People & Family Support Scrutiny Committee).

1.4 As appendices this document includes

- The report relating to the visit to the Hallamshire Hospital, Weston Park and Jessops Wing which took place on 20th March 2014 (appendix A).
- The report relating to the visit to the Sheffield Children's Hospital Trust which took place on 3rd March 2014 (appendix B).

2.0 Matters for consideration

2.1 The Group requested that their visit provide the following opportunities:

- To be able to visit during a meal time
- To see some of the different aspects of the food production system in terms of food preparation and distribution.
- To be able to speak to staff and patients about their experiences

2.2 It should be noted that Scrutiny is not an inspection regime and that both reports relate to single visits undertaken in March 2014, they therefore capture a “snap shot” of a particular day and need to be considered in the context of all other research and consultation undertaken by the Trust.

2.3 A draft of each report was shared with the respective Trust for comments / feedback

3.0 What does this mean for the people of Sheffield?

3.1 High quality nutrition and hydration in Hospitals is an issue which is important for the health and well-being of the people of Sheffield.

4.0 Recommendations

4.0 The Scrutiny Committee is being asked to:

- Approve the two Reports which have been produced by the Nutrition & Hydration Working Group (Appendix A & Appendix B)
- Agree to formally share the Reports with the respective Trusts and request a response.

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Nutrition & Hydration Task & Finish Group – Hallamshire, Weston Park, Jessops Wing Visit Thursday 20th March 2014

Draft Report V00.02

1.0 Background

1.1 The Nutrition & Hydration Task & Finish Group is a sub group of the Healthier Communities & Adult Social Care Scrutiny Committee.

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1.5 This report covers the visit to the Royal Hallamshire Hospital Weston Park and Jessops Wing which took place on 20th March 2014. A separate report will be produced regarding the visit to Sheffield Children's Hospital Trust.

1.6 Membership of the Task Group:

- Councillor Gary Weatherall, Chair of the Task & Finish Group
- Councillor Janet Bragg
- Councillor Roger Davison
- Councillor Tony Downing
- Councillor Diana Stimely - unable to attend visit
- Councillor Joyce Wright – unable to attend visit
- Helen Rowe, Healthwatch, Sheffield

2.0 Introduction

2.1 In March 2014 the Task Group visited the Royal Hallamshire Hospital, Weston Park and Jessops Wing; this report captures the outcomes of their visit. However, it should be noted that Scrutiny is not an inspection regime and that this report relates to their single visit, it therefore captures a "snap shot" of that particular day and needs to be considered in the context of all other research and consultation undertaken by the Trust.

2.2 The Group requested that their visit provide the following opportunities:

- To be able to visit during a meal time
- To see some of the different aspects of the food production system in terms of food preparation and distribution.
- To be able to speak to staff and patients about their experiences

2.3 The visit was co-ordinated by Sam Debbage, Professional and Practice Development Lead and was designed to provide the opportunities that the Group had requested. Due to building work taking place the Group were unable to visit the Hospital kitchens, but the Trust would welcome a visit from the Group to view the kitchens once these works are completed later this year.

3.0 The group's visit

The Group were split into two, this was to enable all of the group members to be able to visit Wards during the lunchtime food service, which gave them an opportunity to observe a meal time at first hand. Each group visited a ward in the Hallamshire Hospital followed by either a ward in Weston Park Hospital or the Jessops Wing. During the tour of the Wards the Group were given the opportunity to speak to various staff members and to observe the serving of meals. Over lunch the group were given an overview of the approach to food preparation and service within the Trust along with an update on the role and purpose of the Trusts Nutritional Steering Group which provides strategic direction and oversight. The Nutrition Steering Group is monitoring implementation of the Hydration & Nutrition Assurance Toolkit (HANAT) which has been developed by the Trust and has recently been tested by two "early adopter" sites.

During the visit the Group had the opportunity to talk to a wide range of staff, including Housekeepers, Nurses and Dieticians along with a small number of patients. The group also had the opportunity to take part in a food tasting session which was being held for staff. This gave the group an opportunity to sample a wide range of food that is currently available on the patient menu, including some of the pureed options.

In addition, Sam Debbage, Professional and Practice Development Lead confirmed that the Trust would be happy for a representative/s from the Working Group to attend a future meeting of the Trusts Nutritional Steering Group to present their final report.

The Group would like to thank Sheffield Teaching Hospital NHS Trust in particular the staff involved in arranging their visit

The following table outlines some of the main areas that were discussed.

Food Service
A wide range of staff were involved in serving food at mealtimes, this included the Ward Housekeepers, Catering Staff and Nurses.
The Food service was led by a member of the clinical staff. The Trust advised this was because good nutrition and hydration were seen as part of the whole package of good clinical care.
The new food production system means food can be presented nicely on the plate and that portion sizes can be managed.

Choice & Menus
The Trust operates a 4 weekly menu cycle and snacks are readily available.
The menu had a wide range of food and drinks available and was felt to be culturally diverse.

Nutrition & Hydration Week
Nutrition & Hydration Week is a global campaign, which in 2014 ran from the 17th to 23rd March. The Trust organised a series of activities for this, including an informative display which included highlighting the "10 Key Characteristics for Good Nutritional Care" (which have been adapted as part of the Nutrition Plan in England to be meaningful in social care settings as well as Hospitals). The Trust also organised a smoothie making session and took part in the "worldwide afternoon tea" on Wednesday 19th March.

Food Tasting Sessions
As part of their visit the Group had the opportunity to take part in a food tasking session.
These sessions are run for hospital staff to give them a chance to sample a wide range of the food available on the patients menu.
The Group were able to taste a wide range of food including some of the pureed options. Feedback forms were also given out so people could give ratings and comments on different aspects of the food such as colour, texture and taste.

Food Waste
The Trust has a systematic approach to monitoring and reporting food waste levels and this information is managed at a strategic level within the organisation.

Strategic approach
There is a trust wide Nutrition Steering Group that leads on nutrition and hydration.
The Steering Group plays a role in ensuring relevant staff receive training on nutrition and hydration. The Steering Group has also developed a Hydration & Nutrition Assurance Toolkit (HANAT). The Toolkit is currently in draft and has been tested with two "early adopter" sites. The Group were invited to give feedback on the draft toolkit.

4.0 Summary

The task Group believes that good nutrition and hydration is essential to aiding a patients' recovery.

Overall they were extremely impressed with their visit in terms of the value placed on good nutrition and hydration within the Trust and also the quality of the food and the approach to food service. The Group felt that they could see further improvements had been made since their visit to the Northern General Hospital in early 2013. They were particularly impressed with the approach to food service, especially the involvement of a wide range of staff, led by a member of the clinical team. In line with the Trust the Group felt this multidisciplinary approach helped embed the importance of good nutrition and hydration as an essential part of the healing process. The group also felt the food service was generally well structured and organised.

The Group felt that the approach to monitoring food waste, as outlined by the Trust, sounded comprehensive and that it was also being managed at a strategic level. The Group also noted some of the "greener" more environmentally friendly action being taken by the Trust, such as waste oil being turned into biofuel and the sourcing of more local produce including meat.

The food tasting session provided an excellent opportunity to sample a wide range of food that was made in the production kitchen and that is currently available on the patient menus. The Group thought these sessions provided a valuable opportunity for staff to try the food and as confirmed by the Trust can mean staff members are able to make recommendations / advise patients on food choices. The Group also welcomed the fact that pureed food options, both mashed and smooth, were included in the tasting sessions and two members of the Group focussed particularly on these dishes. The two Group members felt that the pureed foods were very well presented and that they generally tasted very good.

The fact that attendees could provide detailed feedback on the food they had tasted was felt to be positive and the sessions were clearly a mechanism for trying out new food options and informing the Trusts purchasing decisions. Overall the quality of the food tasted was felt to be excellent and the sessions were seen as good practice. The work being undertaken to recruit volunteers to help support people with eating at mealtimes and the success the Trust has had with this approach were also noted by the Group as positive developments.

The Group felt the display on nutrition and hydration was good and informative and welcomed the fact that it also included the "10 Key Characteristics for Good Nutritional Care" which have been adapted as part of the Nutrition Plan in England. The Group were also pleased to hear about the range of activities that the Trust had organised as part of Nutrition & Hydration Week 2014.

The Nutrition Steering Group was cited as playing a key strategic role in promoting the nutrition and hydration agenda including staff training and was also leading on the Hydration & Nutrition Assurance Toolkit (HANAT) which the Group found very interesting and considered a valuable tool for the future.

Overall the group had a sense that the Trust has yet further increased its focus on good nutrition and hydration as a key element of the healing process.

As already stated Scrutiny is not an inspection regime and so the intention of the visit was not to mirror such an approach but to have an opportunity to informally look around the hospital and speak with staff and patients to gain a better understanding into the hospitals approach to nutrition and hydration

The Group recognise the limitations of this approach and accept that any suggestions they make need to be considered in the context of all other research and consultation undertaken by the Trust. The Group also recognise that the Trust operates in a pressured environment, both in terms of service delivery and budget constraints. Within this context the Group would like to make a small number of observations and suggestions.

5.0 Observations & suggestions

The Task & Finish Group would like to make the following observations and suggestions.

5.1 Food service – on one ward the food service did not seem as well organised due to the fact that not all the staff were assembled and ready when the food service began, this meant that the service started off slowly and there were not enough staff available to start delivering the food to patients, meaning food could begin to deteriorate, however it was noted that once the staff were assembled everything went very well.

5.2 Condiments - a condiments tray should be available to all patients to enable them to flavour food to their individual taste (apart from where exceptions are required for particular dietary requirements) – this was seen on some wards but did not appear to be consistent practice on all wards.

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Appendix B

Nutrition & Hydration Task & Finish Group
Sheffield Children's Hospital Visit Monday 3rd March 2014

Draft Report V00.02

1.0 Background

1.1 The Nutrition & Hydration Task & Finish Group is a sub group of the Healthier Communities & Adult Social Care Scrutiny Committee.

1.2 A public question was put to the Committee at its meeting on the 17th October 2012, raising concerns about the quality of hospital food in Sheffield. The Committee subsequently agreed to establish a working group to look at the quality of food as well as the support that people get to eat and drink whilst they are in hospital.

1.3 The original piece of work focussed on the Northern General Hospital, following which a report was produced and shared with the Trust. This report is available at www.sheffield.gov.uk/scrutiny

1.4 In November 2013 the Committee agreed to extend the piece of work to include observation visits to Weston Park, Royal Hallamshire including the Jessops Wing and the Sheffield Children's Hospital (on behalf of the Children, Young People & Family Support Scrutiny Committee).

1.5 This report covers the Sheffield Children's Hospital Trust. A separate report will be produced following the visits to Weston Park Hospital and the Royal Hallamshire Hospital, including the Jessops Wing.

1.6 Membership of the Task group:

- Councillor Gary Weatherall, Chair of the Task & Finish Group
- Councillor Janet Bragg
- Councillor Roger Davison
- Councillor Tony Downing
- Councillor Diana Stimely
- Councillor Joyce Wright – unable to attend visit
- Helen Rowe, Healthwatch, Sheffield

2.0 Introduction

2.1 In March 2014 the group visited Sheffield Children's Hospital; this report captures the outcomes of their visit. However, it should be noted that Scrutiny is not an inspection regime and that this report relates to their one visit, it therefore captures a "snap shot" of that particular day and needs to be considered in the context of all other research and consultation undertaken by the Trust.

2.2 The Group requested that their visit provide the following opportunities:

- To be able to visit during a meal time
- To see some of the different aspects of the food production system in terms of food preparation and distribution.
- To be able to speak to staff and patients about their experiences

2.3 The visit was co-ordinated by Judith Hodgkinson, Assistant Director Hotel Services, Sheffield Children's NHS Trust and was designed to provide all of the opportunities that the Group had requested.

3.0 The group's visit

The Group were given an overview of the approach to food preparation and service within the Children's Hospital, including the range of choices available and how feedback can be given by young patients and their parents / guardians.

The Group had the opportunity to talk to staff and a small number of young patients and their parents / guardians. They visited the kitchens and saw food being prepared and served. Some members of the group also had the opportunity to sample some of the food available.

The Group would like to thank Sheffield Children's NHS Trust and in particular the staff and patients involved in their visit

The following areas were discussed:

Preparation
The Trust prepares all food freshly from its own kitchens. The kitchens also supply food to the retail outlets, including the restaurant and so at times the menus are the same. Wards are responsible for preparing breakfast for the children (hot breakfast options can also be ordered).

Ordering & Serving
Lunch and evening meal food orders are placed by the Wards. The Kitchen prepares the food and porters transport it, the Wards are then responsible for serving the food. This has led to a number of Wards employing "housekeepers".

Choice
The Trust operates a 3 weekly menu cycle; this was increased from 2 weekly to provide greater choice for those having a longer stay in hospital. There is also a snack menu which patients can order from. Dietary requirements are catered for e.g. halal / dairy free.

Parents / guardians
The Trust provides free hot drinks for parents / guardians which are available on a self-service basis. A 20% discount is available for the Parkside Restaurant for any parent / guardian whose child has been in hospital for more than 4 nights.

Capacity
Food can be requested from 8am-7pm every day. In total the hospital has 125 beds and the kitchens also provide snacks for the Assessment Unit and children who come as day attenders.

Waste
At present food waste levels are not systematically monitored by the Trust. The wards are responsible for dealing with food waste and so feedback on waste levels is anecdotal. This is something the Trust is looking into as part of the new building.

Feedback
There are a number of ways young patients and their parents / guardians can provide feedback e.g. via the comments boxes; the PALS (patient advice and liaison service) or contacting the hospital by email.

.Snack Menu
There was ongoing work to raise awareness of the "Patient Snack Menu" with Wards, so all Wards were fully aware of the menu and were ensuring children and their parents / guardians were also being told about it.

New Building
The new building will create more space and was also seen as an opportunity to do things differently including considering moving to the "cook and chill" food system. There is a plan to centralise the "housekeepers" as at present they are managed through individual wards

The Trust operates a 3 weekly menu cycle and also provides menus for various dietary requirements e.g. dairy free and gluten free, for both lunch and evening meal there was a choice of 2-3 different meal options, which for lunch included a range of hot and cold options. The Trust also produces themed menus for particular celebration events e.g. Halloween and Christmas and also for children's birthdays. There was also a patient Snack Menu referred to as "Theo Friends" all day menu which could be ordered from between 7:30am-6:30pm every day.

An example of the choices available for lunch and an evening meal is outlined below:

Week 1 – Thursday's menu

Lunch		Evening Meal
Beef Burger / Vegi Burger Salad Bun Chips Egg Mayo Sandwich Cheese Salad Flapjack Fruit Salad		Roast chicken Cheese & potato bake Mashed potatoes Hash browns Carrots Broccoli Cheesecake Jam sponge & custard

4.0 Summary

The task Group believes that good nutrition and hydration is essential to aiding a patients' recovery. Overall they were very impressed with what they saw in terms of food preparation and choice. There was also some very positive feedback from the young patients and their parents / guardians both in terms of the quality of the food but also about the choice and availability. As already stated Scrutiny is not an inspection regime and so the intention of the visit was not to mirror such an approach but to have an opportunity to informally look round the hospital and speak with staff and young patients and their parents / guardians to gain a better understanding into the hospitals approach to nutrition and hydration

The Group recognise the limitations of this approach and accept that any suggestions they make need to be considered in the context of all other research and consultation undertaken by the Trust. The Group also recognise that the Trust operates in a pressured environment, both in terms of service delivery and budget constraints. Within this context the Group would like to make a small number of suggestions.

5.0 Observations & Suggestions

The Task & Finish Group would like to make the following observations and suggestions, which they feel would reinforce the important message that good nutrition and hydration is essential to aiding a patients' recovery.

5.1 Monitoring food waste – the Group are aware that the Trust is exploring the possibility of introducing a waste monitoring system as part of the move to the new build. The Group would support the work the Trust is undertaking in this area and would recommend that a systematic approach to monitoring food waste be introduced as soon as possible.

5.2 Raising awareness of choice- the Trust acknowledged there was varied practice across the Wards in terms of raising awareness of the food choices available including the snack menu. This was reflected in the conversations members of the Group had with some of the young patients and their parents / carers, who in particular seemed unaware of the snack menu. Also are patients able to request healthy side orders to accompany lunch such as vegetable sticks? The Group would therefore support continued work with Wards to ensure they raise awareness of the food choices available, including the snack menu and where possible enable young patients and their parents / guardians to play an active role in choosing their meals.

5.3 Cultural variety – it was felt that the range of food available on the main lunch and evening meal menus, though extensive could be more culturally diverse; the group would ask that consideration be given to this suggestion.

5.4 Food presentation – in some instances the Group felt that food presentation could be improved, for example in terms of the sandwiches it was felt that the presentation could be enhanced to make them more appealing to the young patients.

5.5 Food Service – on one Ward the group felt that there was inadequate support for the Housekeeper in terms of serving the meals, which may also have led to a lack of organisation in terms of the service i.e. all the meals were taken out of the trolley at once so there was constant swapping from hot to cold meals (meaning that some food could deteriorate in appearance / quality during the wait). The group appreciate this may have been an isolated incident but would suggest that standard practice should be to serve the hot meals first followed by cold meals or vice versa.

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Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
Draft Work Programme 2014-15

Chair: Cllr Mick Rooney **Vice Chair**: Cllr Sue Alston
Meeting papers: click here **Meeting day/ time**: Wednesday, 10am-1pm
Please note: the Work Programme is a live document and so is subject to change.

Topic	Reasons for selecting topic	Contact	Date	Expected Outcomes
23rd July 2014				
Sheffield Health and Wellbeing Board's Plans for 2014/15	An update on the delivery plan including progress with the Better Care Fund.	Louisa Willoughby, Commissioning Officer	Jul-14	
Clinical Commissioning Group (CCG): Commissioning Intentions 2014-19	An update on the CCG Commissioning Intentions 2014-19	Tim Furness, Director of Business Planning and Partnerships, GGC	Jul-14	
'How did we do?' – Sheffield's Local Account of Adult Social Care Services 2014	Input from Scrutiny as part of the early design and development process.	Chris Blackburn Development Officer, Business Strategy, Communities Howard Middleton, Development Manager - Planning and Performance	Jul-14	

Nutrition & Hydration Working Group	Final draft report following phase 2 of the piece of work which involved visits to the Children Hospital and Hallamshire Hopsital , Jessops Wing and Weston Park	Diane Owens, Policy & Improvement Officer	Jul-14	Presenting a final draft report and recommendations for consideration / approval by the Scrutiny Committee.
Work Programme 2014-15	Presenting the draft work programme for 2014-15.	Diane Owens, Policy & Improvement Officer	Jul-14	To receive comments / suggestions regarding the work programme.
17th September 2014				
Social Care Bill 2013	Implications of the Bill and progress so far.	Moira Wilson, Interim Director of Care and Support	Sep-14	
A Guide to Health Scrutiny in Sheffield	Presenting the final draft health protocol for approval by the Scrutiny Committee.	Cllr Mick Rooney, Chair	Sep-14	

Transitions within the CAMHS service	There was a recommendation in the CAMHS Working Group Report to include this topic on the work programme for 2014-15.	Anthony Hughes (CYPF), Tim Furness (CCG), Steve Jones (SCH)	Sep-14	
15th October 2014				
End of Life Care Strategy	Minutes from 15th January. The Committee requests that "arrangements be made for the Committee to look at the End of Life Care Strategy in the 2014/15 Municipal Year, and that this item includes feedback on the Department of Health's response to the report on the Liverpool care Pathway and any consequent actions in Sheffield"	Jackie Gladden, Senior Commissioning Manager, Long-Term Conditions and End of Life Care / St Luke's Hospice	Oct-14	

Right First Time Programme.	Minutes from 20th November 2014: the committee requests a report in terms of progress in respect of Phase 3 of the Right First Time Programme. including data/statistics on the impact of the Programme to date	Kevan Taylor & Zak McMurray, Sheffield Health & Social Care Foundation Trust	Oct-14	
Dementia Strategy & Integrated Working	Minutes from 20th November 2014: the committee requests, "the Director of Business, Planning and Partnerships, Sheffield CCG, to submit a report to a future meeting of the Committee, containing details of the progress made in terms of the Sheffield Dementia Strategy and Commissioning Plan, with an emphasis on the Action Plan, financial details and work undertaken in terms of public engagement, together with details of an explanation as to how the service was integrated, and (B) the Executive Director, Communities, to attend the same meeting to explain how the Council and Health were responding to the requirement for integrated service provision	Sarah Burt Senior Commissioning Manager (CCG) & Michelle Fearon Service Director - Specialist Services Directorate (SHSC) SCC Executive Director, Communities	Oct-14	

Date TBC				
GP Practices	Minutes from 17th July 2013 the Scrutiny Committee identifies (i) the need for discussions "(A) with the National Commissioning Board's Local Area Board regarding GP practices in the City, including the numbers, location and skill mix."	tbc	tbc	
Joint Commissioning strategy	A report providing an overview of the Joint Commissioning Strategy, to include an overview of the services, timescales etc.	Larraine Manley, Executive Director Communities	tbc	
Briefing Papers				
Sheffield Adult Safeguarding Partnership - Annual Report 2012/13	Minutes from15th January 2014, the Committee requests that the Sheffield Adult Safeguarding Partnership (iii) provide a progress report to the Committee on a quarterly basis.	Simon Richards, Head of Quality & Safeguarding & Sue Fiennes, Independent Chair	(April 2014) July, Oct 2014, Feb 2015	

Update Report on developing a Social Model of Health/ Health Communities Review	Minutes from 19th March 2014, That the Committee:- 8.4 (c) “requests that a written update report on progress with the Social Model of Public Health/Healthy Communities Review be included on the agenda for each future meeting of the Committee”	Chris Shaw, Director of Health Improvement	(April 2014) July, Sept, Oct, Dec 2014, Feb & April 2015	

SASP 2014-15 Business Plan: Update July 2014

Introduction

Each year, SASP Executive Board develops and agrees a business plan setting strategic direction and key outcomes, and connecting these to the council's vision and wider objectives, and matters of national strategy. Members are sufficiently senior in their organisations to influence, lead and support the implementation of the Business Plan and its further development.

Vision Statement

People of Sheffield are able to live a life free from avoidable harm, in communities that

- *do not tolerate abuse,*
- *work together to prevent abuse occurring*
- *know what to do when abuse happens'*

Core objectives and outcomes for 2014-15:

1. Implement an effective Performance Framework and use data and information to improve safety and practice quality
2. Improve the Quality of safeguarding practice, ensuring consistent standards across the partnership
3. Respond to improvement drivers (local and national) ensuring learning is embedded in practice, strengthening of risk mitigation and to ensure partnership working is effective
4. Deliver the Equalities Action
5. Promote public awareness of safeguarding being everyone's business

Key	**G/C**	completed
	G	Performing well / No concern - No further action needed
	A	Slightly off track / Minor concern - Active management needed
	R	Significantly Off track / Major concern - Escalation needed

Key Outcome 1: Implement an effective Performance Framework and use data and information to improve safety and practice quality				
step	What we will do	Update: June-14	Update: Sep:14	RAG
1.1	Interrogate data and information presented to interpret apparent inconsistencies and trend	2013-14 activity data produced, SAR completed. Annual report is progressing well and we aim to publish in July-14. Q1 2014-15 data will be produced mid-July and shared with partners outside of Board meeting cycles: CE/JW/SR to lead on preliminary work, including targeted work on Adult Access. The PI Framework Task and Finish group have completed review of proposed PI indicators, agreed to utilise the combined expertise of Operational Board and Sub-Boards to interpret performance data, and contribute supporting narrative to help us understand and respond.		G
1.2	Seek additional information to verify and explain when things are starting to go wrong so that we can act promptly to safeguard people	Partners have been asked to look ahead and share local intelligence to help predict emerging areas of risk and opportunity. 'horizon scanning' allows us to consider priorities already identified in the 2014-15 Business Plan, and strengthen our ability to respond to the future challenges that we are likely to face. Example: In response to the increasing number of cases where a high risk of fire is identified a new guidance document has been drafted to provide an agreed process for the "Management and Coordination of High Fire Risk Home Safety Checks" This will require a multi-agency approach and joint ownership with relevant partners to manage the risk to the individual and particularly where there is a risk to others A summary of themes will be reported to Operational Board for discussion and action.		G

1.3	Accepting there is no single system that allows us to easily report and analyse concerns that do not meet the Safeguarding threshold, share local intelligence to describe activity, themes and trends. Use this to help predict emerging areas of risk and opportunity	Reality check: The 2013-14 Annual Report includes feedback from Partners – this will help reveal concerns and emerging risk.: report due Jul-14. We know our local demographic continues to change, and use of face-to-face and telephone interpreting services 2013-14 (SCC contract) is a helpful source of intelligence to help target and direct support to vulnerable groups. This will inform our Equalities Action Plan, including awareness and information.		G
1.4	Ensure safeguarding workers have access to appropriate legal and professional advice to support risk management We monitor and report: • Use of Mental Capacity Act, analyse usage and identify areas for concern • Case advice response times, analyse usage and identify areas for concern • DOL These measures will feature as components of the performance, provide assurance that workers know where to access advice, and help identify 'cold' spots	In line with national developments, Sheffield is experiencing an unprecedented rise in the number of Deprivation of Liberty referrals from hospital and residential settings: Apr/May-14 data confirms more applications were received than all of 2013-14. The Supreme Court (Cheshire/West case) has clarified that a far greater member of people require an assessment and this has a significant additional extra cost. Gillian Anderson (SCC Legal) and Gary Haigh (MCA & DOLs SCC) will discuss at Jun-14 Ops Board. Current contingency includes increase in use of Best interest Assessors, to ensure appropriate safeguards are developed and implemented. A longer term response includes possible development of existing job roles, supported by appropriate training and support strategy; this will increase our capacity to respond.		A

Key Outcome 2: Improve the Quality of safeguarding practice, ensuring consistent standards across the partnership

step	What we will do	Update: Jun-14	Update: Sep-14	RAG
2.1	Quality assure Safeguarding process stages - Alerts, Strategy, Investigations via planned audits	Performance Framework includes dip samples to test practice – first audits will start in Jun-14. Findings will be used to improve practice, record keeping and		

		identify common themes. A Performance Improvement Clinic is being held Jul-14 to address key performance issues in the safeguarding pathway/timescale. Outcomes will be reported to Moira Wilson, Interim Director Care & Support (SCC), and used to further develop the Performance Framework. Independent Chairs to seek more face-to-face feedback from service users about feeling safer, and the safeguarding process.		A 
2.2	Continue to link all sources of intelligence to inform Risk management in safeguarding	South Yorkshire Police have appointed a Safeguarding lead, CE is developing working relationship. SR to attend Housing Services Managers meeting in Jul-14 to champion and raise profile of Safeguarding: about 42,000 council properties are managed. ASB intelligence will improve identification of hotspots and possible links to safeguarding concerns. CE working with Safer Neighbourhoods manager to evaluate PRAM data. With the support of Sheffield City Council and South Yorkshire Police, increase the number of registered Sheffield Safe Places and make sure these are based in areas where people need them the most: demonstrate that partially hidden and under reported issue of crime and harassment targeting disabled people is effectively addressed Safeguarding Adults at Risk Audit Tool to be adopted and implemented in Jun/July.		G 
2.3	How good is safeguarding in care homes and how can it improve	Update reports from SCC and CCG Commissioning leads will be requested for SAB Sept-14. Service contracts promote core values of independence, respect, dignity and choice, and reflect the expectation of safeguarding adults who are at risk of harm. Recent changes to the way serious incidents are		G 

		reported and monitored will improve the screening of complaints.		
Key Outcome 3: Respond to improvement drivers (local and national) ensuring learning is embedded in practice, strengthening of risk mitigation and to ensure partnership working is effective				
step	What we will do:	Update: Jun-14	Update: Sept-14	RAG
3.1	Seek and receive assurance that outcomes relevant to Adult Safeguarding are progressed in a timely and effective manner • Winterbourne View • Francis Report • Cheshire/West	A verbal update will be given to the SAB in Jun-14 by by Kevin Clifford, NHS Sheffield CCG : this will provide an over view of local implantation of Francis Report. An update will be given to the Ops Board in Jun-14 by SCC Legal and SCC MCA lead: this will provide an over view of local impact of Cheshire/West ruling.		tbc
3.2	Ensure SASP is able to implement Care Act 2014	A reported will be presented to SAB in Jun-14. An Implementation Project Team has been established, and public consultation closes on 9 July. We are starting to identify what practice and culture will need to change.		G
Key Outcome 4: Deliver the Equalities Action Plan and continue SASP commitment to 'Manifesto for Change' in				
step	What we will do:	Update: Jun-14	Update; Sept-14	RAG
4.1	Encourage, guide and monitor progress of Safe In Sheffield project to reduce disability related harassment and abuse of vulnerable adults	Heeley City Farm (HCF) commissioned to continue work into 2014-15: an SLA and Action plan have been agreed. CE is part of stakeholder group monitoring performance and progress – an update report is expected from HCF in mid Jul-14. Share the purpose of the scheme with young people as they move into adulthood, and their carers, by making links with the Transitions Team to identify key groups		G

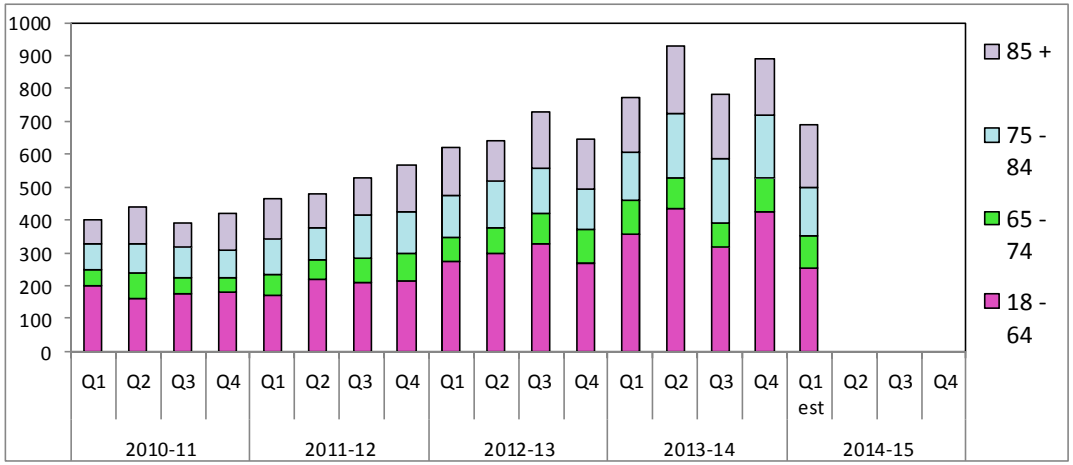
		to link with such as Roundabout, Foyer Project		
4.2	Improve our understanding of the circumstances and motivations of perpetrators, and embed learning in training front line staff and partners in how to recognise and treat disability-related harassment	Safe In Sheffield action plan includes the production of Case Studies and use as part of publicity and training, to engage and empower volunteers: update expected Sept-14.		G
4.3	Review of existing data to produce a map analysis for Safeguarding in Sheffield, and build on analysis to construct a model against which levels of types of Safeguarding activity and outcomes can be effectively assessed	Continuation of developmental work started in 2013/14 to gain a better understanding of the level of abuse across Sheffield will continue. First drafts produced but needs further development to reveal 'hot' and 'cold' spots without compromising confidentiality. Review again by Sep-14.		A
4.4	Implement actions from the Equalities Workshop to improve access to services, and engagement with Adult Safeguarding across all communities in Sheffield	The implementation of the Equalities plan will consider how to overcome barriers which may prevent some communities engaging with the safeguarding agenda and address cultural issues: interpreting data confirms Sheffield demographic is changing. Consider impact of Forced Marriage legislation. Seek and use best practice models from other local authorities and learning from Case Reviews and Serious Case reviews to promote public awareness in Sheffield		A
Key Outcome 5: Promote public awareness of safeguarding being everyone's business				
step	What we will do:	Update: Jun-14	Update: Sept-14	
5.1	Run a campaign to improve awareness and confidence as Safeguarding being an effective way to protect people at risk	Safe in Sheffield Scheme was promoted during Learning Disabilities Week Jun-14, and includes actions to establish and develop effective relationships with Sheffield Community Council for Church Care		G

		(SCCCC), Dementia Alliance and other support groups		
5.2	Target campaigns	Safe In Sheffield Scheme will be extended and promoted to engage key Mental Health (under 65) Adult Dementia and Brain Injuries service providers to help expand the support of this scheme, and improve the response to vulnerable adults. CE is developing a business case to complete scoping work relating to sexual exploitation (18-25 year olds) and what we can put in place to reduce risk (subject to SAB funding approval)		G 

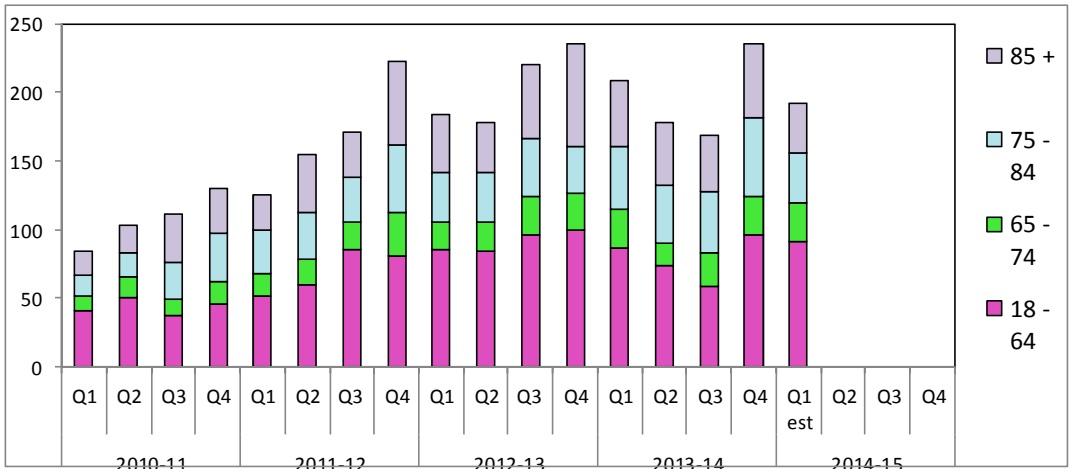
Activity Reports: Q1 2014/15 interim data (based on April-May only)

Note: in response to concerns raised in the PI Task and Finish Group, audit work starts in Jun/July to assess, monitor and/or improve % of alerts moving to referral. Ratios remains low compared to previous years. Q1 data indicates a higher percentage of BME service user alerts move to referral.

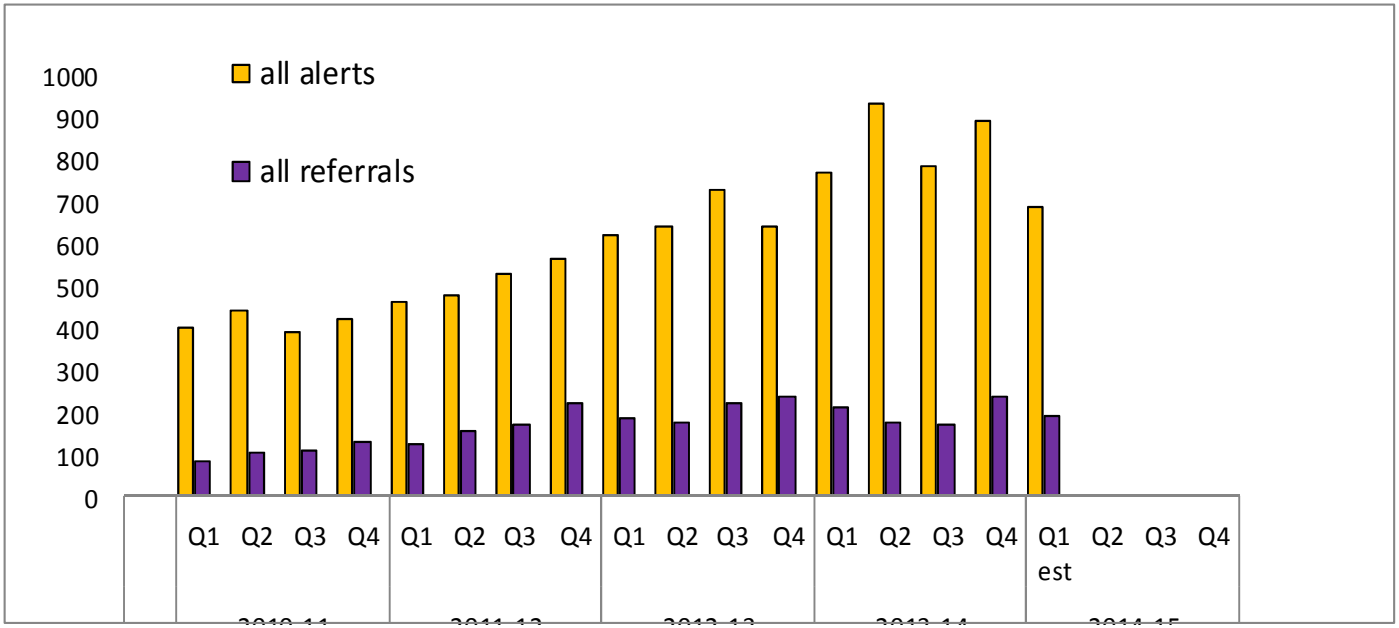
1. Alerts by age



2. Referrals by age



3. Comparison of alerts moving to referrals 2010/11, 2011/12, 2012/13, 2013/14, 2014/15



	2010-11	2011-12	2012-13	2013-14	2014-15 (Aprl-May)
Alerts	1655	2034	2633	3379	690
% BME	6.3%	6.0%	6.2%	7.6%	5.2%
Referral	428	674	818	792	192
% BME	5.6%	6.8%	6.8%	6.8%	8.6%
% of all	**26%**	**33%**	**31%**	**23%**	**28%**

4. Referrals by alleged type of abuse