Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Item 17a ((in support of main agenda item 8 (paper C)

Sheffield CCG

2021/22 Operational Plan

Contents

Introduction and Context:

Overview

This document sets out our Operational Plan for 2021-22, and details the first Sheffield Health & Social Care Joint Commissioning Plan which has brought together health and social care commissioned services in Sheffield.

It focuses on the priorities that we have identified for the Sheffield population, as well as reflects the strong national emphasis on addressing health inequalities and restoring services to pre-Covid-19 levels. This includes improving the access to and quality of services, patient experience and health outcomes for people who are disadvantaged, deprived or who have historically not benefitted equally from our services.

Our Operational Plan for 2021 -22 is written within the context of our Joint Commissioning Intentions, which have been agreed with Sheffield City Council (SCC) and also reflect the Sheffield Accountable Care Partnership's (ACP) emerging priorities for 2021-22. It also looks ahead to the coming changes as we travel further on our transition journey to an Integrated Care System (ICS) working across South Yorkshire & Bassetlaw (SYB). The current development of a Sheffield-wide Outcomes Framework will ensure our Joint Commissioning Intentions have the needs of the Sheffield population at their heart. We are committed to using population and patient feedback to determine whether our Commissioning Intentions are having the right impact.

Being a caring employer that values diversity and maximises the potential of our people is one of our objectives, and ensuring our staff are supported and valued is a priority for Sheffield CCG (SCCG). We detail our ongoing commitment to our staff within this Operational Plan. We recognise the dedication and outstanding work that our staff have done during and continue to do, in response to the Covid-19 pandemic.

This plan is a live document that will adapt to any changes that are driven and agreed either nationally or locally, as circumstances change with the pandemic.

Introduction and Context:

Celebrating key achievements in 2020-21

2020-21 was a momentous year for the National Health Service in the UK, with unprecedented challenges. We are proud of how our staff rose to these challenges, not only working on Covid-19 related projects, but also delivering the normal business of the Clinical Commissioning Group (CCG). Our staff demonstrated flexibility, innovation and team working. Please see our Annual Report for full details. Some examples of our success include:

- We set up a new mental health service in primary care for people with more complex needs;
- We rapidly established a Covid-19 testing service for health, social care, care home and voluntary sector staff and their households, keeping staff in work with fast turnaround of results, & reducing transmission;
- We supported the delivery of the COVID-19 vaccination programme with Primary Care Networks delivering 75% of all vaccinations across Sheffield.
- We supported primary care to work remotely by procuring and distributing IT equipment and offering specialist advice to help them make the transmission to online and remote working;
- We supported primary care to deliver the most successful flu vaccination programme ever;
- A number of our staff have delivered training for their peers on a range of topics such as beating the winter blues, tackling negative self talk, techniques for time management, and creating positive habits;
- Our Primary Care Nurse Development team was nationally recognised and received a national award;
- We delivered a Safeguarding education session for primary care, our first large online PLI event;
- We provide specialist advice and support on infection prevention and control for care homes;
- We achieved financial break even, contributed to the overall SYB system balance, and made savings on CCG running costs.

Chapter 1:

NHS Sheffield CCG: Who we are, and what we do

Our Role & Purpose

The CCG took time to reflect during 2020 to ensure that the overarching strategy of Sheffield CCG remained fit for purpose and responsive to the new challenges posed by Covid-19, its impact on our communities and on health and social care services.

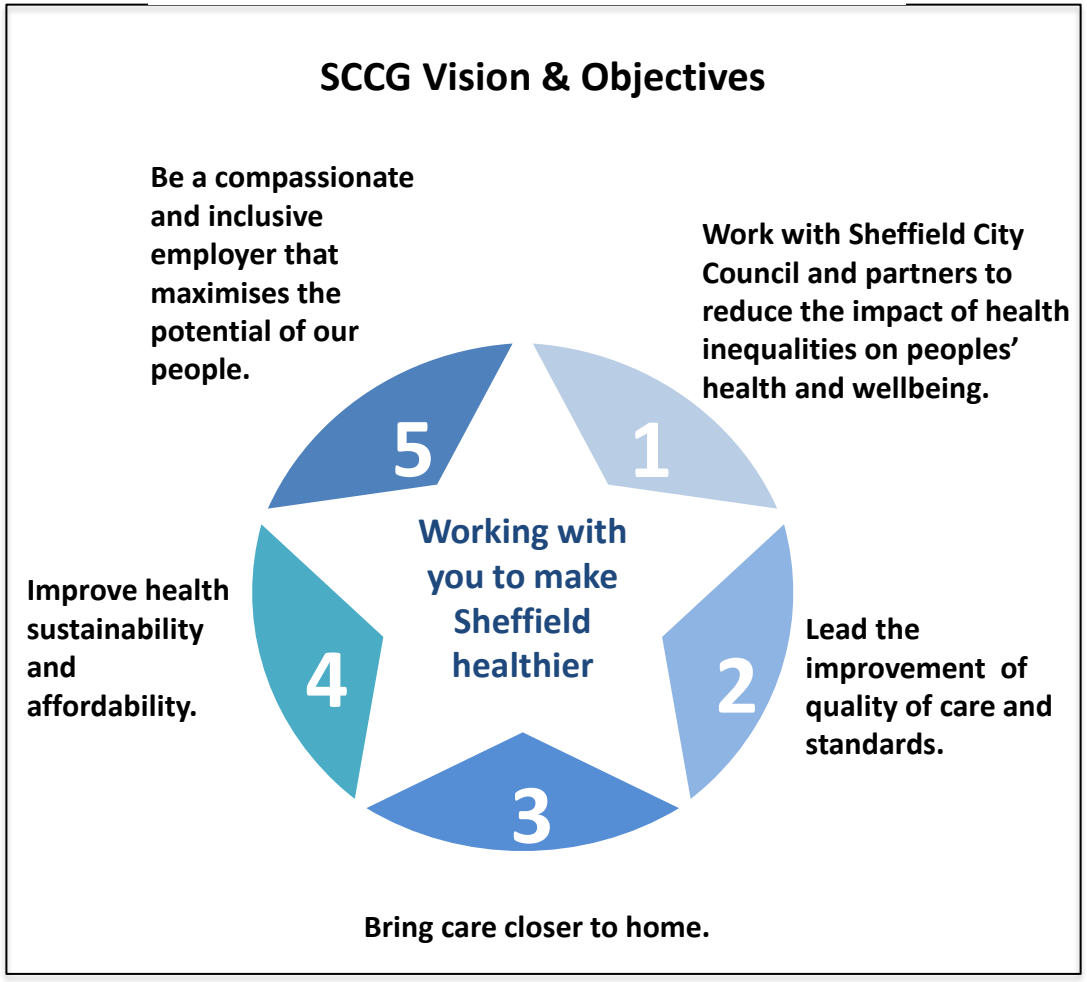
This document has been written in the context of the 2021-22 NHS Planning Guidance and reflects the Joint Commissioning Intentions which the CCG agreed with Sheffield City Council in February 2021. This Operational Plan is a live document which will be revisited and updated during the year.

The vision of Sheffield CCG remains the same:

Working with you to make Sheffield

HEALTHIER

The objectives of the CCG show how we work with our patients, public partners and staff to achieve our vision (see diagram):



Our Role & Purpose

Sheffield CCG is working within the context of a number of challenges which face our City, which we have identified together with our partners.

Sheffield CCG has agreed a number of principles which guide our work: These help us make sure our work is true to our vision and values, and fulfils our purpose. These are set out below.

Challenges

- Mitigate against underlying factors that cause unhealthy lifestyle/patterns of behaviour and contribute to poor outcomes for the Sheffield population.
- Increase the number of people who have their health and related needs identified and supported early enough.
- Increase the number of people who are effectively supported and empowered to manage their health needs to optimal levels.
- Improve the capacity, resilience and capability of Primary and Community service (including Voluntary sector).

Principles

- We will live by our values when working with our staff, public and partners and when making decisions.
- We will tackle health inequalities by designing and investing in services to support those people most in need.
- We will involve people of Sheffield in our decisions, especially target those with the greatest health inequalities and in the poorest health.
- Our work will focus on delivering value for money.
- Our decisions will have a positive, long-term impact on people of Sheffield and the environment.

Our Vision: Working with you to make Sheffield HEALTHIER

Our Objectives

Work with Sheffield City Council and partners to reduce the impact of health inequalities on peoples' health and wellbeing.

Lead the improvement of quality of care and standards.

Bring care closer to home.

Improve healthcare sustainability and, affordability.

Be a compassionate and inclusive employer that maximises the potential of our people.

Our Organisational Challenges

We need to:

Mitigate against underlying factors that cause unhealthy lifestyles/patterns of behaviour and contribute to poor outcomes for the Sheffield population.

Increase the number of people who have their health and related needs identified and supported early enough.

Increase the number of people who are effectively supported to manage their health needs to optimal levels.

Improve the capacity and capability of Primary and Community services (including Voluntary sector).

Our Commissioning Principles

We will live by our values when working with our staff, public and partners and when making decisions.

We will tackle health inequalities by designing and investing in services to support those people most in need.

We will involve people of Sheffield in our decisions, especially target those with the greatest health inequalities and in the poorest health.

Our work will focus on delivering value for money.

Our decisions will have a positive, long-term impact on people of Sheffield and the environment.

Our Commissioning Outcomes

People will be better informed and will choose/be supported to make healthier lifestyle choices for themselves and their families.

Children have the best possible start in life and will grow into happy, healthy adults.

Staff feel confident in knowing how and where to signpost patients to have their needs effectively met.

Everybody will feel confident that they and their families health and related needs will be identified, understood and addressed as early as possible.

People feel supported and empowered to manage their health in the most appropriate setting/community.

People feel confident that they are able to access the right service first time.

Staff will feel confident they are able to meet the needs of the patient population.

Our Role & Purpose

Joint Commissioning

The Joint Commissioning Committee (JCC), established in June 2019, committed to ensuring new models of care deliver the outcomes required for the City of Sheffield and support Sheffield City Council (SCC) and Sheffield Clinical Commissioning Group (SCCG) to deliver national requirements including, but not limited to, the NHS Long Term Plan, Social Care Green Paper and Spending Review.

Co-Chaired by the Chair of SCCG and the SCC Cabinet Member responsible for health and social care, the Joint Commissioning Committee gives strategic direction on Sheffield's health and social care priorities as well as holds the accountability for the successful delivery of the joint commissioning plan. Under section 75 of the NHS Act 2006, the committee gives cabinet members and governing body members the ability to discuss, oversee and develop joint health and social care commissioning intentions. We currently have one of the largest pooled budgets under this arrangement in the country.

The Committee enables a single commissioning voice, integrating health and social care commissioning priorities for the benefit of the Sheffield population. This ensures new models of care deliver the outcomes required for the City and supports the delivery of national requirements. By working together, we aim to coproduce our commissioning plans with the Sheffield population whilst driving forward integrated working across health and social care to not only ensure services are provided to meet the needs of the users but also reduces the impact of health inequalities.

Sheffield Commissioning Plan 2021/22

Health and Social Care Services that deliver what you need

VISION

Working with you to make Sheffield Healthier
&
Helping you to stay Independent, Safe & Well

OBJECTIVES

- Reducing and tackling inequalities across Sheffield
- Better health and wellbeing whilst leading the improvement of quality of care
- Strong health and care economy
- Thriving communities
- Care closer to home
- A caring employer

PRIORITIES


Communities


Voluntary Sector


Ongoing Care


Children & Families


Mental Health & Learning Disability


Frailty

OUTCOMES

Will include:

Personalised Care; Quicker diagnosis; Reduced waiting times; Improved access to Primary Care; Reduced demand on services – those who need treatment will get it; Resilient Communities with more services delivered in the community and closer to home; Improved mental health crisis care; Community children services.

Our Role & Purpose

Working with the Sheffield Accountable Care Partnership

Sheffield CCG is part of the Sheffield Accountable Care Partnership (ACP) that brings together all health and social care organisations to deliver care across Sheffield. The Sheffield ACP was founded in 2017 and the seven partners are:

- Sheffield Children's NHS Foundation Trust (SCHFT)
- Sheffield City Council (SCC)
- NHS Sheffield Clinical Commissioning Group (SCCG)
- Sheffield Health and Social Care NHS Foundation Trust (SHSCFT)
- Primary Care Sheffield Ltd (PCS)
- Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
- Voluntary Action Sheffield (VAS)

All organisations across the ACP have been working closely together during the Covid-19 pandemic and have developed a number of priorities that will play a key role for our system work over the coming months. These are presented on the coming pages and are aligned to our developed commissioning intentions for 2021/22.

Sheffield Accountable Care Partnership Integration Priorities 2021/22	
Planned Care	Task/priority: To develop and implement a different approach across primary and secondary care – generalists and specialists – for a small number of high volume, high impact and prioritised pathways. We would seek to reduce inequalities in access to care and for care to be managed in the most appropriate settings with the necessary specialist advice and in doing so: manage the rising demand for planned care referrals; contribute to the reduction of RTT time; improve people's experience of care; and strengthen relationships between professionals. This work has the potential to reach into long term conditions more generally, and multi-morbidity (including mental illness as a co-morbidity) .
Local Care Coordination and Team Around a Person	To develop Local Care Coordination Centres across the City based on the Team Around the Person (TAP) process. The TAP process supports the integration of health (physical and mental) and social care, reduce demand on the acute/statutory services and to support individuals to build their capabilities and resilience. The process focuses on preventing wellbeing problems escalating, supporting people to be independent at all stages of life and reducing the need for acute hospital and residential care services. Roll-out will be aligned with SCC Localities boundaries considering the Primary Care Networks (PCN), initially with the Mental Health Transformation PCNs, then phase 2 to 4 will be implemented on need and demand. Roll-out to be completed by December 2021, though this will require additional investment from what has been identified currently. If resource does not change then the TAP project will stop at phase 2 (with about half the City reached). If, however, full infrastructure is realised than full roll out could happen through 2021/22. SCC Cabinet approved the proposal in principle and the business case for funding is now being developed in preparation for Joint Commissioning Committee consideration .Alongside preparation for wider roll out there are two other areas of priority work linked to the LCC development: ○ Improving the connection of mental health services into the TAP process; ○ Understanding potential linkages to Local Area Committees as they develop.

Sheffield Accountable Care Partnership Integration Priorities 2021/22 (work in progress)

All Age Crisis Mental Health provision	This is a wide area of work, but for EDG it is suggested our initial focus should be on the development of the 24/7 MH crisis offer in the community for adults (making connections as appropriate to learning disability and dementia crisis response developments) and Children and Young People (CYP) including the provision for 16-17 year olds. For CYP, potential focus areas could be to expand the existing Supportive Treatment and Recovery service (through a phased approach) to a full crisis and community intensive treatment team 24/7 (including a crisis helpline) and review of the current liaison support into STHFT A&E. Context: Following an NHSE-led summit on crisis mental health care in Sheffield an action plan was developed which included: i. Escalation arrangements to Executive Directors at 6 hours ii. CYP emergency bed capacity iii. CYP input to liaison team iv. Additional bed capacity v. PDU capacity vi. Discharge planning vii. Transport viii. Learning from incidents
Children and Young People's Mental Wellbeing	1. Improving our approach to how mental health and LD support is provided, such that children growing into adulthood have a much more seamless and supportive experience (and where necessary, 'transition') of care. 2. Establish a different, improved, and joined up approach for preschool children and their families: improving wellbeing, joining up intelligence, identifying children at risk of poor outcomes and putting in place support (involving MAST, safeguarding, 0-19 service, maternity services, health visitors, perinatal MH, community paediatrics, speech and language and CAMHS).

Sheffield Accountable Care Partnership Integration Priorities 2021/22 (work in progress)	
Urgent Care	*NB: This is being explored as an integration priority.* We have discussed previously developing an integrated pathway for urgent care in Sheffield facilitated by local implementation of the national 111 first agenda, spanning across various primary care settings, the walk--in centre, minor injuries unit , A&Es and urgent mental health provision. It will make it clearer and simpler for people to access urgent, and out of hours 'health' care, including the development of a single point of access to enable patients and the professionals that support them to rapidly and equitably access care and services. (a local clinical advice service triage and record). This needs to be well- communicated and understood by the public and professionals alike.
Long Term Conditions	Deconditioning and the Covid-19-focus of services has led to deterioration of many Long Term Conditions (LTCs) and exacerbated existing inequalities. LTC reviews have been disrupted and done differently through Covid-19, potentially reducing opportunities to implement work to reduce, prevent, and delay multi-morbidity (including mental health). Work is now required to better understand the impact on people with LTCs and use this data to inform the restoration of services and LTC reviews to ensure people at greatest need can access the treatment and care they need in a way which best suits them (taking account of digital technologies available and digital inclusion).

Chapter 2:

Our Ongoing Response to Covid-19, and its impacts on our communities and services.

Our ongoing response to the Covid-19 pandemic

As part of the Covid-19 response, Sheffield was able to build upon the strong relationships of the Joint Commissioning Committee and the Sheffield Accountable Care Partnership, to provide a co-ordinated system response to support statutory providers and independent sector providers through unprecedented times.

Outbreak strategy and surveillance

We will continue to work with Public Health colleagues in Sheffield City Council to maintain an overview of outbreaks, data and trends and to consider local action. We receive regular data and briefings from Public Health England. Communications from the Emergency Preparedness Resilience and Response (EPRR) regional incident control centre are monitored daily and are reported weekly at the Sheffield City Wide Co-ordinating Group, where any action is agreed. This group was established to maintain overview of the pandemic, the vaccination programme and to respond to changes in demand, by supporting healthcare provision in a rapidly evolving situation.

Our Medical Director Dr Zak McMurray is a member of the City wide Outbreak Control Board, which would oversee the implementation of the Outbreak Control Plan, if this needed to be put into action. Zak and our Director of Public Health, Greg Fell, provide regular briefings to our General Practitioner's, via Zoom, as well as regular meetings with Members of Parliament (MPs) to keep them up to date.

Our ongoing response to the Covid-19 pandemic

Partnership Working

System leaders rapidly recognised at the start of the Covid-19 pandemic, that coordinated support across all Sheffield health and social care organisations was required. EPPR leaders were required to meet weekly in a Health and Social Care Gold Group. This provided City wide oversight of emerging issues and ensured comprehensive links back into statutory providers command structures, to monitor implementation.

Health and Social Care Gold provided assurance and oversight of City wide plans inclusive of support to the independent sector providers, to ensure capacity and flow in statutory organisations .

The Sheffield Commissioners implemented immediate plans to support the Independent Sector Providers inclusive of Care Homes that included:

- Infection Control and Personal Protection Equipment (PPE): guidance, best practice and training;
- End of Life Care (EOLC): increased capacity to support Primary Care and all Sheffield citizens (inclusive of Care Homes residents) with managing end of life care. This included commissioning additional support from St Luke's Hospice to provide wrap around care in Care Homes, support for staff who were managing an outbreak and experiencing excess deaths;
- Discharge planning: in line with the national discharged guidance included additional commissioned capacity from Sheffield Churches Council for Community Care to transport patients home and provide support until statutory services were able to attend. Alternative options were considered to create capacity on discharge to assess pathway and for any Sheffield citizens who are unable to safely isolate in their usual place of residence.

This group is currently stood down, but mechanisms are in place to reinstate the group if/when formal command and control arrangements come back in place and a coordinated immediate response is required from the Sheffield system.

Our ongoing response to the Covid-19 pandemic

Establishing a Long Covid-19 service

The Long Covid-19 service has been established by taking a partnered approach between Sheffield Teaching Hospital NHS Foundation Trust, Sheffield Health & Social Care Trust and Sheffield CCG. The programme has been successful in setting up an integrated pathway which considers how best to reach its patients. The team has shared developments in the programme with Citywide organisations such as Primary Care Sheffield (PCS) and the Accountable Care Partnership to ensure the services best suit the needs of different communities.

The Post Covid-19 Rehabilitation Hub is a personalised needs-based service, supporting people to access appropriate information and care based on a holistic assessment. Co-developed with patients, the service adopts a multi-disciplinary approach, attending to the holistic needs of the patient, interfacing with care providers including mental health, primary care, social care and end of life services.

Most post-Covid-19 symptoms are self-managed or with primary care support. Where symptoms persist, referral to the post-Covid-19 service is encouraged. In the Hub, the multi-disciplinary team (MDT) review the referral information and with a care navigator, discuss with the patient, the level of intervention advised for the issues highlights. This ranges from self-help tools, therapeutic interventions, through to a hub rehabilitation physician assessment who may advise referral to another specialist or discuss the patient in the multi-specialty team meeting (MST).

Our ongoing response to the Covid-19 pandemic

Covid-19 Vaccination Programme

Sheffield CCG is working with practices, pharmacies, Primary Care Networks and the voluntary sector to offer the Covid-19 vaccine to all eligible people by the national target date of 31 July 2021, and to maximise uptake across all groups and localities of the City. Extensive and careful engagement with groups where there has been lower uptake is being taken forward in close partnership with local voluntary and faith sector groups who have detailed knowledge of their stakeholders and local population.

Sheffield CCG have invested £235,000 into 26 local voluntary and community organisations working to reduce vaccine hesitancy and physical, cultural, and emotional barriers to encourage people to take up the Covid-19 vaccine offer. Each organisation has co-produced a plan based on their extensive knowledge of working within their communities. Activity has included one to one conversations, hosting targeted vaccine sessions, translating information, booking appointments, addressing accessibility issues, and providing transport. This work will expected to continue into the autumn flu campaign.

At the time of writing, a new Covid-19 variant has been identified in Yorkshire and we will be putting plans in place to roll out the vaccination programme more quickly, moving vaccine around the City to where it is needed, identifying more locations, securing additional workforce, and working with St John's Ambulance. Additional CCG staff are being deployed to the Vaccination Team to expedite the roll out of the vaccine into younger cohorts and more locations.

Our ongoing response to the Covid-19 pandemic

Planning the 2021-22 flu vaccination campaign

Protecting our population against flu is more important than ever whilst Covid-19 remains in circulation. Sheffield CCG piloted a community development approach to work with voluntary sector organisations in the autumn of 2020, to encourage uptake of the flu vaccine. Ten organisations who work with minority ethnic communities were awarded grants totalling £10k and used mixed methodology including promotion of the flu vaccine at foodbanks, on the radio in community languages, via WeChat, WhatsApp, Facebook and Twitter – all tailored to local community demographics. Learning from this pilot enabled learning in time for the Covid-19 vaccine rollout.

The flu programme for 2020-21 was the most successful flu programme in Sheffield both in terms of numbers of our population vaccinated and the almost non-existent presence of circulating flu (social distancing and lock down also had a massive impact on circulation). For the first time, GP Practices were asked to target the healthy 50-64 year olds, along with the usual cohorts who are eligible each year. Record numbers of people were vaccinated in all cohorts by our primary care colleagues.

We have learnt so much from the Covid-19 vaccination programme in targeting our communities where uptake has been lower and these lessons will be translated into the flu plan for 2021-22. Plans are being developed to further improve our take up of vaccinations amongst our care home staff and residents along with education and encouragement from Public Health colleagues. This plan will continue to develop over the coming months as we continue to learn from the Covid-19 vaccination programme.

Chapter 3:

Restoring Services & Building Resilience

Restoring services, building resilience

Supporting Primary Care

Sheffield CCG has committed to delivering the ICS strategic plan at local level, which will include developing the role of the community pharmacy, embedding electronic repeat dispensing and continuing to offer remote consulting alongside face to face service delivery.

Each PCN has developed its own workforce plan to recruit additional staff (under the ARRS scheme) and to provide skills based training to existing staff. The SYB Workforce Hub will be supporting the expansion of the primary care workforce, including Mental Health roles and Paramedics. The PHM work undertaken, so far, shows that we expect increased numbers of people living with frailty, dementia and diabetes; workshops are being held across SYB from June onwards to explore the opportunities for joint working to prevent these conditions and how this will factor into future workforce planning.

In terms of expanding workforce and delivering our share of the target of 50 million more appointments in primary care by 2024, Sheffield PCNs have identified three limiting factors which could impact on our success:

Inability to recruit to Mental Health (MH) workers; Lack of availability of Information Technology (IT) to support remote working (and digital poverty in some sectors of our population);Inadequate physical work space (including premises which were not purpose built and which make physical distancing challenging).

We are working with Primary Care to address these limiting factors through developing our digital strategy, estates and premises strategy and looking at innovative recruitment processes. We continue to offer flexible extended access services and PCNs are developing their integrated urgent care offer to primary care and we are commissioning services such as community phlebotomy, aimed at freeing up capacity in practices.

Restoring services, building resilience

Elective Care

The CCG has worked collaboratively with providers and primary care to agree how we can enable a return activity as close as possible to pre-COVID levels. Our plans include:

- Embedding specialist advice and guidance to minimise inappropriate hospital appointments. Sheffield is developing its own hybrid model building on existing GP Peer Review/Consultant Mentor relationships.
- We will evaluate the current Enhanced Triage pilot operating in neurology and roll out across other areas as appropriate.
- We will seek to implement initiatives to address digital exclusion and enable more patients to be supported to access the technology needed for virtual appointments, remote monitoring, etc.
- Patient Initiated Follow-ups (PIFU) have been identified as one of three areas prioritised by SYB ICS members (in conjunction with Advice & Guidance and Virtual Appointments / Clinics).
- Sheffield Teaching Hospitals have now introduced PIFU within; Diabetes, Neurology, Trauma & Orthopaedics, Continence & Gynaecology. Sheffield Teaching Hospitals have created a PIFU Implementation pack which has been shared regionally.
- Sheffield Children's Hospital are live with a PIFU pilot in Neurology, with expansion to respiratory and Rheumatology planned imminently.
- Rapid implementation of tele-dermatology to enable dermatology/plastics to undertake secondary care triage and Advice and Guidance (A&G) provision. Every GP practice is being offered a dermatoscope to enable them to provide images with all skin referrals.
- We are identifying alternative community locations to enable secondary care clinics to operate in line with social distancing requirements,

Restoring services, building resilience

Elective Care

- We will develop clear principles/criteria/an approach for prioritising elective and planned care, based on clinical risk and need
- We will have a clear set of system principles about supporting the population to access diagnostic tests, including the development of suitable community diagnostic services - minimising visits, minimising attendance in risky settings, with clarity of what's in scope and any limitations/restrictions. Subsequent and more specific challenges and opportunities for how we can improve access to diagnostics and results (including out of hours and across organisational boundaries) will follow on from this.

Across the system, SYB ICS submitted plans in May 2021 to meet the Elective Recovery Fund thresholds. A higher volume of outpatient activity than the threshold is planned both across the ICS and at both our Sheffield acute providers. We plan to reduce 52 weeks and eliminate them by 31 March 2022. This plan is, however, based on a number of assumptions, for example:

- Covid-19 hospitalisation remains at current low levels;
- Urgent referral and overall GP referrals return to pre Covid-19 levels this year;
- That sufficient aligned independent sector (IS) capacity is available and we can mitigate all risks.

Restoring services, building resilience

Elective Care

SYB will run a system wide Patient Tracking List (PTL) in order to focus on recovery plans for the longest wait specialities, and to eradicate 52 week waits by 31/03/22. Addressing inequalities and communicating with patients to provide advice and reassurance are core elements of the PTL approach.

SYB ICS have also been successful in becoming an Accelerator System, which would necessitate a return to 100% activity by 31st July 2021 and sustaining this thereafter to reach 120% at some point during the financial year. The aim of being an Accelerator System is to recover the backlog of patients waiting for elective surgery to pre-COVID levels. The focus will initially be on orthopaedics and children's elective surgery, both of which are existing priority areas for us. Our approach to system PTLs and capacity planning, via the Elective Activity Co-ordination Hub (EACH), would be an essential component of us attaining these Accelerator System goals.

Restoring services, building resilience

Supporting people with long term conditions (LTCs)

Our plan to improve outcomes for people with LTCs is to support patients in Sheffield to have more control over their own health and more personalised care when they need it, as part of the SYB ICS personalised care Memorandum of Understanding with NHSE. We have an extensive Personalised Care programme of work, focussing on the delivery of personalised approaches, building the knowledge skills and confidence of patients with long term conditions to take a more active role in their care and building the knowledge, skills and confidence of health and care professional and the voluntary sector to support a patient/professional partnership in care and support. During Covid-19 we have seen some patients and their carers take a more active role in their care and we are keen to build on this as we move forward.

In terms of physical long term conditions including specifically on Cardio-Vascular Disease (CVD), Stroke, diabetes and respiratory – we continue to work with providers to understand the ongoing Covid-19 and associated restrictions upon these diseases, in order to take remedial action where necessary. This includes on risk stratification/triage and trying to ensure access to key services to ensure the delivery of assessment and treatment in order to prevent long term impact wherever possible.

We are in the process of establishing Primary Care Network hubs to identify diabetic patients whose control will have most deteriorated through the Covid-19 pandemic and gather current biometrics to inform necessary treatment amendments in primary care. We are also looking at whether the same hub idea can be used to safely re-start spirometry in primary care to help with the identification of COPD and asthma. This would allow for correct treatments to be started, and again, to identify patients whose conditions will have deteriorated.

Restoring services, building resilience

Supporting people with long term conditions (LTCs)

- The process to select and re-appoint the provider of the National Diabetes Prevention Programme begins again in June as we approach three years' delivery by the present provider, Reed Wellbeing. The new contract will begin in July 2022;
- The NHSE Low Calorie Diet Pilot continues across SY&B ICS with good referral levels from primary care and encouraging weight loss from participants who have completed the initial meal replacement phase;
- The CCG's team of Primary Care Development Nurses have continued to support practices through Covid-19 with the establishment of a virtual 'practice nurse hub' to disseminate information and guidance as it has been issued, training via webinar events and resources to help practice nurses;
- The CCG has distributed more than 300 blood pressure monitoring machines to primary care patients through the 'Blood Pressure monitoring at Home' initiative from NHSE, with practices distributing to previously shielding patients and those with hypertension.

End of Life

The SYB Palliative and End of Life Care (EOLC) group has undertaken a refresh of the six agreed national ambitions and issued matching priorities to be adopted across the ICS. Currently, CCGs are evaluating how they match up to the ambitions with a view to reporting in September 2021, with the objective being to address inequalities and aim for equality of provision and access across the ICS. In terms of the Sheffield City Wide EOLC group, there is a review of what was achieved through Covid-19, looking to build on and further develop collaborative ways of working as well as an initiative to provide further support to community and Care homes to help improve care and reduce inappropriate 999 calls as well as admissions to hospital.

Restoring services, building resilience

Urgent Care

Our plans for urgent care have been drawn up in the context of the impact on the whole system:

- We will have community based care and support that responds to escalating and de-escalating needs of populations via a coordinated hub approach. The multi-professional, multi-organisational team will have access to the information/intelligence they need in order to respond proactively in a way that prevents people requiring a hospital attendance and enables discharges to happen without delay;

- Hubs will be aligned to Primary Care Network footprints. This will require the established health, care and voluntary sector hubs to work together to achieve the result. It is acknowledged that; **A)** there will be differential starting points across the hubs and therefore not all will be fully functional within the timeframe; and **B)** that the work needs to be tailored to the particular circumstances of different people;

- We will develop an integrated pathway for urgent care, across primary care, the walk-in centre, minor injuries unit and A&E. Our approach will be appropriately and adequately resourced which needs to be well-communicated and understood. Clear offers, expectations, implications for different services, and with overarching coordination of capacity. A single City-wide point of access will be explored as a part of this work;

- We will take a “signposting”/navigation approach- which includes local implementation of the national ‘111 first programme’, supported by further developments to our local Clinical Advice Service (CAS). This will reach across health, care and voluntary services, and will make use of and build upon what is already in place- particularly the linkages between 111 and single points of access which we will develop and deliver in partnership with local providers taking a system rather than an individual approach.

Restoring services, building resilience

Urgent Care

Our plans for urgent care have been drawn up in the context of the impact on the whole system:

- We will work with system partners to improve pathways for people who present at A&E with mental health needs and people trying to access mental health support via 111;
- We will continue to deliver local communications campaigns to support Sheffield patients to access the most appropriate urgent care services to best meet their needs and in addition work with local Voluntary, Community and Faith (VCF) groups to support vulnerable groups;
- We will communicate so that there is clear understanding for staff and public about what out of hours provision exists (and how it is accessed) across all urgent care services, including social care and voluntary sector support.
- We will explore the continuation of the capacity coordinator role, which provides a system wide approach to maximising the use of available capacity across the city, out of hours.
- There will be further integration with increased levels of directly bookable appointments from 111 into local service and service to service booking and referrals.

Restoring services, building resilience

Mental health, learning disability, autism and dementia

Mental health

- We have developed an improved support package for Children's mental and emotional health in schools, and will continue to introduce additional service/offers through Term 1;
- We are working on streamlined and simplified referral and delivery pathways. This includes ensuring that the service offer is consistent for all age groups, and that all transition points are managed through cross organisational working. The Crisis Care Transformation programme will continue to be a substantial piece of work, with five ongoing interdependent work streams ;
- Working with partners, we are seeking to extend the good practice developed through the Mental Health Transformation Programme pilots earlier than had originally been planned;
- We are developing a new “all age” Eating Disorder (ED) pathway which brings together the different agencies which currently provide ED services, in order to create a more effective service which pools expertise and avoids difficult service transitions in young adulthood;
- Sheffield Psychology Board (SPB) is accountable to the Mental Health, Learning Disabilities & Dementia Delivery Board (MHLD&DDB). Under the Sheffield-wide Covid-19 command structures, SPB became tasked with oversight of the psychological offer and information available to Sheffield citizens during the Covid-19 19 pandemic. This includes estimating the potential increase in demand for psychological services and developing a stepped care model of service delivery. The SPB continues to oversee the offer of debriefing and psychological support which is available to frontline health and social care staff;
- The CCG is continuing to work with partners in the Sheffield City Region to implement our employment strategy for people with mental health conditions, learning disabilities and autism.

Restoring services, building resilience

Mental health, learning disability, autism and dementia

Learning disability

- The CCG will be contributing to the Learning Disability Death Review process and this will include deaths where Covid-19 has been a factor; we continue to prioritise these in line with national requirements. Lessons learned from these deaths and emerging themes are being fed into training across the City in all care settings;
- Sheffield CCG and partner organisations are working together through the Physical Health Improvement Group, to address a number of barriers to access to physical health care services in the City for people with learning disabilities. There are a number of work streams in progress, such as improving the uptake of Annual Health Checks; improving access to screening; as well as targeted work through the Sheffield Community Learning Disability Service on Health Action Planning and the uptake and use of “Health Passports” developed by national MENCAP, but adapted for use across Sheffield.

Dementia

- The Mental Health team has committed to producing seven “bitesize” training films on different topics related to dementia which will be accessible and useful to a range of professionals across the health and care sector, including medication, end of life care, monitoring of deterioration, crisis support, as well as awareness raising and top tips for non clinical frontline staff, eg; GP receptionists.

Autism

- We continue to develop the City wide Autism Strategy which includes maximising access to physical health services and employment opportunities.

Restoring services, building resilience

Cancer services

A very high number of patients are now experiencing excessively long waits due to constraints on every stage of cancer pathways; issues with workforce, equipment and theatres; complex pathways, and high demand, which all existed prior to Covid-19. Lower Gastrointestinal (GI) is the most pressured pathway. Across SYB, services are taking a harm minimisation approach, with regular clinical review to ensure that patients with the greatest clinical urgency are treated first.

There are also backlogs in routine screening, adding further delays to detecting and treating cancer. STHFT has a number of actions in place to mitigate clinical risk and to restore services as safely as possible:

- Oversight of all patients on an open cancer pathway continues through the weekly patient tracking list (PTL). The PTL involves review of all pathways with challenge and actions are agreed, as necessary, to ensure that patients are continuing to progress along their diagnostic and/or treatment pathways;
- A new SYB Cancer Alliance Patient Tracking List has been developed which should support improved system capacity management as well as give STHFT additional notice of demand expected for referrals outside of Sheffield;
- STHFT are supporting Sheffield CCG with progressing the work on the non-specific symptom and painless jaundice pathways which will support a rapid diagnostic for suspected cancer patients not meeting standard 2 week wait criteria.

Restoring services, building resilience

Children, Young People & Maternity services

- We have put in place a number of actions to improve early identification of Autism in Children and Young People (CYP) and ensure the needs of CYP and their families are being met whilst they are waiting for an Autism assessment. This work will continue over the course of the year and will incorporate wider aspects of neurodiversity.
- We will continue our work to implement the Inclusion Strategy action plan with Sheffield City Council, some of which was delayed as a result of the pandemic.
- We will expand out approach to integrating health professionals with education and care professionals, working within geographical school localities.
- Whilst Covid-19 remains a risk to pregnant women and their babies, the NHS in England must continue to implement the four actions to minimise the additional risk of Covid-19 for women and their babies from ethnic minority backgrounds. A Standard Operational Policy (SOP) has been produced across SYB for managing the risks of Covid-19 for pregnant women from an ethnic minority background and implemented this to support at-risk pregnant women.
- A collaborative approach to Covid-19 vaccinations during pregnancy has been agreed across SYB; aligned to national guidance and SYB wide communications developed.
- STHFT, along with all other SYB Trusts, has an action plan to achieve the 51% target of women being in receipt of a Continuity of Carer Service by March 2022 and continues to develop plans for continuity of carer pathways to be targeted to address health inequalities for women from ethnic minority backgrounds and those who live in the most deprived areas of the City.
- The SYB Local Maternity System will have a plan in place for immediate and essential actions from The Ockenden Report by early June 2021.

Chapter 4:

Our highest priorities for quality and safety in the remainder of 2021/22

Priorities for quality and safety

Protecting the most vulnerable people

We are continuing with our work from Phases 1 and 2 of the Covid-19 pandemic to support people who are homeless and who sleep rough, in partnership with a range of agencies who have depth of expertise in supporting these extremely vulnerable people, through a multi service “wrap around” approach. Services are in place to case find and treat people with Hepatitis B and Latent Tuberculosis. in at risk populations. and funding has been uplifted for practices which provide our Locally Commissioned Services for homeless people and asylum seekers.

Winter resilience planning

As in previous years, Sheffield CCG will co-ordinate the local system’s response to escalation. Wider support will be provided by Yorkshire Ambulance Services (YAS) through the national ambulance response programme (ARP). This will provide additional support to patients through offering advice and guidance through its call handlers providing ‘hear and treat’ and its crews providing ‘see and treat’ which helps patients to avoid being taken to hospital unless it’s really needed. Over the last few months, Covid-19 has necessitated both of these services to successfully increase their coverage and the learning from this will be applied over winter.

There will be local continued monitoring over the coming months of the national “111 First” programme which will support local patients to access the right services for them. Callers to 111 now have the option to be booked in to arrival time slots at Emergency Departments (EDs), when appropriate, and after triage with the potential for 111 to directly book into more local services in the future. In addition, local discussions continue to take place with stakeholders and providers to further understand the potential to increase volumes of clinical advice offered over the telephone to patients. This will enable them to access the right services and also to maximise appropriate usage of self-care and lower acuity provision, such as in pharmacies.

Priorities for quality and safety

Quality assurance

The Quality Team have reviewed the CCG's quality assurance process in the light of the challenges posed by Covid-19 and new ways of working. The work plan for the next six months includes:

- Increased meeting frequency for provider quality review groups and Quality Assurance Committees;
- Undertaking a programme of provider quality review visits;
- Revision and continued development of provider dashboards to monitor performance;
- Ongoing robust serious incident performance management of providers;
- Undertaking an internal "learning lessons" review on SHSCFT;
- Embarking on Quality Assurance Committee development session;
- Reviewing the Quality Assurance Framework for Managing General Practice.

Quality improvement

The Quality Team will implement a number of projects related to City wide priorities, including:

- Encouraging Primary Care Networks to undertake audits across practices and their networks;
- Development of tools to be used across the City to attain consistency and benchmarking and to identify any trends either in prescribing or disease management;
- A process to identify and celebrate projects, results and successes that have been undertaken;
- Increase the reporting of incident and always events from primary care to the CCG to improve learning across the City;
- Support colleagues to restart clinical services, eg; Spirometry Hubs and Diabetes one stop services.

Priorities for quality and safety

Continuing Health Care

The CHC Team will be focusing on three main work streams:

1. Recovery planning around the backlog of assessments which existed pre-Covid-19; this is expected to take 12-18 months to complete;
2. Reinstating the assessment framework under Business As Usual incorporating the new “Discharge Support Fund pathway”, which entails all health and social care assessments being undertaken within 6 weeks of discharge from hospital or any future legislative changes;
3. Review of the current Sheffield CHC model and workforce in order to ensure a timely response to hospital discharges and quality standards for patients and family/carers.

Safeguarding

The Safeguarding Team will continue to support and gain assurance from all Providers that they are meeting their statutory safeguarding requirements via Key Performance Indicators and the development of an online joint CCG/LA Section 11 Audit Tool. The team will continue to have oversight of all forms of safeguarding reviews and the subsequent implementation of recommendations. Support for GP’s producing case conference reports will continue by being the single point of contact for distribution of report requests and completed reports. This will allow for monitoring of the quality of reports to support the introduction of payments. The CCG has launched the ICON programme to support families when babies cry, to reduce the risks of significant head traumas. The CCG will work with partners across the City, to support the implementation of good practice around the Mental Capacity Act, to prepare for introduction of Liberty Protection Safeguards in 2022.

Priorities for quality and safety

Improving safety

The CCG has identified a full time designated Patient Safety Specialist which is key to the NHS Patient Safety Strategy. They will provide dynamic, senior leadership, visibility and support working across the system and be part of a cohort of safety specialist who will support the development of a patient safety culture and safety systems and improvement activity.

Equality

The Primary Care Development Nurses will support practices on increasing referrals into the NHS Diabetes Prevention Programme on individuals of South Asian, Black African and Black Caribbean ethnicity and those from the most deprived communities.

Supporting primary care

- Supporting practices to deliver Annual Health Checks for people with a learning disability and people with serious mental illness;
- Working with PHE and practices to deliver the flu vaccination programme, as well as reinstating other immunisation and vaccine and screening programmes;
- Supporting Primary Care Network in the delivery of Covid-19 vaccines programme;
- The Chief Nurse providing nursing leadership to Practice Nurses through regular communication and meetings.

Priorities for quality and safety

Supporting care homes

The Quality in Care Homes Team will continue to support care homes and home care providers through the pandemic and beyond. Support will be provided in collaboration with Sheffield City Council partners and also with the wider system such as St Luke's Hospice who will facilitate a Managers' Forum and also education sessions according to the requirements of NHSE, including Infection Prevention and Control training and education that supports positive mental health for staff to manage the high number of deaths.

Care homes will receive support calls based on risk and need to ensure that they have adequate support, PPE and staffing to manage the situation and Citywide outbreak support meetings will continue.

The Infection Prevention and Control (IPC) Team will continue to actively support Care Homes and Primary Care as well as having oversight and support PHE with Covid-19 19 outbreaks for these services. A project examining loneliness and isolation for those living in care homes is about to commence which is pertinent to the issue of care homes re-opening to visitors.

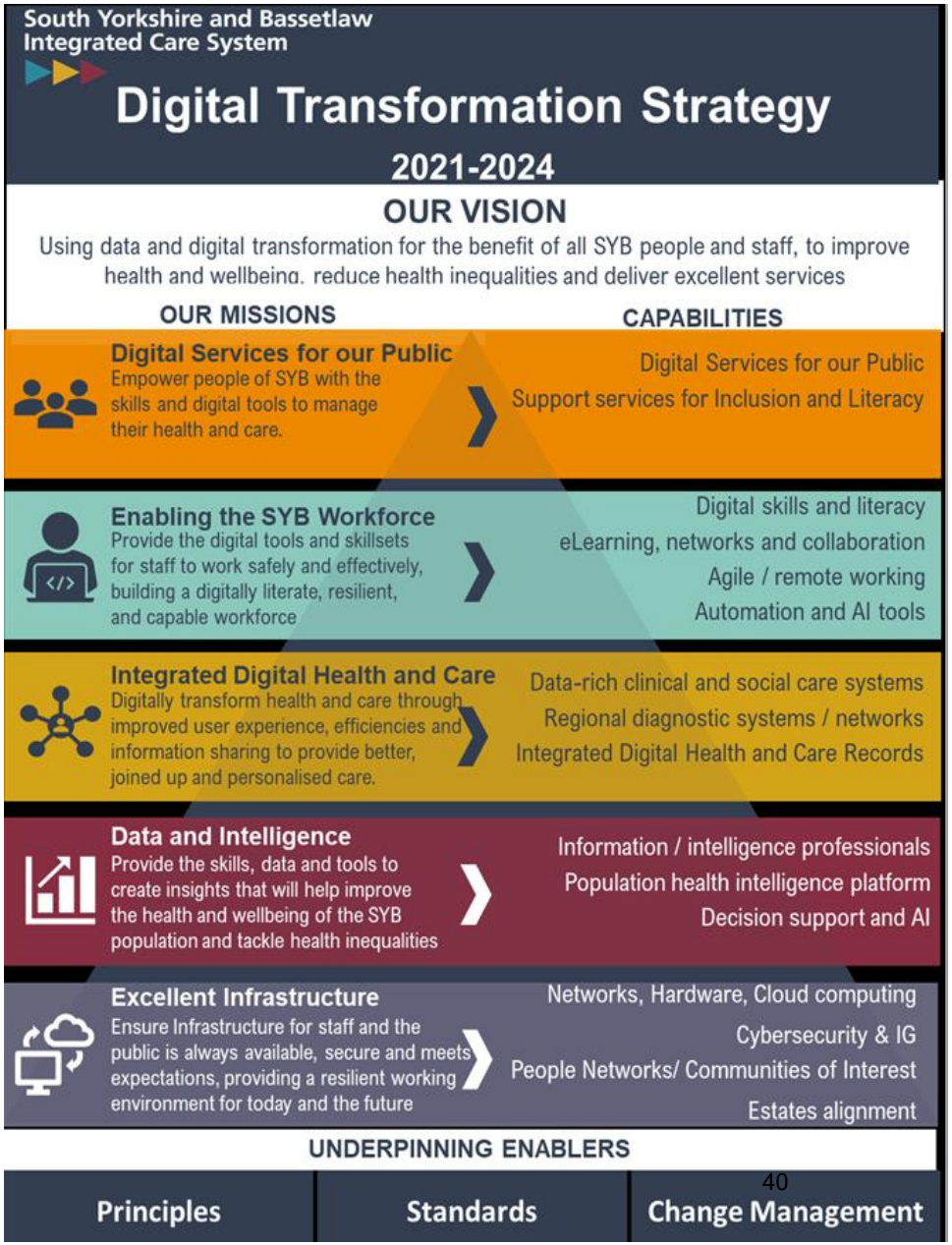
Priorities for quality and safety

Digital Strategy

Sheffield Digital Road Map

The South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) has developed a Digital Transformation Strategy in conjunction with the commissioning and provider partners, including Sheffield CCG.

The strategy is summarised in the diagram opposite:



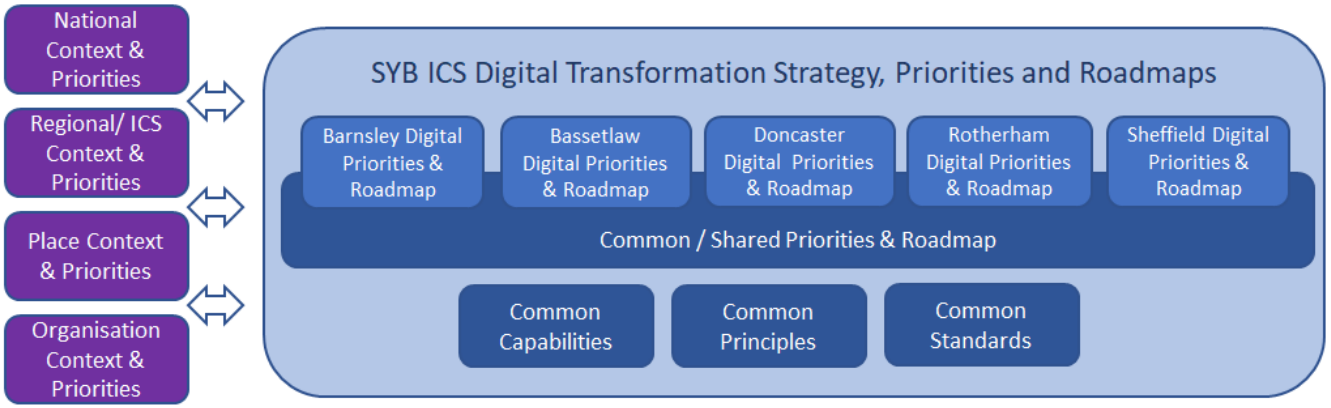
Priorities for quality and safety

Digital Strategy

Sheffield CCG has agreed that the three high level digital development priorities for Sheffield over the next few years will be:

- Integrated digital health and care records to **provide more joined up care** for the people of Sheffield.
- Population health intelligence platform development to enable an **increased level of evidence based decision making** about the commissioning of health and care services in Sheffield;
- Digital services for our public giving the people of Sheffield **access to technology that supports their mental and physical wellbeing** and ensuring that this is **accessible to all Sheffield communities** wherever possible.

The Sheffield CCG IT and Information Teams are currently working with key partners in primary care, Sheffield City Council and other parts of the ICS to produce a Sheffield Digital Roadmap that provides a blueprint for the short and longer term actions required to achieve these ambitious digital priorities. The figure below shows how the Sheffield CCG digital roadmap will be integrated with the roadmaps of the other SYB CCGs and the ICS overall. This will enable the SYB system to take advantage of a larger footprint where it is advantageous to do so.



Priorities for quality and safety

Estates Plan

Sheffield CCG is working with partners in the City to develop our Sheffield Strategic Estates Plan (SEP), which is expected to inform a wider SY&B ICS SEP. It is intended to give us a meaningful platform upon which to develop our estates response to the many challenges ahead and support the delivery of a shared vision for healthcare that aligns the heavily interdependent threads of service strategy and estates strategy. The Sheffield SEP will be finalised by the end of 2021 and will:

- Summarise the current estate and estates issues, needs and priorities for each of the health organisations across Sheffield (STH, SCH, SHSC, Primary Care (GP)).
- Inform better service planning and understanding of opportunities and constraints in relation to Place, ICS and National strategies.
- Promote and inform a collaborative approach to decision making and integration with regards to asset planning.
- Identify potential challenges and opportunities for each organization.
- Support Place level investment planning and priorities, and communication with others (e.g. SY&B ICS / ACP, Sheffield City Council, One Public Estate (OPE) Programme).

SYB Primary Care Capital Programme

SYB ICS has been successful in being awarded outline funding of £57.5m to develop the primary care estate in SYB. Of this £36m is earmarked for schemes within Sheffield. Sheffield CCG is working with colleagues across SYB to develop the programme business case to secure release of this funding, alongside the development of project business cases for different elements of the programme.

Chapter 5:

Our Commissioning Intentions for 2021 – 2022

Commissioning Intentions

Our commissioning intentions are the things we will do this year to improve services and people's experience of these. They are what we need to put in place or change to ensure people get the right care and treatment.

Closer joint working between Sheffield CCG and Sheffield City Council in 2020/21 meant a number of practical gains were achieved, including:

- We brought Social Care and Health staff together with GP's, to provide a 'team around a person' approach to supporting individuals, ensuring people are supported to receive services to support their needs in their local communities – particularly in our new primary care based mental health support service, one of 12 national pilot sites;
- We worked with our mental health and acute hospitals to ensure services work together to enable discharge from hospital to home, is supported by a rapid assessment to determine ongoing care needs;
- We streamlined out assessment and review process to ensure those with ongoing care needs, have their needs met in a timely manner and funded appropriately.

This year we have developed the first ever Sheffield Health & Social Care Joint Commissioning Plan to bring together the commissioning of health and social care services. The plan will be supported by a Sheffield wide Outcomes Framework which will not only monitor whether our commissioning intentions are having the required impact for the Sheffield population, but will also be owned by the Sheffield Accountable Care Partnership, ensuring that all health and social care organisations are aligned in delivering the outcomes that are needed for the City.

The aim of the Framework is to help us focus on real health and quality of life outcomes for our population, not just commissioning outputs such as levels of activity for process measures. We are working towards co-production of the outcomes with patients, carers and members of the public, and closer liaison with the voluntary sector to deliver improved outcomes for the most vulnerable people in our City. This focus on outcomes will be a core element of moving towards a more holistic population health management approach.

Commissioning Intentions

By Sheffield CCG and Sheffield City Council working together and aligned to one joint Sheffield Health & Social Care Commissioning Plan:

- We can make sure that what the Sheffield population need to live full and healthy lives is available to them;
- We will use feedback and the information we collect to make sure health and social care services are of high quality, safe and deliver what our population need whilst we also manage the costs and get the most from our money;
- We will join our workforce and resources to focus on the delivery of our priorities;
- We will listen to what is important to the people of Sheffield and together, make changes to health and social care services.

NHS Sheffield CCG and Sheffield City Council have agreed a set of joint priorities in which all of our commissioning intentions will align to for the Sheffield population. These are:

- We will continue to respond to the Covid-19 pandemic;
- We will reduce health and social care inequalities across Sheffield;
- We will focus on improving access to and availability of health and social care services;
- We will ensure all children across Sheffield have the best possible start in life;
- We will improve the support and treatment for your mental health and wellbeing;
- We will make sure if you need health and social care support then this is personalised to your needs.

Health Inequalities

Sheffield's Health and Wellbeing Strategy (2019-2024) reflects the City's overarching commitment to reducing, and one day eliminating, health inequalities in Sheffield.

We know too many people in Sheffield are struggling with poor health and wellbeing, and this is inequitably distributed across our City.

Inequality is bad for everyone. Places that suffer from greater inequalities have worse overall outcomes, across all population groups, areas, and communities. This makes tackling inequality a whole population issue.

Most of the solutions are not to be found within NHS and social care services alone – these are about tackling the social determinants of health. However, as a commissioner with an annual budget of £1bn, there are lots the CCG can do to help improve people's health and wellbeing. In terms of the Marmot review ("Healthy Society, Healthy Lives", 2010), this is the objective "to strengthen the role and impact of ill health prevention".

The 'golden thread' running through all of our commissioning intentions and programmes of work to improve the health and care of the Sheffield population, is the reduction of health inequalities. In order to address health inequalities and focus our work, the CCG has identified the **people living in the 20% most deprived areas in Sheffield**, **those people who are from ethnic minority backgrounds** and **people who are homeless** as a priority for action.

People living in deprivation, people from ethnic minority backgrounds, and the homeless are on average more likely to have poorer health, poorer access to health services and experiences, lower life expectancy and live more years in ill health. In Sheffield, the difference in life expectancy between the best and worse off is 20 years.

We will listen to our population and ensure health inequalities is addressed in other areas as well. For example:

- mental health;
- learning disability;
- physical disability and impairment;
- LGBTQIA.

Health Inequalities

Improving our understanding of what the data is telling us

The Business Intelligence community across SYB has collaborated to establish a programme of work to develop a deeper understanding of access to health care and waiting times in the context of Health Inequalities and people of ethnic minority backgrounds.

The first stage of this work includes:

- The establishment of a system-wide Business Intelligence Forum;
- The agreement of core principles to enable the flow of data and provide a safe space for the development of analysis. The first data sets have been shared and a draft system baselines is being constructed – this will work will be taken forward jointly with public health colleagues.

Listening to our population

We are learning and listening to our population by reaching out to contacts in the community to find out how they have been coping with the pandemic and subsequent restrictions. We have received over 800 comments and logged them against protected characteristics, so we have been able to analyse the feedback by different communities. We used this feedback to shape our commissioning intentions.

Increasing physical activity

The New Sheffield “Move More” strategy has been launched to encourage wider uptake of exercise, particularly in ethnic minority populations and younger ages. A Sheffield physical activity referral scheme will be re-instated. A Plan is being developed to better engage with people from ethnic minority backgrounds and disadvantaged citizens in exercise programmes for people with Long Term Conditions.

Challenge 1: Mitigate against underlying factors that cause unhealthy lifestyle/patterns of behaviour and contribute to poor outcomes for the Sheffield population.

Why is it a priority?

People who lead unhealthy lifestyles are more likely to develop key health conditions and have shorter lives.
More people in Sheffield die from smoking related causes than the England average.
Children who are born prematurely often have special educational needs (SEN) doing less well at school and increasing demand on services.
Children who are overweight or obese are at risk of developing long term health conditions such as diabetes, mental health issues and likely to have shorter length of healthy life.

Commissioning Intentions:

- Establish a Sheffield Alcohol Liaison Service for individuals who repeatedly present at the Northern General Hospital with alcohol related conditions and support needs.
- Recommission the Individual Placement Support employment service and Working Win.
- Work with the Integrated Care System and Sheffield City Council to continue with and monitor the implementation of QUIT (smoking cessation programme).
- Put in place enhanced SEND (Special Educational Needs and Disabilities) support provision in line with the Sheffield Inclusion Strategy.
- Support Primary Care Networks to improve the health of their patients through funding / information / service specifications / support Quality Outcome Framework delivery.
- Diabetes 'one stop shop' clinics.

Examples of outputs:

- A service for to support with alcohol related conditions.
- Ongoing support for patients with enduring mental illness to access employment successfully.

Examples of benefits:

- Further reductions in smoking in pregnancy and when give birth and lower levels of overweight pregnant women.
- Reduction in childhood obesity rates.
- People better manage their diabetes.

Challenge 2: Increase the number of people who have their health and related needs identified and supported early enough.

Why is it a priority?

Early support or diagnosis makes conditions easier to treat, helps people get better faster and costs less money in the long run.

Supporting children who have experienced Adverse Childhood Experiences (ACEs) as soon as possible is the best way to support them to learn, do well at school, improve their physical and mental health and get a job.

Commissioning Intentions:

- Design a new model of local children and young peoples' health and care services;
- Review and improve existing services that help children who have experienced ACEs;
- Improve the linkage between children's and adults services;
- Further development of a City wide intermediate care offer to sustain the reduced delayed transfers of care position;
- To deliver the 13 recommendations outlined within the Dementia Strategy aimed at improving a range of pathways to support for this population and their families;
- Improve access to mental health support for children and young people focusing on early intervention, prevention, support into schools and access into CAMHS (Child and Adolescent Mental Health Services);
- Commission the Provision of Clinical Advice and Guidance;
- Improve Knowledge about Urgent Care Services;
- Development of the local Clinical Advice Service (CAS);
- Commission Cancer Services in Line with National and Local Cancer Alliance Strategies;

Examples of outputs:

- Increased communication between clinicians working in different services;
- High quality support to families and carers of people with dementia.

Examples of benefits:

- Improved uptake of cancer screening;
- Reduced waiting times for services;
- People will feel more supported and informed.

Challenge 3: Increase the number of people who are effectively supported and empowered to manage their health needs to optimal levels.

Why is it a priority?

Optimal management of conditions improves quality of life and helps to reduce, prevent and delay development of other conditions.

Children whose health needs are not optimally managed from an early age are likely to have poorer long term outcomes in relation to health and education and poorer social and economic outcomes.

Commissioning Intentions:

- Put in place enhanced SEND (Special Educational Needs and Disabilities) support provision in line with the Sheffield Inclusion Strategy;
- Work with partners to adopt and develop a personalised approach to re-establish long term condition monitoring and reviews to recover control and management of conditions to pre-Covid-19 levels;
- Tackling health inequalities within primary care and your community;
- Improve access to healthcare and health outcomes for people experiencing homelessness, vulnerable migrants, sex workers, traveller groups and ex-offenders;
- Establish an all age eating disorder service;
- Improve access to 24/7 crisis services for children, young people and adults; and extend the mental health liaison service;
- To improve and enhance the out of hours crisis care for people with learning disability as part of the national "Building the Right Support model" and aligning to the Crisis Transformation Programme;
- Improve the physical health of people with mental health, learning disability, autism and dementia;
- Actions to support recovery of elective activity;
- Improved Sheffield-wide end of life services.

Examples of outputs:

- More and better community services.
- More patients die in the place of their choice.

Examples of benefits:

- Increase in number of people who feel supported to manage their own condition.
- Demand on specialist services will be reduced.

Challenge 4: Improve the capaCity, resilience and capability of Primary and Community services (including Voluntary sector)

Why is it a priority?
We need excellent, local, joined-up, sustainable primary and community support to deliver the interventions necessary to enable people to live their lives to the full.
Member practices have highlighted that Primary Care Mental Health is an area of concern that requires improvement.

Commissioning Intentions:
- Implement City wide roll out of Mental Health Primary and Community Care new model of neighbourhood support;
- Development of discharge home to assess service to enable assessment at home of any ongoing support needs;
- Primary Care Resilience;
- Develop a robust approach to resilience including workforce recruitment and retention and support to vulnerable practices;
- Redesigned Community Phlebotomy Services.
- Implement an assurance framework to monitor safeguarding and achievement of quality standards across all Sheffield organisations

Examples of outputs:
- Increased mental health support within local areas.
- Increased range of staff working in Primary Care.

Examples of benefits:
- Improved access to primary care services.
- Improved quality and consistency of services provided.
- Increased efficiency.

Commissioning Intentions: Investment Priorities

We are committed to investing in services to improve access and quality. In 2021/22 we will develop and implement plans to improve services and outcomes for our population for the following areas:

- Mental Health investment standard programmes
- Commission for the provision of clinical advise and guidance
- End of Life care and support
- Development of the local clinical advice service (CAS)
- Redesigned community phlebotomy services
- Commission cancer services in line with national and local cancer alliance strategies
- Improve knowledge about urgent care services

This list is not exhaustive and we will continue to drive out improvements where it is deemed essential throughout 2021/22.

Our Quality, Innovation, Productivity and Prevention (QIPP) programme enables us to identify where financial efficiencies can be released in order to for us to invest in services. Our QIPP programme for 2021/22 will focus on the following areas:

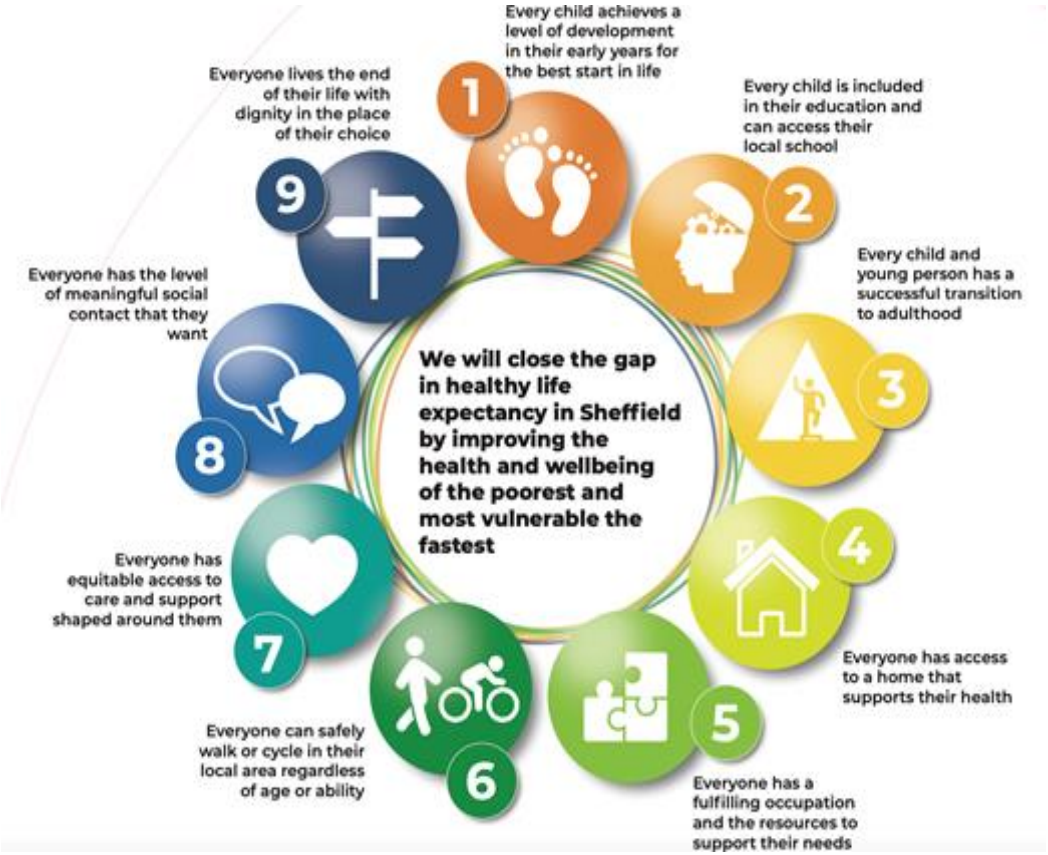
- Review high cost Continuing Healthcare packages to ensure they continue to be fit for purpose
- Review prescribing of medications across Primary Care
- Continue to review our management structure to ensure that it is able to deliver our key priorities and statutory functions in an effective and cost effective way.

All of our commissioning intentions will be monitored for efficiencies as improvements are made to services.

Sheffield Health & Social Care Outcomes Framework

- Working together with citizens, voluntary sector providers, NHS and Local authority providers we want to develop our outcome framework to ensure it delivers what matters to you.
- It will include population health information, performance standards, quality standards, activity data as well as outcomes, to triangulate all of the intelligence we have access to.
- We feel it will need to identify some key themes to focus on, we will work with the voluntary sector, to ensure we receive feedback from the public, staff and look at evaluations.
- We will need to understand the current position and set out what we can achieve.

Sheffield Health & Wellbeing Ambitions



Children have the best possible start in life and will grow into happy, healthy adults.

- Special Educational Needs and Disabilities (SEND) are identified, assessed and met as early as possible – disproportionate no of Children & Young People (CYP) from deprived areas have SEND - improves their health and educational outcomes;
- CYP with vulnerabilities/needs have them met and supported as early as possible and staff and parents have a greater understanding of needs and behaviours – resources and services tailored and targeted for the areas of greatest need, started with one of most deprived localities within the City;
- Improved educational progress and attainment due to increased school attendance rates.

People will be better informed and will choose/be supported to make healthier lifestyle choices for themselves and their families.

- Reduction in impact of Adverse Childhood Events (ACES) – services tailored to meet needs and targeted at areas with greatest occurrence/challenges with ACES (deprived).
- Improved employment support opportunities for people with mental health conditions – programmes target the unemployed/at risk of job loss and have specifically outreached to the ethnic minority population.
- Improved general wellbeing; increased self-esteem; improved social situations and accessing the recovery community for people with particular alcohol needs.
- Improve information-sharing and channels of communication around exploitation & coercion of vulnerable people within the realm of organised and violent crime.

People feel confident that they are able to access the right service first time. Staff will feel confident they are able to meet the needs of the patient population.

- More people are supported to die at home or in their preferred place of death;
- More people on palliative care register with a care plan that reflects “what matters to you?”;
- Increased City coverage of the Primary Care Mental Health model to meet the ambition of full coverage by 2023/24;
- Improved access for homeless people to primary care;
- Nobody is ever discharged to the street;
- Feedback from VCS, evidence of improved uptake of cancer screening & immunisation in the ethnic minority population;
- Improved experience of end of life care for people experiencing homelessness.

People feel supported and empowered to manage their health in the most appropriate setting/community.

7 9

- The Sheffield Eating Disorder Recovery Team will meet national standards resulting in improved health outcomes for people suffering from eating disorders – service will tailor interventions to meet needs of the ethnic minority communities;
- People with eating disorders experience seamless "warm handovers of care" between services and have a clearer understanding of the service on offer;
- Waiting times and interventions for Eating Disorders will meet national standards;
- CYP and their families will get improved access to timelier interventions aimed at reducing the impacts on Mental ill health;
- People with dementia and their families will feel more supported leading up to and after diagnosis, will feel less isolated, and they and the professionals that support them will have easier access to information, signposting and support throughout the progression of their illness;
- Nobody is ever discharged to the street;
- Where clinically appropriate patients will be offered virtual on-line appointments instead of requiring them to travel to hospital;
- Better support available in the community for people with LD, their families and carers beyond Monday to Friday 9-5.

Chapter 6:

Being a caring employer that values diversity and maximises the potential of our people

A Caring Employer

Supporting our staff to stay healthy

During the first phases of the Covid-19 pandemic, we enabled our staff to work from home as per government guidelines. Additional support continues to be offered to mitigate any adverse impacts of home working such as musculo-skeletal problems, by facilitating access to physiotherapy service and taking home office chairs, following physiotherapy assessment.

During 2020, we developed a tool called the Staff Temperature Check that asked our staff to anonymously tell us how they are and whether there were any areas that we could help them with. Recent feedback have shown that a significant number of staff are struggling with their mental health. Additional support has been offered around mental wellbeing through a variety of self accessed tools, and other support both virtually or through CCG provided mental health first aiders, Employee Assistance Programme and Occupational Health. Additional support is offered to support staff with concerns around working hours/carer needs/children off school.

The CCG health support has a strong emphasis on mental health and emotional well being, for example:

- Promotion of Mental Health First Aiders, Employee Assistance Programme;
- Talking about Suicide online training;
- Reciprocal sharing of wellbeing resources across South Yorkshire & Bassetlaw;
- “Time to Talk” Fikas (break from activity);
- Access to courses and resources such as “Life After Lockdown” and Improving Access to Psychological Therapies (IAPT) “Managing Anxiety”.

A Caring Employer

Supporting staff to work flexibly and using our HQ differently

At the time of writing this Plan (late May 2021), most CCG staff continue to work from home. We are, however, now planning how we can safely return to our main office once the government lifts current social distancing requirements. We will be trialling new patterns of working using a flexible office/home working model, when national guidance suggests that it is the right time.

We will be offering staff options around how and where they work, and line managers are currently having conversations with staff about their current preferences – with the option to flex these as the situation changes. It is clear that many staff have valued some aspects of working at home and it appears that a significant number of staff will opt for a hybrid model of home and office working.

A hybrid model of working will need to be thought through in terms of our culture and organisational development. We will need to ensure that there are both physical and virtual opportunities for meetings, learning and activities to ensure that we can optimise communication, relationships, mental health and team spirit.

Our staff are involved in thinking through the practical and Human Resource (HR) policy implications of this new way of working which is likely to become a permanent feature of our organisation.

Virtual meetings with partners across SYB has been and will continue to be an essential way of reducing our carbon footprint now and in the future.

A Caring Employer

Developing the skills and knowledge of our staff

During 2021/22 we will be looking ahead to the expected changes that will happen in 2022 with the establishment of the South Yorkshire and Bassetlaw ICS as a statutory body and the dissolution of all CCGs. We are thinking about what this will mean for our staff and how we can take the development of our organisational culture to the next level.

Our Accountable Officer has shared a vision with staff of place based working as “Sheffield Locality Team”, with stronger partnerships in the City and a clearer context of what work needs to be done at place and what is best undertaken across an SYB footprint.

Some of the skills and knowledge that we might want to explore developing amongst out workforce could include:

- Understanding of the concepts, principles, tool and techniques of Population Health Management – at differing levels of detail and expertise across the CCG. All staff should have a working understanding of health inequalities for the City and their impact;
- Increased knowledge and confidence in using programme and project methods and tools. Some staff/ teams may just need a good grounding in the principles and how to apply them, others may need a formal qualification, eg; in PRINCE or AGILE;
- Staff may need increased understanding of the wider system in Sheffield, learning about the roles, cultures and practices of (for example) the City Council, primary care, voluntary sector. This could be achieved through mini secondments, short tem projects or shadowing;
- Some staff may need a refresh of their IT skills and we need to ensure we have a workforce who are fully confident to exploit the benefits of tools for remote working, eg; the full functionality of MS Teams/ Sharepoint. Every team should have people who are confident to set up and host virtual meetings on different platforms.

A Caring Employer

Promoting diversity, equality and inclusion

The CCG is a diverse organisation in terms of gender and there are many women in senior roles but more needs to be done to increase the number of staff members from ethnic minority backgrounds and address the imbalance in staff from ethnic minority backgrounds in senior roles. We want to be an organisation that truly reflects and represents all our communities.

We are working with our staff, particularly our staff from ethnic minority backgrounds, to look at how we can address inequalities at the CCG. We are currently working towards setting up a network for staff from ethnic minority backgrounds that we hope will offer peer support and networking, to inform our policy around equality issues, and raise awareness of issues that our colleagues from these backgrounds face. We want to listen to the lived experiences of our staff and use these experiences to learn and develop and make our work place more inclusive.

The NHS People Plan contains a number of expectations around the make up of our staff moving to be more representative of the ethnic mix of Sheffield's population, with more ethnic minority staff being represented in senior positions.

We will be looking to build on the great work which was done last year by our staff to raise awareness of issues around diversity and inclusion such as the activities related to Back History Month, LGBTQIA History Month and the Black Lives Matter Fika sessions. The staff working group on Menopause in the workplace is an example of the CCG thinking progressively about how we can create a supportive environment for our people.

A Caring Employer

Promoting diversity, equality and inclusion

The CCG's Promoting Equality and Diversity Group share knowledge with each other, seek to raise the profile of topical issues, and plan events and awareness campaigns.

The CCG is promoting a range of learning opportunities in June and July 2021 around understanding more about LGBTQIA issues, including webinars around supporting colleagues and being an ally in the workplace, and learning about the health needs of LGBTQIA people .

A further reciprocal mentoring opportunity has been made available for staff members from ethnic minority backgrounds to work with senior SYB CCG staff members over a 12 month programme. One of the programme's core objectives includes optimising the career development and talent pipeline of aspiring leaders who are from ethnic minority backgrounds.

Sheffield's 'staffing' subgroup to the City wide Strategic Group for people from ethnic minority backgrounds has a full action plan, which includes the development of a race equality charter to be agreed across the ACP, sharing good practice on recruitment of Non-Executive Directors (NEDs) and data sharing and consolidation.

Chapter 7:

Preparing for the transition to the new SYB ICS

SYB ICS

Journey to date

The South Yorkshire & Bassetlaw journey to becoming one of the first integrated care systems in the country has been one of strong partnerships formed over the last 5 years in each of our 5 places (Sheffield, Barnsley, Rotherham, Doncaster & Bassetlaw) and across SYB, focusing together on delivering our ambitions for the population we serve.

The partnership has been built on excellent foundations of working together and throughout this time, our vision has remained the same: *For everyone in South Yorkshire & Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.*

The proposals outlined in the White Paper set out new ways of working to better support integration and partnership working. This includes establishing ICS's as formal NHS statutory bodies. They also give a renewed ambition for collaboration to form a major part in delivering the best possible outcomes and care, with different parts of the NHS and the NHS and Local Government, where effective and dynamic collaborations address health inequalities and deliver improved outcomes to health and wellbeing for local people.

The timeline and models on the following pages details the transition phase for the implementation of the proposals set out in the White Paper.

ICS Transition Road Map

South Yorkshire and Bassetlaw
Integrated Care System

An illustration which helps us explore some of the key features of the emerging operating model

Providers of health and care are working together in Place:

- in collaboration,
- Collaboratives, and;
- As part of a wider strategic partnership

Local Authorities and the NHS are working Together in Place:

- Joint commissioning in place

Anytown Place Partnership

Delegation from the NHS Integrated Care Authority

- **Leadership, People capacity and skills to co-produce:**
  - Improving population health and reduce health inequalities
  - Development of primary care networks
  - Local integration, provider collaboration and

Appendix 1: Abbreviations

- Accident and Emergency (A&E)
- Accountable Care Partnership (ACP)
- Additional Roles Reimbursement Scheme (ARRS)
- Adverse Childhood Experiences (ACEs);
- Advice and Guidance (A&G)
- Ambulance Response Programme (ARP)
- Atrial fibrillation (AT)
- Better Care Fund (BCF)
- Cardiovascular Disease (CVD)
- Clinical Assessments Education Service (CASES)
- Child and Adolescent Mental Health Service (CAMHS)
- Children and Young People (CYP)
- Chronic obstructive pulmonary disease (COPD)
- Clinical Advice Service (CAS);
- Clinical Commissioning Group (CCG)
- Continuing Health Care (CHC)
- Director of Public Health (DPH)
- Ear Nose and Throat (ENT)
- Eating Disorder (ED)
- Elective Activity Co-ordination Hub (EACH)
- Emergency Departments (EDs)
- Emergency Preparedness Resilience and Response (EPRR)
- End of Life Care (EOLC)
- Executive Delivery Group (EDG)
- Human Resource (HR)
- FIKA (break from activity)
- Gastrointestinal (GI)
- General Practice (GP)
- Improving Access to Psychological Therapies (IAPT)
- Independent Sector (IS)
- Infection Prevention and Control (IPC)
- Information Technology (IT)
- Integrated Care System (ICS)
- Joint Commissioning Committee (JCC)
- Learning Disability (LD)
- Leeds City Council (LCC)
- Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIAQIA)
- Local Authority (LA)
- Long Term Conditions (LTC)
- Management and Supervision Tool (MaST)
- Member of Parliament (MP)
- Mental Health (MH)
- Mental Health, Learning Disabilities & Dementia Delivery Board (MHLD&DDB)
- Multi-Disciplinary Team (MDT)
- Multi-Specialty Team (MST)
- National Health Service England (NHSE)
- National Health Services (NHS)
- Non-Executive Directors (NEDs)
- One Public Estate Programme (OPE)
- Patient Initiated Follow-ups (PIFU)
- Patient Tracking List (PTL)
- Personal Protection Equipment (PPE)
- Population health management (PHM)
- Practice Development Unit (PDU)
- Primary Care Network (PCN)
- Primary Care Sheffield Ltd (PCS)
- Primary Lead Teacher (PLT)
- Projects In Controlled Environments (PRINCE)
- Protected Learning Initiative (PLI)
- Public Health England (PHE)
- Referral to Treatment (RTT)
- Sheffield Children's NHS Foundation Trust (SCHFT)
- Sheffield City Council (SCC)
- Sheffield Clinical Commissioning Group (SCCG)
- Sheffield Health and Social Care NHS Foundation Trust (SHSCFT)
- Sheffield Psychology Board (SPB)
- Sheffield Strategic Estates Plan (SEP)
- Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
- South Yorkshire & Bassetlaw (SYB)
- Special Educational Needs and Disability (SEND)
- Standard Operational Policy (SOP)
- Team Around the Person (TAP)
- Voluntary Action Sheffield (VAS)
- Voluntary, Community and Faith (VCF)
- Yorkshire Ambulance Services (YAS)

Appendix 2: Linked documents providing context for this Plan

- 2021-22 Priorities and Operational Planning: narrative Submission 29.03.21;
- NHS Sheffield CCG Annual Report 2020-21 https://www.sheffieldccg.nhs.uk/Downloads/About%20US/CCG%20Governing%20Body%20Papers/2021/20%20MAY%202021/Item%208i%202020%2021%20Annual%20Report.pdf;
- NHS Sheffield CCG Inequalities Plan *(currently in development);*
- NHS Sheffield CCG People Plan;
- Digital Strategy *(currently in development);*
- NHS Planning and Contracting Guidance 2021-22 https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance/;
- Sheffield Health and Wellbeing Strategy;
- Sheffield Health and Care Plan 2021-22;
- Sheffield Outcomes Framework *(currently in development);*
- SYB Cancer Alliance Cancer Plan 2021-22.

As we review and update the Operational Plan later in the year, we will draw on other plans and reference them here, for example:

- Flu campaign plan;
- Winter Plan for 2021-22;
- Plans to support the transition to the new SYB ICS.