Sheffield Children's NHS Foundation Trust
Sheffield Clinical Commissioning Group
Sheffield Health and Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust

Paper C

Sheffield Accountable Care Partnership (ACP Executive Delivery Group)

Updated Shaping Sheffield Plan

21/06/2019

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Sponsor	**All CEX**

1. Purpose

The ACP Team have been working alongside partner organisations, workstream leads and Strategy Directors to draft the refreshed "Shaping Sheffield: The Plan". The plan is strategically rooted within the Health and Well-Being strategy and helps deliver the HWB strategy, as reflected in the document.

2. Introduction / Background

The plan has been updated to reflect:

- Feedback from the ACP EDG (May 2019)
- Feedback from all partner organisations at executive level/ senior management level
- Feedback from Healthwatch and the ACP Service User Advisory Group
- Contributions made from individuals and teams right across the system

The document very much represents a collective effort, with sections written from different teams/ individuals across the city. There are two documents presented here

- **Shaping Sheffield – The Plan**– aimed at the leadership community setting out the strategic goals
- **Delivery Plan** – incorporating the detail of delivery - 1 page programme plans, partner/ system objective alignment

At the end of this process a summary document for public consumption and staff will be produced.

It is important that the Board secures clear commitment that what is presented is agreed by all partners at the table, before it moves into the formal sign off process at the health and Wellbeing Board and Partner Organisation Boards.

Over the next few weeks it is now imperative that we ensure Shaping Sheffield and Integrated Commissioning is fully aligned.

Two reflections are offered back to the Board through this process:

- There was significant feedback on original plan regarding whether we were **ambitious** enough in the document. The document has been amended. We now need to ensure we are ambitious in our delivery and ways of working together and **challenge ourselves** on this.
- Some areas of the plan were easier to corral than others, reflecting **different levels of**

strategic and operational system working across the city. On some delivery priority areas identified if still feels that the ACP team are "holding the ring" to bring colleagues together, rather than colleagues across the system working easily together. In other areas, there is genuinely a system team working on priorities, and the ACP team has a rightly more peripheral role. This reflects the considerable cultural journey we are taking with this work.

3. Is your report for Approval / Consideration / Noting

Consideration and approval

4. Recommendations / Action Required by Accountable Care Partnership

4.1 Confirm full partner support and ownership of the plan

4.2 Note timetable for final sign off through system and partner boards. The following was agreed at EDG:

ACP Board	21st June
Health and Well-Being Board	27th June
Partner Boards	June/ July Boards
ICS – for information	Q2 review date

4.5 Board should note the intended refresh of the SYB ICS plan in early Autumn. Our timescale in Sheffield is ahead of this. We have engaged with the ICS on drafting this plan and have confirmed the likely consistency. However we do need to keep the ICS appraised of our plans to ensure we do not have to rework local plans in light of the SYB ICS plan.

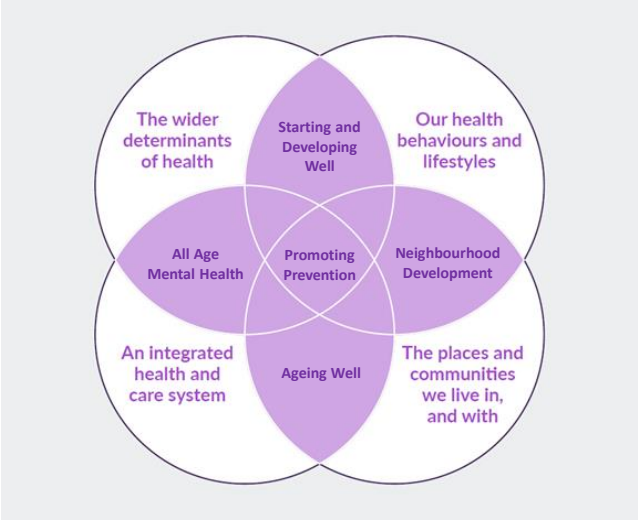
5. Other Headings

Are there any Resource Implications (including Financial, Staffing etc.)?

Not at this stage

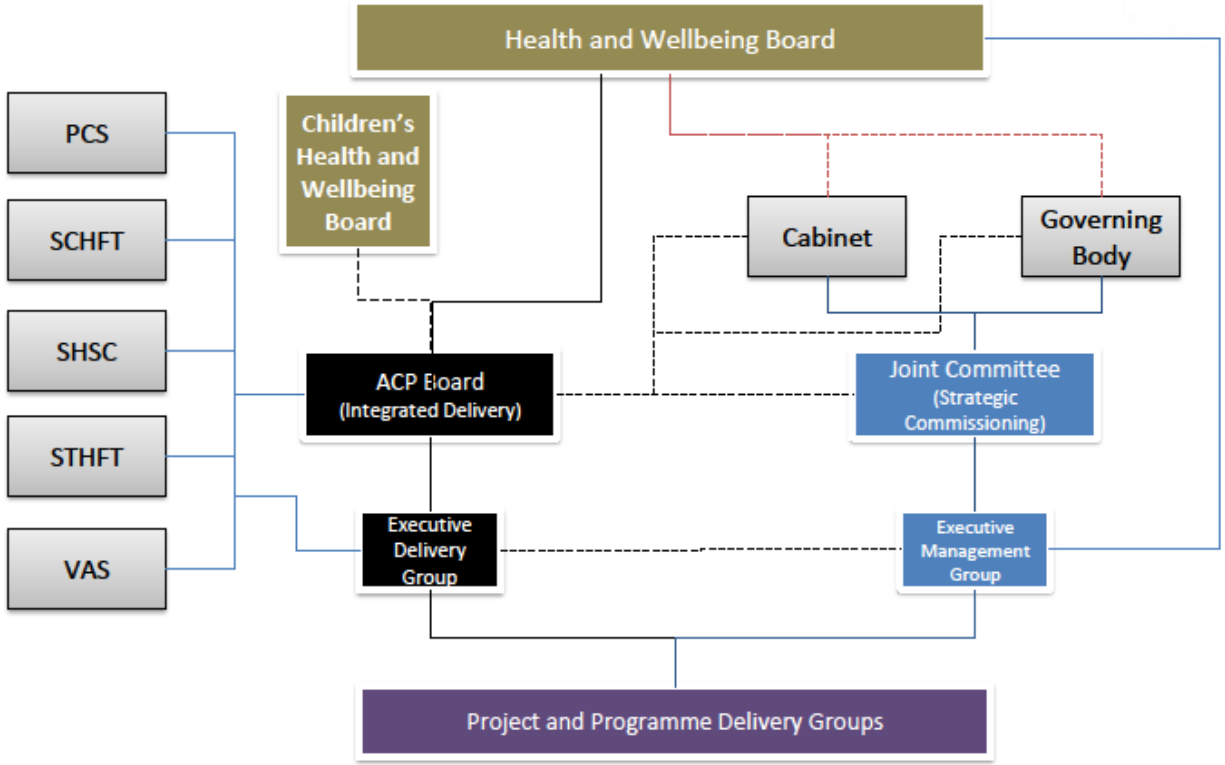
Shaping Sheffield

Delivery Plan Overview



ACP Governance Structures

Accountable Care Partnership Summary Governance Structure



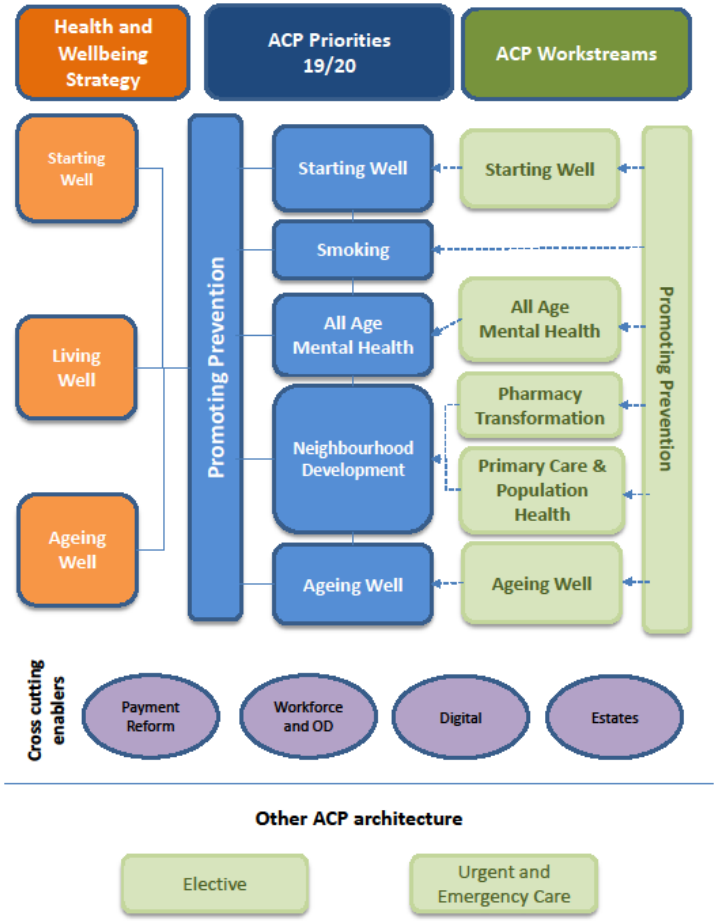
The relationship between the programme delivery groups is shown on the next page

The diagram to the right shows how the ACP programme of work has been broken down into delivery workstreams and its cross cutting enablers.

Each workstream has reporting lines up to the Executive Delivery Group and ACP Board (shown in the governance diagram on the previous page. Each workstream has both an executive and senior clinical lead from one of the ACP partner organisations

Each workstream can be mapped onto one or more of the five ACP priorities and as their work plans develop, they will demonstrate their contribution to them. High level summaries of the work plans are provided in the following pages.

The workstreams will work closely with the ACP Programme Management Team to ensure pieces of work that sits across multiple workstreams/priorities are coordinated to avoid duplication of effort and maximise integrated working opportunities.



ACP Workstreams
Plans on a Page

WORKSTREAM OVERVIEW
CHILDREN'S HEALTH AND WELLBEING TRANSFORMATION BOARD

Purpose

We want all children in the City to have the best life chances and families to be empowered to provide healthy, stable and nurturing environments. We want to connect people to the right levels of support at the right time through universal and targeted prevention, early identification and early support. We want:

- Every child to achieve a level of development in their early years for the best start in life
- Every child included in their education and accessing their local school
- Every young person equipped to be successful in the next stage of their life.

Key Partners

NHS
Sheffield City Council
Sheffield
vas
Primary Care Sheffield

Co- production

The CH&WB Board membership consists of key partners across the City who will share responsibility for decisions made and share their knowledge and experience to shape the delivery of services.

Key Outcome Measures

Measures to be agreed - draft as follows:	
Increased life expectancy at birth	Increase in children who are School ready at age of 5
Reduced waiting list for access to CAMHS and neuro-disability.	Reduction in inequality gap at the end of Foundation stage.
Number of schools teaching lifestyle skills to prepare children for role as parents.	Funding in place to enable establishment of local community hubs to enable tailored approaches and engagement.
Named support workers to assist negotiating various pathways.	Agreed integrated budgets across partners.

Programmes of work

Priorities for 2019/2020	
• Implement the Written Statement of Action following the inspection of SEND.	• Support the delivery of a new all age eating disorder pathway.
• Implement a community nursing model to support the development of locality based working with a focus on complex needs and palliative care.	• Review and refresh the city's 'Great Start in Life Strategy'; recognising what has been achieved to date.
• Finalise the community paediatric pathway with focus on autism and ADHD.	• Undertake stakeholder engagement during 2019 in order to create a Children and Young People's Strategy. Ensure links with other ACP workstreams to ensure C&YP are a priority.

ACP priorities

Starting Well	✓
Promoting Prevention	✓
All Age Mental Health	✓
Neighbourhood Development	✓
Ageing Well	

Exclusions

To be confirmed.

Governance

Please note that this is currently a draft plan and has yet to be discussed with the Children's H&WB Board.

PREVENTION WORKSTREAM OVERVIEW

Purpose

Embedding a preventive approach into the commissioning, planning and delivery of health and care systems of Sheffield

Key Partners

NHS

vas

Sheffield City Council

Primary Care Sheffield

Co- production

Working alongside Healthwatch and the ACP Advisory Group, a plan for increased lay membership on the prevention workstream and opportunities for co-design of new approaches will be explored .

Key Outcome Measures

By March 2020
Clear articulation by all ACP workstreams of prevention approach
Clear articulation by all ACP partners of organisational prevention approach and plans
Increased referrals to stop smoking services
Longer Term
Embed actions on preventative risk factors into ACP partner organisations and wider Sheffield economy
Prevention and wellbeing embedded into all health and social care policies and decisions

Governance

Programmes of work

Priorities for 19/20	
• Improve work and health programmes interface	• Development of organisational level plans to embed prevention approach
• Support and enable a shift to a more person centred approach for our population and workforce	• Embed actions on preventative risk factors into the Sheffield health and care system.
• QUIT programme	• Healthy catering policies across ACP partners
• Move More Strategy Implementation	• Improved linkage into locality working and Neighbourhood development

Additional Programmes / Projects
• Comprehensive programme of public communications and marketing on self care and healthy choices
• Contracts and commissioning plans to promote and resource physical activity as medicine and make referral paths clearer

ACP priorities

Starting well	✓
Promoting Prevention	✓
All Age Mental Health	✓
Neighbourhood Development	✓
Ageing Well	✓

Exclusions

The ACP prevention workstream will not supersede work already ongoing through the Food and Wellbeing Board, Tobacco Control Board and the National Centre for Sports and Exercise Medicine Board. They will however, remain closely aligned

MENTAL HEALTH AND LEARNING DIABILITIES WORKSTREAM OVERVIEW

Purpose

To design and implement a transformational programme of work that will improve the quality of mental health, learning disability and dementia services and the experience of those who use them; whilst simultaneously delivering better value for money.

Key Partners

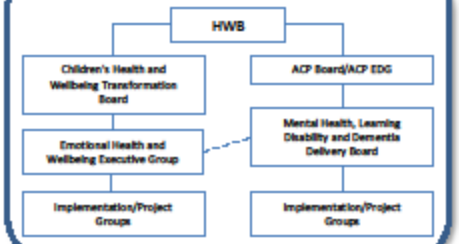
Co- production

Consultation, engagement and co-production activity is a key part of the Mental Health Transformation Programme. During 2019/20 further work will be undertaken to ensure that genuine co-production activity is consistent and sustainable.

Key Outcome Measures

By March 2020
Delivery of LTP for Children and Young People
Dementia Strategy Agreed
Eating Disorders Pathway Fully Operational
Transitions Project Fully Delivered
Longer Term
Reduction in Mortality Gap
Reduction in Suicides
New Model of Neighbourhood Health and Wellbeing Fully Enacted

Governance



Programmes of Work

Priorities for 19/20	
• Dementia Care Pathway	• Neighbourhood Health and Wellbeing Service
• Promoting Independence	• Better Care (Physical Health)
• Door 43	• Transitions
• Eating Disorders	• Transforming Care
• Healthy Minds Framework	• Reduced waiting times in CAMHS
Additional Programmes/Projects	
• Psychological Wellbeing Practitioners (PWP's)	• Primary Mental Health Worker (PMHW) Service
• Section 117 Aftercare	• Perinatal Mental Health
• Reducing Anti-Depressant Use	• Personality Disorders
• Developing a Psychiatric Decision Unit	• Trauma PTSD
• Section 12 Fees	• VCF Sector
• Bespoke Packages of Care	• Prevention and Early Intervention
• Autism	• Access and Waiting Times
• Mental Health Five Year Forward View	• Digital and Data
• SHSC Service Specification Reviews	• Vulnerable Groups
• Crisis Care Pathway (Inc. 136)	• Housing, Benefits and Employment
• Legacy CHC Grant Arrangements	• Engagement of Young People Programme

ACP Priorities

Starting well	✓
Promoting Prevention	✓
All Age Mental Health	✓
Neighbourhood Development	✓
Ageing Well	✓

Exclusions

There are no specific exclusions, although areas of potential overlap/duplication are routinely raised via the ACP Executive Delivery Group.

PHARMACY WORKSTREAM OVERVIEW

Purpose

- Improve system wide medicines optimisation
- Maximise the contribution of pharmacy professionals system-wide
- Support patients with their medicines at all points in their care

Key Partners

NHS

Sheffield City Council

Community Pharmacy Sheffield

Primary Care Sheffield

Co- production

Working with the Improving Accountable Care Forum

Workforce engagement event(s) planned

Key Outcome Measures

By March 2020	
Established proof of concept sites for community pharmacist and GP joint working	Increase in prescribing pharmacists
A community pharmacy led long term condition management service	Increase in the number of specialist and cross sector posts
Longer Term	
Expand the scope of pharmacy practice to ensure all patients receive the benefits from the skills and expertise of pharmacy professionals	

Governance

Pharmacy Workstream planning and delivery is implemented by an ACP Pharmacy Transformation Group comprised of members from each ACP partner

Programmes of work

Priorities for 19/20	
• Set up joint working arrangements between community pharmacists and general practice	• Support pharmacist take up of prescribing training across all sectors
• Develop and test a primary shared care hypertension service	• Develop specific cross sector post opportunities
Additional Programmes / Projects	
• Large scale commissioning of long term condition management by pharmacy professionals	• Establish consultant pharmacists e.g. palliative care
• Expand the scope of long term condition management by pharmacy professionals	• Offer all pharmacists the opportunity to prescribe where appropriate
• Deliver domiciliary medication reviews	• Expand the medicines optimisation support within care homes
• Increase cross sector posts between interface points e.g. primary and secondary care, child to adult, cross discipline	

ACP priorities

Starting Well	✓
Promoting Prevention	✓
All Age Mental Health	✓
Neighbourhood Development	✓
Ageing Well	✓

PRIMARY CARE WORKSTREAM OVERVIEW

Purpose

To ensure that the people of Sheffield have excellent local, joined up, sustainable primary and community support to enable them to live their lives to the full

Key Partners

Primary Care Sheffield

Sheffield Health and Social Care NHS Foundation Trust

Sheffield City Council

vas

NHS Sheffield Clinical Commissioning Group

Sheffield Teaching Hospitals NHS Foundation Trust

Key Outcome Measures

By March 2020
Development of Primary Care Workforce Plan and Strategy
Implementation of GPN VTS Scheme
Evaluation of 7 initial Neighbourhood projects (6 further faster and SCC led SE HUB) with shared learning and duplication across city
Hub implementation across Sheffield
Digital Integrated Care Record accessible to General Practice and Social Care Health Care Professionals
Longer Term
Production of PHM Dashboard at Neighbourhood Level
Mature neighbourhoods delivering multi-disciplinary services to meet address health inequalities and the ACP priorities.

Governance

Programmes of Work

Priorities for 19/20	
• **Centre of Excellence in Primary Care** – understand future workforce demand, gaps and skill mix and provide training in order to support future demand of primary care	• **Neighbourhood Delivery** of multi-organisational, multi-disciplinary teams, increasing patient experience patient wellbeing and reducing health inequalities whilst increasing service delivery around ACP priorities
• **Population Health Management** - Use the 'Infrastructure, Intelligence and Intervention' methodology to design care models, outcomes and evaluations	• **Sheffield Brand of General Practice** – Define a vision of sustainable General Practice delivered across Primary Care Networks, working within the New GP Contract and LTP. Producing a menu of support options.
• **Digital Integrated Care Record** – • Development of an electronic integrated care record accessible to primary care providers.	• **Local First** - promote person centred holistic care, moving appropriate generalist activity into the primary care setting whilst maintaining provider relationships and developing seamless pathways of care
Additional Programmes / Projects	
• Primary Care Research and Innovation	• Development of Digital Primary Care Strategy
• Shared approach to non academic training	• Universal Offer to Neighbourhoods

Co- production

Development of relationships with ACP Service User group and outreach to recruit a Primary Care Champion

Engagement with patients at a Neighbourhood Level to inform service development priorities and methods of delivery.

ACP priorities

Starting well	✓
Promoting Prevention	✓
All Age Mental Health	✓
Neighbourhood development	✓
Ageing Well	✓

ACP ELECTIVE CARE WORKSTREAM OVERVIEW (Draft pending approval 28/3/19)

Purpose

To implement new approaches to outpatient services and develop a system which integrates provision to maximise seamless general, enhanced and specialist care to happen in the right place, delivered by the right people at the right time.

To develop consistency and quality to ensure right patient, right pathway and a person-centred approach.

Key Partners

Primary Care Sheffield

NHS Sheffield Clinical Commissioning Group

Sheffield Children's NHS

NHS Sheffield Teaching Hospitals

Co- production

- Service user input into development of integrated community services via steering groups
- Service user input into cross-cutting themes developments.
- Strategic Patient Engagement, Experience, Equality Committee (SPEEEC) oversight

Key Outcomes

By March 2020	
Integrated community services & care closer to home	Reduction in hospital follow up activity
New technology solutions	Benefits realisation of CASES
Upskilled clinical workforce	Redesigned pathways inc. IAPT & self-care
Delivery against and alignment to primary care strategy, new GP contract and NHS Long Term Plan	
Longer Term	
Redesigned consultant to consultant pathways	Reduced outpatient appointment DNA rates

Governance

Programmes of work

Priorities for 19/20	Cross-Cutting Themes
• Implement Integrated Skin (lesions) Community Service Test of Concept • Implement Tele-dermatology Test of Concept • Implement Integrated Cardiology (Heart Failure) Community Service Test of Concept • Implement Primary Care ECG Test of Concept • Implement ENT Integrated Community Service Test of Concept • Define and implement integrated care pathway for sustainable allergy services. • Strengthen Local Authority input to the work of the group	*Utilise learning from CASES, RightCare and collaborative working to identify opportunities for:* new integrated service developments new/improved pathways, thresholds redesigned follow-up methods vague or medically unexplained symptoms (IAPT) support patient self-management and care reduction in DNAs in problematic clinical pathways diagnostics referral and access development consistent approach for consultant to consultant referrals training and clinical workforce development Reduction in inequalities of access to elective care pathways

ACP priorities

Starting Well	✓
Promoting Prevention	✓
All Age Mental Health	
Neighbourhood Development	
Ageing Well	✓

Exclusions

Gastroenterology has been removed from the work programme due to overlap with Cancer Alliance activities.

Areas of overlap where other ACP work streams are more appropriate to deliver

URGENT AND EMERGENCY CARE WORKSTREAM OVERVIEW

Purpose

To lead city-wide integrated delivery, transformation and improvement of urgent and emergency care through collaborative and supportive actions and behaviours that achieve 'high quality right care, right place'

Key Partners

NHS

Sheffield City Council

Primary Care Sheffield

Co- production

Co-production approach used to identify the problems with Urgent Care in the city.
Patient experience of discharge is contributing to the ongoing development of services
Voluntary sector support to discharge, informed through a co-production approach

Key Outcome Measures

By March 2020	
Longer Term	
More effective use of urgent care resources	
People are only admitted to hospital when clinically necessary	
Increase in the number of patients assessed and discharged on the same day	
Patients stay in hospital for the minimum time required to manage their presenting problem while avoiding the secondary harms arising from hospitalisation	
The majority of patients are discharged back to their usual place of residence	

Programmes of work

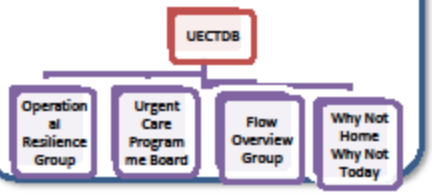
Priorities for 19/20	
• Increase effective usage of community urgent care resources	• Ensure fast assessment directs to appropriate response
• Reduce ED attendances (Type 1 NGH/SCH only)	• Improve flow through and out of hospital
• Improve system resilience	

Additional Programmes / Projects
• Urgent Care Review
• Front Door Programme
• Improved resilience of the Mental Health Crisis Care pathway
• Excellent Emergency Care
• Flow Overview
• Why Not Home Why Not Today

ACP priorities

Starting Well	✓
Promoting Prevention	✓
All Age Mental Health	
Neighbourhood development	✓
Ageing Well	✓

Governance



Interdependencies

- Patients at risk of admission model (sits under LTC Board)
- Primary Care 5yr forward transformation (sits under Primary Care Board)
- Mental Health Crisis Care Concordat

LONG TERM CONDITIONS WORKSTREAM OVERVIEW

Purpose

Key Partners

Primary Care Sheffield

Sheffield Health and Social Care NHS Foundation Trust

NHS Sheffield Clinical Commissioning Group

Sheffield City Council

vas

NHS Sheffield Teaching Hospitals

Key Outcome Measures

By end March 2020	
Blood Pressure	The percentage of patients with hypertension in whom the last
PAM	Patient Activation Measure score
End of life plan	% of people who die with an end of life plan
Longer Term	
Life Expectancy	Inequality in life expectancy at birth for females (Slope Index of
Life Expectancy	Inequality in life expectancy at birth for males (Slope Index of
Preventable years of	Mortality rate from causes considered preventable per 100,000
Deaths under 75 years	Under 75 mortality rate (all causes)
Admissions to care	Number of admissions to care homes per 100,000 population
Reablement	Proportionate of people offered reablement
	Proportionate of people still at home 91 days after discharge

Governance

Programmes of Work

	Themes Priorities for 19/20
• Patient sand Carers as Experts	• Person-centred care • Development of outcome focused commissioning
• Slowing and Managing Multimorbidity	• Hypertension management • Diabetes Prevention Programme • Diabetes Treatment & Care • Early help • Care planning
• Integrated Models of Care	• Neighbourhood approaches to delivery • End of Life Care • Care homes

Co- production

Development of relationships with ACP Service User group and identification of priority areas for co-production

Engagement with patients at a Neighbourhood Level to inform service development priorities and methods of delivery.

ACP priorities

Starting well	✓
Promoting Prevention	✓
All Age Mental Health	✓
Neighbourhood development	✓
Ageing Well	✓

Payment Reform
(to be developed)

WORKFORCE AND ORGANISATIONAL DEVELOPMENT WORKSTREAM OVERVIEW

Purpose

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

Key Partners

NHS

vas

Sheffield City Council

Primary Care Sheffield

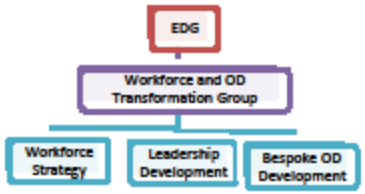
Co- production

Members of the public will be routinely consulted when new systems and processes are being developed, and will be an integral part of all OD interventions.

Key Outcome Measures

By March 2020	
Workforce Strategy	Leadership development
Clear all-age plan in place and in progress	100 staff accessing system leadership development
Executive development	Clear plan in place
Longer Term	
Workforce strategy	Staff absence rates at B2 / equivalent
Diversity of leadership across the system	Staff engagement rates at B2 / equivalent
Measurement against the workforce maturity matrix	Ability to accurately predict demand

Governance



Programmes of work

Priorities for 19/20	
• Develop an all-age system workforce strategy and plan (Sept '19)	• Develop a plan for EDG and ACP Board development (Sept '19)
• Leadership development through Shadow Board and Leading Sheffield (ongoing)	• Mobilise the Older People's chapter of the workforce strategy (June onwards)
• Bespoke development – TCSL for ACP workstreams	• Develop Centre of Excellence for B2 / equivalent staff focused on person-centred approaches

ACP priorities

Starting well	✓
Promoting Prevention	✓
All Age Mental Health	✓
Neighbourhood Development	✓
Ageing Well	✓

This workstream focuses on workforce and OD work *across* the system, intending to complement internal organisational processes and resources

DIGITAL WORKSTREAM OVERVIEW

Purpose

To deliver the digital capabilities that support the 'Shaping Sheffield' ACP transformation.

Key Partners

vas
NHS
Primary Care Sheffield
Sheffield
Yorkshire & Humber Care Record
NHS Digital
South Yorkshire and Bassetlaw Integrated Care System

Co- production

Significant user research and engagement has taken place in the last 6 months across ACP settings. Digital leads have supported several Shaping Sheffield events too. Healthwatch Sheffield has been engaged to understand the public's view of shared records. Engagement has been completed with other places, such as Rotherham, Doncaster, Leeds and Manchester. Work is ongoing with the Yorkshire and Humber Care Record team to ensure any Sheffield solution integrates with the YHCR.

Engagement and research activities will continue to ensure user needs are understood and the right digital and assisted digital service is delivered.

Key Outcome Measures

By March 2020
Reduced time spent on administrative activity across ACP Partners
Longer Term
Reduced length of stay
Reduced number of non elective admissions
Increased adherence to End of Life and Do Not Resuscitate preferences
Reduced number of citizens in crisis
Overall satisfaction of people who use services with their care and support
Workforce satisfaction - overall organisational position for staff engagement from staff survey
Support reduction of Suicide rate over 100,000 population
Reduced number of all types of attendances at A&E
Reduced Delayed transfer of Care - Delayed Days (rate per 100,000 18+ population)
Reduced number of admissions to care homes per 100,000 population

Governance

ACP Board
ACP EDG
ACP Digital Delivery Board

Priorities for 19/20

Deliver a Sheffield Shared Record

1. Integrating health and care data across Sheffield for direct care.
2. Giving professionals in Sheffield access to a shared record to support integrated working and reduce administrative burden
3. Giving citizens access to their health and care records to increase self care and reduce inequalities
4. Connecting Sheffield Shared Record with South Yorkshire place based shared records, e.g. Rotherham Health Record and the Yorkshire and Humber Care Record (YHCR) to support integrated working
5. Enabling other Sheffield health and care providers, e.g. Community Pharmacy and St Lukes Hospice (Palliative Care) access to Shared Record for purposes of direct care

Connectivity to support Shaping Sheffield

Enabling secure, performant IT access for staff working across all partner sites.

Data Sharing to support Shaping Sheffield

1. Ensure safe, secure and compliant data sharing agreements and protocols, governance, and compliant systems exists across Sheffield for the use of citizen's health and care data for the purposes of direct care (shared records) and secondary use (population health management).

Population Health Management

1. Delivering a population health management capability (business intelligence and analytical capability), including secondary use of citizen data to understand the needs of the Sheffield population and reduce health inequalities. This work will be aligned to the work within the Primary Care Workstream.

ACP priorities

Starting Well	✓
Promoting Prevention	✓
All Age Mental Health	✓
Neighbourhood Development	✓
Ageing Well	✓

Exclusions

None currently identified, although this will be tested with the other ACP workstreams.

Estates
(to be developed)

Organisational Priority Alignment to ACP Priority Areas

PCS Priority Alignment

ACP 19/20 Priorities	PCS Priorities	Other linkage
Starting Well	• Delivering new network services ; Vacs' & Imms review	Children's Health & Wellbeing Board
Promoting Prevention	• Supporting care navigation; social prescribing in primary care • Social care integration and support	PCS subsidiary Intercare
All Age Mental Health	• Primary Care Mental Health Service – supporting new model of care for Sheffield	SHSC Primary Care Mental Health Strategy
Neighbourhood Development	• Supporting the development of 15 Primary Care Networks and primary care resilience across Sheffield • Supporting the delivery of primary care at scale • Developing and implementing new models of care out of hospital – Tele Dermatology/ENT/Cardiology • Improving access to primary care for all age groups through an integrated 24/7 primary care offer	NHS GP Contract Digital Solutions
Ageing Well	• Delivering new network services ; Structured medication Reviews; Enhanced Health in Care Homes Service ; Anticipatory Care ; Personalised Care ; Early Cancer Diagnosis ; Inequalities	NHS GP Contract Digital Solutions Workforce planning and additional new roles

SHSC Priority Alignment

ACP 19/20 Priorities	SHSC Priorities	Other linkage
Starting Well	A1 04: We will ensure timely access to effective care - Specialist Perinatal Mental Health services expansion	
Promoting Prevention	A3 04: Deliver effective crisis care pathways and services - Learning disabilities and community focussed support for people with complex needs	Physical health strategy Smoking cessation strategy Integrated IAPT IPS & Employment
All Age Mental Health	A3 02: Deliver effective Recovery services A3 04: Deliver effective crisis care pathways and services - Mental Health Crisis hub	Integrated IAPT Eating Disorders Service pathway development
Neighbourhood Development	A3 01: Develop Primary Mental Health and Neighbourhood services	Integrated IAPT IPS & Employment Outcomes Fund re: Alcohol Service developments
Ageing Well	A3 04: Deliver effective crisis care pathways and services – access and support for people with complex dementia	

VCS Priority Alignment

ACP 19/20 Priorities	VCS Priorities	Other linkage
Starting Well	Volunteering	
Promoting Prevention	Resilient communities	
All Age Mental Health	Volunteering	
Neighbourhood Development	Resilient Communities	
Ageing Well	Health and Wellbeing Volunteering	

SCC Priority Alignment 1:

ACP 19/20 Priorities	SCC Priorities	Other linkage
Starting Well	• Promote and support the health and wellbeing of children in case as corporate parents (C&F) • Working in partnership to develop and embed improved help and protection (C&F) • Ensure sufficient appropriate accommodation for children in care focusing first on prevention (C&F) • Support our care leavers journey to independence (C&F) • Develop resilience and inclusion (CILS)	• Children and Families Improvement Plan • Inclusion and SEND improvement plan • Signs of Safety • Early years centres of excellence • MAST • Future in Mind • Family Centres • Emotional wellbeing online counselling service (Kooth) • Project Aspire

SCC Priority Alignment 2:

ACP 19/20 Priorities	SCC Priorities	Other linkage
Promoting Prevention	• Increasing independence and inclusion (Adults) • Increasing shift to prevention (adults) • Increasing adults able to live at home (adults) • Improved skills for employment (LCLS) • Maintain/increase opportunities to learn and enjoy in the community (LCLS) • Develop resilience and inclusion (CILS) • Increasing shift to prevention (CILS) • Person centred approach to delivery (CILS) • Promoting positive health and wellbeing (CILS) • Working in partnership to develop and embed improved help and protection (C&F)	• Inclusion and SEND improvement plan • Adults Improvement Plan • Dementia strategy • Vulnerable learner reviews • Transitions • Children's improvement plan • Early years centres of excellence • Family Centres

SCC Priority Alignment 3:

ACP 19/20 Priorities	SCC Priorities	Other linkage
All Age Mental Health	• Promoting positive health and wellbeing (CILS) • Develop resilience and inclusion (CILS) • Increasing the shift to prevention (CILS) • Promote and support the health and wellbeing of children in care as corporate parents (C&F) • Support our care leavers journey to independence (C&F)	• Mental Health Transformation Programme • Project Aspire • Project Apollo • Redesign of CAMHS for LAC/edge of care services • Emotional wellbeing online counselling service (Kooth) • Local transformation plan • Inclusion and SEND Improvement Plan
Neighbourhood Development	• Maintain/increase opportunities to learn and enjoy in the community(LCLS) • Increase community cohesion (LCLS) • Support sustainable local initiatives (LCLS) • Increase visibility and opportunities for locally based support (LCLS) • Person centred approach to delivery (CILS)	• Skills strategy • AEB devolution • Controlling migration fund • ESF prep for success and preparing for progress • Locality/neighbourhood development

SCC Priority Alignment 4:

ACP 19/20 Priorities	SCC Priorities	Other linkage
Ageing Well	• Increasing adults able to live at home (adults) • Increasing the shift to prevention (adults) • Increasing independence and inclusion (adults) • Promoting positive health and wellbeing (CILS) • Develop resilience and inclusion (CILS) • Increasing the shift to prevention (CILS) • Person centred approach to delivery (CILS)	• Adults Improvement Plan • Joint commissioning frailty programme • Dementia strategy

STH Priority Alignment

ACP 19/20 Priorities	STH Priorities	Other linkage
Starting Well	• Compliance with the Local Maternity System target – (Ensure 27% of women in Sheffield are booked into the continuity of care model) • Early years – developing more resilient families and communities	Corporate Objectives 2019/20 Annual Operational Plan 2019/20
Promoting Prevention	• SY&B ICS Quit Programme including In-house Stop Smoking Service • A dedicated Promoting Wellbeing Group to be established • Reducing smoking prevalence • Reducing obesity and promoting physical activity	CQUIN Update April 2019 People Strategy 2017-2022 Annual Operational Plan 2019/20
All Age Mental Health	• Mental and physical wellbeing initiatives • Following the National NHSI Health & Wellbeing Framework	People Strategy 2017-2022 Annual Operational Plan 2019/20
Developing Neighbourhoods	• OK To Stay Plan – Reducing admissions • Building community resilience through effective neighbourhood working	BPT May 2019 Annual Operational Plan 2019/20
Ageing Well	• Commitment to improve the experience of older people in the care system	Annual Operational Plan 2019/20

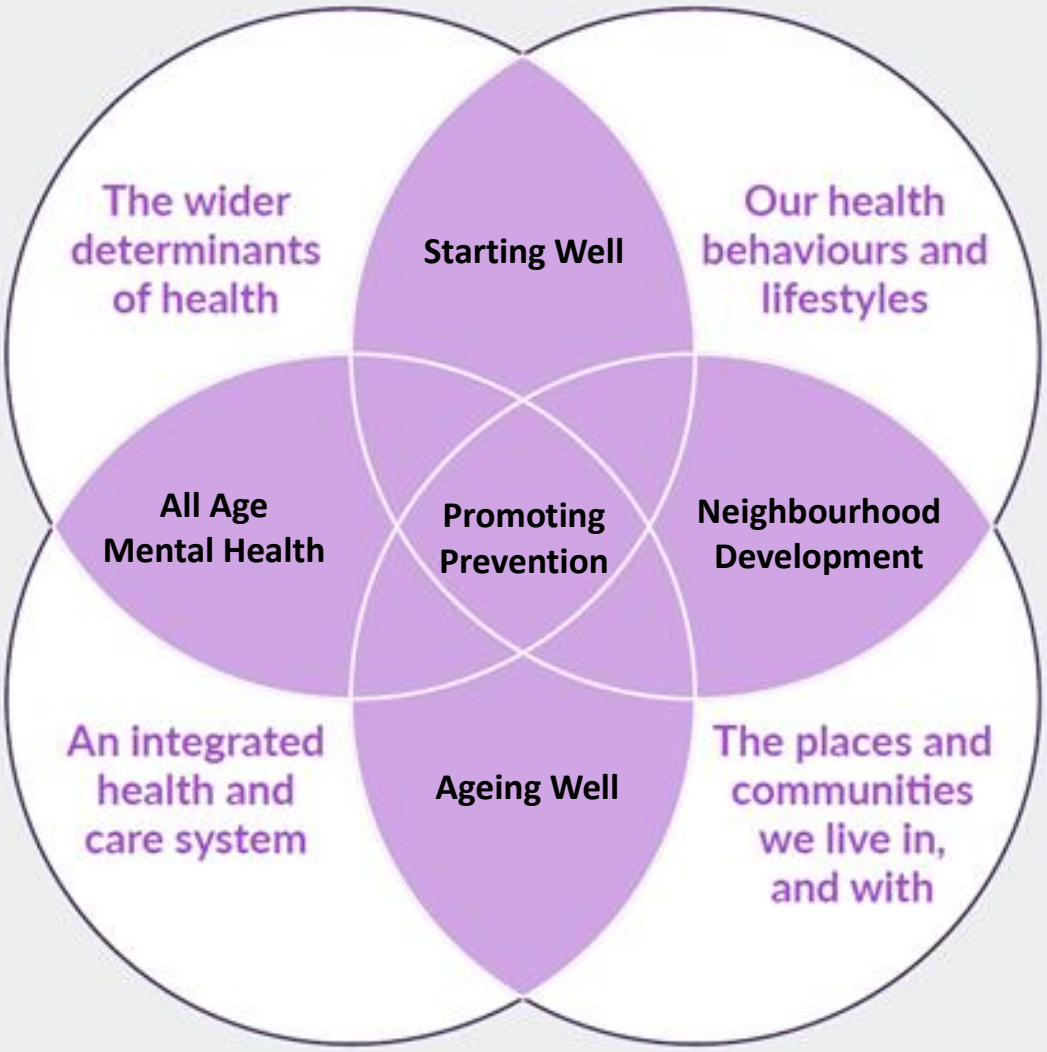
CCG Priority Alignment

ACP 19/20 Priorities	CCG Priorities	Other linkage
Starting Well	Complex Child – Continuing Care Children's Safeguarding Review Review of Community Therapy SEND Short Breaks Review Transitions & CYP Journey	ICS – Children's Surgery & Anaesthesia ICS – Acutely Unwell Child
Promoting Prevention	Diabetes Prevention Programme Person Centred Care Personalisation People Keeping Well	Cancer Alliance: Lung Healthcheck FIT Improving access to cervical screening
All Age Mental Health	Mental Health Joint Work Programme	
Developing Neighbourhoods	Neighbourhoods / Primary Care Networks Primary Care Strategy Integrated Community Services GPIT	
Ageing Well	End of Life Care Care Homes Dementia Care Pathway Enhanced health in care homes	

SCH Priority Alignment

ACP 19/20 Priorities	SCH Priorities	Other linkage
Starting Well	Establish pathway to Excellence Programme Co-production of Trust wide quality strategy Develop provision for complex patients Develop and improve care for patients with learning disabilities Deliver clinical transformation programmes Deliver against quality and safety standards and respond to CQC report Review model and reduce waiting times for neurodisability services	
Promoting Prevention	Develop long term strategy Consider NHS Long Term Plan aspirations	
All Age Mental Health	Develop and improve CAMHS provision. Develop integrated physical and mental health pathways Collaborative lead for Tier 3 and 4 CAMHS Develop closer working with SHSC NHSFT	
Neighbourhood Development	Take active role in Shaping Sheffield Implement level 1 hosted network for Acutely Ill child	

Shaping Sheffield



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1 Introduction

We want to transform our population's health, care and well-being, improving outcomes for the people of all ages of Sheffield.

Too many people in Sheffield still struggle with poor health and wellbeing, and this is inequitably distributed across our city. We want to change this through adopting our shared purpose in all we do: "***Prevention, well-being and great care together***". Our plan and delivery priorities are informed by extensive and ongoing service user, public and staff engagement. What was striking through our 2019 engagement was the consensus from the public and our workforce about the outcomes they wanted, with a focus on integration, prevention and collaboration:

Word cloud developed from "outcomes" discussions at 2019 engagement events

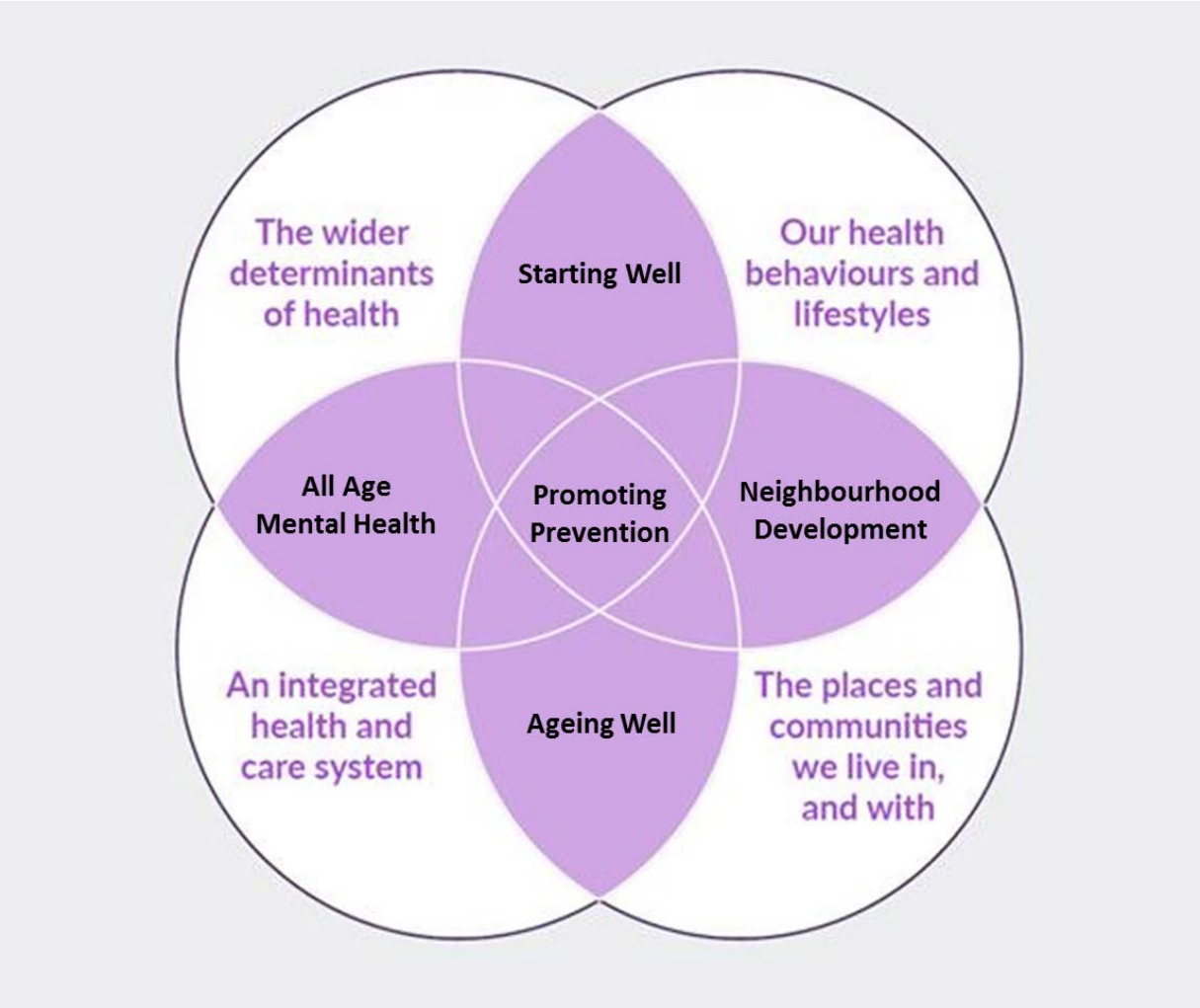
Having the right Strategy and Plan is only the first step; what matters more is how we deliver it. Our Plan therefore sets out our priorities for 1 and 5 years, building on good foundations and accelerating our progress. A full programme delivery document accompanies this strategic overview. We will need to significantly develop our culture and ways of working together to achieve our ambitions.

The Plan will be delivered by the Accountable Care Partnership which brings together seven partners in the city to focus on issues that can only be addressed as a collective endeavour. The partners are: Sheffield Children's NHS Foundation Trust, Sheffield City Council, NHS Sheffield Clinical Commissioning Group, Primary Care Sheffield Ltd, Sheffield Health and Social Care NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Voluntary Action Sheffield.

John Boyington, Chair, Primary Care Sheffield
Jayne Brown, Chair of Sheffield Health and Social Care NHS Foundation Trust
Andy Buck, Chair of Voluntary Action Sheffield
Sarah Jones, Chair of Sheffield Children's Hospital Foundation Trust
Dr Tim Moorhead, Chair of Sheffield Clinical Commissioning Group
Cllr George Lindars-Hammond, Cabinet Member for Health and Social Care
Tony Pedder, Chair of Sheffield Teaching Hospitals Foundation Trust

2. A Vision for Population Health in Sheffield: Towards A Healthier Future

We will adopt a population health approach to achieve our ambition to improve population health, care, and well-being outcomes. Population health extends beyond the care system to the wider determinants of health and the role of people, families and communities in improving health and wellbeing outcomes. The following infographic (adapted from the Kings Fund Population Health System Model (2018) summarises the wider determinants of health and the five Sheffield delivery priorities:



We will focus our efforts on our five priorities, acknowledging the wider connecting factors that shape our population's health. There is a wealth of evidence that the **wider determinants of health** are the most important driver of health. In addition to income and wealth, these determinants include education, housing, transport and leisure.

Our health behaviours and lifestyles are the second most important driver of health. They include smoking, alcohol consumption, diet and exercise. The ambition of the Sheffield ACP is to shift our care system to promote prevention throughout all our work - building on existing work in the city

established to tackle specific lifestyle and behaviour factors. Details of existing work can be found in the Sheffield Tobacco Control Strategy, the Sheffield Food Strategy and the Sheffield Move More Plan.

There is increasing recognition of the key role that **places and communities** play in our health. For example, our local environment is an important influence on our health behaviours, and there is strong evidence of the impact of social relationships and community networks, including on mental health. In Sheffield we have developed 'People Keeping Well' Partnerships, neighbourhood and locality working, our "Ryegate in the Community model" and most recently our Primary Care Networks. Our ambition is to bring these together and to scale up the impact for our population.

Recent years have seen a strong focus on developing an **integrated health and care system**. This reflects the growing number of patients with multiple long-term conditions and the need to integrate health and care services around their needs to deliver better outcomes. We have reviewed international and national evidence in developing our plans for Sheffield and want to scale up our integration work, building on existing pockets of good practice. In this context, **the long term ambitions** of the Shaping Sheffield Plan are:

i. To transform how our care system interacts with the **wider determinants** of health to help create a **happier, healthier and economically active population,** supported by **greater partnership** across ACP partners, police, fire, schools, universities and wider agencies.

ii. To better recognise the inter-play between **mental and physical health** and take **an asset based, holistic, person centred approach** with a shared ambition of **developing and supporting thriving communities, particularly in the most deprived parts of the city.**

iii. To develop an **all age care system**, involving **greater integration** between primary and specialist care; physical and mental health care; health and social care; and children's and adults' care. Services will be organised around the needs of individuals rather than professional boundaries. We will promote **prevention**, focused on transforming the **health and well-being** of the population.

iv. To deliver a **great start in life**, to enable all children in the city to have the best life chances and families to be empowered to provide a healthy, stable and nurturing environment.

v. To **support people to age well, and to improve the experience of those living with frailty and multi-morbidity**. We will support people to live well, keep people out of hospital and provide support and advice when needed in primary and community care environments.

vi. To create a **flourishing and thriving Sheffield** by **developing our workforce** in a joined up way to deliver holistic, person-centred and integrated care. We will be ambitious about our role and responsibilities as anchor organisations within Sheffield for the 38,000 people we employ and mobilise a system workforce strategy through the ACP.

vii. To **transform how we work together** and develop a more system focused culture and leadership, to address the cultural barriers within and between organisations, remove perceived hierarchies and build trust.

viii. To **support and enable strengthened communities,** learning from Wigan and other cities which have developed the relationship with the population to one that supports thriving communities and enables individuals to take responsibility for their health and well-being.

The *principles* and *values* that will guide our work are:

Our Principles:

- A population focused approach
- A preventive approach built into delivery at all levels of complexity
- Care closer to home or a home via neighbourhood, localities hubs
- A focus on reducing health inequalities in Sheffield
- Effective and efficient use of resources whilst assuring safety and effectiveness

How we will work – our values:

- A holistic, person centred approach
- Seamless, integrated working
- Co Design and co-production with our population and our workforce
- Collaboration to achieve transformed outcomes
- Delivery focused - we will be **bold** in holding ourselves to account for better outcomes

Our key **challenges** are as follows and have steered our delivery priorities and approach:

i. Our context of **social and health inequality is stark.** Sheffield is one of the 20% most deprived local authorities in England, with around 1 in 4 children living in poverty. At the same time we have some of the most affluent 1% of areas in the country. Our health outcomes match these extremes, as our infographic in Section 3 illustrates, with significant inequalities in health and the causes of ill-health experienced by both children and adults. We operate within a wider policy context that has implications for our people. Whilst we can influence this context, we do not control it, for example the concerning impact of Universal Credit that the Health and Well-Being Board has observed for our most vulnerable people.

ii. We know there are **challenges in how we deliver care** which we must address including:

   a. Child to adult mental health transitions highlighted in some recent tragic cases.
   b. The poor experience for people caused by our system fragmentation observed by the 2019 combined CQC/ OFSTED Review on Special Educational Needs and the 2018 CQC Local System Review for Older People.
   c. The need to ensure a thriving and sustainable voluntary sector & a stronger strategic voluntary sector voice throughout our partnership arrangements.
   d. The considerable frustration experienced in receiving and delivering care across organisational boundaries due to the fact our care record systems do not connect.

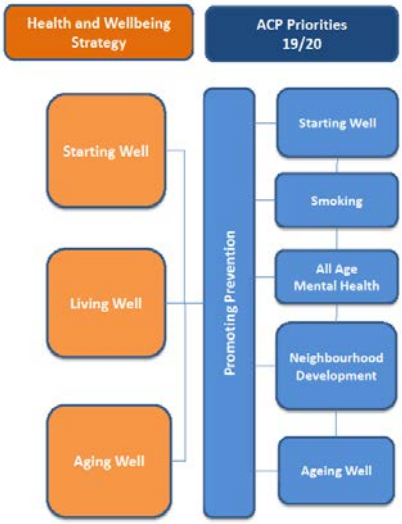
iii. We need to achieve a **changed investment model** across the system that directs more investment towards prevention and a differential investment model to communities experiencing the greatest health inequality. Our integrated commissioning should support this shift. However, we need to maintain system financial sustainability whilst we transform, enabling all system partners to adapt as the strategic and organisational landscape changes in line with our new care models and priorities.

iv. How we **engage, communicate and mobilise strategy** – The Sheffield provider landscape is rich and complex; in 2019 it includes 81 primary care practices, 104 social care contractors, 45 Nursing homes, 67 Residential homes and over 3000 voluntary sector organisations, alongside our statutory NHS and local government providers. We collectively employ over 38,000 staff across care and serve a population of 580,000. Transforming our culture to one focused on prevention and person centred provision will be a significant challenge.

3 The Strategic Context

3.1 The City Wide Context

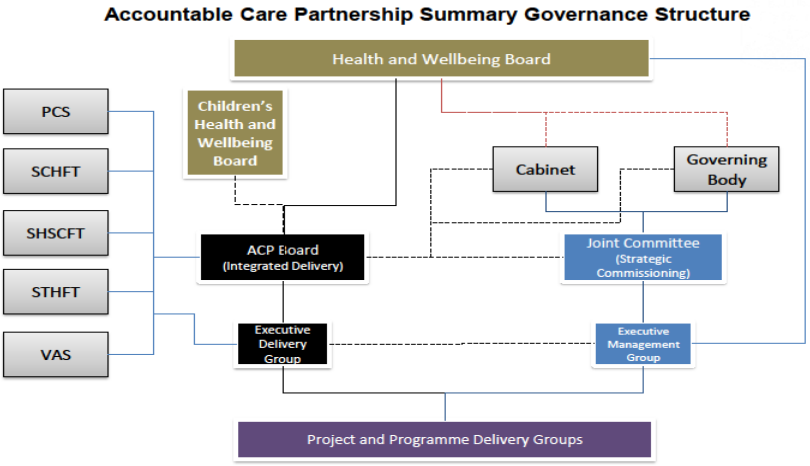
The Shaping Sheffield Plan is rooted within the 2019 Sheffield Health and Well-Being Strategy. The Health and Well-Being Strategy sets out a life course approach and develops a set of ambitions for a healthier city that will make a difference both in the short and long term. Its 3 'chapters' summarise the life course approach – "Starting Well", "Living Well" and "Ageing Well". All of the priorities and actions within the Shaping Sheffield Plan map directly against these 3 chapters



The Shaping Sheffield Plan also drives and is enabled by the move of Sheffield Clinical Commissioning Group (CCG) and Sheffield City Council (SCC), towards establishing joint commissioning arrangements. This aims to develop a single commissioning voice and a single commissioning plan driven by the newly established Joint Commissioning Committee. Joint commissioning priorities, also embedded within our Shaping Sheffield delivery priorities for 2019/20 will be:

- To integrate services across health and care to ensure a seamless service for frail residents.
- To develop a partnership approach to Special Educational Needs and Disabilities (SEND), in the context of the Ofsted / CQC inspection and local required outcomes and resources.
- To consolidate and build on our integrated mental health work.

In order for commissioning to work effectively, strong, mature relationships with providers will be critical to ensure that collectively we co-design provision to achieve high quality outcomes for our population. The governance of joint commissioning and interface with the ACP is summarised below:



3.2 ACP Partner Context

Our partners have committed to embedding the priorities of the Shaping Sheffield Plan into their organisational commitments. The Programme Delivery Document demonstrates the agreed alignment between the system plan and organisational priorities.

3.3 The Regional Context

The South Yorkshire and Bassetlaw Integrated Care System (ICS) was established in 2017 and was one of ten first-wave ICS's identified nationally to develop the blueprint for system working across health and care organisations. In the same year, Sheffield ACP was one of five "places" established across South Yorkshire and Bassetlaw. The different health and care organisations across the five SYB places form the ICS footprint. The ICS is currently developing its response to the NHS Long Term Plan which sets out the requirement for systems to work together with partner organisations to produce a five-year strategic plan by the autumn of 2019. The plan builds on the 2016 SYB Sustainability and Transformation Plan, and will focus on improving population health and wellbeing through prevention, integrating care and partnership working.

3.4 The National Context

In January 2019, the Long Term NHS Plan was published, with a focus on prevention, population health and integration. Underpinning the plan is an emphasis on the "triple integration of primary and specialist care, physical and mental health services, and health with social care." We anticipate the Social Care Green Paper and Prevention Green Paper will further consolidate this focus on a preventative, person-centred, holistic and integrated care approach. Within the Long Term Plan, we see a greater focus on children and mental health. The plan has committed £4.5 billion more for primary medical and community health by 2023/24 and £2.3 billion for mental health.

The new GP contract framework (2019) marks some of the biggest general practice contract changes in over a decade and will be essential to deliver the ambitions set out in the NHS Long Term Plan.

The contract will ensure general practice plays a leading role in every Primary Care Network (PCN), which will include bigger teams of health professionals working together in local communities to develop closer working between networks, Place arrangements and Integrated Care Systems. What will be crucial is aligning Clinical Director and PCN priorities to the broader Place and ICS context to ensure that this changing strategic context meaningfully comes together to deliver better outcomes for the individual, the family, the neighbourhood and the population.

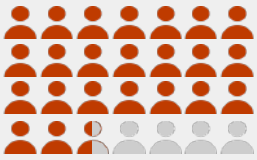
4 About Sheffield

This section explores where we are now, considering demographic trends, health and care outcomes, views of our service users, our public and our staff.

Sheffield is one of the 20% most deprived local authorities in England (around 1 in 4 children live in poverty), whilst at the same time having some of the most affluent 1% of areas in the country. Not surprisingly, Sheffield has health outcomes to match these extremes.

Our Population

580,000 population



81% White British, remaining 19% more than 12 other ethnic groups

64% adults of working age

3% of population unpaid carers

6.4% unemployed

£504 average weekly income
Lower than national average & lower than minimum amount recommended for most household types with children

25% adults physically inactive & 2/3 obese or overweight

30% routine & manual work smoke, up to 60% in some of most deprived areas

Preventable mortality higher than English average
Principle modifiable risk factors: **smoking, hypertension, obesity, inactivity, poor diet,** & **alcohol consumption**

Serious Mental Illness rates higher than national & regional trends.

Significant inequality in health & causes of ill health

Gap in healthy life expectancy- 25 years for woman between most & least deprived. Gap for men & women continues to worsen

Teenage conception rate higher than England average

15% of women smoke at time of birth of baby & higher than average proportion of **low birthweight babies**

54% of 16 year olds achieving A* - C

One in 3 children (10-11) **are overweight**, 1 in 5 obese.

Severe obesity above national & regional levels & rising 2/3 of 4-5 year olds "school ready"

10% of children have mental health disorder

Employment rate 4% for people with learning disability, 20% for people with mental health conditions overall, & 5% for those in contact with secondary mental health services & on a care pathway

Alcohol related mortality significantly higher than the national & regional average

Principal driver of **demand for healthcare is illness** not age

Much of burden of disease preventable

Smoking accounts for 12% of all morbidity & 20% of deaths.

Obesity 2nd most common modifiable risk factor.

Increasingly multi-morbid city

23% of people have 2 or more long term conditions

Prevalence of multi-morbidity increases with age

Onset of **multi-morbidity** 10-15 years earlier for people in most deprived areas

Socio-economic deprivation particularly associated with mental health related multi-morbidity

Main causes of illness: cardiovascular disease, cancer, mental ill health, musculoskeletal, neurological & respiratory conditions.

Main causes of death: cancer, cardiovascular, neurological & respiratory disease.

Within our care system, we have exemplars and many examples of good practice, as cited at our Shaping Sheffield events. We perform well as statutory organisations, in terms of quality, experience, access and financial performance, with some acknowledged areas for improvement. Sheffield also enjoys a thriving voluntary and community sector which makes a vital contribution to the life of the city and its people. It works in essential areas, including health and social care as well as education and training, recreation and environmental care. The sector delivers over 7 million interventions to people each year, is made up of over 3000 organisations, ranging in size but the majority are micro with an income of under £10000 per year. Importantly those organisations are wedded to and embedded in their communities and often have deep-rooted relationships built up over time. We need to ensure that these strengths of different organisations and parts of the system are embedded within our future care models.

We have pockets of innovation in both commissioning and provision. However, when working on a system level, we hear consistent themes from the CQC, OFSTED and our public regarding a fragmented system that is inconsistent and confusing to access. We hear that we sometimes lack a whole person focus. We need to provide high quality care, experience and outcomes across the Sheffield system to match the high quality we usually achieve as organisations.

Our Care System

Starting & Developing Well

Great practice in care services for children include Safe Sleep Initiatives, the Young Carers' Strategy, Sheffield Eating Disorders Strategy, Future in Mind & Children's Pilot IAPT

Holiday hunger initiatives from the voluntary & community sector bringing food as well as skills

Growing burden of mental health issues for children. Access to Child & Adolescent Mental Health service is 94% within 18 weeks target, but deteriorating performance through 2018

CQC & OFSTED Review of SEND found: lack of vision & strategy, inconsistent practice, a need for improved communication & a need for more effective multi-agency transitions

Transition from children to adult mental health services key city improvement theme

Living, Ageing, & Dying Well

Cancer suspects
>95% within 14 days of referral.
Treatment within 31 days declining performance
Treatment within 62 days consistently below target

Psychological Therapies
50% of those treated moved to recovery in Q3 18/19
>90% seen within 6 weeks of referral
99% within 18 weeks

69% of **alcohol treatment** patients re-presenting within 6 months, worse than regional & national rates. **Alcohol related mortality** also higher.

94 % receive treatment within 18 week from referral in children's & adults. Good access to diagnostic services city wide

Care Homes admitting higher than average, especially for respiratory conditions

Dementia diagnosis rates at 79.4%, amongst best. But opportunity to improve how people then access support

DTOC number much improved. More consistently 30-50

Over 3346 voluntary and community sector (VCFS) organisations in the city performing on average more than 1 intervention per month per citizen

Half of all VCFS organisations work in a specific local community or neighbourhood

A&E 4 hour standard at 88% overall, declining national trend. SCH performance at 96%.

Reablement rates improved to over 80% still at home after 91 days. Fewer patients treated on ambulatory basis

Non-elective admissions slightly higher than comparators.

Length of Stay: 37.2% staying over 7 days, compared to 32% nationally.

7% of deaths with three or more emergency admissions in last three months of life. Sheffield in worst quartile in England.

Good practice for Living, Ageing & Dying Well

VCFS work on improving health & wellbeing through healthy initiatives such as park runs, focussing on prevention through lunch clubs and taking a holistic view of people

Innovation in commissioning in mental health pooled budgets.

Musculoskeletal care – integrated & outcomes based model of care.

City wide dementia strategy

CQC rated Good 79/80 GP Practices, SCH, STH, SCCG. SHSC 'requires improvement'

CQC LSR review found our care system doesn't always support staff to help people stay as well as possible in usual place of residence and…

- Fragmented care system
- Lack of strategic commissioning
- Multiple & confusing points of access
- Patients tell their story multiple times
- Undervalued voluntary and community sector

Our Care System

Workforce

38,000 staff across health & care system and 7,500 full time and , 9800 PT staff employed in the VCFS sector

15% of working population

NHS sickness level is better than Yorkshire & Humber.

2018 Staff Survey shows our Sheffield NHS organisations to be around "average" staff engagement against each comparator group.

Service User Feedback

Our carer quality of life in those aged > 65 is lower than the national average at 7.1 compared to 7.7 in 16/17 & has declined since 12/13. Our quality of life for those in receipt of social care is below national & regional position

83% patients rated their overall experience of their GP practice positively, in line with a national average of 84% (GP Survey, 2018).

Most people were positive about individual staff & their kindness & compassion

Family & carers don't feel empowered to be involved in their assessment of care, support and treatment

Children & young people with SEND & their families have widely different experiences

Constantly asked to provide the same information: 'I feel like a broken record'.

CQC Local System Review

CQC special educational needs and disability review

There were multiple & complex access points which caused confusion for people using services, carers & some frontline staff.

People didn't feel listened to or supported in the way they the needed.

Some have been involved fully in developing plans & provision for their children, but for others it is a fight to be heard

Weaknesses in multi-agency transition arrangements lead to children & young people not being supported well enough

Financial Sustainability

£1.1 billion spent on health & care system in Sheffield. Historically break even or better position.

97% of money is spent treating illness, 3% on prevention

The voluntary sector leverages significant resources.

In a context of increasing multi-morbidity, the challenge is to balance the gap between anticipated costs and the funding available.

By 2024 an additional 21% of ££ will be required to keep pace with demand. There is a significant financial challenge to the provision of Social Care services . Table X shows a breakdown for 2019-20.

Split of total spending: 36% in acute, 21% on going care & social care, 9% primary care, 9% GP issued prescriptions, 8% mental health, 8% community, 3% other services, 3% prevention, 2% ambulance & patient travel, 1% commissioning

5 Developing this Plan

In January 2019 we started the process of developing this Shaping Sheffield Plan. This built on and refreshed the original Shaping Sheffield Strategy developed through city wide events held in 2015 and 2016. The 2015/16 vision was based on key principles of prevention, early help and working together differently and is summarised by the following diagram:

Our refresh process in January 2019 needed to:

- Confirm that the original stated priorities were still valid, and would likely remain valid, for the next 5 years
- Engage with front-line staff and members of the public to ensure that their key concerns and priorities were taken into account, and
- Develop a robust action plan to enable all interested parties to monitor the success of ACP activities and investment.

We harnessed staff and public feedback through a number of ways:

- An online questionnaire asking for people's views on the key barriers to working and providing services and support across organisational boundaries, as well as ideas for addressing these barriers
- 5 large (primarily staff focused) workshops. Staff from across health and social care attended these workshops, including representatives from education, the police and sports retail
- Healthwatch ran 3 workshops for members of the public to contribute and conducted individual interviews to collect rich perspectives to feed into the process.

Staff and members of the public shared many examples of progress and good practice through these Shaping Sheffield events, which can be found HERE (Hyperlink to be inserted).

This feedback has been incorporated throughout this plan. Some of the very direct ways that this feedback has been reflected are:

- The emphasis on developing consistency in awareness and application of person-centred approaches across the ACP. This will be embedded within recruitment practices, cross-system workforce development and, through conversations with Higher Education providers, within the accredited professional qualifications.
- The move towards integrated commissioning should enable more whole system thinking and reformed funding approaches.
- Developing an all-age approach to all our services as critical to really embedding prevention as a foundation to all our services.
- A stated ambition of a 'One Central Point of Access (OCPA)' which will bring together all current systems and provide just one number for all queries related to health and social care
- A comprehensive system leadership and organisational development programme, which will develop consistency of practice, leadership and culture across the system.
- A more consistent approach to supporting staff working as carers in care homes and home care environments, developing career pathways and raising the profile of this important and valuable work.
- The alterations to the 5 original ACP priorities that were directly consulted on through the process. Alongside changes in wording and emphasis, the events resulted in "All Age Mental Health" promoted to a top five priority for the ACP.

Our refreshed Plan is about setting out our priorities and planned outcomes for 1 and 5 years, in line with staff and public feedback and taking account of national drivers, while building on good foundations. The themes from our staff and public engagement are shown on the next page. It is our ambition that as the plan develops over the coming months and years, wider relationships will be further embedded into the ACP (e.g. Police, Ambulance Services, Education and Housing).

Feedback from the 'Shaping Sheffield: the Plan' Consultations Events

Person-Centred:

- Using a holistic / whole family approach, support concerns, treat the whole person and not just the presenting issue.
- Focus on the needs of service users, carers and communities rather than organisations
- Develop communities to be more independent and involve them in identifying needs & solutions – don't just listen to the loudest voice
- Use patient activation measures to assess readiness to change
- Asset-based approach: focus on what else motivates the individual as a focus

Funding:

- Need integrated budgets and the freedom to be more flexible, allocate money to local priorities and be more creative
- Long term investment is needed to remove the short term contract culture
- There is a need to invest in prevention activities, including home care and raising the value and profile of this work.
- Infrastructure in communities needs investment

Digital:

- Shared care records, where the patient has access, is critical, with access extending to the voluntary sector, community pharmacies and hospices etc.
- An online 'red book' to help the public understand services and improve access to support.
- Ensure that data is accurate, comparable and shared appropriately

Other:

- *All-age approaches:* promote active ageing across the lifecourse, starting with children and schools teaching lifestyle skills.
- *Policies and processes* need harmonising and simplifying

Integrated Working:

- Have one single point of contact in a holistic approach, integrating physical and mental health care needs, as well as social care needs.
- The health and social care system should be ONE system.
- Recognise the strategic role of the voluntary sector and ensure they are involved in planning and delivery.
- Commissioners and providers need to work together to deliver what is best for the child, not the system
- Need to build networking opportunities to develop relationships, trust and an appreciation of the roles of other professionals – commissioners can facilitate this.
- Work with small businesses, supermarkets, schools and care homes as well as the ACP partners

Workforce & Culture:

- Change the culture to remove the perceived hierarchy of services
- Need to build trust and relationships within and between organisations
- Need to behave differently to get different results
- Develop consistency in career pathways and required competencies across the private and public sector
- System-wide leadership development is needed, focusing on core skills to develop confidence and capabilities required to future proof demands.
- Ensure carers and voluntary sector staff have access to the same development opportunities to develop skills and capabilities as the statutory workforce.
- The top-down culture is stifling innovation – grass roots staff have lots of ideas and solutions
- Staff need to be empowered to think outside the box and spend their time where it will have greatest impact
- The health and social care workforce needs to role model , and be helped to role model, healthy behaviours

6 Our delivery priorities

A commitment to promoting prevention will run as a golden thread throughout all our work to our long term goal to improve population health. We will work with an approach of "triple integration" of primary and specialist care, physical and mental health services, and health, social care and the voluntary sector. In this context, our delivery priorities for 2019/20 are:

- Starting well
- All age mental health
- Promoting prevention
- Thriving communities
- Ageing well

For each of these priorities some initial outcomes and targets have been set. These are under continual review to ensure they develop to reflect the ambitions of the partnership as they grow.

6.1 Starting Well – *Developing more strengthened families and communities*

We want all children in the City to have the best life chances, and families to be empowered to provide healthy, stable and nurturing environments. We want to connect people to the right levels of support at the right time through universal and targeted prevention, early identification and early support. We want:

- Every child to achieve a level of development in their early years for the best start in life
- Every child included in their education and accessing their local school
- Every young person equipped to be successful in the next stage of their life.

We will…..

- Enable Sheffield to be an inclusive city where all children and young people with additional needs get the education, health, and care support they need to achieve their potential and go on to make a positive contribution to society and lead a happy and fulfilled life.
- Work with partners and stakeholders to develop an all age approach to mental health provision ensuring a focus on prevention and early intervention is maintained and developing a joined up response to support families in crisis
- Develop and enhance a locality based model that delivers child centred, young person centred and family centred care that is holistic, high quality, safe, timely and sustainable, in an equitable way across Sheffield
- Refresh the City's 'Great Start in Life Strategy'; recognising what has been achieved to date and setting new joint priorities.

- Develop an Adverse Childhood Experiences (ACE) aware Sheffield; ensuring the Sheffield workforce understands how ACE can impact on families.
- Undertake wide stakeholder engagement during 2019 in order to create a Children and Young People's Strategy for 2020-2023 that reflects national guidance and strategic direction

How will we achieve our vision?

The Children & Young People Health & Well Being Board is a well-established partnership board with wide and active stakeholder engagement. We are committed to:

- Ensuring there is good quality and active engagement with children, young people, families/carers and professionals across this entire area of work to support, signpost, and shape services and the workforce.
- Championing programmes of work that enable children in Sheffield to reach their potential irrespective of their vulnerabilities
- Ensuring all transition points for children are seamless and agencies provide joined up care, developing shared data and information where possible and appropriate
- Having robust governance arrangements in place to oversee delivery and link with other workstreams to ensure children and young people are actively involved and considered

Priorities for 2019/20

- Implement the written statement of action following the CQC and OFSTED SEND inspection
- Support the delivery of a new all age eating disorders pathway and use the learning to develop and inform future models of care for mental health
- Implement a community nursing model to support the development of a locality based working approach, focussing on complex needs and palliative care as a priority
- Finalise the community paediatric pathway with focus on autism and ADHD as a priority and use this learning to develop further pathways to support the development locality working
- Create a 'Great Start in Life Strategy', a refresh of the Best Start Strategy
- Undertake wide stakeholder engagement during 2019 in order to create a Children and Young People's Strategy for 2020 - 2023 which reflects ambition of NHS Long Term Plan for children and wider relevant strategies
- Link with all other ACP work streams and organisational priorities to ensure prevention agenda and C&YP are priority

Outcomes: Currently being developed in the overall context of the ACP dashboard.

6.2 Development of a Lifespan (all-age) Mental Health Approach

In 2018, the ACP committed to assuming ownership of the transitions issues between child and adolescent mental health services (CAMHS) and adult mental health services (AMHS) in Sheffield, to create a sense of collective responsibility across the system, and to consider and explore alternative approaches and options. It has already been agreed that longer-term sustainability should underpin the eventual approach.

This theme has emerged consistently as requiring improvement for Sheffield, and was a strong theme throughout the 2019 Shaping Sheffield engagement events. An emphasis on improving the support and experiences of children and families living with SEND has also emerged through public consultation as a core priority.

In December 2018, a joint children's and adults workshop to discuss these issues concluded that there is:

- Overarching support for embracing **a lifespan (all-age) approach** to the delivery of mental health services. This would promote seamless care, allow us to focus on prevention and early intervention and remove 'commissioner and provider created' transition points;
- Concern about **accessibility and waiting times**. It was noted that the concept of a lifespan approach will only work if there is consistency in delivery and the respective service offer; and if considerable capacity gaps are addressed across the current care pathways;
- A need to increasingly think about the **'whole person'**; we therefore need to stop describing service transitions, and instead create seamless progression through CAMHS and into AMHS (where appropriate). This seamless progression also needs to occur between physical and mental health, primary and secondary care and health and social care; and
- A need to improve **seamless progression** in terms of other populations and care pathways, for example for those with a learning disability and/or a neurodevelopmental disorder and those transitioning from one care setting to another (e.g. from hospital to home).

To provide improved governance to support a lifespan approach, the integrated commissioning teams for children and young people's, adult and older adult mental health services have come together to form one single commissioning team. Work is also underway to ensure that structures are in place to provide robust overview and assurance. In addition a newly designed operational transition protocol has been put in place, which has been developed jointly and collaboratively by clinical and operational staff at both SCH and SHSC. There is also a commitment to put in place a structured programme aimed at reviewing current care pathways which will be led entirely by service users and experts by experience.

Priorities for 2019/20

- Engagement through workshops with Experts by Experience to critically test and redesign current pathways by September 2019;
- Agreement on specific outcomes to achieve across the lifespan approach, moving away from activity based contracting by October 2019; and
- Agreement on next steps on alternative commissioning frameworks by October 2019.

Outcomes We Will Achieve

- We will have coproduced Quality of Life outcome measures against which services are monitored, focusing on patient and family carer experience by the end of March 2020;
- We will , during 2019/20 improve accessibility and reduce waiting times for mental health services in line with the NHS Long Term Plan; and
- We will clearly define pathways of care, with clarification of the responsibilities of clinicians and systems to ensure effective progression ('warm handover') points.

6.3 Promoting Prevention (Inc. Smoking)

We expect each workstream and enabler to embed prevention principles and approaches in all that they do. In the Promoting Prevention workstream we are focused on embedding a preventative approach into the commissioning, planning and delivery of health and care systems of Sheffield. This means changing how we work with people, families and communities in Sheffield to enable them to have greater control of what matters to them. People's own strengths and networks, connected to the assets and resources in their local communities and the wider city, are the key to wellbeing and improving quality of life. We will also use the stated ACP delivery priority on smoking to lift the profile and impact of implementation on smoking, working across the city to accelerate our work.

Improving people's quality of life will benefit everyone in the city and will also help public services be sustainable over the long term. It will involve developing and utilising our voluntary, community and faith sector expertise to build strength in our city.

We will:

- Develop staff (across the ACP partner organisations) to enable them to adopt a prevention approach in their conversations and interactions with people
- Continue to drive forward the QUIT programme across NHS Trusts in the city and other tobacco control measures in line with the Sheffield Tobacco Control Strategy
- Support ACP partners to develop healthy food and drink policies
- Support achievement of the 6 Move More Strategy Outcomes
- Work with and invest in the voluntary and community sector, strengthening existing relationships, developing new ones and enabling greater sustainability
- Support ACP partners to develop links with the employment agenda – including linking with and learning from the Individual Placement and Support (IPS) trial and Working Win

- Support the voice of communities to influence the agenda

Priorities for 2019/20:

- Gaining organisational level commitment across all ACP partners to working with prevention at the core of all they do and embedding actions on preventative risk factors (e.g. smoking, food, physical activity) into the Sheffield health and care system
- Embedding prevention and wellbeing approaches into all ACP workstreams and Joint Commissioning propositions
- Increased referrals to smoking cessation service and reduction in smoking prevalence in the city
- Look to invest in the VCS to build strength and capacity, fostering collaboration between organisations
- Embed employment health into the ACP Programme, establishing links with existing place based work through the Sheffield Local Integration Board and relevant subcommittees.

Outcomes we will achieve:

- From the autumn of 2019, prevention and wellbeing to be embedded into all health and social care policies and decisions of the ACP partners as they come up for review.
- Prevention and wellbeing will become an integral part of organisational induction programmes and ongoing training of health and social care staff across the city by March 2020.
- Significant reductions in smoking prevalence across all groups by 2025
- Reduction in levels of obesity in adults and children living in the 20% most deprived areas of Sheffield by 2025
- Increased percentage of people in Sheffield getting at least 150 minutes of moderate intensity activity per week (currently only 54.6% of adults in Sheffield report achieving this)
- Ensure people can enjoy at least five extra years of healthy, independent years of life by 2035, while narrowing the gap between the richest and the poorest (in line with the Ageing Society Grand Challenge 2017)

6.3 Neighbourhood Development

With an ever increasing demand on health and social care services the impetus of putting people and families at the centre of support, while reducing the need for specialist intervention has never been stronger.

We will therefore shift the focus of care and support towards primary and community care. We will do this through the development and maturity of primary care networks, effectively connecting all age prevention and early help services across the 'system' within communities. When developing Communities we will focus on the wider determinants of wellbeing such as health, housing,

employment, physical activity, skills and volunteering, education, safety etc. We will seek to mobilise the assets within communities, promoting strengthened families and self-care. We will develop our understanding of the needs of each neighbourhood by developing a population health approach and using data to drive our approach.

We will:

- Identify relevant measures across the 'system' to develop a thriving communities index by March 2020
- Integrate (specialist / generalist, physical and mental health etc. to provide care closer to people's homes by March 2020
- Develop a 'system' Early Help strategy by March 2020.
- Develop 'system' training to ensure 'Early Help' is everyone business whether the need falls within their immediate area of expertise or not by March 2020
- Deliver a 'system' workforce development offer by March 2021.Deliver prevention focussed, asset based, person centred care (social prescribing) across all networks by March 2022.
- Evaluate 'Further Faster' projects to establish 'what works' by June 2020
- Invest in communities and the infrastructure they need to develop capacity

Priorities for 2019/20

- All Age Early Help Strategy
- Primary care networks cover the whole of Sheffield's population
- Continued development of new primary care roles and recruitment of network roles
- Continued development of Multi-Disciplinary Teams improving connected practice
- Connected services, organisations and community assets across the City
- VCS contribution to delayed transfer of care and keeping people out of hospitals developed

Outcomes we will achieve:

- Reduced unnecessary admissions to hospital from 4,419 to 3,726
- More people will have care plans to help support them to live well at home (measure TBC).
- Greater equality of access to health and care across the city (measure TBC)
- Increase Patient satisfaction from 83% to 85%
- Delayed transfers of care (days) 1615 - 993
- MDT Collaboration (awaiting measures)
- Under 18 Conceptions 21.2% to 18.8 %
- Mental Health and Employment 64.4% to 68.2%
- Learning Disability and Employment 66.9 % to 69.2%

6.5 Ageing Well – Improving the health and well-being of people who are frail or at risk of frailty

It is a common misconception that 'the ageing population' is responsible for inexorable increases in demand for health and social care services. This is not the case. Many older people, including very elderly people, live fully independent lives - the increase in demand for services far outweighs the increase in older people and is, in fact, due to increasing numbers of people living with one or more long term condition.

Multi-morbidity describes a situation where an individual is living with two or more long term conditions. The number of long term conditions tends to increase across the life course and can, in simple terms be viewed as a precursor to frailty: as the number of medical conditions increases, quality of life decreases and difficulties with everyday activities increases, with a concomitant increase in need for support from informal carers or statutory services.

In Sheffield, people living in the most deprived areas are more likely to find themselves in circumstances that have a harmful impact on their health and wellbeing. This puts them at greater risk of developing multiple long term conditions at a much earlier age than people who are more affluent – by the age of 60, 1 in every 2 people who are in the most deprived 10% of people in Sheffield have multiple long term conditions, compared to only 1 in 5 people in the most affluent 10%.

Prevention of frailty and multi-morbidity therefore requires a comprehensive approach to prevention where 'ageing well' is a life-long concept and interventions to support it, city-wide.

We need to re-balance the health and care system to prioritise person centred approaches, with a focus on "what matters to you?", out-of-hospital care, improved integration and planning in advance of deteriorations in people's heath. This should be supported by a shift in resources towards prevention, at all levels of need. In practice this means action in three, key areas:

- **Strengthened** individuals, families and communities
- **Integration** of care in neighbourhoods, to deliver improved proactive and reactive, multi-disciplinary person centred care for people with complex needs
- Avoidance of and alternatives to emergency hospital admission whenever appropriate.

We will

- Delay the onset of frailty wherever possible
- Develop improved advanced care planning, communication and integration between services
- Identify people who are becoming frail and help them to maximise their independence within their own home and community
- Provide optimal support to people (and their families) who are multi-morbid and/ or approaching end of life

- Build an integrated approach across health and social care, primary and secondary care, mental and physical health, and community and voluntary sector partners.

Throughout our approach we will embed principles of person centred care, promoting use of "what matters to you?" We will focus on prevention, providing care closer to home, reducing health inequalities, and establishing a collective approach to managing risk. We will use our combined resource in the most effective way across the system to do the right thing for people. We will improve the experience of all people living with or at risk of frailty, their health outcomes, and the experience of our staff. Through this we will deliver all aspects of the CQC Local System action plan

Priorities for 2019/20

- Move towards an integrated, person centred care model to support people to age well with triple integration, an underpinning principle. Our themes to support people in a more holistic way and to support our staff to deliver more integrated care are:
    - Strengthened, bold integrated neighbourhood development
    - Enhanced care in Nursing and Residential Homes
    - One standard, scaled up approach to care planning across the system
    - 'One Central Point of Access (OCPA)' for health and social care
    - Scaled up rapid advice, diagnostics and same day emergency care
    - A city that supports wellness
- Strengthen our shared strategy and plan through improved population health needs assessment of the frail and emerging frail population and identification of any gaps in the current commissioned health and care system
- Establish new contractual arrangements to support the delivery between CCG and STH and better embed this agreement within the context of integrated commissioning.

Outcomes we will achieve:

- A greater number of our residents reporting a person centred experience (addressing key themes identified by the CQC) – as evidenced by our joined up service user experience
- A greater number of our staff reporting joined up integrated working (addressing key themes identified by the CQC) – as evidenced by integration measures captured through the implementation of our Ageing Well workforce strategy
- Sustained achievement of fewer than 45 Delayed Transfers of Care from 2019/20
- Delayed days in hospital below 1500 days in total from 2019/20
- 80% or more of people still at home 91 days after discharge from hospital (for those referred for reablement) from 2019/20 onwards
- Maintaining fewer than 725 admissions to care homes a year from 2019/20

7 Our Key Enablers

We have agreed a set of key enablers to help transform our system. We acknowledge the significant workforce, cultural, digital, financial and business change required to deliver our ambitions. We will work in partnership with the ICS where this makes sense – to ensure place is influencing and shaping the SYB approach, gaining the benefits of regional scale and perspective, and of being part of a leading ICS:

- Developing a person centred approach
- Developing system leadership and culture
- Development of a system wide workforce strategy
- Developing a sustainable financial approach
- Digital transformation
- Our communication strategy

7.1 A Person Centred Approach

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

This is our definition of "person centred", which is central to all of the work of the ACP. The key to wellbeing and improving quality of life lies in people's ability to live a life they value – this can be achieved by drawing on their own strengths and networks, connected to the assets and resources in their local communities and the wider city. As a city we will work together – people, families, communities and organisations - to build places and services that support and sustain these assets and resources. This means changing how we do things in Sheffield so that people and communities have greater control of what matters to them.

The principles that underpin 'person centredness'

- Asset based
- Enabling and engaging
- Personalised
- System focused

The benefits of being person centred in Sheffield

- **To People:** Stronger consideration of each person's unique set of strengths and needs. Feels better and helps them to maximise their potential. Great sense of being in control, guiding own destiny.
- **To Professionals:** Better job satisfaction (feeling of doing the right thing), 'joy at work'

- **To Systems:** Achieves best value from limited resources. Builds trust. Over time can reduce waste. 'Teach a person to fish' approach is more sustainable in the medium to long term.
- **To City:** Better quality of life, reduced inequalities, stronger economy (healthier workforce), more sustainable services, positive reputation.

The development of our leadership and our culture, and adopting a more transformational approach to workforce challenges, are key ways of embedding person-centred approaches to improve experience of care for our population. Our strategies in these areas are outlined below.

7.2 System Leadership and Culture

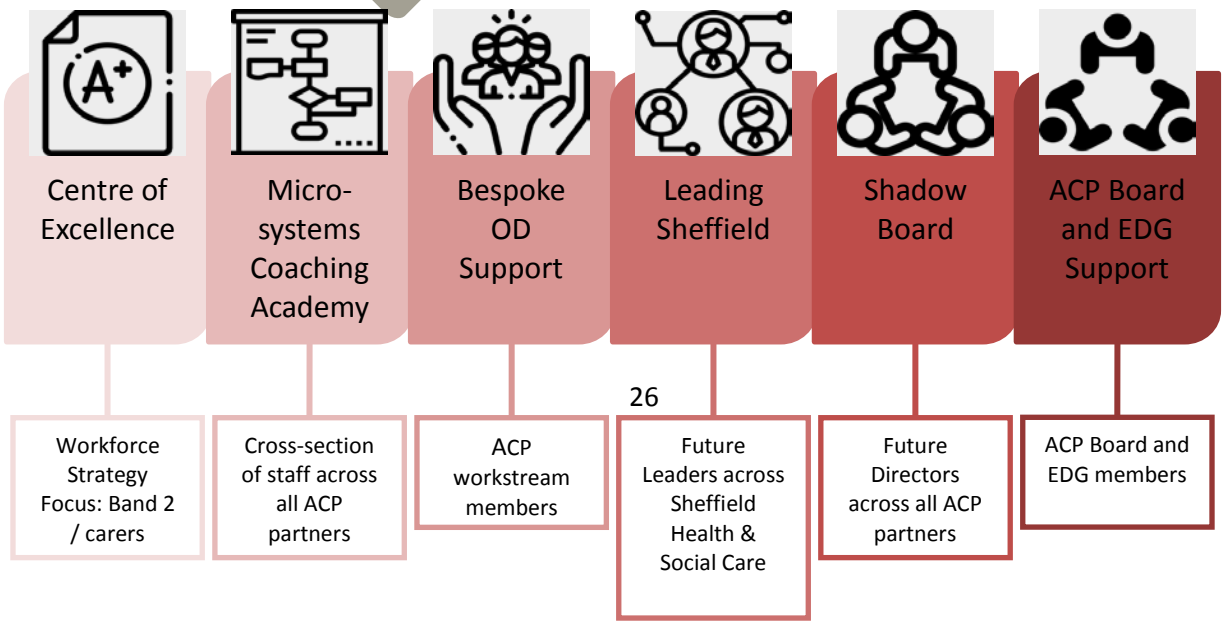
"Successful system leaders are more likely to emerge where there is a common vision and a set of ideals focused on the needs and ambitions of a particular community"

Suzie Bailey, Director of Leadership and Organisational Development, Kings Fund.

To develop greater system focused leadership and culture we will:

- Develop system leadership capability, equipping our emerging system leaders with the skills and confidence to identify and drive forward required changes
- Address the cultural barriers within and between organisations, removing perceived hierarchies and building trust.
- Establish the voluntary sector as a true partner within the system, with VCS staff, volunteers and unpaid carers provided with equitable access to support as staff within the statutory organisations.

Our strategy for achieving the above is broad, encompassing system leadership development initiatives at numerous levels, broader organisational development support and the development and implementation of an all-age system workforce strategy. This emphasis reflects the strong, consistent and repeated message through all of the public and staff consultation events that we need to adopt different approaches and thinking across the ACP if we are to achieve successful and high impact transformational change. The infographic below summarises the approach, with all strands operational for 2019/20.



7.3 System Wide Workforce Strategy

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

Sheffield's ACP partners employ more than 38,000 staff and volunteers –around 15% of the city's working age population. Our workforce, therefore, *is an integral part* of the population we serve. As employers we need to role model good health and wellbeing practice, enabling and encouraging our staff to live the best lives they can, in order to achieve our vision. We need to care for, develop and enable the collective potential of all our people, particularly where they meet and work together across organisational boundaries and harness their passion, ingenuity, talents, differences and shared sense of purpose.

The aim of the all age workforce strategy is to ensure a capable and engaged workforce to implement new care models and transform health and social care in Sheffield. The supporting 5 year plan will cover 3 'chapters' mirroring the Health and Wellbeing Strategy: 'Starting Well', 'Living Well' and 'Ageing Well'. Our 5 priorities for 2019/20 are:

- Understanding capacity and demand
- Embedding person-centred city approaches with frontline staff
- Addressing recruitment and retention issues with Band / Band 2 equivalent staff
- Co-ordinating support for care homes and the care home workforce
- Embed system leadership and organisation development.

In addition to engaging directly with staff, we will work closely with our numerous trade unions to ensure that this workforce strategy reflects good practice and captures the views of as many staff as possible. It is also imperative that this workforce strategy aligns closely with the work of the South Yorkshire and Bassetlaw ICS and the forthcoming national workforce plan (expected later in 2019), ensuring that we maximise the potential impact of all possible resource for the Sheffield workforce.

7.4 Developing a sustainable financial approach

To achieve sustainable system transformation we need to collaborate to use the Sheffield pound as effectively as possible, recognising that each organisation has legal responsibilities for their own financial position. The system needs to collectively meet these obligations by developing a joint response to how financial risk and benefits are managed. In 2018/19 approximately £1.1 billion of funding was spent on the health and care system in Sheffield with **97% of that money spent to support people who are unwell, only 3% is spent on prevention of illness**. Sheffield also receives significant specialised commissioning income from NHS England, with £503m received for 2019/20 (£390m for STH, £109m for SCH, £4.6m for SHSC). This sits outside the remit of the ACP.

As we achieve greater prevention and integration of mental, physical and social care, more support will be delivered upstream. As services move away from a hospital setting, people will be seen in the

community with the voluntary sector playing a greater role. The NHS Long Term plan and GP Contract signals more investment for mental health and primary care. The financial strategy for the Sheffield Place will need to change to reflect this.

Historically Sheffield has achieved a break even or better financial position with varying levels of efficiency requirements to achieve this. Sheffield City Council have invested an additional £10m into Adult Social Care, Home Support services and Community Equipment from internal reserves for 2019/20, yet around half of the financial savings challenge in the system remains in social care. If the system doesn't change, we expect that an **additional 21% of funding will be required by 2024** to keep pace with current levels of demand.

ACP Organisation	CIP/QIPP in within 2019/20 plans	% CIP/QIPP
	£m	*%*
Sheffield Children's NHSFT	8	4.0%
Sheffield Health and Social Care NHSFT	3	2.6%
Sheffield Teaching Hospitals NHSFT	21	2.0%
Sheffield CCG	15	1.7%
Sheffield City Council	42	11.9%
Primary Care Sheffield	0	0.0%
	89	

The table shows a breakdown of the savings required in the 2019/20 financial year. These efficiency targets will be challenging for the system to sustainably deliver without large scale system transformation.

We have already made a start developing new risk and benefit sharing contracts which go above the national requirements and will be a key enabler to transformation. For example:

- The tripartite agreement for mental health services between commissioners and provider
- The extension of the urgent care services 'blended' tariff to include community services.

This will enable service improvement, which would not have been possible under previous contractual inflexibilities. While no formal commitments have been made, further work will explore how we build on these arrangements with partners and expand risk share arrangements.

7.5 Digital Transformation

Investing in the digital capabilities of health and social care is a clear priority in the NHS Long Term Plan and over future years we will see the transformation of care through digital services and data interoperability. There is strong support locally, both at a South Yorkshire and Bassetlaw level as well as in Sheffield to developing integrated digital care records and this was a strong and persistent theme through the Shaping Sheffield engagement events, to improve efficiency and quality of care and reduce time being wasted searching for information about people's care.

Having access to 'live' information about a person at the point of care will enable services to provide more timely and personalised care and provide a better experience for both professionals and citizen. Enabling patients to access their own records could also enable a more person centred approach, helping people to better manage their own health.

Following our engagement events, digital leads across the Sheffield organisations have agreed the following priorities:

- **Shared Care Records**, to be accessed and utilised by both citizens and care professionals
- **Connectivity**, to enable secure IT access for staff working across all partner sites
- **Data Sharing**, to facilitate appropriate service integration across ACP partner organisations
- **Population Health**, to develop business intelligence and analytical capability.

7.6 Our Communication Strategy

We want to achieve a consistent, high quality and vibrant communication and engagement plan, tailored to the needs of different stakeholders. In particular it aims to:

- Ensure a consistent, joined up, and planned approach to communications regarding the ACP
- Ensure an open and transparent approach
- Raise awareness of how we are working together to improve health and care in Sheffield
- Create a platform for engaging local people in transforming services in Sheffield
- Generate support for closer working and potential new structures
- Develop priorities and service models that meet the needs and expectations of service users

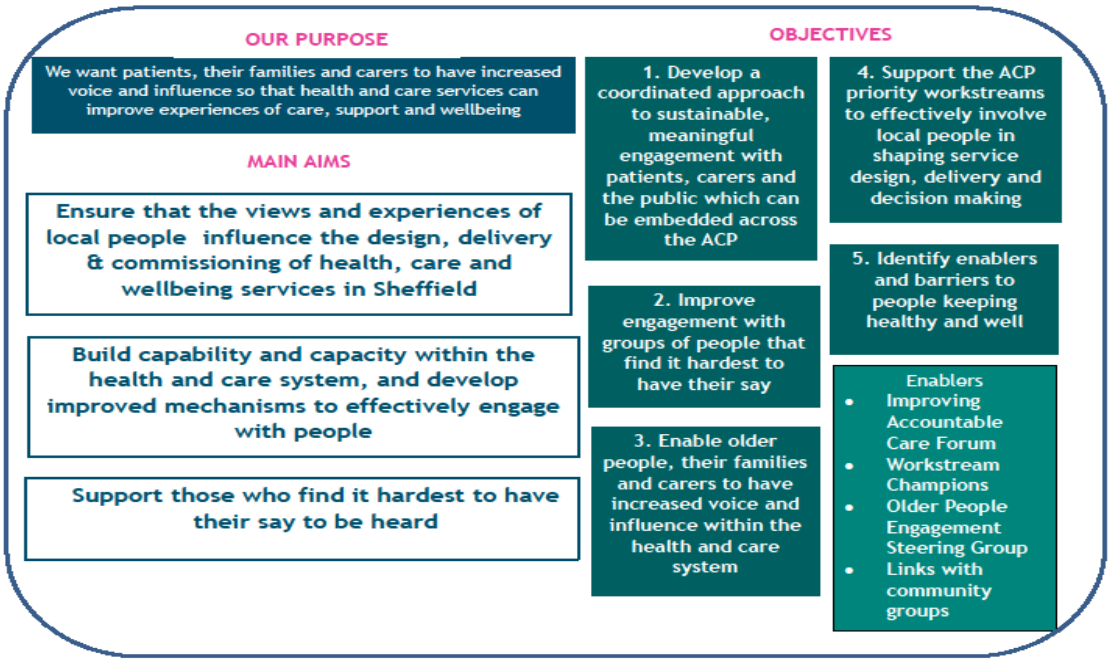
We are now moving into the full launch of the ACP from May 2019 onwards. This will include the full public launch of the ACP and the refreshed Shaping Sheffield Plan with new dedicated website, supporting materials, media package and ongoing events involving all partners. There will be rolling planner of new case studies and stories to keep the website and supporting digital platforms “live” and engaging.

8 Our Service User and Public Engagement Strategy

"When people are involved in and can influence decisions that directly affect their lives, their self-esteem and self-confidence increases and this in turn improves health and well-being. There is growing evidence that having strong social networks and cohesion benefits health. Involvement in discussions about health and health services can help to encourage this social cohesion within communities" (BMA)

The Sheffield ACP is working in partnership with Healthwatch Sheffield to engage with service users and the public to co-design, deliver and transform the Sheffield care system. We will work closely with our partner engagement teams throughout our work. Our strategy is summarised by the infographic below. Practical examples of rich work through this partnership are:

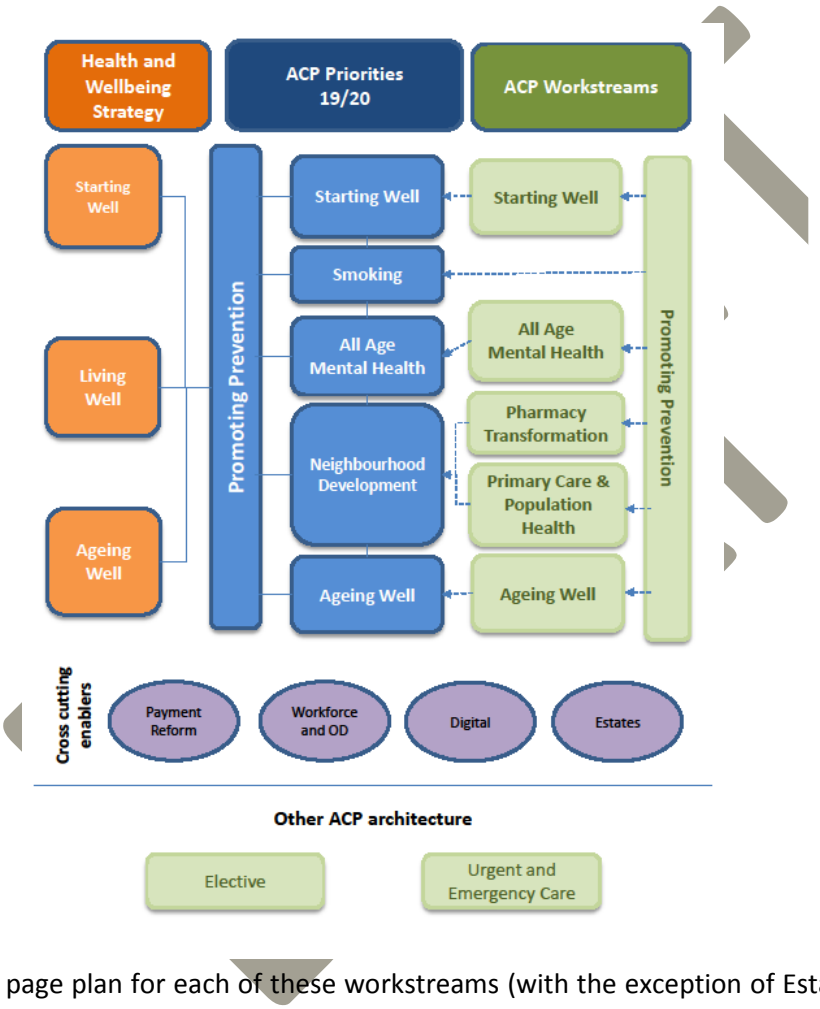
- Collecting system wide service user stories to highlight what works well and areas for improvement
- Actively reaching into communities with seldom heard voices – i.e. for our workforce strategy
- Our service user leads across partners are now working to bring together information from complaints, incidents and other feedback to understand and work together more collectively
- Patients and the public are involved on an ongoing basis through the Improving Accountable Care Forum. This group of volunteers is actively advising on the overall strategy, individual workstreams and engages with staff to bring lived experience to all areas of system work.
- Our ACP Advisory Group will co-design our approach to Person Centred Care with our staff
- The Older People Engagement Steering Group guides our work to increase the voice and influence of older people



9 Delivery of the Transformation Programme

The delivery of the intentions described in section 6 and the key enablers described in section 7 will all be developed and delivered by our ACP workstreams. The diagram below illustrates:

- How each of the six delivery priorities links to the Health and Well-Being Strategy
- How each of the workstreams links to the 2019/20 priorities
- The cross-cutting enablers underpinning the whole programme



Each workstream has a Chief Executive Officer lead and an Executive Director lead from one of the ACP partners as well as a system wide delivery team.

The workstreams will work closely with the ACP Programme Management Team to ensure pieces of work that sit across multiple workstreams/ priorities are coordinated to avoid duplication of effort and maximise integrated working opportunities.

A one page plan for each of these workstreams (with the exception of Estates and Payment Reform as these workstreams are under development) can be found in our Programme Delivery Document, alongside detail about how the objectives and priorities of the individual ACP partner organisations align to the ACP. In such a complex system and programme of work, there are naturally areas of overlap and connection between the workstreams. The ACP will work through other existing networks (e.g. Communication and Strategy Directors across the city) to support the delivery of the plans. The ACP Executive Delivery Group will oversee the full programme to manage this system complexity and maximise effectiveness of the delivery. An annual review of Shaping Sheffield and each of the delivery workstreams and their priorities has been built into the governance of the ACP.

10 Outcomes and Measuring Success

An overarching System Performance Dashboard for 2019/20 was agreed by the ACP Board at the start of 2019. This set of performance measures will be reviewed on an annual basis to ensure the measures remain relevant and any targets set remain ambitious as the work plans develop.

The dashboard fits within the Health and Well-Being Outcome Framework, and has been widely consulted on across the system. Each workstream will co-design its own outcome measures that feed into this high level framework.

Alongside this system data, we will report individual service user and staff stories that illustrate the experience of being cared for through our system, and working within it. A summary diagram of our approach is shown below:

Quarterly Reports

Main sections include 1) experiences from people who use the service & front line staff, 2) population and care system measures across 5 categories, and 3) a more detailed look into a system theme

1) Experiences from people who use the service & front line staff

- Short summaries of good and bad experiences of how the health & care system works in Sheffield
- Experiences come from people who use the service and from front line staff across the different organisations

2) Linking into existing data we look at various measures across the following categories

- Health & Care outcomes for the population e.g. infant mortality rates, inequalities in life expectancy, obesity prevalence, self reported wellbeing, smoking prevalence, avoidable deaths, mental health & employment
- Health & care outcomes for people using the service e.g. AE 4 hour waits, achieving cancer waiting time targets, blood pressure management, end of life plans
- Service user experiences e.g. friends and family test, primary care survey
- Workforce satisfaction e.g. staff survey results, sickness rates, vacancy rates
- Financial sustainability e.g. financial and efficiency position

3) A more detailed look into a system theme

- For each report a different system theme will be looked into a little more deeply
- More data, information, and wider context will be included
- For the first report inequalities in the Sheffield area was focussed on
- Themes will be agreed prior to each report to inform knowledge and understanding around that topic. Staff and service user experience summaries in section 1 will be illustrative of that theme