Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

2015/16 Commissioning Intentions Refresh

Governing Body meeting

E

2 April 2015

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Is your report for Approval / Consideration / Noting

The Governing Body is asked to approve the 2015/16 commissioning plan.

Are there any Resource Implications (including Financial, Staffing etc)?

Our commissioning plan is founded on the principle of being achieved within available resources. Clinical and managerial capacity issues are being reviewed as part of the CET approval process for projects.

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
This paper supports delivery of all CCG objectives.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? No

If not, why not? An individual equality impact assessment will be carried out on each programme and project as they move through the PMO process.

PPE Activity

How does your paper support involving patients, carers and the public?
A full engagement exercise has been undertaken and is attached.

Recommendations

The Governing Body is asked to:

- Approve the 2015/16 Commissioning Plan
- Comment on the principal risks identified in the plan for inclusion in the 2015/16 Assurance Framework

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1. Introduction / Background

In April 2014 the CCG published its commissioning intentions for 2014/19, which included a two year operational plan and a five year strategic plan. We need to review and refresh the operational plan to confirm our commissioning plans for 2015/16, in the light of what we have achieved so far, what new information we have, e.g. on health needs, and changes to the national and local environment, including Government policy. Our plans for 2015/16 must enable us to continue progress towards achieving our strategic aims and ensure that we have a balanced financial plan for the year.

The CCG annual planning process started with some early discussions in late August and early September 2014 and then a Governing Body Organisational Development session in October 2014. This paper and the accompanying draft documents are the result of those discussions and the work of the CCG portfolio teams and Commissioning Executive Team since then.

In essence, the document setting out our plans for 2015/16:

- Confirms the objectives described in our 2014/19 Commissioning Intentions
- Contains a summary of each portfolio's plans for 2015/16, as plans on a page
- Includes a narrative covering some of the issues of national interest – to provide assurance to our public, partners and NHS England on those issues
- Summarises the principal risks to delivery that will be included in the governing Body Assurance Framework
- Should be read alongside the 2015/16 financial plan.

2. National Expectations

Planning guidance on key objectives of the planning process has been issued and details described to Governing Body in previous reports:

- NHS Trust Development Authority (NHS TDA), Monitor and NHS England (NHSE) in a gateway letter to CCG Clinical Leaders and CCG Accountable Officers.
- Email to the CCG on 1 December 2014 from NHS England Local Area Team which included a timetable for the development of plans for 2015/16
- The Forward View into Action: Planning for 2015/16 guidance was issued on Friday 19 December 2014 (which can be accessed at http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf).
- Supplementary information for commissioner planning, 2015/16 was issued on 23 December 2014 which is a supporting document to The Forward View into action: planning for 2015/16. It focuses on the business rules and planning assumptions for commissioners – both clinical commissioning groups (CCGs) and NHS England's regional direct commissioning teams.

3. Financial Plan and Efficiency

The Commissioning Intentions document outlines the overall financial position of the CCG. NHS England has confirmed that the CCG will receive an increase of 1.4% (£9.7m) to our Programme Allocation (i.e. the allocation received for the purchase of healthcare services), together with making £3.8m of systems resilience funding recurrent (combined uplift 1.94%). This compares to the 2.1% cash increase received in 2014/15 and 1.7% previous indicative allocation increase announced by NHS England in December 2013. The CCG separately receives a Running Cost Allowance (RCA) each year to fund the clinical engagement, staff, support services and other infrastructure costs to enable the CCG to undertake its commissioning role. All CCGs have had a 10% reduction in their RCA for 2015/16.

As outlined in the Commissioning Intentions document, NHS Sheffield CCG is planning to deliver a 1% surplus in 2015/16 (£7.4m), in line with the minimum required surplus confirmed in the NHS England planning guidance. £1m of this planned surplus will be delivered through an under-commitment against the RCA. The remaining surplus will be generated against the programme allocation.

Detailed initial budgets are being presented in parallel to Governing Body on 2 April with a recommendation that these are approved.

There remain a number of significant risks in terms of delivery of the financial plan in 2015/16, including:

- Ongoing contract negotiations have highlighted a significant number of financial pressures within the system, linked to the national discussions on tariff arrangements as well as local pressures (both activity and cost related).
- Uncertainty regarding potential additional funding. NHS England has confirmed that there is £150m available nationally to support the voluntary tariff arrangements. Given that our major acute trust has not opted for the voluntary 'Enhanced Tariff Option', it is unclear whether NHS Sheffield CCG will receive any additional funding from this pot. In addition, £ 40m funding is being held centrally by NHS England, with the expectation that this will be allocated to CCG to fund the development of Liaison psychiatry services in acute hospitals and improve access to psychological therapies programme. CCGs have yet to be informed how this £40m will be allocated.
- Delivery of £6m QIPP savings which will require robust programme management arrangements to implement agreed scheme and monitor delivery of the planned savings and/or recovery action plans

4. Progress and Actions

4.1 Timeline

The key planning dates for NHS England are:

Planning Requirement	Deadline	Status
Final guidance, templates and tools	By 23 December 2014	Received
Initial high level plans submitted	13 January 2015	Submitted
Plan data submission	28 January 2015	Submitted
Submission of full draft plan	27 February 2015	Submitted
Contracts signed	31 March 2015	Verbal update will be provided to the meeting. Achievement by 31 March looks very challenging.

Plans approved by CCG Governing Body	31 March 2015	To be approved by Governing Body on 2 April.
Submission of final full plan and supporting templates	7 April 2015	On Track

The timetable agreed at Governing Body in September, which included Governing Body receiving a draft 2015/16 commissioning plan in January 2015 and a final draft in March 2015 was revised due to the ongoing discussions regarding the financial plan; therefore a final draft is now attached for approval.

4.2 2015/16 Refreshed Operational Plan

The draft plan for 2015/16 has been drafted based on the CCGs stated aims and objectives. It should also demonstrate that the CCG is meeting the requirements of the planning guidance as described above. Some context has been included but the plan will mainly focus on what is different for 2015/16.

High level plans on a page have been completed by portfolios and reviewed by the Planning group in November. Portfolios are using the NHS framework for plans on a page, ensuring that the process is aligned to the PMO mandates. The plans are attached at appendix 2 of the commissioning plan. The aim of these is to summarise our work in each area.

Further work is ongoing to finalise specific projects. The starting point has been for portfolios to review the projects set out in the Commissioning Intentions document and propose changes through the CET approvals process, with a view to both ensuring progress towards strategic objectives and ensuring achievement of efficiency and effectiveness improvements to support achievement of financial balance in 2015/16.

Contained within the Supplementary information for commissioner planning, 2015/16 is Annex A which sets out the fundamental requirements of all commissioner plans. The CCG will be expected to demonstrate how the requirements have been met. A planning checklist template has been issued to signpost NHS England to these key elements.

A number of additional emails have been received from NHS England relating to metrics and the submission of a supporting narrative and self assessment checklist which is attached for information.

5. Stakeholder Engagement

The CCG undertook a comprehensive engagement exercise in 2014 on the development of its commissioning intentions and we have not therefore run a similar size exercise for the refreshed 2015/16 plan. However, we are seeking the views of our stakeholders and have undertaken a range of engagement activities to seek views on our proposed priorities, and to seek involvement in the projects we will undertake in 2015/16.

Feedback from this activity is attached for information Appendix 2).

6. Governing Body Assurance Framework

The purpose of the Governing Body Assurance Framework is to understand the main risks to achievement of our strategic objectives and set out mitigating actions to manage or reduce those risks. This year we have included the analysis of risks and mitigating

actions in the commissioning plan, so that our delivery plans include those mitigating actions.

An initial assessment of the principal risks was undertaken by Executive Team members on Monday 9 March 2015 and these are included in the plan.

7. Next Steps and Key Actions

Following consideration of the plan and final agreement, the document will be published on our website and shared with our partners. The plans on a page will form the basis of portfolios plans for the year, delivery of which will be managed through the Programme Management Office.

8. Recommendations

The Governing Body is asked to:

- Approve the 2015/16 Commissioning Plan
- Comment on the principal risks identified in the plan for inclusion in the 2015/16 Assurance Framework

Paper prepared by Jackie White, Interim Head of Governance and Planning

On behalf of Tim Furness, Director of Business Planning and Partnerships

March 2015

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

2015/16 Commissioning Plan

Contents

Executive Summary – Plan on a Page

This plan sets out our actions in 2015/16 towards achieving our ambition for the next five years as set out in our Commissioning Intentions 2014-19. These are based on the aims set out in our prospectus and the outcomes that Sheffield's Health and Wellbeing Strategy intends to achieve.

Our Ambitions for 2019

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

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

With the City Council, through integrated commissioning:

- Extend care planning
- Test the "Keeping People Well in Their Communities" model proposed in our integrated commissioning plans
- Specify and procure improved intermediate care and community nursing services to establish an integrated active support and recovery service
- Establish an integrated approach to long term health and social care
- Agree a new approach to Early Years, building on the Best Start work

CCG specific priorities:

- Mobilisation of the outcomes based contract for musculoskeletal services
- Contributing to delivery of Sheffield Health Inequalities plan
- Transforming Outpatient Services
- Redesigning urgent care services

Working with NHS England:

- Jointly commission primary care services
- Be actively involved in and supporting NHSE commissioning of specialised services

Supporting primary care and community providers to establish a collective approach to care provision, and to working with other providers

In taking forward these projects, we will:

- Be clear about our approach to parity of esteem for mental health
- Be clear that our projects and aims apply to children and MH/LD services too
- Be clear about the end goal for each project
- Identify where what we want to achieve will be through partnership work we're engaged in, rather than CCG specific projects

1. Introduction and Context

NHS Sheffield Clinical Commissioning Group (CCG) was formed in 2013 and is responsible for planning and commissioning services that the public and patients of Sheffield need. The CCG is led by GPs who look after the resident population.

Our mission is to improve the quality, equality and sustainability of the NHS in Sheffield through clinical leadership of commissioning, engaging practices and clinicians to make a real difference for the people of Sheffield.

Our aims are 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

We are committed to working with partners to achieve the outcomes set out in the Joint Health and Wellbeing Strategy:

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

2015/16 is the third year of operation for the CCG and the second year of our ambitious five year strategic plan. This year we intend to continue building 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 remain under significant pressure.

In developing the refresh of the two year plan, the CCG has had a clear focus on making sure that the plans developed in 2014/15 are as realistic as possible and demonstrate progress on implementing the 1st year transformational changes as set out in the NHS Five Year Forward View. The CCG is working with our providers to develop and align plans, ensuring that services continue to be delivered in a financially sustainable way and delivering the required standards and continuous improvements in quality and outcomes.

2. 2015/16 Plan - delivering our Commissioning Intentions

The 2015/16 commissioning plan is a continuation of our work towards achieving our aims. We set ourselves a number of ambitious objectives in our five year plan, published in 2014, 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

We have reviewed our progress to date, considered new information on the health needs of the population, and looked at what else has changed in the last year. We have reviewed our plans in the light of these and have produced a set of "plans on a page" which summarise our work in each of our clinical commissioning portfolios. We have looked again at our list of projects and refreshed this, removing those that have been completed and those that are no longer necessary, and adding new projects to reflect new priorities.

3. Reducing Health Inequalities

We recognise that taking action to reduce health inequalities will result in substantial population health gains, reduced healthcare spend and improved health outcomes.[1]

There are a number of specific actions we can take to reduce health inequalities, particularly the gap in life expectancy between the best and worst off.[2] These mainly take effect through tackling differential access to services, and unwarranted variation in healthcare:

- Ensure widespread, systematic adoption of the most cost-effective high impact interventions as recommended by the National Audit Office report into Health Inequalities,[3] and the Public Accounts Committee Report into Tackling Inequalities in Life Expectancy.[4] This includes:
    - Improving blood pressure control
    - Increase smoking cessation services
    - Increased anticoagulant therapy in atrial fibrillation
- Increase targeted approaches to case finding in hypertension, COPD, lung cancer, cardiovascular risk and harmful drinking.
- Improve access to health care for vulnerable populations.
- Involve people and communities in designing services to meet their health and care needs, to ensure we break down any barriers stopping people from fully utilising services.
- Integrate care and services, so that they are commissioned around the needs of the patient and community rather than the needs of the professional or the service.
- Ensure commitment to and delivery of the 'Making Every Contact Count' initiative.[5]
- Use the Equality Delivery System (EDS)[6] as a toolkit to drive improvements, strengthen the accountability of services to those using them, and bring about workplaces free from discrimination.

[1] Marmot et al. Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010. February 2010 http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf
[2] NHS England. Promoting Equality and Tackling Health Inequalities. December 2013
[3] http://www.nao.org.uk/wp-content/uploads/2010/07/1011186.pdf
[4] http://www.publications.parliament.uk/pa/cm201011/cmselect/cmpubacc/470/470.pdf
[5] http://www.makingeverycontactcount.co.uk/index.html
[6] http://www.england.nhs.uk/ourwork/gov/equality-hub/eds/

4. Local Context – New Information

We published information about the demography and health needs of Sheffield last year. New information since then includes:

- Liver disease: although accounting for a small number of deaths overall, the death rate from liver disease is rising very quickly in Sheffield as well as nationally.
- Sight loss: a significant proportion of sight loss can be prevented, treated or reduced yet the biggest problems faced in Sheffield are the degree of under-diagnosis of people, low levels of referral to appropriate services and, in certain cases, low uptake of relevant specialist screening services.
- Migrant and new arrivals health, including asylum seekers/refugees: parts of the city are seeing increasing numbers of new arrivals. We need to review the health needs of new arrivals, migrants, asylum seekers and refugees and ensure our services meet these needs.
- Cancer inequalities: we know that cancer is a major cause of premature death in Sheffield, and we are seeking to develop a clear picture of inequalities in relation to early diagnosis and treatment.

5. Our portfolio projects and efficiency plans

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

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

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

Each portfolio identified priorities during 2014/15 for the next two years that will contribute to achieving our ambitions. The plans for 2015/16 are set out in appendix 1. Key priorities for the next year include:

With the City Council, through integrated commissioning:

- Extend care planning
- Test the "Keeping People Well in Their Communities" model proposed in our integrated commissioning plans
- Specify and procure improved intermediate care and community nursing services to establish an integrated active support and recovery service
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CCG specific priorities:

- Mobilisation of the outcomes based contract for musculoskeletal services
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Supporting primary care and community providers to establish a collective approach to care provision, and to working with other providers

Within our plans for 2015/16 are a small number of new projects, not identified in the 2014 document. These are highlighted within appendix 2.

6. Summary Financial Plan

The financial plan for 2015/16 has been developed. 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

In line with guidance from NHS England, we are planning to deliver a 1% surplus (£7.4m).

The financial plan has been developed using the following assumptions:

- Confirmed Allocation increase of 1.4% (£9.7m). This compares to the 2.1% cash increase received in 2014/15 and 1.7% previous indicative allocation increase announced by NHS England in December 2013;
- Confirmed allocation for systems resilience of £3.8m – a process for agreeing plans for utilising this funding has been agreed with partner organisations;
- The CCG separately receives a Running Cost Allowance (RCA) each year to fund the clinical engagement, staff, support services and other infrastructure costs to enable the CCG to undertake its commissioning role. All CCGs have had a 10% reduction in their RCA for 2015/16. NHS Sheffield CCG planned for this cut, and is still expecting to generate a surplus of £1m on this allocation to contribute to the overall surplus of £7.4m;
- Inflationary pressures of c£15m have been estimated on the basis of known information;
- Efficiency to be delivered from providers of NHS care of 3.5% from those opting for the voluntary Enhanced Tariff Offer (ETO). For those providers who do not opt for ETO, the expectation is that the 14/15 tariff prices (Default Tariff Rollover – DTR) will apply – i.e. with no adjustment for 15/16 inflation or efficiency. In these cases, the expectation is that providers would not be eligible for CQUINS. Given the on-going discussions (both nationally and locally) the impact of the different options have not been yet been reflected in the financial plan.
- Delivery of £6m efficiency savings via our QIPP schemes;

- Retain a contingency of 0.5% (£3.7m) for in year pressures in line with NHS England planning requirements;
- Estimation of unavoidable cost pressures (£18m) including:
    - additional activity likely to be delivered in 15/16 linked to demographic growth, technological growth and continued focus on reducing waiting lists in order to deliver waiting time targets;
    - additional growth in both activity and cost terms for prescribing spend
    - additional growth in continuing health care packages
    - full year effects of previous years investments
- The plan contains a small number of specific investments (£1m) linked to the priorities identified in this plan.

A number of assumptions outlined above are still subject to final agreement. One of the key uncertainties relates to national tariff arrangements which are still in the process of being confirmed. Changes to the assumptions included above could have a significant impact on the overall viability of the financial plan, and as a result the financial plan could still be subject to change.

7. Commissioning for Quality

We aim to ensure that we drive up the quality of care and treatment of services commissioned for the people of Sheffield, and that there continues to be a culture of continuous quality improvement.

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

- DH Nursing Strategy – 6C's
- A review of the CQC regulatory process and the appointment of Chief Inspectors of Hospitals, social and primary care
- Guidance on involving patients and the public in services
- Publishing Clinical Outcome data by Consultants
- Nursing/Midwifery and fast track leadership programmes
- Friends and Family Test – initially within acute services but for expansion to all NHS providers by April 2015
- 'Hard Truths' (November 2013) "The government's response to the Francis inquiry"
- New legislation – Duty of Candour; being open with patients and families
- Publishing ward staffing levels

8. Patient and Public Engagement

We want to continue to be better at involving patients and the public in both the quality and service development 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.

Our Public and Patient Involvement Plan, approved by Governing Body in November 2013, sets out 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

We have established a Patient and Public Engagement Group, led by two of our Governing Body lay members, 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. This group now reports to the Governing Body on every three months, both setting out progress in improving how we involve people and reporting the outcome of engagement exercises in that quarter.

9. Primary Care Development

We have considered the aims of co-commissioning of primary care. However the way in which Sheffield is looking to achieve them differs to the approach being sought in many other areas. Many of the services changes the CCG would like to see happen in local setting are enshrined within the developing joint approach, e.g. wraparound services to support primary care service delivery to at risk patients.

We have agreed that for the financial year 2015/16 the preferred co-commissioning model is that of level 1 - greater involvement in primary care decision making with NHSE; and that, should our wider commissioning agenda require an increased level of co-commissioning in-year that such a submission will be made at that point.

10. Specialised Commissioning

We are represented at a joint CCG/NHS England Yorkshire and the Humber Specialised Commissioning Oversight Group. This group has been established to ensure that commissioners of local services and specialised services work together in designing pathways of care, in managing contracts with providers, and in the transition of responsibility for commissioning some services from NHS England to CCGs.

11. New Technology

New technology plays a key role in delivery of the Five Year Forward View. It recognises that the use of digital technologies is low in practice and a fundamental business change and cultural shift is required. A greater and more seamless flow of information can transform the way care is delivered, evaluated and rewarded. Technology can provide the capability to help providers across the region provide better access to care, better communicate, and enhance teamwork and efficiency. The CCG hosts a post supporting all the CCGs in Yorkshire and the Humber to make the most of the opportunities new technology provides.

The availability of pertinent information as a shared local resource for ongoing needs analysis, intervention design and delivery, and impact evaluation is a key focus for integrated working in health and social care.

We will develop a roadmap for the introduction of interoperable digital records and services by providers – including in specialised and primary care by April 2016.

12. Developing the Five Year View for Sheffield and new models of care

Responding to the prompt of the national Five Year Forward View, and building on the strategic aims and five year objectives we published last year, over the next year we will continue to work with local providers and partners and with the public of Sheffield to develop a clear vision of how services should be delivered in Sheffield and how we will achieve that vision.

We will consider the new models of care set out in the Five Year Forward View with the Sheffield Health and Care community, including:

- Sheffield City Council
- NHS Sheffield Clinical Commissioning Group
- Sheffield Teaching Hospitals NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- The Sheffield GP Provider Board – (comprising all 87 practices in the city)
- The Yorkshire Ambulance Service NHS Trust
- Sheffield Cubed – The Third sector umbrella organisation for the city

We aim to develop a model of care that will further integrate health and social care services in the community, pooling the available budget. Care will be centred on the person in need, providing earlier intervention and prevention and reducing the need for hospital and long term care, as well as eliminating waste. The change will shift the balance of services from crisis intervention towards earlier prevention and proactive care planning.

A predominantly Multidisciplinary Team (MDT) approach, the wrap-around of health and social care teams around the GP practice and the partnerships of existing specialist secondary care and mental health providers is important to deliver the new service. These attributes are more predominant in the Multi-specialist Community Provider (MCP) model – which is the model we are initially interested in developing, recognising this more formal primary/community based organisational form in the first instance will allow us to increase our integration work and test out further opportunities and models in due course.

Partnership working is crucial to achieving our ambitions and to meeting the challenges of the years ahead. We need to ensure we are able to sustain services whilst we work within the financial and resource constraints across our organisations, ensuring we are able to deliver effective person centred services and simpler patient focussed care pathways that reduce duplication and inappropriate use of resources through integration in the next five years.

13. Working Together in South Yorkshire and Bassetlaw

The seven Clinical Commissioning Groups and NHS England across South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire initiated a strategic transformation programme 'Working Together Programme' to plan and commission collectively for health and care services in collaboration with other public bodies.

The vision for the working together programme is to "Commission together to efficiently deliver improved patient outcomes for all of our local populations".

The programme aims to deliver significant improvements to health outcomes and care experience which would not have been possible on our own for our local population. Working together will enable and support local priorities and will facilitate consistent coordinated delivery which is planned and purposeful.

During the next year the Working Together Programme will focus on engagement and decision-making to test, develop and evolve the strategy. Early work has begun to support engagement with patients, carers and the public, clinicians and staff and provider organisations.

14. Integration of Health and Social Care

NHS Sheffield Clinical Commissioning Group (CCG) and Sheffield City Council (SCC) have agreed to work towards a single budget for health and social care, so that we make decisions about how we use our resource with a focus on what the people of Sheffield need, rather than on individual budgets.

For 2015/16, we have agreed to establish a pooled budget of around £260m, based on an agreed first focus on four areas of need, where we felt there is the greatest opportunity for health outcomes improvement:

- Keeping people well in their communities - incorporating GP care planning, focussed on preventing avoidable crises.
- Independent living solutions - recognising the current joint commissioning arrangements for community equipment and the opportunities presented by the expiry of the current contract.
- Intermediate care - to improve the range and efficiency of out of hospital step up and step down services, to reduce admissions to hospital and support reablement, reducing admissions to long term care.
- Long term high support care - integrating our assessment, placement, quality management and contracting processes to ensure a shared focus on achieving the most effective care for people, and avoiding the unproductive cost shift between health and social care that has often characterised approaches to achieving savings as single organisations.

In addition, we have included the NHS expenditure on non-surgical emergency admissions so that the savings released from that budget can be used to fund investment in the above commissioning projects and to ensure shared commitment to reduction of emergency admissions.

The projects outlined above are critical to the success of the CCG in achieving its aims for 2019. Our plans are in line with the national Better Care Fund expectations, but are significantly greater in scope and ambition than the national minimum.

There is an equally ambitious integrated provider agenda within the city. Over recent years the Right First Time initiative has enabled the FTs of the city to meet and discuss provider solutions to key issues. Over the last few months work has been taking place to enable general practice in its provider role to develop its collective voice and to engage with the city's providers to support and develop integrated provider solutions. The emerging GP Provider Board (GPPB) is starting to work with the city's providers in a more integrated way and to explore how full pathways, not just specific elements, can be seamlessly delivered by such collaborative working.

15. 7 day working

Sheffield is participating, as a whole health and social care community, in the early adopter Seven Day Services Improvement Programme. We are working with partner organisations including Sheffield Teaching Hospitals and Sheffield City Council, to explore opportunities to move towards the commissioning and provision of more responsive and patient centred services, across the seven day week.

16. Research

We have a well-established commitment to supporting research activity, with a particular focus on supporting Primary Care Research. Having hosted an NIHR Grant for the last two years the CCG is benefiting from RCF (Research Capability Funding) which it is investing in areas which either support our commissioning intentions and /or include Primary Care Clinicians among the researchers. In addition the CCG works in partnership with the Research and Development Department at SH&SCT providing funding to support a part time Research Manager and to meet the costs of offering Research Governance advice to the CCG and our member practices. We also fund the development of a small number of potential grant bids either directly with practices or via ScHARR.

In addition the CCG is becoming increasingly active within the local research community, sitting in its own right or representing South Yorkshire CCGs on both the NIHR Clinical research Network for Yorkshire and Humber and the Y&H CLARHC Partnership Groups. The CCG are also building strategic research alliance s with both ScHARR and the Academic Department of General Practice within the University of Sheffield and also with Sheffield Hallam University

17. Supporting Development of the Health and Social Care Workforce

We contribute as an active member of Health Education England's Local Education and Training Board in South Yorkshire and also the Y&H Primary and Community work stream.

This year we have undertaken a workforce analysis in general practice in Sheffield with over 90% of practices providing workforce data via the HEE Workforce tool. This for the first time is giving a full picture of the extent to which the well documented challenges in Primary Care are likely to affect the area.

The CCG along with NHSE and the other 4 CCGs have established a Primary Care workforce group looking to pool the limited resource we have and work together with HEE to scope the current position and, explore ways in which we can utilise the available tools to consider and develop new models in primary care. The group will also to look to inform and support the changing workforce need s as we introduce new models of care, particularly care in the community setting.

18. Parity of esteem

We recognise the current life expectancy gap associated with poor detection, management and treatment of physical health problems for people with mental ill health and learning disabilities. We aim to significantly improve the physical health of people with learning disability, dementia and significant mental illness in order to reduce the current health inequality gap. We will focus on ensuring that there is a systematic approach to improving the physical health of this cohort and develop a process for capturing outcomes and benefits.

We are still working through the implications of the planning requirement to demonstrate a real terms increase in mental health spending. While we plan to make investments in mental health, when the impact of the tariff deflator is taken into account we will not demonstrate real terms growth.

Delivery of this programme will take place over the next 4 years.

19. Child and Adolescent mental health services

We recognise the need to invest in community child and adolescent mental health services to improve the outcomes for patients and families and more appropriately utilise the tier 4 service, and reduce the incidence of young people being admitted to inappropriate settings.

During 2015/16 we will pilot a project and evaluate the implementation of a community Tier 3.5 service within CAMHS to establish if there is a case for change around redesigning CAMHS. This pilot project will inform future commissioning plans for CAMHS. If the pilot demonstrates savings and a reduction in T4 admissions the aim is to negotiate moving resources from T4 to T3.5.

20. Operational Resilience

With the Systems Resilience Funding being made recurrently available in CCG baselines in 2015/16 we can start to plan at an early stage on the best deployment of the funding.

Funding for proposals will be prioritised by their ability to meet both national and local criteria. Current national criteria are set out on the Operational Resilience and Capacity Planning Template and local criteria will attempt to address recent pressures and will focus on supporting delivery of the four hour A&E target and timely discharge of patients from hospital.

Priority will also be given to proposals which support the urgent care system as a whole and can demonstrate cross system approval and support.

In order to allow a greater understanding of what caused the spikes in winter pressures in 2014/15 and the key consequences of these which need addressing in 2015/16, and to allow sufficient time for analysis and evaluation of current schemes applications for funding in 2015/16 to be sent to the CCG by the end of May 2015.

We have also proposed a review of urgent care services which will take place throughout the summer of 2015. The review will be informed by an extensive engagement with patients, public and key stakeholders and any funding in future years will reflect the findings of the urgent care review.

21. Principal Risks to Achieving Our Aims

We set out the principal risks to delivery each year in the Governing Body Assurance Framework, which describes the mains risk we perceive, the mitigating action taken, and action taken to address gaps in control and assurance against the risks. The framework is actively considered by the governing Body on a quarterly basis. The Assurance Framework for 2015/16 will be considered in early May, based on an initial set of risks identified by the Executive Team as follows:

Strategic Objective	Principal Risk identified
1. To improve patient experience and access to care	1.1 Insufficient communication and engagement with patients and the public on CCG priorities and service developments, leading to loss of confidence in CCG decisions
	1.2 System wide or specific provider capacity problems emerge to prevent delivery of NHS Constitution and/or NHS E required pledges
2. To improve the quality and equality of healthcare in Sheffield	2.1 Providers delivering poor quality care and not meeting quality targets
	2.2 CCG unable to influence equality of access to healthcare because insufficient or ineffective mechanisms to change
3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield	3.1 CCG is unable to undertake the actions, and deliver the outcomes from them, that are set out in the HWB's plan for reducing health inequalities, e.g. due to financial constraints
4. To ensure there is a sustainable, affordable healthcare system in Sheffield.	4.1 Financial Plan with insufficient ability to reflect changes to meet demands
	4.2 Risk management and other governance arrangements put in place by CCG and SCC to manage c£270m Better Care Fund to budget prove inadequate
	4.3 Budgetary constraints faced by NHS England in particular re specialised services and primary care contracts adversely impact on CCG's ability to implement our plan
	4.4 Inability to secure partnerships with our main providers that help us to deliver our commissioning plans, including QIPP

	4.5 Contractual and financial constraints facing local practices resulting in an inability of some practices to deliver existing non-core work and/or expand service provision as envisaged in commissioning plans
	4.6 Provider development required to deliver new models of care and achieve CCG stated outcomes does not happen
5. Organisational development to ensure CCG meets organisational health and capability requirements set out in the 6 domains (Annex C NHS England CCG Assurance Framework)	5.1 Unable to secure timely and effective commissioning support to enable us to adequately respond and secure delivery to existing and new emerging requirements.
	5.2 Inability to secure active participation particularly from Member Practices for delivering CCG priorities
	5.3 Inadequate adherence to principles of good governance and legal framework leading to breach of regulations and consequent reputational or financial damage

Appendix 1 – Portfolio Plans on a Page

Children's Young People and Maternity

Programme One - Enhance Paediatric Skills within Primary Care and Community Settings	Project a) Enhance primary care and community care skills in the management of Paediatric Care for common conditions Project b) Develop a range of clinical protocols to support general practice in the management of common health conditions
Programme Two - Develop and Deliver the Best Start Strategy across Sheffield	Project a) Develop the best start strategy and ensure that health provision is integral within the best start delivery teams.
Programme Three - Improve Maternity Care	Project a) Redesign the citywide pathway for maternal mental health Project b) Reduce variation in the maternity care pathway Project c) Develop the specification for Maternity Care and consider a wider range of providers
Programme Four- Implement Sheffield's Urgent Care Strategy for Children	Project a)) Review Paediatric Urgent Care Services in line with the citywide review of Urgent Care Project b) Consider best practice models of care for Children's A&E and the strengths and benefits of adoption them within Sheffield.
Programme Five - Improve Pathways of Planned Care	Project a) Consider the application of CASES within Children's planned care Project b) Undertake a review into variation in inpatient and outpatient activity for Sheffield Children through undertaking national and regional benchmarking. Project c) Develop a plan for reducing variation in pathways for children's planned care locally including consideration of procedures that could be undertaken within primary care and community settings. Project d) Redesign Safeguarding pathways and specifications in line with the review of Safeguarding Services
Programme Six - Redesign Emotional Wellbeing and Mental Health Services for Children and Young People	Project a) Develop and commission models of Early Intervention and Prevention jointly with Sheffield City Council Project b) Explore the development of a co commissioning framework between T3 and T4. Project c) Consider the development of a an enhanced community Service for Sheffield to reduce the need for inpatient provision Project d) Develop a commissioning framework and pathway for Out of Area LAC in need of CAMHS treatment.
Programme Seven - Implement Phase Two of the SEND reforms for Disabled Children and their Families	Project a) Further Develop the Local Offer Project b) Redesign health services to support the EHC planning process Project c) Develop and deliver phase 2 joint commissioning plan, including the joint commissioning of respite care

Outputs measures (the intervention leads to outputs that achieve the outcomes)

- Master Class training programme for primary care to enhance the skills of primary care in the management of Paediatrics.
- A joint strategy to delivery Best Start
- Reduced variation in clinical treatment pathways
- Providing safe and sustainable local services

Outcomes (change enabled by the programme that leads to one of more benefits)

- Increased confidence and management of Paediatrics within primary care.
- Improve health outcomes for Children
- Reduce health inequalities
- Reduction in inappropriate use of A&E and avoidable non elective admissions
- Reduce the amount of hospital treatment and increase treatment within community settings
- Improve patient experience and ensure timely access to mental health treatment

Benefits (measurable improvements resulting from the outcomes)

- Improvement in the quality of services
- Appropriate use of Provision in line with local need
- Meeting of the CCG's statutory duties

Mental Health, Learning Disability and Dementia

Programme One
Primary Care Development

Projects: IAPT review, primary care / secondary care liaison, generalist and specialist workforce development, dementia diagnosis and post-diagnostic support

Programme Two
Improving the Physical Health of People with MH, LD & Dementia

Projects: Liaison psychiatry, the promotion of physical health within SHSC services, work to reduce admissions to STH from SHSC, ensuring RFT4 is embedded into the portfolio, annual health checks

Programme Three
Implementation of the Personality Disorder Strategy

Projects: to be defined

Programme Four
Transforming Care

Projects: Complex needs integrated commissioning plan, Winterbourne, in-patient / community services

Programme Five
Crisis Care Concordat

Projects: gap analysis of current services against the Crisis Care Concordat to inform programme and help define projects required including "Needs-led" projects with SHSC, Street Triage

Programme Six
Dementia

Projects: Prevention, diagnosis, post diagnostic support, end of life care

Programme Seven
Sheffield Programme for Integrated Commissioning

Projects: Keeping people well in their community, independent living solutions, active recovery and support and long term high support

Outputs measures (the intervention leads to outputs that achieve the outcomes)

- Improved diagnosis, management and support for people with SMI, LD and dementia (and their families)
- Physical health checks delivered
- Improved access to services in crisis

Outcomes (change enabled by the programme that leads to one of more benefits)

- Reduced number of people admitted to hospital with a SMI, LD or dementia
- Increased number of people in recovery
- More people supported to manage their mental health and wellbeing effectively in their community
- Improved access to physical health interventions

Benefits (measurable improvements resulting from the outcomes)

- Improved quality of life, health and wellbeing for people with SMI, LD and dementia (and their carers)
- Reduced life expectancy gap
- Reduced health inequalities

Long Term Conditions, Cancer, Older People and End of Life Care

Programme One Respiratory	This is a four year programme which includes the development of an updated respiratory strategy and plan. Projects will be both short term / QIPP and medium to long term
Programme Two Care Planning	Started 13/14. To continue implementation / evaluation / training to embed care planning within the context of person-centred care and support and the promotion of self-care
Programme Three Frailty / Multimorbidity	Projects focused upon the identification, stratification and management of frailty and multimorbidity
Programme Four End of Life Care	Projects to include the commissioning of domiciliary care, the implementation of EPaCCS and work to address access inequalities
Programme Five Cancer	*Survivorship (development of stage 3),* prostate and bladder cancer pathways work, LAEDI, Skin cancer pathway
Programme Six CVD	Primary care focused diabetes projects (to be defined), DESMOND, review of stroke pathway, AF pathway
Programme Seven Portfolio input into the Sheffield Programme for Integrated Commissioning	*Keeping People Well in Their Community, Independent Living Solutions, Active Recovery and Support and Long Term High Support*
Programme Eight Core partnership of the city-wide Ageing Better programme	*To be defined by Core Partnership in 15/16*

Outputs measures (the intervention leads to outputs that achieve the outcomes)

- Person-centred approach – number of care plans delivered
- More skilled primary care workforce
- More effective information, advice and support to patients

Outcomes (change enabled by the programme that leads to one of more benefits)

- Improved diagnosis and disease management
- Reduced number of people with respiratory disease admitted to hospital
- Increased number of people engaged / involved in the management of their condition(s)
- Reduced number of older people living with social isolation and loneliness

Benefits (measurable improvements resulting from the outcomes)

- Improved quality of life, health and wellbeing for people with long term conditions
- Reduced mortality gap for people with SMI and LD
- More people able to die in their preferred place of death
- More people are able to access the care they need closer to home

Urgent Care

Programme One
Strategic Review

- Undertake review of citywide urgent care services

Programme Two
Ambulance/OOHs & avoidance of unplanned admissions

- Conveyancing – SPA of urgent and social care – one number available to ambulances and GPs
- Integration of 111/999 and SPA – explore with YAS
- Getting GP admitted patients into hospital quicker by bed bureau for GP admissions (i.e. early in the day can be assessed and discharged or later in day no choice but to admit)
- Increase OOHs GP home visit – develop a business case for a pilot

Programme Three
Delayed Discharge

- Changing assessment/admissions pathway for MAU and Frailty unit
- Community pharmacists dispensing secondary care TTOs to speed up discharge and flow
- Discharge to assess

Programme Four
Minor Illness/Injury

- Using IT to manage minor illness – (part of Prime Minister's Challenge fund)
- Extend the role of pharmacy to support minor illness via implementation of the new OOH pharmacy contract

Outputs measures (the intervention leads to outputs that achieve the outcomes)

- See projects

Outcomes (change enabled by the programme that leads to one of more benefits)

- Reduction in inappropriate attendances in A&E
- Reduction in avoidable/unplanned admissions
- Reduction of inefficient duplication of services

Benefits (measurable improvements resulting from the outcomes)

- Simplified urgent care system which is understood by the local population
- Urgent care closer to home for the elderly
- Affordable and sustainable urgent care
- Robust local urgent care system with sufficient resilience to cope with periods of sustained high demand

Elective Care

Programme One
Community Choice, Assessment, Services, Education Support (CASES) commissioning model

Projects required to deliver the programme x
'Virtual' Outpatient Services (advice & guidance, care plans)
F

Projects required to deliver the programme x
Community based diagnostics

Projects required to deliver the programme x
Community based outpatient clinic services
(OP First : OP Follow-up : Procedures)
Infrastructure & Estates : IT: Patient Transport : Prescribing : Quality

Projects required to deliver the programme x
New ways of working:
Use of Technology (non-face-to-face, remote monitoring)
ElectronicReferral Implementation

Projects required to deliver the programme x
Education and upskilling

Projects required to deliver the programme x
Supporting Patient self-management and care
(including 3rd sector opportunities)

Projects required to deliver the programme x
Robust Contracting & Procurement

Projects required to deliver the programme x
Comprehensive Patient & Stakeholder Engagement

Programme Two
Commissioning for Outcomes and Value for Citywide Musculoskeletal Services

Projects required to deliver the programme x
Mobilisation of Citywide MSK Service programme

Outputs measures (the intervention leads to outputs that achieve the outcomes)

- Clinical advice & guidance, care plans
- Community based diagnostics
- Community based outpatient first appointments
- Community based outpatient follow-up appointments
- Community based procedures
- Use of technology
- Education and upskilling
- Patient self-management and care support services

Outcomes (change enabled by the programme that leads to one of more benefits)

- Reduced number of people attending hospital for outpatient services and care including diagnostics and procedures
- Upskilled primary and secondary care clinicians
- Increased number of people supported to manage their own healthcare

Benefits (measurable improvements resulting from the outcomes)

- Seamless, joined-up primary and secondary healthcare services
- Improved patient experience
- Reduction in use of hospital based resources
- Increased provision of community based healthcare services.
- Financially viable outpatient service provision.

Health Inequalities

Portfolio	Suggested action	Timescale	Lead	Link to city Health Inequalities Action Plan
LTCs	Develop a CCG strategy for reducing health inequalities from cardiovascular disease (CVD)	To be agreed (will build on Potential Years of Life Lost plan and other work already underway in LTCs portfolio)	Portfolio	2.8 Retain focus on CVD and cancer
	Develop a CCG strategy for reducing health inequalities from cancer	To be agreed (will build on work already underway in LTCs portfolio)	Portfolio	2.8 Retain focus on CVD and cancer
	Ensure the developing CCG respiratory strategy reduces health inequalities and inequalities in access to services	Started Oct 2014 Implementation 2015/16	Portfolio	3.7 Commission disease specific interventions 3.4 Improve access to services
	Undertake a health equity audit on access to End of Life Care services for BME/vulnerable population groups	Due Apr 2015	Public health core offer	3.4 Improve access to services
MH&LD	Review the programme of work aimed at improving the physical health of people with Serious Mental Illness, to assess comprehensiveness and impact of programme	To be agreed	Portfolio	2.8 Retain focus on CVD and cancer 3.4 Improve access to services
	Review the programme of work aimed at improving the physical health of people with Learning Disability, to assess comprehensiveness and impact of programme	To be agreed	Portfolio	2.8 Retain focus on CVD and cancer 3.4 Improve access to services
	Undertake a health equity audit of inequalities in access to primary care and prevention services experienced by people with Learning Disability	Due Apr 2015	Public health core offer	2.8 Retain focus on CVD and cancer 3.4 Improve access to services
	Improve equity of access to primary and community care mental health services for people from vulnerable groups, by implementing the three-part model of care	To be agreed	Joint portfolio and public health core	3.4 Improve access to services

	tested by the National Institute for Health Research (NIHR) http://www.journalslibrary.nihr.ac.uk/pgfar/volume-1/issue-2#abstract		offer	
Acute	Ensure that the programme of work to transform outpatient appointments (CASES) contributes to reducing inequalities by improving access for underserved groups	To be agreed	Portfolio	3.4 Improve access to services
	Support STH and SHSC Trusts to complete audits of services with high levels of people who do not attend (DNA) [this action is part of the citywide Health Inequalities Action Plan] Ensure this information is used to inform transformation of outpatients programme	Due Jun 2015	Public health core offer Portfolio	3.4 Improve access to services
CYPF	Develop a citywide strategy and joint commissioning plans (with SCC) to address the needs identified in the children's emotional wellbeing and mental health needs assessment (published 2014)	In progress	Portfolio	3.5 Best start
	Develop a pathway for low level maternal mental health care, to ensure all women receive access to the right care at the right time	In progress	Portfolio	3.5 Best start
	Ensure targeted provision of allergy services throughout the city in community settings	In progress	Portfolio	3.5 Best start
	Ensure disabled children and their families have access to a range of services and support to meet their identified needs	In progress	Portfolio	3.5 Best start
	Increase the health outcomes of looked after children by development of a targeted Looked After Children (LAC) health strategy and plan	In progress	Portfolio	3.5 Best start
Cross-cutting	Consider commissioning a migrant health service for new arrivals, asylum seekers and refugees that encompasses testing and treatment of (latent) TB, viral hepatitis and possibly HIV	To be agreed	To be agreed	3.7 Commission disease specific interventions 3.4 Improve access to services
	Develop a CCG strategy for improving outcomes from and reducing health inequalities in liver disease	Starting Jan 2015	To be agreed	3.7 Commission disease specific interventions 3.4 Improve access to services
	Build on GPs' and community anchor organisations' experience of addressing health inequalities in Sheffield to develop coherent plans for addressing inequalities at a local level	Started Oct 2014	Mark Gamsu/Leigh Sorsbie/Katrina Cleary	3.4 Improve access to services

Appendix 2

Commissioning Intentions 2015-16
Engagement report - March 2015

As we approach our third year of operation and the second year of our ambitious five year strategic plan we wanted to ask members of the public, staff and clinicians in the city what they think we should concentrate on as we look at refreshing our plans for 2015 onwards.

We asked the following questions about our Commissioning Intention plans.

1. Do you agree that the projects we have identified should be priorities for us? (Please state why)
2. Is there anything about focusing on these projects that concerns you?
3. Do you feel that these plans are too ambitious, about right or not ambitious enough? Please share your thoughts.
4. What will these changes mean for you?

Engagement methods and reach

Our full and summary Commissioning Intentions were made available on our website. We asked people using a wide variety of methods to look at them and comment on the plans and proposed projects for the following year.

Web and Social media

Two pages were set up on the CCG website to include both the full Commissioning Intentions and the summary information. These pages received 2,018 visits between November and January.

Twenty Twitter and Facebook updates were posted which included links to the web pages throughout the exercise. We also made use of the '#involveme' hashtag asking for the public's opinions. Through Twitter, we received sixteen retweets and one unique post, altogether reaching an audience of approximately 18,732 accounts.

The following accounts re-tweeted our tweets:

- SHSC (493 followers)
- Healthwatch Sheffield (1,122 followers)
- Driven by Health Magazine (1,248 followers)
- ShipShape Sheffield X2(246 followers)
- Frank Health (56 followers)
- Shane Baron (12 followers)
- Georgina Craig (633 followers)

- Roz Davies X2 (3,266 followers)
- David Eddy (566 followers)
- Sheffield Health and Wellbeing (992 followers)
- DAA Carers Action (1,828 followers)
- Azmar Talat (506 followers).

We also received publicity from Jo Marsden (@STHLibrarian – 108 followers) who tweeted “How should Sheffield's NHS monies be spent? Have your say on @NHSSheffieldCCG's commissioning plans for 2015/16 (with a link to our website).

BBC Radio Sheffield
In December 2014, the Director of Business Planning and Partnerships was interviewed by BBC Radio Sheffield regarding the CCG’s Commissioning Intentions. This interview was broadcast throughout December. BBC Radio Sheffield has 238,000 listeners, meaning just under 1 in 5 people in Sheffield listens to the radio station.

Involve Me
Information about our Commissioning Intentions was sent to all 693 members of the CCG Involve Me database. This included links to our full and summary plans along with a feedback survey.

CCG Internal
Our Commissioning Intentions were included in the CCG Monthly bulletin for member practices. The plans were also included in the Director of Business Planning and Partnerships’ Governing Body blog. Both of these were circulated in the CCG e-bulletin to GP Practices and uploaded to the intranet for our 164 staff to see.

HealthWatch
HealthWatch Sheffield supported our engagement by including information about our Commissioning Intentions and how to feedback in their Early Spring newsletter. This newsletter was sent to their 818 members and included on their website and available in community locations throughout the city.

ChilyPEP (Children and Young People’s Empowerment Project)
There was recognition that the voice of young people was underrepresented in the incoming feedback for the Commissioning Intentions of the CCG. It was therefore decided to ask ChilyPEP to facilitate engagement work with young people to engage with them on these plans. Following feedback regarding the accessibility of the documents provided, the information was rewritten to be more understandable and engaging. This information was used for general use as well as the session with young people.

ChilyPEP engaged with 24 young people in total including the following groups:

- STAMP (11 young people): Mental health participation group aged 14-25
- Young Healthwatch (6 young people): aged 14-25
- VOYCE PG (7 young people): aged 14-25

Locality councils
NHS Sheffield CCG is a membership organisation of the 87 GP practices across Sheffield. Representatives from these practices make up four Locality Councils. The CCG's Director of Business Planning and Partnerships attended two of the four Locality Councils across Sheffield to explain the approach and proposed new projects.
North – 7th January 2015
West – 21st January 2015

Discussion in Hallam and South and Central localities was led by the Locality Managers.

The Councils had a number of questions of clarification, but there were no concerns or disagreement with the plans. The Director took away a sense of assent from the meetings.

Total reach
It is estimated that a total of 260,536 people will have received information regarding the CCG's Commissioning Intentions as a result of our methods detailed above.

Feedback

Thirty-three responses were received in total including feedback from Sheffield Parent and Carer Forum based upon 320 responses. All the feedback was collated and taken through a process of thematic analysis, with each comment being individually described, coded and themed. The following themes emerged.

Integrated and partnership working
Integrated and partnership working was seen as essential in order to save costs and improve efficiency of healthcare services.

More detail is required in the plans
More detail on how the plans would be implemented was asked for. The plans were seen as high level with a shortage of detail to be able to properly scrutinise.

Inclusion of Mental Health and wellbeing care
The lack of plans around services that support mental health and wellbeing was a concern to people who felt that these important services have suffered through lack of investment. Young people and parent carers were particularly concerned about the provision and quality of crisis care.

Quick, focused and radical action needed
There was a call for specific and focused action to implement these strategic plans. The slow pace of change and watering down of radical ideas was raised as being a barrier to realising cost savings and improving services.

General support for plans
There was a general agreement and support for the plans with only concerns regarding their implementation and likelihood of occurring as originally planned.

Care planning
The effective use of care plans was seen as important, but the right services had to be available to realise these plans. Care plans should be combined for people with multiple long term conditions to avoid duplication for patients and the system. It was also suggested that carers should be included in the care planning process.

Communication throughout the system and sharing data / records
The system, agencies and staff need to communicate better with each other and the public to realise the benefits of partnership working. The sharing of patient data and records was raised as a particular barrier to efficient care.

More public involvement earlier in the development of ideas
People wanted to be involved earlier in the process of developing these plans and priorities. Young people especially were keen to point out that there should be opportunities to generate ideas at an earlier stage. Parent carers wanted more information about disabilities and long term conditions to be systematically collected to inform decisions.

Health Inequalities
Inequalities in access and health outcomes were seen as a key priority, especially by young people. Poverty was a key inequality that people thought was often overlooked.

Concerns over primary care and specialised commissioning
There were some concerns over GPs commissioning their own services destabilising the NHS system and the capacity for CCGs to be fully involved in specialised commissioning.