Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Planning for 2014/19

Governing Body meeting

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Key messages

The attached document is a first full draft of our commissioning intentions, based upon the ambition and summary intentions previously agreed at Governing Body. In line with NHS England's expectations, this document has been written as a five year plan, with more detailed plans for the first two years. It includes the five year ambitions agreed in previous discussions and the planned projects for 2014/16 that will contribute to achieving our ambitions.

The document includes:

- Confirmation of our aims, set out in the prospectus and our vision for the next five years, reflecting the ambitions previously discussed at Governing Body
- Portfolio plans to achieve those ambitions, and of our efficiency plans (QIPP plans)
- A summary of our plans for ensuring patient safety and provision of high quality care
- An overview of our draft five year financial plan designed to underpin our Commissioning Intentions. The information is as per our 14 February submission to NHS England and will need to change to take into account for example more recent national guidance and the outcome of contract negotiations.
- A brief summary of our action on tackling health inequalities and ensuring equality of access to healthcare
- An outline of our work supporting development of primary care capacity to be able to deliver our ambitions
- A description of our plans for integrated commissioning with Sheffield City Council, which will help us achieve our ambitions
- An outline of our planned actions to involve and engage patients and the public in our work.
- Details of the outcome metrics we have submitted to NHS England

A summary of the outcome of our engagement work with regard to these plans is presented alongside this paper (Appendix A), to inform Governing Body's consideration of the document.

Assurance Framework (AF)

Assurance Framework Number: 4.3 Overly ambitious Financial Plan and insufficient financial management (Domain 3)

How does this paper provide assurance to the Governing Body that the risk is being addressed?
Although this paper and report is largely concerned with identifying the key projects the CCG should pursue in 2014/16, and does not reference financial planning directly, the planning is informed by the financial assumptions set out in the October report and the financial plan will set out the financial consequences of our commissioning plan.

Is this an existing or additional control:
Existing – in that this control was also in place last year.

Equality/Diversity Impact

Has an equality impact assessment been undertaken? NOT YET

It is intended that an equality impact assessment will be carried out before the April Governing Body, with a view to identifying both any potentially negative impacts that need mitigating and opportunities to reduce health inequalities.

Which of the 9 Protected Characteristics does it have an impact on? All

Public and Patient Engagement

Our planning has been informed by public and patient engagement throughout the last six months. The attached paper summarises that engagement and the key messages for us from it.

Recommendations

The Governing Body is asked to consider and comment upon the draft commissioning intentions document

NHS Sheffield CCG

Commissioning Intentions 2014-19

Draft

1. Introduction and context

2. Our Population's Health

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

4. Our portfolio projects and efficiency plans

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

6. Tackling health inequalities and ensuring equality of access to healthcare

7. What we will do to enable this to happen
    a. Integration
    b. Patient and public engagement
    c. Primary care development
    d. CCG development

8. Five Year Financial plan

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

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 the priorities 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.

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.

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.

Morbidity

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.

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 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 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 technology 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 holistic 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 also adopt a different approach to delivery of our commissioning intentions, with stronger programme management arrangements in place to ensure that our individual projects are aligned and their contribution to our ambitions clear. These arrangements will include an enhanced focus on delivery and benefits realisation.

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

We have agreed some metrics with NHS England that will reflect delivery of the ambitions above. These are shown in appendix 1.

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 @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	
Put in place a contracting framework for commissioning for outcomes and value in MSK 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 based in Central locality (Gynaecology, ENT, Gastro, Respiratory) to be expanded citywide (subject to business case).	2014/15
Identify services to be delivered in the community via the primary care basket. • Continue to support development of new clinical pathways in 11 specialty areas. • Implement findings from RES evaluation. • Identify opportunities to develop technology to support patient self-care and remote monitoring/increased non-face-to-face activity. • Identify areas where community based diagnostics may support outpatient transformation. • Identify areas for GP education and training, to deliver new services	2014/15-2015/16
Commission secondary care advice & guidance.	2014/15
Review 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 Project 4 – Serious Mental Illness and Physical Health 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 and joint planning and commissioning on a local level through the Children's Health and Wellbeing Board and Children's Joint Commissioning.	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
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 to the above, 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. These are 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 (c)	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

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	1,800	1,900	2,000	7,700
Acute Urgent Care	B	3,700	4,300	7,200	7,100	7,000	29,300
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 £28m 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 the CCG proactively drives up the quality of care and treatment of services commissioned for the people of Sheffield, and 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 excellent 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, Health care funding, 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 – prevent/child sexual exploitation
  -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 – complaints/Friends and Family Test expansion 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 – to 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
- 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

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

<u>General Practice: GP Associations</u>

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, 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 are exploring specific proposals 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.

We have agreed that 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.

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

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. This guidance continues to change and the plan included in this draft commissioning intentions document reflects our draft financial plan submission on 14 February 2014 and does not include certain additional potentially significant financial pressures for the years 2014/15 to 2016/17 as we (and other CCGs) are raising queries on these issues and suggesting alternative approaches. The final version of our plan to be submitted to NHS England on 4 April 2014 will incorporate the impact of these issues as appropriate.

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 also looking at the setting of care and are planning on increasing our spend on community based care and reducing 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. The next iteration of our Commissioning Intentions will seek to provide more detail on how we envisage the distribution of our resources in 5 years time compared to our spend in 2013/14.

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. This will be reflected in our contracts with our local Foundation Trusts, 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, 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>STH</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)

SHSC

- 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

SCH

- 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

Others

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

Appendix 1. Ambitions for Improving Outcomes

We have set out our ambition to improve health outcomes for key measures from the NHS Outcomes Framework in line with national expectations. Our improvement trajectories are based on an assessment of the impact of portfolio plans, and transformational programme.

Securing additional years of life from conditions amenable to health:
Our actions will ensure continued lowering of this indicator. The trajectory reflects the lower improvement rates seen in recent years as a result of the CHD potion of this indicator. We are not assuming faster improvement than in recent years, but a continuation of the impact of our predecessor PCT's actions.

Potential years of life lost (PYLL) from causes considered amenable to healthcare:
Baseline = 2052.5 Target = 1866.3

Improving the health-related quality of life:
We aim to achieve a performance improvement of 1% over the five years in this measure, as a result of improved care for people with long term conditions.

The proportion of people feeling supported to manage their long-term condition: -
Baseline = 70.4 Target = 71.4

Reducing emergency admissions:
The trajectory reflects our ambition to reduce emergency admissions by 20% over the next five years, with the rate of change consistent with contractual assumptions. This target is a composite of four measures of admissions deemed to be most avoidable (for chronic ambulatory care sensitive conditions, for asthma, diabetes and epilepsy in under 19s, for acute conditions that should not usually require hospital admission and for children with Lower Respiratory Tract Infections).

An aggregate of four other indicators relating to avoidable or preventable admissions, expressed as a rate per 100,000 population
Baseline = 2535 Target = 2028

Increasing the proportion of older people living at home independently
This target will be agreed with SCC as part of the Better Care Fund submission. It should reflect the impact of our plans to keep people well at home and to improve outcomes from intermediate care

Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
Baseline = Target = (to be set with SCC)

Improving the proportion of people having a positive experience of inpatient care: (measured as a negative)
We will seek to improve to achieve the best quartile performance
Baseline =1.44 Target = 1.35

Improving the proportion of people having a positive experience of general practice and out-of-hours services: (measured as a negative)

We will seek to improve to achieve best quartile performance
Baseline =6.2 Target = 4.7

In addition to the five national quality premium measures one additional local measure can be chosen based on local priorities. The CCG will continue with its local priority agreed in 2013/14 to increase care out of hospital, and build on this to reflect a number of initiatives from across portfolios which increase care outside of hospital.

DN: Explanation of the numbers needs to be added, to explain what each represents

APPENDIX A

NHS

West and South Yorkshire and Bassetlaw
Commissioning Support Unit

Commissioning intentions

Engagement report

February 2014

Contents

1. Background

One of the values of NHS Sheffield CCG is to 'work together, engaging staff, patients and the public in our local and collective decisions'. This is reflected in the aim to ensure that that the views of patients and the public are considered in all commissioning decisions that the organisation takes. The CCG recognises that to develop quality services which meet the needs of the population of Sheffield, patient feedback needs to be sought and considered.

We started looking at what our priorities should be in August 2013 and continued to build on this throughout the months, using various engagement approaches to gain the views of public, staff and clinicians. This report outlines the work carried out.

We would like to thank all participants in this work for their time and willingness to share their views.

2. Engagement responsibilities of Clinical Commissioning Groups

There are a number of requirements that must to be met when discussions are being made about the development of services, particularly if any of these will impact on the way these services can be accessed by patients. Such requirements include:

- The White Paper, 'Equity and excellence: Liberating the NHS'
- Health and Social Care Act 2012
- The NHS Constitution

The **White Paper, 'Equity and excellence: Liberating the NHS'**, and the subsequent **Health and Social Care Act 2012**, set out the Government's long-term plans for the future of the NHS. It is built on the key principles of the NHS - a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. It sets out how the NHS will:

- put patients at the heart of everything it does, 'no decision about me, without me'
- focus on improving those things that really matter to patients
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

It makes provision for CCGs to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners, and it also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution - and to promote awareness of the NHS Constitution.

Specifically, CCGs must involve and consult patients and the public:

- in their planning of commissioning arrangements

- in the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
- in decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

The duties to involve and consult were reinforced by the **NHS Constitution** which stated: 'You have the right to be involved directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services'.

3. Our engagement approach

NHS Sheffield CCG, supported by West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU) Engagement Team, embarked on engagement with the public and key stakeholders, initially starting in August 2013. During this month, 'crowdsourcing' was used to initiate a debate around the plans for the future. This was an online discussion forum for the public to leave comments as well as for people to have the opportunity to vote on liking or disliking these comments.

From there, more ways were included and the CCG were able to start to identify their priority areas, which include keeping people well, providing more care for people at home, reducing the number and length of hospital stays, offering more people expert care in local settings, redesigning mental health services, improving children's health and wellbeing and improving quality.

A detailed communications and engagement plan was produced to support this work and engagement with the public, staff and local GP practices took place.

The methods used included:

1. Feedback form used during meetings, online and at the CCG's Annual General Meeting
2. Two community events organised in partnership with Healthwatch Sheffield (Commissioning Intentions Discussion Forums)
3. Two meetings with member GP practices
4. Choose Well Roadshow where the public were able to share their views
5. Identification of local groups via Healthwatch Sheffield and Voluntary Action Sheffield
6. Offer to attend local voluntary and community groups to discuss the work in detail

7. Website and social media – NHS Sheffield CCG's website contained information on getting involved in this engagement and included an online link to the feedback form. The initiative was supported by social media promotion to encourage participation.
8. Media – press releases were issued during this engagement, again aimed at encouraging participation.
9. Awareness raising with and a link to partner organisations' websites.
10. Staff awareness via bulletins, notices and staff briefings as well as direct communication to GP practices.

Overall, 44 people commented during the engagement period. It should, however, be noted that some respondents made more than one statement.

Commissioning Intentions Discussion forums

The public had an opportunity to share their views either by submitting a feedback form or by attending one of two engagement events organised for February 2014. Both events had the same format, ensuring that the same information and questions were used during the process. A short promotional video of this can be found at:

http://www.youtube.com/watch?v=oqKiJiknJ4I

This report notes the comments generated through the table top discussions as transcribed by Healthwatch Sheffield. All participants were given background information on the CCG's aims for the next 5 years and the focus of the work that would support the achievement of these (Appendix A). 14 people attended the first session and 17 people attended the second session.

The questions asked during the events included:

1. Do you agree that our aims and four projects we have identified should be priorities for us?
2. Is there anything about focusing on these projects that concerns you?
3. By ensuring everyone who needs one is offered a care plan, reducing emergency admissions and attendances, improving life expectancy, supporting children to have the best start in life and bringing more hospital services closer to home, we are aiming to make life better for people in Sheffield.
    a. Do you feel the scale of these plans is too ambitious, about right or not ambitious enough?
    b. What will these changes mean for you?

As well as discussing the CCG's plans, the engagement events were used as an opportunity to ask all participants to comment on and vote for their preferred branding in relation to engagement in Sheffield. There were 12 designs for 3 potential names to choose from. The names were:

- My Health My Say
- Involve Me
- CCG 1000

The chosen logo, as voted by the public and staff is below and will be used in future engagement initiatives.

4. Summary of findings

The themes arising from the various pieces of engagement work are considered below:

Participations in this engagement process showed broad support for the four areas highlighted in NHS Sheffield CCG's plans. The most common suggestions of the aspects to be considered when taking the projects forward included:

1. The role of GP
2. Services for children and young people
3. Integration

Selfcare and people's own awareness of their health and wellbeing was seen as an important aspect as was care in the community. Community services and the role and ability of the voluntary and community sector to be part of the discussions and service planning were also noted.

The plans were predominantly seen as ambitions and the need to consider how individual aspects of the system can work together to achieve them was noted. Participants also felt, in some instances, that they would find more detailed information going forward useful.

The most common suggestion as to what the changes may mean to individuals was in respect of improvement in services. This, in turn, was predominantly seen in terms of an improved and more equal access. Some suggested that the plans could offer different services and also reduce confusion among the public.

General comments received showed that participants were encouraged to see the Clinical Commissioning Group's engagement aims and that the plans were moving in the right direction. Across the various questions, participations provided suggestions as well as highlighting the considerations that need to be taken into account as part of the overall process.

The engagement around commissioning intentions creates a starting point for future discussions and these findings provide a starting point for future dialogue which will help to build on this work as plans are developed.

5. Commissioning intentions engagement

5.1 Analysis of data gathered during the engagement process

At the Commissioning Intentions Discussion Forum, participants were given an opportunity to raise questions that were important to them. The Question and Answer session saw the following being raised, which was responded to at the events:

- How did a lay member get on the Board?
- What can NHS offer now private providers are able to potentially deliver 'any' service?
- What is the CCG's approach on weight management / obesity?

The four questions used during the engagement process are noted below with corresponding results for each. Actual comments made by participants are indicated separately, either in boxes or in italics. Additional comments received are also analysed below and included in a separate category. Full list of comments received can be found in Appendix B.

Q1 - Do you agree that our aims and four projects we have identified should be priorities for us?

Respondents broadly agreed with the aims and the four projects identified as priorities for the CCG, however noted few suggestions.

"I do agree that the four projects named should be given priority. The NHS caters for millions of patients, over many issues, it is therefore very important that these issues are shortlisted to give the best results to the majority of patients which I consider this has been achieved by the 4 big projects named."

The most common suggestions of the aspects to be considered when taking the projects forward included the role of GP, services for children and young people, and integration.

In respect of the role of a GP, responses for these looked at GP practices signposting the public to local services, locally based services in practices rather than accessing care in a hospital setting, care planning, access to appointments and prevention. Services for children and young people were noted mainly in relation to the need to have community based education programmes and services aimed both at the young people as well as their parents. The accessibility in terms of avoiding stigma as well as funding were noted in this respect. Integration was seen positively by participants to ensure that the needed services are delivered. This was predominantly in respect to working closely with the local authority. However, some respondents noted the need to consider differences, e.g. in respect of Self Directed Support, as well as the fact that aspects of an integrated approach will be outside of the CCG's control.

"GPs should be able to signpost people to services that help people to take control of their own health and wellbeing."

"Children and Young People should have the best start in life. In Young People, there are health inequalities..."

"Health inequalities – difficult for Health to achieve on its own."

The need for public to take responsibility for their own health and the role of selfcare was the next most common theme. This was followed by community based services, which were noted in respect of services for children and young people and the need for familiarity and comfort in accessing services.

"People should think about themselves."

"Needs to be more of a community focus – fund more community activities. If it's part of general activity, young people will not feel penalised or stigmatised..."

Evaluation of the value for money and the overall success was raised specifically in relation to evaluation and measuring outcomes. This was, in two cases, noted in respect of the perceived lack of ability of the Voluntary and Community Sector organisations to be part of taking this forward.

"VCS organisations could do this, but couldn't evaluate, monitor and deliver it without funds (chicken and eggs)."

Additional comments included specific services being noted, namely:

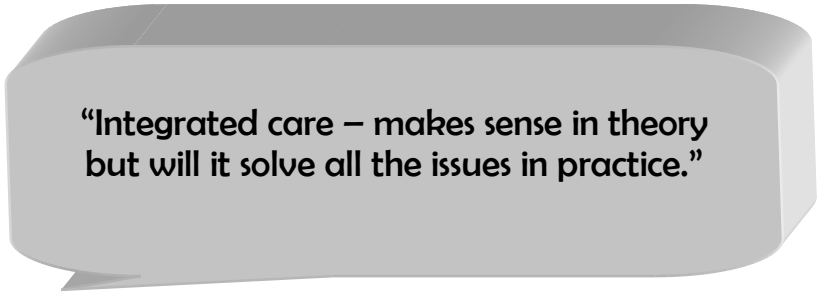
- Dementia
- Diabetes
- MSK services
- Orthotics services
- Long term conditions
- Cancer
- End of life care

One comment was received in respect of the proposed an urgent primary care centre, querying as to where this might be located.

Q2 - Is there anything about focusing on these projects that concerns you?

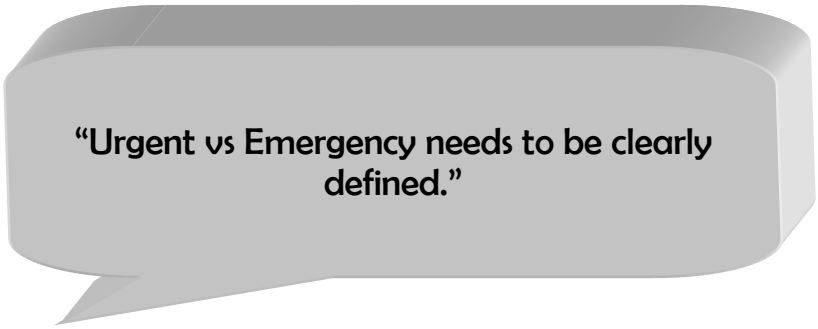
The most common comment in respect of concerns associated with focussing on the four projects involved funding. This was mainly in terms of the associated costs and the ability to retain funding/apply appropriately as well as funding issues small voluntary and community sector groups face.

The concept of co-operation and move to integration was also noted as an area of concern, however, this was considered by participants in various ways. For example, some felt this *makes sense but would it solve all the issues in practice;* some asked for consideration to be give to the wider family and integration of family members in decisions. The topic of integration bridged to another theme, although raised by a minority, of children and young people where a respondent felt that *the integration agenda may need to be wider that just health and social care.*



Engagement was noted in this section in terms of *community involvement* and tapping into existing resources, the need to *engage with people with learning disabilities and mental health* as well as considering *engagement with GPs* and the wider community to reach beyond those who *"engage with services".*

Terminology was raised as a concern in respect of lack of clarity of terms such as *urgent and emergency* as well as *people not understanding what services to use – "lack of knowledge."*
Health inequalities were not a dominant theme, but the comments noted included there not being *an equal access to all* and a concern over a *culture of "seeking out easy patients."*



Procurement was noted with a query about the ease of applying to be a qualified provider and another suggesting *that providers should be based on the quality of service delivered*.

Q3a - Do you feel the scale of these plans is too ambitious, about right or not ambitious enough?

The majority of respondents felt that the plans were ambitious. Two people felt these were too ambitious and another one who felt these were not ambitious enough.

Rather than scoring these, several participants took the opportunity to provide a comment. These were mainly concerning what needed to be taken into account when implementing the plans. This included *true partnership and appreciation that it takes time and commitment, the need for more specific information around the plans and use of evidence* when considering *changes and innovation*, wanting to see more *collaboration between 'patients' and professionals* as well as some *not feeling able to 'work with' the commissioner/health and social care professionals*.

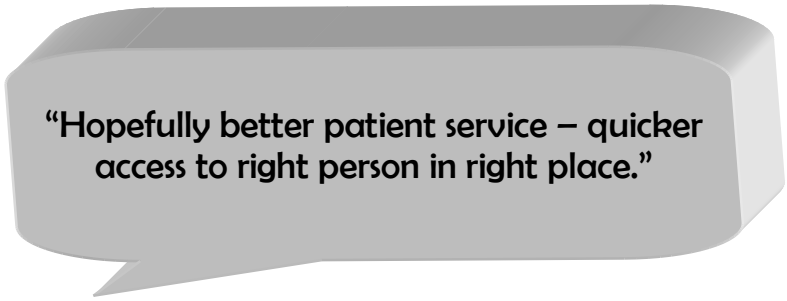
Integration was noted as a concern in terms of barriers involved (*services trying to protect their own*) as well as the cost associated with the integration of services. A linked comment was made in respect of a concern that the *reduction in local authority spending could adversely affect these plans.* A respondent felt that *a system and cultural change was needed.*

Questions were also posed as part of this section, which included:

- *"What specific actions will be taken?"*
- *"What training are GPs getting to transform services?"*
- *"What £/what will it cost – is money available to achieve these plans?"*
- *"Invest to Save" – difficult when there's nothing to invest."*
- *"How will it be measured?"*
- *"Are they based on an effective use of pilots, e.g. care plans?"*

Q3b - What will these changes mean for you?

The most common suggestion as to what the changes may mean to individuals was in respect of improvement in services. This, in turn, was predominantly seen in terms of an improved and more equal access. Some suggested that the plans could offer different services and also reduce confusion among the public.



General comments

Participants were invited to provide general feedback as part of the engagement process. The key themes arising from these are:

- Positive initial thoughts on the plans.
- Encouraging CCG engagement agenda and aims to engage effectively.
- Concern over Long Term Neurological conditions including a spectrum of conditions, not just epilepsy.
- Need to learn from experiences year on year and divert money from areas that do not deliver.
- Good aims and inclusive.
- Reassuring to have partners involved in discussions as links to integration.
- Procurement and delivery of services via large NHS providers who may not include third sector providers.
- Consider isolation issues among different age groups within the community.
- The role of the third sector – potential service delivery partners as well as representatives and champions.

One person felt that there was a degree of rhetoric. Another participant submitted several pieces of feedback. The main themes from this correspondence include the need to provide effective services and support to those who need them, including information, prevention of admission and considering health and wellbeing requirement of older as well as younger generations.

Appendix A – Commissioning Intentions Discussion Forum (letter to participants)

Dear Sir or Madam,
Re: NHS Sheffield Clinical Commissioning Group Plans

Thank you for your continuing interest in NHS Sheffield Clinical Commissioning Group and for wanting to be involved with us in the future.

Following a successful first year, we are now considering what we should concentrate on both in the next financial year and in the longer term. We would really appreciate your views, so we can ensure that the decisions we make in March 2014, genuinely reflect what people across Sheffield want us to prioritise.

Have your say
There are two main ways that you can get your voice heard. The first is by reading the 'Our Plans' information that has been enclosed with this letter and completing the feedback form. All suggestions and ideas will be taken into account when a recommendation is taken to the Governing Body in March 2014.

You also have an opportunity to tell us your views in person by attending an event which will be held in partnership with Healthwatch. The details are:
Date: Tuesday 4th February
Venue: The Circle, Rockingham Lane, Sheffield, S1 4FW
Times: 1:15pm – 2:45pm OR 3:15pm – 4:45pm

Please note that both sessions will be identical and therefore, if you are keen to attend, you only need to commit to one. As we only have 30 places available for each session and we anticipate a lot of interest from people across the City, places will be allocated on a first come, first serve basis. To avoid disappointment, please let us know if you intend to come as soon as possible by completing the enclosed feedback form and returning it to us in the freepost envelope.

Are you a member of a community group?

As well as hearing from people on-line, by post and at the February event, we are keen to speak with people at a more local level. Therefore if you are a member of a group and have something specific to say about our plans, but will be unable to attend the large event, please get in touch. We hope to have contact with as many groups as possible during January and early February to ensure we are on the right track.

Once again, thank you for your commitment to supporting our work and we very much look forward to hearing from you in the near future.

With very best wishes for the festive season and the coming year,

Tim Furness
Director of Business Planning and Partnerships

Our Plans

Following a successful first year, NHS Sheffield CCG is now looking at plans for 2014-16. We started looking at this in August and initially asked members of the public, staff and clinicians in the city what they thought we should concentrate on for 2014 onwards.

We have now set ourselves some ambitious aims for the next 5 years. They are:

- All those who are most likely to need urgent hospital care in the next year to be offered a care plan, agreed between them and their doctors, to help them to stay well (possibly 15,000 people)

- To achieve a 20% reduction in emergency admissions and a 40% reduction in Accident and Emergency attendances by integrating health and social care services to support people to live independently

- Bring specialised health services closer to peoples home by changing how and where they can be accessed, which will mean less travel to the hospital

- Reduce the gap in life expectancy for people with mental health problems and learning disabilities

- Put in place support and services that will help all children have the best possible start in life

In order to achieve those aims, we are considering concentrating on four big projects. They are:

- Develop ways for health and social care teams to work in a more integrated way to support patients to plan their care so it is right for them

- Offer a range of options for patients in need of health care urgently, outside the traditional settings

- Work with consultants, patients and other professionals to transform outpatient services

- Commission services that are based on positive outcomes for patients who live with bone and muscular conditions

These ambitions will be delivered through the existing commissioning teams – who focus on:

- Long Term Conditions, Older people, Cancer and End of Life Care
- Acute Care
- Mental Health, Learning Disabilities and Dementia

- Children, Young People and Maternity

These plans are set against a backdrop of the Call To Action national debate which is encouraging people to consider how the NHS, as we start our 66th year, should adapt to ensure that we best meet the changing world and, most importantly, looks after patient's safely and effectively.

We would now like to offer the opportunity again for public and clinicians to give their thoughts on these local projects and whether having a focus on these projects is the right approach.

Please find enclosed a short feedback form for you to complete about these plans, together with information about the events that are planned during January and February. Please return to us in the freepost envelope provided by no later than Friday 24th January.

Feedback form

Your name_____

Your address_____

Please contribute to shaping our plans by sharing your opinions with us. You can do this by reading the enclosed **'Our Plans'** document and completing the following four questions or attending one of the events (details overleaf).

1. Do you agree that our aims and the four projects we have identified should be priorities for us (please say why)

2. Is there anything about focusing on these projects that concerns you?

3. By ensuring everyone who needs one is offered a care plan, reducing emergency admissions and attendances, improving life expectancy, supporting children to have the best start in life and bringing more hospital services closer to home, we are aiming to make life better for people in Sheffield.
a) Do you feel the scales of these plans are too ambitious, about right or not ambitious enough? Please share your thoughts

b) What will these changes mean for you?

If you would prefer to attend the partnership event hosted by the Clinical Commissioning Group and Healthwatch to discuss the plans rather than completing the questionnaire above, please complete the following information (places offered on a first come, first served basis):

I hope to attend the event at The Circle on 4th February. The session I would like to attend is (please tick the appropriate box):	1:15pm – 2:45pm	
	3:15pm – 4:45pm	

If you are a member of a local group and would like a representative from NHS Sheffield Clinical Commissioning Group to meet with your members to discuss these plans, please give us some information below:

Name of the group	
What does the group cover e.g. geographic area, people with a particular interest etc	
If the group will be meeting in January or February and you would like someone to join you to discuss these plans, please tell us when and where you meet	Date?
	Time?
	Where?
Contact details for who to discuss this with (if someone else)	

Please return this form in the freepost envelope provided at your earliest convenience but no later than Friday 24th January 2014. Thank you.

Appendix B – Feedback from the public

Question	Source	Date Received	Comment
1 - Do you agree that our aims and the four projects we have identified should be priorities for us?	**Commissioning Priorities 2014-16 Forum**	03-Feb-14	In general the projects seem reasonable though they are very broad. Two of Sheffield's pressing problems are dementia and diabetes and it's not clear exactly how they help patients and carers dealing with these conditions. In relation to Urgent Care we are concerned that the establishment of an urgent primary care centre might be at Northern General when we consider there should be accessibility in the city centre and in the East. We hope there will be full and timely public consultation before any steps are taken to reconfigure current NHS arrangements.
	Feedback Form	Mid Jan	Yes - Because these projects should be aimed at prevention towards chronic illness.
	Feedback Form	Mid Jan	I do agree that the four projects named should be given priority, The NHS caters for millions of patients, over many issues, it is therefore very important that these issues are shortlisted to give the best results to the majority of patients which I consider this has been achieved by the 4 big projects named.
	Feedback Form	Mid Jan	Long term conditions? Cancer and end of life care?
	Round Table Discussions - Commissioning Intensions Discussion Forum with Healthwatch	04-Feb-14	Broadly yes but concerned about plans for Urgent Care Centre not being local to everyone
	" "	04-Feb-14	Still not enough emphasis on enabling people to take control of their own health
	" "	04-Feb-14	GP's should be able to signpost people to services that help people to take control of their own health and wellbeing.
	" "	04-Feb-14	Urgent Care Centre – how will people know where and when to go to A & E = referral only?
	" "	04-Feb-14	Trying to free up A&E?
	" "	04-Feb-14	Issue with geography in the city – need to be taken to the appropriate service
	" "	04-Feb-14	Why pick up just MH/LD as opposed to all/other disabilities

	“ “	04-Feb-14	How can you deliver care closer to people’s homes when proposing Urgent Care Centre - is this not a bit difficult?
	“ “	04-Feb-14	Yes
	“ “	04-Feb-14	Health Inequalities – difficult for Health to achieve on its own
	“ “	04-Feb-14	Care Plans stops fragmentation don’t get Social Care and Health Care as a whole – depends on your G.P
	“ “	04-Feb-14	Having a Care Plan means someone having care will be asked what they can do – means people have to work to their care plan
	“ “	04-Feb-14	Minor Operations are done in some GP surgeries but not in all
	“ “	04-Feb-14	Some GPs not want you to go to Walk-In Centre as it costs them money so they will find you an appointment
	“ “	04-Feb-14	Children and Young People should have the nest start in life. In young people there are health inequalities. Some projects addressing this. The Unity project in Broomhall looks at helping young people to eat healthier and does exercise while also working with their parents. The "Community Gym" also offers nutrition advice and gives people an understanding of what choices they can make
	“ “	04-Feb-14	Not that many facilities in communities for Children and Young People to come to, to get healthy, especially for under 16's which as well as leading to obesity leads to mental health issues
	“ “	04-Feb-14	Not enough use of Voluntary and Community organisations – especially for young people who will want to go somewhere where they know and feel comfortable
	“ “	04-Feb-14	Needs to be more of a community focus – fund more community activities. If it’s part of general activity young people will not feel penalised or stigmatised (for having to go to a fat camp), they will be getting fit with their friends in their community
	“ “	04-Feb-14	Needs to be holistic – meet the needs of CYP and support parents also encourage people to use the local services that are already there
	“ “	04-Feb-14	Health and Social Care needs integrating

	" "	04-Feb-14	111 – Longer waiting times for GP out of hour's service to call people back. Some people waiting 7/8 hours for an ambulance
	" "	04-Feb-14	Some GP's offer Doctor First or you speak to a doctor who if you need to be seen will make an appointment for you for that day
	" "	04-Feb-14	Focus on outcomes is good – but how do you quantify for patient not looking after themselves as they should
	" "	04-Feb-14	Should use more community facilities
	" "	04-Feb-14	GP's should be helping people look after themselves at an earlier stage – focus on education and public health?
	" "	04-Feb-14	CYP – amazed at what is offered at Sure Start Centres, but why can't everyone access them?
	" "	04-Feb-14	More community education for parents e.g. weaning/healthy eating
	" "	04-Feb-14	Activity Sheffield offer lots of things locally e.g. Outdoor Gyms
	" "	04-Feb-14	Should be more information on what's available locally
	" "	04-Feb-14	People aren't taking responsibility for own health – "look after yourself" – Self Care
	" "	04-Feb-14	People should think about themselves
	" "	04-Feb-14	How distinctive are these priorities to Sheffield?
	" "	04-Feb-14	Sheffield doing things their own way
	" "	04-Feb-14	4 Projects – yes agree with these but....
	" "	04-Feb-14	Are these nationally driven?
	" "	04-Feb-14	Logical that it achieves outcomes and achieves Value for Money
	" "	04-Feb-14	VCF organisations could do this but couldn't evaluate, monitor and deliver it without funds (chicken and egg).
	" "	04-Feb-14	Could fund some PILOT work with VCF organisations
	" "	04-Feb-14	VCF more accessible in communities
	" "	04-Feb-14	What is the basis for giving a Value – what is the outcome/how is it measured
	" "	04-Feb-14	Who is judging success – timescales for payments?

	“ “	04-Feb-14	Could stagger payments with final payment when patients health and wellbeing has improved
	“ “	04-Feb-14	On the right track – yes referring to reducing hospital based appointments
	“ “	04-Feb-14	Orthotic Services – outpatient services provided in hospital could/should be provided in a community
	“ “	04-Feb-14	“Patient Choice” – currently not utilised
	“ “	04-Feb-14	MSK services - ? Currently split x 2 services/Service Providers
	“ “	04-Feb-14	The right system to measure outcomes – currently too subjective?
	“ “	04-Feb-14	Agree with reducing the gap in life expectancy
	“ “	04-Feb-14	Don’t disagree, lot in common to public health reassuring. Work together more closely. Appreciate investment in some of the services
	“ “	04-Feb-14	Feel monetary led doesn’t take into account care of person. Someone has crisis it impacts on whole family but difficult to measure
	“ “	04-Feb-14	Ways to measure/influence for better outcomes – are we suing them in a timely/effective way
	“ “	04-Feb-14	Priority about working together – SCC/Voluntary Sector/Housing – need to bring everyone together
	“ “	04-Feb-14	Should it be about “commissioning for outcomes” or “activities” need to be co-produced? Practice Manager Champions
	“ “	04-Feb-14	Being taken seriously as a sector and involved in service design – shift of public services into third sector needs to engage and input more
	“ “	04-Feb-14	Partnership and Integration
	“ “	04-Feb-14	Need their own outcomes/co-design
	“ “	04-Feb-14	Need to engage better with younger people
	“ “	04-Feb-14	A lot of this depends on things outside the CCGs control e.g. integration – if SCC is facing cuts is this achievable or possible?
	“ “	04-Feb-14	No integrated budget at the moment = shouldn’t be a fight over who pays for what
	“ “	04-Feb-14	Concerns about non ringfenced budgets – doesn’t help if care homes are being closed
	“ “	04-Feb-14	Don’t stack up with the rest of the picture e.g. Self Directed Support thresholds – almost like a health and council are in opposition in terms of aims

	" "	04-Feb-14	Ambitious but verging on unrealistic
	" "	04-Feb-14	If you want to achieve 20%/40% reduction in targets for A & E attendances than GP practices need to change
	" "	04-Feb-14	Don't want better out of hours services want 24/7 working practices
	" "	04-Feb-14	Mental Health is struggling and needs more focus
	" "	04-Feb-14	Working with City Council
	" "	04-Feb-14	Care planning, good idea in principle
	" "	04-Feb-14	Prefer to be seen in own GP rather than at GP
	" "	04-Feb-14	Most people want to get care at home and don't want to go into hospital
	" "	04-Feb-14	Query over inequalities is it right to spend money when people have free choice on lifestyles – start with the children (work within public health)
	" "	04-Feb-14	Consider isolation
2- Is there anything about focusing on these projects that concerns you?	Feedback Form	Mid Jan	Yes - Monitoring of healthcare at local level.
	Feedback Form	Mid Jan	No
	Feedback Form	Mid Jan	Mental health, Learning disabilities and dementia, cancer and end of life care, to give them a care plan who need it or are at risk.
	Round Table Discussions - Commissioning Intensions Discussion Forum with Healthwatch	04-Feb-14	Outcomes – how Sheffield centred are they meeting national targets
	" "	04-Feb-14	Community involvement – means making best use of community resources e.g. VCF, lunch clubs, healthy living clubs
	" "	04-Feb-14	If they're not there help them to develop - Resources/£
	" "	04-Feb-14	Small Groups not be able to help – lack venues/places to meet and cost of these
	" "	04-Feb-14	Urgent vs. Emergency needs to be clearer defined
	" "	04-Feb-14	Accident and Emergency – what does it mean

	“ “	04-Feb-14	People don’t understand which services to use – “lack of knowledge”
	“ “	04-Feb-14	Costs/£ - especially for smaller VCF organisations may not have £ to continue
	“ “	04-Feb-14	When will commissioning start?
	“ “	04-Feb-14	Communities getting bigger - £ getting less.... Need to Invest in community provision
	“ “	04-Feb-14	Fund what works and keep funding it – “RINGFENCE”
	“ “	04-Feb-14	Where is the engagement with people with LD/MH to talk about how you can increase their
	“ “	04-Feb-14	Not standardised – not equal access to all
	“ “	04-Feb-14	Khat – concern that the reclassification will lead to withdrawals and mental health issues – is anything being put in place?
	“ “	04-Feb-14	Children and Families - Integration agenda may need to be wider than just health and social care
	“ “	04-Feb-14	Young Carers – need support
	“ “	04-Feb-14	If we are all working towards person centred practice is there a need for true integration (should also involve wider family members)
	“ “	04-Feb-14	Can Health/Social Care work more co-operatively (instead of full integration?)
	“ “	04-Feb-14	Lots of jargon around integrated care – all you need is a single point of contact? – Need someone who can be there without handing over – don’t care who?
	“ “	04-Feb-14	Tendency to over professionalise
	“ “	04-Feb-14	Loss of personal contact with some health
	“ “	04-Feb-14	Care closer to home – some people may not necessarily want to be closer to home.
	“ “	04-Feb-14	Outcomes – some patients with complex/difficult needs may not be taken on in the first place – will there be a culture of “seeking out easy patients”
	“ “	04-Feb-14	Hospital needs to make sure that discharged patients are supported and followed up in the longer term and outcomes are linked to this. Supported discharge to care homes may be a good thing
	“ “	04-Feb-14	Care planning – is it possible?
	“ “	04-Feb-14	Managing of workloads

	" "	04-Feb-14	Housing – no taking account of health conditions when bidding for council stock – dedicated housing officers for vulnerable people may be part of the solution. Concerns around support at the point of discharge
	" "	04-Feb-14	Surgeries suffocated with students
	" "	04-Feb-14	Cost of private health services (after 6 weeks free)
	" "	04-Feb-14	Is it realistic to reduce inequalities?
	" "	04-Feb-14	Work with council – how budgets work – needs to be flexible
	" "	04-Feb-14	How delivered/integrated services and voluntary sector work together in a co-ordinated way
	" "	04-Feb-14	CCGs work with providers e.g. Birmingham CCG
	" "	04-Feb-14	Very much looking at individual - needs to look at family support
	" "	04-Feb-14	Need to look at reasons why more e.g. why people are going to A & E
	" "	04-Feb-14	How we use resource – staffing, training, support. If we want people involved in care plans
	" "	04-Feb-14	How people perceive healthcare – passive/ need help to understand
	" "	04-Feb-14	Health workers people going into homes need to "join up" and identify those at risk
	" "	04-Feb-14	Only people who "engage with services" have a voice. Need to be more vocal and ensure people engaged. Need to go out and really engage
	" "	04-Feb-14	Lots of initiatives going on at the moment and complicated. How GPs manage? How to get GP on radar? Work with Practice Managers? Advice sector smaller. Funded through Personal Budgets
	" "	04-Feb-14	Manchester giving funding to voluntary service advising about public health. Should CCG look at giving out grants?
	" "	04-Feb-14	Council less knowledgeable at working at neighbourhood level
	" "	04-Feb-14	Changes in Council means some areas will be outsourced
	" "	04-Feb-14	Need to be avoid "tick box" exercises
	" "	04-Feb-14	Carers concern Sheffield has higher than national average people who care. If council/CCG budget at more families having to pay for care – need to think of whole family not just person

	" "	04-Feb-14	How we measure gap in mental health and learning disabilities
	" "	04-Feb-14	Is it just a rebrand (PCT – CCG) with less power?
	" "	04-Feb-14	Will things go full circle (back to regional health authorities in time?)
	" "	04-Feb-14	Potential budgets swallowed up by re branding and restructuring
	" "	04-Feb-14	All for greater good in terms of plans – as long as we see the results
	" "	04-Feb-14	From personal/business perspective, how easy will it be for us to become a qualified provider in the procurement system – national tariffs?
	" "	04-Feb-14	Orthotics service – massive difference in price - national service
	" "	04-Feb-14	Providers should be based on the quality of service delivered
3a - By ensuring everyone who needs one is offered a care plan, reducing emergency admissions and attendances, improving life expectancy, supporting children to have the best start in life and bringing more hospital services closer to home, we are aiming to make life better for people in Sheffield. a) Do you feel that the scale of these plans are too ambitious, about right or not ambitious enough? Please share your thoughts.	Commissioning Priorities 2014-16 Forum	03-Feb-14	We are very concerned that the severe enforced reductions in local authority spending will adversely affect these plans. We fear that the NHS may embark on plans which the LA will be unable to support leaving patients lost in the middle of an fragmented and even more muddled system. Integration costs before it pays (cf Leutz's rules). Changes and innovation should be based on evidence and concurrent evaluation rather than hopes that community-based services will reduce admissions, especially for older people. This evidence should be presented to the public in an understandable form. Also the effect of austerity measures on the more vulnerable puts health at risk and increases the likelihood of emergency admissions.
	Feedback Form	Mid Jan	Great care must be taken to ensure the action taken is the most suitable for each individual.
	Feedback Form	Mid Jan	About right

	Round Table Discussions - Commissioning Intensions Discussion Forum with Healthwatch	04-Feb-14	Too ambitious – “Learn to walk before you can run”
	“ “	04-Feb-14	Very ambitious – requires a lot of investment, time and working with lot of people
	“ “	04-Feb-14	Not always quick to respond
	“ “	04-Feb-14	Needs true partnership and takes time and commitment and resources stretched
	“ “	04-Feb-14	Needs system change and cultural change
	“ “	04-Feb-14	How to build partnership with limited funds/resources
	“ “	04-Feb-14	Unrealistic – desirable but concerned that not deliverable
	“ “	04-Feb-14	Many people do not feel able to “work with” the commissioners/health and social care
	“ “	04-Feb-14	Concern that GP Champions/other VCF will be used to “offload” some of the day to day work that GP's should be dealing with
	“ “	04-Feb-14	Would like to see more collaboration between “patients” and professionals
	“ “	04-Feb-14	Sheffield has an ageing population
	“ “	04-Feb-14	Risk of being too ambitious and needs to work “on the ground” as well as on a slide
	“ “	04-Feb-14	How are you actually going to make this happen?
	“ “	04-Feb-14	Should be trying to give people the knowledge/support to self-manage
	“ “	04-Feb-14	Are ambitious – equality of access shouldn’t be toned down
	“ “	04-Feb-14	What specific actions will be taken?
	“ “	04-Feb-14	What training are GP’s getting to transform services
	“ “	04-Feb-14	What £/what will it cost – is money available to achieve these plans
	“ “	04-Feb-14	“Invest to Save” – difficult when there’s nothing to invest
	“ “	04-Feb-14	Got to be ambitious
	“ “	04-Feb-14	How will it be measured?

	" "	04-Feb-14	Working with consultants – what does transform mean?
	" "	04-Feb-14	More specific information needed
	" "	04-Feb-14	Train run alongside A&E – not suitable for whole population across the city – why not use Health Centres
	" "	04-Feb-14	Fair starting point – how have you come to the number? E.g. 15,000 care plans, what does 20%/40% represents – where are we now in terms of a reduction in recent times
	" "	04-Feb-14	Risk removing information communities – staff numbers/could cost more. Unless you can increase staff, you could see longer access times spread over a wider area
	" "	04-Feb-14	Always are barriers – services trying to protect their own. Difficult to get surgeons/consultants to buy into things – protect their own
	" "	04-Feb-14	National tariffs – outcomes/contracts = consistency
	" "	04-Feb-14	Not ambitious enough – lots of people struggling with aspects of ill health. Some illnesses appear to be irresolvable. People in NHS willing to think outside the box to help patient find solutions. People often passed between departments
	" "	04-Feb-14	NHS culture of here to keep head down
	" "	04-Feb-14	Needs of patient rather than needs of budget
	" "	04-Feb-14	Harder to get access
	" "	04-Feb-14	Are they based on an effective use of pilots e.g. care plans
3b) What will these changes mean for you?	Feedback Form	Mid Jan	Some services received at present might be changed - Others will not. At present I do not have a health plan but ongoing age may demand one.
	Feedback Form	Mid Jan	For more training staff to give advice on that service for this for the long term illness for people.
	Round Table Discussions - Commissioning Intensions Discussion Forum with Healthwatch	04-Feb-14	If it all works – more fair for everybody
	" "	04-Feb-14	Not a lot – not much talk about individual needs
	" "	04-Feb-14	Fairness and equality- will everyone be treated differently rather than the same

	“ “	04-Feb-14	Admirable aspirations if progress can be made to Value for Money and Equality of access
	“ “	04-Feb-14	High level strategic priorities – what actions are being taken to achieve these?
	“ “	04-Feb-14	Seeing the way the NHS is going – more hopeful things will be put in place so when I need something it will be there
	“ “	04-Feb-14	If it prevents major scandals in Sheffield all the better
	“ “	04-Feb-14	To have equality of access is good if it’s across the city
	“ “	04-Feb-14	Not as much confusion if services are all the same across the city
	“ “	04-Feb-14	Someone save money from health service
	“ “	04-Feb-14	Services changed – Hallamshire Hospital services moved to Northern General Hospital dreadful
	“ “	04-Feb-14	VCC/WIC should be at Hallamshire
	“ “	04-Feb-14	Extra expense for patients in time and hassle
	“ “	04-Feb-14	Different services
	“ “	04-Feb-14	Hopefully better patient service – quicker access to right person in right place
	“ “	04-Feb-14	To be able to invest in services that will provide better outcome – technology – at the moment the £ wasn’t there
	“ “	04-Feb-14	Money is Ringfenced. Can be accessed by more efficient processes and systems
	“ “	04-Feb-14	Difficult to say – it depends on what this translates to in terms of actual outcomes for patients
	“ “	04-Feb-14	Equality of access to services. Equality of access to social opportunities is as important
	“ “	04-Feb-14	Carers need support. When thinking of the “whole person” needs to consider “whole family”
	“ “	04-Feb-14	People work with will welcome but also ask “what means on the ground”. Have heard it before and need to see evidence
	“ “	04-Feb-14	Feel CCG socially aware and have holistic approach
	“ “	04-Feb-14	Hope to see much more joined up services
	“ “	04-Feb-14	Big gap “hospital provision” who engages
	“ “	04-Feb-14	200 tenants and 100 people in residential care. Look at as prevented home health needs increasing as risks delayed

General Comments	Commissioning Intensions Form	14-Nov-13	As a members of LINKS organisation, which is now Healthwatch, I have for many years been very active in all matters regarding Health and Health Care. I found the meeting today very informative and interesting, and would appreciate being kept informed on all matters which the group is engaged in.
	Commissioning Intensions Form	14-Nov-13	Initial thoughts good - you seem to be on a good 'right' rick ahead of the keogh report already.
	Commissioning Intensions Form	14-Nov-13	Learn from your experiences year on year did the areas you made extra investment in e.g. Hosp Trust provide the full expected results, learn not to keep putting money in the same areas if they don't deliver in buckets full.
	Commissioning Intensions Form	14-Nov-13	Good aims and Inclusive. Concerned to see LTC information referring to 'epilepsy.' What about the full range of long term neuro-conditions
	Commissioning Intensions Form	14-Nov-13	I look forward to CCG engaging with groups as they have said they are keen to do. The old LTNC forum is still available for sharing information, please use us!
	Commissioning Intensions Form	14-Nov-13	Encouraging though useful to have 'visual' presence of reps from H&WBB. At least reassure that we're trying for an integrated, cost effective & efficient approach in this city (despite structures). Does "not looking to commission (spend money) outside of the current system" mean not looking at efficiency and effectiveness?
	Commissioning Intensions Form	14-Nov-13	Just a note, as you'd expect on perceives (actual?) 'internal contracting' within NHS. Seems an expectation that you continue to commission with large NHS providers & 'trust' them to deliver in most effective & efficient way - without any mechanic forcing FTs to use third sector IF already delivering rather than re-inventing services but in
	Commissioning Intensions Form	14-Nov-13	The plans for next year seem to be on the right lines.
	Commissioning Intensions Form	14-Nov-13	How to contact people between the community, both young and old, regarding isolation issues. Look at setting up L.O. Friends Groups in local nursing homes.
	Commissioning Intensions Form	14-Nov-13	Voluntary sector should be viewed as potential service delivery partners as well as representatives and champions.
	Commissioning Intensions Form	14-Nov-13	Using commissioning Innovative ways of engaging people and delivery health education e.g. www.madamejucehini.co.uk <- shamseless self publicity.

	Commissioning Intensions Form	14-Nov-13	Generally encouraged that the CCG appears genuine in aim to effectively engage with citizens and will be willing to think differently to meet people's health needs to include / liaise with public health and adult social care - particularly important people living with long term conditions, including neurological conditions. Enabling them to maintain as much independence & self-manage their condition.
	Commissioning Intensions Form	14-Nov-13	Long term neurological conditions seem in danger of being lost in the Long Term Conditions portfolio - the presentation mentions on 'epilepsy' - please engage with us to ensure this important patient group are not overlooked with negative consequences for their wellbeing and increased cost of associate health care.
	Commissioning Intensions Form	14-Nov-13	Good to hear you are open to new services.
	Commissioning Intensions Form	14-Nov-13	To be frank :- a lot of rhetoric, "if we can integrate services, we will get the best services for patients." [!!!]
	Commissioning Intensions Form	14-Nov-13	There is enough money to kill and main 1million++++ people in Iraq. FACT!! Yet we constantly complain that there isn't enough
	Letter	15-Nov-13	3 Day is more less than a week that will reduce more time for them who really need it ok?
	Letter	15-Nov-13	To provide them with better care for them who needs it and supervision for them who really needs it more for them in care?
	Letter	15-Nov-13	For them two to stay a couple of nights is more time for treatment for them?
	Letter	15-Nov-13	To give them more home visits for them who've been in hospital for treatment and home care.
	Letter	15-Nov-13	To give them the best service for them for them who need it for them what would help them ok?
	Letter	15-Nov-13	To get more advice and help for them who at home for their quality of care for them?
	Letter	15-Nov-13	To provide more centres for them to get more help for play groups for them and day centres for them ok?
	Letter	15-Nov-13	And to listen to their views for their care and their needs for them and more staff on call for them who need it for day or night?
	Letter	15-Nov-13	To reduce more people to go to hospital for treatment unless they need it ok for best care for them to be speaking to their doctor first for the best care for them before they go to hospital ok?

	Letter	15-Nov-13	To give them more child care for advice for them to find out where to go for advice for their children by seeing their doctor before they give them the right care for them who need it to get them better ok?
	Letter	15-Nov-13	And to give them the best quality of care home for them to stay in for their care for them?
	Letter	15-Nov-13	To give them the right to choose where they go to day centres for their help and advice ok?
	Letter	15-Nov-13	And to give them the best service for them for help for them to get more advice for treatment ok?
	Letter	15-Nov-13	And to talk to their cares for their treatment and care for them ok and to give best quality of care for them ok?
	Letter	15-Nov-13	To reduce their weight down to get them to eat more 5 a day for them ok?
	Letter	15-Nov-13	And to give them the training for them to get them back in time for them to lose weight ok?
	Letter	15-Nov-13	And go to talk to their families about their children to get their children to get more fit's training for them to eat more 5 a days to get them back in trim for them to best quality of live for them of?
	Letter	15-Nov-13	Supervise all other children care centre if you need more advice of this I am happy to help you for this ok?
	Letter	01-Jan-14	To give people more social care for them at home and support them for their needs.
	Letter	01-Jan-14	For sick people who really need it to get better and help for their care and to look after them for them until.
	Letter	01-Jan-14	To support them for their needs and to support them what's at home what waiting for treatment from hospital.
	Letter	01-Jan-14	To do more things for 5 a day for them and to give them what needs more help and care for others who are waiting for treatment from hospital and doctors to give them special care who needs it more and others.
	Letter	01-Jan-14	To do more for other people who want 5 a day to get more healthier.
	Letter	01-Jan-14	To give more to older people who need it more than others who need special treatment to check on them more who is sick and support them to get them better ok who can’t get to hospital.

	Letter	01-Jan-14	For younger people plus older people who need to go in to a nursing home for day break's who are sick to give other people a rest in.
	Letter	01-Jan-14	Look after other people who need to be supported by nursing staff to help them around the room for the best care for it ok.
	Letter	01-Jan-14	To take older people plus younger people on holiday who can't get holidays who are sick to them better for them for people who need a holiday.
	Letter	01-Jan-14	To give them more quality of care for them who are sick who really needs best care for them who need it more for treatment to get them better for it for the best of quality of life for them who get long term illness.
	Letter	01-Jan-14	And to get more staff to deal with long term illness to work with people who needs round clock treatment for them.
	Letter	01-Jan-14	And to check on them who want more help for treatment plus deal with their appointment for their care with their doctor and nurse for the best of quality of care for them ok
	Letter	01-Jan-14	And to give other people best quality of life for things what they need to get them better.
	Letter	01-Jan-14	And to watch them around the clock for them for their care for them for best quality of care for them to get them best help for them.
	Letter	01-Jan-14	To give them best care for this service for other people to get to know what they are there for treatment for them ok and help for them by doing this service for people and advice for them by day or night if there need it ok.
	Letter	01-Jan-14	And to other people the training for this service for it then they know what to do for it ok for the best care.
	Letter	01-Jan-14	To give them first aid course for staff to do for this service for people is very sick who need it more.
	Letter	01-Jan-14	To give other people more rights to choose for treatment at any hospital or doctors then ok.
	Letter	01-Jan-14	To give them the right to get the treatment.
	Letter	01-Jan-14	And to give them more options for treatment for advice and test for them by talking about the option for them ok.
	Letter	01-Jan-14	For best quality of the service's for people to benefit from it the best quality of care.

	Letter	01-Jan-14	To get more people to know what services we do by buying leaflets out to tell them what we do ok what best quality of care and treatment.
	Letter	01-Jan-14	For best quality of services when they get admitted by sitting with them.
	Letter	01-Jan-14	The best direct of care for train staff to deal with others for people what not to sure to do.
	Letter	01-Jan-14	And to trust this service to go of with a good start for people to trust this service for everyone to benefit from them.
	Letter	01-Jan-14	I get private care for person who needs it ok.
	Letter	01-Jan-14	To give people more choice of hospital for treatment.
	Letter	01-Jan-14	To support them for advice for older people to get their treatment ok.
	Letter	01-Jan-14	To give people more social care for them at home and support them for their needs.
	Letter	01-Jan-14	For sick people who really need it to get better and help for their care and to look after them for them until they need more support from this treatment for them ok.
	Letter	01-Jan-14	To give them more five a day to get their healthier for them ok.
	Letter	01-Jan-14	To do more training for people for them for five a day and advice for them.
	Letter	01-Jan-14	To give people who need a care plan to give them support for them who really need treatment for it to get them better.
	Letter	01-Jan-14	To get them right help for them who need it more then.
	Letter	01-Jan-14	To give them CPR if there need it for treatment for them who need to get better for them ok.
	Letter	01-Jan-14	To give out leaflets for this treatment for people for people for advice for them to get them better for it ok.
	Letter	01-Jan-14	To give them more advice over the phone when they need it for them to get them better to give them more advice for non-emergency.
	Letter	01-Jan-14	To direct people to other units for their care and support and advice for them.

	Letter	01-Jan-14	To direct to people who need emergency treatment for their complaints for them to get them better.
	Letter	01-Jan-14	And to direct to units for people for the care and treatment for them who need it ok and support and advice for it.
	Letter	01-Jan-14	For them with long term illness to give them more treatment for them ok who need it more.
	Letter	01-Jan-14	And care homes for people who can get therapy for them who needs treatment ok.
	Letter	01-Jan-14	And the right to other centre for other people to see what advice to give to them who really needs it for older people to get them better for them ok and sit with them when they get admitted to hospital and to be sent home for their need for some help for their treatment for them.
	Letter	01-Jan-14	All those who are most likely to need urgent hospital care in the next year to be offered a care plan agreed between them and their doctors to help them stay well (possible 15,000 people).
	Letter	01-Jan-14	To achieve a 20% reduction in emergency admission and 40% reduction in accident and emergency attendances by integrating health and social care services to support people to live independently.
	Letter	01-Jan-14	Bring specialised health services closer to peoples home by changing how and where they can be accessed which will mean less travel to the hospital.
	Letter	01-Jan-14	Reduce the gap in life expectancy for people with more mental health problems and learning disabilities.
	Email	16-Nov-13	The problems and health needs are generally known - you can read a textbook of medicine to find the clinical needs, any public health publication to give the wider determinants perspective and numbers publications relating to loneliness and starvation in hospital etc. It is not more information that is required (read the numbers case reviews of child neglect, poor hospital performance etc) but actually action on the ground and resources dedicated to making things happen. If time and attention was given to enabling the information already known and being gathered to be co-ordinated, analysed and acted upon I believe considerable improvement could be demonstrated in a very short time.

	Email	16-Nov-13	Interested people can then be engaged from the community, the clinical department or whoever seems to be appropriate for the job in hand to work on the improvements and make a difference. I thought Mark handled the questions and the situations that arose in a very sensitive constructive and sensible way and so the CCG could, by encouraging him and the team to apply their energy and expertise through the mechanisms mentioned above would yield considerable and visible benefits in a very short time.