

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 29 March 2018 at 3.00 pm

Town Hall, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Cate McDonald
Dr Tim Moorhead
Dr Nikki Bates

Dr Alan Billings
Jayne Brown
Nicki Doherty

Councillor Jackie Drayton

Greg Fell
Phil Holmes
Alison Knowles
Jayne Ludlam
Clare Mappin
Dr Zak McMurray
Peter Moore

Cabinet Member for Health and Social Care
Chair of the Clinical Commissioning Group
Governing Body Member, Clinical Commissioning Group
Police & Crime Commissioner
Sheffield Health & Social Care Trust
Director of Delivery Care out of Hospital, Clinical Commissioning Group
Cabinet Member for Children, Young People and Families
Director of Public Health, Sheffield City Council
Director of Adult Services, Sheffield City Council
Locality Director, NHS England
Executive Director, People Services Portfolio
The Burton Street Foundation
Clinical Director, Clinical Commissioning Group
Director of Strategy and Integration, Clinical Commissioning Group

John Mothersole
Prof Chris Newman
Judy Robinson
Maddy Ruff

Prof Laura Serrant
Dr David Throssell

Chief Executive, Sheffield City Council
University of Sheffield
Chair, Healthwatch Sheffield
Accountable Officer, Clinical Commissioning
Group
Sheffield Hallam University
Sheffield Teaching Hospitals NHS Foundation
Trust



SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council • Sheffield Clinical Commissioning Group

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

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

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

PUBLIC ACCESS TO THE MEETING

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

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

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

FACILITIES

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

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA
Sheffield City Council • Sheffield Clinical Commissioning Group

29 MARCH 2018

Order of Business

- 1. Apologies for Absence**
- 2. Declarations of Interest** (Pages 1 - 4)
Members to declare any interests they have in the business to be considered at the meeting.
- 3. Public Questions**
To receive any questions from members of the public.
- 4. Pharmaceutical Needs Assessment** (Pages 5 - 54)
Report of the Director of Public Health, Sheffield City Council
- 5. Better Care Fund Update** (Pages 55 - 64)
Joint report of the Executive Director, People Services, Sheffield City Council and the Chief Officer, Sheffield CCG.
- 6. Primary Care Strategy** (Pages 65 - 76)
Report of the Director of Delivery Care out of Hospital, Sheffield CCG.
- 7. Minutes of the Previous Meeting** (Pages 77 - 86)
Minutes of the meeting of the Board held on 27 July 2017

NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 27 September 2018 at 3.00 pm

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.
- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

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

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –
 - under which goods or services are to be provided or works are to be executed; and
 - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.
- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.
- Any tenancy where (to your knowledge) –
 - the landlord is your council or authority; and
 - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.
- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -
 - (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
 - (b) either -
 - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
 - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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

You have a personal interest where –

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

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

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

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

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

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

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HEALTH AND WELLBEING BOARD PAPER STRATEGY MEETING

Report of: Greg Fell

Date: 29th March 2018

Subject: Pharmaceutical Needs Assessment 2018-2021

Author of Report: Louise Brewins – 2057455

Summary:

This paper provides a background summary of the Pharmaceutical Needs Assessment (PNA) for 2018-2021, which the Board is asked to approve.

Questions for the Health and Wellbeing Board:

None.

Recommendations for the Health and Wellbeing Board:

The Board is asked to approve publication of the PNA 2018-2021 on the Council's website by 1st April 2018.

Sheffield Pharmaceutical Needs Assessment 2018-2021

1. Background

The Health and Social Care Act (2012) transferred responsibility for the development and updating of pharmaceutical needs assessments (PNAs) from Primary Care Trusts to Health and Wellbeing Boards with effect from 1st April 2013.

The legislative basis for developing, updating and using a PNA is set out in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. The Sheffield Health and Wellbeing Board published its first PNA on 1st April 2015 to cover the period 2015 to 2018. This second PNA must therefore be published by 1st April 2018 to cover the period 2018 to 2021.

The regulations set out how the PNA should be produced, what it should cover, who should be consulted, and how it should be used. Responsibility for production of the PNA, on behalf of the Health and Wellbeing Board, rests with the Director of Public Health of the relevant local authority.

2. Purpose and content of a PNA

The PNA is an assessment of the need for pharmaceutical services for a specific population and is the tool by which the Health and Wellbeing Board ensures its population has access to the right NHS pharmaceutical services, at the right time and in the right place.

The PNA is also used by NHS England to determine applications to open a new pharmacy, or make changes to local NHS pharmaceutical services in the area. It does this by deciding whether the application meets a pharmaceutical need as identified in the corresponding PNA.

The PNA must include information on current provision (including any gaps) in essential, advanced and locally commissioned pharmaceutical services plus details of any other relevant services and improvements required. In addition it should set out the demography of the area, the health and wellbeing needs of the population (derived from the JSNA), level of access to and choice of pharmaceutical services and any local geographical or community variations in need, access and choice.

The PNA should also set out how it was produced, including the results of a 60 day stakeholder consultation.

3. Key results and next steps

The main findings of the PNA for 2018-2021 are as follows:

- ❖ Sheffield is well-served by its pharmacies and dispensing doctors with good coverage and choice across the different areas of the City and good availability and access arrangements, including out of hours, high levels of patient satisfaction and no gaps in provision.

- ❖ Pharmacy has good links with other NHS services within the City both in relation to primary care (especially GP practices) and acute hospital services. Nevertheless, it is recognised that there is potential to develop this much further, particularly in the context of developing integrated primary care services.
- ❖ Local pharmacies are already contributing extensively to raising awareness and understanding of health risks, promoting healthy lifestyles, providing advice and signposting/ referral to treatment and providing services, often in more accessible and acceptable settings.
- ❖ Demographic and cost pressures from patients with long-term conditions is only likely to increase in the coming years and pharmacy's continued role in helping to meet this need is acknowledged. Further development of the public health role of pharmacy and commissioning of relevant services could therefore secure additional improvements in health.
- ❖ Known future other developments are unlikely to generate significant need for additional pharmaceutical provision over the lifetime of the PNA.

Relevant stakeholders were consulted on a draft of the PNA for 60 days from 20th October to 19th December 2017. The results of the consultation were included as Appendix A to the final draft of the PNA.

Board members were sent the final draft of the PNA for comment during February 2018 prior to approval at the meeting on 29th March 2018. Only one substantive comment was received. This led to the inclusion of a section on pharmaceutical needs of people with learning disabilities (section 4.28) to which Sheffield's pharmacies are well placed to respond.

4. Recommendation

The Health and Wellbeing Board is asked to approve the PNA 2018-2021.

Subject to approval, the PNA will be published on the Council's website by 1st April 2018 together with a map of pharmacies in Sheffield:

<https://www.sheffield.gov.uk/content/sheffield/home/public-health/health-wellbeing-needs-assessment.html>

Prepared by:

Louise Brewins
Head of Public Health Intelligence, Sheffield City Council
29th March 2018

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Sheffield Clinical Commissioning Group


NHS
England


healthwatch
Sheffield



Sheffield Pharmaceutical Needs Assessment 2018-21

Date: 29th March 2018
FINAL Version
Ref: 2018 (03) PHIT

Version Control

Title	Sheffield Pharmaceutical Needs Assessment 2018
Reference	PNA 2018 (V.2.0)
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Date Created	29/03/2018
Approved By	Greg Fell (DPH)
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Distribution	Sheffield Health and Wellbeing Board
FOI Category	Open
Author	Louise Brewins
Owner (if different)	Sheffield Health and Wellbeing Board
Amendment History	Amended following stakeholder consultation which ended on 19 th December 2018. Comments and responses are summarised in Appendix A to the document. Further amendments made based on comments received from HWBB members during February 2018 – new section on learning disabilities and stop smoking support for people living with severe and enduring mental illness added.
Review date	
Comments	

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1 Executive Summary

The Pharmaceutical Needs Assessment (PNA) provides a framework to enable the strategic development and commissioning of pharmaceutical services to help meet the needs of the local population. It is produced by the Sheffield Health and Wellbeing Board in accordance with the National Health Service (NHS) (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. This is the second PNA produced by the Sheffield Health and Wellbeing Board and covers the three-year period 2018 to 2021.

The document sets out in section 2: the process that was followed by the Sheffield Health and Wellbeing Board in meeting its statutory duty to produce and publish a robust PNA including the results of the consultation undertaken; in sections 3 and 4 it describes the key demographic features and health and wellbeing needs of the Sheffield population (taken from the Joint Strategic Needs Assessment) and; in section 5 it assesses whether pharmaceutical services delivered via essential, advanced and enhanced services and future developments are sufficient to meet the needs of the population.

In conclusion the PNA identifies that:

- ❖ Sheffield is well-served by its pharmacies and dispensing doctors with good coverage and choice across the different areas of the City and good availability and access arrangements, including out of hours, high levels of patient satisfaction and no gaps in provision.
- ❖ Pharmacy has good links with other NHS services within the City both in relation to primary care (especially GP practices) and acute hospital services. Nevertheless, it is recognised that there is potential to develop this much further, particularly in the context of developing integrated primary care services.
- ❖ Local pharmacies are already contributing extensively to raising awareness and understanding of health risks, promoting healthy lifestyles, providing advice and signposting/ referral to treatment and providing services, often in more accessible and acceptable settings.
- ❖ Demographic and cost pressures from patients with long-term conditions is only likely to increase in the coming years and pharmacy's continued role in helping to meet this need is acknowledged. Further development of the public health role of pharmacy and commissioning of relevant services could therefore secure additional improvements in health.
- ❖ Known future other developments are unlikely to generate significant need for additional pharmaceutical provision over the lifetime of the PNA.

2 Introduction

2.1 Background

The Health and Social Care Act (2012) transferred responsibility for the development and updating of pharmaceutical needs assessments (PNAs) from Primary Care Trusts to Health and Wellbeing Boards with effect from 1st April 2013.

The legislative basis for developing, updating and using a PNA is set out in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. The Sheffield Health and Wellbeing Board published its first PNA on 1st April 2015 to cover the period 2015 to 2018. This second PNA is therefore published on 1st April 2018 and covers the period 2018 to 2021.

The regulations set out how the PNA should be produced, what it should cover, who should be consulted, and how it should be used. Responsibility for production of the PNA, on behalf of the Health and Wellbeing Board, rests with the Director of Public Health of the relevant local authority.

2.2 Purpose

The PNA provides a framework to enable the strategic development and commissioning of pharmaceutical services to help meet the needs of the local population. It plays an essential role in equipping NHS England to deal with applications to provide pharmaceutical services under the Market Entry process; it should also highlight any gaps in pharmaceutical service provision so that relevant commissioners can take appropriate steps to remedy these and ensure the local population has appropriate access to pharmaceutical services.

The production of a robust PNA is set within the context of the local Joint Strategic Needs Assessment (JSNA) which requires that Health and Wellbeing Boards manage knowledge and undertake regular needs assessments that establish a full understanding of current and future local health needs and requirements of the local population. The Sheffield JSNA has been used to provide the evidence of need for this PNA with pharmaceutical needs including dispensing of medication and provision of advice and clinical pharmaceutical interventions, delivered via essential, advanced and enhanced services.

2.3 Definitions

The pharmaceutical services to which each PNA must relate are all the pharmaceutical services that may be provided under arrangements made by NHS England for:

- (a) the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list
- (b) the provision of local pharmaceutical services under a Local Pharmaceutical Service (LPS) scheme (but not LP services which are not local pharmaceutical services) or

-
- (c) the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements made by NHS England with a dispensing doctor).

Pharmaceutical services are defined by reference to the regulations and directions governing pharmaceutical services provided by community pharmacies (which may be LPS providers), dispensing doctors and appliance contractors. Whether a service falls within the scope of pharmaceutical services for the purposes of the PNA depends on who the provider is and what is provided. For the purposes of this PNA we have adopted the following scope:

- Pharmacy contractors
For pharmacy contractors the scope of the services that need to be assessed is broad and comprehensive. It includes the essential, advanced and enhanced service elements of the pharmacy contract whether provided under the terms of services for pharmaceutical contractors or under Local Pharmaceutical Services (LPS) contracts. There are 128 pharmacy contractors in Sheffield. This includes 3 distance selling pharmacies. In addition, there are 15 pharmacy contractors within 1.6km of the Sheffield boundary who provide services to Sheffield residents.
- Dispensing doctors
In some areas GP practices may dispense prescriptions for their own patients and the PNA takes these into account. It is not concerned with assessing the need for other services dispensing doctors may provide as part of their national or local contract arrangements. Sheffield has two dispensing doctors: one is based in Deepcar and the other in Oughtibridge, both of which are in the north of the city.

2.4 Pharmaceutical Services

The NHS Community Pharmacy Contractual Framework is made up of various service types. These are:

2.4.1 Essential services

These are set out in schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. All pharmacy contractors must provide the full range of essential services which include dispensing medicines and actions associated with dispensing and promotion of healthy lifestyles.

2.4.2 Advanced services

Any contractor may choose to provide Advanced Services. There are requirements which need to be met in relation to the pharmacist, standard of premises or notification to NHS England. Advanced services include Medicines Use Reviews (MURs), New Medicines Service (NMS), seasonal influenza vaccination and the NHS Urgent Medicine Supply Scheme.

2.4.3 Enhanced and locally commissioned services

Only those contractors directly commissioned by NHS England can provide enhanced services. Community pharmacy contractors may also provide services commissioned by

local authorities and Clinical Commissioning Groups (CCGs). Although these are not enhanced services, they mirror the services that could be commissioned by NHS England and are therefore included within the list of pharmaceutical services in order to provide a comprehensive picture of pharmaceutical provision in the city.

2.4.4 Exclusions and exceptions from the assessment

Pharmaceutical services and pharmacists are evident in other areas of work in which the local health and wellbeing partners have an interest but which are *excluded* from this assessment. These include prisons and hospitals where patients may be obtaining a type of pharmaceutical service that is not covered by this assessment.

The 2013 Regulations set out the process for dealing with applications for new pharmacies under the regulatory system known as 'market entry'. The market entry test describes the system whereby NHS England assesses an application that offers to:

- Meet an identified current or future need(s)
- Meet identified current or future improvement(s) or better access to pharmaceutical services
- Provide unforeseen benefits i.e. applications that offer to meet a need that is not identified in the PNA but which NHS England is satisfied would lead to significant benefits to people living in the relevant area.

There are two types of application that can be made by a pharmacy or dispensing appliance contractor; routine applications and excepted applications. The regulations allow the following automatic *exceptions* to the test:

- Relocations that do not result in a significant change to pharmaceutical service provision
- Distance selling premises
- Change of ownership
- Temporary listings arising out of suspensions
- Persons exercising a right of return to a pharmaceutical list
- Temporary arrangements during emergencies or because of circumstances beyond the control of the NHS chemists

On 5th December 2016, amendments to the 2013 regulations came into force that will facilitate pharmacy business consolidations from two sites onto a single existing site. This means that a new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes. This would protect the two pharmacies merging onto a single site where this does not cause a gap in provision as a result.

2.5 Process

Early in 2017, the Directors of Public Health for Barnsley, Doncaster, Rotherham and Sheffield respectively, agreed to work together to produce the four PNAs covering South Yorkshire. A joint South Yorkshire PNA steering group was established to take this forward, led by a Public Health Registrar (supported by a Public Health Consultant) and comprising the relevant PNA lead from each local authority. The South Yorkshire and

Bassetlaw Local Professional Network (LPN)¹ acted as the reference group to the joint steering group.

Data on pharmacy provision within each of the four local authority areas was obtained from NHS England, relevant CCGs and the local authorities concerned and this information was combined into a master spreadsheet. Each PNA lead then added relevant health needs information (i.e. demographics, deprivation, mortality and morbidity) to their element of the master spreadsheet respectively.

Utilising the Sheffield element of the master spreadsheet, the Public Health Intelligence Team in Sheffield City Council undertook analysis and mapping of the data for the Sheffield PNA. This included working with Public Health England to use their “SHAPE” (Strategic Health Asset Planning and Evaluation) mapping tool² to analyse pharmacy locations by demographic, health and access factors. A summary of this analysis, based on the 28 wards in Sheffield, is included as Appendix B to this document. In addition, information about proposed housing developments was obtained from Sheffield City Council’s Housing Department and analysed using the SHAPE tool.

An initial draft document was prepared by Sheffield City Council’s PNA lead and this was shared with the DPH for Sheffield and colleagues from: NHS Sheffield CCG (medicines management); Community Pharmacy Sheffield (formerly Sheffield Local Pharmaceutical Committee); NHS England (South Yorkshire and Bassetlaw); and Healthwatch Sheffield for comment and accuracy checks. A further draft was then prepared for stakeholder consultation.

A stakeholder consultation on the first full draft of the PNA took place for a period of 60 days from 20th October to 19th December 2017, in line with the 2013 Regulations. The following stakeholders were consulted:

- Community Pharmacy Sheffield
- Sheffield Local Medical Committee
- NHS Sheffield Clinical Commissioning Group
- Community pharmacy contractors in Sheffield
- Dispensing doctors in Sheffield
- NHS England (South Yorkshire and Bassetlaw)
- Healthwatch Sheffield
- All Sheffield NHS Foundation Trusts
- Neighbouring Health and Wellbeing Boards (Derbyshire, Barnsley and Rotherham)

The consultation responses were collated and analysed by the Sheffield City Council Public Health Intelligence Team and, in consultation with Community Pharmacy Sheffield, NHS Sheffield CCG, Healthwatch Sheffield and NHS England (South Yorkshire and Bassetlaw), the PNA was amended as required. The full consultation report is available at Appendix A to this document.

¹ The South Yorkshire & Bassetlaw LPN comprises representatives from LPCs, CCGs, NHS England, Healthwatch, LMCs, Local Authority Public Health and Pharmacy (community and hospital) from across the area.

² More information about the SHAPE tool can be obtained from Public Health England:
<https://shape.phe.org.uk/>

The final version of the PNA (2018) was approved by the Health and Wellbeing Board at its meeting on 29th March 2018. A copy of the report and associated map of pharmacies in Sheffield is available here: <https://www.sheffield.gov.uk/content/sheffield/home/public-health/health-wellbeing-needs-assessment.html>

3 About Sheffield

3.1 Locality

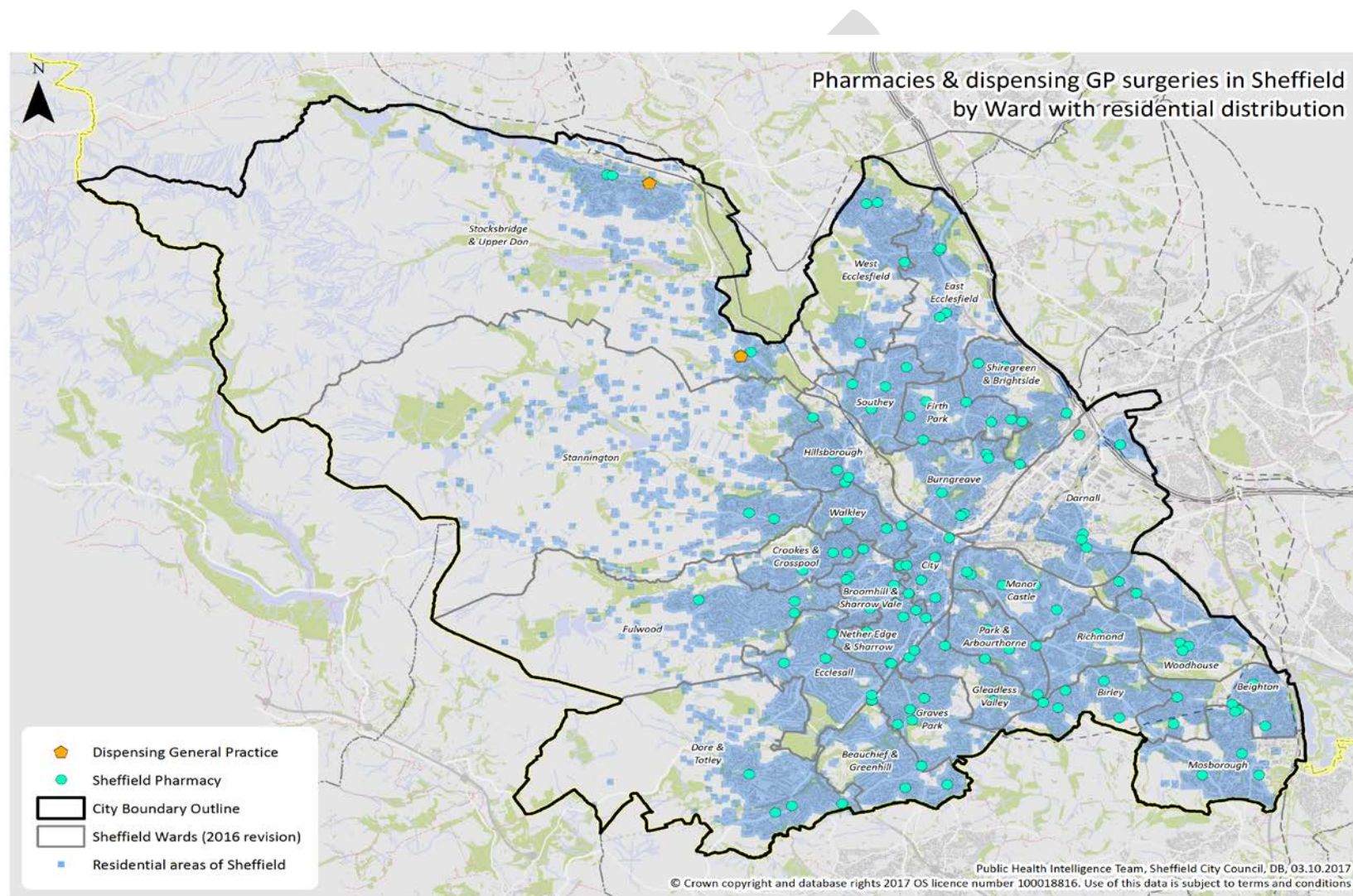
Sheffield is one of England's largest cities, nestled in a natural bowl created by seven hills and the confluence of five rivers and is both geographically and demographically diverse. It is largely an urban area, with population densities highest in the centre and to the immediate southwest and more open estates and suburbs further out. Lying directly to the east of Sheffield is Rotherham, from which it is separated by the M1 motorway. On its northern border lies Barnsley and to the south and west, lies the county of Derbyshire.

One-third of the local authority area lies within the Peak District National Park which imposes significant limitations on housing development and density across much of the west of the city as a result. This means Sheffield is 'over bounded' – the local authority boundary is larger than the city itself. Sheffield is therefore a relatively self-contained area with 73% of house moves taking place within the city boundary.

The local authority boundary is coterminous with NHS Sheffield Clinical Commissioning Group (SCCG) and the city is divided into 28 electoral wards³. The PNA uses both city-wide and ward based data when looking at the health needs and pharmaceutical provision of the population. The map in Figure 1 identifies the wards and locations of community pharmacies and dispensing doctors within Sheffield. Residential areas are shown as shaded grey. A comprehensive summary of wards, pharmacies, services and health needs is available at Appendix B to this document.

³ Ward boundaries were revised in 2016 and although there are still 28 wards covering broadly the same areas and populations as the PNA 2015, the actual residential geographies differ slightly. Some ward names have also changed.

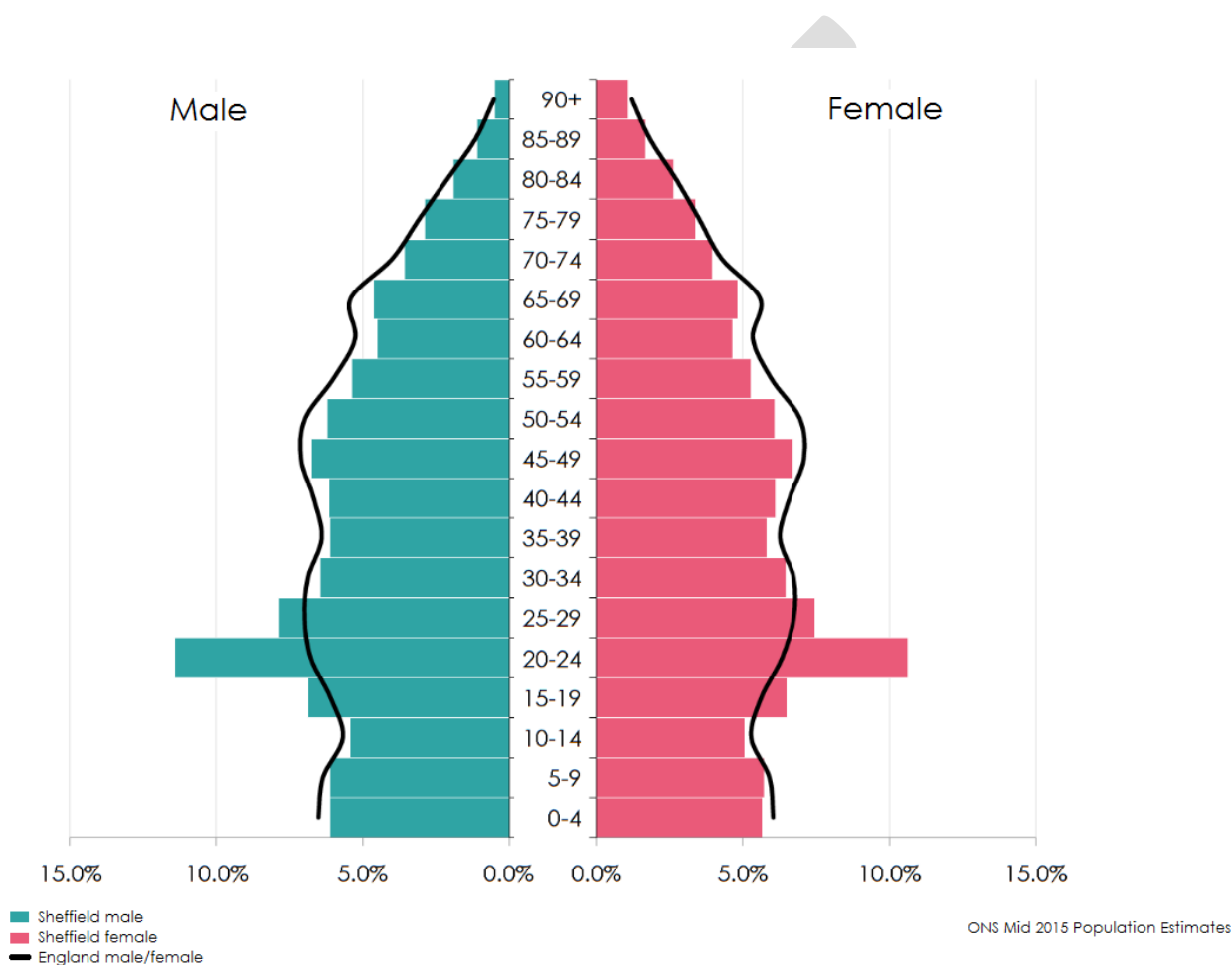
Figure 1: Map of pharmacies and wards in Sheffield (2017)



3.2 Population

The 2011 Census revealed that Sheffield had a population of 552,698 people. Latest estimates from the Office for National Statistics (ONS mid-year estimates 2015) put this at 569,737 representing an increase of 3.1%. This is projected to increase to 591,355 by 2021. Sheffield's growing population results from an increasing birth rate and higher net inward migration. The population pyramid in Figure 2 sets out the current profile of Sheffield's population.

Figure 2: Sheffield population by age group and gender (ONS 2015)



There were 6,582 births in 2015. This represents a very small increase over previous years and Sheffield's general fertility rate is consistently lower than the England average. There are approximately 5,000 deaths a year in Sheffield and this figure has remained relatively unchanged for the past 10 years. The proportion of people from black and minority ethnic communities has increased and is now estimated to be approximately 19% of the general population. Since the Census in 2011 there have also been changes in specific age groups, as the Table in Figure 3 shows.

Figure 3: Sheffield population change (2011 to 2015) by key age group

Age Group	2011	2015	% Change
0-4 years	33,977	33,527	-1.3%
5–11 years	42,113	46,372	10.1%
12-17 years	37,221	35,942	-3.4%
18-64 years	353,689	361,883	2.3%
65 years and over	85,698	92,013	7.4%
Total	552,698	569,737	3.1%

Source: ONS <https://www.ons.gov.uk/peoplepopulationandcommunity>

Population changes and characteristics vary across Sheffield's wards. For example, the City ward contains consistently fewer 0-17 year olds and people over 65. This is consistent with the type of accommodation available in the area, including significant student accommodation (mainly 18-24 year olds). In wards further out in the suburbs there is a more noticeable increase in family accommodation and hence a rise in the proportion of children and young people. In relation to older people, there is a greater proportion generally in the south west of the city which is partly linked to location of care homes whereas elsewhere in the city this is more strongly linked to location of care homes. Ethnic diversity also varies considerably from ward to ward with the proportion of the population from black and minority ethnic communities varying from 3.2% to 63.5%.

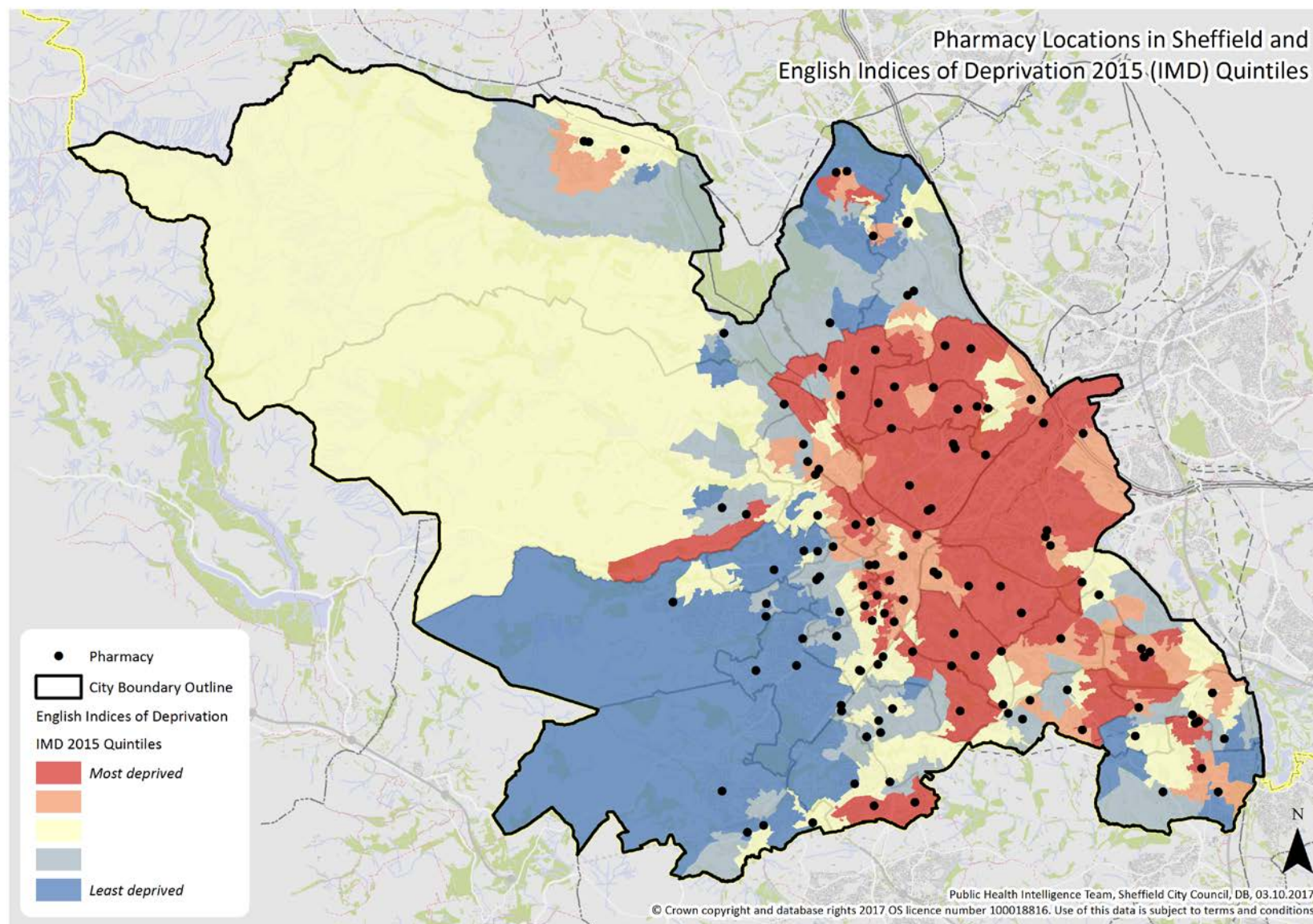
3.3 Deprivation and health inequalities

Sheffield continues to be 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 determinants. It is acknowledged that putting additional support into the most deprived and disadvantaged areas and raising standards there will have a beneficial effect on the whole community.

The Index of Multiple Deprivation (IMD) is used to measure inequalities in the wider determinants of health⁴. It is made up of seven indices of deprivation that are grouped together and weighted to produce the overall index (higher scores indicate greater level of deprivation). The seven indices cover: income; employment; health and disability; education, skills and training; barriers to housing and services; crime; and living environment. As the map in Figure 4 shows, although there are clear geographical inequalities in the wider determinants of health in Sheffield, there is a relatively even distribution of pharmacies.

⁴ <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

Figure 4: Map of index of multiple deprivation (IMD 2015) in Sheffield and pharmacy locations

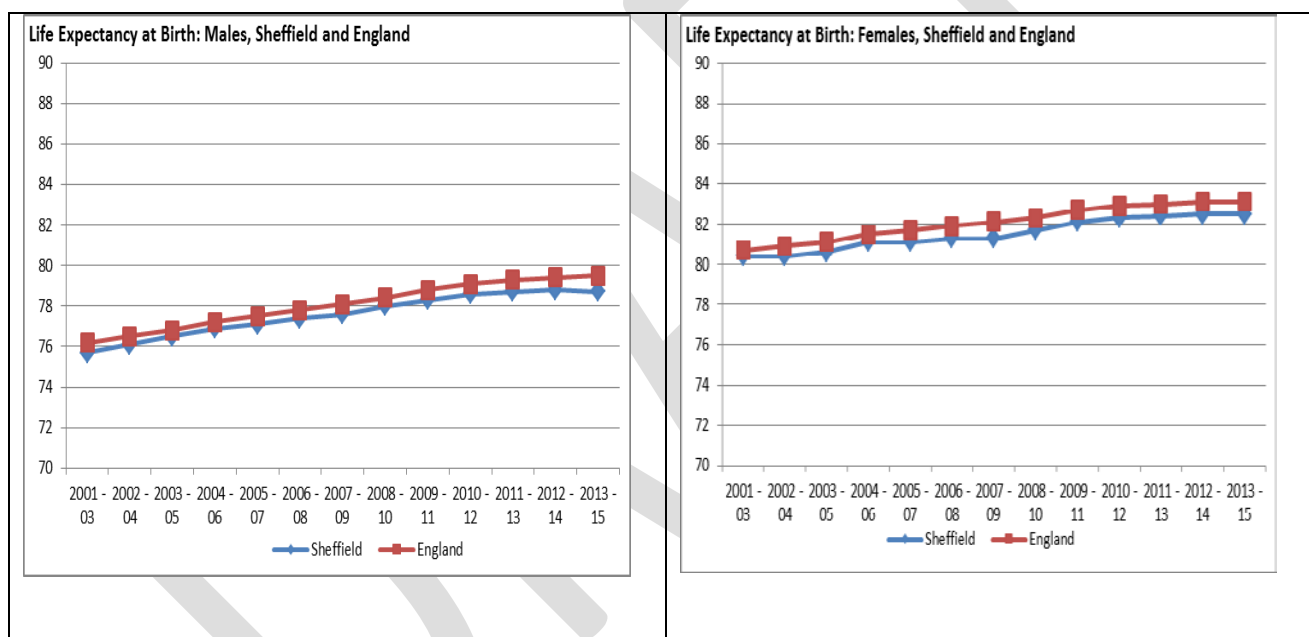


3.4 Life expectancy and healthy life expectancy

The latest figures for life expectancy and healthy life expectancy for both men and women in Sheffield suggest that previous improvements in health and wellbeing may be stalling and, in some cases, worsening. This is a cause for concern.

We have previously noted the very small improvements in women's life expectancy in Sheffield over the last 10 to 15 years and more recently this has ground to a halt. In the most recent period analysed however, we have seen men's life expectancy decrease from 78.8 years in 2012-2014 to 78.7 years in 2013-2015. The graphs in Figure 5 illustrate these trends. This picture is not unique to Sheffield and we are beginning to see similar changes across England as well as internationally. In the USA, for example, life expectancy for both men and women is now in reverse.

Figure 5: Trends in life expectancy (2001-03 to 2013-15) in Sheffield: males and females shown separately



Source: Public Health Outcomes Framework - <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>

A similar picture emerges when we look at how long we can expect to live in good health (healthy life expectancy). For both men and women in Sheffield, healthy life expectancy is declining, although the decline is steeper for women than it is for men. Women's healthy life expectancy decreased from 61.5 years in 2009-11 to 59.9 years in 2013-15 and men's healthy life expectancy decreased from 59.3 years to 59 years over the same period. Although Sheffield's experience is broadly reflective of the national position, it continues to be significantly worse for both indicators.

Inequalities in life expectancy and healthy life expectancy also show relatively little change with the gap in life expectancy between the most and least deprived men in Sheffield narrowing from 10.1 years to 9.9 years over the period 2001-03 to 2013-15 and widening for women from 7.6 years to 8.1 years. These factors are the main drivers of the growth in demand for health and social care services.

Summary

- The population of Sheffield is growing slowly and becoming more ethnically diverse
- The gender and age profile for Sheffield is typical of any major English city including the “bulge” in 18-24 year olds (linked to students)
- These population characteristics vary across Sheffield's 28 wards
- Sheffield experiences significant health inequalities as a result of deprivation but distribution of pharmacies across the city is relatively even
- The north and east of Sheffield stand out as being more deprived whilst the south and west are less deprived although there are small but distinct pockets of deprivation within less-deprived surroundings
- The gap between the most and least deprived areas in Sheffield remains relatively unchanged
- Key indicators of the health of a population (life expectancy and healthy life expectancy) show previous improvements may be stalling and in part, this is linked to the rise in multiple morbidity and broader socio-economic challenges, such as continuing austerity.

4 Health and Wellbeing in Sheffield

Detailed information on health and wellbeing needs in Sheffield is available from our Joint Strategic Needs Assessment (JSNA) online resource⁵. The resource includes ward and neighbourhood summaries of health and wellbeing as well as overviews of key health and wellbeing priorities and more comprehensive Health Needs Assessments.

4.1 Headline health indicators

As the data in Figure 6 show, overall Sheffield's health is similar to or worse than the national average although this varies significantly across its 28 wards.

Figure 6: Headline health indicators for Sheffield (2015)

Indicator	Sheffield	Worst Ward	Best Ward	England
Premature mortality from Cancer (2013-15) (Directly age standardised rate per 100,000 population under 75 year olds)	147.7	208.8	78.6	138.8
Premature mortality from Coronary Heart Disease (2013-15) (Directly age standardised rate per 100,000 population under 75 year olds)	44.8	81.9	17.4	40.6

⁵ <https://data.sheffield.gov.uk/stories/s/fs4w-cygv>

Percentage of adults who Smoke (2015) (Modelled data from national survey)	22.9%	30.5%	11.9%	16.9%
Percentage of 10-11 year olds Overweight and Obese (2015-16) (National Child Weighing and Measuring Programme)	34.3%	44.6%	13.3%	34.2%
Alcohol attributable mortality (2015-16) (Directly age standardised rate per 100,000 population over 35 year olds)	47.1	83.6	20.1	46.1
Teenage Pregnancy (2015) (Conception per 1000 11-17 year old girls)	23.6	62.11	5.89	20.8

Source: Public Health England Fingertips Tool <https://fingertips.phe.org.uk>

4.2 Health and wellbeing priorities

Based on the information from the JSNA, the following health and wellbeing issues are highlighted as being of particular relevance to the PNA and the role community pharmacies play in promoting health within their communities.

4.2.1 Cancer

Over 2,800 cases of cancer are diagnosed each year in Sheffield, which is broadly what we would expect for our population with 1 and 5 year survival rates generally similar to other large, urban areas. Approximately 1,360 people die from cancer every year making it the leading cause of death in the city. Despite a reduction over the last 10-20 years, Sheffield's premature mortality rate (i.e. deaths in people under the age of 75 years) from cancer remains significantly higher than the national average.

Over half of all premature deaths from cancer are considered preventable, which in Sheffield would equate to approximately 375 deaths a year. The main causes of cancer are smoking, poor diet, physical inactivity and alcohol consumption. A large number of premature cancer deaths could therefore be prevented by changes in lifestyle, as well as by earlier detection and treatment of the disease.

Current role of local pharmacies

- Promote awareness of the common signs and symptoms of cancer
- Living With and Beyond Cancer – supplying medicines to cancer patients for common chemo side effects
- Promote the benefits of and sign-posting to screening programmes for bowel, breast and cervical cancers.
- Provide access to palliative care medicines
- Promote and provide advice and support in relation to smoking cessation, alcohol consumption and maintaining a healthy weight (i.e. advice on taking regular exercise and following a healthy diet).

-
- Medicines optimisation⁶
 - Medication administration record service to home care providers
 - Seasonal influenza vaccination
 - Public Health campaign

4.2.2 Cardiovascular Disease

Cardiovascular disease (CVD) is a general term used to describe disorders that can affect the heart and/or the body's system of blood vessels (vascular). Many cardiovascular problems result in chronic conditions that develop or persist over a long period of time. However, it may also result in acute events such as a heart attack or stroke. The risk of CVD increases significantly after the age of 40 years. Around 75% of CVD deaths are from ischaemic heart disease, heart attacks and other heart disease and the remaining 25% are from stroke and other cerebrovascular diseases. It is the second leading cause of death in Sheffield.

CVD occurs more frequently in people who smoke; have high blood pressure; have high blood cholesterol; are overweight; do not exercise; and/or have diabetes. Public health initiatives focus on decreasing CVD by encouraging people to follow a healthy diet, avoid smoking, control their blood pressure, lower their blood cholesterol if necessary, exercise regularly and, if they are diabetic, maintain good control of blood glucose. There are estimated to be around 46,000 people with CVD in Sheffield.

Although the gap between Sheffield and the rest of England has narrowed over the years, the local cardiovascular premature mortality rate remains significantly higher than the national average. Over two thirds of premature mortality associated with cardiovascular disease is considered preventable. In Sheffield this equates to around 230 premature deaths per year.

The national 'Health Checks' programme aims to prevent heart disease, stroke, diabetes and kidney disease by inviting everyone aged between 40 and 74 years, who does not already have one of these diseases, to have their risk of developing such diseases assessed and to be referred on to appropriate services as required. The local programme is currently commissioned by Sheffield City Council from Primary Care Sheffield and delivered by GP practices although many other local authorities commission other providers to deliver this service, including pharmacies. Together with the range of actions we are taking to ensure timely prevention and early intervention in relation to chronic disease, we expect improvements in cardiovascular disease outcomes to be maintained.

Current role of local pharmacies

- Medicines optimisation
- Anti-coagulation monitoring
- Medication administration record service to home care providers
- Promote awareness of the common signs and symptoms of CVD
- Promote the benefits of and signposting to Health Checks
- Promote and provide advice and support in relation to alcohol consumption, stopping smoking and maintaining a healthy weight

⁶ General term for the various ways in which patients can be helped to gain the greatest possible benefit from their medicines.

-
- Seasonal influenza vaccination
 - Public Health campaign

4.2.3 Diabetes

Diabetes is a common life-long condition. When poorly controlled it can lead to a range of complications including blindness, heart attacks and strokes, kidney disease, amputation and depression as well as early death and reduced life expectancy. There are around 30,000 people with diagnosed diabetes in Sheffield with a further 6,000 estimated to have undiagnosed diabetes. Diabetes prevalence is expected to continue to rise for the foreseeable future. Lifestyle interventions (such as exercise combined with dietary advice) have been found to reduce the incidence of diabetes by almost 60% with earlier diagnosis and treatment reducing the risk of complications.

Despite increasing prevalence of diabetes, the care of people with the condition within primary care setting is better than the national average and improving. This means 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. The challenge for the City will be to at least maintain this favourable trend over the coming years in the context of economic and migration pressures, an ageing population and increasing obesity.

Current role of local pharmacies

- Medicines optimisation
- Medication administration record service to home care providers
- Promote and provide advice and support on maintaining healthy weight
- Seasonal influenza vaccination
- Public Health campaign

4.2.4 Dementia

There are currently around 5,000 people recorded by GP practices as living with dementia in the city today but this is expected to rise to over 7,000 by 2020, with the biggest increase in people aged 85 years and over. The 'true' prevalence of dementia is unknown but based on national research we estimate there could be an additional 1,400 people in Sheffield with undiagnosed dementia. It is also now the third leading cause of death in Sheffield, responsible for over 600 deaths a year.

A third of people with dementia currently live in private sector care homes, and the trend is towards entering care with more severe disease. Unpaid carers (mainly female family members) provide the majority of care in the community with support from home care services and other community based health and social care services. Early intervention can be cost effective and improve the quality of life for people with dementia and their families and carers, through enabling people to access suitable support services and in delaying or preventing premature and unnecessary admission to care homes.

Protecting and promoting brain health has been a relatively neglected concept until recently. The public health consensus is that what is good for the heart is good for the brain. In other words, effective public health policies to tackle the major chronic disease

risk factors of smoking, physical inactivity, alcohol and poor diet across the population will also contribute towards reducing the risk of dementia in later life.

Current role of local pharmacies

- Medicines optimisation
- Dementia friendly pharmacies⁷
- Promote and provide advice and support in relation to stopping smoking, reducing alcohol consumption and maintaining a healthy weight.
- Medication administration record service to home care providers
- Provide advice and support to carers
- Seasonal influenza vaccination
- Public Health campaign

4.2.5 Respiratory Disease

Respiratory disease is a general term used to cover a range of lung conditions including asthma and chronic obstructive pulmonary disease (COPD). Respiratory disease is the fourth leading cause of death in Sheffield and COPD the main cause of respiratory mortality. There are over 550 respiratory deaths a year in Sheffield.

COPD is a progressive yet largely preventable disease, with around 85% of cases being caused by smoking. There are over 10,000 people in Sheffield with diagnosed COPD and probably the same number again with undiagnosed COPD. Asthma is a more common condition; an estimated 35,600 people (all ages) in Sheffield have it. In Sheffield, it is estimated that 70 respiratory deaths in people under the age of 75 years could be avoided each year. The single most important contribution to reducing respiratory disease and death is the Sheffield Tobacco Control Programme designed to reduce the prevalence of smoking in the population.

Current role of local pharmacies

- Promote and provide advice and support in relation to smoking cessation, including Nicotine Replacement Therapy (NRT) and Varenicline (Champix)
- Medicines optimisation
- Medication administration record service to home care providers
- Seasonal influenza vaccination
- Public Health campaign

4.2.6 Liver Disease

Liver disease is the only major cause of premature death in Sheffield for which the rate is not reducing although it is better than the national average. People are also dying from it at younger ages. Premature mortality from liver disease in Sheffield accounts for over 70 deaths in people under the age of 75 years per year. It develops silently, often without symptoms, and many people have no idea they have a problem until it is too late.

⁷ Currently communities (and organisations within those communities) can register to be publicly recognised for their work towards becoming dementia-friendly. It shows that they are following common criteria, based on what we know is important to people affected by dementia and that will truly change their experience. More information is available from the Alzheimer's Society www.alzheimers.org.uk

Over 90% of deaths from the disease are considered preventable. The common causes of liver disease are alcohol consumption, obesity and Hepatitis. Alcohol and obesity are considered in more detail later in this chapter.

Hepatitis is inflammation of the liver resulting from infection or exposure to harmful substances (such as alcohol). The types of Hepatitis most closely linked with liver damage and liver failure, are Hepatitis B and Hepatitis C. Hepatitis B is uncommon in England, being more widespread in East Asia and sub-Saharan Africa in particular. A small minority of people develop a long-term infection from the virus, known as Chronic Hepatitis B. In some people, Chronic Hepatitis B can cause cirrhosis of the liver and liver cancer. Hepatitis C is the most common type of viral hepatitis found in the UK and is commonly spread through sharing needles to inject drugs. Around 1 in 4 people will fight off the infection and remain free of it. Of the remaining 3 out of 4, the infection can become chronic where it can also cause cirrhosis and liver cancer.

Current role of local pharmacies

- Promote and provide advice and support in relation to alcohol consumption and on maintaining a healthy weight
- Promote the benefits of and signposting to testing for Hepatitis B/C
- Provide advice on and improve awareness of the transmission of Hepatitis B/C, including ways to reduce infection risk
- Medicines optimisation
- Medication administration record service to home care providers
- Seasonal influenza vaccination
- Public Health campaign

4.2.7 Mental Health

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, 16.1% of Sheffield adults (16-74 year olds) are estimated to have depression, slightly higher than the national average of 15.6%. This is equivalent to approximately 66,500 people.

In terms of children and young people, 9.6% of 5 to 16 year olds in Sheffield are estimated to have a mental health disorder (emotional, conduct, hyperkinetic and autistic spectrum disorders). This equates to around 7,300 children and young people. There are approximately 5,300 adults with a severe mental illness recorded on a GP practice register in Sheffield. This is consistent with what we would expect to see for a population the size and structure of Sheffield.

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.

Current role of local pharmacies

- Medicines optimisation
- Sign-posting to treatment
- Priority face to face stop smoking service
- Mental Health First Aid
- Public Health campaign

4.2.8 Learning Disabilities

Pharmacy teams see many people with learning disabilities although they will not always be identified as such. It is estimated that there could be as many as 12,000 people in Sheffield with some form of learning disability. Formal records identify around 3,600 so it is reasonable to assume that many people with learning disability remain unrecognised.

The health and wellbeing of people with learning disabilities, as with the wider population, is influenced by a range of social, economic and environmental factors however, owing to social, cultural and service inequalities and discrimination they are at greater risk of poorer health and wellbeing outcomes than their non-disabled counterparts.

The key contribution that community pharmacy can make to improving health and wellbeing and reducing health inequalities of people with learning disabilities (above and beyond Equality Act 2010 requirements⁸) is in communicating effectively and appropriately.

Most people with learning disabilities simply require advice and support on dealing with common health problems and promoting general health; some will take a variety of prescribed medicines which may require additional support and review (for example in relation to diabetes, thyroid problems or sleeping disorders). A small proportion of people with learning disabilities will require more complex and significant support. This may include, for example, working in close collaboration with GP practices to stop over medicalisation of people with learning disability, autism or both (STOMP⁹).

In other words, the key pharmacy skills of listening, explaining, advising, questioning and collaborating are highly relevant to meeting the health and wellbeing needs of people with learning disabilities and as such, community pharmacy has much to offer in this regard.

Current role of local pharmacies

- Ensure equity of access to the full range of pharmacy services available including stop smoking support, seasonal influenza vaccination and advice on maintaining a healthy weight
- “Making Time” for people with learning disabilities, their families or their supporters¹⁰

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<https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities/reasonable-adjustments-a-legal-duty>

⁹ <https://www.england.nhs.uk/wp-content/uploads/2017/07/stomp-gp-prescribing-v17.pdf>

¹⁰ <https://easyontheei.worldsecuringsystems.com/get-checked-out-making-time-pharmacy>

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- Support and advice for carers, family members or supporters
 - Working with GP practices to stop over medicalisation of people with learning disabilities, autism or both.

4.2.9 Smoking

Latest estimates (2016) indicate that 16% (reduced from 22.9% in 2015) of Sheffield adults smoke compared with 15.5% nationally. Although the proportion of smokers in Sheffield is reducing, it remains the largest, modifiable cause of ill health and premature death, and inequalities in health in Sheffield and nationally. Moreover, smoking in pregnancy reduces birth weight, and contributes significantly to stillbirth and infant mortality. Reducing the prevalence of smoking within the population must continue to be a top public health priority for the city and the aim is to see this reduce to below 10% over the next 5 years with a particular emphasis on groups of the population where prevalence is highest (e.g. people with severe and enduring mental illness).

Strengthening our Tobacco Control Programme will be the key means by which we will achieve this. The Programme includes protecting people from exposure to second hand smoke, reducing the availability and supply of illegal tobacco products and commissioning help for those who want to quit. The stop smoking service commissioned in Sheffield comprises: brief advice; universal service (group therapy and self-funded NRT); and the priority service which provides face to face support and funded medication for groups of the population with highest prevalence of smoking including routine and manual workers, black and minority ethnic groups, people with mental health problems, homeless people, offenders and ex-offenders, people with learning disabilities and people from deprived communities.

Community pharmacies play a long established role in provision of face to face stop smoking advice and the full range of evidence based quit support to the local population.

Current role of local pharmacies

- Face to face Stop Smoking Service
- Nicotine Replacement Therapy Voucher Scheme
- Varenicline (Champix) via Patient Group Direction
- Patient Group Direction for Bupropion (Zyban) anticipated in 2018
- Advice and promotion of healthy lifestyles
- Sign posting to other services as required and appropriate
- Public Health campaign

4.2.10 Alcohol

Alcohol is linked to over sixty different medical conditions including liver disease, mouth, throat and other cancers, neurological conditions (including dementia), poor mental health, reduction in fertility, as well as acute conditions resulting from accidents, self-harm and violent assault. There are an estimated 51,000 'high risk' drinkers in Sheffield and around 6,500 people are admitted to hospital each year due to alcohol-attributable conditions.

Our local alcohol strategy continues to focus on a range of approaches for tackling this issue, notably promoting screening and identification of people with alcohol related

problems including those from specific population groups (such as 18-25 year olds) to increase the number of individuals engaging with alcohol treatment alongside reducing the accessibility of alcohol, in line with government guidelines.

Current role of local pharmacies

- Provide brief interventions and signposting to treatment to address alcohol misuse
- Support greater integration of alcohol screening with sexual health services
- Public health campaign

4.2.11 Drug Misuse

Drug misusers often suffer from multiple vulnerabilities including poor physical and mental health, offending behaviour, homelessness or inadequate housing, lack of education and unemployment. In the past drug misusers were at high risk of death from an overdose. The number of drug related deaths per year is relatively small in Sheffield (less than 20 a year) although we have seen higher than average numbers over the last few years.

We have also seen an increase in people dying of long term injecting drug use related conditions such as Hepatitis C or venous disease. We continue to provide a full range of harm reduction interventions to prevent blood borne viruses in drug misusers and to minimise the impact of IV drug use, including pharmacy based needle exchanges. We achieve 100% coverage of the treatment population for testing for Hep C and HIV and all eligible problem drug users are offered Hep B vaccinations.

The latest data show there are around 4,270 people in Sheffield with problematic opiate and/or crack drug use. Approximately half of these are in specialist treatment. The majority are male and aged between 20-60 years. Emphasis is placed on attracting and retaining people into treatment alongside a focus on recovery. Increasingly the treatment population includes individuals using non-opiate drugs (cocaine, cannabis, steroids and new psychoactive substances).

Further information about the commissioning plans of the Drug and Alcohol Commissioning Team (DACT) and health needs in relation to substance misuse (drugs and alcohol) can be obtained from the Sheffield [DACT website](#). The pharmacy role in providing support and treatment for drug users is well established in Sheffield and continues to represent a core element of service provision in the city.

Current role of local pharmacies

- Needle exchange scheme
- Supervised administration of methadone and buprenorphine including provision during out of hours periods
- Promote the benefits of and signposting to testing for Hepatitis B/C
- Provide advice on and improve awareness of the transmission of Hepatitis B/C, including ways to reduce infection risk and referral to treatment services
- Medicines optimisation

4.2.12 Obesity

Obesity, poor diet and sedentary behaviour are associated with higher risk of hypertension, heart disease, diabetes and certain cancers. It is estimated that obesity

costs Sheffield £165 million per year.

In relation to childhood obesity, in 2015/16, 22.3% of 4-5 year olds and 34.3% of 10-11 year olds were classed as overweight or obese. This represents a worsening trend and Sheffield's figures are now similar to the national average. Prevalence almost doubles in adults with 64.7% estimated to be overweight or obese although as with children and young people, this is similar to the national average. This amount of excess weight in the population is a cause for concern given that it poses a major risk to future health and wellbeing.

Obesity is typically caused by an unhealthy diet and sedentary behaviour. Sheffield has poor levels of diet and physical activity. Fewer than half of local people eat the recommended five portions of fruit and vegetables a day by the time they reach 15 years of age and almost one in four are physically inactive. However, we must recognise that this is not about the "lifestyle choices" individuals make but the ways in which an unhealthy environment influences people's choices adversely.

Current role of local pharmacies

- Promote and provide advice and support in relation to maintaining a healthy weight
- Public health campaign

4.2.13 Sexual Health

The consequences of poor sexual health include unplanned pregnancy, avoidable illness and mortality from sexually transmitted infections (STIs) and HIV/AIDS. Overall the two main priorities for Sheffield relate to sexually transmitted infections and teenage pregnancy.

Approximately 4,350 acute STIs are diagnosed in Sheffield residents per year, of which 70% are in 15-24 year olds. The burden of sexual ill health is not equally distributed in the population and is concentrated amongst the most vulnerable including men who have sex with men, young people and people from BME communities.

The City has seen a substantial and sustained reduction in the rate of teenage conceptions from 52.8 per 1000 15-17 year old girls in 2001 to 23.6 in 2015. Although Sheffield's rate is still higher than the national average of 20.8 per 1000 this level of sustained reduction is significant. There is a well-established emergency hormonal contraceptive service for teenagers (girls aged 14-17 years) commissioned by Sheffield City Council from community pharmacy, including signposting for long-acting reversible contraception and condom provision.

Current role of local pharmacies

- Emergency hormonal contraception
- Advice on and signposting to Long Acting Reversible Contraception (LARC)
- Chlamydia screening
- Condom distribution
- Referral to relevant treatment and advice services
- Support integration with alcohol screening
- Promote and provide advice and support in relation to stopping smoking, reducing alcohol consumption and maintaining a healthy weight during pregnancy

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- Provide advice for young people – e.g. sexual health, mental health, smoking, alcohol consumption and drug misuse
 - Seasonal influenza vaccination (pregnant women)
 - Public Health campaign

4.2.14 Multiple morbidity

The practice of medicine is highly specialised with specific conditions too often treated individually and usually in isolation from each other as well as from the lived context of the person with the condition. The reality however is that we are seeing more and more people with two or more long term conditions at a time – known as multi morbidity. It is this expansion of multi morbidity, both in terms of overall numbers and at earlier ages, that is not only impacting adversely on healthy life expectancy in Sheffield but is also the key factor driving the increase in demand for health and social care services.

GP records show that almost 40% of the Sheffield population (all ages) has at least one long term condition and all the indications suggest this percentage is unlikely to decrease soon. In 2017, 94,110 people in Sheffield had been diagnosed with *two* or more long term conditions with the most common conditions being hypertension, depression and diabetes. In terms of age distribution, multi morbidity is more common in people under the age of 70 than over. If the ageing population was the key driver for increasing demand for health and care services, we would expect to see this reflected in increases in hospital admissions. But when we look at national hospital admission data for 1994-1995, 2004-2005 and 2014-2015, for example, the proportions of increase that can be attributed to ageing factors in those time periods are 0.33%; 0.63%; and 0.80% respectively. Demand for health and social care in England is currently increasing by about 4% per year, far faster than the ageing population. It is multi morbidity that is driving the increase.

The key response is to focus on prevention and whole person management of multi morbidity in primary and community settings. Our aim should be to shift the whole multi morbidity curve downwards such that instead of developing your first long term condition in your fifties you develop it in your sixties. Evidence suggests there are significant health and economic gains to be made from this approach. Community pharmacy has a significant role to play, not least as a result of the range of services it provides but also in terms of the interaction with patients, location within the community and increasing linkage and integration with GP practices.

Current role of local pharmacies

- Help to tackle the main reasons why people become ill or unwell (prevention)
- Support person centred care – help people to take greater responsibility for their own health and wellbeing by providing professional and accessible advice
- Enhance primary care, community based services and community health interventions that help people to remain independent and stay at or close to home
- Provide a high quality and value for money service
- Help patients to get the very best out of their medication (medicines optimisation)

5 Pharmaceutical Services and Need

5.1 The changing face of pharmacy

It is important to note the ways in which pharmacy and its role within the community has changed since the last PNA was produced and how this may develop over the next three years.

The Community Pharmacy Forward View (2016)¹¹ sets out the sector's ambitions to radically enhance and expand the personalised care, support and wellbeing services that community pharmacies provide. The report outlines how pharmacy teams could be fully integrated with other local health and care services in order to improve quality and access for patients, increase NHS efficiency and produce better health outcomes for all. In particular it focuses on the following three key roles for the community pharmacy of the future:

- As the facilitator of personalised care for people with long-term conditions
- As the trusted, convenient first port of call for episodic healthcare advice and treatment
- As the neighbourhood health and wellbeing hub

NHS Sheffield CCG has endorsed this context and promoted it as “Pharmacy First” – advising patients that they can receive treatment and advice for common illnesses and minor ailments¹² This approach which encourages patients to turn to pharmacy as the first port of call is increasingly being promoted by the NHS and by stakeholders such as Healthwatch Sheffield¹³

5.2 Pharmaceutical Provision in Sheffield

5.2.1 Types and locations

There are 128 pharmacy contractors in Sheffield. This includes 3 distance selling pharmacies. In addition, there are 15 pharmacies within 1.6 km of the Sheffield boundary that provide services to Sheffield residents (6 in Derbyshire and 9 in Rotherham). Sheffield also has two dispensing doctors based in Deepcar and Oughtibridge, both of which are in the Stocksbridge and Upper Don Ward. The map in Figure 7 illustrates this provision.

The two dispensing practices operate within a ‘Controlled Locality’. NHS legislation provides that in certain rural areas classified as controlled localities, general practitioners (GPs) may apply to dispense NHS prescriptions. Permission is granted to GPs providing

¹¹ <https://psnc.org.uk/our-news/community-pharmacy-shares-its-forward-view-a-vision-for-the-future/>

¹² <http://www.sheffieldccg.nhs.uk/Your-Health/pharmacy-first.htm>

¹³ <http://www.healthwatchsheffield.co.uk/news/think-pharmacy-first/>

there is no "prejudice" to the existing medical or pharmaceutical services. The controlled locality in Sheffield was determined in the 1980s to cover the largely rural area in the north west of the City. Patients who live in a controlled locality are entitled to have their prescriptions dispensed by the dispensing practice at which they are registered.

There are three NHS foundation trusts in the city: Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) which includes A&E, community nursing and intermediate care services and acute hospital provision; Sheffield Children's NHS Foundation Trust (SCFT) which includes A&E, acute hospital care, health visiting, school nursing and specialist mental health and learning difficulties services for children and young people; and Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) which provides specialist services for adults with mental health and/or learning disabilities. Other hospital providers include the independent sector Claremont and Thornbury hospitals and the St Luke's Hospice. All three are based in the south west of the city. These are shown together with details of the 82 GP practices in the map in Figure 8.

In addition, the NHS Sheffield Clinical Commissioning Group (SCCG) employs a clinically focused, multidisciplinary Medicines Management Team to improve the care of patients and the outcomes they achieve via the use of safe, clinically effective and cost efficient medicines.

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Figure 7: Map of pharmacies and locations in and around Sheffield (2017)

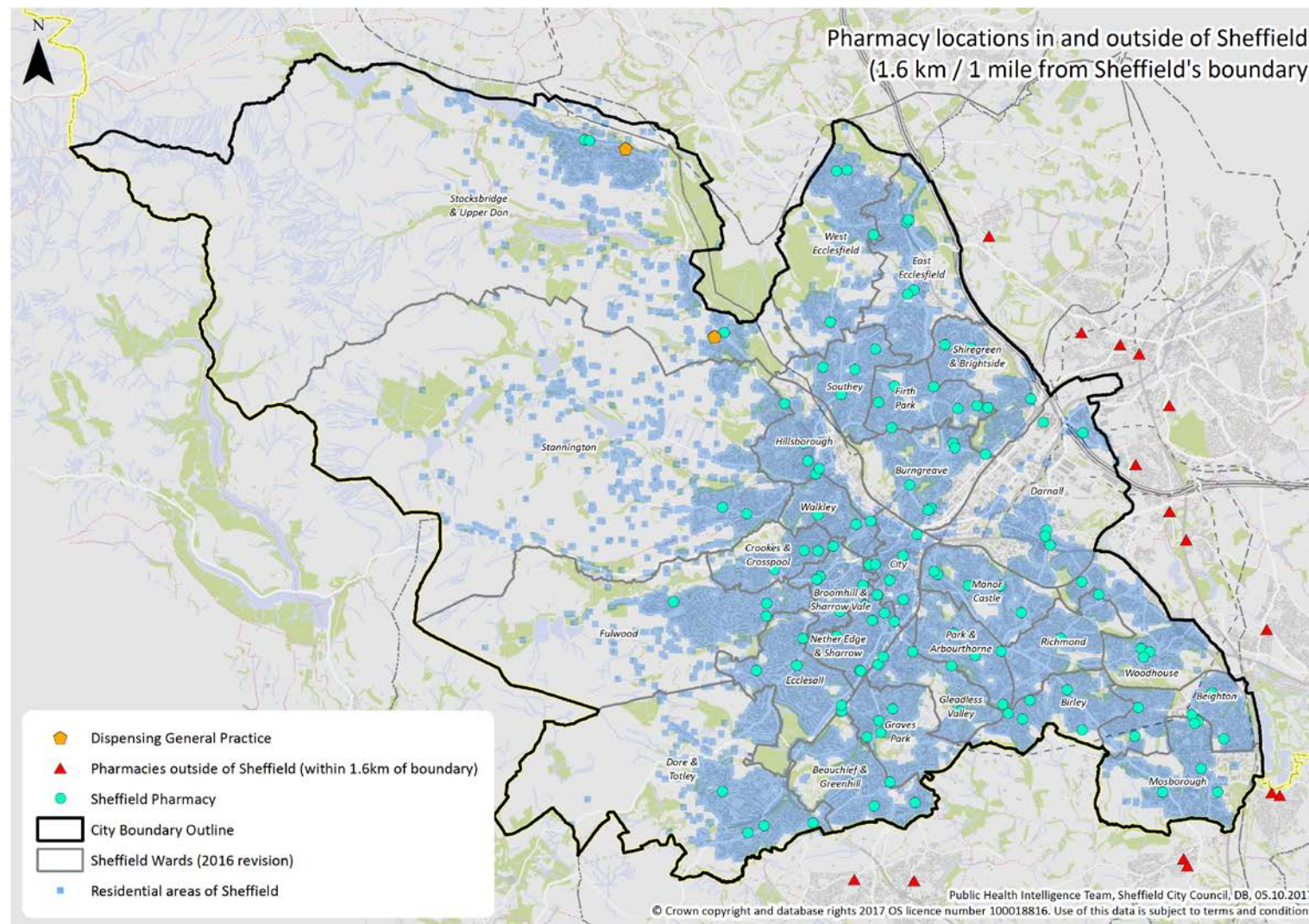
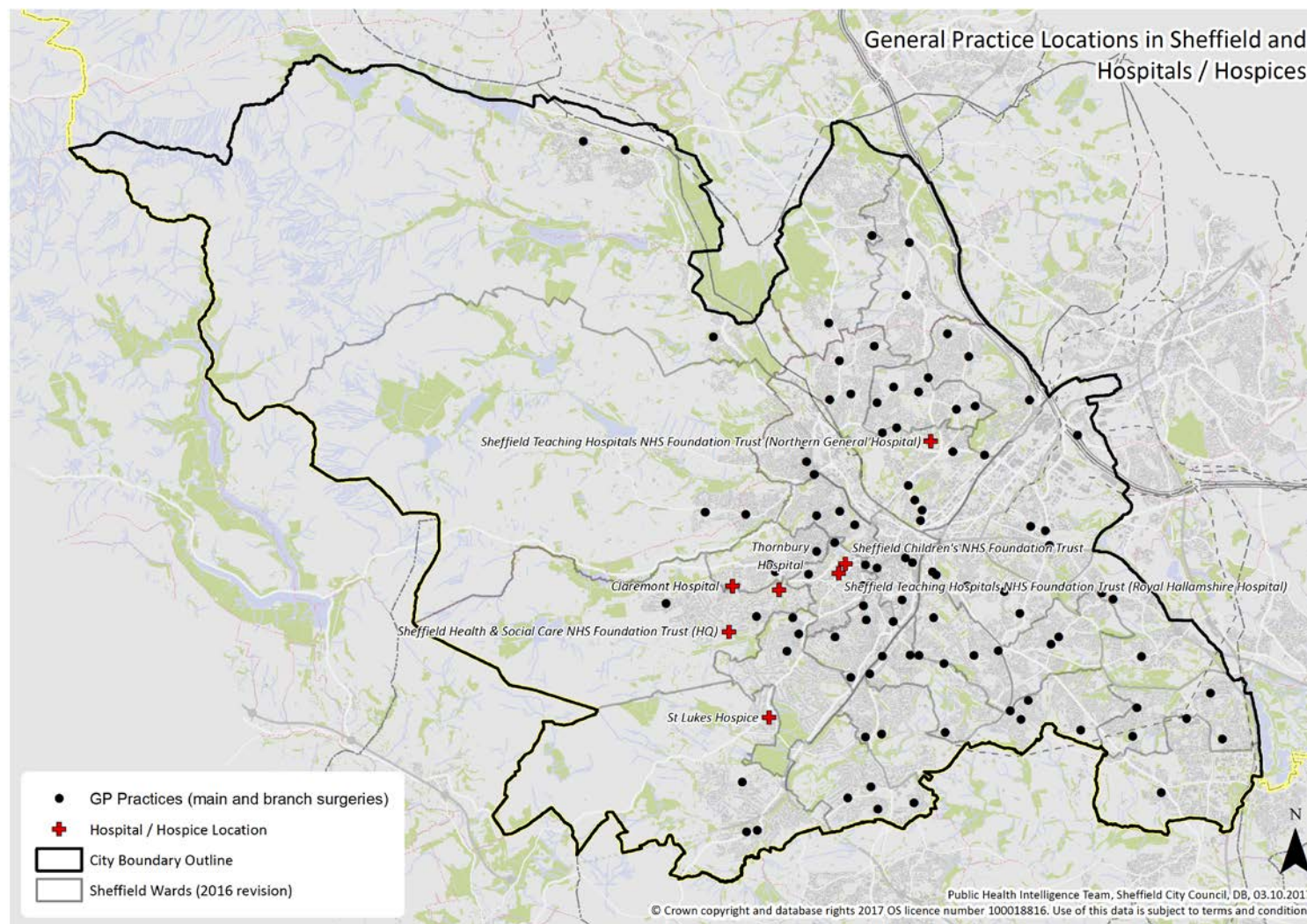


Figure 8: Map of hospital and GP practice providers in Sheffield (2017)

5.2.2 Access

The table in Figure 9 sets out details of the proportion of the resident population that lives within different distances and walking times of a community pharmacy. Overall 98% of the population lives within 1.6km of a pharmacy. This represents a good level of access.

Figure 9: Population distance and time from a community pharmacy (2017)

Distance/time	Number of residents	Percentage of residents
100 metres	103,570	18%
400 metres	266,142	47%
800 metres	451,965	79%
1200 metres	532,142	93%
1600 metres	556,258	98%
3 minutes' walk	160,943	28%
6 minutes' walk	298,287	52%
9 minutes' walk	410,997	72%
12 minutes' walk	485,130	85%
15 minutes' walk	527,801	93%

Source: SHAPE Atlas <https://shapeatlas.net/place/> (Accessed 04/10/2017)

There are no GP practices more than 500 metres from a pharmacy. There is at least one pharmacy located in each of Sheffield's 28 electoral wards. On average, 4,558 people in Sheffield are served per pharmacy - better than the average for England (4,687 per pharmacy)¹⁴.

The Electronic Prescription Service (EPS) allows prescribers, such as GPs and practice nurses, to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. Key benefits for patients include timely provision of medication, improved stock control and improved accuracy as well as being a reliable, safe, convenient and confidential service. All pharmacies in Sheffield provide the EPS.

The NHS Community Pharmacy Contractual Framework also requires pharmacies to have monitoring arrangements in place in respect of compliance with the Equality Act (2010) in terms of facilities and patient assessments. All pharmacies in Sheffield either have wheelchair access or another mechanism for enabling access. Access arrangements are assessed by NHS England as part of its contract monitoring visits.

5.2.3 Opening times (Monday to Friday, Saturday and Sunday)

Most of Sheffield's pharmacies open between 8.30am-9.00am Monday to Friday with some opening much earlier (for example, between 7.00am-8.00am). The majority of pharmacies close between 5.00pm and 6.00pm. The majority of pharmacies are also open

¹⁴ General Pharmaceutical Services in England 2006/07 – 2015/16
<https://digital.nhs.uk/catalogue/PUB22317>

on a Saturday (71) although many close by 1.00pm and 28 are open on a Sunday. The charts in Figure 10 illustrate this provision.

5.2.4 Out of Hours (bank holidays and evenings)

NHS Sheffield CCG is currently conducting a review of urgent care provision within the City. Consultation on the review runs until January 2018 and subsequent arrangements for urgent care provision will reflect the outcomes of this process.

In relation to pharmacy provision, the principal provider of extended opening hours for Sheffield is the Wicker Pharmacy based in the city centre. Over and above standard opening times, the Wicker Pharmacy provides the following extended opening times:

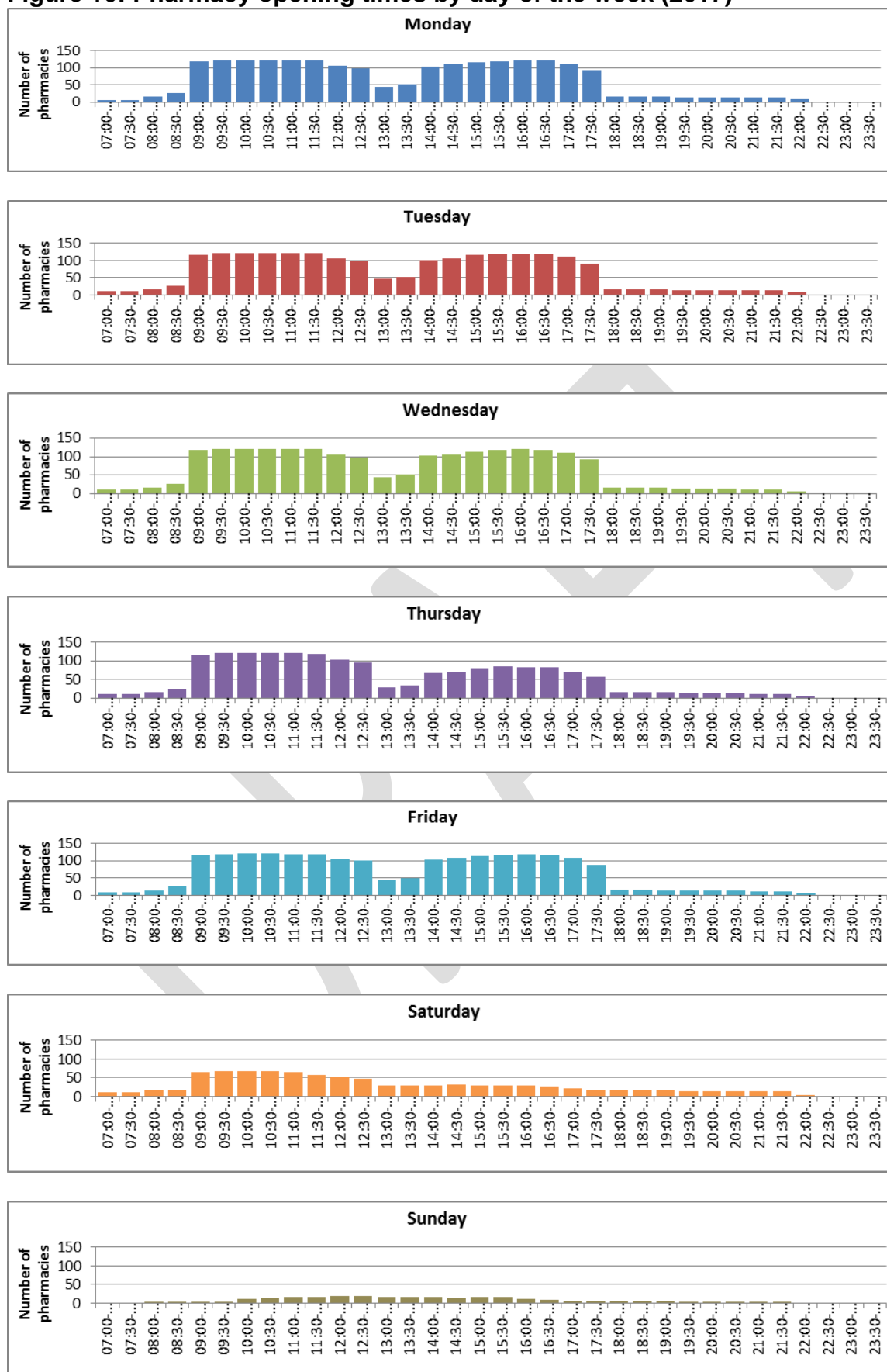
- 17:30 to 22:00 Monday to Friday, Saturdays
- 10:00 to 20:00 Sundays and Bank Holidays/Public Holidays
- 13:00 to 17:00 Christmas Day

Some crucial dispensing services are frequently accessed during the out of hours period (e.g. in relation to substance misuse) and this level of cover provides assurance that the needs of these patients can be met effectively. The current contracting arrangements deliver this assurance.

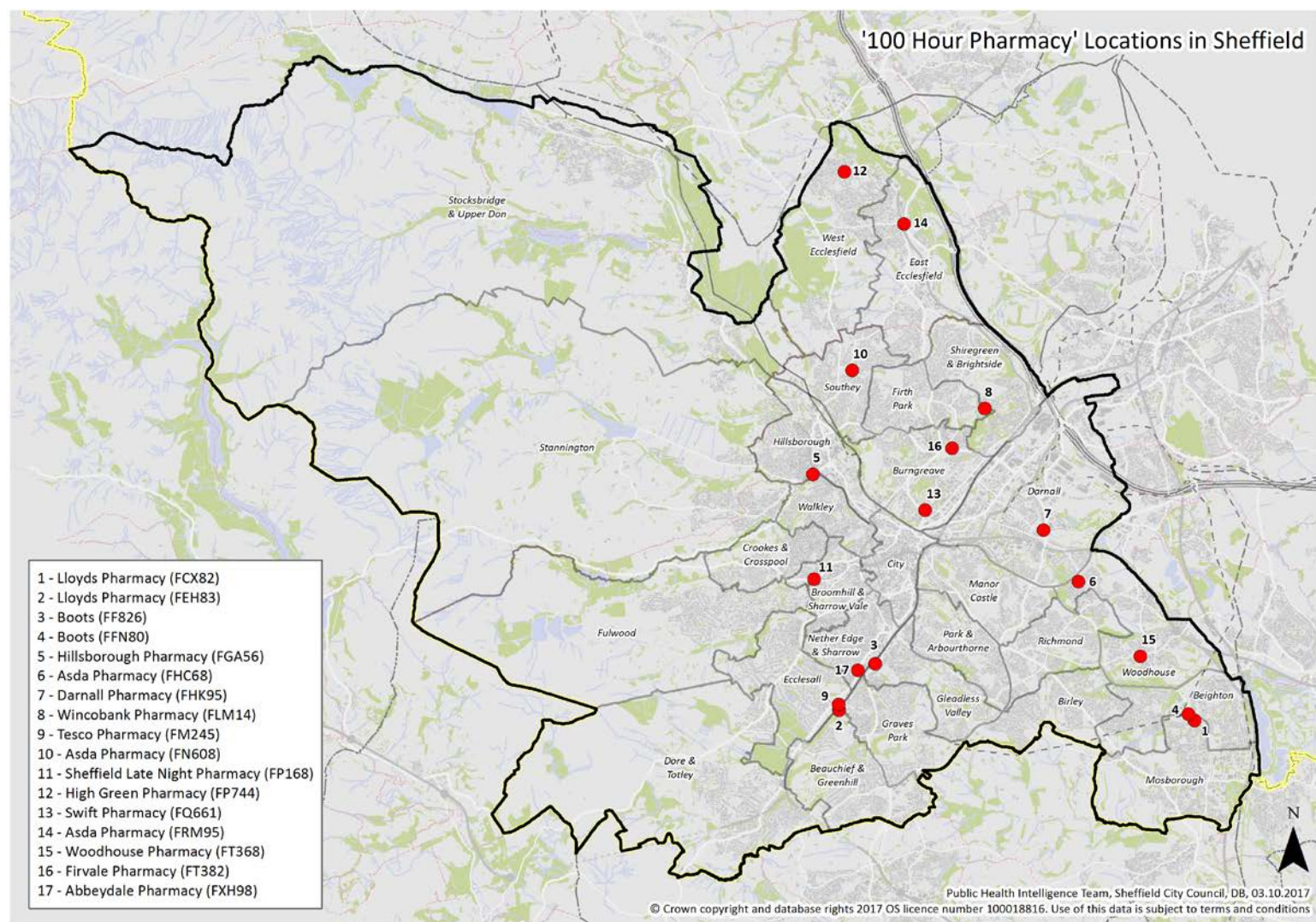
In addition, the Lloyds Pharmacy in Stocksbridge provides extended opening hours of 11.00 to 15.00 for Bank Holidays and Public Holidays except Christmas Day. There are also seventeen 100-hour pharmacies in Sheffield who generally open around 7.00am and close between 10.00pm and Midnight. These pharmacies add considerably to the out of hours pharmaceutical provision within the city. Many of these pharmacies are located within supermarkets or retail areas. The map in Figure 11 shows the locations.

Members of the public may also obtain urgent prescriptions and/or medication when their GP is closed by contacting the NHS 111 Service. This service is able to direct patients to a pharmacy operating the NHS Urgent Medicine Supply Advanced Service (NUMSAS). This national pilot scheme was introduced to run up to March 2018 although it has recently been extended for a further 6 months. Medicines legislation also allows pharmacists to issue urgent supplies to patients under certain circumstances. Healthcare professionals have urgent access to medications (e.g. urgent controlled drugs) outside normal opening hours (i.e. overnight, weekends and public holidays) through the GP Collaborative. The service has access to an on-call pharmacist provided by the Sheffield Teaching Hospitals NHS Foundation Trust and on average this is used approximately 2-3 times a month.

Community pharmacy's traditional role in supporting people to self-care for minor illnesses is an important way in which to manage demand for other NHS services, especially general practices, visits to A&E, and supporting people using the NHS 111 service. This role is being promoted via the "Pharmacy First" approach and includes for example the commissioning of the Minor Ailments Service. This service allows pharmacies to provide care to those who might otherwise visit the GP or A&E; providing a network of pharmacies across Sheffield and which effectively act as healthcare walk-in centres where people live, work and shop. All community pharmacies in Sheffield provide the minor ailments service.

Figure 10: Pharmacy opening times by day of the week (2017)

Source: NHS England – South Yorkshire and Bassetlaw (September 2017)

Figure 11: Map of 100-hour pharmacies in Sheffield (2017)

5.3 Pharmaceutical services in Sheffield

The Community Pharmacy Contractual Framework is made up of the following service types.

5.3.1 Essential services

These services are set out in schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. All pharmacy contractors in Sheffield provide the full range of essential services which are:

- Dispensing medicines and actions associated with dispensing
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted medicines
- Public Health (promotion of healthy lifestyles)
- Signposting
- Support for self-care
- Clinical governance

5.3.2 Advanced services

Any contractor may choose to provide Advanced Services. In so doing there are requirements which need to be met in relation to the pharmacist, standard of premises or notification to NHS England. The majority of Sheffield's pharmacies provide a Medicines Use Reviews service (MURs) (115)¹⁵ and a New Medicines Service (NMS) (100)¹⁶. There are also 6 pharmacies providing an Appliances Use Review service (AURs)¹⁷. In relation to seasonal influenza vaccination, 110 pharmacies provide this service in Sheffield. Pharmacies also provide the NHS Urgent Medicine Supply Scheme (NUMSAS).

5.3.3 Enhanced and locally commissioned services

Only those contractors directly commissioned by NHS England can provide enhanced services. In view of the change in the commissioner landscape however, pharmacy contractors may now also provide services commissioned by local authorities and Clinical Commissioning Groups (CCGs). Although these locally commissioned services are not enhanced services, they mirror the services that

¹⁵ MURs involve pharmacists undertaking structured reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions. The process is designed to establish a picture of the patient's use of their medicines, understand their therapy and identify any problems they may be experiencing and potential solutions.

¹⁶ The NMS provides support for people with long term conditions newly prescribed a medicine, to help them improve adherence and thus lead to better health outcomes.

¹⁷ An Appliance Use Review (AUR) is carried out by a pharmacist or specialist nurse either in the pharmacy or the patient's home and is intended to improve the patient's knowledge and use of any specified appliance (e.g. specialist bandage or wound dressing).

could be (and in other parts of the Country often are) commissioned by NHS England and are therefore included within the list of pharmaceutical services in order to provide a full picture of current provision in the City. For Sheffield, these services are listed in the table in Figure 12.

Figure 12: Enhanced and locally commissioned services by commissioning organisation and number of pharmacies providing the service in Sheffield (September 2017)

Service	Commissioner	Number of pharmacies
Minor ailments scheme	NHS Sheffield CCG	125
Not dispensed scheme (reducing waste)	NHS Sheffield CCG	116
Assured availability of palliative care drugs	NHS Sheffield CCG	17
Needle and syringe exchange	Sheffield City Council	18
Stop smoking service	Sheffield City Council	11
Nicotine Replacement Therapy (NRT)	Sheffield City Council	85
Champix dispensing	Sheffield City Council	71
Supervised administration of methadone and buprenorphine	Sheffield City Council	101
Emergency hormonal contraception	Sheffield City Council	64
Condom Distribution	Sheffield City Council	18
Chlamydia Screening	Sheffield City Council	9
Medication Administration Record Service to home care providers	Sheffield City Council	113

Source: Sheffield City Council and NHS Sheffield CCG

In addition the following services are commissioned from a small number of pharmacies:

- Anticoagulation (3 pharmacies)
- Community script switch (1 pharmacy)
- Sub cutaneous fluid service (1 pharmacy)

The full detail of pharmacy provision by ward is set out in the spreadsheet in Appendix B to this document.

5.3.4 Patient satisfaction

The NHS Choices website¹⁸ provides patients with the opportunity to comment on and rate most NHS services, including pharmacies. As at 3rd October 2017 there were 51 Sheffield pharmacies for which a rating had been submitted to the NHS Choices website. Three quarters of these were highly positive and related to staff

¹⁸ <http://www.nhs.uk/pages/home.aspx>

attitude, knowledge, trust and overall high quality of customer service. The remaining 25% referred to problems with repeat prescriptions including medicines not being in stock, delays in obtaining a prescription and inaccuracies in items dispensed.

Healthwatch Sheffield¹⁹ also provides an online feedback facility for members of the public to rate and comment upon local health and social care services, including pharmacies. As at 3rd October 2017, there were 22 Sheffield pharmacies which had been rated in this way of which 15 duplicated the NHS Choices website. In terms of the remaining 7 pharmacies, 5 were positively rated citing staff as the main reason for this. For the other 2 pharmacies, problems related to delays in obtaining medication and problems with repeat prescriptions.

Finally, the Quality Payments Scheme (part of the Community Pharmacy Contractual Framework) announced by the Department of Health in October 2016, rewards pharmacies for delivering quality criteria in three quality dimensions: clinical effectiveness, patient safety and patient experience. It encourages a range of activities designed to widen the pharmacy role beyond dispensing to improving the quality of health care for patients while at the same time helping to ease demand on other areas of the health system. This involves setting development targets covering, for example:

- More effective treatment of asthma – referring asthma patients who have been dispensed too many short-acting reliever inhalers without any preventer inhaler for an asthma review
- Better care for people with dementia – as part of the drive to ensure 80% of all pharmacy staff working in patient-facing roles take part in the Alzheimer's Society's Dementia Friends training
- Increased support for healthy living – so there is a health champion in every community pharmacy, and ensuring each pharmacy obtains the Healthy Living Pharmacy Level 1 status.

5.3.5 Future housing developments

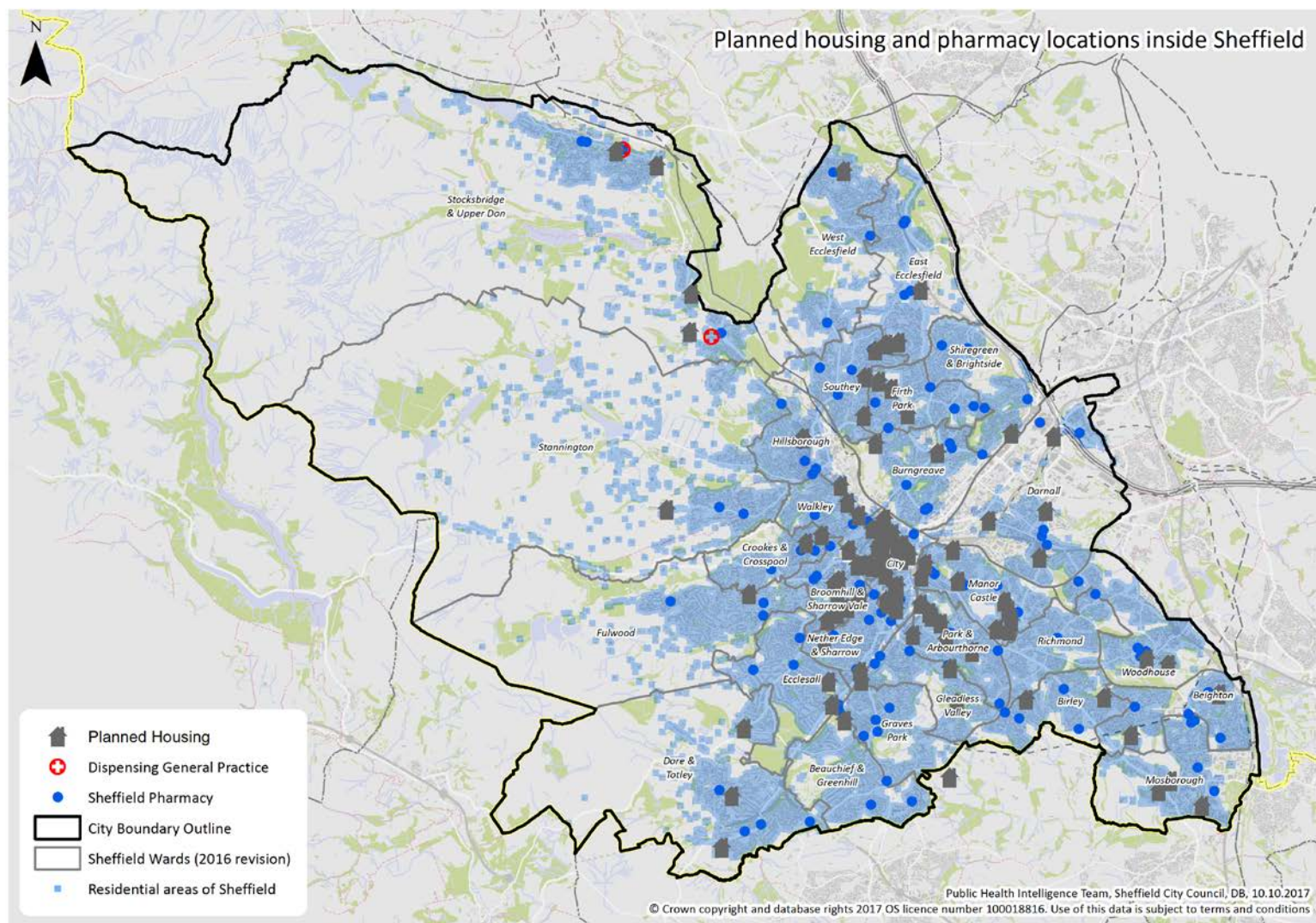
Sheffield's housing stock grows at a relatively slow pace. Over the four year period 2017 to 2021 there are approximately 6,700 new properties planned across Sheffield. The map in Figure 13 shows the detail. Analysis indicates all proposed sites would be within 1.6km of a pharmacy and are relatively evenly distributed across the city. Assuming all sites go ahead as planned, it is concluded that existing pharmaceutical provision in these areas is sufficient to meet need.

Overall where a proposed development is likely to introduce more than 100 new residents into the area, NHS Sheffield CCG is consulted by the Council as part of its overall consideration of implications for the local support infrastructure; this would therefore include potential implications for pharmaceutical provision. As and when

¹⁹ <http://www.healthwatchsheffield.co.uk/>

this arises, the Health and Wellbeing Board will issue a statement supplementary to this PNA where relevant and proportionate.

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Figure 13: Map of proposed housing developments (2017-2021) and pharmacy locations

6 Conclusions

The key element of a pharmaceutical needs assessment is the requirement to assess the extent to which the demography of the local population and its pharmaceutical health and wellbeing needs align with service provision. Information has been collected about pharmaceutical provision within and outside Sheffield and this has been mapped to demographic information and the health needs of our 28 electoral wards. A table setting this information out in detail is included as Appendix B. In addition, details of current service provision and future developments have been considered.

In summary, our analysis of this information shows that:

- Sheffield is well-served by its pharmacies and dispensing doctors with good coverage and choice across the different areas of the City and good availability and access arrangements, including out of hours.
- Patient satisfaction with the facilities and services provided by pharmacies in Sheffield is good with pharmacy staff in particular regularly identified as a trusted, valued and reliable source of advice and support. Areas for improvement are identified and taken forward.
- There are no gaps in current provision.
- There are good links with other NHS services within the City both in relation to primary care (especially GP practices) and acute hospital services. Nevertheless, it is recognised that there is potential to develop this much further, particularly in the context of developing integrated primary care services.
- In terms of health needs, Sheffield's pharmacies are already contributing extensively to raising awareness and understanding of health risks, promoting healthy lifestyles, providing advice and signposting/ referral to treatment and providing services, often in more accessible and acceptable settings.
- Demographic and cost pressures from patients with long-term conditions is only likely to increase in the coming years and pharmacy's continued role in helping to meet this need is acknowledged. Further development of the public health role of pharmacy and commissioning of relevant services could therefore secure additional improvement in health.
- Known other future developments are unlikely to generate significant need for additional pharmaceutical provision over the lifetime of this PNA.

7 Appendix A: Consultation Report

7.1 The consultation process

A consultation on the first full draft of the PNA took place for a period of 60 days from 20th October to 19th December 2017, in line with the 2013 Regulations. A short online questionnaire was prepared for this purpose and stakeholders were contacted by email. The email included a link to the questionnaire and the draft PNA document.

7.2 Responders

The table in Figure 13 sets out the stakeholders consulted and who responded.

Figure 13: Stakeholder responses

Stakeholder	Responded
Community Pharmacy Sheffield	1
NHS Sheffield Clinical Commissioning Group	1
Healthwatch Sheffield	
Sheffield Local Medical Committee	1
Community Pharmacies	4
Dispensing practices	
Sheffield Teaching Hospitals NHS Foundation Trust	
Sheffield Children's NHS Foundation Trust	1
Sheffield Health and Social Care NHS Foundation Trust	
Barnsley Health and Wellbeing Board	
Rotherham Health and Wellbeing Board	
Derbyshire Health and Wellbeing Board	
NHS England (South Yorkshire & Bassetlaw)	1

7.3 Summary of responses

The following tables summarise the responses received to each of the six consultation questions, alongside action taken as a result.

Question 1: Do you agree with our assessment that current pharmaceutical service provision meets the needs of the Sheffield population?

Q1b If no, please explain.

Comment	Response
(i) Given the number of smoking related illnesses that are found in the Sheffield population, smoking cessation services should be universal; at the moment only two thirds of pharmacies provide these services.	(i) A universal smoking cessation offer is available in Sheffield via a number of providers including community pharmacies, GP practices, Sheffield Teaching Hospitals NHS Foundation Trust, some voluntary and community organisations and the SW Yorkshire NHS Foundation Trust. The reason for this is to provide members of the public with a range of options for receiving advice and support to stop smoking according to local requirements.

Question 2: Do you agree with our assessment of the ways in which pharmacies could make a greater contribution to improving the health of Sheffield people?

Q2b If no, please explain.

Comment	Response
(ii) Commissioning additional services from community pharmacies located in the most deprived areas of the City would enhance efforts to tackle health inequalities and improve health and wellbeing in the population. Utilising the existing community pharmacy network in a different way and piloting new models of care could help to reduce inequalities. This could include community pharmacies working together within a neighbourhood to provide an enhanced level of care for patients with particular conditions (e.g. one pharmacy might specialise in diabetes and another in respiratory conditions).	(ii) The Health and Wellbeing Board will be refreshing its Health Inequalities Strategy in 2018 and this will include the role and contribution of community pharmacies alongside other family and community health services.

<p>(iii) Commissioners should consider supporting community pharmacy integration with primary care, working towards the key ambitions set out in the Community Pharmacy Forward View and utilise the increasing number of Healthy Living Pharmacies in the City to improve the current public health offer. Specifically this could include: improving collaborative working across the health and social care system in Sheffield; identifying and incentivising new ways of working; improving community pharmacy access to IT/integrated IT systems; and raising greater awareness of community pharmacy services with the general public.</p> <p>(iv) GP Practices report receiving frequent requests from patients for urgent same-day appointments because <i>“the pharmacist told me I must see a GP today”</i>. The document describes the need for improved sign-posting for patients and with the right support, community pharmacy could reduce the burden on primary care.</p> <p>(v) The Chief Pharmacist has stated that there are too many community pharmacies and he would like to see a reduction of around 3,000 nationally. This would equate to a reduction of over 30 for Sheffield and would take numbers back to the 1990s. Thought needs to be given as to how this might happen in an organised manner and in a way that does not result in a falling off of quality and levels of service due to simple financial attrition. In which areas would combining pharmacies make sense and still meet the needs of the population?</p> <p>(vi) Provision of pharmacy services to housebound patients is largely due to the goodwill of pharmacy contractors. With reduced funding these services will inevitably be curtailed. Provision needs to be made for domiciliary MURs and Truss Fitting. Domiciliary Appliance Use Reviews are covered but for some reason they exclude Trusses.</p>	<p>(iii) Integration with GP practices has been piloted as the GP Access Fund (PM’s Challenge Fund) and HLPs have long been supported in Sheffield and are now part of the national contract framework. Digital development is taken forward as part of the national contract summary care record and collaborative working across the health and social care system is supported as part of the Accountable Care Partnership, including for example the Medicines Administration Record Service. In relation to awareness raising and sign-posting, national patient communication strategies are tailored to the local context by both the Council and the CCG, including public health campaigns.</p> <p>(iv) The CCG and CPS are developing a ‘care navigation’ initiative to improve understanding between GP and pharmacy staff about when/why patients are ‘bounced back’ and to improve the communication between them when that happens. A ‘PharmOutcome’ module, which allows pharmacists to create a bespoke message about what and why for when a patient is signposted back to the GP surgery, has been developed and is due to be trialled in 2018.</p> <p>(v) This falls within the remit of NHS England as the commissioner of pharmaceutical services. However, our PNA will take account of any changes that occur in the number and location of community pharmacies and supplementary statements will be issued if required.</p> <p>(vi) The national contractual framework is limited to funding services provided within pharmacy locations. Nevertheless, the CCG is currently exploring options for providing greater support to patients in their own home. For example, this will include piloting a medicines review service for housebound patients. Other potential services (such as fitting trusses) would be based on an assessment of need.</p>
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Question 3: Do you agree with our assessment that there are acceptable levels of 'out of hours' pharmaceutical provision in Sheffield?

Q3b If no please explain

Comment	Response
(vii) All respondents agreed with our assessment.	(vii) No change to the document.

Question 4a: Are there any additional pharmaceutical services that should be provided in Sheffield?

Q4b If yes please give details

Comment	Response
(viii) Emergency hormonal contraception direct from community pharmacies at no cost to the patient.	(viii) The Council and the CCG intend to develop a business case for a joint locally commissioned EHC service via community pharmacy for consideration in 2018.

Question 5: Was the process used to produce the PNA appropriate?

Q5b If no please explain

Comment	Response
(ix) All respondents agreed with our assessment.	(ix) No change to the document.

Question 6: Any other comments

Comment	Response
<p>(x) The PNA may need to be reviewed in light of decisions following the Urgent Care Review consultation.</p> <p>(xii) Violent Patient Scheme (VPS) – there is no risk assessment undertaken as to how this impinges on community pharmacies. The current scheme allows for additional security when the patient needs to see a GP but fails to follow this through with support for what is often a daily visit to a pharmacy. One option, where a patient breaches rules and has to be refused access to the premises, would be to continue to dispense but deliver to a third party for collection by the patient such as a local police station or similar.</p>	<p>(x) This has been acknowledged within the body of the PNA (see section 5.24 Page 31)</p> <p>(xi) The Violent Patient Scheme is commissioned by NHS England. We have raised this with NHS England and asked them to consider applicability to community pharmacy.</p>

8 Appendix B: Summary of Pharmacy Need and Services by Ward

	Population (all ages) ONS 2015 mid-year estimate	Pharmacies	Population per Pharmacy	IMD 2015 Score	% BME Population (Census 2011)	All Cause Mortality 2011- 2015	Advanced Services			General Health								Tobacco Control			Sexual Health			Drug Misuse		
							Medicine Use Review	New Medicine Service	Appliance Use Review	MAR Advice to HOME CARE	100 Hours Pharmacy	Flu vaccination	Minor Ailments Scheme	Community Script switch	Anticoagulation scheme	Not Dispensed Scheme	Palliative Care Drugs	Sub-cutaneous Fluid scheme	Champlix	NRT	Smoking Cessation	Chlamydia Screening	Condom Distribution	EHC	Needle Exchange	Supervised Consumption
Ward Name																										
Beauchief & Greenhill	19682	3	6560.7	31.61	9.2	393.49	3	2	0	3	0	3	3	0	0	3	0	0	2	2	0	0	0	0	0	2
Beighton	17692	5	3538.4	17.80	5.5	358.75	5	5	0	4	1	4	5	0	0	4	1	0	4	5	1	0	0	2	0	2
Birley	16876	5	3375.2	22.36	4.7	328.67	5	4	0	5	0	5	5	0	1	5	0	0	3	3	1	0	0	4	1	5
Broomhill & Sharrow Vale	23987	5	4797.4	16.47	24.9	384.94	4	4	1	5	1	4	5	0	0	5	1	0	3	4	0	1	0	3	2	5
Burngreave	28816	6	4802.7	52.03	63.5	582.1	5	5	0	5	2	4	6	0	0	5	1	0	3	4	0	0	3	4	1	5
City	23853	6	3975.5	28.85	40.1	314.33	5	6	1	5	0	6	6	0	0	6	1	1	4	4	3	2	5	5	2	6
Crookes & Crosspool	18167	3	6055.7	7.45	14.2	230.23	3	3	1	3	0	3	3	0	0	3	0	0	3	3	0	2	0	3	1	2
Darnall	21863	5	4372.6	46.32	53.8	446.14	4	3	2	4	1	5	5	0	0	5	1	0	4	4	0	0	0	3	1	4
Dore & Totley	18119	4	4529.8	6.87	7.9	229.86	4	3	0	4	0	3	4	0	0	4	0	0	3	4	0	0	0	2	0	3
East Ecclesfield	18103	4	4525.8	18.68	4.0	320.65	4	2	0	3	1	4	4	0	0	4	1	0	1	2	0	0	0	1	0	3
Ecclesall	20339	4	5084.8	4.17	14.9	162.28	4	4	0	3	1	4	4	0	0	4	1	0	3	4	0	0	0	1	0	3
Firth Park	22488	6	3748.0	52.95	25.1	514.44	6	5	0	6	1	5	6	0	0	6	1	0	1	3	1	0	1	2	1	5
Fulwood	20224	3	6741.3	5.90	14.7	234.4	3	2	1	3	0	3	3	1	0	3	0	0	2	2	0	0	1	1	0	2
Gleadless Valley	20923	5	4184.6	37.54	19.4	437.76	5	4	0	4	1	5	5	0	0	4	1	0	1	3	1	0	1	3	0	5
Graves Park	16468	6	2744.7	12.47	8.2	277.04	4	3	0	6	1	4	6	0	0	6	1	0	1	2	0	0	0	4	0	4
Hillsborough	20352	6	3392.0	21.05	9.1	373.02	6	5	0	5	1	5	6	0	0	6	1	0	5	5	0	0	0	2	0	5
Manor Castle	22205	5	4441.0	49.86	26.6	490.97	5	4	0	5	0	4	5	0	0	5	0	0	3	4	0	1	2	4	2	5
Mosborough	17759	5	3551.8	20.90	5.3	310.42	5	4	0	4	1	4	5	0	0	5	0	0	4	4	1	2	1	4	1	2
Nether Edge & Sharrow	23115	8	2889.4	24.18	43.6	338.69	6	7	0	7	1	7	8	0	0	7	2	0	2	3	0	0	3	6	3	4
Park & Arbourthorne	19499	4	4874.8	43.55	17.1	430.72	4	4	0	4	0	3	4	0	1	4	0	0	1	2	1	1	0	1	0	4
Richmond	19701	2	9850.5	29.34	7.4	393.91	2	2	0	2	0	2	2	0	0	1	0	0	2	2	0	0	0	1	0	2
Shiregreen & Brightside	20727	4	5181.8	40.64	18.7	458.3	4	4	0	4	0	4	4	0	0	4	0	0	3	3	0	0	0	1	0	4
Southey	19819	4	4954.8	50.09	7.7	443.82	3	2	0	4	1	4	4	0	0	4	0	0	4	4	0	0	1	2	1	4
Stannington	18473	3	6157.7	16.09	5.3	270.55	3	3	0	3	0	3	3	0	0	1	0	0	2	1	0	0	0	1	0	2
Stocksbridge & Upper Don	18451	4	4612.8	17.25	3.2	309.32	4	4	0	3	0	3	4	0	0	2	1	0	1	1	1	0	0	2	0	4
Walkley	26468	2	13234.0	27.18	31.9	449	2	2	0	2	0	2	2	0	0	2	0	0	2	2	0	0	0	0	0	2
West Ecclesfield	17728	4	4432.0	17.88	3.9	326.82	3	3	0	3	1	3	4	0	1	4	1	0	2	2	0	0	0	1	1	4
Woodhouse	17840	4	4460.0	29.50	8.1	447.63	4	1	0	4	2	4	4	0	0	4	2	0	2	3	1	0	0	1	1	3
Sheffield	569737	125	4557.9	27.57	19.2	363.5	115	100	6	113	17	110	125	1	3	116	17	1	71	85	11	9	18	64	18	101

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HEALTH AND WELLBEING BOARD PAPER FORMAL PUBLIC MEETING

Report of: Jayne Ludlum, Executive Director, People Services, Sheffield City Council
Maddy Ruff, Chief Officer Sheffield CCG

Date: 29 March 2018

Subject: Progress and Challenges of the Better Care Fund and its future Strategic Objectives

Author of Report: Nicki Doherty, Director of Delivery Care out of Hospital

Summary: The Better Care Fund is a term to describe the pooling of health and care commissioning budgets across Sheffield Clinical Commissioning Group and Sheffield City Council. It has operated in Sheffield for over three years.

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

The Better Care Fund covers transformational programmes and business as usual, set out in the following workstreams:

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

In 2017/18, the Better Care Fund was increased to include a second fully pooled budget (£102m) for mental health services and also included national investment called the Improved Better Care Fund (iBCF) which could be spent on all or a number of the following:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

In 2017/18 the size of the Better Care Fund is £364m. The Better Care Fund Narrative Plan for 2017-19 was signed off by Health and Wellbeing Board in September 2017. Although a requirement of NHS England and very much focussed on describing how we are meeting national requirements, the Plan describes Sheffield's aims, objectives and delivery plans for the next two years. We do not believe there will be a national requirement to submit a plan for next year and we are actively working to understand the process to "graduate".

This paper with the accompanying presentation, reminds the board of our strategic objectives, provides an assessment of how well we have done so far and describes our opportunities going into 2018/19.

Questions for the Health and Wellbeing Board:

How could the Better Care Fund better support delivering our health and wellbeing priorities?

Are there further opportunities that we could or should be looking at?

Recommendations for the Health and Wellbeing Board:

The recommendation is to:

Note progress and discuss opportunities for 2018/19

Receive a further report in November 2018

Background Papers:

- [Sheffield Integration and Better Care Fund Narrative Plan 2017-19](#)
- [Integration and Better Care Fund Planning Requirements for 2017-19](#)

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

Sheffield is a health and successful city

Health and wellbeing is improving

Health inequalities are reducing

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

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

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

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

PROGRESS AND CHALLENGES OF THE BETTER CARE FUND AND ITS FUTURE ROLE AND STRATEGIC OBJECTIVES

1.0 SUMMARY

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

1.2 The overall aims of the Better Care Fund are to:

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

2.0 In addition to what our citizens expect from us listed below, we work within a very challenging financial situation and our population needs are increasing. Our aim therefore is together to utilise all our resources better and smarter and shift our focus on avoiding or reducing high cost care by doing much more, closer to or in people's communities/home.

2.1 Sheffield is a leader in integration. As well as a substantial integrated commissioning budget, we have set up an Accountable Care Partnership Board to provide overall leadership represented by commissioners and providers. It provides a stronger framework for delivering the Sheffield Place Based Plan and the Better Care Fund aims. We see the Better Care Fund and its governance arrangements as the emerging integrated commissioning function of the Accountable Care Partnership.

3.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

3.1 Sheffield people have told us:

- If things go wrong it's difficult to receive the care I might need quickly enough
- I find it hard to find my way around all the variety of services – or even to know if what I need is actually provided by someone
- We have to constantly repeat information from one person to another
- I have little control over the care I do or don't receive

- My psychological needs are not met as part of care for my physical needs
- Services often aren't available at night or weekends like they are during the week
- Why don't services plan in advance – surely they should know if I get unwell I'll struggle to cope but don't necessarily want or need to go into hospital
- Why can't I just have one care plan?

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

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

4.0 THE BETTER CARE FUND

4.1 The Workstreams

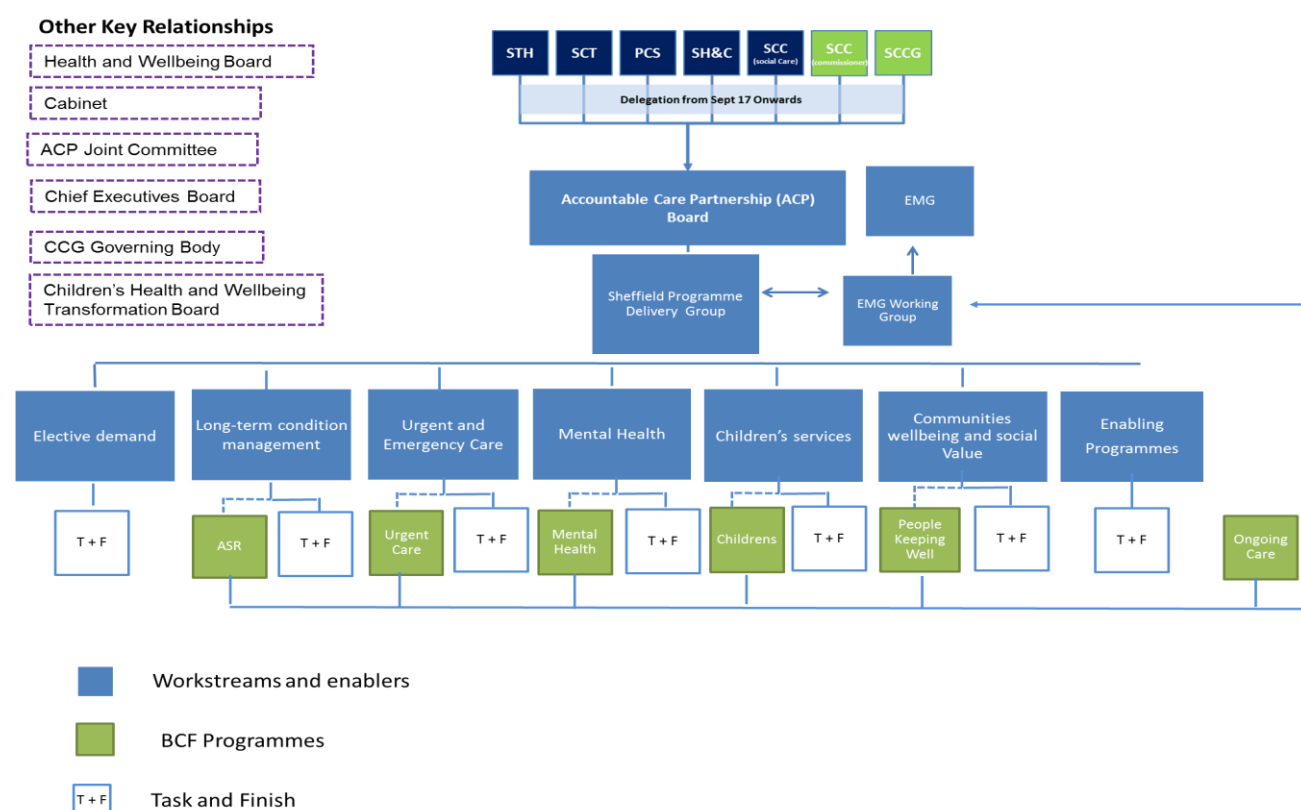
4.1.1 To address what the people of Sheffield have said that they want from our services, and in the context of our reduced financial purse, the Better Care Fund contains the following workstreams:

- People Keeping Well. This aims to increase wellbeing of people at greatest risk of declining health and loss of independence – reducing demand and dependency on more formal health and social care services.
- Active Support and Recovery – This covers mostly services based in the community which support our citizens especially those who may have multiple health and care needs. It aims to support people in their home and avoid being admitted to hospital unnecessarily, responds quickly in a crisis and supports those discharged from hospital, minimising their stay and maximising their recovery and level of independence.
- Independent living solutions – the provision of equipment to support our citizens remain independent at home and build their wellbeing.
- Ongoing Care – to integrate the assessment, the placement and contract management functions for continuing healthcare across CCG and SCC.
- Inpatient Emergency Admissions – a number of our workstreams aim to reduce our unnecessary admissions to hospital. Bringing the budget within the Better Care Fund allows monitoring of the impact of those projects and be able to utilise those savings across the other workstreams.

- Mental Health- to truly integrated our approach across organisations on a number of areas to improve outcomes and deliver better value for money.
- Still to be decided is the inclusion of childrens services within the Better Care Fund.

4.2 The Governance

- 4.2.1 The Better Care Fund is underpinned by a section 75 agreement. This describes the framework for working in a more joined up way. The Executive Management Group (EMG) is responsible for development of the commissioning strategies within the overall direction set by Health & Wellbeing Board, oversight of contracts and provides overall commissioning leadership and direction.
- 4.2.2 The Executive Management Group split into strategy and delivery in 2017, following a review of the Better Care Fund arrangements. EMG strategy group which has a strategic oversight and high level responsibilities of managing the fund and leadership in integrated commissioning; and EMG working group, the latter reports to the former. The working group fulfils the programme management function, assesses monthly highlight reports, tracks progress through highlight reports and manages risk on an exception basis, mitigates risks and manages the interdependences to ensure we deliver our successes.
- 4.2.3 The diagram below illustrates BCF governance in a way that compliments the developing Accountable Care Partnership Programme. Each BCF workstream sits within the ACP structure and is governed by a Board, supported by Delivery Groups. Representatives from Commissioners and Providers sit on those groups.
- 4.2.4 Both the Clinical Commissioning Group and City Council are required nationally to pool funding, report on finance, activity and progress of workstreams within the Better Care Fund. It is possible for areas to 'graduate' from this, however little progress has been made in the first wave. It is hoped that Sheffield will get the opportunity to graduate at some point in the near future.



4.3 The Finance

4.3.1 The Sheffield Better Care Fund Pooled Budget for 2017/2018 is £364m. The funding contributions to the BCF from Sheffield City Council and Sheffield NHS CCG are shown below.

	2017/18 Plan	2018/19 Plan
	£	£
BCF Funding Sources		
Sheffield Local Authority inc iBCF Grant	114,475,400	109,675,400
Sheffield Local Authority Disabled Facilities Grant	4,031,000	4,172,240
Sheffield Local Authority Other Capital (non recurrent)	1,506,000	0
Sub Total Local Authority	120,012,400	113,847,640
Sheffield NHS CCG minimum contribution	38,331,415	39,059,712
Sheffield NHS CCG additional contribution	206,089,895	209,760,061
Sub Total CCG	244,421,310	248,819,773
Grand Total	364,433,710	362,667,413

4.3.2 The Community Equipment Service (part of Independent Living Solutions) and the Mental Health budget are jointly managed schemes with a risk share arrangement for any over or underspends. These schemes represent nearly 305 of expenditure lines within the BCF, with the balance solely managed or jointly managed schemes that are funded solely by the partner responsible for that scheme.

5.0 IMPROVING OUTCOMES FOR THE PEOPLE OF SHEFFIELD

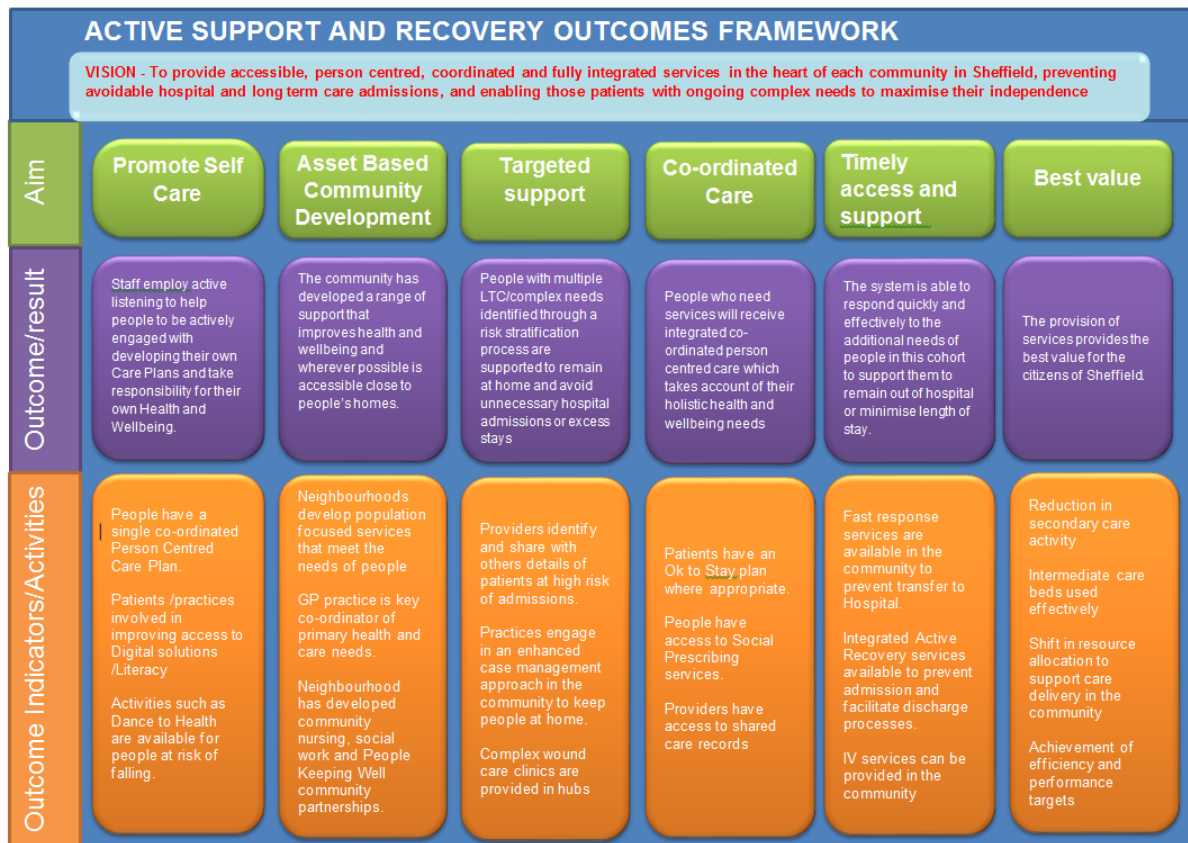
5.1

Two of the workstreams, People Keeping Well and Active Support & Recovery have developed outcomes for their workstreams. In People Keeping Well, these are now embedded in the contracts for the services they commission, changing from commissioning inputs and activity to commissioning tangible benefits and improved outcomes for citizens in contact with the service.

Outcomes Framework – People Keeping Well in their Community						
Function	Risk Stratification	Local Inform & Advise	Asset Based Community Development	Targeted Support	Self-Care – Wellness Planning	Life Navigation
Outcome	Targeting of people (including Carers, children and young people) at moderate to high risk of declining health and wellbeing is informed by comprehensive risk stratification.	People and communities get advice and support locally to make informed choices to improve their health and wellbeing for themselves and/or the person they may care for.	The community has developed a range of support that improves health and wellbeing.	People experiencing poor health, carers, people with a LTC or at risk of declining wellbeing are supported to engage in activities and access targeted support to improve their health and wellbeing.	People at risk or with long term conditions are actively engaged with effective goal setting to improve health and wellbeing.	People who don't have anyone to help them navigate the health and social care system and daily life issues, are enabled to maximise their choice and control in managing their day to day lives.
Outcome Indicators	Written justification for all targeted activity and resource allocation is supported by comprehensive risk stratification data.	Improved wellbeing (5 Ways to Wellbeing). Improved health literacy in target populations. Increased awareness of, and involvement in, community activities. Reduced inequalities in access to services.	Improved wellbeing (5 Ways to Wellbeing). Individuals report feeling engaged & in control of their health. Range of activities to improve health and wellbeing are established and sustained in partnership with other organisations. Local people actively engaged in planning and delivery of activities. Range and take up of volunteering opportunities by local people.	Improved wellbeing (5 Ways to Wellbeing). Maintenance and improvement in independence, health and wellbeing is reported by people identified as being moderate to high risk of hospital admission. Improved health literacy in targeted population. Use of community support, resources and activities within target populations.	Improved wellbeing (5 Ways to Wellbeing). Increase in uptake of vaccinations, annual health checks & screening Self-care based on best evidence (e.g. self-help groups, peer support, structured programmes). People set and achieve personal goals related to their health and wellbeing Access to & take up of training & motivational coaching	Improved wellbeing (5 Ways to Wellbeing). Reductions in missed appointments (DNAs). People report positively on quality of life and clarity about how to seek help to navigate the health and social care system, and daily life issues.

5.2

Active Support & Recovery have also developed a range of outcomes, based on the same themes as People Keeping Well as set out below. However, the current contractual system in which the NHS works, hinders moving away from an activity based contact to an outcomes contract.



6.0 QUESTIONS FOR THE BOARD

6.1 How could the Better Care Fund better support delivering our health and wellbeing priorities?

6.2 Are there further opportunities that we could or should be looking at?

7.0 RECOMMENDATIONS

7.1 Note progress and discuss opportunities for 2018/19

7.2 Receive a further report in November 2018

Appendix 1 The Better Care Fund

Sheffield has a strong history of partnership in health and care, in **providing** care together across organisations putting the patient first, and as **commissioners**. Sheffield Clinical Commissioning group and the Local Authority are both commissioners of health and care. This means they have responsibility for the 'buying' of health and care services for the population of Sheffield.

The following explains why we need a Better Care Fund.

It is known that people are living longer, and they also have more complicated and multiple long term conditions such as diabetes or asthma. People are also becoming more socially isolated and lonely.

The funding we receive in Sheffield to 'buy' services has flat lined and been cut, so that we are finding it difficult to buy all the services we need for the increase in demand.

When the two organisations also looked at what they spent their money on, they found that there was a lot of duplication across the services they commission, and if they did this jointly they could reduce that duplication.

There is also now emerging evidence that it would be better to shift some of the funding which is spent on unnecessary high cost care and better use it on preventing people or reducing the need for high cost care.

As well as the above, people of Sheffield have also said that they want more joined up care, that they want to be more in control of their care and they don't want to be in hospital unnecessarily

That is why, Sheffield Clinical Commissioning Group and Sheffield City Council have joined forces to pool some of that funding in order to get more and better for its' money. This is called the **Better Care Fund**.

It is now in its third year and is slowly making progress to join services together to form teams such as district nurses and social workers. These teams help people in crisis and patients can be seen and treated in their home, rather than unnecessarily go into hospital. The team can also support patients who need a bit of support, but are ready to come out of hospital when they are ready to be discharged.

It also funds services that can help signpost people who may be lonely or need some support; so that they can get the right support they need or perhaps join a community group or luncheon club.

The Better Care Fund is steered by the Health and Wellbeing Board, and this paper provides an update for the Board and also asks the Board whether it remains happy with progress and the objectives, or should these change.



HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of: Nicki Doherty, Director of Delivery Care out of Hospital, Sheffield CCG

Date: 29 March 2018

Subject: Primary Care Strategy for Sheffield

Author of Report: Nicki Doherty, Director of Delivery Care out of Hospital,

Summary:

This strategy is about future primary care services in Sheffield and how they might work differently. Our vision for primary care in the city is three fold:

- To improve the health and wellbeing of people in the city
 - To have high quality, sustainable primary care services that are fit for purpose now and in the future
 - To see health, social and voluntary care services working collaboratively for the benefit of individuals and in time with the needs of the particular population they serve.
-

Questions for the Health and Wellbeing Board:

- What opportunities should we be exploring to reduce health inequalities?
- Are there greater partnership opportunities that we should be exploring through our neighbourhood approach?

Recommendations for the Health and Wellbeing Board:

- To note the primary care strategy
- To confirm further Health and Wellbeing Board consideration in relation to the actions agreed

Background Papers:

- [Primary Care Strategy for Sheffield](#)
- [Neighbourhood News e-bulletin](#)
- [NHS Sheffield CCG website page on Neighbourhoods](#)

PRIMARY CARE STRATEGY FOR SHEFFIELD

1.0 SUMMARY

1.1 This strategy is about future primary care services in Sheffield and how they might work differently. Our vision for primary care in the city is three fold:

- To improve the health and well-being of people in the city
- To have high quality, sustainable primary care services that are fit for purpose now and in the future
- To see health, social and voluntary care services working collaboratively for the benefit of individuals and in tune with the needs of the particular population they serve.

1.2 The CCG agreed the strategy in May 2016

1.3 This session aims to update members of the Health and Wellbeing Board on

- What the strategy set out to achieve
- The progress that has been made to date
- And in particular to discuss the neighbourhood approach and future opportunities

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 If the changes in this strategy are implemented we can expect the following outcomes:

- Better equality in health outcomes for people living in Sheffield; this means improving how people manage their own health and ill health and making sure they have equal access to the support they need, regardless of their social circumstances
- Stable primary care services with sufficient numbers and skill mix of staff to manage the demand plus IT and buildings that support and enhance service provision
- People receiving the right interventions at the right time from the right professional – mostly in their local neighbourhood.

- 2.2 To achieve these outcomes will require a change in behaviour and culture for patients, providers and commissioners.
- 2.3 The public will be encouraged and enabled to seek support and interventions from a wider range of professional and not use their GP as the default option for all health queries; they will play a much bigger part in managing their own health.

3.0 PRIMARY CARE STRATEGY FOR SHEFFIELD

3.1 Our Vision

We know there will be big improvements in people's health and well-being if the existing services already rooted in local communities – health, social care, voluntary sector, police, education and others – work in a more collaborative way. There is a growing recognition that organisational boundaries have prevented healthy collaboration in the past and that this culture is now shifting. Collaboration between services covering populations of 30-50,000 people is recommended in a number of national documents; we refer to this as a neighbourhood and it forms a key part of our strategy.



People will achieve the best health outcomes for themselves if these services work in a truly integrated way. This means each service being able to quickly and easily respond to requests from neighbourhood colleagues for advice or input to an individual patient and, for individuals with more complex needs, working in partnership with a multi-disciplinary team of neighbourhood professionals. Central to our vision are people who take a much more active role in improving their own health, managing their own ill health and being better informed about which professional is best able to help them.

Of course, not all services can or should be provided at a neighbourhood level; high volume services needed by lots of people will be provided to smaller units of population and more specialist services will be provided on a city wide basis. The following picture

illustrates our vision for Primary Care, Active Support and Recovery (AS&R) and Urgent Care services within the broader range of out of hospital services:



3.2 The case for change

3.2.1 National drivers for change

These drivers are well documented and can be summarised as:

- The number and proportion of older people in the population is increasing; the health and social care needs of older people are often more complex.
- There are more people being diagnosed with long term conditions and a greater proportion of people living with co-morbidity; this increases the demand for services and demands a different type of service provision.
- Greater prevalence of mental health needs and co-morbidity of physical and mental health illness.
- The healthcare expectations of the population are changing in line with greater consumer choice, 24/7 access, fast response times and better informed consumers.
- The approach to healthcare provision is shifting away from a paternalistic model with a greater onus on patients taking a more active role in the care of their own health; the Collaborative Care and Support Planning (CCSP) or person-centred care approach.

- Significant differences in health outcomes for different population groups; a persistence of health inequalities.
- Funding levels have decreased in real terms; the same resources are being spread more thinly requiring more efficient use of funds available.
- Greater integration between health and social care commissioners as a result of the Care Act and introduction of the Better Care Fund (BCF).
- Changes in technology are enabling improved survival rates, more complex conditions to be managed in a community or home setting and alternative ways of seeing and assessing patients.
- There are significant workforce issues in many parts of healthcare and this is keenly felt in primary care where fewer GPs are entering the profession and more are leaving it early; there are too few practice nurses and a lack of dedicated training and career structure; physician's assistants courses are in their infancy
- A combination of workload and workforce pressures and, in some cases, reductions in funding, are pushing some general practices to consider closure.
- A shift in culture towards patient centred care.

3.2.2 Local drivers for change

There are many local drivers for change; the most pressing of these are:

- The variation in quality and length of life of people living in different parts of the city and in different social circumstances. Not only are those living in deprived areas, with a disability or with a mental health illness more likely to die at a younger age but they are also more likely to live their life in poorer health and find it harder to get the healthcare services they need.
- There are not enough staff to manage the growing need for services and the number of staff approaching retirement or leaving their jobs early due to work pressures suggest that the workforce will shrink over the next few years; this has been further exacerbated by the primary care funding equalisation exercise.

It is imperative that the strategy for primary care addresses these 2 issues. Primary care services must:

- Be of a consistent standard and quality
- Engage with and be accessible to anyone, regardless of their social circumstances
- Offer the same level of service to people with mental ill health and disability as is available to the rest of the population

- Have the right workforce, IT and buildings to be able to do their job.

3.3 What people have told us?

For a number of years Sheffield Clinical Commissioning Group (CCG) has been engaging with local people who have told us that:

- They are confused about what services to use for what type of need;
- The health and social care system is complicated, fragmented and lacks communication between services and organisations – services need to be joined up better with greater integration across health and social care;
- They want services in their local community;
- They need more publicity about public and voluntary services in their local area and how they can use these to address their health needs before escalating to their GP, 999 or A&E;
- They want to be treated as a whole, with their mental health needs treated as equal to their physical needs;
- They use urgent care services for convenience if they have difficulty in getting a GP appointment.

The CCG has listened to these messages and to what providers of primary care services across the city are saying; these discussions have generated ideas and momentum and have resulted in the development of this strategy.

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

4.1 What do we need from a primary care service?

Primary care services refer to general medical, pharmaceutical, ophthalmic and dental services which any member of the public can refer themselves to. People want to be able to access these services easily without travelling long distances; as a CCG we expect these services to be of a high quality and to positively impact on the health outcomes of the local populations they serve. We anticipate that ophthalmic and dental services will not be significantly changed and have focused our attention in this section on general medical and pharmaceutical services.

Patients want high quality care, provided by a familiar team of GPs who know their medical history, and they want to be able to receive that care in a timely fashion when they need it.

We want to see a primary medical service that retains the core values of general practice, as identified by a group of Sheffield GPs at a seminar in October 2015:

- Care centred around the person
- Shifting power to the patient
- An holistic approach to care

- Advocacy.

Maintaining the system of list-based care is key to retaining these core values and puts general practice at the heart of a patient's care/ The continuity of care that results from many years of the GP and patient working together brings significant benefits.

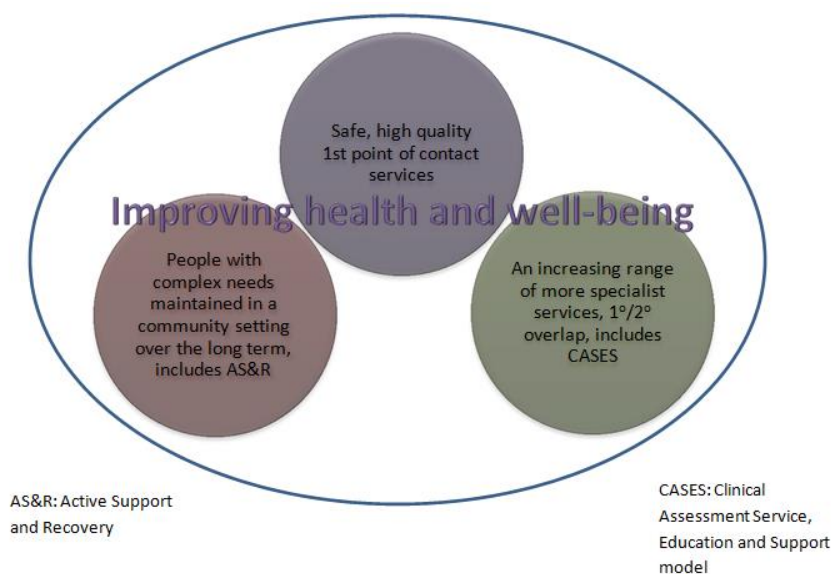
The patient-GP relationship has become increasingly important as the health and social care system has evolved and become more fragmented; the range of services available to people and the number of agencies involved in delivering these services has increased over the last two decades.

The patient receiving input from multiple parts of the system must feel that they are at the heart of a single system that knows them, understands their physical health, mental health and social care needs and delivers those needs, in line with their own health goals, without delay or interruption. We believe that GPs must be able to easily access and deploy other parts of the health, social care and voluntary sector in the interest of their patients.

In addition to providing continuity of care for many of their patients, GPs also provide 1st point of contact services for their local population, managing acute presentations and undifferentiated need on a daily basis. We see these elements of service continuing to be managed within the primary care setting and believe that:

- Some services must be provided in a different way in order to have a greater impact on health outcomes for some population groups
- Some services must be provided in a different way in order to manage the increasing demand
- General practice, community and mental health providers, social care providers and the voluntary sector must be enabled to coordinate their care around the needs of the patient.

The third element of provision for the primary care setting is a greater range of specialist services. We recognise that there has been a shift from secondary care to primary care for some services in recent years and believe it is beneficial for patients to be managed at home/in their local community where this is clinically appropriate. We would like to enable all providers of primary care to deliver a broader range of services and acknowledge that this must be supported by a different contractual approach. To summarise, we would like all people in Sheffield to be able to access the following out of hospital services:



To have maximum impact on the health and well-being of local populations we believe that these 3 elements of service must all be delivered in a way that:

- Addresses mental and physical health needs concurrently.
- Adopts a person centred care approach to all interactions with patients.

4.2 What do we want a future primary care service to look like?

As with the current system of primary care the GP-Patient relationship will sit at the centre. Health, social and 3rd sector services will be better integrated, with GPs providing leadership on individual patient care within this wider system. There are many ways of describing how this complex system might work in practice and the following takes the perspective of services provided to different size population groupings.

The CCG wants to see primary care resources being used to maximum efficiency and proposes that services are organised in layers of different size populations.

- A typical practice population
- A neighbourhood population of 30,000-50,000 people
- A locality population of 100,000-150,000 people
- A city wide population.

To help achieve this the CCG will encourage larger scale, more collaborative and coherent working between practices and other organisations.

4.3 Neighbourhoods

Active Support and Recovery and People Keeping Well

Central to this model is the introduction of neighbourhood working – health and social care professionals and the voluntary sector providing services to population groupings of 30,000-50,000 people. Although these professionals may work for a

range of organisations and agencies the intention is for them to work as a single, multi-disciplinary team for the benefit of individual patients.

Population groupings of this size are being favoured across the country as the size allows for professionals to know each other, know the patients, know the local voluntary sector services available and easily access resources within their neighbourhood¹⁵. Active Support and Recovery (AS&R) will be one of the services on offer. Those patients with more complex needs living within the neighbourhood would work closely with a team of health, care and voluntary sector professionals to get the inputs needed to keep them well in their home setting or to support them during periods of ill health in their home setting. Under this model, professionals working within a neighbourhood would build close relationships with those patients with more complex needs; this more intimate knowledge of individuals will mean services that are better tailored, more effective and seamless, reducing the gaps, duplication and confusion often reported by this cohort of patients in the current system of provision. It is anticipated that the GP would lead the multi-professional team, identifying jointly with the patient the inputs needed and overseeing their single care plan.

GPs would lead the care of those complex patients already on their list.

4.4 Neighbourhoods and the voluntary sector

Sheffield has an active and diverse voluntary and community sector. Many of the smaller local organisations share a similar focus of community and neighbourhood to general practice. Voluntary, Charity and Faith (VCF) organisations have a track record of being able to work flexibly and collaboratively to meet the needs of local people. Additionally, many organisations in this diverse sector work with local people, recognising their contribution to community life, and enable local people to develop their own skills, capability and capacity to cope and respond positively to their own health issues.

The voluntary and community sector has an important role to play in helping rebalance health and care provision so that people can be supported to live successfully in their homes and communities. Central to this is the role of smaller community organisations and so called Community Anchors; generic neighbourhood based organisations.

A number of general practices have long standing collaborations with their local voluntary organisations - these include specialist organisations working with particularly vulnerable people such as the homeless, substance misusers and migrants and asylum seekers, people with disabilities and long term conditions and people from different ethnic backgrounds.

The neighbourhood described above incorporates the voluntary sector which is now being seen by the public sector as a partner provider of services to local people. There is a recognition that we need to move from a reliance on ad hoc commissioning of voluntary sector services to a more systematic approach which will give greater stability allowing development and innovation.

VCF and other organisations in Sheffield were recently invited to form, develop and manage Collaborative Partnerships (CPs), via a pseudo-framework²¹, covering geographic areas of the city of between 20,000 and 30,000. 11 CPs have now been formed all of which have general practices as partners. Once on the framework the CPs can provide PKW services. The Council and the CCG will approach CPs on the framework when investing in neighbourhood based preventative health and wellbeing services.

CPs will take on the delivery of more local health and wellbeing services over time, using their local intelligence and flexibility to: support more people to improve their health and wellbeing; target their support intelligently; and, to ensure that the development of community services and activities meets local needs.

The geographic coverage of each CP will be proposed by the partnership and will be aligned with neighbourhood boundaries as closely as possible to enable more integrated working within the neighbourhood.

4.5 Empowering patients

The CCG acknowledges and values the central role that patients play in the effective planning and delivery of primary care. Putting patient care at the heart of this strategy is vital to ensuring that primary care remains focused on improving patient outcomes and experience. Sheffield CCG is committed to ensuring that patients remain at the heart of systems and processes, and that patients' views and experiences are listened to and acted upon as part of this commitment/

Sheffield CCG will ensure that patients know that their voices have been heard and that consideration has been given to their views. Patients will continue to responsibly access health and social care services and, to support them with this, Sheffield CCG will provide patients with the resources to enable them to make informed, positive choices for themselves and their families.

Patients will be empowered to manage their own health and ill health through the use of a person- centred care approach. Social prescribing will become a core part of the services available to enable people to address other issues in their lives that are impacting on their ability to address their health/ill health such as employment, housing, benefits, transport etc.

Overall significant progress has been made and we believe that there are more opportunities to explore as a city as we progress through our delivery of the strategy. We look forward to discussing some of them with the Board.

5.0 QUESTIONS FOR THE BOARD

- What opportunities should we be exploring to reduce health inequalities?
- Are there greater partnership opportunities that we should be exploring through our neighbourhood approach?

6.0 RECOMMENDATIONS

- To note the primary care strategy
- To confirm further Health and Wellbeing Board consideration in relation to the actions agreed

Appendix 1 Primary Care Strategy for Sheffield

The Primary Care Strategy for Sheffield is about future primary care services in Sheffield and how they might work differently. Primary care is a collective term for general practice, general pharmacy services, general eye-care services and general dental services.

Our vision for primary care in the city is three fold:

- To improve the health and well-being of people in the city
- To have high quality, sustainable primary care services that are fit for purpose now and in the future
- To see health, social and voluntary care services working collaboratively for the benefit of individuals and in tune with the needs of the particular population they serve.

The CCG agreed the strategy in May 2016

This session aims to update members of the Health and Wellbeing Board on

- What the strategy set out to achieve
- The progress that has been made to date
- And in particular to discuss the neighbourhood approach and future opportunities

SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 27 July 2017

PRESENT: Councillor Cate McDonald (Chair), Cabinet Member for Health and Social Care
Dr Tim Moorhead (Chair), Chair of the Clinical Commissioning Group
Dr Nikki Bates, Governing Body Member, Clinical Commissioning Group
Dr Alan Billings, South Yorkshire Police and Crime Commissioner
Jayne Brown, Sheffield Health and Social Care Trust
Councillor Jackie Drayton, Cabinet Member for Children, Young People and Families
Greg Fell, Director of Public Health
Phil Holmes, Director of Adult Services, Sheffield City Council
Margaret Kilner, Sheffield Healthwatch
Alison Knowles, Locality Director, NHS England
Clare Mappin, The Burton Street Foundation
Peter Moore, Director of Strategy and Integration, Clinical Commissioning Group
Maddy Ruff, Accountable Officer, Clinical Commissioning Group
Prof. Laura Serrant, Sheffield Hallam University
Dr David Throssell, Sheffield Teaching Hospitals NHS Foundation Trust

In Attendance:

Rachel Dillon, Sheffield Clinical Commissioning Group
Kate Gleave, Sheffield Clinical Commissioning Group

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1. APOLOGIES FOR ABSENCE

Apologies were received from Jayne Ludlam, Dr Zak McMurray, John Mothersole, Professor Chris Newman and Judy Robinson. Margaret Kilner, Sheffield Healthwatch, attended as the appointed deputy in place of Judy Robinson.

2. DECLARATIONS OF INTEREST

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

3. PUBLIC QUESTIONS

There were no questions received from members of the public.

4. SHEFFIELD'S 2017/18 AND 18/19 DRAFT BETTER CARE FUND NARRATIVE SUBMISSION

The Board considered a joint report of the Executive Director Communities (now People Services), Sheffield City Council and the Chief Officer, NHS Sheffield Clinical Commissioning Group (CCG). Peter Moore, the Director of Strategy and Integration, Sheffield Clinical Commissioning Group introduced the report together with Rachel Dillon, Sheffield CCG.

The CCG and City Council were required to submit a plan for 2017-2019 to describe plans and targets by 11 September. The Health and Wellbeing Board would need to approve the narrative plan for Sheffield's Better Care Fund 2017/18 and 2018/19.

The Board was informed that the Better Care Fund was key to bringing about parts of the transformation the NHS, the Local Authority and local communities and was linked to public sector reform, place based plans and the Shaping Sheffield plan. There were challenges both at national and local level which related to Sustainability and Transformation Plans and integration. Nonetheless, Sheffield had remained clear to its outcomes. There had also been successes, including a pooled mental health budget, a pooled budget for equipment, the building of stronger relationships and the delivery of care through the development of community partnerships. The adoption of a neighbourhood model would mean that care could be delivered by groups of clinical and social care teams and allow earlier intervention and prevention and early diagnosis.

There were challenges around provider integration and the involvement of providers. There was also enabling work to be done in relation to infrastructure such as ICT. The financial position was also challenging and the Board had to be mindful of that and an example of a positive response was the planning of a pooled budget for mental health services. Sheffield was to receive an additional £24m non-recurrent funding in total over 3 years to spend on adult social care services. It was intended to progress the inclusion of provision for Children and Young People into the pooled budget from April 2018. There was also a plan relating to reducing delayed transfers of care out of hospital and in relation to management and governance. The ambition was to move to a more fully integrated system.

Members of the Board were asked to consider whether they were satisfied that the plans would progress the Board's ambition to transform the health and care landscape, reduce health inequalities and deliver better outcomes for Sheffield people; and to identify where there might be further opportunities for integration and joint working, in particular reference to commissioners and providers working together as an Accountable Care Partnership.

Members of the Board asked questions and commented on the issues and the comments and responses are summarised below:

It was hoped that with a less fragmented approach to commissioning of health and social care, there would also be less fragmented provision. The challenge was to use the existing resources more efficiently and not a reduction in the overall amount spent. There were some interventions, such as social prescribing, which provided benefit in other parts of the system, including secondary and tertiary care. However, at the present time, there was considered to be a capacity issue in relation in community provision and managing demand for social prescribing. It was thought that there should be cost effectiveness in all interventions.

It was considered that the Board would be assisted if there were appropriate metrics relating to the progress and impact of integration. Whilst the ambition for change presented in the draft narrative to the plan could be supported, the plan also required greater precision.

There was agreement that the term 'integration' should be something as seen from the perspective of the citizen and not an organisational viewpoint.

It was necessary for the Board to keep sight of what it wished to achieve and to demonstrate leadership, using the Better Care Fund to enable the use of resources where needed in the community and through providers.

There were examples of good practice in relation to the self-care strategy, where patients were enabled and supported to take on those tasks in relation to which they felt comfortable relating to their own health and wellbeing. In relation to patient satisfaction, outcomes were thought to be better if patients were properly involved.

Whilst issues of culture and cultural change had been put forward, it was acknowledged that it was difficult to define what was meant by the term 'culture' and therefore difficult to say how it might be changed. There were issues relating to clinical and professional boundaries which needed to be taken into account.

The main emphasis and audience for the narrative plan needed to be considered. Factors such as the implications for risk and the risk management associated with the movement of resources from one area to another might need to be more clearly detailed. Similarly, the factors specific to Sheffield may need to be more clearly set out.

There was acknowledgement that the issues for Sheffield's population were also contained in the Joint Strategic Needs Assessment and the State of Sheffield report, which gave a snapshot of the City. Moreover, the changes brought about through the Accountable Care Partnership and Better Care Fund should also become apparent in those documents.

As regards the intended audience for the narrative document, the Better Care Fund Plan was to be submitted to NHS England and it was a subset of the Shaping Sheffield Plan. The guidance in relation to the Better Care Fund required it to be 'signed off' by the Board, although it was not specific as to the

detail. There was a balance and choice for the Board as to whether it wished to see a highly detailed document or a narrative one, which might be high level or easier to follow.

The Better Care Fund might also be seen as a catalyst for change in terms of building partnerships and relationships. The plan might be considered to set the tone and expectations for integration of health and social care. This included the use of the plan to think about the Board's ambitions relative to the present state of things. As part of that thinking, the detail of the plan and issues such as public accountability would be considered.

There needed to be more in the narrative specifically about Sheffield and there were links to the content of the Public Health Strategy, which was to be considered by the Board later at this meeting. Whilst there were a number of different strategies, the Board would need to be clear about whether those strategies were sufficiently joined up. The right metrics needed to be worked upon. It was recognised that there had been sizable change in the past two years in the extent to which organisations were beginning to work together and understand their respective issues. This type of cultural change took time, but it was important to take into account risk, limitations and dynamics in organisations and the extent of public buy-in and understanding.

At its forthcoming development day, the Board might look at questions of leadership to enable cultural change and how strategies could be co-produced with patients and employees.

Appropriate metrics relating to the Better Care Fund might include measurement of what was being achieved and other aspects including cultural change and influence that the plan was bringing about. This included evaluation from the patient's perspective of their experiences. Actual health improvement may not be easy to measure and proxy measures might need to be utilised. Reference could be made to the JSNA, to clarify which of the populations in the City the plan was to target. There were various methods of measuring and evidencing the extent of achievement and change and these could include quantitative and qualitative measures, such as numbers, expenditure and patient voice by asking patients how they might articulate change. The measures could be based around the outcomes, themes and priorities in the plan.

It was **RESOLVED** that:

1. Approval is given to the narrative of the Better Care Fund plans;
2. the Health and Wellbeing Board delegates final approval of the Better Care Fund submission to NHS England to the lead executive officers in the Council and the CCG.
3. the Health and Wellbeing Board receives an update on progress at its public meeting in November 2017.

5. URGENT PRIMARY CARE

The Board considered a report of the Director of Strategy and Integration, Sheffield Clinical Commissioning Group concerning Urgent Primary Care. The item was presented by Kate Gleave, Sheffield CCG.

The report stated that the Clinical Commissioning Group's Strategy for Urgent Care articulated a need to improve urgent care services, in recognition of national policy to improve access and because people found the existing service arrangements confusing and difficult to use appropriately.

The Strategy recognised that local urgent primary care and services needed to be reorganised and the CCG had considered how this might be achieved with a view to agreeing a set of options for the delivery of services on which to consult from September 2017. The report summarised the case for change and the principles upon which the options had been based and it outlined the timescales involved.

The Board was informed that engagement with patients had found that patients did not always access urgent care based on the level of need and patients were confused as to what services to use and when. There was inequality and a differing experience and knowledge of services depending on where people lived in Sheffield. People were not always treated by the most appropriate service and there were issues relating to systems not operating cohesively and with regard to communication. The cost of travel on public transport was a barrier for some people, as were language issues.

The Board was asked to consider whether it could confirm that the objectives of the Urgent Primary Care review and redesign were in line with its own objectives; whether the Board would support and inform the formal public consultation; and whether the Board supported disproportionate re-investment into the areas of greatest need.

Members of the Board made comments and asked questions with reference to the questions outlined above and these are summarised below:

A question was asked about the consequences of moving financial resources if there was disproportionate re-investment into the areas of greatest need. The response to this was that the NHS would usually make the same service offer to everyone. In this case, it had been identified that greater resource could be deployed to where need was greater and the need/demand was something which could be shown geographically and was highlighted in relation to urgent care. Such an intervention and investment in those communities would provide the best value for money and it would lead to improved health outcomes.

It would be considered helpful to communicate what changes to urgent care provision would mean for people and for particular groups of people. There was support for differential investment based on a clear understanding of need and there would also need to be transparency and consistency with regards to services which were available. The Board might also look at engagement in a

similar way and apply disproportionate effort or investment to mobilise people and also ensure that they had a voice.

It was not intended that capacity for planned care would be adversely affected by the proposed changes to improve access to urgent care. The approach which had been taken recognised the relationship between planned and urgent care.

The Board would inform the options relating to consultation. There was no ability to give the perfect level of urgent care and therefore, it was proposed to provide a generic offer and also a more specific one for those communities which had particular circumstances, for example people who were homeless. There was also a wish to make sure patients with 'urgent' care needs received triage in a timely manner and were transferred to appropriate 'planned' care as soon as possible and also to ensure that there was capacity in primary care for a patient to be seen the same day or urgently. Whilst there were many fragmented services in the NHS, patients wished to see continuity of care.

It was confirmed that the issue would be submitted to the Board for further consideration and, at this point in time, the Board was being asked to confirm that it supported consultation in relating to urgent care. It was important to properly frame questions in the consultation and address uncertainty with regards to need and to recognise that there might be a range of different public opinion.

It was considered that proportionate re-investment would be a suitable approach and that there should be clarity as to what was meant by greatest need and in relation to where investment would be made.

The Board RESOLVED to:

1. Note the plans and intentions with regard to consultation on Urgent Primary Care as outlined in the report of Director of Strategy and Integration now submitted;
2. Confirm that the objectives of the Urgent Primary Care review and redesign are in line with its own objectives; and
3. Support proportionate re-investment into the areas of greatest need.

6. PUBLIC HEALTH STRATEGY

The Board considered a report of the Director of Public Health concerning the Public Health Strategy. The City Council's Cabinet agreed a Public Health Strategy at its meeting on 15th March 2017. Greg Fell, the Director of Public Health, explained that the strategy aimed to describe the Council's ambition to redress inequalities and, specifically, the 25 year difference in healthy life expectancy through the totality of its functions.

A key feature of the strategy was a focus on the concept of Health in All Policies

in order to make explicit and increase health gain from policies and service areas that are not traditionally considered as “health” related. There was also an acknowledgement that to deliver such an approach, it would be necessary to change the way the organisation thinks and does its business. The four objectives of the Strategy related to: health inequalities, health in all policies, health protection and healthy lifestyles. There were 10 specific areas within the Strategy upon which the Council would initially focus as set out in the Strategy.

The Health and Wellbeing Board was asked to consider how this approach could be developed.

The Board was asked to consider a number of questions, namely: whether priority areas identified in the Strategy were the right areas to be focusing on, and if there were any that were of more immediate interest; were there other areas we should be looking at; what role the Health and Wellbeing Board could play in maximising the impact of the strategy; how the Health and Wellbeing system in Sheffield could build upon this direction to improve wellbeing in the city; and how the Health and Wellbeing Board could work with the Council’s Scrutiny function to support the delivery of the Strategy?

Members of the Board asked questions and commented on this item of business, as summarised below:

There was a significant amount of activity in addition to the Public Health Strategy, including in relation to smoking cessation and prevention and air quality. The Strategy also had links to the Joint Strategic Needs Assessment and the Annual Report of Director of Public Health.

The Board expressed a number of different observations about the respective merits of having a broad strategic document as opposed to one which covered greater detail about activity, projects and operational matters.

It was considered that, whilst the Public Health Strategy was broad, it might be useful to identify where it could influence (and where it would not) and for the Board to consider some of the ten priority areas in greater detail and what organisations other than the Council were expected to contribute in this regard. It would also be helpful to say, if the priorities as set out in the Strategy were achieved, what was expected to happen to indicate that these were indeed the right priorities and how would we know that we had made a difference.

In relation to a work and health strategy, the three main issues were firstly, employability (i.e. ensuring that people could get back into work) and this was in progress; secondly, the health of people who were in work but poorly (sickness management); and thirdly, looking at those people who were both in work and well to make sure that issues of poor environments in the workplace were addressed.

The Strategy document identified that childhood experiences and inequalities in educational attainment were a key determinant of health outcomes. The Board may also consider how the ten priority areas would be brought back to the Board

in future.

There would be further discussion about the detail of activity outlined in the Strategy and it was acknowledged that the Strategy would need both to describe the means by which there would be accountability and be more explicit in some areas, including in relation to education, communities and neighbourhoods and inequalities. Specific issues such as tobacco control and air quality would be brought to the Health and Wellbeing Board for consideration in the future.

The strategy was an “all age” strategy and it was considered that investment in children was the best thing to do in terms of its value. The timeframe of the strategy was two years (2017-19) and progress would be reviewed at the end of the two years, which would be subject of consideration by the Board. Whilst the Council did not control other organisations in the City, the strategy had a role in influencing and setting a direction for Sheffield in respect of public health. The Strategy would also be submitted to the CCG in September 2017 and might also be presented to other organisations.

It was RESOLVED that the report and Public Health Strategy 2017-19 be noted and that the Director of Public Health be requested to submit a report to the Board having reviewed progress relating to the Strategy after March 2019.

7. SHEFFIELD HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

The Board considered revised the Terms of Reference for the Board and were asked to comment as appropriate.

It was expected that deputies would be in attendance at meetings of the Board on an exceptional basis and agreed that this should be made clear in the Terms of Reference at paragraph 3.2.

In terms of the authority of representatives, it was accepted that each of the organisations represented on the Board were sovereign and that some decisions or representations would need to be made in accordance with the governance arrangements of individual organisations.

It was RESOLVED that:

1. the Terms of Reference of the Board are amended as follows:
 - The addition at paragraph 3.2 of the words “in exceptional circumstances” following the words “... attend a meeting and vote in place of the member.”
 - The addition at paragraph 3.5 of the words “and/or representations” after the words “It is accepted that some decisions”
2. The revised Terms of Reference are circulated to Members of the Board.

8. HEALTH AND WELLBEING BOARD FORWARD PLAN

The Board considered its forthcoming Work Programme as circulated.

The Board RESOLVED:

1. to note the Programme as submitted and the expected times and dates of Strategy Meetings (from 2pm to 5pm) and those Meetings of the Board to be held in public (from 3pm to 6pm).
2. to note the addition of cancer services to the list of topics for future consideration.

9. MINUTES OF THE PREVIOUS MEETING

It was RESOLVED that the minutes of the meeting of the Board held on 30 March 2017 be approved as a correct record.

10. DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Wellbeing Board would be held on Wednesday 27 September 2017, starting at 3.00pm.

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