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,

- 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,

and the outcomes that Sheffield's Health and Wellbeing Strategy intends to achieve.

Our Ambitions for 2019 (as set out in our Commissioning Intentions 2014-19)

- 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 and its appendix set 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
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**CCG specific priorities:**

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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 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 (£7.45m).

The financial plan which was approved by the CCG's Governing Body on 2 April and submitted to NHS England on 7 April may need to change in some areas because there are a few key contracts still to be agreed primarily as a result of late changes to national tariff arrangements. The aim is to conclude negotiations by the end of April. The plan as it currently stands has been developed using the following key information and assumptions:

- Confirmed general allocation increase of 1.4% (£9.7m). This is less than the 2.1% cash increase received in 2014/15 and the 1.7% previous indicative increase announced in December 2013. This created a £2m pressure.
- When the element of systems resilience funding (£3.8m) which has been made recurrent is added, this gives the 1.94% headline increase in NHS England published information. This is the minimum cash uplift for CCGs as Sheffield's baseline allocation was 5% above its fair shares target allocation. £1.98 billion of additional resources were made available to the NHS as part of this year's settlement of which c£1.1 billion was made available directly to CCGs. However, with the exception of the systems resilience funding, all of this was distributed to CCGs below their fair shares target allocation.
- The Sheffield health & social care system received systems resilience funding of £3.8m compared to the non recurrent resources of £8.1m in 2014/15. CCGs have been advised to assume no further in year national funding for 2015/16. A process during Q1 for agreeing the use of the £3.8m has been agreed with partner organisations taking into account what worked well in 2014/15;

- Our plan assumes return of c£3.8m of surplus expected to be delivered in 2014/15 over and above 1%. We were able to generate additional surplus primarily due to the return of funding in Q4 from the national CHC retrospective claim risk share arrangements and elective activity volume/case mix being lower than the challenging targets agreed with local trusts set as part of aiming to achieve RTT targets sustainably. This returned surplus can be used non recurrently in 2015/16 against one off costs and we plan to use it for the RTT activity which has effectively transferred into 2015/16 from Q4 and to support systems change work primarily related to our ambitious integrated commissioning work with Sheffield City Council through our Better Care Fund arrangements.
- 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;
- The use of national inflation and efficiency assumptions, unless otherwise agreed locally. Efficiency is at 3.5% from those providers opting for the voluntary Enhanced Tariff Offer (ETO), which is most local providers. For those providers not opting for ETO, which includes our main acute hospital provider, Sheffield Teaching Hospitals NHS FT, 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, providers will not be eligible to earn the 2.5% CQUIN (quality) incentive payments, but we may offer a local incentive scheme of a lesser value as part of our overall contract settlement as the CCG remains committed to improving quality with all our providers.
- 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.

## 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.

The CCG has supported the successful bid by the GP Provider Board to the Prime Minister's Challenge Fund, which will bring £9.7m into Sheffield in 2015/16. This funding is for one year only and we will work with the GP Provider Board and partners in the city to ensure that the changes the funding will support, where successful, can be continued within ongoing resources.

## 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 will be important to deliver the new service. These attributes are more predominant in the Multi-specialist Community Provider (MCP) model set out in the Five Year Forward View, 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.

Our financial plan will demonstrate our compliance with the planning requirement to show a real terms increase in mental health spending, including planned investments in mental health.

## 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 tier 4 services, 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. This pilot project will inform future commissioning plans for CAMHS. If the pilot demonstrates savings and a reduction in tier 4 admissions the aim is to negotiate moving resources from inpatient services to support children and young people at home.

## 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<br>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<br>Project b) Reduce variation in the maternity care pathway<br>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<br>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<br>Project b) Undertake a review into variation in inpatient and outpatient activity for Sheffield Children through undertaking national and regional benchmarking.<br>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.<br>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<br>Project b) Explore the development of a co commissioning framework between T3 and T4.<br>Project c) Consider the development of a an enhanced community Service for Sheffield to reduce the need for inpatient provision<br>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<br>Project b) Redesign health services to support the EHC planning process<br>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/response to Confidential Inquiry into the Premature Deaths of People with LD profound and multiple impairment strategy

**Programme Three**
Implementation of the Personality Disorder Strategy

**Projects:** to be defined, but will include work on dual diagnosis with Learning Disability

**Programme Four**
Transforming Care

**Projects:** Complex needs integrated commissioning plan, accommodation strategy; Winterbourne, in-patient / community services /forensic and offender health.

**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, short breaks strategy; 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 when avoidable
- 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
- Less people accessing care in crisis
- People needing out of city placement will reduce

**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)
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**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<br>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<br>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<br>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<br>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 |

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|---|---|---|---|---|
| | 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]<br><br>Ensure this information is used to inform transformation of outpatients programme | Due Jun 2015 | Public health core offer<br><br>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<br>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<br>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 |