

# Future Shape Children's Health

## Programme Blueprint

and

## Programme Initiation Document

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# **Future Shape Children's Health Programme Blueprint and Programme Initiation Document**

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## 1. Background

This programme was initiated by the Children's Health and Wellbeing Partnership Board – CHWPB (formally the Transforming Community Services Partnership Board, Children). Following approval by the CHWPB, this document has been widely consulted upon (Appendix 6) and is scheduled for presentation to the overarching Shadow Health and Wellbeing Board in April 2012. The programme objectives are based on the original TCS Board Terms of Reference (Appendix 2) and the outputs of two multiagency stakeholder workshops in February and July 2011. The programme is focused on identifying opportunities to improve health and social care pathways that will directly impact health inequalities and improve outcomes for children and families. This will effectively be the work programme of the CHWPB – however the anticipated changes are wide ranging and require the support of the wider health and children's services community. There are also elements of this programme which overlap with other projects and programmes, so care is being taken to understand these overlaps and work collaboratively with those programme leads.

The CHWPB is essentially a partnership environment so will not be making commissioning decisions. However the Board's expert advice and shaping of children's health strategy will feed into the JSNA and the commissioning cycle so that these priorities are visible in the shaping of wider city health strategies.

The scale of the challenge facing all organisations providing health and wellbeing is substantial. The legislative and financial context coupled with rising demand dictates major redesign of public services based on new partnerships and a 'whole system' approach. Multi-agency models are becoming the norm and whilst there is some effective joint working in Sheffield, evidence is that all services are not integrated, transitions need to be improved, data sharing is a challenge and processes are in many cases 'clunky'.

This programme seeks to join up the work of Sheffield City Council, Sheffield Children's NHS Foundation Trust, NHS Sheffield, Sheffield Teaching Hospitals NHS Foundation Trust and the Sheffield Clinical Commissioning Group in defining new ways of working and service designs to address these issues and improve health (and life) outcomes for children and young people.

Blueprinting is useful to define the structure and composition of the changed organisation that will deliver the environment expressed in the Vision Statement and the outcomes by which success will be measured. When complete, it is a description of what the new system will look like in terms of structures, performance, information and data platforms and outcomes for young people and families in Sheffield.

This document is a start to this whole system blueprint. The ongoing workstream activity will design the detail of the new organisation and integrated service models.

## 1.1 The Legislative Context and Policy

The July 2010 White Paper: '**Equity and Excellence: Liberating the NHS**' sets out the Government's plans for transforming health and social care to face the challenges of the 21<sup>st</sup> century. The Operating Framework for NHS in England outlines how the health service will find the £20 billion savings identified as required.

The transformation required by both are wide-ranging and mark a watershed in the health service as policies, accountabilities, funding flows, commissioning methods and service delivery are changed. Although challenging, these changes are also opportunities for transformation and integration.

The White Paper has developed into the Health and Social Care Bill and the following are the key policy changes subject to the bill's successful passage through parliament:

- **Clinically led commissioning** – The Bill puts clinicians in charge of shaping and commissioning services. Clinical Commissioning Groups will now directly commission services for their populations
- **Provider regulation to support innovative service** – This is intended to enable greater choice for patients to choose services that best fit their needs from a variety of providers. Providers will be free to innovate to deliver quality services.
- **Greater voice for patients** – The Bill establishes new HealthWatch patient organisations locally and nationally to act as the consumer champions for health and social care service users to drive patient involvement.
- **New focus for public health** – Public Health functions will be transferred to local authorities and a new organisation, Public Health England, will be established to drive improvements in the public's health.
- **Greater accountability locally and nationally** – The Bill sets out clear roles and responsibilities to avoid political micro-management. It also gives local authorities a new role to join up local services.
- **Streamlined arms-length bodies** – The Bill tries to remove unnecessary tiers of management to release resources to frontline services.

The Health and Social Care Bill has a number of cross-cutting themes many of which are reflected in the Future Shape Children's Health Programme:

- Improving quality of care
- Tackling inequalities in healthcare
- Promoting better integration of health and care services
- Choice and competition
- The role of the Secretary of State
- Reconfiguration of services

The *Operating Framework for the NHS in England for 2011/12* sets out a new commitment to developing expanded and stronger Health Visiting Services with a substantial increase in Health Visiting services planned by 2015. The Department of Health is seeking to provide greater support to families and develop local community capacity in support of children and families, working closely with Sure Start Children's Centres and other local services. The Framework for 12/13 is also issued now and this programme will also work within these guidelines.

The March 2011 Green Paper 'Support and Aspiration: A new approach to special educational needs and disability' is also a feature of the new children's policy environment which expects public resource and support to be focused on a narrower definition of need.

## **1.2 Sheffield's Response**

Health organisations across the city have developed teams, boards and initiatives to deliver the change required by the new environment. These include the following charged with managing and overseeing the transfer to a new citywide model.

The Council and Health Transition Project Board is currently working on the development of the Health and Wellbeing Board, HealthWatch development, scrutiny engagement and council support for the public health transition.

- The Adults and Children Transforming Community Services Boards were originally established so that providers could work through new models for community based service delivery. The Children's TCS Board has now evolved into the Children's Health and Wellbeing Partnership Board with a clear remit for children's health, its broader membership includes representation from the Clinical Commissioning Group and Adults Partnership Board and a clearly defined work programme.
- NHS Sheffield has completed the transfer of its commissioning functions to the new CCG structure. They are now overseeing a programme of Quality Innovation Productivity and Prevention initiatives, QIPP – designed to deliver sustained savings.
- The provider services that used to be managed by NHS Sheffield transferred into the NHS Foundation Trusts in April 2011. Community based health services for children are now provided by NHS Sheffield Children's NHS Foundation Trust.
- The Transforming Sheffield Health Steering Group was established to oversee the commissioning and implementation of a city-wide 'Right First Time - Unscheduled Care Programme' including consideration of how GPs will work together in localities across the city.
- Sheffield City Council is also leading work to establish the new Health and Wellbeing Board which will commission the Health and Well Being Strategy (HWS), based upon the evidence drawn together in the Joint Strategic Needs Assessment (JSNA), and to establish Healthwatch as the public voice in health and social care strategy development. The Council has also developed a set of Strategic

Outcomes that shapes its work across the health and young people agendas and prioritises its work in the new straitened fiscal environment.

- An Early Years Review has been completed by Sheffield City Council and the findings are now being implemented focusing on early intervention, reorganisation of Sure Start Centres and further development of the Multi Agency Support Teams (MAST). Together with community health services, these teams deliver early intervention and support services for children and families in localities.
- The Support and Aspiration Strategy group is a multiagency group focused on planning for children with special educational, health and social care needs.
- The Maternal and Child Health Planning and Commissioning Group and the Children and Young People's Emotional Wellbeing and Mental Health Strategy Group are multiagency groups, both accountable to the 0-19+ Partnership Board. They focus on improving specific priorities for children's health and well being within the overarching framework of the 0-19+ Partnership Board Children and the Young People's Plan 2011-13.

All of the above has resulted in a complex health and decision making environment such that further work is required to define where decisions are being made (see Appendix 3). Currently, there is high risk that silo working will deliver overlapping and competing solutions to the same issues, duplication of effort, wasted resource and health outcomes that do not improve. There is also the potential for decisions to be made in some places that impact work that has been commissioned elsewhere.

### 1.3 Children and Families Health in Sheffield

Sheffield is a much divided city marked by significant health inequalities and these directly impact children:

- Between the 'best' and the 'worst' wards in the city we have:
  - a 2 fold difference in achievement at Early Years Foundation Stage;
  - a 4 fold difference in infant mortality rates;
  - a 7 fold difference in smoking in pregnancy; and
  - an 8 year gap in male and female life expectancy at birth
- There are 130,000 children aged 0-19 years in Sheffield and this is expected to rise by 2% over the next 5 years. The highest growth will be within the 0-4 age range which is projected to increase by 6% in the same time frame. 20% of 0-15s are of black and minority ethnic origin; BME proportion in younger age groups is higher.
- Around 11,000 young people currently have some form of learning difficulty or disability and this is projected to increase at a rate of 5.1% per annum which is 2% above the projected national rate of increase. The fastest growing Special Educational Needs categories nationally and locally are Speech, Language and Communication Needs, and Autistic Spectrum Disorder. 3,500 young people have continuing care and end of life care needs within the city.
- Infant mortality rate (2009-11) is 4.5 deaths <1 yr per 1000 live births. Sudden infant death rates are higher in Sheffield than nationally and concentrated in more

deprived areas. Analysis of mothers who lose children to sudden infant death shows that 90% of the mothers smoke and 83% have social or mental health factors.

- Smoking during pregnancy is reducing but is still above the national rate and there is a seven fold difference at Community Assembly level in the proportion of women who are smoking 'at delivery'.
- Breastfeeding rates are above the national average - currently 52.3% women are breastfeeding at 6-8 weeks compared to a national average of 45.2%, but again wide inequalities exist within the city.
- 2,000 pre-school children and 9,500 5-17 year olds are estimated to have a mental health difficulty of some kind. The most common disorders are conduct disorders, emotional disorders and ADHD. 3.4% of Y7, 6.8% of Y7s with SENs; 6.8% of Y7s eligible for free school meals report they 'always feel sad or unhappy' (ECM Survey 2009). Certain groups, including children of black and minority ethnic origin, young offenders and looked after children, are more likely to experience mental health difficulties and achieve lower educational attainment than their peers.
- There is currently high use of children's emergency care with the highest <5yrs A and E attendance from the most deprived areas of the city. In 2010/2011 there was a total of 51,540 visits to Sheffield's Children's Hospital A&E department, of which 25,512 were under 5s.
- Sheffield benchmarks very poorly against the national average and core city average for A&E attendances and emergency admissions for the under-fives e.g. emergency admissions rate (09/10) for respiratory conditions in 0-4 year olds in Sheffield is highest in England at 239.41 per 10,000 compared with Bristol (98.05) and nationally (115.26) (ChiMat 2009/10). Local data show that the highest use of A&E attendance in Sheffield is from the most deprived areas where rates are up to 50% above the city wide average.
- Sheffield also has some particular issues relating to minority groups such as the Slovak, Roma community which impacts the attainment of these children and disproportionately impacts health and education provision in some areas of the city and the Children's Hospital A&E department.
- There has been some successful partnership working which has helped to slow the rise of childhood obesity but downstream the problem is still significant, which will impact health outcomes in later life and demand for hospital and primary healthcare services. Sheffield teenage pregnancy rates are lower than ever – although still above the national rate. Fewer children are in care overall and the number of children with a Child Protection Plan has fallen recently.

As a city inequality for adults is also significant: the life expectancy for men and women is still below the national average and in-city variations mean that men in less affluent areas die on average 8.6 years before men in more affluent areas. For women this figure is 8.2 years and has actually widened from 6.3 years.

It is the CHWPB's view that early intervention and prevention work is the key to breaking the cycle of disadvantage which perpetuates health inequalities across Sheffield. Upstream activity improving health and educational outcomes for children underpins improved outcomes for adults. Closing the gap in educational achievement remains a particular challenge as it remains highly influenced by socio-economic status with little positive movement.

At a multi-agency workshop on 6<sup>th</sup> July 2011, the Strengths, Weaknesses, Opportunities and Threats of Sheffield's current children's health and wellbeing system were evaluated as follows:

**Strengths identified** include:

- a workforce across the city that is passionate about improving services for children and families
- a dedicated NHS Trust for the provision of healthcare for children
- a Children's TCS Board that enabled good relationship development across partners within the city
- Strength and depth in terms of overall provision across health and social care
- examples of good multiagency working, such as MAST and Children's Trust Resource Panel
- widely held consensus that we need to change and develop to meet the challenges that we face together

**Weaknesses** include:

- lack of joint corporate objectives
- poor communication between agencies
- duplication of services to families and limited success in delivering services to the most vulnerable and most deprived

**Opportunities** include:

- joining up of community services with secondary care services
- families of schools working with children's centres and community services as a test bed for service redesign within localities
- maximisation of benefits from all points of contact with families

**Threats** include:

- NHS and local government structural changes and financial constraints
- scale of the inequalities challenge
- leadership direction being spread across too many objectives

## 1.4 Current Health Strategies in Sheffield

All member organisations on the CHWPB have their own plans and strategies to improve health outcomes in Sheffield. There are however common themes.

NHS Sheffield's strategy 'Achieving Balanced Health (4)' identifies the following key outcomes: establishing a sustainable health system for Sheffield with good provision

provided locally, supporting people to stay at home, and ensuring that urgent emergency care is used effectively and efficiently.

The Clinical Commissioning Group has produced a 'Strategy and Prospectus' that sets out the ambitions and values for the organisation. These include the reduction of health inequalities, improving the quality of healthcare in Sheffield and working closely with other health and social care providers.

Sheffield City Council's corporate plan has 2 of its 5 strategic cores relating directly to children's health (Health, and Successful Young People). Key outcomes include; better physical and mental health and wellbeing, making Sheffield a great place to grow up, educational attainment, safe and healthy children, focus on special educational needs and creating a really good early year's environment for a great start in life.

Sheffield Children's NHS Foundation Trust, as an organisation is dedicated to the healthcare of children and has a strategy which aims to improve health outcomes and healthcare for children in Sheffield and across the region. The Trust has a specific objective of working in partnership with others to reshape the healthcare of children in Sheffield, with a focus on prevention and early intervention. It aims to work with partners on developing locally based integrated multi-professional teams for children and on providing greater support to more vulnerable children.

## 2. The Future Shape Children's Health Programme

The Future Shape Children's Health Programme was commissioned by the CHWPB (formally the TCS, Children's Board) in May 2011. This decision was based on a shared vision for children's health and wellbeing and the fact that all organisations want to work in a 'whole system' way to deliver better health outcomes for the City and a sustainable service model.

### The shared objectives and outcomes include:

- Improving the health and wellbeing of children, young people and families
- Reducing inequality in health outcomes specifically for children and young people
- Partnership and joined up working between health and children's services including some service integration
- Care pathways that work effectively and efficiently in a multi-agency environment in the best interests of the patient
- The effective management of transitions for children and young people with complex needs into adulthood
- Delivering improved outcomes with reduced resources and greater demand
- Improved transitions from childhood to adulthood
- Efficient and effective use of emergency care and support services
- Care and services provided as close to home as possible
- The principle of the 'whole household' model - an holistic approach to improving health outcomes for families and therefore children and young people
- Delivering savings

There are clear benefits to working on a multiagency basis rather than organisational silos and the programme will deliver a framework to ensure these common objectives are drawn together into a 'whole-system' approach which seeks to ensure that all activities contribute to a set of priority outcome indicators.

This programme will also ensure alignment between the governance of the adult and children's health environments to ensure the following are delivered:

- economies of scale
- synergies for service integration
- alignment of outcomes and activity
- improved transition pathways
- clear and consistent communications messages
- Better health outcomes for children and then adults

This programme will also reference work continuing outside the programme that will impact its outcomes. The CHWPB has been clear that they will commission appropriate updates and will ensure that governance links are made to bridge across to such areas as education, infant mortality, children's emotional health and wellbeing, youth and healthy settings. An example of this mapping is shown as Appendix 7.

## 2.1 Vision for Children's Health in Sheffield

The following vision for children's health in Sheffield was agreed at the CHWPB, formally the TCS Board, in July 2010:

- To keep Sheffield's children healthy, to help them achieve their potential and live their lives to the full.
- To provide integrated, joined up and seamless services that are easy to navigate for children, young people and professionals.
- To provide services that join together to meet the needs of the child when they need it, in a place as close to home as possible, that works in partnership to ensure smooth transition and to avoid duplication.
- To provide a service that aims to keep children out of hospital and other 'high tier' care by addressing their needs as soon as possible, as locally as possible, focussing on prevention and public health.
- To provide a service that is affordable, demonstrates value for money, is sustainable and flexible to respond to changing local needs.

The programme will:

- Reduce health inequality for children in the most deprived areas
- Reduce infant mortality
- Reduce smoking rates in expectant mothers
- Increase the uptake of childhood immunisation targets
- Reduce the number of under 5's A& E attendances
- Improve children and young people's emotional wellbeing and development
- Improve children's dental health
- Increase the rate of breastfeeding across the city
- Reduce teenage conceptions
- Reduce obesity in children and young people
- Positively impact educational attainment in Early Years and reduce school absence by improving levels of children's health across the city

**Success will be defined by progress against a stretching set of outcome – based targets achieved through a fundamental shift to a 'whole system approach'.**

These targets should be reflected in the city's Health and Wellbeing Strategy developed by the new Health and Wellbeing Board and delivered by the CHWPB. Clearly healthier young people should do better at schools and therefore the programme will contribute towards education targets but accountability for these remains the responsibility of schools and the Citywide Learning Body. There is also a clear link across to the Troubled Families Initiative focusing on 1600 families in Sheffield who have intergenerational unemployment. These families are the most likely to suffer health inequality and are also likely to fall within the scope of this programme.

It is therefore essential that appropriate links are made to this other work so that duplication of resource and effort is avoided and integrated project planning delivers outcomes within a streamlined framework.

### **Health and Wellbeing outcomes**

Performance targets have been identified at city level, with specific focus on reducing inequality at local (community assembly) level and in some cases GP Practice or Family of School level.

- Infant mortality is currently 4.8 deaths <1 yr per 1000 live births.  
The slope index of inequality for this measure has been reducing since 2000, and will continue to reduce to 2014/15 and beyond.  
The rate of sudden infant death per 1000 live births will fall from 0.64 to 0.54 by 2013.  
The Infant mortality rate for the BME population is currently significantly worse than the average; from 2011 to 2015 these figures will improve at a faster rate than the city average.
- The national childhood immunisation targets will be met by 2014/15
- Smoking rates amongst expectant mothers will fall by 2% to 11.8% by 2014/15 across the city.  
No community assembly will have more than 17% of mothers that smoke at delivery.
- The average number of decayed, missing or filled teeth at 5 years in 2008/09 was 1.7. By 2015/16 it will have reduced to 1.5.  
No community assembly area will be above 2.2 decayed, missing or filled teeth by 2015/16
- The rate per 100,000 for under 5s A & E attendances at the Children's Hospital for 2009/10 was 78,654 this will fall by 25% by 2014/15.
- The 2011 Every Child Matters survey reported that 7.6% of Y5's and 8.8% of Y10's 'feel very sad' most of the time these results will improve significantly in the 2013 survey (scheduled to include every school).
- Rates of breastfeeding at 6-8 weeks, will rise from current levels of 52.3% to 54.8% by 2014/15.  
By 2014/15 there will be no community assembly area in the city with less than 41.9% of mothers that breastfeed at 6-8 weeks
- Teenage conception rates will fall from their 2009 level of 42.9 conceptions per 1000 females aged 15-17 to 40.3 by 2013
- Amongst children and young people there is currently an overweight and obese prevalence of 24.74% in YR, this level will be maintained to 2014/15. The difference between the worst performing community assembly area and the average will fall from 4% to 2%.
- Achieving the national average in attainment by 2015 in Early Years Foundation Stage performance and reducing the gap between the lowest achieving 20% and the rest
- Reducing levels of persistent absence in primary and secondary schools to achieve the national average by 2012/13

Much of the work improving children's health will also impact within schools and educational attainment and vice versa. This is an urgent area of focus as Sheffield

continues to struggle to narrow the educational gap. This programme will make a substantial contribution towards the educational attainment improvements commissioned by the City Wide Learning Board and SCC.

**See Appendix 1 for the detailed performance targets for health and wellbeing for the next 5 years**

**A dashboard type of approach is being developed to monitor outcomes at the Board, quarterly.**

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## 2.3 Scope

At the TCS Board in July 2011 the following programme scope was agreed and this was reaffirmed by the CHWPB in December 2011:

Sheffield's Future Shape Children's Health programme entails redesigning and integrating a system of services for 0-19 year olds and families that improve their health outcomes and reduce inequalities across: community paediatric services; MAST, safeguarding, children's health services, sure start, community nursing, primary mental health, GP services and services to vulnerable children.

The programme will also assist in the design of integrated community health and social care services for children that focus on prevention, early intervention and local delivery of care within effective and integrated models of service delivery.

The programme will ensure that the children's health and wellbeing agenda and priorities are embedded in the wider SCC/NHS health transition programme and that appropriate links are made to work impacting children's health outcomes across the city. In essence the programme will shape and help to deliver the future model for services and supporting structures across the whole-system of services to children and families.

The following work streams are agreed for the programme:-

- WS1 Integrated Practice in localities
- WS2 Parenting and Emotional Wellbeing in Early Years (Parenting)
- WS3 Unscheduled Care
- WS4 Children with Complex Needs
- WS5 Governance, Communications and Engagement

## 2.4 WORKSTREAMS

**WS1 Integrated Practice** – led by Dr Margaret Ainger, GP, portfolio holder for children in the Clinical Commissioning Group.

All parties delivering health, social care and education for children and adults recognise the need to develop more integrated and collaborative working. This is essential to reducing inequality, improving the quality of health and wellbeing for the growing population, ensuring the financial sustainability of key services and ensuring best use of resource.

There are a number of challenges to a fully integrated 'whole system' approach that's responsive to local needs, including:

- A history of silo solutioning in different health, social service and education environments and even within organisations
- Duplication of targeted support for individual families
- Lack of impact with the most vulnerable families including targeting that does not reach the most disadvantaged
- Poor screening results for low level need
- Issues with capacity to deliver 'front line' early intervention work
- Misalignment between primary care professionals and MAST teams
- Families of schools and children's centres under-utilised to aid integration
- Variable communication between GPs, community health services, Children's Centres and MAST Teams
- Underperforming information sharing practices
- Financial drivers that can work against a 'whole system' integrated approach
- The need to closely align elements of this programme with the Right First Time – Unscheduled Care Programme

Moreover, while Sheffield has a workforce committed to improving Health Services for children and families, it is now evident that without a fully integrated approach financial pressures may reduce individual service capacity and those in most need of Sheffield's Health Services will continue to be the most vulnerable.

This workstream will:

- focus on the most disadvantaged in the city, identifying families through mapping work and targeting interventions
- develop cost savings through redefined joint commissioning activity
- develop comprehensive information on services and ensure it is readily available to both professionals and families
- through integrated team working make these services more effective and reduce duplication
- reduce cost and target more effectively those in most need (disadvantaged families)
- develop a model which sees Primary Care alignment with other healthcare and provision
- contribute to the improvement in Early Years outcomes detailed in Appendix 1
- use and advocate the 'whole household' model
- develop clarity on identified lead professionals and the key worker for individual families
- develop a locality community health infrastructure based around associations of GPs and schools that work to improve outcomes for families and children
- develop a locality community health infrastructure based around associations of GPs to improve outcomes for both adults and children
- develop appropriate information sharing practices, including case management (families) between professionals, without breaching any of the confidentiality to ensure local teams are fully informed with information that is relevant, avoids duplication and is sensitive to work already in hand.

This workstream will also work proactively with the Adults focused 'Right First Time' programme, especially workstream 1 (developing community based multiagency teams

and the new commissioning GP model) and ensuring alignment of activity with other key citywide strategies, such as the forthcoming Child Poverty Strategy.

Phase 1 of this work will be the development of a prototype approach in the Brightside, Wincobank, Shiregreen area of the city based around the Hinde House family of schools.

***WS2 Parenting and Emotional Wellbeing in Early Years*** – led by Sue Greig, Consultant, Public Health

Children's early experiences of sensitive care set the foundation for their future life chances, determining health, emotional wellbeing and capacity for learning through childhood and beyond. Empathy, self regulation, attention, sociability and motivation are well embedded patterns in a child's brain by the age of 3. A child's wellbeing is the result of healthy development within a nurturing environment. Lack of parenting skills and/or support to develop these skills especially for 0-3s life can have far reaching health, social and economic effects on children, families and wider society.

In Sheffield, a number of parenting-related issues have been identified including:

- Significant parenting issues in some areas of the community which create downstream impact on health, social care and education services and adversely impact the life chances for a significant number of children and young people
- Lack of family/parent/carer confidence and knowledge to manage common childhood conditions
- Wide inequality in early years foundation scores with a severely deprived 20%
- Lack of common understanding of the evidence base for effective interventions on parenting and emotional well-being in early years
- Inconsistent identification of and response to need for parenting support for 0-3s
- Some poorly targeted and/or non evidence based investment
- Diverse nature of services and programmes in contact with and/or providing support to families in the early years
- Lack of consistent approach to parenting support within universal services for children and families
- Lack of effective joined up commissioning

These issues underpin the drive to reduce inequality not just in health but also socially and economically. Proxy indicators for parenting include healthy behaviors' in pregnancy and infancy, early years foundation scores, oral health, childhood obesity, mental and emotional wellbeing, school attendance and contact with police e.g. numbers of ASBOs and behaviour contracts. Effects of poor parenting continue throughout a child and family's life with consequent strain on the city's resources. Conversely, effective targeted investment in this area is central to the development of resilient families and communities and reduces the need for later, costly, crisis interventions.

This workstream will:

- Further develop sound parenting support for vulnerable families and individuals to improve life outcomes for these people particularly in the most deprived areas and groups within the city

- Use the findings of the Parenting Review (reporting Nov 2011) to inform development of a refreshed citywide parenting strategy
- Use the best practice model known as ‘the Solihull approach’ to implement a programme of workforce development to build and sustain capacity and capability to ensure universal services consistently provide parenting support
- Identify standardised tools to assess parenting skills and family emotional well being and embed through multi-agency training within the early years workforce (0-3s)
- Build into relevant service specifications pathways for early identification of need for additional parenting and mental health support in pregnancy and infancy
- Develop differentiated evidence based packages of support targeting the 15% of children at risk of developing insecure attachment
- Build the business case for joint commissioning and delivery of parenting and family emotional well being support focussing upon the most vulnerable in the early years
- Develop confidence and knowledge of parents/families and carers to better manage common childhood conditions through parenting

**WS3 *Unscheduled Care*** - led by Dr Richard Oliver, NHS Sheffield

Unscheduled Care is defined as: ‘all systems of care available within Sheffield which are provided in response to unplanned and unexpected health related events in the lives of all it’s citizens’.

It is recognised that Sheffield has a fragmented *Unscheduled Care* system. While it offers a wide range of choice to services users, there is little integration and the degree of choice confuses the public and health care professionals alike. In addition, integration between services is often superficial, in part as a result of the commissioning of services in isolation and in ‘silos’.

Sheffield benchmarks poorly against the national average for A&E attendances and admissions for under 5s (ChiMat 2009/10). There are many reasons for this including:

- As Sheffield has a specialist Children’s Hospital, some people attend the A&E dept rather than primary care believing they will receive better levels of treatment
- High levels of deprivation and therefore need
- Access to primary care is perceived to be an issue
- Some significant minority communities that use the children’s hospital as the first point of contact e.g. the Roma Slovak community, especially out-of-hours
- Lack of family/parent/carer confidence and knowledge to manage common childhood conditions
- a culture of over-reliance by families and young people on the Children’s Hospital service.
- lack of GP paediatric training in Sheffield and perceived lower threshold for referral to acute care
- the city does not have a community paediatric nursing service.

There are, then, several drivers for transforming *Unscheduled Care* within the city;

- Rising hospital attendances, including greater use of A&E for primary care
- Rising hospital non-elective admissions
- The need to better manage acutely ill children who require admission to hospital
- Increasing financial pressure on the healthcare system in Sheffield
- Rising population in the city
- The need to deliver care closer to home
- Greater integration and understanding between primary and secondary care professionals
- Need to improve the skills and knowledge of parents/families/carers and clinicians for identifying and managing common childhood conditions

This workstream will:

- Reduce unscheduled admissions to the children's hospital through service redesign, including the implementation of a Consultant-led AAU telephone triage service plus other potential system changes
- Develop a Rapid Access outpatient clinic which will support the triage away from admission
- Encourage appropriate use of A&E by helping parents, families, carers and children to a) understand the options for urgent care and to choose well and b) spreading and increasing the impact of public health messages and programmes which aim to improve skills and knowledge and support sustainable behaviour change in identifying and managing common childhood conditions and illnesses.
- Link with the Right First Time Programme with the aim of supporting children to access the right care, in the right place at the right time.

The workstream will have two distinct phases.

Element 1: Focus will be to better manage presentations at SCH to reduce admissions.

Element 2: will be to develop a multi-agency approach in the community to reduce A&E attendances and emergency admissions

**WS4 Children with Complex Needs** – led by Kate Laurance, NHS Sheffield

This workstream will focus on children and young people up to 19 years of age. A complex child / young person is hard to define but can include those with medical needs that meet the criteria of needing continuing care. This can include individuals with severe disabilities, life limiting conditions, acute behaviour issues and acute/highly specialised mental health problems. Current costs for meeting the needs of complex children/young people from Sheffield out of area, exceeds £8million per year across health, education and social services. Needs and costs of complex children and young people are met by a number of partners throughout the city, collective annual spend can exceed £300k per child. From 2005-8 the numbers of children and young people with learning disabilities or difficulties grew at an annual average rate of 5.1% per year. This growth is expected to continue at a time when the NHS is looking to fund £20 billion of efficiency savings, nationally and increasing financial pressure on Local Authority, educations and social care services.

There are a number of problems for the care and support of these complex children and young people that must be remedied to meet rising demand with diminishing resources. These include:

- a lack of integrated response and planning to prevent children from being placed out of city
- lack of a single integrated assessment process
- duplication of effort
- capacity issues
- inequalities issues
- service inconsistency
- a variation in the pathways to access specialist services and a lack of capability of universal services in supporting and signposting children and families

There are also inconsistencies in the use of specialist services by complex and non-complex children and young people. This is due to a lack of clearly defined care pathways which has resulted in intensive and expensive specialist services being used inappropriately. Needs in many cases, could have been met by less intensive support within local universal services. Given the increasing financial pressures this is a priority issue to address on a multi-agency basis to ensure the effective collective use of resources.

This workstream will:

- Develop a joint data base of children and young people between health and social care for those meeting the criteria of a child and young person with complex needs and with significant health needs. This will aid joint planning and joint commissioning of local services.
- Deliver integration of assessment and care plans for children and young people with complex needs evidenced by a joint health/education/social support plan in place and reviewed regularly by a multi disciplinary team. The assessment and planning will be in line with the SEN Green paper and involve children, young people and parents/carers.
- Identify and implement the best pathway for screening and assessment of children with complex neuro-disability and complex mental health. Clarify the pathway from schools, general practices and other universal services including health visitors and school nurses and clarify how they work with community health services, specialist health services and specialist services including those available in schools
- Clarify the treatment pathways for children and young people with complex needs within secondary healthcare services
- Identify a citywide pathway and have a co-ordinated approach to accessing equipment for children with complex medical and physical needs to enable access to mainstream provision
- Undertake a joint needs assessment of respite provision for children and young people with complex needs and develop a joint and streamlined approach to accessing respite care, within models of care that meet families needs

WS1-4 will deliver the main activity to effect the changes and impact targeted by the Programme. Through the project planning process specific measures will be detailed in each workstream that track back to the programme targets

**WS5 Governance, Communications and Engagement** – led by Jayne Ludlam, Director Children and Families CYPF, SCC and Antony Hughes, Children’s Commissioning, CYPF, SCC

As previously stated the Health and Social Care Bill includes the abolishment of PCTs, the statutory requirement for a Health and Wellbeing Board at city level, implementation of a new clinical commissioning group, the transfer of the Public Health function into the Council and the movement of some services (e.g. School nurses and health visitors) to the children’s hospital.

This also drives the requirement for all agencies to agree to redefine the role, terms of reference and in some cases relationships for many existing health-related Boards and groups at city and sub regional level.

It has become increasingly clear that to achieve cohesive and collaborative multiagency working, we must work through to agreement on the future whole system model for governance and decision making. This has been described as “understanding which conversations need to be had where, who is making decisions and on what and on whom these are binding”. Appendix 3 and 4 show the current decision making environment.

It is also important that the children’s health agenda is visible and grounded in the outcomes and working of the Health and Wellbeing Board and its emerging substructures and effectively links across to the Clinical Commissioning Group and the development of the new regional and city commissioning structures.

To be effective in this whole system change will require the delivery of a challenging agenda with diverse stakeholders across a range of environments. Success will require significant culture change and changes to the way in which organisations and partners across the NHS, Foundations Trusts, SCC and the third sector work together to improve health outcomes for children and young people. It requires a good understanding of the programme, outcomes and context from the top and considerable advocacy and championing by senior leaders to ensure sustainable change happens and is embedded in the frontline. Communications and engagement activity to support this will be critical. The following issues and challenges have been highlighted:

- Differing and sometimes inconsistent messages from different organisations about change in relation to health: both the wider context and the Sheffield response to change
- Conflicting timelines for change that drive mixed messages to staff and the general public
- Lack of clarity and unified voice on key messages from providers
- Underutilisation of the children’s workforce to promote positive health messages and therefore not realising the opportunities to maximise the health promoting impact of front line services (e.g. schools, GPs, Children’s Centres, A & E)
- Lack of understanding across agencies and services of who does what with different access paths to services

- Understanding of dependencies and interfaces for the programme is incomplete risking initiative overlap or counterproductive or even detrimental activity impacting progress and timelines.

This workstream will:

- Develop and gain agreement on proposals to redefine the Terms of Reference for the original TCS Partnership Board to accommodate commissioning input through nominated CCG representatives and membership required to deliver the agreed programme outcomes
- Engage all appropriate stakeholders in a constructive dialogue to secure agreement on the roles and responsibilities particularly with respect to the Children's Joint Commissioning Group (and necessary changes to Terms of Reference) as set out in Appendix 4
- Where possible secure agreement to reduce and streamline entities
- Determine how health decisions will be made and influenced locally especially around the allocation of resources
- Evaluate and make proposals around resources and potential changes to flows of health funding and budgeting practice to complement new models for service delivery
- Facilitate the necessary links with other Boards and programmes interfacing with the work of the Children's health programme
- Ensure the visibility of the children's health strategy and priorities within the outcomes of the Health and Wellbeing Board
- Positively connect with and help shape the Health and Wellbeing Board substructures and relationships between commissioners and providers
- Effectively connect with the process for the disestablishment of the Health and Wellbeing Partnership Board and ensure the interests of children's health are served through the following structures
- Work with the Clinical Commissioning Group on the development of the commissioning structures
- Develop communication and engagement strategies with other programmes so that messages across organisations, to stakeholders and to the public are joined up and coherent
- Ensure that the voice and involvement of young people, families and carers is incorporated into workstream activity
- Ensure clear communications to key health and social care organisations including the Health and Wellbeing Board, HealthWatch, the Health Scrutiny Committee and the providers and commissioners of health and social care
- Develop the 'Every Contact Counts' health promotion training programme across the multiagency children's workforce

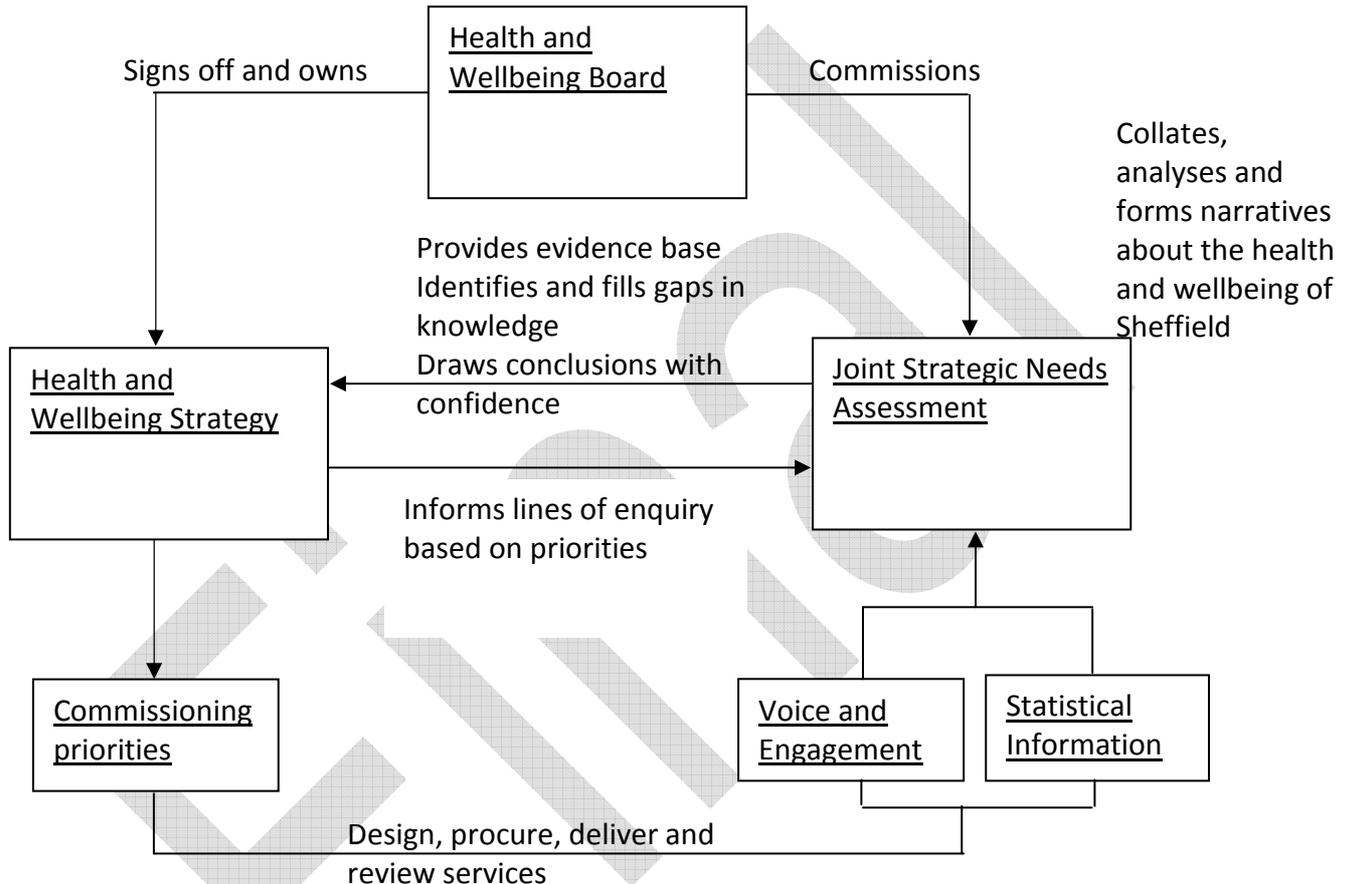
Links to other Programmes and strategies

In the planning for each of the workstreams, links will be made to other work that is directly impacting the outcomes and targets for this programme but are not within the remit of this work. Examples of this are shown at Appendix 7.

**2.5 Children's Health Strategy and the city's commissioning Cycle**

The Health and Wellbeing Board (HWB) will commission the Joint Health and Wellbeing strategy that reflects the key health priorities from birth to old age for the city. When the Board is statutorily formed, from April 2013, the strategies of commissioners will be based upon the JHWS and this will be based upon the qualitative, quantitative and narrative evidence of the JSNA.

The diagram below indicates that the JSNA will be part of the commissioning cycle, providing the evidence base for the JHWS, which in turn determines a set of outcomes and commissioning priorities for the city. The JSNA will also be informed by those priorities and will be focused on areas of interest for commissioners.



The 2012 JHWS will be developed slightly differently than those JHWS that are produced post-April 2013. The current period of transition and the differing timetables for approval and establishment of new organisations and structures in the health and wellbeing system has led to some infelicities of timing with the potential for confusion about how strategies should be linked. As a result, existing outcome strategies that have been already agreed for SCC and the CCG will be used by the Health & Wellbeing Board to provide broad areas of focus.

Although the JHWS will not simply collate or conflate existing outcome frameworks it will be informed by them for this year's strategy. SCC and CCG strategic priorities are currently being developed by the Health & Wellbeing Board to decide what the focus of the first JHWS will be. This will involve Board members selecting from a series of outcomes those that they believe the board can most readily influence and/or are most important for the city. The JSNA will be produced in the early summer and its evidence will

then be combined and analysed in parallel with what the Board has agreed. The output of this process will be the 2012 JHWS.

The JHWS produced in autumn 2012 will be used as a basis by the CCG, the Council and other commissioners to review their own commissioning strategies, and these organisations will need to demonstrate that they are contributing to the achievement of the outcomes set out in the JHWS.

The Future Shape Health Programme has developed a number of key outcomes that will be delivered through the programme (see section 2.1 and 2.4). In order that these are reflected in the 2012 JHWS the following will happen:

1. The initial outcomes presented to the HWB will reflect all of the outcomes that Future Shape Health has agreed
2. The 2012 JSNA process will be informed by the partners evidence and needs that have informed the development of FSCH

For JHWS's that follow April 2013, the evidence base of the partners of the CHWPB will need to consistently feed into the JSNA process as illustrated by the design, procure, deliver and review services section of the diagram above. This will ensure that each JHWS is influenced by a rich evidence base from all partners on children's health priorities

## **2.6 Programme Organisation and Resource**

The CHWPB will be the Programme Board responsible for ensuring that the programme is delivered and accountable for the delivery of benefits. It will address the issues escalated to it for decision by the programme team and will oversee and support the resolution of issues arising from multiagency working. The programme is complex with a high risk of failure if sufficient capacity is not invested in programme delivery.

The Programme Manager will have the responsibility for the delivery of the programme and benefits, initiating recommendations on programme structure and change reflecting changing requirements and the environment during delivery, management of programme dependencies, coordination of resource, management of risk and delivery of effective reporting to the Board. The PM will ensure that appropriate coordination is in place with other projects and programmes and that effective communication and engagement with stakeholders underpins all activity.

Each of the workstreams has a lead, however these are senior experts in their fields so will require project resource in support. The leads will shape and manage the delivery of their workstream projects using largely existing resource across the various organisations. Part of the brief will be to produce a resource plan so that any additional capacity required can be agreed by the Board. Leads will be invited to attend Programme Board meetings to provide progress reports and escalate issues as appropriate.

The workstream leads will collectively form the programme team and be responsible for delivery to the Programme Manager.

It is anticipated that programme costs will be shared across all partner organisations: SCC, NHS Sheffield and NHS Foundation Trust and will deliver both the programme and support to the CHWPB.

Resource is based on the fact that the Programme Manager and Project Officers will provide much of the delivery capacity. Therefore, the Programme Manager is factored in at 4 days per week and Project Officer's are full time. Resource would be required as follows:

- Programme Manager and 3 Project Officers
- Workstream working budgets
- Communications Management Support
- Communications and engagement budget for printing, meetings and events

## 2.7 Programme Milestones

Programme approved by CHWPB and recommended to Children's Trust Executive Board	November 2011
Children's Trust Executive Board endorsed proposed Programme	November 2011
Transforming Sheffield Health Steering Group reviewed and endorsed proposed Programme	December 2011
Presentation of the Programme to the Adults TCS Board	December 2011
Terms of Reference for Children's TCS Board reviewed in line with programme responsibilities	December 2011
Agreement to high level workstream briefs by CHPB and commencement of project planning	December 2011
Process to agree whole system Governance Model defined	November 2011
Programme launched across organisations	January 2012
Programme Resource and programme budget confirmed	January 2012
Workstreams initiated, team members confirmed, workstream workshops held to develop high level project plans	January 2012
All workstreams identify proposals for fast track changes to deliver 12 month improvements and cost savings	February 2012
CHPB to review an updated Programme Brief for the Shadow Health and Wellbeing Board	March 2012
Fast track change initiatives approved by Programme Board	April 2012
Workstream project work commences according to project plans	February 2012
Programme approved by Shadow Health and Wellbeing Board	April 2012
Programme Review will be monthly at Board around agreed milestones	

## 2.8 High level risks linked to the programme

### The Health and Social Care Bill

This programme is based on the successful passage and infrastructure to be established by the Health and Social Care Bill when it is passed by parliament. The central themes of the work streams underpinning the programme are aligned to the policy intentions in the Bill. As a result, delay in the Bill's passage is likely to have negative effect on the programme and the organisations that have collectively commissioned it.

### Partner support and sponsorship

Programme success is dependent on senior level sponsorship across all organisations on the Transforming Community Services Board. The challenge and complexity in each area of work requires sustained senior level commitment throughout the programme duration to ensure the necessary decisions and change is effectively implemented.

### Political support

Political support is necessary for the implementation of new models for services and the necessary multiagency working.

### Support of the Shadow Health and Wellbeing Board

The Health and Wellbeing Board's purpose is to ensure and enable integration between health and social care providers and commissioners. It is crucial that this programme informs and shapes the citywide Health and Wellbeing Strategy that the future Board will commission.

## **High Level Risks if the Programme is not approved**

- There will not be a 'whole-system' programme to integrate the efforts of health and children's service providers in the city
- The visibility and identity for the children and young people's health and wellbeing agenda will be low. This could mean that design principles, structures and service commissions from other adult based work could overwhelm the children's agenda to the detriment of health outcomes for this population group
- Health and wellbeing outcomes are likely to deteriorate with reduced funding and no programme to innovate and integrate efforts within the financial context that this creates
- Increased demand for health and children's services is unlikely to be met to expected standards of care and support
- The individual benefits for each of the programme work streams will not be delivered

### 3. Recommendations to the CHWPB

**3.1 That the Board approves this updated document outlining the Future Shape Children's Health Programme and recommends it onto the overarching Health and Wellbeing Board for endorsement**

**3.2 That the Board makes decisions on the following:**

- That Appendix 3 is an accurate reflection of the current governance situation
- That the Board **agrees with the roles and functions of the various groups outlined in Appendix 4** and **advocates** on behalf of any necessary change to Terms of Reference to health colleagues and stakeholders
- That the CHWPB will **facilitate both commissioner and provider discussion** on the inputs for children in the JSNA and **provide expert advice** to the Health and Wellbeing Board on children's health strategy
- That the CHWPB will be the **Programme Board accountable** for delivery of the programme's health benefits. The programme will contribute towards the education targets but accountability for these remains the responsibility of schools and the Citywide Learning Body.
- The CHWPB will be the **sponsors and advocates** for the programme, driving the implementation of the agreed service development and integration to transform outcomes for children and young people in the city
- The CHWPB will work closely with the Children's Trust Executive Board as the main **coordinator of overarching strategies** for children across the city including health, education and social care
- That the Transforming Sheffield Health Steering Group will be the point of escalation for issues arising from joint working with the RFT Unscheduled Care Programme
- That the work of the SCC Strategic Outcomes activity will take place in the sphere of the Joint Commissioning Group and Adults and Children's Partnership Boards

**3.4 That the Board agrees the proposed programme resource profile and commits to agree appropriate resource allocation and, or, funding from partners**

**3.5 That the Board issue a communication regarding the progress of this programme to all organisations**

**3.6 This Blueprint will be reviewed after 6 months**

## Appendix 1

### Benefits for TCS Children's Health & Well Being Programme (Health)

Measure (all data quoted are for 2010/11 period unless otherwise indicated)	Area/population	Programme Year				
		2010/11	2011/12	2012/13	2013/14	2014/15
<b>1. Infant mortality:</b> deaths <1 yr per 1000 live births (3 yr pooled average):	Sheffield	4.8 (2008/10)	4.5 (2009/11)			4.1 (2012/14)
	England	4.5 (2008/10)				
	Core cities ranking					
Closing the gap: Slope Index of Inequality (gap between most and least deprived)	Sheffield	Slope Index of Inequality reducing trend 2000/03-2008/10 to continue 2008/10 – 2012/14				
Infant mortality in BME population	BME population	7.6 (2010)	BME rate improving each year at a faster rate than city average			
	All Sheffield	5.1 (2010)				
Sudden Infant Deaths: deaths <1 yr per 1000 live births (5 yr pooled average)	Sheffield	0.65 (2005/09)	0.64	0.61	0.57	0.54 (2009/13)
	England	0.42 (2005/09)				
<b>2. Maternal smoking:</b> % women smoking at delivery	Sheffield	13.8%	13.3%	12.8%	12.3%	11.8%
	England	13.5%				
	Core cities ranking	4				
Closing the gap: no community assembly more than ...	Worst CA	20%	19.3%	18.5%	17.8%	17.0%
<b>3. Breastfeeding:</b> % mothers breastfeeding at 6-8 weeks (rolling Q4 prevalence)	Sheffield	52.3%	51.9%	52.6%	53.2%	54.8%
	England	45.2%				
	Core cities ranking	2				
Closing the gap : no community assembly less than ...	Worst CA	38%	37.7%			41.9%
<b>4. Teenage pregnancy:</b> conceptions per 1000 females aged 15-17 years	Sheffield	42.9 (2009)				40.3 (2013)
	England	38.2 (2009)				
	Core cities ranking	1				
<b>5. Early Years Foundation Stage:</b> percentage achieving 78+ points including at least 6 points in both Personal, Social and Emotional Development, and Communication, Language and Literacy	Sheffield	52%		At least 57%		National average
	National ranking	109		2 <sup>nd</sup>		

				quartile		
	Core cities ranking	6		at least 4		
Closing the gap between the lowest achieving 20% and the rest		37.6%		No more than 32%		
	National ranking	150		3 <sup>rd</sup> quartile/at least 113		
<b>6. School absence</b> The Programme will contribute towards the reduction of persistent absence: students missing more than 15% school time	Sheffield Primary Secondary	Autumn term 2010 / spring term 2011 6.4% 11.7%		Current national average by 2012/13		
	England Primary Secondary	Autumn term 2010 / spring term 2011 5.2% 9.5%				
	Core cities ranking	Primary ranked 3rd; secondary ranked 1st		Both primary and secondary phase at least 2nd		
Closing the gap: no Community Assembly Area more than .... TBC						
<b>7. Childhood immunisations</b> Achievement of all national targets for: x 6 immunisation programmes	Sheffield: DTap@1yr PCV@2yrs HibMenC@2yrs MMR@2yrs MMR@5yrs DTap@5yrs	94.2% 92.6% 94.9% 92.2% 89.9% 91.3%				95% 95% 95% 95% 90% 92%
	National DTap@1yr PCV@2yrs HibMenC@2yrs MMR@2yrs	93.6% 89.3% 91.6% 89.1%				

	MMR@5yrs DTap@5yrs	84.2% 85.9%				
Immunisations: closing the gap measure TBC % children missing vaccinations NB: not routinely reported at the moment	5 year olds					
	16 year olds					
	Looked After Children					
<b>8. Childhood obesity</b> Prevalence of overweight and obesity at YR	Sheffield	20.6% (2009/10)				
	National	TBC (2010/11)				
	Core cities ranking	TBC (2010/11)				
Closing the gap: overall improvement in the baseline across all Community Assembly areas.	Minimum baseline	24.2% (2009/10)				
<b>9. Mental health:</b>  Y5's reporting that they 'feel very sad' most of the time Y5's reporting that they 'feel very sad' some of the time  Y10's reporting that they feel very sad or depressed most of the time Y10's reporting that they feel very sad or depressed some of the time  All figures from ECM 2011.	All students	Baseline from ECM survey spring 2011 7.6% 32.7%  8.8% 32.2%				
Closing the gap measures: TBC	Worst CA					
	FSM students					
	LAAC students					
<b>10. Oral health:</b> number of decayed, missing, filled teeth at age 5 yrs	Sheffield	1.7 (2007/08)				1.5
	National	1.1 (2007/08)				
	Core cities ranking	3				
Closing the gap measure: CA ceiling target	Worst CA	2.6				2.2

<b>11. Unscheduled care: A&amp;E attendance &lt;5 yrs</b> Directly age standardised rate per 100,000 population	Sheffield	78654				
	National					
	Core cities ranking					
Closing the gap measure: CA ceiling target	Worst CA					

**The Programme will also contribute towards delivery of these education targets but overall accountability for them remains the remit of the Citywide Learning Body**

Level	Measure	Current National Ranking	Current Core City Ranking	Target Ranking	Target Core City Ranking
Key Stage1	Level 2+ Reading	137 <sup>th</sup>	5 <sup>th</sup>	3 <sup>rd</sup> Quartile (2012)	2 <sup>nd</sup> (2012)
Key Stage 1	Level 2+ Writing	118 <sup>th</sup>	5 <sup>th</sup>	Top 100 (2012)	3 <sup>rd</sup> (2012)
Key Stage 1	Level 2+ Maths	142 <sup>nd</sup>	5 <sup>th</sup>	3 <sup>rd</sup> Quartile (2012)	3 <sup>rd</sup> (2012)
Key Stage 2	English & Maths	116 <sup>th</sup>	5 <sup>th</sup>	3 <sup>rd</sup> Quartile & Top 100 (2012)	3 <sup>rd</sup> (2012)
Key Stage 4	Including English and Maths	132 <sup>nd</sup>	5 <sup>th</sup>	3 <sup>rd</sup> Quartile to at least 112 <sup>th</sup> (2012)	3 <sup>rd</sup> (2012)

**Persistent Absence from School**

Level	Measure	Current %	2012/13 Target %	2012/13 Core City Target Rank
Primary	Children missing more than 15% school time	6.4	5.2	2 <sup>nd</sup>
Secondary	Children missing more than 15% school time	11.7	9.5	2 <sup>nd</sup>

## Appendix 2

### CHILDREN'S HEALTH AND WELLBEING PARTNERSHIP BOARD Terms of Reference

#### 1. Purpose

The **Children's Health and Wellbeing Partnership Board (CHWPB)** consists of providers and commissioners of community health and social care services for children in Sheffield.

The overall aim of the Board is to improve health outcomes and reduce health inequalities for children living in Sheffield.

The basis for decisions about strategy and service delivery should be the joint strategic needs assessment for children in Sheffield.

Within this context the overarching strategy for community health and social care services for children should focus on prevention, early intervention and local delivery of care, provided within effective and integrated models of service delivery.

The members of the Board, through working together and developing integrated services, will:

- 1) Provide a forum to enable provider and commissioner dialogue
- 2) Play an expert and advisory function to the Health and Wellbeing Board in respect of the setting of strategic priorities for children's health and wellbeing.
- 3) Implement the agreed programme of service transformation to meet the needs of children, provide services as close to home as possible, safeguard children and avoid duplication.

#### 2. Principles

The partners:

- Are committed to build relationships formed on trust and understanding and with the focus on outcomes for the child.

- Understand and recognise the distinct value of locally-based community services, and the importance and value of managing and leading these services from within the community.
- Recognise that families and children interact with a range of services and that organisational boundaries should not impede support or delay intervention.
- Recognise that good health is not just about health services and requires a holistic approach which seeks to understand and meet the needs of families.
- Are committed to using evidence based approaches to maximise the effectiveness of community based services for children, with a particular emphasis on early year's provision and services for children with long-term conditions.

### **3. Objectives**

- 1) The Board will provide expert advice around all issues of children's health to the Health and Wellbeing Board. It will support the shaping of children's health strategy and priorities for the city to reduce health inequalities and improve outcomes for children and families. Commissioning decisions remain the remit of the commissioning groups
- 2) The Board will develop and deliver a 5-year strategic and implementation plan. This will identify opportunities to improve health and social care pathways to directly impact health inequalities and redesign services to deliver seamless care with better outcomes for patients. This will:
  - Keep Sheffield's children healthy, to help them achieve their potential and live their lives to the full.
  - Make measurable improvement to the health of the children living in the city
  - Deliver integrated, joined up and seamless services that are easy to navigate for children, young people, carers and professionals.

- Deliver services that join together to meet the needs of the child when they need it, in a place as close to home as possible, that works in partnership to ensure smooth transition and avoid duplication, and that ensures every child has the opportunity to live life to the full.
- Deliver services that are affordable, demonstrates value for money, and are sustainable and flexible to respond to changing local needs.
- Provide services for children which are staffed by a workforce which is confident and empowered to enable them to work flexibly and share roles to the benefit of the children in their care, but with clarity in roles and responsibilities.

#### **4. Scope**

The Board will consider within its remit, any community health and social care services the provision of which is the responsibility of any of the members. This will include but is not exclusive to:

- Community paediatric services
- Multi agency support teams
- Safeguarding services
- Children's centre health services/Sure-start
- Community nursing including health visiting and school nursing,
- Community therapies including physiotherapy, occupational therapy, speech and language,
- Primary Mental Health services
- GP services for children
- Services to vulnerable children e.g. travellers, homeless families, asylum seekers

#### **5. Key areas of Responsibility:**

- The provision of expert advice on children's health across the city and input to strategic commissioning as required
- Development and implementation of delivery plans for seamless pathways and integrated service delivery.
- Agreeing operational processes to deliver joined up care.

- Driving forward with further integration of multi-agency services.
- Developing children's workforce planning in partnership
- 'Unblocking' pathways where organisational boundaries are causing challenges.
- Driving change and bring challenge to encourage new ways of working.
- Agreeing joint working principles e.g. information sharing, consensus on consent etc.
- Developing a joint delivery plan for improvement within children's community health services with milestones for achievement.

## 6. **Accountability:**

Individual members will be accountable to their own organisation.

Within the partnership framework, organisations commit to holding each other to account, and for managing the performance of each organisation against delivery of the Board's objectives.

Within the wider health and social care environment, the Board will seek to advise, inform and consider issues referred to it by, and in conjunction with:

- Individual member organisations
- Children's Trust Executive Board
- 0-19+ Partnership Board
- The Sheffield Safeguarding Children Board
- Health and Well-being Board
- Children's Joint Commissioning Group

## 7. **The Board**

The Board will meet monthly and have joint Chairs: Executive Lead for Children and Young People's Service (Sheffield City Council) and the Chief Executive (Sheffield Children's NHS Foundation Trust), who will alternately chair meetings

**The core partnership** is comprised of the following:

Sheffield City Council (2 seats)

NHS Sheffield Clinical Commissioning Group (2 seats)  
Sheffield Children's NHS Foundation Trust (2 seats)  
Sheffield Teaching Hospitals NHS Foundation Trust (1 seat)  
South Yorkshire Police (1 seat)  
User representation (2 seats)

The named representatives should be of appropriate seniority to commit their organisation. GP representation should cover core primary care provision and GP provider companies; GP representatives will need to have the confidence of the GP community; GPs with a formal commissioning role will declare this.

The focus of business will be to reach decisions through consensus or, where necessary, voting.

Each seat will have one vote. The chair will maintain their voting rights and in the event of a dispute will have a casting vote.

Each core member to be permitted a named deputy, sufficiently senior to discharge the agreed Board responsibilities

### **Extended Membership**

The Board will have the following extended membership:

A representative from the Local medical Committee (LMC)  
Nursing Director, Head of Midwifery, Sheffield Teaching Hospitals Trust  
Consultant in Public Health - Maternity, Children and Young People  
Assistant Director Strategy, NHS Sheffield  
Programme Manager, Children & Young People, SCCC  
Communication Manager, Sheffield City Council  
Account Manager, HR Media (NHS Communications)

The extended membership does not have voting rights at the Board and do not need to assign a deputy in the event of non-attendance. This group will be able to express opinions and provide expert advice to the Board.

A public record of all interests will be maintained.

The programme office supporting delivery of the Board's work programme (led by the Programme Manager) will support the Board.

## **8. Process for Appointment to the Children's Health and Wellbeing Board**

### *a. Voting Members (Core)*

In the event of a core member of the CHWPB resigning from the Board. The Chairs of the CHWPB will write to the organisation and request the name of a replacement. This nomination will be considered at the following Board meeting and the core membership will vote to confirm the replacement.

### *b. Non-voting members (Extended)*

The process for changes in non-voting members of the Board will be the same as for voting members. Resignations will prompt a decision on the necessity for a replacement and a written request will follow from the Board. The organisation nomination will be considered for approval by vote at the following Board meeting.

For those who want to attend the Board temporarily (i.e. for a maximum of one or two meetings consecutively) permission must be sought and agreed by the joint chairs.

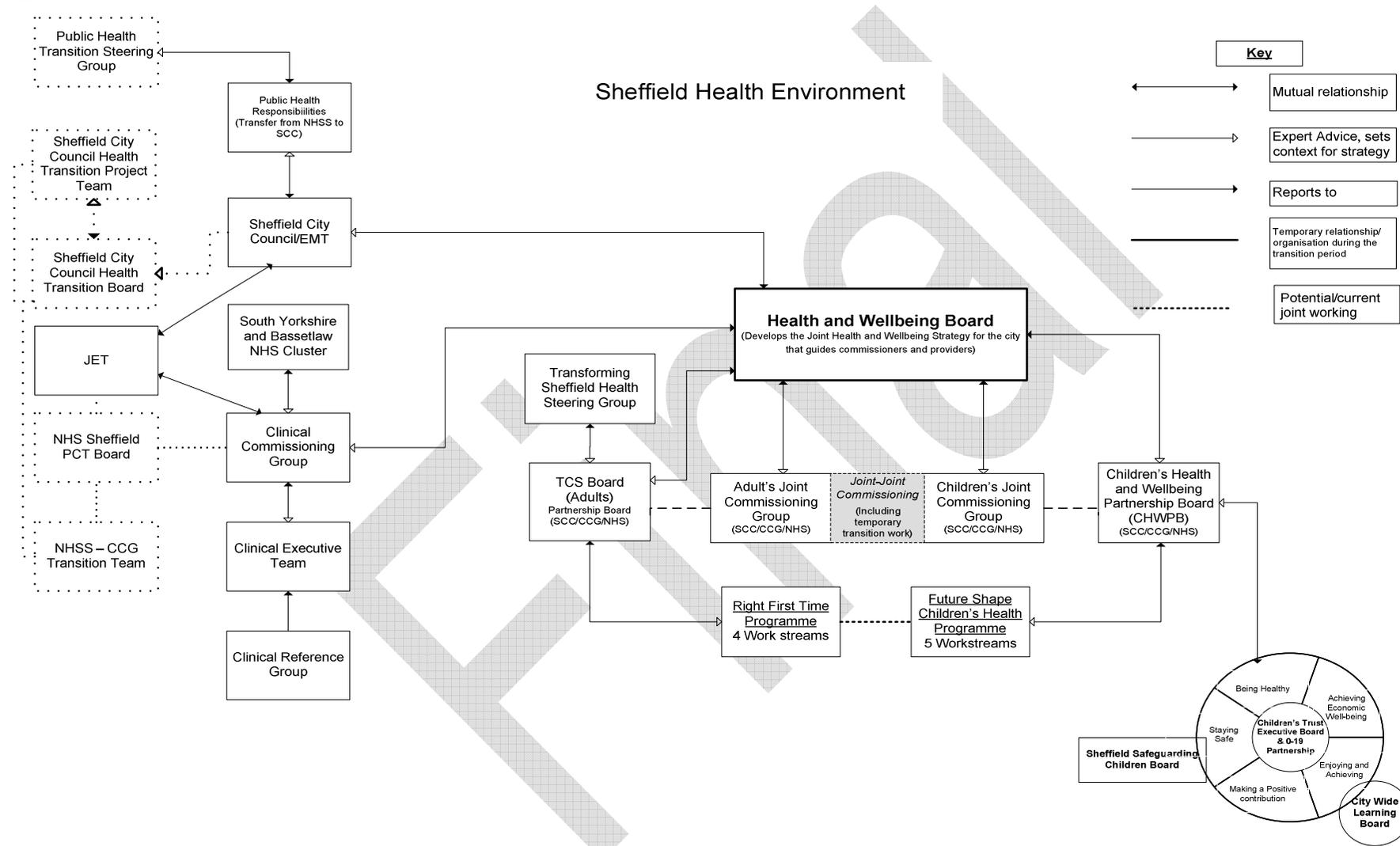
## **9. User and stakeholder engagement:**

The Board will develop mechanisms for engaging with service users, local representatives (e.g. elected representatives, the LMC, voluntary, community and faith sectors), and with staff on future delivery models and integration of services.

## **10. Review**

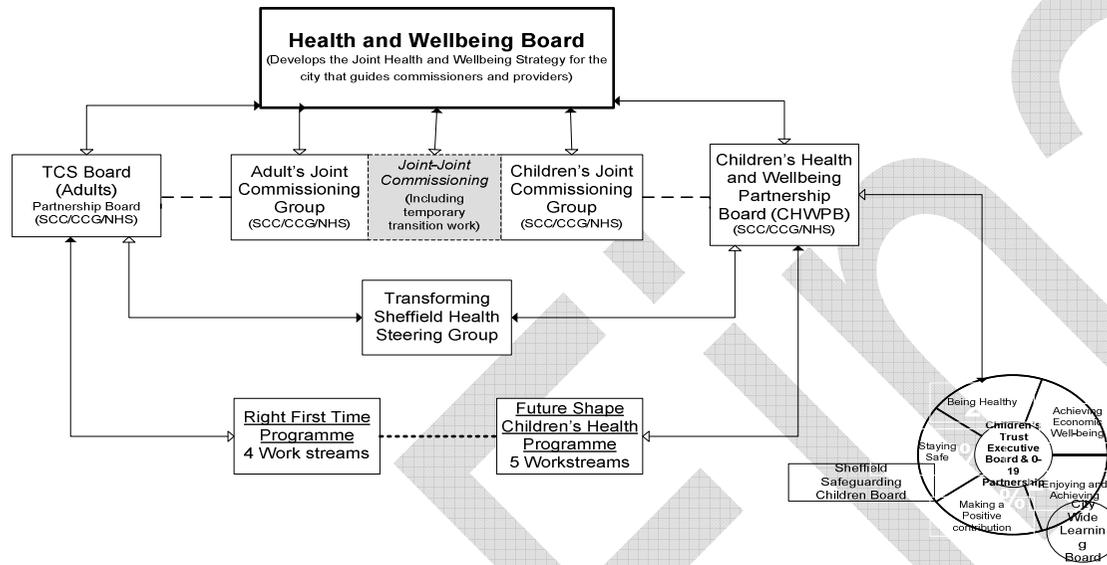
These Terms of Reference will be reviewed after 6 months (September 2012)

# Appendix 3



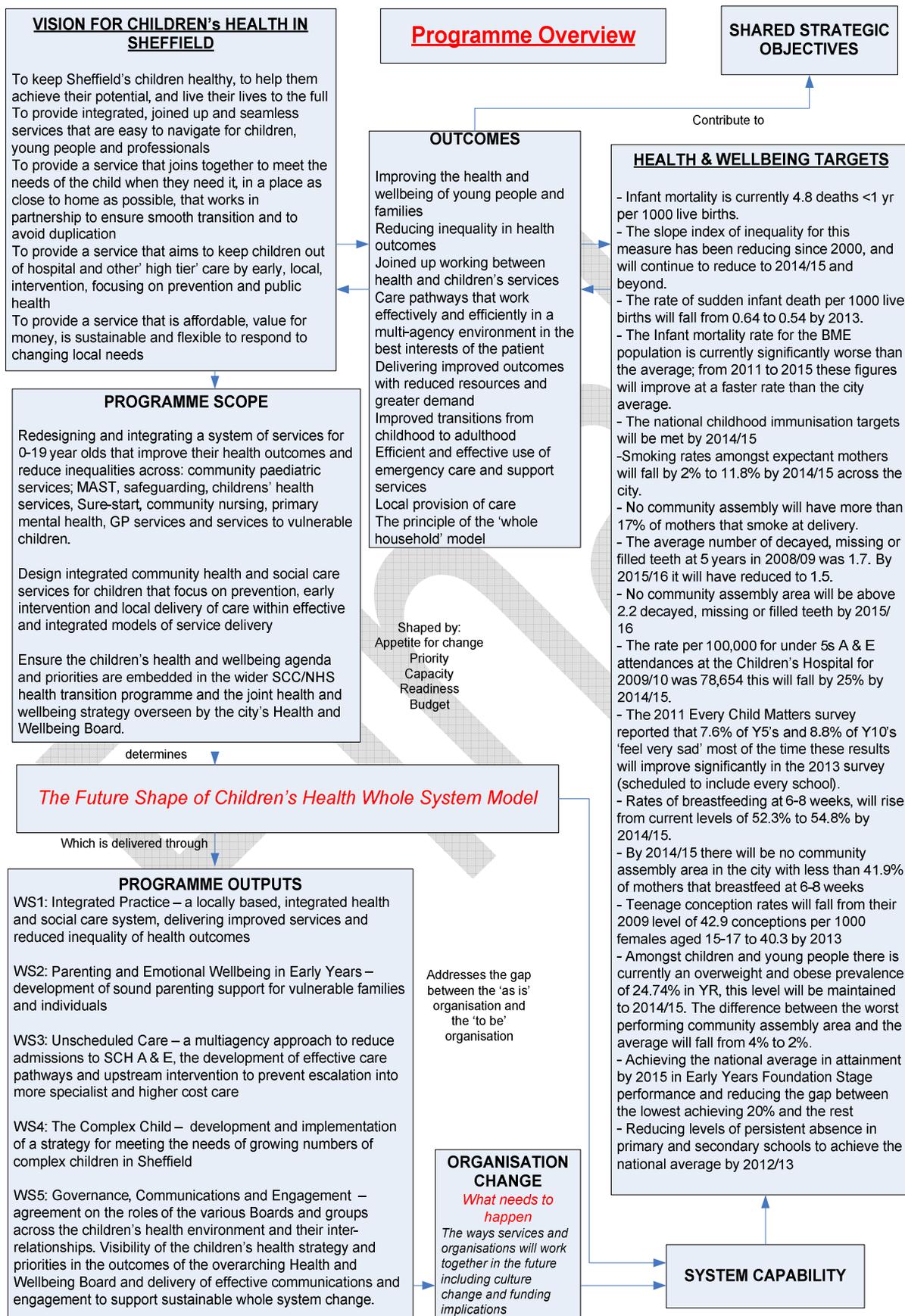
# Appendix 4

## Sheffield Children's Health Environment



<p><b>Health and Wellbeing Board</b> The role of this board is to bring together those who buy services across the NHS, public health, social care and children's services, elected representatives and representatives from HealthWatch to plan the right services for their area. They will look at all health and care needs together, rather than creating artificial divisions between services. A central role of Health and Wellbeing Boards is to drive through system change so that the full benefits of the new health and social care environment can be realised. The Health and Wellbeing Board will have the statutory responsibility to commission the Joint Strategic Needs Assessment that will inform the Joint Health and Wellbeing Strategy. All providers and commissioners will be obligated to follow this strategy as they seek to improve health and social care outcomes for the city. The Board will promote integration and partnership working, improve democratic accountability, and ensure a strong role for public voice at the heart of health and social care planning.</p>
<p><b>Children's Joint Commissioning Group</b> This group brings together the commissioners of children's services from NHSS, SCC, and the CCG. The central role of the group is to ascertain possibilities for joint commissioning and to ensure that commissioning at lesser levels of integration is mutually informed to ensure optimal outcomes for the city. CJCG helps to inform the JSNA and JHWS through the work that the partners do in relation to children's services in each stage of their commissioning cycles, in effect they feed into the HWBB to ensure the JHWS reflects the needs of children and young people. Group members also set high level strategy for the TCS Board member organisations.</p>
<p><b>Children's Health and Wellbeing Partnership Board (CHWPB)</b> The Board brings together the providers of health and social care for children from across the city. The central role of the Board is to improve health outcomes for children living in Sheffield and to foster strong partnership working and integration. Providers of services share many of the same objectives and this board helps to bring these commonalities together for a shared view of how the city wants children's services to develop, it develops programmes for how this is to be done. The Board works closely with the CCG to ensure that expertise from the provider side informs strategy and commissioning decisions, as a result, this expertise flows into the JHWS developed by the Health and Wellbeing Board.</p>
<p><b>CHWPB Work Stream Groups</b> These groups constitute the Future Shape Health Programme that works on the priorities set by the Board. The work streams are priorities for providers, commissioners, and the JHWS.</p>
<p><b>Children's Trust Executive Board</b> The Board is accountable for improving outcomes for children and young people, ensuring strong safeguarding practice across agencies. The Board is statutorily obligated to ensure that members of the board work together to improve services for children and young people. The Board concentrates on the Every Child Matters five key outcomes, one of which is Being Healthy. As a result of this, the Board has a key role as the overseer of the CJCG and CHWPB to ensure that the interests of young people and children are realised within the health and social care environment. Although it will not have direct accountability links to the HWBB, CTEB will work to ensure that the JHWS reflects the needs of children and young people and works to improve services to young people.</p>
<p><b>Joint-Joint Commissioning Group</b> This group brings together the CJCG and the Adults Joint Commissioning Group. The central role of the group is to ascertain possibilities for joint commissioning and to ensure that commissioning at lesser levels of integration is mutually informed to ensure optimal outcomes for the city.</p>

# Appendix 5



Appendix 6

<b><u>Future Shape Children's Health Blueprint Consultation Pathway</u></b>	
<p><b>SCC Senior Leadership Team - SLT</b> 8<sup>th</sup> November 2011 – Sarah Homer</p> <p style="text-align: center;">▼</p> <p>Draft Blueprint presented - Endorsed</p>	
<p><b>NHS Sheffield Clinical Executive Team</b> October Sue Greig and Margaret Ainger</p> <p>Cover paper on approach to the Children's health programme development - Programme supported and referred to CCG for endorsement</p>	
<p><b>TCS Adults Partnership Board</b> 14<sup>th</sup> November 2011- Sue Greig, Jayne Ludlam and Isabel Hemmings</p> <p style="text-align: center;">▼</p> <p>Draft Blueprint document - Progress Noted- Agreement to joint working</p>	
<p><b>CTEB</b> 21<sup>st</sup> November 2011 – Simon Morritt /Sonia Sharp</p> <p style="text-align: center;">▼</p> <p>Cover Paper and Draft Blueprint document – Programme endorsed</p>	
<p><b>CCG</b> 8<sup>th</sup> December 2011 - Sue Greig/Margaret Ainger</p> <p style="text-align: center;">▼</p> <p>Cover Paper and Summary of programme Blueprint – Endorsed new governance arrangements to incorporate CCG membership of Children's Health and Wellbeing Partnership Board</p>	
<p><b>Children's Health and Wellbeing Partnership Board</b> 12 December 2011 – Sarah Homer</p> <p style="text-align: center;">▼</p> <p><u>Draft Blueprint document – Approved</u></p>	<p><b>Transforming Community Services Shadow (Adults) Partnership Board</b> 13<sup>th</sup> December 2011 – Sarah Homer</p> <p style="text-align: center;">▼</p> <p>Cover Paper and draft copy of Blueprint document – Endorsed</p>
<p><b>Sheffield Transforming Health Steering Group (STHSG)</b> 15<sup>th</sup> December 2011 –Sonia Sharp &amp; Simon Morritt</p> <p style="text-align: center;">▼</p> <p>Draft Blueprint document – Endorsed and Supported</p>	
<p><b>0-19+ Children's &amp; Young Peoples Partnership Board</b> 19<sup>th</sup> January 2012 Sue Greig</p> <p style="text-align: center;">▼</p> <p>Cover paper and Blueprint document – Endorsed and Supported</p>	
<p><b>Executive Management Team (EMT)</b> 31<sup>st</sup> January Sonia Sharpe &amp; Jeremy Wight</p> <p style="text-align: center;">▼</p> <p>Briefing Paper and Blueprint document – Endorsed and Supported</p>	
<p><b>CCG</b> 2<sup>nd</sup> Feb 2012 Margaret Ainger &amp; Sue Greig</p>	

<p>▼</p> <p>Blueprint Cover Paper – Programme Endorsed</p>
<p><b>CTEB</b></p> <p>20<sup>th</sup> February 2012 – Simon Morritt /Sonia Sharp</p> <p>▼</p> <p>Update</p>
<p><b>Briefing to Cllr Jackie Drayton – Sheffield City Council Lead for Children Young People and Families</b></p> <p>22 March 2012 - Jayne Ludlam and Sarah Homer</p> <p>Progress Report and Programme Update</p>
<p><b>Sheffield Executive Board</b></p> <p>March 14<sup>th</sup></p> <p>For Information Briefing Paper</p>
<p><b>Shadow Health and Wellbeing Board</b></p> <p>26<sup>th</sup> April 2012 – Cllr Jackie Drayton and Dr Margaret Ainger</p> <p>Cover Paper and Blueprint document scheduled</p>

Final

Final

## Appendix 7

### Children and Young People's Plan 2011-2014

<p><b>Achieving Well-being Economic Well-being</b></p>	<ul style="list-style-type: none"> <li>• Children and young people across our city will achieve greater attainment and skills, to enable them to fulfil their aspirations and contribute to an economically vibrant city. <b>(1.1)</b></li> <li>• We will maintain and further develop strong partnerships which connect the educational sector, training providers and the business sector, in order to provide young people with the best possible preparation for work. <b>(1.2)</b></li> <li>• Young people will have access to, and be equipped to take advantage of, a range of training, employment or entrepreneurship opportunities. <b>(1.3)</b></li> <li>• There will be fewer children, young people and their families living in poverty. <b>(1.4)</b></li> </ul>
<p><b>Equality of Outcomes and Opportunity</b></p>	<ul style="list-style-type: none"> <li>• The attainment and achievement levels between our least and highest achieving children and young people will have narrowed, in particular with improvements for our looked after children, children from economically disadvantaged families, children and young people not in education, employment, training or apprenticeships, and children and young people who are from BME heritage. <b>(2.1)</b></li> <li>• Children, young people and families will have broader and higher aspirations and expectations, particular looked after children and other vulnerable children and young people. <b>(2.2)</b></li> <li>• We will improve the life chances of children, young people and their families who are experiencing disadvantage, in particular families living in, or on the fringe of, poverty. <b>(2.3)</b></li> <li>• Children and young people will have equitable access to and positive experiences of all services irrespective of [dis]ability, age, gender, ethnicity, sexuality or vulnerability. <b>(2.4)</b></li> </ul>
<p><b>Families</b></p>	<ul style="list-style-type: none"> <li>• Families will be supported to provide the best possible parenting and home learning environment. <b>(3.1)</b></li> <li>• Children and young people will be supported where they are living with parental difficulties, specifically hidden harm, parental mental ill-health or domestic violence. <b>(3.2)</b></li> <li>• Children, young people and families will have joined-up early support and intervention throughout pregnancy and early years; and across the childhood years for those most at risk. <b>(3.3)</b></li> <li>• Families' resilience will be strengthened through child-and family-centred and personalised whole household approaches. <b>(3.4)</b></li> </ul>
<p><b>Enjoying and Making Positive Contributions</b></p>	<ul style="list-style-type: none"> <li>• More children, young people and families will be involved in decision-making that affects their lives, particularly including personal care, life choices, service delivery, locality issues and city wide strategic matters, based upon honest two-way partnerships. <b>(4.1)</b></li> <li>• Community cohesion will be promoted and initiatives targeted at reducing community tensions for vulnerable areas and communities. <b>(4.2)</b></li> <li>• Children and young people will access positive volunteering opportunities which offer tailored, flexible, and enriching experiences, with a particular increase in targeted volunteering for our vulnerable groups. <b>(4.3)</b></li> <li>• All young people from vulnerable groups will have access to a choice and variety of affordable, quality cultural, leisure and physical positive activities. <b>(4.4)</b></li> </ul>

<p style="text-align: center;"><b>Safety</b></p>	<ul style="list-style-type: none"> <li>• Children, young people have increased awareness and understanding of the potential risks of online activity, and there is reduced risk-taking behaviour. <b>(5.1)</b></li> <li>• Children and young people are safe using the roads, using public transport, and driving, and there will a reduction in differential level of incidents experienced by disadvantaged families and vulnerable groups.<b>(5.2)</b></li> <li>• Children and young people are equipped to make decisions and take positive choices, particularly in relation to drug and alcohol use, offending behaviour, sexual activity, and safe choices <b>(5.3)</b></li> <li>• Children and young people will be able to access 'trusted routes' for support and guidance, particularly where there are family or community sensitivities to their disclosure, such as where it relates to sexuality, for those involved in street gangs, girls facing forced marriage, sexual exploitation, etc. <b>(5.4)</b></li> </ul>
<p style="text-align: center;"><b>Physical and Emotional Health and Well-being</b></p>	<ul style="list-style-type: none"> <li>• There will be improved health outcomes for children and young people and a narrowing of the gap in health outcomes between the most and least disadvantaged and vulnerable, and the population as a whole. <b>(6.1)</b></li> <li>• Children and young people will be supported by a holistic approach to health and well-being through access to healthy early years, healthy schools, and healthy further education settings, irrespective of where they live in the city. <b>(6.2)</b></li> <li>• Children and young people will receive the best possible support with respect to their emotional well-being and mental health, from families and from professionals within universal services, including access to and from a specialist service. <b>(6.3)</b></li> <li>• Children and young people with complex needs will be provided with care closer to home. <b>(6.4)</b></li> </ul>



**Mapping maternity, children and young people 0-19+partnership strategic planning groups & workstreams against  
Future Shape Children's Health outcomes**

Group/ workstream	CYYP	Infant mortality	Smoking in pregnancy	Breast feeding	Teen pregnancy	Oral health u-5s	Childhood obesity	Children & young people emotional well being	A&E attendances u-5s	Early Years Foundation Stage scores	Persistent school absence	Childhood immunisations	Efficiency savings
FSCH: Integrated practice	3.2-3.4 6.1	*	*	*	*	*	*	*	*	*	*	*	*
FSCH: Unscheduled care									***		*	*	***
FSCH: Parenting & emotional well being@	3.1	**	**	**	*	**	*	***	**	***	*	**	
FSCH: Complex child@@	6.3							**	*		*		***
MCHPCG: Reducing infant mortality: <ul style="list-style-type: none"> <li>• Smoking in pregnancy</li> <li>• Breastfeeding</li> <li>• Maternal obesity</li> <li>• Teen pregnancy</li> <li>• Access to maternity services</li> <li>• Sudden Infant Death</li> <li>• Recessive genetic disorders</li> <li>• Child poverty</li> </ul>	6.1	***	***	***	**	*	*	*	*	*			
MCHPCG: 0-5 healthy child programme	3.1 3.2	**	**	**	**	*	*	*	*	**		*	
EWBMHSG: <ul style="list-style-type: none"> <li>• Participation</li> <li>• Information</li> <li>• Resilience</li> <li>• Workforce</li> </ul>	2.4 3.1 6.4	**	**	**	*	**	*	***	**	***	*	**	***

development • Parenting@ • Complex child@@ • Transition													
Healthy Settings Board • Early years • Schools • Colleges • Youth • Care	5.3 6.2	*	**	**	**	**	**	**	*	*	*	*	
Sheffield Lets Change for Life				*		*	***	*					

FSCH: Future Shape Children's Health: MCHPCG: Maternal & Child Health Planning and Commissioning Group

EWBMHSG: 0-19+ Emotional Well Being & Mental Health Strategy Group

\*enabling/some impact \*\*moderate impact \*\*\* significant impact

@ these are the same workstream

@@ these are at this stage separate workstreams but may be combined at a later stage

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