Sheffield Clinical Commissioning Group

CCG Strategy for Commissioning More Care in a Community Setting

Governing Body meeting

6 June 2013

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Key messages

Governing Body discussed an outline strategy for achieving our commissioning intentions in November 2012 and January 2013. The Chair wrote to all practices with a copy of the draft strategy at the end of January, inviting comments by the middle of March, either to the Chief of Business Planning and Partnerships or via Governing Body members.

This paper summarises those comments and includes a revised version of the strategy that takes them into account.

Assurance Framework (AF)

Risk Reference Number: **2012/13** RR Ref 1022, (AF)1.4.1 (and others)

Failure to develop and implement effective strategies.

This strategy supplements the commissioning intentions, which provide the main assurance and control in managing this risk. It also contributes to assurance on a number of other risks, including 1.1.2, not taking the opportunity to decommission ineffective services, 2012/13 RR Ref 578, 2.2.2, Failure to focus resources on priority, 2012/13 RR Ref 904 and 4.1.2, and Unable to Increase capacity in primary & community care, 2012/13 RR Ref 992.

Is this an existing or additional control :
Additional – replace current control (ABH4)

Equality/Diversity Impact

Has an equality impact assessment been undertaken?
Not explicitly, but the EIA of the commissioning intentions covers the same proposals.

Which of the 9 Protected Characteristics does it have an impact on?
The equality impact assessment of the commissioning intentions indicates potential differential impact on most of the protected characteristics. An equalities impact assessment will be necessary for each specific service change proposed.

Recommendations

It is recommended that the Governing Body approves the strategy document describing how we intend to commission more care in a community setting.

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1. Introduction

Governing Body discussed an outline strategy for achieving our commissioning intentions in November 2012 and January 2013. The Chair wrote to all practices with a copy of the draft strategy at the end of January, inviting comments. This short paper summarises the responses received and proposes a final version of the document.

2. Comments Received and Proposed Changes to the Document

Comment	Change to Document
Strategy document is clear	
Query about CCG requirement to formally tender and GPA capacity and resource to do so	Amend to include section on procurement and appropriate support to GPA development
It's a big agenda and a big ask locally	Acknowledge in the document
Concern about new work in primary care diverting GPs from core responsibilities and/or capacity in primary care – does the strategy require practices to work longer hours?	Acknowledge and describe CCG expectation that new work will be delivered with additional resource, through contracts, not diverting from core GMS
Clarification requested on meaning of "specialist" activity	Terms "secondary care" and "consultant" used instead
Noted that hospitals are actually quite accessible for some patients – rationale for change for them is less clear.	Expand – surgery still more convenient than hospital, better continuity of care, potential for non-face-to-face opportunities
Not convinced that this strategy would save money.	Explain CCG assumption
There was confusion about what was meant by new primary care providers in para 4.	Explain in section on procurement
Need to clarify that this is a five year strategy	Amend in title and introduction
there's not much about what support will be given to primary care in 2013/14	Support to provider development described

3. Recommendations

It is recommended that the Governing Body approves the strategy document describing how we intend to commission more care in a community setting.

Tim Furness
Director of Business Planning and Partnerships
16 May 2013

CCG Strategy to Commission More Care in Community Settings

This strategy outlines our intention to achieve our aims by commissioning a major shift in acute care to a community setting.

To achieve this, we will work with current and potential providers to develop capacity and fund activity in community settings.

1. Introduction

NHS Sheffield CCG published its prospectus in January 2012. In it, we set out our four priority aims:

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

These four aims are central to our ambition and our planning to achieve that ambition. Ensuring patient safety and reducing unexplained variation in the quality of care provided in primary, community and hospital care are key elements of this, and relate to each of the four aims described above.

Drawing on our experience of working with our practices and with local clinicians, and our preparation for authorisation, we are now very clear that we will only succeed by being innovative in our approach to commissioning and requiring innovation from all of our providers in the way that services are delivered.

Our aim is to see major change in the way healthcare is delivered in Sheffield by 2015. We recognise that this strategy will be challenging for both primary care and secondary care providers and will work with them to manage that change. This document describes those changes we propose to make and how we will implement them over the next five years.

2. What We Want to Achieve

A system of healthcare that is centred on the patient, with all possible care taking place in a community setting, and access to specialist (i.e. secondary care) advice and care promptly available when needed. This means:

- Many more services and staff in the community
- Major investment in community and community based services
- GPs at the centre of integrated teams, with many specialist skills (e.g. specialist nurses) within primary care teams, and many staff having a wider range of expertise, so there is less fragmentation of care
- Closer working between health and social care

- More emphasis on prevention of health crises through early intervention and through greater control by patients of their care
- Emergency admissions to hospital significantly reduced
- Follow up of outpatient attendances largely in a community setting, and opportunities for non-face-to-face consultation available.
- Access to care outside of GP hours is straightforward, through NHS111
- Services that are of the highest quality and responsiveness for the patients they serve

This represents a transformation of the way healthcare is provided in Sheffield and major change for the way that clinicians in hospitals and community settings work. It also, of course, represents a major change for patients – one which will make care more accessible (in terms of travel and convenience) and more joined up. We will not achieve it without the support of the public of Sheffield and clinicians in primary and secondary care.

3. Why Change is Necessary and Achievable

Although the NHS in Sheffield is currently financially stable, changes in the age and make up of our population will increase demand on healthcare at a time when savings have to be made by all organisations. As a result, we do not think the current way of providing services can continue to meet health care needs. If we do not act, primary care and hospitals alike will be overwhelmed, compromising the quality of care that clinicians can offer and creating the risk of financial problems that will lead to short term decision making to manage within NHS budgets.

However, we know that around 40% of nights spent in hospital by patients are avoidable, that improved quality of care in a primary care setting reduces the number of health crises that lead to hospital admission and increases the ability of GP practices to manage problems, that a stay in hospital can present risks to patients, and that new ways of working, including the use of technology, mean many more problems can be treated outside of hospital.

Our modelling shows that providing earlier support to avoid crises and providing more care in a community setting is not only better and more convenient for patients, it is also a better use of NHS resources

4. How We Will Achieve It.

To achieve the change we seek we will

- Invest in care in community settings, improving the support people get outside of hospital, working with the city council to developed integrated services where appropriate
- Commission primary care providers to continue to care for patients, with the benefit of consultant advice, eliminating the need for most consultant follow up
- Work with practices to tackle unwarranted variation in quality of care and access to care
- Support all our patients to take control of their health, so that they manage their own care when they can and seek advice and care as soon as they need it

- Support practices to identify patients whose health is at risk, so that they can, with the patient, take action to prevent crises
- Ensure our services meet the needs of all communities and population groups

We will work with our providers and commissioning partners to make sure that the contracts we have support these changes, so that funding is released and new primary care providers, including GP practices, are properly paid for the work that they do.

As a result, we expect to see many more doctors, nurses and other professionals working in community settings for at least part of their time. Not only will this provide care outside hospital, it will improve communication between GPs and consultants about their patients, which will improve care.

We will, with the support of our providers, seek flexibility in nationally designated contract rules to enable changes to be put in place without placing any organisation in too much risk. We will be clear about the potential conflict of interest GPs who wish to provide services may have, and will ensure rigorous probity in our decision making, including procurement.

Procurement

We know there is not currently capacity in Sheffield to deliver this change. New work will be funded through a shift of resources - we do not, for example, expect GP practices to take on new work at the expense of current GMS commitments.

We will support the development of primary care providers through market stimulation and a clear statement of the services we wish to commission. We expect to see new service organisations established, recognising that the scale of change we seek cannot be achieved simply by asking current primary care providers to do more. It is part of our role as commissioners to support the development of organisations that can provide the services we want for our patients.

We want to achieve our ambition through partnership with our current providers, and (whilst the two are not incompatible) our preferred approach is one of integration rather than diversity, and partnership rather than competition for the sake of it. We will, however, ensure we get the best for our patients and best value through rigorous procurement and contracting processes, with open tendering for services where that will achieve better care for patients.

5. Clinical Commissioning

The development of NHS Sheffield CCG, authorised without conditions and established as a statutory body from 1 April 2013, creates a unique opportunity to achieve this change. The CCG has demonstrated that it is ready to take responsibility for commissioning healthcare in Sheffield. Although we will continue to develop our capacity and skills, we have all the elements in place to lead and implement significant change.

We have a strong and committed cohort of clinical leaders, great clinical engagement with our member practices and with secondary care clinicians, excellent Foundation Trusts in Sheffield, with whom we have good working relationships, a mutually supportive relationship with Sheffield City Council, commitment to establishing strong public and patient engagement, and a system that is currently financially stable.

Alongside the clinical energy and willingness for change within the CCG and in Sheffield generally, the national conditions are now also right. The Government and the DH want to see CCGs succeed and make a difference. As one of only a few CCGs authorised without conditions, we are well placed to seek autonomy and flexibility to ensure we can implement our locally produced plans for Sheffield and have the capability to deliver them.

We will achieve change through clinical leadership of our discussions with providers and the public, using new commissioning and contracting approaches which focus on patient outcomes, basing our specific plans on clinical evidence and robust modelling of activity and money, and working with providers of education and training to ensure the workforce of tomorrow is ready for the change.

6. Making this Happen

If we are to see the change we want by 2015, we need to start making it happen now. To do this, we will:

- Build upon our clinical partnerships with SCC and the FTs in the city to identify opportunities for change
- Identify services that can be provided in primary care, and changes to services that help people stay healthy and help them to get the right care first time, through our commissioning intentions
- Develop and start to implement a provider development plan that will help all our providers understand the opportunities our strategy presents and develop their capacity to provide the services we need. This will include supporting the development of primary care provision through GP Associations, enabling practices to work together effectively and efficiently to deliver services to patients
- Discuss our plans with partner organisations and the public, building public and clinical confidence and ensuring that change is well managed for all organisations
- Put in place contracts that fund care in community settings, with appropriate quality controls
- Build upon our current activity to support practices to tackle unexplained variation in care
- Develop and implement our plans to ensure equality of access to healthcare and reduce health inequalities
- Develop commissioning intentions for 2014/15 and beyond that will lead to a radical change in the provision of care

Tim Furness
Director of Business Planning and Partnerships
May 2013