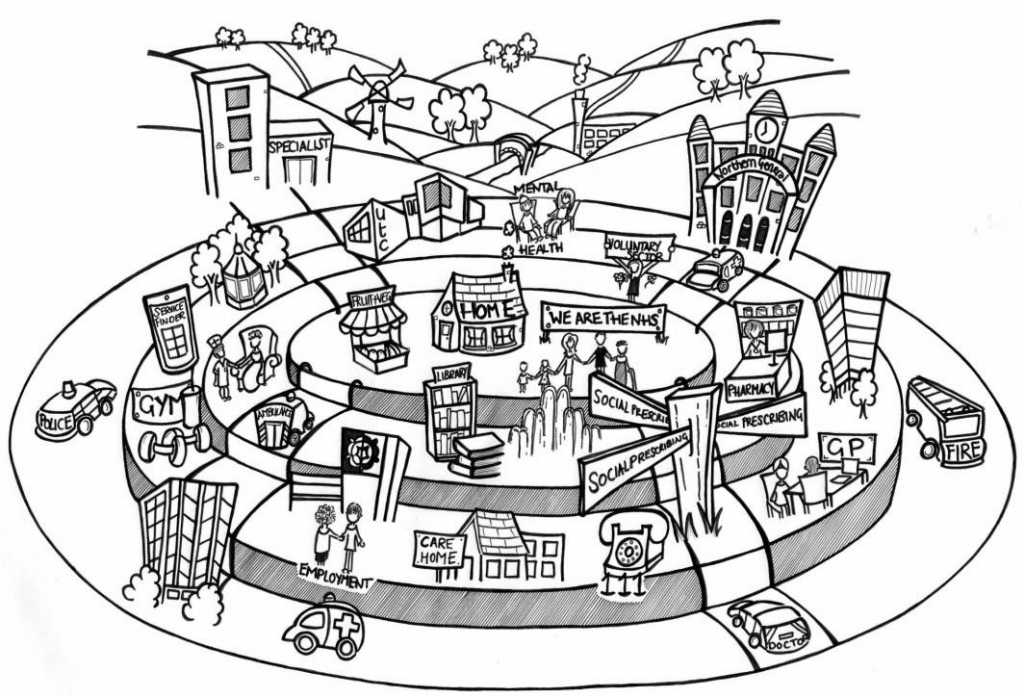
Working with you to make Sheffield
HEALTHIER

NHS
Sheffield
Clinical Commissioning Group

Operational Plan 2017 to 2019
NARRATIVE



Version 2.0

Document Information	
Status:	DRAFT
Owner:	Matt Powls, Director of Commissioning
Title:	SCCG Operational Plan 2017- 2019
Prepared by:	Commissioning Directorate

Version Control			
Version	Summary Changes	Author	Date
0.1	First draft	A Tebbs	10/11/16
0.2	Amended for contents and confirm leads and contributors	A Tebbs	14/11/16
0.3	Added Portfolio plans	A Tebbs	21/11/16
0.4	Editing section 2 and formatting	A Tebbs	22/11/16
0.5	Edits and formatting all sections	A Tebbs	23/11/16
0.6	Amendments to finance and urgent care sections,	A Tebbs	24/11/16
0.7	Final edits	M Powls	24/11/16
1.0	Draft approved for first submission to NHS England	A Tebbs	24/11/16
1.1	Amendments to Section 1 and 2 updates relating to draft submission KLOEs	A Tebbs	20/12/16
2.0	Final version approved for submission to NHS England	M Powls	22/12/16

Contents

Purpose

'NHS Operational Planning and Contract Guidance for the period 2017 to 2019' re-affirmed the shared objectives of the NHS to implement the Five Year Forward View (FYFV), set out the planning and contracting processes to support Sustainability and Transformation Plans (STPs) and the financial reset, and stated national priorities and financial rules for both 2017/18 and 2018/19.

The NHS Sheffield CCG (SCCG) Financial Plan and Operational and Activity Plan set out how SCCG will deliver the transformational plans set out in the South Yorkshire and Bassetlaw Sustainability and Transformational Plan (SY&B STP) and the Sheffield Place Based Plan, alongside the '9 Must Do's and other national requirements detailed in the NHS Operational Planning and Contracting Guidance. The transformation and strengthening of primary care is the bedrock on which wider system transformation will be delivered. As such, the transformational objectives and 'Must Do's' for primary care are set out separately in SCCG's response to the *GP Forward View* which is submitted alongside this document.

This Operational Plan narrative, submitted alongside the Operational and Activity Plan template and the Sheffield Response to the GP Forward View, provides further detail on the process and approach taken by SCCG to develop its plans for 2017 – 19 in four key sections:

Section 1: Details how the SY&B STP links with the *Sheffield Place Based Plan* and the priorities identified for SCCG in our operational planning for 2017 – 19;

Section 2: Describes SCCG's approach to operational planning and, within the framework of delivery of the '9 Must Do' areas, provides details of the Organisation's approach and plans to achieve the transformational objectives of the STP and Sheffield Place Based Plan;

Section 3: Provides further supporting details and rational for SCCG's activity submission;

Section 4: Provides and assessment of SCCG's current position and any risks to reaching agreement on two year contracts to support the delivery of the CCG's planning objectives by 23 December 2016.

.

Section 1: STP, Transforming Sheffield Programme and Operational Plan Links

SCCG is part of the **South Yorkshire and Bassetlaw Sustainability and Transformational Plan** footprint (SY&B STP). The SY&B STP was submitted to NHS England on 16 October 2016 and has been signed off for implementation. It describes the road map at regional level to achieve the vision set out in the Five Year Forward View to transform the NHS and close the three gaps – improve health, deliver financial balance and sustain quality and access standards.

Within Sheffield, health and social care partners have come together through **Shaping Sheffield** and the **Transforming Sheffield Board** to develop a five year plan for health and social care in the City, this is encapsulated within the **Sheffield Place Based Plan**. It is expected that this will be signed off by all partner organisations by January 2017. Following wide consultation, the Sheffield Place Based Plan articulates the systems key priorities to meet the sustainability challenge we face in the City and clearly links to the meeting of region challenge and SY&B STP.

The SY&B STP sets out an ambitious vision for system transformation. The Sheffield Based Plan describes the local approach to transforming care, in line with the national direction, within the context of the SY&B STP and articulates a set of commissioning intentions for all organisations for the next two years aligned with the strategic direction of the STP. Figure 1 (page 9) describes how the Sheffield Place Based Plan was developed with clear alignment and read across to the STP.

The SCCG Operational Plan for 2017 to 2019 and the Sheffield Response to the *GP Forward View* articulates the detail of how this transformation will be delivered through collaboration with our partners across the City of Sheffield.

South Yorkshire and Bassetlaw Strategic Commissioning

In the development of the SY&B STP it is recognised that a large proportion, circa 70%, of the £570m financial gap will be delivered at place level through demand management and new models of integrated planning and care delivery. All CCGs within the SY&B STP are focused on developing New Models of Care that will support the delivery of this requirement locally whilst fundamentally changing the way each local system operates. The developments within each place will be critical to the overall success and implementation of the ambitions within the SY&B plan.

At a System Level circa 30% of the challenge sits at the SY&B level or wider and SY&B Commissioners, together with other system partners, must respond to this and ensure that fit for purpose governance, function and arrangements are in place to be able to influence, shape and respond to change require to deliver this challenge.

In order to achieve this and to secure delivery of the SY&B STP benefits, a review of commissioning across SY&B will be undertaken, reporting to the STP Collaborative Partnership Board in March. Critical to this is the need to respond to the gap in commissioning perspective at a System Level and therefore the review will enable shadow System Level Commissioning arrangements to be in place from April 2017. SCCG is fully committed to this process and will ensure that senior level resource is made available to support the delivery of this process.

How the SY&B STP and Sheffield Plans Fit Together

The work streams being developed through the SYB STP are:

- Healthy lives, living well and prevention;
- Primary & community care;
- Mental health and learning disabilities;
- Urgent and Emergency Care;
- Elective and diagnostic care
- Children's and Maternity services;
- Cancer;
- Streamlining back office services;
- Cross Cutting Transformation – clinical standards, medicines optimisation, workforce, digital IT, prevention, sustainability.

These map to the tiers of care identified in the *Sheffield Place Based Plan*, the programmes and projects that form part of this Plan have been developed to work across these tiers of care with the intention of minimising the silo approach we have traditionally had to transformation. The overarching priorities for 2017 – 2019 have been identified:

- We will empower parents, families and carers to provide healthy, stable and nurturing family environments;
- We will have midwife led care in every community;
- We will Implement a new services that helps grow and nurture life chances;
- We will Increase the proportion of children and young people who are school and life ready;
- We will recognise the link between employment and physical and mental health and help more people into work;

- We will design our services to support improved emotional wellbeing and mental health for children, young people and adults;
- We will agree a single risk stratification process for our population and agree how we use this so that we can then target our resources so we can help those most at risk;
- We will invest heavily into the development of neighbourhood working;
- We will work with our staff and teams to promote flexibility, to promote patient centred services and to promote a culture in Sheffield where staff across organisations are enabled to resolve difficult issues which impact on patients and communities;
- We will tackle inequalities head on by making disproportionate investments in effort and resources into those communities with most need;
- We will collectively support implementing the Sheffield Tackling Poverty Strategy.

The Sheffield Vision and Model for Change – an Accountable Care System

The *Sheffield Place Based Plan* sets out the Sheffield systems ambition to be recognised nationally and internationally as a person-centred City that has created a culture which drives population health and wellbeing, equality, and access to care and health interventions that are high quality and sustainable for future generations.

We will have a reputation for working in partnership to co-produce, improve outcomes, experience and inclusion and to influence national policy and regulation; this will be visible in our success.

More care will be provided closer to home with services designed around the person and will be tiered dependent on need. The levels of tier articulated with the Plan are:

- Person, Household, Family and Friends – for example holistic assessments, self-care;
- Neighbourhood (30k-50k population) – for example employment advice, support groups, and family centres;
- Locality (120-150k population) – for example urgent care centres;
- City – for example the services provided in hospital;
- Beyond City – for example ambulance services.

Each level requires increasing expertise/input and has less demand per head of population than for services in the levels below.
In order for this to work existing providers will need to work differently, with workforce working flexibly across organisational boundaries and services being delivered collaboratively. An Accountable Care System model will be used to enable this, supported by

the established Memorandum of Understanding that has already been signed by key stakeholders within the Sheffield system. At locality level we will see providers working collaborative as a whole to deliver services.

Led by the Transforming Sheffield Board, SCCG will work in partnership with primary, secondary care, social care and voluntary sector providers to develop this system on a city-wide basis. This work is linked closely to our localities that will both identify key areas for action or consideration and also be responsible for the implementation of locality based services.

Figure 1: How the Sheffield Plan was Developed

Understanding Where We Are

- We have a Joint Strategic Needs Assessment and an Health and Wellbeing Strategy that sets out what we need to do
- We have growing need for services and an ageing population
- The money available in 5 years time won't be able to meet this need; we have to do something different
- We need to reduce the number of children, young people and adults needing health and care by keeping them well for longer
- We need to change the way that we work together; reducing duplication and removing barriers to streamlined care

Consultation:

We consulted with you during 2014-15 on what we need in Sheffield, including:

- 2020 Vision
- Active Support and Recovery
- Health and Wellbeing Strategy
- Urgent Care
- Primary Care
- Best Start Strategy
- Children's Transformation Plan
- Learn Sheffield

Strategies and Plans

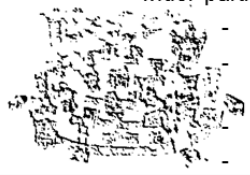
From the consultations multiple strategies and plans were produced to describe, across health and care, what we need to do

The South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Health and Care partners across South Yorkshire and Bassetlaw have developed a plan that sets out the case for change across a wider regional footprint. These plans feed from and back into the Sheffield Plan

Developing A Single Plan:

The Sheffield Plan brings the strategies and plan together into a single place. It also brings in wider plans such as employment and education and links with wider partners. We need this through



- Shaping Sheffield Events
- The Sheffield Transformation Board (see page 19)
- Health and Wellbeing Board
- Sheffield Strategic Planning Group

Confidence in Delivery

Recognising the challenges to our health and care system being greater than ever before this plan goes further on assuring we deliver the sustainable transformation required. We have:

- System wide commitment
- Robust Governance
- Measureable impact expectations
- Agreed ways of cross organisation working and behaviours

How the Sheffield Population's Health Needs Shaped the Plans

The Changing Population

Sheffield's population is growing very slowly following a long period of decline. The factors that drive population growth are birth rate and international (inward) migration. Sheffield is also a highly diverse population with around 17% of people from black and minority ethnic communities. This is likely to increase further over the coming years. Overall, Sheffield's population is expected to increase by around 1% per year over the next 5 to 10 years.

Following a period of increase, the Sheffield birth rate is beginning to flatten out – there is a similar trend across Yorkshire and the Humber. The growth in our total population will further slow as a result.

Key Challenges with Health

Life expectancy continues to increase in Sheffield and now stands at 78.9 years for men and 82.5 years for women. This compares favourably with the other major English cities but still falls short of the England average of 79.5 years for men and 83.2 years for women.

A more important measure of overall health and wellbeing however is "Healthy Life Expectancy". It reflects both the length and quality of life and represents the number of years someone can expect to live in good health. When healthy life expectancy is taken into account, a different picture of health and wellbeing emerges. For men in Sheffield healthy life expectancy is currently 60.8 years which means around the last 18 years of their life will be spent in poor health. For women it's worse, healthy life expectancy is 60.3 years so the last 22 years of their lives are likely to be spent in poor health. This does not compare well with the other Core Cities and is significantly worse than the England average. Moreover, whilst life expectancy is increasing, healthy life expectancy is not and this represents a key challenge for the City.

It is this overall level of illness and disability in a population that drives demand for health and social care services rather than whether we are living longer. It's what makes 'life worth living' that counts rather than how long we live.

Causes of Death

The two main causes of death in Sheffield people are cancer and cardiovascular disease (which together account for more than half of all deaths each year). When causes of death in men and women are considered separately, dementia is the third main cause of death in women whilst respiratory disease is the third main cause of death in men. Although death rates are reducing in Sheffield they remain higher than England with the exception of deaths from certain infectious and parasitic diseases.

Overall it is estimated that around half of all deaths in Sheffield could be prevented each year – that's equivalent to around 900 deaths every year. This is significantly higher than for England. The main direct causes of preventable deaths are high blood pressure, obesity, high cholesterol, smoking, alcohol consumption and lack of physical activity. Addressing these causes saves lives and livelihoods.

Causes of Ill Health

Over half of all the years spent in poor health (both in Sheffield and nationally) can be attributed to musculoskeletal conditions (such as chronic back pain) and mental ill health.

Good mental health and wellbeing protects our overall health and increases our healthy life expectancy. When it's poor it is often seen in combination with long term physical health conditions (such as heart disease) adding to the burden of years spent in poor health.
Diabetes is also an important factor in healthy life expectancy because it can lead to serious complications such as heart disease, kidney disease, blindness or limb amputation. Around 6% of the Sheffield population has diabetes, similar to the national average.
Dementia is an increasingly important factor as we age. Although prevalence of dementia in Sheffield is not significantly different from the national picture, as mentioned previously, it's a particularly important factor in older women's healthy life expectancy.

Social Inequality as a Determinant of Health

Recent data on life expectancy and related social causes of poor health and wellbeing show that over the last 10-20 years little has changed in terms of the size of the gap between the most and least deprived people in Sheffield. The gap in life expectancy between the most and least deprived men in Sheffield is still around 10 years while it is almost 7 years for women. The gaps are greater when we consider Healthy Life Expectancy: there remains a 20 year difference between the most and least deprived men (72.1 years versus 50.2 years) and 25 years for women (75.6 years versus 50.8 years). In the context of continuing economic austerity and further cuts to public sector funding, these health inequalities could worsen significantly in the future.

The gap in healthy life expectancy is not just geographically based; there is a similar gap for people with serious mental illness and those with a learning disability. Children and adults in the more deprived parts of the City suffer a greater burden of ill health, disability and early death than those who are born and live in the less deprived areas. We know that a significant proportion of deaths and ill health are preventable. Stepping up our actions to prevent premature death, disability and ill health in our more deprived and vulnerable communities represents economic sense as well as being the right thing to do. SCCG is wholly cognisant of the absolute need to address this issue of inequality both as a strong commissioning organisation and also as a system.

Full details can be found in the Director of Public Health's Report for 2016 at: https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report.html

Governance and Delivery of the Sheffield Plan

The programmes will sit under the Transforming Sheffield Programme Infrastructure and will bring together and strengthen existing programmes of work through a single governance structure, strong leadership, and consistency in delivery where this adds value.

A draft delivery structure has been developed to oversee the Transforming Sheffield Programme and delivery of the *Sheffield Place Based Plan* across the City and with all stakeholders. This links to the City Region and the SY&B STP governance structures to ensure that plans at organisational level are fully integrated and aligned into the wider process. The draft structure is set out at Figure 2 (page14).

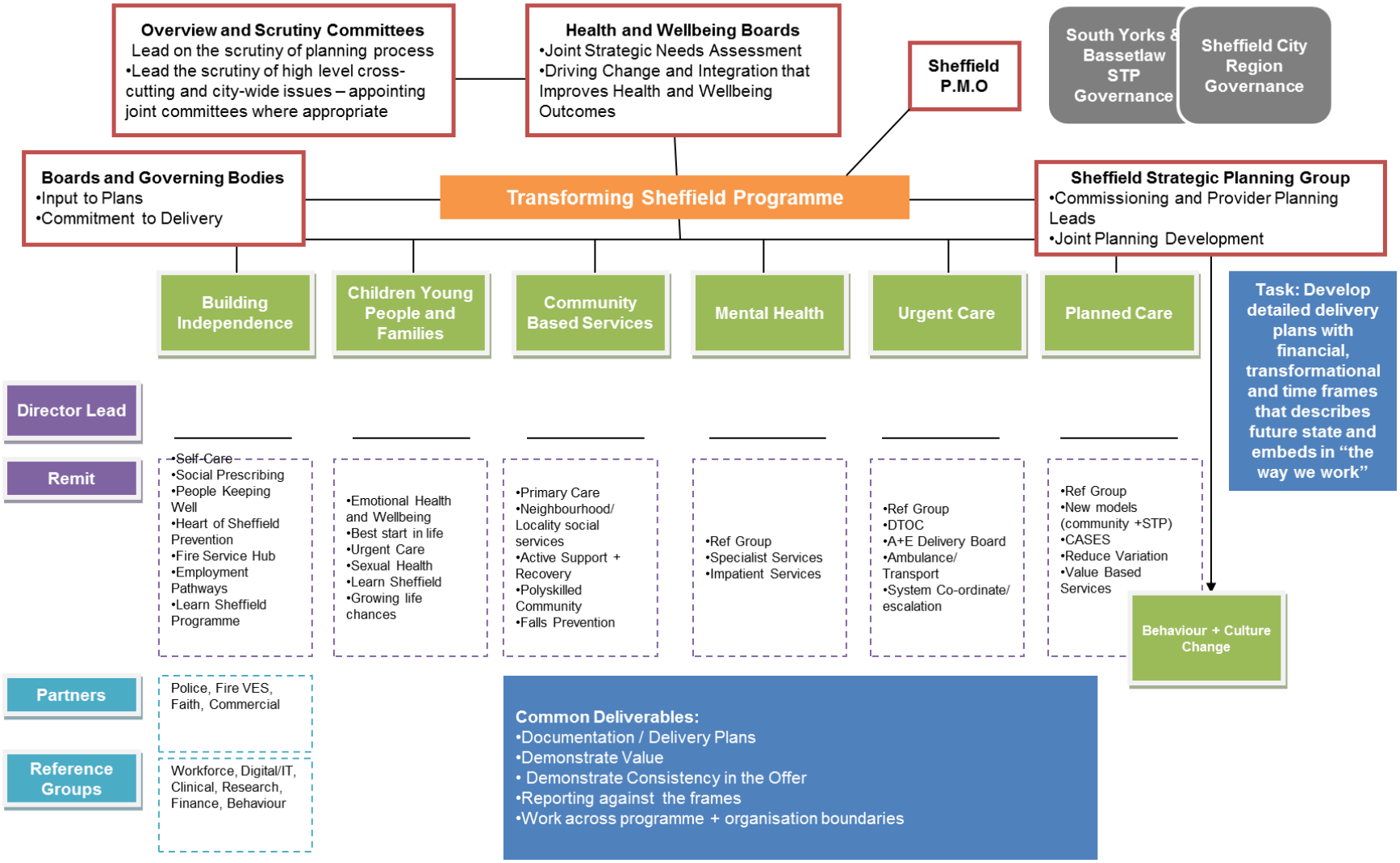
Through a memorandum of understanding the key partners in the Sheffield Plan and Transforming Sheffield Programme have signed up to a shared set or expectations and outcomes, this is set out in table 1 (page 12):

Table 1: Memorandum of Understanding – Expectations and Outcomes

Sheffield Teaching Hospitals	• Working with partners, supported by the memorandum of understanding, to use our collective resources to provide services for the Sheffield population. The test? Pooling the budget for CIC, STIT, Active Recovery and Independent Sector. • Using the Sheffield Teaching Hospitals brand as a quality mark for some services provided outside of the hospital. • More services in the community, wrapped around people and neighbourhoods, with our staff working as part of a neighbourhood multi-disciplinary team. • A focus on preventing acute health and care need, responding early, using standardised risk stratification as a means to work consistently across the city to support those more at risk stay independent. • Training staff to support improving person activation levels and in recognising mental health as well as physical health needs

Sheffield Children's Hospital FT	• Working with partners, supported by the memorandum of understanding, to use our collective resources to provide services for the Sheffield population. The test? Pooling the budget for 0-19s. • Using the Sheffield Children's Hospital brand as a quality mark for some services provided outside of the hospital. • More services in the community, wrapped around people and neighbourhoods, with our staff working as part of a neighbourhood multi-disciplinary team. • A focus on preventing acute health and care need, responding early, using standardised risk stratification as a means to work consistently across the city to support those more at risk stay independent. • Training staff to support improving person activation levels and in recognising mental health as well as physical health needs • Strengthened links into education pathways, Learn Sheffield. • Continued support to the four work streams under the Children's Health and Wellbeing Transformation Board
Sheffield Health and Care FT	• Working with partners, supported by the memorandum of understanding, to use our collective resources to provide services for the Sheffield population. The test? Pooling the budget for mental health commissioning. • More services in the community, wrapped around people and neighbourhoods, with our staff working as part of a neighbourhood multi-disciplinary team. • A focus on preventing acute health and care need, responding early, using standardised risk stratification as a means to work consistently across the city to support those more at risk stay independent. Reducing the proportion of patients requiring inpatient care. • Training staff to support improving person activation levels and in recognising physical health as well as mental health needs. Support the training of other provider workforce to increase the proportion of professionals who are mental health first aid trained.
Primary Care	• Working with partners, supported by the memorandum of understanding, to use our collective resources to provide services for the Sheffield population. The test? Neighbourhoods and localities working together to deliver services. • Designing a model of delivery and infrastructure that supports resilience and sustainability in primary care. • More services in the community, wrapped around people and neighbourhoods, with our staff working as part of a neighbourhood multi-disciplinary team. • A focus on preventing acute health and care need, responding early, using standardised risk stratification as a means to work consistently across the city to support those more at risk stay independent. • Training staff to support improving person activation levels and in recognising mental health as well as physical health needs

Figure 2: The Sheffield Transformation Programme Governance Structure (draft)



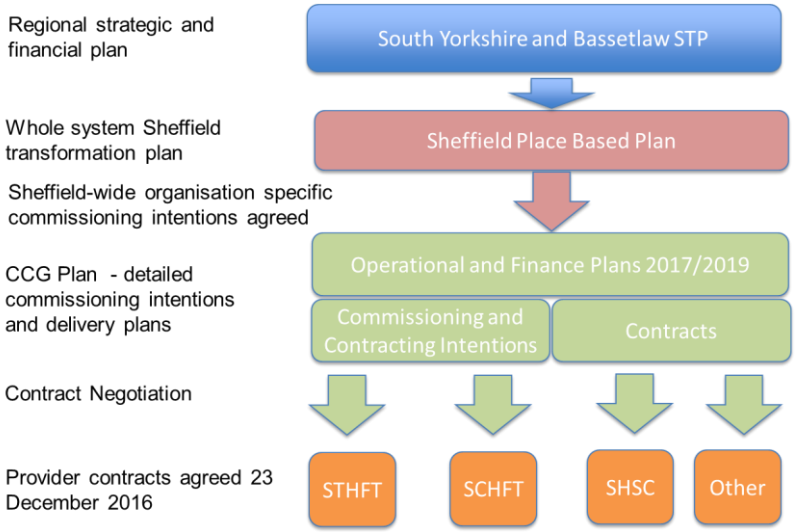
Developing the Operational Plan for Sheffield

Each of the organisations that are part of the Transforming Sheffield Board will be developing an organisational operational plan for 2017 – 19. Each of these plans will reflect the agreed priorities for 2017 – 2019 set out in the Sheffield *Place Based Plan*.

In support of this process, commissioning and planning intentions for 2017-19 have been developed that will be translated into practice through the agreement of two year contracts by 23 December 2016. These intentions are expressed at three levels: STP wide, Sheffield Joint Commissioner (SCCG and Sheffield City Council) and organisation specific plans. There are intentions set out within each level that ensure delivery across the strategic priorities set out in our Plan. These intentions have then been translated into impact for providers in Sheffield. Figure 3 below sets out how this process flows.

The SCCG Operational Plan 2017-19 has been developed to secure deliver of the key outcomes described in the SY&B STP, *Sheffield Place Based Plan*, and secure the 9 'Must Dos' set out in the Operational Planning Guidance. SCCG has ensured that the financial and activity modelling undertaken by the SY&B STP footprint is fully reflected in our assumptions. However, Sheffield, like many other areas, faces significant challenges to ensure sustainable and affordable services are available now and in the future

Figure 3: How the STP and Sheffield Plan relate to the Operational Plan and Contracts



Risk Assessment

Working with our partners across Sheffield, we have undertaken a comprehensive assessment of the risks to our successful delivery of the *Sheffield Place Based Plan* and SY&B STP over the next five years. These are set out in Figure 4 (see page 16) together with SCCG's plans for mitigation.

Figure 4: Sheffield Plan Risk Assessment

Public Consultation

Description: The public response to the development and change to services required as part of this transformational approach may delay progress if not well managed. The public need to be part of the transformational work from the beginning.

Mitigation: Co-production of plans with the public
Using the collective communications and engagement resource to ensure a robust and well managed approach to co-production, engagement and consultation.
A branding approach that reinforces quality of service regardless of setting.
Taking an evidence based approach

Resource to Deliver

Description: This plan is ambitious and a real opportunity to genuinely transform the way we work in Sheffield to make a real impact for our population in a sustainable, affordable way; it will make real improvements to quality of care and health outcomes. This will not be achieved if we try and deliver it on top of "Business as Usual".

Mitigation: Develop and support a realistic and targeted resource plan that is aligned to the Sheffield Plan in a way that is responsive to 5 year delivery programme and that supports the Transforming Sheffield Programme governance structure

Contractual and Payment Mechanisms

Description: Acute providers are currently paid by results using a tariff based system, this incentives acute activity (particularly with the hospital provider financial pressures) and therefore disincentives the intention within the Sheffield Plan to increase the proportion of care outside of hospital

Mitigation: Review of contractual and payment mechanisms with a move towards capitated budgets and a supply chain approach

Unintended Consequences

Description: Making change can easily have unintended consequences on people, staff or other services

Mitigation: We will have a city-wide approach to Quality Impact Assessment and to Equality Impact Assessment that is embedded in the way we work and the Transforming Sheffield Programme governance

Regulation and Policy

Description: There will be regulations and nationally imposed policies that will not support new ways of working

Mitigation: Work with statutory and regulatory bodies to develop approaches that allow testing of the new ways of working and inform development of revised policy/regulation that support the new models of care.
Secure elected member support by embedding in governance

Transformational Funding

Description: Funding is required that enables the investment that will be needed to deliver the transformation change before the longer term funding is available through savings made as a result of the new models of care

Mitigation: Develop Commercial Partnerships
Develop approach to using non-recurrent innovation and research funds through the Transforming Sheffield Programme Board to support transformational change.
External expertise and additional capacity from Price Waterhouse Cooper to support a robust financial mapping of investment and saving

Organisational Behaviour

Description: Each organisation has financial and delivery targets to deliver that system wide transformation may put at risk over the transformational period. Individual organisational approaches to managing that risk will potentially compromise the system wide delivery and Place Based Plan

Mitigation: Transforming Sheffield Programme Board ownership of and commitment to the plan with a risk share approach
Memorandum of Understanding in place to support development of services outside of hospital and based around neighbourhoods
Specific programme of work around changing behaviours

Ensuring Delivery – SCCG Matrix Management Approach

To provide consistency and ensure that the SY&B STP is delivered within the Sheffield footprint, all QIPP schemes for 2017/18 and 2018/19 are aligned to key 5 strategic programmes (described in Governance Arrangements below and figure 5) that reflect the SY&B work streams and the tiers of care within the Sheffield Plan:

- Promoting self-care, integrated primary community and social care, wrap around services (Planned Prevention);
- Developing a range of urgent responses and services that prevent avoidable unplanned activity and admissions within secondary care (Urgent Care);
- Developing end-to-end pathways across primary, community and secondary care (Planned Care);
- Care outside of Hospital : planned admission, streamlined stay and discharge (D2A) with robust rehabilitation and enablement;
- Robust care plans and integrated care (Long Term Condition Management).

Governance Arrangements

There are a lot of interdependencies between projects and programmes within the SCCG Operational Plan that are being brought together into a Matrix Working Framework. This is broken down into five key focus areas that align to the Sheffield Place Based Plan and SY&B STP programmes, illustrated in figure 5, page 18:

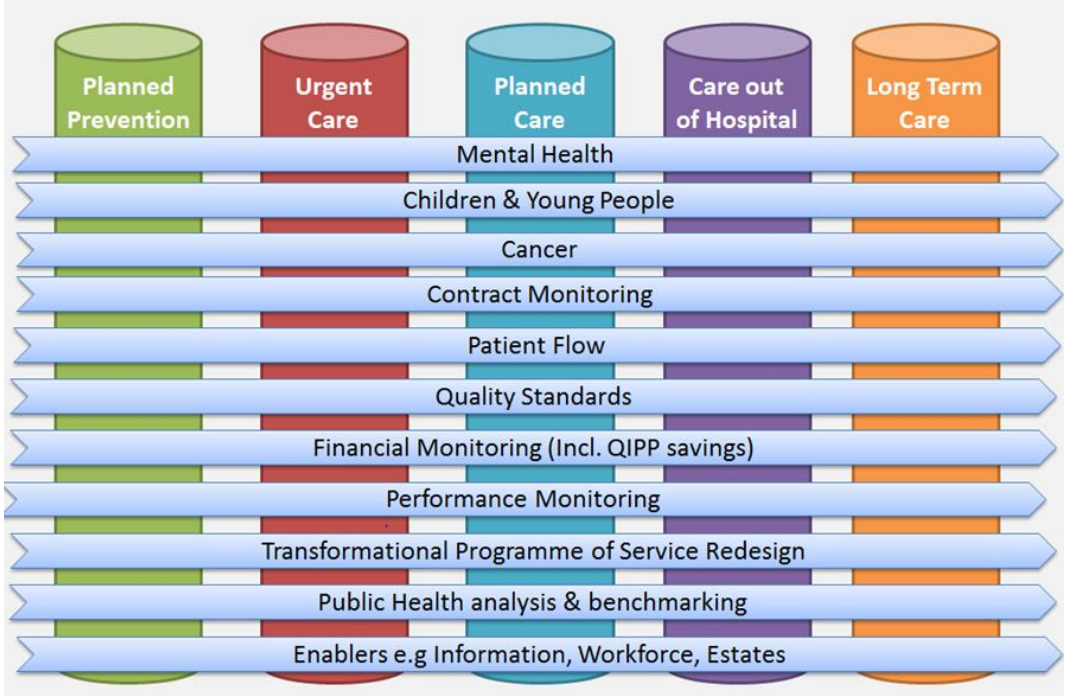
Planned Prevention – keeping people well and well supported in the Community (Active Support and Recovery);

Urgent Care – preventing avoidable, unplanned admissions and visits to A&E;

Planned Care – this includes both elective pathways and streamlining patient journey through diagnosis, treatment discharge with follow up care and support through individualised management plans;

Care Outside of Hospital – this includes Discharge Planning and Discharge to Assess to ensure patients do not stay longer than necessary in hospital and have the right care package and support to enable them to total independence or enabling them to live as independent life as possible in the community and reduce risks of exacerbation's and unplanned re- admissions;

Figure 5: SCCG Matrix Management Framework



Long Term Care – Linking back to Active Support and Recovery working in partnership with the local authority and third sector to manage the patient long term health problems and needs

Taking an initial idea into a process of fruition and implementation needs a robust governance process. The CCG has recently revised this pathway. We are currently revising our Programme Management Framework documentation and publishing it alongside a range of tools onto the CCG Intranet. There are regular staff breakout sessions that we are using to explain what this means supported by dedicated session either one to one or in group to explain this in detail.

The Head of PMO and Deputy Director of QIPP is also working closely with the Senior Management Team and QIPP Sub Group (Sub Group of the Governing Body) members to gain agreement and embed into SCCG planning and commissioning processes.

All programmes and plans referred to in the SCCG Operational Plan have project briefs and robust delivery plans and are clearly aligned to QIPP by area of change and area of impact to enable benefit realisation to be tracked.

Prioritisation

The monitoring of the whole programme and adherence to process including the prioritisation of projects will be managed by the QIPP Sub Group and monthly reports submitted to the Governing Body.

A prioritisation methodology has been published to inform scoring. The importance of the use of robust documentation is high. The priority is to make sure all projects follow the correct process to deploy staff and financial resources appropriately

Section 2: The Nine Must Do's

Must Do 1: Delivery of Key STP Milestones and Trajectories

The SCCG Operational Plan 2017-2019 has been developed to enable the delivery of the Sheffield Plan, the wider SY&B STP and ensure that SCCG delivers the 9 key Must Do's described by NHS England.

In line with the NHS Operational Planning and Contracting Guidance – 2017 – 2020, the SY&B STP is reviewing the baseline metrics to be published for STPs in November 2016 and will agree trajectories for these, which will, as a minimum include the metrics outlined in Table 2 below. SCCG has, as would be expected, undertaken an assessment of its delivery plans against these anticipated measures to ensure alignment:

Table 2: SCCG Assessment Against SY&B STP Metrics

Area	Assessment and Triangulation to STP
Finance	The STP is predicated on delivering overall financial balance across all organisations and whilst this remains a significant challenge, the scale of transformation required reflects this. **Sheffield: achieving financial balance within individual organisations in individual financial years is a significant challenge and a focus on sustaining commissioner and provider positions while driving forward change requires additional efficiencies in 2017 – 19.**
Quality	A&E performance across the STP is below the National Constitutional Standard. Work continues within each health economy to improve this position, the strategic commissioning intentions have a number of areas that aim to improve access to, simplify and reduce demand, where possible, on the urgent and emergency care system. **Sheffield: performance is below National Constitutional Standard and SCCG is working with partners across the City, through the Urgent Care Delivery Board to put in place a whole system approach to drive sustainable performance improvements.** Referral to Treatment (RTT) access remains good across the STP with some variation against achieving the target, the strategic commissioning intentions for Elective and Diagnostics reflect the level of demand management and standardisation across clinical pathways which will help to improve performance in this area. **Sheffield: our main providers continue to meet key Constitutional Standards, through the CCG's activity planning and performance review process the Organisation is working to confirm effective use of**

Area	Assessment and Triangulation to STP
	resources using national demand management tools. Key plans reflect focus on clinical pathway development and demand management.
Health outcomes and care redesign	Progress against cancer taskforce implementation plan, the Mental Health Five Year Forward View implementation plan and the General Practice Forward View will be delivered through the strategic commissioning intentions and through work undertaken in each CCG, progress against these will be reviewed across the STP to ensure consistency in delivery and implementation, working at both local health economy and a system level. Across the STP it is apparent that there is variation relating to hospital total bed days per 1,000 population and Emergency hospital admissions per 1,000 population which will be addressed through the implementation of our plans **Sheffield has in place a comprehensive plan to deliver the Mental Health Five Year Forward View (described in Section 2) and agreed two year delivery plans. Accompanying this submission is our response to the GP Forward View setting out how we will meet the challenges posed. Sheffield is actively engaged with the Cancer Alliance to deliver the Cancer Taskforce Implementation Plan (see Section 2). A cornerstone of our plans to achieve sustainable healthcare in the STP footprint and within Sheffield are our plans to reduce hospital admissions by improving both our community and prevention services (see Section 2).**

Must Do 2: Financial Plan

CCG Organisational Control Totals

CCG financial allocations for 2016-17 to 2020-21 were published by NHS England on 8 January 2016. For 2017/18, the average cash uplift for CCGs was 2.14%. However as SCCG is deemed to have historic funding 6.6% in excess of its "fair shares" allocation based on the nationally agreed formula, Sheffield will only receive a cash uplift of 1.62% (£3.9m less than if we had received the England average). For 2018/19, the average cash uplift for CCGs is 2.15%. Sheffield CCG will receive a cash uplift of 1.72% (£3.2m less than if we had received the England average).

The NHS Act of 2012 sets a statutory requirement for CCGs not to spend more than their total allocation for any year including return of historic surplus. However, in addition to this basic requirement, NHS England has established a set of business rules which it expects all CCGs to comply with. In 2016/17, these were as follows:

- Holding an uncommitted reserve equivalent to 1% of the total allocation;
- Establishing a general contingency equivalent to 0.5% of the total allocation;
- Maintaining a minimum cumulative reserve (surplus) of 1% or £7.5m.

In 2016/17, SCCG submitted a plan to NHS England which did not comply with one of the three business rules in that the financial plan only delivered a surplus equivalent to 0.5% of the resources available. NHS England accepted this position for 2016/17 but with an expectation that we would put in a recovery plan to move to 1% surplus in 2017/18. As at November 2016, SCCG continues to forecast the achievement of a £3.5m surplus by the end of March 2017, but partly through non recurrent measures which has a 'knock on' adverse impact into our opening financial position for 2017/18.

2017/18

For 2017/18 and 2018/19, NHS England has maintained the same 3 business rules, with the amendment that CCGs can make non recurrent expenditure commitments against half of the 1% reserve. SCCG has reviewed the significant financial challenges which the Sheffield Health and Social Care system as a whole (including General Practices and NHS Foundation Trusts and Sheffield City Council) face in 2017/18 and 2018/19. The pressures are such that to move to a 1% surplus (or in NHSE terminology "draw up" £4m) we would need a level of QIPP which based on our current overall assessment does not look realistic as it would be in excess of £30m

or 4% of our CCG programme allocation *i.e.* excluding the primary care co-commissioning allocation which we do not believe it is appropriate to subject to a QIPP requirement. **Our plan therefore at this stage is for the CCG to maintain its current position of a £3.5m (0.5%) cumulative surplus.** We acknowledge that as South Yorkshire and Bassetlaw CCGs, through the STP Process, have been set a collective 'draw down' control total of -£1m this would mean that to meet our collective control total the other CCGs in our STP footprint would need to defer draw down of £4m of the original £5m offer. This requires further discussion.

To deliver the 0.5% surplus and to manage a diverse set of risks, challenges and uncertainties we are seeking to put together QIPP opportunities of £30m with the expectation of needing to deliver as an absolute minimum a Gross QIPP saving of £20m (which is the equivalent of 2.7% of CCG programme allocation). Delivery of the QIPP Programme will require substantial and positive clinical engagement in supporting the service changes required, as well as focussed management resource. The QIPP plan is being created through a combination of the opportunities identified as part of the SY&B system wide STP work, from our Place Based Plan work and other "bottom up" ideas. The opportunities identified through the STP planning process do not present SCCG with sufficient QIPP to maintain a 0.5% surplus in 2017/18.

2018/19

The starting point for the 2018/19 plan has to be full recurrent delivery of the 2017/18 plan. If this is achieved, we are able to plan to move to a 1% or £7.7m surplus in 2018/19 requiring around £13m of 2% QIPP delivery. This would mean that we would "draw up" £4m in 2018/19 and hence be ahead of SCCG's share of SY&B wide CCGs control total and hence a corresponding increase to the release of the resources to the other CCGs in that year.

SY&B STP Plans and Sheffield Plan to Moderate Demand Growth and Increase Provider Efficiencies

SCCG's Operational Plan has been developed from the SY&B STP and the Sheffield Place Based Plan. Demand reduction measures are described in the sections on implementing Right Care; elective care redesign; urgent and emergency care reform; supporting self-care and prevention; progressing population-health new care models; medicines optimisation; and improving the management of continuing healthcare processes. Our plans to address these are summarized in table 3 on page 23.

Table 3: Demand Reduction Measures – an Overview

Implementing RightCare	SCCG will undertake a continuous programme of efficiency benchmarking to ensure value for money and cost effectiveness using the NHS England sponsored RightCare methodology. These are described below.
Elective care redesign	Our approach to elective care redesign is set out under Must Do 5 below
Urgent and emergency care reform	Our plans for delivering the reform to urgent and emergency care services for Sheffield are articulates in the Sheffield Plan and triangulate with the SY&B STP. Our delivery plans are set out in further detail in Section 2 Must do 3 of the Operational Plan below
Supporting self care and prevention	A radical upgrade in prevention and strengthening communities are cornerstones of the Sheffield Plan which describes the shared priority to invest significantly in prevention, brief intervention and social prescribing as well as other measures, to support our communities to stay well. Further detail can be found in Section 3 Supporting and Enabling Plans below.
Progressing population-health new care models such as multispecialty community providers (MCPs)	The Sheffield Plan sets our plans to develop an accountable care system for the City. Details of how this will develop and how it supports our pans are set out in our vision and model for change in Section 1.
Medicines optimisation	An effective Medicines Management programme is key to the delivery of the SCCG financial plan and supports the realisation of the Sheffield Plan. Further details of our plans for 2017 – 19 can be found at pages 66 - 68
Improving the management of continuing healthcare processes	SCCG has put in place robust measures through the Better Care Fund (BCF) to secure effective CHC processes these are set out below.
Using Demand Management Good Practice	To support the sustainable delivery of the NHS Constitutional Standards, SCCG is embedding demand management good practice in our work with providers, details of progress to date and our intention to develop this are included in Must Do 5 below.

Improving the Management of Continuing Healthcare Processes

One of the key vehicles for delivering the *Sheffield Placed Based Plan* is the Better Care Fund (BCF), which includes all of our expenditure on continuing healthcare and adult social care. SCCG and Sheffield City Council have agreed an integrated programme

of work, to secure better quality and value from services arranged under the BCF. This includes simplified assessment processes, reduced administration and providing our communities with sustainable alternatives to hospital care.

Through the BCF, discharge to assess (D2A) beds will be reintroduced to Sheffield, using the pathways of discharge mandated by ADASS, NHS Improvement and NHS England. This will enable people to be discharged from hospital when it is safe to do so and focus on supporting more people to return home, rather than moving to a care home. The CCG is also undertaking projects to secure better value for money from providers of ongoing care, reducing its reliance on block contracts and improving its specifications.

SCCG and Sheffield City Council are also implementing changes to care management arrangements for people with a learning disability. This will enable the Council to focus its work on supporting people to remain independent, whilst people whose needs are primarily for healthcare will have a clinically-led service. This builds on the implementation of a streamlined decision-making with the Council for people eligible for aftercare, in 2015-16. Further plans are being developed under the BCF to integrate assessment and care management, decision-making in respect of care packages and combined approaches to managing the care provider market.

NHS England's Operating Model sets out the strategic importance of continuing healthcare for delivering long term care and enabling the wider NHS and social care systems to function effectively. SCCG monitors activity and expenditure openly with colleagues from the Council. Our joint governance of the BCF enables us to manage strategic pressures collaboratively and to foster patient-centered, partnership approaches towards system improvement.

Personal Health Budgets

Sheffield's success in delivering Personal Health Budgets (PHBs) for people eligible for Continuing Healthcare is an example of patients benefitting from this approach. Partnership working has led to reduced bureaucracy for people who have a personalised budget, particularly where their eligibility changes.

The latest benchmarking data shows that Sheffield has over 170 people with a PHB under Continuing Healthcare. We anticipate that the number of people having a PHB under continuing healthcare will rise modestly over the coming year.

However, Sheffield CCG has successfully bid to become an early adopter of NHS England's integrated personalised commissioning programme. This means that we will be extending PHBs to people outside of the Continuing Healthcare Programme, to several further cohorts.

By March 2018 a minimum of 560 people will have a personal health budget (either solely funded by the NHS or jointly with the LA) and we will have a plan for reaching 1,200-2,400 by March 2019.

Implementing RightCare

To support the development of the 2017 – 19 Operational plans and QIPP, SCCG has used the information produced by RightCare to determine priority areas and understand variation in demand and outcomes. In line with national expectations SCCG has plans in place to review at least 40% of opportunities by March 2018 and 80% by March 2019. SCCG has developed a methodology for reviewing RightCare information, identifying areas for further investigation and then developing detailed action plans where appropriate.

Opportunity areas have been identified and plans are summarised in table 4 below. Actions will be addressed through a range of initiatives covering primary care, acute care, community care, and social care. Governance will be provided through the Transforming Sheffield Board, thus ensuring all organisations are working towards the same standards to effectively reduce unwarranted variations. The priority programmes identified by SCCG are Gynaecology, Neurology and Cancer, together with Mental Health where the CCG is using RightCare as part of actions to address Parity of Esteem. However,

Table 4: SCCG and RightCare – an Overview of Progress to Date

Opportunity	Action to Date	Progress to Date
Cancer	SCCG has a Task and Finish Group established to lead on Cancer with a Clinical Director Lead, Dr Antony Gore, supported by: Commissioning Lead, Business Intelligence, Medicine Management, Finance, Quality and Public Health.	Priorities: Breast and Colorectal. Taking a full service review approach.
Mental Health and Learning	Mental Health and Learning Disability Portfolio Group led by a Clinical Director, Dr Steve Thomas, supported by	Dementia Care Pathway detailed service review to produce revised Dementia Care Pathway across all

Opportunity	Action to Date	Progress to Date
Disability	Commissioning, Business Intelligence, Medicines Management, Finance, Quality, Contracting and Public Health.	providers to meet the national requirements.
Neurology	Review will be undertaken with recommendations. It is anticipated that the clinicians engaged in the decision making will be our clinical leaders. To review Individual Funding Requests and decision making and access to appropriate capacity.	Focus on brain injury rehabilitation. Audit to assess opportunities to develop local provision within a cash envelope that aligns with CHC and Local Authority care market capacity and costs. Ensure on-going rehabilitation of individuals is built into care packages.
Circulatory	Two areas of action identified - Heart Failure and Stroke. Clinical Director, Dr Andrew McGinty, supported by a Commissioning Lead, Business Intelligence, Medicine Management, Finance, Quality, Contracting and Public health.	Develop **Heart Failure** service specification and mobilise in January 2017. Review 'Right Care' information to understand why we appear low on **Early Supported Discharge,** link to Urgent Care and Active Support and Recovery to identify interdependencies and potential improvements, use of existing 3rd sector contractors (Stroke Association).
Maternity and Neonatal	Clinical Director overseeing programme within a 'Children's Portfolio' supported by Commissioning lead, Business Intelligence, Medicine Management, Finance, Quality, Contracting and Public Health.	Currently the Children's portfolio is addressing other priorities. Consider as a programme for 2017/18
Endocrine	Clinical Director, Dr Andrew McGinty, supported by a Commissioning Lead, Business Intelligence, Medicines Management, Finance, Quality, Contracting and Public Health.	NHS Assessment Framework identifies very low levels of education and support alongside high levels of Primary Care prescribing spend, and high non-elective admissions indicating opportunities to support patients living with or at risk of diabetes in primary care. Using the Risk Stratification tool to identify numbers and link to AS&R and Urgent Care to identify improvements to the care pathway and develop support.
Genito-Urinary	Initial scoping identifies that the problem is Renal.	Currently low prescribing in primary care, high number of first outpatient appointments, high non-elective admissions. Develop a service specification jointly with STH describing responsibilities of primary care prior to

Opportunity	Action to Date	Progress to Date
		and post diagnosis and expectations from secondary care in relation to access to advice. Ensure patients managed out of hospital whenever possible. Link to AS&R and Urgent care to identify interdependencies.

Whole System Pathway Approach

A programme of work to bring about service improvements and implement service changes to realise the opportunitites identified in table 4 is now being progressed within SCCG with system partners. This also informs a programme of work identified as Quality Innovation Productivity and Prevention (QIPP). This overall programme embraces tools that the 'Right Care' programme provides. SCCG does not consider Right Care to be separate and isolated process.

The SCCG are using the Managing Successful Programmes (MSP) methodology. Using the Programme Management Approach enables all projects programmes to be managed together within one programme whether they have been identified through the 'Right Care' toolkit or identified through day to day contract and service management as areas of concern in relation to quality and performance. The Director of Contracting and Performance with the support of the Head of Programme Management Office (PMO) and Deputy Director for Quality Innovation Productivity and Prevention (QIPP) is leading this process.

The complex interdependencies between different work streams will be recognised using the matrix management approach, described in Section 1 page 17, to ensure that pathways address all parts of the pathway.

Areas of Focus and Process for the Reviews

The CCG has developed and agreed a Process of Service Review being a four phased process, this tool is being utilised to progress service reviews across a number of areas, focussed on developing end to end whole system pathways cutting across all the five focus areas identified in the SY&B STP and Sheffield Plan.

Table 5, page 28 describes the proposed list of reviews with Clinical Leads and Management Leads. Reviews have been prioritised to reflect RightCare and our identified four priority areas and local factors and align to the SCCG QIPP programme.

Table 5: Pathways Identified for Focus from RightCare Prioritisation

Review	Timescale (TBC)	Specialty	Clinical Lead	Management Lead	Programme Lead	Status
1	Ongoing	Gastroenterology	Charles Heatley	Linda Cutter	Diane Meddick	Outcomes incorporated into planned care workstream
2	Q4 2016/17	Cardiology	Emma Reynolds	Steve Ashmore	Abby Tebbs	Outcomes incorporated into planned care workstream
3	Ongoing	Gynaecology	Charles Heatley	Linda Cutter	Diane Meddick	Outcomes incorporated into planned care workstream
4	Q4 2016/17	Dermatology	Helen Story	Steve Ashmore	Diane Meddick	Outcomes incorporated into planned care workstream
5	Q4 2016/17	Respiratory	Liz Angier and Andrew McGinty	Sarah Burt	Rachel Gillott	Outcomes incorporated into care out of hospital workstream, links to planned care
6	Q1 2017/18	ENT	Jon Dickson	Linda Cutter	Abby Tebbs	Outcomes incorporated into planned care workstream
7	Q1 2017/18	Urology	Charles Heatley	Linda Cutter	Abby Tebbs	Outcomes incorporated into planned care workstream
8	Q1 2017/18	General Surgery	Charles Heatley	Diane Meddick	Diane Meddick	Outcomes incorporated into planned care workstream
9	Q1 2017/18	Ophthalmolgy	Charles Heatley	Abby Tebbs	Abby Tebbs	Outcomes incorporated into planned care workstream
10	Q1 2017/18	Neurology	Andrew McGinty	Sarah Burt	Rachel Gillott	Outcomes incorporated into care out of hospital workstream, links to planned care
11	Q4 2016/16	Cancer: colorectal and breast	Anthony Gore	Marianna Hargreaves	Abby Tebbs	Outcomes incorporated into planned care workstream
12		Mental Health	Steve Thomas	Heather Burns	Diane Meddick	Outcomes incorporated into mental health workstream

SCCG Quality, Improvement, Productivity and Prevention Schemes 2017 – 2019

As part of developing the 2017 – 2019 programme, SCCG undertook a review of current programme management processes. A revised programme management approach has been developed to complement the matrix working approach now adopted by the CCG. How QIPP was built up and tie back to QIPP plan at Appendix 1 page 77.

SCCG has developed a 2017/18 QIPP programme with a total planned savings target for 2017/18 of £20m. The schemes have been developed as a combination of the following:

- full year effect of 2016/17 schemes (reassessed as part of the process) and expansion of existing schemes established in 2016/17;
- new schemes identified by assessment of RightCare opportunities, local implementation plans to address SY&B STP plans;
- new schemes local implementation of commissioning teams from local intelligence, deep dives of contracts and service reviews

The QIPP programme is embedded into the delivery plans for SCCG's five identified focus areas as. A summary of these plans is set out in section 2 of this narrative and detail of the schemes, linked to RightCare opportunities, is set out at Appendix 1 to this narrative.

The work completed to develop the 2017/18 QIPP has ensured that the schemes have been linked to SCCG commissioning intentions through the Sheffield Place Based Plan and formed part of our contract negotiations with providers. SCCG has ensured that all schemes align with the wider SY&B STP work programme and full triangulation has been completed to create a fully collaborated and shared programme across all five focus areas.

Must Do 3: Primary Care

SCCG has developed and are submitting alongside this document our response to the GP Forward View. This describes in full how we plan to deliver the 'Must Do' in relation to Primary Care, as such, it is not contained within this document. However, primary care development and investment is central to SCCG plans to deliver the SY&B STP and *Sheffield Place Based Plan* objectives and all 9 'must do's' and a responsive and resilient primary care system is key to the achievement of the transformation described in the *Sheffield Place Based Plan*, as articulated previously, it is the bedrock for wider transformation within the City and STP footprint.

Our response to the GPFV and our plans for how we will invest in primary care including additional funding through the GPFV (*Appendix 1 and 2*) are ambitious. The Sheffield Primary Care Strategy, along with the Urgent Care Strategy and the Active Support and Recovery Programme, comprise the key components of the Sheffield Out of Hospital Strategy that will help us transform care in Sheffield and deliver the GPFV response required. The CCG is working with GP practices in Sheffield to transform primary care in order to respond to transferring services out of hospital over the next 3-5 years. We expect to achieve the following key outcomes:

- Improved consistency in access to general practice; a combined, collaborative workforce across primary, secondary and community care providing a seamless pathway for patients with GPs as the linchpin for care;
- Patients able to self-manage their conditions from home utilising technology to connect with healthcare professionals;
- Reduction in health inequalities by delivering appropriate access, ensuring greater need has greater access, achieving equity of access (versus equity of outcome) with patients accessing equivalent, consistent standard and high quality services;
- Increase of the wider workforce within general practice to improve consistency in patient experience;
- A programme of patient education and engagement with strong outcomes;
- Support of the requisite infrastructure in Information Technology (IT) and estates in order to deliver sustainable primary care;
- A programme of service shifts from traditional hospital settings to community bases.

We will do this by delivering an *implementation plan* supported by a detailed *primary care work plan* over the course of the GPFV 5 years (appendix 1) the implementation plan has three main aims:

AIM 1 - To ensure that all practices have a clear plan to remain sustainable to deliver the future primary care agenda
AIM 2 - To develop our existing primary care workforce to increase capacity as necessary to deliver high quality, capable service offer in out of hospital community and primary care settings
AIM 3 - To ensure that our estate and technology strategies support the sustainability and transformation of primary care

Must Do 4: Urgent and Emergency Care

Current Position

Our main provider of A&E services, Sheffield Teaching Hospitals NHS Foundation Trust, (STHFT) is currently non-compliant with the A&E Constitutional Standard. SCCG has a Remedial Action Plan (RAP) in place and is working with STHFT and other system partners, including Social Care to improve delivery and recover the position to deliver the agreed Sustainability and Transformation Fund trajectory by the end of 2016/17.

SCCG Objectives

Delivering of the 4 hour A&E Constitutional Standard

Delivery of the 4 hour constitutional standard requires a whole systems approach and leadership is provided by the local A&E Delivery Board jointly chaired by SCCG's Accountable Officer and the Chief Executive of STHFT.

Local transformation will be delivered through the implementation of national guidance including ***the Five High Impact Changes*** and ***Safer Faster Better Guidance***. Assurance around operational delivery will be through the key projects and programmes highlighted within the local remedial action plan and achievement of the STF trajectory agreed with NHSE. This work will be further supported through STHFT's Excellent Emergency Care programme and further development of a joined up citywide approach to supporting patient flow.

With regard to patient flow in Sheffield there are particular issues regarding length of stay and delayed transfers of care (DTOC). Whilst it anticipated that implementation of key elements of national guidance will address many of the issues significant additional work is being undertaken with regard to reducing length of stay and DTOC levels.

The three key areas of focus for the coming year will be development of real time local data systems informing daily management of capacity and demand across entire patient pathways; addressing processes for discharge management

including medical, therapy processes, key local pathways and ensuring a local culture focussed on ensuring timely and efficient patient flow across the entire local health and social care system.

Meeting the Four Priority Standards for Seven-day Hospital Services by November 2017

The Sheffield Children's Hospital NHS Foundation Trust (SCH) and STHFT are pioneer sites for implementing 7 day hospital services and have a clear plan to deliver the four priority standards. There remains significant challenge in relation to priority standard number 8. SCCG will continue to work with the acute Hospital Trusts to support and ensure delivery of the action plan.

Implementing the Urgent Care Review

SCCG are working with partners across the STP to support implementation of the integrated urgent care commissioning standards and will be actively working with Yorkshire Ambulance Service to ensure that the clinical hub model is integrated with the local Sheffield infrastructure. A Mental Health Liaison Service will be put in place to support integrated delivery of physical and mental health. Neighbourhoods and urgent care hubs will have workforce trained with mental health first aid, and work in a multi-disciplinary way, supported by technology as appropriate, to deliver an integrated model across all disciplines including mental health. This work is underpinned by an Urgent Care Review that will be discussed in depth at the SCCG Governing Body developments Session on xx January 2017. However, SCCG is already actively delivering

Reducing the Proportion of Ambulance 999 Calls that Result in Avoidable Transportation to an A&E Department

Continue with the ECP Programme and the Dispatch on Disposition and Hear See and Treat Programmes and ongoing review of Directory of Services (DOS) to ensure that as new alternatives become available the DOS is updated. Consider models of urgent primary care that support access to primary care intervention. Develop direct booking to satellite hubs and the Walk in Centre. Targeted support to GP practices and nursing homes with higher 999 call activity and conveyance to increase confidence in managing patients outside of hospital.

Rapid access clinics for patients managed with higher acuity in primary care, agreeing the capacity and demand plan with partners, specifically SCCG and localities for example Heart Failure, COPD/asthma, MGUS (haematology), prostate cancer survivorship, inflammatory bowel disease, valvular heart disease, Parkinson's Disease and Epilepsy, dermatological conditions requiring DMARDs, ocular hypertension.

Community geriatrician services: developing the general physician role in primary care: avoiding attendance at multiple specialty clinics by Q3 2017/18

Waiting time Standard for Urgent Care for Those in a Mental Health Crisis

Our plans are included in Must Do 7, we have have already implemented schemes to deliver the forthcoming Constitutional Standard.

SCCG Projects and Plans for 2017/18 and 2018/19

We have a system wide approach to delivering the four hour A&E standard. There are four key workstreams: primary care response, assessment, hospital flow, discharge. Each has a focused delivery programme that supports implementation of our Urgent Care Strategy (in line with the place based plan and the STP) and implementation of the 5 High Impact Interventions. In particular for 2017 – 19 SCCG will focus on:

- **Efficient delivery of local urgent care pathways** – ensure Sheffield has a resilient and sustainable local urgent care system we will explore the development of urgent primary care access solutions working collaborative with Primary Care Sheffield (PCS), STHFT and One Medicare (OM) leading to the development of a consistent and integrated offer across primary and secondary care. To implement clear and robust pathways committed to by all local partners, primary care, social care, community and acute providers and the Yorkshire Ambulance Service.
- **Maintenance of a local Sheffield model** with regard to the development of Regional Clinical Primary Care resilience and response – to develop a consistent offer across primary care to ensure that patients requiring urgent care receive a timely response, where clinically appropriate without recourse to A&E services. Including extended access;
- **System wide attendance and admission avoidance** – To implement key initiatives across the system to reduce acute emergency demand, including the development of primary care led coordination, the development of alternative

community based approach to delivery, better use of ongoing care provision, work with STHFT to deflect minor injuries/primary care conditions presenting at A&E and implementation of the assess to admit model;

- **Optimising patient flow through acute settings** – To ensure implementation of national best practice (including 7 day working) to enhance patient flow including proactive admission avoidance and discharge planning and ensuring incentives and behaviours are aligned so that 'assess to admit' and 'discharge to assess' trusted assessor models can be implemented through collaborative work with all key partners. There will be fewer people readmitted following a hospital stay;
- Ensure incentives and behaviours are aligned so that **discharge to assess trusted assessor models** can be implemented through collaborative work with all key stakeholders.

SCCG Projects and Plans for 2017/18 and 2018/19

SCCGs priorities will be to ensure effective local patient flow through local pathways recognising that these are the areas that provide the greatest opportunity for improving patient care and reducing overall system costs. It should also be noted that with regard to reducing inappropriate use of A&E significant work has already been undertaken (and continues to be) across all areas of the CCG's commissioning agenda (particularly the AS&R programmes and mental health). With regard to reducing conveyance this has been an area of real local success in the last twelve months with numbers of patients conveyed who do not receive significant diagnostic or treatment reduced by over 50%.

Improved flow from urgent care perspective will be through the following areas:

Table 6: SCCG Project and Plans 2017/18 – 2018/19

Project	Description	Key Deliverables
Reconfiguration of urgent primary care	A neighbourhood model in the community and from an acute perspective development of a local co-located urgent care centre. It should be noted that there have already been positive developments in this area with the co-location of the GP Out Of Hours Collaborative with A&E at the Northern General Hospital.	Improved flow, sustain 4 hour target, reduced admissions, reduce A&E attendances
Reducing avoidable admissions through	Outside of hospital this will be achieved through greater integration with primary care and Active Support and Recovery which has a number of	Improved flow, sustain 4 hour target, reduced admissions

Project	Description	Key Deliverables
routine usage of Assess to Admit pathways	programmes and projects specifically focussed on supporting patients in the community and avoiding unplanned hospital. Within hospital urgent care Assess to Admit pathways will be routinely used and supported by the newly reconfigured assessment units and also through greater integration with primary care, the AS&R programmes and key community services (health and social care).	
Reduce Length of Stay	The key focus of developments in the coming year will be the consolidation of the areas highlighted in the five High Impact Changes along with local developments e.g. improving the responsiveness of patient transport and continuing to develop citywide working to ensure timely and efficient patient flow across the entire local health and social care system.	Improved flow, sustain 4 hour target
Reduce excess bed days and Delayed Transfers of Care (DTOC)	Recognising the often very different needs of local patients nine individual cohorts have been identified recognising age, frailty and pathways such as where patients have been admitted from and are being discharged to (e.g. own home or care/residential). This approach will ensure that key supporting areas highlighted by national guidance are implemented wherever appropriate and that local initiatives are also targeted effectively. Work will continue to further develop the scope of the citywide sponsored programme outlined above into the coming year and beyond.	Target DTOC and improve discharge pathways and patient outcomes. Discharge to assess pathways fully implemented

Must Do 5: Referral to Treatment Times and Elective Care

The Challenge

Our main providers of planned care continue to meet the key NHS Constitution Standards, however, we know that we have too many children, young people and adults receiving planned in a hospital setting. As our population ages, this demand will continue to increase unless we take action. Whilst this is often the right thing there is a significant proportion of care that is either better provided in a community setting or not needed at all. We need to ensure that the hospital services work in harmony with community and primary care based services, enabling earlier discharge and a reduction in demand (new, follow-up and readmission) for hospital-based services. By doing this our model of care will become affordable, children, young people and adults will receive care closer to their homes and we will be able to support hospital based delivery with the right workforce

Current Position

SCCG is working closely with our main providers ensure we can deliver and maintain the NHS Constitution Standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT). SCCG and our main providers continue to achieve the Operational Standard although performance has deteriorated slightly in quarter 2 2016/17.

E referral – CASES referral guidance service is now operational in 7 high volume specialties, and all but one practice is signed up to CASES meaning that all but two week wait and other red flag referrals will flow through CASES by e-referral.

Demand Reduction Good Practice

SCCG has a Remedial Action Plan in place with STHFT to ensure achievement of the Constitution Standard in all specialties except gastroenterology be the end of 2016/17. A specialty review is underway in gastroenterology to identify additional actions to support delivery of the Constitutional Standard in 2017/18. SCCG has undertaken a comprehensive activity planning process with providers to identify specialties with limited capacity to inform our ongoing development plans.

SCCG Objectives

Whole system pathways across planned care that enable:

- Increased self-care and patient initiated follow-up, supported by clear pathways and timeframes;
- Pre-operative assessment outside of hospital unless clinically indicated;
- Increased access to specialist advice through a range of approaches (telephone, video-call, face to face);
- Preparation before hospital attendance;
- Advanced surgical and enhanced recovery techniques;
- Electronic discharge summary sent to GP within 24 hours of Inpatient or Day case Care;
- Agreed "whole journey" care pathways for diagnostics and assessment, including direct access from primary care;
- Radical upgrade to diagnostic access and turnaround times to reduce patient anxiety and improve outcomes through earlier intervention;
- Results to be appropriately communicated directly to the patient;
- Where diagnostics are better provided on a regional STP footprint we work with partners and public to design them.

Utilising community hubs to offer effective, efficient care close to home wherever clinically appropriate supported by robsit prevention and enhanced community support and recovery services.

Progress to Date

In 2016/17 SCCG launched a two year pilot scheme – CASES – to transform the delivery of planned care in the City. CASES provided advice and support to referring GPs but also captures vital data and intelligence to further refine and shape the transformation of care. CASES launched in July 2016 across seven specialties – chosen on the basis of volume of referrals and performance metrics. All but one practice are now signed up to using the service for non-urgent planned referrals.

Other schemes delivered include implementation of primary care based endometrial sampling service and new therapies in secondary care of patients with age related macular degeneration which may reduce the frequency of drug therapy. SCCG has worked with our main providers with advice from the Intensive Support Team to understand how demand management good practice can be applied, the demand management tool and stress test have been used to assess provider delivery.

SCCG Projects and Plans for 2017/18 and 2018/19

SCCG's vision and outcomes for planned care transformation are identified in the SY&B STP and the objectives articulated on the Sheffield Place Based Plan. SCCG will develop a system that enables people to manage their own health wherever possible, to enable primary care to support more people and to have efficient and effective secondary care services where these are the only alternative.

Work priorities link with Urgent Care programmes to support development if effective discharge arrangements so that people can return to their usual place of residence in a timely manner and ongoing support will be provided through our programmes of work in Active Support and Recovery and the evolution of localities and neighbourhood hubs described in our enabling strategies – Enabler 1. As condition specific pathways are developed SCCG will work with partners to commission or re-commission services that fit our new model of care offering primary and community care alternatives wherever clinically appropriate. This model is presented in figure 4.

Developing Whole System Pathways – Streamlining Planned Care

Our priority in 2017/18 and 2-18/19 will be to develop and implement whole system end to end planned care pathways across a number of specialties. SCCG will use RightCare methodology and local intelligence developed from CASES to support the development and delivery of local 'Whole Journey' elective care pathways working with partners across the SY&B STP and within Sheffield. This will be the priority programme within planned care and our vision for pathways is set out in figure 6, page 39.

Pathways will ensure consistent implementation of best practice and national guidance in relation to local elective care pathways. Where there should be community based provision we will enable this to happen, where hospital care is required we will significantly increase the number of referral through CASES and achieve system wide outpatient and admission reduction.

This approach will support the achievement of key initiatives across the system to reduce elective demand for first and follow up attendances, reducing clinical variation in primary care, development of alternative community services, enhanced self-care models, working collaboratively across the system to ensure individuals are able to maximise their own health potential.

Two underpinning strategies will support the delivery of much of the work programme in planned care in the next two years:

- CASES – SCCG referral review programme is active in 7 specialties and as well as providing immediate support and advice to GPs on referral gathers essential information on opportunities for education and pathway development;

- Clinical Specialty Review – using the SCCG methodology for undertaking specialty review that is being rolled out on 2016/17 to our three main providers of secondary care services. This will support the development of whole journey pathways for patients.

Figure 6: Planned Care Whole System Pathway linked to Localities and Neighbourhoods

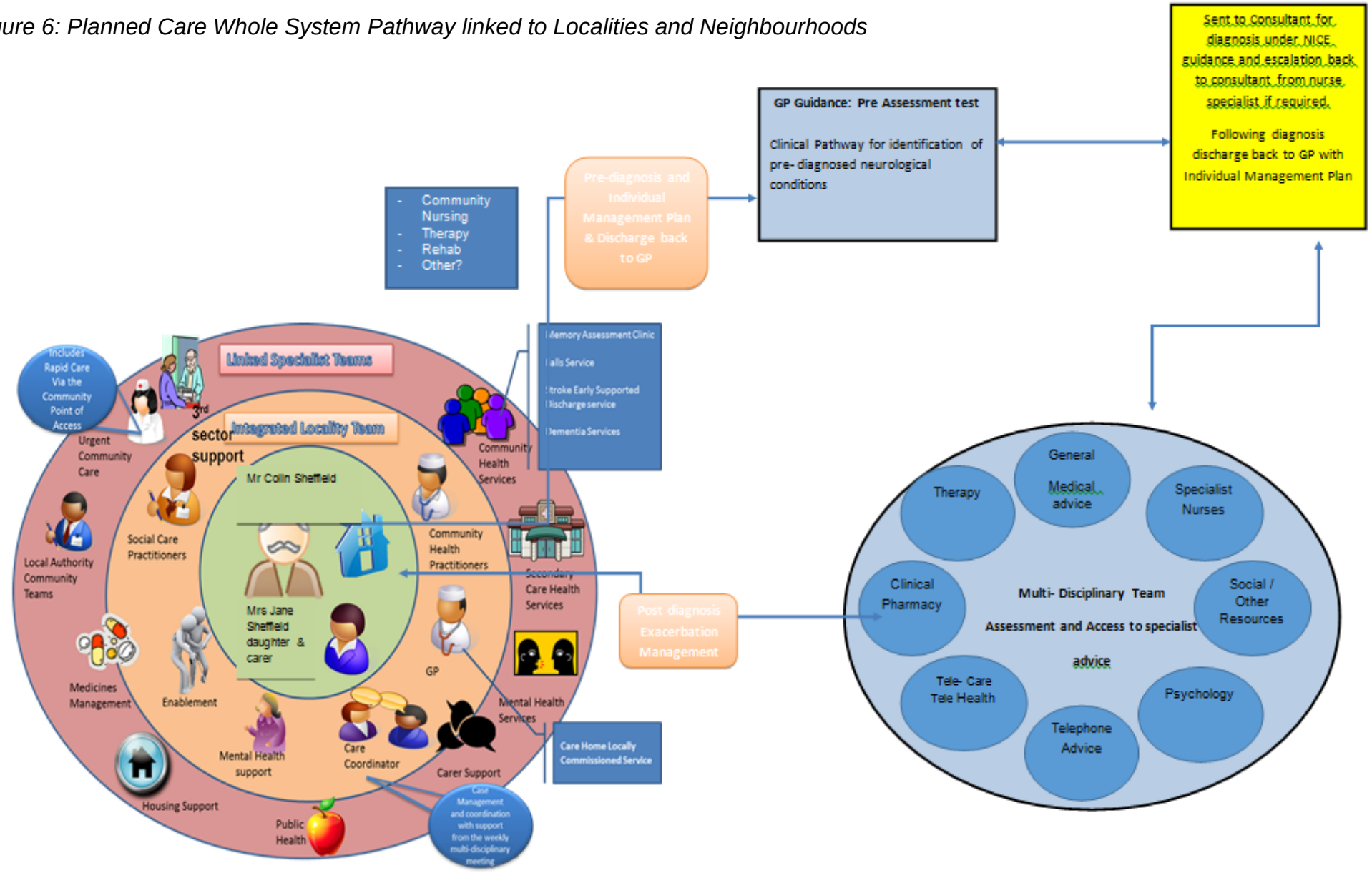


Table 7: SCCG Project and Plans 2017/18 – 2018/19

Project	Description	Key Deliverables
Whole journey planned care pathway development:		
Gastroenterology	Support new models of care. Primary care resilience and response. Supporting and strengthening referrals, to develop a consistent offer across primary care to ensure that patients requiring a planned treatment receive the right service in the right place and in a timely way with diagnostics and care outside hospital when appropriate Development of community services in neighbourhoods or other appropriate provider models including Personal Health Budgets, Primary Care will offer enhanced services and support for patients to actively manage their healthcare including support to self-care. Key outcomes include: • Effective care pathways • Reduce first and follow up attendances • Support delivery of 18 week RTT • Support diagnostic access KPIs would then relate to: **Pre diagnosis:** • New to follow ups expected to diagnose agree number • Reduced activity / unplanned admissions and A&E attendances • Multiple activity and referrals to eliminate other conditions through poor MDT assessment and Individualised management Plans • RTT targets met	Pathway development to be completed January 2017 – 5 condition pathways agreed for implementation
Urology		Commences April 2017
Neurology		Commences January 2017
Gynaecology		Commenced November 2016, to be completed by March 2016. Pathway development ongoing and alternative primary care service bundle including endometrial sampling, LARK, ring pessary fitting in development.
Cardiology		Commences January 2017 – 11 pathways for development and new services to be commissioned for 24 hour ECG, 12 lead ECG and EEG. Heart Failure Nurse specification to be reviewed
Dermatology		Commenced December 2016 6 pathways identified for development Community dermatology service

Project	Description	Key Deliverables
	Post diagnosis:	development and
Respiratory	• Number of Management Plans in place against patient diagnosed • Number of reduced A&E • Number of reduced unplanned admissions • Reduced outpatient follow ups	Review underway through Active Support and Recovery workstream
ENT		Commences March 2017.
Procedures of Limited Clinical Value	Complete review of existing policies, development of additional policies and thresholds.	Reduce clinically inappropriate interventions - ongoing
Pathology and Laboratory Transport	Reviewing service provision and recommissioning services.	To be confirmed via SY&B STP
E-Referrals and Choice	Increase e-referral at practice level - CASES pilot programme development to significantly increase the use of e-referral and support the offer of choice in Sheffield across 7 high volume specialties. Extend the pilot to paediatrics by March 2018. GP local incentive scheme to support transfer. Work with providers to ensure sufficient slots available to support e-booking and address capacity issues that affect uptake of e-referral. Ongoing monitoring and management in primary care.	All referrals will be electronic by October 2018. Deliver choice of first consultant outpatient attendance. By March 2017 agree trajectory with providers to deliver target

How/Who will we work with to achieve the change?

We will engage with secondary care providers, primary care, local authority, patients and the public

The Benefits

- Reduction in follow-up and in inpatient surgery
- Reduced Length of Stay
- Reduced morbidity
- Reduced in variation

Must Do 4 and 5: Children and Maternity Services

The Challenge

- SCCG needs to ensure it commissions Maternity Care Services in line with the National Maternity Review, this includes the provision of the four choices of care for women identified within the National Review;
- SCCG need to develop and sustain community child health services providing an integrated model of delivery within locality hubs to reduce remand on hospital care services. This will mean redesigning existing provision to provide new models of care, sustain community care and child health surveillance and health promotion providing evidence based Child Health Intervention and Prevention Services and improve health outcomes;
- We need to find new ways of working between health, education and care to better support Children and Families with Complex Needs and reduce publication;
- To deliver our local transformation plan for Children and Young People's Emotional Wellbeing and Mental Health and improve Early Intervention and Access to services and support.

Current Positon

SCH is currently delivering all national waiting times targets. The current key local performance issues are around access and waiting times for therapy services. SCCG expects to commission an average of 5% growth in new outpatient appointments in 2017/18.

There are challenges on provision for Child Health Surveillance, early intervention and early support within community settings to sustain the local offer and reduce demand on hospital care services. With increase in demand and challenged resources community cohesion early intervention and support are critical to maintain locally delivered care services.

SCCG Objectives

To provide locality based Integrated Care and Support that provides, early Intervention and Prevention of ill health, with explicit links to parenting and family support. Provision of responsive community and primary care services, active paediatric, assessment and advice to support reducing unnecessary hospital attendances and admissions.

Progress to Date

- Established the joint governance arrangements and a joint work plan across education, health and care, this includes the scoping of community provision in scope to work within locality hubs;
- Identification of a 3 hub locality model, local needs assessment underway and outline timeline and deliverables in progress;
- Progression of specific discreet projects to support new ways of working to manage Urgent Care;
- Local self-assessment of Maternity provision against the national maternity review has been completed, further work on gaining the voice of users on the current state of provision in underway.

SCCG Projects and Plans for 2017/18 and 2018/19

SCCG will deliver these objectives through the following programmes and plans:

Table 8: SCCG Projects and Plans for 2017/18 and 2018/19

Project	Description	Key Deliverables
Best and Maternity Care programme	Review and remodelling of local Maternity care services	Redesign into local hubs
Community Health programme	Redesign/ Integrate 0-19 Healthy Child programme into community hubs Integrated Delivery model between health and care New models of community care for child health Redesign pre hospital urgent care pathway Sustain and more effectively manage urgent care within acute setting.	Redefined offer meets national mandate Reduce referrals, OPFU, NEL Reduce primary care activity managed by ED
Emotional Wellbeing and Mental Health	Promoting resilience prevention and early intervention Improving access to effective support Care for the most vulnerable Accountability Workforce development	Early intervention less need for treatment. Reduce waiting times Clear pathways/services Effective workforce
Complex Needs	Redesign respite care jointly with social care Combine assessment and review processes for complex needs Jointly commission placement provision for children with complex needs	Reduce demand

How/Who will we work with to achieve the change?

We will work through the Sheffield Children's Health and Wellbeing Transformation Board to deliver this change in partnership with Sheffield City Council Children's Services, Local Education Services, Primary Care and Community Children's Health and Maternity Care Services.

The Benefits

- Reduction in paediatric referrals, appointments and follow ups where care can be provided within alternative settings;
- Planned reduction in non-elective admissions;
- Early Intervention and Prevention within Integrated locality hubs;
- Reduce demand for Complex Needs high cost placements.

Must Do 6: Cancer

The Challenge

Sheffield's Cancer Health Needs Assessment (https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA.html) outlines that Sheffield has a slightly higher cancer incidence than the England average. In comparison it also has a slightly higher emergency presentation rate and a lower early stage diagnosis although this is improving. Sheffield is similar to the average in relation to cancer screening uptake, 1 year and 5 year survival (except for breast). However premature mortality (u75) rates and all age mortality rates are higher. Cancer remains one of the main causes of death in Sheffield. The public health spend and outcome tool identifies that the overall spend on cancer in Sheffield is lower when compared to England, but there are specific areas such as non elective spend for lung and lower GI where it is higher.

The findings of our needs assessment (and the national priorities for cancer) have been shared with local residents in Sheffield and their feedback has been utilised to shape our plans. Sheffield has also undertaken a gap analysis against the recommendations in the National Cancer Strategy and is working with partners to support the development of the plan for the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance (SYBND) ensuring that there is alignment with the plan for Sheffield.

A number of challenges are identified nationally including the need to upgrade prevention to reduce preventable cancers, create a shift that enables earlier diagnosis where clinically possible, continue to enable treatment advances in an increasingly complex environment and transform the approach to supporting people living with and beyond cancer. These translate into local challenges for Sheffield. In addition the needs assessment identifies the significant variation and inequalities within the city as a key challenge. Sheffield has established a cancer work programme (aligned to STP/Cancer Alliance) to tackle these challenges. It focuses on:

1. Enabling early diagnosis;
2. Optimising treatment and care;
3. Supporting those living with and beyond cancer (aligned to the regional Macmillan programme).

Current Position

STHFT is meeting all the pledges for Sheffield residents. Operationally Sheffield is performing well against the cancer waiting times standards with the exception of 62 Day Treatment where there are challenges identified for upgraded pathways (no national standard) and for shared pathways, the latter is identified as a key challenge for the Cancer Alliance.

SCCG Objectives

The overall aim in Sheffield is to improve cancer outcomes, improve survival, reduce premature mortality and reduce inequalities. This will require us to reduce variation in screening uptake, increase the proportion of cancers diagnosed at an early stage and reduce those diagnosed via an emergency presentation.

Progress to Date

- Detailed cancer health needs assessment (HNA) and equality impact assessment (EIA) complete;
- Engagement work initiated with Sheffield residents and ongoing plan agreed;
- Sheffield work programme established informed by HNA, EIA and patient feedback and aligned to developing Alliance Plan;
- **To enable early diagnosis**- A series of Macmillan cancer awareness events have been delivered to frontline staff
  Local arrangements have been established to support National Be Clear on Cancer Campaigns;
  Practice facilitation is in place with a Macmillan GP and Cancer Research UK Facilitator;
  An improvement plan has been agreed to reduce variation in the uptake of cancer screening programmes
  The NICE suspected cancer recognition and referral guidelines have been implemented (including direct access diagnostics);
- **To optimise treatment and care** - Bisphosphonates have been implemented in the breast cancer pathway to reduce premature mortality. An inter provider transfer policy has been developed and agreed to improve the timeliness of shared pathways and performance against waiting times. Regionally a new delivery model for chemotherapy is progressing and a number of high value pathways have been developed;
- **To support those living with and beyond cancer** – Sheffield commissions a risk stratified pathway for those with colorectal cancer. A locality group is well established aligned to the regional programme, a gap analysis has been undertaken. A wide range of specialist and generalist support is in place. Plans are now under development to enable more risk stratified pathways and implementation of the recovery package (for agreed pathways). Currently SCCG have the following elements of the Recovery Package in place:

  1. Holistic needs assessment and care plan at the point of diagnosis - in place for colorectal
  2. A treatment summary sent to the patient's GP at the end of treatment - in place for colorectal
  3. A cancer care review completed by the GP within six months of a cancer diagnosis – in place as part of QOF

SCCG Projects and Plans for 2017/18 and 2018/19

A detailed plan for the SYBND Cancer Alliance to implement the cancer taskforce recommendations is under development. The following areas/projects align to those within the Alliance Plan and it will be through working with the Alliance that we will be able to achieve delivery. Ensuring sustainable whole system pathways will be the key focus of work in 2017 – 19, RightCare has highlighted two areas for priority focus – colorectal and breast:

Table 9: SCCG Projects and Plans for 2017/18 and 2018/19

Project	Description	Key Deliverables
Enabling Early Diagnosis	• Activities to raise cancer awareness with front line staff (making every contact count) and to engage with patients and the public (those identified with greatest need); • An annual improvement plan to reduce variation in the uptake of cancer screening programmes; • Work will be undertaken to review learning from Vanguards/ACE pilots to inform site specific work to enable early diagnosis; • Work through the Alliance to plan for the delivery of the new 28 day waiting time standard (diagnostic capacity planning).	Awareness & engagement plan. Annual screening improvement plan. Site specific plan(s). Plan(s) to enable delivery of 28 days.
Optimising Treatment & Care	• Work to enable delivery of optimum clinical pathways national & regional, includes reviewing the right care cancer pack; • Work will be encouraged through the Alliance to enable networked models of provision to reduce variation and make effective use of workforce skills and capacity.	Implementation of agreed national and/or regional best practice pathways
Living with and beyond Cancer (LWABC)	• Work will be undertaken to commission and implement risk stratified pathways (including breast, colorectal, prostate) • Implement recovery package (including support for self-management) where not already in place (breast and prostate) – to include the key aspects of the recovery package, HNA, TS, CCR and enhanced access to support to enable self-management.	Sheffield LWABC plan sets out SCCG detailed delivery plan. Risk stratified pathways. New referral routes for support
Ensuring Sustainability for Key Cancer Waiting	• Ongoing dialogue with STHFT to ensure internal improvement plans improve delivery against CWTs for Sheffield residents, currently being	Work commenced, Alliance approach will improve

Time Targets (CWT)	achieved (CPN to be closed). • Implement agreed Cancer Alliance approach to the performance management of CWTs, and the 62 day standard for STHFT.	timeliness of shared pathways enabling sustained recovery for STHFT.
Whole journey pathway review – colorectal and breast services	• Through RightCare work plan and linked to planned care portfolio develop: • Effective care pathways • Reduce first and follow up attendances • Support delivery of 18 week RTT • Support diagnostic access	Rightcare review completed. Specialty Review begins January 2017, delivery of Right Care Opportunities

How/Who will we work with to achieve the change?

Working through the Cancer Alliance on a SY&B STP footprint and with our local providers in line with the Sheffield Placed Based Plan.

The Benefits

- An increase in the proportion of cancers diagnosed at an early stage (stage 1&2);
- Improved cancer survival (1 year, 5 year);
- Reduced premature mortality from cancer;
- Reduced inequalities;
- Improved experience of cancer care (patient experience survey);
- Improved quality of life (living with and beyond cancer metric under development).

Must Do 7: Adult Mental Health

The Challenge

- To achieve the 2.1% increase in investment in mental health service provision to address Parity of Esteem; noting that we are already the eighth highest spending CCG on mental health provision;
- To achieve an equitable and sustainable Early Intervention in Psychosis Service which offers NICE compliant guidance given that national prevalence rates under predicted Sheffield's population local people experiencing first episode psychosis;
- To maintain local service provision in the face of potential threats to stability of local mental health NHS provider due to reductions in contracts and income from other commissioners;
- To address the waiting lists for access to diagnostic and post diagnostic support for people with autistic spectrum conditions;
- We are developing joint communications plans with Transforming Care Partners across South Yorkshire and North Lincolnshire relating to managing public perception of delivering care closer to home and closing hospital beds. We have plans to do joint communication with our MH provider relating to reinvestment of resources into community settings in place of acute inpatient beds to ensure the positive messages about prevention.

Current Position

- Maintaining recovery and waiting time targets in IAPT access and RTT, current IAPT recovery rate is 48.18% against the 50% standard (July 2016);
- Extending EIS when prevalence rates were under assessed nationally, as demand outstrips current supply;
- We intend to achieve parity of esteem in relation to waiting times and access targets for all services commissioned by the portfolio;
- Currently we have long waiting times in some areas, for example 27 week average wait for autistic spectrum condition diagnosis and post diagnostic support, and unacceptable long waits for specialist psychological therapies.

SCCG Objectives

- Deliver the required transformation to develop services through reinvestment of current resources and re-profiling of current service provision through work on the Acute Care reconfiguration programme
- Integrate our commissioning intentions, budgets and teams with Sheffield Local Authority to create a joint commissioning unit and approach. This will include an in depth review and the development of a radically reshaped mental health provision
- Develop business cases with our main NHS provider and other providers to enhance the IAPT and EIS services

- Work more collegiately with providers across the city through the Mental Health Delivery Board;
- Develop a more localised offer for provision based on neighbourhood working and our primary care mental health offer; through a shift of resources towards primary care
- Develop least restrictive services for people that are closer to home, working in partnership with CCGs and Local Authorities across South Yorkshire and North Lincolnshire through the STP.
- Continue to work on our Crisis Care Concordat published action plan
- Develop our Action Plan to better implement the Think Autism Strategy.
- We will develop a Comprehensive Mental Health Liaison service firstly through developing our core 24 service through national bids, and through a review of the Psychological Health Services that are available to support mental and physical health

Progress to Date

- SCCG has invested in community crisis and recovery services as an alternative to hospital acute inpatient beds, this includes development of an improved response to crisis and home treatment teams, and complex needs such as personality disorder;
- SCCG has had no acute mental health inpatient out of city placements over the last 2 years;
- SCCG has opened a state of the art Psychiatric Intensive Care Unit (PICU);
- SCCG has have met the access targets for IAPT service and improved the methods of access to the service including access to wider digital support through a redesigned website;
- SCCG has have achieved the national access standards for Early Intervention in Psychosis;
- SCCG has developed a robust partnership with other CCGs and local authorities to progress the Transforming Care Partnership plans across South Yorkshire and North Lincolnshire;
- SCCG has developed a robust partnership with other CCGs and local authorities to progress the Transforming Care Partnership plans across South Yorkshire and North Lincolnshire.

Meeting the Mental Health Investment Standard and Parity of Esteem

SCCG is committed to the parity of esteem agenda and currently has one of the highest percentage spend on Mental Health (8th highest CCG). Due to the financial pressures the CCG is facing in 2016/17 it has not been possible to plan to meet the financial investment standard in 2017/18 however the CCG is planning to meet the investment standard in 2018/19. The CCG is continuing to evaluate investments and cost pressures to understand whether more investment can be made into Mental Health. SCCG are using Right Care and the methodology described in section 1 of this narrative to undertake a holistic review of mental health services

(including those not provided by SHSCFT) to identify opportunities to achieve efficiency or release funds for reinvestment rto support wrap around care for people with both physical and mental health problems. This will link to our development of pooled budgets with Sheffield City Council, a review of the dementia pathway has commenced and identified areas for reinvestment and development.

SCCG is continuing to invest in its local transformation plan and is planning to spend £1m on the jointly commissioned plan with Sheffield City Council.

Maintaining IAPT Standards – 6/18 week waiting times and people moving towards recovery

SCCG's IAPT provider, NHS Sheffield Heath and Social Care NHS Foundation Trust (SHSSCFT), continues to achieve the standard for access and SCCG works with the service to ensure sustainable provision.
SCCG have an agreed recovery trajectory with SHSCFT for IAPT Recovery Rate and at July 2016 performance is at 48.18%. SCCG continues to work with the Trust to deliver the target in 2016/17. A number of identified issues have affected achievement of this target:

- Sheffield is a National pilot site for expanding offer to LTC and medically unexplained symptoms - increased complexity reduced patient likelihood of reaching recovery targets although clinically significant improvement demonstrated, SCCG continued to commission service after pilot ended as a result of positive evaluation.
- Local data quality issues compounded positon (local system and historic measurement) have beenaddressed but legacy cases are working through the system still.
- CCG performance manage delivery though Contract Management Group on a monthly basis.

SCCG Projects and Plans for 2017/18 and 2018/19

SCCG has developed a five year plan to deliver the Five Year Forward View for Mental Health and have mapped these onto our commissioning intentions, the delivery plans summarised below demonstrate how we will deliver the objectives identified for the next two years.

Table 10: SCCG Projects and Plans for 2017/18 and 2018/19

Project	Description	Key Deliverables
Mental health Quality and access standards including 24/7 access to crisis and Liaison	Re-procure a comprehensive mental health liaison programme, extended to include a review of all mental health commissioned contracts with STHFT e.g. psychological health Crisis and home treatment team available 24/7 - review capacity	Deliver mental health liaison service for Sheffield to meet the 5 year forward target
Autism and neurodevelopment service	Procure a replacement Autism and neuro-disability diagnostic and post diagnostic service for Sheffield	Reduce waiting times, achieve NICE/ Think Autism standards
Dementia	Agree an affordable implementation plan to continue to achieve the national diagnostic rates and ensure that we meet the new national standards for effective treatment and support Review the services which we currently commission for dementia	Sustain or exceed national diagnostic rates. Ensure improved access to national standards for treatment and support
Crisis Care	Continue to deliver and monitor the multi-agency Crisis Care Concordat work to improve mental health crisis services	Prevent hospital admissions, reduce self-harm to meet 10% reduction in suicide against the baseline
Physical Health/ Parity of Esteem	Review budgets for mental health interventions and invest to save proposals to improve access to health services Challenge services to make reasonable adjustments to service delivery - audits to demonstrate providers are addressing physical and mental health needs	Ensure that the mental and physical health needs of the population are met by addressing parity between physical and mental health.
Improving Access to Psychological Therapies	Identify additional capacity required to achieve the 19% target. Review other psychological therapies on offer within the city.	Deliver national access targets
Access to Early Intervention in Psychosis	Identify what additional capacity will be required to achieve the 53% target and access to NICE compliant treatment	National targets will be met
Individual Placement Support	Sheffield IAPT service was successful in achieving pilot bid status and will be recruiting additional IPS workers from April 2017	Additional employment advisers in the IAPT service
Suicide Reduction	Continue working with partners on a joint suicide strategy for Sheffield. This will include leadership from SCCG Clinical Director in Mental Health	Achieve 10% reduction against baseline

Project	Description	Key Deliverables
Eliminate out of area placements for non specialist acute care	Maintain performance - Sheffield has already achieved this target	Achieved

How/Who will we work with to achieve the change?

- Mental Health Delivery Board and Mental health Partnership Board;
- Learning Disability Partnership Board;
- Autism Partnership Board (in development);
- Transforming Care Partnerships;
- Dementia Networks.

The Benefits

- Review the whole investment into mental health services, through an in depth review of our provision as part of an integrated commissioning plan with local authority;
- Move services into neighbourhoods and primary care to focus upstream on prevention and early intervention within community rather than inpatient settings;
- Care closer to home in the least restrictive environments, with a focus on prevention and recovery as well as enhancing crisis responses within the community;
- Choice of providers and include the opportunity afforded through personal health budgets.

Must Do 7: CAMHS

The Challenge

For Children and Young People from our initial review to inform our local transformation plan we know that there was a lack of clarity on services and support available, a growth in referral to mental health treatment and increase in waiting times, this was combined with a growth in need and increase in Children and Young Peoples negative emotional wellbeing state.

There are no issues for Children and Young People Services in terms of meeting national performance indicators. We expect to continue investment to improve access to timely treatment and support; we will continue to support investment into evidence based early intervention and prevention programme that improve outcomes and reduce the need for mental health treatment.

SCCG Objectives

For Children and Young people our objective is to provide more early intervention and early help and support and reduce the need for Children to receive highly specialised care. We want to improve access to early intervention and ensure improved access to mental healthcare treatment for those Children that need it.

Progress to Date

We have delivered the first phase of our local transformation plan for Emotional Wellbeing and Mental Health for Children and Young People, which has seen an increase in Early Intervention and Prevention, improved access and waiting times for mental health treatment, along with the development of crisis care provision. Our progress has also included improving community eating disorder support to provide better community services and reduce admissions to inpatient provision.

SCCG Projects and Plans for 2017/18 and 2018/19

The Five Year Forward View and 'Future in Mind', sets the direction of travel to improve emotional wellbeing and mental health services for children and young people. This includes Improve access and waiting times for Mental Health Treatment for Children and Young People providing parity with physical health access and waiting times.

We have a local Transformation Plan that is agreed within the local partnership and has a joint governance arrangement reporting to Children's Health and Wellbeing Transformation Board.

Table 11: SCCG Projects and Plans for 2017/18 and 2018/19

Programme	Description	Key Deliverables
Local Emotional Wellbeing and Mental Health Transformation Programme for Children and Young people: http://www.sheffieldccg.nhs.uk/our-projects/emotional-wellbeing-and-mental-health-strategy.htm	• Promoting resilience prevention and early intervention; • Improving access to effective support; • Care for the most vulnerable; • Accountability; • Workforce development.	More Early intervention less need for treatment. Reduce waiting times Clarity of services and support and pathways Develop an effective workforce

How/Who will we work with to achieve the change?

Key partner organisations through the Children's Health and Wellbeing Transformation Board.

The Benefits

- Meeting our constitution targets and improving the health and wellbeing of Sheffield Children and Young People;
- Supporting reduction in A&E activity;
- Reduction in admissions to inpatient care.

Must Do 8: People with Learning Disabilities

The Challenge

Transforming Care

- We plan to reduce our beds by 2019 to 9 maximum, as a mixture of rehabilitation and assessment beds.
- Our target for end March 2017 is 19 inpatients. However, NHS England will have stepped down 3 more Sheffield clients against their planned trajectory by year end. Despite this, by the end of this financial year we intend to have 8 rehabilitation beds net, of which 5 will have been stepped down from NHS E this year. We have given notice to reduce our block contract for our Assessment Treatment Beds to our provider, and await their response to this proposal.
- We have been working on financial modelling and projections around current and future demands. However, the national dowry position and lack of funding flow from NHS E remains a challenge.
- We are implementing a CTR process and pathway in children's services and will integrate this with the existing adult service process and register. The recently announced national imperative to deliver this process to children in 52 week placements has been noted by children's commissioning colleagues as a new expectation to be delivered.

Annual Health Check Increased Target:

- We need to work to engage primary care more in the Direct Enhanced Services for improving the long term conditions of people with learning disability to both increase the numbers of GPs who sign up to the contract, and who then deliver the AHCs.
- In order to reduce premature mortality we need to work with all of our mainstream providers to improve access to health services, including our mainstream providers, Sheffield Teaching Hospital and Primary Care Sheffield.
- It should be noted that Sheffield has the Sheffield Case Register, which has existed for 40 years and which is one of the most comprehensive in the country. Therefore whilst we note that numbers of health checks delivered as a percentage could be improved when compared to national figures, we are making the whole population with LD eligible in Sheffield, as Sheffield uses its Case register to establish eligibility, and therefore are able to identify more people than most other cities. We will continue however to target lower performing GPs on this agenda

SCCG Objectives

Transforming Care:

- To reduce the numbers of commissioned inpatient beds through reduced length of stay in LD hospitals and reduced admissions through our local multiagency delivery plan which includes:
    - better community CTR and early interventions;
    - improved market stimulation and performance of care providers commissioned to provide competent support for people with complex needs;
    - delivery of a PBS Academy;
    - improved accommodation choice and availability;
    - improved pathway coordination and collaboration across LD/ MH and forensic care;
    - refocused resources into enhanced community teams instead of hospital care.

SCCG Projects and Plans for 2017/18 and 2018/19

Transforming Care:

- Sheffield CCG leads the local Transforming Care Steering Group in Sheffield which has multiagency membership which includes CCG, Local Authority; NHS Learning Disability Provider; representatives from children's services; family carers, BME family representative and experts by experience.
- The Steering Group meets monthly to oversee the work plan (highlights above), and to ensure progress against the bed trajectory to provide governance across the TC programme.
- We have a detailed local programme with a number of work streams focussing on demand management and supply management. This means that we are focussing on both discharge of current cohorts of patients whilst addressing measures that reduce hospital admissions.
- The local plan is also reported monthly into the regional Transforming Care partnership programme Board and project group. This has milestone trackers which are reported to NHS E.
- There is a monthly multiagency Care and Treatment Review Monitoring meeting which tracks individual admissions and discharges, and unblocks issues if they arise.
- We have a discharge wrap around team to focus on individual person centred solutions, with strategic commissioners linked in to provide relevant market stimulation.

- Strategic commissioners have been engaging with providers and are focussing on market development over the next 2 years
- We will deliver a Positive Behaviour Support Academy led by our Local LD Clinical Director to upskill frontline staff on supporting people whose behaviour can be challenging to support, and forensic skills.
- We already have a Community Intensive Support Service function which will be enhanced when we are able to disinvest from some of current commissioned beds that we have in spot and block contracts.
- We will develop our joint Accommodation Strategy to provide greater choice and control for individuals. We have capital projects planned that we will develop bids for.

Annual health Check

- To improve general healthcare through delivery of increased numbers of Annual Health Checks which we will enhance through Clinical Director engagement in training for GPs and through a project lead for AHCs
- To reduce premature mortality by ensuring reasonable adjustments are made to commissioning pathways in CCG within Active support and recovery, urgent and emergency care and through coordinated work on children's pathways and the SEND Education, Health and Social Care Plans

Must Do 9: Improving Quality in Organisations

The Challenge

To ensure that the quality of care we commission from our providers continues to improve against a background of increased financial pressure and demand.

SCCG Objectives

Our ambition is to be an excellent performing CCG that commissions the right services, delivered in the right places by skilled staff for the people of Sheffield. Our agreed objectives are:

1. Improve governance, assurance and management processes;
2. Ensure effective partnership and stakeholder relationships;
3. Commission for innovation and continuous improvement;
4. Improve quality in care home and domiciliary providers;
5. Ensure that CHC and IFR deliver high quality services;
6. Promote quality improvement and innovation within Primary Care.

Specifically, the CCG has a Commissioning for Quality Strategy and Plan which sets out in detail our plans. Priorities are:

- Ensure that providers have systems in place to Identify, screen, investigate and share learning from Deaths, and involve families and carers;
- Supportive site visits will commence in January 2017 where the CCG has concerns about services not delivering CQC action plans;
- A three year programme of Infection Prevention & Control audit visits has been commenced from March 2016 in independent Care Homes;
- Implement the NHSE Quality Risk tool to monitor and manage provider performance.

Delivery of the objectives will be achieved by the following:

- Identifying gaps in Quality via review of services. Data sources – safety, effectiveness and patient/staff feedback;
- Triangulating both qualitative and quantitative to give a full picture of quality;
- Having service specifications which are clinically outcome based and include key performance and quality indicators;
- Having focused Quality schedules in contracts;
- Having timely and accurate quality data flows;
- Reviewing provider performance data;
- Ensuring information sharing;
- Undertaking regular Contract Quality Review meetings;
- Utilising escalation and contract levers for underperformance;
- Conducting provider quality visits;
- Redesigning services to improve quality;
- Involvement of patients in redesign;
- Ensuring outcomes are derived from best evidence/practice and patient feedback;
- Consider de-commissioning poor quality services.

Progress to Date

As part of the contractual process with providers, regular quality review group (QRG) meetings are held with each acute and mental health provider organisation, and these meetings are chaired by CCG senior leads. Meetings are also held with the ambulance service and independent providers. The focus of QRG meetings is on quality assurance and provides the CCG with the opportunity to review and monitor areas for improvement, highlight good practice and allows for challenge if areas of concern arise. QRGs are fundamental in maintaining the positive relationships that have been developed with providers since establishment of the CCG and ensures that quality is reported on in an honest and transparent way.

SCCG does not currently commission services from any providers in special measures. In 2016/17 all three of our main providers of secondary, community or mental healthcare received CQC inspections and SCCG participated actively in these visits and in the agreement of action plans to address any areas identified for improvement by the CQC we will continue to monitor delivery of these improvement measures as part of our ongoing relationship with providers.

SCCG Projects and Plans for 2017/18 and 2018/19

We will be working with providers to ensure quality improvement via CQUIN schemes and local and national quality requirements. In addition we will deliver our quality strategy action plans which include:

- Commissioning for Quality Action plan;
- Patient Experience Action Plan;
- Safeguarding Children's Action plan;
- Safeguarding Adults Action plan;

Cross Cutting Enabling and Underpinning Programmes

Enabler 1: Care Outside of Hospital and Planned Prevention – Active Support and Recovery

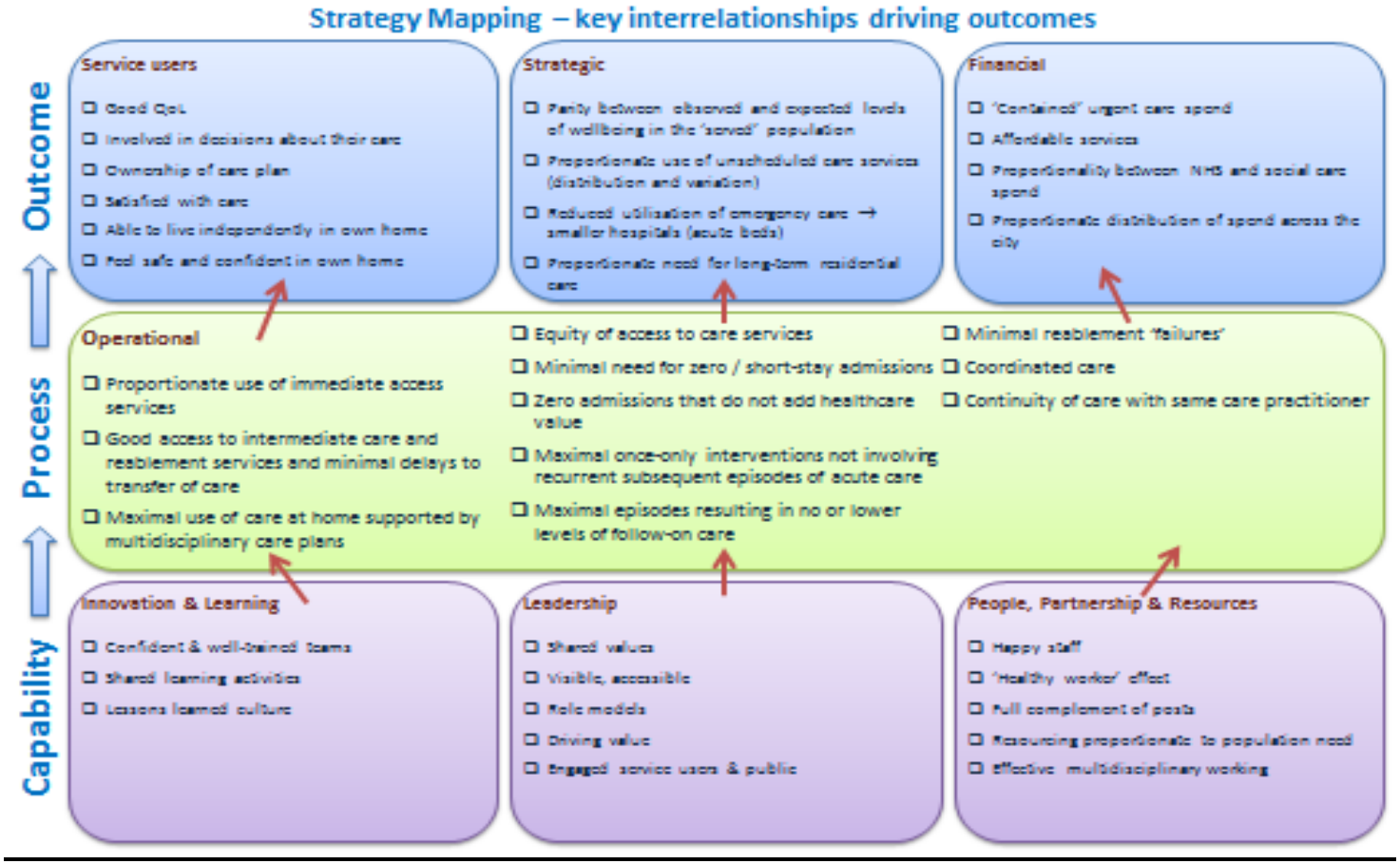
The Challenge

We do not have a sustainable health and care system. The current model is not affordable. We believe that we can deliver services closer to home, reduce unnecessary admissions, improve access to a person-centred, integrated approach which has the potential to improve patient / carer and family experience of health and care and deliver a financially sustainable model. Regarding community health and care services, stakeholders have told us that they want:

- A consistent response to an identified need any time, any day, getting the person the right support and help that they need;
- A service that addresses all aspects of a person's wellbeing, listens to the person and their carers to find out what matters to them and plans a response with them;
- People plan their care and support with others who work together to understand the person and their carer(s), allow personal-control, and bring together services to achieve the outcomes important to the person;
- Organisations trust each other, are supported by professionals giving them clear guidance and support and share information with common standards of care;
- People, carers and professionals actively identify people with a high level of need and get them the help and support they need quickly;
- Flexible staff and resources across the system that work towards increasing a person's ability to keep themselves well as part of their agreed shared plan.

These have become the core aims of the Active Support and Recovery Programme (AS&R). The AS&R Programme Board has representation from CCG Commissioners, Social Care Commissioners, STH, SHSC, PCS, SCC and VCF sector. It has a strong ethos of co-production and has had extensive involvement of the Citizens Reference Group. The AS&R objectives are presented in figure 7, page 63.

Figure 7: AS&R Objectives



Assumptions

- The development of a more pro-active approach with the person at the centre will deliver through the AS&R Programme will result in:
    - Reduced cost due to greater efficiency – less duplication, greater information sharing, greater levels of patient activation;
    - Reduced cost due to less unplanned admissions – less ambulance journeys, less A & E attendances, less admissions;
    - Reduced cost within ongoing care as less multi-morbid frail people admitted and progressing to permanent residential care.
- There will be investment in services that enable people to remain in the community when they would otherwise have been admitted *e.g.* community IV to enable achievement of financial savings;
- The initial scope of Active Support and Recovery included intermediate care beds and later community nursing was added. However, in recognition of the fact that the development of a person-centred approach requires a more holistic approach and as such will include parity of approach for mental health and physical health. It will also employ a range of prevention strategies.

Progress to Date

- Governance structure;
- Stakeholder engagement;
- Memorandum of Understanding signed by all main commissioner and provider organisations;
- Set up 16 neighbourhoods in Sheffield based around a group of GP practices with a population of 20-60k people;
- Set up a Neighbourhood Learning Network to enable the sharing of good practice / experiences;
- Started work to align the City.

SCCG Projects and Plans for 2017/18 and 2018/19

SCCG programmes for planned prevention and care outside of hospital are key to the achievement of our overall system transformation and delivering significant QIPP efficiencies. Our plans have interdependencies across both primary care, planned and unplanned care work streams and these programmes will drive a significant reduction in elective and non-elective admissions in 2017 – 2019 aligning with the SY&B STP and Sheffield Place Based Plan ambitions and objectives.

Table 12: SCCG Projects and Plans for 2017/18 and 2018/19

Project	Description	Key Deliverables
Service redesign / pathway reconfiguration: • Citywide • Neighbourhood	• Citywide alignment to support neighbourhood delivery model; • Person-centred approach in local community; • Promotion of self-care / self-management – care in a community setting rather than traditional hospital environment; • Patient activation; • Prevention; • People remaining active and recovering well.	Citywide working group draft plan to ASR Board by end 16/17; Delivery of agreed plan in 17/18 and 18/19; Rapid response to people in crisis One plan that is shared Integrated team working Greater efficiencies Reduced NEL activity for ASR patient cohort.
New models of care	• Neighbourhood models of care established; • Neighbourhood Learning Network; • Public and patient engagement; • Develop options for future contracting models to support evolution of neighbourhoods; • Implement new contracting model; • Digital and IT plan aligned to delivery of AS&R outcomes.	More services delivered at neighbourhood level Reduced admissions for people who have multiple long term conditions / are frail.

The Benefits

- Active Support and Recovery is required to make £24M of savings over 5 years. It is estimated that it will be required to save £5M in 17/18 and 18/19 in efficiency and non-elective admission reduction;
- This level of savings will require improved quality of care through a more person-centred approach, greater levels of innovation through the use of new ways of working, the testing of digital and IT solutions, the ability to flex and adapt to a rapidly changing health and care delivery model and a focus on prevention;
- The benefits realisation map for ASR below articulates the key benefits expected from the programme.

Enabler 2: Medicines Management

The Challenge

The provision of medicines is by far the most common form of NHS treatment and advances in therapies and patient demographics are driving demand ahead of funding provision. The cost pressures generated by increasing patient demand compounded by the introduction of new, more expensive medicines, including some that come with a very high cost.

In terms of performance, given the challenge, the position in Sheffield is generally good. Working collaboratively with our GPs the medicines management team have promoted evidence based affordable prescribing and contributed to the achievement of QIPP prescribing savings. There is also an ongoing focus on quality and medicines safety which is essential if patients are to obtain the best results from their NHS medicines.

All of this is against the backdrop of increasing activity, prescription volume in year is running at 3% ahead of last year and in the first 5 months of this year over 5,500,000 prescriptions were issued in Sheffield.

SCCG Objectives

To continue to work across Sheffield to ensure that patients are treated with safe, clinically effective and affordable medicines that provide them with the best possible outcomes. We therefore need to ensure that we have systems in place to provide clinically effective and cost efficient medicines for patients that enable them to achieve the best possible outcomes.

We also need to promote self-care and encourage patients to manage short term self-limiting conditions themselves –without resort to NHS prescriptions, where these are not essential. The challenge will be greater as the population expands and ages – these drivers are currently more powerful than mitigating factors such as healthy lifestyles, self-care and social prescribing.

Progress to Date

The medicines management team have, year on year, substantially exceeded the QIPP targets set and have thus made a demonstrable contribution to affordable care in Sheffield. In addition work around quality and safety has been recognised via national awards with Sheffield noted for delivery of innovation in medicines management.

SCCG Projects and Plans for 2017/18 and 2018/19

Table 13: SCCG Projects and Plans for 2017/18 and 2018/19

Project	Description	Key Deliverables
Programme of prescribing efficiencies	The MMT will continue to identify opportunities for prescribing efficiency and devise plans to work collaboratively with GP colleagues in order to realise these efficiency gains. The prescription order line (POL) will continue to identify and reduce prescription waste.	Organisational QIPP targets will be achieved
Secondary Care	The MMT will also work collaboratively across the primary secondary care interface. This will be achieved via the work of the Area Prescribing Group and by the structured implementation of NICE guidance.	Joint programmes of work to deliver safe, high quality and affordable prescribing across Sheffield
Quality and medicines optimisation	The MMT will also undertake targeted work aimed at increasing the quality of prescribing and medicines optimisation whilst reducing the incidence of drug related adverse events.	Reduction in adverse drug related non-elective admissions
Community Pharmacy	Develop community pharmacies into Heathy Living Pharmacies, becoming the ”go-to” destination for support, advice and resources on staying well and living independently Fully integrate “pharmacy first” for non-emergency episodic care in all local urgent care pathways, including implementation of the national programme for NHS 111 referrals to community pharmacy Develop and implement health economy wide systems to reduce pharmaceutical waste related to inappropriate repeat medicine ordering. Implement digital solutions which allow electronic transfer of medication information between hospital and community pharmacy to help minimise	Supports delivery of planned prevention and care out of hospital – further detail is set out in the GP Forward View Response and Delivery Plan.

	medication errors Increase the number of clinical pharmacists working in all care settings to undertake clinical medication reviews in addition to maximising utilisation of MURs and patient support under the new medicine service (NMS) Work on developing systems which allow pharmacists working in partnership with GPs to provide LTC support following diagnosis, monitoring and adjustment of treatments in accordance to patient care plans	

How/Who will we work with to achieve the change?

The medicines management team will work to achieve their objectives via programmes of:

- Clinical effectiveness;
- Quality and safety;
- Practice support.

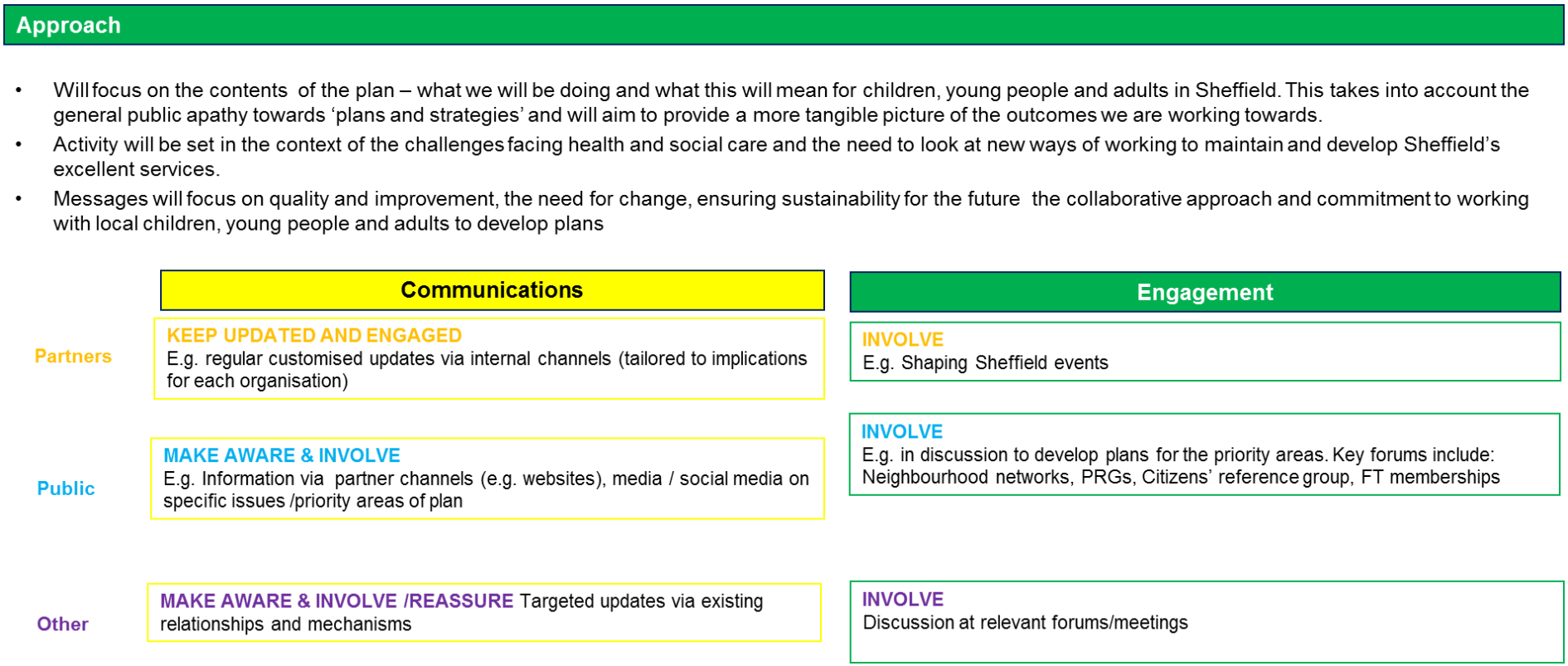
The Benefits

- QIPP efficiency savings;
- Better outcomes for patients taking medicines;
- Improved safety and governance around prescribing and medicines use.

Enabler 3: Communications and Engagement

Effective communication and engagement has been key to the development of the Sheffield Place Based Plan. Through the Transforming Sheffield Board, Shaping Sheffield (i.e. engagement programme) has undertaken significant engagement work across the City and we have listened to what how people have told us about the care they receive and how they would like this to change in the future when developing our transformational plans for Sheffield. We have developed and will continue to use the following model to ensure that we fully engage patients, the public and other stakeholders in our transformational plans as they develop and are implemented. Figure 8 below sets out this model.

Figure 8: Shaping Sheffield – Our Approach to Communications and Engagement



Enabler 4: Technology and Digital Roadmap

The Challenge

SCCG submitted its first Digital Roadmap to NHS England on 30 June 2016. The roadmap has been generated with key partners across the city. These have included Sheffield Hospitals NHS Foundation Trust, Sheffield Health and Social Care Trust, Sheffield Children's Hospital, Yorkshire Ambulance Service, Sheffield City Council, PCS and eMBED Health Consortium (providing CCG commissioning support for IT).

To ensure there is alignment with our wider SYB STP Digital/IT workstream, there has also been close collaboration in the development of Local Digital Roadmaps (LDR) across the five SYB CCGs via an established forum coordinated by SCCG.

Specific engagement initiatives linked to our digital and technology capability elicited some of the key challenges experienced by patients, clinicians and health and care practitioners across our current environment. This feedback supported our understanding of the specific issues that our LDR and SYB STP Digital Chapter need to address. These events, stimulated by the development of our LDR and our Test Bed Programme, engaged over 150 stakeholders over 6 months across patient, public, voluntary, charitable, commercial, provider and commissioning sectors including a wide array of clinical and non-clinical staff across acute and primary care sectors.

Key requirements emerging from this engagement include the need for:

- shared health and care records;
- mobile working (including WiFi and remote devices for staff);
- accelerated use of technology to promote ill-health prevention and support people to look after their own health and wellbeing *e.g.* risk stratification.

SCCG Objectives

- **Shared care records** will enable view access by clinical /professional care delivery staff to relevant patient details from across the health and care system that supports the delivery of better co-ordinated informed patient care;**Mobile Working** will enable staff access anywhere, anytime to clinical & business systems - enables working from any building, patient's homes.
- **Technology supporting self care** will enable some patients with given long term conditions to support themselves at home

Progress to Date

- **Shared Care Records** – in April 2016 we started sharing the Primary Care record with Sheffield Teaching Hospital via their Clinical Portal. This enables adult acute clinicians (with patient consent) to view the primary care record;
- **Mobile Working** – We have a mixed picture of equipment/devices that support mobile working – many practices have one or two laptops that may be used out of the practice;
- **Technology supporting self care** – the Test Bed Programme has identified potential technology to support Diabetes patients and will be trialling its use in early 2017.

SCCG Projects and Plans for 2017/18 and 2018/19

Table 14: SCCG Projects and Plans for 2017/18 and 2018/19

Project	Description	Key Deliverables	Lead
GP Connect	Interconnectivity between EMIS and SystmOne enables read only viewing of other practice records, ability to make appointments across systems	Interconnectivity between EMIS and SystmOne within Neighbourhoods	CCG
MIG Shared Record Viewer	Implement MIG Shared Record Viewer enabling read only access to a summary of the primary care record (via login to separate standalone viewer) for non-acute clinical/care staff.	SCH, SHSC, social care staff can view a primary care record summary	DRMIG
Shared Care Record User Requirement	"Sheffield" Shared Record data set agreed	User requirement for Shared Care Records	DRMIG
Wifi / Remote working	Procure new Health and Social Care IT Network, Wifi points, increase number of mobile devices.	Staff access anywhere, anytime to clinical & business systems - enables working from any building, patients homes	DRMIG
Patient wearable technology	Patient wearable technology via TestBed programme - pilot test solutions targeted to agreed cohorts & live	Patient empowerment & independence	TestBed
Patient / professional video/phone consultation	Enable video/phone consultations between patients (home) and care professionals (clinics)	Supported Care in the home	DRMIG

How/Who will we work with to achieve the change?

We have recently established a Sheffield Chief Information Officers Digital Steering Group (chaired by SCCG) to take this work forward for the city. The pre-existing Digital Roadmap Development Group is to be replaced with a Digital Roadmap Implementation Group (chaired by the IT Director from the Sheffield Health and Social Care FT). Sheffield, Barnsley and Bassetlaw CCGs are recruiting to a new Joint Head of IT post who will take a lead for this work and link with the STP.

The Benefits

Shared care records will enable view access by clinical /professional care delivery staff to relevant patient details from across the health and care system that supports the delivery of better co-ordinated informed patient care;
Mobile Working will enable staff access anywhere, anytime to clinical & business systems - enables working from any building, patients homes;
Technology supporting self care will enable some patients with given long term conditions to support themselves at home.

Section 4: Building the Activity Plans and Contract Assurance

SCCG Planning Process

SCCG has developed a detailed Activity Plan that sits alongside this document and the SCCG Financial Plan. The Plan incorporates the modelled activity impact of the programmes outlined in the SY&B STP and the Sheffield Place Based Plan, in addition to the 'Business as Usual' CCG QIPP plans. Section 1 of this plan highlights the key elements of the different plans and how these form the basis of our Operational Plan for 2017 - 2019.

Both our financial and activity plans have been produced on a consistent basis, using the same assumptions on growth and the impact of demand management schemes and QIPP plans.

SCCG activity plans are created from 2016/17 forecast out turn. We have adjusted for known historic data quality issues the main issue being the impact of migration to a new PAS system, Lorenzo, at STHFT in 2015/16 which affected reported outpatient and inpatient activity and referral data in that year and into 2016/17.

Other factors taken in to consideration include the relative number of working days in 2016/17, 2017/18 and 2018/19, the effect of junior doctor industrial action in early 2016/17 and known service changes at our main providers. These adjustments are reflected in the forecast out turn difference column in the waterfall diagram.

In addition to these issues there are further factors that may change activity in 2017/18 driven by the introduction of HRG 4+ and planned changes to the Prescribed Specialised Services Identification Rules which mean that activity and prices across different specialties and points of delivery may move in different directions or between responsible commissioners. Further work is required to finalise our impact assessment of these changes, any additional changes will be reflected in our final activity plan submission.

The CCG has built demographic growth into activity plans at a locally determinded level base using the following methodology. This differs from both the IHAM model and the figures used to dayte in the SY&B STP modelling which were applied at STP level.

The methodlology uses was as follows, the data for recent years was analysesd at point of delivery and age band and changes in population noted. The rates per population cell were then uplifted by ONS forcest demographic growths. This gives a crude estimate of the aging effect, coupled with net migration derived from age bands. The model will not be able to identify health need gain via net migration, so will always assume the incoming population health status is as per leavers. The churn for students (particularly overseas

students) Is not seperately identified - this may lower the net migration age as students leave and are replaced. This model process has been used for the last 3 years and SCCG are confident that it accurately refelcts likely population growth, table 15 below highlights historic trends supporting SCCG panning assumptions compared to IHAM/SY&B STP assumptions.

Table 15: SCCG Historic Trends and Growth Assumtions Compared to IHAM/SY&B STP

TRUST	POD	SCCG				SCCG Growth			IHAM Model			SY&B STP Model			
		15/16 Actual	16/17 FOT	17/18 Projected	18/19 Projected	16/17	17/18	18/19	2016-17	2017-18	2018-19	17/18 Do Nothing	18/19 Do Nothing	17/18 Do Something	18/19 Do Something
STHFT	Outpatient First Attendances	239,267	241,702	243,632	245,721	1.02%	**0.80%**	0.86%	3.48%	**3.63%**	3.51%	3.50%	3.60%	1.31%	1.45%
	Outpatient Follow Up Attendances	503,721	509,735	514,432	519,041	1.19%	**0.92%**	0.90%							
	Elective Admissions	70,589	71,360	71,982	72,655	1.09%	**0.87%**	0.93%	1.64%	**1.79%**	1.66%	1.70%	1.80%	0.33%	0.40%
	Non Elective Admissions	66,557	67,318	67,933	68,589	1.14%	**0.91%**	0.97%	1.71%	**1.99%**	1.88%	1.80%	1.90%	-2.09%	-2.10%
	A&E Attendances								2.14%	**2.20%**	2.12%	2.10%	2.10%	-3.25%	-3.45%
All	Outpatient First Attendances	80,216	81,048	81,738	82,468	1.04%	**0.85%**	0.89%							
	Outpatient Follow Up Attendances	74,186	74,993	75,669	76,389	1.09%	**0.90%**	0.95%							
	Elective Admissions	269,533	272,086	274,222	276,500	0.95%	**0.78%**	0.83%							
	Non Elective Admissions	553,423	559,769	564,804	569,675	1.15%	**0.90%**	0.86%							

An assessment of historic growth rates has been made and no additional non-demographic growth has been added to the plan at this stage. As part of our activity planning, SCCG has historically built non-recurrent activity into baselines to account for outpatient queues and elective waiting lists to ensure sufficient activity is commissioned to meet the NHS Constitutional Standards. Negotiations on the level of non-recurrent activity are ongoing with STHFT and as such the plan is currently based on historic levels of non-recurrent activity.

Triangulating Activity Plans to QIPP and SY&B STP

SCCG activity plans are consistent with financial plans and include the full identified impact of service transformations as articulated in the SY&B STP for 2017/18 and 2018/19 and Sheffield place-based plan as well as other QIPP effects described in our Financial Plan and in section 2 and appendix 1 to this narrative. Where these plans result in reduced activity this has been quantified using an agreed methodology and included within our activity plans.

Our QIPP plans and assumptions have been shared ad discussed with our main providers and activity changes are refelcted in contract activity and finance plans and baselines.

SCCG activity change exceeds the stated SY&B STP plans in most points of delviery as SCCG has developed QIPP plans to achieve a balanced financial position that require the delviery of £20m QIPP in 2017/18. Furthermore because the planed SCCG growthrates for 2017/17 and 2018/19 are lower than hose used in the STP modelling, the net impact of SCCG QIPP schemes is greater.

The exceptions are:

- A&E - SCCG has plans in place through the Urgent Care Review process described in Section 2 to transform delivery of urgent care services however untill these are confirmed the full impact cannot be modelled or refelcted in our QIPP plans. This will be amended following agreement.

NHS Constitutional Indicators

An assessment of our current position is incuded within the ‘Must Dos’ in Section 2 of this document.

SCCG is planning to achieve all NHS Constitution Indicators and other commitments in 2017/18 and 2018/19, this is refelcted in our activity assumptions where appropriate. Detailed discussions havetaken place with providers, as part of the contract negotiation process to understand performance and plans for delviery and assure these will meet the consititutional indicators.

Delivering Two Year Contracts

Robust Contract Negotiation Framework

In June 2016 SCCG reviewed the 2016/17 planning processes. The key 'lessons learned' were developed into an action plan, endorsed by the Clinical and Executive Team, and built onto our approach to planning for 2017 – 19. Key steps include:

- Enhancing shared ownership of QIPP delivery and transformational change;
- Building on clinical engagement in contract negotiation processes;
- Confirming clear executive leadership for negotiation and building robust contract negotiation teams.

The national changes to the planning and contracting timetable, first announced in July 2016, have placed pressure on the planning process. However, the system wide approach taken in Sheffield, and led by the Sheffield Transformation Board, to agree plans and commissioning intentions for the next two years across all organisations will significantly support achievement of these challenging timescales to reach contract agreement with our providers.

APPENDIX 1

SCCG QIPP Schemes linked to RightCare Opportunities

Must Do Area	Provider	SCCG QIPP Scheme	Revised Gross Savings 1718	RightCare Opportunity 2017/18
PLANNED CARE	STH	12 Lead ECGs – re-provision in the community	-100	Circulatory
		CASES - full year effect of existing 7 specialties	-600	
		Expansion of CASES beyond the existing 7 specialties	0	
		Disorders of the blood	-499	Blood
		Endometrial sampling (PIPELLE) - full year effect	-131	Gynaecology
		Heart Failure Nurses	0	Circulatory
		Managing first follow ups including consultant to consultant referrals	-474	
		Oraya Therapy - full year effect	-169	
		Primary Care pathology & lab transport services (EL)	-200	
		Procedures of Limited Clinical Value (PLVC)	-250	
		Promote the use of Biosimilar Drugs	-400	
		Respiratory Nurses	0	
		Service Review - CVD/Cardiology (EL)	-100	Circulatory
		Service Review - Gastroenterology (EL)	-250	
		Service Review - Gynaecology (EL)	-150	Gynaecology
		Service Reviews	-1,284	
		Expansion of Endoscopy Scheme - Bundling	0	
		Non F2F - Pay at National Tariff	0	
		Ophthalmology - Close loop under PEARs	0	
		Pre-op Assessment	0	
URGENT CARE	STH	Active Support & Recovery	-2,715	
		Care Co-ordination		
		Care Homes - based on national guidance (silver book)	-200	
		Dance to Health	-110	
		Improving self-care and managing long term conditions - Heart of Sheffield Model	-91	
		Mental Health Liaison Services - part year impact of service to be procured 17/18	-281	Mental Health

Must Do Area	Provider	SCCG QIPP Scheme	Revised Gross Savings 1718	RightCare Opportunity 2017/18
		Prevention Programmes		
		Prevention Programmes (EL)		
		Prevention Programmes (OP)		
		Reduce Number of Admissions - Assess to Admit	-1,054	
		Reduce Number of Excess Bed Days	-1,073	
		Respiratory – large scale change in community - implementation of Breathing Space type facility	0	
		Service Review - CVD/Cardiology (NEL)	-100	Circulatory
		Service Review - Gastroenterology (NEL)	-250	
		Service Review - Gynaecology (NEL)	-150	Gynaecology
		Social Prescribing		
		Targeted medication reviews - full year effect of service commenced in 2016-17	-150	
		Urgent Care Centre(s) - A&E		
		Urgent Care in Primary Care - A&E	-520	
		Urgent Care Strategy - Development of a local assessment rather than an admission tariff		
		Urgent Care Strategy - Reduction in conveyances in ambulance via YAS		
		Urgent Care Strategy - Reduction in excess bed days linked to discharge to assess		
		Urgent Care Strategy - Reduction in excess bed days linked to reversal of increase seen in 16/17		
CANCER	STH	Cancer Service Reviews - Elective Inpatients - per STP modelling	0	Cancer
		Other initiatives post right care review	0	Cancer
CHILD HEALTH	SCH	Care Co-ordination - Children	-87	
		Community Child Health: Allergy specialty review (links into Community Child Health redesign)	-42	
		Community Child Health: Reduce number of paediatric outpatient firsts	-44	
		Community Child Health: Reduce the number of tonsil removals	-97	
		Community Child Health: Reduction in Child Health outpatient follow-ups	-114	

Must Do Area	Provider	SCCG QIPP Scheme	Revised Gross Savings 1718	RightCare Opportunity 2017/18
		Community Child Health: Shift of non Sheffield costs/activity to other CCGs associated with community services	-352	
		OPAT Service Redesign - FYE of service commenced in 2016-17	-37	
		Respite Care	-50	
		Transformation Schemes	-556	Maternity & Neonates
		Urgent Care: Urgent Care Strategy for Child Health - Rapid Access Clinic	-121	
CONTINUING HEALTHCARE	CHC	BCF - Integrated Commissioning programme Ongoing Care	0	
		Children's Continuing Healthcare	0	
		Close a bungalow at Woodland View	-184	
		Complex Needs: Child Healths Continuing Care :Review in changing care packages	-100	
		Discharge to Assess	-250	
		Non Rehab Pathway	-966	
MENTAL HEALTH	SHSCT	Joint work with Local Authority - per STP modelling	-750	Mental Health
		Right Care - Mental Health - per STP modelling	-750	Mental Health
OTHER	IFR	IFR - in addition to above	0	Neurology
		IFR Brain Injury - working with with NHSE	0	Neurology
	Local Authority	Review use of sec 256 monies - Safeguarding Training	0	
	Other	Estates Rationalisation	-300	
		SBS Review of Spend		
PRESCRIBING	Prescribing	Disorders of the blood	-250	Blood
		Other medicines management efficiencies - these are current QIPP targets for future years - assume be some help from STP work stream	-1,600	
		Prescribing Stop Campaign	0	
		Rebates	-250	
		Target top 10 highest prescribers - Locality Managers to organise (leads PM, ZM) By end of August	-100	
PRIMARY CARE	Other	Interpreting Services	0	

Must Do Area	Provider	SCCG QIPP Scheme	Revised Gross Savings 1718	RightCare Opportunity 2017/18
AND COMMUNITY SERVICES	STH	ARC decommissioning	-500	
		AS&R - efficiencies from within community /intermediate care funding	-500	
		Block elements of STH contract - deep dive reviews	-200	
		Stroke pathway - review of pathway for rehabilitation patients	-499	Neurology
Grand Total			**-20,000**	**-4,617**