Shaping Sheffield: The Plan

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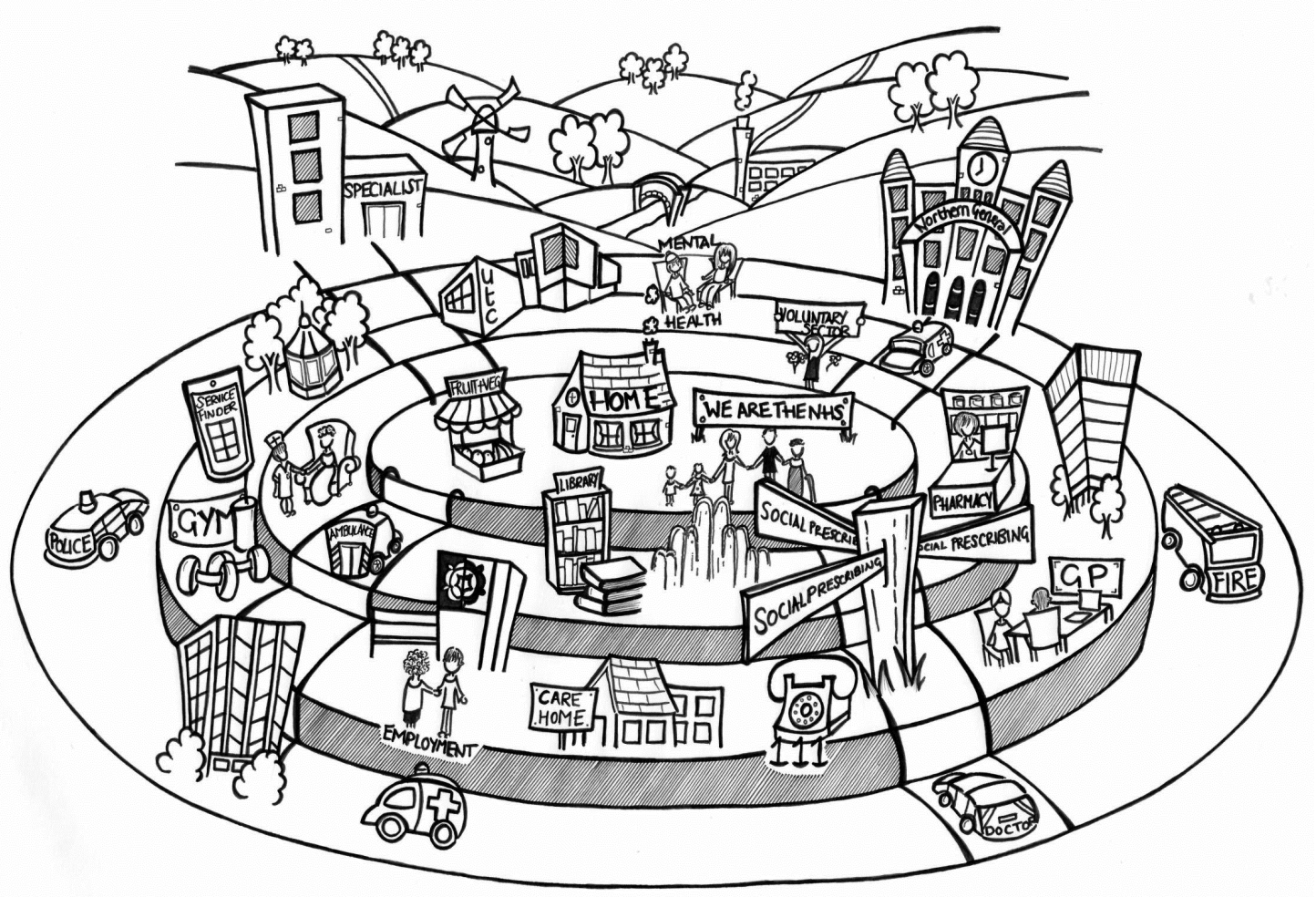


Shaping Sheffield: The Plan

Who's Involved in Shaping Sheffield:

Burton Street Foundation
Carers' Centre
Cavendish Centre
Chesterfield Royal Hospital FT
Citizen's Advice
Common Purpose
Community Pharmacy Sheffield
Creative Pathways
Creative Sheffield
Darnall Wellbeing
Disability Sheffield
Equalities and Involvement
HealthWatch Sheffield
Heeley City Farm
Heeley Development Trust
Horizon Care
Imam Sheikh Mohammad Ismail
Inspire UK
Manor and Castle Development Trust
Meadowhall
Mixim
PACES
Primary Care Sheffield
Public Health
Reach South Sheffield
Sheffield 50+
Sheffield Age UK
Sheffield CCG
Sheffield Chambers of Commerce
Sheffield Children's NHS FT
Sheffield Churches Council for Community Care
Sheffield City Council
Sheffield City Counsellors
Sheffield City Primary Care Localities
Sheffield Equality Hub
Sheffield Hallam University
Sheffield Health and Care Foundation Trust
Sheffield Health and Wellbeing Board
Sheffield International Venues
Sheffield Jesus Centre
Sheffield Local Medical Committee
Sheffield Mencap
Sheffield Mind
Sheffield Save Our NHS
Sheffield Teaching Hospitals FT
Sheffield Walk In Centre
Sheffield Young Carer's Project
Shipshape Community Health
SOAR
South Yorkshire Fire and Rescue
South Yorkshire Housing
South Yorkshire Passenger Transport Executive
South Yorkshire Police
St Luke's Hospice
St Mary's Community Centre
St Wilfred's Centre
Survivors of Depression in Transition
The Key Fund
The Rock Christian Centre
University of Sheffield
University Technical College (UTC)
Voluntary Action Sheffield
We Love Life and Recovery Enterprises
Yorkshire Ambulance Service
Zest Community

Content

Summary

This document is one of three pillars required to deliver the ambition and outcomes articulated within the plan. Firstly **the Sheffield Plan** is the collected and shared ambition of patients, clinicians and organisations . Secondly, alongside this is work to develop Sheffield Health and Wellbeing System as an **Accountable Care and Wellbeing System** to resolve the longstanding issue of the system set up preventing the service change required. Thirdly is a shared **Financial Strategy for the Sheffield Public Services** which allows organisations the ability to change behaviours when all are signed up to a shared financial plan.

STP

Place Based Plan

Operational Plan

The Sheffield Plan aims to do four key things:

1. Create the **Culture and Leadership required to design integrated ways of working** across the city; creating sustainable health and care for the future as well as supporting empowering Sheffielders to live independently and well
2. **Improve the quality** of our services
3. **Increase efficiency** across our services
4. Meet the need of the Sheffield population and **improve health and wellbeing outcomes**

The Sheffield Plan builds on the successes that Sheffield already has across the city, strengthens our collaborative single system approach to working, builds on the strategic case for change set out for the South Yorkshire and Bassetlaw Sustainability and Transformation Programme.

Importantly the plan will:

- **Tackle barriers** that have previously prevented us from realising the full benefit of our programmes and services – the challenges we face are not new challenges and therefore we need to think about how we solve them very differently, more strategically and together
- Bring us together as a single voice using an **accountable care system** approach to make us stronger
- Build a strong and resilience neighbourhood approach across the city; a shared major priority

which will start by initiating four key deliverables in Year 1

1) **Tackles the barriers** to success

2) Commits to **gearing organisations to serve our 16 Neighbourhoods**

- Tackles Inequalities head on
- Employment into health and health into employment
- Exercise
- Risk stratification of population
- Social prescribing
- 4 prioritised pathways
  (being finalised but likely to include respiratory and diabetes)
- Take a lifecycle approach to services

3) Provides a commitment to working as **an accountable care and wellbeing system in Sheffield**

4) Local delivery of **change programmes are closely aligned to the priorities of the STP** to allow the STP to align progress across its constituent places
(Wellbeing and Prevention, Primary Care, Mental Health & Learning Disability, Urgent Care, Elective Care, Diagnostics, Cancer and Children & Maternity)

How We Got Here

The Sheffield Plan has been developed by:

Understanding Where We Are

- We have a Joint Strategic Needs Assessment and an Health and Wellbeing Strategy that sets out what we need to do
- We have growing need for services and an ageing population
- The money available in 5 years time won't be able to meet this need; we have to do something different
- We need to reduce the number of children, young people and adults needing health and care by keeping them well for longer
- We need to change the way that we work together; reducing duplication and removing barriers to streamlined care

Consultation:

We consulted with you during 2014-15 on what we need in Sheffield, including:

- 2020 Vision
- Active Support and Recovery
- Health and Wellbeing Strategy
- Urgent Care
- Primary Care
- Best Start Strategy
- Children's Transformation Plan
- Learn Sheffield

Strategies and Plans

From the consultations multiple strategies and plans were produced to describe, across health and care, what we need to do

The South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Health and Care partners across South Yorkshire and Bassetlaw have developed a plan that sets out the case for change across a wider regional footprint. These plans feed from and back into the Sheffield Plan

Developing A Single Plan:

The Sheffield Plan brings the strategies and plan together into a single place. It also brings in wider plans such as employment and education and links with wider partners. We need this through

- Shaping Sheffield Events
- The Sheffield Transformation Board (see page 19)
- Health and Wellbeing Board
- Sheffield Strategic Planning Group

Confidence in Delivery

Recognising the challenges to our health and care system being greater than ever before this plan goes further on assuring we deliver the sustainable transformation required. We have:

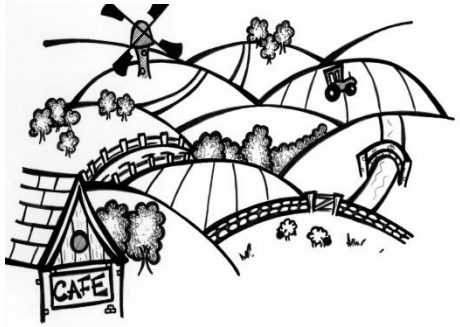
- System wide commitment
- Robust Governance
- Measureable impact expectations
- Agreed ways of cross organisation working and behaviours

Introduction

Children, young people and adults of Sheffield have helped to shape our plans for transforming services through a number of consultations (2020 Vision, Health and Wellbeing Strategy, Urgent Care, Primary Care, Active Support and Recovery, service feedback).

We have a sustainability challenge that means we have to align our programmes to ensure we achieve our transformation and see its benefits in improved outcomes and services that offer value (quality and benefit) to us all.

This plan brings together the transformation plans from health and care, from education, from employment and from wider partners. Drawing together Sheffield's collective energy to shape and transform for a sustainable future.



WHAT ARE WE GOING TO DO? THE SHFFIELD PRORITIES

- **Invest in prevention**
- **Take a lifecycle approach to services by investing in** services supporting pre-birth, early years and families, education and building and supporting aspiration, building emotional and mental wellbeing
- **Help more people back to work**, with stronger health and employment connectivity with links to emotional and mental wellbeing
- **Invest heavily in the development and delivery of neighbourhood working**
- **Tackle inequalities head on** by disproportionate investments in effort and resources into those communities with most need, for example through an integrated approach to mental health
- **Agree a single risk-stratification process for our** population and use this to inform the wrapping around of services in neighbourhoods
- **Work with our staff and teams to promote flexibility**; enabling person centred services and a culture where staff work across organisational boundaries
- Strengthen **Primary Care** to meet todays needs and future needs
- **Help more children, young people and adults to stay independent** through self-care, support in the community, and pathway coordination
- **Design an infrastructure** that supports this that evolves in support of the way of working that we design, with better use of technology and information sharing

WHAT'S DIFFERENT?

- **Memorandum of Understanding** to transform the way we provide services across organisational boundaries
- Manage our resources as **a single account for the city;** every decision in the best interest of the city not individual organisations
- **Financial Strategy** that underpins the transformation
- **Stronger Together**: agree a set of principles and behaviours that develop us as system leaders working together to do the best for Sheffield and to unlock solutions that we cannot do when thinking only of individual organisations

WHAT HAPPENS NEXT?

- 17/19 plans (with contracts) developed in more detail
- 17/19 plans (with contracts) signed off by 23rd December
- System-wide alignment of work to support Sheffield Priorities
- Detailed delivery plans signed-off by February 2017
- Detailed piece of work to develop a single Sheffield Investment and Expenditure Plan (complete by March 2017)
- Review of progress on a monthly basis
- Transparent reporting through Shaping Sheffield and Shaping Sheffield Transformation Programme governance
- Build links to the Sheffield City Region Plan, which is longer term and broader

About Sheffield

'We have one of the greatest opportunities available to us to make Sheffield a person-centred, healthy and successful city'

Sheffield is a city and metropolitan borough in South Yorkshire. We have a strong track record for working in partnership across all public sectors through well established networks, for example the Working Together Programme. This partnership approach has been recently strengthened by the established Sustainability and Transformation Plan (STP) agenda.

With the Peak District on our doorstep, excellent culture through our theatres, museums, parks and activities, and nationally prominent organisations with a track record for success (Fig 1), and a wealth of national leaders across our public and voluntary sectors, we have one of the greatest opportunities available to us to make Sheffield a person-centred, healthy and successful city. Collectively we spend circa £1.2bn on health and care for the city.

In spite of this Sheffield has consistently lagged behind the England average for health and social care outcomes. We know that Sheffield has for the last ten years not delivered its potential to reduce the substantial gap in healthy life expectancy:

- Over 20 years between the most and least deprived men; 25 years for women; up to 20 years for people with serious mental illness or learning disability
- 40% of current illness in the city is either preventable or 'delay-able' and the financial benefit of reducing this matches the moral imperative to do so
- We know why; because no one organisation has it in its power to deliver this, it requires whole system solutions where every member understands their role.

The Sheffield Plan

This plan, under the umbrella of Shaping Sheffield and the Transforming Sheffield Programme addresses that. By developing our whole systems leadership at the most advanced level and by working with national partners and regulators we will ensure we deliver real change and close the gaps that we have previously been unable to fully address.

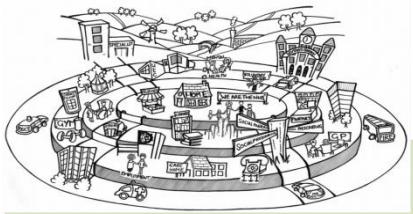
Fig 1. Sheffield Strengths

Co-terminus citywide council and CCG: citywide commissioning
A strong city council with a Devolution agenda
Two acute hospitals also providing specialist tertiary services to South Yorkshire and Bassetlaw and beyond and Sheffield Health and Social Care Trust
Citywide Health and Wellbeing Board
Primary Care Sheffield
Track record of strong partnership Transforming Sheffield Programme
Two major universities: training; research and development
Great schools and colleges and Learn Sheffield
Baby Friendly City with full UNICEF Baby Friendly accreditation
The UK's first National City of Sport
Innovation: Vanguards, Test Bed, Prime Minister's Challenge Fund, Innovation Park, Care 2050
Culture: Theatres, The Greenest city in Europe, Retail, Music

The Sheffield Vision

Mission

The mission is simple. It is for the children, young people and adults of Sheffield to live long and healthy lives with affordable and quality support in place to help them do that.



Vision

To be recognised nationally and internationally as a person-centred city that has created a culture which drives population health and wellbeing, equality, and access to care and health interventions that are high quality and sustainable for future generations.

We will have a reputation for working in partnership to co-produce, improve outcomes, experience and inclusion and to influence national policy and regulation; this will be visible in our success.

Aims

- Develop Sheffield as a healthy and successful city
- Increase Health and Wellbeing
- Reduce Health Inequalities
- Provide children, young people and adults with the help, support and care they need and feel is right for them
- Design a Health and Wellbeing System that is innovative, affordable and offers good value for money
- Be employers of caring and cared for staff with the right skills , knowledge and experience and supported to work across organisational boundaries
- Deliver excellent research, innovation and education
- To develop and expand specialised services for children and adults across the region

New Models of Care

More care will be provided closer to home with services designed around the person and will work in levels depending on need. These levels are:

1. Person, Household, Family and Friends – for example holistic assessments, self-care
2. Neighbourhood (30k-50k population) – for example employment advice, support groups, and family centres
3. Locality (120-150k population) – for example urgent care centres
4. City – for example the services provided in hospital
5. Beyond City – for example ambulance services

Each level requires increasing expertise/input and has less demand per head of population than for services in the levels below

How

In order for this to work existing providers will need to work differently, with workforce working flexibly across organisational boundaries and services being delivered collaboratively. An Accountable Care System model will be used to enable this, supported by the established Memorandum of Understanding. At locality level we will see providers working collaborative as a whole to deliver services.

Challenge

At one level, our challenge is clear. At present, and on average, the people of Sheffield are not living lives that are as long and as healthy as they could be. At the same time, projections show that the money that we have to spend on supporting children, young people and adults when they become ill and to help them live long and healthy levels will not be enough to keep everything that we do now in place. If we can better help children, young people and adults to live longer healthy lives then there will be less ill-health, less demand for medical and care services and therefore more money for those services that will still be needed.

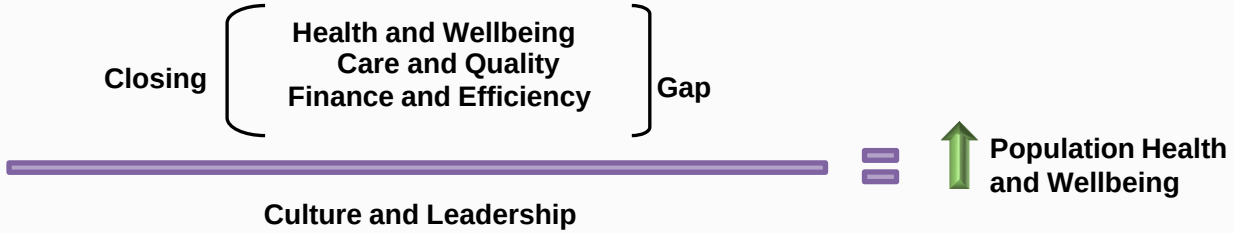
We also know that there are inefficiencies in how money is currently spent, sometimes because we spend money on the symptom and not the cause and sometimes because we don't join-up enough to get the best value.

Our challenge now is to find the money and actions that see people living longer and healthier lives and also to change how we do things and what we do to get more out of what we spend, and to design this approach in a way that enables our communities to support the plan. We need to start doing this now and with a sense of urgency.

Why Sheffield Has to Change

Health and Wellbeing System Challenge

In Sheffield we have defined four key system challenges to improving population health and wellbeing and to providing high quality sustainable services to our population. This plan needs to address each of these four areas. We will specifically set out what each of theses challenges mean, the detail of this is set out in Appendix I (The Sheffield Case for Change).



The scale of the challenge demands:

- a significant step change in the scale and pace in service transformation
- importantly the way we work in order that we are able to provide affordable and sustainable services

This will depend upon us working together as a city in a partnership of:

- Patients
- Public
- Voluntary sector
- Commercial sector
- Religious sector
- Public sector

This means planning for the future through:

- a radical upgrade in prevention
- streamlining and aligning services that work independently of organisational boundaries
- tackling inequalities head on (the cost of inequalities is £30bn to the NHS)
- tackling the broader determinants of health and wellbeing
- Applying an agreed financial strategy that supports
  - investing in transformation
  - targeting money at community based service provision and population need
  - Supporting the community, primary care and voluntary sector infrastructure
- Supporting and understanding the change in behaviours for organisations, professionals and the public that is needed to design and implement models of wellbeing and of care that build sustainable services for Sheffielders now and in the future

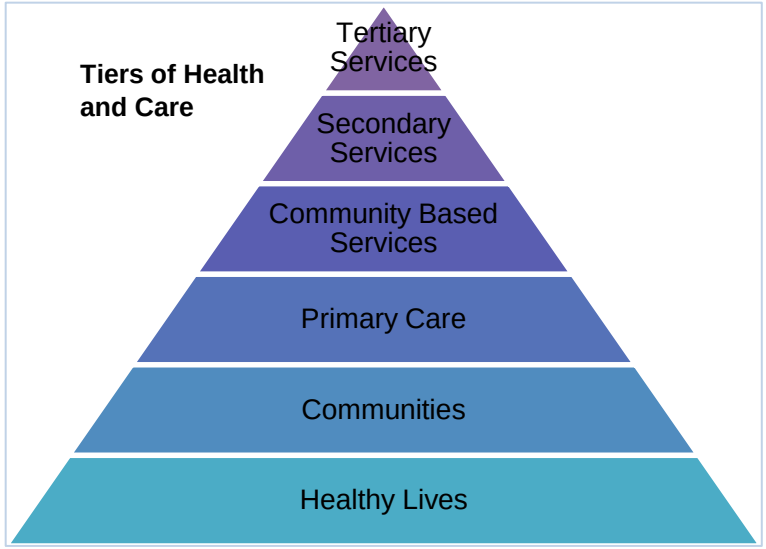
The NHS Five Year Forward View reinforces this approach and provides us with an opportunity to genuinely transform the way we work

What Will We Do?

Overview

The plan draws together key programmes of work across the city that are focussed on improving health and wellbeing in a sustainable way. It uses tiers of health to set out how each of those programmes impacts across the system.

This page summarises the key programmes that Sheffield is committed to over the next 5 years. We then describes the timeframes and then how these look against each of the tiers of health (where there is also more detail about what sites within each programme. (See page 34 for detailed outcomes)



Impact

Managing Resources as a Single Account for the City

- **Improve Physical and Emotional Health and Wellbeing**
- **More People Working**
- **More Children and Young People Ready for School and for Life**
- **More Care Provided in Communities**
- **Reduce Demand for Hospital Based Services**
- **More People Staying at Home for Longer**
- **Integration of Physical and Mental Health Support and Care**
- **Better Use of our Shared Resource**

Sustainable Health and Care Services for Sheffield

Plan on a Page

About Sheffield

- This city is confident about its future, but knows that it must also face up to and deal with its challenges for that future to be successful and fair.
- A record of and commitment to systems leadership
- A successful city with established record of partnership working
- The UK's first National City of Sport
- Three hospitals offering specialist services
- Primary Care Sheffield: unifying primary care
- Great schools and Colleges and Learn Sheffield
- A baby friendly city
- We are part of the Sheffield City Region Partnership Board

The Sheffield Challenge

- The people of Sheffield are not living lives that are as long and as healthy as they could be.
- Projections show that the money that we have to spend on supporting children, young people and adults when they become ill and to help them live long and healthy levels will not be enough to keep everything that we do now in place.
- If we can better help people to live longer healthy lives then there will be less ill-health, less demand for medical and care services and therefore more money for those services that will still be needed.
- There are inefficiencies in how money is currently spent,
- We need to find the money and actions that see people living longer and healthier lives

What We Are Going To Do

- Invest in prevention
- Invest in our children and young people: as part of our life cycle approach supporting pre-birth, early years and families, education and building and supporting aspiration
- Help more people back to work, with stronger health and employment connectivity
- Strengthen Primary Care to meet todays needs and future needs
- Help more children, young people and adults to stay independent through self-care, support in the community, and pathway coordination
- Design an infrastructure that supports this that evolves in support of the way of working that we design

What Does Success Look Like?

Each of the programmes will have clear measures of success as described in Appendix II. Success of this plan will be in successful mitigation of the system wide risks (page 17), including, for example:

- A single account for the city
- Successful neighbourhood working supported by the Memorandum of Understanding
- A city wide approach to implementation
- New contractual and payment mechanisms that support models that work across and beyond organisational boundaries
- A robust financial strategy that enables investment, flexibility in savings and an affordable health and care system

Governance

We will have a structure that assures Sheffield that we will deliver what we have set out to.

- Shaping Sheffield will bring the city partners together to shape our direction as we transform and to align our work to support transforming
- Transforming Sheffield will deliver the programmes of work under the direction of the Chief Executives across Health and Care
- The Health and Wellbeing Board will have oversight of progress in delivering our Health and Wellbeing strategy
- Planning will be done collaboratively through a Strategic Planning Group responsible for a co-production agenda
- Significant service decision will have public consultation and go through the overview and scrutiny committee

Sheffield Resources

We cannot achieve sustainable transformation without both using our money differently. We need a strategy that allows money to be spent where Sheffielders get greatest value (quality and benefit). We will

- Manage our resources as a single account for the city
- Have payment mechanisms that incentivise the behaviours needed to make our transformation work
- Disproportionately invest our effort and resources into those communities with most need
- Invest in prevention and primary care
- Work as organisations to support the voluntary sector, for example a social value approach

The Sheffield Plan: Programmes

OVERVIEW:

Appendix II sets out in more detail programmes and projects. The approach in pulling together the initiatives described in Appendix II was to work across tiers of care with the intention of minimising the silo approach we have traditionally had to transformation. This has identified key themes: prevention; early years, young people and families; education and aspiration; prevention (Heart of Sheffield), helping more people into work; building independence; strengthening primary care; care planning and person activation; community based approach to services; developing an accountable care system; coordination of referrals and pathways.

The programmes that will deliver the transformational work will sit under the Transforming Sheffield Programme Infrastructure (see page 14) and will bring together and strengthen existing programmes of work through a single governance structure, strong leadership, and consistency in delivery where this brings value to delivering.

The detail is high level and each project and programme will have detailed delivery plans and timelines to deliver them.

Appendix III sets out the commissioning intentions for 2017/19 where it is possible to see some clear intention of what will be delivered over the first two year cycle of delivering the Sheffield Plan.

Fig 2. on this page summarises the overarching priorities that we will be focussing on over the first two year cycle of delivery. This will be reflected in each of the organisational operational plans

WHAT'S DIFFERENT?

- **Memorandum of Understanding** to transform the way we provide services across organisational boundaries
- Manage our resources as **a single account for the city;** every decision in the best interest of the city not individual organisations
- **Financial Strategy** that underpins the transformation
- **Stronger Together**: agree a set of principles and behaviours that develop us as system leaders working together to do the best for Sheffield and to unlock solutions that we cannot do when thinking only of individual organisations

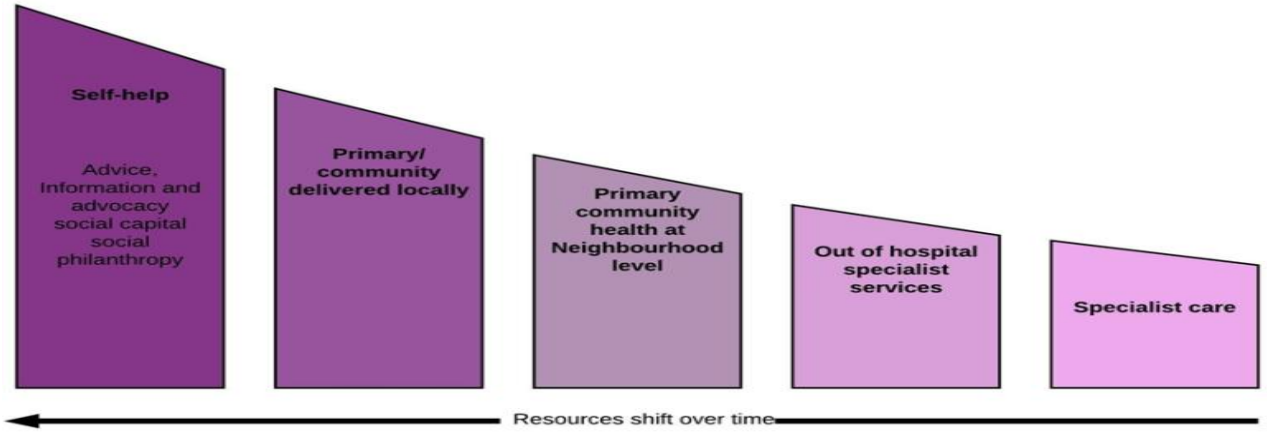
Fig 2. Priorities

2017-19 Priorities
• We will empower parents, families and carers to provide healthy, stable and nurturing family environments • We will have midwife led care in every community
• We will Implement a new services that helps grow and nurture life chances • We will Increase the proportion of children and young people who are school and life ready
• We will recognise the link between employment and physical and mental health and help more people into work • We will design our services to support improved emotional wellbeing and mental health for children, young people and adults
• We will agree a single risk stratification process for our population and agree how we use this so that we can then target our resources so we can help those most at risk • We will invest heavily into the development of neighbourhood working • We will work with our staff and teams to promote flexibility, to promote patient centred services and to promote a culture in Sheffield where staff across organisations are enabled to resolve difficult issues which impact on patients and communities
• We will tackle inequalities head on by making disproportionate investments in effort and resources into those communities with most need • We will collectively support implementing the Sheffield Tackling Poverty Strategy

Sheffield Resources: Developing Our Financial Strategy

We will manage our resources as a single account for the city so that every decision is in the best interest of our city rather than for an organisational benefit. This will also start to unlock some of the drivers of the perverse incentives in the current system. This will be in place by December 2016. We will look to Government to respond collaboratively to this.

We will shift our spend from high cost care into care that provides the greatest value in improving population health and wellbeing.



We will develop an financial strategy that:

- enables us to pump prime the transformation that enables the shift in spend
- promotes a whole system model of delivery
- incentivise services that deliver population health outcomes
- Secures investment to develop critical enablers to successful and efficient delivery of services for the children, young people and adults of Sheffield

As a system we will require a financial strategy that maps out our Investment and Expenditure plan for the next five years; a plan that is owned by our financial teams.

We will secure dedicated and credible leadership to make this happen with collective commitment from the city to transparent and constructive input

Social Value Approach:
In line with this plan we will adopt a social value approach to the services we commission and procure aiming to improve the economic, social and environmental well-being of Sheffield and to the benefit of Sheffielders

Single Account for the City:
Manage our resources as a single account for the city so that every decision is in the best interest of our city rather than for an organisational benefit. By being efficient we will invest in the services we need and work with the money we have to provide them.

New Contract and Payment Models – move away from PBR
Introduce contracts and payment models that incentivise system working, increasing care outside of hospital and improved population health outcomes. A value based focus rather than volume/activity

Partnerships and Social Investment
Work across partnerships, both public and private, to secure transformational investment that drives value (quality and benefit) and releases savings to reinvest in sustainable delivery. We will use new approaches such as time banking to optimise our collective resource

Releasing Fixed Assets to Best Deploy System Resource
Through more efficient use of our collective estate we will secure capital as well as recurrent funds to divert into system transformation and delivering the Sheffield Plan that shapes health and care for now and for the future

The Sheffield Plan: Governance

Overview of Shaping Sheffield

By using our collective strengths, resources and expertise we will work jointly to remove the barriers that have historically prevented us from realising the full benefits of our programmes. Success will be evidenced through measurably achieving our aims and ambitions.

Shaping Sheffield:

- Brings together the city with a shared goal to improve the Health and Wellbeing of our Sheffield citizens
- Listens to the city's voice using patients, citizens, business and service providers to shape the strategic direction and plans to deliver it
- Agrees key actions and jointly commits to making them happen; this is not just for health and care to solve

Click here for videos and packs for the Shaping Sheffield Programme

Transforming Sheffield Programme

The Transforming Sheffield Programme Board represents the Chief Executives of our Health and Social Care organisations . It has signed up to the principles below to secure our collective success in realising our vision, our aims and our ambitions.

Transforming Sheffield Programme Board Principles:

- Collectively committed to a single plan for Sheffield and for its successful delivery
- Transparency and openness about organisational challenges, risks and development
- No unilateral changes without understanding the wider system impact
- Solving system problems will be a collective responsibility
- Provide a collective and united front to external policy and regulation development
- Seek to be ambitious, learning from each other and our partners

South Yorkshire and Bassetlaw Sustainability and Transformation Programme (STP)

This plan is an regional plan that brings together opportunities for better ways of:

- The radical upgrade in prevention
- health and care services that increase quality in care (for example where the is specialist expertise required)
- services that offer greater value for every pound spent (for example back office functions)

This over arching STP sets out high level expectations for local service provision and therefore the Sheffield Plan, and in turn the Sheffield Plan sets out expectations of the STP

The Sheffield Plan: Governance (cont.)

Overview

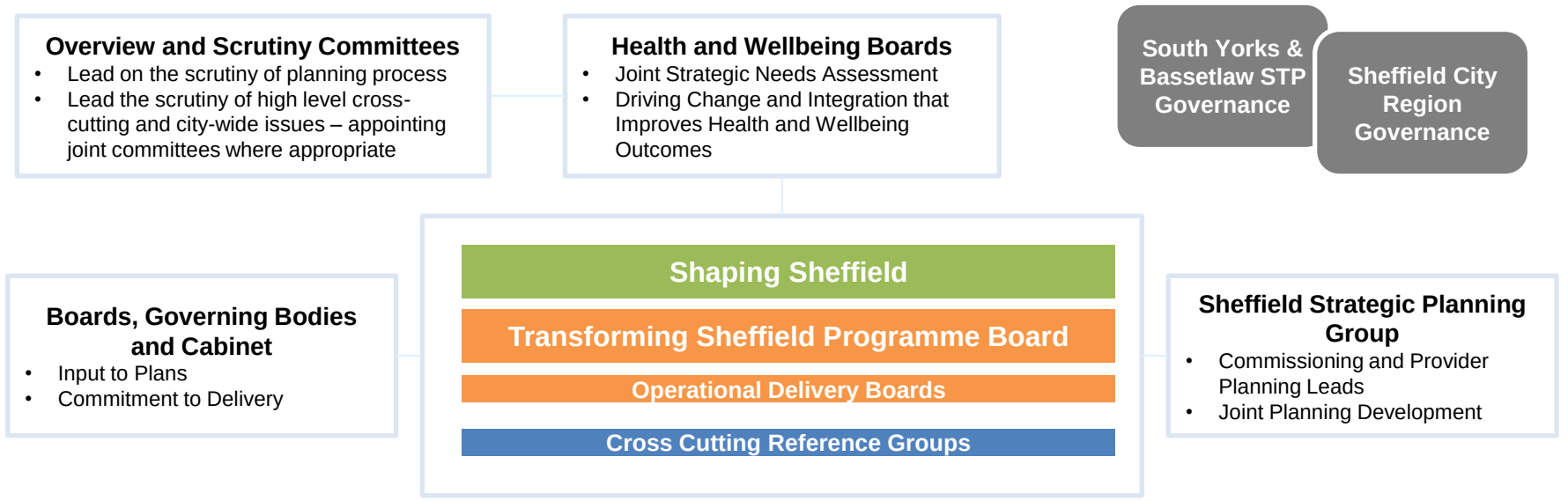
We need a way of working that assures Sheffield that we will deliver what we have set out to.

- Shaping Sheffield will bring the city partners together to shape our direction as we transform and to align our work to support transforming
- Transforming Sheffield will deliver the programmes of work under the direction of the Chief Executives across Health and Care
- The Health and Wellbeing Board will have oversight of progress in delivering our Health and Wellbeing strategy
- Planning will be done collaboratively through a Strategic Planning Group responsible for a co-production agenda
- Significant service decision will have public consultation and go through the overview and scrutiny committee

Each of our priorities will have a series of robust delivery plans drawn up (where they do not already exist)

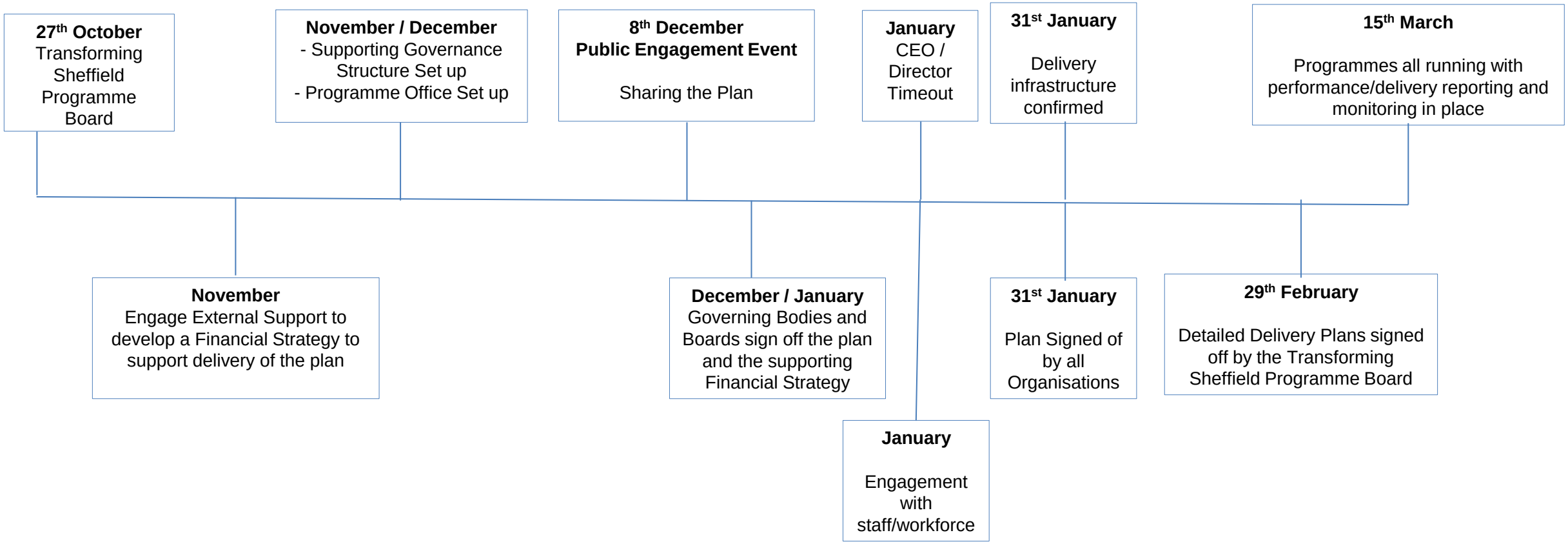
The Programme Management Offices will work in partnership to drive implementation

Governance



- Each of the delivery plans will have dashboards aligned to the outcomes described under measuring success
- These will be reviewed on a monthly basis to:
  1. Measure implementation progress and map through any impact from faster or delayed implementation
  2. Measure impact after implementation to provide assurance that our identified benefits are realised, make any adjustments or inform future transformation

Timescales to March 2017



Communications and Engagement

Approach

- Will focus on the contents of the plan – what we will be doing and what this will mean for children, young people and adults in Sheffield. This takes into account the general public apathy towards 'plans and strategies' and will aim to provide a more tangible picture of the outcomes we are working towards.
- Activity will be set in the context of the challenges facing health and social care and the need to look at new ways of working to maintain and develop Sheffield's excellent services.
- Messages will focus on quality and improvement, the need for change, ensuring sustainability for the future the collaborative approach and commitment to working with local children, young people and adults to develop plans

	Communications	Engagement
Partners	**KEEP UPDATED AND ENGAGED** E.g. regular customised updates via internal channels (tailored to implications for each organisation)	**INVOLVE** E.g. Shaping Sheffield events
Public	**MAKE AWARE & INVOLVE** E.g. Information via partner channels (e.g. websites), media / social media on specific issues /priority areas of plan	**INVOLVE** E.g. in discussion to develop plans for the priority areas. Key forums include: Neighbourhood networks, PRGs, Citizens' reference group, FT memberships
Other	**MAKE AWARE & INVOLVE /REASSURE** Targeted updates via existing relationships and mechanisms	**INVOLVE** Discussion at relevant forums/meetings

Risks

Public Consultation

Description: The public response to the development and change to services required as part of this transformational approach may delay progress if not well managed. The public need to be part of the transformational work from the beginning.

Mitigation: Co-production of plans with the public
Using the collective communications and engagement resource to ensure a robust and well managed approach to co-production, engagement and consultation.
A branding approach that reinforces quality of service regardless of setting.
Taking an evidence based approach

Resource to Deliver

Description: This plan is ambitious and a real opportunity to genuinely transform the way we work in Sheffield to make a real impact for our population in a sustainable, affordable way; it will make real improvements to quality of care and health outcomes. This will not be achieved if we try and deliver it on top of "Business as Usual".

Mitigation: Develop and support a realistic and targeted resource plan that is aligned to the Sheffield Plan in a way that is responsive to 5 year delivery programme and that supports the Transforming Sheffield Programme governance structure

Contractual and Payment Mechanisms

Description: Acute providers are currently paid by results using a tariff based system, this incentives acute activity (particularly with the hospital provider financial pressures) and therefore disincentives the intention within the Sheffield Plan to increase the proportion of care outside of hospital

Mitigation: Review of contractual and payment mechanisms with a move towards capitated budgets and a supply chain approach

Unintended Consequences

Description: Making change can easily have unintended consequences on people, staff or other services

Mitigation: We will have a city-wide approach to Quality Impact Assessment and to Equality Impact Assessment that is embedded in the way we work and the Transforming Sheffield Programme governance

Regulation and Policy

Description: There will be regulations and nationally imposed policies that will not support new ways of working

Mitigation: Work with statutory and regulatory bodies to develop approaches that allow testing of the new ways of working and inform development of revised policy/regulation that support the new models of care.
Secure elected member support by embedding in governance

Transformational Funding

Description: Funding is required that enables the investment that will be needed to deliver the transformation change before the longer term funding is available through savings made as a result of the new models of care

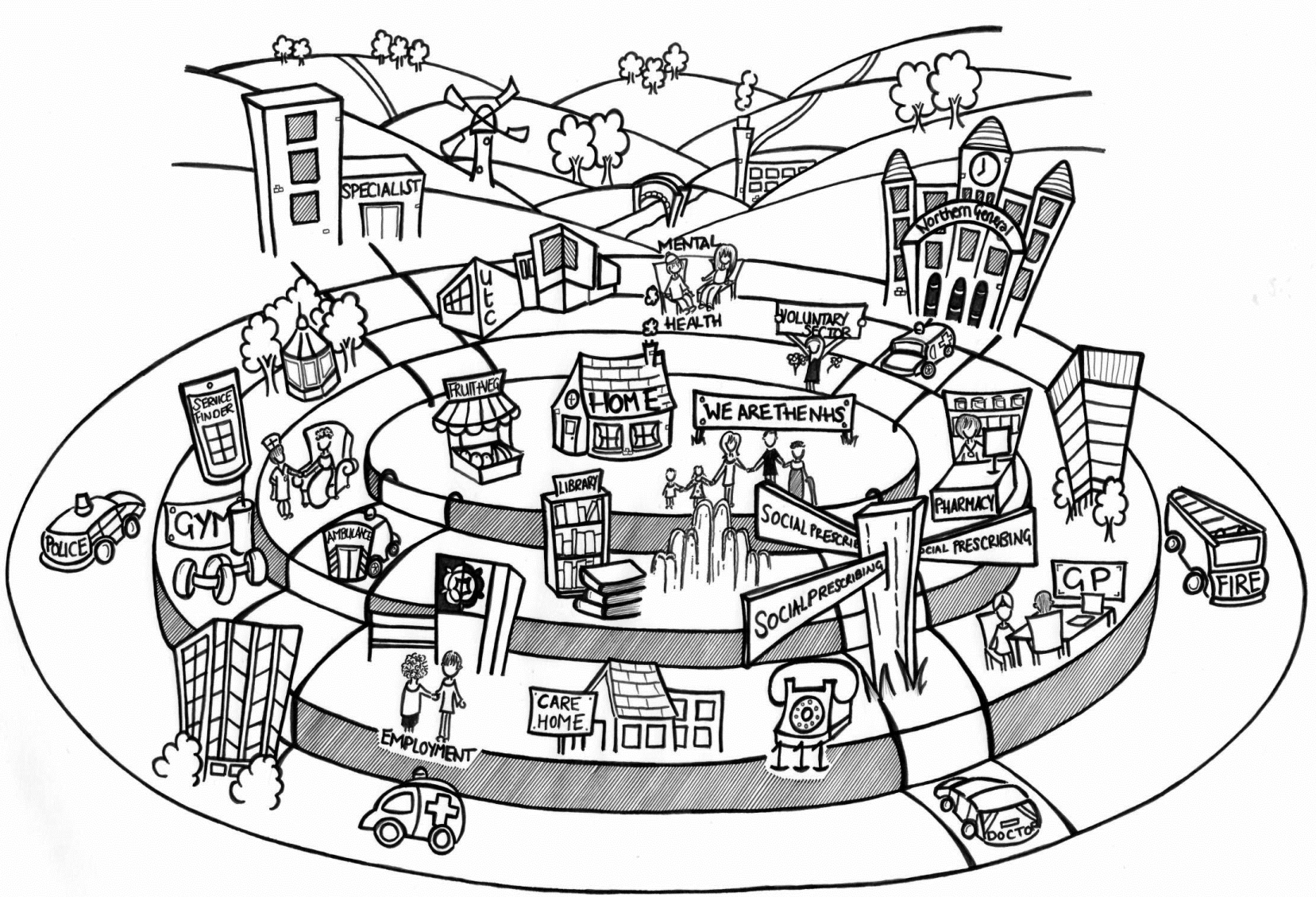
Mitigation: Develop Commercial Partnerships
Develop approach to using non-recurrent innovation and research funds through the Transforming Sheffield Programme Board to support transformational change.
External expertise and additional capacity from Price Waterhouse Cooper to support a robust financial mapping of investment and saving

Organisational Behaviour

Description: Each organisation has financial and delivery targets to deliver that system wide transformation may put at risk over the transformational period. Individual organisational approaches to managing that risk will potentially compromise the system wide delivery and Place Based Plan

Mitigation: Transforming Sheffield Programme Board ownership of and commitment to the plan with a risk share approach
Memorandum of Understanding in place to support development of services outside of hospital and based around neighbourhoods
Specific programme of work around changing behaviours

Appendix I: The Sheffield Case For Change



The Case for A Radical Upgrade in Prevention and Early Help

'If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.' Simon Stevens, FYFV

Why Take Prevention and Early Help Seriously?

- Illness is driving the growth in demand for services, not ageing
- Cost of treatments is increasing
- Therefore prevention is the only long-term sustainable solution to:
  - reducing need of individuals for state-funded care; AND
  - reducing cost
- Our current models of health and social care are not meeting population health needs or delivering prevention
- Current incentives are misaligned – despite the Wanless Review recommendations in 2002, the investment in prevention has not moved beyond the 'slow uptake' scenario
- Continuing with this status quo is financially and clinically sub-optimal and harms future populations through avoidable illness and complications
- At least 40% of illness is preventable or 'delay-able' but only 5% of the total healthcare budget is spent on prevention
- Contrast this with the fact that the direct healthcare costs of treating diseases caused by smoking have been estimated at 6.5% of the total healthcare budget
- Prevention can contribute to reduced healthcare demand and costs in the short term e.g. reduction in smoking prevalence reduces hospital admissions for heart attacks and strokes over 5 years
- Saves money and, importantly, changes lives for the better

What Does the Radical Upgrade in Prevention and Early Help Do?

1. Improve life chances by expanding and developing employment pathways for people furthest from the labour market

2. Achieve healthier lives by developing a 'Heart of Sheffield' programme to deliver healthy public policies and services at scale

3. Enhance neighbourhood and GP services by developing comprehensive local services that support children, young people and adults to better manager their own health and stay well in their communities

The Health and Wellbeing Challenge

Overview

Over the last 10 years, Sheffield's position relative to the rest of the country has remained virtually unchanged for most health and wellbeing indicators.

Sheffield continues to lag behind the England average on most outcomes including life expectancy, healthy life expectancy, educational attainment, unemployment and housing.

The gap in healthy life expectancy in Sheffield is substantial: over 20 years between the most and least deprived men; 25 years for women; and up to 20 years for people with serious mental illness or learning disability.

The cost of inequalities is £30bn to the NHS (the financial challenge is £20bn)

Wider Determinants of Health

- Almost 23% of all Sheffield children live in poverty compared with 18.6% nationally.
- 69.9% of Sheffield children in Year 1 achieved the 'school readiness' standard compared to 74.2% for England. Children with free school meal status achieved only 57.1% in Sheffield compared to 61.3% for England
- 6.6% of Sheffield's 16-18 year olds were not in education, employment or training in 2013 compared with 5.3% for England
- 11.3% of households (26,604) in Sheffield experienced fuel poverty, compared with 10.4% in England
- 11.4% of Job Seekers Allowance claimants in Sheffield are long term claimants (greater than one year), compared to 7.1% for England
- Between 12 and 18 per cent of all NHS expenditure on long term conditions is linked to poor mental health – most commonly in the form of depression or anxiety disorders which if untreated can exacerbate physical illness and increase the cost of care. This affects around 4.5 million people in England and they experience significantly worse health and social outcomes as a result (Naylor et al 2016 Bringing Together Physical and Mental health)

Health Improvement

- Smoking, physical inactivity, poor diet and alcohol misuse make up the four main health risk behaviours responsible for the four main causes of early death (cancer, cardiovascular disease, respiratory disease and liver disease)
- The proportion of Sheffield mothers smoking at the time of the birth of their baby is consistently higher than the national average (15.1% in 2014/2015)
- Despite an overall reduction in teen pregnancies, Sheffield's rate remains significantly higher than the national average (24.3 per 1000)
- The number of alcohol related hospital admissions is increasing and in 2012/2013 was 706 per 100,000 population, significantly higher than the England rate of 637
- Severe Mental Illness is linked to reduced life expectancy and poorer physical health

Health Protection

- Just over half of all patients newly diagnosed with HIV in Sheffield are diagnosed late (51%), which is significantly higher than the figure nationally (45%). Late diagnosis is associated with poorer patient outcomes and higher healthcare costs
- The incidence of TB in Sheffield has increased from 10.5 new cases per 100,000 population in the early 1980s to 16.7 per 100,000 in 2011-2013 (approximately 100 new cases per year); significantly higher than the England average

The Care and Quality Challenge

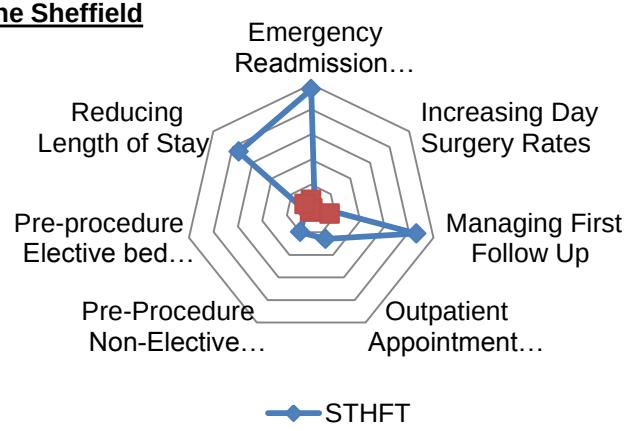
Demand

- Increased diagnosis of long term conditions as well as co-morbidity
- Increased patient expectation
- With more people working longer those able to care for their relatives are reducing
- Increasing number of children with complex health needs
- Significantly high number of delayed transfers of care
- Variation in rates of cancer mortality across the city
- We have more long-term admissions to care homes per 100,000 population
- We have fewer people at home 91 days after leaving hospital
- People experiencing a crisis in their mental health need access to community based treatment 24/7

Value

- The Better Care Better Value Tool (Fig 1) identifies areas where there is an opportunity for us to redesign services to reduce hospital based activity that is either better provided in another setting or not at all:
  - Reducing length of stay
  - Reducing emergency readmission within 14 days
  - Managing the number of follow-up; appointments
  - Patients not attending appointments
- The Right Care tool identifies procedures that offer limited clinical value; these need review

Fig 1. Better Care Better Value Tool: The Sheffield Opportunity



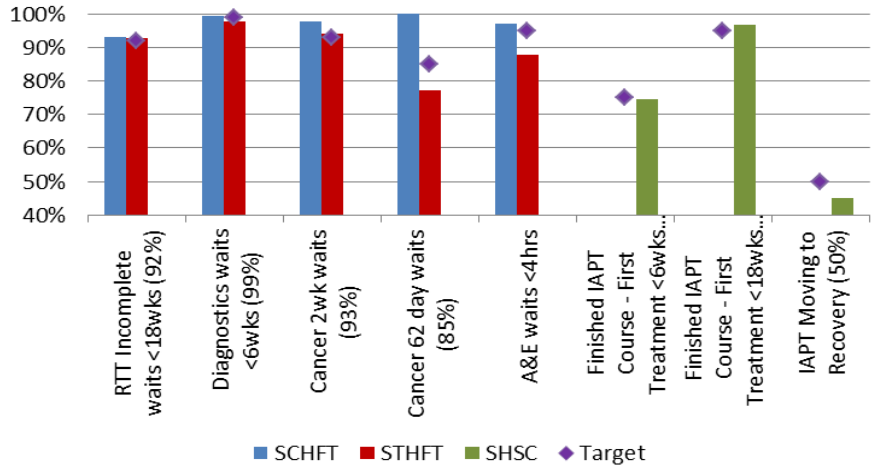
Access

- Access to adult services, against national targets, is challenged (Fig 2)
- Access to children's services meets or exceeds national thresholds (Fig 2)
- The proportion of people receiving IAPT moving into recovery is a new measure and plans are in place to improve
- Cancer Screening coverage for the Sheffield population is above national average for all programmes
- Increase access to evidence based treatments for a range of mental health needs including psychological therapies (IAPT), perinatal, eating disorders, crisis care

Experience

- Poor experience can happen when multiple agencies are involved
- Complaints feedback indicates themes including communication and values and behaviours.
- The Annual HealthWatch report also identifies themes including:
- Waiting too long for a service, or not getting help early enough
- Physical and mental needs treated separately

Fig 2. Sheffield Healthcare Provider Performance



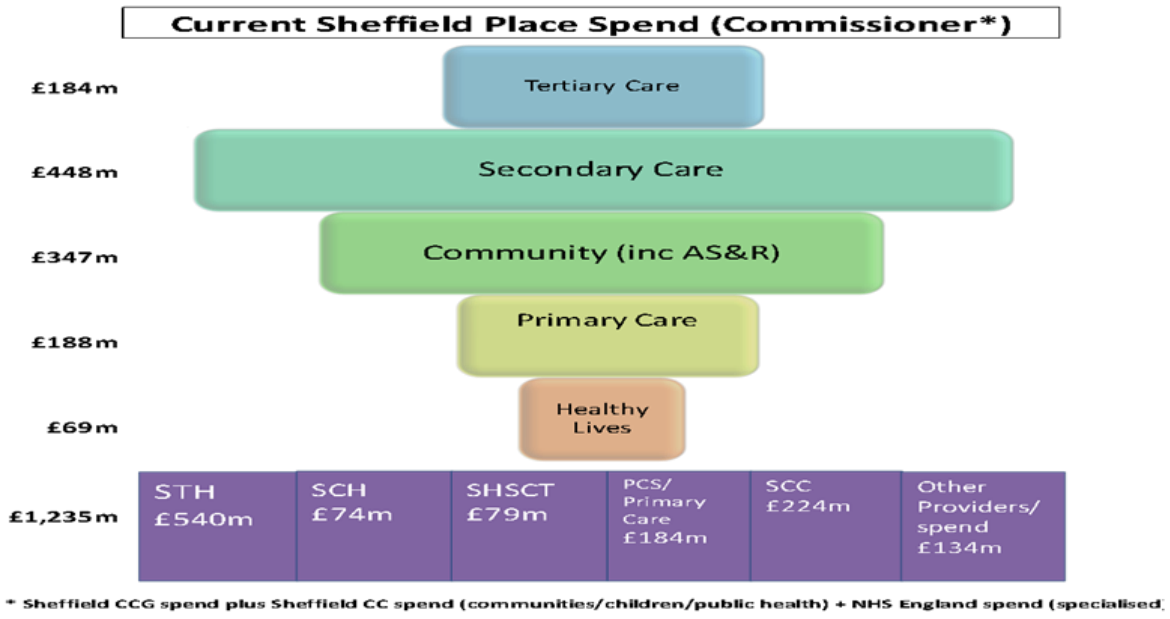
The Finance and Efficiency Challenge

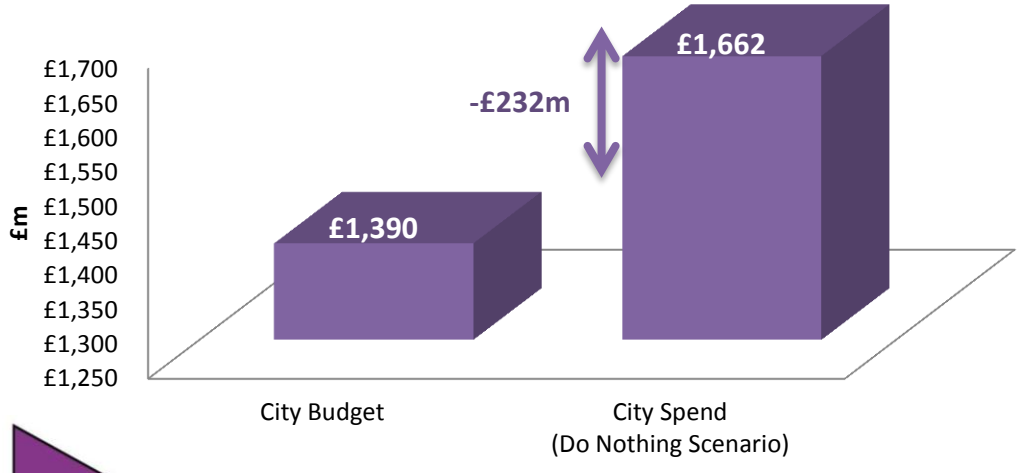
By 2020-21 the combined health and care budget for Sheffield will be £1,390m. Whilst significant it is approx. £232m less than we will need if we don't change the way that we work or how services are provided.

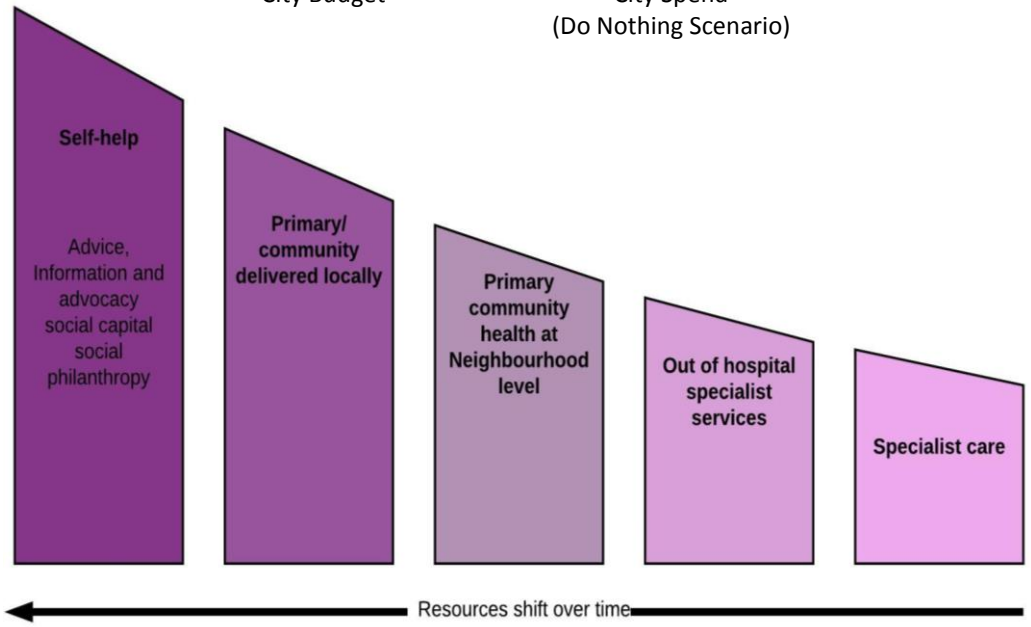
We want to provide Sheffielders with the services that they need and this means that we need to ensure that we get value (that delivers quality and benefit) for the Sheffield pound.

As well as the new models of care and new ways of working there will need to be a strong financial strategy that underpins the plan. This will describe:

- how we shift of resources over time away from the more expensive reactive services into planned and preventative services that offer greater value
- a single account for the city
- release of resource from fixed assets to secure a sustainable service transformation







The Culture and Leadership Challenge

'The whole Council should become a Public Health Organisation. We want to ensure that every contact we have with the people of Sheffield is designed to have a positive impact on health' Julie Dore, Council Leader, SCC Corporate Plan 2015 -18

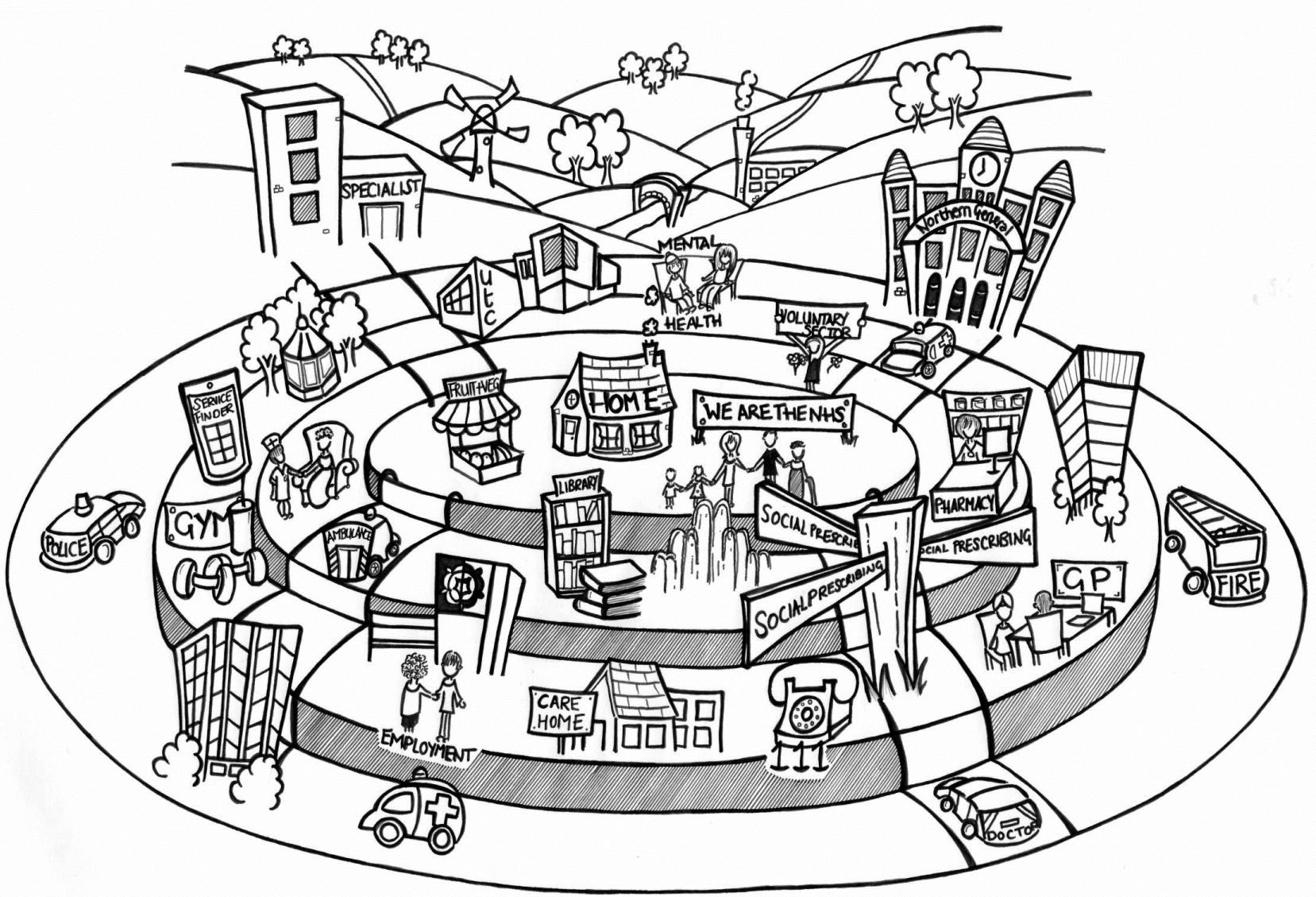
Overview

- We often don't fully understand the pre-conditions needed in order to really make change happen
- By not defining causal links and behavioural drivers we often don't see the full benefit or impact of planned changes and therefore in spite of can feel like successful implementation of a transformational project we still face the same problem
- Often the timeframes we set ourselves for designing and implementing change are challenging and taking time to understanding the theory behind it is compromised
- We need to be clearer on how we get from where we are to where we plan to be (really be)

Leadership and Behaviours

- To drive the innovation, creativity and socio-economic development required to close the health and wellbeing, care and quality and finance gaps we must first close our leadership gap
- As a system we have been experiencing significant and rapid change, and there is more ahead. This kind of changing environment requires the leadership capacity needed to adapt and succeed in the future
- Our challenges are multi-dimensional as we face a range of complex needs
- We need to develop strong and consistent leadership across our system using shared strategies and behaviours. This in turn will shape the behaviours across the system both in our workforce and in the Sheffield children, young people and adults
- The challenge to create the space to do this has never been greater
- To achieve the shift from high cost care to increased care in the community and self-care behavioural changes will need to be achieved across the system; this means professionals, organisations and people (children, young people and adults)

Appendix II: Programmes and Enablers



1. People Living Healthy Lives

Why Is This A Priority?

The cost to Sheffield of avoidable illness and disease is in the region of £m.
The broader determinants of health and wellbeing need to be a key part of our plan as they will both reduced preventable illness and disease and close the inequalities gap. If left unaddressed the increasing demand for more expensive health and care interventions will continue with costs exceeding what we are publicly able to afford.
A radical upgrade in prevention is essential and the Sheffield Plan sets out strong ambitions for making this a reality.

What Does Feedback Tell Us?

"Sport activities/interests could be used for education and screening awareness in men. Different types of methods need to be used for different communities."
"Work with other departments such as education, housing, transport, town planning, police etc. to work on the wider determinants of health. Security and safety are essential to good health."

Outcomes/Impact

- Reduced gap in healthy life expectancy from 20 to 15 years between best and worst off
- Children healthy and 'learning ready' at age 4 increase from 66% to 75%
- Fewer young people not in employment, education or training
- more people moving into economic activity or meaningful employment
- Reduced impact of social isolation
- Increased social capital via resilient communities

Heart of Sheffield

A radical upgrade in prevention. We will

- Scale up smoking and alcohol brief interventions at all points of patient/client interactions; done at scale. Includes National Diabetes Programme
- Implement a model of life style services that scales up an affordable level off support; targeting those groups that will benefit most
- Implement healthy public policy initiatives, making the healthy choice the default and easiest

CVD risk factor management at scale
Health Child Programme

Helping More People Into Work

Supporting people moving into meaningful economic activity or meaningful employment. We will:

- Put in place new and expanded employment pathways will enable referrals from health into employment and from employment into health; keeping people well at work and helping people back into work
- Have mentally healthy workplaces through implement the Mindful Employer Programme across all organisations
- Support people in their return to work

Education and Aspiration

Supporting children and young people in education and to achieve their aspirations:

- Implement a new service to grow and nurture young people; targeted multi-agency early intervention and prevention ; improving key outcomes and life changes for c. 1000 teenagers and young adults per year
- Increase the proportion of school and life ready children through a programme of initiatives including targeted early learning initiatives and partnership development and children and family hubs to support health and wellbeing locally
- Supporting the Learn Sheffield programme

People Being Well

Sheffield children, young people and adults will get support they need to stay well by:

- Promote Five Ways to Wellbeing to reduce the impact of social isolation on people with learning disabilities, mental ill-health, autism and dementia
- Providing more emotional wellbeing and mental health support through schools and localities
- Single point of contact for health professionals to make patients' houses warmer
- Falls Preventions Service (reducing number of elderly fallers – top callers for ambulances)
- Providing parity of esteem for those with mental health diagnoses as well as parity of esteem in reverse for those with physical health diagnoses who also require mental health services

Working in Partnership

- Work with Age UK to reduce social isolation and loneliness in older people
- Work with voluntary, community, faith and commercial partners to align prevention, health and wellbeing agendas and maximise impact through aligned priorities and work
- Feed into and draw upon the South Yorkshire and Bassetlaw Chief Fire Officers Health and Wellbeing Programme
- Improve the standard of private rented sector housing; focus on the key impacts of poor housing on health and wellbeing.
- Making every contact count - optimise conversations and maximise the potential of citizen contact with public services to promote health and wellbeing for service use. At the same time promoting health and wellbeing for professionals
- Building resilient communities where children, young people and adults can control their own lives, where there is social connection and where children, young people and adults can form positive relationships.

2. Strengthening Communities

Why Is This A Priority?

Strong communities are essential to good health and wellbeing and building individual resilience and independence . By strengthening our communities we will improve physical, emotional and mental wellbeing, we will promote healthier lifestyles and we will provide clear and simple signposting to services and support that enables children, young people and adults to take control of their health.

What Does Feedback Tell Us?

“Need to celebrate community/voluntary support as they take on more care responsibilities.”
“Rural communities seem to have a stronger bond. How do we create that spirit in pockets of a city? Communities used to be built around churches or pubs, could health centres be made into community hubs.”
“ ’Walter’ used to call 999 all the time and an ambulance would come and he would be admitted to hospital. He was supported by a Community Support Worker. Avoided 999 calls and hospital admittance. He was just a lonely man.”

Outcomes/Impact

- Reduced demand on the secondary care system (elective and non-elective admissions and attendances)
- More children, young people and adults Cared for at Home
- Increased level of Person Activation
- Increased social capital through more resilient communities

We Are The NHS

- Major shift to supporting people to take ownership and control of their own health and wellbeing - e.g., referral to info, advice, community activities and support.
- Social Prescribing **will be an assertive first response** to presenting issues such as low level depression, obesity, aches and pains; a social prescribing approach.
- Development of the mental health support in schools to role out the healthy minds framework

People Keeping Well

- Radical upgrade to emotional and mental health wellbeing services (e.g. increased access to talking therapies and peer support groups, mental health services coordinated with other services at neighbourhood level)
- New Home Care support arrangements: local, responsive, flexible and personalised
- Improve Health Literacy In Sheffield
- Improve support to carers, reducing carer stress and ill-health

Early Years and Families

- Improve access to health and wellbeing initiatives for children and families
- Empower parents, families and carers to provide healthy, stable and nurturing family environments
- Engage families in local communities to influence and play a positive role in shaping activities and services
- Reach into our communities and ensure that service provision is accountable to local communities and response to community

Successful Young People

- **Successful Young People -** targeted support for 1,000 at risk teenagers and young adults though integrated, multi-agency teams combining youth and health workers, police officers and a range of advice and support services. Zero Tolerance approach to suicide prevention

Working in Partnership

- Working with voluntary, community, faith and commercial partners to align community and neighbourhood programmes giving a consistent message, consistent support and creating the greatest opportunities for communities to take full advantage of the support and activities available to them
- Linking across established programmes such as Learn Sheffield . Healthy Minds Framework and Move

3. Primary Care for Now and For the Future

Why Is This A Priority?

General practice is under significant pressure. With more care moving to local primary and community settings both General Practice and Primary Care (including pharmacy, optometry, dentists) in general need to be redesigned to meet demand, provide the right services by the right professionals and support patients to manage their own health and wellbeing as well as more easily navigate the services available to them.
The GP Forward View sets out a case for practices working at scale, at a neighbourhood level.
Additionally as we move more care into community settings primary care services will need to be configured to respond to this; recognising that people with long term conditions need a more holistic approach.

What Does Feedback Tell Us?

"Health Centres should be designed as community hubs with newsagents, other services, libraries."
"Continuity of care and access to care for people with mental health problems and disabilities.."

Outcomes/Impact

- Strong and sustainable General Practice as part of Primary Care through access to services and that supports continuity
- Reduced demand on the secondary care system (elective and non-elective admissions and attendances)
- More People Cared for at Home
- Increased Access to Primary Care across the week

Primary Care Services

- Targeted and increased sexual health provision available and offered across primary care settings
- **Midwife led care in every community** – new family centres to support new mums and dads to make a healthy and happy start to family life. Strong focus on those at risk of struggling with family life
- Supporting self-care and independence through promoting healthy living and sign posting to community support
- Increased use of tele-health to support self-care
- Develop child and adult community clinics

Working in Partnership

- Secondary care consultants support primary care to deliver strategic outcomes
- Working at scale: where demand is less services will be provided at neighbourhood or locality level
- Support practices to become key stakeholders in developing the neighbourhood working approach alongside all other health and social care providers and 3rd sector partners
- Services will be designed to support transition between child and adult services

A Multidisciplinary Approach

- Neighbourhoods working across health, social care, voluntary sector, police, education and housing to design and coordinate services that meet the needs of that neighbourhood
- Use of care plans for those with long term conditions, increasing patient confidence, knowledge and skills for them to manage their own health and wellbeing as well as providing informed and smooth handover of care over of care between partners.
- Increasing person activation in their own health using the Person Activation Measure (PAM) as a tool

Estate and Infrastructure

- Greater use of technology to enhance patient care and experience (e.g. online booking and appointment management, online access to your healthcare record)
- Support practice development and Quality Improvement processes and expertise
- One Public Estate Programme
- A fit for purpose estate for now and in future for core and expanded services, aligned to practices working at scale
- Maximising void LIFT space

A Consistent Offer

- A Sheffield-wide locally accepted model of care with agreed and followed pathways. For primary care this means referral guidelines, adhering to prescribing policy and reducing variation in clinical practice
- Access – extended access through 111 and local clinical hubs ,offering consistent access across all localities
- Clinical Assessment s, Services , Education and Support (CASES) will support GPs to manage patients in primary care
- Providing parity of esteem for those with mental health diagnoses as well as parity of esteem in reverse for those with physical health diagnoses who also require mental health services

4. Community Based Services

Why Is This A Priority?

There is national and international recognition of the need to integrate services outside of hospital in order to provide safe, effective and efficient care for the increasing number of people living with multiple long term conditions. It would be unthinkable for numerous providers, with largely unconnected specifications, separate management arrangements with different objectives and plans and with different contractual arrangements, to be working within a single hospital. But health and social care services provided to the same communities, households and individuals outside of hospital are currently provided in this way.
Where longer term care placements are needed the market needs to be responsive and local.

What Does Feedback Tell Us?

"Rapid response care in people's homes/care settings instead of an ambulance taking someone to A&E because support services aren't in place."
"There should be a clear plan of what to do in a crisis."

Outcomes/Impact

- Reduced demand on the secondary care system (elective and non-elective admissions and attendances)
- More People Cared for at Home
- Reduced Readmissions
- Increase the number of people who are supported to die in their own home
- Reduce from 23 to 6 people with Learning Disability/Autism cared for in a specialist hospital
- A few contracts as possible (ideally moving to one)
- Shared measurements of success and performance

Care Planning & Coordination

- A single care plan for patients with long term conditions , at increased risk of admission or end of life that supports staying at home
- Core focus on person-centred care principles that increase and enable population level of activation across health and care
- Prevention approach to reduce incidence of common reasons for admission in frail elderly and people with dementia
- The GP will be the expert generalist and lead clinician for their patients regardless of the service providing care

Help to Stay at Home

- Primary Care supported step-up and step down provision; model to include access to short stay Learn Disability and Mental Health placements (e.g. Section 136 beds/PDU/short breaks/respite/Intensive Home Support)
- Locality hubs to support children and young people managing their conditions at home with their families
- Domiciliary care (care in homes) that supports people staying at home for longer
- Providing parity of esteem for those with mental health diagnoses as well as parity of esteem in reverse for those with physical health diagnoses who also require mental health services
- effective crisis care provision for people in MH crisis 24/7

Signposting & Partnership

- 111 Clinical Advisory Service partnered with local clinical hubs managing care pathways; directly booking GP appointments
- Paramedic Pathfinder supporting alternatives to hospital
- The Single Point of Access will directly access all relevant services
- As well as education the CASES service will direct patients where onward referral is needed to the most appropriate services
- More streamlined, integrated and individually-tailored housing services, giving better access to advice and preventative services

Urgent & Planned Care in the Community

- Make more services available at community and neighbourhood level to support children, young people and adults remaining at home (e.g. community IV administration and diagnostic services)
- New Primary Care led Urgent Care Centre(s) to enable diversion from and demand reduction for secondary care, with one in front of A&E
- Develop "Assess to Admit" approach in the person's own home
- Emergency Care Practitioners providing in situ treatment
- access to evidence based interventions for perinatal, eating disorders and first episode psychosis

Multidisciplinary Working

- Multidisciplinary team working with patient centred care approach at neighbourhood level
- Multidisciplinary team meetings to agree interventions to provide support, keyworker and coordination, including links across adult, family and child services and across physical and mental health
- Where diagnostics are better provided in a community setting services will be set up accordingly
- An upgrade to psychiatric liaison services
- Upskilling staff to ensure they have the range of skills and knowledge to provide the care and support that people need
- Providing the tools, such as mobile devises that can access records and information, to support people and professionals in community based settings

5. Hospital Based Services When Hospital is The Right Place

Why Is This A Priority?

We know that we have too many children, young people and adults receiving both planned and urgent care in a hospital setting. Whilst this is often the right thing there is a significant proportion of care that is either better provided in a community setting or not needed at all. We need to ensure that the hospital services work in harmony with community and primary care based services, enabling earlier discharge and a reduction in demand (new , follow-up and readmission) for hospital based services. By doing this our model of care will become affordable, children, young people and adults will receive care closer to their homes and we will be able to support hospital based delivery with the right workforce

What Does Feedback Tell Us?

"People are thrown off a cliff edge when they finish their treatment. There needs to be an intermediary."
"Links need to be made by the out of hours service with the relevant consultants in hospital which allows for the out of hours service to speak to the on call Registrar when they think one of their long term patients should be admitted to them directly."

Outcomes/Impact

- Reduction in follow-up
- Reduction in inpatient surgery
- Reduction in non-elective admissions
- Reduced Length of Stay
- Reduced morbidity
- Reduction in variation

Doing Only What Hospitals Can Do Best

- Ambulatory Care Sensitive Conditions to be managed out of hospital, supported by clear pathways of care
- Increased self-care and patient initiated follow-up, supported by clear pathways and timeframes
- Pre-operative assessment outside of hospital unless clinically indicated
- Increased access to specialist advice through a range of approaches (telephone, video-call, face to face)
- Preparation before hospital attendance
- Mental health inpatient care system characterised by low admission rates, effective gatekeeping, low lengths of stay and low re-admission rates

Care Planning & Coordination

- Every patient admitted to have a clear plan for care and discharge from decision to admit
- Involvement of carers in assessment, care planning and care delivery
- Social prescribing infrastructure to be accessible from secondary care
- Services will be designed to support transition between child and adult services
- Development of managed clinical networks for hospital services across the region
- Every child with complex needs will have an Education, Health and Care Plan or a MYPLAN that integrates health and education provision and care in a personalised way
- Shared Decision making between professionals and patients

Driving Value

- We will review services to ensure that they that offer value and quality. Where this is not found to be true we will work with the public to decide on which services need to be redesigned and which we should no longer provider. We will use tools such as Right Care to support this.
- Through internal and external benchmarking we will drive down unexplained variation in practice, supported by "whole journey" care pathways

Getting People Home

- Advanced surgical and enhanced recovery techniques
- Implement and embed the "Discharge to Assess" model; care needs assessed in an alternative setting to hospital
- Patients supplied with min. 7 days medications or discharge
- Electronic discharge summary sent to GP within 24 hours of A&E, Inpatient or Day case Care

Diagnostics

- Agreed "whole journey" care pathways for diagnostics and assessment, including direct access from primary care
- Radical upgrade to diagnostic access and turnaround times to reduce patient anxiety and improve outcomes through earlier intervention
- Results to be appropriately communicated directly to the patient
- Where diagnostics (e.g. histopathology) are better provided on a regional STP footprint we work with partners and public to design them

6. Specialised Services

Why Is This A Priority?

Specialised services are services that are provided to a smaller number of children, young people and adults than general services. Therefore they are generally better provided centrally and usually across a wider geography (for Sheffield – South Yorkshire and Bassetlaw), these ensures that the professionals are able to undertake sufficient practice to keep their skills up to date and in line with best practice and it also makes purchasing of expensive technology and kit more affordable .
We need to work with our partners to ensure specialised services are configured optimally across the region

What Does Feedback Tell Us?

"If we had to travel to go to a specialist place, then it wouldn't bother us, as long as they know what they are doing and get her better"

Outcomes/Impact

- Increased proportion of specialist activity in Sheffield
- Improved outcomes through increased expertise

Whole System Pathways

- We will participate in a region wide piece of work to look at what services should be provided at what level (locally, or by a specialised centre or by a highly specialised centre). This will ensure that where specialised knowledge, expertise and equipment are required we are able to properly resourced.
- develop a whole system, pathway led approach to provision and commissioning of services, particularly where transformational change is required
- tiering of provision for surgery and anaesthesia for children and young people, supported by the development of a managed clinical network for surgery and anaesthesia and paediatric acute care
- Develop bundles of care that support clear pathway management across the South Yorkshire and Bassetlaw system
- Priority areas for 2017/18 include children's and neonatal, vascular, cancer (including chemotherapy and pancreatic services) and some specialist mental health services

Workforce

- A workforce passport will enable the skills and expertise of our workforce to be deployed flexibly across the South Yorkshire and Bassetlaw Health and Care system
- Coordinated workforce planning and skills development
- A flexible workforce that comes together in neighbourhood hubs and specialist centres to offer people the best and most appropriate care

Sheffield as a Tertiary Centre

- We will
  - develop our workforce to support expertise and practice that is best in class
  - Ensure seamless pathways of care where multiple providers are involved
  - Ensure patients receive care and support as close to home as appropriate

Working With Partners

- Working with NHS England to agree local priorities and develop plans for any change, we will focus on the outcomes that matter most to patients, ensuring a stronger focus on prevention and connecting the commissioning of specialised services more strongly to the prevention and personalised medicine agendas
- We will work with the public to inform any changes
- We will work with our voluntary sector partners to support pathways across localities
- Services will be designed to support transition between child and adult services
- Development of managed clinical networks for hospital services across the region; developing a standardised and consistent approach to hospital care
- We will make sure that no matter where people live in our region, they will be able to get to the most appropriate hospital or specialist service as quickly as possible with necessary treatments given on route by our paramedics when needed.

What We Need to Make This Happen

Why Is This Important

The programme under each of our priorities will not deliver themselves. There are several enabling programmes that cut across each of the priorities and are fundamental to their success.. There are:

- Business Intelligence and Analytics
- Information Technology
- A Strategy for Estates
- Organisational Development (OD) and Workforce
- Research and Development
- Governance
- Our Digital Roadmap
- Communications and Engagement
- Finance and Resource

Business Intelligence, Analytics & IT

A single cross city Business Intelligence (BI) function that:

- optimises the BI expertise and resource
- supports 'a single version of the truth' to inform measurement, assessment and future planning

Information Governance and record sharing agreement

A single cross city IT function working collaboratively to:

- optimise the IT expertise and resource
- provide capacity to support implementation of the Digital Roadmap as well as providing responsive systems support to users
- Develop a Big Data approach

Estates

Sheffield Public Sector Estate Vehicle
As part of the National One Public Estate Programme we will:

- Plan for integration and co-location of services where possible
- Purposefully create voids in LIFT assets, and positively relocate services to them ('Strategic Hubs'); using these to enable new service delivery models for care closer to home,
- Agree a strategy to accelerate and promote Agile Working across the Sheffield First strategic partnership members

Standardising other back office functions across the STP such as procurement and pharmacy management.

Governance

- A single joined up communications and engagement plan to ensure a consistent and reliable message about plans and what they mean
- Clear citywide governance and leadership to oversee implementation, delivery and future planning
- A single income and expenditure account for the city

Behavioural Change

To achieve the shift from high cost care to increased care in the community and self-care behavioural changes will need to be achieved across the system; this means professionals, organisations and people (children, young people and adults). We will establish a focussed programme of work on this including:

- Making Every Contact Count approach
- Optimising conversations and maximising the potential of citizen contact with public services to promote health and wellbeing
- The Henry Programme (tackling obesity in children)
- Realising the Value (engaging people in their healthcare)
- Designing services and job roles in a way that is accessible to those who need to access them (not necessarily those that do)
- Applying the tools provided through the Person Centre Care Resource Centre

OD and Workforce

- Task shifting: tasks moved where appropriate to less specialised workers
- Working in partnership with the universities and the colleges to develop skills across multidisciplinary teams to support new roles and delivery of new models of care (particular focus on mental health and communications skills)
- A workforce passport that enables seamless working across organisational boundaries and all organisations
- Leadership development (esp. primary care and voluntary and community sector)
- Values based recruitment

Research & Development

- Development of risk stratification models for predicting health and social care use
- New contractual models that remove any perverse incentives to reducing use of medical interventions and support management of demand
- Combined models for personal health and care budgets
- New technology and treatments that improve patient outcomes and reduce spend in hospital settings
- Developing healthy public policy approach
- Use the strength of our research collaborations and align our research programmes to support implementation, evaluation, and review of Sheffield health and wellbeing models/services – using this to take forward further innovation and improvement

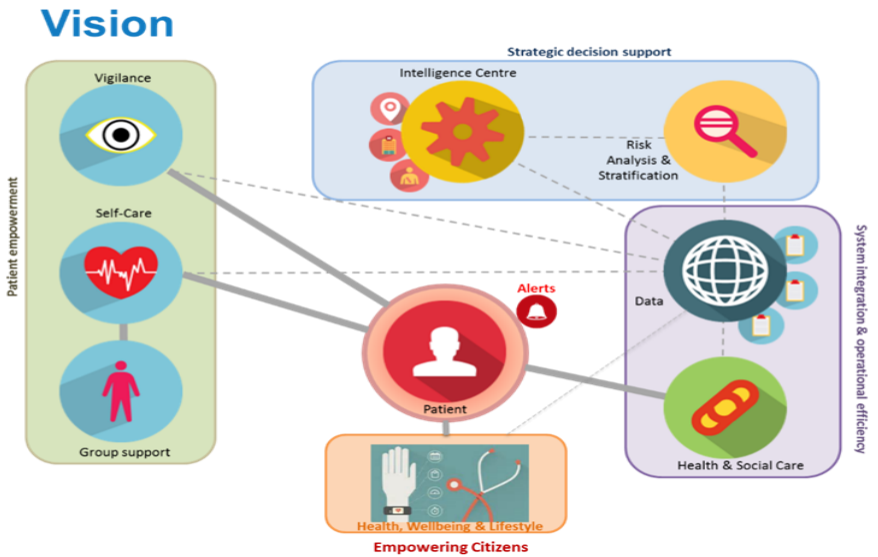
How Will Digital Technology Help?

Overview

Through the Test Bed and working collaboratively across our wider health and care region we will drive innovation and deliver cost effective digital and technology enabled solutions. Strategic infrastructure development, generating better inter-organisational interoperability and data sharing across our community, combined with innovation in patient focussed digital solutions will accelerate our ability to respond to local challenges and drive efficiencies in the delivery of high quality services to patients across our city and our region

Citizen and Patient Empowerment

Through the Test Bed and working collaboratively across our wider health and care region we will drive innovation and deliver cost effective digital and technology enabled solutions. Strategic infrastructure development, generating better inter-organisational interoperability and data sharing across our community, combined with innovation in patient focussed digital solutions will accelerate our ability to respond to local challenges and drive efficiencies in the delivery of high quality services to patients across our city and our region



System Integration and Operational Efficiency

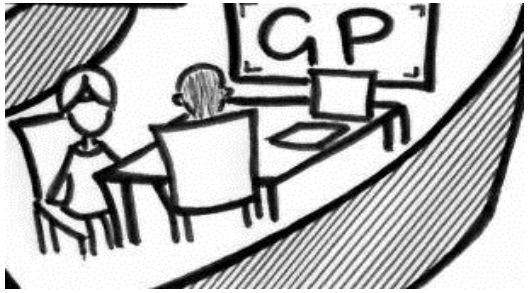
The Sheffield health and care community have a shared commitment to achieve the 10 Universal Capabilities and 7 PF@PoC capabilities. Supplemented by shared governance arrangements this will rapidly result in system interoperability and integration. Key developments will include:

- Shared records (including N3 link to the Child Protection Information System))offering increased access to relevant, real time, information about a patient by health and care providers.
- Improved interoperability to enable more effective and efficient transfer of care across providers (e.g. through e-referral and discharge processes) supporting reduced waiting times and access to appropriate support
- Promote mobile working of practitioners through Wi-Fi accessibility and roll-out of remote working solutions for practitioners
- Promotion of remote monitoring, new forms of consultation (e.g. video, phone) and mobile health (mHealth) will also support care based in the citizen's own home, reducing the burden of routine care on patients, their carers and families, and health professionals
- Better tracking and scheduling of staff and resources will enhance operational efficiencies (e.g. via OrderComms, e-rostering, e-prescribing etc.)

Strategic Decision Support

- Use population data to help identify and provide evidence for best practice and quantitatively assess quality outcomes
- Ensure better informed clinical decisions enabling more appropriate cost effective and safe care (e.g. avoiding drug contra-indications) as well as support for safeguarding
- Increased reliance on validated risk stratification and population analytics will enable more efficient case finding and targeted intervention
- Digital solutions to measuring benefits and outcomes (e.g. collecting Patient Reported Outcomes Measures)
- Social prescribing referral system
- Improved data flows supporting more efficient resource deployment (e.g. care coordination hub)
- Population analytics to support supply/demand modelling in response to changes in population health and care needs

Sheffield and the Five Year Forward View Clinical Priorities



The planning guidance " Delivering The Forward View" makes specific reference to delivering six clinical priorities. These are woven through each of our priority areas, but for ease we have drawn them out specifically in this section

Cancer

- Gap analysis against the National Cancer Strategy
- Active members of South Yorkshire Cancer Strategy Group and developing Cancer Alliance
- Optimise cancer screening programmes
- Implementation of the new NICE suspected cancer referral guidelines
- Suspected cancers will be diagnosed within 28 days of GP referral
- Risk stratified pathways and recovery packages for people living with and beyond cancer

Dementia

- Further develop the post diagnostic support offer in Sheffield
- Better support people with dementia and their carers to live well at home
- Maintain / continue to improve the diagnostic rate
- Dementia prevention programme
- Sheffield as a centre for dementia related research
- Improve experience of people with dementia (and their carers) at the end of life
- Develop new care pathways and services

Diabetes

- Sheffield has been selected as a first wave site to become one of the early deliverers of the National Diabetes prevention Programme
- We will deliver NHSE procured weight reduction, exercise and lifestyle change interventions targeted at children, young people and adults or are at risk of developing Type 2 diabetes
- There will also be joint action between the CCG and the City Council to reduce obesity in adults and children

Learning Disabilities

- Reduction in number of children, young people and adults requiring specialist hospital placement
- Integrated working to improve physical health of children, young people and adults with LD & SMI.
- Radical upgrade in psychiatric liaison.
- Set requirement for providers to have Easy Read documentation.
- Annual health checks for this population.
- Re-commission autism diagnostic and post diagnostic service with a new specification

Maternity

- Develop a midwifery lead care model within community hubs
- Develop choice of maternity care provision
- Improve health outcomes. Implement the NHS Personal Care Budget for Maternity Care
- Improve perinatal mental health
- Review the parenting offer
- Develop support to improve infant attachment and attunement
- Improve oral health
- Expand community partnerships and community involvement

Mental Health

- Improved access for children, young people and adults to emotional and mental health wellbeing services; providing early intervention
- Expand method of access to mental health services through wider digital/IT opportunities and different talking therapy interventions being made available.
- Mindful employer programme
- Developing an integrated Primary Care Mental Health Service

What Success Looks Like

The plan sets Sheffield ambitious measureable 5 year goals as set out here. Though ambitious they are also tested and there is confidence across the system that by working in strong partnership to deliver the programmes set out they are achievable.

These are ambitious programmes of work, underpinning a commitment to measurably demonstrate achievement of our aims and ambitions through closing each of the four gaps set out in the Case for Change.
To do this each of our Transforming Sheffield programmes of work will have clear and defined metrics. These metrics will be used to assess impact as well as to feed into on-going transformation, adjusting programmes where the actions are not successful (learning from each other and our work as we go) and embedding them where they have clearly added value and had an impact.

Collectively these will achieve improved population health and wellbeing, improved patient access and experience (developing a consistent offer so that people know what to expect), and significant reductions in demand for acute services (through preventing ill health as well as providing more appropriate alternatives where hospital isn't the right care setting).

Fewer People Going to Hospital

- Increased average level of 'activation' for people with Long Term Conditions
- Fewer falls in the homes
- 5% reduction in births requiring intensive care
- Reduction from 23 to 6 people with Learning Disability/Autism requiring specialist hospital admission
- More people still at home 90 days after discharge
- 30% less non-elective admissions
- 20% less elective admissions
- 30% less new outpatient activity (adults)
- 35% less follow-up activity (adults)

Reduced Inequalities

- Overarching long term strategic outcome (20 year timescale): an improvement in overall healthy life expectancy, with greater and faster improvement n those with the poorest healthy life expectancy. Measured by reducing the gap in healthy life expectancy from 20 years to 15 years between best and worst off
- Fewer people not in employment, education or training by 2021
- 5000 more people who are currently long term unemployed moving into meaningful employment (equally benefitting people with disabilities and mental health problems')

Improved Health and Wellbeing

- Improve school readiness at the end of reception and entry into Year 1 at four: from 66% to 75%
- More children, young people and adults reaching national standards of physical activity
- Reduced conception rates in under 18s from 27.9 to 9 per 1000 females
- Full access for all cancer patients to all elements of the Living With and Beyond Cancer 'Recovery Package'
- 25% of people with common mental health problems accessing treatment

Driving Value

- Reduction in prescribing costs
- Greater proportion of Ambulatory Care Sensitive Conditions managed without admission
- Reduce volume of Delayed Transfers of Care to below national Benchmark
- Clinical services able to demonstrate clinical value
- Social capital through building community resilience
- Out of town care for mental health rehabilitation and secure inpatient care reduced to a minimum

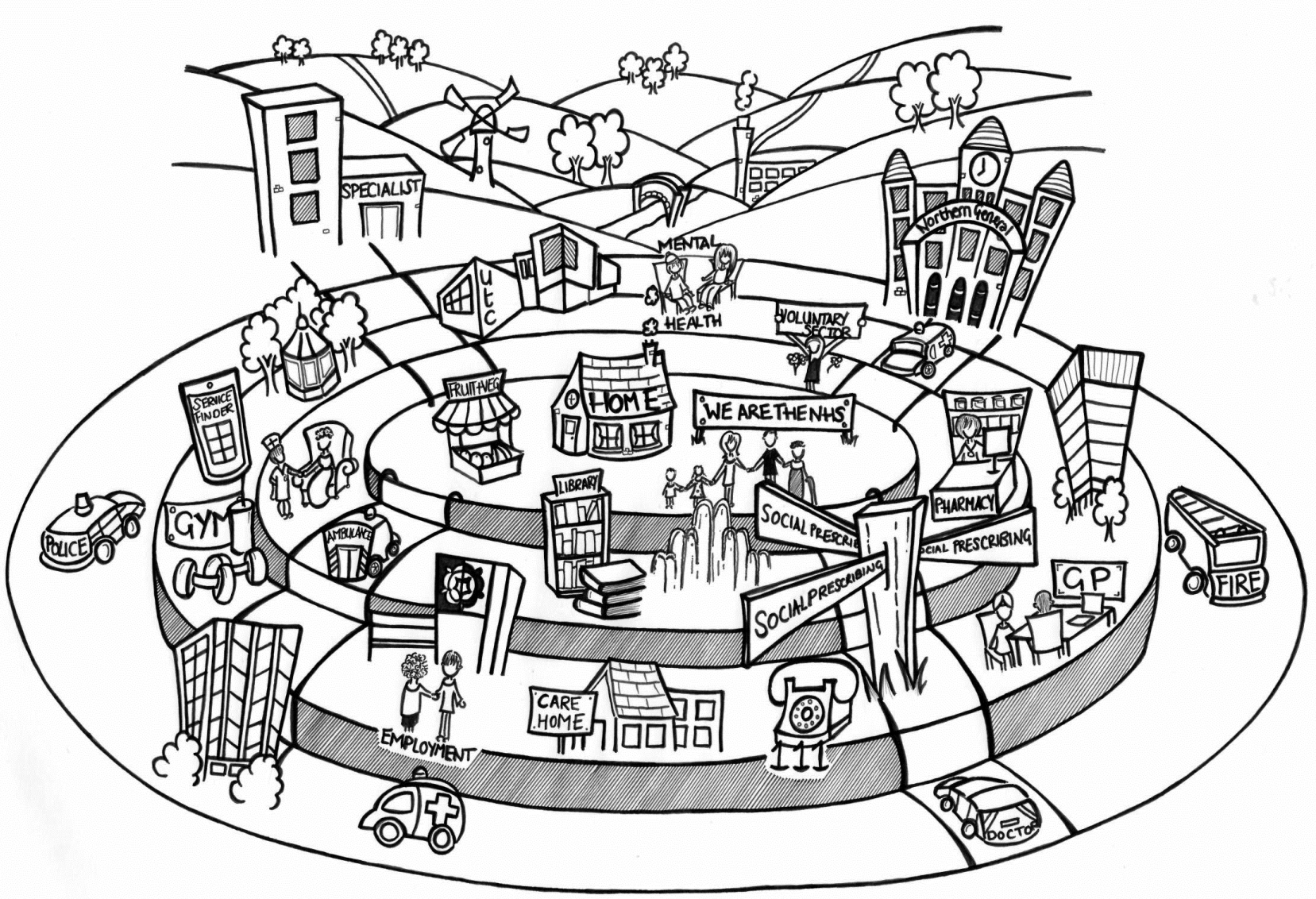
Experience

- More children, young people and adults who are mostly or completely satisfied with the health (National Wellbeing)
- More children, young people and adults who are satisfied with their life overall (National Wellbeing)
- Increase in children's' emotional wellbeing reported through the ECM survey
- Increase in average score reporting positive statements of feelings and thoughts (Short Warwick-Edinburgh Mental Well0Being Scale)
- Improved access as measured through the nationally set performance indicators
- More people supported to die in their own home

Back Office Efficiency

- Reduction in administrative and management overheads
- Reduction and more efficient use of public sector estate
- More efficient running of services across the South Yorkshire and Bassetlaw STP footprint in relation to procurement and diagnostics (e.g. pathology)

Shaping Sheffield Commissioning Intentions



Date – 04-11-16
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Author – Antony Nelson
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Contents

Introduction

Purpose

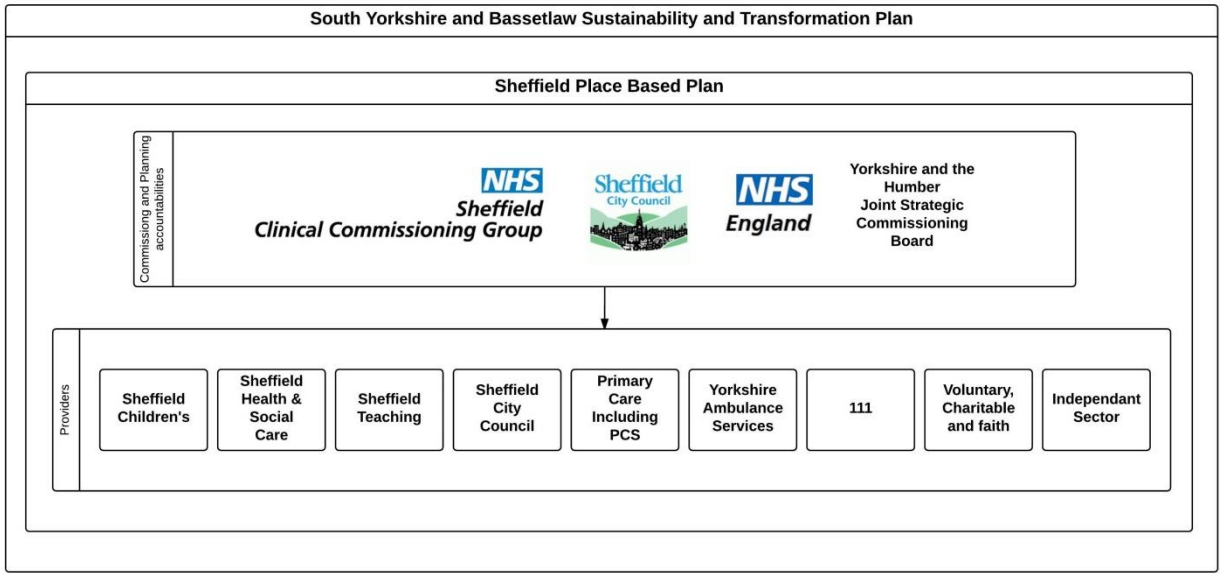
The purpose of this document is to set out the draft Sheffield commissioning and planning intentions for discussion and further collaborative development with all stakeholders for 2017/18 and 2018/19. They have been developed in partnership across the city through informal discussions and based on a longstanding history and experience of collaboration. They represent a shared view between the CCG and City Council of how the Sheffield Pound could be spent better to achieve the health and wellbeing objectives of the city. These intentions are described at a high level the detail will be developed, negotiated and agreed through further discussion including through the annual contract negotiation and agreement processes.

Our commissioning and planning intentions sit within and reference back to the wider context of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan, the Sheffield Place Based Plan and NHS England Specialised Commissioning intentions.

These commissioning and planning intentions have been developed with reference to the delivery of Sheffield's Health and Wellbeing Strategy . The Health and Wellbeing Strategy is underpinned by Sheffield's Out of Hospital Care Strategy within which the Primary Care, Urgent Care and Active Support and Recovery Strategies come together, in conjunction with our Public Health Strategy.

The Place Based Plan describes our shared vision for Sheffield, objectives and future models of care, It identifies 6 priority areas aligned to the objectives in the Health and Wellbeing Strategy:

1. People living with healthier lives – Sets out a radical upgrade in prevention with a number of components requiring commitment across the system. It includes expanding and developing employment opportunities, scaling up brief interventions in clinical practice, refreshing current lifestyle services and strategies, delivery of policy changes and evidence based clinical risk factor management at scale. In addition to enhancing neighbourhood and primary care services in way they enable children, young people and adults to better manage their own health and stay well in their communities.
2. Strengthening Communities – Sets out the plans to improve physical, emotional and mental wellbeing. The plans to promote healthier lifestyles and provide clear signposting to services through which we enable children, young people and adults to take control of their health and wellbeing.
3. Redesigning Primary Care – now and for the future - Sets out the need to redesign primary care and general practice to meet demand, provide the right services by the right professionals and support patients to manage their own health and wellbeing. As well as more easily navigate the services available to them.
4. Community based services providing care closer to home – Sets out the need (as recognised nationally and internationally) to integrate services outside of hospital to provide safe, effective and efficient care for the increasing number of people living with multiple long term conditions and complex needs.
5. Hospital services when hospital is the right place – Outlines the need to ensure that hospital services work in harmony with community and primary care based services, more effectively managing demand and enabling earlier discharge.
6. Specialised services – These will be developed through the Regional and National footprints



"Only through a system-wide set of changes will {we} be sure of being able to deliver the right care, in the right place, with optimal value. This means improving and investing in preventative, primary and community based care. It means creating new relationships with patients and communities, seeing the totality of health and care in identifying solutions, using social care and wider services to support improved productivity and quality as well as people's wellbeing. We need new care models that break down the boundaries between different types of provider, and foster stronger collaboration across services – drawing on, and strengthening, joint work with partners, including local government."

NHS Operational Planning and Contracting Guidance 2017-2019

The Sheffield Vision

This table brings together the mission, vision, aims, strengths and success definitions from the Sheffield Place Based Plan.

Mission

Our mission is simple: For the children, young people and adults of Sheffield to live long and healthy lives with affordable and quality support in place to help them do that.

Vision

To be recognised nationally and internationally as a person-centred city that has created a culture which drives population health and wellbeing, equality, and access to care and health interventions that are high quality and sustainable for future generations.
We will have a reputation for working in partnership to co-produce, improve outcomes, experience and inclusion and to influence national policy and regulation; this will be visible in our success.

Aims

- Develop Sheffield as a healthy and successful city
- Increase Health and Wellbeing
- Reduce mental and physical health Inequalities
- Provide children, young people and adults with the help, support and care they need and feel is right for them
- Design a Health and Wellbeing System that is innovative, affordable and offers good value for money
- Improve people's experience of and access to care
- Be employers of caring and cared for staff with the right skills , knowledge and experience and supported to work across organisational boundaries
- Deliver excellent research, innovation and education
- To develop and expand specialised services for children and adults across the region

Strengths

- Coterminous citywide council and CCG: citywide commissioning
- A strong city council with a Devolution agenda
- Two acute hospitals also providing specialist tertiary services to South Yorkshire and Bassetlaw and beyond
- Sheffield Health and Social Care Trust
- Primary Care Sheffield
- Track record of strong partnership Transforming Sheffield Programme
- Two thriving universities producing local health and care research and workers
- Very strong and vibrant Voluntary, Charity and Faith Sector

What does success look like?

- Measurable improvement in mental and physical health and wellbeing, including education and employment
- Reduced inequalities across the city
- Improved experience, including good access to services when children, young people and adults need them
- Fewer children, young people and adults going to hospital
- Services that demonstrate value for all Sheffield people
- Efficient use of estate and back office functions

Statement of intent and behaviours

We will….

1. Support 5,000 young people and adults currently in, or at risk of, long term unemployment into sustained, meaningful employment by 2020 focussing particularly on the link between employment and physical and mental health
2. Invest heavily into the development and delivery of neighbourhood working setting up clear health and social care neighbourhoods and wrapping voluntary care, social care, community care and specialist care services around them. To bring support closer to children, young people and adults in their home.
3. Tackle inequalities head on by making disproportionate investments in effort and resources into those communities with most need. This will include redistributing social care, primary care and GP services to match the needs and levels of disadvantage, and in particular we will focus on cardiovascular risk management. We will incorporate secondary care specialist skills in this prevention initiative.
4. Agree a single risk stratification process for our population, then each neighbourhood will develop care preventative care plans for those most at risk (3,ooo) and then those who will be most at risk in 1-2 years (15000). We will use this risk stratification to inform the wrapping round of services outlined above.
5. Work with our staff and teams to promote flexibility, to promote patient centred services and to promote a culture in Sheffield where staff across organisations are enabled to resolve difficult issues which impact on patients and communities. This will be the aim of the Workforce and Organisational Development Delivery Group and will start working on this in October 2016.
6. Work collaboratively with those neighbouring health and social care systems. We will provide leadership and support into the South Yorkshire and Bassetlaw STP, and we will continue to make progress with the Sheffield City Region.
7. Agree a set of principles and behaviours that we will all sign up to, which articulates how as a team we will develop ourselves to be Whole System Leaders; to enable us to work better together, but equally to unlock solutions that we cannot do as organisational leaders.
8. Manage our resources as a single account for the city so that every decision is in the best interest of our city rather than for an organisational benefit. This will also start to unlock some of the drivers of the perverse incentives in the current system. This will be in place by December 2016. We will look to Government to respond collaboratively to this

Our approach is to work collaboratively to plan across and manage networks of care and support rather than focussing on organisations. Flexibility and collaboration will underpin not just how the system will operate to deliver outcomes for the children, young people and adults of Sheffield but also how Sheffield City Council and NHS Sheffield CCG approach their responsibilities. This document presents, for the first time, the shared planning priorities of both organisations and provides a series of radical collaborative approaches to addressing the significant challenges the city faces in meeting the Health and wellbeing agenda over the next two years. We have a set of (draft) shared behaviours that should underpin our future interactions across the system, these are described below.

We are…

- Committed to agreeing a single plan for Sheffield and driving its successful delivery; with a consistent way of articulating it
- Up front, open and honest about the challenges and proposed developments; we will collectively understand them and work to resolve them
- Committed to understanding the wider system impact of change, no organisation will make unilateral changes: where any negative impact is unavoidable we will collectively address it and seek to minimise the impact
- Clear that solving system challenges is a collective responsibility, even where they sit in a single organisation

We will …

- Work to support each other as a group and as teams of individuals
- Provide a cooperative and united front to external partners
- Seek to be ambitious and be successful in our ambitions; learning from each other and from our broader Sheffield partners through the Shaping Sheffield membership

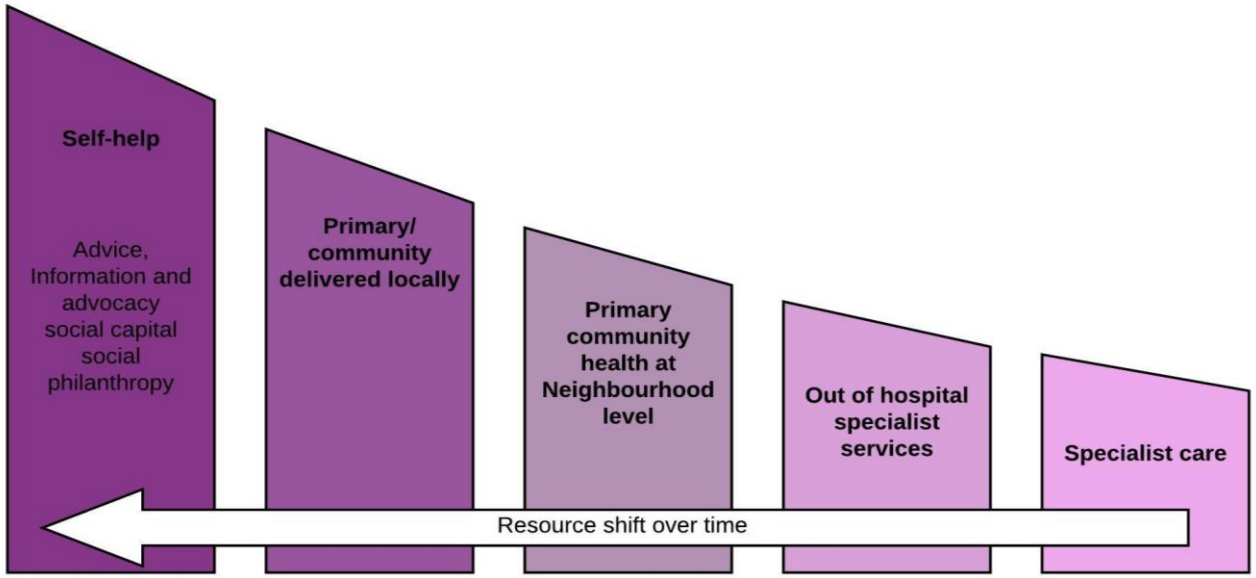
DRAFT – Sheffield system behaviours

The city has recently signed a Memorandum of Understanding that sets out the ambition for the transformation of health and social care across Sheffield as part of the Active Support & Recovery Programme with the intention as a city to operate more proactively to reduce risks of admission or escalating health needs for who have at least one long term condition (many of whom are ageing) and require support from mainstream health and/or social care to manage their health conditions and social care needs. The CCG and City Council will take steps to support development based on this agreement in support of the achievement of the city-wide health and wellbeing objectives. In so doing the city will seek opportunities to spend money on achieving strategic objectives by sharing risk across organisational boundaries. Areas in which we will seek to explore further how opportunities may be developed to make radical steps forward in achieving our vision for the people of Sheffield may include for example.

- Pooling budgets around STIT/CICS (Active Recovery) and Independent Home Care.
- Take the opportunity to provide a neighbourhood-focused Intermediate care service
- Rationalise care plans and care planning processes as a city-wide piece of work. Move to a position wherever possible that there is one care and support plan per individual.
- Explore with partners ways in which we can significantly expand the range of planned care referrals into the CASES model before the end of 2017/18.
- Behave as an Accountable Care System. At Neighbourhood level we will act as single providers delivering more integrated services.
- Develop a city-wide consistent response to first point of contact. To ensure that wherever a person presents for care or support they receive the same consistent high quality response.

Impact

This document does not seek to reiterate the scale of the financial challenge faced by the current model of spend in improving the Health ad wellbeing of the people of Sheffield. Recent work undertaken by PwC in support of the Place-Based Plan analysis does this. We do however expect to see a change in the profile of our investment; with a shift in spend leftwards along the care and support continuum shown in the diagram below with a bias towards increased prevention. The table at the bottom of the page shows in which areas the PwC analysis expects to show changes in activity. The changes we anticipate through the commissioning and planning intentions in this document should seek to impact in these areas.



		Savings (£m)				
Programme	Approach	16/17	17/18	18/19	19/20	20/21
1.Early Years & Families	Skewed	0	0	0.91	2.27	4.54
3. Heart of Sheffield	Skewed	0	0	1.06	2.67	5.32
4. Helping More People Into Work	Linear	0.11	0.22	0.33	0.44	0.55
5. We Are the NHS	Linear	1.62	3.24	4.86	6.47	8.09
6. Strengthening Primary Care	Skewed	0	0	0.35	0.88	1.76
8. Active Support & Recovery	Skewed	0	0	4.66	11.66	23.31
10. Referrals and Pathway coordination	Skewed	0	0	0.48	1.19	2.39
	Total:	**1.73**	**3.46**	**12.65**	**25.58**	**45.96**

Notional potential savings profile (DRAFT PwC work Sept 16)

Impact	
Reduction in non-elective admissions for mostly healthy children	Reduction in GP attendances from the elderly
Reduction in elective admissions for mostly healthy children	Reduction in social care costs among the elderly
Reduction in outpatient appointments for mostly healthy children	Efficiency savings in Estates
Reduction in A&E, non-elective, elective, outpatient, and social care activity for adults with CVD, and a reduction in prescribing costs	Reduction in non-elective admissions for specialties covered by the scheme
More adults from Sheffield in work	Reductions in length of stay
Reduction in A&E attendances for the elderly	Reduction in Mental Health costs
Reduction in non-elective admissions for the elderly	Reduction in outpatient appointments for adults and the elderly
Reduction in elective admissions for the elderly	

Approach to developing our commissioning and planning intentions

In order to deliver against our priorities we have developed a set of commissioning and planning intentions that will be translated into practice through the individual organisational contract negotiation processes.

In this document we have set out the Sheffield draft intentions and these are described across three distinct levels.

1) South Yorkshire and Bassetlaw Sustainability and Transformation Plan Intentions: including Specialised Commissioning Intentions for 'at-scale' services (NHS England) –
2) Jointly shared intentions between NHS Sheffield and Sheffield City Council – Self Care and Prevention, Mental Health, Learning Disability, Community Care and Children's Services
3) Organisational Specific Plans
    I. CCG specific intentions: Urgent, Planned, and Primary Care
    II. Local Authority specific Intentions – Housing These intentions are interrelated and together they deliver the responsibilities for the health and wellbeing of the population of Sheffield. There are intentions set out within each level that ensures delivery across the strategic priorities set out in our plan and we will continue to work together to identify explicitly the impact of the draft intentions. The intentions are not exhaustive and do not reiterate expectations that are set out in the quality schedule to be appended to relevant NHS contract(s), the requirements detailed in the 2017/19 planning guidance and the NHS constitutional rights and pledges, nor where there is need for compliance with legislation (for example deprivation of liberty DOLs).

Our aim is that through collaboratively agreeing the Sheffield intentions there will be a clear steer provided for the 2017/19 contract round delivering against jointly owned health and wellbeing outcomes to meet the needs of the local population

In the following pages we set out our draft whole system transformation requirements for each priority delivery area. It is these statement of intent against which individual organisational agreements will be able to be referenced. This will enable those who lead the 2017/19 contract processes to see the negotiations as part of delivering the bigger whole Sheffield picture.

From page 50 onwards the document details how these system wide intentions begin to translate to the impact for providers in Sheffield. In order for our ambition to have the greatest chance of success existing providers will need to work differently, together we will enable greater flexibility in our workforce supporting them to deliver across organisational boundaries and work to provide them and the people they support with the necessary infrastructure including a step change improvement in IT through the Digital Roadmap.

South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP)

The over arching STP (and the regional Transforming Care Partnership - TCP) sets out the South Yorkshire and Bassetlaw expectations for driving transformation across the geographical footprint across the system for changes to service provision. The Sheffield Place Based Plan, and in turn the Sheffield Commissioning and Planning Intentions Plan set out how we will meet the expectations of the STP and the TCP.

In the period of this plan (2017-19) Sheffield will implement agreed STP milestones, in order to be on track for full achievement by 2020/21 and achieve agreed trajectories against the STP core metrics set for 2017-19.

The STP has set the following objectives

To improve health and wellbeing for everyone - We want to support people to choose healthier lifestyles –by making it easier to get expert advice and access to free healthy living schemes. And to help them connect and develop local links and networks in their neighbourhoods

To improve the quality of care people receive - We want the same quality of service for people, as close to them as possible

To ensure our services are efficient - This doesn't mean doing less for patients or reducing the quality of care. Rather, it means more preventative care, bringing care out of hospitals and closer to home

Plan specifics for 2017-19: The STP has produced a set of commissioning intentions that can be referred to seperately

Specialised Commissioning

Some NHS Commissioning responsibilities are 'reserved' to NHS England, delivery against these accountabilities are increasingly focused on STP footprints and as such NHS Sheffield CCG and Sheffield City Council will continue to engage in the development of transformation initiatives for the people of Sheffield through the STP processes.

NHS England has published its Specialised Services Commissioning Intentions here: - https://www.england.nhs.uk/wp-content/uploads/2015/12/spec-comm-intent.pdf .

These commissioning intentions outline the strategic interventions to improve the way NHS England will commission and contract, review and transform specialised services. They build on progress already made to deliver consistent care standards across the country: The focus on sustainability will be enhanced by:

- Reducing variation in cost and outcomes, driven by greater consistency of care and a coordinated pathway; Greater links to CCG commissioned pathways and prevention work;
- Better coordination and flexible use of scarce workforce
- Improved access for all patients regardless of where thy reside
- Potential for leveraging backroom costs and contributing to provider CIPs, as well as closing the financial gap across the health systems in the North of England.

Key intentions of specific relevance to Sheffield are:

North - Mental Health: - Work with CCGs and other partners to better integrate Specialised Mental Health services into place-based commissioning approaches and pathways. Reduce the capacity of Learning Disability secure services across the North of England. The North is aiming to reduce the numbers of patients in a specialised inpatient bed by 187 by March 2019.

North – Cancer: - Work with the new cancer alliances to deliver the national cancer strategy objectives relating to specialised services. Undertake local reviews of Pancreatic Cancer and Head and Neck Cancer services in Yorkshire and the Humber.

North - Blood and Infection: - Address service specification and network issues in HIV services. Work will also be undertaken to harmonise contractual and pricing arrangements for this service;

North - Internal Medicine: - During 2016/17 we have undertaken work to examine variation across the North in Dermatology; Rheumatology; Respiratory; and Hepatobiliary services. We will implement changes that address these areas of variation.

North – Trauma: - Implement a case-management model for Neuro-rehabilitation services, working with providers on complex rehab cases across the North. Undertake a regional review of specialised Orthopaedics Services. Undertake a review of the National Artificial Eye Service hosted by Blackpool Teaching Hospital. Undertake a local review of Specialist Rehabilitation for Complex needs in Yorkshire & Humber.

North – Women and Children: - Congenital Heart Disease: ensure that contracts with all relevant providers will include the new service specification and time-limited derogations as necessary and work with providers to implement the outcome of the national review following public consultation. Undertake local reviews in Yorkshire & Humber on Paediatric Medicine; Paediatric Oncology; and Paediatric Neurosciences services

South Yorkshire Police Authority and South Yorkshire Fire and Rescue Services

This plan acknowledges the role and contributions that both the Police and Fire Services make in supporting and facilitating health and well being developments in Sheffield.

The Police and Fire service will be supported with engaging with Health and Care providers within the influence of this plan.

Jointly owned system transformation plans

Self-care and Prevention

Transformation Requirements

- **Improve life chances:** Expanding and developing employment pathways for children, young people and adults furthest from the labour market, such as those with mental illness or learning disability
- **Enhance neighbourhood and GP services**: Developing comprehensive local services that support children, young people and adults to better manage their own mental health and stay well in their communities by: providing low level mental health interventions to prevent escalation of improving health literacy, self care and self management; and social prescribing.
- B**uild stronger and more resilient communities**: Including more health-related volunteering and peer support
- **Achieve healthier lives**: Developing a 'Sheffield Lives' programme to deliver healthy public policies and prevention services at scale

Mental Health and Learning Disability (Adults)

Transformational Requirement: to modernise mental health services to enhance prevention, early intervention, and recovery approaches, and ensure integrated crisis responses are in place

- **Parity of esteem**: to create an environment whereby people's needs arising from mental health, learning disability and autism are given equal priority to the needs people have to due to their physical health to improve experience, reduce inequalities, and avoidable premature deaths in people with MH/LD/Autism/Dementia.
- **Shift to services/ pathways providing greater access to psychological therapies,** particularly were inequalities are greatest (homeless, substance misuse, disadvantaged communities, physical/mental health co-morbidities, LTCs
- **Learning Disability Transforming Care Programme:** to redesign services for people with learning disabilities, challenging behaviour, forensic needs and autism, creating alternatives to hospital, which provide value for money, improved experience care closer to home in less restrictive environments. Physical health of people with LD, working of the LD mortality review and improving health national priority
- **Primary Care Mental Ill Health Prevention and Treatment:** to develop a new model of delivery offering support to neighbourhoods with a primary care-based service to offer care closest to home where people can access services when and where they need it to prevent onset or severity of mental illness where possible) and supports them in the community if they've been users of secondary care mental health services
- **Mental Health Liaison:** to ensure that when people with mental health needs, autism, learning disability and/or dementia attend hospital for physical health conditions that their needs are properly understood and supported.
- **Acute Care Configuration**: to mobilise community developments and partnerships to ensure more appropriate services are provided in the community setting and inpatient beds are not reopened consistent with and connected to the Out-of-Hospital, Neighbourhood and Primary Care strategies
- **Crisis and early intervention**: to review and reconfigure services with partners to deliver an effective integrated early intervention, crisis and recovery pathway (as per crisis concordat requirements).
- **Ongoing Care**: to rationalise decision making, so that people get the services they require without delay. To ensure that the provider market for ongoing care is managed so that good quality, affordable, person-centred care is available that maximises independence for all service-users.
- Reduce specialist hospital admissions for people with learning disabilities requiring specialist hospital admission. An increase in the number of people moving out of IAPT into recovery.

Community Offer (Adults)

The following transformation requirements are set out in the context of the care outside of hospital programme which includes MH/LD/autism/dementia.

- **Resilience and response** – to ensure a consistent approach to the promotion of health and wellbeing and a pro-active approach to the prevention of illness / crisis. Increase prevention of ill health by scaling up brief interventions in clinical practice, and delivering a quality improvement programme focused on improving clinical risk factor management. To implement a person-centred approach in collaboration with other providers that supports independence, active ageing and self-care. Treatment of unemployment as major risk factor for poor health, by referring appropriate people to employment and health programmes
- **Risk Stratification -** We will develop and then implement a risk stratification tool to inform us how best to use our resources to deliver the right support in the right way to meet the need of our neighbourhoods.
- **Efficient and effective community services** - to develop services within neighbourhoods that reflect and are responsive to the needs of the neighbourhood population. Develop an integrated community offer which ensures a person-centred approach including the shared ownership of the care planning approach for those who will benefit. Understand how AS&R neighbourhoods will work with Community Partnerships (where they exist) including formalisation of Social Prescribing.
- **Crisis reduction** – to implement key initiatives across the health and care system to reduce the incidence of crisis and acute emergency demand, including proactive prevention work with a range of health and care providers, the development of alternative community services the implementation of the assess to admit model in people's own homes and activity to reduce readmission rates across the city
- **Intermediate care** – to ensure that intermediate care services are able to respond quickly to crisis in the community as well as the flow up to and out from acute hospital beds. Intermediate care services will deliver a person-centred approach providing step up care led by Primary Care to avoid admission wherever possible and step down care led by acute services, delivering appropriate therapeutic input.

(continues…)

Jointly owned system transformation plans

Community Offer (Adults) (cont..)

- **Ongoing Care** – to rationalise decision making, so that people get the services they require without delay. To ensure that the provider market for ongoing care is effectively managed so that good quality, affordable, person-centred care is available. This care will seek at every opportunity to maximise independence for all users of the services

Children Young People and Maternity

There are well developed joint and collaborative planning and partnership forums in existence where citywide priorities have been agreed. We plan to work on focused transformation programmes with a number of projects to redesign the system and provide early intervention, early help and sustainable health -care as close to people's local area as possible. We will adopt a locality model of delivery aligned to the current Children's and Families localities model emerging within the city working across education, health and care. We plan to provide as much care and support within localities as possible, and outside of hospital, developing new models of care that provide a pathway of Early Intervention, Early Help, through to targeted and specialist care.

Transformation requirements

1. Emotional Wellbeing and Mental Health – to redesign services that support the emotional wellbeing and mental health of children and young people to ensure timely access to and a good experience of appropriate services as well as reducing the need for higher level intervention.

- **Emotional Wellbeing within the Community -** Develop and deliver a community based universal offer within localities of early intervention and Early Help that brings together the key elements of CAMHS early intervention: primary mental health workers, the development and delivery of the Sheffield Healthy Minds Framework in schools and a core training offer.
- **Access & Waiting Times** - to improve access from our community offer and ensure that for specialist services all access and waiting times standards are met for all mental health services, including eating disorders and psychosis (including national waiting time targets and our local commitment to 18 weeks waiting time for CAMHS).
- **Improve Access Psychological Therapy (IAPT) –** to improve access to evidence based therapies through workforce development (training CAMHs staff with evidence based therapies and agreeing treatment pathways).
- **Children and Young People with Eating disorders** – to increase the number of young people accessing interventions, Early Help and treatment through the existing community eating disorder services. We will provide a citywide collaborative pathway of care.
  Intensive Home Treatment – to implement a new intensive home treatment service, Support Treatment and Recovery (STAR) to reduce the number of children/young people requiring a hospital based care model of CAMHS provision (Cohort of young people TBC).
- **An alternative model to hospital provision that supports inclusion** - to provide family centred specialist day patient, outpatient and outreach mental health care to children (and their families) with severe and/or complex mental health conditions that are unable to be supported in the community or within their local school.
- **Care for the most vulnerable** – Improve the pathway of care for Children and Young People who are Looked After. Develop a targeted offer for vulnerable young people
- **Mental Health Liaison and Crisis Care –** to provide a mental health liaison service that provides rapid staffing of section 136 to enable access 24/7 and reduce emergency re-admissions for these children and young people. To provide a community based crisis response service within Sheffield for Young People. Explore opportunities to develop a pathway of care for section 136 across South Yorkshire in collaboration with other health services.
- **Learning disability/Mental Health (LD/MH)** – to provide a service that meets the needs of children with learning LD/MH with CAMHs that reduces out of city placements both for respite, assertive outreach and residential placements.

This will result in more care delivered in local areas and communities

2. Community Health Programme – to redesign health, education and wider support services to develop an integrated locality based offer that improves access and experience, avoids duplication and reduces the need for higher level interventions.

- **Locality hubs/Integrated delivery**– to review the referral pathways of those services within the agreed scope. To redesign community health services for families identifying those that could be delivered through a locality hub model resulting in less hospital based care. To integrate this model with the Children's and families model of family support services and targeted interventions.
- **Redesign of Paediatric Care pathways and community provision** – Develop new models of care within localities that support care outside of hospital between primary and community care.
- **Urgent Care** - To define the pathway of care for pre hospital urgent care for the acutely ill child and children with common conditions and develop new models of care between primary and secondary care.
- **Healthy Child Programme 0-19 redesign** – To redesign health visiting and school nursing, integrating both services, enhancing skill mix, minimising duplication and ensuring an effective targeted provision and offer to vulnerable and at risk groups.
- **Childhood Obesity** Influence citywide initiatives that have an evidence based impact on reducing Childhood Obesity.
- **Neurodisability** – to commission a new pathway of care jointly with NHSE for neurodisability services within a locality model for ADHD and ASD.
- **Sexual Health** – to redesign and enhance community based sexual health services, to align with the community child health redesign, and whilst enhancing community provision, to construct robust pathways to enable access to specialist sexual health services where appropriate.

Jointly owned system transformation plans

Children Young People and Maternity (cont)

3. Children with Complex Needs – to jointly implement needs based approaches to care packages efficiently aligning assessments and review processes across education, health and social care to improve experience, increase choice and control for children, young people and families. To ensure a targeted offer of Respite Provision – Following the review of health and social care respite provision, redefine the offer enabling choice for families within the context of personalisation.

- **Speech and Language Therapy** – to commission a new speech and language pathway with new referral thresholds reducing waiting times.
- **Placements for complex Needs** - to develop the commissioning framework and market for jointly commissioned complex care packages with SCC
- **Transition to Adulthood** – to ensure that all children who might be eligible for adult continuing health care, have an eligibility outcome by the age of 17.

Best Start and Maternity Care

4. Maternity Services – to redesign maternity services, providing improved experience, choice, continuity of care, including antenatal and post natal care to be delivered outside hospital in a locality hub model enabling joined up/aligned provision with existing early years services and enable choice of provision in with Better Births.

- **Develop a midwifery lead care model within 'community hubs'** in line with 'Better Births' and ensure timely discharge from hospital care and access to wider family support services.
- **Develop choice of maternity care provision**, while ensuring safe care
- **Improve health outcomes** for babies, children and families through targeted public health interventions (smoking cessation, infant feeding, childhood obesity, avoidable harm, safe sleeping)
- **Implement the NHS Personal Care Budget for Maternity Care**
- **Improve Perinatal Mental Health** provision for families
- **Review the parenting offer** for infants from 0-3
- **Develop support to improve infant attachment and attunement** in early years.
- **Improve oral health** for 0-3 year olds .
- **Expand community partnerships and community involvement** in activities that support Best Start.

CCG specific system transformation plans

Urgent Care

Transformational Requirements

- **Efficient delivery of local urgent care pathways** – To ensure Sheffield has a resilient and sustainable local urgent care system we will explore the development of urgent primary care access solutions working collaborative with PCS, STHFT and One Medicare leading to the development of a consistent and integrated offer across primary and secondary care. To implement clear and robust pathways committed to by all local partners, primary care, social care, community and acute providers and the Yorkshire Ambulance Service. Maintenance of a local Sheffield model with regard to the development of regional clinical hubs.
- **Primary care resilience and response** – to develop a consistent offer across primary care to ensure that patients requiring urgent care receive a timely response, where clinically appropriate without recourse to A&E services.
- **System wide attendance and admission avoidance** – to implement key initiatives across the system to reduce acute emergency demand, including the development of primary care led coordination, the development of alternative community based approach to delivery, better use of ongoing care provision, work with STHFT to deflect minor injuries/primary care conditions presenting at A&E and implementation of the assess to admit model.
- **Optimising patient flow through acute settings** – to ensure implementation of national best practice (including 7 day working) to enhance patient flow including proactive admission avoidance and discharge planning and ensuring incentives and behaviours are aligned so that assess to admit and discharge to assess trusted assessor models can be implemented through collaborative work with all key partners. There will be fewer people readmitted following a hospital stay.

Planned Care

Transformational Requirements

- **Primary care resilience and response** – Supporting and strengthening referrals, to develop a consistent offer across primary care to ensure that patients requiring a planned treatment receive the right service in the right place and in a timely way with diagnostics and care outside hospital when appropriate.
- **Development and Efficient delivery of local 'Whole Journey' elective care pathways** – to ensure consistent implementation of best practice and national guidance in relation to local elective care pathways. To collaboratively develop robust whole-journey care pathways, to ensure joined-up primary and secondary care healthcare provision. Where there should be community based provision we will enable this to happen, where hospital care is required we will significantly increase the number of referral through CASES.
- **Optimising patient flow through rapid access clinics** – Patients whose higher acuity needs are being effectively managed in the primary care setting are able to be offered priority access to hospital based speciality services
- **System wide outpatient and admission reduction** – to implement key initiatives across the system to reduce elective demand. These will include proactive work with primary care, the development of alternative community services, work with the whole system to enhance self care models, working collaboratively across the system to ensure individuals are able to maximise their own health potential.
- **Develop new models of care** - Ensure patients are able to access services closer to home through the development of community services in neighbourhoods or other appropriate provider models including Personal Health Budgets, Primary Care will offer enhanced services and support for patients to actively manage their healthcare including support to self-care.

Primary Care

Transformational Requirements

- **Patients will have confidence in new system,** they will be knowledgeable about how to access all services including new developments to meet their primary care needs. They will be signposted by care navigators in Primary Care to the right health or other sector provider who can help them. Those most in need of accessing a Primary Care clinician will be able to do so in a timely manner. Those most in need e.g. frail elderly with care needs and their carers will have a partnership approach in the management of their conditions. They will only be referred to Hospital from PC when they genuinely need it.
- **Primary Care and Support at Scale -**
  - **Neighbourhoods** - A range of professionals supporting patients and the wider population appropriately and seamlessly. Members of the professional neighbourhood team will have such trust and confidence in each other that they will be enabled to work independently as far as possible and call on colleagues when needed.
  - **Extension of service provision** - There will be a extensive range of services that have only previously been accessible in the acute sector and these will be provided across a wide range of community settings
  - **Locally Commissioned Services** – Take opportunities to look at how they might be strengthened and become more sustainable by being developed at neighbourhood level e.g. Rationalisation of Care Planning approaches
  - **Primary Care Sheffield** - Explore the role and contribution of Primary Care Sheffield into the community provider developments, opportunities to take on the employer role for at scale provision in primary care – e.g. Practice Pharmacists and explore what current CCG functions might sit more appropriately in PCS. Including practice at scale.

CCG specific system transformation plans

- **Pharmacy**
  - Continue roll out of Blue Teq in line with previously agreed framework, i.e. to include: gastroenterology in Crohn's disease, omalizumab for chronic urticaria and evolocumab and alirocumab in patients with primary (heterozygous familial and non-familial) hypercholesterolemia and mixed dyslipidaemia, whilst expanding use to include other specialities.
  - Continue to introduce biosimilars and generics so that all new and existing patients are switched as soon as is practically possible.
  - In line with Hackett report, provide written details of all homecare provision which will include a breakdown of delivery frequencies, any ancillary costs, details of KPIs. This will start from any new drug approved via MMTC from January 2017.
  - Consider use of bevacizumab (Avastin®) "off label" to treat wet AMD rather than ranibizumab (Lucentis®) – there are already ongoing discussions involving Dr Zak McMurray and STH clinicians
  - Prescribe and supply the most cost effective drugs and formulations and to include CCG in any procurement or rebate process that has the potential to impact on primary care or hospital prescribing budgets. To include e.g. prescribing of generic drugs, oral nutritional supplements, dressings, continence and stoma products.
  - Any changes to prescribing choices must consider the costs on all parts of the health care economy e.g. costs in primary care for secondary care drugs.

LA specific system transformation plans

Housing

Transformation Requirements

Tenants and their families will receive more streamlined, integrated and individually-tailored services. Closer working between housing and other Council services will give tenants better access to a variety of advice and preventative services, leading to improved health outcomes, less social isolation and improved financial wellbeing.

More staff will be moved to locally-based area teams - By reducing management layers and streamlining specialist and support services. Staff will spend more of their time working with tenants in their homes and on estates and so will be a visible local Council presence

Earlier, more effective responses to tenancy issues – such as rent arrears and ASB – will allow the wider underlying issues (e.g. financial exclusion) to be tackled more effectively. This will lead to lower rent arrears and a reduction in the number of more serious issues.

Increased community resilience through encouraging and supporting community engagement and networks, and through enabling tenants and their families to take advantage of opportunities offered by the local community

- Local community-based approaches to delivering services.
- Better joined-up working between Council and Healthcare services to respond to tenants' needs more effectively, and to achieve better value-for-money by reducing duplication of activity.
- Enabling tenants and their families to independently manage their finances, health, well-being and housing circumstances and so improve their household resilience.
- A 'whole household' approach, building better links with GPs and other health staff.
- Building community resilience by encouraging more 'grassroots' tenant involvement
- Strengthening democracy and transparency in decision-making.
- More pre-tenancy support for applicants.
- Well looked-after and effectively managed estates and neighbourhoods
- Protecting the Decent Homes investment made in council housing properties
- Ensuring value-for-money and making the best use of tenants' rents.

Provider Implications

The previous pages of this document present our plans as intended system outcomes rather than the actions required of individual organisation's. However in order to facilitate the next steps of contract negotiation and agreement the following pages break down our intentions into Provider-specific elements. It is anticipated that these pages will form the basis for conversations, discussions and negotiations with individual providers through the established contract mechanisms. The aim being that by the appropriate and agreed deadlines (23 December 2016 in the case of NHS contracts) Sheffield will have in place agreed contracts for the relevant services for the period 2017-19 that reflect these transformation intentions. At all times through the next stage of this process the system-wide collaboration objectives should hold firm and act as a reference point.

Given the evolving nature of the plans, in particular the impact of STP and the Sheffield Place-based plan these provider implications should not be seen as static. We anticipate there will be a larger than usual level of in year contract variations throughout this period as collaborations around plans come to fruition. We will work in partnership through out the system to minimise the inconvenience that this may cause.

Understanding the following pages:

Each of the following pages provides the organisational specific commissioning and planning intentions

Provider Name

Intentions	Provider dependencies
These describe the organisation specific commissioning or planning intentions. They describe at a high level the programmes of work, service reviews, changes in activity type or location, service or delivery model that will form the basis of contract discussions and negotiations to support the system as a whole to deliver the system-wide ambitions	This column identifies some of the 'other' provider pieces of work on which the delivery of some of the things in the leftmost column are dependant. In detailing it in this way we recognise that providers are interdependent, that people in the city want a more joined up approach and that driving change in one part of the system is most often supported by actions in another

All Providers

The following intentions are specific to all providers and commissioners across the system

Intentions
Support the development of a set of system-wide behaviours that underpin the outcomes we have to achieve
Engage in the development of an accountable Care System including the contractual models to support
Engage in the Driving Value programme, to identify and implement appropriate opportunities
Engage in the development of the IT test bed and digital roadmap
Actively seek feedback from children, young people and adults across all our communities and demonstrate improvements to services as a result of feedback. Provide quantitate and qualitative patient experience data that can be used to drive improvements in commissioning
To reduce premature mortality and provide services in the most appropriate, accessible and least restrictive environment for people with mental illness, LD, autistic spectrum condition and dementia
Work collaboratively to improve physical health and reduce physical health deterioration and acute hospital admission for all irrespective of mental health/learning disability or dementia needs
Work collaboratively to improve the mental health and emotional wellbeing and reduce mental health and acute hospital admission for all irrespective of Physical health presentation
Engage in the development of a City-Wide workforce planning approach, taking a collaborative approach to understanding and solving the workforce development challenges inherent in this programme of work
development of a city wide estates strategy which supports estate rationalisation to release costs across primary, community, acute and care settings
Active participation in the leadership of neighbourhood steering groups, the Active support and Recovery Delivery Board and the work streams that will be part of the wider programme.

Intentions	Provider dependencies
Emotional wellbeing and mental health – Deliver a tier 2 offer bringing together key elements. Ensure all access and waiting times standards are met for all mental health services. Develop skills throughout existing workforce (CAMHs) to increase IAPT provision. Ensure Eating Disorder Service is in line with NICE, increase access, reduce waiting times. Deliver STAR pilot, evaluate and if successful roll out, if unsuccessful review and reconsider. Redesign Amber lodge in partnership with CCGs Provide a mental health liaison service, staff section 136 provision to ensure 24/7 access and evaluate section 136 provision during first 12 months. Provide an LD/MH service with in-reach CAMHs to reduce out of city placements. Collaborate with other emotional wellbeing and mental health service providers to help deliver the Future in Mind Transformation Plan, and explore innovative opportunities to improve services. Community Child Health Programme – Review services in the scope of the community health children redesign, develop robust referral processes, consolidate access and consider how they could operate through a locality hub. Specifically review health visiting and school nursing and work with SCC and SCCG to develop a locality based model of 0-19 years HCP service delivery, aligned with MAST and the wider community child health programme redesign. Develop proposals for the management of community pathways of care to reduce the need for care inside hospital Work with CCG and NHSE to establish a Neuro-disability Service, in line with guidance that provides assessment, diagnosis and treatment, and educational support to referrers. Children with complex needs – Collaborate with partners on the implementation of a joint needs based approach to care packages across education, health and social care. Work with partners to review and redesign respite provision. Work with commissioners to develop and deliver a new speech and language pathway with new referrals threshold. Specialised services – Collaborate in the development of a network of provision for surgery and anaesthesia and acute care across South Yorkshire, including preparation for potential additional activity. Transitions to Adulthood: Ensure a Checklist is sent to the CCG so that each child eligible for continuing healthcare, can be screened for eligibility for adult continuing healthcare. Checklist to be sent within 2 weeks of their 16th birthday. Prevention - Commit to participating in a Value Improvement Programme Carter review recommendations - develop and deliver against plans for reconfiguration of 'back office functions'.	SHSC - To work with SC FT and CCG to develop the pathway of care for emotional wellbeing and mental health for young people Primary Care - Primary care providers as appropriate to collaborate with the work to explore potential locality delivery of services (in the scope for the child health programme) and utilise agreed referral processes/access routes. Primary care providers are expected to collaborate with partners as appropriate to support the pilot of an integrated primary care model with the SCH emergency department.

Sheffield Health and Social Care Foundation Trust

Intentions	Provider dependencies
Overall to contribute to a shift from urgent unplanned care, to a planned prevention and planned care model in which mental health care is seen as an equal priority to physical health care and care happens closer to home rather than in hospitals Mental Health Liaison - SHSC to commit to attend and participate in Alliance Contract Meetings to ensure the liaison service is successfully integrated within other SHSC managed care pathways and with primary and community care so that there is a focus on prevention of ill health and morbidity Learning Disability Transforming Care - In line with TCP plan, work with partners to reduce Sheffield bed usage to 9 inpatient beds (across in city LD and MH inpatient and out of city provision) by 31st March 2019, and interim plan is to reduce to 14 by 31st March 2018 (figures includes patients with learning disability within a mental health inpatient bed). To develop credible community based alternatives to hospital care, integrating the mental health and learning disability speciality skills to meet the needs of this population. Autism and Neuro Development - Meet the requirements of the Autism Act and "Think Autism" Statutory guidance, and to develop an action plan to address shortfalls by end of quarter 3 2016, in order to ensure implementation plan commences by April 2017 to enhance the lives of people with autistic spectrum condition in the city Parity of Esteem - Staff to have appropriate skills, knowledge and attitudes regarding physical health needs to the population they support (ensuring maximum uptake of appropriate Annual Health Checks, screening and access to physical healthcare pathways through signposting and support. Staff to ensure equality of access fir SHSC services for everyone, consistent with the Equality Act, Greenlight Toolkit, Prime Minister's Challenge on Dementia and Think Autism Work collaboratively with providers of physical care (Primary Care and STH) to reduce physical health deterioration and avoidable admissions to STH from SHSC inpatient wards (parity of esteem). MHLDA parity of esteem in physical health settings will be improved through the Mental Health Liaison service and associated pathways which SHSC will contribute to this aim through integrating care delivered in the community aims to prevent avoidable health deterioration. Crisis and Early Intervention Services - Review and evaluate current Crisis Pathways to optimally reconfigure services to better meet the needs of the population, including more inclusive response to people with different needs (e.g. learning disability and autism). Effectively manage the Section 136 pathways and inpatient resource, including the development of a Psychiatric decision Unit Deprivation of Liberty: ensure that every person eligible for aftercare, or who is an in-patient, has care arranged that is compliant with Mental Capacity Act. Primary Care Mental Health & Acute Care admission Prevention – Develop the model of primary and community out of hospital care through planned prevention and planned care to reduce urgent care. . SHSC to work with CCG to deliver a new model for joint partnership working and level of support to practices and/or neighbourhoods to support an agreed number of people effectively in this setting. (to be agreed with CCG and Primary Care). Acute Care Reconfiguration - SHSC to provide evaluation of Acute Care Reconfiguration plan in April 2017 showing that the reinvestment in community services achieved from 2016/17 QIPP reinvestment plans (including day care service for patients with complex needs (Personality Disorder service) and OOH) has resulted in the expected outcomes. Aftercare: ensure that all aftercare is funded in line with local joint resource allocation agreement, including leave of absence and CTOs.	SCC - Mental Health Act section 117 Aftercare arrangements: Joint resource allocation with a jointly developed framework of high cost providers. Jointly funded section 117 reviewed to ensure provision is of the right level, quality and best value. Agreed policy with CCG, including for discharges from s117. Outcome: joint working with providers to reduce the risk of providers playing off to commissioners. One clear market development plan, less likely to give mixed messages to the market. Reduced delayed discharges. To support CCG to extend the reach of Personal Health Budgets beyond continuing healthcare. Mental Health Act section 136: To have a clear offer to under 18yrs with consideration on a South Yorkshire wide approach to ensure The Mental Health Act Assessment can be carried out. This includes resources for AMHPs Service. Outcome: other areas passing resources to SCC AMHPs , clear offer for south Yorkshire, young people have care plans for their local area. Accommodation: To have a clear offer to people with high needs which is an alternative to 24hr residential or Nursing. To understand and increase the accessibility of mental health services to people who are homeless or unsettled accommodation (results from SCC homeless audit reports that 80% of people self-reported Mental ill Health). Outcome: Earlier discharge from acute care and less people in residential and nursing with a reduced cost to SCC and CCG (117 Early intervention and prevention: To link up projects with universal services in People Keeping Well, this includes the Grants which are awarded by both SCC and CCG. Outcome: to support move to neighbourhood approach by supporting local areas not cohorts of diagnosed people. Increase the local offer Public Health: To work with Public health to deliver a suicide prevention strategy. Outcome: reduction in the rate of suicides. Employment: We know that only 5% of adults on with SMI on CPA are in employment this is below the Yorkshire and Humber average. We also know that a reported mental health condition is the most common disorder for people on Employment Support Allowance. There are opportunities with the Sheffield City Region (Devolution) to develop projects to increase the number of people in employment with mental illness. Outcome : more people supported into employment use of opportunities in devolution. Step –down from Mental Health Acute: to review the offer, need, provision for people leaving acute care in to stepdown provision. All partners to ensure people are supported to live in non-acute settings . Ensure embedding of a person centred approach for ongoing care. YAS/SYP work on crisis care concordat in partnership ALL - Work collaboratively with providers of mental health care and support to reduce physical health deterioration and avoidable admissions to STH from SHSC inpatient wards (parity of esteem)

Sheffield Health and Social Care

Intentions	Provider dependencies
In depth service and financial review : To contribute to the review of the pattern of service delivery and spend across SHSC contract and the wider £130m spend on MH in the city. Understand and agree actions from findings on where CCG resource is most effectively used in providing MHLDA services for Sheffield population in order to align care in the right place at the right time in the least restrictive environment . Commit to participating in a Value Improvement Programme in relation to this, and to identify future QIPP opportunities and reinvestment plans that achieve ambitions outlined in 5 years forward. Dementia Care: SHSC to work with CCG, LA and other partners to develop a new vision and strategy for dementia care in the city Work with partners to ensure people are supported to live in the least restrictive environments in non-acute settings by exploring creative alternative partnerships and models of service delivery. Ensure embedding of a person centred approach for ongoing care. Prevention: Commitment to adding value to every clinical contact in secondary care by treating tobacco dependence, by implementing the London Clinical Senate model http://www.londonsenate.nhs.uk/helping-smokers-quit/ Employment and health: commitment to supporting the success of the Sheffield City Region employment and health programme as part of the STP, including identifying and referring appropriate clients Resilience and response - Work with provider partners at neighbourhood level to agree development priorities that integrate SHSC community offer. To include a consistent, pro-active approach to the promotion of health and wellbeing, risk stratification and the deployment of health and care resource. Efficient and effective community services - Development of Workforce Development plan to include assessment of workforce needs and exploration of partnership working. To include development of the person-centred approach, care planning, patient activation and potential use of enabling technologies. Crisis reduction - Work with partners in an interdisciplinary way to develop and deliver schemes that aim to reduce crisis, provide clinically and cost effective alternatives to hospital in the community and promote independence. – such as dementia case management, DRRT, MH liaison Intermediate care - Take the opportunity to collaborate on the provision of a neighbourhood-focused Intermediate care service (particularly in relation to care for people with dementia but also in recognition of the high level of cognitive impairment within general intermediate care services). Children's - To work with SC FT and CCG to develop the pathway of care for emotional wellbeing and mental health for young people To reduce premature mortality and provide services in the most appropriate, accessible and least restrictive environment for people with mental illness, LD, autistic spectrum condition and dementia Think autism – to deliver the recommendation of the national strategy to enable people with autistic spectrum conditions to live more fulfilling and rewarding life Dementia – to work on a local improved strategy for dementia to ensure services are configured to adequately meet anticipated incidence of dementia Engage to deliver shorter times from referral to diagnosis and integration of dementia needs into care plans. Carter review recommendations - develop and deliver against plans for reconfiguration of 'back office functions'.	STH - Participate in relevant emerging streamlined strategic and operational infrastructure (e.g. MH Delivery Board/ MH Liaison Alliance Contract Group) Deliver Parity of Esteem by ensuring equity of access to STH services for people with MH/LD/Autism/dementia and to correctly identify and co-manage clients with the MH Liaison service Identify the MH/LD/Autism/Dementia comorbidities of STH patients are understood for people under the care of STH for physical health conditions (working with the MH Liaison Service and in house STH psychology expertise) Appropriate management of people who are brought to A&E who require a Section 136 Place of Safety response, and to manage their physical care needs as part of their care pathway Ensure staff are trained to appropriate levels of knowledge, skills and attitudes relating to e.g. Mental Health First Aid/ Autism Awareness/ LD Awareness/ Dementia Friendly Identify champions for each ward area for MHLDA who have additional knowledge and skills, with overarching leadership in place (as per LD and Dementia Nurse Leadership and champion approach) Implement relevant recommendations in Think Autism Strategy, developing an action plan by Quarter 4 of 2016 ready to implement in April 2017. To work with partners to ensure people are supported to live in non-acute settings . Ensure embedding of a person centred approach for ongoing care. Primary Care - To work with partners at neighbourhood level in an interdisciplinary way to ensure integration of mental health (including learning disabilities, dementia and autism) alongside physical health. To include development of the person-centred approach, care planning patient activation and potential use of enabling technologies. VCF - To explore and propose models of service delivery within the VCF sector, through networked consortia relationships and alliances, to help address waiting times and service gaps as well as other initiatives within this document, as both adjuncts and alternatives to mainstream services To explore "invest to save" innovative opportunities, and suggest these to the CCG. To attend the Mental Health/LD/Autism/ Dementia Delivery Board to represent the VCF sector network/ alliance, and to present alternative viewpoints within the health and social care landscape during these discussions. To support commissioners to extend the reach of Personal Health Budgets beyond continuing healthcare

Primary Care – including Primary Care Sheffield

Intentions	Provider dependencies
Urgent Primary Care – explore development of urgent primary care access solutions working collaborative with STHFT and One medicare Increase capacity of GP assessment service to support CASES receiving routine, urgent, 2ww and consultant to consultant referrals in the existing 7 CASES pilot specialties from 1 April 2017. Increase capacity of GP assessment service to support CASES receiving all referrals in all specialties -implemented by March 31 2018 Localities to work with GP practices to reduce referral and diagnostic variation Engage in neighbourhoods development to offer community services at local level, including explore opportunities to bring together individual practice LCSs Workforce Primary care to upskill to deliver enhanced services, engage proactively and effectively in how to provider greater testing and diagnostic in the community plus wider neighbourhoods Developments for the provision of non-core services, previously under PMS, through appropriate investment within the PC Strategy Engage in opportunities presented for Clinical and Managerial development programmes take steps to staff structures and roles to support practice staff to be fit for future of PC. Engage in the Productive GP Programme roll out. Promote change and sustainability to ensure Primary Care is able to play its role in promoting and ensuring system wide sustainability. Support the development of a broader range of clinical and managerial skills to include Clinical Pharmacist and Physician's Associates in Primary Care model to deliver an integrated primary care healthcare team. In support of patients managing their conditions. Also to include the Care Navigator role amongst primary care front of house staff to signpost patients effectively to other appropriate interventions including social prescribing Support developments in research and education in Primary Care Setting. Resilience and response - Work with provider partners at neighbourhood level to agree development priorities. To include a consistent, pro-active approach to the promotion of health and wellbeing, risk stratification and the deployment of health and care resource. To take a proactive approach to prevention of disease e.g. diabetes. To proactively identify those approaching their end of life, care plan and work with other providers to enable them to die in their preferred place. Efficient and effective community services - Development of Workforce Development plan to include assessment of workforce needs and exploration of partnership working. To include development of the person-centred approach, care planning, patient activation and potential use of enabling technologies. Support further development of community IVs to deliver at scale and pace in 17/18 to maximise benefits Mental Health - To work with partners at neighbourhood level in an interdisciplinary way to ensure integration of mental health (including learning disabilities, dementia and autism) alongside physical health. To include development of the person-centred approach, care planning patient activation and potential use of enabling technologies. Work with PCS as key provider of GP access fund can be used to support the implementation of GP strategy - increasing access and support urgent care strategy.	ALL – to engage in a facilitative manner to support commissioners in their intent to develop the Primary Care offer and delivery SCC – development of employment and health pathways through Sheffield City Region work Health and Wellbeing Board – support for delivery of Sheffield Lives programme Urgent Care – explore development of joined-up urgent care access solutions working collaborative with PCS, STHFT and One medicare. STH, SHSC – Engage productively to share expertise from within the organisational form where existing resource is currently engaged

Primary Care – including Primary Care Sheffield

Intentions	Provider dependencies
Crisis reduction - Work with partners in an interdisciplinary way to develop and deliver schemes that aim to reduce crisis, provide clinically and cost effective alternatives to hospital in the community and promote independence. Readmissions – work with partners across the city to reduce readmission rates whilst also minimising length of stay Intermediate care - Take the opportunity to collaborate on the provision of a neighbourhood-focused Intermediate care service. To ensure optimal provision of medical care and support to future bed-based intermediate care and work to reduce the unwarranted variation in the use of intermediate care. Children's - Primary care providers are expected to as appropriate collaborate with the work to explore potential locality delivery of services (in the scope for the child health programme) and utilise agreed referral processes/access routes. Primary care providers are expected to collaborate with partners as appropriate to support the pilot of an integrated primary care model with the SCH emergency department. Prevention - Lead population approaches to the management of cholesterol and blood pressure, atrial fibrillation anticoagulation, and scaling up delivery of brief interventions on smoking and alcohol. This will include the potential for lifestyle services such as smoking cessation and weight management to be delivered through Neighbourhoods Delivery of Primary Care aspects of Sheffield Lives programme, such as: supporting the success of the employment and health programme by identifying and referring appropriate patients; delivery of population approaches to the management of cholesterol and blood pressure, atrial fibrillation anticoagulation; and scaling up delivery of very brief interventions especially for smoking and alcohol. Urgent Primary Care – explore development of urgent primary care access solutions working collaboratively with STHFT and One medicare	

Sheffield Teaching Hospital

Intentions

Avoid inappropriate attendance and admissions - Implement effective systems to redirect those with primary care/minor ailments presenting at A&E to appropriate alternatives. Implement assess to admit pathways for clinically appropriate patients. Develop the assessment model with telephone support consultants to GPs, access to urgent planned care and signposting to alternatives. Participation by secondary care clinicians in a Value Improvement Programme to improve use of resources and good medical stewardship of resources. Support further development of community IVs to deliver at scale and pace in 17/18 to maximise benefits

Readmissions – work with partners across the city to reduce readmission rates whilst also minimising length of stay

Improve internal flow and reduction in length of stay - Implement proactive care and discharge planning with routine use of planned discharge dates determined by a consultant. Implement best practice guidance for patient flow and discharge processes including moving towards a significant number of patients discharged in the morning, implementation of the 4 priority clinical standards (Time to consultant review, Diagnostics, Consultant directed interventions, ongoing review in high dependency areas).

For complex patients implement the discharge to assess trusted assessor models 7 days a week through the agreement of a joint delivery plan with SCC/CHC.

Urgent care centre - work with partners to support the implementation of a collocated urgent care centre on the NGH site that meets appropriate national commissioning standards (implementation to commence October 2016). TO be integrated with all primary care provision accessed outside general practice and pharmacies.

Support the implementation of the mental health liaison service (as outlined in the mental health section).

Supporting and strengthening referral - Full engagement in CASES pilot in 7 specialties in 16/17 and engage in implementing an expanded pilot scope and scale in 17/18.

Expand the CASES model where appropriate to include all referrals including urgent referrals, 2 week wait referrals in selected specialties, early examples dermatology, ENT, urology by Q2 2017/18;

Expand CASES model to all specialties during 17/18.

Consultant mentors aligned with PCS assessing GPs to develop and extend existing mentorship plans for 17/18. Plans to be agreed via Joint CASES Delivery Programme Board by 31 March 2017.

Mentors to input into service and whole journey pathway development

Provide dedicated consultant and specialist nurse time for GP and practice nurse education from April 2017 ;

Reduce first total outpatient first appointments by 10% (and associated follow-on procedures by 3%), expand model to all CCG commissioned GP referred specialities by Q2 2017/18;

Consultant to consultant referrals: revise agreement to include use of CASES where non urgent/non 2ww by April 2017. Reduce C2C referrals by 20% by end of 2017-18;

Implement clinical guidance collaboratively developed for GPs within STHFT for use by secondary care clinicians where appropriate, e.g. diagnostics, repeat testing guidelines

Reduce outpatient follow-up attendances - Commence a 'no 'routine' follow-ups principle applied in all specialties from April 2017 implement follow-up models that reduce follow up activity

Implement OPFU ratios to best benchmark or below as per NHS Better Care, Better Value Indicators (incorporating Opportunity Locator) from April 2017. Implement restructured model for outpatient services to include virtual/telephone follow-ups (consultant and other clinician led) in place of face-to-face, advice and guidance to GPs and empowering patients through care planning, community provided follow-ups, patient-determined long-term follow-up frequency. Jointly developed through CASES.(continues…)

Provider dependencies

SCC - For complex patients collaborate to enable implementation of the discharge to assess trusted assessor models 7 days a week through the agreement of a joint delivery plan.

Work with provider partners at neighbourhood level to agree development priorities. To include a consistent, pro-active approach to the promotion of health and wellbeing, risk stratification and the deployment of health and care resource.

Development of Workforce Development plan to include assessment of workforce needs and exploration of partnership working. To include development of the person-centred approach, care planning, patient activation and potential use of enabling technologies.

Work with partners in an interdisciplinary way to develop and deliver schemes that aim to reduce crisis, provide clinically and cost effective alternatives to hospital in the community and promote independence.

ALL - Take the opportunity to collaborate on the provision of a neighbourhood-focused Intermediate care service

SCH - Pilot integrated primary care model with the emergency department.

Implement the rapid access clinic in a sustainable way, moving urgent care into planned care.

YAS - To reduce conveyance through maximising the use of community alternatives (existing and new) through continuing to offer expert clinical advice via the ECP service over weekends as well as core week days (support 7 day working).

To reduce conveyance to A&E through Dispatch on Disposition and code review pilots through 'hear and treat' and 'see and treat'. As advocated by the A & E improvement plan – 5 interventions.

All Sheffield partners to explore alternative pathways of care for people in crisis in the community. To include OK to stay and the development of new pathways to maximise the number of people who can receive care in their own home / intermediate care rather than hospital to include MH/LD/autism/dementia

111 - To work with partners on the work programme set out by the Urgent and Emergency Care Network to ensure deliverables are achieved as set out in the route map.

Develop to reflect the national guidance setting out integration of 111/999.

Sign post to local services in Sheffield and develop the functionality to support direct booking to GP appointments (in and OOHs).

Collaborate with Sheffield GP OOHs service to enable integrated working so as to ensure wherever possible admissions are avoided by timely access to GPs and community services.

Intentions	Provider dependencies
Reduce outpatient follow-up attendances – (cont) Implement group consultations involving more than one patient or clinician Interpreting investigative results and communicating directly with patients where no primary care action required from April 2017 Agree with the CCG clinical pathways where an open OPFU appointment will be available in place of routine follow-ups. Implement remote monitoring and shared care records to support collaborative care of patients across providers. Work collaboratively with primary care to establish OPFU services in the community via Neighbourhoods or other appropriate provider mechanisms Supporting diagnostics (including cancer services) - Engage in the development of guidelines and pathways to deliver enhanced access to diagnostic services to support elective care pathways and achievement of cancer waiting times. 'Whole Journey' Patient Pathways - Work collaboratively with SCCG to develop 'whole journey' pathway guidelines covering primary care guidance, referral diagnostics pre-operative assessment, enhanced discharge, follow up and self-care/long term care: 2016/17 - complete in-patient/Outpatient/Day Case Pathway Reviews of identified high impact pathways in four specialties and develop agreed pathways. 2017/18 - fully implement agreed pathways for four specialties, complete review of five specialties, agree pathways and commissioner/provider to agree number to be implemented, monitor and evaluate. 2018/19 – complete pathway implementation if required, monitor and evaluate. Developing new models for care closer to home - Enhanced self-care - work with commissioner, community and primary care providers to develop and agree guidelines for management of key conditions in primary care to include enhanced support for self-management, services for patients to support active self-care. Develop rapid access clinics for patients managed with higher acuity in primary care; agreeing the capacity and demand plan with partners, specifically SCCG and localities for example Heart Failure, COPD/asthma, MGUS (haematology), prostate cancer survivorship, inflammatory bowel disease, valvular heart disease, Parkinson's Disease and Epilepsy, dermatological conditions requiring DMARDs, ocular hypertension. Identify alternative service models that may utilise community/primary care workforce supported by STH consultants where appropriate leading to Jointly developed pathways guidelines and community based, consultant led services commencing April 2017. MSK combined with CASES approach to develop educational opportunities to enable GPs to manage more MSK work in surgeries, reducing demand on secondary care services, from April 2017 completed by end Q2 2017. Pre-operative assessments: developing primary care based assessment for low risk patients for implementation before Q3 2017/18. Community geriatrician services: developing the general physician role in primary care: avoiding attendance at multiple specialty clinics by Q3 2017/18. Work with the CCG and partners to evaluate and redesign existing community services delivered by STH in the CASES pilot specialties to enable new service specifications to be finalised by 31 March 2017 Regional elective care reconfiguration – by reducing patients receiving acute care support a focus on reconfiguration and STHFT as a centre of excellence for tertiary care in line with timescales determined through the STP process. Carter review recommendations - develop and deliver against plans for reconfiguration of 'back office functions'. Deliver key national performance targets - Ensure flexible clinic capacity to deliver 18 week referral to treatment targets on a whole year basis and support urgent care system pressures as part of system resilience planning for 2017/18	SHSC - Resilience and response Work with provider partners at neighbourhood level to agree development priorities that integrate SHSC community offer. To include a consistent, pro-active approach to the promotion of health and wellbeing, risk stratification and the deployment of health and care resource. To ensure SHSC Efficient and effective community services Development of Workforce Development plan to include assessment of workforce needs and exploration of partnership working. To include development of the person-centred approach, care planning, patient activation and potential use of enabling technologies. Crisis reduction Work with partners in an interdisciplinary way to develop and deliver schemes that aim to reduce crisis, provide clinically and cost effective alternatives to hospital in the community and promote independence. – such as dementia case management, DRRT, MH liaison All- Take the opportunity to collaborate on the provision of a neighbourhood-focused Intermediate care service (particular in relation to care for people with dementia but also in recognition of the high level of cognitive impairment within general intermediate care services). Independent Sector - To work with ASR to develop the offer of the IS in supporting care outside of hospital, to include but not be limited to intermediate care bed provision, home care provision within the context of interdisciplinary team working at neighbourhood level, workforce development to ensure staff are able to respond to the increasing demands of supporting more people and greater complexity within the community setting. Care homes –engage with commissioners / providers to enable coordination of existing and new initiatives to reduce the number of hospital admissions and enable people to die in their care home. To support commissioners to extend the reach of Personal Health Budgets beyond continuing healthcare.

Sheffield Teaching Hospital

Intentions	Provider dependencies
Standardising care and delivering efficiency - From April 2017 STH manager/clinical representative for to attend bi-annual benchmarking review meetings with CCG and public health colleagues to review latest data and identify subsequent actions. Input into identification of procedures of limited clinical value and work collaboratively to expand the list of procedures of limited clinical value. Participation in potential Value Improvement Programme as part of this Support efficient patient transport services, ensuring application of the rules and guidance for use of patient transport services, reducing demand and aborted journeys in line with agreed timescales and implementation plans before April 2017. Resilience and response - Work with provider partners at neighbourhood level to agree development priorities. To include a consistent, pro-active approach to the promotion of health and wellbeing, risk stratification and the deployment of health and care resource. In relation to promotion of health and wellbeing, add value to every clinical contact by treating tobacco dependences by implementing the London Clinical Senate model http://www.londonsenate.nhs.uk/helping-smokers-quit/ Efficient and effective community services - To have in place a Workforce Development plan to include assessment Scaling up use of brief interventions in clinical practice Efficient and effective community services - To have in place a Workforce Development plan to include assessment of workforce needs and exploration of partnership working. Development of the person-centred approach, care planning patient activation and potential use of enabling technologies. To work collaboratively with primary care to identify those approaching their end of life, care plan and enable them to die in their preferred place. To work collaboratively with the CCG to resolve disagreements about which services should be provided by Community Services and which from independent providers, such as PEG care, with consequential budgetary adjustments. Crisis reduction - Work with partners in an interdisciplinary way to develop and deliver schemes that aim to reduce crisis, provide clinically and cost effective alternatives to hospital in the community and promote independence. -such as the development and delivery of the enhanced community IV offer, falls and fracture prevention, OK2S, enhanced SPA function Intermediate care - Take the opportunity to collaborate on the provision of a neighbourhood-focused Intermediate care service Mental Health - Participate in relevant emerging streamlined strategic and operational infrastructure (e.g. MH Delivery Board/ MH Liaison Alliance Contract Group) Deliver Parity of Esteem by ensuring equity of access to STH services for people with MH/LD/Autism/dementia and to correctly identify and co-manage clients with the MH Liaison service Identify the MH/LD/Autism/Dementia comorbidities of STH patients are understood for people under the care of STH for physical health conditions (working with the MH Liaison Service and in house STH psychology expertise) Appropriate management of people who are brought to A&E who require a Section 136 Place of Safety response, and to manage their physical care needs as part of their care pathway Ensure staff are trained to appropriate levels of knowledge, skills and attitudes relating to e.g. Mental Health First Aid/ Autism Awareness/ LD Awareness/ Dementia Friendly (continues)	Primary Care - collaborate with partners as appropriate to support the implementation of a collocated urgent care centre on the NGH site (implementation to commence October 2016). We will seek to integrate this with all primary care provision accessed outside general practice and pharmacies Support the implementation of the mental health liaison service Primary Care Sheffield to increase capacity of GP assessment service to support CASES receiving routine, urgent, 2ww and consultant to consultant referrals in the existing 7 CASES pilot specialties from 1 April 2017. Primary Care Sheffield to increase capacity of GP assessment service to support CASES receiving all referrals in all specialties -implemented by March 31 2018 Work with provider partners at neighbourhood level to agree development priorities. To include a consistent, pro-active approach to the promotion of health and wellbeing, risk stratification and the deployment of health and care resource. To take a proactive approach to prevention of disease e.g. diabetes. To proactively identify those approaching their end of life, care plan and work with other providers to enable them to die in their preferred place. Development of Workforce Development plan to include assessment of workforce needs and exploration of partnership working. To include development of the person-centred approach, care planning, patient activation and potential use of enabling technologies. Work with partners in an interdisciplinary way to develop and deliver schemes that aim to reduce crisis, provide clinically and cost effective alternatives to hospital in the community and promote independence. All - Collaborate on re commissioning intermediate care. To ensure optimal provision of medical care and support to future bed-based intermediate care and work to reduce the unwarranted variation in the use of intermediate care.

Intentions	Provider dependencies
Mental Health – (cont) Identify champions for each ward area for MHLDA who have additional knowledge and skills, with overarching leadership in place (as per LD and Dementia Nurse Leadership and champion approach) Implement relevant recommendations in Think Autism Strategy, developing an action plan by Quarter 4 of 2016 ready to implement in April 2017. To work with partners to ensure people are supported to live in non-acute settings . Ensure embedding of a person centred approach for ongoing care. Children's Community Health Programme – Sexual Health – Alongside providing system leadership STHFT are expected to Work with partners (SCCG and other providers through Sexual Health Redesign Group) to redesign and enhance community based sexual health services. Collaborate to construct and ensure robust pathways for access to sexual health services. Ensure access to contraception, long acting reversible contraception is available across termination of pregnancy and maternity services. Work with SCCG to review impact of co location of services. Implement universal opt out HIV testing across emergency departments/MAUs Offer HIV testing within termination of pregnancy service Implement a new clinical pathway in the emergency department for provision of post exposure prophylaxis following sexual exposure. Maternity Collaborate with SCCG to develop the case loading midwifery lead care model within locality hubs for antenatal and post natal care. Work with SCCG to enable a choice offer and personalisation of provision in line with Better Births and the four choices of maternity provision. Implement new monitoring of quality and outcomes in line with Safer Births and the national Care bundle	

Intentions	Provider dependencies
Mental Health Act section 117 Aftercare arrangements: Joint resource allocation with a jointly developed framework of high cost providers. Jointly funded section 117 reviewed to ensure provision is of the right level, quality and best value. Agreed policy with CCG, including for discharges from s117. Outcome: joint working with providers to reduce the risk of providers playing off to commissioners. One clear market development plan, less likely to give mixed messages to the market. Reduced delayed discharges. To support CCG to extend the reach of Personal Health Budgets beyond continuing healthcare. Mental Health Act section 136: To have a clear offer to under 18yrs with consideration on a South Yorkshire wide approach to ensure The Mental Health Act Assessment can be carried out. This includes resources for AMHPs Service. Outcome: other areas passing resources to SCC AMHPs , clear offer for south Yorkshire, young people have care plans for their local area. Accommodation: To have a clear offer to people with high needs which is an alternative to 24hr residential or Nursing. To understand and increase the accessibility of mental health services to people who are homeless or unsettled accommodation (results from SCC homeless audit reports that 80% of people self-reported Mental ill Health). Outcome: Earlier discharge from acute care and less people in residential and nursing with a reduced cost to SCC and CCG (117 Early intervention and prevention: To link up projects with universal services in People Keeping Well, this includes the Grants which are awarded by both SCC and CCG. Outcome: to support move to neighbourhood approach by supporting local areas not cohorts of diagnosed people. Increase the local offer Public Health: Deliver a suicide prevention strategy. Outcome: reduction in the rate of suicides. Employment: We know that only 5% of adults on with SMI on CPA are in employment this is below the Yorkshire and Humber average. We also know that a reported mental health condition is the most common disorder for people on Employment Support Allowance. There are opportunities with the Sheffield City Region (Devolution) to develop projects to increase the number of people in employment with mental illness. Outcome : more people supported into employment use of opportunities in devolution. Step –down from Mental Health Acute: to review the offer, need, provision for people leaving acute care in to stepdown provision. To work with partners to ensure people are supported to live in non-acute settings . Ensure embedding of a person centred approach for ongoing care. Children's Emotional wellbeing and mental health - Work with partners (SCCG and providers) to deliver the Future in Mind Transformation Plan. Lead on the Early Intervention and Resilience, and Developing the Workforce workstreams. Lead the development of the Future in Mind priorities including universal early intervention through schools, improving emotional wellbeing and resilience and developing a robust workforce plan. Support the development of the YIAC by Sheffield Futures. Engage in the redesign and delivery of CAMHS services. Work on Transforming Care/Think Autism/Crisis Care Concordat/Liaison/Dementia Integrated Team	All - Collaborate on re commissioning intermediate care. To ensure optimal provision of medical care and support to future bed-based intermediate care and work to reduce the unwarranted variation in the use of intermediate care ALL – to engage in a facilitative manner to support commissioners in their intent to develop the SCC offer and delivery

Intentions	Provider dependencies
Community Health Programme – Working with CCG and SCC to sustain the local healthcare provision and provide more care within community settings and less care inside hospital. Readmissions – work with partners across the city to reduce readmission rates whilst also minimising length of stay Sexual Health – Work with partners (SCCG and other providers through Sexual Health Redesign Group) to redesign and enhance community based sexual health services, including developing the role of Primary Care.. Collaborate to construct and ensure robust pathways for access to sexual health services. Children with complex needs – Collaborate with partners on the implementation of a joint needs based approach to care packages across education, health and social care. Work with partners to review respite provision. Transitions to Adulthood: Ensure a Checklist is sent to the CCG so that each child eligible for continuing healthcare, can be screened for eligibility for adult continuing healthcare. Checklist to be sent within 2 weeks of their 16th birthday. Housing Providing city leadership and working in partnership: The CHS will work with other services and organisations to achieve the best possible outcomes for tenants and their families. Helping people to help themselves: Enabling tenants to be more self-reliant by providing information and early support to help them independently maintain their tenancy. Providing affordable and cost-effective services: Housing+ will support the long-term sustainability of the HRA Business Plan and so help ensure that the commitments made to tenants within the Plan can be fulfilled. Being creative and innovative: The implementation of Housing+ will result in a major shift in the Council's approach to housing management, in line with the ambitious vision developed by tenants for their housing service. Focusing on early intervention and prevention: A key part of Housing+ will be identifying and addressing potential issues as soon as they arise, reducing the need for costly high-level interventions later on. Providing flexible and responsive services: By tailoring the approach according to the needs of each household, the Housing+ model will help ensure that tenants receive the services they need, when they need them.	

YAS, 111, SYFS and SYP

Intentions	Provider dependencies
YAS – There is a joint commissioning arrangement across the YAS footprint and these intentions reflect those agreements – Sheffield influences the YAS contract intentions through the lead commissioner arrangements the headline intentions are • Increasing the number of calls transferred for clinical advice to reduce demand on 999 services (Hear, see and treat) • The development of a Clinical Advice & Assessment service linked to local health and care systems existing models of care • The piloting of NHS E led changes to Despatch on Disposition and 999 call coding • Requirements to ensure NHS 111 and GP OOH services are jointly planned • A requirement for 999/111 access to care records • The requirement to deliver more services as 'see and treat' rather than 'see, treat and convey'. • Direct booking of patients from a Clinical Advice and Assessment service into third parties. To continue to work in partnership to deliver ongoing as well as new initiatives through the Crisis Care Concordat making progress on priority actions, and address gaps that are identified. Work with Sheffield partners to explore alternative pathways of care for people in crisis in the community. To include OK to stay and the development of new pathways to maximise the number of people who can receive care in their own home / intermediate care rather than hospital. Engage in the Driving Value programme, to identify and implement appropriate opportunities To work with partners on the work programme set out by the Urgent and Emergency Care Network to ensure deliverables are achieved as set out in the route map. It is expected that 111 will develop to reflect the national guidance setting out integration of 111/999. Locally it is expected that 111 will be enabled to sign post to local services in Sheffield and develop the functionality to support direct booking into appointments for a range of providers including Primary Care (in and OOHs). For 111 and OOHs service to be planned together to enable integrated working so as to ensure wherever possible admissions are avoided by timely access to GPs and community services To address the needs of vulnerable patients through partnership working with health and social care providers: e.g. accessible Fire Safety in the Home materials	STHFT - Enforce the rules and guidance for use of patient transport services, reducing demand and aborted journeys in line with agreed timescales and implementation plans before April 2017. ALL – to engage in a facilitative manner to support commissioners in their intent to work with the 111 services ALL – to engage in a facilitative manner to support commissioners in their intent to work with the Police and Fire services sector To support commissioners to extend the reach of Personal Health Budgets beyond continuing healthcare

Sheffield Voluntary, Charitable and Faith Sector

Intentions	Provider dependencies
Engage in the development of an Accountable Care System including the contractual models to support as appropriate Work with Active Support and Recovery to develop the offer from the VCF sector within each of the neighbourhoods and at a city wide level to maximise the use of resource. Promote health and wellbeing and person-centred care. Reduce social isolation and loneliness in at-risk populations (Age Better). Support commissioners to extend the reach of Personal Health Budgets beyond continuing healthcare. Engage in delivery of additional social prescribing activity including access arrangements To explore and propose models of service delivery within the VCF sector, through networked consortia relationships and alliances, to help address waiting times and service gaps as well as other initiatives within this document, as both adjuncts and alternatives to mainstream services. To attend the Mental Health/LD/Autism/ Dementia Delivery Board to represent the VCF sector network/ alliance, and to present alternative viewpoints within the health and social care landscape during these discussions. To support commissioners to extend the reach of Personal Health Budgets beyond continuing healthcare Support work on the delivery of initiatives within the Crisis Care Concordat	ALL – to engage in a facilitative manner to support commissioners in their intent to work with VCF sector All - To work with VCF sector partners to ensure that initiatives that are funded are those that support the delivery of the commissioning/planning intentions of the city.

Independent Sector (e.g. - independent hospital care, nursing homes)

Intentions	Provider dependencies
Engage in the development of an Accountable Care System including the contractual models to support as appropriate Collaborate as appropriate with transformation changes, including elective care pathways, initiatives such as CASES, Personal Health Budgets and new models of care/Positive Behaviour support To work with ASR to develop the offer of the IS in supporting care outside of hospital, to include but not be limited to intermediate care bed provision, home care provision within the context of interdisciplinary team working at neighbourhood level, workforce development to ensure staff are able to respond to the increasing demands of supporting more people and greater complexity within the community setting. Engage with commissioners / providers to enable coordination of existing and new initiatives to reduce the number of hospital admissions and enable people to die in their care home.). To support commissioners to extend the reach of Personal Health Budgets beyond continuing healthcare. Work with us on Transforming Care Partnership cohorts of people being discharged from hospital	ALL – to engage in a facilitative manner to support commissioners in their intent to work with the independent sector

Sheffield commissioners' supporting actions

This table details some of the commitments that Sheffield CCG and the City Council will need to make in order to support the delivery of the provider intentions and dependencies detailed in the previous tables.

Programme	Commitments
Whole system transformation	Commissioners support to help shape and enable this and to work to ensure that all providers are and remain engaged For appropriate transformations Identify and describe/share granular detail about the level of resources available from across the system, and begin to map out how this could look at citywide/ local/ neighbourhood levels to develop a detailed plan for resource deployment Support the aim of having 1 plan per patient across the system and the infrastructure to enable this to happen Commitment to find opportunities to use commissioning processes and financial levers to support an integrated model of service delivery and to encourage and enable services to share capabilities in collaborative ways. Support the development of a set of system-wide behaviours that underpin the outcomes we have to achieve Develop robust processes to work collaboratively with providers to ensure that patient and public feedback supports the development of services, resulting in improved experience
Urgent Care	SCC - Ensure robust demand modelling and commissioning of independent sector care provision SCCG - Ensure incentives and behaviours are aligned so that discharge to assess trusted assessor models can be implemented through collaborative work with all key partners. Explore whether the Vanguard developments for care homes would safely enable fewer residents to be admitted to hospital.
Planned Care	SCCG - set a flat rate payment for none face-to-face activity in 2016/17.
VCF and independent Sector	Work jointly with Voluntary, charitable and faith sectors, as well as Commercial Sector partners to align community and neighbourhood programmes giving a consistent message, consistent support and creating the greatest opportunities for communities to take full advantage of the support and activities available to them. To work with VCF sector partners to ensure that initiatives that are funded are those that jointly agreed between CCG and SCC, and support the delivery of the commissioning/planning intentions of the city.
Community Offer	To work with partners to ensure people are supported to live well in non-acute settings. Ensure embedding of a person centred approach for ongoing care, by resolving disagreements about which services should be provided by Community Services and which from independent providers, such as PEG care, with consequential budgetary adjustments. Work with provider partners at neighbourhood level to agree development priorities. To include a consistent, pro-active approach to the promotion of health and wellbeing, risk stratification and the deployment of health and care resource. Development of Workforce Development plan to include assessment of workforce needs and exploration of partnership working. To include development of the person-centred approach, care planning, patient activation and potential use of enabling technologies. Work with partners in an interdisciplinary way to develop and deliver schemes that aim to reduce crisis, provide clinically and cost effective alternatives to hospital in the community and promote independence. Provide support to make progress on and leadership for recommissioning intermediate care to collaborate on the provision of a neighbourhood-focused Intermediate care service
Mental Health	There will be Agreed s117 policy, including for discharges from s117. To work with partners to ensure people are supported to live in non-acute settings . Ensure embedding of a person centred approach for ongoing care.
Children's	NHSE - Work with CCG on the further development of co commissioning for emotional wellbeing and Mental Health for implement the STAR service and Amber lodge model of care. Work with CCG to development the care pathway for ASD and ADHD as part of the redesigned neuro disability pathway CCG and SCC - Ensure that all children who may be eligible for adult continuing healthcare (when they reach 18) are assessed for eligibility by their 17th birthday, on receipt of a Checklist. CCG and SCC - promote the Future in Mind Transformation Plan jointly and agree the allocation of Future in Mind resource
Neighbourhoods	Support the principle of neighbourhood developments based on a ground up approach, encouraging plurality of approach to meet specific needs in line with the overarching transformation principles. Take a system-coordination approach to minimise duplication finding effective ways to facilitate cooperat8ion where appropriate