Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Interim Accountable Officer Report

Governing Body meeting

Item 13b

3 September 2015

Author(s)	Idris Griffiths, Interim Accountable Officer
Is your report for Approval / Consideration / Noting	
Noting	
Are there any Resource Implications	
No	
Audit Requirement	

CCG Objectives

Which of the CCG's objectives does this paper support?
This paper provides assurance that risks will be identified and managed to help ensure the achievement of the CCG's objectives.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? No
There are no specific issues associated with this report.

PPE Activity

How does your paper support involving patients, carers and the public?
None required.

Recommendations
The Governing Body is asked to note the report.

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This is my final Accountable Officer's Report. Maddy Ruff takes up the substantive Chief Officer post from 1st September and I know everyone on Governing Body and the wider organisation will join me in welcoming her to the role.

On a personal note, I'd like to take this opportunity to thank all those who have provided me their support over the last three months, particularly the members of our Commissioning Executive Team. In addition to addressing some very challenging issues, I am pleased to say that we have made significant headway on essential areas over the last five months, such as:

- Progress on aligning the interrelated programmes of the better care fund (in particular active support and recovery), the urgent care strategy review, prime minister's challenge fund and investing in primary care to enable them to be a driving force behind the development of services outside of hospital. There's much more to do but the course is set.

- With regard to investing in Primary Care, our recent decision to support non-core services by £5 per waited population is a constructive move but we must recognise it is inadequate to support any transfer of work from hospital to the community. We must now develop the case to provide more significant resource as part of the wider development of services outside of hospital. By aligning the key programmes described above we can create the scale, and the connections between currently fragmented services, that are needed to support care closer to home and to reduce our over reliance on secondary care.

- Next month we will discuss whether we should take on co-commissioning of GP Contracts. Our decision should be based on whether doing so supports our wider ambition of care closer to home and whether it makes more sense for the CCG to create a single relationship with GP practices without the current separation of their contractual relationship with NHS England. It is essential that we ask practices if they would prefer that the CCG take on the co-commissioning role.

- The NHS national contract and tariff based payment system is an obstacle to redesigning services. We must continue to influence the national review being carried out by Monitor. However, there are alternative approaches we can pursue locally. The MSK outcome based contract is nearing completion and if agreed will become one of the most significant contracts of its type in the country. We are also pursuing an alliance model for services covered by the Active Support and Recovery programme, with Primary Care Sheffield as a key partner in that arrangement.

- Practice engagement is improving alongside our commitment to 'end-to-end engagement' – from initial ideas right through to delivery. The Portfolios are working

hard to improve engagement and the Locality Managers are providing invaluable support.

- Our staff are more engaged and informed than ever with an excellent set of initiatives that are driving that forward (eg learning lunches). Having an engaged workforce that is well informed and valued is pivotal to being more productive as an organisation

- We're getting deeper into other organisations rather than relying on connections at senior management level. We have held our first exec to exec meeting with STH, at which the strength of our clinical leadership was clear. We are sitting on key steering groups for the first time eg our Clinical Director for Urgent Care and Chief Operating Officer are members of STH's Strategic A&E group. Most importantly we have far more clinician to clinician contact – as exemplified by both the MSK and CASES work

- Leadership is more widespread through the organisation – most notably we have made excellent progress on the roles of the CDs and that of the managerial leads for the portfolios

- We are also being effective at working with the wider system. For example, our work with the other 22 CCGs on new arrangements for the CSU has led to the imminent return of a wide range of services and people from the CSU to the CCG

- We are spending more time thinking, debating, exploring and sharing ideas and views. For example, we spent 50 minutes of GB discussing the essential topic of engagement with our members, in addition to other discussions across the CCG on topics such as devolution and our vision for 2020

At the same time as pursuing the transformational change that is needed, we must also address operational challenges of quality, NHS Constitutional commitments and ensuring we maintain a sound financial footing. There are clear signs of activity and financial pressure – in particular regarding acute admissions and pharmacy expenditure. During quarter 3 we must improve in these areas, before we face further winter pressures.

Recommendation
The Governing Body is asked to note the report.

Idris Griffiths
Interim Accountable Officer
August 2015