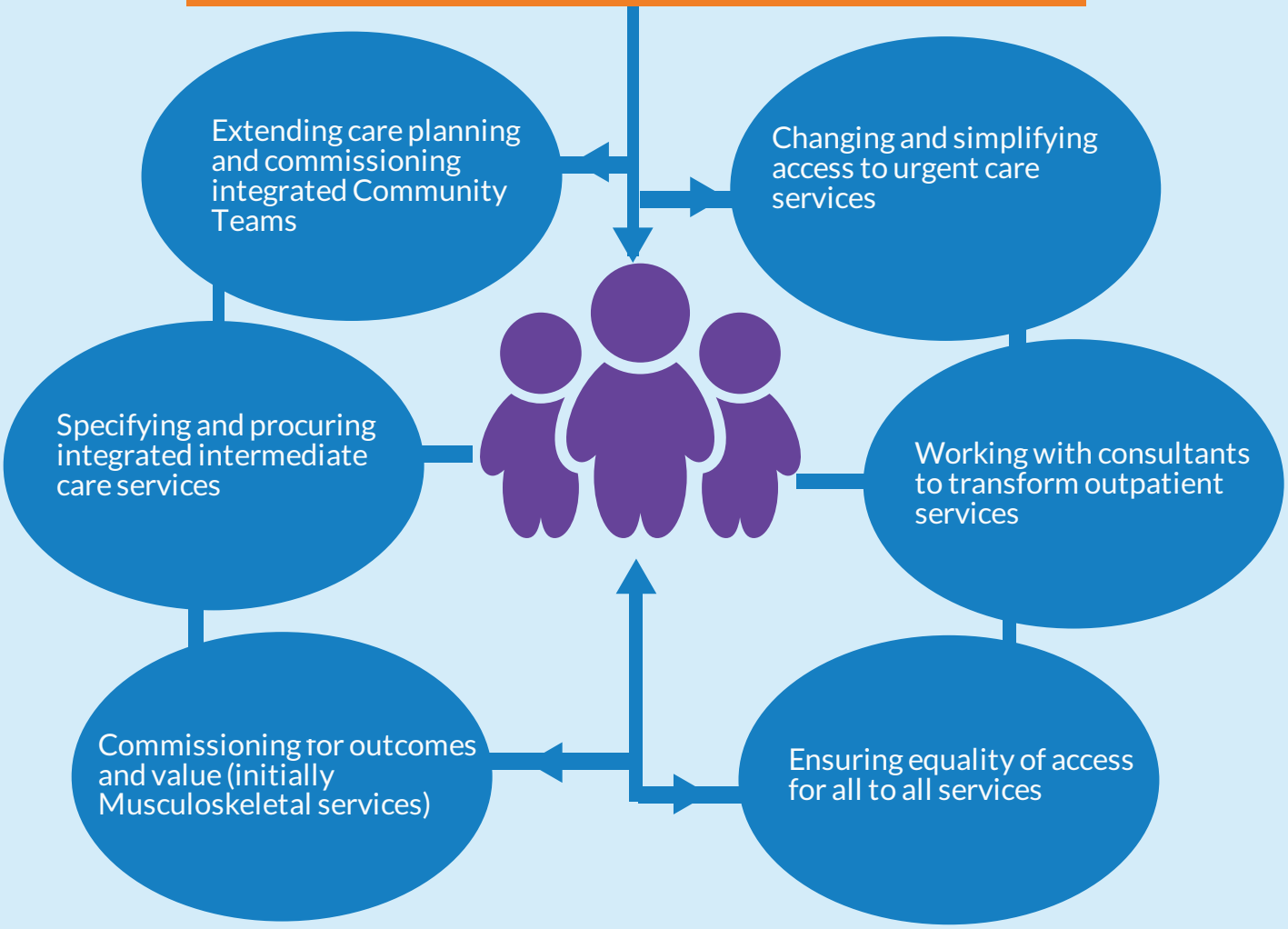
Commissioning Intentions 2014-19

Ambitions for 2014-2019

based on aims from our prospectus and the outcomes of Sheffield's Health and Wellbeing Strategy - see over

- Care plans offered to all those identified as having emerging risk of hospital admission
- Care requiring specialist clinician brought closer to home
- Support and services in place to help all children have the best possible start in life
- Services taking a more joined-up approach to managing long term conditions across primary and community based health and social care, to help reduce emergency hospital admissions by up to 20%
- Reduced excess early deaths in adults with serious mental illness and improvement in life expectancy for people with learning disabilities

Projects to ACHIEVE these ambitions include



Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Develop a Commissioning for Quality Strategy

Significantly strengthen our public and patient engagement

To achieve these ambitions we will also

Put in place integrated commissioning of health and social care with Sheffield City Council

Support the development of primary care providers

Intended outcomes of the Joint Health and Wellbeing Strategy

People get the help and support they need

Health inequalities are reducing

Sheffield is a healthy and successful city

Services are affordable, innovative and deliver value for money

Health and wellbeing is improving

CCG Prospectus aims

- Improve patient EXPERIENCE and ACCESS to care
- Improve QUALITY and EQUALITY of healthcare in Sheffield
- Work with Sheffield City Council to continue to REDUCE health INEQUALITIES in Sheffield
- Ensure there is a SUSTAINABLE and AFFORDABLE healthcare system in Sheffield

Commissioning Intentions 2014-19

Executive Summary – Plan on a Page

This plan sets out our ambition for the next five years (2014-19) and our actions for the years 2014-16 towards those aims. These are based on the aims set out in our prospectus and the outcomes that Sheffield's Health and Wellbeing Strategy intends to achieve.

Prospectus Aims

- To improve patient experience and access to care.
- To improve the quality and equality of healthcare in Sheffield.
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield.
- To ensure there is a sustainable, affordable healthcare system in Sheffield.

The outcomes set out in the Joint Health and Wellbeing Strategy

- Sheffield is a healthy and successful city.
- Health and Wellbeing is improving.
- Health inequalities are reducing.
- People get the help and support they need.
- Services are affordable, innovative and deliver value for money.

Our Ambitions for 2019

- All those who are identified to have an emerging risk of hospital admission are offered a care plan.
- To have an integrated primary and community based health and social care services approach to long-term conditions management to support people living independently at home, reducing emergency hospital admissions by up to 20%.
- Care requiring a specialist clinician will be brought closer to home.
- Reduce the number of excess early deaths in adults with serious mental illness and achieve similar improvements in life expectancy for people with learning disabilities.
- To put in place support and services that will help all children have the best possible start in life.

This document sets out the actions we will take towards these ambitions in the next two years. Key projects include:

- Extending care planning and commissioning Integrated Community Teams.
- Changing and simplifying access to urgent care services and establishing an urgent primary care centre.
- Specifying and procuring integrated intermediate care services.
- Working with consultants to transform outpatient services.
- Commissioning for outcomes and value, initially in Musculoskeletal services.
- Ensuring equality of access for all to all services.

To achieve these aims, we will develop a Commissioning for Quality strategy, support the development of primary care providers, put in place integrated commissioning of health and social care with Sheffield City Council, and significantly strengthen our public and patient engagement.

1. Introduction and Context

We published our Prospectus in January 2012, in the early stages of the development of the Clinical Commissioning Group in shadow form, and renewed it in April 2013, as an established statutory body. Our four Prospectus aims are unaltered and remain at the heart of our ambition:

- To improve patient experience and access to care.
- To improve the quality and equality of healthcare in Sheffield.
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield.
- To ensure there is a sustainable, affordable healthcare system in Sheffield.

The Health and Wellbeing Board in Sheffield, which works as a strategic commissioning partnership between the CCG and the City Council, published its strategy in 2013. We are committed to working with partners to achieve the outcomes set out in the Joint Health and Wellbeing Strategy:

- Sheffield is a healthy and successful city.
- Health and Wellbeing is improving.
- Health inequalities are reducing.
- People get the help and support they need.
- Services are affordable, innovative and deliver value for money.

1st April 2014 is the beginning of the second year of operation for the CCG. We expect in our first annual report to demonstrate significant achievements for 2013/14 including delivery of the required 1% financial surplus, meeting the majority of NHS Constitution standards, delivering over three quarters of the 84 commissioning intentions we published for 2013/14, and making great progress in developing as an organisation, with strong clinical leadership and good management support.

In our second and subsequent years of operation, we intend to build on our work so far to achieve our aims, set out in our prospectus, recognising that most health services in Sheffield are seeing increased demand and our acute hospitals in particular remain under significant pressure, that we have not yet made a difference to health inequalities, and that change may seem marginal to many of our patients and our member practices.

We want to now make faster progress towards achieving our aims. To do that, we have set ourselves a number of ambitious objectives for the next five years, which will transform the way healthcare is delivered in Sheffield and improve the health and wellbeing of people in Sheffield, especially those population groups with the poorest health.

We are doing this in the context of some major challenges facing the NHS, including:

- Demography – ageing and changes in make-up of population
- National funding constraints; the CCG will see minimal increases in funding in real terms and need to deliver efficiencies in all areas of our spend
- Increasing public expectation and rising demand
- Cost of new drugs and procedures

The NHS "Call to Action" summarises these challenges in the diagram below, and can be found at
http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf.

More now than ever we need to work in partnership with other organisations that meet people's health and social care needs. We will be working with Sheffield City Council to join together our commissioning arrangements so that we can commission services that are integrated around people's needs, and so that we can make the best possible use of the resources available to support people in Sheffield. We are also strengthening our partnerships with the Foundation Trusts in Sheffield, so that our contractual relationships are set in the context of shared aims and objectives to ensure health services in Sheffield achieve the highest standards for our patients. The voluntary sector led partnership that has developed Sheffield's "Best Start" bid to the Big Lottery will be critical for us in achieving our aims for children and families in the city.

Our five year vision for healthcare in Sheffield, and the commissioning plans for 2014/16 that it contains, will help us to achieve the aims we set out in our Prospectus and in the Health and Wellbeing Strategy.

This document describes our vision and ambitions, and our priorities for action in 2014/15 and 2015/16. Its primary purpose is to share our intentions with providers of healthcare, with partner organisations in the city, and with the public we serve. These intentions will inform our contract negotiations and our detailed business planning for the next two years.

This document has been discussed and endorsed by the Health and Wellbeing Board in Sheffield, as part of a discussion to ensure that all partner organisations' (the CCG, Sheffield City Council and NHS England) plans contribute to achieving the outcomes set out in our Health and Wellbeing Strategy.

2. Our Population's Health

The current population of Sheffield (based on ONS Mid-Year estimate for 2012) is 557,382 people of which 275,673 are males (49.5%) and 281,709 females (50.5%). This represents an increase in population of 8.6% since 2001. The population is projected to rise by a further 5.2% to around 586,500 in the year 2020. 0-4 year olds make up around 6% of the population (approximately 34,300) and 4.4% are 75 years and over (approximately 24,700). This older age group will increase by around 17% by the year 2020 to approximately 29,000 people.

Life Expectancy

Life expectancy for both men and women in Sheffield is improving year on year. For men average life expectancy at birth is 78.4 years and 82.1 years for women (2009-2011). Whilst this represents a longstanding trend of improvement, both remain lower than the national average of 78.9 years for men and 82.9 years for women.

A different picture of health emerges when we look at the gap in life expectancy between the most and least deprived people in Sheffield. This shows that the current (2009-2011) gap between the most and least deprived men in Sheffield is 8.69 years and 7.35 years for women. This compares with the 2001-2003 gap of 8.69 years for men and 7.10 years for women i.e. a significant and persistent health inequality in the City.

Preventable premature mortality

Cancer and cardiovascular disease account for around 60% of all premature deaths in Sheffield, consistent with the national picture. For both the premature mortality rate from all cancers and cardiovascular disease, Sheffield has among the lowest rates of the Core Cities but figures remain higher than the national average.

Over half of all premature deaths from cancer are considered preventable, which in Sheffield equates to approximately 350 deaths a year. Common preventable causes of cancer are smoking, poor diet and physical inactivity. A large number of cancer deaths may also be prevented through earlier detection and treatment of signs and symptoms.

Widespread changes in lifestyle, systematic identification of people at risk, and better treatment for cardiovascular disease has resulted in the premature mortality rate falling year on year in Sheffield, and at a faster pace than nationally. Nevertheless although the gap between Sheffield and rest of the country has narrowed, our rate remains significantly higher than the national average. Over two thirds of premature mortality associated with CVD is considered preventable. In Sheffield this equates to over 230 premature deaths per year. The NHS Health Check programme, together with the range of other actions to ensure timely prevention and early intervention in relation to chronic disease, supports improvements in this area.

We are detecting a worrying upward trend in both ill health and premature mortality linked to liver disease. Liver disease is the only major cause of premature death in Sheffield for which the rate is increasing. People are also dying from it at younger ages. Premature mortality from liver disease in Sheffield now accounts for just over 70

deaths in people under the age of 75 years per year. Over 90% of these deaths are considered preventable. The common avoidable causes of liver disease are alcohol consumption and obesity.

In Sheffield around 1,000 new cases of diabetes are diagnosed every year and prevalence is expected to continue to rise for the foreseeable future. In spite of the rate of increase there is evidence that diabetes care is improving in the City. For example, the proportion of diabetes patients with good control of their blood sugar level, according to their GP record, has improved from 63% in 2009 to 73% in 2012. This means that Sheffield has a favourable profile in terms of preventable morbidity and mortality outcomes and the individual disease contributions to that; especially so for a city population.

Mental Health and Dementia

There are currently around 6,400 people living with dementia in the City, and this is expected to rise to over 7,300 by 2020 and over 9,300 by 2030. Early diagnosis and intervention improves quality of life and can delay or prevent premature and unnecessary admission to care homes. Around one third of people with dementia currently live in (largely) private sector care homes, and the trend is towards entering care with more severe disease. If current policies remain in place, by 2025 the demand for this type of care home accommodation is predicted to increase by 55% with 71% of the increase coming from people aged 85 and over.

Mental health problems are common, with one in four people experiencing a mental health problem in their lifetime and around one in one hundred people suffering a severe mental health problem. In relation to common mental health problems, such as depression and anxiety, around 12.27% of Sheffield adults are estimated to have depression compared with 11.68% in England.

Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for individuals, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In terms of severe mental illness the latest figures for Sheffield (2011-12) suggest that the number of people with a psychosis (all ages) registered with a Sheffield GP practice was approximately 4,500. When considered as a percentage of all people registered with a Sheffield GP, this represents 0.80% which is on a par with the England average of 0.82%.

People with a severe mental illness have a threefold increased risk of premature death than those without such an illness and a reduced life expectancy of approximately 16 years for women and 20 years for men. The excess premature mortality rate in Sheffield people with a mental illness (988 per 100,000 population) is higher than that for England (921 per 100,000 population). The mortality rate from suicide and undetermined injury however, at 6.45 per 100,000 population (2009-2011) is much lower than the average for England (7.87 per 100,000 population). In the recent National Audit of Schizophrenia (2012) while Sheffield had the second best record nationally for avoiding prescribing more than one antipsychotic drug and the best for not exceeding recommended doses, it was ranked lowest in the sample of service users for having their weight monitored in the previous 12 months and was below the

national average for checking blood pressure, smoking status and alcohol intake, and general physical health monitoring.

Child and Maternal Health

There is now overwhelming evidence that conception through to the early years is a crucial phase of human development. The mental and physical health of mothers during and immediately after pregnancy can have lifelong impacts on the child.

A key priority for providing the best start in life for a child is breastfeeding. When compared with national, regional and peer city averages, Sheffield performs well in terms of the percentage of babies who continue to be breast fed at 6-8 weeks after birth. The latest figure for the period 2012-2013 puts this at 50.8%. However this has remained virtually unchanged over the last 4-5 years, and almost one third of all babies who are breast fed at birth are no longer breastfeeding 6 to 8 weeks later.

Whilst not as great in terms of overall numbers of deaths, infant mortality (deaths in babies under the age of 1 year) also impacts significantly on the overall average calculation of life expectancy. Currently the Sheffield rate is 5.2 per 1,000 live and still births (2011) compared with a national rate of 4.3 per 1,000 and is ranked fifth of the eight Core Cities. The rate in Sheffield has been rising slowly, widening the gap with national outcomes. The incidence of infant mortality (2009/2012) in the Asian & Asian British ethnic group (10 per 1,000 live births) in Sheffield is more than double the incidence for the White ethnic group (4.5 per 1,000 live births) as is the rate in the Black and Black British group (10.5 per 1,000 live births).

Other key issues for Sheffield include:

- Maternal obesity is a factor in around 30% of still births or neonatal deaths (and approximately 35% of maternal deaths). The trend in the proportion of Sheffield women who are obese or morbidly obese is almost 22% and is increasing.
- The percentage of Sheffield mothers smoking at delivery was lowest in 2009-2010 (13.6% equivalent to around 860 mothers). Over the last three years this has increased to 14.1% (just over 900 mothers), counter to the national trend.
- Sheffield's teenage pregnancy rate has reduced significantly over the last few years and now stands at 35.2 per 1,000 births in girls aged 15-17 years (2011), but is above the national average of 30.7.
- A key strand of our infant mortality strategy, for example, is concerned with reducing infant deaths and severe disability related to consanguinity.

Sexual Health

The consequences of poor sexual health can be serious including unplanned pregnancy, avoidable illness and mortality from sexually transmitted infections and HIV/AIDS. Sheffield is ranked 83 (out of 326 local authorities, first in the rank has the highest rates) in England for rates of STIs in 2011. 4350 acute STIs were diagnosed in Sheffield residents, a rate of 783.1 per 100,000 residents, and 64% of acute STIs were in young people aged 15-24 years old.

In 2011 the diagnosed HIV prevalence in Sheffield was 1.8 per 1,000 population aged 15-59 years compared to 2 per 1,000 in England. Between 2009-2011 48% of HIV diagnoses were made at late stage of infection compared to 50% in England. The

current chlamydia diagnosis rate is 1851 per 100,000 (aged 15-24 year olds) against a national target of 2300 per 100,000 (aged 15-24 year olds).

Marked inequalities exist in sexual and reproductive health in Sheffield. The burden of sexual ill health is not equally distributed among the population but concentrated amongst those who are the most vulnerable including men who have sex with men, young people and minority ethnic groups.

Vulnerable Children and Young People

Half of adult mental health problems start before the age of 14. Early intervention to support children and young people with mental health and emotional wellbeing issues is vital. The Sheffield Every Child Matters Survey (ECM 2012) identified that the number of Y10s (14 and 15 year olds) saying they feel sad or depressed 'most of the time' has increased from 9% in 2011 to 14% in 2012. Children who qualify for free school meals report high levels of sadness and lower levels of wellbeing than average. In addition, Looked after Children are particularly at risk of developing mental health problems.

Particularly vulnerable groups, such as young people living in poverty, those 'Not in Education, Employment or Training' (NEETs), or those who are homeless or in care, are more likely to suffer poor emotional health than other young people. They are also more likely to misuse alcohol and other substances.

Health Inequalities

There are significant health inequalities in Sheffield, despite the progress made in improving the health of the population over the last few years. These inequalities are described in detail in the reports of the Director of Public Health and the Joint Strategic Needs Assessment. Although they do not represent the full picture of health inequalities in Sheffield, the following give a clear indication of the scale of the issue.

- The difference in life expectancy at birth for males, as measured by the Slope Index of Inequality, is 8.7 years, ranging from 74.4 years in the most deprived areas of the City to 83.1 years in the least.
- The difference in life expectancy at birth for females, as measured by the Slope Index of Inequality, is 7.3 years, ranging from 78.7 years in the most deprived areas of the City to 86 years in the least.
- Infant mortality rates (per 1000 live births) in Sheffield are 5.5 for White British mothers, 10.9 for Black and Black British mothers, and 13.4 for Asian and Asian British mothers.
- Smoking in pregnancy is strongly related to socio-economic status and the prevalence of smoking around the time of delivery varies from 0% to 40% across Sheffield neighbourhoods.
- The Confidential Inquiry into the premature deaths of people with learning disability (CIPOLD 2013) found that men with learning disabilities die on average 13 years and women with learning disability 20 years earlier than the general population.
- People with schizophrenia will on average die 14.6 years earlier than the general population.

3. What services will look like in five years' time and how we will improve health and outcomes for the people of Sheffield

To respond to the challenges the NHS faces, meet the expectations of our patients, and achieve the aims set out in our Prospectus, we want the way healthcare is delivered in Sheffield to have changed so that:

- Primary and community care will become the setting of choice for more services and as result patients in Sheffield will receive as much of their care as possible within a community setting.
- The care and services people receive will be of high quality delivered by fully supported clinicians, with seamless transfer to expert hospital-based secondary care when and if that is needed.
- Primary and secondary care clinicians will be enabled to work together with the patient, using a single patient record to support communication and ensure input is provided at the appropriate time, in the most appropriate setting and by the most appropriate professional for the patient.
- Patients will be supported in the self-management of their conditions where appropriate and we will seek to ensure technology is fully utilised in order to support patient care and monitoring without the need to travel to a hospital setting.
- Where appropriate services will be integrated to meet the needs of the patients and partners and co-commissioners will work collectively and collaboratively to achieve this.
- We use strong commissioning principles to deliver the best clinical outcomes for all our patients and we ensure services provide the highest quality of care while representing best value for money.

To achieve this vision, we have set ourselves a number of ambitions for 2019:

- All those who are identified to have emerging risk of admission through risk stratification, are offered a care plan, agreed between them and their clinicians (potentially 15,000 people).
- To have integrated primary and community based health and social care services underpinned by care planning and a holistic approach to long-term conditions management to support people living independently at home, reducing emergency hospital admissions by up to 20% and emergency department attendances by up to 40%.
- Care requiring a specialist clinician will be brought closer to home, changing the place or method of delivery for a significant proportion of current hospital attendances (numbers to be agreed in year).
- We will reduce the number of excess early deaths in adults with serious mental illness to be in line with the average of the best three core cities in England, and achieve similar improvements in life expectancy for people with learning disabilities.
- We will have put in place support and services that will help all children have the best possible start in life.

How we will improve health and outcomes for the people of Sheffield

We need to change the way we work to achieve these ambitions, and will:

- Adopt a whole person approach to the identification and response to the needs of an individual and their carer.
- Work with Sheffield City Council to plan, commission and where appropriate competitively procure services together to improve services and outcomes within the funding available.
- Involve patients and the public in our decision making, to ensure the changes we plan meet their needs, and support people and communities to look after themselves and remain independent.
- Work with providers to develop the capacity and skills to deliver many more services in local settings and develop contractual models to commission from primary care providers.
- Aim to ensure equality of access for all, to all services.

We will adopt a strong programme management approach to delivery of our commissioning intentions, with arrangements in place to ensure that individual projects are aligned and with an enhanced focus on delivery and benefits realisation, to ensure that we achieve our aims and patients and clinicians can see the improvements in services and in health we make.

Our work will continue to be largely delivered by our clinical portfolios, each led by a GP member of our Commissioning Executive Team and a nominated Governing Body member, and supported by our commissioning managers, with our quality work led by our Chief Nurse. Our clinical portfolios are:

- Acute Elective care
- Acute Urgent care
- Long Term Conditions, Cancer and Older People
- Mental Health, Learning Disabilities and Dementia
- Children and Young People

Each portfolio has identified priorities for the next two years that will contribute to achieving our ambitions. These are set out in the following section. It should be noted that many of the projects will contribute to more than one of the five ambitions, but for brevity, for presentational purposes, each project appears only once, aligned with the ambition it most directly contributes to.

Key priorities for the next two years include:

- Extending care planning and commissioning Integrated Community Teams.
- Changing and simplifying access to urgent care services or them and establishing an urgent primary care centre.
- Specifying and procuring integrated intermediate care services.
- Working with consultants to transform outpatient services.
- Commissioning for outcomes and value, initially in Musculoskeletal services.
- Ensuring equality of access for all to all services.

Some of our projects will be delivered through integrated commissioning arrangements with Sheffield City Council, as set out in section 7.

4. Our portfolio projects and efficiency plans

We have identified the projects we intend to undertake in the next two years, to move towards achievement of our five year vision and to make the efficiency gains we require to meet our financial duties and support the service changes and improvements we would like to make.

The projects are firstly listed by the ambition they most contribute to (noting that many projects will help achieve more than one aim). There is then a table of the financial assumptions underpinning the projects, showing the net saving or expenditure expected from the projects and therefore how we expect to achieve the savings required. The full financial plan is shown in section 8.

4.1. All those who are identified to have emerging risk of admission through risk stratification, are offered a care plan, agreed between them and their clinicians (potentially 15,000 people.)

Project Title	Delivery
Long Term conditions, Cancer and Older People	
Complete the care planning evaluation, recommend any changes arising for the way care planning is delivered and develop a specification and commissioning plan to operate from October 2014.	2014/15
Ensure the delivery of an integrated community nursing service that is responsive and delivers holistic, high quality care to those that need it, focussed on admission avoidance and upstream care management.	2014/15
Develop a new outcome based specification for integrated community health and social care services to include nursing, adult social care, community geriatricians, therapy services, care home support team, and intermediate care.	2015/16
Identify people with 5+ emergency admissions or A&E attendances and implement care plans jointly across primary and secondary care addressing physical and mental health care needs.	2015/16
Improve community resilience to help keep people safe at home and enable them to return home following an inpatient episode providing practical support to help minimise avoidable readmissions.	2014/5 & 2015/16
Work with partners including Public Health colleagues and providers so that all health and social care staff will deliver the same health promoting messages.	2014/15
Put a new model of domiciliary care for people at the end of life in place in one locality to improve care and reduce admissions.	2014/15
Evaluate domiciliary care for people at the end of life to inform commissioning intentions for 16/17.	2015/16
Implement use of Electronic Palliative Care Coordination Systems (EPaCCS) as a co-ordination system.	2014/15
New EPaCCS in place across Sheffield and all relevant providers able to access shared care plans for EOLC patients. Lessons learned for extension to LTC patients and plans to extend system agreed.	2015/16
Develop a dashboard looking at key indicators across selected condition-specific pathways, to identify any under-diagnosis and under-treatment of those populations with a learning disability, a serious mental illness or those who are socially isolated and outcomes for the whole population with these diseases.	2014/15
Ensure there are effective self-care programmes available to support people.	2015/16
Commission services to ensure early detection and diagnosis of disease.	2015/16
Work to implement opportunities within CVD and cancer to reduce potential years of life lost that are amenable to health interventions.	2014/15

Implement Cancer Survivorship Programme underpinned by a service specification in contracts.	2015/16

Acute Urgent Care

Ensure Flu, Pneumonia, Hep B and TB vaccinations for public and staff are at recommended levels. Put in place prophylactic prescribing of antibiotics for people at risk of developing infections e.g. COPD	2014/5-2018/9

Mental Health, Learning Disabilities and Dementia

Explore models of social prescribing and navigator/signposting service.	2015/16
Ensure risk stratification and care planning include people with LD, SMI and dementia.	2015/16

4.2 To have integrated primary and community based health and social care services underpinned by care planning and a holistic approach to long-term conditions management to support people living independently at home, reducing emergency admissions by up to 20% of and emergency department attendances by up to 40%.

Project Title	**Delivery**
Acute Urgent Care	
Evaluate current projects delivered through the Right First Time programme and determine which, if any, should continue.	2014/15
Pilot an Urgent Primary Care Centre to manage around 52,000 minor illness and minor injury attendances and reduce Emergency Department attendances by 40% if fully implemented.	2014/15-2015/16
Consider application of the Urgent Primary Care Centre model to Sheffield Children's Hospital and develop Patient Pathways in conjunction with Primary Care Clinicians for the top 20 presenting minor illness conditions.	2014/15-2015/16
In developing the expected full business case for the permanent model for the Urgent Primary Care Centre take into account .the future of the Minor Injuries Unit.	2014/15-2015/16
Undertake a systematic review of major specialties with the highest numbers of patients admitted as emergencies – one specialty per year with review and pathway redesign in year 1 and impact in year 2. • Respiratory Medicine - 2014/15 - 2015/16 • General Surgery - 2015/16 - 2016/17 • Geriatric Medicine and Paediatrics - 2016/17 - 2017/18 • General Medicine - 2017/18 - 2018/19	2014/15-2018/19
Ensure constant and ongoing update to the Directory of Services, which supports the correct signposting of callers to 111 to available services, to minimise the risk of callers being inappropriately directed to a service which is not designed to meet their urgent or emergency care needs.	2014/15-2018/19
Make direct access to available NHS and Social Care services for people with a Mental Health or Learning Disabilities condition possible via NHS111. Develop interventions for people with a cognitive impairment to reduce the frequency of them attending the Emergency Department or being admitted as an emergency.	2014/15
Develop the role of advanced paramedic and improved direct access for Ambulance Crews to rapid response services such as the Single Point of Access, GP In and Out of Hours Services, and Crisis Mental Health Teams to enable reduced conveyances to acute hospital from 65% to 50%.	2014/15-2018/19
Maximise the take up of the minor ailments scheme and the role of Pharmacists in providing advice on a range of minor illnesses by targeted communication and positive redirection from other parts of the urgent care system.	2014/15

Ensure common specifications for the following are developed to inform contracting for 2015/6 for all Sheffield's Emergency, Urgent and GP Out of Hours services: • Major Trauma (in future Major Emergency Centres) • Emergency Department (in future Emergency Centres) • Minor Injuries • Minor Illness • Positive redirection of(of non-urgent cases)	2014/5

Long Term Conditions, Cancer and Older People

Work with Sheffield City Council to re-specify intermediate care services, focussing on step up and step down services, including admission avoidance, active recovery, bed based rehabilitation, assessment for long term care, incorporating the results of the Right First Time external evaluation.	2014/15
Deliver a programme of redesign work on Ambulatory Care Sensitive Conditions, initially focussed on the frail older adult population, targeting falls and fracture prevention, the prevention and community based treatment of common infections and continence issues.	2015/16

Mental Health, Learning Disabilities and Dementia

Explore opportunities for redesign of specialist MH/LD/dementia care pathways.	2014/15
Develop adult liaison psychiatry to ensure coordinated management of complex needs within acute care for adults aged 18-64 .	2014/15
Improve the out of hours crisis response for people with Mental Health problems or Learning Disabilities, working in collaboration with SY Police, and exploring better support for forensic health.	2015/16
Ensure the Acute Care Reconfiguration results in appropriate bed capacity with commensurate increase in community provision.	2015/16

4.3 Care requiring a specialist clinician will be brought closer to home, changing the place or method of delivery for a significant proportion of current hospital attendances

Project Title	**Delivery**
Acute Elective Care	
Commission for outcomes and value for citywide musculoskeletal services.	2015/16
Commission management of stable glaucoma patients out of hospital.	2014/15
Understand the opportunity for the development of community clinics to support transformation of outpatients, reviewing the suitability of existing community clinics (Gynaecology, ENT, Gastro, Respiratory) to be expanded citywide.	2014/15
Identify services to be delivered in the community via the primary care basket of services.	2014/15-2015/16
Continue to support development of new clinical pathways Implement findings from Referral Education Support evaluation.	2014/15-2015/16
Identify opportunities to develop technology to support patient self-care and remote monitoring/increased non-face-to-face activity.	2014/15-2015/16
Identify areas where GP direct laboratory requesting and joint partnership working supports patient care within a primary/community setting. Identify areas for GP education and training, to deliver new services.	2014/15-2015/16
Utilise advice & guidance to support referrers.	2014/15
Review community dermatology/minor surgery services.	2014/15

Reduce (via contract) non-clinically value-adding activity using benchmarking in: • Colorectal surgery • Urology • Endocrinology • Rheumatology • Orthopaedics	2014/15
Implement agreed non face to face tariffs	2014/15-2015/16

Mental Health, Learning Disabilities and Dementia

Develop the model for primary care prevention and early intervention mental health services/LD/dementia services, enabling improved access to specialist advice and support within primary care, shifting resources from acute care to primary and community care.	2015/16

Children, Young People and Families

Develop training for General Practice to increase confidence in the management of Paediatrics at a primary care level and reduce the need to attend hospital for Paediatric problems.	2015/16
Redesign services to ensure more teams are joined up within community settings and ensure that key community services that impact upon child health are targeted in the right local communities to reduce health inequalities, focusing on: • Maternity Care Pathways • Children's Urgent Care • Elective Care Pathways (Including Paediatrics, Community Paediatrics and Nursing, Dermatology and Continence Services) • Speech and Language Therapy Services	2015/16

4.4 We will reduce the number of excess early deaths in adults with serious mental illness to be in line with the average of the best three core cities in England, and achieve similar improvements in life expectancy for people with learning disabilities.

Project Title	**Delivery**

Mental Health, Learning Disabilities and Dementia

Use Equality Impact Assessments to address the inequality faced by this population and ensure mainstream services make "reasonable adjustments" to their service delivery to ensure equitable access (working with contracts and all portfolios).	2014/15
Work as part of Right First Time to ensure the SMI population of Sheffield have annual physical health checks and to improve management of physical health in SHSC.	2014/15-2015/16
Reduce out of city placements for people with LD or Dementia, in line with Winterbourne concordat actions.	
Establish better coordination/case finding of people with complex health and cognitive impairments to target prevention and early interventions around physical and mental health needs.	2014/15

NB. Many of the projects in the three areas above will also have a positive impact on this ambition, but are not listed here as well to avoid duplication. In total, around 40 of our projects will contribute.

4.5 We will have put in place support and services that will help all children have the best possible start in life

Project Title	Delivery
Children, Young People and Families	
Develop stronger partnerships for joint planning and commissioning through the Children's Health and Wellbeing Board and Children's Joint Commissioning Group.	2014/15
Ensure that all key stakeholders and providers are working to the same outcomes and success measures.	2014/15
For Children with Special Education Needs and Children with Complex Needs, identify new pathways for assessment of need, care planning and reviews to deliver the requirements of the Children and Families Bill.	2014/15
For these children we will also redesign and clarify the pathway for access to equipment within the community and the offer of respite care provision.	2014/15-2015/16
Develop Emotional Wellbeing and Mental Health Services by supporting the implementation of Children's IAPT.	2014/15-2015/16
Develop the pathway for supporting Maternal Mental Health ensuring the specification for these services are clear.	2014/15-2015/16
Review and redesign Safeguarding pathways to ensure clarity of use and appropriate targeting of resources.	2014/15
Work with partners to achieve the aims of the "Best Start" bid to the Big Lottery fund.	2014/15-2015/16
Redesign Looked After Children's Health services to provide better continuity of care for children placed out of area.	2014/15
Mental Health, Learning Disabilities and Dementia	
Ensure a seamless transition from children's to adult services and address the 16-18 transitional gap, commissioning a single service from one provider.	2014/15

4.6 Portfolio Specific Projects

In addition, there are some important actions for the next two years that do not directly support achievement of the five ambitions, but are no less important, listed below.

Project Title	Delivery
Long Term Conditions, Cancer and Older People	
Implement changes to spirometry testing to bring about improvements in quality.	2014/15
New sleep apnoea service in place**,** subject to business case.	2014/15
Commission stroke 6 month review.	2014/15
Mental Health, Learning Disabilities and Dementia	
Conduct an in depth review to develop a baseline of the cost and outcomes of current commissioned mental health, dementia and LD services.	2014/15
Ensure the reconfiguration of community mental health services for older adults & CLDT achieves the intended benefits.	2014/15-2015/16
Explore opportunities for use of assistive technology to maximise recovery and independence.	2014/15-2015/16

Seven Day Working

Sheffield's health and social care community is taking part in the Seven Day Services Improvement Programme. We want to move towards the provision of more responsive patient centred services, across the seven day week, to tackle apparent variation in outcomes for patients admitted to hospitals at the weekend across the NHS in England.

4.7 Achieving Efficiency Improvements

As noted at the beginning of this section, we need to make significant efficiency gains (i.e. savings) over and above those which accrue to the CCG through use of the national tariff (price) deflator for most of our contracts. These are required to be able to meet the challenges we face.

The table below sets out where the projects above are expected to deliver savings and the confirmed investments we will be making to help support delivery.

Summary of QIPP Plan 2014/15 to 2018/19

	Note	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	TOTAL £'000
Acute Elective	A	1,300	700	3,350	3,100	2,500	10,950
Acute Urgent Care	B	3,700	4,300	5,650	5,900	6,500	25,050
CHC	C	500	500	0	0	0	1,000
Prescribing	D	500	500	500	500	500	2,500
Total Gross Savings		6,000	6,000	9,500	9,500	9,500	40,500
Planned Investment	E	(1,000)					(1,000)
NET QIPP		5,000	6,000	9,500	9,500	9,500	39,500

Notes:

A) Acute elective care - savings to be a combination of outpatient reductions and other initiatives such as pathway changes and contracting efficiencies.

B) Acute urgent care – our plan is to reduce non elective admissions (including excess bed days) by 20% over 5 years, equating to £25m or around 28% in £'s terms. More of this saving will be in the latter part of the five year plan, as the services put in place to achieve this, such as care planning, will have an increasing impact over time.

C) CHC - modest savings targets in years 1 and 2 given underlying demand. From 2015/16 we expect CHC budget to be part of Better Care Fund arrangements and savings will therefore be within the pooled budget we will put in place.

D) Prescribing - budgets have been increased by 4.5% each year with expectation that this increase will be mitigated against by a continuing programme to maximise cost effective prescribing.

E) There will be very modest investment in 2014/15 - with additional investment via the Call to Action Fund. Any investment from 2015/16 will have to be as a result of achieving additional efficiencies as a result of the BCF arrangements.

Full details of the financial plan and the assumptions underpinning it are in section 8.

5. Commissioning for Quality: How we will improve the quality of services and patients' experience of healthcare

Our aim is to ensure that the CCG drives up the quality of care and treatment of services commissioned for the people of Sheffield, and that there continues to be a culture of continuous quality improvement.

We will develop a comprehensive and challenging CCG Commissioning for Quality Strategy and action plan that describes the CCG's aspiration to be an excellently performing organisation and clarifies its roles and responsibilities in relation to the new commissioning landscape and significant commissioning requirements. These requirements have arisen from a wealth of government and regulatory reviews during the last two years including:

- Government Response to Mid Staffordshire Public Inquiry and a number of other safety reviews (as detailed in 'Hard Truths' November 2013).
- Actions following the review of Winterbourne View, outlined in "Transforming Care".
- Recommendations arising out of Confidential Inquiry into the Premature Deaths. of People with Learning Disability (CIPOLD) 2013.
- Regulatory changes to CQC and Monitor.
- Nursing review – the 6 C's.

The CCG aspires to be a high performing CCG, demonstrating excellence in commissioning health care provision by having in place the following:

- Effective Internal Quality Governance.
- Effective Partnership and Integration processes with all key stakeholders.
- Excellent relationships with providers.
- High performing providers and continuous quality improvement.
- Robust Quality Assurance and Risk Management processes.
- Effective Primary Care and care pathway development.
- Research and Education.

The Commissioning for Quality Strategy will set out actions to achieve these, including:

<u>Internal Quality Governance</u>

- Development of good clinical leadership via OD workshops and 1:1 development.
- Effective internal CCG working relationships – Quality linked to all portfolios.
- Raising the focus of Quality at Governing Body.
- Systematically gaining, reviewing and acting on Patient experience feedback.
- Transparency and duty of Candour – public reporting and website.

<u>Partnership and Integration with all key stakeholders</u>

Continue to develop effective working and reporting relationships with the following:

- NHSE Area Team
- Local Authority – Care Home provision, Safeguarding, Public Health
- Police
- Clinical Networks
- Local Education and Training Boards

- Academic Health Science Network
- The Coroner
- Local Committees
- Quality and Professional regulators – CQC/NMC/GMC/AHP's
- Quality Surveillance Groups

Relationships with Providers

- Primary Care and Secondary Care – via care pathway development
- Executive level contact – 1:1's, Board to Board
- Specific Quality Work streams – Specialist contacts within each provider
- Contractual relationships – via the quality requirements of contracts

Quality Assurance and Risk Management processes

- Review provider monitoring data – information flows and data timing and quality.
- Data analysis and triangulation of information – more provider focused. Monitoring.
- Risk Profiling – at provider and health community level.
- Improve collaboration with CQC to share data and manage provider performance.
- Review assurance methodology - site visits / joint CQC/health watch to ensure it is evidence based.
- Implement specific new initiatives relating to monitoring Trust Staffing Levels via the contracting process, new priorities for safeguarding to prevent/child sexual. exploitation and development of seven day services and the impact on quality
- Review formal processes for managing failing services and Trusts.
- Strengthen patient and staff experience assurance, e.g. through complaints and Friends and Family Test, and triangulate the data with other data.
- Medicines Safety and Governance – continue to demonstrate compliance.
- Care Home Quality – develop enhanced quality assurance with LA to care homes not previously included (LD homes) and review the monitoring of Community / Domiciliary services.
- Continuing Health Care / IFR – ensure accountable systems of delivery for individual commissioned services with CHC and IFR.

High performing providers and continuous quality improvement

- Provider standards for quality embedded in contracts - National Quality. Dashboards/Metrics/Quality Premium/NHS England assurance framework/CQC new standards.
- Effective Benchmarking – timely national and local performance.
- Implement Quality Incentive Schemes – CQUIN's and contract levers.
- Continue joint working where appropriate – via the portfolios/infection control.
- CHC & Section117 aftercare - implement contract frameworks.

Primary Care - Membership Support and Provision

- Ensure continuous quality improvement - infection control/ safeguarding/ SI reporting/ audit and research in primary care.
- Ensure effective working relationships with the Area Team to fulfil our membership duties for quality – via CCG MOU.
- Joint care pathways and protocols – Evidence based, shared care protocols.

- Develop quality assurance processes and outcome monitoring for Local Commissioned Services – GP Associations and other LCS's.
- Review Workforce with AT – Practice Nurses and GP's.
- Improving Prescribing – support to prescribers / enhancement of GP clinical systems.
- Develop the research capacity and capability within Primary Care.

Primary Care - Commissioning for quality

- Effective GP engagement – Develop the role of the GP Quality Lead.
- Effective communication and information sharing - Assurance Committee/intranet.
- Continue GP involvement with quality incentive schemes – CQUINS.
- Develop a quality improvement scheme for general practice that will complement the work of NHSE.

Research and Education

- Establish research credibility of CCG both locally and nationally.
- Develop effective relationship with Health Education England, as Education commissioner ensuring educational needs of future are identified and met.
- Establish effective working relationships with Sheffield Hallam University and University of Sheffield.

Medicines Management - 2014/15 Key Areas of Work

Medicines Optimisation

The overarching area of work for the medicines management team in 2014/15 will be medicines optimisation. This is a patient focussed approach to ensuring the best use of NHS medicines, taking account of safety, clinical effectiveness and value for money. In Sheffield we will build upon success achieved to date and aim to secure improved patient outcomes via high levels of patient engagement and enhanced inter and intra professional collaboration.

Areas of work that will contribute to the delivery medicines optimisation and which will be prioritised in 14/15 include:

Medicines Safety

The team will continue to support implementation of MHRA alerts and recommendations at GP practices to ensure safe prescribing of medicines.

The team will undertake a programme of quality work to ensure that medicines are prescribed and/or monitored in accordance with guidelines. Proposals for 14/15 include:

- Review patients on amiodarone to ensure prescribing is in line with the shared care protocol.
- Review patients with heart failure to ensure they are on appropriate treatment and stepped up accordingly, in line with NICE clinical guideline 108.
- Continued review of dual therapy antiplatelet medication post MI to ensure that outcomes are optimised and balanced against the risks of bleeding.

- Targeted medicines review e.g. recently discharged patients, care homes residents, patients receiving domiciliary care to reduce hospital admissions and where appropriate promote independent medicine taking.

Support to GP practices – including Clinical Systems development.
The team will continue to offer regular sessional assistance to every practice in the city to support high quality prescribing. In addition work to maximise the potential of clinical systems in practice will be progressed in order support medicines optimisation.

Medicines Quality
Working collaboratively with local stakeholders and under the auspices of the Area Prescribing Group the team will continue to maintain the Sheffield Formulary and Traffic Light System. Local guidelines and shared care protocols (SCPs) will be developed and updated according to need. This work will include updating the Amiodarone SCP, the Epilepsies in Children SCP and the Childhood and Adolescence ADHD SCP. Improved signposting of anticoagulation guidelines, including clarification of local options relating to warfarin and choice of recently introduced novel oral anticoagulants.

Community pharmacy
The team will continue to support community pharmacy:
- As part of the integrated unscheduled care strategy e.g. minor ailment scheme, assured availability of palliative care medicines, emergency supply of medicines.
- In embedding and promoting established successful services e.g. NHS flu immunisation.
- In expansion and development of the Healthy Living Pharmacy initiative.
- By developing responsive services to support public health priorities of Sheffield CCG.
- In maintaining good clinical governance via available resources.
- By ensuring community pharmacy integration in applicable care pathways and city-wide medicines related policies.

Cost Efficiency and best use of resources
The team will implement a series of interventions, set out within the prescribing workstream plan, to deliver significant savings over the year and ensure that Sheffield prescribing continues to deliver value for money and benchmarks well.

6. Tackling Health Inequalities and Ensuring Equality of Access to Healthcare

Many of the interventions and actions required to reduce health inequalities address the wider determinants of health or are public health initiatives. NHS Sheffield CCG backs these actions and will work with Sheffield City Council in support of them, through the Health and Wellbeing Board. However, we are also clear that we, as clinical commissioners of healthcare, can take action ourselves, and have identified five themes for action:

1. Providing high profile clinical support for national and local actions that reduce health inequalities, including public health interventions.
2. Supporting individuals to be aware of their own health and their health risks, and to take responsibility for their health.
3. Ensuring equality of access to healthcare, targeting resources to areas and populations with the greatest need.
4. Commissioning disease specific interventions that are known to help reduce health inequalities.
5. Ensuring compliance with the Equality Act, taking action to eliminate any discrimination in the provision of healthcare in Sheffield.

As clinical commissioners, we will act through:

- Our contracts and relationships with the Foundation Trusts, VCF and private providers of healthcare to the people of Sheffield.
- Our partnership with Sheffield City Council, including our role at the Health and Wellbeing Board, and with the NHS Commissioning Board (particularly with regard to implementing actions in primary care).
- As clinical leaders, influencing GPs and hospital clinicians, and advising patients and the public of Sheffield.

We want to ensure there is equality of access and treatment for all people to the services that we commission, both as a matter of fairness and as an essential part of our drive to reduce health inequalities and increase the health and wellbeing of all our population.

We have set ourselves the following equality objectives:

- Ensuring equality is core commissioning business.
- Improve the range of activity information we have about patients in protected groups and how this is being used.
- Improve our understanding of patient experience of services, re E&D, and act upon instances of potential discrimination.
- Developing strong and consistent leadership on equality issues.
- Improving access to services i.e. contracting.

We are ensuring that all our staff are embedding equality and diversity in all their work and through our contracts and partnerships with providers we are supporting them to tackle inequities and barriers to services for patients. We monitor the performance of all providers in Sheffield.

7. What we will do to enable this to happen

A. Primary care development

General Practice: GP Associations

General practice will need to consider how it best operates at a scale that can deal with the increasing demands placed on it, whilst retaining the highly valued local relationships with their patient groups. There is growing recognition that practices should move forward on establishing practice federations, and to bring isolated practices more formally into larger provider organisations or networks. General Practice in Sheffield is already well placed to move forward on this way of working via our GP Association (GPA) model.

Initially heralded via the Right First Time programme and to promote MDTs working together to plan and manage the health needs of patients with multiple co-morbidities, GPAs over the last 18 months have been forming and rising to this particular challenge with a range of positive outcomes.

The emerging GP Provider Assembly is developing in a way which will give general practice providers a voice within city wide fora, and beyond.

The Assembly should become well placed to move even further with the collaborative way of working started by the GPAs and, as a minimum could:

- Consider how the transition needed within the changing landscape of primary care, sharing learning and propagating developments across practices might be further.
- Work with the Right First Time (RFT) Programme to further integrated community team working.
- As the city-wide voice for general practice provides , offer services to commissioners at different levels – practice, GPA, Locality, City which deliver their objectives/priorities – which contribute to meeting the priorities outlined in our commissioning plans in a way which secures services for all relevant patients.

In short, The Assembly, working with other providers, could be a key vehicle to support the delivery of the services we wish to see provided closer to people's home and not in a hospital setting.

Pharmacy

Pharmacists are the third largest health profession, with community pharmacy in Sheffield acting as the gateway to health for around 16,000 people each day.

The pharmacy service supports the public to stay well, live healthier lives and to 'self-care': Sheffield is a pathfinder site for the "Healthy Living Pharmacy" initiative; pharmacy already plays a key role in the management of long term conditions; and pharmacists currently carry out Medicines Use Reviews (MURs) and provide the New Medicine Service (NMS) to patients newly prescribed certain medicines.

We intend to explore the areas in which pharmacy could contribute further, for example in providing a broader range of clinical and public health services that will deliver

improved health and offer consistently high quality to patients; having a stronger role in the management of long term conditions; working more closely with GPs and Associations in an integrated primary healthcare team approach, etc.

We intend to further explore the potential Pharmacy has to provide services that will contribute more to our plans for out of hospital care.

Optometry and Dentistry

Whilst less core to the delivery of our overall strategy than General Practice and Pharmacy we recognise that these two contractor groups still have much to offer in their field of expertise.

We intend to continue building on the positive working relationships we have nurtured in recent years with the Local Dental and Optical Committees to explore with them how their respective professions might further support the delivery of our commissioning intentions.

Responding to the Market

We urge the four contractor groups to consider how – as the CCG increasingly tests the market in specific service areas – they intend to develop the necessary skills, capacity and collaborative relationships to be able to respond accordingly. For our part the CCG will explore the extent to which we can support this work with a view to further stimulating the market.

B. Integration of Health and Social Care

We have developed a strong co-commissioning relationship with Sheffield City Council (SCC), building on the pre-existing relationships the Council had with the predecessor PCT and establishing the Health and Wellbeing Board as a genuine partnership of commissioners. We have published our Joint Health and Wellbeing Strategy and have agreed that we should integrate our commissioning wherever there is clear benefit to service users.

We have established a Joint Commissioning Executive Team, made up of Directors of SCC and the CCG, and have agreed to deliver some of our commissioning intentions jointly. We believe that this will lead to improved experience of services for our patients, stronger community support, increased ability to invest in keeping people well at home, and more efficient delivery of services.

Integrated commissioning should support Sheffield's current transformation programmes, Right First time and Future Shape Children's Health, both of which are partnerships between SCC, the CCG and provider organisations.

Our initial priorities for integrated commissioning are:

- Keeping people well at home – including community support, care planning and integrated community health teams.
- Intermediate care– to provide more alternatives to hospital, closer to home, and improve discharge from hospital, so that more people can return to their own homes after a period of hospital care.

- Community equipment – to bring together several elements of equipment provision in health and social care.
- Long term high support to people – to integrate assessment, placement and quality assurance of long term care provided to people, removing as much as possible the distinction between health and social care, whilst maintaining eligibility rules to NHS and council funding.

We will use the Better Care Fund (previously known as the Integration Transformation Fund) to support integrated commissioning. We are proposing to establish a pooled budget in 2015/16 to cover at least the above areas, which will be well in excess of the Governments minimum requirements. We will publish further information about this during 2014/15 and will work together as integrated commissioners in 2014/15, as a "shadow" year of the pooled budget. This means that we will take decisions together on the areas above, and agree how we contract, manage performance and share risks and benefits between us as if we had a pooled budget.

C. Public and patient involvement (PPI)

The CCG's Governing Body agreed a communications and engagement strategy in June 2013 and endorsed the involvement plan which will deliver the engagement aspects of the strategy in November 2013.

The plan sets out how we should inform, involve, engage and enable the people of Sheffield. Key features of the plan include working with Healthwatch, establishing a database of people willing to be involved in our work, establishing a patient panel, supporting clinical portfolios to embed PPI in their work, and working with partners to support increased health literacy and strengthened community resilience.

We have established a PPI task and finish group to work with partners to develop a citywide approach to PPI, moving beyond the mechanics of good engagement in our decision making to working with communities to improve health and wellbeing.

We want to involve patients and the public in both the quality improvement and service change aspects of our work, and to support people in Sheffield to have a better understanding of health issues and be able to take control of their health. There are different mechanisms required for each of three main areas of work and our Public and Patient Involvement Plan, approved by Governing Body in November 2013, sets these out.
In brief, our plan is based on three levels of involvement:

- Informing – ensuring our patients and public know what we are doing.
- Involving & Engaging – ensuring those who want to have opportunity to tell us what they think & establishing a real conversation with patients and the public about what we do.
- Enabling – working in partnership to ensure that appropriate support is available for people to contribute.

The main ways in which we will inform, involve and engage are:

- Using the Internet, social media and written documents.
- Making sure that practice participation groups can be involved in CCG issues as well as issues about their own practice, if they wish to.

- Setting up an involvement database so we know who wants to be involved, in what areas of work.
- Establishing a patient panel.
- Supporting our GPs and commissioning managers to inform, involve and engage patients and the public in their work.
- Working with Healthwatch.
- Developing joint approaches with partner organisations.

D. CCG development

2014/15 is only the second year of the CCG's statutory existence, and we will continue to work on the development of the CCG as a member organisation, focussing on the following areas.

<u>CCG Workforce</u>

- Structure
- CSS
- Ways of working including embedded staff
- Employer of choice – skills
- Systems / processes / policies
- Culture / style / shared values
- Commissioning capability and capacity

<u>Working with Partners</u>

- ALB / LA / Patients / CSS / NHSCB
- Providers including FTs and VCF organisations
- Engagement
- Strategy development
- Systems and structures

<u>Membership Organisation</u>

- Governing Body development
- Compliance and System development
- Governance and Assurance
- Member engagement
- Wider clinical engagement including succession planning
- CRG
- Portfolios
- Membership Office

E. Partnerships

We have established strong working partnerships with Sheffield City Council, with neighbouring CCGs, with our providers in the city and more broadly within the city. We need to continue to work with our partners, and strengthen those partnerships, to deliver our ambition.

Within Sheffield we will continue to be actively engaged in a range of partnerships to deliver improvement to health and wellbeing in the city. Much of this work will be led by the Health and Wellbeing Board, in which we are active partners with SCC, NHS England and Healthwatch. We will contribute to and support partnership initiatives that are established for specific aims.

Currently, these include the VCF sector led development of the Best Start bid to the Big Lottery, which if successful will bring significant resource in the city to improve the health of children in the city (starting with three of our most deprived wards); the MoveMore initiative to increase physical activity in the city, and the development of a Food strategy to tackle obesity.

With neighbouring CCGs and with providers across South Yorkshire and beyond, we are working on a collaborative programme work designed to ensure that health services across the area are of high quality and affordable in the future. This programme includes a number of areas of work, some of which CCGs will be actively involved in. The major themes are

- Sharing and adopting good practice in staff management and procurement – which is largely about how hospital services are managed.
- Ensuring all patients have access to safe, high quality clinical services 24 hours a day, seven days a week – which CCGs will collectively take a lead role in, as it is about how services are delivered to patients across the area.

8. Five Year Financial plan: April 2014 to March 2019

All CCGs are being required to produce a five year financial plan with the first two years of the plan in more detail. The main purposes of our plan are twofold:

- To ensure we can deliver on CCG financial statutory duties and
- To support delivery of the CCG's Commissioning Intentions.

To support CCGs in putting together a five year plan a range of national information, guidance and planning assumptions has been issued by NHS England and Monitor. The plan included in this document reflects our financial plan submission on 4 April 2014. In this submission we have highlighted that in line with other CCGs, we remain in discussion with NHS England on how the legacy issue of CHC retrospective costs should be funded, but have confirmed that the CCG has identified how it would flex its non recurrent investment in 2014/15 to fund its proposed share (£2.7m) of the £250m national risk pool, should this risk crystallise. For future years we have noted as a potential further risk. In our downside risk assessment we have shown the potential £7m pressure in 2016/17 for changes to national pension costs should the CCG have to fund providers through the tariff arrangements for these costs, without any equivalent increase in our funding. The Governing Body has discussed a range of potential mitigating actions to manage the pressure and further work on this downside scenario plan will continue over coming months.

The CCG's plan is also based on local intelligence and takes into account local priorities. Inevitably it has to be based on a whole series of assumptions which are discussed in more detail below and each year the plan will need to be flexed to deal with unexpected issues and a range of risks and challenges.

CCG Allocations

NHS England is responsible for allocating resources for commissioning NHS services, both for the services that it commissions directly as well as the resources to be allocated to CCGs. NHS England's Board met on 17 December 2013 to consider options for the CCG allocations formula and the level of cash uplift which each CCG should receive for the next two years in the light of the new formula.

Each CCG will receive an increase its baseline funding which as a minimum is in line with a national inflation measure. CCGs which are seeing significant population growth and which have actual baseline funding below their new "target" will receive additional growth funding. Sheffield's population is growing but at a slower rate than a number of other places in the country. The information on target allocations was published on 20 December 2013 and shows Sheffield CCG to be more than 5% "above target". **As a result, Sheffield CCG will receive the minimum uplift.** This puts us in the same position as around two thirds of CCGs. NHS England has subsequently provided further modelling on how individual CCG positions might change over years 3 to 5 and hence the growth funding which each might expect. On this modelling Sheffield CCG remains over 5% above target and would therefore receive the minimum growth. Details are set out in **Table A** below.

CCGs separately receive a Running Cost Allowance each year to fund the clinical engagement, staff, support services and other infrastructure costs to enable the CCG

to undertake its commissioning role. The 2014/15 allowance at £14m shows a very small reduction from the current year and then all CCGs see a 10% reduction in their RCA (so budget becomes £12.6m for Sheffield). For the first 2 years of the plan we are looking to non recurrently underspend our RCA by £1.5m and £0.5m respectively to support commissioning spend.

Table A: Allocations

	2014/15 £'m	2015/16 £'m note 1	2016/17 £'m	2017/18 £'m	2018/19 £'m
Expected Recurrent Allocation	**694.6**	**718.8**	**731.8**	**744.2**	**756.9**
Target Allocation per NHSE agreed formula	657.1	682.2	Information not available (note 2)		
Distance ABOVE target	37.5	36.6	Information not available (note 2)		
as a % of actual allocation	+5.63%	+5.41%	Expected to remain over 5%		
Expected Growth in funding	14.6	11.8	12.9	12.4	12.7
as a % of prior year allocation	+2.14%	+1.70%	+1.80%	+1.70%	+1.70%
Note 1: In 15/16 and beyond actual and target allocation INCLUDES £12.4m which will be added to CCG allocation for transfer to Better Care Fund ex NHS England			*Note 2: NHS E have not published target allocations beyond 2015/16 but have provided assumptions on growth uplift - Sheffield to receive min growth meaning we are expected to stay more than 5% above target*		

Development of Financial Plan – Key Assumptions

The CCG's Governing Body has approved a set of planning assumptions for all 5 years of the plan but with a particular focus on the first two years as follows:

1. Delivery of 1% reported surplus:
   The CCG has a statutory duty of financial breakeven but NHS England guidance requires each CCG to plan for a 1% surplus which it will carry forward to future years. This is £7m in 2014/15 rising to £7.7m in 2018/19.

2. Retain % of baseline resources for NON recurrent expenditure
   In **2014/15** 1.5% of resources held back for non recurrent spend plus a 1% "call to action" fund in line with national guidance. Thus in total 2.5% (£17.3m). Governing Body has agreed the deployment of these resources on a range of issues such as continuing existing test of change projects (elective and Right First Time) until evaluation complete, piloting new initiatives, winter resilience and 18 week back log activity. It is envisaged that some of this funding will be made recurrent and incorporated into the Better Care Fund arrangements from 2015/16.

   From 2015/16 onwards the requirement is to hold a 1% fund (or around £7m), which will be used for similar purposes as those outlined for 2014/15.

3. Start each year with 0.5% (£3.5m in 2014/15) general contingency reserve
   The reserve is to help manage unexpected in year pressures such as those that can be created by exceptional winter conditions, flu pandemic, or of course as part of managing risk if planned QIPP savings are not fully delivered. Should such pressures not materialise the funding can be used for local priority investments in year.

4. Recurrent baseline opening budgets:
   For each contract or service area an assessment of the recurrent baseline requirements has been made as a starting point for the next year's budget.

5. Inflation, Tariff efficiency and PbR changes:
   The default position is the application of national guidance on these issues. Tariff (price) assumptions are shown in Table B below. However, Governing Body has agreed that there are a few areas of spend where the CCG may find it appropriate to not impose a cash releasing efficiency requirement such as certain community and primary care services where to impose the efficiency would probably reduce the quantity/level of service and would be counter to CCG strategic intentions. In such circumstances the CCG will be looking for improvements in outcomes.

   GP prescribing is a major budget (£86m in 2014/15) where we have applied no price reduction as prices are set nationally through national negotiations or by individual suppliers and the CCG has no control over price setting.

6. Underlying/Technological led demand:
   A critical element of the financial planning process is to understand the underlying demand due to population changes, new technologies and other factors influencing demand for health services. Modelling has been undertaken jointly via public health, information and contracting colleagues to identify possible cost pressures and these are summarised in table B below. They are stated before the impact of any efficiency (QIPP) savings.

7. Investment Priorities:
   The plan contains a small number of specific investments outside of QIPP for the next 2 years and then a small reserve for new investments in years 3 to 5.

8. Efficiency Savings (QIPP)
   The key driver for QIPP is to improve services to patients. We are looking to achieve a major shift in the setting in which patients receive services and reduce the need for acute interventions where appropriate. From a financial perspective the CCG needs to undertake QIPP for 2 reasons:

   - To deliver the planned financial position where we need NET savings from QIPP to meet cost pressures as the cash uplift for the next 2 years will be insufficient to meet assessed pressures– ie primarily those set out in assumption 6 above.

   - To allow the CCG to invest in new quality developments.

A high level summary of our plan can be found in section 4.7 above.

Summary of Plan

The CCG is focussing on how to best utilise our total allocation in each year (figures shown in Table A above.) We are looking at the setting of care and planning to increase our spend on community based care and reduce spend on acute hospital care where appropriate. At this stage it is difficult to be precise on how our resources will move year on year as this will be influenced by the outcome of delivery of our efficiency (QIPP) programme, year on year contract negotiations and procurements and whether our assumptions on underlying/other demand prove accurate. It will also be influenced by the level of funding we place into the Better Care Fund and the integrated commissioning arrangements with Sheffield City Council from 2015/16.

Table B below, however, summarises how we expect our funding to increase over the next 5 years and how we might use that increase.

Table B Incremental Change in Funding and Spend 2014/15 - 2018/19

		2014/15 £'m	2015/16 £'m	2016/17 £'m	2017/18 £'m	2018/19 £'m
A	**Cash increase to CCG Recurrent Baseline Resources**					
	Cash Uplift - see table below for assumptions	**14.6**	**11.8**	**12.9**	**12.4**	**12.7**
B	**Impact of Tariff**					
	Inflation including CNST - cost to CCG - see below for %s	-14.7	-16.3	-17.7	-20.2	-20.3
	4% efficiency where applied in contracts – benefit to CCG	19.4	18.8	19.1	19.0	18.9
		4.7	**2.5**	**1.4**	**-1.2**	**-1.4**
C	**Cost Pressure/ Investments**					
1	High Cost Drugs - growth in demand / technological changes	-1.5	-1.5	-1.5	-1.0	-1.0
2	Activity pressures covering Acute/Community/Mental Health/Ambulance	-5.9	-6.2	-6.4	-5.6	-5.2
3	CHC est of underlying demand growth	-1.5	-1.5	-1.5	-1.0	-1.0
4	Prescribing - volume growth at 4.5% and price fluctuation	-3.9	-4.1	-4.2	-4.4	-4.6
5	Investment in local and national imperatives - estimates from 2015/16	-0.8	-1.1	-1.1	-0.6	-0.6
6	Adjustment to create correct non recurrent budget and correct underlying surplus to comply with national planning requirements	-6.7	4.6	-4.6	-3.4	-3.5
7	Assume most of £7m Call to Action Fund created in 2014/15 is deployed on initiatives which then recurrently become part of Better Care Fund arrangements, together with an estimate of new requirements		-6.5	-0.7	-0.7	-0.7
8	0.5% general contingency - national planning requirement - assume use each year so need to reinstate in each subsequent year	-3.5	-3.6	-3.8	-3.9	-4.0
9	Increase surplus so maintained at 1% minimum requirement	-0.3	-0.2	-0.2	-0.1	-0.1
		-24.1	**-20.1**	**-24.0**	**-20.7**	**-20.7**
D	**Efficiency (QIPP)**					
	Target Savings	6.0	6.0	9.5	9.5	9.5
	Planned Investment (From 15/16 via Better Care Fund arrangements)	-1.0	0.0	0.0	0.0	0.0
	MINIMUM NET QIPP	**5.0**	**6.0**	**9.5**	**9.5**	**9.5**
E	**Delivery of 1% surplus**					
	Return of prior year surplus	6.9	7.2	7.4	7.6	7.7
	In year increase/(decrease) to meet national requirement	0.3	0.2	0.2	0.1	0.1
		7.2	**7.4**	**7.6**	**7.7**	**7.8**

CCG minimum cash uplift per planning guidance	2.14%	1.7%	1.8%	1.7%	1.7%
Inflation rates - acute sector - includes 0.4% for service development in 14/15 and 0.3% for CNST all years	2.8%	3.2%	3.3%	3.7%	3.7%
Inflation rates - mental health & community - allows 0.1% for service development in 14/15 and nil for CNST	2.2%	2.9%	3.0%	3.4%	3.4%
Efficiency - all sectors unless CCG agrees to "waive"	-4.0%	-4.0%	-4.0%	-4.0%	-4.0%

9. What this means for our local providers of health care

The transformational changes we are planning will alter the way healthcare is delivered in Sheffield, with more emphasis on supporting people to keep well and more care and treatment in community settings, with less care delivered in hospitals.

This will be reflected in our contracts with our local Foundation Trusts, primary care providers, voluntary sector organisations and a wide range of other providers of acute and community healthcare. For some, it will mean significant change in how they deliver services and this will of course affect the clinicians delivering those services.

Most significantly we expect to see a reduction in non-elective admissions, a change in the way elective care is delivered, which will reduce hospital activity, and increase activity in community settings (including GP practices), and an increased level of community services intended to help keep people well at home. Taking into account the impact of demographic changes, technological changes, efficiency schemes (QIPP) and activity to ensure we meet NHS Constitution standards, our planned secondary care activity for the next five years is as summarised in the table below.

CCG Activity	Elective Admissions - Ordinary Admissions	Total Elective Admissions - Day Cases (FFCEs)	Total Elective FFCEs	GP Written Referrals (G&A)	Other referrals (G&A)	Total Referrals	Non-elective FFCEs	All First Outpatient Attendances	First Outpatient Attendances - following GP Referral	All Subsequent Outpatient Attendances (G&A)
2013/14 Forecast Outturn	15578	58665	74243	90943	110856	201799	58911	176951	78127	430017
Forecast growth in 2014/15	3.8%	3.7%	3.7%	2.5%	2.1%	2.3%	0.2%	2.8%	3.1%	2.5%
2014/15 Total	16163	60863	77026	93194	113231	206425	59019	181925	80526	440812
Forecast growth in 2015/16	1.4%	1.7%	1.6%	0.2%	3.8%	2.2%	-1.2%	0.8%	-0.1%	-0.1%
2015/16 Total	16393	61885	78278	93351	117539	210890	58324	183316	80412	440214
	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-	-
Forecast growth in 2016/17	1.6%	1.7%	1.7%	-1.9%	0.9%	-0.3%	-3.6%	-1.1%	-0.7%	-1.9%
2016/17 Total	16660	62928	79588	91536	118616	210152	56209	181307	79829	431693
Forecast growth in 2017/18	1.5%	1.6%	1.6%	-0.9%	-0.9%	-0.9%	-4.0%	-0.9%	-0.9%	-1.9%
2017/18 Total	16918	63956	80874	90714	117570	208284	53951	179693	79116	423516
Forecast growth in 2018/19	1.5%	1.6%	1.6%	-0.9%	-0.9%	-0.9%	-4.0%	-0.9%	-0.9%	-1.9%
2018/19 Total	17180	64965	82145	89881	116506	206387	51807	178055	78392	415500

Changes will include:

<u>Sheffield Teaching Hospitals NHS FT</u>

- Investment in activity to deliver NHS Constitution pledges such as treatment within 18 weeks.
- Reducing hospital based outpatient activity in a number of areas.
- Reducing emergency admissions and hence capacity requirements.
- Development of commissioning for outcomes in MSK services initially.
- Piloting of urgent primary care centre and responding to further commissioning plans on the redesign of urgent ambulatory care.
- Establishment of integrated community teams.
- Responding to new specifications and potentially competitive procurements for intermediate care services.
- Amendment to maternity services specification and negotiation of activity and tariff for antenatal and post natal care.

- Addressing recommendations of the Confidential enquiry into the premature deaths of people in hospital (CIPOLD).

Sheffield Health and Social Care NHS FT

- Ensuring acute care reconfiguration results in the right bed and community capacity.
- Moving resources from secondary care to primary care, through a stepped model of care routed in prevention and early intervention.
- Incentives to support action on out of city placements.
- New model for 16-17 year old MH care.
- Development of outcome focussed contracts.

Sheffield Children's NHS FT

- Investment in activity to deliver NHS Constitution pledges such as treatment within 18 weeks.
- New model for 16-17 year old MH care - an extension of the CAMHS specification.
- Work on the development and delivery of the Urgent care plan.
- Redesigned service pathways as indicated in this document.

Primary Care Providers

- Extension of care planning (subject to evaluation).
- eReferral utilising C&B system.
- Development of locality based urgent care.
- Focus on primary prevention and earlier presentation from primary care.

Voluntary Sector Providers

- Potential development of partnerships with primary care to keep people well at home.

Others

- Assessment and care coordination to meet requirements of SEN reforms.
- Ensuring all CHC-funded care is purchased under formally contracted arrangements.